

**BUILDING TRUST AND DEVELOPING EFFECTIVE
SCHIP /MEDICAID OUTREACH TO IMMIGRATION CHILDREN
HIGHLIGHTS OF THE IMMIGRATION WORKSHOP
(CALIFORNIA, FLORIDA, ILLINOIS, NEW JERSEY,
NEW YORK, AND TEXAS)**

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EXECUTIVE SUMMARY

On June 9-10, 1999, HCFA sponsored an “**Immigration Workshop: Building Trust and Developing Effective SCHIP/Medicaid Outreach to Immigrant Children.**”

This was the **eighth in a series of Technical Advisory Panels (TAPs)** and included approximately 135 attendees from fifteen States (six of the States that represent 80 percent of the U.S. immigrant population and nine other interested States), the Immigration and Naturalization Service (INS), the Department of Agriculture (USDA), the Health Services and Resources Administration (HRSA), the Department of Health and Human Services (DHHS), and the Health Care Financing Administration (HCFA), as well as many advocacy and community-based organizations.

Below is a short description of the six panel topics discussed during the workshop:

- ◆ **Panel 1, Federal Regulation on Public Charge: Implications for SCHIP/Medicaid Enrollment**, included presentations by representatives from the INS, DHHS, and USDA. The INS presentation highlighted the public charge guidance published in the May 26, 1999 Federal Register; two documents were published in the Federal Register: INS field office guidance that took effect as of May 26, 1999 and proposed regulations for public charge with a 60 day comment period. The proposed public charge regulations do two important things:
 - ◇ Places all references (statutes, regulations, INS policy memos, State Department manuals) to public charge under a consolidated framework; and
 - ◇ Defines the term “Public Charge” for the first time as an alien who is “primarily dependent on the government for subsistence...”

Dependence is based on the following two criteria: 1) receipt of cash public assistance for income maintenance purposes; and 2) institutionalization for long term care. These criteria exclude non-cash benefits that are supplementary in nature, such as SCHIP, Medicaid, and Food Stamps. DHHS added that it has sent letters to grantees and State agencies to communicate the latest guidance and stressed that the biggest role will be played by State, local, and advocacy groups to get the word out to those affected by public charge. A representative of the USDA’s Food and Nutrition Service cited misunderstandings of public charge as one of the causative factors leading to a dramatic decline in Food Stamp Program recipients since the passage of the Welfare Reform Act in August 1996. A lively question and answer session followed the presentations and included clarification of the proposed public charge regulations and INS plans for dissemination, monitoring, and evaluation of the proposed public charge regulations. (See Chapter I for details.)

- ◆ **Panel 2, Cultural Diversity: Working Effectively with Ethnic Populations**, included presentations by Hispanic/Latino and Asian/Pacific Islander (A/PI) advocacy groups. An overview of access to health care for Hispanics was delivered, which included demographic statistics of this population and characteristics of the current health care system. For Hispanics/Latinos, low literacy in both their native language and English is a significant

barrier to enrollment in public health programs, which can be alleviated when State and/or county agencies place bilingual workers in the community.

The A/PI portion of the panel explored the vast diversity of this population noting the existence of over forty distinct sub-populations, each with its own culture, history, and language. An overview of relevant demographic statistics of this population was presented. It was noted that public charge fears have caused many patients of a local community health center to request that their medical records be deleted; other patients do not apply for public health programs because they believe they would not see a physician who spoke their language or understood their culture. Effective SCHIP outreach strategies for the A/PI population emphasized included the use of local service organizations, ethnic media sources, cultural events and holidays, and bilingual application assistance. A brief question and answer period followed the presentations that included dissemination methods to inform the immigrant population and reflecting immigrant populations in research samples. (See Chapter II for more details.)

- ◆ **Panel 3, Overcoming Barriers and Building Culturally Sensitive Strategies to Access Care for the Uninsured**, was broken into two sub-sessions. The first sub-session provided lessons for East Coast enrollment of immigrant children and included representatives from Florida and New York. A Florida door-to-door non-academic project, the Barriers Project, found that 85 percent of families surveyed were afraid to apply for Florida’s SCHIP, Florida KidCare, or Medicaid. During follow-up, the Barriers Project found that some 75-76 percent of respondents cited some form of barrier related to public charge, the INS, or documentation. Based on the results of the follow-up, Florida’s KidCare and Medicaid programs are implementing creative outreach approaches. A pilot project by the New York Task Force on Immigrant Health, working in collaboration with the New York Immigration Coalition, is being conducted to determine the best ways to facilitate and simplify the enrollment process for eligible immigrants’ children into SCHIP. Barriers to enrolling eligible immigrants’ children into SCHIP include:

- ◇ Fear of being reported to the INS (they would be jeopardizing their immigration status);
- ◇ Cultural barriers (managed care is a new and difficult concept to understand);
- ◇ Institutional barriers (too many procedures and processes to deal with once in the system, and discrimination and general poor treatment);
- ◇ Linguistic barriers (lack of available printed material at appropriate literacy levels and lack of interpreter services);
- ◇ Medicaid stigma (Medicaid is equated with “welfare” and government “handouts”); and
- ◇ Inaccessible and inconvenient enrollment office locations and hours.

Identified solutions to overcome these barriers included: the funding of community-based organizations to conduct SCHIP outreach and enrollment activities with the immigrant population; facilitated SCHIP/Medicaid enrollment process(es) that focus on community-driven initiatives; and changing Federal policy to simplify and clarify Medicaid eligibility requirements.

The second sub-session presented the West Coast lessons and had representatives from California and Arizona. Participants identified barriers to enrollment and current and future efforts to address and overcome these barriers. In addition to many of the barriers identified by the East Coast sub-session, a representative from an Arizona advocacy group noted that immigrants face the following barriers related to public charge:

- ◇ Families with at least one undocumented household member fear being deported, with such fears being fueled by personal experiences that are told throughout a community.
- ◇ Families have reported “leaving the welfare office in tears,” despite the helpfulness of individual welfare office staff. How families are treated, and the attitudes of welfare and office enrollment staff deter all eligible families, regardless of ethnicity, from applying.
- ◇ Family income can fluctuate widely from month to month, as individuals are often paid in cash or work seasonally. Families of difficulty producing pay stubs to prove their income levels when they are paid in cash. There is the added difficulty of keeping individuals enrolled in a program.

Representatives from California noted that California has a high rate of uninsured individuals; approximately 60 percent of whom are Latino and 24 percent of whom are Asian. For example, California’s immigrant population faces:

- ◇ Language barriers due to the diverse population—managed care organizations in the Los Angeles County must provide translation and interpretive services in Armenian, Cantonese, Cambodian, Korean, Russian, Spanish, Tagalog (a dialect of the Philippines), and Vietnamese.
- ◇ Negative past experiences, such as Proposition 187, linger.

To alleviate some of the barriers, the State of California has:

- ◇ Created a joint SCHIP and Medicaid application;
- ◇ Implemented a certified application process;
- ◇ Established a toll-free telephone line;
- ◇ Conducted an extensive multi-media (television, radio, and print) campaign;
- ◇ Worked to develop sponsorships with private industries; and
- ◇ Conducted school-based outreach activities.

Once more, there was an interesting and informative question and answer period that included clarification of Federal and State policy. (See Chapter III for more details.)

- ◆ **Panel 4, Successful Community-Based Enrollment Models**, opened with a reminder to Workshop attendees that ensuring linguistic access is the law under Section 601 of the Title VI of the Civil Rights Act. The first presentation highlighted the community-based enrollment model employed by the Border Vision Fronteriza Project (BVFP), an outreach program with the U.S.-Mexico border States of California, Arizona, New Mexico, and Texas. The BVFP uses assertive community-based outreach efforts to enroll immigrant children into health insurance programs and, once enrolled, to assist them in accessing services. A key to success is having a well-defined program that clearly outlines the role of the volunteer community health workers, training, supervision, and evaluation.

The next presentation highlighted the successes of two outreach models in California: a community-based model and a Promotores model. The community-based model uses multilingual outreach workers to conduct a variety of outreach activities in a culturally and linguistically competent manner. Outreach activities include providing SCHIP and Medicaid application assistance; making presentations; going door-to-door; following-up on scheduled visits; and making referrals. The Promotores Model uses local lay advisors to conduct outreach to enroll eligible children into children’s health insurance programs. Promotores are recruited from the communities they serve; they often have specific diseases/medical conditions, or they have family members with a specific disease/medical condition. Promotores receive weekly training sessions. Because the promotores have the trust of the community, and are culturally and linguistically competent, they are highly effective at assisting others to help themselves. The final presentation highlighted the strengths and successes of a community-based outreach effort in a Chinese community located in New York City. The speaker emphasized the critical importance of using word of mouth and ethnic media sources, such as radio programming, in reaching the Chinese population. The panel closed with a brief question and answer session. (See Chapter IV for more details.)

- ◆ **Panel 5, State Experiences/Challenges Enrolling Immigrant Populations**, involved presentations by the six invited States **California, Florida, Illinois, New Jersey, New York, and Texas**. These six States represent 80 percent of the nation’s immigrant population. Each invited State discussed the activities it has undertaken, the challenges encountered, and the solutions identified and/or implemented to enroll eligible children into SCHIP/Medicaid. (See Chapter V and Attachment II for further details.)
- ◆ **Panel 6, Plenary Session – Designing State Strategies**, involved dividing participants into five workgroups. Each group was assigned a facilitator to expedite the discussion process. Each group was instructed to identify key issues/information from the first day of panels and other sources relative to shaping a “problem statement” and challenges facing outreach/enrollment of multi-cultural populations. Common themes that were raised by the five groups included:
 - ◇ Collaboration and coordination,
 - ◇ Policy clarifications,
 - ◇ Simplification,
 - ◇ Training,
 - ◇ Partnerships,
 - ◇ Data, and
 - ◇ Alternative Innovations.

The session concluded with a brief question and answer session. (See Chapter VI for more details.)

The reader is encouraged to read those accounts that may assist you in reaching out to your specific constituents.

INTRODUCTION

The co-chairs of the Immigration Workshop, Dr. Lillian Gibbons, from the Health Care Financing Administration (HCFA), and Ms. Carol Galaty, from the Health Resources and Services Administration (HRSA), opened the Workshop by thanking participants for attending (see **Attachment 1** for a listing of participants) and noting their appreciation for the evolving partnership between HCFA, HRSA, State Children’s Health Insurance Program (SCHIP)/Medicaid administrators, and children/immigrant advocates. The public charge issue surfaced repeatedly in Technical Advisory Panels hosted by HCFA and HRSA during the past year as an obstacle to SCHIP/Medicaid outreach and enrollment efforts, resulting in this Workshop that focuses on SCHIP/Medicaid outreach and enrollment to immigrant children. Representatives from **California, Florida, Illinois, New Jersey, New York, and Texas** were formally invited to attend the Workshop as these six States represent 80 percent of the nation’s immigrant population.

Ms. Rachel Block, *Deputy Director of the Center for Medicaid and State Operations at HCFA*, welcomed Workshop participants and noted that HCFA, as an agency, wants to provide the forum for continued State/Federal collaboration in reaching SCHIP goals and dealing with the challenges posed by SCHIP legislation. From a historical perspective, Medicaid is an effective program that, after three decades of service, has provided health care services to millions of individuals who might not have otherwise received these services. Now, as a result of the enactment of SCHIP legislation, combined with the flexibility of State implementation, there is an extraordinary opportunity to get health care services to children in need. At the same time, to ensure continued funding, it is imperative that SCHIP/Medicaid enroll those children for which these programs were created, sustain their enrollment, and assure their access to needed health care services.

Dr. Peter Van Dyck, *Associate Administrator for Maternal and Child Health at HRSA*, welcomed Workshop participants. HRSA works to assure access for underserved populations, including culturally diverse immigrants, through a broad spectrum of health programs. This Workshop provides a forum to exchange ideas on how to work more effectively to reach and serve eligible immigrant families. State Medicaid programs have seen a net decrease of enrolled children. This decrease places a strain on HRSA funded programs; State MCH programs reported that in the last two years they have seen a 70 percent increase in the number of children served, from 11 million to 19 million. Many of these children are eligible for SCHIP or Medicaid. Clearly stating that immigrant participation in SCHIP and Medicaid is exempt from public charge considerations should help reduce the negative enrollment trend.

**CHAPTER I:
FEDERAL REGULATION ON PUBLIC CHARGE: IMPLICATIONS FOR
SCHIP/MEDICAID ENROLLMENT-
PERSPECTIVES FROM THE INS, DHHS, AND USDA**

Mr. Marty Svolos, *Director, Division of Eligibility, Enrollment and Outreach, Families and Children Health Programs Group, Center for Medicaid and State Operations at HCFA*, served as the moderator for the Workshop panel discussing “Federal Regulation on Public Charge: Implications for SCHIP/Medicaid Enrollment.”

INS Perspective

Ms. Barbara Strack, *Special Assistant to the Executive Associate Commissioner of the Office of Policy and Planning at the Immigration and Naturalization Service*, thanked HCFA and HRSA for the opportunity to address the issue of public charge with Workshop attendees. On May 26, 1999, the Immigration and Naturalization Service (INS) published in the Federal Register two documents: INS field office guidelines, which take effect immediately, and proposed regulations for public charge that have a 60-day public comment period. Because State officials and advocacy groups must deal with the implications, and any perceived limitations, of the final rules, Ms. Strack encouraged interested parties to submit their comments and interpretations. The proposed public charge regulations are the result of representatives from the U.S. Department of Health and Human Services (DHHS), the U.S. Department of Agriculture (USDA), State programs, and advocacy groups working effectively with the INS to clarify policy and technical matters, as well as the potential impacts on other Federal programs.

The proposed regulations put all references to public charge under a consolidated framework; in the past, public charge rules were scattered among a number of sources—including in statutes, regulations, INS policy memos (not readily available to the public), and State Department manuals. More importantly, the term ‘public charge’ is defined in regulations for the first time. Although the term ‘public charge’ has been in use in immigration law for the past 100 years, the term has been undefined and ambiguous. Public charge is defined in the proposed regulations as:

An alien who is “primarily dependent on the government for subsistence...”

Having defined public charge, the INS worked closely with benefit granting agencies to define what kinds of evidence constitute subsistence/dependence. Dependence is based on the following two criteria, which exclude non-cash benefits that are supplementary in nature (such as SCHIP, Medicaid, and Food Stamps):

1. Receipt of cash public assistance for income maintenance purposes; and
2. Institutionalization for long term care.

Other issues related to public charge that have been clarified in the proposed regulations include:

- ◆ **Fraud.** If there is fraudulent receipt of benefits, the person remains liable and could be subject to deportation.

- ◆ **Attribution of Benefits.** Generally, there is no attribution of benefits received by one family member to another family member for public charge purposes, with the exception of cash benefits that constitute the sole support of the family.
- ◆ **Naturalization.** There is no public charge test for naturalization.
- ◆ **Sponsorship.** There is no public charge test for sponsoring a relative to come to the U.S., although there is an income test. To support an alien, a sponsor must be able to demonstrate that he/she can support the sponsored alien at 125 percent of the Federal Poverty Level (FPL). In the context of sponsorship, the INS considers whether the alien proposed for sponsorship is likely to become a public charge.
- ◆ **Receipt of Non-Cash Benefits.** Receipt of non-cash benefits and special-purpose cash benefits that are not intended for income maintenance are not subject to public charge consideration, including, but not limited to: SCHIP, Medicaid, Food Stamps, or the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).
- ◆ **Receipt of Cash Benefits for Income Maintenance.** Receipt of a cash benefit in the past, such as Supplemental Security Income (SSI), does not make a recipient, per se, likely to become a public charge and, therefore, likely to be deported as a public charge.
 - ◇ For admission and adjustment purposes for becoming a lawful resident, the INS and State Department prospectively apply a “totality of circumstances” test. The fact that SSI benefits were received in the past is not necessarily predictive of a person’s likely dependence on the government in the future (such as, the person could now be gainfully employed, or married with a family member who could support him/her).
 - ◇ Receipt of cash benefits is considered in conjunction with other relevant variables, such as age, health status, income, family size, educational level, and skills. Actual public charge deportations are infrequent due to the strict standards that are in place.

INS has held conference calls with INS field offices prior to release of the field guidance and proposed regulations. In July-September 1999, training meetings were conducted in selected cities with large immigrant populations, including Los Angeles, San Francisco, Chicago, and New York City, with INS field staff and other interested groups. The training curriculum addressed the proposed public charge rules and other issues related to the adjudication of immigration applications. INS has also developed fact sheets and “Qs and As,” which are available at the INS web site in English and Spanish (www.ins.usdoj.gov/graphics/publicaffairs/ – once at the address select “Public Information” on the left and then “public charge” from the alphabetical listing).

DHHS Perspective

Mr. David Nielsen, *Senior Policy Analyst in Office of the Assistant Secretary for Planning and Evaluation at DHHS*, commended HCFA for taking a strong lead in convening this Workshop to enable participants to understand the proposed public charge regulations and to have an opportunity to identify challenges that remain. With the public release of the proposed public charge regulations, where do DHHS and other agencies go from here?

- ◆ DHHS has made a conscious effort to communicate the new policy, through letters, to all of its grantees and State agencies. This effort has been successful, as most of the State agencies have posted the proposed regulations on their web sites. Other agencies within DHHS are likely to conduct special outreach efforts.
- ◆ A significant role needs to be undertaken by State and local agencies, provider groups, and advocacy groups in communicating the public charge regulations to families and communities affected (or believe they are affected) by public charge.
- ◆ Feedback on the proposed regulations is essential. The sooner implementation problems are uncovered and communicated back to the Federal government, the sooner effective interventions or modifications can be developed.

The proposed regulations, as written, will generate questions and comments that will require further clarifications, such as what does it mean operationally to be institutionalized for long term care? Additionally, while the public charge guidelines are clear that a benefit must be cash assistance for income maintenance purposes, there may be confusion in how such benefits are defined, in part because of the different names a program can be called from one State to another. As an example, while childcare services may be a benefit delivered in cash form, it is excluded from the public charge test. While DHHS is assured that health services are available to immigrant families without fear of deportation, it is concerned by the decline in Medicaid participation, particularly at the time of redetermination. DHHS is currently trying to better understand the phenomenon of declining Medicaid enrollment and the degree to which such factors as rising incomes, the effects of welfare reform, and the effects of public charge are affecting SCHIP/Medicaid participation.

Food and Nutrition Service of the Department of Agriculture Perspective

Mr. Art Folley, *Director of the Program Development Division with the Food and Nutrition Service of the USDA*, addressed the Food Stamp program and its relationship to SCHIP/Medicaid and immigrants. Over the past five consecutive years, USDA has witnessed declining enrollment in the Food Stamp program. Looking to SCHIP/Medicaid as role models, USDA is changing its culture to be less focused on enforcement and more focused on access and enrollment.

