



THE Children's
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NEW YORK CITY'S IMMIGRANT CHILDREN:
THE CHALLENGE OF ENSURING ACCESS TO CARE

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Although a country of immigrants, the United States [US] has an often contradictory history of providing for the inextricable health care and civil rights of immigrants.¹ Medicaid had been available to immigrants on the same basis as citizens until the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 [PRWORA], reforming the welfare program. Denying all but emergency medical assistance for five years to immigrants arriving after August 1996,² it marked a distinct and questionable change in public health policy.³ Additionally, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 [IIRIRA] heightened concerns among immigrants about the legitimate use of public benefits. As a result, low-income immigrant children may be ineligible for Medicaid or unable to access the program for other real or perceived reasons. It is however, especially pernicious to deny low-income immigrant children the advantages of a medical home necessary for full and proper physical and intellectual development.

Low-income immigrants have always encountered the same barriers to accessing health services as citizen families living in poverty. New concerns of decreased accessibility and subsequent declines in the use of prenatal care, delaying of care, lack of preventive and primary care, unattended chronic conditions and increases in communicable diseases⁴ were raised by the creation of barriers based on citizenship status rather than lawful residency.⁵ Misunderstanding of the new legal framework by immigrants and by administrative agency personnel could potentially contribute additional barriers. Studies find PRWORA has detrimentally effected health care access, but there is only rudimentary information about how that has translated into the health status of immigrant children. This brief will examine the effects of immigration policy on the entangled relationships of recent immigration, poverty, access to health care coverage and services and the health status of children in immigrant families.

Recent Immigrants and Income

New York City, has been, and continues to be the main portal to the New World. Thirty eight percent of the 8 million⁶ people living in New York City are immigrants, of whom 14 percent are estimated to reside without legal recognition.⁷ Dominicans, Mexicans, Russians, Chinese, Jamaicans, Guyanese, Trinidadians and Tobagnians , Ecuadorians, Indians, and Haitians comprise what was once called the colorful mosaic of New York City.⁸ Seventy five percent of their children are born in the United States [US-born], and therefore citizens.⁹ Of the more than 150,000 immigrants arriving in New York City each year, about half as many leave for other parts of the country,¹⁰ continually replenishing the community with recent arrivals.

Nationally, the number of foreign-born United States residents, both citizen and non-citizen, doubled during the 1990's to nearly 31 million, or 11% of the nation's population.¹¹ Immigrants have approximately the same unemployment rate as native citizens, but are much more likely to be poor,¹² predominantly employed in low paying, unskilled jobs such as agriculture or hotel and restaurant services that usually offer few benefits. Only 29 percent of employed immigrants have employer sponsored health coverage versus 59 percent of employed citizens.¹³

Twenty percent of children, or one out of five children in the United States is a child of immigrants,¹⁴ of which four out of every five are US-born.¹⁵ Immigrant families with children have lower income levels and higher hardship levels than native born families.¹⁶ One-fourth of poor children and one-third of uninsured children are born to immigrant parents,¹⁷ despite immigrants comprising only 11 percent of the population. Fifty two percent of immigrants in New York City earn below 200 percent of the federal poverty level [FPL], with the vast majority living in poverty.¹⁸ Yet immigrants living in the United States for ten or more years acculturate and have incomes that are roughly equal to those of native born citizens.¹⁹ Immigrants living in the United States longer have lower uninsurance rates than recent immigrants do, attributable to higher rates of employer sponsored health insurance. Naturalized citizens have even lower rates of uninsurance.²⁰ “Ironically, PRWORA bars lawfully present immigrant families from the federal public benefit programs, including Medicaid, during the early part of their residence in the United States when they are poorer and may be more in need of assistance, and become eligible later, when they are somewhat better off “²¹

Immigrants and Health Insurance

“Health insurance is a major determinant of access to health care for immigrants. It promotes financial access to care, connects children to a regular source of care, and enables use of services”²² But PRWORA has reduced access to health care for immigrant families. National data show that the number of non-citizen children and parents receiving Medicaid fell by 7 to 8 percentage points between 1995 and 2000. Moreover, the percentage of low-income, non-citizen children and parents who lack health insurance increased by 6 to 7 percentage points, even as uninsurance rates for native children fell.²³ While Medicaid enrollment of native children declined 2.5 percentage points between 1995 and 1999, enrollment of immigrant children declined from 37 percent to 29 percent, a difference of 8 percentage points, a decline three times greater.²⁴

