

Chapter 14: Medi-Cal Services for Immigrants, Including Non-Citizens and Undocumented Immigrants¹

Since the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA),² there has been a misperception in many communities that immigrants and noncitizens are no longer entitled to any federal or state public health benefits. In reality, many immigrants and non-citizens remain eligible to receive a wide range of publicly funded health benefits, including Medi-Cal and Healthy Families. The extent of the services depends on the immigration status of the immigrant. Qualified immigrants or immigrants who are PRUCOL (Permanently Residing Under Color of Law) are eligible for full-scope Medi-Cal, as long as they are “otherwise eligible,” that is, they meet the financial, residential, and categorical requirements of the Medi-Cal program.³ See Chapter 2 for the definition of “qualified,” “not qualified,” and PRUCOL immigrants.

Those immigrants who are not eligible for full scope Medi-Cal still can receive emergency and pregnancy-related services under restricted or emergency Medi-Cal,⁴ as well as other types of services. This chapter explains the range of publicly funded health services available to these immigrants.

Restricted or Emergency Medi-Cal, Including Pregnancy-Related Care⁵

The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- (1) Placing the patient's health in serious jeopardy.
- (2) Serious impairment to bodily functions.
- (3) Serious dysfunction to any bodily organ or part. It is the intent of this section to entitle

¹ This manual uses the term “immigrant” or “noncitizen” rather than the technical immigration law term, “alien,” for a person who is not a citizen. According to 8 U.S.C. § 1101(15), “immigrants” refers to most “aliens,” except for a list that includes those with temporary visas or those who do not intend to stay permanently in the U.S. Nonimmigrants, such as foreign visitors or students who do not have an intent to stay permanently or for an indefinite period of time may not meet the residency requirements to receive Medi-Cal. For those persons who have a nonimmigrant visa, applying for Medi-Cal may cause problems if the Department of Homeland Security suspects that the application for the temporary visa was fraudulent. It is advisable to consult an immigration attorney for additional information.

² Public L. No. 104-193, 110 Stat. 2105 (Aug. 22, 1996). PRWORA created new restrictions on immigrant eligibility for Medicaid and prohibited federal financial participation for “qualified” immigrants for five years if the immigrant arrived after August 22, 1996, and “not qualified immigrants,” which includes PRUCOL immigrants, regardless of when they entered the U.S.

³ Cal. Welf. & Inst. Code § 14007.5(b); Cal. Welf. & Inst. Code § 11104 (eligibility of immigrants who are PRUCOL).

⁴ Cal. Welf. & Inst. Code § 14007.5(d); 8 U.S.C. § 1611(b)(1)(A). This also includes continued coverage of “inpatient and outpatient services that are necessary for the treatment of the emergency condition.” Cal. Welf. & Inst. Code § 14007.5(d)(3). *See also Crespin v. Kizer*, 226 Cal.App.3d. 498, 516-18, 581-582; 276 Cal. Rptr. 571, 581-82 (Cal. App. 1 Dist. 1990)(state created a state-only funded program to provide non-emergency pregnancy care to “illegal” or undocumented immigrants).

⁵ Although the terms are used interchangeably, restricted Medi-Cal covers more services than services to address emergency medical conditions.

eligible individuals to inpatient and outpatient services that are necessary for the treatment of the emergency medical condition in the same manner as administered by the department through regulations and provisions of federal law.⁶

Immigrants eligible for restricted or emergency Medi-Cal benefits can be pre-certified and apply in advance of needed health care services.⁷ They will receive Medi-Cal cards noting their entitlement to services to treat an emergency medical condition and pregnancy-related services.

Under restricted Medi-Cal, pregnant immigrants can receive pregnancy-related services, which include prenatal care, labor, delivery, up to 60 days post-partum care and family planning services.⁸ Women can also receive abortion services. See Chapter 13 for more information about pregnancy-related services.

Breast and Cervical Cancer Treatment Programs

There are two Breast and Cervical Cancer Treatment Programs (BCCTP), one that receives federal matching payments,⁹ and one that is state-only funded and which provides more limited treatment for “not qualified” immigrants, including undocumented immigrants.¹⁰ See Chapter 7 for additional information about both programs.

In order to qualify for the state-only BCCTP, female and male immigrants of any age must meet all of the following requirements:

- Be diagnosed with breast or cervical cancer.¹¹
- Be underinsured or not have any other creditable health insurance.¹²
- Be a California resident.¹³
- Be found ineligible for the federally funded BCCTP.¹⁴
- Must have monthly income at or below 200% of the Federal Poverty Level.¹⁵

Like the federal BCCTP, this program does consider an applicant’s resources. Unlike the federal BCCTP that provides full-scope Medi-Cal benefits, the state-only program provides *time-limited* Medi-Cal benefits *for only* breast and cervical cancer-related treatment for up to 18 months for

⁶ Cal. Welf. & Inst. Code § 14007.5(d); Cal. Code of Regs. tit. 22, § 51056. For the federal definition, *see* 42 U.S.C. § 1396b(v)(3); 42 C.F.R. § 440.255.

⁷ Cal. Code of Regs. tit. 22, § 50740.

⁸ Cal. Welf. & Inst. Code § 14007.7. *See also* ACWDL # 98-12 (Mar. 3, 1998);

www.ladpss.org/dpss/health_care/pregnant_women/pregnant_only_medical.cfm. Although the pregnant woman can get presumptive eligibility for Medi-Cal through a qualified provider, she must apply for Medi-Cal. If she fails to apply before the last day of the month following the month in which she was determined presumptively eligible for Medi-Cal, her benefits will end. 42 U.S.C. § 1396r-1(b)(a)(B); Medi-Cal Eligibility Procedures Manual, 5M-4, 5M-6.

