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The Impact of the Affordable Care Act on the Safety-Net. A Focus on Two Community-based Clinics Serving Latin@ Immigrants in the Greater New Orleans Region

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The Impact of the Affordable Care Act on the Safety-Net
A Focus on Two Community-based Clinics Serving Latin@ Immigrants
in the Greater New Orleans Region

A Thesis

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University of New Orleans
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By

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B.A. University of Southern Mississippi, 2006

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Abstract

Latin@ immigrants face many obstacles to affordable healthcare that push them to disproportionately rely on the primary safety-net for their healthcare needs. This system is mostly funded with public monies that will be significantly reduced when Affordable Care Act is fully implemented. Since undocumented Latin@ immigrants are prohibited from accessing publicly funded healthcare, this thesis examines two community-based clinics in the Greater New Orleans area that serve this population, and have developed linguistically and culturally appropriate programs that address its needs. The New Orleans Faith Health Alliance and Common-Ground Health Clinic are cases used to explore the impact that the Affordable Care Act will have in the already unstable safety-net in New Orleans. Also, through the analysis of other models around the nation that deliver affordable healthcare services to undocumented immigrants, this thesis presents viable recommendations to both clinics and the City of New Orleans Health Department.

Healthcare for Latino Immigrants, the Affordable Care Act, Healthcare Coverage for Undocumented Immigrants, Primary Safety-Net

Introduction

Access to primary health care services by Latin@¹ immigrants in the New Orleans metropolitan area is limited as this underserved population faces many barriers and systemic obstacles. The availability and quality of services depends on the individual's immigration status, English proficiency, access to transportation, place of residency, and socioeconomic background. Federal, state, and local policies on access to publicly funded health care also play a major role on the marginalization of this group, forcing most Latin@s immigrants to disproportionately rely on safety-net providers for their primary health care needs. The full implementation of the Affordable Care Act will make it more difficult for the primary safety-net to financially maintain its services, forcing many community-based clinics to become more self-sustainable and less dependent on public funds. Federal funds have been used to offset the cost of serving Latin@ immigrants who are barred from accessing federally funded programs.

This thesis examines two community based-clinics that serve Latin@ immigrants, regardless of their immigration status, and have developed linguistically and culturally appropriate programs that target this population. They are the New Orleans Faith Health Alliance (NOFHA), located in Mid-City; and Common-Ground Health Clinic on the area known as the Westbank of New Orleans. This thesis also examines other

¹ "For many years Latin American feminists and advocates have used the @ sign as a means to address gender-specific nouns in the Spanish language and to promote gender inclusion" (Arte Sana, 2011:1)

models around the nation that deliver affordable health care services to undocumented immigrants, in order to provide insight on how they operate, and present viable recommendations to local service providers and the City of New Orleans Health Department.

As the new health care law, the Patient Protection and Affordable Care Act, also known as the Affordable Care Act (ACA), goes into effect some questions need to be answered regarding the impact that this law will have on the already unstable primary safety-net providing healthcare to Latin@ immigrants, undocumented and legally present, in the Greater New Orleans area. The primary research questions are: How can community-based clinics serving the uninsured continue to provide these services to undocumented Latin@ immigrants when the Affordable Care Act is fully implemented in 2014? What role the City of New Orleans Health Department can play to enhance the sustainability of primary care safety net in the Greater New Orleans region?

Latin@ Immigrants in New Orleans

The Latin@ population is a diverse ethnic group that encompasses individuals with roots in any of the twenty three Latin American countries that share a common history of colonization and resistance, and similar cultural characteristics. Latin@s can be of any race, religion, political affiliation, and linguistic background. But in the United States,

they are often perceived as a heterogeneous group composed of mainly undocumented immigrants. The anti-immigrant sentiment is growing in this nation of immigrants. The assumption is that all Latin@s lack immigration legal status, and they are the cause of all problems. The reality is more complex, undocumented immigrants are those who entered the country without authorization, have overstayed their visas, or have violated the terms of their admission into the U.S., and therefore are ineligible to adjust their immigration legal status under the current legal system.

Historically, immigration policies have shaped this nation by excluding and including certain groups of people. Today, these policies restrict entry to the United States to individuals coming from Latin America, Africa, Eastern Europe and most of Asia. Fussell (2011) and Bauer (2009) argue that immigration policies have failed to respond to the needs of this nation making it virtually impossible for many immigrants to obtain legal status, thus pushing millions of people into the shadows. A comprehensive immigration reform coupled with strict enforcement of labor and civil rights protections is needed to make our communities safer, as well as improve the wages and working conditions of all workers. The U.S. Department of Homeland Security (Hoefer, Rytina and Baker 2011) estimates that 77% of the 11.5 million undocumented immigrants residing in the United States as of January 2011 were from North America, including

Canada, Mexico, the Caribbean, and Central America; the next largest regions of origin are Asia with 1.3 million, and South America with 0.8 million.

In contrast, the legally present immigrant population is composed of lawful permanent residents; individuals granted asylum; admitted as refugees; or admitted as non-immigrants for a temporary stay in the U.S., such as students and temporary workers, whose permission has not yet expired. The Pew Hispanic Research Center estimates that there are 40 million immigrants residing in the United States, representing 13% of the total population; out of which 28% are undocumented. This modern wave of immigration began with the passage of the Immigration and Nationality Act of 1965, and has been dominated by arrivals from Latin America and Asia.

While other southern states experienced a dramatic increase in their foreign-born population between 2000 and 2005, Louisiana's foreign-born only increased by 6% due to its stagnant economy. Since hurricane Katrina hit the Gulf Coast, Louisiana has joined the list of new migrant destinations. As reconstruction jobs became available, immigrants and native-born workers from other states came to the Gulf Coast looking for work. By August of 2006, the Latin@ population in Orleans and Jefferson parishes was 9.6 and 9.7 percent respectively, a significant increase from the 3.1 and 8.1 percent

in 2005. But these percentages likely underestimate the true population since the data about countries of origin and date of arrival to New Orleans do not exist (Fusell 2010).

The Latin@ population in the Greater New Orleans region expanded rapidly after hurricane Katrina. According to the Greater New Orleans Community Data Center, this population increased by 57% from 2000 to 2010 (Plyer 2011). Still, Latin@s remain somewhat invisible to local government and health care providers, and a variety of issues, such as racial prejudices and lack of language access, make Latin@ immigrants more vulnerable to exclusion and exploitation. In the New Orleans metropolitan area², the pre-Katrina Latin@ community was more likely to be Cuban, Honduran, or of Spanish descent. From 2000 to 2010, the Latin@ population grew by 123% in the parishes of St. Charles, St. John, St. Tammany, and Jefferson. During the same time period, the total number of Latin@s began to grow in Orleans and Plaquemines parishes, reversing the decreasing trend experienced from 1980 to 2000. Currently, as shown on Table 1, the majority of Latin@s reside in Jefferson parish, 19% of whom are Mexican, 7% are Cuban, 5% are Puerto Rican, and 69% are “other”. Orleans parish has the second largest number of Latin@s, 24% of whom are Mexican, 7% are Cuban, 5% are Puerto Rican, and 64% are “other”, many of whom may be Honduran (Plyer 2011).

