

# Public Charge and Private Dilemmas:

Key Challenges and Best Practices for Fighting  
the Chilling Effect in Texas, 2017-2019



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## Key Challenges and Best Practices for Fighting the Chilling Effect in Texas, 2017-2019

**Cheasty Anderson, M.A., Ph.D.**

Director of Immigration Policy and Advocacy  
Children's Defense Fund – Texas

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# Executive Summary

**B**etween 2016-2019, Texas experienced a precipitous drop in enrollment in benefit programs such as Medicaid, CHIP, SNAP, and WIC, among others. This report explains that a significant proportion of this drop in enrollment is attributable to the climate of fear in which immigrant and mixed-status families have been living under the current administration. Anti-immigrant policies such as “Public Charge” have caused many low-income mixed-status families to fear enrolling even their citizen children in programs for which they qualify. Texans from mixed-status families comprise the bulk of our recent decline in enrollment among eligible Texans.

This report offers a qualitative study of 32 geographically diverse organizations in Texas, all of whom are in the public service sector, and most of whom report a disproportionate impact on the immigrant families they serve. This report is geared to two audiences: first, Texas’ state government and our Health and Human Services Commission, and second, to the broad community of enrollment and outreach organizations. It is our hope that the findings contained here will offer a road map for our Governor, the Legislature and the Agency to implement corrective policies and practices that will educate and encourage Texans in immigrant families to enroll in the programs for which they are eligible. It is also our hope that the best practices summarized here will be useful for outreach workers, enrollment assisters, and health insurance navigators as they exert themselves to re-enroll the eligible Texans who have withdrawn from public benefits.





# Introduction

In July of 2019, Maria Hernandez was on the phone with a colleague from another organization. She typed a few numbers into a spreadsheet, and hit enter on a calculation.

“Oh, wow,” she murmured. “Can that be right?”

“What does it say?” asked the colleague. Hernandez checked the numbers and tried the calculation again. Same answer.

“Eighty percent,” Hernandez said.

“Did you say eighty?” asked the colleague. “Like eight-zero?”

“Yeah, eighty. That is... quite a bit worse than I had expected,” Hernandez said.<sup>1</sup>

**H**ernandez is the founder and Executive Director of an organization in Austin, TX, called [VELA](#), which provides assistance, support, and training to families who have children with disabilities. These children rely on programs like Medicaid and SSI for the therapies that help them communicate, learn, and sometimes even walk or swallow. VELA's job, in part, is to help them enroll in SSI, Medicaid, SNAP, WIC – any program for which they or their children are eligible that would help the family care and provide for that child. They work with around 1,000 families a year, 85 percent of which are mixed immigration status families.

In 2017, VELA staff began noticing a change that went hand-in-hand with an uptick in conversations and questions about public charge and ICE raids. “In 2018, 2019, we began noticing that during our support groups, on our Facebook groups, and even in one-on-one encounters, a lot of the information they were sharing had changed. Before, it was always where to find kid supplies, educational materials, stuff like that. But suddenly so much of it was food pantry-based. They were sharing pictures, images of everywhere you could go to get food. And that’s when I realized people were starting to worry a lot more about, you know, what do we eat, and where can we find food?”<sup>2</sup> Most VELA families traditionally qualified for SNAP, so Hernandez wondered how much of a drop-off in the number of families receiving nutrition assistance for their children there had been.

**“It meant that, even us, so closely tied to the families we work with, are unaware of the daily battles these families are going through.”**

The number Hernandez had calculated during that phone call in July, 2019, was the “year-over-year” change in families enrolled in SNAP; that is to say, 80 percent fewer VELA families were enrolled in SNAP in the summer of 2019 than had been in the summer of 2018. “I was surprised by what a huge drop it had been, in terms of accessing SNAP,” said Hernandez. “Even though we had seen patterns, seeing that it was 80 percent was shocking just because it meant that, even us, so closely tied to the families we work with, are unaware of the daily battles these families are going through.”<sup>3</sup> Hernandez said that, without SNAP, families became hugely reliant on a network of food pantries, standing in

<sup>1</sup> Maria Hernandez (Founder and Executive Director, VELA), interview with Cheasty Anderson, August 28, 2020.

<sup>2</sup> M. Hernandez, interview.

<sup>3</sup> M. Hernandez, interview.

line at one and then another, day after day, to feed their families. It was an additional stressor on these parents, but, she stated, “they were trying to create a shield of protection around their family by doing that.”<sup>4</sup>

This story, a tale of hundreds of families in one community, en masse, abandoning a support upon which they had relied, is the story that launched this research project. The colleague on the other end of the line with Hernandez was Cheasty Anderson, Director of Immigration Policy and Advocacy at the [Children’s Defense Fund – Texas](#) (CDF-TX), and the author of the report you are reading now. CDF-TX works on policy and advocacy work on issues facing immigrant families, and is in coalitions with other state and national organizations who have led the fight against many anti-immigrant policies. As an active member of the nation-wide [Protecting Immigrant Families Campaign](#), CDF-TX and other member organizations were taking the lead on public education around a change to the regulations around immigration processing called “public charge.” Hernandez was on the phone with Anderson that day to schedule a training on the new rule change for their staff and members.

The startling number that Hernandez reported prompted Anderson to investigate further. Conversations in the weeks that followed with other direct service organizations cemented the understanding that there was data available, albeit in a patchwork fashion, to answer pressing questions about troubling recent trends in Texas benefit enrollment in SNAP, but also, urgently, in Medicaid and CHIP.

For example, data from Foundation Communities, an organization in Austin that offers health insurance enrollment assistance (among other programs) revealed that in 2018 during the Open Enrollment for the Affordable Care Act (ACA) Health Insurance Marketplace, they had seen a 16.9 percent reduction in immigrant clients, compared with only a 5.4 percent reduction in non-immigrant clients, over their 2017 Open Enrollment numbers.<sup>5</sup> ECHOS, a non-profit organization in Houston that connects low-income, largely immigrant clients with health, social and educational resources, shared even more troubling data. They had seen, between 2016 and 2019, a 42 percent reduction in Children’s Medicaid enrollments, a 42 percent reduction in adult Medicaid and CHIP-Perinatal services, and a 37 percent decrease in SNAP enrollments.<sup>6</sup> ECHOS also has an on-site food pantry. Revealingly, during the time period in which SNAP applications dropped 37 percent in their enrollment office, demand at their food pantry and food fairs shot up by 327 percent.<sup>7</sup> The need, obviously, was still very present. What had changed was immigrant families’ willingness to use government-based programs designed to ameliorate those needs.

In the story above about VELA families, those who kept their children enrolled in Medicaid and SSI did so because they have children with disabilities and, as Hernandez put it, “Removing a benefit like Medicaid would have implications that were too hard even to consider.”<sup>8</sup> Instead they did what they could to protect their families by dropping SNAP. These families, so reliant on the health care that helped their children survive and thrive, felt like they were at increased risk – especially those on SSI, who are under a heightened amount of state supervision. Hernandez noted that, “even with that exposure, they still felt that this was the only thing that was within their control to protect their families.”<sup>9</sup> Families could opt out of SNAP, but still manage to feed their families by standing in line

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<sup>4</sup> M. Hernandez, interview.

<sup>5</sup> Arianna Anaya (Program Manager for Health Coverage Program, Foundation Communities), email message to Cheasty Anderson, July 7, 2020.

<sup>6</sup> Cathy Moore (Executive Director, ECHOS), interview with Cheasty Anderson, August 15, 2020.

<sup>7</sup> Moore, interview.

<sup>8</sup> M. Hernandez, interview.

<sup>9</sup> M. Hernandez, interview.

for a few hours. Given that the money they received from SNAP every month, while essential, is never really enough, families were used to seeking out additional resources. This rejection of a key benefit was their way of protecting themselves.

But for many mixed-status Texas families with non-disabled children, the consequences of abandoning health insurance, while potentially dire, seemed more manageable than the fear of future immigration trouble that could one day separate their family. As a consequence, immigrant families across Texas began to withdraw their citizen and lawfully-present children from Medicaid and CHIP in addition to SNAP.

## Background Information on Health and Nutrition in Texas

It is widely known, at least among health policy circles, that Texas has the highest child uninsured rate in the nation. In 2019 our rate was 12.7 percent – more than twice the national average of 5.7 percent.<sup>10</sup> When these numbers are disaggregated for race and ethnicity, it becomes apparent that there are broad disparities. Hispanic children, for example, have an uninsured rate of 17.5 percent, while Black and White (non-Hispanic) children have 8.5 and 8.3 percent uninsured rates, respectively.<sup>11</sup> Obviously, the uninsured rate for Hispanic children is pulling the average up, though this should not be used to cloak the bigger problem. At 8.3 percent, even the uninsured rate among non-Hispanic White children is considerably higher than the national average and would alone rank Texas as the sixth-worst uninsured rate in the country.<sup>12</sup> Furthermore, states with higher proportions of Hispanic children than Texas have successfully been able to lower their uninsured rates, underscoring that the high rates of uninsured are not the problem of a particular population, but are a result of state decisions and policy choices.<sup>13</sup>

These recent numbers are a dramatic and concerning departure from the recent past. In early 2017, child health advocates had reason to feel cautiously optimistic. For the previous decade, the uninsured rate for children in Texas had steadily declined.<sup>14</sup> Thanks to the hard work of advocates, enrollment assisters, community-based organizations, and the generous funders who supported these efforts, the percentage of eligible children who were actually enrolled in Medicaid had never been higher. While enrollment growth had plateaued in 2014 with the advent of a problematic administrative adjustment to eligibility periods (more on that later) the numbers were still higher than ever before.

On the other hand, there was still ample room for concern: the change of administration from Obama to Trump had presaged a radical shift in priorities; Texas state leadership remained committed to reducing Medicaid rolls and suing to end the Affordable Care Act (ACA); and state policy and practice of benefits administration still needed to be changed. But for this brief moment in time, health advocates could look at the data and feel good about what they had accomplished over the last decade. This feeling of relative positivity, however, did not withstand the next couple of years.

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<sup>10</sup> Joan Alker and Alexandra Corcoran, [Children's Uninsured Rate Rises by Largest Annual Jump in More Than a Decade](#) (Center for Children & Families of the Georgetown University Health Policy Institute, October 2020).

<sup>11</sup> ["Children's Health Coverage in Texas."](#) Center for Children & Families of the Georgetown University Health Policy Institute, Children's Health Report Card, October 2020.

<sup>12</sup> ["Children's Health Coverage in Texas;"](#) Alker and Corcoran, [Children's Uninsured Rate Rises.](#)

<sup>13</sup> ["Population Distribution of Children by Race/Ethnicity,"](#) State Health Facts, Kaiser Family Foundation, 2018; ["New Mexico Snapshot of Children's Coverage: How Medicaid, CHIP, and the ACA Cover Children,"](#) Center for Children & Families of the Georgetown University Health Policy Institute and the American Academy of Pediatrics, April 19, 2017.

<sup>14</sup> Alker and Roygardner, [The Number of Uninsured Children; "Backsliding On Texas Children's Health: More Uninsured, Fewer Enrolled In Medicaid And CHIP,"](#) Center for Public Policy Priorities, Cover Texas Now, September 13, 2019.

In late 2017, the Texas Health and Human Services Commission's (HHSC) monthly data reports started indicating rapidly dropping enrollment numbers in both CHIP and Medicaid. By mid-2019, the data showed that within a 17-month period (December 2017-April 2019) Texas had lost about six percent of its enrollment in CHIP and Children's Medicaid – more than 200,000 children.<sup>15</sup> By February of 2020, the total had grown to 237,000 children, representing a seven percent decline in enrollment since December 2017.<sup>16</sup>

After more than a decade of steadily increasing enrollment numbers, this precipitous drop was alarming. Also distressing was the drop in SNAP and WIC over the same time period; between December 2017 and April 2019, SNAP lost 520,000 of its enrollees, a drop of 13.5 percent.<sup>17</sup> WIC, even more startlingly, had lost 155,726 enrollees, or 18.8 percent of its caseload.<sup>18</sup>

Policy analysts and advocates began looking for answers as soon as the enrollment trend became obvious. Who had dropped off? Why had they dropped? Was this a reflection of decreasing numbers of eligible children, or a reflection of the State's successful efforts to cut enrollment? In response to initial queries about the availability of demographics on children who lost coverage, HHSC indicated they do not routinely report on or analyze these topics. In order to get that information, then, it would be necessary for an organization or coalition to make a formal open records request, for which they could be charged costs for analysis time, or for members of the legislature to make a formal request that the Agency do a special analysis to get this information.<sup>19</sup>

It is worth pointing out that HHSC's inability to easily produce this critical demographic data is puzzling. HHSC includes demographic questions on the applications for public benefit programs, including race and ethnicity. Withdrawing from a program does not delete this information from their database – if a person were to re-enroll, even years later, the demographic data they submitted on their initial application automatically populates the later application. Furthermore, even if there were some technical challenge in looking at the data of individuals who did not renew their enrollment, a simple subtraction of demographic apportionment within the state-wide Medicaid program would yield a result that could point out any disproportionate withdrawals.

Instead of looking for answers to this troubling trend, the Texas HHSC, along with the Trump administration, offered a rosy explanation, though it failed to hold water. These numbers, they argued, were actually good news – the drop was a result of strong economic indicators, as more parents gained employer-sponsored insurance.<sup>20</sup> But this was illogical in two respects. First, Texas's employment numbers had been strong for years while Medicaid and CHIP enrollment numbers



**“In late 2017, the Texas Health and Human Services Commission’s (HHSC) monthly data reports started indicating rapidly dropping enrollment numbers in both CHIP and Medicaid.”**

<sup>15</sup> [“Backsliding on Texas Children’s Health.”](#)

<sup>16</sup> [“Medicaid and CHIP Monthly Enrollment by Risk Group \(September 2014 - July 2020\).”](#) Every Texan Analysis of Texas Health and Human Services, email message from Melissa McChesney to Cheasty Anderson, October 7, 2020.

<sup>17</sup> [“Supplemental Nutritional Assistance Program \(SNAP\) Statistics, December 2017- April 2019.”](#) Texas Health and Human Services, updated July 2020.

<sup>18</sup> [“WIC Participation History - June 2020.”](#) Texas Health and Human Services, updated August 4, 2020.

<sup>19</sup> Anne Dunkelberg (Associate Director, Program Director - Health & Wellness Team, Every Texan), email message to Cheasty Anderson, October 8, 2020.

<sup>20</sup> Abby Goodnough and Margot Sanger-Katz, [“Medicaid Covers a Million Fewer Children. Baby Elijah was One of Them.”](#) *New York Times*, October 25, 2019; Matt Broaddus, [“Research Note: Medicaid Enrollment Decline Among Adults and Children Too Large to Be Explained by Falling Unemployment.”](#) Center on Budget and Policy Priorities, July 17, 2019.

consistently climbed.<sup>21</sup> Second, this data reflected the significant part of our economy that does not offer employer-sponsored insurance, or even wages above the poverty line. And third, during the period of time in which enrollment numbers were plummeting, there was a concurrent increase in the child uninsured rate in Texas.<sup>22</sup> That is to say, those children who dropped off of the Medicaid and CHIP rolls were not simply shifting over to Marketplace or employer-sponsored coverage.<sup>23</sup> If that were the case, as Anne Dunkelberg of [Every Texan](#) noted, “Then you’d see kids gaining insurance, not an increase in the uninsured rate.”<sup>24</sup> In summary, the optimistic spin that Texas leadership offered was unsupported by the data.

The same was true for SNAP and WIC. SNAP enrollment generally follows the poverty rate and the unemployment rate. As Rachel Cooper of Every Texan noted, “In the last five years we just haven’t seen any numbers to indicate a big change in eligibility. No big proportional changes to the economy, or the poverty numbers. When unemployment spikes, SNAP spikes. When poverty spikes, SNAP spikes. And the reverse is true, as well.”<sup>25</sup> In other words, if the Texas economy were truly booming, and the boom were tied to the years 2018 and 2019, then the precipitous drop in enrollment might have made sense, though even then that argument would push the limits of plausibility.<sup>26</sup> But nothing had changed radically in either the poverty or unemployment data.<sup>27</sup> If the hope was that this abrupt drop was because of the improving economy, there just wasn’t any such dramatic shift in Texas – and certainly not at the low-income job level, where it would need to be in order for a decrease in SNAP enrollments to be attributable to economic pressures.<sup>28</sup>

We needed to understand the cause of this drop. Was this a result of changing HHSC policies and procedures? There had been a few policy changes that advocates knew were depressing enrollment numbers. In SNAP, for example, in years subsequent to the Great Recession of 2008 (which had caused an increase in enrollment) improving economic indicators had depressed enrollment.<sup>29</sup> And in 2014, SNAP had changed the way it reported data, making continuity in long-term trends more of a challenge to track.

In Medicaid, there was one big challenge. In 2014, the state had shifted from a six month continuous eligibility period to a single 6 month period followed by monthly periodic income checks (PICs) in the second half of the year. These PICs were riddled with administrative problems, the result of which was that over 4,000 children each month were kicked off of Medicaid – 92 percent of whom were removed because their paperwork did not arrive in the prescribed 10-day period. In total between 2017 and 2018, 99,889 children were kicked off Medicaid for failing to clear a narrow administrative hurdle rather than because of a negative eligibility determination.<sup>30</sup> Of those 99,889 children, 52 percent re-enrolled in Medicaid or CHIP within a year, suggesting that they were eligible the entire

<sup>21</sup> [“Databases, Tables & Calculators by Subject: Texas Local Area Unemployment Statistics,”](#) U.S. Department of Labor Statistics, accessed September 10, 2020.

<sup>22</sup> Tricia Brooks, Edwin Park, and Lauren Roygardner, [Medicaid and CHIP Enrollment Decline Suggests the Child Uninsured Rate May Rise Again](#), (Center for Children & Families of the Georgetown University Health Policy Institute, May 2019); Alker and Roygardner, [The Number of Uninsured Children](#).

<sup>23</sup> Brooks, Park, and Roygardner, [Medicaid and CHIP Enrollment Decline](#)

<sup>24</sup> Anne Dunkelberg (Associate Director, Program Director - Health & Wellness Team, Every Texan), interview with Cheasty Anderson, August 28, 2020.

<sup>25</sup> Rachel Cooper (Senior Policy Analyst, Every Texan), interview with Cheasty Anderson, August 27, 2020.

<sup>26</sup> Though as Matt Broadus says, “Historically, Medicaid enrollment tends to grow more slowly but not decline during a period of economic growth, and neither the Congressional Budget Office nor the Medicaid Office of the Actuary projected Medicaid enrollment declines in 2017 or 2018, despite anticipating a growing economy.” Broadus, [“Research Note: Medicaid Enrollment Decline.”](#)

<sup>27</sup> [“Databases, Tables & Calculators by Subject;” “Table 19. Percent of Persons in Poverty, by State,”](#) in [Historical Poverty Tables: People and Families-1959 to 2018](#) (United States Census Bureau, March 2019).

<sup>28</sup> Cooper, interview.

<sup>29</sup> JC Dwyer (Senior Director of Civic Engagement, Feeding Texas) and Jamie Olson (Director of Government Affairs, Feeding Texas), interview with Cheasty Anderson, April 20, 2020.

<sup>30</sup> [“Analysis of HHSC Data for Children’s Medicaid - Based on HHSC Data,”](#) Children’s Health Care Coalition, February 23, 2019.

time.<sup>31</sup> Even worse, the state's own data showed that the databases they rely on to flag families for review is wrong *at least* 30 percent of the time.<sup>32</sup> But, as previously noted, even this tremendous challenge had merely caused the 10-year streak of increasing enrollment to plateau. What was happening in 2018 and 2019, as Dunkelberg noted, was “a brand new factor that was driving down enrollment, rather than just flattening it.”<sup>33</sup>

The problem with any theory predicated on suppressive policies or economic indicators was that we already knew what the impact of those had been on enrollment, and it was certainly not a six or 13 percent reduction in children enrolled. Moreover, the policy changes and environmental shifts we were aware of were not isolated to Medicaid or SNAP or CHIP. But the statistically significant drop in these HHSC numbers was consistent across all three programs. It is also significant that this trend, while certainly bigger in scale in Texas than in other states, was part of a national trend that began at the same time (December 2017), which points to a change that goes beyond Texas policies.<sup>34</sup>

We began, therefore, to ask a different set of questions, and to look at what *had* changed in Texas over the past two years. We found an answer close at hand – something that immigration advocates had begun warning about in early 2017.