By 1998, 45 percent of New York City immigrants were uninsured versus 34 percent in 1994.²⁵ Twenty eight percent of foreign-born children and 8 percent of US-born children in immigrant families are without health insurance, rates that are significantly higher than those for native children.²⁶ Seventy five percent of children in immigrant families are born in the United States.²⁷ Because PRWORA conditions eligibility for Medicaid on citizenship, rather than lawful residence, there has been an enormous growth of “mixed families” of immigrant parents with US-born children who are Medicaid eligible. The unintended consequences are more confusion about a program notorious for its complication, greater uncertainty about immigration policies, and the disruption of family centered care.²⁸

PRWORA devolves to the states responsibility for immigration policy in that it allows states to determine how to fund public benefits for immigrant groups.²⁹ New York is one of sixteen states that chose to use state funds to extend coverage for immigrant children.³⁰ An estimated 46,000 immigrant children are enrolled in the New York State Children’s Health Insurance Program [Child Health Plus B] which permits the enrollment of children regardless of immigration status.³¹ New York does not receive the Federal Medical Assistance Percentages [FMAP] funds for those children.

Effects on the Health Care Infrastructure

To the extent that the laws have led to more uninsured immigrants, the indirect effect has been to place an additional strain on safety-net institutions, jeopardizing access for all uninsured and low-income New Yorkers.³² New York City's public hospital system, the Health and Hospital Corporation [HHC], serves the lion's share of the uninsured and a large immigrant population. The New York Immigration Coalition recently examined the uninsured care being provided by those hospitals serving larger immigrant communities, as opposed to those with smaller immigrant populations. From 1995 to 1997, hospitals serving more immigrants experienced a 20.5% increase in self-pay patients, almost double an increase of 10.5% at hospitals serving smaller numbers of immigrants, and a 14.2% increase in bad debt and charity care, as opposed to a 7% increase for those serving less immigrants.³³ Services have been directly impacted. For example, hospitals reported being unable to transfer to rehabilitation clinics and nursing homes immigrants admitted using Emergency Medicaid, but who were barred from regular Medicaid. The result has been longer, and costlier inpatient stays.³⁴

Yet very few immigrants use the Emergency Room [ER],³⁵ preferring to rely on clinics or private physicians when care cannot be delayed or foregone. Immigrants avoid hospitals because of the long waiting and high costs associated with ER usage.³⁶ Although commendable from a resource utilization perspective, it more likely masks under-utilization of Emergency Medicaid, the only medical assistance available to undocumented and lawfully present immigrants who do not qualify for public benefits.³⁷

Creation and Exacerbation of Barriers to Accessing Health Care

Barriers Based on Citizenship and Immigration Status

PRWORA barred from Medicaid low-income, previously eligible legal immigrants who have not yet met the five year residency requirement necessary to become naturalized citizens. Additionally, it extended to Medicaid "sponsor deeming", which counts the income and resources of the sponsor in determining the immigrant's financial eligibility.³⁸ Moreover, state and local governments were prohibited from restricting their employees from reporting immigrants to the Immigration and Naturalization Service [INS].³⁹ Finally, the long standing "public charge" policy, permits the INS to consider whether an applicant is likely to be dependent on state support in its determinations. Thus, many immigrants, fearing INS action, were discouraged from applying for Medicaid for their eligible children or from seeking care for themselves. A California study showed that 39 percent of undocumented adult immigrants avoided seeking medical care because they were afraid of being reported to immigration officials.⁴⁰

The piling on of restrictions fueled long standing fears of the INS, or especially for refugees and asylum seekers, government in general.⁴¹ Immigrant concerns included the fear of detection and deportation; the erroneous belief that their children's use of benefits would bar them from naturalizing or adjusting their legal status; they would be unable to sponsor a

relative; or that they, or their sponsors, would have to repay the government for benefits provided.⁴² That such fears were palpable can be found in the decline of Medicaid enrollment by those immigrants, such as US-born children and refugees who remain eligible.⁴³

Barriers of Discrimination and Stigma

The prevalence of anti-immigrant sentiment added to perceived discrimination, attaching additional stigma to receiving public benefits. Discrimination is difficult to affix, yet it was frequently cited by immigrants when identifying barriers to enrolling in Medicaid.⁴⁴ As native applicants often report feeling discriminated against by agency personnel, it is conceivable that individuals with different culture, ethnicity and limited English proficiency [LEP], would prompt inappropriate behavior by agency personnel. Language, discussed below in the context of access to health services, immediately sets the immigrant apart.

