

*Investing in Texas: Financing Health Coverage Expansion  
Conference Proceedings*

**Breakout Session:  
Expanding Health Care Access to Immigrants**

Medicaid expansions would not cover undocumented persons and immigrants who entered the U.S. after August 1996 (“unqualified” immigrants). Community Health Centers (CHCs) are a critical source of health care for these underserved populations. In December 2001, Congress approved the largest ever funding increase for CHCs: \$175 million for FY2002. The Texas Association of Community Health Centers’ Statewide Strategic Plan outlines a plan to expand access to approximately 573,000 new and current patients over the next five years by expanding existing and building new centers, and hiring new providers. This session focused on the barriers to access for Texas’ immigrants, and the potential for expansion under TACHC’s Statewide Strategic Plan. A presentation was provided regarding health care access for immigrants in Texas, with particular emphasis on the role of CHCs in providing care to this underserved population.

*Presentation Summary by Jen Eldridge and Liz Kaufman*

*Full report available at: <http://www.insuretexans.org> or  
<http://www.utexas.edu/lbj/faculty/warner/uninsured/conf2002.html>.*

There are 1.8 million immigrants in Texas, and 78 percent of these immigrants are of Hispanic origin. Approximately 500,000 of these immigrants are undocumented. In addition, there are 4.5 million uninsured individuals in Texas; 24 percent of the uninsured are immigrants, and 86 percent of the uninsured immigrants are Hispanic.

Barriers to private insurance coverage exist in that noncitizens are much more likely to work in industries that do not offer private insurance, or are not able to afford to buy coverage for themselves.

In terms of public insurance coverage, there are both perceived and real barriers. One perceived barrier is the misconception that applying for public benefits for eligible dependents will negatively impact one’s own immigration status. (Although there is anecdotal evidence to suggest that this may in fact be a real barrier.)

Real barriers include:

- Cultural insensitivity due to the majority of providers being U.S.-trained non-Hispanics;
- Language issues when providers are not fluent in Spanish;

- The common sentiment among the immigrant population that enrollment is very difficult at Medicaid offices; and
- The provisions outlined in the 1996 welfare reform legislation.

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was enacted in 1996 in an effort to reform the nation's welfare system. In order to determine who should receive which benefits, the legislation drew the distinction between "qualified" and "not qualified" immigrants. Included in the "not qualified" category are both undocumented immigrants and immigrants who entered the U.S. after August 1996, when the legislation was enacted. For this latter group, a five-year bar period was imposed following the date of entry, during which time an immigrant to the U.S. can receive no public benefits, including public insurance. States were given the option to offer benefits to immigrants following the five-year bar period, however, Texas has not yet exercised this option. As a result, August 2001, marked the end of the five-year bar period for the first wave of post-PRWORA immigrants, and these individuals continue to be ineligible for public insurance. PRWORA also resulted in some confusion among mixed-citizenship families by complicating the rules regarding eligibility for public benefits.

Immigrants in Texas are served in large part by county-funded programs, including hospital districts, which serve 112 counties; public hospitals, which serve 32 counties; and the County Indigent Health Care Program (CIHCP), which serves 138 counties. In addition, many immigrants receive care from charity clinics. However, a crucial component of the health care safety net for immigrants is Community Health Centers (CHCs).

### **The Role of Community Health Centers**

CHCs fall under the broader category of Federally-Qualified Health Centers (FQHCs). CHCs are supported in large part by federal Section 330 funds, which are administered by the Bureau of Primary Health Care. CHCs serve what are designated as Medically Underserved Areas/Populations. They are governed by consumer boards, which are made up of 51 percent service consumers. CHC services are subsidized for individuals below 200 percent of FPL: people below 100 percent of FPL receive free services, and people between 101 and 199 percent of FPL pay on a sliding-fee scale. There are currently 31 CHCs operating a total of 201 service sites throughout the state.