## Public Charge: the Chilling Effect and the Climate of Fear

Anti-immigrant rhetoric and policy has been a hallmark of the current presidential administration. From early in his campaign in 2016, then-candidate Donald Trump promised to build a wall between the U.S. and Mexico. He called Mexicans “rapists” and “criminals,”<sup>35</sup> and spoke from a binary “us vs. them” worldview that placed white anxieties and insecurities front and center. His rhetoric stoked a bonfire of racism, and fanned the flames of race-based fear. While some hoped that, upon assuming the presidency, Mr. Trump would cease inciting rage, racism, and hatred, the winter of 2017 proved the optimists wrong.

Within the first year of his administration, an incomplete list of the policies that the Trump administration enacted that fall under the general category of “anti-immigrant” would include: issuing the first “Muslim ban;”<sup>36</sup> canceling DACA;<sup>37</sup> ending temporary protected status for thousands of immigrants holding TPS visas;<sup>38</sup> beginning a long battle to build his promised wall;<sup>39</sup> dramatically reducing the number of refugees the United States would accept;<sup>40</sup> expanding “fast track” interior deportations;<sup>41</sup> launching a series of ICE raids on immigrant communities;<sup>42</sup> and beginning his efforts to bar asylum seekers from being able to request asylum on the Southern Border.<sup>43</sup> This listing could

<sup>31</sup> [“Analysis of HHSC Data.”](#)

<sup>32</sup> [“Analysis of HHSC Data.”](#)

<sup>33</sup> Dunkelberg, interview.

<sup>34</sup> [“Children’s Health Coverage in Texas.”](#)

<sup>35</sup> [“‘Drug dealers, criminals, rapists’: What Trump thinks of Mexicans.”](#) BBC News, August 31, 2016.

<sup>36</sup> [“One Year After the SCOTUS Ruling: Understanding the Muslim Ban and How We’ll Keep Fighting It.”](#) National Immigration Law Center, June 2019; [“Timeline of the Muslim Ban.”](#) ACLU Washington, updated February 10, 2020.

<sup>37</sup> Michael Shear and Julie Hirschfeld Davis, [“Trump Moves to End DACA and Calls on Congress to Act.”](#) *New York Times*, September 5, 2017.

<sup>38</sup> [“Temporary Protected Status: Overview and Current Issues.”](#) Congressional Research Service, updated April 1, 2020; Nicole Prchal Svajlenka, [“What Do We Know About Immigrants With Temporary Protected Status?”](#) Center for American Progress, February 11, 2019.

<sup>39</sup> Manny Fernandez and Mitchell Ferman, [“Under Construction in Texas: The First New Section of Border Wall.”](#) *New York Times*, November 8, 2019.

<sup>40</sup> Bobby Allyn, [“Trump Administration Drastically Cuts Number Of Refugees Allowed To Enter The U.S.”](#) *NPR*, September 26, 2019.

<sup>41</sup> Associated Press, [“Trump administration moves to expand fast-track deportations.”](#) *Guardian*, July 22, 2019.

<sup>42</sup> Abigail Hauslohner, Maria Sacchetti, and Colby Itkowitz, [“Trump says ICE raids to start Sunday, emphasizing purge of criminal immigrants.”](#) *Washington Post*, July 12, 2019.

<sup>43</sup> [“Asylum Seekers & Refugees.”](#) National Immigrant Justice Center, updated August 2020.

go on for several sentences more, but for the purposes of this report, there is one item outstanding that merits consideration vis-a-vis the crashing enrollment numbers of 2019.

In January 2017, Trump issued the first in a series of efforts to expand the definition of an arcane immigration test called the “public charge.” While few Americans had even heard the term, it soon permeated discussions in immigrant communities. Early leaked drafts appeared – first of an Executive Order (EO), and later, of a proposed regulatory change at the Department of Homeland Security (DHS) that would radically expand the public charge test, and change the definition of what constitutes a “public charge.” These leaks threw both immigrant communities and immigration rights advocates into a state of alarm and confusion.

The early leaked drafts of the EO and the DHS proposed regulation were extraordinarily wide-ranging. They proposed that if any immigrant used a public benefit for which they were eligible, or if even their citizen children enrolled in benefits for which they were eligible, the immigrant might no longer be a viable candidate for legal permanent residency (also known as a green card).<sup>44</sup> The list of benefits proposed early on was expansive: Medicaid, CHIP, SNAP, WIC, free and reduced school lunches, and the HeadStart program, among others.<sup>45</sup> News coverage of these leaked documents, alongside a robust peppering of confusion and misinformation, increased the anxiety that immigrant and mixed-status families were already feeling.<sup>46</sup>

Advocates and some local governments launched into action to do community outreach and education based on what we knew to try and stay ahead of the rumor mill. Most significantly, the [Center on Law and Social Policy](#) (CLASP) and the [National Immigration Law Center](#) (NILC) collaborated to build a national campaign called [Protecting Immigrant Families \(PIF\)](#). Member organizations were dedicated to fighting back against this proposed policy change. The PIF campaign was active in education and organizing from the very first leaked draft. By the time the proposed rule was finally published in the Federal Register in August 2018, PIF was able to coordinate the biggest “public comment” campaign in DHS history. Overall, more than 265,000 organizations and individuals submitted public comments to the Federal Register – the overwhelming majority of those comments were in opposition to the proposed rule change.

As the government pushed inexorably toward finalization of the rule, PIF raced to produce accurate, community-facing public education resources for mass distribution. There were a few hiccups in making translations available quickly in a variety of languages, and feedback from community members indicated that initially some of the language

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<sup>44</sup> It is important to note that the DHS regulation does change eligibility criteria - it would merely punish the use of benefits for which one was eligible.

<sup>45</sup> Jeanne Batalova, Michael Fix, and Mark Greenberg, [Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families' Public Benefits Use](#) (Migration Policy Institute, June 2018).

<sup>46</sup> Hamutal Bernstein et al., [Amid Confusion over the Public Charge Rule, Immigrant Families Continued Avoiding Public Benefits in 2019](#) (Urban Institute, May 2020); Batalova, Fix, and Greenberg, [Chilling Effects](#)

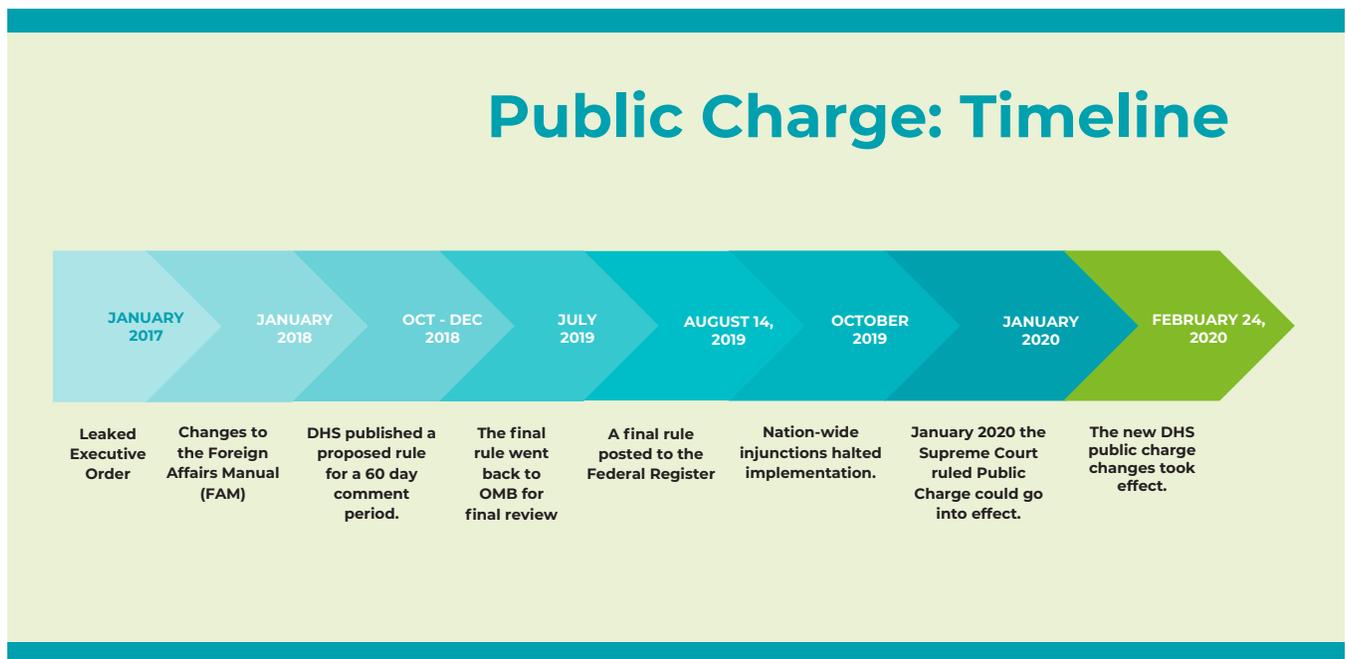
was too technical. Nonetheless, by 2019, a set of useful, community-tested resources was readily available and widely distributed in Texas.<sup>47</sup>

Additionally, teams of PIF member organizations had become subject matter experts within each state. In Texas, the state leads for the PIF campaign are Every Texan (formerly known as the Center for Public Policy Priorities) and the Children’s Defense Fund – TX. These organizations, and several others who simply took it upon themselves, offered numerous avenues to share the information, from webinars, to conferences, to in-person training. There was high demand for these trainings. Between March 2017 and February 2020, Every Texan and CDF-TX offered more than 60 public charge trainings (combined) to a variety of organizations all over Texas, from food banks to local bar associations, to hospital groups and everything in between.

In spite of this tremendous effort, however, the Trump administration, with its herky-jerky roll-out of the policy, kept shifting the ground under our feet. It was extraordinarily difficult to inform families accurately, given the uncertainty.

A brief explanation of the timeline might help make clear just how chaotic this period was, as immigrant communities tried to wrap their heads around this new threat. The final rule was published on August 14, 2019 – more than two and a half years after the draft of the Executive Order was first leaked. But in the intervening years, we had seen that first leaked EO, and then two separate leaked drafts of the proposed regulation, each of which outlined different rules. Efforts to prepare were stymied by the constantly changing information and the unknown publication date of the final draft.

<sup>47</sup> [“Know Your Rights.”](#) Protecting Immigrant Families, updated 2020.



Making this even more complicated, in January 2018, the Department of State (DOS) changed its policies on public charge for external applicants for visas in their Foreign Affairs Manual (FAM).<sup>48</sup> This meant that from early 2018, immigrant and mixed status families were hearing about relatives from abroad who had been denied visas based on the most draconian version of the Trump administration's proposed public charge rule, while the public charge regulation had not yet been changed for internal applicants for a green card.<sup>49</sup> Immigration attorneys, not always fully informed on the proposed rule, began warning their clients away from public benefits, even for their citizen children, in large numbers.<sup>50</sup>

The public charge regulation (which eventually went into effect on Feb 24, 2020) ended up, in its final form, being a harsh adjustment to previous policy, but less explicitly draconian than the initial drafts.<sup>51</sup> The FAM, which still mandated a more severe form of the public charge test, aligned their policy with the DHS final rule shortly after it went into effect.<sup>52</sup>

As finalized in 2020, the new public charge rule delineated a broader set of public benefit programs, the use of which would negatively affect an application for legal permanent residency.<sup>53</sup> The programs explicitly included were adult Medicaid, SNAP, housing subsidies, and cash assistance. It also broadened the set of information USCIS would interrogate when looking at a candidate's "totality of circumstances" (more on this in the previous footnote). Lastly, it established what advocates call the "wealth test," wherein low- and moderate-income applicants are more likely to be deemed a public charge than those with greater assets, income, and resources.

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<sup>48</sup> ["Changes to 'Public Charge' Instructions in the U.S. State Department's Manual."](#) National Immigration Law Center, February 8, 2018; DOS could change the FAM without a public comment period or lengthy review process. DHS, on the other hand, had to issue their proposed regulation on public charge and then undergo a public comment period, a review period, and then publication of a final rule.

<sup>49</sup> A Green Card holder (permanent resident) is someone who has been granted authorization to live and work in the United States on a permanent basis. As proof of that status, U.S. Citizenship and Immigration Services (USCIS) grants a person a permanent resident card, commonly called a "Green Card." An immigrant can become a permanent resident several different ways. Most individuals are sponsored by a family member or employer in the United States. Other individuals may become permanent residents through refugee or asylee status or other humanitarian programs. In some cases, an immigrant may be eligible to file for themselves.

<sup>50</sup> Holly Straut-Eppsteiner, ["Documenting through Service Provider Accounts Harm Caused by the Department of Homeland Security's Public Charge Rule."](#) National Immigration Law Center, February 2020.

<sup>51</sup> A detailed explanation of the fianl public charge rule can be found at [https://docs.google.com/document/d/1fbPuxkyf3oV5Z-phor\\_uEyFunG\\_MOVjQ2vfuxzSWX13Q/edit](https://docs.google.com/document/d/1fbPuxkyf3oV5Z-phor_uEyFunG_MOVjQ2vfuxzSWX13Q/edit).

<sup>52</sup> ["DOS Updates Its Information on Public Charge for Visa Applicants."](#) American Immigration Lawyers Association, March 5, 2020; ["9 FAM 302.8 \(U\) PUBLIC CHARGE - INA 212\(A\)\(4\)."](#) in *Foreign Affairs Manual* (U.S. Department of State, updated August 5, 2020).

<sup>53</sup> ["Public Charge: What Advocates Need to Know."](#) Protecting Immigrant Families, August 14, 2020;

*"The 'public charge' inadmissibility test was designed to identify people who may depend on the government as their primary source of support in the future. If the government determines that a person is 'likely at any time to become a public charge,' it can deny that person admission to the U.S. or lawful permanent residence (or 'green card' status). The statute requires adjudicators to predict whether a person will become a public charge in the future based on their current characteristics, including their age, health, family status, income and resources and skills and education. ([Immigration and Naturalization Act section 212\(a\)\(4\)](#), [8 USC 1182\(a\)\(4\)](#)). Analysis of these factors is called the 'totality of circumstances' test.*

*The regulations redefine a 'public charge' as a non-citizen who receives one or more public benefits specified at [8 CFR §212.21\(b\)](#) for more than 12 months in the aggregate within any 36-month period. The test counts the months of benefits receipt so that receiving two benefits in one month is counted as two months of benefits.*

*The regulations add new standards and evidentiary requirements to the totality of circumstances test. These make it more difficult for low- and moderate- income people to have a successful outcome. The regulations treat each of the following negatively in public charge decisions: a household income below 125% of the U.S. federal poverty level (FPL), being a child or a senior, having certain health conditions, limited English ability, less than a high school education, a poor credit history, prior receipt of certain benefits, and other factors. The rule also expands the list of public assistance programs that may be considered as negative factors in a 'public charge' determination, excluding anyone who is deemed more likely than not to use the enumerated cash, health care, nutrition, or housing programs in the future. More details are available in [Public Charge: Analysis and Frequently Asked Questions](#)."*

The new rule did not, however, count a dependent's use of public benefit programs against a green card applicant, as previous drafts had threatened. That is to say, children who are enrolled in benefits (Medicaid or SNAP, for example) would not negatively affect their parent's application. Further, while the only programs explicitly included were adult Medicaid, SNAP, housing subsidies, and cash assistance, a host of exceptions meant that relatively few immigrants that would technically be affected. An immigrant using emergency Medicaid or pregnancy Medicaid, for example, would not have that benefit counted against them in their application for legal permanent residency. Nonetheless, despite the much smaller and focused instances where an immigrant's use of benefits could harm them, the *fear* of using any kind of benefit had been installed.

By the time the new public charge regulation went into effect, to many low-income immigrants, it didn't really matter what the regulation actually said. What mattered was the public perception of what the Trump administration was doing. A significant portion of the immigrant public believed that if they, or even their citizen dependents, used any public benefit program, that they wouldn't be allowed to become citizens. Slowly but perceptibly, families started backing away from the programs for which they, and in much greater numbers, their children, were eligible. Advocates called this withdrawal "the chilling effect."

But the chilling effect was not solely the product of the public charge changes. Rather, it was part of a wider climate of fear that the Trump administration was deliberately inculcating among immigrants in the United States. Immigrant communities' fear grew as they saw ICE raids and increased enforcement and deportations. The Obama administration had increased deportations for recent arrivals and targeted undocumented individuals with a criminal record;<sup>54</sup> ICE under the Trump administration has no such priorities – they targeted (and still target) any and all undocumented immigrants.<sup>55</sup> Immigrants became fearful of sending their children to school, of leaving their homes to run errands or go to work.

Other anti-immigrant policies reinforced this fear. For a complete laundry list of anti-immigrant policies, please read [The Invisible Wall: Policies that Threaten Immigrant Families](#) on the PIF website, but what follows is a truncated synopsis.<sup>56</sup> Regulations from the Department of Housing and Urban Development (HUD) barred undocumented immigrants from residing in subsidized housing with their eligible family members.<sup>57</sup> The administration implemented travel bans and "extreme vetting," and developed policies to slow or stop the admission of temporary skilled workers.<sup>58</sup> An alphabet soup of federal agencies made administrative

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<sup>54</sup> Muzaffar Chishti, Sarah Pierce, and Jessica Bolter, "[The Obama Record on Deportations: Deporter in Chief or Not?](#)" Migration Policy Institute, January 26, 2017.

<sup>55</sup> Peniel Ibe, "[Trump's attacks on the legal immigration system explained.](#)" American Friends Service Committee, updated April 23, 2020; Sarah Pierce and Jessica Bolter, [Dismantling and Reconstructing the U.S. Immigration System: Catalog of Changes under the Trump Presidency](#) (Migration Policy Institute, July 2020).

<sup>56</sup> "[The Invisible Wall: Policies that Threaten Immigrant Families.](#)" Protecting Immigrant Families, updated August 14, 2020.

<sup>57</sup> Milicent Sasu, "[HUD's 'Mixed-Status' Rule Is the Latest Attack on the Immigrant Community.](#)" National Immigration Law Center, July 8, 2019.

<sup>58</sup> Julia Gelatt, "[Under Trump Administration, United States Takes Steps to Narrow Legal Immigration.](#)" Migration Policy Institute, December 20, 2017.

changes that made nutrition, housing, education, and labor more complicated, difficult, and threatening for immigrants. President Trump ordered the cancellation of the DACA program, placing almost 700,000 Dreamers at risk of deportation.<sup>59</sup> The administration placed obstacles in the naturalization path for foreign-born members of the U.S. Armed Forces.<sup>60</sup> They formed a “de-naturalization” office, dedicated to tracking down problems in naturalization applications that would permit them to revoke the citizenship of naturalized foreign-born Americans.<sup>61</sup> These, and many other policies of this ilk, made immigrants feel that the walls were closing in on them, and that the Federal government was watching them with hostile eyes.

Lastly, it is important to note how federal policies at the border, particularly targeting asylum seekers, made it abundantly clear to immigrants in the United States just how little value the administration placed on human rights, human life, and human dignity. In late 2017, CBP and ICE began separating children from their parents at the border, with no plan or protocol for reunification. This went on relatively quietly from early 2017 until mid-2018, when the news broke nation-wide to a horrified public.<sup>62</sup> Then in 2019 the news broke of the overcrowded, squalid conditions in which children, and the parents from which they had been separated, were being kept for weeks at a time by CBP.<sup>63</sup> The American public erupted in protest. The administration responded to each discovery with half-hearted commitments to stop separating families and improve conditions in detention and processing centers, but the practices continued, albeit in smaller numbers, more quietly, and under careful cloaking.<sup>64</sup> Other policies like the Migrant Protection Protocols (MPP) refused to allow admission to asylum applicants, even after those applicants had been deemed worthy of review.<sup>65</sup> They forced asylum seekers, many who were already hungry, traumatized, ill, and injured, to wait in Mexico with no resources for their care. This created squalid encampments of poverty-stricken asylum seekers on the Mexican side of the Rio Grande.<sup>66</sup>

**“What advocates have called the “chilling effect” is simply the natural offshoot of this climate of intimidation, exclusion, and hostility; that is to say, an overarching fear of interacting with any governmental agency or program. It is no surprise at all, when considered in this light, that Texas’ enrollment numbers for Medicaid, CHIP, SNAP, WIC, and many local programs, dropped.”**

These were policies without compassion or empathy, and immigrants in the United States were watching and learning. What advocates have called the “chilling effect” is simply the natural offshoot of this climate of intimidation, exclusion, and hostility; that is to say, an overarching fear of interacting with any governmental agency or program. It is no surprise at all, when considered in this light, that Texas’ enrollment numbers for Medicaid, CHIP, SNAP, WIC, and many local programs, dropped.

