HEALTHCARE FOR ALL IMMIGRANTS:

A CASE STUDY OF HEALTHIER OREGON'S IMPLEMENTATION

by

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Immigrants are a vulnerable population that faces significant barriers to healthcare access and coverage due to their legal status. In 2021, Oregon passed HB 3352: Healthier Oregon, a program that opened state Medicaid benefits to Oregonians who qualify, regardless of immigration status. This study reviews the national healthcare options for low-income immigrants, framing Healthier Oregon's implementation as a case study. This study collected qualitative data through two sets of interviews: 1) in-depth interviews with community partners across Oregon to identify the successes of implementation and remaining barriers and 2) brief interviews with state officials to understand their programs and efforts to expand coverage to this population. The main success of Healthier Oregon, thus far, according to community partners is offering access to care to an underserved population. However, community partners note persistent barriers such as fear, language barriers, difficulty navigating medical systems, and capacity limitations impede many people from enrolling. State officials echo these barriers immigrants face in their states and demonstrate the variety of avenues, both creative and complicated, states may take to expand healthcare coverage. This research aims to inform future policy decisions to foster equitable healthcare access for all residents, irrespective of documentation status.

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Introduction

Immigrants are one of the fastest-growing vulnerable communities in the United States, making up 15.5% of the US population in February 2024, growing at a rate of 172,000 a month (Camarota & Zeigler, 2024). The rate of growth is so high that the Census Bureau estimates from November 2023 are now obsolete, not predicting that the share of foreign-born individuals would reach 15.5 percent until 2039. This unprecedented growth underscores the need to address the unique challenges faced by immigrant communities. Immigration is a highly politicized topic in the US with political and social rhetoric impacting perceptions, treatment, and social mobility of immigrant communities. Immigrants face numerous and complex barriers that impact their ability to gain stability, security, and prosperity.

One of the most pressing factors is access to high-quality, affordable, and culturally competent healthcare. Immigrants, especially those without permanent legal status or who have low-income backgrounds, encounter significant barriers to accessing regular health services or any at all. Among these barriers are limited eligibility for health insurance programs, fear of deportation or jeopardizing one's immigration status, language and cultural differences, and technical obstacles such as navigating complicated health systems. As compared with US-born individuals, immigrants are more likely to be underinsured, have a lower socioeconomic status, and overall have poorer health outcomes (Schumacher et al., 2023). As a result of the intersections of immigration, health, and welfare policy with political and social climates, immigrants are overrepresented in the underinsured population (*Key Facts on Health Coverage of Immigrants*, 2023). Numerous barriers to accessing important health services have prevented adequate care for both documented and undocumented immigrants.

Medical insurance coverage is a significant determinant of health outcomes. Medicaid, federally funded insurance for low-income individuals, is a vital program to bridge gaps in insurance coverage. Both a federal and state program, Medicaid particularly helps close gaps for vulnerable populations who may otherwise struggle to access healthcare services. However, Medicaid, as a federal program categorically excludes many immigrant categories. Individuals who have undocumented or otherwise non-qualifying immigration statuses are barred from enrolling in federal programs, even if they otherwise qualify. Individuals who are not eligible due to their immigration status are more likely to go uninsured and seek less healthcare (A. Pillai et al., 2024). Health coverage opens the door to accessing regular medical care, managing chronic conditions, and engaging in preventive care. Already a vulnerable group, low-income immigrants who must go without healthcare are at risk of developing or worsening health conditions and outcomes (Schumacher et al., 2023). Struggling with health conditions, including poor mental health, can affect other areas of one's life such as employment, education, social relationships, and daily stress, among others.