In terms of access and enrollment, the Food Stamp program presents some problems for immigrants. The Welfare Reform Law, enacted in August of 1996, made most legal immigrants ineligible for food stamps. In 1998 legislation was passed that enabled refugees, and those seeking asylum, to have Food Stamp coverage for seven years (broadened from five years); the same legislation expanded Food Stamp coverage for immigrant children, the elderly, and the disabled who were in the U.S. by August of 1996. At the time the welfare reform legislation was enacted, the USDA discovered that, in spite of the number of households affected by the welfare reform legislation, there remained eligible people in the household—typically a citizen child in the household of immigrant parents. Since then, the participation of children in households with immigrant parents has declined by over 430,000 cases. This represents a 37 percent drop in participation in the Food Stamp program of families with immigrant parents, compared to a 15 percent drop in participation by those families with citizen parents. Multiple explanations can probably explain this drop, including the public charge issue. For instance, there is an assumption

that if the parent is ineligible for Food Stamps, their child is also ineligible—this assumption is incorrect and such misconceptions need to be corrected.

Questions and Answers

A ‘Q & A’ session followed the panel presentation. For ease of reference, we have restated the questions and condensed responses as follows:

Q: *What constitutes “institutionalization” eligibility for low birth-weight infants that may require long-term care?*

A: A child born in the U.S. is a U.S. citizen and the public charge issue does not arise. On the other hand, a low-birth weight infant coming to the U.S. to receive medical care for his/her condition would have to be evaluated. The new public charge guidance does specifically indicate that shorter stays for rehabilitation purposes are not considered as long-term care for institutionalization, such as a stay in a skilled nursing facility following surgery. Regarding “institutionalization” the proposed guidelines purposefully:

- ◆ Do not define the type of facility, such as an acute care hospital, rehabilitation facility, a nursing home, or a long-term facility. The focus of institutionalization is on the person, not on the type of building.
- ◆ Do not define a specific time frame constituting long term care as INS and State Department consular officers should not be put into a position of making medical judgments.

Public charge deportations have been rare, with three or fewer cases occurring per year in the past thirty years.¹

Q: *Does the INS have any plans to monitor and evaluate that the written guidance is being properly implemented in the field?*

A: The proposed rules are clearer now—the benefits that can be considered for public charge are SSI, TANF, State general assistance, and institutionalization. Field staff do have to consider additional considerations that are in the statute, including age, health, income, family size, education, and skills.

The INS indicated that it is in the process of developing effective means by which to disseminate the new public charge guidance. The INS, in conjunction with disseminating the written materials, held conference calls with all of its field offices and has contracted with the National Council of State Legislatures for assistance in the effective communication of the new

¹ There are numerous protections, as well as a legal requirement, that must be met for public charge deportations:

- ◆ The alien has to have become a public charge in the first five years he/she is in the U.S.
- ◆ There has to be a right to demand repayment for the government cost.
- ◆ The benefit-granting agency (the agency providing the benefit) has to demand repayment for the costs.
- ◆ There has to be failure to meet the demand for repayment.
- ◆ There has to be a final legal judgement from a court for the repayment.
- ◆ All required collection steps have to have been taken.
- ◆ Lastly, the alien can provide a defense that the reason for receiving cash assistance for income maintenance or being institutionalized arose after the alien arrived in the U.S.

public charge policies. If there are implementation problems at the local level, and inevitably there are, States and advocates should contact their local INS contacts, such as an INS District Director, an INS Port Director, or an Assistant District Director for Examinations, to discuss identified issues so that corrective action can be taken.

The INS guidance does not promise that any individual is not going to be found likely to be a public charge. Rather, the INS guidance tries to promise that the use of SCHIP or Medicaid will not be used against an individual—immigrant families should enroll their children to receive health care services.

Q: *What type of monitoring will occur with Consulate Posts?*

A: On the same day the INS published the field guidance and the proposed regulations in the Federal Register, the State Department wired the information, adopting the same standards effective immediately, to its consular posts. The State Department does not anticipate any special monitoring of the implementation of the new guidelines outside of its established procedures. The new guidelines are incorporated into their manuals and training materials.

Q: *What consideration does “good moral character,” in terms of the use of public benefits, play in Naturalization?*

A: The INS has field guidance in place, issued in December 1997, regarding naturalization and good moral character that outlines that legitimate use of public benefits for which an alien is qualified is not evidence of lack of good moral character. The caveat is if benefits were obtained fraudulently, which would be considered in determining good moral character. The public charge regulations are consistent with the December 1997 field guidance.

Q: *How would a self-petitioner, under the Violence Against Women Act (VAWA), or a recent resident who is a survivor of domestic violence, be affected by the use of public cash benefits for herself and her children?*

A: The field guidance and the proposed regulations do not address the issue of self-petitioners under the VAWA or battered women as the Department of Justice is in the process of discussing this further. Self-petitioners are exempt from the affidavit of support but it is not as clear at this time if they are also exempt from public charge generally. There is legislation currently under consideration to extend the VAWA to exempt specifically self-petitioners from public charge.

Q: *Please clarify the affidavit of support for newly immigrated legal children entering the U.S.*

A: The guidance on the general issue of affidavit of support is clear in respect to the receipt of health care services—the receipt of health care services does not affect a sponsor’s ability to sponsor someone entering the U.S. New immigrants entering the U.S. under the new affidavits of support, effective December 1997, are currently ineligible from receiving Federal means-tested programs for the first five years they are in the U.S. There is sponsored alien deeming in place until these individuals become citizens or obtain forty quarters of coverage.

The Federal government does not have control of State determined benefits, such as whether or not a State institutes deeming, its benefit eligibility rules, or its repayment requests. The Clinton administration has proposed legislation that would restore SCHIP/Medicaid eligibility to pregnant women and children entering the U.S. after 1996, as well as waiving the requirements of affidavit of support and deeming for these cases.

Q: Are there guidelines for adjudicators to follow that will help ensure eligibility questions are asked in an appropriate manner?

A: In general, the INS does not give instructions to its field offices on what questions to ask and how to ask those questions. Outside of the area of asylum, the INS does not “script” inspectors or adjudicators—a question that may be inappropriate as the first question may be appropriate as the tenth question.

A Workshop attendee suggested that INS officers could ask questions in a manner that does not key to an immigrant’s receipt of a public benefit. For instance, rather than asking about receipt of particular benefits, an INS officer could ask “what is your family income and how are you supporting yourself?” Regarding an immigrant’s health status, an INS officer could ask “what are your health problems?”

Q: What plans does the INS have for the dissemination of “official” information to immigrants, such as “Q and A” materials and/or “Fact Sheets” in additional languages on INS letterhead or through public service announcements?

A: At the time of the Workshop, the INS had no concrete plans to publish a public charge “Q and A” or fact sheet in languages other than English and Spanish. The INS, as part of the government, is hesitant about making definitive statements without all of the accompanying caveats—a “Fact Sheet” needs to be precise and legally defensible.

Several members of Congress, including California representatives, have indicated a willingness to participate in a public service announcement. The INS is aware that immigrant populations place a great deal of trust in official messages conveyed by INS, such as on the INS letterhead. The INS is open to suggestions from States, community-based organizations, and advocacy groups on effective methods for communicating to immigrants that the public charge guidance is official INS policy—that the INS means it and immigrants can rely on it.

IMPORTANT UPDATE: Subsequent to the Workshop, the INS issued a one page (front and back) flyer, on INS letterhead, in English and Spanish. The flyer is available on the INS web site (www.ins.usdoj.gov/graphics/publicaffairs/presinfo – once at the address select “public charge”). In addition, the longer fact sheet and “Q & A” are available in four Asian languages, Chinese, Korean, Vietnamese, and Thai.

Q: Can the INS educational tour to targeted cities be expanded and can information be forwarded to community-based organizations for their participation?

A: The INS is open to the idea of expanding the number of presentations. Typically, the INS educational workshops, run by staff from INS headquarters, are a day and a half. The first day is in-house training to field staff that addresses a broad array of issues, one of which is public charge. This is usually followed by a half-day session that is open to other interested community groups. The INS will make every effort to notify national advocacy groups of the educational tours so that they can inform their affiliates. The INS also works with its network of Community Relation Officers as these individuals have a good sense of the community-based organizations (CBOs) in their cities.

Q: Does the use of non-cash benefits by a sponsoring family impact the income determination for sponsorship?

A: The use of non-cash benefits by a sponsoring family **does not** impact the income determination for sponsorship.

Q: Please provide clarification on how the criteria for sponsor deeming should be applied (addressed to HCFA from a State attendee).

A: DHHS acknowledged that this is important issue and various options are currently under review. The strictness of deeming is more a legislative issue than a guidance issue. While the Federal government has given States guidance on what is a Federal means-tested program, guidance has not been given, nor will be given, on what is a State means-tested program and what the eligibility rules should be. State-funded programs are a State and local concern, and individuals should work with their State legislators to resolve any barriers.

Q: Please clarify if any cooperative projects are currently occurring between State Medicaid Fraud Units and INS enforcement agencies? Has HCFA communicated with its State Medicaid Fraud Units about what constitutes proper cooperation and reporting with the INS?

A: DHHS noted that most of this type of collaboration between State Medicaid Fraud Units and INS enforcement agencies has been curtailed (for instance the most recent DHHS State auditor report from one State noted the discontinuation of such a program). HCFA’s policy is that any information collected by the State can only be released for purposes directly connected to the administration of a State’s Medicaid program, which has been clarified in a “Dear State Medicaid Director” letter.

DHSS is preparing guidance regarding the quarterly reporting requirements of State TANF agencies, SSI agencies, and housing authorities. The INS, in December 1997, issued guidance clarifying that it is not the role of INS to seek repayment for benefits.

Q: There have been scattered, undocumented, reports in one State of INS “stake-outs” at State eligibility offices, schools, and churches looking for undocumented aliens. What is the INS policy on this?

A: Historically, in terms of INS enforcement activity, leads generated by use of, or application for, public benefits have not been a priority--nor is this contemplated as a priority now or in the future. While INS panelists were unaware of “stake-outs” occurring by INS agents, it was noted that the INS has given clear guidance that INS officers do not belong in such places as schools or churches. It was reiterated that activities of concern should be discussed with local INS contacts for resolution.

Q: Undocumented individuals can receive Medicaid for emergency services in a State. What impact would receipt of such services have upon the individual when he/she applied to change their immigrant status to legal citizen?

A: INS representatives noted that this would have **no impact** as the individual would not be receiving cash for income maintenance purposes nor being institutionalized.

CHAPTER II: CULTURAL DIVERSITY: WORKING EFFECTIVELY WITH ETHNIC POPULATIONS-PERSPECTIVES OF THE HISPANIC/LATINO AND ASIAN/PACIFIC ISLANDER COMMUNITIES

The second Workshop panel, “Cultural Diversity-Working Effectively with Ethnic Populations,” was co-chaired by Dr. Lillian Gibbons and Ms. Carol Galaty. Workshop attendees heard from panelists regarding their perspectives on the cultural characteristics of the Hispanic/Latino and Asian/Pacific Islander populations.

Hispanic/Latino Perspective

Dr. Cristóbal Berry-Cabán, *President of the National Institute of Managed Care, Inc.*, provided an overview of the factors affecting Hispanics² and their access to the health care system in the U.S.

Barriers to Access for the Hispanic Population. The scientific and medical literature has discussed the barriers Hispanics face in accessing health care services in the U.S. since the 1950s—the same barriers to access that exist today. Dr. Berry-Cabán has conducted research, using an Access Model³ of interrelated components. Through the application of the Access Model, entry into the health care system by the Hispanic population is characterized and classified by three characteristics:

- ◆ **Predisposing** factors (the biological or social factors that can either facilitate or inhibit Hispanics from using the health care system);
- ◆ **Enabling** factors (factors that describe the resources available to Hispanics to access the health care system, such as convenience, type of regular source of medical care, type/extent of health insurance, and geographic location); and
- ◆ **Need** factors (illness indicators that are the strongest predictors of health care needs, such as self-perceived health status).

These three characteristics are considered in relation to the structural characteristics of the health care delivery system, including the access and availability of health facilities, the staffing composition of the health facility, and the organization of health care services. Lastly, the outcome component of the Access Model indicates the level and patterns of use of health services by Hispanics and the attitudes of Hispanics toward the health care delivery system. Dr. Berry-Cabán indicated that the Access Model does not include legal impediments to the receipt of health care services by Hispanics and noted that he has found few references in the literature that discuss public charge and how it serves as an impediment to accessing the health care system—while such barriers may exist, they are not referenced in professional journals.

² The terms Hispanic and Latino were used interchangeably.

³ The Access Model used in the analysis was developed at the University of Chicago by Andersen (1968) and expanded by Aday and others over the years (Aday & Andersen, 1980; Aday et al. 1998).

Selected Characteristics of the Hispanic Population. Dr. Berry-Cabán, using an Access Model, highlighted selected characteristics of the Hispanic population and how these characteristics impact their access to health care services.

- ◆ The Hispanic population is young, with an average age of 23. Thirty-seven percent of the Hispanic population is 18 years of age or younger (March 1997 Current Population Survey).
 - ◇ Understanding the age factor provides an indication of the types of health services most needed, such as prenatal and pediatric care.
- ◆ Fifty (50) percent of all Hispanics do not finish high school.
 - ◇ Low literacy impacts the types of written SCHIP/Medicaid materials produced, such as the need to be at the fourth or fifth grade reading level.
 - ◇ Dr. Berry-Cabán noted a project he recently completed to develop a prescription registration card for use by Hispanic women that includes homeopathic/folk remedies that enables their pharmacist to minimize adverse drug interactions.
- ◆ The younger age distribution, lower education levels, and lower labor participation rates of Hispanics are reflected in lower income rates for the Hispanic population.
- ◆ The Hispanic population has a tremendous growth rate within the U.S., with Census estimates of Hispanics comprising the largest minority group within the U.S. by 2020-2030. Factors contributing to the growth rate of Hispanics in the U.S. include a constant migration of new immigrant groups entering the U.S. and the demand for labor resulting from a strong U.S. economy.

A Community Perspective-Hispanic Apostolate

Evelyn Reyes, *Administrative Assistant to the Director of the Hispanic Apostolate-Catholic Charities*,⁴ presented her observations in assisting Hispanic immigrants and her impressions of where outreach assistance is needed and why.

- ◆ **Language Barrier.** Many of Hispanic Apostolate immigrant clients have difficulty understanding English; some are immigrants coming to the U.S. from small villages and towns in their own countries, with low education levels, who have difficulty understanding Spanish. Even though they may receive a SCHIP/Medicaid application in Spanish, they cannot read it.
 - ◇ Clients of Hispanic Apostolate have difficulty understanding the difference between being eligible for Medicaid and being eligible for welfare benefits and are fearful of obtaining health care services because of their immigration status.
- ◆ **Application Process.** There are instances when Hispanic Apostolate’s clients, after applying for SCHIP/Medicaid or other social services, do not receive a response from the State indicating the receipt or status of the application. Hispanic Apostolate encourages their

⁴ The Hispanic Apostolate is a non-profit organization that provides pastoral, social, and educational services to Hispanics and other immigrants to facilitate their integration into the American culture.

clients, although they may be afraid, to re-apply for services until they hear from the State; Ms. Reyes indicated that this typically results in the immigrant receiving needed services.

- ◆ **Appropriate Bilingual Staffing/Community Outreach.** Ms. Reyes noted the presence of three bilingual individuals within a local Department of Health that conduct outreach directly in the community, such as through a monthly visit made in a mobile van in front of Hispanic Apostolate’s office. Members of the community trust these workers and go to them for assistance in accessing health care benefits for their children, such as free immunizations and enrolling into SCHIP/Medicaid, and other social services. Ms. Reyes noted that the outreach approach of bilingual Department of Health staff coming to the community has been successful as many of Hispanic Apostolate’s clients have received the benefits to which they are entitled.

Asian/Pacific Islander Perspective

Mr. Dong Suh, *Policy Analyst with the Asian & Pacific Islander American Health Forum*,⁵ began by stressing the **diversity** of the Asian and Pacific Islander⁶ (A/PI) population, noting that A/PI, as a label, represents about half of the world population. The A/PI population includes over forty distinct sub-populations, each with its own culture, history, and language, and is largely foreign-born (two-thirds of the A/PI population). A/PIs, as a population, have widely varying socio-economic status and health status. For instance:

- ◆ In terms of education, the A/PI population has the highest percentage of individuals with a college education or more; conversely, the A/PI population has the highest percentage of individuals with less than five years of education.
- ◆ In terms of health status, Mr. Suh noted:
 - ◇ In California, Asian Americans have the second highest rate of appropriate immunizations by age two, whereas Southeast Asians have the lowest level of appropriate immunizations by age two.
 - ◇ In California, during a measles outbreak several years ago, 29 percent of measles deaths were from Cambodian, Laotian, Hmong, and Samoan groups although they represent less than 1 percent of the California population.
 - ◇ In Minnesota, half of the children who contracted measles were Hmong and they represent less than 1 percent of the Minnesota population.
- ◆ In terms of median age, Japanese Americans have one of the highest median ages, while the median age for Hmong in 1990 was eleven (resulting in over half of the Hmong population being aged eleven or younger).

Geographic Location of the A/PI Population. Eighty percent of the A/PI population in the U.S. in 1990 lived in ten states: California (39.1 percent); New York (9.5 percent); Hawaii

⁵ Asian & Pacific Islander American Health Forum is a national advisory organization dedicated to promoting policy, program, and research efforts for the improvement of the health status of all Asian and Pacific Islander Americans.

⁶ In 1997, OMB divided Asian and Pacific Islanders race categories into two race categories: Asian Americans and Pacific Islanders.

(9.4 percent); Texas (4.4 percent); Illinois (3.9 percent); New Jersey (3.7 percent); Washington (2.9 percent); Virginia (2.2 percent); Florida (2.1 percent); and Massachusetts (2.0 percent). There has also been a growth of the A/PI population in areas outside of these ten states, including a growth in the South, particularly in Georgia, as well as a concentration of Hmongs living in Minnesota and Wisconsin.

Percent of Legal Permanent Residents Among the A/PI Population. The A/PI populations in the U.S. with the highest percentage of legal permanent residents (not yet citizens) in 1990 included: Laotian (66.1 percent); Cambodian (65 percent); Hmong (60.4 percent); Asian Indian (51.5 percent); and Thai (50.6 percent). The A/PI populations in the U.S. with the lowest percentage of legal permanent residents in 1990 included: Hawaiian (0.7 percent); Guamanian (8.3 percent); and Samoan (11 percent).

Percent of the A/PI Population That Do Not Speak English “Very Well”/Limited English Proficiency. Overall, 40 percent of the A/PI population does not speak English “very well.” However, there is tremendous variation among A/PI sub-populations, from 76 percent of Hmongs to 51 percent of Chinese to 30 percent of Pakistanis to 24 percent of Asian Indians.

Cultural and linguistic competency is key not only for outreach but also to the provision of health care services by health care professionals.