<sup>59</sup> The Supreme Court ruled in June, 2020, that the Trump Administration could not end the DACA program in the manner they had used. While a relief, the Administration went back to the drawing board and promised to re-issue the ban on sounder legal footing.

<sup>60</sup> [“Patriotic Immigrants Who Have Served America: Veterans and Active Duty Service Members, and Their Families, Face Increasing Immigration and Naturalization Obstacles Under Trump Administration,”](#) America’s Voice, October 28, 2019.

<sup>61</sup> [“The Department of Justice Creates Section Dedicated to Denaturalization Cases,”](#) U.S. Department of Justice, February 26, 2020.

<sup>62</sup> Jonathan Blitzer, [“A New Report on Family Separations Shows the Depths of Trump’s Negligence,”](#) *New Yorker*, December 6, 2019; [“Family separation under the Trump administration – a timeline,”](#) Southern Poverty Law Center, June 17, 2020.

<sup>63</sup> Isaac Chotiner, [“Inside a Texas Building Where the Government Is Holding Immigrant Children,”](#) *New Yorker*, June 22, 2019; Dara Lind, [“The horrifying conditions facing kids in border detention, explained,”](#) *Vox*, June 25, 2019.

<sup>64</sup> Nila Bala and Arthur Rizer, [“Trump’s family separation policy never really ended. This is why,”](#) *NBC News*, July 1, 2019.

<sup>65</sup> [“Q&A: Trump Administration’s ‘Remain in Mexico’ Program,”](#) Human Rights Watch, January 29, 2020.

<sup>66</sup> [“Trump Administration’s ‘Remain in Mexico’ Program.”](#)

## Themes, Methodology, and Conclusions

This report sprang from seeds that germinated throughout the last several years, as CDF-TX, in conjunction with a variety of organizations (though most especially the team at Every Texan) have worked to educate Texans about public charge. In the process of interviewing staff at enrollment assistance entities, community-based organizations, food banks, health districts, federally-qualified health centers (FQHCs), and more, it became clear that, while HHSC may not collect data on who withdraws from public benefits, the organizations that work to enroll Texans in those programs, and that provide services to Texans under the auspices of those programs, do indeed collect data. What we see in that data can help us understand the scope of the problem, and hopefully, to find solutions and strategies for combating it.

It is a basic premise of the scientific method that in order to stop something from happening (for example, widespread disenrollment) we must first understand why that thing is happening. This report, therefore, is a careful collection of research conducted with 32 organizations geographically spread across the state of Texas, presented in this format to help fill the data gap we currently face. Some of that is “hard” data (enrollment numbers), and some of it is “soft” data (anecdotes and storytelling). But both the hard and soft data are uniform in their conclusions: immigrant and mixed-status families are afraid. Because of that fear, they are stepping away from public benefits, putting their own health and well-being, as well as that of their children, at risk.

Without a doubt, the climate of fear is not the *only* reason mixed-status families began dropping off of public benefit rolls, but the research collected here presents compelling evidence that it is indeed the most significant reason for that drop-off. From El Paso to Tyler, from McAllen up to Dallas and Fort Worth, people who work in the world of public benefits were resoundingly clear: it is the withdrawal among families of mixed immigration status that caused the enormous drop in enrollment across a variety of public benefits, beginning in late 2017.

This is no small sector of our population. Statewide, 26 percent of children have at least one non-citizen parent (of any immigration status).<sup>67</sup> That is an enormous number; in 2018, 4.5 million people in Texas (16 percent of the state's population) were native-born Americans who had at least one immigrant parent.<sup>68</sup> This begs the question: knowing that the climate of fear, along with a lack of clear, community-wide understanding about public charge and similar regulations, is a major cause of disenrollment, what can the state of Texas do to reverse this trend, increase the enrollment of eligible Texans, and improve health and nutrition outcomes statewide?

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<sup>67</sup> [“Health Care Immigrant Access: Background.”](#) Every Texan, 2020.

<sup>68</sup> [Immigrants in Texas](#) (American Immigration Council, 2020).

## Section I: The Chilling Effect

*Generally speaking, our numbers have not been improved by this administration.*

— Arianna Anaya, Foundation Communities<sup>69</sup>

**W**hen this research report was first conceptualized in early 2020, the idea that the benefits drop of 2018 and 2019 was driven by the climate of fear among immigrant communities in Texas was a working hypothesis. It was an educated hypothesis, but a hypothesis nonetheless. At the time of writing this report, however, it is a conclusion. Every single participant in the research process indicated that they had seen heightened concern, statistically anomalous data, or a disproportionate withdrawal among immigrant and mixed-status families. Not a single respondent answered in the negative.

These answers, however, were more nuanced than a simple “yes, the withdrawal is obvious and disproportionate.” As respondents spoke about what their organizations, their staff, and their clients had gone through over the last several years, several key themes emerged from their stories and the numbers they shared. Those themes are as follows:

First, families of mixed immigration status are afraid of the federal government, and that fear is causing widespread withdrawal, both from benefits for which they are eligible and from resource assistance they could receive. This withdrawal is happening in spite of the needs they have and the fact that they and their children are legally eligible for these programs.

Second, while HHSC has not provided statewide data analytics, the numbers are there for anybody actually looking. Those numbers, even at an organizational level, unambiguously indicate withdrawal in great numbers and an increased reliance on charity care.

And finally, there are certain factors making the problem worse. First, these harmful policies – such as public charge – are complicated, and inadequate staff training about them can be an inhibiting factor. Second, there are clear pressure points at which parents balk during the enrollment or service-seeking process. And third, mixed signals coming from advocates, attorneys, and the media, in conjunction with the silence from HHSC, are worsening the confusion. It would be cumbersome to quote from every single organization that spoke at length on these topics, but what follows is a summary of the findings with some of the clearer descriptions of the themes identified above.

### A Climate of Fear

*What has changed over the last few years, since Trump took office, and all the anti-immigrant attacks have been so harsh, is that many families used to seek out services their children needed. And what has changed is that people are afraid to seek it out now. As the environment changed, public charge, DACA attacks, ICE raids, closing the borders, all these things, fear has multiplied. And now even if they do need the services, they're saying, no, our families will be torn apart, we don't want to do this.*

— Graciela Camarena, CDF-TX Child Health Outreach Program Director<sup>70</sup>

<sup>69</sup> Arianna Anaya (Program Manager for Health Coverage Program, Foundation Communities), interview with Cheasty Anderson, July 7, 2020.

<sup>70</sup> Graciela Camarena (Child Health Outreach Program Director, Children's Defense Fund-Texas), interview with Cheasty Anderson, July 23, 2020.

Graciela Camarena has led the CDF-TX outreach and enrollment work in the Rio Grande Valley since 2012, but she has worked in this field for 25 years. She is deeply connected to the community, fully integrated in the professional networks of organizations working to improve health outcomes in the Valley, and a local leader in educating people about public charge. Camarena is also wholeheartedly committed to helping eligible families get enrolled and stay enrolled in CHIP and Children's Medicaid.

Camarena and her team noted a clear decline beginning in 2017. "It used to be, when we did parent meetings on a topic like CHIP and Children's Medicaid, we'd have at least half a room full. After Trump, there were fewer people coming to these meetings, but there were more one-on-one conversations, lots of questions 'for a friend.' Even now, families will come when there's a need, but they are still scared, and we'll have to follow up several times to build the trust they need."<sup>71</sup> This shift led to longer hours and more effort for her team. Camarena explained that a process that would have taken one meeting in the past now takes as many as four or five "touches" before that parent is willing to fill out the paperwork, if they will at all. And while families still come out to information sessions she and her colleagues do at schools or health fairs, the numbers have dropped significantly. "We have always worked hard for every enrollment, but it's a lot harder now. People are just very afraid."<sup>72</sup>

A similar pattern emerged at St. Paul Children's Services in Tyler, TX. Their enrollment team reported that beginning in mid 2019, the number of Spanish-speaking clients who would come in to enroll their children in Medicaid or SNAP has dwindled significantly. Dr. Valerie Smith said that, "we still get some families who'll apply for Medicaid, though usually only if they have a child with a health issue, but they are saying no to applying for SNAP."<sup>73</sup> Smith spoke movingly about the desperate choices parents are facing. One mother, hoping to apply for her green card later in 2020, refused Medicaid for her epileptic daughter because of her concern that it would hurt the mother's application, lead to deportation, and ultimately, family separation. No amount of reassurance could overcome her fear.

On the other side of the state in El Paso, Kathy Revtyak of the El Paso Child Guidance Center, reports the same trend. Revtyak noted that over the last few years, "It's been one wave of trauma after another. ICE raids, family separation, public charge. Our collaborators are telling us that they are afraid to come for therapy. We are constantly scrambling to figure out how to build trust, how to provide for families' needs, and a persistent theme in those conversations is the fear families feel."<sup>74</sup>

**"It used to be, when we did parent meetings on a topic like CHIP and Children's Medicaid, we'd have at least half a room full. After Trump, there were fewer people coming to these meetings, but there were more one-on-one conversations, lots of questions 'for a friend.'"**

**"One mother, hoping to apply for her green card later in 2020, refused Medicaid for her epileptic daughter because of her concern that it would hurt the mother's application, lead to deportation, and ultimately, family separation. No amount of reassurance could overcome her fear."**

<sup>71</sup> Camarena, interview.

<sup>72</sup> Camarena, interview.

<sup>73</sup> Valerie Smith (Pediatrician, St. Paul's Children's Services), interview with Cheasty Anderson, March 23, 2020.

<sup>74</sup> Kathy Revtyak (Director of Systems of Care, El Paso Child Guidance Center), interview with Cheasty Anderson, June 12, 2020.

Revyak also spoke about the stress that the coalitions of client service organizations in El Paso are under. “We just had our bimonthly collaborative meeting and we were discussing food insecurity, economic hardship, health care – basically trying to develop an understanding of what services are available that are not tied to social security number or immigration services. We are constantly scrambling.”<sup>75</sup> Organizations like hers have long relied on these partnerships to make sure their clients’ needs are met, but even these networks are feeling the strain placed upon them by this climate of fear and the resulting chilling effect.

Euphemia (“Pema”) Garcia is the Western Rio Grande Regional Director of the Colonias Project in El Paso. She oversees a team of 15 promotoras who all work in the colonias (off-grid residential areas along the Texas-Mexico border). Even with the deep trust the promotoras have developed over time in these communities, the decline in enrollments has been substantial. Garcia noted that “I only have anecdotal data, but we have seen the numbers go down by incredible amounts. Public charge really has been insurmountable. They are afraid of what could happen if they do the wrong thing, and the rumor mill is just very hard to overcome.”<sup>76</sup> Garcia worries about what this withdrawal from public benefits will mean for the communities she and her team serve, as vulnerable as they already are. “You know, we have some parents who follow through, but it’s hard to convince them to do it. And I worry about the children who are missing out on important health care. It could get really bad for us here.”<sup>77</sup>

Ester Valladares, the Program Director for the Humble Area Assistance Ministries (HAAM), also shared the extent to which people, even those in great need, are afraid to take any assistance. “Just three weeks ago we had some families in need. This family didn’t have money for food or rent, never mind health care. And they were so afraid, they just kept saying no, it’s too dangerous. I’m saying to myself, I can’t believe people are this fearful, because they need the help. It was just sad to hear that. They have kids who are going to go hungry. We were offering assistance with rent. In the end I was able to convince the lady to at least take the food, but she would not take rental assistance.”<sup>78</sup> Valladares has been doing this job a long time, and said she had never seen a climate of fear like this. But HAAM serves a population that is at least 80 percent in an immigrant or mixed-status family. Many refuse to even leave the immediate surroundings of their homes. “We used to be able to do enrollment more straightforwardly,” she said. “Now, it’s a struggle just to get in front of the individuals. This is one of the hardest times I’ve ever seen.”<sup>79</sup>

Rebecca Stocker, Executive Director of the Hope Family Health Center in McAllen, oversees a team that provides sliding scale assistance to people in the Rio Grande Valley. She also talked about the climate of fear. “Our PAs, case management and care coordination teams, and our therapists all reflect a high degree of fear in the community regarding public charge. It started in 2016 and it’s just gotten worse.”<sup>80</sup> Stocker said clients will often do reconnaissance before deciding to come in, even when there is a medical need. “Instead of just coming in now, we get a lot of people calling with questions, you know, ‘asking for a friend’ – do you collect SSN, does Border Patrol or ICE come to your clinic. It’s a lot harder just to get them to come to the clinic.”<sup>81</sup> This presents obvious problems when it comes to delayed treatment for injury or chronic illness among their patient population.

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<sup>75</sup> Revtyak, interview.

<sup>76</sup> Euphemia (“Pema”) Garcia (Western Rio Grande Regional Director, Colonias Project), interview with Cheasty Anderson, June 17, 2020.

<sup>77</sup> Garcia, interview.

<sup>78</sup> Ester Valladares (Program Director, Humble Area Assistance Ministries (HAAM)), interview with Cheasty Anderson, May 27, 2020.

<sup>79</sup> Valladares, interview.

<sup>80</sup> Rebecca Stocker (Executive Director, Hope Family Health Center), interview with Cheasty Anderson, April 13, 2020.

<sup>81</sup> Stocker, interview.

Mary Lou Martinez is a Community Outreach and Enrollment Specialist at the North Texas Area Community Health Centers in Fort Worth and Arlington, and she has been overwhelmed by the resistance her clients have to enrolling in benefit programs for which they are eligible. Beginning in 2018, she noted a huge change. “It used to be, in a year I’d hear one or two people say they were skeptical. But it got worse in 2018, and then last year, 2019, in the summer, things got even more scary. People would pretty much only come in after a medical event.”<sup>82</sup> She spoke with client after client who was too frightened to sign up for the programs that Martinez reassured them were safe for them to use. “One couple came to me at least three times. She was pregnant and the attorney told them ‘NO.’ But I told them that if they want to receive prenatal care, they were eligible for CHIP-P. They were filled with so much anxiety. And I see that all the time. The child will get sick or injured and they take the kid to the ER and I say you were due for renewal 3 months ago, why didn’t you come in? ‘We were too afraid,’ they say.”<sup>83</sup>

**“They were filled with so much anxiety. And I see that all the time. The child will get sick or injured and they take the kid to the ER and I say you were due for renewal 3 months ago, why didn’t you come in? ‘We were too afraid,’ they say.”**

Sara Albert, a consultant with Dallas Area Hunger Solutions, shared an anecdote that illustrates the crisis in health and nutrition that can develop in low-income immigrant families who live in fear. Albert spoke on a panel in 2019 about the public charge rule, and shared the stage with a pediatrician who works at Children’s Health in Dallas. The pediatrician, Albert said, “shared a story that has really stuck with me.”<sup>84</sup>

*She was saying that one of the most horrific consequences she’d seen from public charge is how, among families who’d chosen to disenroll their children from Medicaid, there had been instances where the children were so malnourished, or hadn’t received appropriate medical care that Child Protective Services had been called in. That was one of the most heart-wrenching things I’ve heard throughout this whole debacle. You think you’re protecting your kids, and then next thing you know you’re subject to a CPS investigation for failing to protect your kids.*<sup>85</sup>

These cases may be outliers, but they point toward the worst-case scenario when entire communities live in fear of deportation and family separation.<sup>86</sup>

Even immigration attorneys are feeling the pressure of immigrants’ fear. Kate Lincoln-Goldfinch, an Austin-area immigration attorney, reflected on the many clients she sees who are worried about the public charge. She is able to reassure most of them that they would not be affected, but she expressed frustration over the misinformation that makes it hard for her clients to believe her. “It’s hard enough having to navigate all this new and rapidly changing information, but on top of that there’s this additional work we have to do to convince them that it’s okay to keep their children enrolled in benefits. Often they don’t believe us because they saw some local news ‘scare headline,’ and they don’t know whether to trust us.”<sup>87</sup> For families worried about minimizing their risk, anybody offering good news is suspect – even traditionally respected authorities like immigration attorneys.

<sup>82</sup> Mary Lou Martinez (Community Outreach and Enrollment Specialist, North Texas Area Community Health Centers), interview with Cheasty Anderson, April 16, 2020.

<sup>83</sup> Martinez, interview.

<sup>84</sup> Sara Albert (Independent Consultant, Dallas Coalition for Hunger Solutions), interview with Cheasty Anderson, October 16, 2020.

<sup>85</sup> Albert, interview.

<sup>86</sup> Albert, interview.

<sup>87</sup> Kate Lincoln-Goldfinch (Immigration Attorney, Lincoln-Goldfinch Law), interview with Cheasty Anderson, September 2, 2020.

The climate of fear is also depressing participation outside of programs strictly defined by the public charge regulation. Chevella Layne, the Director of Mission Services at Goodwill Industries of East Texas reflected this reality. “When I talk to [health insurance] navigators, they tell me that there seems to be fear. Fear of giving their address because now they’ll know where I live. That fear hovers over them, especially when you hear about the raids when people are just at work trying to support their families. They worry that people are telling ICE we are here, and they can’t trust anymore.”<sup>88</sup> Goodwill Services, of course, is well known for their work-support programs like re-entry and veterans programs, but people from mixed-status families – even those in need of job transition after incarceration or military service – are now afraid to use even these well-established programs.

**“That fear hovers over them, especially when you hear about the raids when people are just at work trying to support their families. They worry that people are telling ICE we are here, and they can’t trust anymore.”**

Annali Fuentes works at the Literacy Coalition of Central Texas as the Program Manager for their English At Work and Integrative Education and Training Program (IET) job training programs. Both programs serve immigrants seeking better employment opportunities. The English at Work program teaches workplace-specific English to employees, takes place inside the workplace, and asks for no information about immigration or work status. Nonetheless, said Fuentes, she’s had students get up and walk out if she asks for a picture ID or a document with their name on it. “It’s all out of fear that ICE will trace them back through us.”<sup>89</sup> Fuentes always explains that the Literacy Coalition is an education service, and participation won’t affect them, but with little impact. “They are afraid of workplace raids, and of public charge. During our outreach events, I get the question over and over – how is this going to affect my immigration status.”<sup>90</sup> About two years ago, when there were workplace raids around Austin, Fuentes taught a class in a food manufacturing place, and saw an immediate effect. “Just knowing that the raids were happening, students were not coming to class. We started off with 15 students and as time went on, it went down to six students.”<sup>91</sup> A 60 percent decline in enrollment is startling and troubling, but not at all unusual. Immigrant families are immediately responsive to events they perceive as threatening to their safety.

These drop-offs in service-seeking behavior that are prompted by a unique event – a nearby workplace raid, for example, or ICE staking out a particular neighborhood – are spikes in an otherwise more gradual downward sloping trend. After each event, and each spike, the numbers do not rebound fully. The spikes drive down participation, increase fear, and damage what trust an organization or clinic had built with its clientele.

From these and other stories, it is clear that reactions to “spike” events are not anomalous. Rather, they highlight the desperation in which immigrant families live constantly. This report is time-limited from the post-Hurricane Harvey period through the pre-COVID period, but Natalie Wood of Catholic Charities in Houston shared an anecdote from the fall of 2017 that exposed the full extent of the fear families have of interacting with government in any way, be it federal, state, or local. She explained that after Harvey hit, she became aware of an apartment complex where many undocumented immigrants lived. Many of their children were citizens, eligible for Medicaid and SNAP, and for disaster relief. “But for three weeks they did not come out because they didn’t want

<sup>88</sup> Chevella Layne (Director of Mission Services, Goodwill Industries of East Texas), interview with Cheasty Anderson, May 19, 2020.

<sup>89</sup> Annali Fuentes (Program Manager for the English At Work and Integrative Education and Training Program (IET), Literacy Coalition of Central Texas), interview with Cheasty Anderson, June 18, 2020.

<sup>90</sup> Fuentes, interview.