States are aware of the gap in insurance coverage that exists for low-income immigrant groups. The gaps that Medicaid is intended to fill are left vacant for this population. States have power over the management and organization of their own Medicaid programs. Several states have opted to expand coverage to immigrant groups or ease restrictions by taking advantage of federal options and using state dollars to pay for services federal funding will not (Schumacher et al., 2023). In the past decade, Oregon has sought to provide healthcare coverage to immigrant groups who are unable to qualify for Oregon's Medicaid program, Oregon Health Plan (OHP). Coverage expansion has been gradual, first limited to federally required Emergency Medicaid, then expanded to children and pregnant women. In July 2021, Oregon state legislature passed

House Bill 3352: Healthier Oregon (formally "Cover all People"). Under the bill, OHP benefits are open to all Oregonians, regardless of immigration status. The program rolled out over two years to encompass all age groups. Now, all immigrants residing in Oregon who meet income guidelines are eligible for encompassing, Medicaid-like coverage for themselves and their families.

A severe lack of literature exists on state programs that have expanded coverage to low-income immigrant residents, including Healthier Oregon. Increased independent research and scholarship around how programs like Oregon's function, are implemented, engage with communities, and lead to service use and health outcomes are important to improving, maintaining, and expanding coverage to immigrant communities. Even fewer studies have tried to compare how these Medicaid programs differ or are similar in regard to administration. My first research question addresses this gap in scholarship. In Oregon, just two reports on Healthier Oregon have been published by Oregon Health Authority (OHA). This case study seeks to add to the limited information collected about this program during the first few years of its rollout.

This study will investigate the following questions:

1. *What are the key roles, challenges, and successes experienced by community partners involved in the implementation of the Healthier Oregon program, particularly in terms of barriers to outreach, enrollment, and service navigation for individuals with undocumented statuses?*
2. *How does the Healthier Oregon program compare with other state programs that offer healthcare coverage for low-income populations with undocumented statuses, in terms of breadth, challenges, and effectiveness?*

The objective of this study is to investigate the state of healthcare access for undocumented immigrants, focusing on healthcare coverage. To conduct this research, a federal overview of healthcare access and coverage options is summarized, highlighting how Oregon and other states offer coverage options for undocumented individuals. The investigation will exist on multiple levels to situate Oregon compared to other states and understand how different states can leverage their health systems to provide accessible and efficient care. First, I use a case study of the implementation of Oregon's recent policy, Healthier Oregon. This case study involves interviews conducted with community partners, individuals who are a key part of Healthier Oregon's implementation and whose roles are vital to connecting with this vulnerable population. Second, interviews were conducted with a handful of six states that have expanded widespread healthcare coverage to undocumented populations.

The findings of this research will be an important contribution to understanding how states can expand healthcare access to immigrant groups or different documentation states. My findings will be useful for states looking to expand or improve healthcare access to immigrant populations by understanding what other states have done. This is especially relevant now, marked by multiple states passing legislation and making plans to increase coverage for undocumented populations in the past few years. New York and Oregon, for example, expanded coverage in 2023. States like Colorado and Washington have expansion plans rolling out in 2024 (Pillai et al., 2024). The findings of the in-depth Healthier Oregon case study can help provide more information about the program evaluation from the perspective of community partners. This information is useful for OHA and community partners.

A Note on Vocabulary

Vocabulary is important, especially regarding vocabulary used to describe different populations. Immigrant groups in particular have been referred to using stigmatizing, incorrect, and misrepresenting language. In this thesis, I will refer to immigrant populations using neutral language. Due to the complicated nature of immigrant status categories used by the US and state governments, the variety of categories does not always accurately describe an individual's actual status. Referring to immigrants by their status categories can also decenter the human experiences of individuals. This thesis will be referring to immigration status groups at times, aiming to stay away from stigmatizing vocabulary. Some states elect to refer to “undocumented” statuses as “individuals with non-qualifying statuses.” When possible, I will use vocabulary that is a variation of that but at times, for lack of a better word, the “undocumented” label will also be used to refer to that specific category. In general, I try to use “non-qualifying immigrant groups.”