² The New Orleans Metropolitan area (also known as the New Orleans-Metairie-Kenner, LA Metro area) is defined by the U.S. Census Bureau as the area comprised of Jefferson, Orleans, Plaquemines, St. Bernard, St. Charles, St. John the Baptist, and St. Tammany Parishes in Louisiana (U.S. Census Bureau, 2007).

Table 1: Latin@ Population by County of Origin, Jefferson and Orleans parishes. 2010

Country of Origin	Foreign Born Population in Jefferson Parish	Foreign Born Population in Orleans Paris
Mexico	19%	24%
Cuba	7%	7%
Puerto Rico	5%	5%
Other	69%	64%

Source: Table created by author using data from GNODCD Analysis of Data from US Census Bureau (Plyer, 2011).

Since Latin@s represent the majority of the undocumented population, it's commonly assumed that they all are undocumented. The Pew Hispanic Research Center estimates that in the state of Louisiana the undocumented immigrant population tripled from 20,000 in the year 2000 to 65,000 in 2010. About one-quarter of all adult Latin@s are undocumented nationwide (Livingston, 2009; Passel and Cohn, 2011). In Post-Katrina New Orleans, the group of newly arrived Latin@s lacked indigenous, communal infrastructures and support networks upon which immigrants have relied in other locations, and these deficiencies contribute to the lack of economic mobility of immigrants in the South, compared to their counterparts in other more traditional settlement areas (Bickman 2010).

Latin@ Immigrants and Access to Health Care in New Orleans

Immigrants' access to health care has been the topic of many scholarly research projects. Several studies have shown that immigrants, specially the undocumented population, use less health care than U.S. citizens. Mohanty, Woolhandler, Himmelstein, Patu, Carrasquillo, and Bor (2005) found that the per capita total health care expenditures of immigrants were 55% lower than those US born individuals; the expenditures for uninsured and publicly insured immigrants were about half those of US born persons; and immigrant children had 74% lower per capita health care expenses than US born children. They also found that immigrants use the emergency department more than their US born counterparts, which can be explained by their lack of access to preventive care and by the restrictions imposed on legal immigrants by the 1996 welfare reform legislation. This federal policy restricted access to publicly funded health care by legal permanent residents during the first five years of their residency. Similarly, other researchers have found that contrary to the popular belief, the overwhelming majority of undocumented Latino immigrants do not come to this country to obtain government funded health care services, instead they come looking for work and they use disproportionately fewer medical services and contribute less to health care costs in relation to their population share (Berk, Schur, Chavez and Frankel, 2000; Ku and Matani, 2001; Goldmand, Smith and Sood, 2006).

Historically, the southern region of the United States has been characterized by a poor health status, and unfavorable ratings on most health and illness indicators. According to Sperling's Best Places index, which ranks the health status of the largest U.S. cities based on five different dimensions, New Orleans and San Antonio are the least healthy of all southern cities. Although the poor health status of southern cities is commonly assumed to be correlated with concentrations of low-income minority populations, epidemiologists argue that it is the socioeconomic status, instead of race or ethnicity, the underlying contributor (Thomas, 2010).

Hilfinger and Lacy (2007) have estimated that 300,000 Latin@s living in the Deep South (Alabama, Mississippi and Louisiana) were affected by hurricane Katrina and that health concerns played a major role on whether or not people decided to stay, evacuate, or return home after the hurricane. These authors and other researchers have found that in New Orleans, lack of access to health care coupled with being uninsured, language and cultural barriers, and immigration status, placed this population at higher risk and made them more vulnerable to environmental hazards. Undocumented immigrants were at higher risk since they do not qualify for most types of emergency federal assistance (Hilfinger and Lacy, 2007; Behrhorst, 2009).

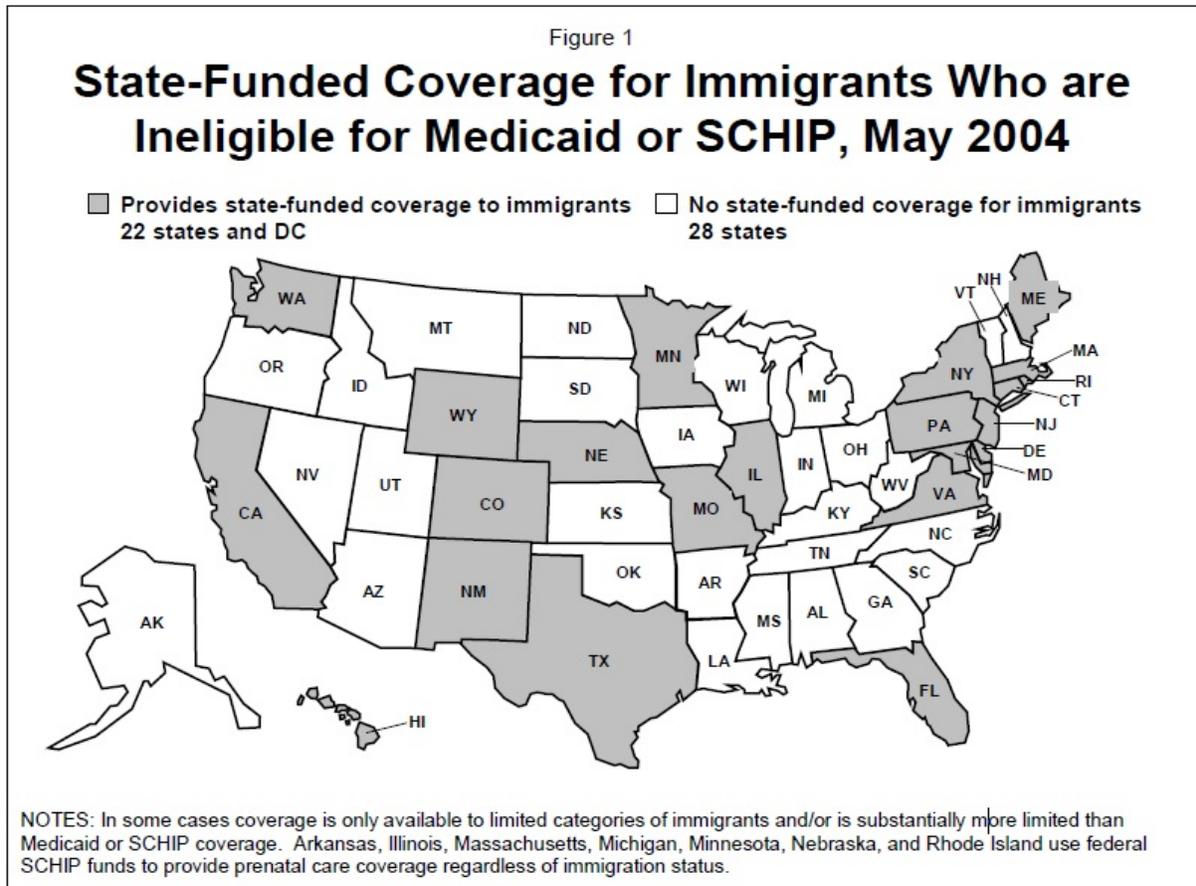
A survey of Latin@ residents conducted in New Orleans in 2012 found that 58% of the respondents stated that healthcare was one of the primary issues that they were concerned about, ranking third among a list of concerns, with immigration in the first place (79%), and education in the second (67%). More than a third (38%) of the participants stated that they would like to have better access to healthcare (Puentes New Orleans and The Committee for a Better New Orleans, 2012).