⁹ Cal. Welf. & Inst. Code § 14007.71.

¹⁰ Cal. Health & Safety Code § 104161-104163.

¹¹ Cal. Health & Safety Code § 104162(c).

¹² Cal. Health & Safety Code § 104161(g); Cal. Health & Safety Code § 104162(b).

¹³ Cal. Health & Safety Code § 104162(a)

¹⁴ Cal. Health & Safety Code § 104162(e).

¹⁵ Cal. Health & Safety Code § 104162(d).

breast cancer and 24 months for cervical cancer.¹⁶ However, an applicant for this program does not have to provide her social security number and can have her provider help her complete the application online.

Long-Term Care and Kidney Dialysis

Long-term care services are provided for “otherwise eligible” immigrants through a state-funded program.¹⁷ Initially, the state created a state-funded program of long-term care and renal dialysis for “not qualified” and undocumented immigrants as a result of a court decision.¹⁸ The Department of Health Care Services, formerly known as the Department of Health Services, acknowledged that “in most cases renal dialysis does constitute ‘emergency’ treatment’ for which federal financial participation is available....”¹⁹ The court interpreted the statute as creating a “safety net” program to only fund long-term care and renal dialysis that did not qualify for federal reimbursement as an “emergency medical condition.”²⁰

Family Planning, Access, Care and Treatment (Family PACT)

The Family PACT²¹ program provides family planning including emergency contraception, screening and treatment for sexually transmitted diseases and other related services to women to age 55, men to age 60, and adolescents who are at risk for pregnancy prevention or at risk for causing pregnancy. Immigration status is not considered for Family PACT services. Eligible persons must have incomes below 200% FPL, and be uninsured or underinsured, meaning either that their insurance does not cover family planning or that they have share-of-cost Medi-Cal. Family PACT services are confidential, and providers are prohibited from notifying parents or spouses. Family PACT does not cover abortion services, but immigrants can obtain abortion services under pregnancy-related care.

Minor Consent Services

This program offers specific confidential services to some female and male minors under age 21, regardless of immigration status, who are unmarried and living with a parent or guardian or are claimed as a dependent on a parent’s tax return.²² Eligibility is based on the minor’s income and resources, not the parental income or property, and there is no share of cost. A minor should not

¹⁶ Cal. Health & Safety Code § 104161.1

¹⁷ Cal. Welf. & Inst. Code § 14007.65. See *Crespin v. Belshe*, Alameda County Superior Court, No. 636714-5 (court denied state’s motion to dissolve a permanent injunction prohibiting the state from denying long-term care services to undocumented immigrants).

¹⁸ *Crespin v. Kizer*, 226 Cal.App.3d. 498, 517-18; 276 Cal. Rptr. 571, 583 (Cal. App. 1 Dist. 1990). Although the decision was published before PRWORA was passed in 1996, the state must fund the state-only Medi-Cal program that covers medically necessary long-term care and renal dialysis for these immigrants, as well as “otherwise eligible” immigrants, such as undocumented immigrants.

¹⁹ *Crespin v. Kizer*, 226 Cal.App.3d. at 510; 276 Cal. Rptr. at 577. See *Crespin v. Belshe*, Alameda County Superior Court, No. 636714-5 (court denied state’s motion to dissolve a permanent injunction prohibiting the state from denying long term care services to undocumented immigrants).

²⁰ *Crespin v. Kizer*, 226 Cal.App.3d. at 515; 276 Cal. Rptr. at 581.

²¹ Cal. Welf. & Inst. Code § 24007.5; Family PACT: An Overview, California Department of Public Health, [www.familypact.org/ Resources/Documents/FS_060517_FPACTOverview_Final.pdf](http://www.familypact.org/Resources/Documents/FS_060517_FPACTOverview_Final.pdf).

²² Cal. Code Regs. tit. 22, § 50147.1.

be asked for her or his immigration documents or social security number. Minor Consent services are provided only for 30 days, and the minor has to recertify his or her need for services with the county every month.²³ Minors can obtain these services without a parent's consent, and, with limited exceptions, providers are prohibited from notifying the minor's parents unless the minor agrees.²⁴ Minor consent services cover:

- Substance abuse treatment for children age 12 or older.
- Mental health services for children age 12 or older who are mature enough to participate intelligently and which are needed to prevent the children from seriously harming themselves or others or because the children are the alleged victims of incest or child abuse.
- Family planning including emergency contraception, abortion, and pregnancy/prenatal services, but not sterilization.
- Sexually transmitted and venereal disease screening and treatment for children age 12 or older.
- Sexual assault and rape treatment²⁵

Minors can also receive family planning services, pregnancy tests, and screening and treatment for sexually transmitted infections through the Family PACT program. Family PACT guarantees confidentiality and provides enrollment at the provider's office or clinic, making it an easier system for teens to navigate.

See Chapter 7 for additional information about the Minor Consent program and Chapter 13 about Family PACT.

Advocacy Tip ► Advocates should refer teens (male and female) to a Family PACT provider rather than Minor Consent Medi-Cal for family planning and screening for sexually transmitted diseases.

Child Health and Disability Prevention Program (CHDP)

CHDP provides for the early detection and prevention of disease and disabilities²⁶ for low-income children under age 20 whose family income is 200% FPL or below, regardless of immigration status.²⁷ The program pays for regular infant and child health assessments or check-ups, immunizations, nutrition screening, lead screening, vision and hearing tests, lab tests, dental assessments, outreach and educational services, and referrals for further diagnosis and treatment, if necessary, but not hospital care.²⁸ There is a CHDP periodicity schedule for child health

²³ Cal. Code Regs. tit. 22, § 50195(d).

