RESEARCH REPORT

Supporting North Carolina's Immigrant Families

Addressing Barriers and Promoting Solutions for a More Inclusive Safety Net

Hamutal Bernstein
URBAN INSTITUTE

Jennifer M. Haley
URBAN INSTITUTE

Diana Guelespe
URBAN INSTITUTE

Sofia Hinojosa
URBAN INSTITUTE

Luis Gallardo
URBAN INSTITUTE

Hannah Gill
UNIV. OF NORTH CAROLINA

Krista Perreira
UNIV. OF NORTH CAROLINA

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- Jennifer McCracken, Catawba CountyPublic Health
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- Abbey McCall, Crisis Control Ministry
- Andrew Herrera, Curamericas Global Health
- Steven Branch, East Coast Migrant Head Start
- Fiorella Horna, El Centro Hispano, Inc
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- Patricia Dykstra-Lalangui, Legal Aid of North Carolina (Greenville Office)
- Frida Ayala and Milda Cardenas, Mi Casa-Community Services/Servicios Comunitarios
- Crystal Zellous, NC African Services Coalition
- Honey Yang Estrada, NC Community Health Workers Association
- Kate Woomer Deters, NC Justice Center
- April Morgan, North Carolina Community Health Center Association (NCCHCA)
- Norma Marti (Retired), NC Department of Health and Human Services
- Elizabeth Hudgins, North Carolina Pediatric Society
- Sylvia Zapata Shoemaker, Student Action with Farmworkers
- Michael Burger, Tri-Area Ministry Food Pantry
- Mark Bumgarner, Catawba County United Way
- Patricia Carolina, Venezuela Para Ti
- Katie Thompson and Janny Mealor, Wake County Department of Human Services
- Rebecca Stuckey and Jarrell Johnson, World Relief (Triad Office)
- 8 staff members from the North Carolina Department of Health and Human Services

Executive Summary

Complicated eligibility rules, burdensome enrollment processes, and concerns about mistreatment during interactions with staff keep many people from enrolling in safety net programs such as Medicaid and the Children's Health Insurance Program (CHIP), the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), and the Supplemental Nutrition Assistance Program (SNAP; Barnes, Michener, and Rains 2023; Herd and Moynihan 2018; Michener 2018; Moynihan, Herd, and Harvey 2015; OMB 2021; Pratt and Hahn 2021; Wikle et al. 2022). But research finds that immigrants face additional barriers to enrollment, including lack of language access and fears of immigration-related consequences, on top of eligibility restrictions that prohibit many from qualifying (Bernstein, Gonzalez, Echave, and Guelespe 2022; Gennetian, Hill, and Ross-Cabrera 2020; Haldar et al. 2022; Food Research & Action Center and National Immigration Law Center 2020; Musumeci et al. 2022; Perreira 2012). Given states' roles in financing and delivering many safety net programs, state- and local-level policies and practices can contribute to how well programs meet the needs of state populations, including immigrants and people who live in families with immigrants.

In this report, we assess barriers to immigrant families' enrollment safety net programs in North Carolina and strategies for state- and county-level improvements to promote access and inclusion. These findings are based on 42 interviews with stakeholders at the state level and in four counties across the state, as well as four focus groups (in Spanish, Swahili, and Hmong) with members of immigrant families who have experience with safety net programs in the state. Key findings are as follows:

- **Immigrant families in North Carolina face the universal structural barriers that many program applicants confront in navigating program enrollment in addition to unique challenges specific to their immigration status and language backgrounds.**
  - » **Broad structural challenges** include limited awareness of available supports, transportation and scheduling hurdles, challenges communicating with agencies, and technology barriers.
  - » **Additional challenges specific to immigrant families** include the following:

    - **Language access**, especially related to diverse language needs and lack of resources and in-person assistance in languages beyond Spanish, as well as shortages of linguistically competent staff at state and county agencies
    - **Immigration-related fears and hesitancy**, including fear of exposure to immigration enforcement, local immigration enforcement risks, and concerns and misinformation about public charge
    - **Complex immigrant eligibility rules and documentation challenges**, including confusion in mixed-status families and unique documentation barriers for proving employment and identification
    - **Discriminatory treatment** from safety net program personnel based on language preference, race and ethnicity, or immigration status

- **Immigrant-serving CBOs and community health workers were highlighted as playing an especially important role** in supporting families' safety net access, though they face key challenges related to capacity and funding to support immigrant clients.
- **State- and county-level Department of Health and Human Services (HHS) agencies supporting North Carolina's immigrant families also have challenges supporting immigrants** related to staff capacity, variation across the state in resources, and difficulty staying up to date on changing rules and populations.
- **This research identified a range of solutions for state and county HHS agencies that could most effectively address these challenges and improve safety net benefit access for immigrant families**, including ideas for the state and counties in addressing mistrust and immigration-related concerns, simplifying complex enrollment and recertification processes, removing language access barriers, and improving connections across various safety net programs.
- **Priority solutions include** customized engagement and outreach by government agencies, supporting language access needs beyond Spanish, partnership with immigrant-serving CBOs and community health workers, diversifying HHS agency staff, simplifying program enrollment and retention processes, and state action to expand eligibility to additional immigrant populations.

North Carolina is at a dynamic stage under several policy changes related to the end of the COVID-19 pandemic and upcoming expansions in health insurance coverage in the state, including implementation of Medicaid expansion beginning in December 2023. A wide variety of North

Carolinians—including state legislators, state- and county-level agency decisionmakers and staff, health system leaders and providers, community health workers, advocates, representatives of immigrant-serving CBOs, and engaged community members—all have a unique role to play in improving safety net program access of the state's immigrant families. The research here identifies several changes to policy and practice for both state and county agencies that could improve immigrant families' access to supports. Improvements have the potential not only to better ensure families' nutritional, health care, and other needs are met but also to reduce inequities and contribute to a stronger, more stable, and healthier North Carolina. Moreover, these lessons could apply to other states seeking to better support their immigrant communities.

Supporting North Carolina's Immigrant Families

We begin with background on immigrants and safety net programs in North Carolina, followed by a description of study methods, including key stakeholder interviews and focus groups. Next, we present findings on key barriers to immigrants' access to the safety net in North Carolina, the ecosystem of supports for families and the role of immigrant-serving CBOs, and challenges serving immigrants for state and county government, followed by key changes to policy and practice that stakeholders and individuals identified to improve North Carolina immigrant families' access to safety net programs. We conclude with a discussion of policy implications of our findings.

Background

Immigrant Families and the Safety Net

In 2021, more than one in eight people living in the US, or 45.3 million individuals, were immigrants born outside the US, a group that includes naturalized citizens, lawful permanent residents (green card holders), unauthorized noncitizens, refugees, asylees, and others (Ward and Batalova 2023). Many more lived in immigrant families, including US-citizen children with one or more immigrant parents, who comprise nearly one in four children in the US.[1] Despite working disproportionately in low-wage jobs, immigrants make large contributions to the US economy (Dyssegaard Kallick and Capote 2023). Related research finds that immigrants and people in families that include immigrant members are at greater risk of experiencing financial insecurity and material hardships, such as food insecurity and problems paying utility bills, rent, mortgage, or family medical bills than those in only-US-born families (Bernstein et al. 2022; Guelespe, Echave, and Gonzalez 2023).

Public programs like health insurance coverage through Medicaid or CHIP and nutritional supports including SNAP and WIC are intended to serve as a safety net to help meet families' health care, nutritional, and other needs. However, federal restrictions limit the availability of many such benefits for immigrants, with variation across different immigration statuses (Acevedo-Garcia et al. 2021; Broder and Lessard 2023; Office of Refugee Resettlement 2023a). For instance, humanitarian arrivals such as refugees or certain recently arrived Afghan and Ukrainian parolees who have been admitted to

the US because of conflict and the threat of persecution in their home countries have access to benefits, including cash assistance and medical assistance, with supports through the Office of Refugee Resettlement (Office of Refugee Resettlement 2023b). But many other immigrants only qualify for most federal benefit programs like Medicaid, CHIP, and SNAP if they are lawful permanent residents with more than five years of residency status, and unauthorized immigrants are excluded from most major federal benefits programs (Broder and Lessard 2023; Goran et al. 2023). Some federal relief programs created in response to the COVID-19 pandemic also excluded many immigrants (Gelatt, Capps, and Fix 2021).

However, immigrant families' challenges accessing safety net programs extend beyond eligibility restrictions. Like many program applicants, they also face administrative barriers, such as complicated eligibility requirements and enrollment processes, as well as risks of unfair treatment that especially affect people of color (Gonzalez et al. 2021; Moynihan, Herd, and Harvey 2015; OMB 2021; Pratt and Hahn 2021, Wikle et al. 2022). But prior research has found that immigrant families also face additional barriers related to immigration concerns. For instance, the proposed Trump-era public charge rule to extend the scope of use of public programs as criteria for denial of permanent residency status was found to have "chilling effects," or avoidance of program use out of fear or immigration-related consequences, even among immigrant families not subject to the rule and after the proposed rule change was terminated (Barofsky et al. 2020; Bernstein, Gonzalez, and Karpman 2021; Bernstein et al. 2019, 2020, 2021; Food Research & Action Center and National Immigration Law Center 2021; Haley et al. 2020, 2021; Haley, Gonzalez, and Kenney 2022). Prior research has also identified barriers related to language access, requests for unnecessary information such as Social Security numbers for family members not applying for benefits, and other immigration-related hurdles and concerns (Bernstein et al. 2022; Gennetian, Hill, and Ross-Cabrera 2020; Haldar et al. 2022; Musumeci et al. 2022; Food Research & Action Center and National Immigration Law Center 2020; Perreira et al. 2012). According to federal civil rights legislation, federal, state, and local programs using federal funding are required to provide linguistically appropriate access to programs. However, enforcement and resources for carrying out this requirement vary (Hofstter, McHugh, and O'Toole 2021). Many of these challenges also pertain to "mixed status" families (which include both undocumented members and members with lawful status, such as those including US citizen children with undocumented immigrant parents); such families often include a mix of program-eligible and ineligible people.