Barriers to Accessing Health Services Related to Culture and Poverty

Language and health literacy is often reported as a barrier, with consequences beyond the frustration of poor communication. Ineffective communication impedes understanding eligibility criteria and enrollment, and can result in misdiagnosis, medical errors and misunderstanding of treatment regimens.⁴⁵ Relying on family or friends may be embarrassing or culturally inappropriate, prone to error, is often infeasible⁴⁶ and interferes with the development of beneficial physician-patient relationships that add to the quality of health care and successful medical outcomes. A 1999-2000 study examining immigrants' perceptions and knowledge of Medicaid found that of three questions, half of the respondents could answer one question correctly, but only 37 percent of respondents in New York City could answer all three.⁴⁷ More knowledgeable respondents were more likely to overcome perceived barriers and be Medicaid enrolled.

English is not the primary language used at home by approximately 14 percent of the national population.⁴⁸ Immigrants comprise nearly one-third of New York City public school students, and almost 200,000 are considered [LEP] and have federal and New York State entitlement to attend an English as a Second Language [ESL] program.⁴⁹ The number of US residents whose health care is jeopardized by LEP has prompted the Office of Civil Rights [OCR], Health and Human Services [HHS] to require translation services under Title VI of the Civil Rights Act of 1964.⁵⁰ The Office of Minority Health [OMH], HHS, has followed suit and issued standards for culturally and linguistically appropriate services in health care.⁵¹ Although federal policy allows for the use of Medicaid and SCHIP funds to pay for oral or written translation administrative services, compliance is costly and it is unclear how states utilize this option.⁵²

Resources rooted in the culture of the immigrant's homeland are often the only source of care, although their efficacy and cost-savings are questionable. Uninsured immigrants often rely on pharmaceuticals sold over the counter in their homeland, which are sold at local markets or dispensed in underground networks of clinics. Traditional folk medicines and herbal remedies are more familiar to immigrants and fill a gap in access to western medicines. Yet immigrants who seek alternative care risk substandard care, inappropriate or

ineffective medication, negative interactions with western medicine, and the consequences of untreated and delayed care.⁵³ Clinics that cater to immigrant cultures may be staffed by foreign-born physicians, who may or may not be US licensed. Adverse treatment outcomes recently prompted an investigation into the clinics flourishing in New York City's Chinese community, bringing to light not only the prevalence and practices of the clinics, but the circumstances that promote their use.⁵⁴

Issues relating to the navigation of a managed care system, transportation, and getting time off from work are common to all Medicaid beneficiaries, but may be more pronounced for immigrants struggling with language and literacy problems, lack of familiarity with the concept of health insurance, and living in a "foreign" country.⁵⁵ Yet, despite fear, confusion, and discrimination, immigrants will use benefit programs when necessary,⁵⁶ and are less likely to be discouraged from applying for Medicaid and SCHIP, or seeking medical care, when it is for their children.⁵⁷ Mandatory school requirements may partially reinforce the focus on seeking care for children.⁵⁸

Health Status and Risk Factors for Immigrant Children

National Health Interview Survey (NHIS) data consistently found adult immigrants to be in better health than socio-demographically similar U.S. citizens, although their health deteriorates over time with residency in the United States.⁵⁹ For example, the incidence of elevated blood lead levels among recently arrived refugee children is double that of children born in the United States. Yet a significant number of those conditions were acquired after arriving in the United States.⁶⁰ Immigrants report, however, somewhat poorer health than native families, although cultural differences in perception and reporting may be partially accountable.⁶¹ Sixty five percent of immigrant parents in New York City reported their children to be in excellent or good health, as compared to 77% of reports by native parents.