The barriers or obstacles to health care experienced by Latin@ immigrants in New Orleans parallel those found in other immigrant communities around the nation. Derose, Escarce and Lurie (2007) found that many factors impact immigrants' vulnerability to inadequate health care, such as socioeconomic background; immigration status; language barriers; residential location; federal, state, and local policies on access to publicly funded health care; and stigma and marginalization. They also found that immigrants have lower rates of health insurance, use less health care, and receive lower quality of care compared to US born populations, but there are differences among undocumented, legal immigrants and naturalized US citizens. David and Rhee (1998) argued that language barrier correlated negatively with patient satisfaction and quality of care. Ku (2006) indicated that immigrants face serious barriers to health care because almost half of this population is uninsured, which is three times higher than US born people.

Most of the scholarly literature on immigrants' access to health care focuses on how the immigrant provisions of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), known as the Welfare Reform Act, restricted immigrants access to publicly funded health care services. This law made most legally present immigrants ineligible for federally funded health care services such as Medicaid and SCHIP (State Children's Health Insurance Program) for the first five years of legal residence.

Although PRWORA altered legal immigrants' access to public health insurance by denying immigrants who arrived in the U.S. after August 1996 Medicaid coverage for all but emergency care in the first five years of their residency, Figure 1 shows the twenty two states that have created substitute Medicaid programs for newly arrived legal immigrants using state funds (Fremstad and Cox, 2004; Kaushal and Kaestner, 2005; Muñiz, 2006; Derose, Escarse and Lurie, 2007; Broder and Blazer, 2011; National Immigration Law Center, 2013). However, even in states that have preserved eligibility for permanent residents before the 5 year bar, "PRWORA seems to have diminished immigrants' enrollment in safety-net programs, which suggests confusion, fear, and a 'chilling effect' whereby even eligible immigrants are discouraged from applying for or using publicly funded health coverage or services" (Derose, 2007: 1,264).

The Patient Protection and Affordable Care Act, also known as the healthcare reform bill or The Affordable Care Act (ACA), will allow for legal immigrants, who do not qualify for Medicaid or SCHIP due to the welfare reform restrictions, to purchase their own private medical insurance and to receive federal subsidies to off-set the cost (if their employer does not provide them with affordable health insurance) through the new health insurance marketplace that was launched on October 1, 2013. But undocumented immigrants will be disproportionately impacted by this policy because they will not be allowed to participate in the exchange market, thus they will be forced to continue to be uninsured and they will have to pay a tax penalty for doing so, unless they self-report their immigration status on their tax forms. Also, Tunzi (2012) raised concerns about the rigorous identification requirements and changes to federal funding for community health clinics serving the uninsured as the Affordable Care Act assumes that most people will be insured, thus it will significantly reduce federal reimbursement for clinics serving the uninsured.



Source: *Covering New Americans: A Review of Federal and State Policies Related to Immigrants' Eligibility and Access to Publicly Funded Health Insurance*. Shawn Fremstad and Laura Cox. 2004. Center on Budget and Policy Priorities. Kaiser Commission on Medicaid and the Uninsured.

The majority of the undocumented immigrant population is concentrated in four states: California, New York, Texas and Florida (Pew Hispanic Research Center, 2013). All four have chosen to utilize state funds to provide Medicaid coverage to legal immigrants restricted to access federally funded programs during the first five years of their residency in the United States. But when it comes to providing coverage for the undocumented, only California has created a restricted Medi-Cal program, while the

other three do not offer state level coverage to this population (National Immigration Law Center, 2012).

Louisiana is one of the twenty eight states that do not offer state-funded healthcare coverage for immigrants, forcing them to rely on the primary safety-net for their unmet needs. But this system is unstable and heavily reliant on public funds, especially for the care of uninsured residents, thus the City of New Orleans Health Department has published a report with policy recommendations to enhance the sustainability of primary care safety-net in the Greater New Orleans region, in anticipation of the full-implementation of the Affordable Care Act and its expected impact on the funding structure of the safety-net. The report is an action plan with specific recommendations, for which it presents an analysis of currently operating model systems across the country, looking at seventeen cases that have the common goal of serving the uninsured. The scope of service the systems provide varies, some programs are statewide, but the majority is organized at the city or county levels. Also, the mechanisms for funding vary significantly, thus the authors present a typology based on the funding structure of the models that is summarized on Table 2 (The City of New Orleans Health Department, 2012). This thesis uses the typology developed by the Health Department to categorize the funding structure and eligibility requirements of selected health care providers in New Orleans.

Table 2: Types of Community-based Health Centers

Model Type	Funding Sources	Eligibility Requirements
Multi-Share Programs (Shared Responsibility Model)	Premium payments paid by members on sliding scale, and contributions from other sources include employers, providers, state and federal government, and the county or city.	Individuals who are not eligible for Medicare or Medicaid, and cannot afford to purchase private insurance. Income limits range between 100% and 500% of the Federal Poverty Line. Most programs enroll only U.S. citizens and request that applicants have an eligible immigration status, some enroll people regardless of their immigration status.
Subsidized Access Programs	Designated federal, state, and city funds accompanied by philanthropic grants, and donated care from hospitals and physicians.	
Dedicated Tax Programs	Levied city or county taxes for the specific purpose of providing health care for the poor.	
Hospital System Models	Federal and state funding grants to a centralized hospital system that provides care through the hospital and its affiliated community centers.	
Financial Assistance Programs	Members pay for services in a monthly basis based on an income-adjusted sliding scale. State, county or federal funds are used to pay costs not covered by the members.	
Subsidized Insurance Plans	Federal, state and city funds are used to buy private insurance plans	

	for the uninsured.	
1115 Demonstration Projects	Medicaid fund to expand coverage for the uninsured.	
Donated Care Programs	Donated services by hospitals and physicians.	
Hospital Funded Models	Funds from local hospitals to decrease the cost of avoidable uncompensated hospitalizations in the future.	

Source: Table created by author from report by the City of New Orleans Health Department. 2012. *Greater New Orleans Primary Safety Net Access Plan*.