Immigrant Families in North Carolina

North Carolina, a largely rural state with urban concentrations, is the ninth largest state in the nation (United States Census Bureau 2023). Its immigrant population is diverse and evolving, including individuals and families with a variety of ethnic and linguistic backgrounds and immigration histories. Some key features include the following:

- In 2021, an estimated 872,000 residents of North Carolina—1 in 12—were immigrants, and 1 in 5 children in the state had an immigrant parent, with variation in immigrants' shares of the population across counties (Perreira and Carlson 2023).
- Recent growth in the size of the immigrant population was larger in North Carolina than nationwide (23 versus 12 percent, respectively, between 2011 and 2021; Perreira and Carlson 2023).
- The largest shares of immigrants came from Mexico, followed by India, Honduras, El Salvador, and China, and over a thousand refugees were resettled in the state in fiscal year (FY) 2022 (Perreira and Carlson 2023).
- Overall, about a quarter of the state's immigrant adults had limited English proficiency; the top language among non-English-speaking foreign-born people overall was Spanish, but more than 4 in 10 spoke another language (Perreira and Carlson 2023). Among all people in North Carolina with limited English proficiency in 2021, the top five languages were Spanish, Chinese, Vietnamese, French, and Arabic.[2]
- Overall, North Carolina residents had similar rates of household food insecurity as the nation in 2019-21 (Coleman-Jensen et al. 2022), and many residents faced other unmet needs, such as lack of access to affordable housing (Rapfogel and Rosenthal 2022). But immigrants in the state were less likely to report being enrolled in safety net programs like Medicaid and SNAP than US-born people in the state, and immigrants in North Carolina were less likely to be enrolled in safety net programs than immigrants nationally (Perreira and Carlson 2023). In 2017-18, about 15 percent of children with an immigrant parent in North Carolina were in households severely burdened by housing and utility costs (Lou, Greenberg, and Thomas 2021).

Additionally, prior research has identified several barriers to accessing safety net programs among immigrants in the state, such as inadequate in-language support and difficulties navigating program enrollment requirements (Basurto and Gennetian 2022; Perreira et al. 2012). In addition, North Carolina legislators have passed a series of policies over the past two decades barring immigrants'

access to transportation, education, and health care, including restricting access to drivers' licenses and in-state college tuition (Gill 2018). They have also recently proposed legislation to require local law enforcement to cooperate with immigration enforcement;[3] prior research has found negative effects of local and federal law enforcement partnerships such as the 287(g) program on public safety and immigrants' access to services (Nguyen and Gill 2016).

Safety Net Programs in North Carolina

States have considerable latitude over their residents' enrollment in safety net programs, including setting policies related to eligibility guidelines and ease of enrolling in and retaining benefits. For instance, North Carolina did not approve Medicaid expansion under the Affordable Care Act until March 2023, and it will not be implemented until December 2023, leaving many poor adults unable to qualify for Medicaid except through specific pathways like pregnancy or disability. Just over half of all people with incomes below 200 percent of federal poverty level (FPL) in North Carolina received some assistance from the safety net in 2012-14, similar to the national median (Minton and Giannarelli 2019).

Rules for the state's major public programs, including Medicaid and North Carolina Food and Nutrition Services (FNS, the state's SNAP program), also reflect federal restrictions with respect to immigration-related eligibility requirements (table 1). WIC is an exception; per federal guidelines, it is open to families who meet other eligibility criteria regardless of immigration status. Like many states, North Carolina has waived the five-year waiting period for lawfully present noncitizens to enroll in Medicaid and CHIP for pregnant women and children (Kaiser Family Foundation 2022a). But like most states, North Carolina does not use state funding to cover additional immigrant groups excluded from Medicaid and CHIP (Kaiser Family Foundation 2022b). Access to benefits that are available may also vary within the state. Local or county-level data to identify language needs may be limited, and multilingual availability of information about safety net programs in North Carolina varies by language; for instance, the state's Medicaid website offers information in 15 languages in addition to English,[4] while the online application for Medicaid is available only in English and Spanish.[5]

TABLE 1

Overview of Selected Safety Net Programs in North Carolina, 2023

Program	Income eligibility rules and benefits	Immigrant eligibility rules	Applying and using benefits
North Carolina Medicaid– Health insurance for eligible adults, children, pregnant women, seniors, and people with disabilities	▪ Children: 216% of FPL ▪ Pregnant women: 201% of FPL ▪ Adults: 37% of FPL for parents; 0% of FPL for other adults ○ Medicaid expansion to 138% of FPL adopted in March 2023; will be implemented Dec. 2023 ▪ People receiving SSI or assistance for aged/disabled qualify automatically	▪ US citizens; qualified lawfully residing immigrants with at least five years residency status; refugees; asylees; lawfully-residing immigrant children and pregnant women (no five-year waiting period) ▪ All others only eligible for emergency Medicaid services	▪ Applications online (ePASS) or in person; as of July 2021, most serviced through Medicaid Managed Care; annual enrollment fees or copayments may apply
North Carolina Food and Nutrition Services (FNS) – Resources to purchase food, also known as food stamps or SNAP	▪ Eligibility is based on income (generally gross income <130% of FPL), assets (<$2,750, or <$4,250 if household member age >60 or older or disabled), and other factors ▪ Non-exempt households are further subject to work/training requirements and time limits ▪ Benefits vary by household size	▪ US citizens; lawfully-residing immigrant children; refugees; asylees; and qualified immigrant adults with at least five years residency status or have worked for at least 40 quarters ▪ Children who qualify living with parents who do not can receive child-only benefits	▪ Applications online (ePASS) or in person; requires telephone or in-person interview with eligibility worker; cardholder portal for account management
WIC – Resources to purchase food for pregnant, breastfeeding, and postpartum women and children < age 6	▪ Income <185% FPL (or participating in Medicaid, TANF, or FNS) and at "nutritional risk"	▪ No restrictions based on immigration status	▪ Electronic benefit transfer system (eWIC) card for use at authorized stores

Sources: "Food and Nutrition Services (Food Stamps)," NC Department of Health and Human Services, accessed September 29, 2023, https://www.ncdhhs.gov/divisions/child-and-family-well-being/food-and-nutrition-services-food-stamps; "North Carolina Food and Nutrition Services (FNS)," NC Department of Health and Human Services, accessed September 29, 2023, https://www.ncdhhs.gov/fns-brochure-english/download?attachment; "Learn," NC Department of Health and Human Services, accessed September 29, 2023, https://ncgov.servicenowservices.com/sp_beneficiary?id=bnf_learn; https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/"A Quick Guide to SNAP Eligibility and Benefits," Center for Benefits and Public Policy, March 2023, https://www.cbpp.org/research/food-assistance/a-quick-guide-to-snap-eligibility-and-benefits#_ftn8; "SNAP Policy on Non-Citizen Eligibility," US Department of Agriculture Food and Nutrition Service, accessed September 29, 2023, https://www.fns.usda.gov/snap/eligibility/citizen/non-citizen-policy; "WIC Program – Immigration Participation in the WIC Program," US Department of Agriculture Food and Nutrition

Service, accessed September 29, 2023, https://www.fns.usda.gov/wic/immigration-participation; "My WIC," NC Department of Health and Human Services, accessed September 29, 2023, https://www.ncdhhs.gov/ncwic/mywic#Eligibility-3521; "State SNAP Interview Toolkit," U.S. Department of Agriculture Food and Nutrition Service, accessed September 29, 2023, https://www.fns.usda.gov/snap/state-agency-interview-toolkit; "Eligibility," NC Department of Health and Human Services, accessed September 29, 2023, https://ncgov.servicenowservices.com/sp_beneficiary?id=bnf_eligibility; "North Carolina ePASS," NC Department of Health and Human Services, accessed September 29, 2023, https://epass.nc.gov/; "Children in the NC Health Choice Program Moving to NC Medicaid April 1," NC Department of Health and Human Services, accessed September 29, 2023, https://www.ncdhhs.gov/news/press-releases/2023/01/30/children-nc-health-choice-program-moving-nc-medicaid-april-1; Broder, Tanya, and Gabrielle Lessard. 2023. "Overview of Immigrant Eligibility for Federal Program." National Immigration Law Center; KFF 2023b.

Notes: FPL = federal poverty level. SNAP = Supplemental Nutrition Assistance Program; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children. Income limits are for January 2023 unless otherwise specified. The FPL in 2023 is $24,860 annually for a family of three. Some programs also apply requirements related to income of sponsors of immigrants. Paper applications are viewable at https://epass.nc.gov. NC's Children's Health Insurance Program, NC Health Choice, was combined with Medicaid in April 2023. See "Children in the NC Health Choice Program Moving to NC Medicaid April 1," NC Department of Health and Human Services, accessed September 29, 2023, https://www.ncdhhs.gov/news/press-releases/2023/01/30/children-nc-health-choice-program-moving-nc-medicaid-april-1. "Qualified" immigrants are defined in Broder, Tanya, and Gabrielle Lessard. 2023. "Overview of Immigrant Eligibility for Federal Program." National Immigration Law Center.

Unique Characteristics of North Carolina's Safety Net

North Carolina's safety net system is unique from much of the nation. It is one of only 10 states that administer programs like SNAP and Medicaid through a decentralized county-based system rather than through state-administered programs with local offices (Hahn et al. 2015; National Association of Counties 2018; Mackey 2023). Though county-administered programs must still meet state guidelines about eligibility and administration, this decentralized approach can lead to variation in enrollees' experiences across the state. In terms of Medicaid, in addition to being one of only 11 states that had not yet implemented Medicaid expansion as of the time of our research, the state only recently converted from a fee-for-service system (paying providers for services) to a largely managed care delivery system (establishing contracts between Medicaid and managed care organizations [MCOs] to pay MCOs a set amount per member to deliver health care services) beginning in 2021 under Medicaid transition (Allen et al. 2022). Thirty-eight states and the District of Columbia had implemented such a change earlier. The state is also innovating by piloting Healthy Opportunities programs in select locations to use Medicaid funding to support housing, food, transportation, and interpersonal safety needs for qualifying Medicaid enrollees.[6] Recent changes to improve access to safety net benefits and other community resources also include the establishment of NCCARE360, a public-private network to better connect families in the state with information on local nutritional, housing, transportation, or other social services.[7]

Dynamic Conditions during and Following the COVID-19 Pandemic

Several recent policy changes related to the COVID-19 pandemic have also affected North Carolinians' access to health and nutritional supports. A range of increased resources became available for individuals and organizations as COVID relief,[8] including increases in SNAP allotments[9] and the state's adoption of an optional federal program to provide COVID-19 testing, vaccination, and treatment for uninsured individuals.[10] North Carolina was one of 35 states that continued SNAP emergency allotments until they were ended by the federal government in February 2023 (Rosenbaum, Bergh, and Hall 2023). A nationwide policy beginning in March 2020 under the Families First Coronavirus Response Act enacted a Medicaid continuous enrollment requirement in response to concerns about coverage loss during the pandemic, prohibiting states from disenrolling individuals during the public health emergency in exchange for enhanced federal funding. Overall, 2.4 million children and adults were enrolled in Medicaid and CHIP in the state by March 2023 (Centers for Medicare and Medicaid Services 2023). A range of multistakeholder coalitions were also advanced in North Carolina to support needs of immigrant families during the pandemic, including the Latinx Advocacy Team & Interdisciplinary Network for COVID-19 (LATIN-19; Panayotti et al. 2022), the North Carolina Latino Health Alliance, and the NC Community Engagement Alliance (NC CEAL).[11] Greater federal investment was also made in community health workers—also known as *Promotores de Salud*[12]—frontline public health workers with close understanding of the communities they serve; many activities were focused on vaccine outreach but also connected community members to safety net programs.