Background

Immigration in the United States

The latest US Census data shows that the total immigrant population in the US reached nearly 51.4 million individuals in 2024 (Camarota & Zeigler, 2024). From the first recorded numbers in 1851, the US has had a steady stream of immigrants entering the country each year. Since the 1970s, the number of immigrants has increased rapidly due to several economic, social, and political factors (Batalova, 2024). In most recent years, these factors have included the Covid-19 pandemic, the war in Ukraine, and perceptions of a more welcoming US migration policy under the Biden administration. In a Kaiser Family Foundation (KFF) Survey of immigrants, the top reasons listed for immigrating to the US include better economic and job opportunities, a better future for their children, better educational opportunities, to have more rights and freedoms, to join family members, and to escape unsafe or violent conditions (Schumacher et al., 2023). Rising numbers of migrants are not unique to the US with international migrants making up 3.5 percent of the global population in 2020 compared to 2.8 percent in 2000 (*International Migration*)

Immigrants in the US come from a variety of backgrounds. Self-reported race and ethnicity data collected by the KFF reveals 44% identify as Hispanic, 27% as Asian, 17% as white, 8% as Black, and 3% identify as multiple races. A quarter of adult immigrants in the US hail from Mexico followed by India (6%), China (5%), the Philippines (5%), El Salvador (3%), and Vietnam (3%) (Schumacher et al., 2023). Over half (55%) of US immigrants are naturalized citizens, meaning they are considered full US citizens. The remaining 45% of immigrants are considered noncitizens, with either lawfully present or undocumented statuses. It is estimated that 60% of noncitizens are lawfully present holding either a green card or a valid visa. The

remaining 40% of noncitizens can be assumed to be residing in the US without a lawfully present status, generally referred to as “undocumented” immigrants (Schumacher et al., 2023).

Measuring the exact numbers of undocumented immigrants is difficult as many individuals hesitate to disclose an undocumented immigration status for themselves or a family member for fear of deportation or endangerment. The size of the undocumented population was estimated to be around 11.2 million in 2021 according to the Migration Policy Institute (Soto, 2023). The main mode of entry for undocumented immigrants was arriving by plane and overstaying a visa. Of arrivals in 2016, 62% overstayed visas, and 38% entered the country without inspection (such as border crossings) (Warren, 2019)). Once in the US, immigrants without authorized statuses are ineligible for federally funded social programs such as food, housing, and healthcare subsidies. Notably, their immigration status bars them from enrolling in Medicaid and Medicare. Though undocumented immigrants cannot receive federally funded benefits, they do pay taxes through payroll and state sales taxes.

Healthcare Access and Barriers for Low-income Immigrants

The variety of barriers that recent, low-income, and undocumented immigrants face to accessing healthcare services significantly influence immigrant health. Since the late 1990s, several policies and regulatory changes have restricted and worsened the quality of care for immigrants. From the immigration policy perspective, one paper found that these changes include “restrictions on access to public health insurance programs rhetoric discouraging the use of social services, aggressive immigration enforcement activities, intimidation within healthcare settings, decreased caps to the number of admitted refugees, and rescission of protection from deportation” (Khullar & Chokshi, 2019). Changes in immigration policy and enforcement have made documentation status a powerful determinant of health access and outcomes.

Access to medical insurance is among one of the largest barriers to obtaining consistent, affordable healthcare. However, eligibility is not the only barrier immigrants face to benefit from medical insurance and human service programs. A Health and Human Services (HHS) brief reports that barriers exist on multiple levels, including program administration state to state, individual immigrants and their perceptions and understanding of the programs, and the general attitude towards immigrants in a community or state. The report identified several factors that contributed to lower application and usage rates for HHS programs, listed as "the complexity of the application process and eligibility rules; related administrative burdens; language, literacy, and cultural barriers; transportation and other logistical challenges; and climates of fear and mistrust" (Pereira et al.).