<sup>91</sup> Fuentes, interview.

the government to know they were there. Then we drove up in a Catholic Charities USA truck. They saw the logo, realized we were not the government, and people just started pouring out of the apartments asking for help.”<sup>92</sup> Their apartments were in ruins, they had no food, no utilities, no plumbing, but were so afraid that they would rather live that way than risk a run-in with the government. Wood reflected that the fear people felt in 2017 has only gotten more extreme with the advent of public charge and other policies. She said, “If people were that afraid during Harvey, you can only imagine what public charge is doing.”<sup>93</sup>

**“Their apartments were in ruins, they had no food, no utilities, no plumbing, but were so afraid that they would rather live that way than risk a run-in with the government.”**

## The Numbers

*It’s largely to do with immigration and public charge. SNAP enrollment has varied over that time period, obviously. In October of 2014, that’s when they adjusted their methodology for counting, and from that point enrollment was always 3.8 million, almost 3.9. It always hovered in that same range, and never really changed much until 2017. There was a bump for Harvey, but the overall trend continued. But when public charge started, the numbers started drifting down consistently every month.*

— Rachel Cooper, Senior Policy Analyst, Every Texan<sup>94</sup>

Even given the lack of HHSC data, we don’t have to, as Natalie Wood said, “imagine what public charge is doing.” The data is available, albeit at an organizational level rather than statewide. In the process of researching, dozens of organizations offered data on what the climate of fear had done to their numbers. Those numbers were clear – and, particularly for organizations serving a majority immigrant population, they were grim.

This report began with a description of the significant and disproportionate drop-off that three organizations in particular had seen between 2017 and 2019. As stated in the introduction, VELA in Austin, whose membership is 85 percent immigrant families, saw an 80 percent drop in SNAP-enrolled families.<sup>95</sup> ECHOS in Houston, whose clientele are 99 percent below poverty line and 82 percent mixed status families, saw declines of 42 percent in Children’s Medicaid enrollment, 42 percent in adult Medicaid and CHIP-Perinatal enrollment, and a 37 percent drop in SNAP enrollment, from 2017 through 2019.<sup>96</sup> And Foundation Communities, which does ACA Marketplace enrollment, saw a disproportionately large drop-off in immigrant clients (16.9 percent) versus the decline in non-immigrant clients (5.4 percent) from open enrollment periods for the 2018 and 2019 insurance years.<sup>97</sup> That is to say, their immigrant client base declined 68 percent more than their non-immigrant clients. These numbers paint a clear picture of immigrant families, frightened by anti-immigrant policies and actions, actively avoiding public benefit programs for which they or their children were eligible.

<sup>92</sup> Natalie Wood (Senior Vice President, Catholic Charities in Houston), interview with Cheasty Anderson, April 2, 2020.

<sup>93</sup> Wood, interview.

<sup>94</sup> Cooper, interview.

<sup>95</sup> M. Hernandez, interview.

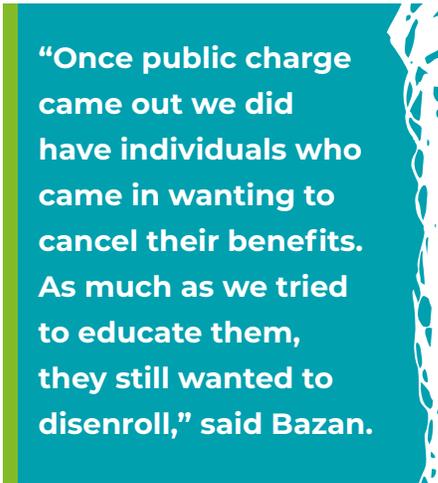
<sup>96</sup> Moore, interview.

<sup>97</sup> Anaya, email.

While not all organizations saw such alarming declines (the statewide average decline in CHIP and Children's Medicaid enrollment, remember, was seven percent, and for SNAP it was 13.5 percent),<sup>98</sup> the higher numbers reported by organizations working with mostly immigrant families reflect the fact that, in communities and cities with a high population of low-income immigrant families, the direct impact of this climate of fear is obvious – immigrant families comprise the bulk of the decline in Texas's enrollment data. Data collected from the other organizations in this study confirm this trend.

Amanda Foust of the East Texas Food Bank in Tyler was precise about the cause for the trend she noticed in Titus County. Titus County has a small but concentrated community of low-income, immigrant families who work in the chicken industry in Mt. Pleasant. Enrollment trends in other food pantries in Foust's region had remained relatively stable, showing a more narrow downward trend. But the food pantry in Mt. Pleasant, called Titus County Cares, experienced a stark decline in enrollment for SNAP shortly after the Trump administration began implementing anti-immigrant policies. "Right about the time that Trump came into office, and then when all the public charge started taking effect, we started noticing the numbers dropping in the area. Previously, [Titus County Cares] was doing 10-15 applications a month, but they have now dropped. Within the past two years, they're barely reporting any numbers – a couple of months ago they had two, but many months they're reporting zero."<sup>99</sup> These numbers on their own, she explained, might seem small – the community of immigrants who work in the chicken processing facilities is, after all, not large. But when you look at those numbers as percentages, the scope of the problem is obvious. Titus County Cares experienced at least an 80 to 90 percent drop in SNAP applications over the course of the last three years, which is both astonishing and alarming.

Yesenia Bazan, Site Manager for the Community Partner Program at the San Antonio Food Bank, reported a similar statistical impact at her organization. From 2017 to 2019, the San Antonio Food Bank saw a decline in applications submitted for SNAP. In 2017 they assisted with approximately 22,000 applications. In 2018 the number dropped to 18,000, and by 2019, the number was 17,000. That is, over a three year period, a 23 percent decline in enrollments. Within their client base, she reported, approximately 40 percent of the families they serve live in a home with at least one undocumented family member. "Once public charge came out we did have individuals who came in wanting to cancel their benefits. As much as we tried to educate them, they still wanted to disenroll," said Bazan. The San Antonio Food Bank did make the effort to educate their staff about public charge, and used flyers distributed by their parent organization, Feeding Texas. Bazan said that while public charge does not account for the entirety of that decline, it is the main reason applications have dropped off so sharply. "Some of this has to do with us training families to do this on their own, and a few other factors, but public charge is responsible for a significant part of the decline in enrollments we saw."<sup>100</sup>



**"Once public charge came out we did have individuals who came in wanting to cancel their benefits. As much as we tried to educate them, they still wanted to disenroll," said Bazan.**

Mary Lou Martinez confirmed this pattern in her work at the North Texas Area Community Health Centers. Martinez has been in this job since 2013, but started noticing the heightened fear in 2016, and then lower enrollment numbers in 2018. "I started hearing it more in 2018, even from permanent residents, or people with US citizen children. Sometimes they come into the office and they say

<sup>98</sup> ["Too Many Texas Children Lack Health Coverage,"](#) Cover Texas Now, October 15, 2019; ["Supplemental Nutritional Assistance Program \(SNAP\) Statistics."](#)

<sup>99</sup> Amanda Foust (Client Benefits Manager, East Texas Food Bank), interview with Cheasty Anderson, May 14, 2020.

<sup>100</sup> Yesenia Bazan (Site Manager for Community Partner Program, San Antonio Food Bank), interview with Cheasty Anderson, October 14, 2020.

'We are worried we could get in trouble,' or 'My husband tells me not to.' I reassure them that they aren't applying for benefits for themselves, but for their children who are eligible. But rumors and misinformation in the media is really hard to beat."<sup>101</sup> Martinez provided data that indicated a 58-percent decrease in enrollments from 2017 to 2019, though she cautioned that there were some problems with the data relating to staffing changes at their three centers. But she asserted that the decline was still noticeable. "Anecdotally speaking, I would say 10 to 15 percent of our clients in a year were reluctant to enroll because of concern about immigration dilemmas or public charge uncertainties."<sup>102</sup>

Cesar Varon, of the Barrios Unidos Community Clinic in Dallas, also reported the heightened fear families are experiencing over the last few years. "We've noticed a lot of people with visas, they were very scared. People that have already been here for a while, most of the cases they went ahead and did it, but they always asked. There's a lot of fear out there."<sup>103</sup> While Varon, uniquely among respondents, was hesitant to explicitly attribute their reductions in their enrollment numbers to fear, their clinic did see a seven percent decline from 2018 to 2019,<sup>104</sup> which tracks precisely with the state enrollment numbers that were so shocking.

At the community level, then, the decline was outsized and obvious, but even in a larger population sample, the trend was still downward. Jennifer Babcock is the Senior Vice President of Medicaid Policy at the Association for Community Affiliated Plans (ACAP). She was frank about the enrollment trend her organization is seeing. "Plans are very careful to track their enrollment data, and they are seeing a downturn in enrollment."<sup>105</sup> Babcock explicitly linked this decline in enrollment to public charge. "We have opposed public charge forcefully and publicly for several reasons. At the highest, broadest level, at ACAP we've been in favor of federal policy that expands coverage to the greatest number of people. And secondly, we heard alarm from our members about public charge [and disenrollment]."<sup>106</sup> That distress signal came loudly from inside Texas, especially from Community Health Choice (CHC), a safety net health plan and ACAP member in Houston.

Angela Waltman is the Vice President of Business Development and Call Center Operations at CHC. She explained the reason they raised the issue with ACAP had to do with steep drops in enrollment. In 2018 CHC had 291,000 members. By 2019, that number had dropped to 278,000, and in February of 2020, it had dropped still further to 272,000. In total that is a 6.5 percent reduction.<sup>107</sup>

Waltman and her team have little doubt that this outcome is tied to public charge. "There's no mystery at all in the decline," she said. "[Public charge] is the reason people tell us when we call for re-enrollments, and it's the reason they give us when we go to community events to get new enrollments. It's self-reporting, and very clearly attributable to immigration backlash."<sup>108</sup>

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<sup>101</sup> Martinez, interview.

<sup>102</sup> Martinez, interview.

<sup>103</sup> Cesar Varon (Eligibility Manager, Barrios Unidos Community Clinic), interview with Cheasty Anderson, April 15, 2020.

<sup>104</sup> Varon, interview.

<sup>105</sup> Jennifer Babcock (Senior Vice President of Medicaid Policy, Association for Community Affiliated Plans (ACAP)), interview with Cheasty Anderson, April 28, 2020.

<sup>106</sup> Babcock, interview.

<sup>107</sup> Angela Waltman (Vice President, Business Development and Call Center Operations, Community Health Choice), interview with Cheasty Anderson, March 20, 2020.

<sup>108</sup> Waltman, interview.

Waltman even reported having trouble giving away free supplies at public events. “People reject items we’re trying to hand out for free, things like backpacks and school supplies. And they’ll tell us it’s because they don’t want to get in any immigration trouble. They refuse flu shots and immunizations for kids, fearing immigration backlash.”<sup>109</sup> This self-reporting, in combination with obvious fear of accepting assistance of any form, cemented CHC’s belief that their disenrollment numbers were tied to the fear generated by public charge and other anti-immigrant policies.

CHC’s data confirm Waltman’s statement about immigrant families refusing vaccines. Catherine Mitchell and Justin Yoo, Chief Operations Officer and Policy Director, respectively, of CHC report that, in their membership, “we have already seen over a 40 percent decrease in routine immunizations like MMR.”<sup>110</sup> This decline is outsized to the decline in enrollments, indicating that not only are parents fearful of enrolling their children, but that, even after enrolling, they avoid seeking medical care, especially preventive care.

There is additional data to support the claim that parents are avoiding taking their children to the doctor, even when they are enrolled in Medicaid or CHIP. At VELA, for example, Nadine Rueb, a clinical social worker who helps support their members, noticed in the spring of 2017 that she had started getting calls from families about whether it was safe to go to the doctor. VELA families have children with disabilities; taking their children off SSI or Medicaid is not usually an option for them. But they started making choices about which care was the most important, and prioritizing their decisions based on fear of using “too much” of their child’s benefit, somehow. “I do think that families were really trying to do as much as they can as smart as they can. But they’d plan it out – what appointments mattered, which therapies were most important. They’re prioritizing for their safety, and having to make really impossible choices.”<sup>111</sup> The stress of having to choose between a child’s health and development and a parent’s fear of horrible immigration consequences is almost impossible to imagine, but that is the situation these parents are in.

This contraction is noticeable not only in families with disabilities. Angela Waltman of CHC said that even the families who keep their children enrolled aren’t taking them to the doctor, especially for preventive care and checkups. “We had pediatricians calling to ask if we’ve stopped assigning them patients because their caseload had dropped 20 percent,” she said.<sup>112</sup> “They’re refusing not just health insurance, but they’re also reluctant to get the care these benefits provide.”<sup>113</sup> Cathy Moore of ECHOS confirmed this trend. “What we are seeing is that people aren’t going to doctors. They’re coming to us when it’s too late. They’ve been diagnosed with late-stage cancer, or they have a family member dying in the hospital.”<sup>114</sup>

**“People reject items we’re trying to hand out for free, things like backpacks and school supplies. And they’ll tell us it’s because they don’t want to get in any immigration trouble. They refuse flu shots and immunizations for kids, fearing immigration backlash.”**

**“The stress of having to choose between a child’s health and development and a parent’s fear of horrible immigration consequences is almost impossible to imagine, but that is the situation these parents are in.”**

<sup>109</sup> Waltman, interview.

<sup>110</sup> Catherine Mitchell (COO, Community Health Choice) and Justin Yoo (Policy Director, Community Health Choice), email response to questionnaire sent to Jennifer Babcock, forwarded to Cheasty Anderson, May 5, 2020.

<sup>111</sup> Nadine Rueb (Clinical Social Worker, VELA), interview with Cheasty Anderson, August 19, 2020.

<sup>112</sup> Waltman, interview.

<sup>113</sup> Waltman, interview.

<sup>114</sup> Moore, interview.

Again, this trend extends to community-serving organizations outside of the health and nutrition spheres. Chevella Layne, of Goodwill Industries in Tyler, said her organization does not collect data on immigration status, but that they had seen a reduction in the proportion of their clients who are Hispanic. “From 2016 to 2019 the percentage dropped from 13 percent of our clients being Hispanic to only 10 percent.”<sup>115</sup> That is a 23 percent reduction in the total number of Hispanic clients they serve, and Layne noted that there had been no concurrent drop in the overall Hispanic population in Tyler – only in the Hispanic residents willing to reach out for help and support.

At the Literacy Coalition of Central Texas, mentioned above, the IET program, which caters exclusively to immigrants with “right to work” status, also experienced difficulties due to the climate of fear. Fuentes reported that “there was a drop in our enrollment – it was so hard to recruit at events, or with our vocational partners. We’d hand out a lot of flyers, but nobody would call us back. Compared to 2018 we were filling up the classes with no problem, and in 2019 we weren’t able to fill up our numbers.”<sup>116</sup>

Other data indicates that, where families are withdrawing their children from public benefit programs like Children’s Medicaid and SNAP, they are increasingly relying on charity care programs. For many immigrant families, charity care, such as a food pantry or a sliding-scale clinic, is the only option they have in desperate times when they are not enrolling their children in health insurance and nutritional support programs. The bulk of our respondents indicated that charity care was under increased pressure to meet the needs of desperate families.

Charity care programs are feeling the strain of the increase in their client load. Marisol Resendez of Milagro Clinic in McAllen said that one way she has seen the impact of this fear is through an increase in pediatric patients. Milagro Clinic does not have a pediatric line of service, but they do offer \$20 medical care to any patient, regardless of immigration status. In the last couple of years, Resendez reported, they’ve seen a large uptick in parents coming in when their kids are sick. “It used to be 4 or 6 in a year, but in our 2018-2019 fiscal year we saw 35 kids, unduplicated. And right now, mid 2019-2020, we are already at 34 kids, so it has increased and will likely be double the last year.”<sup>117</sup> The first year of data alone reflects a 583 percent increase in their pediatric patient load. If Resendez’s projections for the 2019-2020 fiscal year prove to be true, Milagro Clinic would have experienced a 1,167 percent increase in pediatric patients within a two year period.

Food pantries are also feeling the pressure. As VELA’s Executive Director Maria Hernandez noted in the introduction, hundreds of their families that had dropped their children’s SNAP benefits are now relying on the system of food pantries to feed their families. As mentioned earlier, ECHOS experienced a 327 percent increase in reliance on their food pantry by the summer of 2019, all while seeing a 37 percent decline in clients enrolling in SNAP.<sup>118</sup> Marisol Resendez, who above spoke about the uptick in pediatric appointments, also explained that Milagro Clinic had added a food distribution service to help meet their client’s needs. The demand is so great, she reported, that they run out of food every time.<sup>119</sup>

It should be noted that in some instances, organizations have reported a fear-based decrease in families’ willingness to use charity care – at St. Paul and at HAAM, for example, they’ve seen people being more reluctant to access their food pantries.<sup>120</sup> But the preponderance of evidence is clear – frightened of using government programs to feed and care for their children, families in direct financial straits are forced to rely more heavily on charity care.

<sup>115</sup> Layne, interview.

<sup>116</sup> Fuentes, interview.

<sup>117</sup> Marisol Resendez (Executive Director, El Milagro Clinic), interview with Cheasty Anderson, April 17, 2020.

<sup>118</sup> Moore, interview.

<sup>119</sup> Resendez, interview.

<sup>120</sup> Smith, interview; Valladares, interview.

The state of Texas, both its government and the Health and Human Services Commission, can no longer hide behind the lack of data. There is abundant evidence that immigrant and mixed-status families constitute an outsized and disproportionate share of the recent decline in enrollment numbers statewide. One only has to look for it.

## Financial Impact

*So far we're making it work, but as a manager, I'm worried about this trend, and how to keep our funding going.*

— Annali Fuentes, Literacy Coalition of Central Texas<sup>121</sup>

Many of the organizations interviewed for this report indicated some degree of negative financial impact on their organizations as a result of the chilling effect. The clinics, health plans, and community-based organizations who work with immigrant families do not exist within a vacuum. The sudden disappearance of sizable percentages of their usual client base, or the sudden appearance of new clients, depending on the organization, has already had a fiscal impact. For some, this means staff reductions or hiring freezes. For others, a loss of revenue from the state. Privately funded organizations have to rely even more heavily on philanthropic giving. This decline in health and nutrition coverage, in other words, is hurting the very organizations that exist to provide it.

Angela Waltman at Community Health Choice was clear about the impact this disproportionate withdrawal has already had on their bottom line. CHC is paid a “per member per month” fee by the state, also known as a capitation rate. This is the rate they get each month, for each member, to provide health care services. “If our enrollment goes down, our capitation payment goes down. It already has,” Waltman said.<sup>122</sup> Mitchell and Yoo, also of CHC, concurred with this, offering additional considerations about the loss of revenue through premiums when the pool of members shrinks. They point out that if this happens, then “the risk pool [also] worsens through adverse selection.”<sup>123</sup> CHC participates in the Medicaid Pay For Quality (P4Q) Program through HHSC. They also said, “[A reduction in membership and reluctance to seek primary care] could also hurt us if members in P4Q programs are forgoing care and our quality metrics suffer as a result.”<sup>124</sup> In sum, fewer and sicker members will cost the health plan money.

Some of these concerns have already come to fruition at CHC, leading to a secondary outcome: job loss. Waltman expressed regret about the workforce reduction they had already undergone. “We don’t need as many people answering the phone and processing claims if people are going to reject enrollment. In member services we’ve cut about 15 percent of the workforce since 2018. And we’ve also cut about 20 percent of eligibility staff.”<sup>125</sup> These are jobs lost because of a federal government determined to drive out immigrants regardless of the cost, a state government unwilling to defend the rights of immigrant Texans, and a Health and Human Services agency constrained by state leadership from doing even bare bones public education about public charge.

**“The state of Texas, both its government and the Health and Human Services Commission, can no longer hide behind the lack of data. There is abundant evidence that immigrant and mixed-status families constitute an outsized and disproportionate share of the recent decline in enrollment numbers statewide. One only has to look for it.”**

<sup>121</sup> Fuentes, interview.

<sup>122</sup> Waltman, interview.

<sup>123</sup> Mitchell and Yoo, email.

<sup>124</sup> Mitchell and Yoo, email.

<sup>125</sup> Waltman, interview.

At the clinic level, FQHCs in Texas have felt the financial pinch from lower participation rates, both from their insured patients, but also from community reticence to seek medical attention except in the case of a medical event. Mary Lou Martinez of the North Texas Area Community Health centers reflected on this. “If in fact fewer and fewer immigrants choose to do renewal of benefits for their children, we will see loss of revenue from that category of payer mix.”<sup>126</sup> The clinic themselves will have to make difficult choices if their funding streams are constrained by a reduction of Medicaid patients.