However, several of these COVID-19 related resources and programs were temporary and are now being terminated or scaled back. For instance, as of April 1, 2023, the Medicaid continuous eligibility requirement has ended and states are renewing periodic redeterminations of Medicaid, or "unwinding" the requirement, with an estimated 375,000 of North Carolina's Medicaid enrollees projected to lose Medicaid and at risk of becoming uninsured by the time unwinding is complete (Buettgens and Green 2022). At the same time, as noted above, on March 27, 2023, legislation to adopt Medicaid expansion was signed by Governor Roy Cooper (Kaiser Family Foundation 2023b). When expansion is implemented in December 2023, this will increase Medicaid eligibility thresholds for parents from below 50 percent of FPL to 138 percent of FPL and offer eligibility for other adults who previously had no pathway to eligibility outside of pregnancy or disability, though the legislation does not change eligibility rules related to immigration and citizenship requirements. A projected 653,000 more people are expected to be enrolled in Medicaid under expansion, an increase of 30.9 percent (Buettgens and Ramchandani 2022). This would reduce the number of uninsured North Carolinians by a projected 346,000, though only 7 percent of the newly insured are expected to be members of immigrant families

(Simpson and Brett-Turner 2022). In September 2022, the state also received federal approval to extend pregnancy-related Medicaid from 60 days following the end of pregnancy to a full 12 months, a policy that was implemented in 2023 and that most other states have also adopted or plan to adopt (Kaiser Family Foundation 2023a).

Thus, North Carolina's safety net landscape is at a dynamic stage. Understanding strategies to forge and maintain immigrant families' connections to safety net programs is more important than ever, as several policy changes are affecting the structure and administration of key state programs, especially Medicaid. Some of the state's population is gaining new pathways to health insurance coverage (such as under Medicaid expansion or postpartum extension), and a subset could be eligible for certain social services under Healthy Opportunities pilots. But others are at risk of losing coverage (during Medicaid unwinding, especially prior to implementation of Medicaid expansion) or not being connected to newly expanded coverage, in addition to other changes related to the end of the pandemic (such as reductions in the size of SNAP allotments). To inform state and county efforts, this study incorporates insights from dozens of stakeholders and immigrant families to understand barriers immigrants face and highlight a range of strategies to better support immigrant families in accessing safety net programs to meet their needs.

Study Methodology

This research included literature scans, stakeholder interviews, and focus groups to collect perspectives on access to safety net programs among immigrant families in North Carolina.

First, between December 2022 and April 2023, members of the research team conducted 42 60-minute virtual interviews with 49 stakeholders representing local, regional, and statewide organizations. Interviews were primarily focused in four counties (Catawba, Pitt, Forsyth, and Wake) that were selected based on relatively larger presence of immigrant populations and to capture a variety of types of immigrant communities, though state-level agencies and organizations were also included. In total, we interviewed representatives of 15 state and county HHS agencies, 21 refugee- or immigrant-serving CBOs (including refugee resettlement agencies, food banks, faith groups, consulates, advocacy organizations, a legal provider, a Head Start program, and a school system), and six federally qualified health centers and other health organizations (generally referred to in study results by stakeholder category, e.g., state or county HHS, CBO, health, etc.). We conducted stakeholder interviews in English or Spanish (according to interviewee preference) using protocols tailored by

organization type. The research team analyzed interview notes to identify common themes and select illustrative quotes. Table 2 summarizes interviews by location and type.

TABLE 2

Number of Study Interviews, by Interviewee Type and Location

	HHS	Immigrant-serving organization	Health	Total
Statewide	5	3	1	9
Catawba County	3	4	2	9
Forsyth County	2	6	1	9
Pitt County	1	5	1	7
Wake County	1	6	1	8
Total	12	24	6	42

Source: Urban Institute and University of North Carolina stakeholder interviews December 2022 through April 2023.
Notes: HHS=Health and Human Services agency.

Additionally, to obtain perspectives from diverse groups of immigrants in the state, we organized four virtual 90-minute focus groups from March to May 2023, totaling 29 participants in three different languages (Spanish, Hmong, and Swahili). We worked with community partner organizations to recruit focus group participants. Two Spanish-language focus groups were held virtually on Zoom and led by research team members, the Hmong-language focus group was held virtually and led by a Hmong-speaking consultant, and the Swahili focus group was held onsite at the community partner facilities with interpretation provided by a staff person. During both interviews and focus groups, we probed on immigrants families' access to safety net programs (in particular, Medicaid, CHIP, and SNAP) throughout the process of obtaining and retaining benefits; barriers (for immigrant communities, CBOs, and government agencies); and promising practices and policy changes to improve access.

In addition, drawing from principles of Data Walks as an innovative tool for sharing research with communities (Murray, Falkenburger, and Saxena 2015), after gathering and analyzing preliminary data, we organized two virtual community listening sessions with participants representing government agencies, community health workers, and immigrant-serving CBOs. The purpose of the sessions was to solicit feedback from stakeholders closest to the ground to help further inform our study during its analysis phase, aiming to measure whether our analysis was robust, identify priority areas, elevate actionable policy solutions, and identify any themes that participants thought had not yet been identified.

Our research has several limitations. First, our study does not capture all perspectives and experiences; we selected the four counties and three languages for focus groups to include a range of immigrant communities, but findings may not be generalizable for all other counties or groups. To gain other perspectives, we also interviewed statewide stakeholders. Data collection also took place during a time of considerable transition in the state and nationwide, so some insights may reflect policies and circumstances in place during that time.

This analysis is supplemented by a data feature using 2015–19 American Community Survey data to examine the characteristics of immigrants and their households living in each of North Carolina's 100 counties and statewide.[13] For instance, statewide data show that 8.7 percent of US-born residents and 12.4 percent of foreign-born citizen residents were uninsured in the 2015–19 period, compared with 46.6 percent of foreign-born noncitizens.

North Carolina Immigrant Families' Challenges Accessing the Safety Net

Stakeholder interviews indicated that immigrant families not only face the universal structural barriers that many program applicants confront in navigating program enrollment but also unique challenges specific to their immigration status and language backgrounds.

Broad Structural Challenges Common for All Program Applicants

Like all program enrollees, immigrant families in North Carolina must navigate complex processes to access safety net programs. These include learning about programs and attempting to apply, navigating drawn-out paperwork processes with unfamiliar terminology, wondering whether they are eligible or will ultimately get enrolled, all while arranging time away from work and other responsibilities to spend time on burdensome interactions with the system. Specific barriers are included in the following sections.

- ***Limited awareness of available supports and stigma.*** Stakeholders shared that even among immigrants or their family members who may be eligible, people may be unaware or confused about where to start. Many said that immigrants have not been informed about where to get help, and do not expect that they have any eligible family members. One CBO stakeholder described lack of eligibility as the number one barrier for their clients, "but for those that are eligible, it's the unfamiliarity with the health care system in the US ... or with … understanding Medicaid, understanding WIC." Some also discussed stigma related to safety net program use, especially in some Hispanic communities.
- ***Transportation and scheduling hurdles.*** Transportation and scheduling challenges to visiting HHS agencies in person, in particular in rural counties where public transportation is limited, were raised repeatedly as a key enrollment barrier. One health stakeholder noted that public transit is not available outside of the area's urban core. Another mentioned that many immigrants do not drive because North Carolina does not offer driver's licenses to undocumented immigrants, and they fear being stopped by police. Many stakeholders described how individuals rely on others to get to appointments, and some mentioned resources or transportation services that

fill in some of the gaps. A CBO stakeholder further explained that immigrant applicants are already dealing with challenging life circumstances, demanding and vulnerable job situations, and unreliable cars, all of which "really gets in the way of them to be able to complete the process and be able to apply." Many also said that long working hours are a barrier to visiting HHS agencies. A CBO stakeholder noted that county agencies are only open 9:00 a.m. to 5:00 p.m., making it hard for workers to schedule around their work hours.

- ***Challenges communicating with agencies.*** Stakeholders also shared instances where communications with county agencies easily break down, preventing many families from being able to enroll in or stay connected to services. One mentioned barriers such as agencies using voicemails to communicate with applicants who do not regularly check voicemails; they may miss messages left by HHS staff. But texts also introduce concerns, such as fears about scams that may be particularly magnified for immigrant families. One CBO stakeholder described an example of a client who received a text indicating she needed to renew her Medicaid coverage, but since she did not know how to verify the validity of the message, she did not know how to proceed. Limited agency staff capacity makes navigating systems even harder; a CBO stakeholder related that even "community health workers … really have trouble navigating the system" and face long delays reaching live help. As a result, "it can be very disheartening, and people start feeling defeated."
- ***Technology barriers.*** Although North Carolina has made the enrollment process available online through a system called ePASS, several stakeholders expressed that most immigrant clients are still submitting paper applications, often due to difficulties navigating a non-user-friendly interface. ePASS is also only available in English and Spanish, and we heard from several CBOs that they do the work of navigating the online system on behalf of applicants because of the system's unwieldy nature and the technology barriers that applicants face, like difficulties setting up an online account and not consistently using email to receive important communications. Applicants who must note sponsor income, have multiple last names, or who do not have a Social Security number were among those mentioned as having unique troubles with online forms. Some areas, especially rural communities, of North Carolina also lack access to high-speed internet.[14]
- ***Benefits cliffs.*** Other stakeholders raised challenges like income cutoffs that make people ineligible for needed programs when their income rises marginally. As a CBO stakeholder noted, "If their income changes a little bit, they're dropped, they're denied [from SNAP

benefits]. They just make $100 more a month, and then all of the sudden, they don't qualify for a family of four children. It is terrible."

- ***Long wait times for benefits.*** A refugee resettlement stakeholder noted they normally file SNAP and Medicaid applications for refugee clients a day or two after they arrive, but that recently families have been waiting months to receive their cards. Delays in Medicaid benefits posed particular risks for clients with significant and urgent health difficulties.
- ***Tradeoffs between enrollment process burdens and benefits***. Stakeholders discussed the onerous process to interact with HHS agencies and how much paperwork and documentation is required. As one CBO stakeholder reported: "The amount of paperwork that is required in order for people to sign up, people get lost in jargon and terminology." Others mentioned that some applicants may decide it is not worth the work, as a CBO stakeholder shared:

> I have clients that only have one child and they get like $180 or $190 [for SNAP]. And they have told me they don't want it anymore. And they don't even bother applying because you have to do so much work for that money. She says, "I'll rather go sell food on the weekends and make that money instead of going through all this process."