The evidence of lacking eligibility and access to insurance coverage in immigrant populations is extensive. A study compared the rates of uninsurance between US-born individuals and foreign-born individuals (it can be assumed that most were legal residents) in the years 2014 and 2015 (Doty et al., 2016). The study found that while both groups saw insurance gains, the foreign-born group remained three times more likely to be chronically uninsured. More recent numbers suggest this disparity in coverage remains and has likely worsened between immigrant statuses. A Kaiser Family Fund survey reports "As of 2023, half (50%) of likely undocumented immigrant adults and one in five (18%) lawfully present immigrant adults report being uninsured compared to less than one in ten naturalized citizens (6%) and U.S.-born citizen (8%) adults" (*Key Facts on Health Coverage of Immigrants*, 2023). Extending coverage was connected to more efficient use of resources (in line with the primary preventative care model). The study found that individuals who gained insurance had a substantial increase in routine, office-based physician care and an increase in medications filled (*Key Facts on Health*

Coverage of Immigrants, 2023). Research indicates that extending coverage to immigrant groups led to an increased use of healthcare services and in more efficient ways following a prevention model.

While health insurance coverage can increase the use of healthcare services, access to services is not only dependent on coverage. Eligibility for a program does not equate to access to care. Other barriers exist for immigrants that must also be addressed. Several studies use data from the annual California Health Interview Survey. California has a large, majority Latinx, immigrant population, providing a large dataset for studying differences in healthcare access and outcomes. A 2012 study was the first to compare healthcare access and utilization between documented and undocumented immigrant groups (Vargas Bustamante et al., 2012). The study obtained data from the 2007 California Health Interview Survey to examine disparities between Mexican immigrants. Undocumented immigrants were found to be less likely to have a doctor's visit in the previous year or a reliable source of consistent care than documented immigrants. The study found "sex, marital status, education, poverty status, and health insurance coverage" to be the most relevant factors to explain these differences, noting that time lived in the US and English proficiency are also important predictors of healthcare access and utilization. Conducted before the rollout of the Affordable Care Act (ACA), Bustamante predicts that if trends continue, "healthcare access and utilization disparities will diverge between documented and undocumented immigrants" (Vargas Bustamante et al., 2012). Documented immigrants have benefited from the rollout and expansion of the ACA in relevant states while undocumented immigrants remain ineligible for benefits.

Two other studies conducted using California Health Interview Survey data continue to support the findings that undocumented immigrants have the worst patterns of healthcare access

and utilization (Ortega et al., 2018). Compared to US citizens and other immigrant groups, undocumented immigrants had similar or fewer numbers of doctor visits, emergency department visits, and preventative services (Pourat et al., 2014). Despite undocumented immigrants consistently lower access to and use of health care services, a 2018 study finds that undocumented immigrants have the best health outcomes in comparison to other immigrant groups and US-born citizens. This study offers support for the "healthy immigrant paradox" in which recent immigrants are found to have the best health outcomes despite lower usage of health services. A variety of factors offer to explain this paradox and the protective effect of the paradox diminishes over time and through generations (Bacong & Menjívar, 2021). Supporting Bustamante's concerns, Ortega finds that "while the ACA has reduced racial/ethnic and income-based health care disparities, it has the potential to exacerbate disparities among undocumented immigrants." Comparing their findings to those from a decade earlier, disparities and utilization have worsened within this population. This evidence suggests that limited access to health coverage is an important factor that may contribute to the diminishing protective effects of the healthy paradox effect.

Concerns regarding healthcare access and outcomes among immigrant communities were further heightened during the COVID-19 pandemic. This population face heightened risk factors of contracting COVID-19 in medical, economic, legal, and social areas, resulting in poor socioeconomic outcomes throughout (Clark et al., 2020). A systematic review demonstrated how the COVID-19 pandemic exacerbated pre-pandemic disparities for two vulnerable groups of immigrants, asylum seekers and immigrants without qualified immigration statuses (*Health Coverage for Lawfully Present Immigrants*). The review found that these groups faced "pre-pandemic social and economic marginalization, exclusion from pandemic induced policy

measures, lack of appropriate pandemic communication, and reduced trust in governments and authority." Misinformation, confusion, and fear surrounding immigration policies and their enforcement have deterred immigrants from seeking medical attention throughout the COVID-19 pandemic. One study explains how limited coverage and a lack of trust among immigrants create a public health risk for all communities (Duncan & Horton, 2020). The COVID-19 pandemic revealed existing health disparities and will also continue to negatively impact health disparities and health equality (Hill et al., 2021).