State Level Healthcare Coverage for Undocumented Immigrants

This section reviews what other states are doing to fill in the gap created by federal policies in order to provide affordable health care services to immigrants. Due to the restrictions imposed by the welfare reform of 1996, federally funded medical assistance programs like Medicaid and CHIP are only available to eligible “qualified” immigrants who came into the U.S. before August 22, 1996, and have maintained permanent legal residency for at least five years. “Qualified” immigrants are those who have legal status, there are several categories such as individuals who are admitted to the U.S. as refugees, people who have been granted asylum, parole, conditional residency, permanent residency, etc.

The National Immigration Law Center and the Urban Institute have conducted national reviews of the types of medical assistance program that each state provides to qualified and undocumented immigrants, focusing on their funding structures and eligibility

requirements (National Immigration Law Center, 2013; Fortuny and Chaudry, 2011).

These reports found that the majority of states that offer some form of coverage to low-income immigrants restricts it to qualified immigrants. Although twenty two states have chosen to use state funds to serve those qualified immigrants who do not meet the five year residency requirement to benefit from federal funded healthcare services (see Figure 1), only the District of Columbia and three states have chosen to use state funds to provide some form of coverage to undocumented immigrants (Table 3). This population is defined as permanently residing under the color of law, known as PRUCOLs, which is “not an immigration status, but a benefit eligibility category. The term generally means that immigration authorities are aware of the person’s presence but have no plans to deport/remove him or her from the country” (National Immigration Law Center 2012:4).

Table 3: States Providing Healthcare Coverage to Undocumented Immigrants

Type	State	Eligibility Requirements
Dedicated Tax Program	California	Low-income PRUCOLs earning up to 185% of the FPL, regardless of their immigration status, may be eligible for restricted Medi-Cal.
Subsidized Insurance Plan	District of Columbia	Adults and children, regardless of immigration status may be eligible for the DC Health Care Alliance, and the Immigrant’s Children Program respectively, as long as their household income does not exceed 200% of the FPL.

Dedicated Tax Program	Massachusetts	Certain PRUCOL seniors and persons with disabilities earning up to 100% of the FPL. All children, regardless of immigration status or income, are eligible for the Children’s Medical Security Plan.
Dedicated Tax Program	Washington	PRUCOLs who are blind or disabled can qualified for a limited medical care services program. Children, regardless of their immigration status, may qualify for the Children’ Healthcare Program if their household income is below 200% of the FPL.

Source: Table created by author using data from: National Immigration Law Center. 2012. *Medical Assistance Programs for Immigrants in Various States*. Fortuny, Karina and Ajay Chaudry. 2011. *A Comprehensive Review of Immigrant Access to Health and Human Services*. Urban Institute

Based on the typology developed by the City of New Orleans Health Department, each state program is assigned a model type according to its funding structure, which shows that three out of four follow the dedicated tax program model but using state funds instead of city or county taxes; and only the District of Columbia can be categorized as a subsidized insurance plan because it uses city money to fund an insurance-like program that supplies low-income residents with access to primary and specialty services from participating private providers. The following section describes restricted Medi-Cal in California, the largest state funded program providing healthcare coverage to undocumented immigrants in the nation.

Medi-Cal, California

As indicated in Table 3 very few states provide healthcare coverage to low-income undocumented immigrants, and although they all offer some form of limited coverage

and use state funds, California offers more options than any other state (Hoefer, Rytina and Baker, 2011), which may be due to having the largest share of undocumented immigrants in the nation. Restricted Medi-Cal is California's Medicaid health care program funded with state money to allow undocumented immigrants classified as PRUCOLs (Permanent Residence Under Color of Law) to access restricted Medi-Cal for emergency situations, pregnancy, kidney dialysis, and for home care and treatment for breast and cervical cancer. This state-funded Medi-Cal provides restricted services to low-income immigrants who reside in California, but they must be either the sole provider of a US citizen child, 65 or over, blind, or disabled. California residents can qualify for this program regardless of sex, race, religion, color, national origin, sexual orientation, marital status, age, disability, or veteran status. Individuals whose income is up to 185% of the FPL, or up to 200% for qualified disabled persons, can obtain Medi-Cal at no cost; if their income exceeds these limits, they have to pay a portion of their medical expenses called the share of cost (SOC), and Medi-Cal will cover the remaining balance (California Department of Public Health, 2010).

The state funded Medi-Cal was created after the federal Welfare reform was passed in 1996 when California state officials opposed the restrictions on Medicaid imposed by this legislation, arguing that legally present immigrants should not have to wait five years to qualify for Medicaid. Today, this means that about 73,000 immigrant youth

who meet DACA (Deferred Action for Childhood Arrivals) eligibility requirements can apply for Medi-Cal and they will qualify for the expanded benefits that will be implemented with ACA in 2014 (Richard, 2013).

Medi-Cal delivers health care coverage through fees for services and managed care. The fees for services are paid to health care providers for each medical service delivered to a beneficiary. Under the managed care system, the Department of Health Care Services contracts with managed care plans to provide health care services to Medi-Cal recipients enrolled in these plans. These services can be obtained from providers that accept payments from the plans, which are reimbursed with a predetermined amount per beneficiary per month, regardless of the number of services each Medi-Cal beneficiary actually receives (Legislative Analyst's Office, 2013).

California's population is composed of 38.2% Latin@s, 27.2% foreign born, and 14.4% of its residents earns below the FPL (US Census Bureau, 2011). But California is home to almost one quarter of the undocumented immigrant population nationwide, and most of them will continue to lack access to adequate and affordable health care even after ACA provisions that expand Medi-Cal are implemented. Therefore, the safety net in California will be particularly impacted by the reduction of disproportionate share funding payments that provide compensation for uninsured care to federally qualified

health centers (Wallace, Torres, Nobari, and Pourat, 2013). Although the state budget does not explicitly assign any funds to pay for health care for undocumented immigrants, it does not prohibit counties to use state money to provide health care coverage to this population (Medina 2013). A recent report by the Pew Hispanic Research Center found that out of the 100 largest counties by Latin@ population, half of them are in three states: California, Texas and Florida. In addition, they found that fourteen of the 60 metropolitan areas with the largest share of Latin@s are located in the state of California, with Los Angeles – Long Beach, CA, on the 1st place, with 44.8% Latin@s living in this area, out of which 42.2% are foreign born (Brown and Lopez, 2013).

Starting on January 1st, 2014, millions of low-income residents in California will have access to affordable health insurance under the Affordable Care Act, but the UC Berkeley Labor Center estimates that 1 million undocumented immigrants in California will continue to be uninsured because most people without legal status are prohibited to access federally funded Medi-Cal (Lucia, Jacobs, Watson, Dietz and Roby, 2013).