Additional Challenges for Immigrant Families

Beyond these universal structural challenges, immigrant families in North Carolina were reported to face several unique challenges related to their language use, immigration status, and other characteristics.

Language Access

Language access is a primary barrier that came up in every interview and focus group, particularly for immigrants who speak languages other than Spanish. Although Spanish translations of many materials for accessing and using safety net programs are available, translations in other languages spoken by immigrants and refugees in the state are less common. Even if applications may be available in non-Spanish languages, they may not be used because county HHS staff are not aware of their availability or how to process them. Furthermore, follow-up communication by mail and telephone is generally in English, putting the onus on applicants to seek out help from resettlement agencies, CBO staff, family members, or other people to help them navigate enrollment or recertification processes. Specific barriers mentioned included the following:

- ***Diversity of language needs.*** Stakeholders shared how diverse the language needs are in North Carolina, although few were able to easily articulate the specific languages most common in their area in detail. A school system stakeholder was an exception, sharing that there are 155 languages in the schools in their county, where they can focus on the top eight: English, Spanish, Arabic, Korean, Chinese Mandarin, French, Vietnamese, and Hindi. In addition to languages spoken by diverse immigrant and refugee populations from Africa, the Middle East, and Asia, stakeholders discussed the access needs for many immigrants from Central and South America who speak Indigenous languages like Mam, Mixteco Alto, or Mixteco Bajo, rather than Spanish.

- ***Limited non-Spanish language resources.*** Many stakeholders noted that language access is very limited for non-Spanish speakers. A health stakeholder shared that "for families that are non-English and non-Spanish speaking … language is definitely the number one barrier." A refugee resettlement stakeholder said that even clients who wanted to navigate the system on their own were not served unless they had an English-speaking intermediary advocating on their behalf. They referred specifically to the important role of case workers from refugee resettlement organizations in advocating for such clients:

  > Personally, one of the biggest challenges we've seen as far as the clients we serve being able to access benefits would be language barriers, absolutely. Clients are unable to access those services without the help of a case worker or the help of someone advocating for them. We've seen clients who were really self-sufficient, clients who were eager and wanted to take those things upon themselves tried to do that, but if they didn't have someone who was English-speaking with them, we noticed that those clients were pushed aside ... it is very hard for them to access services on their own.

  One county HHS stakeholder noted specifically that all their written correspondence with applicants goes out only in English and Spanish, meaning that speakers of other languages must seek help from other people to translate for them. She noted that mailed communications are often "mass sent … just in English," that is, machine-produced correspondence is regularly sent out only in English, despite the foreign language needs of clients. We also heard this in the Swahili focus group, where participants shared that they receive mailed communications in English and Spanish and wondered why they could not receive documents translated into Swahili.

- ***Little awareness and use of available multilingual resources.*** Even when resources were available in other languages, many stakeholders were unsure about which languages beyond Spanish are supported in HHS agencies, potentially limiting the usefulness of such resources. A state HHS stakeholder shared that all HHS materials are translated into five languages common in the state, and that interpretation is available for additional languages. She also shared that state

agency policy is that all written communications that are beneficiary-focused are automatically translated and released in Spanish alongside English. But county HHS agency stakeholders indicated they must use their own resources to procure translation for additional languages, and some have invested more than others in developing printed translations and hiring multilingual staff members. Those counties with larger shares of language groups that are less common statewide must fill in more gaps.

While some program applications are available in a short list of additional languages, a county HHS stakeholder said she had never seen one completed in anything other than English or Spanish. She was surprised to learn that the applications were available in other non-Spanish languages, and questioned staff capacity to review applications completed in other languages.

> When we receive [an application in a language other than English or Spanish at the agency] … what would we do with it? I have not encountered that yet. It's a resource that the state makes available, but yet, I don't even know if it's been used. We didn't even know what was out there. Is it being well-publicized by the state?

- ***Shortage of linguistically competent staff at agencies.*** Because of language needs and limitations of online resources, many stakeholders shared that immigrants prefer to get services in-person versus by telephone or online. But for Spanish as well as other languages, there are insufficient multilingual staff in HHS offices; and although interpretation telephone lines are supposed to be available, stakeholders expressed challenges with accessibility and insufficient languages and dialects available. One mentioned that people are surprised when they learn that there are five dialects among immigrants from Vietnam, for instance. Another mentioned challenges for new Afghan evacuee arrivals who speak Dari and Pashto, and a lack of interpretation access for their linguistic needs. A Spanish-speaking CBO stakeholder explained the following:

> *Los centros o departamentos ...no tienen personas capacitados bicultural y lingüistas. Ahí es donde vemos el gran desafío, especialmente en zonas rurales donde muchos de estos departamentos no cuentan con el personal capacitado de instruir o guiar al consumidor... la comunidad se frustra. Si van la primera vez y no lo pueden atender o corregir el problema, el consumidor ya no va regresar, y mucho menos si esta la deficiencia del lenguaje.*
>
> The centers or departments … do not have bicultural and [language] trained staff. That is where we see the greatest challenge, especially in rural areas where many of these departments do not have trained personnel to instruct or guide the consumer… the community gets frustrated. If they go the first time and they cannot address or correct the problem, they will not return, much less if there is a language challenge.

We heard that immigrants often must bring their own interpreters to offices, many times their own children, who are then put in an uncomfortable position of translating sensitive or mature

information. Challenges extend beyond enrolling in programs to using benefits; one Spanish-language focus group participant shared that they rely on their daughter at the doctor's office since an interpreter is never available. Some stakeholders also indicated that language compatibility was insufficient, stating that ideally caseworkers and clients need to share cultural characteristics as well if clients are to find them trustworthy.

Conversely, some stakeholders described notable improvements in language access over time within county agencies, in particular more Spanish-speaking bilingual caseworkers. One county HHS stakeholder remarked that when she started out as an eligibility worker, immigrants would come in with their children to interpret for them, but today there are multiple staff members with different language abilities and a multilingual language line. A CBO stakeholder also reflected on the improvement over time in their county, where there are now Spanish-speaking HHS employees and in-house interpreters, which they believed contributed to a huge difference in clients' comfort level. But these improvements were not consistent across the state.

- ***Poor accessibility of translations when available.*** Despite wider availability of resources in Spanish, Spanish speakers also face barriers to accessible materials. A CBO stakeholder noted that clients come to them because they do not find materials available in Spanish, or they have trouble understanding available Spanish-language materials. Many stakeholders raised the need for simple language to communicate effectively, especially with clients who have limited reading ability in English and their own native language. A county HHS stakeholder shared how challenging it is to rely only on written agency communications:

  > A few things that we've noticed is that a lot of times they can't even read the Spanish [language application]. So, they have to have someone that can either read the English [language application] to them or the Spanish language [application] to read to them. So that is hard to overcome sometimes, especially when they're at home and they get these letters.

Immigration-Related Fears and Hesitancy

In addition to language barriers, immigration-related fears were consistently cited as a concern for many potential program participants. This includes fear of exposure to immigration enforcement through sharing of personal information, as well as concerns about consequences for future immigration prospects for themselves or family members, especially regarding public charge regulations.

- ***Fear of exposure to immigration enforcement.*** Fear of interaction with government offices and staff is a major challenge to access, as many immigrants are afraid of potential exposure to questions about immigration status for themselves or a family member, sharing their information, or being flagged to immigration enforcement authorities. As one county HHS stakeholder described immigrants' experiences when accessing services in their local office,

  > When immigrants come to us for services or hear about us being a place that they can come for services, sometimes the government aspect is what will deter them from coming. They are fearful that we would ask them their immigration status or that we will turn them in if they were undocumented. That is simply not the case, we serve anybody. It doesn't matter what their immigration status is, it doesn't matter if they are documented or undocumented.

  Specifically, many stakeholders described immigrants' hesitancy in sharing information and filling out forms. A CBO stakeholder said that to apply for the free-and-reduced-price lunch program, a family would need to report income, employer name, and Social Security number, which they are hesitant to do,[15] and attributed children going hungry to the resulting lack of participation in the program. Potential questions about a parent's own immigration status cause fear for potential applicants without legal status, even if their child is a US citizen. This stakeholder reported that their organization purposely asks as few questions as possible and attempts to make their programs "low barrier" to ensure families in need feel comfortable accessing their services.

- ***Variation in local immigration enforcement climates.*** Many stakeholders described the climate of fear that immigrant families faced during the Trump administration, and continue to experience, particularly in counties where local police are focused on immigration enforcement. A CBO stakeholder shared that the overall climate a few years ago had many immigrant families afraid to leave their homes, particularly at night, which translated into a large drop in participation of Spanish-speaking families in the parenting groups they were running. Several stakeholders shared that immigrants are afraid of being pulled over by police and identified to immigration enforcement authorities, especially in rural counties where police departments may be more likely to cooperate with Immigration and Customs Enforcement (ICE).[16] A CBO stakeholder shared that even though social services and public health agencies are very welcoming in their county, it is a challenge for immigrants to "get to the place where they can learn about the services that are available to them."

  Many stakeholders shared stories of immigrants driving to different cities or counties to avoid perceived areas of risk, for example driving a sick child to an emergency room in Chapel Hill rather than staying in Duplin County. And stakeholders shared that in some counties, that fear is well founded. A CBO stakeholder said that although the social services agency is welcoming

in Pitt County, "if they go two counties out or even one county out, they are liable and threatened of being reported … as undocumented. And that is [very] common."

- ***Concerns and misinformation about public charge.*** In addition to fears about potential enforcement action, stakeholders shared that many immigrants were worried about potential impacts on future citizenship and green card applications. Nearly every interviewee highlighted heightened concern about "public charge" in recent years regarding a Trump-administration effort to impose stricter public charge guidance that led to widespread chilling effects for immigrant families. A CBO stakeholder shared,

  > [During the] Trump Administration, there was misinformation [spreading] all over the community. They said, "If you are a green card [holder] and you applied for food stamps, they can deport you." A lot of them [were] afraid. A lot of them said, "We don't want to apply, even though we live here, [and] we're hiding." It's really sad.

  A county HHS stakeholder said that the Trump-era discourse about public charge worsened preexisting fears, saying that people avoided programs because they were concerned about having future problems with their status—and for programs not even considered in the revised rule, such as parenting support programs or WIC. A health stakeholder shared clients' fears about providing personally identifying and status information to their health center, even though they hired bilingual staff and coordinated efforts with the Mexican consulate to allay fears.