Medicaid and Insurance Health Coverage. According to 1992 data, 9.6 percent of the A/PI population was enrolled in Medicaid for thirty-two months; however 16 percent were enrolled in Medicaid from one to thirty-two months. This difference can be attributed to women accessing Medicaid while they are pregnant. Overall, according to 1997 data, about 20 percent of the A/PI population was uninsured; among children, 15 percent were uninsured, increasing to 20 percent among poor children.

Use of Services. In concluding his discussion, Mr. Suh discussed a telephone survey conducted by the Commonwealth Fund in New York to assess health care behaviors and utilization. The results of the survey showed that among race groups, the A/PI (specifically, Chinese, Korean, and Vietnamese) had the lowest level of utilization of preventive services and, at the same time, had the lowest levels of satisfaction when they received services. These are key issues that State agencies need to be cognizant of when enrolling and providing services to the A/PI population. Mr. Suh also noted President Clinton’s signing of an executive order, number 13125 signed June 7, 1999, that created the President’s Advisory Commission on Asian Americans and Pacific Islanders, as well as a DHHS interagency working group.⁷

A Community Perspective-Asian Health Services

Ms. Lisa Hasegawa, with HRSA but at the time of the Workshop was on assignment with the Asian Health Services (AHS)⁸ as part of an initiative called *Community Voices for Immigrant*

⁷ Ms. Shamina Singh has been named executive director of the White House Initiative on Asian Americans and Pacific Islanders.

⁸ Asian Health Services is a federally funded community health center in Oakland, California. The Community Voices for Immigrant Health project, which Asian Health Services is conducting in partnership with another

Health, began by noting that AHS has a twenty-five year history of working with a diverse A/PI population and in determining effective outreach methods. Ms. Hasegawa described AHS’ clients, highlighting why outreach can be challenging:

- ◆ On a somewhat regular basis, clients are demanding, without specific justification, that AHS delete any evidence that they have used the clinic. Their fear in accessing services goes beyond their use of SCHIP/Medicaid—clients know that AHS receives government funding and they do not want to take any chances in jeopardizing their immigrant status. Clients also believe that there is a stigma in receiving public assistance. Finally, clients are frustrated by the lack of culturally and linguistically appropriate providers available, and by not having the health care services they want, such as alternative therapies, covered.
- ◆ The A/PI population in California is more likely to work in small firms that are less likely to provide health insurance; indeed, the A/PI population in California has the second highest rate of being uninsured, particularly among Southeast Asians, Chinese, Koreans, and Filipinos. Relative to other ethnic populations, the number of uninsured is increasing among the A/PI population at a higher rate—in part because Medicaid enrollment is decreasing while job-based health insurance is not increasing.

Effective Outreach Strategies. Ms. Hasegawa then provided Workshop attendees with outreach strategies that have been effective in reaching the diverse A/PI population. It should be noted that these outreach strategies can be used to reach any ethnic population.

- ◆ **Local Service Organizations.** Within almost every A/PI community throughout the U.S., there is a community-based service organization or program that works with the A/PI community, such as tutoring and ethnic dance classes for youths. *It is important to work with each community to determine the most effective outreach strategies for that particular community.*
- ◆ **Ethnic Media.** Working with ethnic media (television, radio, and newspapers) is an effective outreach strategy, as limited distribution does not translate into a limited audience. For example, many individuals often read a single copy of an ethnic newspaper.
 - ◇ **Radio.** Focus groups run by AHS to determine where clients find their health information found the most frequent source of information was Chinese radio stations. This can be extrapolated to other groups—Hmongs in Fresno, California share the information they hear on the radio with family and friends living in Minnesota.
- ◆ **Cultural Events and Holidays.** Outreach events can be timed with celebrated holidays. For example, the Lunar New Year, which takes place in January or February each year, is an important holiday for Chinese, Korean, and Vietnamese communities and is celebrated with fairs and festivals.
- ◆ **Application Assistance.** AHS has several bilingual certified application assistants. While linguistically appropriate outreach materials are important, AHS focus groups have found

organization, is part of the Kellogg Foundation’s initiative to improve access to health care for the under-served and is the only project of 13 that focuses specifically on improving immigrants’ access to health care services. For more information, please contact Linda Okahara at 510-986-6830.

that the availability of a bilingual eligibility worker providing assistance in a client’s native language is more important. Even though a State may not receive any completed translated applications this does not mean that the translated applications are not reaching a community. For example, AHS’ clients work with AHS’ eligibility workers and translators, who complete the applications in English.

- ◇ A representative of the California agency administering the Healthy Families Program (HFP), California’s SCHIP, requested that applicants use the appropriate translated application (which is available in ten languages besides English and Spanish) as subsequent mailings are sent based on the language of the completed application. In addition, California maintains statistical data on the volume of translated applications being used and delete/add languages based on need. An individual can indicate on the English version of the application his/her primary language—the issue is that this question is often not completed.
- ◇ It is imperative that community-based health advisors/workers and eligibility workers who interact daily with communities be kept informed of Federal and State policy developments that impact their communities as they are seen as a trusted source of accurate information. Established networks can be useful in disseminating information, such as the network of community organizations participating in the National Community Health Advisor Study.
- ◆ **Data on Primary Languages and Ethnicity.** In California, the agency administering HFP collects data on enrollees’ primary language and ethnicity by A/PI subgroup. This information has been extremely useful to AHS in tracking the effectiveness of its community-based outreach strategies relative to Alameda County. For instance, in Los Angeles, Korean applications for the HFP could be tracked to the door-to-door efforts of a particular CBO.

In closing, Ms. Hasegawa noted a George Washington University finding that the dissemination of culturally and linguistically appropriate outreach materials may have only a modest impact in actual enrollment if not accompanied by culturally and linguistically appropriate services at all points of contact, from translators and interpreters to face-to-face enrollment assistance in their native language from competent providers in health plan panels.

Questions and Answers

A ‘Q & A’ session followed the panel presentation. For ease of reference we have restated the questions and condensed the responses as follows.

Q: *What are some of the ways that the proposed rules for public charge can be disseminated to immigrants, some of whom cannot read?*

A: Panelists suggested the use of ethnic media, particularly radio, and community health advisors/workers as effective dissemination methods.

Q: *Why is there such disparity in enrollment statistics between Hispanics and A/PIs in California’s HFP given the size of the respective eligible populations?*

A: In California, the public charge issue disproportionately affects the Hispanic population because of the larger number of undocumented people. However, the public charge issue, including confusion about sponsorship and deeming, is of high concern for the A/PI population. Several CBOs working the A/PI population voluntarily offered aggressive outreach and enrollment assistance in the population’s primary, native language.

Q: *How can one counter the exclusion of the A/PI population in research samples (which tend to focus on Caucasians, African Americans, and Hispanics)? Please provide examples of the most important questions to be asked regarding health care access by the A/PI population.*

A: In conducting research, the bottom line is funding. For example, the study conducted by the Commonwealth Fund was a national, random survey targeted at Caucasians, African Americans, and Latinos. The survey, because of the small sample size of Koreans and Vietnamese, used surnames and targeted States with the highest Korean/Vietnamese populations; it was not financially feasible to incorporate the entire A/PI population. Consequently, the Asian & Pacific Islander American Health Forum advocates for the conduct of regional studies that are manageable in size to build a base for the conduct of a national survey in the future.

Another panelist noted that a general perception held by researchers is that the A/PI population does not have the same level of problems that affect African Americans or Hispanics. For example, Asians have a lower mortality rate from traffic fatalities compared to other ethnic groups, although Hmongs account for a higher proportion of car fatalities compared to the overall Asian population. There is a tendency in research to lump distinct sub-populations into broad categories—the challenge for researchers is to disaggregate data.

In response to the type of research questions that could be asked, Ms. Hasegawa noted the following:

- ◆ Assessing the A/PI population’s attitude towards health insurance and understanding of the health care delivery systems, as well as the barriers, besides cost, of small businesses providing health insurance for their employees;
- ◆ Assessing the level of confusion or clarity on the public charge issue among the general refugee population; and,
- ◆ Assessing the extent to which different A/PI populations are accessing traditional Asian medical services versus mainstream medical services.

The results of such research could then be used to create health insurance products that meet the specific needs of the A/PI population.

CHAPTER III: OVERCOMING BARRIERS AND BUILDING CULTURALLY SENSITIVE STRATEGIES TO ACCESS CARE FOR THE UNINSURED-LESSONS LEARNED FROM THE EAST AND WEST COASTS

The third Workshop panel, “Overcoming Barriers and Building Culturally Sensitive Strategies to Access Care for the Uninsured,” consisted of representatives from the East and West Coasts. Each panelist provided insight on the lessons they have learned in the outreach and enrollment of immigrant populations into SCHIP/Medicaid in their respective geographic locations using culturally competent solutions to overcome barriers to accessing health care services.

Lessons Learned from East Coast Enrollment of Immigrant Children

Mr. Josh Bernstein, a *Policy Analyst at the National Immigration Law Center (NILC)*⁹ served as the moderator of the East Coast Panel. In his opening remarks, Mr. Bernstein noted that all States are grappling with the public charge issue, since immigrants are a large part of the community and reside throughout the U.S. For instance, approximately 20 percent of all children in the U.S. have at least one foreign-born parent. In other words, the policies and issues being discussed during the Workshop affect one in five families throughout the U.S. and are important not only to immigrants but to health care generally. Mr. Bernstein posed general questions to which each of the East Coast panelists responded.

Barriers to Seeking Proper Health Care

Q: *Based on your experience, what are the barriers that prevent children and immigrant families from seeking proper health care?*

A1: **Ms. Betsey Cooke**, *President and CEO of Health Choice Network (HCN)*¹⁰ in Florida, discussed HCN’s Barriers Project. Community Health Centers (CHCs) are a significant provider in Florida, serving a large immigrant, as well as African American, population. HCN sees approximately 100,000 patients a year. In a partnership with the Human Services Coalition of Miami-Dade County and Florida Legal Services, HCN began the Barriers Project, in the Spring of 1998, to understand the barriers to accessing health care.

- ◆ More than 290,000 children in Florida are eligible for, but not enrolled in Medicaid, and HCN sees a large number of uninsured children and families in its thirty-five sites throughout Florida.¹¹
- ◆ To investigate common barriers that impede enrolling into Medicaid, a preliminary survey was conducted door-to-door by outreach workers, as well as by CHC intake workers. Initial findings indicated that as many as 85 percent of families were afraid to apply for Florida’s SCHIP, Florida KidCare, or Medicaid.

⁹ NILC is a national public interest law firm, whose mission is to protect and promote the rights of low income immigrants.

¹⁰ Health Choice Network is a horizontally integrated delivery system composed of community health centers (urban, rural, migrant, and homeless) in South Florida.

¹¹ Sixty-five percent of HCN’s patients are uninsured and 65 percent are women and children.

- ◆ This finding led, beginning in September 1998, to the second phase of the Barriers Project, whereby outreach and intake workers in South Florida interviewed parents and completed a checklist of barriers. As of May 31, 1999,¹² 801 families had been interviewed and the following barriers had been identified (note that respondents could check multiple barriers):¹³
 - ◇ 75 – 76 percent of respondents cited some form of barrier related to public charge, the INS, or documentation.
 - 22 percent indicated that parents were reluctant or unable to produce proper documentation that their children were citizens or legal residents or they had an application for legal residency pending and were unwilling to participate.
 - 26 percent indicated fear issues: fear of being reported to the INS; fear of being unable bring other family members to the U.S.; fear of being unable to obtain lawful permanent resident status; or fear of having to pay the government back for the cost of benefits received.

From the perspective of the CHCs it is frustrating and a tragic deployment of resources to serve such a large number of uninsured children—children who are eligible for Medicaid or Florida KidCare but who are deterred from applying because of deep instilled fears related to immigration or deportation. True stories, as well as myths, perpetuate these fears and spread rapidly within immigrant communities.

- ◆ A judge in South Florida ruled that four emergency aliens had to pay back the cost of receiving Medicaid benefits. Even though the State agreed to cease this practice immediately and the INS issued letters clearly stating the law, there was nothing the CHCs could say to relieve immigrants’ fears and concerns.

Florida’s KidCare and Medicaid programs are devising creative outreach approaches based on the checklist results. For example, the results of the checklist showed that 24 percent of parents believed that they did not meet income (too high) or residential eligibility requirements to enroll their child in Medicaid—in part because of their belief that Medicaid is tied to cash assistance and welfare. Indeed, some well-informed outreach and eligibility workers share the same belief and do not realize that the income eligibility levels for Medicaid are much lower. As a result, HCN, under a cooperative agreement, has begun an education series for community health workers focused on the impact of immigration and welfare reform and the associated rules and regulations.

¹² The Barriers Project has expanded to a statewide effort in collaboration with the Florida Association of Community Health Centers and Florida Legal Services.

¹³ Additional results include: 6 percent indicated that the parent did not have time to attend an eligibility determination meeting at the Department of Children and Families (DCF); 25 percent indicated that the parent had experienced a problem while at a meeting at the DCF (such as Medicaid benefits denied/terminated; linguistic barriers; and/or discrimination); 3 percent indicated the parent was reluctant to report the father to child support enforcement; 2 percent indicated that the family had recently lost benefits/cash assistance and was unaware that Medicaid coverage was available to them; and 15 percent indicated other reasons (such as, custody/legal issues; already has private insurance coverage; unwilling to accept public assistance).

A2: Dr. Francesca Gany, *Founder and Executive Director of the New York Task Force on Immigrant Health (NYTFIH)*¹⁴ and *Assistant Professor at the New York University School of Medicine, New York*, discussed a pilot project that the NYTFIH is conducting with the New York Immigration Coalition. The pilot project is determining the best ways to facilitate and simplify the enrollment process for immigrants’ children into SCHIP. Findings of the pilot project revealed the following barriers:

- ◆ **Fear of Being Reported to the INS.** Immigrants are afraid that applying for SCHIP/Medicaid will jeopardize their immigration status, or that information that they provide will be turned over to the INS and used for deportation. Often, the information that is requested is not needed to process an application, such as a parent’s social security number, causing immigrants to be discouraged from applying.
- ◆ **Cultural Barriers.** Many immigrants are not familiar with the U.S. health care delivery system and do not understand the concept of health insurance (as it is not part of the health system in their native countries), let alone the concept of managed care (gatekeeper). Many immigrants need to be “shepherded” through the process and immigrant communities need to be educated about the U.S. health care system in general, how it works, and how SCHIP can benefit them.
- ◆ **Institutional Barriers.** Once an immigrant family has entered the system, they face a bureaucratic and cumbersome process. Many immigrants perceive the application process as demeaning as some eligibility workers treat them in what is perceived to be a discriminatory manner.
- ◆ **Linguistic Barriers.** Some governmental programs do not have appropriate translation and interpretive services or bilingual workers. Or, these programs lack appropriate outreach materials (e.g. at appropriate literacy levels and in multiple languages). While providers may advertise and promote the availability of interpretive services for intake and registration, many of these services disappear once an applicant enrolls in a program or plan.

A3: Ms. Betty Rice, *Director of the Division of Consumer and Local District Relations in the Office of Medicaid Management of the New York State Department of Health (NYDOH)*, noted two additional barriers that tend to deter immigrants from applying to Child Health Plus (ChPlus), New York’s SCHIP, and Medicaid:

- ◆ Medicaid stigma; and
- ◆ Inaccessible and inconvenient enrollment office locations and hours.

¹⁴ Established in 1989, the NYTFIH is a network of community members, practitioners, policy makers and administrators, social scientists and researchers who work together with the goal of overcoming the barriers immigrants face in the health care system and facilitating the delivery of epidemiologically informed and culturally and linguistically sensitive health services.

While not unique to New York, the size of the State and the diversity of individuals, make outreach challenging. NYDOH has been working actively to alleviate these barriers by seeking feedback from local communities and looking to them for new ideas (see response to the next question).

Necessary Policy and/or Programmatic Changes Necessary to Address Identified Barriers

The next question posed by Mr. Bernstein to the panelists was:

Q: What policy and/or programmatic responses are necessary to address these barriers?

A1: Ms Rice responded that changes have to occur at both the Federal and State level. At the Federal level, States would benefit from HCFA implementing policy changes to simplify and clarify Medicaid eligibility requirements, including the financial rules and the definition of qualified and non-qualified aliens. The State of New York, like other States, would like HCFA to advocate for an extension of the timeframe States have for accessing excess welfare reform funds with the intent of applying these funds to remove some of the SCHIP/Medicaid outreach and enrollment barriers. At the State level, New York is implementing facilitated enrollment, whereby funding is being provided to CBOs and agencies to conduct on-site SCHIP/Medicaid application assistance.

A2: Dr. Gany indicated that to ensure the effective implementation of the proposed public charge regulations, Dr. Gany indicated that the following actions should occur:

- ◆ Provide *ongoing training*, offered multiple times, to field staff at all levels (staff from government agencies, CBOs, and health care facilities).
 - ◇ Support this training/educational effort by providing funding to CBOs to cover the cost, as many CBOs are already operating on tight budgets.
- ◆ Educate the community by having a broader community-based outreach presence—from churches to hair braiding saloons to day care facilities.
- ◆ Increase the use of ethnic media, using trusted individuals such as ethnic musicians.
- ◆ Clarify public charge reporting and confidentiality issues.
- ◆ Include in public policy discussions the need to provide health care services to those children ineligible for SCHIP or Medicaid (if one child is eligible and another child is ineligible, the whole family is deterred from applying).
- ◆ Implement programs for linguistically and culturally appropriate outreach, enrollment, and services, such as developing a medical interpreter work force.
- ◆ Conduct research and gather data to devise ways to target messages in an informed manner, based on what is happening within a community.

A3: Ms. Cooke concurred with the recommendations of the other panelists and indicated the need for the following policy changes:

- ◆ Increased funding to CBOs, CHCs, and other providers is critical to break down the barriers to outreach and enrollment, such as for the type of research conducted under the Barriers Project.
- ◆ Stronger guidance and policy emphasis for out-posted eligibility workers in the community. Having out-posted workers conducting on-site eligibility in a community-based provider site increases the level of trust between the applicant and the worker.
- ◆ Educating the community about the public charge regulations, in particular, private immigration attorneys who are seen by immigrants as trusted sources of information.
- ◆ Reexamine the rationality of the five year bar from participating in Federally means-tested programs.

