



CALIFORNIA IMMIGRANT WELFARE COLLABORATIVE

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California Performance Review Recommendations Threaten Immigrants' Access to Health and Human Services

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The California Performance Review (CPR), as described in the governor's budget summary, was intended to increase the efficiency of California's government while recognizing "that state government has a special obligation to serve the public." However, many of the recommendations in the CPR Commission's 2,500-page report appear to disregard that "special obligation" when it comes to the needs of immigrant families. This is particularly true in the health and human services arena, where efforts to streamline program enrollment and operations could make those programs significantly less accessible to immigrants and their families.

Policy changes that overlook the issues and concerns of immigrant households will not be effective in California. Immigrant families comprise a substantial share of the state's population. According to the 2000 U.S. Census, 26 percent of California residents were born outside the U.S. Almost half of the children in California have at least one immigrant parent.¹ Any new health and human services system that works for California must be designed to consider and meet the needs of these immigrant families.

In this issue of the CALIFORNIA UPDATE, we review some of the CPR report's Health and Human Services provisions that present the most significant concerns for immigrant families. Because the report was written in general terms, no information is available for comment on the details of these proposals. In addition, the CPR Commission has recommended that any major reorganization of the state Health and Human Services agency be "coordinated with or postponed until the Medi-Cal, CalWORKs and other program reforms and realignment initiatives are completed."² It is not clear how many of the recommendations discussed below are considered by the commission to be part of the reorganization and subject to postponement.

Consolidated Application Process

The CPR report proposes to "transform" the eligibility process for public benefit programs by centralizing Medi-Cal,

CalWORKs, and the Food Stamp Program application processes at the state level. The report cites as a model the Healthy Families Program's statewide eligibility processing and use of a public-private partnership. The report further recommends the development of a consolidated Internet-based application process for all programs.

There is no question that California's complex benefit application processes must be simplified. CIWC's 2002 survey of immigrant service providers found that the burdensome application process was the most frequently cited obstacle to immigrants' accessing health care. A specific CPR recommendation, to provide self-declaration of assets for most Medi-Cal applicants, provides an important starting point. Nonetheless, there are significant risks in the proposed consolidation of the application processes for Medi-Cal and Healthy Families, for which the eligibility unit is an individual, with the application processes for food stamps and CalWORKs, which are provided to households.

Immigrant households typically include family members with a range of immigration statuses: 85 percent of immigrant-headed households include at least one U.S. citizen.³ Such households frequently include members who are eligible for public benefits and others who are ineligible, or who are simply concerned that applying for benefits will have an adverse effect on their immigration status. The implementation of a consolidated application process could decrease access to needed benefits for eligible members of such mixed-status families. Health care providers

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and social service organizations rely on their ability to reassure immigrant parents of eligible children that they can apply for Medi-Cal or Healthy Families on their children's behalf without being forced to respond to questions about their own immigration status. Care must be taken to ensure that any consolidated benefit application process is implemented in a manner that provides family members assurances about their privacy and protects their right to designate themselves as nonapplicants.⁴

The CPR report also recommends the payment of application assistance fees to certified application assisters (CAAs). If the availability of linguistically and culturally competent CAAs is assured and the CAAs receive adequate training, this approach may help offset some of the burdens associated with the application process. However, the report recommends that the CAAs receive a one-time application fee only. Many families, especially those that are more recent arrivals from countries that do not have comparable social welfare or managed health care systems, will need ongoing support in securing and using benefits. In addition, many families will need assistance with eligibility renewals. Meaningful CAA assistance would require more continuous funding.

Children's Health Initiatives

Statewide centralization of health care benefits application processes also risks a reversal of the important progress by local communities in ensuring that every child within their jurisdiction has health insurance. A growing number of California counties, including Santa Clara, San Francisco and Los Angeles, use local funds to provide health coverage for children who are not eligible for Medi-Cal or Healthy Families. An important principle of these "Children's Health Initiatives" is the use of a "seamless" application process for families applying to cover their children.

Through the seamless application process, families apply once for all health programs, and workers direct the application to the appropriate program. This process is of particular benefit to families whose children are eligible for different programs—for example, mixed status families with older undocumented siblings and younger U.S.-born siblings, or families whose income level makes their younger children eligible for Medi-Cal and their older children eligible for Healthy Families.

Efforts to centralize benefits application processes at the state level should ensure that local communities maintain the ability to adopt a user interface that provides seamless access to their programs. Until the state provides access to health coverage for all California children, this will require an application that can be customized to meet the needs of individual counties.

Privacy Issues

The CPR report proposed the use of a "smart card," one that includes a biometric identifier, to identify persons enrolled in the Medi-Cal program. Many immigrants are reluctant to provide information to benefits agencies because they are concerned

that using benefits could interfere with their ability to adjust their status or sponsor relatives, or that it could cause them to be separated from their families and communities by increasing the risk that they or their family members will be removed from the country.