Although immigrant parents have shown a profound willingness to ensure their children receive health care, it remains clear that the consequence of real and perceived barriers, is that much needed care goes untended. Despite being at-risk, low-income immigrant children do not have access to the health care resources of the medical home, promulgated by the American Academy of Pediatrics [AAP]. They miss out on the primary and preventive care that is the intention of Medicaid's Early and Periodic, Screening, Diagnostic and Treatment [EPSDT] program for low-income children who are at greater risk for developmental delays and adverse health conditions. Additionally, they miss out on the comprehensive, longitudinal care that should be continued following initial health screenings.

While 92 percent of native children have a regular source of care, only 66 percent of foreign-born children of the working poor have a regular source of care, and are less likely to receive care at a physician's office.⁶² Citizen children have an average of 3.7 medical visits per year, compared with 1.5 for non-citizen children.⁶³ Less than full health coverage for immigrant children undermines public health efforts to screen children at highest risk for the illnesses and diseases that disproportionately effect low-income populations, including pediatric tuberculosis.⁶⁴

Foreign-born Children

Children, including international adoptions, frequently arrive without medical records or informed adults. Additionally, U S trained pediatricians may be inexperienced in diagnosing or treating the health problems of foreign-born children. Conditions could include malaria, amebiasis, helminthic and other parasitic infections, congenital syphilis for which foreign-born children are not screened at birth, hepatitis A and B, and tuberculosis.⁶⁵ Although the rate of tuberculosis for citizens has significantly declined during the period 1990 – 1998, the rate for tuberculosis among the foreign-born has increased slightly. As a result, the rate of tuberculosis among the foreign-born rose from half that of native born, to more than twice that of native born.⁶⁶ In New York City, immigrants account for more than 50 percent of new tuberculosis cases, primarily affecting the Chinese, Haitian, Dominican and Ecuadorian communities.⁶⁷

Many foreign-born children are under-immunized.⁶⁸ Chart review of 1,389 refugee children who came to Minnesota in 1998 revealed nearly 82% lacked documentation of up-to-date immunization status. Children born in sub-Saharan Africa had the lowest rate of documented immunization.⁶⁹ Additionally, the stress of immigration and separation from familiarity, or the traumatic experiences behind those seeking refuge, may precipitate mental health problems.⁷⁰

Risk Factors for Children in Immigrant Families

Any child without access to a pediatric medical home is at risk for less than full development and health. Yet children born in the United States to immigrant families are at risk for the illnesses that disproportionately affect low-income children and the diverse racial and ethnic populations of which they are members. Disparities in minority health have long been recognized but remain largely unaddressed. A Commonwealth Fund report assessing the health care quality for minority Americans documents on a wide range of quality measures, African Americans, Asian Americans, and Hispanics fare worse than whites.⁷¹ Hispanics and Asian Americans frequently stand out as the least well-served by the health care system. To understand the relationship to immigration, it is notable that one third of all Hispanics in the United States and two thirds of Asians are foreign-born.⁷²

Among the public benefits for which immigrants became ineligible are food stamps. Although many states have elected to provide food stamps for families with US-born children, the benefit is reduced, and, the same barriers to participation in Medicaid dissuade immigrant families from applying.⁷³ Food insecurity and hunger in immigrant communities are well documented; thirty seven percent of all children of immigrants live in families that have worried about or encountered difficulties affording food, compared with 27 percent of native families.⁷⁴ Without proper nutrition the health of children in immigrant families will inevitably be compromised.

The implications for infants born to malnourished immigrant women are obvious, including low-birth weight and its sequelae. Late or no prenatal care compounds the risk. Obesity and impaired glucose tolerance are two to four times higher among Mexican-American women

than white non-Hispanic women, which also increases the risk of low birth weight births.⁷⁵ In New York State, the Prenatal Care Assistance Program [PCAP] provides prenatal care to all low-income pregnant women, regardless of immigration status. Yet despite the availability of medical care, the communities of Bedford-Styvesant and Brownsville where 42 percent of the women are foreign-born, have among the highest infant mortality rates in the country.⁷⁶ Missing are the supportive services of the full Medicaid benefit package.