"Public Charge" and Impacts on Healthcare Access

The Trump Administration's 2019 "public charge" rule is a change to immigration policy that increased fear and deterred immigrants from enrolling in public benefits. The public charge rule made an immigrant "inadmissible" on the ground that they are likely to become a "public charge," or likely to become primarily dependent on the government for subsistence (public benefits)(*Proposed Rule - Inadmissibility on Public Charge Grounds*, 2018). The public charge rule can prevent one from entering the United States as well as a reason to withhold permanent residency. Trump's public charge rule newly considered including noncash programs like Medicaid in this plan (Pillai & Artiga, 2022). This policy has direct effects on the review of green card applications and the ability to change immigration status (Katz & Chokshi, 2018). The rule also creates confusion about which immigrant groups and what services are subject to this rule.

The public charge rule has even wider indirect effects on immigrants by creating more reasons for immigrants and their families to avoid the use of public benefits such as healthcare. Kaiser Family Fund found that one-quarter of potentially undocumented Hispanic adults say they or a family member did not participate in an assistance program due to immigration fears (Katz

& Chokshi, 2018). One study analyzed the potential magnitude and chilling effect" of Trump's rule by analyzing data on the use of public benefits between 2014 and 2016 (Batalova, 2018). The study found that the rule may discourage millions of immigrants from accessing health, food, and social services. The "chilling effects" may particularly affect families with mixed immigration statuses, with US citizen children's parents disenrolling out of fear of immigration consequences. Batalova et al. predict these impacts will most impact states with large immigrant populations and inclusive public benefit policies. According at a survey in 2023, nearly three out of four immigrant adults, including nine in ten of those likely undocumented, reported "uncertainty about how use of non-cash assistance programs may impact immigration status or incorrectly believe use may reduce the chances of getting a green card in the future"

A nationwide injunction was issued by a district court in 2020, blocking the Department of Homeland Security from enforcing the rule during the COVID-19 pandemic (Irwin, 2020). The Biden Administration adopted a narrower definition of "public charge" following a 1999 policy, limiting the application of the rule (Kruzel, 2023). In January of 2023, the US Supreme Court dismissed an appeal by a group of 14 Republication state attorneys general seeking to revive Trump's public charge rule. Though the rule was only in effect from February of 2020 to March 2021, it had dire immediate consequences on the health of immigrant families, especially during a pandemic. The rule has had long-lasting effects of fear, discrimination, and hesitancy to enroll in public benefit programs for fear of jeopardizing an individual or family member's chances of gaining permanent resident status.

Medicaid Programs Available for Immigrants in the US

In the US, immigrants may have access to different insurance coverage and programs based on their immigration status, income, and state in which they reside. A lawfully present

immigrant includes those who have a “qualified non-citizen” status without a waiting period, humanitarian statuses, or circumstances (asylum applications or victims of human trafficking for example), or valid, non-immigrant visas (*Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Individuals*). Lawfully present immigrants (LPI) can buy private health insurance on the Marketplace. If an LPI meets their state’s income and residency rules, they may qualify for Medicaid and the Children's Health Insurance Program (CHIP). States have the option to eliminate a 5-year waiting period for pregnant women and children. If an immigrant meets their state’s income and residency rules but doesn’t have eligible immigration status, they may be able to seek benefits from Emergency Medicaid (*Health Coverage for Lawfully Present Immigrants*). Emergency Medicaid (EM) is the primary source of healthcare coverage available to undocumented or recent LPIs.

