

ASPE ISSUE BRIEF

OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HUMAN SERVICES POLICY - U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

PROMISING PRACTICES FOR INCREASING IMMIGRANTS' ACCESS TO HEALTH AND HUMAN SERVICES

Project Purpose

The Immigrant Access to Health and Human Services project maps and describes the legal and policy contexts that govern and affect immigrant access to health and human services. Through a synthesis of existing information, supplemented by in-depth visits to purposively selected sites, the study aims to identify and describe federal, state, and local program eligibility provisions related to immigrants, major barriers (such as language and family structure) to immigrants' access to health and human services for which they are legally eligible, and innovative or promising practices that can help states manage their programs.

The Context for This Brief

This brief is a companion to another brief on barriers to immigrants' health and human services based on an Urban Institute study (Perreira, et al.). That brief describes in more detail the protocol and activities of the four site visits, including why these states were chosen, and so only a short overview is provided here.

The site visits were conducted between May and December of 2011. Each included both in-person and phone consultations with three sets of stakeholders: (1) state and local government agencies, including officials from public agencies responsible for administering Medicaid/CHIP, SNAP, and TANF; (2) community-based nonprofit service providers including managers of state and local health care organizations and community-based and faith-based organizations; and (3) advocates including directors of grassroots and statewide advocacy organizations, local community leaders, and immigration legal aid experts. *No immigrant families themselves were interviewed during the site visits.* All consultations followed a conversation guide designed to

ABOUT THIS ISSUE BRIEF

This Issue Brief is one of several under the "Immigrant Access to Health and Human Services" project; for more information see <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/index.shtml>.

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elicit information about respondents' experiences serving immigrant clients and their knowledge of standard practices, barriers, and innovative or promising practices influencing immigrants' access to health and human services. Overall, the team received feedback from 120 professionals across 67 different health and human service organizations in Maryland, Massachusetts, North Carolina, and Texas.

The four focal states were selected through a systematic process. Initially, the team compiled a large amount of information on all 50 states. This information was then mined to identify the study sites that would provide useful variation on health and human services programs, eligibility, and use; the immigration policy climate (related to health and human services but also state immigration enforcement activities); the demographics of the immigrant population; and geographic location. This variation is useful for understanding both diversity and commonalities in practices for immigrant access to health and human services (again, see Perreira et al. for greater detail, including statistics and more specific information about policies and practices).

First, Massachusetts has a sizeable and diverse immigrant population. In terms of health and human services, it has a long-standing history of broad coverage that is quite inclusive, for immigrants as well as in general, and a centralized system. Of the four states studied, it had among poor families with children the highest rates of use for Medicaid/CHIP, SNAP, and TANF (all above national rates) and the smallest utilization gaps between poor families headed by immigrant parents and those headed by native-born parents. After PRWORA passed, Massachusetts created state programs to provide benefits to those who lost eligibility under federal programs, including immigrants. The state created its own health care and food assistance programs that extended eligibility to immigrants lawfully present in the country but excluded from federal programs, such as those who had been in the country less than five years. Budget crises in the early 2000s led to some cuts, specifically, in the coverage of qualified immigrants,¹ but the 2006 state health care reform partially offset these reductions. More recently, the Massachusetts Supreme Court ruled that excluding lawfully present immigrants from state health programs was illegal. Finally, the state also has a health insurance program "of last resort" that nonqualified immigrants (e.g., unauthorized immigrants) can access.

Second, Texas is a heavily populated state with a large immigrant population that, while diverse, primarily consists of Latin American, especially Mexican, immigrants. Texas is a traditional immigration state, with a long history of immigration and accompanying racial/ethnic diversity. Its health and human services administration is highly centralized at the state level, and its rules for TANF and Medicaid are generally restrictive, with low benefit levels and reimbursement rates (e.g., under Medicaid) and short eligibility periods, regardless of immigration status. Program use among poor families with children was the lowest of the four states studied and below the national rates for all the focal programs. The gaps between children in immigrant families and those with native-born parents, however, were generally similar to the national levels. Under PRWORA, Texas chose restrictive eligibility for almost every program. It has not created state-only programs to serve post-enactment qualified immigrants during the five-year waiting period, and it has denied them access to TANF and Medicaid after the five-year waiting period. The one exception to this trend is that the state has enacted the CHIPRA option,² covering lawfully present pregnant women and children under Medicaid/CHIP.