Operational Plans to Address Identified Barriers

Mr. Bernstein noted that simplicity and expansion of eligibility were the main themes of the East Coast Panel in overcoming immigrants’ barriers to SCHIP/Medicaid outreach and enrollment. In April 1999, Senator Moynihan and Representative Levin, and then in June 1999, the late Senator John H. Chafee, sponsored legislation¹⁵ that would provide States with the option of allowing legal immigrant pregnant women, children, and disabled individuals to be eligible for SCHIP and Medicaid. As of December 1999, Congress had not enacted legislation. Mr. Bernstein then asked panelists to respond to a final question:

Q: *What is being done or planned operationally to address these barriers and issues?*

A1: Dr. Gany responded that a true partnership/coalition with the community, from the beginning, is key in developing outreach, education, and enrollment strategies. The community truly knows what will, and will not, work. In addition to a partnership with the community, the following are also necessary:

- ◆ Fund CBOs for their efforts.
- ◆ Go where immigrants congregate and target their everyday places as discussed above.
- ◇ The NYTFIH is conducting a project where it has subcontracted with three CBOs in immigrant communities to conduct SCHIP/Medicaid education, outreach, and enrollment. NYTFIH trains the CBO staff, on such topics as the health care system in general, the concept of health insurance, managed care, eligibility requirements, and public charge. Once trained, the CBO staff conduct SCHIP/Medicaid education, outreach, and enrollment within the community. The project has an advisory board, with representation from the CBOs, public health care system, and managed care organizations, to facilitate a working relationship. Lessons learned include an awareness that the enrollment process needs to be simplified and done in a more

¹⁵ The late Senator Chafee sponsored S. 1227, “The Immigrant Children’s Health Improvement Act of 1999.”

efficient manner. For example, NYTFIH has developed a user friendly computer program that an outreach worker uses to make eligibility determinations.

A2: Ms. Rice, in summarizing the findings from a NYTFIH report, “Child Health Insurance of Immigrants: Overcoming the Barriers,” noted the need to address the following:

- ◆ Simplification of complicated Medicaid eligibility rules;
- ◆ Explicit statements regarding when social security numbers are, and are not, required by family members;
- ◆ Production of outreach materials at a fourth or fifth grade reading level;
- ◆ Identification of CBOs as a resource for help;
- ◆ Creation of computer-based support; and,
- ◆ Provision of appropriate training to human resource workers about ChPlus availability.

The NYDOH is implementing strategies to address each of these barriers, including:

- ◆ Piloting a combined ChPlus/Medicaid application. Results from the piloting are being used to redesign the application so that it is user-friendly, understandable, and at an appropriate reading level.
- ◆ Implementing a simplified screening document to facilitate self-screening by outreach workers.
- ◆ Implementing facilitated enrollment that focuses on community-driven initiatives.
- ◆ Providing computer-based support. The NYDOH recently completed a pilot project at Ryan’s Center, a CBO in New York City, to test a computer-based Medicaid application that uses a question format. The local case worker records the information, including the scanning of documents, and completes the application with the applicant. Once completed, the file is electronically sent to the State’s Welfare Management System; after review by a local service worker, a Medicaid case file is created. Upon approval of the Medicaid application, the State sends out a Medicaid card to the applicant. So far the computer-based Medicaid application has been successful at Ryan's Center, and hopefully their success forecasts the potential success of a computer-based ChPlus application.
- ◆ Educating local human resources departments about ChPlus availability, as well as training social services workers in New York City on ways that ChPlus availability can be coordinated with Medicaid denials and discontinuation notices.

A3: From the perspective of community-based groups, Ms. Cooke noted three policy changes that need to be addressed:

- ◆ INS monitoring is crucial for the proposed public charge regulations to be implemented successfully as a lack of it can undermine all of the community-based efforts.

- ◆ Ms. Cooke recommended that HCFA carefully review the process of how States will handle lock-in periods for enrollees in mandatory Medicaid managed care programs, especially the impact on transient populations, such as migrant workers and the homeless.
- ◆ Strategies need to be developed to ensure that all families understand that they can continue with Medicaid when their cash assistance eligibility expires.

Closing Remarks of the East Coast Panel

While the INS and State Department are the primary enforcement agents for the public charge policy, every person has a responsibility to report specific incidents observed to the INS so that the INS has the opportunity to resolve the issues. States are encouraged to review their SCHIP/Medicaid application(s) to ensure that the questions that need to be asked are kept to a minimum. In addition, States should review their policies regarding how the requested information on an application is used (such as, does the requested information have to be recorded? to what extent does the recorded information have to be made available to others?).

Lessons Learned from West Coast Enrollment of Immigrant Children

Ms. Donna Cohen Ross, *Director of Outreach at the Center on Budget and Policy Priorities (CBPP)*,¹⁶ served as the moderator of the West Coast Panel and started the discussion by stressing the importance of States simplifying their SCHIP/Medicaid application(s). A number of States, including California, Illinois, and Kansas, have revised their SCHIP/Medicaid application(s) to reflect HCFA’s guidance on simplifying applications.¹⁷ States’ SCHIP/Medicaid application(s) can be viewed or downloaded from CBPP’s web site (www.cbpp.org). Many States are actively in the process of simplifying their applications.

Barriers to Enrollment in California

Ms. Yolanda Vera, *an attorney with the Western Center on Law & Poverty in California*,¹⁸ discussed the obstacles California has encountered with its immigrant populations.

California’s Eligible, Uninsured Children. California operates two programs, HFP and Medi-Cal (Medicaid). California has a high rate of uninsured individuals, approximately 60 percent of whom are Latino and 24 percent of whom are Asian. Many of these uninsured persons are eligible for HFP or Medi-Cal. A study conducted by the University of California at Los Angeles (UCLA) revealed that 328,000 uninsured children are eligible but not enrolled in HFP and 788,000 uninsured children are eligible but not enrolled in Medi-Cal. Since the study was conducted, California has reached approximately 40 percent of those children that were eligible for HFP but not enrolled.

¹⁶ The Center on Budget and Policy Priorities is a Washington-based, non-profit organization that conducts research and policy analysis on issues that have an impact on low-income Americans.

¹⁷ HCFA has issued “Dear State Official” guidance letters (January 23, 1998 and September 10, 1998) on simplifying applications, copies of which can be on HCFA’s web site (<http://www.hcfa.gov/init/chstltrs.htm>).

¹⁸ The Western Center on Law & Poverty is a nonprofit law office dedicated to preserving and promoting the health, housing, and welfare rights of California’s low-income families.

Obstacles to Enrollment. The following are obstacles hindering the enrollment of eligible, uninsured children in HFP or Medi-Cal in California.

- ◆ **Language Barriers.** Given its diverse population, California is faced with accommodating many different populations and subgroups. In Los Angeles County alone, the threshold languages for MCOs to provide translation and interpretive services include Armenian, Cantonese, Cambodian, Korean, Russian, Spanish, Tagalog, and Vietnamese.
 - ◇ While California’s joint SCHIP/Medicaid application has been simplified and is available in multiple languages, other applications still need to be simplified and made available in multiple languages (such as the joint TANF/Medicaid application¹⁹ and the forms needed to reenroll in Medicaid).
- ◆ **Families' Negative Past Experiences.** Fears from past events, such as Proposition 187 and the Court of Entry Project (a discontinued practice), still linger, causing many families to be reluctant to trust new policies or new programs.
- ◆ **Stigma.** While the public charge policy goes a long way towards eliminating the perception that Medi-Cal is somehow worse than HFP, there remains the stigma of having to go a welfare office, and waiting in long lines, to apply for benefits. While children and pregnant women can use a mail-in application, additional effort is needed to create an easier system for all family members.
- ◆ **Documentation and Verification Requirements.** California is in the process of minimizing the amount of verification that must be provided to establish eligibility. To apply for HFP or Medi-Cal, an individual must provide proof of California residency. Regarding proof of residency, the HFP/Medi-Cal mail-in application enables an applicant to simply show that he/she lives in California. However, many eligible families hold jobs where they are not paid in written form. This problem is alleviated for applicants of HFP, where a written statement from the employer is permitted; self-declaration is not permitted under Medi-Cal.
 - ◇ The Medi-Cal program should consider replacing the quarterly status reports with an annual reverification process.
- ◆ **Complicated Eligibility Requirements.** California, like other States, has a set of complicated eligibility requirements for a variety of programs. Often, local welfare offices, which administer TANF, are not completely aware of all the rules, resulting in inappropriate denials. Improved coordination between medical assistance programs and welfare offices is needed.

¹⁹ At the time of the Workshop, California was being sued to modify the joint TANF/Medi-Cal application to remove a question that requires all applicants to say if any member of their household, regardless of whether or not that member is applying for benefits, is undocumented.

Efforts to Reduce Enrollment Barriers in California

Ms. Angeline Mrva, from the *Medi-Cal Eligibility Branch*,²⁰ *California’s Medicaid Program*, discussed the various activities California is doing to simplify the outreach and enrollment process. To date, California has received positive feedback from these activities, including:

- ◆ **Joint Medi-Cal and Healthy Families Program Application.** In April 1999, California revised and shortened its cumbersome 28-page application. The new joint application focuses on clarifying the differences and similarities between the two programs. Based on results from focus groups and input from community advocates, California also implemented in April 1999 a single point of entry for HFP/Medi-Cal applications, whereby a single contractor screens all applications to determine the appropriate program to receive the application for determination.
- ◆ **Certified Application Process.** Many outreach workers have been trained on HFP and Medi-Cal by a State contractor to assist families in completing an application. California offers \$50 per successful HFP enrollment or Medi-Cal (for example, a certified application assistant could receive \$100 for the successful enrollment of family members into HFP as well as Medi-Cal). As of June 1999, California had spent \$2 million in incentive payments and had trained over 10,000 individuals on the application process for both programs.
- ◆ **Toll-free Telephone Line.** California has established a toll-free helpline, available in English and ten other languages and advertised in all outreach materials, that individuals can call to have their questions answered or to request an application. To date, the hotline has been well received, requiring the State to double its staffing to handle the volume of calls. Hotline staff do ask a person if he/she would like someone to follow-up with them after the application has been received. Call-backs are made by certified application assistants in the language the person specifies. The number of individuals requesting assistance has been steadily increasing over time.
- ◆ **Mass Media Campaign.** In the Summer of 1998, California began an extensive multi-media (television, radio, print) outreach campaign that incorporates culturally appropriate print outreach materials. The State has designed posters that CBOs can customize with their name, contact information, and phone number; the State is developing other materials that can be customized by CBOs. California works with local newspapers, such as working in collaboration with *La Opinion*, a Spanish newspaper with a large circulation, to produce a HFP/Medi-Cal supplement that includes the joint application. California is working with a non-profit foundation to have the supplement produced throughout the State.
- ◆ **Sponsorship Efforts.** California has been working to develop sponsorships with private industries such as supermarkets, phone companies, gas companies, and drugstores. For instance, ads for HFP and Medi-Cal appear on milk cartons, electric bills, and at local shopping places. California is seeking to expand its sponsorship/partnership efforts in the future.

²⁰ The Medi-Cal Eligibility Branch administers the Education and Outreach campaign for HFP and Medi-Cal for children.

- ◆ **School Outreach.** California has supplied HFP and Medi-Cal information to all schools. Various collaborative efforts are underway with boards of supervisors, school districts, and school boards to educate them about HFP and Medi-Cal, and to encourage them to engage principals and local organizations in the dissemination of information.

For the 1999-2000 fiscal year, California is increasing the funding for community-based outreach enrollment efforts, focused on language and culture issues, underserved geographic areas, and access issues, such as transportation. The State has approved a \$6 million outreach budget, increased from \$1 million during the 1998-1999 fiscal year.

Barriers to Enrollment of Immigrants in Arizona

Dr. Peggy Stemmler, *Senior Program Associate in Health Policy at the Children’s Action Alliance*²¹ (CAA) in Phoenix, Arizona. Dr. Stemmler discussed, from the perspective of a CBO, the barriers caused by the public charge issue. In Arizona, the majority (60 percent) of individuals enrolling into SCHIP and Medicaid (as a result of applying for SCHIP) are of Hispanic descent. The newly issued public charge clarification will hopefully break down some of the enrollment barriers.

To investigate what barriers deter immigrants from applying to Medicaid, CAA conducted a series of focus groups. The main finding was that the policy questions, as perceived at the administrative levels of State agencies, is quite different from what a family experiences at an enrollment office. For example:

- ◆ **Public Charge/Fear of Deportation.** Families with at least one undocumented household member fear being deported. This fear is fueled by personal experiences that are then told throughout a community. These fears are exacerbated further by the relaying of inaccurate information by the staff in the Department of Economic Security (DES), the agency that determines Medicaid eligibility. For instance, a DES worker told an undocumented mother who was applying on behalf of her citizen children that she was ineligible for Medicaid. The mother was then requested to sign a statement indicating her refusal to participate in Medicaid or face deportation.
- ◆ **Treatment/Attitudes of Welfare and Office Enrollment Staff (“Medicaid Stigma”).** This barrier deters all eligible families, regardless of ethnicity, from applying. While individual welfare office staff are helpful, many families reported “leaving the welfare office in tears.”
- ◆ **Lack of Understanding of Health Insurance.** Many eligible families, especially immigrant families, might not understand the concept of health insurance or the importance of using preventive services that are not tangible.
- ◆ **Transportation.** Given its geographic layout, a car is a necessity, not a luxury, in Arizona. There are only two areas in Arizona that have public transportation. However, one of the first questions asked of a family applying for the Food Stamp program is about their resources—

²¹ Children’s Action Alliance is a non-profit, nonpartisan research, policy, and advocacy organization dedicated to promoting the well-being of all of Arizona’s children and families.

having a car can make a family ineligible for Food Stamps. This experience impacts a family’s willingness to apply for Medicaid.

- ◆ **Income Verification.** Arizona has a number of seasonal workers who are paid in cash or on a seasonal basis, where their monthly incomes fluctuate from month to month. This makes it difficult for individuals to enroll into Medicaid and to stay enrolled.
- ◆ **Lack of Rural Provider Networks.** The Medicaid health care delivery system in Arizona is entirely managed care and there are questions of the availability of providers in rural areas or for migrant workers. This lack of rural providers could lead an applicant to ask questions such as: Is this worth my time? Who do I get to see as my primary care physician? If I travel across the State, how do I receive care?
- ◆ **Stigma of Illegal Residents.** The general public perceives immigrants as being in the U.S. illegally. However, the majority of immigrants are legal residents. This stigma primarily affects the Border States.

SCHIP and Medicaid have unintentionally impacted the State’s ability to provide health care services to undocumented families and children. In the coming year, some programs, such as the Children’s Rehabilitation Services Program, Arizona’s program for children with special health care needs, will be required to document if the applicant is legal or illegal and will be unable to provide services to children that cannot produce proof of citizenship.

Questions and Answers

A ‘Q & A’ session followed the panel presentation. For ease of reference we have restated the questions and condensed the responses as follows.

Q: *Ms. Cooke, during her presentation, indicated that there has been an increase in demand for services at CHCs as people are leaving Medicaid. Has there been an increase in funding to CHCs in Florida, as well other States, to provide health care services to the uninsured, unqualified, and parents of children enrolled in SCHIP?*

A: Ms. Cooke responded that CHCs in Florida received an extra \$100 million last year to expand access to the uninsured. The reimbursement methodology for CHCs is being phased-out. This year, the rate is set at 90 percent and the rate will continue to decline until it expires in four years. The effect of this phase-out will immediately negate the effect of gaining the extra \$100 million.

CHCs in Florida have not seen an increase in the State funding; in fact, there has been a rollback in primary care funding for CHCs and local health departments. CHCs across the country, especially CHCs that do not have State-based programs, will be faced with cutbacks that jeopardize their ability to be part of the provider safety network. The situation is exacerbated by the large number of children who are eligible for Medicaid but not enrolled who seek CHC services.

A HRSA representative also commented that Maternal and Child Health (MCH) clinics are facing the same funding problems. As a result, two HRSA agencies, the Maternal and Child Health Bureau and the Bureau for Primary Health, are making requests in future budgets for

additional funds for MCH clinics. It is imperative that States’ outreach efforts are successful in enrolling eligible children into SCHIP/Medicaid, where health care costs are reimbursed.

Q: *Minnesota’s 1999 Legislature passed a provision that any person submitting an application can be found eligible based on the income information provided in the application; the person then has 30 days to provide documentation of income. Can the State still receive Federal funding if the person is found ineligible after the appropriate documentation is produced?*

A: Minnesota has not implemented the presumptive eligibility option. A carefully thought out presumptive eligibility program can minimize the number of children who are incorrectly deemed eligible (false positives). Nebraska was cited as a State that was having success in the implementation of the presumptive eligibility process.

Q: *How involved are private immigrant attorneys in outreach efforts?*

A: The problem is convincing the immigrant attorneys that they are not breaching their fiduciary duty by informing their clients of the public charge regulations and how they impact their clients. The initial experience of immigration attorneys will be critical. Problems need to be reported and addressed so that over time individuals believe what they are told.

Q: *Some States have experienced income documentation problems. What type of flexibility do States have to accept self-declaration of income?*

A: CBPP is in the process of completing an application and enrollment survey on procedures of verification requirements. Currently six states accept self-declaration of income. But, self-declaration of income creates a “catch-22” because these States are asking for the parent’s social security number for a third-party check with a State’s wage reporting system. While one enrollment barrier is being eliminated (self-declaration) another is being created by requiring the parent’s social security number.

One State, Washington, allows self-declaration for applicants that apply over the phone. This was so successful that it is now a statewide policy. Washington conducted a study that showed that the children of families who had misreported their income were still found to qualify for Medicaid.²² Georgia previously offered self-declaration only to families below the poverty line and now self-declaration is offered to all families.

Q: *How are States blending programs while also trying to promote simplicity? What are some recommendations to ensure eligibility rules to immigrants are maximized? (California is looking to blend Medi-Cal, AIM, and the Healthy Families Program).*

A: Panelists’ recommendations included:

- ◆ Ensure that families understand what program they are applying for.
- ◆ Ensure that families understand what questions apply to specific programs.
- ◇ Stage the application process so that the program requiring the least amount of information is presented first.

²² In Washington, children with family incomes up to 200 percent of the Federal Poverty Level are eligible for Medicaid.

- ◆ Ensure that families know the recertification requirements for each program.

Q: Can HCFA provide an update on Quality Controls (QC), specifically that States will not be negatively impacted if they implement self-declaration?

A: HCFA is carefully examining the QC issue and guidance is forthcoming. A number of States have pilot programs, which locks them into the error rate they had the year prior to starting the pilot project.

Q: What do panelists envision as an ideal monitoring system? Who are the key players involved? What makes it successful?

A: Panelists made the following suggestions for a successful monitoring system:

- ◆ Conduct exit interviews with clients after they go through the application process of various agencies. Track what questions are being asked and follow-up with clients about their experiences over different periods of time (due to agency staff turnover) and in a variety of locations. State employees should go through the process themselves.
- ◆ Allocate funds that are devoted to implementing monitoring processes in a variety of ways.
- ◆ Ensure that agency staff understand the public charge guidance so that the dissemination of misinformation is minimized.

CHAPTER IV: SUCCESSFUL COMMUNITY-BASED ENROLLMENT MODELS

Ms. Claudia Schlosberg, a *Staff Attorney with the National Health Law Program*²³ who specializes in immigrant health issues, served as the moderator for the Panel entitled “Successful Community-Based Enrollment Models.” Ms. Schlosberg opened the discussion by encouraging States and medical providers to obtain and use the manual “Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities.”²⁴ Ensuring linguistic access is the law under Section 601 of Title VI of the Civil Rights Act, which states that:

“...no person in the United States shall on the ground 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.”