According to Texas Association of Community Health Centers data from 2000:

- The total population served by CHCs is 432,000;
- The population served is largely Hispanic (72 percent);
- The population served is largely poor (69 percent below 100 percent of FPL); and
- The population served is largely uninsured (61 percent).

CHCs are a critical part of the health care safety net for immigrants because they are community-oriented, affordable, culturally sensitive, and do not require documentation of citizenship status from patients.

### **Community Health Centers Operating in Texas Border Counties**

CHC	Counties Served	Sites Operated	Percent Hispanic
Brownsville	Cameron	4	99
Centro de Salud Familiar Le Fe	El Paso	9	99
Centro San Vicente	El Paso	3	99
Community Action Council of South Texas	Jim Hogg, Starr, Zapata	12	99
Gateway	Webb	6	99
Nuestra Clinica del Valle	Hidalgo	6	99
Su Clinica Familiar	Cameron, Willacy	6	98
United Medical Centers	Kinney, Maverick, Val Verde	11	91
Valley AIDS Council	Cameron, Hidalgo, Willacy	3	87

CHCs provide a wide range of primary care services including preventive health services such as well child care, adult primary care, preventive dental services, pre- and perinatal care, immunizations, and family planning. In addition to direct health care services, CHCs also provide emergency medical services, pharmaceuticals, transportation to and from the clinic for those who need it, referrals for advanced care, and health education and outreach. *Promotoras* are trained Spanish-speaking volunteer (in most cases) outreach workers who go out in the community to educate people about services provided by CHCs, conduct classes, and enroll eligible children in Medicaid and SCHIP.

### **Barriers to Advanced Care**

As effective as CHCs are at providing high-quality, culturally-sensitive primary care services to much of Texas' immigrant population, when a patient requires advanced care several barriers exist. Three of the biggest ones are described below:

- “Tin-Cup” medicine: “Tin-Cup” medicine refers to the practice often employed by CHC physicians of essentially begging for advanced care services for their patients. CHC physicians are often required to spend a good deal of their time on the phone, calling in favors from physician colleagues and bartering with other health care providers in order to obtain necessary services for their patients.
- The “second border”: Some physicians cite the “second border” as a major barrier to access for immigrants. Immigrants often come across the U.S.-Mexico border and live in the Lower Rio Grande Valley for years without experiencing any threat to their immigration status. However, individuals requiring advanced medical care that cannot be provided in the Valley are often sent to one of the hospitals in Houston or Galveston. This requires crossing a second border checkpoint, like the Sarita

Checkpoint, located 60 miles north of McAllen on US 77. An undocumented immigrant attempting to cross this checkpoint faces a 50 percent chance of deportation. Physicians report having to send notes addressed to INS along with their patients seeking care past the second border.

- The “gatekeeper” system: The “gatekeeper” system refers to the system in some counties whereby CHC physicians are required to refer patients in need of secondary care to a gatekeeper physician instead of directly to a specialist. The gatekeeper then authorizes whether secondary care is actually warranted. This system creates an unnecessary burden for both physician and patient, who suffer while waiting to be processed through the system. Counties have the power to waive this requirement, thereby allowing CHCs physicians to certify the type of care a patient requires and to refer them directly to the services they need.

### **Community Health Center Expansion**

CHCs have recently been enjoying the spotlight as a popular and relatively inexpensive solution for dealing with the problem of the uninsured. In December 2001, a house/senate conference committee approved the Resolution to Expand Access to Community Health Centers (REACH), representing a \$175 million funding increase for CHCs for FY2002—the largest-ever increase for this program. The National Association of Community Health Centers (NACHC) plans to put this new funding towards its goal of doubling of the capacity of health centers over the next five years.

The Statewide Strategic Plan set forth in August 2001 by the Texas Association of Community Health Centers outlines a plan to expand access to 325,361 new patients and expand services to 247,993 new and current patients over the next five years. This represents a potential 75 percent increase over current patient capacity. TACHC’s plan would involve expansions to 247 new and existing centers, and hiring another 338 providers. TACHC has estimated that these expansions would require \$99 million in additional grant support. To meet this goal, TACHC is working with CHCs to develop and submit applications for federal Section 330 funding.