Although undocumented immigrants in California can only access restricted Medi-Cal when they are pregnant or have an emergency medical condition, this state is the only one in the nation that provides more health programs to low-income undocumented immigrants than any other state. Medi-Cal has recently expanded its coverage to

immigrants who were granted temporary legal status under the DACA program that was implemented at the deferral level in 2012 (Diaz, 2013).

As the ACA goes into effect, there is a push in the state of California to provide health insurance coverage to immigrants regardless of their immigration status. The California Endowment is leading a coalition of elected representatives, public health officials, and advocacy organizations that has started a public campaign to find means to provide preventive care to undocumented immigrants, who will be remained uninsured after ACA and the Medicaid expansion are implemented (Medina, 2013). Contrary to the refusal of Louisiana's elected officials to extend Medicaid coverage, California has accepted to expand Medicaid to residents earning up to 138% of the Federal Poverty Line (FPL). Although the restricted Medi-Cal program has a limited scope of service for undocumented immigrants, it serves as an example for Louisiana legislators of how state level healthcare coverage can be funded and operated if they are willing to take on the challenge.

City Level Healthcare Coverage for Undocumented Immigrants

Due to the refusal by state elected officials to expand Medicaid coverage as part of the implementation of the Affordable Care Act, the City of New Orleans Health Department estimates that 65,000 uninsured individuals earning below 138% of the FPL

in the Greater New Orleans region will be left out of the health care reform. The majority of this group of people has had access to affordable healthcare through the Medicaid Section 1115(a) Waiver, known as the Greater New Orleans Community Health Connection (GNOCHC), which currently delivers healthcare services through community based-clinics, but it will expire at the end of 2014.³ Due to this potential crisis the Health Department has been exploring other healthcare delivery models around the nation, focusing on those that do not rely so heavily on public funds because they have been proven to be hard to access, unpredictable, and unreliable. They reviewed seventeen models, out of which only five provide healthcare services to their residents, regardless of their immigration status (The City of New Orleans Health Department, 2013).

³ In August, 2013, federal funding for the GNOCHC Waiver was extended to December 31, 2014 by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), in response to a 3 year extension request submitted by the Louisiana Department of Health and Hospitals. This additional year will provide state and local officials with more time to find the funding needed to ensure the program continues without reliance on federal money (Louisiana Department of Health and Hospitals, 2013).

Table 4: Healthcare Plans Providing Coverage to Undocumented Immigrants

Type	Plan	Eligibility Requirements	Funding Structure
Multi-Share Program	Healthy San Francisco San Francisco, CA	San Francisco residents, regardless of immigration status, who earn up to 500% of the FPL	Medicaid Waiver Employer contributions Member contributions City/County funds
	Seton Care Plus Austin, TX	Austin residents, regardless of their immigration status, who earn between 100% and 250% of the FPL, and are not eligible for other programs.	Member Co-pays Seton Network Philanthropic funds Donated services
	CareLink San Antonio, TX	San Antonio residents, regardless of their immigration status, who earn up to 200% of the FPL. Those earning up to 300% of the FPL are eligible for limited coverage.	City and Disproportionate Share Hospital funds Member contributions
Subsidized Insurance Program	CareNet Boston, MA	Boston residents, regardless of their immigration status, who earn up to 200% of the FPL, and are not eligible for other programs.	Disproportionate Share Hospital funds Hospital surcharges on insurers State funds
Hospital System Program	DenverHealth Denver, CO	Denver residents, regardless of their immigration status, who earn up to 200% of the FPL.	Patient revenue Disproportionate Share Hospital funds City funds Federal grants Philanthropic funds

Source: Table created by author using data from The City of New Orleans Health Department. 2013. *Methods for Financing the Safety-Net: An Analysis of Existing Models and Applications for the Greater New Orleans Region.*

Table 4 summarizes the funding structure and eligibility requirements for these five models. They all operate at the city level and rely on a variety of funding sources; three out of five are multi-share programs, the remaining two are models of the subsidized insurance program and the hospital system program. In addition, New York City has the largest municipal healthcare program in the nation. This system serves all its low income residents, regardless of their immigration status. The following section describes this program, its funding structure and eligibility requirement.

New York City Health and Hospitals Corporation, New York

The New York City Health and Hospitals Corporation (HHC) is a quasi-independent authority created in 1970 by the New York State Legislature. Today, it is the largest municipal hospital and health care system in the nation. HHC is a \$5.4 billion public benefit corporation that serves over 1.3 million New York City residents, including over 450,000 uninsured patients. HHC is mission-driven, patient-centered, and it encompasses eleven acute care hospitals, six diagnostic and treatment centers, four nursing facilities, the MetroPlus Health Plan, a Health and Home Care division, and over 80 community-based clinics. The MetroPlus Health Plan is a subsidiary of HHC that was created in 1985 to coordinate Medicaid managed care, Medicare Advantage, and the State Children's Health Insurance Program (SCHIP). Metro Plus Health Plan uses HCC facilities to provide primary health care services to more than 320,000 New

York City residents enrolled in publicly funded programs as of 2008 (McCarthy and Mueller, 2008), the number of enrollees increased to 426,000 in 2011 (Sollars and Brecher, 2012).

As part of its commitment to offer health care services to New York City residents, regardless of their immigration or financial status, the HCC Options program connects uninsured patients with a primary care provider and it offers a sliding-fee scale to residents earning up to 400% of the FPL. In 2008, under the leadership of Mayor Michael Bloomberg, HHC invested \$30 million to provide linguistically and culturally appropriate services for their immigrant patients, who speak more than 150 different languages. But, HHC officials are anticipating that the full implementation of the Affordable Care Act will force the corporation to compete for already scarce public resources to fund care for this population. (McCarthy and Mueller, 2008).

The New York City's population is composed of 28.6% Latin@s, 36.8% foreign born, and 19.4% persons earning below the FPL (US Census Bureau 2011). It is estimated that there are 500,000 undocumented immigrants living and working in New York City, who rely disproportionately on HHC for their health care needs, and will remain uninsured after the health care reform is fully enacted. Enactment will worsen the budget deficit experienced in the last few years by HHC given the reduction on federal

reimbursement to provide care for the uninsured. In addition, due to increases in pensions and fringe benefits, the corporation's expenses have been growing much faster than its revenues, which forced its leadership to develop a plan to reduce expenses, called The Road Ahead, that was implemented starting in 2011 and projects a reduction of \$300 million in annual expenditures when fully implemented (New York City Health and Hospitals Corporation, 2010).

Funding for HHC comes from three main sources: the state Medicaid mandate, Medicaid supplemental payments, and direct city appropriations. The direct city appropriations are transferred from New York City to HHC from debt service payments on bonds issued by the City for HHC capital investment projects, and payments by the city on behalf of HHC for malpractice settlements. Although Mayor Bloomberg has increased the support from the City by relying less on direct appropriations and more on Medicaid supplemental payments, the corporation's annual operating budget expects to continue to run deficits in the coming years, even after the full implementation of The Road Ahead. It is also expected that the Affordable Care Act will make it more difficult for the City to leverage federal funds as this law will reduce funding for the uninsured (Sollars and Brecher, 2012:4).