Virtually all health care programs in the United States receive Federal funding and, therefore, are responsible for being in compliance with Title VI. The U.S. Department of Justice’s Office of Civil Rights has responsibility for enforcing Title VI and is mindful of the fact that appropriate language access must be provided to **all persons** of low-English proficiency.

The Border Vision Fronteriza Project

Ms. Shelley Davis, *Co-Executive Director of the Farmworker Justice Fund*, shared with Workshop participants the experiences of the Border Vision Fronteriza (BVF) Project. BVF uses assertive community-based outreach efforts to enroll immigrant children living in low-income communities²⁵ along the U.S.-Mexico border (the States of Texas, Arizona, New Mexico, and California) into health insurance programs and, once enrolled, to assist them in accessing services. The BVF Project began by establishing a Coalition and recruiting individuals to join the BVF Network of volunteer community health workers. From the beginning of the project, the BVF Project Manager, Ms. Eva Moya, has stressed the importance of having a well-designed program. Components of the BVF Project include defining the role of the volunteer community health workers, training, supervision, and evaluation:

- ◆ **Role of Volunteer Community Health Workers.** The role of volunteer community health workers is to bridge the cultural gap between the U.S. health care system and a community by providing accurate information in an easy-to-understand format about the availability of health care services and how to access those services. Volunteer community health workers

²³ The National Health Law Project 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.

²⁴ Copies of the Henry J. Kaiser Family Foundation publication “Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities,” authored by Jane Perkins, Harry Simon, Francis Cheng, Kristi Olson, and Yolanda Vera of the National Health Law Program, can be ordered by calling 1-800-656-4533. A section of the manual provides a listing of the Office of Civil Rights’ requirements for providers for ensuring linguistic access based upon an analysis of discrimination decisions rendered by the Office of Civil Rights over a ten-year period.

²⁵ Over half of the individuals living in the targeted communities live below the poverty level. A continuum of languages is spoken, with many individuals living in families that speak only Spanish. Literacy rates vary considerable within targeted communities and between targeted communities.

also provide informal support to individuals as they are making a decision about whether or not to enroll into a health insurance program.

- ◆ **Training.** Training provides the volunteer community health workers with the information that they need to do outreach within a community. Training for the BVF project emphasizes SCHIP/Medicaid outreach techniques and eligibility requirements, as well as leadership and communication skills (listening, writing, and how to convey information accurately and effectively). A goal of the BVF project is to build the leadership capacity of volunteer community health workers to feel comfortable in providing information about other health topics, such as childhood immunizations and HIV/AIDS.
- ◆ **Supervision.** Supervision includes having a person in a supervisory role that the volunteer community health workers trust. The BVF project uses a pyramid structure, where a full-time person from the community supervises ten to twelve volunteer community health workers.
- ◆ **Evaluation.** Evaluation for the BVF project includes assessing the completeness of applications received and interviewing individuals volunteer community health workers assisted in enrolling into a health insurance program to ascertain whether or not they are receiving health care services.

The public charge issue does make it difficult to enroll immigrant families into SCHIP/Medicaid programs. States should bear in mind that immigrant families live in continual fear that enrolling their child(ren) in SCHIP or Medicaid will result in the parents being reported to the INS, the parents being deported, and, the separation of their families. One recommendation from the BVF volunteer community health workers is to have INS representatives go to communities to explain the public charge policy so that individuals in the community “know it is what community health volunteers say it is.” Word of mouth also carries a lot of weight with immigrants, so bad messages resonate throughout a community.

Community-Based Outreach Models

Ms. Patricia Barrera, the *former Director of Policy for the Latino Coalition for a Healthy California*,²⁶ began by noting that for SCHIP/Medicaid enrollment efforts to be successful, outreach workers must know and believe that the health insurance programs that they are offering to individuals are effective and meet the needs of a multi-cultural, multi-lingual population. She commended California for contractually requiring managed care organizations participating in California’s Medi-Cal (Medicaid) program to meet cultural and linguistic competency requirements and standards.²⁷ California, in developing the cultural and linguistic

²⁶ The Latino Coalition for a Healthy California is a statewide Latino health policy and advocacy organization that is committed to developing, initiating, and advancing policies that build healthy communities.

²⁷ California’s cultural and linguistic standards, which are evolving continually, for participating Medi-Cal managed care plans include such items as:

- ◆ Threshold and concentration standards (3,000 with a primary language other than English in the proposed service area; 1,000 in a single zip code; 1,500 in two contiguous zip codes);
- ◆ Twenty-four hour access to interpreter services for all members, including a language line, appropriate interpreter services, and/or bilingual staff at key points of contacts for medical and non-medical services;
- ◆ Required linguistic services (such as, interpreters, translated signage and written materials, and referrals to culturally and linguistically appropriate services and programs);

competency requirements, incorporated many of the recommendations of the Cultural and Linguistic Task Force, of which the Latino Coalition for a Healthy California was a member. Ms. Barrera then described two community-based outreach models, the Health Families Outreach Project initiated by El Concilio and the promotores model initiated by Latino Health Access.

In September 1998, El Concilio in Stockton, California initiated a community-based outreach program to inform families and enroll eligible children into California’s HFP. By February 1999, outreach workers had enrolled 1,800 eligible persons into HFP and, by June 1999, approximately 2,000 individuals had been enrolled (Ms. Barrera noted that the plateau in enrollment was, in part, due to the “public charge” issue). Funding for the project is provided by the San Joaquin County Department of Health, as well as through HFP community-based grants available from the State. The purpose of the project is to conduct outreach activities in two zip code areas of San Joaquin County that have the highest number of children and the highest number of families with incomes at 100 to 200 percent of the federal poverty level.²⁸

El Concilio has fourteen multilingual outreach workers, who together speak a total of ten languages, perform a variety of outreach activities throughout San Joaquin County. Each outreach worker is certified by California as a certified application assistant and receives further training by El Concilio staff before being assigned to any outreach activities. The El Concilio training is similar to that of the BVF project in that it educates outreach workers in the areas of leadership skills, communication skills, and information about other health and social service programs that are available to families. All outreach activities are conducted in a culturally and linguistically competent manner and include:

- ◆ Making presentations to eligible families in targeted settings, such as businesses with a large percentage of uninsured workers;
- ◆ Going door-to-door within an assigned neighborhood to educate eligible families about HFP;
- ◆ Following-up by scheduling home visits to enroll eligible children into HFP; and,
- ◆ Making referrals, which address all the needs of a family, to other health and human services programs that a family could be eligible for and access.

The Promotores Model

The Latino Health Access (LHA), a community-based organization located in Orange County, uses promotores, or local lay advisors,²⁹ to conduct outreach to enroll eligible children into HFP,

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- ◆ Required documentation regarding linguistic services and staffing in subcontracts with traditional and safety net providers;
 - ◆ Implementation of a Group Needs Assessment; and
 - ◆ Implementation of a Community Advisory Committee.

Note that these standards, as of the time of the Immigration Workshop, are not applicable to health plans participating in the HFP.

²⁸ Outreach activities have since expanded to reach multilingual and immigrant populations throughout San Joaquin County.

²⁹ The promotores model uses community health workers who are local residents that have been trained to lead their communities toward healthier lives.

as well as to enroll individuals into disease-specific educational programs offered by LHA. The promotores are recruited from the communities they serve—they are local residents who have assumed the responsibility for identifying community needs on behalf of LHA, and organizing, facilitating, and hosting programs that lead to better, healthy lives. Promotores from LHA are often individuals with specific diseases/medical conditions, such as diabetes or cardiovascular conditions, or they have family members with these conditions, and are recruited through their participation in one of LHA’s health education classes or disease management programs. Some individuals recruited to be promotores are initially uninsured, thus providing a motivational factor to assist other members of their communities in obtaining health insurance coverage. LHA provides weekly training sessions for the promotores. Because the promotores have the trust of the community, and are culturally and linguistically competent, they are highly effective at assisting others to help themselves. The promotores program has earned the support of the community it serves, as well as the support of the health provider community.

Ms. Barrera closed by indicating that any type of outreach efforts addressing the public charge issue have to be done in partnership with community-based organizations.

The Experience of the Chinatown Health Center

Ms. An Hoang, former Director of Social Work for the Chinatown Health Center (CHC)³⁰ in New York City, shared with Workshop attendees the strengths and successes of the Chinatown Health Center (CHC) in enrolling Chinese Americans and advocating on their behalf. CHC’s users come from the five boroughs of New York City, as well as from Connecticut, New Jersey, and Philadelphia, Pennsylvania, with approximately 50,000 patient visits.³¹ CHC began enrolling patients into New York’s SCHIP in November 1993 and in the first few months enrolled 50 patients; by May 1999, CHC had enrolled some 5,550 SCHIP patients.

Utilization Patterns of CHC Clients. In general, CHC’s clients do not seek preventive medicine. Rather, CHC’s clients tend to seek medical attention at the time of an emergency or in response to prompts from schools for immunizations or physical exams. Most of CHC’s clients require education about New York’s SCHIP and Medicaid programs, particularly the concepts of managed care. Even those clients with commercial insurance, which often provides for limited hospital coverage, tend to pay cash for health services at CHC or delay seeking care. Often CHC’s uninsured clients will try home remedies first or hope that a family member will get well soon in order to avoid paying medical bills.

CHC sponsors several programs that are aimed at connecting CHC’s clients with health care services. For instance, CHC sponsors a daily workshop, Monday through Friday, that is targeted at pregnant women. During the workshop, a CHC social worker discusses the availability of

³⁰ CHC, a non-project community-based health care facility established in New York City in 1972, provides primary care and emphasizes preventive medicine, health education, and community involvement. In 1997, expanded services by opening another center in Flushing Queens, New York City. Mr. Kenny Kwong is the current Director of Social Work and can be reached at 518-473-7922.

³¹ Nineteen percent of visits are CHIP; 45 percent are Medicaid; and the remaining visits are covered by Medicare or commercial health insurance, or are self-pay.

programs for pregnant women, such as prenatal care, and assists them in utilizing health care services and following-up with them.

How CHC Communicates with its Clients. *Word of mouth* is an effective form of communication among CHC’s clients, whether from a doctor, a CHC staff member, a family member, or a friend. CHC also operates a hotline, and uses a variety of media formats, such as a bilingual local cable station, articles in Chinese newspapers, and Chinese radio stations. CHC has found *ethnic radio programming* to be one of the most effective tools in reaching a group with low-literacy in English and recent immigrants, who often listen to the radio throughout the day as a means of gathering information. CHC also acts as a facilitator in connecting its clients with other social services, such as the social service agencies in Manhattan.

CHC staff spend a lot of one-on-one time discussing with their clients how to utilize health care services offered by their insurance product. Families often doctor-shop, because of the long hours they work, and because they do not understand the concept of gatekeeping/referrals. CHC staff often spend a great deal of time assisting clients in obtaining specialty referrals. Ms. Hoang noted that CHC clients initially view the referral system as inconvenient, but once educated, they no longer view it as a barrier. Clients often find the bilingual automated answering systems of health plans too confusing.

Barriers to Enrolling CHC’s Clients into SCHIP/Medicaid. Ms. Hoang noted four barriers for CHC clients enrolling into SCHIP/Medicaid:

- ◆ **Obtaining a SCHIP/Medicaid Application.** The majority of CHC’s population do not speak English as their primary language and find it difficult to communicate with the staff of the local Medicaid offices; only one individual at the local Medicaid office speaks Chinese. Consequently, CHC’s population often, after going to a local Medicaid office, return to CHC to have staff write a note indicating that the person would like to receive a SCHIP/Medicaid application. To minimize this problem, CHC has requested that it receive blank Medicaid applications so that they can assist their clients on-site in completing them.
- ◆ **Completing the SCHIP/Medicaid Application.** Because of the language barrier, CHC’s population need an interpreter during the face-to-face Medicaid interview. CHC users occasionally bring an interpreter with them, often a minor who speaks English; consequently, CHC staff make every effort to go with individuals to their Medicaid interviews.
- ◆ **Receiving the Medicaid Recertification Notice.** Another barrier is that individuals applying for Medicaid often do not receive their recertification notice, or, if they receive it, do not understand the significance of it. Consequently, CHC users begin the time-consuming process of reapplying.
- ◆ **Length of SCHIP/Medicaid Application.** In New York, the Medicaid program uses two forms, a shorter form for pregnant women younger children and a longer one for others applying for Medicaid. The first form can take up to one hour to complete; the second form is more complicated and can take two or more hours to complete.

CHC has found it effective to schedule a time to assist individuals in completing their Medicaid applications and then sending a group of applications to the local Medicaid office.

Questions and Answers

A ‘Q & A’ session followed the panel presentation. For ease of reference we have restated the questions and condensed the responses as follows.

Q: *How are the outreach workers in the four States of the BVF project funded?*

A: The BVF project is funded through grants from HRSA and a private foundation. The Medicaid statute requires managed care plans to demonstrate how they train Medicaid recipients to serve as community health workers in their program. BVF does use former welfare recipients.

Q: *How is the promotores model measured to demonstrate effectiveness?*

A: The promotores model does have a yearly evaluation component. The model is primarily funded through “soft” money streams, including a foundation and some Federal funds from the Office of Minority Health.

Recommendation. A Workshop attendee requested that HCFA review the regulations pertaining to outstationing and consider modifying it to reflect the current outreach situation.

Q: *Was the Medicaid application in New York consumer-tested?*

A: Ms. Hoang responded that she was uncertain if the Medicaid application had been consumer-tested. Another panelist noted that while a lot of work has been done by States to simplify SCHIP/Medicaid forms, there is still more than can be done. HCFA is willing to work with States in simplifying their forms.

CHAPTER V: STATE EXPERIENCES

HCFA/HRSA invited **California, Florida, Illinois, New Jersey, New York, and Texas**, the six States with the largest immigrant populations to attend the Immigration Workshop. Each invited State was asked to discuss the activities it has undertaken, the challenges encountered, and the solutions identified and/or implemented to enroll eligible immigrant children into SCHIP/Medicaid. Each State team represented SCHIP, Medicaid, and Maternal and Child Health, although one person was designated as a State presenter. See **Attachment II** for highlights of each State’s presentation.

CHAPTER VI: PLENARY SESSION – DESIGNING STATE STRATEGIES

Federal, State, and advocacy representatives split into five groups to discuss and develop strategies for identifying, educating, and enrolling State-specific target populations into SCHIP/Medicaid. The following provides a synthesis of the common themes raised by the five groups.

Collaboration and Coordination

- ◆ Encourage the INS to continue implementing highly visible communication strategies.
 - ◇ Develop fact sheets on immigration issues, such as public charge; fact sheets should: include the INS seal/logo and a contact phone number; be easy to read; be in multiple languages; and disseminated widely.
 - ◇ Be accessible to CBOs.
 - Participate in meetings with CBOs and advocacy groups to openly discuss the public charge guidance, as well as on an on-going basis to resolve identified issues.
 - Provide access to designated INS employees who are willing to participate in CBOs’ training programs as a means of desensitizing communities of their negative image of the INS.
- ◆ Continue collaboration and coordination among the agencies of the Federal government, including DHHS (HCFA and HRSA), INS, USDA, State agencies and local communities sites to:
 - ◇ Ensure SCHIP activities are coordinated, such as ensuring accurate and consistent messages about SCHIP, and public charge, especially as information/policy interpretations flow from the Federal level, to the State level and, ultimately, to the community level. Everyone needs to “be on the same page.”
 - ◇ Develop communication strategies that address:
 - Diminishing the stigma targeted individuals appear to associate with SCHIP/Medicaid.
 - Educating targeted individuals about the importance and value of health insurance, how to access the health care delivery system, and how to utilize it (concepts of managed care and preventive health services).
- ◆ Have DHHS Regional Offices work collaboratively with States in the development and implementation of “roll-out plans” that identify, educate, and enroll State-specific target populations.
 - ◇ The Federal Interagency Task Force Outreach to Children, comprised of twelve agencies, could act as a liaison to provide guidance in the development and implementation of “roll-out plans.”
- ◆ To share information, discuss policies and regulations, identify barriers, and develop effective solutions, States could convene quarterly meetings of local application

assistants/facilitators; create county-level coalitions of outreach workers with formal communication lines to the State.

Policy Clarifications

- ◆ Provide written clarification and/or verification, at the Federal and State levels, regarding:
 - ◇ That a State **does not** have to require an individual to report his/her immigrant status in applying for SCHIP and Medicaid.
 - ◇ The circumstances under the TANF program when reporting of an individual’s immigration status is required, as in many States individuals apply for Medicaid at the same time that they apply for TANF benefits.
 - ◇ That using State dollars for enrollment of a non-legal immigrant child into SCHIP would not hold that child’s sponsor for citizenship liable for having to repay the government.
 - HCFA indicated that the Social Security Act in section 1137 requires, as a condition of eligibility for Medicaid, that each applicant for Medicaid declare whether he/she is a citizen or qualified alien. If the applicant declares he/she is a qualified alien, the applicant **must** supply immigration documents supporting the claim and the State Medicaid agency must verify such information with the INS. This provision, which predates welfare reform, was unaffected by the passage of welfare reform. If the applicant does not declare being a qualified alien then no further documentation or verification is required (see section 1137(f) of the Social Security Act).
 - Even though an alien is not a qualified alien, that person may, if otherwise eligible for Medicaid, have payment made under Medicaid for treatment of an emergency medical condition.
 - Under SCHIP only qualified aliens may be eligible. Non-qualified aliens are not eligible for SCHIP under any circumstances because of the provisions of welfare reform as a Federal Means Tested benefit. Section 432 of welfare reform requires that States implement a program of verification of immigration status for recipients of certain public benefits described in that section. This verification requirement has not yet been implemented.
 - The reporting to INS of aliens whom the State knows are not lawfully present in the United States is governed by section 434 of welfare reform except for certain other programs, such as TANF, governed by section 404 of welfare reform.
 - The use of State only funds to provide benefits to non-qualified aliens is subject to the requirements of section 411 of welfare reform.
 - Section 421 of welfare reform requires that the income and resources of a sponsor be attributed to the sponsored alien when determining the eligibility of the sponsored alien for any Federal Means Tested benefit. Further all non-emergency benefits are subject to the requirement that the State request repayment by the sponsor. Therefore, both SCHIP and Medicaid must seek repayment. States do not have the option to decide whether to implement this option.