  Stakeholders also spoke about significant misinformation on public charge among immigrant communities and the need for education. For instance, some families have the mistaken fear that if children received food stamps or Medicaid, they would be required to serve in the military, described by CBO stakeholder as follows: "I do have clients that believe that if your child receives Medicaid and all these benefits, or food stamps, they're going to be enrolled in the army and taken to war. I heard that multiple times." One Spanish focus group participant articulated this regarding fears about applying for SNAP, saying they had heard their sons would be drafted in the military if the family received benefits. Another focus group participant shared that though they were a US citizen, they feared that SNAP participation would impact potential petitioning on behalf of their parents to come to the US.

  Even though the Trump-era public charge rule had been stricken and a new rule was in place at the time of our stakeholder interviews, many shared that public charge concerns remained, and very few mentioned that they were aware there was a new public charge rule in place. A CBO stakeholder shared her frustration:

> I've given dozens of presentations on the public charge rule, but the actual effect of the rule on real people is really not very different under Trump and under Biden. During [the] Trump [administration], everyone wanted me to come out and talk about the public charge rule. [People stopped asking me] after Biden; it's frustrating because it's not the reality of either what the rule says or how [it's] going to impact people.

While it was not a common view, one CBO stakeholder noted that they had seen some reversal in the trend, saying that immigrants are applying for SNAP again because they feel safer to do so and because of the extra stress of inflation and the economic crisis forcing them to seek help.

> A lot of that fear is due to the public charge rule that was put forth by the Trump administration. Even though it was only implemented for a short amount of time, it did its job in the sense that it instilled fear among immigrant households, and [from] what I've seen in working with CHCs [community health centers] who try to help immigrant households apply to Medicaid, there remains a reluctance… [e]ven when Biden came in…. The challenge in the last 5 years or so has been convincing people that it's safe to apply … What we've found, even after it became safe again for folks to apply to SNAP and Medicaid, that it's going to take is time—time to reassure people that it's safe to apply for these programs.

Stakeholders also shared difficulties of correcting the perceptions and hesitancy described above and challenges communicating about the changes in policy. A state HHS stakeholder shared that in 2021 they added text to their webpage to direct people to accurate information about public charge and sent guidance to county public health and social services directors to make them aware about the changes in public charge policy, encouraging them to display educational flyers in their agencies. But they faced hesitancy from county staff, saying some "don't feel comfortable talking about immigration and they don't know enough to have a conversation. Even when you present specific talking points, [people] are nervous to give wrong information…. People who do not understand feel very overwhelmed, it's a push and pull in trying to figure out how to put that information out into the community." Thus, they believed insufficient education among county staff contributed to misinformation and families' reluctance to seek assistance.

Complex Immigrant Eligibility Rules and Documentation Challenges

Both interviewees and focus group participants repeatedly cited variation in eligibility rules across benefit programs and for different groups of immigrants, as well as challenges completing enrollment procedures, as key challenges.

- ***Complex immigrant eligibility rules.*** Variation in eligibility rules across safety net programs and within families according to immigration status is confusing for both potential participants and

HHS agency staff. Variation in rules within families was a particular concern for mixed-status families. In fact, some stakeholders noted that mixed-status families often had children of varying statuses (e.g., US-born and undocumented) who would receive medical attention at different doctor's offices or clinics because of their varying eligibility for certain programs, which created an additional hardship on the family.

Lack of clarity related to immigration rules extended beyond individuals to include service providers and immigrant-serving organizations. Some CBO stakeholders expressed confusion on access for new groups of immigrants in their areas, for example, about whether new groups like Ukrainian and Venezuelan parolees are eligible for federal safety net programs. One Spanish-language participant said the following:

Hay cosas que uno maneja porque hay situaciones que son solo para ciudadanos, o solo son para los que pide asilo, todo varia dependiendo con el estatus que tú tienes.	There are things that one handles because there are situations that are only for citizens, or are only for those who request asylum, everything varies depending on the status that you have.

- ***Unique documentation challenges.*** Although providing required documentation is onerous for many program applicants, this can be additionally challenging for immigrants because of difficulties reporting immigration status, employment (such as in situations of informal work), or residency (such as when homes are shared or leases are in other people's names). Stakeholders also highlighted particular challenges for new arrivals, for whom providing an address can be difficult or living situations fluctuate, and people may not have a clear sense of their expenses or income. Specific examples included the following:
  - ***Challenges proving employment and income.*** A CBO stakeholder noted immigrant applicants' difficulties providing formal letters certifying employment, citing an example of a caseworker asking a client for a formal notarized letter of employment even though the client's employment was informal domestic caregiving: "If it's a lady that pays this other lady for watching their child, she is not going to have a letterhead, because she doesn't have a company." Similarly, a Spanish focus group member mentioned that her husband is self-employed and believed that providing pay stubs to county agencies is not possible.
  - ***Hurdles providing acceptable identification.*** Immigrants who lack a US-based ID, especially if they are undocumented and unable to get a state driver's license, also face challenges providing valid identification documents. Some stakeholders raised examples of alternative

community IDs, such as the Faith Action ID,[17] to fill this gap. They said that it was being accepted by police departments, as well as for program enrollment. A health stakeholder shared that having these IDs in place was helpful for multiple purposes, including improving the relationship between law enforcement and immigrant communities and encouraging reporting of crimes, for registering to volunteer, or for opening a bank account. However, this ID was not available in all localities across the state. Two CBO stakeholders also reported that police officers prefer immigrants have a consular identification card, which has their home address, rather than have no identification at all, so they can ensure the individual is a North Carolina resident.

- ***Unique barriers for families of migrant workers.*** Stakeholders shared that connecting farmworker migrants and their children to safety net programs was particularly challenging given the short period of time they spend in a county or in the state.[18] A CBO stakeholder shared, "The farmworkers are not here long enough for the institution to get the paperwork through, to get the kid covered." One stakeholder described the challenge of connecting a family to Medicaid in North Carolina even though they had been successfully enrolled in South Carolina; that family chose to travel back to South Carolina to access health care services to avoid the challenges of reenrolling.

- ***Concerns of intergenerational households.*** Many immigrant families live in households that may include children, parents, grandparents, and other relatives. In the Hmong language focus group, several adult participants reported concerns about agencies determining eligibility because of their elderly parents living in the same household as younger generations. They worried that their parents would not qualify for safety net programs because of their adult children's income being considered as part of household income.

Discriminatory Treatment

Many stakeholders raised the issue of racism and discrimination against immigrants. They discussed hostile or discriminatory treatment of immigrants by some staff members in HHS agencies. Some stakeholders reported that there are HHS employees who hold anti-immigrant views and do not want to support program access for this population. One CBO stakeholder described this perspective as follows:

> [Immigrants] are just not seen as deserving of a service. In some counties, even though I am documented and have every right to this service, or my child has the right to this service in the case of CHIP, regardless what my background is, the DSS's [Division of Social Services offices] are not always friendly and will make it very difficult … I mean clearly, my child is entitled to it, but [staff seem to be saying], "I am not going to talk to you because you people don't belong here or you don't speak English."

We also heard a similar perspective in the Spanish focus group when a participant shared their experience of mistreatment because of discrimination:

Yo creo que desde el momento que usted entra al servicio social para pedir estos beneficios, nada más con que te mire el color y la raza, ya con eso es un desafío. A mí me toco para renovar el Medicaid de mi hija. Siento que no me dieron el buen servicio solamente porque me estaban viendo el color y todo eso. Pero si va otra persona, si lo atienden muI bien.	I think the moment you walk into social services to request these benefits, they look at your color and race, and just that is a challenge. [When] it was time to renew my daughter's Medicaid, I [felt] like they didn't give good service just because they were seeing my [skin] color…. But if another person goes, they take care of them very well.

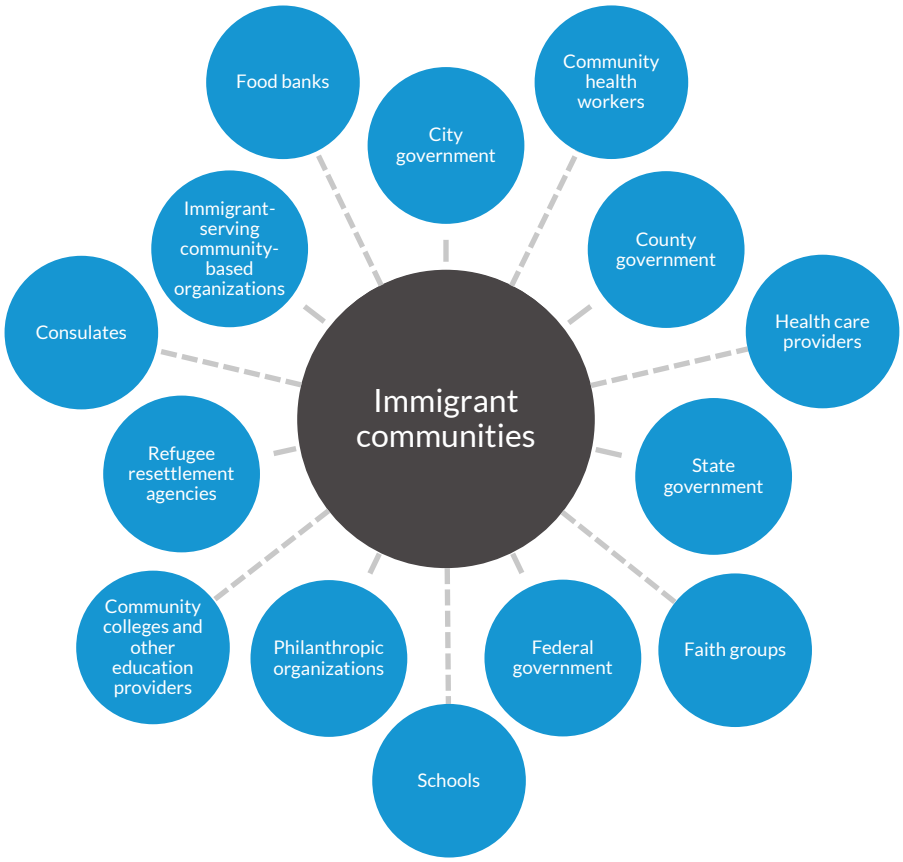
The Ecosystem Supporting Immigrant Families and the Key Role of Community-Based Organizations

Many organizations reach immigrant families, from the state- and county-level HHS agencies that are the focus of this report, to many other actors, including federal and local governments, immigrant-serving CBOs, refugee resettlement organizations, federally qualified health centers and other health care providers, schools and colleges, food banks, faith groups, consulates, and philanthropic organizations (figure 1). All of these are part of the ecosystem of organizations that could be leveraged to improve immigrant families' access to safety net programs.