In Tyler, Dr. Valerie Smith and her team struggle with the same challenge. Because of the uptick in uninsured children coming to their clinic, they are bringing in less money every year. Medicaid pays the clinic \$87 for a child’s visit – but St. Paul only charges a \$15 copay if the client is uninsured but eligible for public health insurance (up to 200% of the federal poverty level). Above that 200% of FPL, they charge the \$87 Medicaid reimbursement rate for an uninsured child. Smith explained, “If you have eligible but unenrolled children, St. Paul is collecting less money because we ask [impoverished families] to contribute \$15 whereas Medicaid would pay us \$87 if they were enrolled. So we have to do one of two things. We either have to increase volume and see more patients to bring in the same money, or we have to raise money from the community, and that money has to cover the medical clinic at the expense of other programs that aren’t Medicaid reimbursables, like the food pantry, or education classes.”<sup>127</sup> Smith was frank about the result for administrators at St. Paul. “My Executive Director is super stressed about payroll right now.”<sup>128</sup>

Another clinic leaped to tackle the fiscal cliff they envisioned when they started to see plummeting enrollment numbers from HHSC. CentroMed is a FQHC with 20 locations around San Antonio. Early on in the Trump administration, as the impact of anti-immigrant rhetoric and policies began to come into focus, the leadership at CentroMed grasped how important staff training, energetic advocacy, and community education would be. As a result, CentroMed is the only clinic interviewed for this report that did not see a statistically significant drop in their enrollment numbers, in spite of having clients who were every bit as afraid as immigrant families across the state. Herlinda Ibarra, the Eligibility Manager and a Certified Application Assistant (CAC), attributed the strength of CentroMed’s response, in part, to the speed with which their finance department reacted to the public charge rule. “The bottom line is that if families aren’t enrolled in coverage, they’ll come in as an unfunded patient, and then we’re losing money. That’s what interests our finance folks and why they were paying attention.”<sup>129</sup> Joe Ibarra, also a CAC and the Census Manager, agreed, and said that CentroMed sees a reduction of enrollment numbers as a holistic problem for the entire enterprise of assisting low-income families in need of help. Not every program receives equal funding, but, he said, “If we are bringing in insured patients, it helps offset resources for other programs that are underfunded.”<sup>130</sup>

Other organizations are not feeling the financial pinch yet, but can see the writing on the wall. Rebecca Stocker of the Hope Family Health Center spoke about the uncertainty of relying on federal grants in a time when the federal government is contracting its funding for health services, especially for low-income communities. According to Stocker, Hope was a recipient of a federal grant that started in 2015 under the Obama administration. “There was so much fear that it would be pulled and just go away. It didn’t, but it also didn’t get re-granted, so we’re kind of on a ticking clock

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<sup>126</sup> Martinez, interview.

<sup>127</sup> Smith, interview.

<sup>128</sup> Smith, interview.

<sup>129</sup> Herlinda Ibarra (Eligibility Manager, Certified Application Assistant, CentroMed), interview with Cheasty Anderson, April 30, 2020.

<sup>130</sup> Joe Ibarra (Census Outreach Manager, Certified Application Assistant, CentroMed), interview with Cheasty Anderson, April 30, 2020.

for that funding.”<sup>131</sup> Hope has also received some community development block grants from the Department of Housing and Urban Development, but they fear that those, too, will not be re-granted. “The fear and the threat is constant,” said Stocker.<sup>132</sup>

Yesenia Bazan at the San Antonio Food Bank said that the drop in enrollments could have had negative consequences for them, if it weren’t for a few long-term contracts and grants they have. “We have been fortunate enough not to have to let any of our employees go because we are in a 3-year contract with the possibility of 2 additional years after. And then we have two grants [for special projects]. Without these grants we probably would have been in the position of having to let some of our staff go.”

Annali Fuentes and her team at the Literacy Coalition also have their eyes on funding. Because of community fear, their numbers were shrinking, and they had to get creative in order to fulfill their grant requirements. “We used to do two bigger classes each year, but this grant year we are adapting by doing four smaller classes. So far we’re making it work but as a manager, I’m worried about this trend, and how to keep our funding going.”<sup>133</sup> These workarounds, such as doubling their run of classes with smaller student headcounts, are only a temporary solution; twice the number of classes means twice the amount of work for her staff, an unsustainable model for the long term.

Many charity organizations are feeling some financial pressure, and private funders are currently, at least for these respondents, meeting that need. Ester Valladares of HAAM, described the additional costs and complications of having entirely restructured the way they deliver services to their communities. Families used to drive to the HAAM office in Humble to pick up food and other supplies, or to do enrollment. But now, they are often too scared to make the drive over, and so HAAM has adapted by going to the specific communities to deliver their services. Valladares said, “Well, because of having to do outreach, that brings another layer of expense to the Agency. That brings in a way another stressor to the Agency – you have to pay not only for the food you’ll give the families, but now the coordination for a food fair, additional staffing and volunteer crews to go out and distribute the food, and transportation for the food and staff.”<sup>134</sup> HAAM also relies on private funders for most of their programming, and those funders have been willing, thus far, to meet the need. But Valladares acknowledges the central dilemma. “It’s hard and frustrating, because without this fear, people would be able to come to us for help, to enroll in programs, and we wouldn’t need so much from the funders.”<sup>135</sup>

The world of philanthropic giving is substantial, but it is also competitive, and the available funds are limited. Cathy Moore of ECHOS, in describing the 502 percent increase in demand for their on-site food pantry, expressed gratitude for their funders, many of whom have been, as she put it, “incredibly generous.”<sup>136</sup> Marisol Resendez seconded that feeling. “We are so blessed, especially with our private foundation grants. They get it. When public charge came out, they asked us how our patients were handling it, and have been very, very supportive. I would say the funding has become more readily available.”<sup>137</sup> Certainly, without the increase in philanthropic giving, immigrant families would be in even more dire circumstances than they currently are.

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<sup>131</sup> Stocker, interview.

<sup>132</sup> Stocker, interview.

<sup>133</sup> Fuentes, interview.

<sup>134</sup> Valladares, interview.

<sup>135</sup> Valladares, interview.

<sup>136</sup> Moore, interview.

<sup>137</sup> Resendez, interview.

But to put it plainly, private foundations should not have to shoulder the additional cost of these piecemeal solutions when federal programs, to which the taxpayers of Texas contribute, are available to fill the needs of low-income eligible Texans. One of the key cruelties of the public charge rule is that it did not change eligibility requirements for any of the public benefit programs; it merely punished the use of them for some, and used the resulting fear as a wedge to drive immigrant families out of programs. Texas's state leadership, and our congressional delegation, need to take immediate legislative, regulatory, and administrative action to ameliorate the climate of fear and bring immigrant families back into Children's Medicaid, CHIP, and SNAP.



## Section II:

# How to Combat the Trend: Inhibiting Factors and Best Practices

After three or more years of this climate of fear, there is a better understanding about both the problems that exacerbate fear, and the techniques that help families overcome that fear: inhibiting factors, and best practices. Many of the organizations interviewed for this report have been able to identify what these factors are – and for some, even develop best practices to navigate around the problem.

### Inhibiting Factors

*Our clients are really scared. I had a family of 4 and the mom was pregnant. They were very reluctant. The daughter was 18 months old and wasn't walking. They had insurance before, but her husband lost his job. Mom and Dad came in here, and I had to convince them – they thought they weren't allowed to apply for Medicaid. They worried they'd be singled out, and they'd be deported. And they worried it'd hurt their immigration status. They're told that if they try to apply for any benefit program that they'll be denied citizenship and deported. In just the last couple of months over 20 families have told me that.*

— Janie Hernandez, Amistad Community Health Care<sup>138</sup>

#### Inhibiting Factors

1. Limited reassurance from HHSC on public charge
2. Conflicting messages between public benefit advocates and immigration attorneys
3. Fear of personal data collection
4. Inadequate training and education on public charge

The use of fear as a wedge has been tremendously successful, as we have seen in the previous pages. But there are other problems that exacerbate the problem and act as inhibiting factors to enrollment. These issues include: first, failure from HHSC to issue any reassuring language; second, contradictory messages coming from enrollment advocates on the one hand, and immigration attorneys on the other; third, mandatory personal data collection, and; fourth, a lack of staff training and community education.

Given the rapidly plummeting enrollment numbers between 2017 and 2019, the lack of action from Texas' HHSC on public charge is unusual. Back in the 1990s, after the welfare reform act, there was similar confusion and hesitancy for immigrant families around benefits eligibility.<sup>139</sup> At that time, HHSC created language to include on their enrollment forms underscoring the privacy of their information, and made more full explanations available through resources they promoted.

<sup>138</sup> Janie Hernandez (Outreach and Enrollment Coordinator, Amistad Community Health Care), interview with Cheasty Anderson, July 15, 2020.

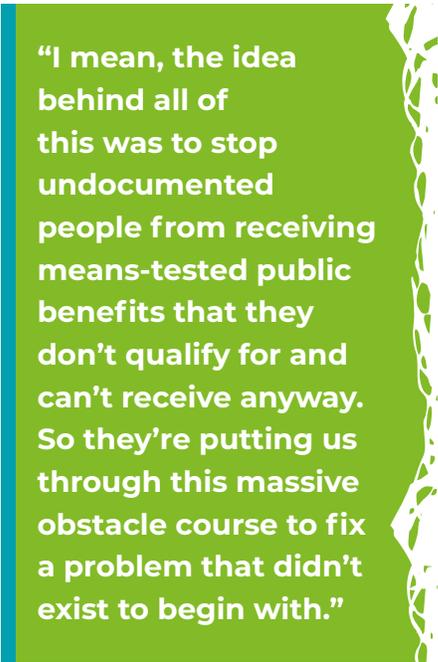
<sup>139</sup> King Hillier (Vice President, Public Policy, Government Relations & Corporate Communication, Harris Health System), interview with Cheasty Anderson, August 8, 2020.

While the language on their paper application still exists, the online application (which more than 80 percent of applicants use) has no reassuring language until the very last stage, after the online form populates the application.<sup>140</sup>

While certainly things could have been worse – HHSC could have actively removed reassuring language about privacy, for example – they could also have been better. For example, HHSC could have circulated informational flyers, or invested resources into doing training, education, and outreach for eligibility staff during the past several years to lessen the impact of policies like the public charge. Laura Guerra-Cardus, CDF-TX Deputy Director, has worked, along with many health care advocates, to urge the Agency to take an active role in providing families accurate information about the public charge rule. “HHSC’s participation is essential to ensuring families have the information they need. The community stands ready to partner with the Agency on a public education campaign that can turn around the concerning trend of year-by-year increase in Texas’ child uninsured rate.” HHSC had originally claimed that public charge was a national issue, and therefore they had no authority to speak on it. But with such a near-historic level of disenrollment, Guerra-Cardus believes, “It is the role and responsibility of the Agency to provide guidance, reassurance, and explanation to families who are understandably confused.”<sup>141</sup>

This silence coming from the Agency is made worse by the wide gap between what public benefit advocates are telling families, and what those families may be hearing from their immigration attorneys. Immigration attorneys, historically, have not had to be public benefit specialists, and to make things worse, they themselves are dealing with a barrage of new rules, changed rules, increased paperwork and wait times, and dozens of other obstacles that make it harder to get their clients from the initial application to their green card. Immigration attorney Kate Lincoln-Goldfinch described the changes as follows. “It’s way more difficult now to do a green card application than before. For those who are impacted by public charge, the effort of preparing their application is almost double what it was.”<sup>142</sup>

Prior to this administration’s changes, the two big challenges in a green card application were proving good-faith marriage and sponsorship eligibility for the petitioner. Applicants would have to gather their tax returns, check stubs, and an employment verification letter, according to Lincoln-Goldfinch. “Now,” she added, “we have the financial inquiry into both people, the sponsor and the applicant. So gathering their work history, skill and training history, debts, assets, credit score, employment records, proof of income, check stubs, tax returns, and any potential public benefit receipts. It is exponentially more than anything we had to do previously.”<sup>143</sup> Lincoln-Goldfinch described the experience as absurd. “I mean, the idea behind all of this was to stop undocumented people from receiving means-tested public benefits that they don’t qualify for and can’t receive anyway. So they’re putting us through this massive obstacle course to fix a problem that didn’t exist to begin with.”<sup>144</sup>



**“I mean, the idea behind all of this was to stop undocumented people from receiving means-tested public benefits that they don’t qualify for and can’t receive anyway. So they’re putting us through this massive obstacle course to fix a problem that didn’t exist to begin with.”**

<sup>140</sup> Melissa McChesney (Senior Policy Analyst, Health & Wellness Team, Every Texan), interview with Cheasty Anderson, October 20, 2020.

<sup>141</sup> Laura Guerra-Cardus (Deputy Director, Children’s Defense Fund - Texas), interview with Cheasty Anderson, September 2, 2020.

<sup>142</sup> Lincoln-Goldfinch, interview.

<sup>143</sup> Lincoln-Goldfinch, interview.

<sup>144</sup> Lincoln-Goldfinch, interview.

Lincoln-Goldfinch said that the majority of immigration attorneys are not informed sufficiently on public benefit law and public charge, but was at a loss to explain why attorneys would advise clients to drop benefits, other than ignorance. She herself has done Continuing Legal Education (CLE) and trainings on public charge, which are available from a number of different professional organizations – the local bar association, CDF-TX, ILRC, the American Immigration Lawyers Association (AILA), and more – but expressed that the quantity of information is simply too much to gain expertise in. “We do our best, but at a certain point it’s like trying to teach an immigration lawyer how to be a tax lawyer. It would be reckless for me to advise a family on eligibility. I can learn the basics, but beyond that I have to refer them over to a public benefits attorney.”<sup>145</sup>

But Lincoln-Goldfinch nonetheless asserted that professional ethics require that attorneys give accurate information to the families they work with. When asked to reflect on the fact that, at least anecdotally, many immigration attorneys are telling families to drop benefits for their citizen children, Lincoln-Goldfinch was disturbed. “That is so unethical to tell a family to drop all benefits. It makes my stomach turn, honestly. I would guess that the reason they tell people to drop benefits is that they haven’t gone to the effort of finding out which benefits impact an applicant and which don’t. I mean, the information is out there, I don’t know why they wouldn’t seek it out.”<sup>146</sup>

While there is little data about which attorneys, or how many attorneys, are giving incorrect information, the evidence is clear that this spread of misinformation by lawyers has been damaging to the families they advise.<sup>147</sup> Pema Garcia of the Colonias Program in El Paso says this trend is hurting her families. “Oh, it’s bad. We hear this over and over – we offer reassurances, and the individual says, ‘That may be true, but my attorney says I have to drop out of programs.’ And there’s nothing we can do about that, except be here for whenever they are ready to re-enroll.”<sup>148</sup> Herlinda Ibarra at CentroMed in San Antonio shared a similar frustration. “A lot of pregnant women are worried about how much this will cost, but they’re also worried about enrolling because they say, my lawyer told me not to apply.”<sup>149</sup> While there are many attorneys and legal service providers in Texas who have gone above and beyond to make sure that they are well-informed and positioned to be helpful, the proportion of immigration attorneys still telling their clients to drop all services is problematic, and increasing the rate of disenrollment.

Another pressure point in a parent’s decision to disenroll their eligible child revolves around data collection. Because some level of data collection is required at various stages of the application process for health care, nutrition, and community-based services, families who are leery of enrolling their children in SNAP, CHIP, or Children’s Medicaid face multiple points in the process where they are asked to submit personal information. It may be immigration status, proof of income, an address, or photo identification, but no matter what it is, or where in the process, that fear of being able to be traced back for immigration purposes can stop a parent dead in their tracks.

Rebecca Stocker of the Hope Family Health Center in McAllen confirmed this was inhibiting clients from seeking services. “As hard as it is to get clients in the door, there’s an additional problem, and that is the enrollment form they have to fill out. Proof of income and proof of address – we need that for our grants. People were hesitant to show us any information.”<sup>150</sup> Chevella Layne has seen the same problem at Goodwill Industries in Tyler. “There are some that just go without because they won’t give the children’s info. So they come in to get help, and then walk away when they are asked to give personal information.”<sup>151</sup>

<sup>145</sup> Lincoln-Goldfinch, interview.

<sup>146</sup> Lincoln-Goldfinch, interview.

<sup>147</sup> Straut-Eppsteiner, “[Documenting through Service Provider Accounts.](#)”

<sup>148</sup> Garcia, interview.

<sup>149</sup> H. Ibarra, interview.

<sup>150</sup> Stocker, interview.

<sup>151</sup> Layne, interview.

As a state, and as a support services sector, we need to be clear on what data does for agencies, clinics, funders, and community based organizations, versus what it does for, or to, immigrant families.

All of this could be remediated by enrollment assisters who are well trained and feel confident in their ability to answer a family's questions. Unfortunately, there are a variety of factors stopping that from happening at many points in the enrollment process around the state. Some staff are overworked, and don't feel they have sufficient time with each client to dive deeply into their anxieties. Some staff are themselves members of mixed-status families, and may feel inhibited by their own fear from offering reassurances. And finally, some have received little training or direction from their supervisors or organization.

CDF-TX provided public charge training at various clinics and enrollment entities throughout 2018 and 2019. Staffers were anxious to learn, but some were forthcoming about the constraints on their time. One staffer, whose name was unintentionally not recorded, at a clinic in South Austin memorably protested the expectation that they have mastery of public charge information given the other responsibilities of their job. "I am only with this family for a short while, usually," he explained. "And I have a line of other people waiting to see me. I want to share the right information, but if I did that, I'd never get my job done."<sup>152</sup> The staffer wanted to help, but the time limitations on his job made it challenging. Having materials on hand to distribute to anxious families is a partial solution to this problem, but the time pressures of the work itself inhibit some staff from feeling fully able to address their concerns.

In other instances, an enrollment assister may themselves be a member of an immigrant or mixed status family, or have had experiences that make them mistrustful of enrolling in government programs. For example, Janie Hernandez of Amistad Community Health Center took over her job from the person prior to her and discovered that this person had been recommending that families not enroll. "I think it's just that she was fearful *for* them, and would tell them purposely not to enroll. I'm assuming it's because she went through problems like that. But that's not helpful, we have to tell them that there are programs that they are eligible for, or at least their kids are eligible, and we need to help them understand the right information."<sup>153</sup>

For Cesar Varon, the Eligibility Manager of Barrios Unidos, the challenge is more complicated than simply learning about public charge. Varon has done abundant work to make sure he and his staff have the information they need. He attended a conference to learn more, and they created materials to distribute at the clinic. "We know the right information, but there's a lot of bad information out there, and people are scared. And then some people aren't even aware of what's happening. It's a tricky thing. 'Do you want to ask any questions about public charge?' is a weird question to ask if they haven't asked you about it first."<sup>154</sup> Varon and his team felt informed, but still challenged in providing information to families who came in for enrollment assistance.

At other organizations, access to information was a real challenge, and some staff felt unprepared to speak about public charge with confidence. One food bank employee indicated that they had received only limited guidance. "We haven't been provided with much public charge information.



**“Making sure that staff have the time and material they need to learn, and that they feel empowered to answer questions with confidence are essential components of an effective frontline response.”**

<sup>152</sup> Interview with clinic staffer, Fall, 2019.

<sup>153</sup> J. Hernandez, interview.

<sup>154</sup> Varon, interview.

We've been discouraged from talking about it since we don't know much, and to answer as few questions as we can. Trying to explain public charge to people, I wouldn't feel comfortable putting together talking points."<sup>155</sup> Making sure that staff have the time and material they need to learn, and that they feel empowered to answer questions with confidence are essential components of an effective frontline response.

## Best Practices

*We get it in the clinics every day that folks are feeling that fear. But we've worked very hard to combat the misinformation, to educate our staff about public charge, and our patient population of their rights. And we have been able to convince families that their citizen children are eligible, and that they can safely enroll.*

— Herlinda Ibarra, CentroMed<sup>156</sup>

## Best Practices

1. Staff training on public charge
2. Resource documents
3. Partnerships, collaboration, and outreach
4. Relentless empathy

As providers and organizations have grappled with immigrant families' reticence to engage with social services, many have come up with creative and effective strategies to provide the services those families need, to reassure them that it is safe to keep their kids enrolled in public benefits, and to use programs that will not hurt their immigration status. These best practices include: comprehensive and repeated staff education; providing resources and hand-outs to families; investing heavily in community partnerships; and working around inhibiting factors. Many of the organizations interviewed for this research have adopted one or more of these strategies to better serve their clients.

## Staff Training

Staff and community education efforts are perhaps the most immediately useful tools when it comes to client-facing work with immigrant families. As news began circulating that looming changes to the public charge rule were going to change how immigrant families interacted with public benefits, a clamor arose from many in the service sector for information.