Conversely, Louisiana opted out of using state funds to provide coverage to ineligible immigrants, and the Greater New Orleans region does not have a municipal hospital system that can offer the services offered in New York City. But this area has a city level Health Department with a mission to “protect, promote and ensure the health of all in New Orleans; foster an optimum health-related quality of life for those that live, learn, work, and play in New Orleans; ensure conditions that enable health and healthy choices” (New Orleans Health Department, 2013:1). In order to accomplish this mission, the Department works to improve the health of the New Orleans population through data-driven decision making, dissemination of vital information, and policy development. Also, it oversees four federally funded programs: Healthy Start New Orleans; Women, Infants and Children (WIC), Health Care for the Homeless, and the Ryan White HIV/AIDS Program (New Orleans Health Department, 2013).

City health departments have the mission to keep their residents healthy and safe, as well as prevent disease and injury. They accomplish this goal by working with “state and federal governments, non-profit organizations and private sector partners every day to keep people from getting sick and protect them from health threats (...) they develop and enforce new policies and standards to create the conditions that make communities healthier”(RWJF Policy Highlight, 2009:1). The Affordable Care Act presents challenges and opportunities for agencies like the New Orleans Health

Department because this law changes the financing of healthcare for the uninsured, but it acknowledges the vital importance of prevention interventions. The health care reform mandates \$15 billion over 10 years in funding for community-based prevention efforts, and it “promotes collaboration among providers of medical care, the public health system, and their partners in private and public sectors to create healthier communities” (NACCHO, 2011: 1).

Relevance of Community-based Health Centers in New Orleans

The healthcare delivery system in New Orleans was drastically changed by hurricanes Katrina & Rita in 2005. The one large public hospital that served as the care safety net for the urban poor was flooded. The Medical Center of Louisiana at New Orleans, popularly known as Charity Hospital, that used to have 200,000 annual outpatient visits was declared condemned by the State of Louisiana shortly after the disaster (DeSalvo, Muntner, and Fox 2005).

The lack of access to primary health care services by affected residents after the hurricane brought about many of the community-based health centers that still operate in New Orleans. NOFHA, in Mid-City, and Common Ground, in Algiers, are two of them. The former only served uninsured patients, but has recently suspended operations due to funding limitations. The latter, which serves insured and under-

insured patients, has experienced budget reductions in the last few years, but continues to provide services. Both health centers share a holistic approach to health, and they have developed culturally & linguistically relevant programs that target the Latin@ community.

Community-based health centers are “patient-directed organizations that serve populations with limited access to care” (U.S. Department of Health and Human Services, August 30, 2013: 1). They provide comprehensive, culturally competent, quality primary health care services to medically underserved communities and vulnerable populations. There are three types of community-based health centers: grant-supported federally qualified health centers, non-grant-supported health centers, and outpatient health programs/facilities operated by tribal organizations. The first type encompasses public and private non-profit centers that meet certain criteria under the Medicare and Medicaid Programs of the Social Security Act, and receive federal funds. The second type refers to clinics that do not receive federal funding though they have been identified and certified by the Centers for Medicare and Medicaid Services as meeting the definition of health center. The third type includes clinics operated under the Indian Self-Determination Act.

According to the Greater New Orleans Community Clinics site, there are 76 community based-health centers in the region, operating in more than 90 locations, out of which 32 offer adult primary care. Thirty nine of those clinics are part of the Greater New Orleans Health Connection (Greater New Orleans Community Clinics, 2013). This is a Medicaid Waiver that reimburses health care centers for providing free healthcare services to uninsured adult residents earning up to 200% of the Federal Poverty Line, this federally funded program explicitly excludes undocumented immigrants.

Research Design

Through a multiple-case study design, this thesis seeks to identify the systemic barriers faced by two community-based clinics providing health care services to Latin@ immigrants, regardless of their immigration status, in the New Orleans metropolitan area. The New Orleans Faith Health Alliance (NOFHA) and Common Ground Health Center represent two contrasting approaches to healthcare delivery for uninsured residents. Both have the mission to provide affordable and quality primary healthcare, but their funding structures are fundamentally different, which can influence how they are impacted by the Affordable Care Act (ACA).

For the research design, the case study method was chosen as a research strategy because it is “an empirical enquiry that investigates a contemporary phenomenon

within its real life context” (Yin, 2003: 13). The multiple case study approach not only seeks to cover contextual conditions, but it compares two cases with contrasting characteristics under the same social context. At first, both cases were chosen based on their similar characteristics: both clinics have the mission to serve the uninsured, they have developed culturally and linguistically appropriate programs that target Latin@s, and they serve all people regardless of their immigration status. Then, their differences came to light and turn them into comparable cases because the main difference between both is their funding structure. Each one represent contrasting characteristics that can have a different outcome, as the financial steadiness of the already unstable primary safety-net is expected to endure worsen financial limitations when the ACA is fully implemented, NOFHA and Common Ground can be impacted differently because of their divergent funding structures.

This research looks at the impact that the full implementation of the ACA will have on the already unstable primary care safety-net in the New Orleans metro area. Two primary research questions are posted: How can community-based clinics serving the uninsured continue to provide these services to undocumented Latin@ immigrants when the Affordable Care Act is fully implemented in 2014, as it assumes that most people will be insured, and it considerably reduces federal funding for the uninsured?

What role can the City of New Orleans Health Department play to enhance the sustainability of primary care safety net in the Greater New Orleans region?

This is a qualitative multiple case study that explores a phenomenon within its context using diverse data sources to ensure that the issue is looked at from different perspectives. The evidence for this research is collected by reviewing annual reports, financial statements, and other documents published by both clinics, as well as open-ended interviews with executive leadership at NOFHA and Common Ground.

Interview questions will focus on their sustainability plans and the systemic barriers they face. Due to NOFHA's recent suspension of services, the questions to its leadership also focused on the crisis they are facing, and the alternatives they are evaluating during the re-structuring process.

The Impact of the Affordable Care Act on the Primary Safety Net in New Orleans

The full implementation of the Affordable Care Act will impact the funding structure of the primary safety-net as it assumes that most people will be insured, and it considerably reduces federal funding for the uninsured, which has historically helped clinics offset the cost of providing services to immigrants restricted from accessing federally funded programs. In the Greater New Orleans region, community-based health centers that are part of the primary safety-net are already struggling to

financially support their services due to their heavy reliance on public funds. Thus, when it comes to serving uninsured Latin@ immigrants, the ACA is expected to worsen this situation. This section describes two community-based clinics that serve the uninsured, and have created culturally and linguistically appropriate programs to cater to Latin@ immigrants, regardless of their immigration status. First, this section focuses on NOFHA as a healthcare delivery model that did not use public funds, looking at its history, structure, financial struggles that led to its suspension of services, and its plans to re-open after the ACA is fully implemented. Then, it looks at Common Ground Health Center as a healthcare delivery model that uses public and non-public funds, focusing on its history, structure, and plans to respond to the anticipated impact of the ACA.