Though all of these organizations reach immigrant communities in different ways and have unique resources and capacity to contribute, we heard the most from stakeholders about the role of CBOs (including those employing community health workers) and the unique role of consulates in facilitating safety net access for immigrant families, with opportunities for each of these to support immigrant families as well as remaining challenges.

FIGURE 1

Organizations that May Support Immigrants in Accessing Safety Net Programs in North Carolina



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Importance of Trusted CBOs as Intermediaries

As mentioned earlier, interviewees raised immigration-related fears and language access barriers repeatedly as major challenges for immigrant families applying for safety net programs. Consistent with prior research (Yoshikawa et al. 2014), we consistently heard that immigrant-serving CBOs offer key support for informing and supporting families in navigating enrollment processes. This includes outreach efforts and raising awareness of benefit programs, explaining and interpreting English- and foreign-language materials, assisting with completing and submitting paper and online applications, contacting and scheduling appointments with county agency staff, sending appointment and documentation reminders, attending appointments with immigrant clients to provide interpretative support, and responding to county correspondence. A CBO stakeholder shared,

> That's what our job is—it's setting up an appointment to go down to Social Services or to meet wherever. We set it up. Sometimes they may need someone to go with them if they don't have a translator available.

HHS county agency staff we interviewed were encouraging of this function, recognizing that CBOs are sought out by immigrant communities for being trusted entities and equipped to provide linguistically and culturally responsive assistance in navigating the process of applying for and renewing benefits. A state HHS stakeholder acknowledged the agency's limited capacity to engage with some community members and infrastructure for language access, including bilingual staff.[19] A CBO stakeholder articulated CBOs' key intermediary function:

> [Immigrants] need to have access to a place where they're going to talk to them in their language. Otherwise, they are very intimidated. So, when they come to us [an immigrant-serving CBO], they know that we're going to explain to them the whole process in Spanish and they're going to feel safe.

Recognizing that many immigrants will first contact trusted CBOs, which are often identified by word of mouth, to ask for guidance on how to apply for safety net programs, a state HHS stakeholder shared that they are aiming to increase enrollment of immigrant families in Medicaid by training CBO staff on the program and having them engage with community members. She described this as a way to supplement county agency staff capacity:

> My favorite model is "train the trainer" model. By assigning community-based organizations and training them [on] Medicaid, we can then deploy them back to the community…. I'm just thinking about how we can take some pressure off from county DSS offices.

Another CBO stakeholder noted the importance of leveraging community spaces as access points to enroll immigrant clients, suggesting the possibility of placing agency staff physically at CBOs rather than county agencies:

> The location of the service has to be local [and] has to be trusted. [We should consider] moving away that DSS [is the] only [entity] that can enroll someone. Can you open up a kiosk in [a trusted immigrant-serving CBO], or our [local church] …? Some place where people [can] go to and they can fill out an application, that would be easier.

Precarious Funding for CBOs

With the exception of refugee resettlement agencies that receive federal funding, many immigrant-focused outreach and assistance efforts are not funded by HHS agencies; rather, CBOs provide these needed supports with their own funding. A CBO stakeholder stated that immigrant-serving CBOs often conduct enrollment assistance akin to government employees, but the compensation and financial

support is absent, and urged agencies to "compensate the nonprofit, don't just ask them to do it. Pay them because they are now filling in the role of a DHHS worker."

Unlike immigrant-serving CBOs, refugee resettlement providers are government-contracted for their enrollment assistance work as part of the refugee resettlement system. But even there, a refugee resettlement stakeholder mentioned that they have limited staff capacity because of limited funding, which hinders their ability to meet case-management demands and requires them to seek additional funds to provide effective care. They mentioned the very high caseloads, noting for example that there were only two case workers to serve 300 clients in one city.

Geographic Variability of CBO Availability across the State

The availability of CBO support for immigrant families appears to vary across counties. In general, urban areas tend to have more immigrant-serving CBOs, whereas rural counties have fewer resources generally and fewer immigrant-serving CBOs specifically. As noted above, stakeholders shared examples of immigrants traveling from rural communities to cities to seek enrollment in programs or to access services. Some interviewees noted exceptions in cases of immigrants or immigrant-serving organizations across multiple rural counties forming multicounty coalitions to advocate for support and resources.

Inadequate Community Health Worker Capacity

Multiple stakeholders emphasized that training and deploying community health workers has been a promising strategy to improve safety net access for immigrant families. A CBO stakeholder articulated that community health workers can provide culturally responsive guidance because of their shared identities with clients, ability to speak with immigrants in their native language, and first-hand experience of navigating and applying for public programs:

> We ourselves have navigated these systems and understand what it means to navigate these systems and then to teach others in our communities to access these systems. As community health workers, we provide that cultural expertise to our communities that you really can't get anywhere else. We empathize with the communities we're working with because we know the struggle. We've lived it, we understand it, and we know how to help them get what they're looking for.

A county HHS stakeholder commented that with the COVID-19 pandemic, their public health department had created a community health worker program to facilitate COVID-19-vaccination outreach. The stakeholder attributed the success of the department's vaccine outreach efforts to their

community health workers being viewed as trusted messengers. They shared that community health workers are an important strategy:

> The goal in what we are really working towards with the community health workers is to link people back to public health services. So going out into the communities and have people who are Latina or African American, who are Hmong, who can go out into their communities as trusted individuals and they can talk about the services to people in a nonthreatening way, in a safe way, and refer people back into our services that we provide; as well as the services that other community partners provide.

A CBO stakeholder shared that they train their community health workers to meet community members where they are by knocking on doors, conversing with them, and connecting them to resources immediately afterward. They are also trained to frequent cultural hubs, churches, and centers where they can identify more eligible immigrant family members to enroll. But despite the overwhelmingly positive benefits of community health workers, according to this stakeholder, they described challenges and frustrations associated with obtaining state funding to support these activities. Multiple CBO stakeholders argued for state and county agencies respecting community health workers as key partners; as one mentioned, their role should be "part of the outreach, policymaking, [and] coordinating of care processes." Another health stakeholder mentioned the state agency's current interest in assessing the value of community health workers and advocated for Medicaid reimbursement for their services—a benefit that would be "so valuable to all patients but particularly to people who don't speak English or are recent immigrants." She pointed specifically to the need "to recognize the value of community health workers for the larger health system and the savings that it can create."

Unique Role of Consulates for Immigrants

Stakeholders also shared that consulates provide an important source of information and resources for immigrant communities, in particular recent arrivals. A Mexican consulate stakeholder shared that in addition to offering Mexican government specific programs for immigrants residing in the US, they explain to immigrants how benefit programs offered in the US differ from Mexico. Both the Mexican and Guatemalan consulates offer kiosk space at their offices where HHS agencies and local immigrant-serving CBOs rotate their presence and support program access by presenting information to immigrant families and referring them to trusted CBOs for further assistance. A consulate representative shared the following:

Nosotros somos un puente entre la comunidad y las diferentes organizaciones (organizaciones no lucrativas e instituciones gubernamentales). Somos un puente para que esas personas puedan tener la información y recursos que a veces, por la mal información que existe, no saben o piensan que es otra cosa.	We are the bridge between the community and different organizations (nonprofits and government agencies). We are the bridge that provides information to people and share resources that sometimes, due to incorrect information, people are not aware exist or think it's something else.

Challenges Faced by State and County HHS Agencies

Interviews with stakeholders across the state also identified several challenges faced by state and county HHS agency staff, which make it harder for them to serve clients, especially immigrant clients.

Staff Capacity Challenges

Many key stakeholders outside of state and local government reported that county agency staff tasked with processing safety net program enrollment were overwhelmed because of understaffing of county agencies.[20] For instance, in one county, though a CBO stakeholder reported that responses from county agencies were "pretty quick," another reported a much more common perception: "calling and calling the number on the letter … and she never answers the phone. And I've heard it many times that they never answer the phone because … their workload is [very high]." Another state HHS stakeholder speaking about county agencies across the state said there was not enough staff capacity to assist families in completing applications and cited staff vacancies at the state and local levels as well as the large numbers of clients for each case worker as key challenges.

County agency staff themselves also shared challenges keeping up with demands, especially in the COVID-19 and post-COVID-19 eras, related to factors such as COVID-19-related absences and vacancies in positions (such as related to increased competition for workers who could more easily find jobs offering telework options) while demands for their work increased. As one explained, "We had internal staff that were impacted by COVID, our caseloads went up, and our vacancy rate increased as well. We were hit with [a] double whammy trying to assist our families and making sure that families had the services they needed in a timely manner." Although these limitations can limit access for all program applicants, the implications may be even larger for immigrant clients. A county HHS stakeholder identified staff turnover as a particular challenge to effectively building trust with immigrant clients. Another noted that although outreach events are more successful when held outside of standard

working hours, on weekends when immigrant families may be more available, it is a challenge to find sufficient HHS staff to attend such events.

Variation across Counties and Regions

Stakeholders also cited North Carolina's county-based social services program structure as a challenge to informing immigrant families about available benefits. Though county HHS stakeholders indicated they can and do process applications for residents of other counties, some also described county variation in the availability of resources for clients and in procedures. For instance, one shared that though their county offered in-person assistance for clients who preferred to walk into offices and inquire about programs, others did not have that capacity. Moreover, we learned that each county does their own training, which can result in differences in understanding of various program rules and may even be related to different counties assessing eligibility differently. Multiple county HHS stakeholders shared that the subjectivity inherent in determining eligibility by applying complex rules to assess clients' circumstances can lead to variation in outcomes across counties. A county HHS stakeholder described this challenge:

> Some counties may say that [clients] are not eligible based on their interpretation of that piece of policy; [but] that other counties may say that they are. We all try our best to work with the same guidelines, but there is always a grey area on how you interpret certain things.

Such variation may be especially pertinent for immigrant clients, given more complex documentation requirements described above. A state HHS stakeholder furthermore shared an additional challenge of relaying and applying different eligibility rules for different programs; a colleague might assess a family for eligibility for food benefits, but that would not necessarily indicate the family's eligibility for health benefits, so lack of alignment in program rules across various programs introduces inefficiencies. And a CBO stakeholder shared that the state's division into Medicaid regions, where different managed care plans operate in different geographic areas, causes confusion and makes it harder to help clients who may live in a different county from the CBO location understand and access needed benefits.

Staying Up to Date on Changing Rules and Populations

In a state like North Carolina with quickly shifting patterns of immigrant settlement, HHS staff face challenges learning and relearning about the complex eligibility rules for different statuses, especially in geographic areas of the state receiving new populations for whom new rules apply. A county HHS

stakeholder referred, for example, to recent Afghan arrivals and other humanitarian arrivals who are eligible for federal safety net programs and not impacted by the five-year bar on benefit program enrollment. Knowledge of the details of such rules was also described as variable across counties, and the lack of standardized communication across counties resulted in one county learning about a certain population's status but not necessarily sharing it with other counties, resulting in inefficient variability of how to process certain immigrant groups' applications across localities.