The PIF campaign churned out resources while policy and advocacy organizations in Texas (Every Texan, CDF-TX, ILRC, the Houston Immigrant Legal Services Collaborative, Central Health, and the Equal Voice Network, among others) developed and hosted trainings on the topic. Some organizations used the PIF campaign's documents, and others went a step farther to create their own specific resource materials for clients. Central Health, in Austin, for example, produced a series of excellent resources that built on PIF guidance about Medicaid and SNAP, but also answered client questions about the use of resources like Travis County's MAP program.<sup>157</sup>

Most organizations interviewed for this project invested at least some staff time to training on the public charge, though some did not. Those who did not provide any or much training offered the following as obstacles: a lack of clear guidance from leadership, or conflicting guidance coming from various directions; feelings of confusion and uncertainty; or feeling hesitant to offer what they felt was legal advice, rather than benefits assistance.

<sup>155</sup> Interview with food bank employee, Spring, 2020.

<sup>156</sup> H. Ibarra, interview.

<sup>157</sup> "Public Charge: Removing Fears from Accessing Central Health's Medical Access Programs," Central Health, February 25, 2020.

There is no fault in any of those reasons. The public charge rule is complicated, and the time investment needed to become a subject matter expert is considerable. These reasons are precisely why there is such an important role for HHSC to play in helping Texans understand their benefits eligibility and any immigration risk that may entail.

Nonetheless, what became clear through the course of this research is that organizations who made staff education and empowerment a priority saw an immediate improvement in their outcomes. Annali Fuentes, who earlier described widespread anxiety from potential clients about participating in their job training courses, said that when she and her staff invested in training they were able to convince more clients to enroll, simply by speaking with confidence. “Before the training, my staff and I were constantly googling questions, and very uncertain about whether we were giving good information. After the training, we felt a lot more confident knowing that our program wouldn’t affect our students, and knowing that there are agencies and organizations we can refer our students to if they need more help. We could reassure them with confidence, knowing we had the right information and good resources.”<sup>158</sup> She also acknowledged the improvement of morale that training provided her staff, who had been feeling discouraged by the steady stream of clients who were too afraid to engage. “It was a boost in confidence. Seeing that we were all on the same page – all confused, all needing education on this, it made me feel better, like, I’m not alone.”<sup>159</sup> Fuentes emphasized how important it is to be able to speak to a frightened client with confidence. “I have the materials, I know the information. I’m not going to give somebody legal advice, but I can look at these resources and say with full confidence that participating in our particular program is not going to hurt their immigration status.”<sup>160</sup> She said that while they still struggle to recruit the same numbers as before, they had more success after trainings.

**“ Before the training, my staff and I were constantly googling questions, and very uncertain about whether we were giving good information. After the training, we felt a lot more confident knowing that our program wouldn’t affect our students, and knowing that there are agencies and organizations we can refer our students to if they need more help.”**

Arianna Anaya expressed a similar result after an investment in staff training, and also messaging to the public. In 2018, responding to input from their media consultant, Foundation Communities had opted to say nothing about public charge while doing their outreach, messaging, and phone banking. “The idea was, ‘there is no good way to talk about it so don’t say anything, so we had a defensive messaging. This was not useful – just look at the data.’”<sup>161</sup> As a result of this strategy, enrollment numbers dropped significantly for clients in immigrant families. For the open enrollment period in 2019, however, Foundation Communities decided to go all-in on public charge messaging, taking control of the narrative. “We saw an immediate positive response,” said Anaya. “When you see a headline that says ‘Public charge can hurt chances of getting a green card,’ that sucks up oxygen, and we need to combat it with facts. You cannot say ‘I am not an immigration attorney,’ because that undercuts the strength of your message.”<sup>162</sup> Anaya said that this deliberate and specific messaging used in outreach was useful, and it was bolstered by strong staff training on public charge. “First, people were more likely to come in for assistance, but also because we focused so

<sup>158</sup> Fuentes, interview.

<sup>159</sup> Fuentes, interview.

<sup>160</sup> Fuentes, interview.

<sup>161</sup> Anaya, interview.

<sup>162</sup> Anaya, interview.

strongly on staff training, when people came in with concerns we were able to answer with enough certainty and authority that they were more likely to believe us.”<sup>163</sup> Anaya’s staff worked hard to learn, and saw positive results from this strategy. “What I especially enjoyed this 2019 season was that this was a goal of ours – no one with a concern about public charge would leave our office afraid. I was really impressed with my staff and the extent to which they took it on.”<sup>164</sup> As a result of this adjusted approach to public charge, Anaya said that their enrollment numbers for 2019 Open Enrollment were actually improved over their 2018 numbers. “In 2019 we saw a significant drop in new clients who were non-citizens, but did see an uptick during OE as a result of our concentrated outreach efforts. It showed us that education and outreach were successful.”<sup>165</sup>

In San Antonio, heavy investment in training and community education helped CentroMed distinguish itself as the only organization interviewed for this research that experienced no drop in enrollment, in spite of experiencing the same fear coming from their patients. Herlinda Ibarra, CentroMed’s Eligibility Manager, said “We get it in the clinics every day that folks are feeling that fear. But locally here, and my team at our clinic, we’ve worked very hard to combat the misinformation, to educate ourselves and our patient population of their rights. And we are able to convince families that their citizen children can remain on public benefits. Anecdotally we know there’s a chilling effect, but we’re doing a good job educating here, and so we haven’t seen the same drop that other areas of the state have.”<sup>166</sup>

CentroMed went above and beyond simply providing staff training, however. Between October and December of 2019, their staff partnered with the City of San Antonio’s Immigration Liaison to put on four separate public charge education sessions for their staff. All were open to the public. They scheduled them in the evenings, to capitalize on the convenience of after-work hours, and then conducted biweekly follow-up conversations. “We invited the public and our staff. Staff did attend. And for those who didn’t attend, we shared slides, and in our biweekly check-in calls we talked about it. We had less success getting our patients to come, but it still worked out well for our enrollment and outreach efforts, just because the staff was so well trained,” said Herlinda.<sup>167</sup> Her colleague Joe Ibarra emphasized that Herlinda was too modest in describing the success of her training sessions. “Herlinda downplays the materials and presentations that she’s brought to the clinics. She simplified the material, took it step by step, and showed people that [benefits use] really doesn’t affect almost anybody in Texas. She trained the whole staff. One large training with all staff, directors, admin, management. And then monthly or twice monthly for about six months they’d have refresher discussions with CACs, the outreach team, and eligibility specialists. That’s 50 to 60 individuals that really understood this information because of Herlinda’s persistence. And our enrollment numbers reflect that.”<sup>168</sup>

CentroMed even went the extra steps of first, challenging the bad advice immigrants were getting from immigration attorneys, and second, putting effort into directly educating poorly-informed immigration attorneys. Herlinda Ibarra told the following story as an illustration of the problem. “One pregnant woman was here on vacation from Mexico. She got in a car accident and couldn’t go back, but she was seven months pregnant, and they didn’t know when the legal process would wrap up. The immigration lawyer told her to apply for the ‘immigrant Medicaid program,’ which of course doesn’t exist. We were able to put her at ease, get her on whatever program she was eligible for. And then we call the attorney.”<sup>169</sup> CentroMed has developed these strategies to cope with misinformation

<sup>163</sup> Anaya, interview.

<sup>164</sup> Anaya, interview.

<sup>165</sup> Anaya, interview.

<sup>166</sup> H. Ibarra, interview.

<sup>167</sup> H. Ibarra, interview.

<sup>168</sup> J. Ibarra, interview.

<sup>169</sup> H. Ibarra, interview.

that is in conflict with their core mission of outreach and enrollment. “We see cases like this all the time, where pregnant moms are worried because their attorneys told them not to apply.”<sup>170</sup> Tackling one poorly informed attorney at a time is perhaps inefficient, but it manifests change at the community level.

The training they invested in at all staff levels paid off, Herlinda said. “We have cases [of frightened clients] every day, but we know how to handle it. We’ll get on the phone with their attorneys, *notarios*, whatever. I’ll tell them that the lawyers are wrong, and then educate the attorneys. Our staff will tell a patient, take this letter [explaining public charge] to your attorney, they don’t know what they are talking about.”<sup>171</sup> Given CentroMed’s robust enrollment numbers over the past few years, it is obvious that these strategies of frequently repeated staff training, coupled with assertive outreach messaging and direct re-education of immigration attorneys, is a successful method of combating the fear that is keeping families away from public benefit programs for which they are eligible.

Similar strategies were also effective in Houston, where Community Health Choice confronted their staff’s fear of giving incorrect legal advice to clients by bringing in well-versed immigration attorneys to do train-the-trainer sessions for their staff. Angela Waltman said that “staff felt more confident after hearing from the attorneys. Now when members refuse care they can explain what their rights are, and what the rules are. This has helped quite a bit.”<sup>172</sup> CHC also saw the utility in repeated instruction, said Waltman, and so they re-educate their staff every six months, “to keep the information top of mind, and keep them feeling up to date on the latest information.”<sup>173</sup>

## Resource Documents

Not all clinics or organizations engaged in the same vigorous staff training and public engagement, but many did utilize community resource documents with a positive effect. One-page resources, flyers, and posters all helped communicate the core message of safety to families sitting in waiting rooms or in the enrollment process.

Mary Lou Martinez, of the North Texas Area Community Health Centers, said that the one-pager she used in her own interactions with clients was helpful. “Back in October [2019] I got those newsletters from TACHC, which was an FAQ document. I taped it to the other side of my laptop so that as I was entering information in their application, the client could read it.”<sup>174</sup> Though her organization didn’t do much community or staff education, Martinez found that for her, having that document right at hand helped appease the fears some clients had, simply by being able to read it. She sent it around to her colleagues, hoping that it would help to have these resources available not just in enrollment offices, but also in the clinic.

Several organizations mentioned the usefulness of the PIF flyers and one-pagers that were distributed widely through local and state-wide health care coalitions. Marisol Resendez of the Milagro Clinic in McAllen spoke about using the “wonderful flyers from [PIF] distributed through [her local public service coalition], the Equal Voice network.”<sup>175</sup> Rebecca Stocker also uses the PIF resources distributed through the Equal Voice Network, saying “We’re doing what we can to educate within the clinic. Those flyers really help.”<sup>176</sup> Arianna Anaya of Foundation Communities also spoke about the efficacy of PIF’s simple one page flyers in her work. “The resources PIF and other support groups

<sup>170</sup> H. Ibarra, interview.

<sup>171</sup> H. Ibarra, interview.

<sup>172</sup> Waltman, interview.

<sup>173</sup> Waltman, interview.

<sup>174</sup> Martinez, interview.

<sup>175</sup> Resendez, interview.

<sup>176</sup> Stocker, interview.

produce are so useful. The very first thing on our resource page was a list of PIF docs in English, Spanish, and Arabic – it helps us convince families. We can say, ‘You don’t have to just take my word on this, here’s resources from national immigration experts,’ and it helps.”<sup>177</sup> Herlinda Ibarra of CentroMed agreed. “Anecdotally when staff would speak to them, they’d pull out the flyer and mom would look it over, say ‘Oh I see, this is safe for me,’ and they’d enroll.”<sup>178</sup>

From in-person training to information distribution, education clearly is a fundamental step toward calming the fears of immigrant families and enabling parents to make informed choices.

## Partnerships, Collaboration, Outreach

A third best practice that organizations relied upon to continue reaching eligible families is the development of community partnerships and collaborations. These partnerships enable the public service sector to reach more deeply into their community, ease the difficulty families have in accessing particular locations, or reduce the number of “errands” a family has to run in order to feed, clothe, and care for their children. As immigrant families have increasingly withdrawn from public life, and feel fear about entering certain locations, these partnerships have been successful at continuing outreach and enrollment efforts that otherwise would have languished.

Foundation Communities in Austin has established working partnerships with a variety of organizations that serve specific populations – for example, cancer patients, HIV patients, immigrant communities, and so on. Arianna Anaya described the process as a mutually beneficial one. “We individually contact the person we have at each partnership. We’ll offer up a presentation for the staff to keep them up to date on the newest information. Generally our partners all take us up on that.”<sup>179</sup> In return, these partner organizations remind their members when Open Enrollment comes around, and refer their members to Foundation Communities.

Cathy Moore described a network of relationships that ECHOS has developed within the Houston community. “We do just about anything you can think of to get in front of people. We do a lot of outreach events, which have been helpful. We do them at schools, at health fairs, at city events when we’re invited. We do them at our food fairs.”<sup>180</sup> Finding clients where they already are going and informing them of the food pantry and enrollment services available at ECHOS has helped draw people in where they otherwise would have hesitated to go because of fear.

Earlier, Ester Valladares of HAAM spoke about how her clients are increasingly frightened to leave their immediate neighborhood, and so the HAAM offices were getting very quiet. Valladares and her team adapted by bringing the services to where their families live. “We’ve developed partnerships – with a church, for example, in New Caney. A HAAM worker goes to the church every week. We have somebody bring enrollment packets to them. And we started doing food fairs. The food fairs will bring people. We get them in the door with food, but also other supports – including how to access benefits. Sometimes we’ll have enrollment assistance on-site, but even when we can’t we always provide information.”<sup>181</sup> HAAM has established working partnerships with around 10 churches in Harris County.

Food is a common theme in the stories of successful partnerships that health service organizations have formed. Mary Lou Martinez of the North Texas Area Community Health Centers said that last year she proposed that their clinics in Fort Worth and Arlington partner with the Tarrant Area Food Bank. “I said, I know this program would work if we did a monthly mobile food pantry here at the clinic where people could come get food and end up getting health care. We did that, until COVID.

<sup>177</sup> Anaya, interview.

<sup>178</sup> H. Ibarra, interview.

<sup>179</sup> Anaya, interview.

<sup>180</sup> Moore, interview.

<sup>181</sup> Valladares, interview.

All of the events were very successful. There are so many people who have needs and food needs are the main one here. We'll find people, for example, in diabetic programs, and tell them they can come pick up food here. It's helped us increase who we reach with our services."<sup>182</sup>

In their effort to meet the food needs of their clients, some organizations went a step beyond partnerships, and even developed their own secondary wraparound services for nutritional support. At ECHOS, the food pantry has become integral to bringing people in. Cathy Moore said, "They come to us for food, and we try to talk to them about the possibility of signing up for food stamps."<sup>183</sup> In McAllen, Milagro Clinic opened a food distribution program about a year ago. Marisol Resendez said that they began doing it because it was coming up in their data. "We've been asking questions for a long time about the various social determinants of health, and food wasn't always at the top of the list. But in the last two years food became such a huge problem because people were dropping off of SNAP. And then food insecurity kept coming up in our surveys."<sup>184</sup> The response in their community has been "tremendous. We have the food pantry monthly, and we do bags once monthly, and every week we do fresh produce. And we run out every single time."<sup>185</sup> By filling this one need, clinics and enrollment entities were able to get patients in the door who would otherwise avoid medical care.

Another key partnership that came up in this research was legal services. Pema Garcia of the Colonias Program in El Paso said she and her team have undertaken a concerted effort to work with their local bar association. "We hear this over and over – the individual says 'that may be true, but my attorney says I have to drop out of programs.' So we've been working with the bar association to educate their members."<sup>186</sup> Community Health Choice in Houston has also partnered with legal service providers to better help their clients. Angela Waltman said, "We've adopted referral services with immigration attorneys so that when clients have questions we know that we can refer them to attorneys who are well trained on public charge and will give their clients good information. When I first came in 2016 we didn't have these partnerships, but we've had to adapt."<sup>187</sup> As the public service sector has experienced this contraction from immigrant communities, the partnerships they've been able to develop have been instrumental to their ability to continue reaching the families they have historically served, and to making sure their families have access to accurate information about the public charge, public benefits, and their immigration status.

## Relentless Empathy

*Our success is rooted in personal contact, personal relationships. We see this person has a need, and we're going to help because we care. And I think when you are honest, people can just read that in you, and they'll trust you and refer people to you. I wish everybody could see that. We are dealing with people's lives. It's not numbers, or enrollments. It's people's lives. And they say, "I would've never done it. I don't know how to read or how to write, I just never would've done this."*

— Graciela Camarena, Children's Defense Fund TX<sup>188</sup>

Empathy and persistence are intangible qualities, but without question these are best practices. Any enrollment system is rife with opportunities to slip through the cracks, fail to understand, miss deadlines, or receive incorrect determinations. When the system has been altered to make access even more difficult, as it has in the past few years, the problem grows even worse. An empathetic

<sup>182</sup> Martinez, interview.

<sup>183</sup> Moore, interview.

<sup>184</sup> Resendez, interview.

<sup>185</sup> Resendez, interview.

<sup>186</sup> Garcia, interview.

<sup>187</sup> Waltman, interview.

<sup>188</sup> Camarena, interview.

enrollment assister must also be relentless, because that very bureaucracy demands it of them. In the course of this research, there was no way to quantify the qualities and characteristics of an enrollment worker who goes the metaphorical extra mile to assist their clients, and yet it emerged repeatedly as a definitive best practice for helping families confront their fear and misinformation, get enrolled and stay enrolled.

Graciela Camarena and her staff at CDF-TX, approach their work with the discipline of relentless empathy. “If this isn’t your calling, if you don’t have the passion, you aren’t going to be able to serve the people.”<sup>189</sup> Camarena and her team prioritize educating their clients. “We do clear assessments, we clearly explain the process so families know what to expect.” They do this to help mitigate the pitfalls of a frequently confusing and frustrating enrollment process. Camarena explains, “It is a cold drop off at the application submission. And then the family would receive a letter they didn’t understand, and if they didn’t respond, they didn’t get enrolled. And it was all for a lack of understanding. So our system has been to describe things as completely as possible: what to expect, what their role will be as parents. What they will see in the mail, what it’ll look like, what they have to do. That’s the best practice, because once they understand, then they will follow through.”<sup>190</sup>

After the initial submission, the CDF-TX team continues to take responsibility for that client’s case. “After their paperwork is submitted we do our follow-ups, calling to see how that family’s process is going. We can help them with hiccups, or give them updates. They’ll often see a request for income verification, and they’ll say, ‘Oh I didn’t know what that meant.’ And that’s a problem we can solve, and educate around. There’s a difference between how things are *supposed* to happen versus how they *really* happen. And we understand those differences, those complications.”<sup>191</sup> Camarena said that over the past several years this job of shepherding families through the application process has become more time and labor intensive because of the fear and the complicated nature of the new rules.

Camarena was clear that persistence was a critical component of the job. “You have to be available, and you can’t take no for an answer. Many times we’ve found there are errors committed by the system or by workers. Human error happens all the time in these applications. If we have a set of data that makes us think they qualify, we will pursue a denial again and again. We call and ask questions, and lo and behold, there were errors in the system. We’ll escalate to a supervisor, and sometimes we’ll get a little backlash from people saying ‘How dare you,’ or ‘Don’t push too hard, I’ve been here 20 years,’ and I say ‘Thank you for your service, and can you just double check.’ And then we find they were using old data even though we sent new paycheck stubs.”<sup>192</sup> Camarena acknowledges that her team does not serve the same quantity of clients as some of the major enrollment organizations, but emphasizes that the families they do serve come back to them year after year due to the trust they have developed. At the end of the day, says Camarena, “they feel safe with us.”<sup>193</sup>



**“There’s a difference between how things are *supposed* to happen versus how they *really* happen. And we understand those differences, those complications.”**

CDF-TX’s service model is based on lower volume, but high quality enrollment assistance. But even at major enrollment organizations, relentless empathy is a remarkably effective practice. Arianna Anaya of Foundation Communities related a story in which persistence and empathy convinced a terrified client to enroll in benefits that were safe for her. “An immigrant client we had served – a woman with cancer – had signed up for a health insurance tax credit, but her sponsor sent her back to disenroll,

<sup>189</sup> Camarena, interview.

<sup>190</sup> Camarena, interview.

<sup>191</sup> Camarena, interview.

<sup>192</sup> Camarena, interview.