Third, North Carolina is often characterized as one of the "new" immigrant destination states, with rapid increases in the size of the immigrant population in recent years, although the proportion of immigrants is still low to moderate. Many of these new immigrants are of Latin American origin, and the state is currently grappling with how to serve this fast-growing population. For North Carolina, the overall Medicaid/CHIP and SNAP use among poor families was close to the national level. The gap between children in immigrant families and those with native-born parents, however, was generally wider than nationally, and were the widest among the four study sites. No state programs were created to address the new restrictions on legal immigrants imposed by PRWORA, and the state has generally taken restrictive options in immigrant eligibility

for federal programs (again, CHIPRA being the exception). A major difference between North Carolina and the other three states is that its health and human services programs are highly decentralized, administered at the county rather than state level. Importantly, of the four states studied, North Carolina has been more actively experimenting with restrictive immigration enforcement laws.

Fourth, Maryland, like Massachusetts, offers relatively broad opportunities for immigrants' access to health and human services and the state as a whole has long-standing experience integrating immigrant populations. The majority of the immigrant population is concentrated in the greater Washington, D.C., metropolitan area, but, in the last 20 years, immigrants have settled in greater numbers throughout the state and in counties that traditionally had few immigrants. The immigrant population in Maryland has much more diverse origins and cultural and linguistic backgrounds than nationally. Maryland is the only state in the study that has extended state-funded cash assistance during the five-year ban to qualified immigrants who lost TANF coverage under PRWORA. It also provides Medicaid/CHIP coverage to lawfully present children and pregnant women under CHIPRA. The state has engaged in statewide outreach efforts to enroll children in Medicaid/CHIP and has a significantly smaller utilization gap for children of immigrants (versus children of native-born parents) for these two programs compared national rates. To facilitate access to public benefits for immigrants, Maryland has institutionalized a language-access policy that requires state and local agencies to provide interpretation and translation services. The state also has a less restrictive policy climate with regard to immigrants overall, and the state government has aimed to implement policies promoting immigrant inclusion.

The promising practices in these four states were identified in a variety of ways. Most directly, the stakeholders spoke about an approach that they knew of and believed had worked or suggested an approach they had not seen tried but thought might work. Consideration was also given to how well these comments matched the analysis of barriers to access reported in the companion brief (Perreira et al.), giving more weight to suggestions that addressed a specific barrier identified during the site visit. In some cases, the barriers were so clear that possible actions to remove them are identified even when no respondent mentioned such actions. For example, because interviewees reported that caseworkers and managers were sometimes wrong about the specific immigrant classifications in their state's policy, training is identified as a possible approach. Where possible, independent evidence is cited for approaches cited as promising that have actually worked. However, the most striking feature of this endeavor was how limited the evidence of promising practices was, partly because states do not typically track access for immigrant families, but also because so few researchers have directly studied the impact of various practices. Consequently, the suggestions in this brief should be seen as opportunities worth carefully considering and exploring, not as recommendations or demonstrated best practices.

Promising Practices in Four States

The companion brief on barriers to immigrants' access to health and human services is organized around four broad categories of barriers: (1) language, literacy, and culture; (2) transportation and other logistical barriers; (3) climates of fear and mistrust; and (4) special challenges for mixed-status families and refugees (Perreira et al.). Since promising practices often target barriers to access, each category of promising practices highlighted here tends to map onto one or more of the barriers identified in the companion brief.

Partnerships between Government Agencies and Community-Based Organizations

The most consistent theme to arise from the site visits was the crucial role of community-based organizations (CBOs) in addressing barriers related to the complicated application process, as well as issues of language, literacy, fear, and mistrust. All four states had established partnerships with local CBOs to help reach immigrant populations in need of health and human services. According to both state and CBO workers, CBOs

have access to social networks that enable them to better reach immigrant families, who often feel more comfortable in community-based settings than in government-identified offices, so that they can serve as liaisons between state agencies and immigrant populations.

The partnerships described below have a few caveats. First, because immigrant families were not interviewed for this project, we cannot directly draw on their experiences with and perceptions of CBOs or state agencies. Second, many of the partnerships between state agencies and CBOs were created to serve the low-income population as a whole rather than immigrant families specifically. But the perceptions of both state and CBO workers were that the various language, literacy, and cultural issues of immigrant families resulted in their being more comfortable working with CBO staff in their own communities rather than with government entities. Third, given the possibility that outsourcing may reduce state agencies' motivations to fix system-wide problems, partnerships with CBOs could be problematic in some instances.

In Massachusetts, an extensive state-community partnership has developed over several years. SNAP/TANF agency administrators, Medicaid agency administrators, and representatives from numerous advocacy organizations meet monthly. Agency administrators hear about concerns of the immigrant population, and advocacy groups hear about upcoming policy or administrative changes in a timely fashion. These regular face-to-face interactions have kept the state and community representatives on the same page and were seen by both sides as highly beneficial.