Processing Eligibility Determination for Immigrant Families

Consistent with reports from CBO stakeholders and focus group participants, county HHS stakeholders shared challenges related to clients accessing needed documents and verifying those documents, which can result in delays in connecting families to programs. Overall, interviewees described some processes as having gotten easier in recent years, such as during the COVID-19 pandemic when verification processes were eased, but waits related to getting documentation from individuals and having to verify the documentation with the state persisted. Both the greater likelihood of immigrants working in jobs that were harder to document via ongoing pay stubs and having to submit immigration documentation were contributors to delays. A county HHS stakeholder described feelings of frustration about complicated documentation requirements contributing to such delays, saying the week that it would take for a family to gather all the documents needed to verify eligibility "is a week I could have put a Medicaid card in [their] hand, or an EBT [electronic benefits transfer, or SNAP] card." Challenges were exacerbated by the transient residency status of some immigrants, who may move between counties within short periods or even cross state lines and face changing rules for benefits.

Changes in State and County Policy and Practice to Support Immigrant Families in North Carolina

Stakeholders, focus group participants, and community listening session participants discussed a wide range of solutions to address the challenges described above and improve safety net access for immigrant families, many of which would also improve outcomes and experiences for families regardless of immigration status. In table 3, we describe a range of best practices and solutions that emerged from the research, with specific recommendations for two primary sets of actors: the state HHS agency and county-level HHS agencies.

TABLE 3

Policy and Practice Changes for State and County Department of Health and Human Services Agencies to Address Challenges Immigrants Face Accessing Safety Net Programs in North Carolina

	Changes to Policy and Practice	
Key Challenges	**State**	**County**
Mistrust and immigration-related concerns	▪ Invest in **community health workers with diverse backgrounds who serve as intermediaries** to connect immigrants to enrollment processes and other community resources ▪ Remove any **unnecessary requests for information** such as Social Security numbers (SSN) for family members applying on others' behalf from applications; ensure programs, such as school nutrition and health programs actively inform parents that they do not have to have an SSN to apply on behalf of their children; provide clear public messaging about available resources that do not require an SSN ▪ Conduct **welcoming outreach and disseminate clear, accurate information** about complex eligibility rules to both the public and state and county HHS employees, especially for varying immigration status qualifications ▪ Leverage **popular social media websites** and trusted organizations such as **immigrant-serving CBOs and consulates** to share official state	▪ Co-locate **HHS agency offices or staff in other organizations** such as food banks, health care providers, and schools ▪ For communications and engagement, **use trusted community spaces and events** where immigrant communities are present, such as schools, food markets, salons, and faith institutions ▪ Hire **more diverse staff** who represent immigrant populations; dedicate **outreach staff** to serve various immigrant communities ▪ Work with **community colleges to develop training** for future staff members representing diverse populations to build pipeline of workers ▪ Develop **county-level community advisory councils** and ensure that leadership of county agencies represents diverse populations ▪ Continue education efforts to inform and reassure against **public charge concerns**

Key Challenges	Changes to Policy and Practice	
	State	**County**
	resources and connect with community members ▪ Consider **state-funded Medicaid coverage expansions** such as for children regardless of immigration status ▪ Develop **state-level community advisory councils** and ensure that leadership of government agencies represents immigrant populations ▪ Continue education efforts to inform and reassure against **public charge concerns**	
Complex enrollment and recertification processes, including documentation requirements	▪ **Fund enrollment assistance services** provided by CBOs and community health workers; consider **training and authorizing CBO staff** to conduct screening and enrollment ▪ Provide more consistent **updates to county staff** to keep them up to date on changing policies and developments on eligible populations ▪ Mandate **consistent staff training** across counties on enrolling and serving immigrants, including complex immigration eligibility rules, and foster connections between county agencies for shared learning ▪ **Increase ePASS (online application portal) accessibility** for immigrants by addressing logistical challenges and seeking input from CBOs on needed improvements ▪ Expand list of approved **alternative identification documents** and encourage county agencies to use consistent requirements for documentation ▪ **Clearly communicate detailed eligibility rules** regarding sources of confusion, such as income fluctuations, self-employment income, income for multigenerational households, how benefits may change under a change in status, and procedures for maintaining benefits when moving across state lines ▪ Regularly collect feedback from county agencies for **addressing emerging developments** being encountered on the ground ▪ Provide **easy-to-use resources** to support county staff in serving diverse immigrant clients	▪ Simplify enrollment process by supporting **easy sharing of documentation materials**, such as transmission of required documents by phone or online rather than in person ▪ **Collect feedback from clients** on their experiences, including experiences of discrimination and mistreatment, to identify common obstacles and target improvements to process stages where challenges often occur ▪ Improve communications challenges by implementing a text policy to **alert clients when action is needed**, and **allowing CBO case workers to directly receive communications** and act on behalf of clients

Key Challenges	Changes to Policy and Practice: State	Changes to Policy and Practice: County
Lack of language access and other communication hurdles	▪ Collect and analyze **data to assess language needs**, understand gaps in access and where communication breaks down, set priorities for outreach and improved service processes, and dedicate funding for solving identified problems ▪ Better leverage **Medicaid funds for translation and interpretation** and provide resources to county agencies to support language needs ▪ Centralize **translation and interpretation contracts** within the state HHS and across county agencies ▪ Centralize **language support for medical providers and others** serving immigrant populations using safety net programs ▪ Fund **targeted multilingual outreach efforts** that work with CBOs to reach underserved immigrant populations, especially in non-Spanish languages ▪ Provide **ePASS accessibility in multiple languages** ▪ Ensure **translated materials are understandable** for people with lower literacy levels and **culturally relevant** for different immigrant groups in the state	▪ **Hire and retain more bilingual/multilingual staff,** such as through encouraging speakers of non-English languages to apply in position listings and ensuring compensation is commensurate with the additional language support they provide ▪ Use available **multilingual staff in direct client-serving positions** ▪ Seek **additional funding to support emerging non-Spanish languages needs** and connect with immigrant- and refugee-serving community organizations with needed linguistic competence ▪ Identify **top county language needs** ▪ Work to **align communications** with clients' language preferences and use all available resources and intermediaries to support clients ▪ Utilize **in-person contact** when needed to assist with challenges faced by clients with limited reading ability ▪ Ensure staff are **aware of available translated materials** and offering them to clients
Disconnects across various safety net programs	▪ **Leverage NCCARE360**, the state platform to connect people to a broad range of community resources, by expanding the number of immigrant-serving CBOs and other resources that are part of the platform ▪ Continue **cross-enrollment efforts** working to connect applicants for one program to others they may be eligible for ▪ Work toward **more consistent eligibility rules** across programs ▪ Develop **tools for potential applicants to better estimate their eligibility** for available benefits	▪ **Co-locate** multiple social service agencies in locations frequented by immigrant families

Source: Key informant interviews.

Notes: CBOs=community-based organizations; HHS=North Carolina Department of Health and Human Services.

Discussion

Interviews with key stakeholders and focus groups with immigrants identified a range of challenges faced by North Carolina's immigrant families in accessing safety net programs. They face structural barriers common for all applicants navigating program enrollment processes including limited awareness, transportation and scheduling difficulties, and communications and technology challenges, as well as barriers specific to their immigration status and language backgrounds, related to language access, immigration-related fears and hesitancy, complex immigrant eligibility rules and documentation challenges, and experiences of discrimination. Moreover, stakeholders noted challenges faced by state and county-level HHS agencies and CBOs in supporting North Carolina's immigrant applicants and enrollees. Findings from focus groups also identified specific barriers accessing safety net programs for Spanish, Swahili, and Hmong speakers in North Carolina (Guelespe et al. 2023a, b, c), suggesting variation in these barriers across groups.

Several of these barriers stem from structural limitations of the safety net system, such as federal and state policies that bar many immigrants from programs altogether, insufficient and undertrained staff, and complex eligibility rules that vary across programs and across family members in mixed-status families (Acevedo-Garcia et al. 2021; Allen et al. 2023). Moreover, barriers identified here are likely not unique to North Carolina, given longstanding national immigration policies, federal rules that bar undocumented noncitizens and many noncitizens with lawful status from safety net programs, a labor market that disproportionately limits many immigrant workers to low-income jobs, and underresourced state agencies and CBOs (Dyssegaard Kallick and Capote 2023; Hacker et al. 2015; Perreira and Pedroza 2019; Perreira et al. 2012).

Interviewees and focus group participants identified multiple ideas for state- and county-level changes to policy and practice to address mistrust and immigration-related concerns, simplify complex enrollment and recertification processes, remove language and other communication barriers, and improve connections across various safety net programs. In particular, several priorities arose as key to improving the equitable access of North Carolina's immigrant families to safety net programs, including the following:

- **Customized engagement and outreach by government agencies** can help change how North Carolina's immigrant communities view safety net programs and work to change presumptions of ineligibility or immigration-related concerns. Efforts need to be multifaceted and customized for the needs of different immigrant communities. Prior research has found that information

from government agencies is trusted as the most credible source for information on intersections of safety net use and immigration (Bernstein et al. 2020; Vision Strategy and Insights 2020). Government outreach can convey welcoming messaging that clarifies who is eligible and reassures families about their immigration-related concerns, such as public charge (Hager 2020), while emphasizing the importance of seeking needed benefits for eligible family members[21]. Different immigrant groups may respond to different messaging and communications platforms such as Facebook, TikTok, or WeChat (Vision Strategy and Insights 2020). Agencies can seek immigrant communities' input to identify priority problems and potential solutions that center their experiences, such as through diverse representation in advisory councils or consistent collection of client feedback; the current language access task force mentioned by a few stakeholders could be a useful vehicle for gathering and using community input. Additional tools to allow families, CBO staff, and other stakeholders to quickly estimate applicants' likely eligibility for benefits prior to applying—especially if such tools were available in a variety of languages and incorporated variation in immigration statuses into eligibility estimates—could be especially useful for immigrant and mixed-status families.