²⁴ Cal. Code Regs. tit. 22, § 50157(f)(3).

²⁵ Cal. Welf. & Inst. Code § 14010; Cal. Fam. Code §§ 6924-6929; Cal. Code Regs. tit. 22, § 50063.5.

²⁶ See www.dhcs.ca.gov/services/chdp/Pages/default.aspx and Chapter 12 for additional information about the program.

²⁷ Cal. Health & Safety Code §§ 124025 & 124090. However, if the county screens the joint Medi-Cal/Healthy Families application and the child is not a citizen, "qualified" immigrant or PRUCOL, she will only receive restricted Medi-Cal.

²⁸ Cal. Health & Safety Code § 124040.

assessments, based on the age of the child. To obtain CHDP services, the child must be taken to a doctor, clinic or other health care provider enrolled in the CHDP program who can enroll the child.²⁹

There is a related program, the CHDP Gateway Program that helps eligible children enroll in Medi-Cal or Healthy Families and provides the full scope of benefits covered by Medi-Cal for two months each time they return for a periodic medical visit.³⁰ The provider can enroll the child through an electronic application process when she has an appointment by filling out a confidential “pre-enrollment” form.³¹ The information is entered into a computer to determine the child’s eligibility. If the child is determined to be eligible for CHDP and preenrollment into the Medi-Cal program, she will receive full scope Medi-Cal with no Share of Cost for at least the month of screening and the following month.³² The child will get a receipt allowing her to get temporary Medi-Cal services until the end of the following month. A temporary Medi-Cal card will be sent to the home. The pre-enrollment form does not ask about immigration status and any information provided will be kept confidential, and only used to determine eligibility for temporary Medi-Cal or other CHDP services.³³ The Parent can also check a box to request a Medi-Cal/Healthy Families Joint Application. In order to continue coverage, the Joint Application must be submitted before the temporary Medi-Cal card expires. Chapter 6 has additional information about the Medi-Cal application process.

Refugee Medical Assistance

Immigrants who flee persecution in their home country are classified as refugees by the Department of Homeland Security (DHS). Refugees and entrants who are not otherwise eligible for Medi-Cal under federally-funded TANF, SSI/SSP, MN or Medically Indigent Child programs may be eligible for Medi-Cal through the special federal programs of Refugee Medical Assistance (RMA) or Entrant Medical Assistance (EMA).³⁴ The purpose of the Refugee Assistance is to “allow refugees to more quickly adapt to their new country, become economically self-sufficient, and ultimately participate in and contribute to their new community.”³⁵ The federal Office of Refugee Resettlement administers the program and the DHCS’s Medi-Cal Eligibility Branch oversees the special refugee programs, which fully federally funded.³⁶

²⁹ Cal. Health & Safety Code § 124033. Referrals to local CHDP providers are made by county health departments. County health departments are listed on the Web at: www.dhcs.ca.gov/services/chdp/Pages/countyoffices.aspx.

³⁰ Cal. Welf. & Inst. Code § 14011.7.

³¹ Cal. Welf. & Inst. Code § 14011.7(c)(1).

³² Cal. Welf. & Inst. Code § 14011.7(e)(3)(B).

³³ Any information and results of the health screening and evaluation of each child shall be confidential and shall not be released without the informed consent of a parent or guardian of the child. Cal. Health & Safety Code § 124110.

³⁴ Cal. Welf. & Inst. Code § 14005.2; Cal. Code Regs. tit. 22, § 50257(a). In § 50257(b)(1), there is a reference for the definition of “refugee.” See also *Article 24: Refugee Medical Assistance Program*, 24B-1, Medi-Cal Eligibility Procedures Manual (hereinafter MEPM). RMA and EMA have very similar eligibility requirements and beneficiaries have the same time period limits. The EMA program, however, is for Cuban and Haitian entrants who are usually not considered refugees.

³⁵ MEPM, *Article 24: Refugee Medical Assistance Program*, 24A-1.

³⁶ MEPM, *Article 24: Refugee Medical Assistance Program*, 24A-1.

Recipients of Refugee Cash Assistance (RCA) or Entrant Cash Assistance (ECA) automatically receive a Medi-Cal card. But receipt of RCA/ECA is not a condition of RMA/EMA eligibility and refugees may apply for "RMA/EMA-Only" benefits even if they don't get cash assistance.³⁷ Every eligible refugee is guaranteed eight months medical assistance and receives the same benefits as Medi-Cal beneficiaries.³⁸

Under the Victims of Trafficking and Violence Protection Act of 2000,³⁹ adults and children who are certified as being victims of a severe form of trafficking can receive the same benefits and services as refugees.⁴⁰ The victim must be either under 18 years of age or be certified by HHS as willing to assist in the investigation and prosecution of severe forms of trafficking persons. To be certified, the person must make a bona fide application for a T visa, the visa must not have been denied, and HHS must determine that the person's continued presence in the U.S. is being ensured by the attorney general in order to prosecute traffickers.

Access for Infants and Mothers (AIM) Program

The AIM program was created to provide perinatal health care to women and children of limited economic means, to focus attention on the need for a more efficient system of perinatal care, including the need for consolidation of services within the existing programs, and to promote better access and coordination of comprehensive services for women and children.⁴¹ This program is available to women who have resided in California for at least six months, regardless of immigration status. The Managed Risk Medical Insurance Board (MRMIB) administers the program.⁴²

In order to be eligible, a woman must be uninsured or have health insurance with a deductible or co-payment for maternity services of over \$500. All pregnancy and delivery related services are provided by a private health plan. Services provided include hospital services, physician services, clinical services, preventive and primary care,⁴³ case management,⁴⁴ outreach, immunizations, nutrition, perinatal substance abuse services,⁴⁵ health education services related to tobacco use,⁴⁶ medically necessary prescription drugs, and basic health services.⁴⁷ The pregnant woman, regardless of her immigration status, is covered for her pregnancy, and for 60 days

³⁷ Cal. Code Regs. tit. 22, § 50257(c).