States can also explicitly contract with local organizations to provide certain services, such as application assistance and submission. For example, the Texas Health and Human Services Commission (HHSC) has two contracts in Central Texas, one with Catholic Charities of Central Texas and another with the Capital Area Food Bank, to submit SNAP applications and assist with applications for other federal programs in the process. Massachusetts contracts with multiple CBOs to provide application assistance and outreach. Additionally, Massachusetts organizes an annual summit for CBOs to share successful strategies and train staff in state application procedures. Currently, the Texas HHSC is experimenting with a new CBO contract. Two years into a five-year demonstration, the commission trains food bank workers to conduct application assistance and face-to-face eligibility interviews for SNAP. A backlog of applications fueled in part by the SNAP interview requirement served as motivation for the demonstration. HHSC workers see this practice as particularly important in efforts to serve immigrant families, and they are happy with early results. Yet, the aforementioned issue of "outsourcing" and its potential to disincentivize further change within the state system is important, especially given how the state agency faced significant challenges last decade when it tried to privatize its services.

State agencies also work with CBOs for similar services outside of formal contracts. For example, CBOs assist immigrant families with applications in their offices (often located close to immigrant neighborhoods) and at key locations throughout communities, such as hospitals, health care clinics, schools, and juvenile courts. North Carolina has located state eligibility workers in CBO offices, where they can more easily connect to immigrant families. In Massachusetts, CBOs help gather applications and verification documents in SNAP satellite offices, such as the one located at Boston Medical Center. CBOs complement the work of state employees, who could only be in the medical center one day a week. Because CBOs are motivated to help eligible immigrant families receive benefits, they spend time helping families understand the application documents, including translating forms when needed, and gather required income and other verification documents.

CBOs provide other services in addition to enrollment assistance. Since CBOs are embedded within local communities, they are well positioned for outreach. Indeed, they often directly and indirectly help state agencies by providing immigrant communities with information about health benefits and enrollment

procedures. Some CBOs hold health fairs that often provide immigrant families with direct services and information about government health and human service programs. CBOs also leverage their partnerships with other community stakeholders to “get the word out,” often partnering with local ethnic media.

Maryland offers two examples of how CBOs specifically target the immigrant population. First, a CBO can obtain income letters for day laborers who lack stable employment from one day to the next. The organization vouches for the number of days a worker has secured employment and how much they make. Second, CBOs can issue a membership document that immigrant families can use to complement their application for benefits. The document helps families overcome potential roadblocks. For example, it resolves cases in which a lease or utility bill for a family’s residence features the name of a different person (e.g., the owner or another family member). Respondents in Maryland mentioned that local community members see the organizations’ many offices as safe spaces and view the membership document as a welcoming device that helps them have more positive experiences at local public agencies.

Although partnerships between CBOs and government agencies certainly assist states and families, they are not without challenges. In particular, when partnerships are not state funded, their services are less permanent. CBOs may struggle to raise enough money to retain the staff needed to assist immigrant families with applications.

Another challenge is when multiple CBOs provide the same service in one geographic area. In North Carolina, CBOs combined services to make better use of their resources. This strategy enabled them to expand the areas in which they provided assistance. One way Massachusetts circumvented the issue of duplicate services was to work with the Mutual Assistance Association, an umbrella of CBOs serving immigrant communities. In order to ensure successful continued partnerships with CBOs, states might consider establishing an infrastructure that will support sustained CBO involvement with immigrant families.

Streamlined Application and Eligibility Procedures

As discussed in the companion brief on barriers to health and human services (Perreira et al.), major challenges for all families, but particularly immigrant families, are that the application is long and burdensome and that there is no “one-stop shopping.” These challenges touch on a much larger issue. Many researchers, state and federal officials, advocates, and policy experts have observed that application procedures and eligibility rules for federal programs are not well coordinated (Rosenbaum and Dean 2011). In fact, one of the four states in this study, North Carolina, is participating in a national demonstration program to enable states to integrate and streamline benefits for low-income families, including Medicaid/CHIP and SNAP (Mills, Compton, and Golden 2011). Clients and advocates interviewed under this study shared this concern about complexity and burden of applications and voiced support for efforts to do something about it.

Rather than review the broader integration and streamlining efforts, this brief focuses on their implications for immigrant families. However, those ongoing efforts can have different effects on immigrant families. If some programs have more restrictive provisions than others, integration programs could have the perverse effect of reducing immigrant access; for example, if a common application requests adult Social Security numbers because one program requires it, immigrants might be discouraged from applying for the others that do not. On the other hand, streamlining efforts that reduce burden and eliminate the need to appear at an office could have a particularly positive effect on immigrants, given their work and transportation barriers. For example, passive redetermination allows recertification under certain circumstances, if clients do not correct or change the information on file that is sent to them.