Simplification

- ◆ Simplify SCHIP/Medicaid application processes:
 - ◇ Simplify application language; minimize information asked and eliminate unnecessary questions; evaluate the tone of questions; and continually review, test, and redesign the application.
 - To ensure proper idioms are used in translations, engage community organizations and agencies in different locations in the translation of materials, such as reverse translation (from Spanish to English) to assess clarity.
 - ◇ Make the application process for SCHIP and Medicaid consistent--for instance, separate applications should ask the same questions.
 - ◇ Eliminate face-to-face meetings (initial certification and recertification) and the assets test.
 - ◇ Review notices to ensure that they are linguistically appropriate.
- ◆ To ensure children “do not become lost in the system,” States should consider implementing systems that automatically enroll eligible children into SCHIP when they are found ineligible for Medicaid (in others, coordinating eligibility if SCHIP and Medicaid are separate programs).

Training

- ◆ The INS should consider designating INS employees who are willing to participate in CBOs’ training programs as a means of desensitizing communities of their negative image of the INS.
 - ◇ Local INS field staff should be trained on issues of importance to immigrants, such as public charge, **prior to** disseminating any information to immigrant communities.
 - ◇ The Administration for Children and Families, on April 27, 1999, proposed State allocations, and \$15.5 million set-aside to:
 - Provide outreach and referral to ensure that eligible refugees access SCHIP and other programs for low income working populations; and,
 - Provide specialized interpreter training and the hiring of interpreters to enable refugees to have equal access to medical and legal services.
- ◆ States should consider providing on-going, continuous training of program eligibility requirements to State eligibility workers, so that applications are appropriately approved.
 - ◇ Community-based Application assistants/facilitators should receive the same type of training as they are the front-line communicators of information to the community; States can use the “train-the-trainer” concept to expand their supply of trained outreach workers.

Partnerships

- ◆ Involve the CBOs in SCHIP outreach to targeted communities about SCHIP.

- ◇ Work closely with trusted community leaders and businesses; involve a mixture of representatives from the community (citizens, advocates, and businesses) in focus groups to discuss identified issues and solutions.
 - Suggested outreach partners were numerous and include political candidates, schools (run poster contests), local public health departments/agencies, food banks, homeless shelters, religious organizations, recreation centers and parks, and primary care associations.
- ◇ Develop relationships with local ethnic media sources, including radio, newspapers, and television/cable stations.
- ◇ Involve children in outreach, such as providing community credits for performing outreach services; or having local students perform a skit, with health as the topic, during a school assembly, PTA meeting, or church gathering. Children can help in educating their own families.
- ◆ Seek in-kind contributions, such as recruiting sports celebrities or musicians to participate in public service announcements or businesses to donate services needed by immigrant communities, such as having H&R Block offer a tax class free or at a reduced rate.
- ◆ Develop mechanisms to ensure critical funding is directed to communities for outreach and enrollment as “money is a demonstration of good faith.” States can leverage relationships to secure funding with not only a Governor, but also with key State and County commissioners.

Data

- ◆ Data are vital for States to develop, implement, and evaluate the successfulness of their SCHIP/Medicaid outreach and enrollment efforts to immigrant populations
 - ◇ Use internal State data systems to track Medicaid applications that are not completed (withdrawals, procedural denials, programmatic denials) to target potentially eligible children for SCHIP enrollment
 - ◇ Collect data from targeted communities through focus groups and surveys.
- ◆ Set realistic, specific SCHIP goals that demonstrate success—does the immigrant community trust the State more? The bottom line is whether SCHIP is making a difference in the long-range health of this nation’s children.

Alternative Innovations

- ◆ To reduce stigma, States can use an enrollment card that is applicable for SCHIP and Medicaid (in other words, when looking at an enrollment card, individuals would not know which program they were enrolled in).

Miscellaneous

- ◆ States must address how to provide health care services to undocumented individuals and individuals who do not qualify for SCHIP, such as identifying ways to work with local community groups that have referral systems in place.

- ◆ What civil rights do immigrants have through participation in a program?

Questions and Answers

A brief ‘Q&A’ session followed the plenary session. For ease of reference, we have restated the questions and condensed responses as follows:

HRSA Initiatives. A representative from HRSA’s Maternal and Child Health Bureau (MCHB) responded to the question “What are States offering to individuals who enroll into SCHIP/Medicaid?” MCHB has awarded grants to eight national organizations with local constituents to develop systems of care in the community. Grantees will work within their respective communities: to have primary care providers see SCHIP enrollees; to have primary care services more accessible to the working poor; and to provide integrated health and social services to families. MCHB is also funding a systems development contractor to work with State MCH programs, including assisting State MCH program in working with SCHIP to foster systems of care in the community.

Q: *How much time should elapse between the start of SCHIP outreach activities and the acceptance of SCHIP applications?*

A: State representatives concurred that the timing sequence depends on a State’s operational readiness to accept and process SCHIP applications. A State should be ready to accept and process SCHIP applications, and to ensure that application processing will be timely and correct prior to initiating statewide SCHIP outreach activities.

Florida is considering implementing a phased-in, targeted marketing and enrollment campaign.

CHAPTER VII: CLOSING REMARKS

In closing the Workshop, Dr. Lillian Gibbons and Ms. Carol Galaty thanked Federal and State representatives and child/immigrant advocates for their active participation in the Workshop and their continued commitment and support in ensuring accessible health care services for our nation’s children. The challenge lies ahead as States develop rollout plans for targeting immigrant communities for culturally and linguistically appropriate SCHIP/Medicaid outreach and enrollment services. To this end, HCFA, for fiscal year 1999-2000, has designated the following five priority areas:

1. To increase enrollment in SCHIP/Medicaid, with a special focus on the TANF/Medicaid populations;
2. To conduct a national education campaign to educate families on health insurance/health coverage and preventive care services;
3. To increase SCHIP/Medicaid outreach and enrollment of children from immigrant families;
4. To improve retention of eligible beneficiaries in SCHIP/Medicaid; and
5. To build a nationwide school-based outreach and enrollment program targeting uninsured children.

States are encouraged to continue the exchange of information of successes and lessons learned with each other, as well to HCFA for posting on its outreach strategy web site.

**ATTACHMENT I:
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**ATTACHMENT II:
STATE EXPERIENCES/CHALLENGES
ENROLLING ELIGIBLE IMMIGRANT CHILDREN
INTO SCHIP/MEDICAID
IMMIGRATION WORKSHOP – June 9-10, 1999
(California, Florida, Illinois, New Jersey, New York, and Texas)**

The six States with the highest immigrant populations-**California, Florida, Illinois, New Jersey, New York, and Texas**-were invited to the INS Workshop to share their experiences, as well as any lessons they have learned, in enrolling eligible immigrant children into SCHIP/Medicaid. Each State team was comprised of representatives from three different State health care agencies-Medicaid, SCHIP, and Maternal and Child Health (MCH)-with one spokesperson designated to address the following issues:

- ◆ Description of State-specific immigrant population;
- ◆ State demographics (percentage of immigrant children by ethnic population);
- ◆ SCHIP/Medicaid enrollment/disenrollment data;
- ◆ Barriers/challenges of enrolling immigrant children; and
- ◆ Outreach strategies to foster enrollment towards, and to overcome disenrollment of, immigrant children.

Highlights of each State’s presentation, in alphabetical order, are presented below. A ‘Q & A’ session followed the State presentations.

California

Dr. Rugmini Shah, Chief of the California Department of Health Services’ Maternal and Child Health (MCH) Branch and **Mr. Mauricio Leiva** from California’s Managed Risk Medical Insurance Board (MRMIB) delivered California’s presentation. The California team also included **Ms. Angeline Mrva**, with California’s Medi-Cal Eligibility Branch.

Dr. Shah began California’s presentation by emphasizing the vital role of the MCH program, funded through the Title V Block Grant, in finding eligible children for enrollment into California’s Medi-Cal (Medicaid) and SCHIP, the Healthy Families Program (HFP). The role of the MCH program is to provide and ensure that all mothers and children, especially those with low income or limited availability to services, have access to quality MCH services. The MCH program also assures the quality of care being provided. For instance, MCH has developed a linkage system to identify children with special health care needs enrolled in the HFP or Medi-Cal to ensure they have access to appropriate health care services.³³ Finally, the MCH program, with Medi-Cal and HFP, administered by the Managed Risk Medical Insurance Board

³³ California’s children with special health care needs program has approximately 120,000 enrollees and is a carve-out, with the exception of primary care services, from HFP and Medi-Cal.

(MRMIB), study profiles and data on California’s immigrant families to understand where they are located, as well as their beliefs, customs, and motivations.

Demographics of California’s Immigrant Population. According to 1997 data, immigrants represent 9.7 percent (25.8 million) of the population in the United States (U.S.); 24.8 percent (6.5 million) of immigrants reside in California alone, the largest percentage of immigrants residing in one state. This translates into approximately 9 million immigrant children in California, of whom approximately 1 million are uninsured. The demographics of immigrant families (their cultures/beliefs and needs) need to be recognized and understood to be successful in reaching and enrolling uninsured, eligible immigrant children (or for that manner, any population that faces barriers to accessing health care). For example, immigrants’ experiences with the health care delivery system in their native countries, as well as their customs, influence their health insurance purchasing decisions in the U.S. California has studied profiles and data,³⁴ including, but not limited to, the following demographics to gain a better understanding of immigrant families and their children:

◆ **Education Status**

- ◇ 25 percent of the native-born immigrants and 25 percent of foreign-born immigrants in California are college graduates.
- ◇ 35 percent of the foreign-born immigrants and 50 percent of native-born immigrants do not have a high school education.

◆ **Unemployment Status**

- ◇ 8.4 percent of non-citizens and 4.3 percent of naturalized citizens are unemployed.³⁵

◆ **Use of Public Assistance**

- ◇ 3.3 percent of native-born and 4.9 of foreign-born immigrants receive some form of public assistance.
- ◇ 10.5 percent of naturalized citizens, 12.0 percent of native-born citizens, and 26.8 percent of foreign-born non-citizens are living at the poverty level.

◆ **Immigrant Newborn Labor Rates**

- ◇ 44.9 percent of all infants, or 235,189, delivered in California were born to foreign-born mothers, with 70 percent of Hispanic mothers being immigrants and 86 percent of Asian/Pacific Islander mothers being immigrants.

³⁴ California relies on different types of data sources to identify uninsured immigrants and immigrants eligible for CHIP such as: “Current Population Reports” (US Department of Commerce); State demographic projections; provider-based information; MCH data that tracks foreign childrens’ births; and, surrogate data, such as race and ethnicity, income, and place of residence.

³⁵ The unemployment rate increases the longer an immigrant resides in the U.S., in part because it takes five years to become a U.S. citizen.

◆ Uninsured Rates

- ◇ 288,000, or 42 percent, of children ages 0-18 are eligible but not enrolled in Medi-Cal; 328,000, or 18 percent, are eligible but not enrolled in the HFP;³⁶ 289,000, or 16 percent, are undocumented immigrants ineligible for either Medi-Cal or the HFP; and, 440,000, or 24 percent, of children that are citizens or legal immigrants who are ineligible for Medi-Cal or the HFP for one reason or another.
- ◇ In 1997, 49 percent of non-citizens ages 0-64 were uninsured and did not have health insurance coverage; 11 percent had Medi-Cal; and 35 percent had employer-based insurance (understanding the profiles of children will reflect the family).

Closing Comments of Dr. Shah. In closing, Dr. Shah emphasized the following points:

- ◆ California relies heavily on profiles and demographic data to learn about various populations without health insurance. Unfortunately, few informational systems collect a full array of data on immigrants and their children. The book, “From Generation to Generation The Health and Well-Being of Children in Immigrant Families” published by the National Academy Press discusses profiling the immigration population and the lack of reliable data sources.
- ◆ The cultural differences of immigrant families impact their ability to enroll their children in available children’s health insurance programs. Outreach strategies to enroll eligible immigrant children should include traditional MCH programs (the safety net) and community-based organizations (CBOs).
- ◆ Strategies to assure a payer source for health care for immigrant children need to be multi-dimensional and broad-based.

Enrollment Barriers and Solutions. Mr. Mauricio Leiva, with MRMIB, then discussed the challenges and barriers that deter immigrant families and their children from applying and enrolling in Medi-Cal or the HFP. The Department of Health Services, the agency that administers Medi-Cal, and MRMIB work closely together and share many goals, including the development of strategies to overcome barriers to enrollment. The following are some example of barriers and solutions California is implementing:

- ◆ **Language Barriers.** The number of languages spoken in California has presented a challenge for the State. To accommodate many of the ethnic populations, California’s Medi-Cal and HFP joint application and handbook are translated and printed in English, Spanish, Vietnamese, Cantonese, Cambodian, Hmong, Armenian, Korean, Russian, and Farsi. Not only must outreach materials be provided in different languages, but also services. California contracts with an experienced statewide vendor, with a staff that speaks each of the languages referenced above. In addition, California requires its health plans to provide materials and services in all of the threshold languages, either through staff or a language line.

³⁶ There is a disproportional number of minorities enrolled in the HFP.

Communicating to communities, especially rural areas, in all the different languages is a continuing struggle for California. To date, most of California's media outreach activities have been conducted in Spanish and English. However, California is working closely with CBOs throughout the State to address this issue.

- ◆ **Geographic Barriers.** Since California is a large State, geographic barriers make access to services and enrollment difficult. To alleviate the geographic barriers, California implemented a rural health demonstration project in January 1999. Working with the health plans, MRMIB providing funding for projects aimed at increasing access to services. Projects include a contract with the University of California at Davis and Cedar Sinai Medical Center to provide tele-medicine services; mobile dental clinics; and expansion of health centers' operating hours (such as remaining open beyond normal working hours and on Saturdays).
- ◆ **Barriers Facing Migrant Communities.** California has a large migrant population, mostly Hispanic, consisting of migrant farm workers that travel up and down the State, as well as individuals in the fishing and forestry industries. To address the needs of migrants, MRMIB created a program whereby a migrant can select a health plan that will serve them (health, dental, and vision) in any one of the fifty-eight counties within the State.
- ◆ **Cultural Barriers.** Lack of understanding of our health care and insurance system has been a factor in the slow response of some ethnic groups to enrollment outreach activities. California has researched this problem through evaluating the types of inquires California's toll-free line receives. Most inquires from families were related the role of HMOs, open enrollment, the annual eligibility review, and about how to change doctors within a health plan. California recognizes that more consumer education and assistance is needed in order to increase participation in the SCHIP program and is developing strategies to increase consumer education.
- ◆ **Public Charge.** Based on feedback from immigrant rights organizations in California, the lack of clear policy regarding “public charge” has deterred immigrants from enrolling in Medi-Cal or the HFP. The same message was heard when MRMIB conducted a survey of the top twenty enrollment entities that assist individuals with the application process and entering the health care system. As a solution, California produced a HFP/Medi-Cal fact sheet to clarify misconceptions and/or misinformation about eligibility and “public charge.” Feedback on the fact sheet has been positive.
- ◆ **Application and Enrollment Process.** The original joint application for the HFP and Medi-Cal was too long and perceived as a barrier to enrollment. In April 1999, California simplified its joint application that children use to four pages, which has been well received by enrollment entities throughout the State. California clearly states within the joint application, that HFP and Medi-Cal do not collect data on the immigration status of parents (only for the children enrolling). California also revised the HFP and Medi-Cal handbook, a supplement to the application, which includes detailed examples of documents required to prove income. For example, to provide proof of income, the applicant has many choices of documentation, including: one monthly pay stub from the last forty-five days (which California's contractor uses to compute income); a copy of the 1040 or 1040 EZ form; quarterly profit statements from a business; or a letter from an employer.

- ◆ **Welfare Stigma.** The stigma surrounding Medicaid and other government programs continues to be a deterrent to enrollment. California, like many States, acknowledges this barrier and is working to overcome families’ perceptions of Medicaid and government programs. California has eliminated the face-to-face meeting requirement only for children applicants applying for Medi-Cal.

Disenrollment Statistics in California. Less than 2 percent of those who enroll in HFP disenroll. Reasons for disenrollment from the HFP include: 19.58 percent have reached 19 years of age and are no longer eligible; 37.9 percent did not pay the premium; 31.8 percent did not request an application for reenrollment; 8.5 percent did not submit an application or did not have the proper immigration documents as required; and 2.21 percent for other specified reasons. California is actively working with its State legislature, which has significant Hispanic representation, to remove remaining barriers to enrolling immigrant children into the HFP or Medi-Cal, such as providing benefits to children entering the U.S. after August 22, 1996.

IMPORTANT UPDATE. In July 1999, California implemented a change in enrollment which includes immigrants that entered the U.S. after August 22, 1996.

Florida

Ms. Annette Phelps, Chief of the Bureau of Family and Community Health, Florida Department of Health served as the designated spokesperson. The other member of the Florida team was **Ms. Betsey Cooke**, President and CEO of the Health Choice Network.

Florida’s SCHIP Approach–Florida KidCare. Florida has implemented a combination SCHIP approach in two phases. First, Florida expanded Medicaid coverage to teenagers ages 15-19 in families with incomes up to 100 percent of the FPL, and expanded its existing Florida Healthy Kids program. The Florida Healthy Kids program, like New York and Pennsylvania, was “grandfathered” into SCHIP and provides subsidized premiums for children in families with incomes up to 185 percent of the FPL. Second, on July 17, 1998, Florida submitted an amendment to its original SCHIP plan, which HCFA approved on September 8, 1998, that made Florida KidCare an “umbrella” program with one simple application that includes: Florida Healthy Kids,³⁷ MediKids,³⁸ Medicaid; the Children’s Medical Services (CMS) Network,³⁹ and a behavioral health network.⁴⁰ Florida has submitted a second amendment to HCFA to implement Phase III,

³⁷ Florida Healthy Kids is available to children ages 5-19 who are ineligible for Medicaid but live in families with incomes up to 200% of the FPL. Florida Healthy Kids, in June 1999, was available in forty-four out of sixty-seven counties; Florida is working with the remaining counties, several of which are rural, and provider networks to make Florida Healthy Kids available statewide. Families above 200 percent of the FPL are allowed to buy-in to the program; the average cost to buy-in, if paying the full fee, is \$75 per family per month. Florida Healthy Kids does serve some non-Title XXI eligible children with non-federal funds.

³⁸ A Medicaid look-alike program, MediKids is a non-entitlement program that provides coverage to children ages 0-5 with family incomes up to 200 percent of the FPL who are ineligible for Medicaid. MediKids offers the same benefits, infrastructure, and providers as Medicaid and has open enrollment periods. Families pay a monthly \$15 premium. However, Florida has found that many families do not understand the open enrollment process, such as when they should apply.

³⁹ A division of the Title V program, the CMS Network provides coverage to children ages 0-19 with special health care needs and with family incomes up to 200 percent of the FPL.

an expansion to offer coverage to all dependent children under employer-sponsored health insurance plans using the KidCare benefits as the "gold standard" for the benefit package.

KidCare Enrollment. Since Florida's October 1998 implementation date, enrollment in the KidCare program has been steadily increasing.