³⁸ MEPM, *Article 24: Refugee Medical Assistance Program*, 24A-2.

³⁹ Pub. L. No. 106-386 § 107 (Oct. 28, 2000).

⁴⁰ Cal. Welf. & Inst. Code § 14005.2; MEPM, *Article 24: Refugee Medical Assistance Program*, 24A-2. For the definition of trafficking victims and the eligibility requirements, see MEPM, *Article 24: Refugee Medical Assistance Program*, 24B-16-17.

⁴¹ Cal. Ins. Code 12695. For a description of the AIM program, see the Web site: www.mrmib.ca.gov/mrmib/AIM.html.

⁴² Cal. Ins. Code §§ 12695.08, 12696.

⁴³ Cal. Ins. Code § 12695.12.

⁴⁴ Cal. Ins. Code § 12695.10.

⁴⁵ Cal. Ins. Code § 12695(b)(3).

⁴⁶ Cal. Ins. Code §§ 12695.16, 12696.10 & 12698.30(c).

⁴⁷ Cal. Ins. Code § 12698.30(b). This includes physician services, outpatient services, inpatient and outpatient hospital services, diagnostic laboratory and radiologic services, home health services, voluntary family planning services, services for infertility, well-child care from birth, periodic health evaluations for adults, and eye and ear examinations. 42 C.F.R. § 417.101.

thereafter, and her infant is automatically eligible for Healthy Families coverage.⁴⁸ She must be a resident of California with a family income between 200%-300% of FPL.⁴⁹ Applicants can be reimbursed for up to \$125 for pregnancy-related services received in the period from 40 days before the completed application is received by AIM until the beginning date of coverage, so long as she submits the original bills within 90 days of the date she received the services.⁵⁰

Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA was passed in 1986 to prevent hospital emergency rooms from refusing to treat people who need emergency medical assistance but have no health insurance or other means to pay the bill.⁵¹ It is sometimes called the federal “antidumping” statute. EMTALA applies to a person’s treatment at a hospital emergency department, regardless of the person’s citizenship or immigration status.

Under EMTALA, any hospital that participates in Medicare, which includes almost all acute care hospitals, and has an emergency room must:

- Examine every patient who comes to the emergency room to determine whether they have an emergency medical condition, or are in active labor. If they have an emergency medical condition, the hospital must provide stabilizing treatment within the capacity of the facility.⁵²
- Not transfer a patient prior to stabilization unless the physician on duty (or another qualified medical person with the doctor’s permission) certifies in writing that the medical benefits of transfer outweigh the increased risks to the individual or fetus, because proper medical treatment is unavailable there.⁵³

There are other important provisions of EMTALA:

- Nondiscrimination: Hospitals with specialized capabilities or facilities cannot refuse to accept an appropriate transfer of a patient who requires the specialized care if the hospital has the capability of treating the patient.⁵⁴
- No delay in examination or treatment: Hospitals may not delay the screening or treatment of a patient to inquire about the individual’s health insurance status or proposed method of payment.⁵⁵

⁴⁸ Cal. Ins. Code § 12698.30(a). The infant may not enroll in Healthy Families coverage if she has employer-sponsored coverage through a parent or is enrolled in Medi-Cal with no share of cost.

⁴⁹ Cal. Ins. Code § 12698.

⁵⁰ Cal. Ins. Code § 12698.25; Cal. Code Regs. tit. 10, § 2699.303.

⁵¹ 42 U.S.C. § 1395dd.

⁵² 42 U.S.C. § 1395dd(a) & (b).

⁵³ 42 U.S.C. § 1395dd(c). A transfer is appropriate only when: 1) it is made to a facility that has space and qualified personnel to treat the patient and has agreed to accept the transfer and to provide appropriate care; 2) the transferring hospital provides all medical records relating to the emergency medical condition available at the time of transfer; 3) the transfer is effected through qualified personnel and by suitable transportation equipment; and 4) reasonable steps have been taken to obtain a written consent from individuals who refuse treatment or transfer.

⁵⁴ 42 U.S.C. § 1395dd(g).

⁵⁵ 42 U.S.C. § 1395dd(h).

- No retaliation: Hospitals may not take adverse action against or penalize a physician or other qualified medical person who refuses to authorize the transfer of a patient with an unstabilized emergency medical condition, or any hospital employee because the employee reports a violation of the statute.⁵⁶
- Compliance: Hospitals must have and enforce policies to ensure compliance with the law.
- Notice: Hospitals must post signs in emergency rooms alerting individuals, including women in labor, of their right to examination and stabilizing treatment and post information indicating whether the hospital participates in Medicare.
- Penalties: Hospitals and physicians that fail to comply with EMTALA can be fined up to \$50,000 by the U.S. Dept. of Health & Human Services for each violation, lose their right to participate in Medicare, and can be sued by individuals for damages for personal injury or to obtain a court order to require the hospital to comply with the law.⁵⁷

Hill-Burton Act

The Hill-Burton Act is a federal law that provided hospitals and nursing homes with construction and renovation grant funds.⁵⁸ As a condition of accepting the funds, the facilities incurred two distinct obligations:⁵⁹

- Uncompensated care obligation:
Facilities receiving Hill-Burton funds agree to provide a reasonable amount of services to persons unable to pay for their health care services. The annual amount of free care provided must be worth 10% of all grants received or 3% of their annual operating costs. The obligation only lasts about 20 years after the date of the grant, so most facilities are no longer bound by it, but some are.⁶⁰ Facilities with uncompensated care obligations are required to post notices about their program in the facility in English and Spanish, as well as in the “usual language of households” comprising ten percent or more of the population in the service area of the facility.⁶¹
- Community service obligation:
Unlike the uncompensated care obligation, the community service obligation never ends.⁶² It prohibits the facility from discriminating on any ground unrelated to an individual’s need for services or the availability of the needed service in the facility. Hill-Burton facilities are obligated to accept all persons able to pay for their care, either directly or through insurance coverage including Medi-Cal, Healthy Families, Medicare, and state and local government programs. The hospital also has a duty to take

⁵⁶ 42 U.S.C. § 1395dd(i).