<sup>193</sup> Camarena, interview.

because he was afraid about having to pay it back or getting in trouble. None of this was going to happen, we knew, but this poor woman came in in tears, super upset. My colleague was able to calm her down, and then I spent over an hour on the phone with her slowly taking her through it, helping her understand public charge and how it works.”<sup>194</sup> Anaya attributed her success to being able to share a personal story. “Something I said to her that changed the conversation was, ‘You know, my mother is an immigrant from Holland. And when we first came over, she signed my sister and I up for CHIP, food stamps, for everything, without any fear. ‘This is what this is there for,’ she said, and she’d encourage other families to sign up where they’re eligible.’ There’s so much fear – but literally that’s what these programs are there for: to help people lift up out of a difficult situation.”<sup>195</sup> Anaya highlighted the contrast between how the system treated this brown-skinned woman versus her own white mother. “This client was told to never ever use these programs – they’ll hurt your application. And meanwhile my white, European, immigrant mother was being treated very well by the system.”<sup>196</sup> Foundation Communities’ policies emphasize compassion with their clients. “If a client gets upset and emotional, we slow the appointment and give them all the time they need to ask questions and get clarity. [This public charge rule] is literally putting a price tag on your family’s well being. It is a ‘Sophie’s choice.’ It shouldn’t be a choice that families feel they have to make, and the fact that families feel so scared is just terrible.”<sup>197</sup> The time, patience, and empathy that Foundation Communities staff is able to extend to their clients helps achieve the end goal, which is more eligible Texans enrolled in the programs that will help support their health needs.

CentroMed also takes this same approach. Joe Ibarra shared a story about Herlinda Ibarra that shows, in his words, “just how relentless Herlinda is in fighting for patient’s rights.”<sup>198</sup> One morning, he recounted walking into his office and hearing Herlinda shouting on the phone down the hall. “So I walked in and saw she had a family with her. The mother had an ACA health insurance plan. She had Stage 4 cancer, and somehow had a mixup in her BCBS plan. She had somehow been auto-re-enrolled in an old health plan after she signed up for a different new one. She didn’t know. But the Marketplace saw she had two plans, and automatically cancelled them both. And she couldn’t get any health care or treatment for her cancer.”<sup>199</sup> Typically, this situation would leave a person without any health insurance until the next Open Enrollment period. But CentroMed did not give up. “Herlinda was on the phone with Marketplace, pushing and pushing. She went all the way up to CMS in DC. She’d called Methodist Healthcare Ministries and got them to reach out to the Methodist hospital where she was getting treatment to make it work while she got it sorted out. I reached out to Representative Lloyd Doggett for help. And suddenly, where it had looked like there was no hope for this family, we had it resolved in a week or two. And that’s the kind

**“If a client gets upset and emotional, we slow the appointment and give them all the time they need to ask questions and get clarity. [This public charge rule] is literally putting a price tag on your family’s well being. It is a ‘Sophie’s choice.’ It shouldn’t be a choice that families feel they have to make, and the fact that families feel so scared is just terrible.”**

<sup>194</sup> Anaya, interview.

<sup>195</sup> Anaya, interview.

<sup>196</sup> Anaya, interview.

<sup>197</sup> Anaya, interview.

<sup>198</sup> J. Ibarra, interview.

<sup>199</sup> J. Ibarra, interview.

of advocacy we believe in for our families.”<sup>200</sup> This approach is precisely why CentroMed invested so strongly in staff training about public charge – so they could advocate from a position of knowledge for their clients.

Janie Hernandez at Amistad Community Health Center in Corpus Christi shared a similar perspective on helping her clients. “You have to be persistent. I had a family of four, and the mom was pregnant. The daughter was 18 months old and wasn’t walking. They had insurance before, but her husband lost his job. Mom and Dad came in here, and I had to convince them. They were very reluctant. They thought they weren’t allowed to apply for Medicaid. They worried they’d be singled out, and they’d be deported. And they worried it’d hurt their immigration status, that they’d be denied citizenship.”<sup>201</sup> Hernandez said she spent a long time talking with this family, reviewing the information many times. “They were very scared, but I was able to convince them and eventually they enrolled. They had to take the daughter to the neurologist, and we were able to get her a wheelchair. You know, she’s a citizen, this is her right.”<sup>202</sup> The assistance, however, did not stop at enrollment. “You have to keep helping, because it’s a complicated system, and it’s hard to figure out. So I worked with them hand in hand, helping them get set up with a primary care provider, and helping them choose an insurance provider that would work best for them. They don’t know any of this; how could they? It’s my full time job to know how it works. So just being able to hold their hand through the process really helps. At first they were fighting me, but now both of her kids have insurance and she’s on Pregnancy Medicaid.”<sup>203</sup>

Examples like this illustrate the many pitfalls inherent in navigating health insurance programs for average families. Often, the difficulties they have when they fail to fully understand a system, or get caught in a bureaucratic or administrative snafu can only be resolved by the kind of relentless and empathetic approach described in the stories above. These hardships occur in even the best of times, but now, more than ever, this best practice can go a long way to making sure a family has access to the health care, nutritional support, and other assistance they are eligible for.

All of the best practices discussed above are critical guideposts for the public service sector in Texas to follow as we collectively grapple with the massive withdrawal from public benefits that the Trump administration has engineered. What the research revealed was that each best practice pays off some dividends, and the more an organization invests in these practices, the more it pays off. Absent leadership from HHSC or state leader on this problem, social service and advocacy organizations can stem the tide at an organizational level by adopting as many of the best practices outlined above as they can. Of course, the best outcome for immigrant families in Texas would be if HHSC joined in the effort to ensure families have accurate information about the public charge rule.

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<sup>200</sup> J. Ibarra, interview.

<sup>201</sup> J. Hernandez, interview.

<sup>202</sup> J. Hernandez, interview.

<sup>203</sup> J. Hernandez, interview.



## Section III:

# What Happens If We Do Nothing – Current Trends and Inevitable Outcomes

Respondents were universal in their warnings of what could happen in Texas if current trends continue. Their predictions covered a range of possibilities, but they were of one voice: if we don't reverse this trend, if we fail to reverse policies that scare immigrant families away from public benefits, or to enact policies that welcome immigrant families, we face disastrous outcomes in public health, education, and the economy. These trends, of course, have already begun. What happens in the future is up to our leadership.

### Public Health

The most immediate and obvious impact, according to most respondents, had to do with public health. Respondents were concerned about the absence of preventive care for large numbers of children in Texas. Angela Waltman of Community Health Choice put it this way: “The number one fear is widespread disease. We and some of our contracted providers are worried about a public health crisis. If you have folks who won't vaccinate because they are afraid, then we're facing a public health crisis. Because those little kids are going to sit in the same classrooms as other kids who have been vaccinated, but vaccines only work if we have herd immunity. More people, more kids are going to get sick, and this is entirely preventable.”<sup>204</sup> Vaccination rates, as we saw above, have already dropped precipitously in some low-income immigrant communities, indicating the extent to which the problem is already well underway.<sup>205</sup>

Mary Lou Martinez concurred, and drew a connection between the need for vaccinations, but also preventive care generally. If immigrant families are afraid to engage with the health care system in all its forms, she said, “The health disparities will increase. People won't be bringing kids in for well checks. I explain to parents that you don't only bring them in when they are sick; you need a baseline. If the drop in enrollment for benefits continues, you're going to see so many more issues coming up.”<sup>206</sup>

Natalie Wood of Catholic Charities spoke about the horror of watching sick families struggle with fear and with poor health. “I've seen people, even when they themselves are very ill, and they will not even apply for a Gold Card. They become horribly ill before they go to the emergency room, and it's awful to see the deterioration. And they won't be cared for – they just get stabilized – because

**“If we don't reverse this trend, if we fail to reverse policies that scare immigrant families away from public benefits, or to enact policies that welcome immigrant families, we face disastrous outcomes in public health, education, and the economy.”**

<sup>204</sup> Waltman, interview.

<sup>205</sup> Mitchell and Yoo, email.

<sup>206</sup> Martinez, interview.

they don't have health insurance."<sup>207</sup> This is the root of the health disparities that Martinez mentioned above – failing to seek care early leads to worse outcomes in medical events and chronic disease management. And these disparities disproportionately impact low-income immigrant families.

Jennifer Babcock of ACAP offered an eloquent summary of how public health disparities are inextricably linked with racial and ethnic discrimination. She said, “The linkages between health coverage and access to needed health care services, and health outcomes are clear throughout history. Coverage creates access, and access improves outcomes. The research is increasingly clear, too, that racial and ethnic discrimination is very clearly linked to worse health outcomes. With the public charge regulation, we see one reason why there are ethnic and racial disparities. I suspect we’ll see a diminishing of public health outcomes in communities impacted by public charge. There’s no way that this can bode well for people’s health outcomes.”<sup>208</sup> Texas already struggles with high disparities in health, education, and poverty rates between different racial and ethnic populations. The new public health rule will only increase the gap, causing harm not just to the directly affected communities, but for all Texans.

One of the clearest ways this will affect all Texans is the uptick in charity care, or “uncompensated care” at Texas hospitals. King Hillier of the Harris County Health District pointed out that the uptick in charity care will put additional strain on the for-profit hospital networks and funders. “I think if the folks aren’t insured, and they aren’t seeking preventive care out of fear, charity care increases. And because Harris health is a government entity, they are scared to come to us, but they’ll end up going to private hospitals. Charity care takes place 80 percent in the private sector, as opposed to the 20 percent we do at Harris Health. So the private sector will have to absorb the brunt of the shift. I’ve told my colleagues to get out there and start advocating to defeat the public charge rule.”<sup>209</sup> This uptick in charity care translates to higher premiums and higher health care costs for Texans with health insurance, as the hospitals attempt to recoup their losses on uncompensated care. Hillier expressed frustration that there wasn’t more concerted opposition to public charge among private hospitals. “It’s so short-sighted. We already went through this in the ‘90s with the welfare reform act. We know what’s going to happen, and we need to act now.”<sup>210</sup>

Poor health leads to poor outcomes in other arenas of life. Compound that with the nutrition crisis that public charge has ignited, and the situation worsens. It is a proverbial snowball rolling downhill. A sick and hungry child will struggle to excel in school. A quorum of sick and hungry children

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<sup>207</sup> Wood, interview.

<sup>208</sup> Babcock, interview.

<sup>209</sup> Hillier, interview.

<sup>210</sup> Hillier, interview.

struggling in school leads to the school itself, or the entire school district, struggling. Dr. Valerie Smith of St. Paul Children's Services in Tyler put it like this: "There's a tipping point somewhere, where if you get a large enough number of kids who don't have access to care, you hit a tipping point of an entire cohort of kids who aren't going to do as well, graduate from high school, get good jobs, and so forth."<sup>211</sup> In other words, lack of access to health care is just the tip of a very big iceberg.

When families are systematically scared away from accessing housing, health, nutritional supports, and other benefits available through the public service sector, the impact reverberates throughout society. Natalie Wood notes: "The public charge is just a piece of the overall subculture they are promoting. When you have families who are unable to access housing, food, or health, and on top of that, they're financially inhibited even from the minimum wage in under-the-table work, you know... this is inhumane. First we don't have to pay them, and now we're saying we won't give them benefits, and also we don't care if they die. It is the overall lack of humanity that is so troubling to me."<sup>212</sup>

Wood was not the only respondent that talked about the inhumanity of a system, or a set of rules, that forces desperate families to the precipice. Ester Valladares, who is originally from Honduras, has lived in several states. She talked about the poverty she sees here in the U.S.

*I see more poor people here, and more people in the streets than back in Honduras where I'm from. And if I say that out loud, people will think, oh no, that's not true, but it is. I've lived in New York, Florida, California, and Texas, and I'm telling you, it's true. We have a poverty problem, and to add this fear of using the anti-poverty programs, we have a big problem here. Kids will be dropped out of school. There is no equality – we are raising kids who could end up in prison because of this cycle of poverty. They don't have the health care, or the home stability. And I don't mean to make them sound like victims, because they aren't, but when you block families from the little support that would help poor families lift their children out of poverty, that is the outcome. These families are working. They are trying to do well, to succeed. And they pay taxes. They deserve better than what our government is doing.*<sup>213</sup>

The poverty, of course, is balkanized, and not visible to people who live in middle class and wealthy areas of the state. But it is real, and it is getting worse, due to the anti-immigrant policies of the Trump administration.

The troubling patterns described above related to health care, education, and poverty, are already well underway in Texas. Graciela Camarena of the Children's Defense Fund sees it in her work every day.

*We are already seeing this – children not getting immunized. Families not getting needed medications for their kids or for themselves. Seeking emergency services when it's preventable. Getting into debt when there are programs they clearly qualify for, but they're afraid to access it because of public charge. They are hearing it'll hurt their immigration status. The impact will be disastrous, not just for immigrants, but for all of us. If somebody contracts a communicable disease, they will expose everybody at the movie theater or the grocery store or the gas station. And when people say, 'Oh that's not going to affect me because I pay taxes,' that is not it. Everybody pays taxes. Undocumented people pay taxes. What are you crying about? You don't like it that other people can get health insurance?*

<sup>211</sup> Smith, interview.

<sup>212</sup> Wood, interview.

<sup>213</sup> Valladares, interview.

*Health care, safe child care, public health programs are needed. It affects all of us. Look at COVID. It's not going to skip you because you pay taxes. It'll affect you just like all these other issues. It'll impact us all – it's your job, your pocketbook, your health. And we can all step back and ask, 'What can I do to help?' We need to open people's eyes, open their hearts. It's about immigration, yes, but it's also about affordability, access to services, job security, mental health – it's all wrapped up together, and we are all struggling.<sup>214</sup>*

Camarena's description of a system in which we are all interconnected is perhaps not one that feels so obvious to people who do not worry about their own immediate access to food, health, education, and fair pay. But, as we have seen from the COVID pandemic of recent months, when public health systems are undermined or break down, it affects us all. The impact may fall harder on low-income communities, exacerbated by underlying structural racism that has always created more barriers for communities of color, but it will cause harm even to everyone in the community, including whiter and wealthier neighborhoods. It should not take a reminder that you, too, might be hurt for each of us – as human beings – to push back against injustice and cruelty. Fixing this crisis requires all of us to care, and to act.

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<sup>214</sup> Camarena, interview.



## Section IV: Red Flags and Suggested Improvements

If Texas HHSC decides to address the problem of plummeting enrollment numbers in Texas, there are several long-standing best practices that they could employ, most of which are well documented and frequently recommended. In the process of conducting this research, however, respondents also pointed out specific problems and best practices that are worth highlighting here. Some have to do with the structure and function of the Agency itself. Others have to do with particular problems in application portals. And others are recommendations of culture shifts the Agency could adopt that would improve outcomes across the board.

One recommendation stems from the unintended consequences of the streamlining process that HHSC has undergone in recent years. Improvements would be immediately noticeable, said Pema Garcia, if the Agency invested more in personal contact. “I think for the population that is so distrusting, they need human contact. They need to hear from individuals from the Agency, from the program, and they need reassurance. There is so much misinformation. What we have to go back to is, many of these agencies need to up their contact with their clientele and potential clientele.”<sup>215</sup> Garcia pointed out that the lack of personal contact is, in part, a function of many years of legislatively-mandated streamlining at HHSC. “For the past decade we’ve streamlined and created efficiencies, which is great on the agency side, but not great for their clients – especially for those families and communities who have less access to technology, to information, and even to the language and literacy.”<sup>216</sup> The problem, of course, is a knotty one, as the streamlining is not just a result of a philosophical approach, but also the result of budget reductions for health and human services at the state Legislature.

Nonetheless, given the best practices listed earlier in this report, it is evident that human contact and relationship-building is integral to reducing fear and building trust with a provider or enrollment entity. Some organizations interviewed for this report have working relationships with HHSC, where an eligibility worker, called an “outstationed eligibility worker,” offices at an FQHC, for example, and processes applications. At Barrios Unidos, Cesar Varon said that the recent addition of a state worker in their office has helped significantly. “Now the [HHSC] worker handles all our applications,

### Policy Recommendations

1. Increase placements of outstationed eligibility workers in communities
2. Adequate staffing of front line workers at HHSC
3. More accountability and transparency from public agencies
4. Fix compliance issue on Your Texas Benefits online application
5. 12-month continuous coverage for children’s Medicaid
6. Reinstate HHSC funding for outreach and enrollment, including partnership grants
7. Expand Medicaid eligibility to low-income adults in Texas
8. Targeted outreach and enrollment efforts for populations with disproportionately low enrollment numbers

<sup>215</sup> Garcia, interview.

<sup>216</sup> Garcia, interview.

which makes things move more smoothly here.”<sup>217</sup> Stationing HHSC eligibility workers in more local offices might be one way to achieve some part of Garcia’s goal above, of building trust and increasing enrollments.<sup>218</sup> According to Melissa McChesney of Every Texan, “The practice of having HHSC place their staff in FQHCs has proven so effective that community health centers have been requesting more placements from HHSC for years.”<sup>219</sup> This is a clear and straightforward step the Agency could take that would streamline applications and build trust with communities who live in fear.

Another suggestion that came up in the course of this research is that the current culture at HHSC is not conducive to accountability, which in turn inhibits assistance. Graciela Camarena and her team encounter human error and database errors all the time in the course of their work, but struggle to navigate a system that doesn’t seem to want to acknowledge that there could be any error on the Agency’s part. Her narrative is lengthy, but worth including in its entirety to convey the scope and frequency of the problem.

*The concerns I have (and always have) have to do with faulty denials of eligibility and problems with the actual process of eligibility determinations. Sometimes letters are not received in a timely manner, especially if they need to return supporting documents within 10 days of the date of the letter. Sometimes income verifications are wrong. When you apply for Medicaid or CHIP there is no assets test, but sometimes they do that anyway. The husband only receives unemployment benefits and the amount shown is not what he receives.*

*When this happens, and we are confident that the family is eligible, we call 211, with the family in front of us. They can authorize us to speak on their behalf. I speak to the person on the phone and verify all my information. And they don’t have access to all the data. They’ll tell us, you’ll have to call back. So I say, OK, call back where? You have to call 211, they say. And I say, but I’m with you on 211 right now. So I ask to speak to the supervisor. Well, the supervisor isn’t available. OK, I say, we’ll wait. Then the supervisor comes on, but says they’ll stand by the denial based on this income check. And I say, ‘But we showed you that that is old data.’ And we hit a wall. Then we have to use these specific terms like ‘we need to escalate,’ that trigger some process internally.*

*Sometimes out of frustration, I hang up with them, and I’ll call my local friend at HHSC, and she’ll say, ‘OK mama give me the case number.’ And she has access to all notes, entries, everything. And she’ll be on saying, ‘Nope, nope, uh-uh, that’s wrong.’ And then she re-assigns it to another worker. Because if a review is triggered, it gets automatically assigned to the same worker that made or allowed the error in the first place, which is not effective oversight. They don’t want to re-examine their own work. So then we get fresh eyes on it, and she’ll have added notes like ‘look at this area, check this code.’ And then it gets fixed. But it shouldn’t take that much intervention to function. If it takes me that much effort to fix a mistake, how can a family ever navigate this on their own?*

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<sup>217</sup> Varon, interview.

<sup>218</sup> Melissa McChesney (Senior Policy Analyst, Health & Wellness Team, Every Texan), email message forwarded to Cheasty Anderson, October 15, 2020.

<sup>219</sup> McChesney, interview.

*And it doesn't have to be this hard. We all do typos, we all make mistakes, nobody's saying these are bad people. I'm not saying all workers commit errors, or that we have faulty systems in place, but there is a need to check for weak spots in the system. The blame always gets shifted to families in the community. They never want to take responsibility at the state level.*<sup>220</sup>

Camarena is careful to acknowledge the many times that the Agency's system works correctly, and the individual employees who work hard to track down resolutions for her. "I really do understand," she said. "The eligibility teams are overworked, turnover is high, new staff hasn't been fully trained, and there's mandatory overtime."<sup>221</sup> But at the same time, she urges, "Accountability and transparency need to be seen as a virtue, not a threat. If you made a mistake, fix it. If the database was wrong, just say, 'Hey, let me help,' and then try to fix the problem."<sup>222</sup>

HHSC's own data shows that rapid employee turnover and a high percentage of new hires is detrimental to their ability to process applications in a timely manner.<sup>223</sup> A statement published in July 2019 by the Texas State Employees Union reflected the low morale at the Agency.<sup>224</sup> Low pay and poor working conditions were the top reasons employees gave for leaving, other than retirement.<sup>225</sup> Much of this, points out Melissa McChesney of Every Texan, "is a direct consequence of years of the Texas Legislature underfunding the Health and Human Services Commission. We have a growing population in Texas, and increasing cost of living, but they haven't increased HHSC's budget sufficiently to keep pace. This results in high turnover that leads to lower productivity. It's a rotating door of eligibility workers, and many never gain enough experience and institutional knowledge to master such complicated policy."<sup>226</sup>

Low pay is a chronic problem at HHSC. As the TSEU statement said, "The current reality of Human Services Eligibility offices is thousands of hard-working men and women struggling to make ends meet, while trying to keep up with unrealistic work expectations. Workers in eligibility offices deserve a cost-of-living pay raise."<sup>227</sup> Even the State Comptroller's report confirmed this for HHSC, stating, "Eligibility workforce making less than \$40,000, regularly leave the state at a higher rate than their peers earning more."<sup>228</sup>

Working conditions are similarly problematic. The TSEU report stated that "temporary" restructuring of job duties, increased work expectations, and periods of mandatory overtime are straining morale among eligibility workers.<sup>229</sup> "With a growing state population, increased work expectations are being placed on all Texas public servants. These new demands are straining an already reduced Health and Human Services workforce and adding to turnover."<sup>230</sup>

As a result of these factors, Agency turnover was 19.3 percent in the 2018 budget year.<sup>231</sup> HHSC indicated in reports that an astonishing 48 percent of the eligibility workforce in early 2019 was in training and not capable of meeting current Human Services work demands.<sup>232</sup> In response, the Agency implemented a mandatory overtime work requirement.<sup>233</sup>

<sup>220</sup> Camarena, interview.