- ◆ As of May 1, 1999, 81,223 children were enrolled in Healthy Kids;⁴¹ 5,479 in MediKids; and 1,565 in the CMS Network. At the same time, there were over 30,000 additional applications that were being processed for enrollment.
 - ◇ Over 34,000 children have enrolled in Medicaid through the KidCare application.
- ◆ As of May 10, 1999, Healthy Kids enrollment included 7,045 non-citizen children; 1,059 with unknown citizenship status; and, 229 dependents of State employees who cannot afford the health insurance benefits.

Florida's Immigrant Population Given its geographic location, Florida has a high number of immigrants that continues to increase.

- ◆ 62,023 immigrants, primarily from Cuba, Haiti, Jamaica, and Columbia were admitted legally into Florida in 1995.
- ◆ 174,825 legal immigrants received some form of public assistance in December of 1996.
- ◆ An estimated 350,000 undocumented residents reside in Florida, which is the fourth largest undocumented population in the U.S. (behind California, New York, and Texas). Of the 350,000 undocumented residents, an estimated 94,000 are children (ages 0 to 18).

Barriers/Challenges of Enrolling Immigrant Children. Findings from a Collaborative Targeted KidCare Outreach and Education Project Survey indicated that the barriers that deter immigrant families from enrolling in KidCare include, but are not limited to:

- ◆ Fear of being reported to Immigrant and Naturalization Service (INS),
- ◆ Problems with obtaining the necessary documentation,
- ◆ Problems with the public assistance offices,
- ◆ Concerns over the public charge issue, and
- ◆ Lack of knowledge and misinformation about KidCare and health care in general.

Strategies to Overcome Immigrant Barriers. During the past year (1998-1999 fiscal year), Florida has had \$6 million to conduct a comprehensive outreach strategy, at the State and regional level, to raise awareness of, and foster enrollment of eligible children, into KidCare. As part of its outreach campaign, Florida stresses certain themes, such as "easier," "healthier," and "affordable" rather than "free."

⁴⁰ The behavioral health component provides coverage to severely emotionally disturbed children ages 0-19 with family incomes up to 200 percent of the FPL.

⁴¹ This number includes the enrollment of some non-Title XXI eligible children.

State Level Outreach Projects

- ◆ Funding outreach projects throughout the State to identify and employ effective outreach strategies, build trust, and disseminate information at the local level and partnering with organizations that immigrant communities trust.
 - ◇ Implementing seventeen regional outreach projects that are funded through the local county health departments, who in turn subcontract with local providers in a community. The purpose of the regional outreach projects are to identify uninsured children; facilitate KidCare enrollment; reduce the barriers to enrollment and access to KidCare; and implement effective outreach policies and strategies to reach immigrant populations.
- ◆ Producing and providing outreach materials to outreach workers, providers, and facilitators—those that assist individuals with the KidCare application and enrollment process, including:
 - ◇ A toll-free KidCare information phone line that is staffed from 8:00 a.m. to 8:00 p.m. Monday through Friday, with voice mail coverage at other times, including bilingual staff and use of a language line;
 - ◇ Marketing materials and a web site in Spanish and Creole;⁴²
 - ◇ Fact Sheets;
 - ◇ Question and Answer sheets targeted to providers and specific populations;
 - ◇ Outreach contact lists for farm workers;
 - ◇ A Glossary of terms, including the definitions of different categories of qualified immigrants eligible for public assistance benefits and Florida KidCare (such as lawful permanent residents, refugees, asylees);
 - ◇ Radio and newspaper spots, developed by an advertising agency; and
 - ◇ Newsletter articles in minority-based papers, such as Minority Health newsletter.
- ◆ Creating, under Florida legislation, a Coordinating Council comprised of eight subgroups/task forces with representation from health care providers, institutions that provide care, and special population groups. The Council works directly with the Governor and the Florida legislature with its recommendations that have filtered up from the grassroots level.
 - ◇ For instance, a Special Populations Outreach Task Force has been established to provide insights and outreach strategy ideas to reach immigrants, such as migrant workers.
- ◆ Receiving a Covering Kids grant from the Robert Wood Johnson Foundation (RWJ), in partnership with the University of South Florida’s Child Center for Healthy Mothers and Babies, to conduct five pilot projects across twelve counties. The pilot projects are evaluating the effectiveness of outreach models designed to reach targeted populations, including: welfare-to-work; Hispanics; migrants; Native Americans; legal immigrants; Asian Americans; Haitians; and individuals living in rural areas.

⁴² The web site received 10,000 hits during the first month it was on-line.

Regional Outreach Projects

- ◆ **Partnering with existing CBOs and networks that are already working with immigrant families, and who immigrant families trust, to disseminate KidCare information.** For example, Florida is working with local Hispanic foundations and civic organizations and is providing in-service training to farm worker agencies.
- ◆ **Participating in local community events popular with immigrant families.** For example, Florida conducts presentations and distributes KidCare applications at Caribbean festivals and at Haitian and Spanish churches and the Hope for Kids campaign has gone door-to-door.
- ◆ **Conducting outreach to migrant populations.** Florida is actively working to increase KidCare enrollment by migrant populations. Initiatives include:
 - ◇ Conducting evening programs with Migrant Head Start Centers and day care centers for parents and staff; training staff in giving KidCare application assistance;
 - ◇ Disseminating KidCare information and applications are available to migrant programs, such as at migrant housing developments and migrant worker health fairs; and
 - ◇ Training the local job training offices to conduct KidCare outreach at migrant camps.
- ◆ **Developing outreach materials specific to immigrant populations.** Florida is reaching out to different immigrant communities to inform and educate them about KidCare and health insurance, including:
 - ◇ Hiring bilingual staff to develop materials and programs for the Haitian community, including producing print advertisements in Spanish and Haitian publications and radio spots on Spanish and Haitian radio stations.
 - ◇ Working with immigrant populations, including focus groups, in the development of linguistically and culturally competent outreach materials (including several Asian languages and Bosnian).

Moving Forward. Florida’s next challenge is to continue and expand upon its successful outreach initiatives to date. Unfortunately, the Florida legislature allocated less money to KidCare for the 1999-2000 fiscal year than anticipated as it annualized a monthly KidCare enrollment figure rather than annualizing based upon the increasing number of KidCare enrollees. Florida is already approaching the point where all KidCare slots will be filled (the Florida legislature limits the number of available KidCare slots). Consequently, the question becomes how much outreach should be done if interested individuals are simply going to be placed on a waiting list to enroll. Further, the Florida legislature restricted the use of new funding to funding services only and not for administration; outreach is considered to be an administrative cost. One possible solution is to use partners who benefit from the availability of children’s health insurance programs, such as large hospitals or provider groups, to provide the State with a match. The State is also investigating its ability to draw down additional TANF outreach dollars.

Illinois

Ms. Jacquetta Ellinger, Deputy Administrator for Programs, Division of Medical Programs, Illinois Department of Public Aid, as well as **Ms. Lisa Simeone**, Director of Programs at the Illinois Coalition for Immigrant and Refugee Rights, served as the spokespersons for Illinois. The Illinois team also included **Ms. Joy Getzenberg**, Associate Director of Planning and Policy, Chicago Department of Public Health.

Illinois’ SCHIP Approach-Illinois KidCare. Illinois is using its SCHIP funds to implement an umbrella program called KidCare that offers health insurance coverage to eligible low-income children and pregnant women. KidCare is comprised of five plans: KidCare Assist and KidCare Moms and Babies (Medicaid and Medicaid expansion plans); KidCare Share and KidCare Premium (Medicaid look-alike plans); and KidCare Rebate (a State run plan that provides a support mechanism, rebates, to enable insured children to keep their coverage, which is viewed as an anti-crowd-out strategy). The KidCare programs were implemented on a phased-in schedule. The Medicaid expansion began on January 5, 1998. The Medicaid look-alike and insurance rebate programs were implemented on August 12, 1998. These five programs are highly integrated and administered by the Illinois Department of Public Aid; simplification of SCHIP results in simplification for Medicaid children and pregnant women. KidCare coverage is broader than federal law provides, with State funds being used to provide health care services to documented immigrant children entering the U.S. on or after August 22, 1996.

Illinois had estimated that it would enroll half of its eligible population of 40,400 into the Medicaid expansion within the first year of SCHIP implementation. Illinois has exceeded this estimate, having enrolled 28,491 eligible children, or 141 percent of the estimated eligible population. Illinois commissioned the University of Illinois to conduct a population survey to study uninsured children in Illinois and consequently, Illinois estimates that some 43,835 children are eligible (children in families with incomes between 133 to 185 percent of the FPL). As of June 1, 1999, approximately 15 percent of the 43,000 have enrolled into KidCare.

Illinois KidCare Outreach. Illinois began a significant outreach initiative in April 1999 that, to date, has been successful and received positive press coverage. As a result, Illinois was deluged with an influx of applications within a short period of time (an average of over 300 applications a day). Of the applications being received, approximately 70 percent are being approved and over 80 percent of the individuals approved are enrolling into Medicaid rather than the Medicaid expansion. Illinois has undertaken the following outreach activities:

- ◆ **Simplifying Enrollment.** In August 1998, Illinois established a simplified application process including a mail-in option. Eight months later, the application was again revised to make it simpler, shorter, and to clarify immigration requirements. Advocacy groups have assisted the State in revising the application, including the elimination of all but essential documentation. Illinois considered eliminating documentation of income, using self-declaration with back-end verification through employer systems, but decided against it.
- ◇ Illinois advised any State considering the elimination of documentation of income to ensure that there is a clear understanding of the type of quality assurance activities that will occur on the back-end. Some activities, such as calls to employers or home visits to

families to verify income could have negative consequences. (Illinois has a well-developed quality assurance and fraud control system.)

- ◆ **Hard to Reach Children and Pregnant Women.** An RFP designed for outreach to Hard to Reach Children and Pregnant Women was released May 28, 1999. Immigrant and refugee children and children whose families do not speak English are considered “hard to reach.” Through the RFP, Illinois will disperse up to \$1 million in grants to organizations working at a community level to find eligible children and assist their families to apply for KidCare.
- ◆ **KidCare Hotline.** The KidCare Hotline is answered by a “live” voice from 8:00 a.m. to 8:00 p.m., Monday through Friday, and 8:00 a.m. to 5:00 p.m. on Saturdays. In addition, voice mail messaging is available after hours. Staff includes operators who are bilingual in English and Spanish and translator support is available for over 140 languages. Since October 1998, the KidCare Hotline has handled calls, in addition to English, for at least twelve languages including: Spanish, Mandarin, Polish, Cantonese, Russian, Vietnamese, Serbian, Bosnian, Greek, Gujarati, Romanian, and Arabic.
- ◆ **Written Materials.** Applications, brochures, posters, fact sheets, and mass transit placards (Chicago Transit Authority bus and train) have been produced in English and Spanish. Brochures in additional languages are under development. Chicago Public Schools outreach efforts in November 1998 and April 1999 included written materials translated into Polish, Arabic, Chinese, Bosnian, and Spanish.
- ◆ **Covering Kids Grant.** The State is working closely with the RWJ funded Covering Kids Illinois, a broad coalition of organizations, including those interested in immigrant children who are working to promote KidCare enrollment.
- ◆ **Application Fee.** Illinois is providing outstation sites, called KidCare Application Agents, with an application fee for the submission of completed applications, similar to California’s program. The State is implementing high standards to become a KidCare Application Agent and is recruiting a variety of CBOs from across the State, many of whom serve minority and immigrant populations.
- ◆ **Reaching Employers.** Illinois is working with chamber of commerce to reach employers. For instance, Chicago’s chamber of commerce is reaching out to employers of large number of minorities.
- ◆ **Coordinating with the School Lunch Program.** Illinois State has disseminated to all public schools the new school lunch program application that includes a provision that permits the schools to release information to the State to promote KidCare outreach.

Illinois’ Immigrant Population. Ms. Lisa Simeone, representing the Illinois Coalition for Immigrant and Refugee Rights,⁴³ began by noting that there are an estimated 1,058,466 legal residents and naturalized citizens⁴⁴ currently living in Illinois, with an estimated 290,000

⁴³ The Illinois Coalition for Immigrant and Refugee Rights is a statewide coalition of immigrant legal and service providers and community organizations whose services include providing technical assistance and training to immigrant communities and the organizations that serve them.

⁴⁴ The figures presented are old; CPS data were used to estimate legal immigration since 1990. The next census is likely to show a significant increase in immigrants.

undocumented immigrants. Immigrants represent about 12 percent of Illinois' total population. Illinois' immigration is diverse:

- ◆ According to recent INS data, approximately 184,000 legal immigrants and refugees came to Illinois in the period between the 1990 census and September 1995. This represents an average annual number of 33,531 arrivals.
- ◆ Since 1990, Illinois immigrants have come from more than 175 countries, with the largest number of legal immigrants from Poland (40,413), followed by Mexico (32,801), and India (17,372). Illinois also has large populations of Filipinos, Chinese, Koreans, and Arabs from throughout the Middle East.
- ◆ Approximately 41 percent of the new immigrants and refugees are immigrating directly to the suburbs of metropolitan Chicago; 23.3 percent settled in suburban Cook County (the inner suburbs directly around Chicago); and 9.2 percent settled in DuPage County (the outer suburbs), with Des Plaines, Cicero and Skokie receiving the largest number of immigrants.

Coalition Education Efforts. The counties surrounding the city of Chicago, in particular DuPage County, until recently, had a homogeneous population; the changing population has resulted in social change, as well as conflict. The situation has also created outreach and education challenges because of the dearth of provider networks in this area. County health departments, hospitals, and community health centers, all of whom have invested in bilingual and culturally competent staff, are being strained in providing health care services to an ever growing immigrant population that is avoiding SCHIP and Medicaid enrollment. Consequently, the Illinois Coalition for Immigrants and Refugee Rights:

- ◆ Works closely with CBOs, in Chicago and the suburbs, to educate immigrant communities about changes in welfare laws through such activities as presentations and in-service training sessions.
 - ◇ Through the collaborative work between Chicago Public Schools and the Illinois Department of Aid, 350,000 of the Coalition's one-page, bilingual fact sheets on public charge were distributed to families throughout the Chicago area.
- ◆ Works closely with the Illinois Department of Human Services:
 - ◇ To educate local case workers, as well as policy staff, on changes in immigration laws.
 - ◇ To develop a curriculum on immigration law and welfare eligibility, which will be used to train newly designated immigration specialists that will be placed in local offices. This effort should assist in ceasing the dissemination of incorrect information.

Closing Remarks of Ms. Simeone. The collaborative efforts of State governments with local governments, CBOs, and coalitions have been key to the growing effectiveness of KidCare outreach. Intensive outreach and education at the community level, using such strategies as facilitated enrollment and certified enrollment assistants, is essential to systematically address immigration related concerns. If immigration concerns are not addressed and integrated into all outreach efforts, it will be difficult to reach out to families that are persistently reluctant to enroll into SCHIP or Medicaid.

New Jersey

Ms. Kathryn Plant, Chief of Operations within the Division of Medicaid Assistance and Health Services, served as the spokesperson for New Jersey. The New Jersey team also included, **Dr. Henry Spring**, formerly the Assistant Commissioner of the Department of Health and Human Services, Division of Family Services, and **Ms. Michelle Walsky**, Community Relations Manager of the New Jersey KidCare program, Division of Medicaid Assistance and Health Services.

New Jersey’s Immigrant Population. New Jersey is a small State that is densely populated with 7.7 million residents. Approximately 14.6 percent of the population, or 1.1 million individuals, is foreign born, of which 463,000 are legal permanent residents (the fifth highest proportion in the nation). New Jersey’s immigrant population is diverse, with the highest representation⁴⁵ from the Dominican Republic (74,000), India (48,000), the Philippines (29,000), and Mexico (26,000). Thirty-three percent of non-citizens had an income greater than \$30,000 and 62 percent were employed. New Jersey’s immigrant population is young, with 37 percent under the age of 17 and almost half (49 percent) are under the age of 24. Contrary to public perception, 645,000 received no public assistance. The actual number of non-citizens receiving assistance is small, with some 6,000 receiving cash benefits and 2,000 receiving other welfare benefits.

KidCare Enrollment. New Jersey implemented KidCare, a SCHIP Medicaid expansion, on December 1, 1997 and initially experienced slow enrollment growth. Consequently, the State began to focus on the reasons for the slow growth of KidCare enrollment, including the enrollment experience of immigrants. New Jersey uses a statewide enrollment vendor that is able to provide the State with enrollment data for each of its twenty-one counties (see below). New Jersey also uses a statewide media vendor that enables the State to implement a dynamic KidCare campaign that can be redesigned to reach targeted populations.

Using data from the statewide enrollment vendor, New Jersey knows that KidCare enrollment is largest after Caucasian children, for Hispanics (approximately 34 percent of enrolled children), then African Americans (approximately 18 percent), followed by Asian (approximately 4 percent). KidCare disenrollment patterns mirror KidCare enrollment patterns. The reasons individuals have disenrolled from KidCare include:

- ◆ Voluntarily disenrolling (individuals do not understand the concept of preventive care or that a premium must be continually paid),
- ◆ Involuntarily disenrolling (individuals did not pay the premium),
- ◆ Having existing government insurance (individuals do not understand what services are covered),
- ◆ Exceeding the KidCare age limit, and
- ◆ Exceeding the KidCare income limits.

⁴⁵ Numbers and percentages are derived from 1994 CPS data.

Outreach/Enrollment Strategy. A critical component of the New Jersey’s SCHIP outreach and enrollment strategy is its partnerships with other State agencies, coalitions and networks, and community-based organizations, including:

- ◆ **Immigration and Refugee Services Networks.** After the passage of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, the State partnered with the Immigration and Refugee Services Networks to fund and promote naturalization for individuals at risk of losing their SSI and food stamp benefits. Through this relationship, the State receives information and feedback about what is occurring in various communities.
- ◆ **Department of Health and Senior Services.** The State also partners with the Department of Health and Senior Services, which has responsibility for the State’s safety net providers, including WIC, FQHCs, and local health departments, in the implementation of consumer and provider education initiatives that address immigrant issues.
- ◆ **Department of Agriculture.** The State partners with the Department of Agriculture to coordinate KidCare outreach with the school lunch program.

The State is also using community connections, such as radio, television, newspapers, and magazines in multiple languages to reach immigrants with information about KidCare. For instance, the State has worked closely with a radio station to develop a program about KidCare that includes a question and answer segment. In addition, the State has committed \$1 million to work with thirty-two community-based organizations to perform KidCare outreach and enrollment, and is participating in a HCFA demonstration project to reach and enroll Hispanics in targeted communities. Lastly, the State works with elected officials who represent cultural diversity to disseminate accurate KidCare information within their communities.

Moving Forward. New Jersey has redesigned its brochures and application forms to be sensitive to immigrant issues, such as immigrant parents do not have to provide their social security numbers to enroll their children into KidCare. The State is committed to implementing a KidCare outreach and enrollment campaign that is flexible to meet the needs of the State’s immigrant populations. New Jersey values its diversity and is focused on the challenge of enrolling and assuring culturally competent health care to its children.