⁵⁷ 42 U.S.C. § 1395dd(d).

⁵⁸ Hill-Burton Act is the popular name for Title VI of the Hospital Survey and Construction Act of 1946. *See generally*, 42 U.S.C. §§ 291-291o-1.

⁵⁹ 42 U.S.C. § 291c(e)

⁶⁰ To obtain a current list of facilities with an uncompensated care obligation go to: www.hrsa.gov/hillburton/hillburtonfacilities.htm.

⁶¹ 42 C.F.R. § 124.604.

⁶² However, it is unclear whether the obligation continues when a facility changes ownership, and many of the original structures built with Hill-Burton funds have since been torn down and replaced.

reasonable steps to ensure that the facility and its services are available to public assistance beneficiaries and to notify patients of any governmental programs for which they may be eligible. Notably, Hill-Burton hospitals must maintain an open emergency room for everyone in the service area, even those unable to pay.⁶³

Hill-Burton protections apply regardless of a person's citizenship or immigration status. The Health Resources and Services Administration (HRSA) of the U.S. Department of Health & Human Services (HHS) administers the uncompensated care obligation.

Advocacy Tip ► HHS's Office for Civil Rights is responsible for investigating complaints of hospitals that refuse to honor their community service obligations. Hill-Burton obligations may be enforced by filing an action in court after administrative remedies have been exhausted.

Federally Qualified Health Centers (FQHCs) & Other Clinics

FQHCs receive grants from the federal government to provide health services to underserved populations without regard to a person's ability to pay.⁶⁴ Underserved populations include migratory and seasonal agricultural workers, homeless people, public housing residents, and people who face barriers in accessing health services because they have difficulty paying for services, because they have cultural or linguistic challenges, or because there is an insufficient number of health professionals/resources available in their community.⁶⁵

All FQHCs must provide:⁶⁶

- Basic health service, including primary care, diagnostic, laboratory, and radiology services; prenatal and perinatal services; cancer and other disease screening; well-child services, immunizations against vaccine-preventable diseases; screening for elevated blood lead levels, communicable diseases, and cholesterol; eye, ear, and dental screenings for children; family planning services; preventive dental services; emergency medical and dental services; and pharmaceutical services as appropriate to a particular health center.
- Services that help ensure access to basic health and social services, including case management, referrals to other medical and health-related providers; outreach, transportation, and interpreter services; health education; and help applying for benefits, including Medi-Cal.

HHS also makes grants to migrant health clinics, which are public and private non-profit health clinics that agree to provide services to migratory agricultural workers, seasonal agricultural workers, and their families.⁶⁷ The required services and obligations are almost identical to those of

⁶³ To obtain a list of facilities with a community service obligation go to the National Health Law Program Web site at: www.healthlaw.org. The Web site has a list of all facilities that received Hill-Burton funds, even if the loans are repaid and the uncompensated care obligations are extinguished.

⁶⁴ 42 U.S.C. § 254b et seq.; 42 U.S.C. §§ 1395x(aa)(1) & (2). To find a nearby health center, visit the Web site: <http://ask.hrsa.gov/pc/>.

⁶⁵ 42 U.S.C. § 254b(b)(3).

⁶⁶ 42 U.S.C. § 254b(b)(1).

⁶⁷ 42 U.S.C. § 254b.

community health centers, such as FQHCs, except that migrant health clinic funds can only be used to serve migrants. However, funding for these clinics is inadequate as it only serves a small percentage of the estimated farm worker population.

The Centers for Medicare and Medicaid Services designate certain clinics in rural areas to receive grant assistance.⁶⁸ Services at these clinics are similar to community clinics, which include services of physicians, nurse practitioners, and physician assistants.

Public Health Programs

Immigrants, regardless of immigration status, are also eligible to receive the following non-Medi-Cal public health assistance:⁶⁹

- Short-term, non-cash, emergency disaster relief, such as emergency shelter, food, and clothing⁷⁰
- Immunizations for children and adolescents
- HIV/AIDS-related care and treatment including services funded under the Ryan White Act
- Tuberculosis screening, diagnosis, and treatment
- Sexually transmitted disease screening, diagnosis, and treatment
- Testing and treatment of symptoms of other communicable diseases even if a communicable disease is not the cause of the symptoms.

Under PRWORA, the U.S. Attorney General is authorized to designate other community-based programs, services, and assistance for which all immigrants are eligible as long as three criteria are met:

- The services are delivered in-kind at the community level, including through public or private non-profit agencies.
- The provision of assistance, the amount of assistance provided, or the cost of assistance provided is not conditioned on the individual recipient's income or resources.
- The services are necessary for the protection of life and safety.⁷¹

⁶⁸ 42 U.S.C. §§ 1395x(aa)(3) & (4).

⁶⁹ 8 U.S.C. § 1611(b)(1)(C).

⁷⁰ 8 U.S.C. § 1611(b)(1)(B).