- **Supporting language access needs beyond Spanish** is especially critical for North Carolina's HHS agencies to improve safety net access for immigrants. In addition to continuing to improve access for Spanish speakers, North Carolina's county agencies could do more to serve other language needs specific to their local area, whether that is indigenous languages for immigrants from Central America, or languages more commonly spoken by refugees, such as Swahili or Arabic. Immigrant demographics and corresponding language needs vary across localities, and gathering accurate and current information on immigrants can be a challenge given data limitations.[22] Collecting input from CBOs that are supporting families is one way to gather information on emerging language needs, in addition to being attentive to expressed language needs among current program enrollees. The state can provide additional translated materials for smaller language groups that do not meet minimum state thresholds, and can ensure that available translated text is accurate, understandable for people of varying literacy levels, and culturally effective (Hofstetter, McHugh, and O'Toole 2021). Given many immigrant families' preferences for in-person enrollment processes, additional ideas for improving language access include creating staff directories of multilingual employees and suggesting bilingual staff wear language identification cards, in addition to incentives for multilingual staff during staff recruitment, staff training on language access, and public postings of language access rights (Hofstetter, McHugh, and O'Toole 2021).

- **Partnership with immigrant-serving CBOs and community health workers** is also critical. Several stakeholders noted that the racial and ethnic health disparities exposed by the COVID-19 pandemic provided an opportunity for CBOs and agencies to work collaboratively. Several statewide coalitions and task forces were created to work alongside CBOs and agencies, and funding for community health workers was increased. The combination of setting goals that address disparities; collecting, monitoring, and communication of data; and community outreach can be replicated for the purpose of increasing immigrants' safety net access and experiences.

  Despite CBOs' and community health workers' importance for increasing immigrant communities' access to the safety net, interviewees repeatedly highlighted the need for the state to better support these organizations in the key enrollment assistance and navigation roles they provide. Several states are currently supporting CBOs in outreach and engagement around the unwinding of the Medicaid continuous coverage provision. For instance, Arkansas is awarding a range of mini grants to CBOs to conduct informational meetings, share materials, and assist enrollees with renewal processes (Lopez and Buddenbam 2022). In addition to the state, cities, counties, localities, and philanthropies can also assist CBOs in their work supporting immigrant communities, such as through developing sustainable funding mechanisms, promoting multisector collaboration, and engaging communities (Allen et al. 2021).[23] North Carolina could also take advantage of opportunities to fund community health workers to support Medicaid enrollees. In 2021, half of states—including southeastern states like Georgia and Louisiana—had integrated community health workers into Medicaid: 15 states used Medicaid funding to reimburse community health workers and in another 10, managed care organizations reimbursed or hired such workers.[24] Increased state financing would need to be structured to be sustainable over time (National Association of Community Health Workers 2020, Kumar and Muñiz 2022).

- **Diversifying HHS staff, through both hiring and retention,** can help address the structural barriers of lack of language access and discriminatory treatment and racism. Consistent observations from stakeholders and focus group participants on the lack of diverse HHS agency staff speak to the lack of voice, support, and representation of immigrant populations at the local, county, and state levels of government. They also speak to the need for equitable work environments so that people who represent immigrant communities feel welcome to join and remain in HHS agency positions. In addition, several stakeholders referred to varying levels of information gaps among county HHS staff and insufficient information sharing across counties,

suggesting that more expansive and consistent training of staff and provision of support resources could not only improve the customer service caseworkers deliver but reduce their workload. To support caseworkers in serving immigrant clients, New Mexico's Medicaid agency launched new training to inform caseworkers about immigrant eligibility, appointed an expert on immigrant eligibility to lend consistency to enrollment and application processes across the state, and developed an internal immigrant eligibility tool (Hager 2020). Efforts may also need to be accompanied by anti-bias training and other efforts to promote a more inclusive workplace.

Interviewees also recognized burnout by HHS staff, and a few connected mistreatment to high workloads. The federal government has acknowledged staffing crises in the human service sector, with workers reporting high caseloads, long hours, and stress, which can result in inconsistent services for families.[25] These factors are then compounded for staff who are the only, or one of a few, multilingual speakers or people of color. Strategies for building a more sustainable, equitable workforce could include building the capacity of people with lived experience; fostering a culture that values justice, equity, diversity and belonging; creating leadership development programs among racial and ethnic minorities; specific supports for multilingual staff; and managing workload through streamlined processes (Children's Bureau, Administration for Children and Families 2022).[26]

- **Simplifying program enrollment and retention processes**, especially during the current Medicaid unwinding period and upcoming implementation of Medicaid expansion, would benefit all enrollees but could disproportionately reduce burdens among eligible immigrant clients. Expiration of pandemic protections like the Medicaid continuous coverage requirement is especially risky for immigrant populations because of the barriers mentioned in this report (D'Avanzo 2023). Thus, greater use of *ex parte*, or automatic, Medicaid renewal procedures is especially important for immigrant families. Centers for Medicare & Medicaid Services resources offer states specific guidance for ensuring people with limited English proficiency can access key communications about unwinding, including reviewing language access plans, ensuring documents are translated and reviewed in languages needed for local areas, utilizing telephone interpreters, and increasing public awareness of language services (Centers for Medicare & Medicaid Services 2021). North Carolina agencies can follow other states in collaborating with CBOs or following models such as California's Coverage Ambassador program[27] to promote Medicaid retention in the wake of unwinding (Haldar, Artiga, and Rudowitz 2022; Lopez and Buddenbaum 2022).

Once Medicaid expansion is implemented in North Carolina, beginning in December 2023, there are several steps the state can take to enroll people quickly, including using information from other programs and expanding presumptive eligibility (Schubel 2020). Providing accurate, welcoming, multilingual information about eligibility rules that addresses concerns such as public charge will be important. Reducing enrollment barriers that are especially troublesome for immigrant families and people with limited English proficiency, such as difficulties navigating ePASS that came up repeatedly in our interviews, would also help support such families in accessing newly available coverage, as would supporting the CBO staff who current assist families in navigating ePASS.

- Finally, **state action to expand eligibility to additional immigrant populations** would improve access to safety net programs**.** Even under restrictions on federal funding for excluded immigrants, the state can take advantage of options under current law or elect to use state funding to extend eligibility. North Carolina has already taken up the option to remove the five-year wait after receiving qualified status for immigrant children and pregnant women to qualify for Medicaid. But it has not taken up the option that 20 states have adopted as of July 2023, including other Southern states such as Louisiana, Tennessee, Texas, and Virginia, to provide CHIP "unborn child" coverage for pregnant people regardless of immigration status (Brooks et al. 2023). In addition to North Carolina's implementation of a 12-month postpartum extension under the American Rescue Plan Act, it could also join seven other states in extending such coverage regardless of immigration status using CHIP health services initiative funding or state dollars (Brooks et al. 2023). More broadly, a total of 12 states and the District of Columbia cover income-eligible children and five states and the District of Columbia cover income-eligible adults regardless of immigration status using state funds, while others offer Marketplace coverage for excluded immigrants with state funding—opportunities North Carolina could also adopt to dramatically improve health coverage options for immigrant families (Kaiser Family Foundation 2023c).

Ultimately, a range of changes to policy and practice will likely be needed to ensure that all of North Carolina's residents can access the safety net programs they need to meet their nutritional, health, housing, and other needs. Some changes, such as broadening program access for more immigrants and strengthening support for immigrant-serving CBOs, may require statewide or legislative action. Others, such as promoting more inclusive messaging and improving HHS' staff awareness and use of multilingual resources already available, may be more attainable for counties and localities in the shorter term. In addition, stronger accountability may be required for safety net program offices,

counties, and the state to provide immigrant families with the benefits for which they are eligible and quality service they deserve—with the goal of creating a more inclusive safety net for North Carolina's immigrant families.

Notes

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About the Authors

Hamutal Bernstein is a senior fellow in the Income and Benefits Policy Center at the Urban Institute, where she leads Urban's program on immigrants and immigration. Her research focuses on the well-being and inclusion of immigrant and refugee families and workers. Her areas of expertise include immigration, workforce development and training, and human services. She is a mixed-methods researcher, with experience in policy analysis, program monitoring and evaluation, technical assistance, multilingual qualitative and survey data collection, and qualitative and quantitative data analysis. She is a principal investigator on the Annual Survey of Refugees for the US Department of Health and Human Services and leads research on immigrant families' access to safety net supports. Bernstein received her BA in international relations from Brown University and her PhD in government from Georgetown University.

Jennifer Haley is a principal research associate in the Health Policy Center at the Urban Institute, focusing on maternal, child, and parental health and health care; Medicaid and the Children's Health Insurance Program; and health equity. Her current research assesses challenges immigrant families face accessing public programs; coverage, access, and health care utilization during the postpartum period; barriers to enrollment in publicly subsidized health insurance coverage; opportunities for improved collection and use of data on race and ethnicity; implications of the unwinding of pandemic-related coverage policies; and other issues related to coverage and care for children and families. Haley holds an MA in sociology from Temple University.

Diana Guelespe is a senior research associate in the Income and Benefits Policy Center at the Urban Institute and a member of Urban's inaugural 2022–24 Equity Scholars Program. She is a sociologist with several years of experience working with immigrant and refugee communities at the local, state, and national levels. Her areas of expertise include immigrant integration, well-being and access to community and government programs. Her qualitative research on mixed-status immigrant families and their daily challenge of driving without a license led to subsequent changes in state and local policies to improve access to driver's licenses for undocumented immigrants in Illinois and Washington, DC. It has also served as a resource to community groups in other states seeking similar policy changes. Guelespe holds a PhD in sociology from Loyola University Chicago.

Sofia Hinojosa is a research analyst at the Health Policy Center at the Urban Institute. Her research focuses on health equity, immigration policy, and strengthening safety net programs. She also completed health policy fellowships at Carnegie Mellon University and the University of Michigan School of Public Health. Sofia graduated with honors from American University, where she earned a BA in public health and a certification on community-based participatory research.

Luis Hassan Gallardo is a research analyst with the Health Policy Center at the Urban Institute. His past research focused on United States immigration policy and the barriers vulnerable populations face in accessing health and welfare services. Gallardo graduated from the University of California, Berkeley with degrees in political science and ethnic studies.

Hannah Gill is associate director of the Institute for the Study of the Americas and director of the Latino Migration Project at the University of North Carolina – Chapel Hill. Gill is an anthropologist and oral historian with a specialization in Latin American and Caribbean migration studies. Her research has examined local immigration enforcement, transnational migrant communities, and the history of Latin American migration in North Carolina. She received a DPhil in social anthropology from the University of Oxford, England, and a BA from the University of North Carolina – Chapel Hill.

Krista Perreira is a professor of social medicine in the School of Medicine at the University of North Carolina – Chapel Hill. Perreira is a health economist who studies disparities in health, education, and economic well-being and interrelationships between family, health, and social policy. Focusing on children in immigrant families, her most recent work combines qualitative and quantitative methodologies to study migration from Latin America and the health and educational consequences of migration. Through her research, she aims to develop programs and policies to improve the well-being of immigrant families and their children. She holds a PhD in health economics from the University of California at Berkeley.

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