Many states have developed integrated application systems for some or all of the focal federal programs. Massachusetts has gone even further by also including state programs. In Texas, advocates are pushing for an even more comprehensive approach, one that provides eligibility information and access to applications for a wide variety of federal programs (e.g., Pell Grants, housing subsidies), as well as state and local programs. Such a system could be localized within specific communities while also incorporating eligibility criteria and other guidelines and information across counties and cities. Such integration efforts come with a host of complicating factors, including eligibility differences across programs and potential obstacles to sharing information and documents across programs or agencies (e.g., potential violations of the Health Insurance Portability and Accountability Act, or HIPAA, when dealing with health information or medical records).

Although the lack of integration and streamlining is a problem for all potential applicants, state and CBO workers see these barriers as especially troublesome for immigrants because of language and literacy issues, diversity in citizenship and eligibility within families, and frequent migration within and across states, all of which are discussed further below. But a few efforts to address the issues salient to immigrant families are highlighted here. Massachusetts has implemented a virtual gateway system that simultaneously checks eligibility for multiple family members and links them to the appropriate applications while also allowing non-eligible family members to opt out. An integrated system being advocated in Texas would create password-protected files that clients could log-in to in any CBO, so CBO workers could help them navigate the system. Such a system could stabilize services for mobile immigrant families. Related to this issue, the Migrant Health Network of clinics in the United States and Mexico was highlighted by state and CBO workers in North Carolina. The network stores and shares patient files so migrant workers can retain access as they move from place to place.

Most of the promising practices described so far are predicated on improvements in technology that allow integration among programs to occur seamlessly from the applicants' and workers' perspectives. States including Massachusetts and Texas are focusing on online application portals that make the front end simple for the family but may not integrate processing across state programs. North Carolina is currently developing North Carolina Families Accessing Services through Technology (NC FAST), an integrated system for all stages of eligibility determination and redetermination. State agencies, as well as the community, expressed a growing consensus that improved technology is a pressing need. Similarly, Maryland is piloting a mechanism for document imaging and electronic submission for all social service and child support programs, to ease the administrative and client burden and to allow information sharing across jurisdictions.

Although promising, changing technology can pose risks for immigrant families' access. For example, some advocates have voiced concerns about the push for online applications, especially given low-income families' difficulties in accessing the Internet and the potential language and literacy obstacles particularly relevant to the immigrant population.

Efforts to Overcome Cultural Issues

The companion barriers brief highlights the cultural and social issues that keep even eligible immigrants from applying for and enrolling in federal programs (Perreira et al.). These issues include fear and mistrust of government, lack of knowledge about the system, unfamiliarity with Western medicine and other health and human service systems, and myths about the potential risks of program enrollment. Partnerships between states and CBOs are seen by both staffs as possible remedies to these barriers.

Across the states, agencies often allow CBOs to serve as liaisons between immigrants and their services, perceiving that CBOs will be more trusted in immigrant communities. As an informant in the North Carolina site visit explained, the goal is to have no "wrong door" for potential clients seeking access to federal or state

programs—if they want to come through a CBO rather than directly to the state office, then that door is open to them. Using CBOs or other trusted entities to vouch for federal and state programs can greatly ease fears that even applying can trigger deportation or interfere with current or future chances of citizenship.

In Maryland, Massachusetts, and Texas the state contracts with CBOs to provide application assistance. *Promotoras* in North Carolina link public health organizations to the community through advising and information dissemination. CBOs can also do outreach, speaking with immigrants to explain eligibility and other rules and dispel myths. In North Carolina, CBOs send trained workers and volunteers to meet migrant workers where they live and work so the workers are aware of services available to them and know how to apply. In all states, religious groups seem particularly effective at prescreening and referring immigrants to federal and state programs. Many outreach efforts, however, are vulnerable as budgets tighten.

Other efforts to increase trust and awareness in the immigrant population include partnerships between government offices and CBOs with ethnic media and local businesses. Univision, for example, has broad reach among many Latino immigrants and has been used effectively to get out the word about services and programs. In North Carolina, Spanish-language radio *novelas* tell vivid stories with a related instructional or educational component. As another example, grocery stores have proven to be useful sites for outreach efforts in Texas, providing convenience and familiarity for immigrants who may be wary of applying for assistance or seeking information.

The use of CBOs and other partnerships to address cultural barriers raises several important issues. For example, immigrants' fears about deportation and related problems are not entirely unfounded. Participation in some programs (e.g., TANF cash assistance) may interfere with obtaining U.S. citizenship, and so CBOs and state agencies need to be careful about how these partnerships are used. The key is for state agencies to make sure that their partner CBOs are clear about the complex issues, rules, and implications involved. A larger issue concerns the possibility that state agencies make themselves more trustworthy to the immigrant population without working through CBOs or other partnerships, by hiring bicultural staff and providing much better and clearer information inside and outside offices, among other options.

Efforts to Overcome Language, Literacy, Transportation, and Logistical Issues

Beyond cultural and social issues like fear, misunderstanding, and unfamiliarity, more practical matters also keep immigrants from accessing health and human services. Difficulties with language, literacy, child care, and transportation can also make a difference in whether eligible immigrants apply, enroll, and re-enroll in federal and state programs.