⁷¹ 8 U.S.C. § 1611(b)(1)(D). Examples of designated programs include: police, fire, ambulance, transportation, sanitation services; crisis counseling and intervention programs; short-term shelter or housing assistance for the homeless, victims of domestic violence, or abused or abandoned children; programs serving victims of adverse weather conditions; soup kitchens, community food banks, and senior nutrition programs; and medical and public health services and mental health, disability, and substance abuse assistance necessary to protect life and safety. U.S. Dept. of Justice, *Final Specification of Community Programs Necessary for Protection of Life and Safety Under Welfare Reform Legislation*, A.G. Order No. 2353-2001, published in 66 Fed. Reg. 3612-16 (Jan. 16, 2001).

County Health Programs

California counties are required to provide health services as the provider of last resort for their medically indigent residents.⁷² However, the degree to which a particular county provides services to people who are not covered by Medi-Cal or other programs varies from county to county.

Many counties have Children's Health Initiatives (CHI's) which are county programs to cover children who are uninsured and ineligible for either Medi-Cal or Healthy Families, often due to the child's immigration status. Eligibility for these programs varies from county to county and not all California counties have these programs. A search on the Internet or a call to the county health department may be the best way to find out whether a particular county has a CHI.

Immigration-Related Issues

Sponsor Liability and Affidavits of Support

In order to go through the immigration process, many immigrants will need to have a sponsor, someone willing to sign an agreement called an "affidavit of support," promising to provide financial support to the immigrant.⁷³ Prior to the enactment of PRWORA and the Illegal Immigration Reform and Immigrant Responsibility Act⁷⁴ of 1996 (IIRIRA), the sponsor would sign an affidavit of support to provide assurances that the immigrant would not become a "public charge." (See the discussion of "public charge" below.) Once signed, the income of the sponsor could be deemed available to the immigrant for three years.

After passage of PRWORA and IIRIRA, however, the rules regarding affidavits of support and sponsor deeming of income were substantially changed. The new changes impose greater legal liability on sponsors and could make it more difficult for new immigrants to qualify for Medi-Cal in the future.⁷⁵ The new "affidavit of support," Form I-864, is a legally enforceable agreement between the sponsor and the government whereby the sponsor agrees to provide sufficient support to maintain an immigrant at 125% of the FPL.⁷⁶ Although states have the option to use the

⁷² Cal. Welf. & Inst. Code § 17000.

⁷³ 8 C.F.R. Part 213a.1. A sponsor can be anyone who is: 1) a U.S. citizen, national, or Legal Permanent Resident; 2) at least 18 years of age; 3) domiciled in the U.S. or any U.S. territory or possession; and 4) able to meet income/assets requirements.

⁷⁴ Pub. L. No. 104-208, 110 Stat. 3008 (Sept. 30, 1996).

⁷⁵ 8 U.S.C. § 1631. Deeming means that in determining an immigrant's financial eligibility for a public program, DHCS could count the income and resources of the sponsor and the sponsor's spouse as though they were available to the sponsored immigrant. The rules do not apply to: 1) refugees, 2) asylees, 3) battered spouses and their children for one year; and 4) indigent immigrants who have been abandoned by their sponsor and would otherwise go without food or shelter. 8 U.S.C. §§ 1631(e) & (f). Fortunately, California has not applied "sponsor-deeming" of income to the immigrant or sponsor liability for those applying for Medi-Cal benefits. Please contact the National Health Law Program if any problems arise.

⁷⁶ 62 Fed. Reg. 54346-56 (Oct. 20, 1997); 8 C.F.R. Part 213a.2. The new Form I-864 became effective on December 19, 1997. Almost all family-based immigrants who have counselor interviews or who are filing adjustment of status applications on or after December 19, 1997 must file the I-864 form. It is legally binding upon the sponsor until: 1) the sponsor dies, or 2) the immigrant becomes a U.S. citizen, obtains 40 quarters of creditable Social Security coverage, leaves the U.S. and gives up Legal Permanent Resident status, or dies.

sponsor-deeming rules when determining immigrants' eligibility for state and local benefit programs, it cannot use the rules to determine eligibility for:

- Emergency Medicaid
- Short-term emergency relief
- Child nutrition programs
- Public health assistance for immunizations
- Testing and treatment of communicable diseases
- Foster care and adoption assistance
- Service delivered in-kind, at the community level, that are necessary to protect life or safety⁷⁷

If the sponsored immigrant receives a federal means-tested public benefit, such as Medi-Cal, Health Families, Food Stamps, Supplemental Security Income (SSI), Temporary Aid to Need Families (TANF), the sponsor may be held responsible for repayment of the benefit within 45 days of a request for repayment by the benefit-granting agency. The state has up to ten years from the date on which the immigrant last received Medi-Cal or Healthy Families benefits to bring an action for repayment against the sponsor.⁷⁸

Verification of Status, Confidentiality and Reporting

One of the major barriers to health care services for immigrants is their fear that their use of benefits and accessing health services may be reported to the Department of Homeland Security (DHS) and that the mere use of benefits will have an adverse impact on their immigration status. Since 1986, Medicaid agencies have been required to verify immigration status using a system operated by DHS called the Systematic Alien Verification for Entitlements system (SAVE). PRWORA and IIRIRA required the U.S. Attorney General to issue new regulations establishing a system to verify the status of immigrants applying for federal public benefits and to establish a fair and nondiscriminatory procedure for a person to prove citizenship.⁷⁹

Advocacy Tip ► As explained in Chapter 2, the rules for verification of immigration status for immigrants have not changed, despite the Deficit Reduction Act (DRA), which created a new requirement for citizens and nationals who must now show proof of citizenship and identity. The DRA made no changes to immigrants' eligibility or ineligibility for Medi-Cal or any other benefits.