Recommendations

It is clearly necessary for both the public health and the public welfare, that immigrant children receive the medical and health services attention necessary for them to make a full contribution to their, or their parents' adoptive country. While the US has learned to value its racial, ethnic and cultural diversity, it has yet to provide equity in accessing health care for children in immigrant families. Our children must have the means to take their rightful place in the global community. No matter where a child calls home, they must have a medical home. Toward that objective, the CHF makes the following recommendations:

1. Congress will reauthorize the Temporary Assistance to Needy Families [TANF] program during the current session. There are indications that passage of the Immigrant Childrens Health Improvement Act [ICHIA], which would restore benefits for immigrant children may be enacted. Evidence shows that providing coverage for parents increases participation rates for children. CHF believes that healthy children deserve and require healthy parents, and urges Congress and the President to act responsibly.
2. The events of 9/11, the economic recession and strain on state funding for Medicaid programs and the so-called SCHIP dip could have devastating effects on the ability of states that use state funds to provide coverage for immigrant children to sustain those programs. CHF believes government must step up to the plate and ensure continuation of coverage for children receiving medical assistance through endangered state funded programs or support Medicaid viability through other means.
3. There is sufficient research documenting that PRWORA has led to significantly decreased access to care. But the real short term and long term effects on the health status of children in immigrant families is yet to be studied. CHF recommends the various public and private resources dedicated to tracking the health of Americans begin comprehensive data collection and monitoring of the health status and gaps in health care services for immigrant children.
4. Immigrants without access to health insurance access the ER only as a last resort when unmet health needs become severe and require inpatient care. Yet it is too time consuming and costly for hospitals to assist with Emergency Medicaid applications on behalf of patients released without an inpatient admission.⁷⁷ CHF recommends States do more to facilitate awareness of Emergency Medicaid especially among communities of undocumented immigrants, and make it easier for immigrants to access Emergency Medicaid for health issues before they become life threatening.

5. Significant numbers of immigrant children live in linguistically isolated families in which no one over the age of 14 can communicate effectively in English. Children whose parents are unable to communicate with medical and health care providers will not benefit fully from their services. CHF recommends increased use of funds available for translation services and the replication of successful interpretation models. Additionally, CHF recommends simplification of the Medicaid and SCHIP application and supports availability of pertinent printed materials in appropriate languages and literacy levels.
6. Recently arrived immigrants are often isolated in their community, not aware of community resources and without the know how to access them. CHF recommends increased outreach to immigrant communities regarding availability of Medicaid and SCHIP for children, the benefits of preventive care, and availability of prenatal care for pregnant women.
7. Immigrants place great trust in community-based organizations and rely on them and safety-net providers for information and assistance in seeking services and benefits.⁷⁸ It has been shown that localities with vocal advocacy communities are better able to better overcome perceptions of discrimination and misconstrued fears of government reprisals, thus increasing enrollment in public programs.⁷⁹ CHF supports enlisting community-based providers and organizations for outreach, to foster health empowerment and increase knowledge of health systems navigation. Additionally, CFH supports an enhanced role for community-based organizations in public benefits eligibility determinations and enrollment.

¹ For purposes of this report, an immigrant is anyone entering to reside in the United States, without regard to legal status. Most immigrants seek entry for family reunification purposes; refugee refers specifically to those seeking entry for humanitarian reasons. Other children arrive as international adoptions.

² Certain other groups of immigrants previously eligible for Medicaid were also denied eligibility.

³ The Balanced Budget Act of 1997 created the State Children's Health Insurance Program extending the ban on use of federal funds for immigrants.

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⁵ Fremstad, S. (2002). "Immigrants and Welfare Reauthorization." Washington, DC: Center on Budget and Policy Priorities, 1.

⁶ Perry, M. and Mackun, P. (2001). "Population Change and Distribution." US Census Bureau, 7.

⁷ New York Academy of Medicine. New York Forum of Child Health, <http://www.nyam.org/divisions/healthscience/childhealth/projects.shtml>. on May 14,2002.

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¹⁰ New York Immigration Coalition. (2000). "Welfare Reform and Health Care: The Wrong Prescription for Immigrants." New York: 7.

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¹² 'Immigrants' Health Care: Coverage and Access." (2000). Washington DC: The Kaiser Commission on Medicaid and the Uninsured. internet

¹³ New York Immigration Coalition, at 13.

¹⁴ Maloy, at 6.

¹⁵ Ku, L. and Matani, S. (2001). "Left Out: Immigrants' Access to Health Care and Insurance," Health Affairs, 20(1): 248.

¹⁶ Fremstad, at 1.