<sup>221</sup> Camarena interview.

<sup>222</sup> Camarena, interview.

<sup>223</sup> ["Turnover crisis leads HHSC to reinstate mandatory overtime,"](#) Texas State Employees Union, July 8, 2019.

<sup>224</sup> ["Turnover crisis."](#)

<sup>225</sup> ["Turnover crisis."](#)

<sup>226</sup> McChesney, interview.

<sup>227</sup> ["Turnover crisis."](#)

<sup>228</sup> ["Turnover crisis."](#)

<sup>229</sup> ["Turnover crisis."](#)

<sup>230</sup> ["Turnover crisis."](#)

<sup>231</sup> ["Turnover crisis."](#)

<sup>232</sup> ["Turnover crisis."](#)

<sup>233</sup> ["Turnover crisis."](#)

These working conditions, of course, had consequences for productivity. For example, there was a significant backlog and delay in processing applications for Medicaid, CHIP, and SNAP.<sup>234</sup> By February 2020 HHSC hit its low point, when only 67 percent of applications for Medicaid were processed within the federally-required 45 days.<sup>235</sup> This is well below Texas' normal "timeliness" of around 95 percent.<sup>236</sup>

McChesney said, "Chronic underfunding state agencies limits their ability to provide adequate pay and retain experienced employees, and, in turn, respond when economic conditions create increased need for public benefit programs."<sup>237</sup> Texas must invest in state agencies so that they are able to responsively and functionally address the changing demands of a state with a growing population and an alarming uninsured rate.

In addition to personnel problems at HHSC, there is also a notable problem on the Agency's [Your Texas Benefits](#) (YTB) online application.

One respondent flagged that there is a troubling element on the YTB application that scares immigrant families off of enrolling. Janie Hernandez said that when she helps families navigate their application, "On YourTexasBenefits they want to know even the parent's immigration status, their A number, [and other identifying information]. That's a huge red alert for [immigrant clients]."<sup>238</sup> Hernandez was referring to a situation where, for example, a parent fills out an application on behalf of their child. By law, HHSC is allowed to ask questions of the non-applicant (in this case, the parent) that are relevant to eligibility, such as income or address. But they are not permitted to ask questions about immigration status for that parent, because it is not pertinent to their child's eligibility.

This problem actually places HHSC out of compliance with Federal regulations issued by the Centers for Medicare and Medicaid Services (CMS). In section two of CMS's "Guidance on State Alternative Applications for Health Coverage," the regulations state that

*"States must only ask questions that are necessary for determining eligibility for coverage in a Qualified Health Plan (QHP) and all insurance affordability programs, or for the administration of these programs. Questions that are not essential to these purposes or programs cannot be required. For example, in accordance with 42 CFR 435.907, states may not request citizenship and immigration information from "non-applicants," or individuals who are identified on an application of an individual who is applying for coverage but who are themselves not applying for coverage. Requests for Social Security Numbers of non applicants must be optional."<sup>239</sup>*

**"Chronic underfunding state agencies limits their ability to provide adequate pay and retain experienced employees, and, in turn, respond when economic conditions create increased need for public benefit programs."**

<sup>234</sup> ["Turnover crisis."](#)

<sup>235</sup> McChesney, email.

<sup>236</sup> McChesney, email.

<sup>237</sup> McChesney email.

<sup>238</sup> J. Hernandez, interview.

<sup>239</sup> Gary Cohen and Cindy Mann, "[Guidance on State Alternative Applications for Health Coverage.](#)" U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information & Insurance Oversight, June 18, 2013.

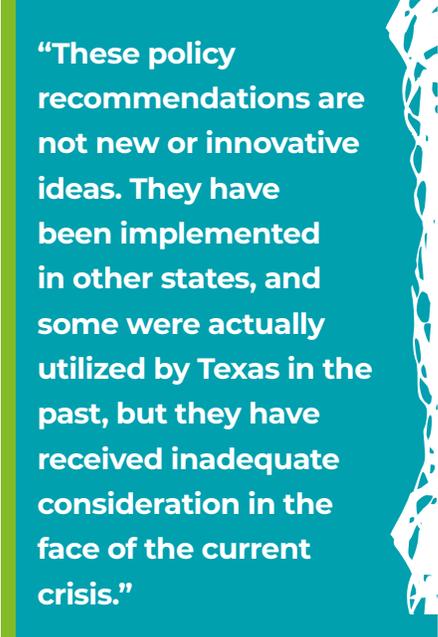
While the paper application does have language under Section U, ('legal information,') that explains data privacy laws, more than 80 percent of applicants fill out their application online. And the online YTB application, out of compliance with the regulation, does ask the non-applicant (parent) for their immigration status.

McChesney tested the application to be sure. "I started an application and went through as head of household, but not applying for myself, applying for my child. And as I went through the application, it asked me my immigration status, and my A number. I was stunned. It shouldn't ask me any of that. They also asked for my Social Security number, which they aren't supposed to ask for either, but at least they made the SSN question optional. They didn't make the same effort for immigration status."<sup>240</sup>

While immigrant families are struggling to trust agencies and organizations with personal data, HHSC must be in compliance with basic personal data privacy regulations such as these. Full transparency on data privacy protections, as well as the cessation of data collection on non-essential information of non-applicants, are necessary steps toward improving trust between immigrant communities and the Agency.

There are other well-known problems with enrollment and income verifications that HHSC has long grappled with. Recommendations from statewide coalitions like the Children's Health Care Coalition (CHCC), Cover Texas Now, and many hospital and provider groups have provided recommendations to the Agency, and lobbied for changes to Texas's Medicaid eligibility criteria.<sup>241</sup> Twelve months of continuous enrollment for Children's Medicaid (without multiple mid-year income checks), and an expanded Medicaid program for low-income adults are among the top contenders for policy changes that could meaningfully improve both Texas's abysmal uninsured rate and our poor health outcomes. Another set of improvements would simply require reverting to practices from previous years: reinstating funding for outreach and enrollment, including partnerships grants to community-based organizations to help get families enrolled; and, forming a standing advisory committee with members of community organizations and clients to review letters and other Agency communications with families to ensure clarity. Lastly, given the specific, and troubling, enrollment declines in Hispanic and mixed-status communities, the Agency needs a targeted public outreach and education plan for these populations.

These policy recommendations are not new or innovative ideas. They have been implemented in other states, and some were actually utilized by Texas in the past, but they have received inadequate consideration in the face of the current crisis. It is time for state leadership to directly address declining enrollment in the public programs that are critical to the health and wellbeing of all Texans.



**“These policy recommendations are not new or innovative ideas. They have been implemented in other states, and some were actually utilized by Texas in the past, but they have received inadequate consideration in the face of the current crisis.”**

<sup>240</sup> McChesney, interview.

<sup>241</sup> Texas Children's Health Coverage Coalition memo to Courtney N. Phillips (Executive Commissioner of the Texas Health and Human Services Commission), "Decreasing the number of Texas children eligible for Medicaid or the Children's Health Insurance Program but not enrolled," January 17, 2020; Texas Children's Health Coverage Coalition memo to Courtney N. Phillips (Executive Commissioner of the Texas Health and Human Services Commission), "Enrollment and retention of eligible children from mixed-status families in Texas Medicaid and CHIP: Recommendations, resources, and best practices to respond to the Public Charge 'chilling effect,'" January 22, 2020; ["TMA: Expand Coverage and Reform Medicaid,"](#) Texas Medical Association, updated January 6, 2020; ["State's Inaction On Coverage For The Working Poor Has Consequences For Uninsured, Taxpayers, Hospitals,"](#) Texas Hospital Association, 2020; ["Coalition Urges TX Leaders To Address Kids' Health Coverage Amid COVID-19,"](#) Cover Texas Now, May 14, 2020.



# Conclusion

**W**e are currently in the midst of a pandemic, and current enrollment trends may be different from what we experienced from 2017 through 2019. But the underlying problem, the climate of fear among too many Texans, remains. If anything, the pandemic is likely to exacerbate the health and nutrition disparities already caused by the chilling effect we have documented in this report. Until federal, state and local anti-immigrant policies change, it will continue driving families away from public benefit programs for which they are eligible.

As outlined above, this is an enormous problem for Texas. More than one in four Texas children has at least one parent who is a non-citizen.<sup>242</sup> The proportion is greater in urban areas. In Houston, for example, the number exceeds 40 percent.<sup>243</sup> While statewide, the proportional drops in enrollment for Children's Medicaid, CHIP, SNAP, and WIC ranged from seven to 19 percent, as the research above outlines, taking the average obscures the disproportionate impact on specific communities, most particularly mixed-status Hispanic communities. The data on the outer edges of the bell curve is shocking. In some low-income immigrant communities, there was a decline as high as eighty percent in enrollment for certain programs.

It would be shockingly irresponsible for our state leadership to look at this data and do nothing, and yet there continues to be inaction at the state level. It is past time for the Governor and Texas leaders to acknowledge the problem and direct the Legislature and HHSC to take action. We have known about this declining enrollment problem for years. Advocates have been pushing for action, offering proven remedies, and yet there's been no attention from state leadership. The Agency has neither been asked to produce, nor has it produced, any demographic data relevant to this challenge, nor has it been directed to act.

Without a dedicated response to address the chilling effect and to rebuild a robust community outreach and enrollment effort, negative outcomes are inevitable. We must recognize that widespread reduction in benefits enrollment has direct impacts on Texas' public health outcomes, educational attainment, and its economy. We must also take action now to rebuild trust between public programs and the communities they are supposed to serve.

This report illustrates the cause and effect of the climate of fear engendered by the Trump administration's barrage of anti-immigrant policies, including public charge. It also outlines some best practices that clinics, health insurers, food pantries, and community-based organizations can adopt to help reassure frightened families and, where possible, let them know that using public benefits or community assistance of any kind will not endanger their family. But state action is needed to confront this problem, and to implement solutions that can stave off the public health and poverty crisis that experts warn us will ensue if this trend is left unchecked. We are hopeful that this report will help generate the state-level response that this crisis demands and we stand ready to work with the state agency and our many dedicated community partners to tackle it head on.

<sup>242</sup> "Health Care Immigrant Access: Background," Every Texan, accessed September 18, 2020.

<sup>243</sup> Elizabeth Trovall, "43 Percent Of Houston-Area Children Have An Immigrant Parent," *Houston Public Media*, March 14, 2019.

## The Children's Defense Fund – Texas: Who We Are

The Children's Defense Fund (CDF) began in 1973 and is a private, nonprofit, and non-partisan child advocacy organization that has worked relentlessly for nearly 50 years to ensure a level playing field for all children.

CDF's Leave No Child Behind® mission is to ensure every child a *Healthy Start*, a *Head Start*, a *Fair Start*, a *Safe Start*, and a *Moral Start* in life and successful passage to adulthood with the help of caring families and communities.

Children's Defense Fund-Texas (CDF-Texas) began in 1999 and has offices in Houston, Austin, McAllen, and Tyler. Paying particular attention to the needs of children living in poverty, children of color, children in immigrant families and those with disabilities, we monitor state and federal policies and programs and organize public engagement to ensure that child wellbeing is a shared priority. CDF-Texas works to ensure every child a healthy start in life through access to affordable health coverage through the Children's Health Insurance Program (CHIP) and Children's Medicaid. Our Beat the Odds® scholarship program and CDF Freedom Schools® offer innovative programming and mentoring to young people in under-resourced communities. And our Youth Civic Education & Engagement initiative works to lift the youth voice in our democratic processes, with a focus on underrepresented communities of color.



## Process and Protocol of the Research and Report

- In February 2020, CDF-TX began reaching out through our networks to set up interviews with organizations that worked in a community-serving capacity. Those organizations included, but are not limited to:
  - FQHCs,
  - free and sliding-scale health clinics,
  - county hospital districts,
  - food banks,
  - enrollment assisters,
  - community relief organizations,
  - job training and placement services,
  - health insurance plans,
  - hospital leadership.
- In March, 2020, we began conducting 30 minute interviews with a standard questionnaire to guide the conversations.<sup>244</sup> Interviews were conducted, a few every week, through early October, 2020. All interviews were conducted and transcribed by Cheasty Anderson, CDF-TX's Director of Immigration Policy and Advocacy. Additional transcription support provided by CDF-TX interns Ana Ruiz and Sara Albanna.
- The report is time-limited to preclude data from the COVID-19 pandemic skewing the results: all data collection ceases at the end of February, 2020.
- This report was drafted by Cheasty Anderson. Editing support from Patrick Bresette, Laura Guerra-Cardus, Sara Albanna, Melissa McChesney, and Ronin DePrang. Citations and bibliography by Sara Albanna.

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<sup>244</sup> Questionnaire is included in the appendix.

## Research Participants

**Amanda Foust** (Client Benefits Manager, East Texas Food Bank), interview with Cheasty Anderson, May 14, 2020.

**Angela Waltman** (Vice President, Business Development and Call Center Operations, Community Health Choice), interview with Cheasty Anderson, March 20, 2020.

**Anita Gupta** (Staff Attorney, Immigrant Legal Resource Center), email message to Cheasty Anderson, September 8, 2020.

**Annali Fuentes** (Program Manager for the English At Work and Integrative Education and Training Program (IET), Literacy Coalition of Central Texas), interview with Cheasty Anderson, June 18, 2020.

**Anne Dunkelberg** (Associate Director, Program Director - Health & Wellness Team, Every Texan), email message to Cheasty Anderson, October 8, 2020.

**Anne Dunkelberg** (Associate Director, Program Director - Health & Wellness Team, Every Texan), interview with Cheasty Anderson, August 28, 2020.

**Arianna Anaya** (Program Manager for Health Coverage Program, Foundation Communities), email message to Cheasty Anderson, July 7, 2020.

**Arianna Anaya** (Program Manager for Health Coverage Program, Foundation Communities), interview with Cheasty Anderson, July 7, 2020.

**Catherine Mitchell** (COO, Community Health Choice) and Justin Yoo (Policy Director, Community Health Choice), email response to questionnaire sent to Jennifer Babcock, forwarded to Cheasty Anderson, May 5, 2020.

**Cathy Moore** (Executive Director, ECHOS), interview with Cheasty Anderson, August 15, 2020.

**Cesar Varon** (Eligibility Manager, Barrios Unidos Community Clinic), interview with Cheasty Anderson, April 15, 2020.

**Chevella Layne** (Director of Mission Services, Goodwill Industries of East Texas), interview with Cheasty Anderson, May 19, 2020.

**Ester Valladares** (Program Director, Humble Area Assistance Ministries (HAAM)), interview with Cheasty Anderson, May 27, 2020.

**Euphemia (“Pema”) Garcia** (Western Rio Grande Regional Director, Colonias Project), interview with Cheasty Anderson, June 17, 2020.

**Graciela Camarena** (Child Health Outreach Program Director, Children's Defense Fund -Texas), interview with Cheasty Anderson, July 23, 2020.

**Herlinda Ibarra** (Eligibility Manager, Certified Application Assistant, CentroMed), interview with Cheasty Anderson, April 30, 2020.

Interview with clinic staffer, Fall, 2019.

Interview with food bank employee, Spring, 2020.

**Janie Hernandez** (Outreach and Enrollment Coordinator, Amistad Community Health Care), interview with Cheasty Anderson, July 15, 2020.

**JC Dwyer** (Senior Director of Civic Engagement, Feeding Texas) and Jamie Olson (Director of Government Affairs, Feeding Texas), interview with Cheasty Anderson, April 20, 2020.

**Jennifer Babcock** (Senior Vice President of Medicaid Policy, Association for Community Affiliated Plans (ACAP)), interview with Cheasty Anderson, April 28, 2020.

**Joe Ibarra** (Census Outreach Manager, Certified Application Assistant, CentroMed), interview with Cheasty Anderson, April 30, 2020.

**Kate Lincoln-Goldfinch** (Immigration Attorney, Lincoln-Goldfinch Law), interview with Cheasty Anderson, September 2, 2020.

**Kathy Revtyak** (Director of Systems of Care, El Paso Child Guidance Center), interview with Cheasty Anderson, June 12, 2020.

**Ken Janda** (Principal, Wild Blue Health Solutions, LLC), email response to questionnaire sent to Jennifer Babcock, forwarded to Cheasty Anderson, May 5, 2020.

**King Hillier** (Vice President, Public Policy, Government Relations & Corporate Communication, Harris Health System), interview with Cheasty Anderson, August 8, 2020.

**Laura Guerra-Cardus** (Deputy Director, Children's Defense Fund - Texas), interview with Cheasty Anderson, September 2, 2020.

**Maria Hernandez** (Founder and Executive Director, VELA), interview with Cheasty Anderson, August 28, 2020.

**Marisol Resendez** (Executive Director, El Milagro Clinic), interview with Cheasty Anderson, April 17, 2020.

**Mary Carreon** (Community Health Outreach Associate, Children's Defense Fund - Texas), interview with Cheasty Anderson, July 23, 2020.

**Mary Lou Martinez** (Community Outreach and Enrollment Specialist, North Texas Area Community Health Centers), interview with Cheasty Anderson, April 16, 2020.

**Melissa McChesney** (Senior Policy Analyst, Health & Wellness Team, Every Texan), email message forwarded to Cheasty Anderson, October 15, 2020.

**Melissa McChesney** (Senior Policy Analyst, Health & Wellness Team, Every Texan), interview with Cheasty Anderson, October 20, 2020.

**Nadine Rueb** (Clinical Social Worker, VELA), interview with Cheasty Anderson, August 19, 2020.

**Natalie Wood** (Senior Vice President, Catholic Charities in Houston), interview with Cheasty Anderson, April 2, 2020.

**Rachel Cooper** (Senior Policy Analyst, Every Texan), interview with Cheasty Anderson, August 27, 2020.

**Rebecca Stocker** (Executive Director, Hope Family Health Center), interview with Cheasty Anderson, April 13, 2020.

**Sara Albert** (Independent Consultant, Dallas Coalition for Hunger Solutions), interview with Cheasty Anderson, October 16, 2020.

**Sharon Zachary** (CEO, Alliance of Community Assistance Ministries, Inc. (ACAM)), interview with Cheasty Anderson, March 18, 2020.

**Valerie Smith** (Pediatrician, St. Paul's Children's Services), interview with Cheasty Anderson, March 23, 2020.

**Yesenia Bazan** (Site Manager for Community Partner Program, San Antonio Food Bank), interview with Cheasty Anderson, October 14, 2020.



## Interview Questionnaire

1. Can you describe the services your organization provides, and your role in particular?
2. What portion of your clientele is in an immigrant or mixed-status family?
3. What changes, if any, have you noted since 2016?
  - a. Disproportionate impact?
  - b. Reductions in enrollment/service usage?
  - c. Increase in charity care program use?
  - d. Changes in clientele demographics?
4. Has there been any effect on your funding streams or mechanisms?
5. Has your organization adjusted to mitigate any trends that indicate withdrawal from public services?
6. Is your organization doing anything to inform/educate your clientele about public charge and program eligibility/use?
7. Do you have any anecdotes you can share about a family that was concerned about enrolling/re-enrolling due to immigration concerns?
8. What are some of the key best practices that have evolved for your organization?
9. What do you think the public health impact in your community will be from the data trends you are seeing unfold?
10. Can you recommend any other organizations, clinics, CBOs, or food banks in your city that you think I ought to speak with?

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# children's defense fund texas

1910 E. Martin Luther King Jr. Blvd.

Austin, Texas 78702

(512) 925-8125

[cdftexas.org](http://cdftexas.org)