Language is a major issue for immigrants, and all states have made progress in language access. In all four states, materials, applications, and assistance are widely available in English and Spanish, and government offices contract with various interpreter services to increase their ability to serve all clients. Each state uses an international language line to use when bi- or multi-lingual staff are not available. These lines provide translation services in a number of languages and dialects so that staff, clients, and interpreters can have three-way calls. Although staff view this practice as less preferable than in-person services and as occasionally unreliable, it is better than having no translation services at all.

The Maryland Department of Human Resources oversees the language access policy to ensure state and local agencies provide interpretation and translation services at the point of contact with the client. Massachusetts has gone further than the other states in implementing practices to reduce language barriers among foreign-language speakers who do not speak Spanish, by making available materials for federal and state programs in nearly two dozen languages. SNAP offices in the state also use a “show me the language you speak” chart to

assist potential clients when they walk in the door, ensuring a welcoming environment for a variety of non-English speakers. Bilingual staff cover 18 languages, and the state contracts with an agency for interpreter services in others.

Beyond language, literacy can be a problem. Given the relatively low educational attainment in many immigrant groups, some immigrants lack literacy in their home languages as well as in English and, therefore, have trouble navigating program materials, applications, and public assistance offices. The Affordable Care Act (ACA) actually emphasizes the need to use plain language in all materials, expressly to address literacy barriers in general and for the immigrant population in particular. Texas convened an application review group, consisting of CBOs and other advocates, to vet the new online portal precisely to deal with literacy barriers. Like North Carolina's, Texas's new application employs visual alerts and symbols to designate different programs. Visual information can also be integrated into mail sent to family homes, including recertification notices.

Other logistical issues, such as child care and transportation, remain intractable, although efforts by CBOs in North Carolina to provide refugees with "enabling services" could be a potential model for overcoming them. This initiative allows CBOs to go beyond direct application assistance and provide other services to overcome issues that might interfere with applications and enrollments. Examples include transportation, lessons in reading bus schedules, and driver's education, as well as English, computer, and financial literacy classes. The intent, according to one CBO worker, is to teach clients how to "spread their wings and fly." Also important to consider are broader efforts to reduce requirements for in-person application and recertification to alleviate child care and transportation troubles (Mills et al. 2011; Rosenbaum and Dean 2011), efforts that would be relevant to immigrants given their employment circumstances and number of young children per family.

Efforts to Integrate Services for Immigrant Families

Along with integrating applications for federal and state programs, states continue to explore ways to integrate the services themselves. Much like the one-stop shopping goal, the intent is to serve immigrants and their children in multiple ways at once rather than in a more piecemeal fashion. This issue, of course, goes beyond immigrant families specifically, but once again, there are opportunities to implement case management, patient navigator, or colocation strategies in ways particularly helpful to immigrant families.

Stakeholders cited several service integration strategies that had been or could be adapted to serve immigrant families. For example, in North Carolina, the Senior Health Insurance Information Program, the Division of Social Services, and the Department of Insurance established a program to certify counselors who can help elderly clients navigate health insurance plans. The program's emphasis on assisting customers and overcoming barriers could serve as a model for training patient navigators as required under the ACA; the approach could also be applied to assist immigrants across health and human service systems.

In Houston, multiservice centers operated by the city are good examples of how services can be better integrated in ways that expand immigrant access to health and human services in general. These strategically located centers house offices for multiple programs, including Women, Infants, and Children (WIC), food pantries, and health clinics, as well as application assistance services for federal and local programs. Program directors, service providers, and city officials meet monthly and refer clients to each other, thereby ensuring clients receive all needed services. Furthermore, in Houston, the centers tend to be surrounded by CBOs and other programs (e.g., Big Brothers and Sisters), allowing clients to meet multiple needs at one location and service providers to create a comprehensive web of services.

Maryland uses a similar model with funds from the Office of Refugee Resettlement, under HHS' Administration for Children and Families (ACF). The public-private partnership model provides comprehensive services to refugees and asylees in two centers operating as one-stop shops for cultural orientation, employment services, English-language training, health services and case management, and public benefits application assistance. Also in Maryland, a CBO assigns a case manager or mentor to a young adult, who receives wrap-around services and help applying for benefits. The CBO focuses on the youth and their family units, and staff members familiarize themselves with the financial circumstances and household composition of youth in their caseload. As a result, CBO staff tailor a menu of services for each family unit according to the youth's needs and the family's, which can include the youth's own children, siblings, parents, and other household members. A mentor typically accompanies youth and family members to meetings at public agencies.