⁷⁷ 8 U.S.C. § 1632(b).

⁷⁸ Similar to the issue of sponsor-deeming of income, there have been no reported attempts by the State of California to obtain repayment from sponsors for Medi-Cal or Healthy Families benefits. Please contact the National Health Law Program if any problems arise. Sponsors must keep the Department of Homeland Security informed of his/her current address or be subject to fines ranging from \$2-5,000.

⁷⁹ 8 U.S.C.A. § 1642. *See also* U.S. Dept. of Justice, *Interim Guidance on Verification of Citizenship, Qualified Alien Status and Eligibility Under Title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996*, 62 Fed. Reg. 61344-416 (Nov. 17, 1997); *Verification of Eligibility for Public Benefits*, 63 Fed. Reg. 41662-86 (Aug. 4, 1998).

“Qualified immigrants” and PRUCOL immigrants must show documentation of satisfactory immigration status when applying for Medi-Cal,⁸⁰ and the state must verify this status using SAVE.⁸¹ Verification procedures must be administered in a nondiscriminatory manner because various federal civil rights laws and regulations prohibit discrimination by government and private entities on the basis of race, color, national origin, gender, religion, age, and disability.⁸² For example, providers and benefit-granting agencies are prohibited from singling out individuals who “look foreign” or from requiring certain groups of people to provide additional documentation. Moreover, non-profit, charitable organizations that provide federal, state, or local public benefits are not required to determine, verify, or otherwise require proof of an applicant’s eligibility for such benefits based on the applicant’s immigration status.⁸³

The Medicaid program operates under strict privacy protections. DHCS should be sensitive to privacy interests, and immigration status information should be used only for purposes of verifying the applicants’ eligibility for benefits. By law, federal and state Medicaid authorities must:

- Safeguard information regarding applicants for and recipients of Medicaid benefits,⁸⁴
- Not disclose information to an outside entity unless it relates directly to the administration of the state plan.⁸⁵

The Privacy Act of 1974⁸⁶ and state and local privacy protections and program requirements may also provide protection for immigrants.⁸⁷

There is some confusion regarding the mandatory reporting requirements under Section 404 of PRWORA. This section only applies to agencies that administer SSI, housing assistance programs under Sections 6 and 8 of the U.S. Housing Act of 1937, or block grants under Temporary Aid to Needy Families, to make a quarterly report to DHS of the name and other identifying information of persons the agency knows are not legally present in the U.S.⁸⁸ There is no mandatory reporting of

⁸⁰ Non-citizens must complete the MC-13 form, Medi-Cal’s “Statement of Citizenship, Alienage, and Immigration Status,” and the eligibility worker must fill out the MC 845, “Documentation Verification Request” and send it to the Department of Homeland Security (DHS) with a copy of the applicant’s documentation. The applicant has up to 30 days to provide the documentation and once provided, can receive Medi-Cal while pending a determination by DHS.

⁸¹ For a list of acceptable documentation, see MEPM, *Article 7: Alienage, Citizenship & Residence*, 7A1-3.

⁸² See e.g., Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d et seq; § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the Americans with Disabilities Act of 1990, 42 U.S.C. §12101 et seq; the Age Discrimination Act of 1975, 42 U.S.C. § 6101 et seq.; and the Fair Housing Act, 42 U.S.C. § 3601 et seq.

⁸³ 8 U.S.C. § 1642(d).

⁸⁴ 42 U.S.C. § 1396a(a)(7).

⁸⁵ 42 U.S.C. § 1396a(a)(7). For example, DHCS is prohibited from providing information about the receipt of benefits or the dollar amount of those benefits to DHS, the State Department, or immigration judges. The only exception would be if the disclosures were necessary to assist the state to collect outstanding debts incurred for the receipt of benefits paid. See *Letter from Sally Richardson to State Medicaid Directors* (Dec. 17, 1997), available at: <http://www.cms.hhs.gov/SMDL/>.

⁸⁶ 5 U.S.C. § 552a.

⁸⁷ For example, Cal. Welf. & Inst. Code § 10500 states that persons administering public assistance shall secure aid “without attempting to elicit any information not necessary to carry out” the program.

⁸⁸ Six federal agencies, including U.S. Dept. of Health and Human Services, Dept. of Justice, Dept. of Homeland Security, issued a notice defining what it means to “know” that an immigrant is not lawfully present in the U.S. According to the notice, an entity is not required to make quarterly reports unless it has knowledge of an individual who is not lawfully present. An entity will “know” only as a result of a finding of fact or conclusion of law that is:

Medicaid or other health programs to DHS because Section 404 of PRWORA does not apply to these programs.

Public Charge Determinations

Immigrants' fear of being found a public charge has deterred many immigrants from seeking and accepting public benefits, including health care benefits like Medi-Cal and Healthy Families, even when they are lawfully entitled to receive them and may safely benefit from the services that the programs cover. The term "public charge" is an immigration term used to identify a person who does not have a reasonable means of self-sufficiency and is likely to become a public burden because of her dependence on some forms of public assistance. Under U.S. immigration law, a person who is likely to become a "public charge" can be excluded from entering or reentering the U.S. as an immigrant, denied permanent resident status, or under very limited circumstances, deported.