New York

Dr. Suzanne Moore, Director of the New York State Child Health Plus program (ChPlus), was New York’s designated spokesperson. The New York team also included **Dr. George DiFerdinando**, Director of the Division of Family and Local Health, New York State Department of Health, and **Ms. Betty Rice**, Director of the Division of Consumer and Local District Relations, Office of Medicaid Management, New York State Department of Health.

New York’s SCHIP Approach-Child Health Plus. In response to the SCHIP legislation, New York, along with Florida and Pennsylvania, “grandfathered” and expanded its already

established child health insurance program,⁴⁶ which is now called Child Health Plus (ChPlus). ChPlus is a separate health insurance program that is a partnership between the State and private insurers with the State subsidizing private coverage for enrollees. In 1998, the New York State Legislature passed legislation that expanded eligibility for ChPlus⁴⁷ (up to age 19) and Medicaid; expanded benefits; and reduced family cost-sharing (including the removal of all copayments for family visits). New York also passed a law to increase State outreach funding from \$1 million a year to approximately \$15 million a year.

Because ChPlus is a separate program from Medicaid, New York is continually striving to improve the coordination between ChPlus and Medicaid⁴⁸, including:

- ◆ Using the same Medicaid managed care health plans to ensure statewide access, with the exception of one health plan in the rural area of Western Central New York that is not a Medicaid managed care plan;
- ◆ Using a common application, which, at the time of the Workshop, was being piloted and revised; and
- ◆ Implementing a facilitated enrollment model (see below).

Currently there are 326,000 children enrolled in ChPlus, and, in the month of May 1999 alone, approximately 14,000 children enrolled in ChPlus. However, the children who have been reached and already enrolled are the “easy-to-reach” populations. Outreach efforts are currently underway that are targeted at the “hard-to-reach” populations that do not respond to media exposure (see below for a discussion of outreach initiatives).

Barriers to Enrollment. New York identified some of the common barriers that deter families from enrolling in ChPlus and/or Medicaid, including:

- ◆ Families lack knowledge about the availability of SCHIP/Medicaid, and do not understand the concepts of health insurance;
- ◆ Families do not understand the ChPlus or Medicaid information they receive, including income eligibility rules;
- ◆ Immigrants fear of retribution;
- ◆ Families lack of time (because they work full-time) to access a local agency; and
- ◆ Separate ChPlus and Medicaid enrollment processes. Applying for Medicaid is a complex and time-consuming process due to a lengthy application; a mandatory face-to-face eligibility interview at a local agency; and, confusing eligibility rules. On the other hand, ChPlus has a simple application with a mail-in option; ChPlus applications are sent directly to an insurer

⁴⁶ New York created its child health insurance program, now called Child Health Plus, in 1991.

⁴⁷ CHPlus offers coverage to children up to age 19 in families with incomes at or below 185 percent of the FPL.

⁴⁸ To create a seamless program, New York submitted an amendment to HCFA, on April 1, 1999, to combine its current ChPlus and Medicaid programs.

who determines eligibility; and, families can call a 1-800 number to order applications or to have questions answered.

Demographics of New York’s Immigrant Population. The State of New York has a large, diverse immigrant population. For instance, immigrant groups residing in Queens include, but are not limited to: Asians from China, Korea, India, Bangladesh, and Pakistan; South Americans from Columbia, Peru, and Ecuador; and, Caribbean Hispanics. In contrast, over 199,000 immigrants settled in Brooklyn between 1990 and 1994, with 34 percent arriving from the former Soviet Union and Poland.

Facilitated Enrollment. New York has made tremendous efforts to simplify the enrollment process and to eliminate process problems that appear to deter eligible immigrant families from enrolling into ChPlus or Medicaid. A major effort currently underway is to conduct facilitated enrollment by providing application assistance at community-based enrollment sites through outreach workers.

In March 1999, New York issued a statewide Request for Proposal (RFP) to make Medicaid and ChPlus enrollment easier, more accessible, and user-friendly, as well as to enroll eligible children into the correct program. Total funding for the RFP is \$10 million dollars, with \$5 million going to New York City alone. As of the Workshop, New York had received between 50 to 100 proposal from a variety of organizations, ranging from community-based organizations (CBOs); school-based health centers (SBHCs); child advocacy groups; local governments; and, health care providers. The State prefers a “tiered model,” with a designated lead agency contracting with several subcontractors (such as, CBOs) that would provide facilitated enrollment in many sites throughout the community that families are able to access conveniently. The lead agency is responsible for providing training, support, and technical assistance to its subcontractors, as well as assuring the quality (completeness) of submitted applications to the local office or ChPlus insurer. The State is impressed with the number of coalitions that are being formed, especially diverse coalitions in New York City that appear to target the ethnic diversity of communities. It was noted that the Children’s Defense Fund in New York City assisted communities in establishing their coalitions.

The lead agency’s subcontractors would provide the active outreach workers, or enrollers, in the community. The responsibilities of the community-based enrollers include:

- ◆ Explaining ChPlus and Medicaid application and eligibility requirements;
- ◆ Helping families obtain necessary documents;
- ◆ Conducting the face-to-face Medicaid interviews and forwarding completed Medicaid applications to the local Medicaid office (the local Medicaid offices will still make eligibility determinations);
- ◆ Maintaining close contact with families with extensive follow-up;
- ◆ Educating families about managed care plans and how managed care plans operate;

- ◆ Explaining to families, and assisting them with, the ChPlus and Medicaid recertification process; and
- ◆ Working with DOH Medicaid presumptive eligibility procedures (when established).

Closing Remarks. A copy of the RFP, as well as a question and answer sheet, can be found on New York Department of Health’s web site, www.health.state.ny.us. New York has issued another RFP to obtain an organization(s) to train the community-based enrollers on Medicaid and ChPlus eligibility rules.

Texas

Ms. Kimberly Davis, Texas SCHIP Outreach Director, Texas Department of Health, served as the designated spokesperson. The Texas team also included **Ms. Gay Stokes**, Medicaid Policy Specialist for TANF-related Medical programs, Texas Department of Human Services; and **Ms. Debra Wanser**, Director of Systems and Process Development for the Associateship for Community Health and Resources Development, Texas Department of Health.

Texas’ SCHIP Approach-TX CHIP. Texas is in the process of implementing its SCHIP plan because the Texas Legislature only meets for six months every other year. Therefore, the first time the Texas Legislature meet since the passage of SCHIP legislation was in January 1999. Texas’ situation has proven to be fortuitous, as Texas has been able to learn valuable lessons from other States’ SCHIP experiences. Texas is implementing its SCHIP program in two phases: Phase I, implemented in July 1998, expanded eligibility to Texas’ existing Medicaid program to teenagers ages 15 to 18 in families with incomes at or below 100 percent of the FPL. As of May 1999, Texas had successfully enrolled 39,000 teenagers from this expanded population. Those teenagers eligible for TX CHIP are offered the same full benefit package as Medicaid and care is provided through the current delivery system for Medicaid.⁴⁹ Families and children are not subject to cost sharing under the TX CHIP program.

On May 27, 1999, Governor George W. Bush signed the plan for implementing Phase II of TX CHIP. The signed legislation includes the creation of a state-funded SCHIP look-alike program for children who immigrated to the U.S. after August 22, 1996 and for State employees (with the State paying up to 80 percent of health care services for children). If approved by HCFA, Phase II proposes a state-designed plan that will cover children through age 18 in families with net incomes between 100 percent and 200 percent of the FPL. The project implementation date of Phase II is May 1, 2000.

To prepare for the implementation of Phase II, Texas is conducting a statewide outreach efficacy study to learn which outreach strategies work, or do not work, for targeted populations. The study includes conducting, during the Summer of 1999, some twenty-four focus groups of differing income levels and ethnic groups, such as first, second, and third Hispanic generational

⁴⁹ Eligible children for Medicaid receive services through the regular fee-for-service system, or the managed care STAR system.

groups. The study will also include test marketing of methods for delivering information and a joint TX CHIP/Medicaid application.⁵⁰

TX CHIP Outreach Approach For Phase I, outreach activities include, but are not limited to:

- ◆ Allocating \$700,000 to contract with local health departments to identify and enroll eligible teenagers;
- ◆ Coordinating with a network of public health providers to disseminate outreach materials to families with potentially eligible children; and
- ◆ Using 500 local Texas Department of Human Services offices, hospitals, and clinics to conduct face-to-face interviews and home visits.

Future outreach plans, under Phase II, include:

- ◆ Implementing a generic outreach campaign similar to the Children’s Defense Fund’s “Sign Them Up!” campaign and the Health Resources and Services Administration’s (HRSA) “Insure Kids Now!”
 - ◇ Contracting with an advertising agency to conduct an ethnic and English media campaign (television, print (outreach materials, the application, and a guide for CBOs), and radio).
- ◆ Implementing a toll-free 1-800 number to request an application or to apply over the phone.
- ◆ Implementing one location for Medicaid, TX CHIP, and Texas Healthy Kids Corporation applications to be mailed.
 - ◇ All applications will be sent a third party administrator for eligibility screening. If the applicant appears eligible for Medicaid, then the application will be forwarded to the Texas Department of Human Services who would contact the family to arrange for a mandatory face-to-face interview. If the applicant is deemed eligible for TX CHIP, the applicant is enrolled and contacted to select a health plan provider. If the applicant is not eligible for Medicaid or TX CHIP, the person will be referred to the Texas Healthy Kids Corporation for enrollment as this plan has no income limits.
- ◆ Issuing RFPs for: 1) the conduct of a Statewide multi-media-radio, television, newspaper-campaign; 2) the delivery of comprehensive health insurance services for TX CHIP; 3) the delivery of comprehensive administrative services TX CHIP; and 4) funding coalitions of CBOs to identify families of uninsured children regardless of income and application assistance.

Texas’ Immigrant Population. Currently there are approximately 19 million persons residing in the State of Texas, of which approximately 32 percent are of Hispanic descent and 4 percent are of Asian descent, with the majority being Vietnamese.

⁵⁰ Currently the application for Texas’ Medicaid Program, CHIP, and the Texas Healthy Kids Corporation is two pages. The Texas Healthy Kids Corporation (THKC) is a private/public non-profit corporation created by the Texas Legislature in 1995 as an administrative structure for designing and implementing a health insurance program for uninsured children up to age 18.

According to 1997 data, the breakdown of families living below poverty is as follows:

- ◆ 15 percent are native U.S. citizens,
- ◆ 13 percent are naturalized U.S. citizens, and
- ◆ 32 percent are not U.S. citizens.

In addition, the breakdown of families living without health insurance is as follows:

- ◆ 21 percent are native U.S. citizens,
- ◆ 33 percent are naturalized U.S. citizens, and
- ◆ 53 percent are not U.S. citizens.

Barriers and Challenges of Enrolling Immigrant Children. Many of the immigrant families residing in Texas are not enrolling in SCHIP/Medicaid. Indeed, Texas, like many States, is experiencing a decline in Medicaid enrollment of about 300,000 cases. This decline in Medicaid enrollment is due to several issues, including public charge; fear of deportation or being reported to the INS; and language/translation barriers.

- ◆ Being deported is a real fear among Texas' Latino and Hispanic populations and is fueled by real life stories that are not soon forgotten. For instance, a promotoras' son, an U.S. citizen, was confronted by an INS officer at the school as he got off his school bus, and requested that he produce proof of U.S. citizenship; fortunately, a near-by school teacher intervened.
- ◆ Fear of sponsorship is predominant among Asians.

Texas has also had difficulty recruiting Asian speaking outreach workers for Medicaid and/or county-based indigent health care programs. One local health department had one Vietnamese individual that the Vietnamese population followed because they trusted her.

Strategies to Overcome Barriers and Foster Enrollment. Texas recognizes the barriers mentioned above, especially the barriers associated with fear that prevent immigrants from applying to SCHIP, and, in response, is taking a proactive approach to implement strategies to foster the enrollment of immigrant children. Strategies include:

- ◆ **Recruitment of "Promotores" to Conduct Outreach to Ethnic Populations.** Texas is a Covering Kids grantee and has received a grant to conduct "Project Alberto," using 'Promotores' or indigenous health workers to conduct outreach in Brownsville.
- ◆ **Building on Established Coalition Networks.** Texas intends to work with, on a statewide basis, CBOs, refugee coalitions, and immigration attorneys to implement a community-based TX CHIP/Medicaid outreach and enrollment initiative (similar to New York) whereby Texas intends to provide funding to organizations to conduct TX CHIP/Medicaid outreach and application assistance.
- ◆ **Conducting a Grass-Roots Campaign.** Texas is planning a grass-roots campaign with CBOs, as well as with local and State offices throughout Texas, to educate communities about policy changes, such as the public charge issue.

Questions and Answers

After each State presented, Workshop attendees were given the opportunity to pose questions to each of the States.

Q: *What types of strategies have States implemented to measure the effectiveness of outreach strategies (such as, tracking applications from CBOs or school-based enrollment efforts and responses after PSAs)?*

A: *New Jersey.* New Jersey has implemented several evaluation strategies, including:

- ◆ Soliciting help from CBOs throughout the State to enroll as voluntary assistance locations. Each CBO responding to the solicitation was assigned a four-digit code that enables New Jersey’s vendor to provide feedback to CBOs on the status of submitted applications.
- ◆ Sorting data, by county, to assess the reasons particular outreach strategies are effective across different areas of the State.
- ◆ Asking each caller of the NJ KidCare 1-800 hotline where he or she heard about NJ KidCare.⁵¹ New Jersey noted that partnerships with public and private vendors make it possible to collect and evaluate data on an ongoing basis.

A: *Illinois.* Illinois noted that due to the volume of applications received, it is difficult to track the origin of each application. Several efforts currently underway include:

- ◆ Paying CBOs and hospitals a fee to be KidCare Application Agents, which enhances the State’s ability to track the point of entry of applications.
- ◆ Asking the applicant, on the Illinois Kid Care application, where he or she heard about Illinois Kid Care. This information is collected whether or not an applicant is approved for enrollment.
- ◆ Using the Medicaid Information Management System (MIMS) to support the Kid Care program. MIMS does not collect information on disapprovals, so Illinois is designing a system to capture the results of every application received (approved and not approved) and to capture the demographic information provided in applications.

A: *California.* California indicated that it:

- ◆ Collects data on a monthly basis on “everything;” data indicate that there is a direct correlation between high outreach activity and high enrollments within a month.
- ◆ Collects data on languages to assess the effectiveness of outreach performed in ethnic languages.
- ◆ Uses the GIS mapping system to identify eligible populations by address and zip code to track enrollment patterns.

A: *Florida.* Florida indicated that it collects enrollment data at the county level and evaluates it against outreach activities. The hotline also tracks how individuals have heard about Florida KidCare. Florida’s original application asked a question about where the applicant had heard

⁵¹ Friends and Families and schools are frequently cited sources of information.

about SCHIP; however, State advocates encouraged the State to remove the question in an effort to streamline the application through the removal of all unessential questions.

A: *Texas.* Texas currently tracks Medicaid information by county and zip code. The same type of information will be collected for TX CHIP, including how the applicant heard about TX CHIP. The joint application being developed will also have a designation question about where people heard about TX CHIP. Texas uses the information to evaluate the effectiveness of the outreach campaign and the activities of the CBOs.

Q: *Many SCHIP applications and outreach materials produced by States affirm that the information collected is not shared with the INS. Are there cases when States are compelled to disclose this information to the INS?*

A: An Workshop attendee from the INS’ Community Relations Department stated his understanding that there are no circumstances when the INS has to be notified, with the exception of fraud. However, as another Workshop attendee indicated, these rules do not stop “whistle blowers” from reporting information to the INS.

A: *California.* California reiterated that the joint application and fact sheets it produces indicate that Medi-Cal and the HFP do not collect information on the immigration status of parents and that this information, because it is not collected, is not reported to the INS.

◆ The current version of the joint application, under Question 25, states:

“Immigration information we get as part of this application is private and confidential. The State will use this information only for eligibility determination and program administration.”

◆ Legal advice received led to the inclusion of language in the Privacy Notice of the joint application, which contains the following statements:

“...This information may be shared with federal, state, and local agencies for purposes of verifying eligibility and for other purposes related to the administration of the Medi-Cal program, including confirmation with the INS of the immigration status of only those person seeking the full scope of Medi-Cal benefits. (Federal law says the INS cannot use the information for anything else except in the cases of fraud.)”

◆ There is a provision in the Immigration Law of 1996 that prohibits States and local governments from passing laws prohibiting employees from reporting individuals to the INS. Consequently, there is an isolated possibility that a “whistle blower” could report an individual.

◆ States should educate and empower immigrant individuals to know their rights, as well as the limits on questions that can be asked of them.

Q: *Do SCHIP programs have strong partnerships with local health departments? Are they successful or unsuccessful?*

A: *California.* California uses its federal MCH block grant to fund a local MCH program in each county. Each county administers the State’s EPSDT program. Each county program reports

back to the State how many children they have found and referred for enrollment into the HFP.

- A: *Texas.*** The role of local health departments differs by community. In some communities, the local health department and CBOs are integrated and work effectively together. In the future, Texas will be giving grants to a local lead agency to form coalitions, with the hope that some of the selected lead agencies will be local health departments.
- A: *New York.*** Some coalitions that responded to the State’s RFP for facilitated enrollment include local health departments.
- Q: *What funding streams do Texas and Illinois use to pay the State programs that cover non-qualified aliens? What funds does Texas use for State employees who are not eligible for the SCHIP program by federal rules, but are eligible by income standards?***
- A: *Texas & Illinois.*** Texas and Illinois use State general fund revenues to cover those qualified immigrants under the five year bar.
- A: *California.*** The Medi-Cal program extends benefits, supported by State general funds, to immigrants who entered the United States after August 22, 1996.
- A: *Florida.*** Florida uses general revenue with a local match that is capped. Tobacco settlement dollars have been put towards Florida’s KidCare program.
- Q: *Do States track data, such as country of birth and age at the same time, for immigrant adolescents and teens? What strategies, if any, do States use to target adolescents in general?***
- A: *Texas.*** Texas is aware that most of the TX CHIP outreach materials are targeted towards younger audiences. In order to develop outreach materials geared towards different age groups, Texas is conducting focus groups to test the effectiveness of words, such as “children,” “kids,” and “children and teenagers.” In addition, Texas also plans to seek input from community-based coalitions as to what are appropriate messages to reach adolescents.
- A: *Illinois.*** Illinois does not collect place of birth data on immigrant adolescents (or any children for that matter) due to efforts to simplify the application and facilitate enrollment. County of birth is not collected as it is not needed to determine an applicant’s eligibility.
- A: *Florida.*** Reaching the adolescent population has been a challenge in Florida. Florida has produced some promotional items that are specifically targeted at teens, particularly as a part of school-based outreach programs.
- A: *California.*** California created a case managers program specifically for adolescents. Case managers have approximately 38,000 cases; they also serve as certified application assistants to “shepherd” adolescents through the system to ensure these adolescents receive appropriate care.