NOFHA: “Affordable Health Care for Uninsured Workers and Families”

The New Orleans Faith Health Alliance (NOFHA) was founded in 2009 under the leadership of its current Board President, Janet DiLeo Wade, a nurse who evacuated to Memphis after hurricane Katrina and was assigned to work at the Church Health Center, which is a system of clinics that was created two decades earlier with the mission of serving the working uninsured. This model was built and supported by the faith, business, and health communities in Memphis. Following this ideal, NOFHA,

located in Mid-City, was created as a low cost holistic primary-care clinic on a mission to provide physical, emotional and spiritual health care to the working uninsured.

NOFHA's funding structure was similar to the shared responsibility model, also known as the multi-share program. As such, it was never meant to become a federally qualified health center, instead the clinic's plan was to sustain its services with sliding scale fees from its membership, and contributions from employers, providers, and the faith community. But the clinic was not able to galvanize the financial support needed to maintain its services, causing it to suspend services starting on August 10, 2013.

NOFHA was forced to stop offering medical care for an undetermined amount of time while the organization goes through a strategic planning and re-structuring process, focusing on finding viable options to re-open the clinic in the future.

The Church Health Center was founded by Dr. Scott Morris, a family practice physician and ordained minister, with the goal of providing quality, affordable healthcare for working, uninsured people and their families, who pay fees on a sliding scale based on income and family size. Today, this clinic is the largest faith-based healthcare organization in the nation, taking care of more than 58,000 patients without relying on federal money. The success of this model is credited to the broad base of financial support from the faith community, donated services from healthcare professionals, and

increasing financial support from the business community. The center offers an employer-sponsored healthcare plan, called the Memphis Plan, for small business and self-employed individuals, which focuses on providing quality, affordable healthcare to people working low-wage jobs (Church Health Center, 2013).

NOFHA attempted to follow this model by providing affordable healthcare to low income uninsured working people, regardless of their immigration status, without receiving any public funds. But according to its executive director, Luanne Francis, they were not successful because the Greater New Orleans region is already strapped for resources and they were not able to get the buy-in from the faith and business communities that they expected. After hurricane Katrina, the city of New Orleans was awarded \$10 million in federal funding to strengthen its safety-net, though this money was received in 2009, it was allocated to the Medicaid office, which in turn created the Greater New Orleans Community Health Connection (GNOCHC), also known as the Medicaid Section 1115(a) Waiver, but NOFHA's leadership decided not to apply for this funding in order to maintain their freedom to serve all uninsured working people. In addition, as a start-up clinic it takes time to build a reputation and become the charity of choice for uninsured working people.

During its operation, the clinic attracted many Latin@ immigrants because it developed culturally and linguistically appropriate programs that target this community. NOFHA offered interpretation services, culturally relevant health education, and did not require a Social Security number. All patients were only asked to provide a picture ID and proof of income. Although NOFHA never asked for their patients to reveal their immigration status, Ms. Francis believes that many of the Latin@ people they served may have been undocumented because of the type of identification documents that they provided (i.e. non- U.S. passports, foreign IDs, etc.). In 2012, NOFHA's patient base increased by 20% compared to 2011, the clinic saw 325 new patients and close to 1,000 visits. 59% of these patients were Latin@s, 24% were Whites, and 16% were African Americans (New Orleans Faith Health Alliance, 2013).

Since NOFHA only provided primary care, its staff worked closely with the LSU (Louisiana State University) referral system, both parties signed a Memorandum of Understanding and NOFHA was able to refer its patients using the online referral system. This partnership allowed for patients to have a system generated ID number, and all their information in the LSU system by the time they arrived for their appointment with a specialist. The clinic's staff was also instrumental in informing patients of their rights and responsibilities when using the LSU referral system. As explained by Ms. Francis, obtaining relevant information and then translating it to lay

terms for NOFHA's clients was a labor intensive task and it required the development of personal relationships. For instance, when patients receive a bill from LSU they can call and say that they can't pay it, then LSU will reduce the bill by 40% and allow patients to establish a payment plan that requires a minimum payment of \$25 per month. But this vital information is not readily available to patients, thus NOFHA's case managers were in charge of explaining this system to their clients beforehand, as well as scheduling their appointment, following-up, etc.

Currently, NOFHA is composed of its board of directors only. Ms. Frances resigned from her position as executive director shortly after the clinic suspended its services due to lack of funds. NOFHA is now going through a restructuring phase that will require time and dedication from all its current board members. The first step is to conduct a community needs assessment to determine how it can better serve its patients, and how to build successful relationships with the faith and business communities. Then, when NOFHA re-opens it will move to take private insurance and look for other ways to diversify their funding stream. If they are successful at replicating the Church Health Center model in the Greater New Orleans region, they will be able to benefit from the Affordable Care Act as it will allow for many of the uninsured to purchase affordable health insurance coverage. Learning from its past experience, NOFHA now has the

opportunity to develop a sustainability plan establishing strategic formal partnerships to improve its capacity to serve the New Orleans community.

Common Ground Health Clinic: “Solidarity Not Charity”

The Common Ground Health Clinic started eleven days after hurricane Katrina devastated the Gulf Coast. Two community activists, Sharon Johnson and Malik Rahim, responded to the lack of governmental support in Algiers, a New Orleans community on the Westbank of the Mississippi River, by calling volunteer healthcare workers to help meet the overwhelming need of the population. The clinic started as a volunteer-run effort operating out of a mosque; today it “is a registered non profit organization that strives to be an anti-racists, radical, integrative, and neighborhood based health clinic that provides free, high quality health care for all. The Common Ground Health Clinic remains true to its roots and to the vision that made this free clinic a reality” (Arend, 2007: 1).

Through the Integrative Primary Care Services model that coordinates primary health care needs with other related services, Common Ground provides primary and alternative health care services to underinsured and uninsured residents. The clinic offers prescription assistance, access to herbal medicine, health education, and other related services. In addition, Common Ground provides full-time Spanish language

interpretation services to all patients in need through the Latino Health Outreach Project (LHOP), which also operates a mobile clinic in Central City, at a day-labor pick up site. This project came about a few weeks after hurricane Katrina when Common Ground volunteers realized that Latin@ residents lacked culturally and linguistically competent healthcare services in New Orleans. Since its creation, LHOP volunteers and staff have been instrumental in promoting and supporting other organizations that serve Latin@s across the city.