The collection and use of biometric identification can be expected to heighten immigrant communities' fears about using public programs. Recent proposals to require reporting of undocumented emergency patients, as well as "national security" initiatives taken in the wake of the 9/11 terrorist attacks, have increased fears among lawfully present as well as undocumented persons. The American Immigration Lawyers Association stated in a recent comment letter to the Center for Medicare and Medicaid Services (CMS):

We cannot over-emphasize the fear in the immigrant community—both documented and undocumented—of the "immigration authorities." The fear by undocumented immigrants is clearly one of removal. Similar fear exists in many documented immigrants. They fear introducing government authorities into their community, out of concern for those whose status may not be as clean as theirs. Also, as the result of administrative actions in the past three years, even the documented fear their own detention and removal, as they have watched people who believed themselves to be present legally be detained, brought under removal proceedings and, in some cases, actually removed. There is no trust of government in this community—only fear.⁵

Of particular concern is the suggestion that parents' fingerprints might be used on their children's cards. As discussed above, many California families include immigrant parents and U.S. citizen children. Requiring parents to provide their fingerprints when they enroll their children in Medi-Cal will deter immigrant parents from enrolling their children in this vital health insurance program. This recommendation also has practical problems for any family in which a person other than the fingerprinted parent might take a child to the doctor.

Similarly, efforts to improve the collection and tracking of information, such as the very positive goal of establishing a children's immunization registry, should not rely on Social Security numbers as a unique identifier. The use of SSNs as an identifier may intimidate immigrant families, which often regard such a practice as a proxy for requiring that they prove their immigration status.

Realigning Health and Human Services

The CPR report proposes a realignment of state and county responsibilities for several programs, including the medically indigent adult (MIA) program. The CPR Commission's recommendation that "major reorganization" be deferred appears to affect this recommendation.

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The report recommends the creation of a statewide MIA program, with standard eligibility criteria. The state would contract for MIA services as it does for services for Medi-Cal and Healthy Families. The report further notes that the state “could open up opportunities for federal financial participation by including the MIA population in Medi-Cal.” It is not clear how MIA participants would qualify for federally supported Medicaid, since childless, nondisabled adults (who are not pregnant) are not categorically eligible for Medicaid under federal rules. Several states have obtained Medicaid waivers to serve this population.⁶

Consolidation of the MIA program could have a disproportionate effect on immigrant families that rely on safety-net health care providers. Immigrants are less likely than other workers to receive job-based insurance, and their eligibility for public programs is more limited than U.S. citizens’. As a result they are uninsured at much higher rates than the general population and are more reliant on safety-net health care providers.⁷ Many safety-net providers have invested in service to particular minority and immigrant communities, and have a high degree of cultural competence. County health financing provides a source of support for safety-net healthcare providers. State contracting for MIA services could undermine the existing network of safety-net service providers with expertise in meeting the needs of medically indigent and culturally diverse adults. If the proposal is implemented, the state needs to ensure that cost-effective and expert service providers, such as community clinics and health centers, are included in and strengthened by a state-run program.

County MIA programs vary in terms of eligibility standards and the scope of services they provide. While the CPR proposal provides minimal detail, it is likely that a statewide consolidation would reduce access to care for individuals living in counties that currently have generous programs. Developing a consolidated statewide program that denies eligibility to low-income county residents would be self-defeating, because there would be a continued need to provide health services at the community level to avoid the public health consequences of denying the uninsured access to health care.⁸

Similar concerns arise with respect to the CPR proposal to change the standards by which Disproportionate Share Hospitals (DSH) funds are distributed to hospitals. The DSH program provides funds to help sustain safety-net hospitals that serve a disproportionate share of uninsured or Medi-Cal patients. DSH

program standards should be aligned with this purpose, rather than being based on criteria such as a facility’s compliance with seismic standards or services provided.

* * *

The rules governing immigrants’ eligibility for benefits are complex. Ensuring access to benefits further requires that services are provided in a culturally and linguistically competent manner, and that families’ concerns about immigration status are not triggered. Addressing these concerns successfully will require close attention to the details of any implementation plan.

NOTES

¹ Nadereh Pourat, Gabrielle Lessard, Armine Lulejian, Lida Becerra, and Rini Chakraborty, *Demographics, Health and Access to Care of Immigrant Children in California: Confronting Barriers to Staying Healthy* (UCLA Center for Health Policy Research, March 2003).

² *The Commission’s Perspective: A Report of the California Performance Review Commission* (November 2004).

³ Michael Fix, Wendy Zimmerman, and Jeffrey Passell, *The Integration of Immigrant Families in the United States* (Urban Institute, July 2001).

⁴ See “U.S. Department of Health and Human Services/Department of Agriculture Policy Guidance Regarding Inquiries into Citizenship, Immigration Status and Social Security Numbers in State Applications for Medicaid, State Children’s Health Insurance Program (SCHIP), Temporary Assistance for Needy Families (TANF), and Food Stamp Benefits,” September 21, 2000.

⁵ Letter from American Immigration Lawyers Association to Jim Bossenmeyer, CMS, regarding the implementation of Section 1011 of the Medicare Act.

⁶ Dorn, *et al.*, *Medicaid and Other Public Programs for Low-Income Childless Adults: An Overview of Coverage in Eight States* (Kaiser Commission on Medicaid and the Uninsured, August 2004).

⁷ Leighton Ku and Alyse Freilich, *Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami and Houston*, Kaiser Commission on Medicaid and the Uninsured (Feb. 2001)

⁸ See “Comprehensive HealthCare for Immigrants: A Sound Strategy for Fiscal and Public Health” (National Immigration Law Center, April 2004).

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