In Texas, partnerships between health care systems and school districts offer opportunities for coordination that could be particularly helpful to immigrant families, given that schools are the one public institution with an explicit requirement to serve all children, regardless of their or their families' immigration status. Supported by funds from the American Recovery and Reinvestment Act and private foundations (e.g., Michael and Susan Dell Foundation) and with the help of CBOs and other advocacy organizations (e.g., Children's Defense Fund, Insure-a-Kid), the Austin Independent School District collects data on students' insurance statuses; reports back to schools on their uninsured populations by race, grade, and other factors; and maps out risk zones in the city for more targeted services. School personnel are also trained to screen families for federal and county program eligibility, often within the district-created family resource centers housed in all middle schools. The district also contracts out all health services to the Seton hospital system. As a result, school nurses are also centrally trained hospital employees who can screen for Medicaid and CHIP eligibility. This contract also sends mobile health care vans to schools to provide children with medical and dental services. Given the proportion of children from immigrant families that are low-income and/or uninsured, these services are a valuable way to serve children's health needs while promoting their education.

Although Austin has been successful with this effort, the district health coordinator fears that reduced state and local budgets will jeopardize their ongoing operation. Maryland has also tried a similar approach, partnering with school districts to share SNAP information with families whose children are enrolled in free and reduced-price lunch programs. Technical challenges, however, are limiting capacity to share information across systems.

Efforts to Address the Unique Challenges of Mixed-Status Families

Because most immigrant families include members with different immigration statuses as well as citizens, family members may have different eligibility for public programs. In these cases of mixed-status households, an immigrant parent may hesitate to complete an application for U.S. citizen children if they believe doing so may have immigration-related consequences. This problem is exacerbated by ambiguous applications and directions that tend to dissuade mixed-status households from seeking assistance (see companion brief on barriers to access for more detail on this problem, Perreira, et al.).

Massachusetts has taken direct steps to allay fears among mixed-status households. The state has implemented an opt-out policy in which ineligible family members can take themselves out of consideration for benefits without affecting the applications of others. In other words, an unauthorized immigrant parent does not have to provide information about whether he or she is lawfully present when enrolling a child. This opt-out option is conveyed early in the application questions. The Department of Transitional Assistance (DTA), which administers TANF and SNAP, effectively allows immigrant parents to opt out of benefits for ineligible individuals within a household while enrolling those who are eligible. All local offices now have an

opt-out policy. Income and assets for household members who opt out still play a role in eligibility determination, but the state does not delve into their immigration status.

The Massachusetts opt-out policy has helped address fears about SNAP receipt in particular. Although this policy did not carry over to the online application, it still encourages households to seek benefits for eligible household members, such as U.S.-born children. In addition, the DTA created a special brochure on the opt-out policy, targeting unauthorized immigrants. Materials explicitly stated that no one will be turned in to immigration authorities unless they already have a deportation order. In Maryland, the application materials clearly state that Social Security numbers are only required of family members applying for benefits. Also, public agencies allow families without ready access to required documentation to submit an affidavit of identification. This helps families—including mixed-status households—who would not otherwise move forward to the eligibility determination phase. In contrast, Texas and North Carolina applications still ask for citizenship and Social Security numbers for parents even when they are enrolling children only.

Although less explicitly than the opt out possibility, other practices do encourage immigrant parents to seek benefits for their children or other individual household members, even when they are not themselves eligible. Some North Carolina forms are structured and worded differently and more clearly than the general forms that include vague documentation items. For example, refugee resettlement organizations can complete screening forms with clear guidance and disclaimers regarding immigration questions. In addition, the TANF (“Work First”) application specifies that Social Security numbers must be provided for applicants only, not all household members. Such disclaimers could be helpful in general applications, which currently offer little or no clarification for immigration-related items. General applications could include clear instructions about which items are necessary, and that this information is required only from applicants, not from any non-applicant family or household member.

For screening purposes, simplified forms can mitigate fears in mixed-status households. North Carolina has a streamlined SNAP application for Supplemental Security Income (SSI) recipients. It asks how many people live in the household and whether they buy and cook food separately. A version of such a screening form could be used to determine income for mixed-status households. Asking families about applicants’ immigration status as a separate, later step during the eligibility determination phase could encourage more households to seek benefits for eligible members. The state already uses an alien worksheet to determine eligibility based on immigrants’ income and whether they are lawfully present. It could be amended to decouple household income from individual applicants’ immigration status.

Again, CBOs play a key role in addressing the barriers faced by mixed-status families. Community-based service providers help households secure benefits for individual members. Outreach efforts help clarify confusion and allay fears about who qualifies for services. Absent changes in application requirements or opt-out policies, community outreach can help families understand how to navigate health and human services. Indeed, immigrants are much more likely to come forward when they understand what they are eligible for and can present the documentation that they have.