Common Ground is a federally qualified health center classified as one of many non-grant-supported health centers. The only federal funds the clinic receives are Medicaid (through the Greater New Orleans Community Health Connection) and Medicare reimbursements. Based on the typology developed by the City of New Orleans Health Department, this health center is a form of financial assistance program because it sustains its services with income from sliding scale fees for services, using philanthropic and federal funds to offset the costs not covered by the those fees. The clinic was founded following the subsidized access program model, where all services are funded with designated federal, state, and city funds accompanied by philanthropic grants, and donated care from hospitals and physicians. But operating exclusively on volunteer labor is no longer a viable option for Common Ground because its client base continues

to grow (the clinic has gone from serving an average of 355 patients per month in 2010 to an average of 693 in May 2013).

Although the clinic does not receive any funds from the local government, Ms. Tarver, its executive director, stated that its staff is working on learning how to comply with federal regulations to eventually qualify for federal grants. At the local level, Common Ground has a good working relationship with the City of New Orleans Health Department, the clinic is part of the 504 HealthNet, where Karen DeSalvo, Health Commissioner for the City's Health Department, serves as the Chair. The 504 HealthNet is a partnership composed of 19 community-based health centers, created "to provide support to an integrated and coordinated network of healthcare providers in the Greater New Orleans region" (504 HealthNet, 2013:1).

Common Ground serves all people, regardless of their immigration status or ability to pay. Patients are not required to provide a Social Security number, if they do not have it, as long as they can show a picture ID and proof of income. The clinic offers primary care and has a dermatologist in house, but for all other specialized care it uses the LSU referral system, following a similar protocol as NOFHA's to ensure its patients can navigate this system. Also, Common Ground provides Spanish language interpretation to all patients in need, which allows them to better serve the Latin@ community, which

represents one third of the clients seen each day. Through the Latino Health Outreach program (LHOP), the center provides culturally and linguistically relevant services to Latin@s, setting up a mobile unit at a day laborer location in Central City every Friday. Common Ground has partnered with local and national organizations that target Latin@ immigrants to conduct research to be able to implement a health promoter model of its own, which started during the summer of 2013 and has allowed the clinic to hire five additional health promoters that also happen to be Spanish-speaking day laborers (Common Ground, 2013).

In anticipation of the full implementation of the Affordable Care Act, the clinic is working on creating a sustainability plan that would allow it to support its services with revenue from diverse sources, without relying heavily on public funds. In light of the recent one year extension granted to the Greater New Orleans Community Health Connection, also known as the Medicaid Section 1115(a) Waiver, the director of Common Ground indicated her relief as this will give them another year to work on their sustainability plan. Ms. Tarver also indicated that the center's finances are patient revenue driven, and they are evaluating if those who can pay 100% of the cost should be asked to do so. The clinic's staff is educating its patients on the ACA and its implications, and they are also working with insurance providers that will participate in the exchange market because Common Ground also accepts private insurance coverage.

Conclusion and Recommendations

The full implementation of the Affordable Care Act is expected to decrease the number of uninsured individuals in the United States, but the undocumented immigrant population, who are mostly from Latin American countries, will be left uninsured and with limited access to affordable and quality healthcare services. This community relies disproportionately on the safety-net for their primary care needs, but community-based clinics providing these services will face a significant reduction on federal reimbursements for serving the uninsured since the ACA assumes that most people will be insured. This federal policy not only excludes undocumented immigrants without taking into account their financial contributions to our society as working people, but it also assumes that most states will choose to expand Medicaid coverage for those individuals making between up to 138% of the FPL, which did not happen in Louisiana and will leave thousands of people without access to affordable healthcare when the Medicaid Section 1115(a) Waiver extension expires at the end of 2014.

Two publicly funded models were described, the New York City Health and Hospitals Corporation in New York City, and Medi-Cal in California. The former provides an insight view of how a hospital system model operates using city funds. Though it does

not serve as an example of a financially viable model, it is the largest municipal healthcare delivery system in the nation, and some lessons can be learned from this program. The latter is a dedicated tax program that although appears to be more financially stable than the city level model, it provides very limited healthcare services to undocumented immigrants, but nationally it is the most extensive state level coverage offered to this population.

The California state model offers restricted access to emergency care for undocumented immigrants and it is financially self-sustainable, while the New York City model offers comprehensive services but it is financially unstable. Both models serve as examples of how state and local governments can take a proactive approach to ensuring that all their residents have access to affordable and quality healthcare. Unfortunately, state funded support for undocumented immigrants is not a realistic plan for Louisiana given the conservative politics of most of its elected officials. Similarly, the New York City model would be hard to replicate in New Orleans because it lacks a public municipal hospital system like New York's. But the City of New Orleans Health Department has already taken steps to enhance the sustainability of the safety-net by researching other models around the nation to provide alternatives to local community-based clinics. They created a typology based on the nine different funding structures they found, although they were not able to find a model that uses exclusively non-public funds, they

recommended that the City of New Orleans and its partners work aggressively to raise awareness of services and healthcare funding options for the primary safety-net.

As Common Ground Health Center develops its own sustainability plan in preparation for the ACA, the clinic should consider a long term fundraising plan that seeks to diminish its reliance on public funds, utilizing the resources that already exist in the community they work, and exploring other more permanent ways to generate income. Although applying for philanthropic grants can be an effective revenue generating measure, it is as unstable and unpredictable as relying on public funds. Thus, the clinic should take into account what other health centers are doing to prepare for the ACA to determine how other models can inform their sustainability plans. Since the center is already planning a patient revenue driven strategy, it may be a good option to look at the share responsibility model where premium payments are paid by members on sliding scale, and contributions from other sources (like employers, providers, state and federal government) complement this income stream.

If the New Orleans Faith Health Alliance (NOFHA) plans to re-open its door and remain faithful to its original mission, it should take full advantage of this restructuring phase to develop a strategic plan that would ensure that their operations can be sustained without public funds. Its current board of directors will have to commit to

this effort since the clinic does not have any employee at this time. Before re-opening, the center should establish formal partnerships with faith and business community, as well as with healthcare providers that can donate their services in a regular basis. The shared responsibility model, without including the contributions from public funds, seems appropriate for NOFHA's funding structure because it requires all parties involved to equally share the financial responsibility of maintaining a balanced budget.

The role that the City' Health Department can play in facilitating the sustainability efforts of community-based centers like NOFHA and Common Ground is to develop policies that facilitate access to affordable healthcare by undocumented immigrants. Also, the department should create locally-based standards on improving culturally and linguistically appropriate healthcare services to ethnic minorities. This can encourage other service providers to establish programs that effectively serve Latin@ immigrants, who disproportionate rely on the safety net, which could be better balanced around the Greater New Orleans region if more clinics are given the tools to better serve this population, other health centers should follow NOFHA and Common Ground holistic approach to healthcare, which includes not serving all people but creating programs that effectively address the needs of Latin@s. The 504 Health Net partnership could be the starting point of this strategy, the Health Department can start with the 19 health centers that already belong to this partnership. Then, as more

community-based health centers join, the system will be already set-up, making it easier for others to adapt and implement those standards.

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