### **Conclusions**

Community Health Centers are a source for accessible, affordable, high-quality, and culturally sensitive care for Texas’ immigrant population. TACHC’s proposed expansions could potentially pick up the undocumented and post-1996 “unqualified” immigrants who would not be covered by a Medicaid waiver expansion. Although immigrants in Texas receive health care services from a wide variety of sources, it seems that emphasis should be placed on expansion solutions that capitalize on federal sources of funding. Considering the crucial role that CHCs play in providing care to Texas’ uninsured regardless of immigration status, the recent increase in federal Section 330 funding signifies one of the very few bright spots for expanding access to this underserved population.

## **Participant Discussion**

Discussion on CHC expansion followed the presentation. Participants addressed such issues as the need for CHC expansions in urban areas including Dallas and Houston, the safety net issue for immigrants, and the relationship between CHC expansion and the provider network.

Some participants questioned the accuracy of estimates of the undocumented immigrant population in Texas. One expert felt that the Urban Institute's latest survey provided a more precise estimate that cited undocumented citizens numbering approximately 1.1 to 1.2 million people. This same expert noted that in just counting undocumented children attending public school, there were over 300,000 undocumented students (not including pre-school). It was agreed that the actual number of undocumented immigrants was important to find out in order to more accurately target the population for health services.

In this respect, other participants also believed that the actual location of these immigrants were a key component in the expansion of CHCs. Medicaid providers from Dallas and Houston both noted that there were many unacknowledged undocumented immigrants in the urban areas. They felt that most of the attention to the uninsured immigrants was focused on the border and that, in reality, these immigrants were moving to the cities for jobs. They therefore recommended that a network of CHCs be established in these urban areas for the first time.

Following the discussion of establishing CHCs in larger urban areas, there was commentary that Texas needed a unique health care system due to its diverse needs. Many participants felt that Texas could establish different health care systems based on geographic location within such a large state. It was argued that this would ease the burden on the government to find a "one answer fits all" solution and allow funding to be tailored to the particular needs of the service area.

Some participants questioned the desirability of CHC expansion, noting that CHCs have the potential to isolate primary care and thus reduce continuous care. There was also concern that CHCs, serving predominantly poor women and children, were going to receive this extra funding without equal funding also being given to specialty care. These participants felt that the health care need right now was to serve the people at the beginning or middle of chronic illness. They felt that CHCs are incapable of treating these clients with such short appointment times and such limited resources. For example, a 15-minute visit at a CHC cannot help people discover and diagnose conditions such as heart problems, nor is it sufficient or capable of treating these special health care needs. One provider pointed out that a budget increase for CHCs sounds excellent but may be harmful since Bush's plan calls for a similar reduction in tertiary and trauma services. Many participants agreed that any expansion in CHCs would need to be accompanied by an expansion in specialty care.

Many providers in the group remarked that CHC expansion, or any health care expansion, could not be viewed in isolation from the rest of the system. They felt that any increase in clients or services mandated an increase in providers. One commented

that, “if you don’t have providers with you, you don’t have anything.” They stated several reasons why they felt that providers did not want to participate in public health care programs. The primary reason cited was inadequate reimbursement rates. They stated that these low rates were the reason why the provider participation rate is low for Medicaid, SCHIP, Medicare, and CHCs. Participants felt that this lack of financial incentive resulted in a provider movement against expansions such as the CHC plan under consideration.

Some providers felt that the administrative burdens of working with such programs as Medicaid also deters providers from participating the program. As such, one participant described his initiative to recruit providers to volunteer to serve the low-income clientele. Some debate ensued regarding whether it was financially sound to reduce the number of official Medicaid providers through volunteerism when this type of work did not draw down federal dollars.

Other providers felt that the managed care roll-out in the public programs resulted in a backlash from the medical community. One provider felt that the burden has now been placed on the medical schools to take care of the indigent, uninsured, and underinsured population and that these schools are already saturated.