Other Changes in Policy and Practice

The companion brief on barriers (Perreira, et al.) indicates that many of the issues reducing immigrant access to health and human services often concern state and local agencies’ staff recruitment, training, and support. Staff might not know how to interpret complex and/or changing federal or state laws, they might be unfamiliar with the documents immigrants submit, and they might have little awareness of cultural issues that could create distance between themselves and their clients.

Although the site visits did not highlight particular remedies, these persistent barriers suggest the need to consider training as a source of promising practices, not just for state agencies' staff but also for partner CBOs. For example, some respondents in public agencies mentioned additional guidance would be helpful regarding citizenship and immigration documents, such as visual aids to help them sift through the myriad immigration-related documents issued by federal agencies.

As this brief and its companion brief illustrate, immigrant families face a complex set of barriers, including some that face all low-income families and others that are either more intense among or limited to immigrant families. Knowing how effectively various strategies for access are working for immigrant families and mixed-status families, therefore, is challenging absent the collection and analyses of relevant data.

Useful data include estimates of participation and participation rates (which requires estimates of the underlying eligible families) broken down by individual and family immigration status, information about what happens to applications (for example, the rate of procedural denials compared to applications from native-born parents), information about participation in multiple programs, and information directly from families about their own sense of the issues. Also useful is information about caseworkers' and supervisors' understanding of policy, as well as observation of actual office practice, given the complexity of immigration rules. As a foundation for all other suggestions, states and the federal agencies may want to consider how to gather information and continuously improve access strategies based on evidence about how those strategies play out in practice.

Conclusion

Currently, immigrants face many barriers in their access to health and human services. The site visits conducted for this project in Maryland, Massachusetts, North Carolina, and Texas revealed several examples of what can be done to ease some of these barriers moving forward. Given the limited nature of data collection under this study, these examples require further exploration and consideration and should not be viewed as definitive or directive.

CBOs Acting as Liaisons between State Agencies and Immigrant Populations

Contracted partnerships may ease public offices' workload and help eligible immigrant families feel more comfortable applying for services. Other partnerships allow CBOs to assist immigrant families with applications in key locations throughout communities. CBOs can also combine services to maximize their resources. To ensure continued partnerships with CBOs, states can take steps to establish an infrastructure that will support CBO involvement with immigrant families and benefit enrollment on an ongoing basis, and they should view these partnerships as complements to but not replacements for their own services and activities.

Simplifying Application and Eligibility Procedures

In line with a much broader movement, the states have developed or are developing integrated application systems, including online versions. The shift to integrated systems poses document-sharing dilemmas and other challenges, but the systems are especially relevant to serving the immigrant population.

Using Community Partnerships to Address Cultural Issues

CBOs play a crucial role in addressing fears and mistrust of government within many immigrant communities, lack of knowledge about the health and human service systems, unfamiliarity with Western medicine, and

myths about the potential risks of program enrollment. CBOs can serve as trusted liaisons to government services, which can ease immigrants' fears about deportation or future prospects for adjusting status or becoming citizens. Partnerships between government offices and CBOs with ethnic media and local businesses can also increase trust and awareness of public programs.

Overcoming Language, Literacy, and Logistical Issues

Addressing language, literacy, child care, and transportation challenges helps immigrants apply, enroll, and re-enroll in public programs. In all three states, materials, applications, and assistance are available in English and Spanish, and government offices contract with interpreter services to increase their ability to serve clients. Each state also uses an international language line. Massachusetts has addressed language barriers among foreign language speakers who do not speak Spanish. The use of plain language and visual information can also address literacy challenges. Enabling services such as transportation or help caring for young children also helps connect immigrants to services.

Enabling Families to Meet Multiple Needs Simultaneously

States have begun integrating services themselves, much like a “one-stop shopping” model intended to serve applicants in multiple ways at once rather than in piecemeal fashion. Multiservice centers allow several programs to co-locate, and partnerships between health care systems and school districts link families to important health services.

Meeting the Needs of Individuals within Mixed-Status Families

Applications that provide clear guidance and disclaimers regarding immigration questions help immigrants apply for assistance for eligible family members such as citizen children. Clear distinctions between required fields for applicants and items that can remain blank for non-applicants are useful. Screening tools can differentiate household income data and information about individual household members' immigration status. The Massachusetts opt-out policy allows ineligible household members to take themselves out of consideration for benefits without affecting applications for others in the household. CBOs help families secure benefits for individual household members by clarifying confusion and allaying fears about who qualifies for services.

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Figure 1. Definitions

Foreign born: Someone born outside the United States and its territories, except those born abroad to U.S.-citizen parents. The foreign born include those who have obtained U.S. citizenship through naturalization and other persons in different immigration statuses. People born in the United States, Puerto Rico, and other territories, or born abroad to U.S.-citizen parents, are native born.