On May 26, 1999, the Immigration and Naturalization Service (INS), now reorganized as the Immigration and Customs Enforcement (ICE) division of the Department of Homeland Security, issued clarifying guidance and a proposed rule on public charge determinations.⁸⁹ Under these new rules and guidance, "public charge" is defined as an immigrant who has or is likely to become primarily dependent on the government for subsistence as demonstrated by:

- Receipt of public cash assistance for income maintenance, including SSI, TANF,⁹⁰ state and local cash assistance programs for income maintenance, such as General Assistance or
- Institutionalization for long term care at government expense.⁹¹

Noncash, supplemental public benefits are not relevant to the public charge determination, including Medi-Cal benefits (other than for long term care); Healthy Families; Food Stamps; CHDP; other types of health insurance and health services benefits, such as emergency medical assistance, immunizations, testing for and treatment of communicable diseases, and use of health clinics; nutrition programs, emergency disaster relief, housing benefits, child care services, energy benefits, foster care and adoption benefits; transportation vouchers, or other noncash transportation services; educational benefits, such as Head Start and aid for elementary, secondary, or higher education; noncash benefits funded under TANF; state and local supplemental, noncash benefits; and other

1) made as part of a formal determination by the entity, 2) subject to administrative review, and 3) supported by a determination by DHS, such as a final order of deportation. A response from the SAVE system that an immigrant had no record or is ineligible for benefits does not equal "knowing" an immigrant is not lawfully present. Unless necessary to determine eligibility, an entity does not have to make a formal determination as to whether the immigrant is lawfully present. *Responsibility of certain entities to notify Immigration and Naturalization Service of any alien who entity knows is not lawfully present in United States*, 65 Fed. Reg. 58301-03 (Sept. 28, 2000).

⁸⁹ U.S. Dept. of Justice, *Field Guidance on Deportability and Inadmissibility on Public Charge Grounds*, 64 Fed. Reg. 28689-93 (May 26, 1999); *see also Inadmissibility and Deportability on Public Charge Grounds*, Proposed Rule and Notice, 64 Fed. Reg. 28676-88 (May 26, 1999).

⁹⁰ *See* 45 C.F.R. 260.31 for list of TANF exclusions

⁹¹ The guidance and rule does not clearly define what is meant by institutionalization for long term care, but short term institutionalization for periods of rehabilitation does not demonstrate primary dependence on the government. Arguably, institutionalization must be permanent and the government support substantial. *Letter from Kevin Thurm, Deputy Sec. of Health & Human Services, to Doris Meissner, Comm. INS* (March 25, 1999), printed at 64 Fed. Reg. 28686 (May 26, 1999).

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

Public charge decisions are based on the totality of the circumstances and a case-by-case basis, taking into account the following factors, with no single factor controlling the decision:⁹²

- Age
- Health
- Family status
- Assets
- Resources
- Financial status
- Education
- Skills
- Affidavit of support filed by the immigrant's sponsor

While the receipt of Medicaid, by itself, is not relevant to the public charge decision, a person receiving Medicaid may still be found to be a public charge if, under the totality of the circumstances test, it is determined that the person is, or is likely to become, dependent on public benefits for subsistence. On the other hand, past receipt of cash benefits and prior institutionalization for long term care will not necessarily mean that an immigrant will be found inadmissible as a public charge or ineligible to adjust her status. The decision must be made in light of the totality of the circumstances, including the length of time during which the immigrant previously received benefits or was institutionalized, and how long ago the benefits were received. The negative implication of past receipt of cash benefits for income maintenance or institutionalization for long term care may be overcome by positive factors demonstrating that the immigrant is unlikely to become dependent on the government in the future.

There are certain immigrants who are exempt from public charge determinations:

- Refugees and asylees at the time of admission and adjustment of status to legal permanent residency
- Amerasian immigrants at the time of admission
- Cuban and Haitian entrants at adjustment
- Nicaraguans and other Central Americans who are adjusting their status under the Nicaraguan Adjustment Central American Relief Act
- Haitians who are adjusting their status under the Haitian Refugee Immigration Fairness Act of 1998
- Immigrants who entered the U.S prior to January 1, 1972 and who are otherwise "registry" eligible⁹³
- Other immigrants who are exempted by future legislation.

⁹² 8 U.S.C. §1182(a)(4)(B).

⁹³ 8 U.S.C. § 1259.

As noted above, deportation on public charge grounds is rare. An immigrant can only be deported on public charge grounds if the immigrant became a public charge within five years after entry into the U.S. Before an immigrant can be deported on public charge grounds, it must be demonstrated that:

- The government entity that provided the cash assistance has a legal right to seek repayment of those benefits against the immigrant or another obligated party such as a family member.⁹⁴
- The public entity providing the benefit demanded repayment of the benefit within five years of the immigrants' entry into the U.S.
- The immigrant or the obligated party failed to repay the benefits,
- There is a final administrative or court judgment obligating the immigrant or another party to repay the benefit.
- The benefit-granting agency has taken all actions necessary to enforce the judgment, including collection action.

Only the benefit-granting agency, DHCS, not DHS, has the authority to request repayment of the cash assistance received. A Legal Permanent Resident (LPR) is not subject to public charge determinations unless she has traveled outside the U.S. for more than 180 days. As noted above, an LPR who applies for citizenship is not subject to public charge determinations. There is no public charge test for naturalization purposes, and no one can lose their citizenship because they have received public benefits.

Advocacy Tips ►

- Receipt of Medi-Cal benefits (other than long term care) and Healthy Families benefits by themselves are not relevant to a public charge determination.
- Public charge determinations have nothing to do with whether or not an immigrant is eligible to receive a public benefit. DHCS does not make public charge determinations.
- Legal Permanent Residents (LPRs or people with “green cards”) who apply for citizenship are not subject to public charge determinations. Public charge determinations can be made when immigrants adjust their status to LPRs and obtain their “green card.”
- Deportation on public charge grounds is extremely rare.

⁹⁴ An immigrant cannot be deported if the immigrant can prove that the causes that led to becoming a public charge arose after entry to the U.S.