¹⁷ Center on Budget and Policy Priorities analysis of US Census Bureau data

¹⁸ Capps, R, Ku, L. and Fix,M. (2002). "How are Immigrants Faring After Welfare Reform? Preliminary Evidence from Los Angeles and New York City." Washington, DC: The Urban Institute, 18.

¹⁹ Holahan, J, Ku, L. and Pohl, M. (2002). "Is Immigration Responsible for the Growth in the Number of the Uninsured?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 6.

²⁰ Ibid. at 5

²¹ Capps, Ku and Fix, at 20.

²² Guendelman, S., Schaufler, H. and Pearl, M. (2001). "Unfriendly Shores: How Immigrant Children Fare in the US Health System," Health Affairs, 20(1): 257.

²³ Fremstad at 9.

²⁴ Ku, L and Blaney, S. (2000). "Health Coverage for Legal Immigrant Children: New Census Data Highlight Importance of Restoring Medicaid and SCHIP Coverage." Washington, DC: Center on Budget and Policy Priorities, 1.

²⁵ New York Immigration Coalition, at 14.

²⁶ Capps, Ku and Fix, at v.

²⁷ New York Academy of Medicine.

²⁸ Morse, A. "SCHIP and Access for Children in Immigrant Families." National Conference of State Legislatures. http://www.ask.com/main/metaanswer.asp?metaEngine=directhit&origin=7039&MetaURL=http%3A%2F%2Fask%2Edirecthit%2Ecom%2Fcgi%2Dbin%2FRedirectURL%2Efcg%3Furl%3Dhttp%3A%2F%2Fwww%2Encsl%2Eorg%2F%26qry%3Dnational%2Bconference%2Bof%2Bstate%2Blegislatures%26mk%3D1%26src%3DDH%5Fask%5FSRCH&qCategory=gov_&metaTopic=National+Conference+of+State+Legislatures&ItemOrdinal=0&logOID=8826EC4FE4E0C14AACC5928918299CEE.

²⁹ Maloy, at I.

³⁰ Morse.

³¹ New York Immigration Coalition, at 2.

³² Maloy, at iii.

³³ New York Immigration Coalition, at 29.

³⁴ ibid. at vi.

³⁵ Ku and Matani, at 250.

³⁶ Feld and Power, at iii.

³⁷ Ku and Matani, at 254.

³⁸ Bachrach, D. Lipson, K. and Tassi, A. (2001). "Expanding Access to Health Insurance Coverage for Low-Income Immigrants in New York State." New York: The Commonwealth Fund, 15.

³⁹ Fremstad, at 4.

⁴⁰ Berk and Schur. (2001). "The Effect Of Fear On Access To Care Among Undocumented Latino Immigrants." Journal of Immigrant Health, 3:151-156.

⁴¹ Ku and Freilich, at 13.

⁴² Bachrach, Lipson and Tassi, at 11; Fremstad, at 5 and 15.

⁴³ New York Immigration Coalition, at 12.

⁴⁴ Feld and Power, at 8; Ku and Freilich, at 8.

⁴⁵ Ku and Freilich, at 12.

⁴⁶ Ibid. at 14.

⁴⁷ Fremstad, at 16.

⁴⁸ Morse.

⁴⁹ Rivera-Batiz. "The Education of Immigrant Children in New York City." ERIC Digest #117. Internet.

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⁵³ Ibid. at 15.

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⁵⁷ Maloy, at ii.

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⁶¹ Capps, Ku and Fix, at v.

⁶² Guendelman, Schauffler and Pearl, at 261.

⁶³ Ku and Matani, at 251.

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⁶⁶ Bachrach, Lipson, and Tassi, at 11.

⁶⁷ Center for Immigrant Health, New York University School of Health. <http://www.med.nyu.edu/cih/tb/index.html>, May, 14, 2002.

⁶⁸ American Academy of Pediatrics.

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⁷⁰ American Academy of Pediatrics.

⁷¹ Collins, K, et al. (2002). “Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans.” New York: The Commonwealth Fund, v.

⁷² Ku and Matanai, at 247.

⁷³ American Public Human Services Association. “Immigrant Provisions in Welfare Reform, Title IV.” Internet.

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⁷⁸ Maloy, at 9.

⁷⁹ Ibid. at 25