Immigrant: A foreign-born person who is not a citizen of the United States as defined by the Immigration and Nationality Act, Section 101 et seq (similar to the statutory term “alien”). This definition of immigrant is narrower than some common definitions that treat any foreign-born person as an immigrant, including those who have become naturalized citizens. Since a central focus of this study is on immigrant eligibility, and citizenship is a key factor in determining eligibility for benefit programs, this paper adheres to the legal definition of immigrant.

Lawful permanent residents (LPRs): People lawfully admitted to live permanently in the United States by either qualifying for immigrant visas abroad or adjusting to permanent resident status in the United States. Many but not all LPRs are sponsored (i.e., brought to the United States) by close family members or employers.

Naturalized citizens: LPRs who have become U.S. citizens through the naturalization process. Typically, LPRs must be in the United States for five or more years to qualify for naturalization. Immigrants who marry citizens can qualify in three years, and some smaller categories can qualify sooner. LPRs generally must take a citizenship test—in English—and pass background checks before qualifying to naturalize.

Refugees and asylees: Persons granted legal status due to persecution or a well-founded fear of persecution in their home countries. Refugee status is granted before entry to the United States. Asylees usually arrive in the United States without authorization (or overstay a valid visa), claim asylum, and are granted asylee status once their asylum application is approved. Refugees and asylees are eligible to apply for permanent residency after one year.

Undocumented or unauthorized immigrants: Immigrants who are not LPRs, refugees, or asylees and have not otherwise been granted permission under specific authorized temporary statuses for lawful residence and work.

Lawfully present immigrants: The term “lawfully present” is used for applying for Title II Social Security benefits and is defined in the Department of Homeland Security (DHS) regulations at 8 CFR 103.12(a). The same definition is also used by the U.S. Department of Agriculture for determining eligibility for food stamp benefits. In 2010, the Centers for Medicare and Medicaid (CMS) issued a guidance to states that further defined “lawfully present” for determining eligibility for Medicaid/CHIP benefits under the Children’s Health Insurance Program Reauthorization Act of 2009 (CMS, “Re: Medicaid and CHIP Coverage of ‘Lawfully Residing’ Children and Pregnant Women,” SHO # 10-006, CHIPRA #17, Center for Medicaid, CHIP, and Survey and Certification, July 1, 2010, <https://www.cms.gov/smdl/downloads/SHO10006.pdf>). Lawfully present immigrants broadly include LPRs, refugees, and asylees, as well as other foreign-born persons who are permitted to remain in the United States either temporarily or indefinitely but are not LPRs. Some lawfully present immigrants have entered for a temporary period, for work, as students, or because of political disruption or natural disasters in their home countries, and some may seek to adjust their status and may have a status that allows them to remain in the country but do not have the same rights as LPRs.

Qualified immigrants: The following foreign-born persons are considered for eligibility for federal benefits:

- LPRs
- refugees
- asylees
- persons paroled into the United States for at least one year
- persons granted withholding of deportation or removal
- persons granted conditional entry (before April 1, 1980)
- battered spouses and children (with a pending or approved spousal visa or a self-petition for relief under the Violence Against Women Act)
- Cuban and Haitian entrants (nationals of Cuba and Haiti who were paroled into the United States, applied for asylum, or are in exclusion or deportation proceedings without a final order)
- victims of severe human trafficking (since 2000, victims of trafficking and their derivative beneficiaries [e.g., children], are eligible for federal benefits to the same extent as refugees/asylees)

Nonqualified immigrants: Immigrants who do not fall under the qualified immigrant groups, including immigrants formerly considered permanently residing under color of law (PRUCOLs), persons with temporary protected status, asylum applicants, other lawfully present immigrants (such as students and tourists), and unauthorized immigrants.

Five-year ban: Under TANF, SNAP, Medicaid, and CHIP, post-enactment qualified immigrants, with important exemptions, are generally banned from receiving federal means-tested benefits during their first five years in the United States. Detailed immigrant eligibility criteria for these programs are provided in the discussion and tables of the report.

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¹ *Qualified* refers to guidelines imposed by PRWORA about which immigrants are eligible for federal programs, including lawfully present permanent residents, refugees, and asylees, as well as some other special groups, such as victims of spousal abuse (under the Violence Against Women Act). PRWORA also imposed a distinction between *pre-* and *post-enactment* immigrants, referring to whether the person immigrated before or after the law passed, with post-enactment immigrants generally facing more restrictions. For example, PRWORA imposed on many post-enactment legal immigrants a five-year waiting period for some means-tested programs.

² The Children's Health Insurance Program Reauthorization Act (2009) gave states the option to receive federal funding to cover lawfully present children up to age 21 and pregnant women up to 60 days postpartum, including during the five-year ban, through their Medicaid/ CHIP programs (see Fortuny and Chaudry 2011).