Federal Requirements

Under federal law, states must offer a set minimum of coverage for LPIs and those in certain humanitarian categories using federal funds. States have the option to further expand coverage to immigrant groups, commonly eliminating the 5-year waiting period for children and/or pregnant women or providing programs for nonqualifying statuses using federal matching funds. As of March 2024, 37 states and territories have taken up this option for children and 30 states and territories have adopted the option for pregnant individuals (*Key Facts on Health Coverage of Immigrants*, 2023). Many state expansion options also came under the ACA. For example, states could choose to extend CHIP under Medicaid expansions to provide care for children whose families may exceed the income limits (Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)) (*Immigrant Eligibility for Health Care Programs in the United States*, 2009). One study examining the expansion of the ACA in California found that

while the ACA led to major coverage gains for lawful permanent residents in California, undocumented immigrants only experienced modest increases in coverage gains (Porteny et al., 2022). Various implementation options and program configurations determine the federal funding available to the states for these programs. Additional coverage for LPIs is available in states that chose to expand the ACA though coverage does not extend to nonqualifying immigrants.

A table compiled and managed by the National Immigration Law Center displays medical assistance programs available for immigrants in each state (*Medical Assistance Programs for Immigrants in Various States*, 2024). The table aims to demonstrate not just the programs available but also if and how a state has chosen to take advantage of federal coverage options. These options are the use of federal funds to "provide medical coverage to lawfully residing children and/or pregnant persons, regardless of their date of entry into the U.S.; and/or federal CHIP funds are used to provide prenatal care, regardless of the pregnant person's immigration status"(Porteny et al., 2022). Services outside of those federal coverage options are funded entirely with state funds. In some states, such as Kentucky or Utah, only lawfully residing children qualify for medical assistance programs. Others, such as Delaware, also include pregnant people. In Michigan, Missouri, and Louisiana, prenatal care is available regardless of immigration status. Some states such as Colorado have chosen to further expand qualifications to different immigration states for certain services while others, like Texas, deny Medicaid availability to most qualified immigrants even after 5 years. This table demonstrates the variability in qualifications between the states and the diverse ways in which states have chosen to take advantage of federal assistance, or not.

Emergency Medicaid

Emergency Medicaid is available regardless of immigration status and provides limited coverage for emergency use. The Emergency Medicaid program is legally required in all 50 states due to the Emergency Medical Treatment and Labor Act (EMTALA) (*EMTALA Fact Sheet*). EMTALA is a federal law enacted in 1986 that requires "Medicare-participating hospitals with emergency departments to screen and treat the emergency medical conditions of patients in a non-discriminatory manner to anyone, regardless of their ability to pay, insurance status, national origin, race, creed or color" (Khullar & Chokshi, 2019). The policy requires emergency departments to "treat and stabilize" patients, designed to prevent hospitals from transferring and "dumping" patients to public hospitals without screening or treating them. Individual states can decide the scope of services provided under Emergency Medicaid including how an "emergency" is defined. Emergency Medicaid reimburses hospitals for emergency care and accounts for about $2 billion in spending annually (Khullar and Chokshi, 2019).

Contribution to Literature

To my knowledge, the Healthier Oregon case study is the first study concerning the implementation of a state program intending to expand coverage to immigrants unable to qualify for their state's Medicaid program due to their immigration status. The study provides an example of the vital role of community partner networks, examines implementation across geographic diversity, and is based on interviews conducted as primary data. The case study fits into the larger national context of state coverage expansions. In addition to contributing a case study, this study also provides a review of federal and state Medicaid expansion options to cover this population.

Literature Review: Community Partners

This study focuses on health or immigrant-focused non-profit organizations (NPOs) and community-based organizations (CBOs) and their role in the implementation of Healthier Oregon. This section focuses on literature that highlights the purpose, role, and position of NPOs and CBOs in the larger public health system. CBOs are “a public or private non-profit organization that represents a community or a specific part of a larger community, and targets meeting a specific need in that community” (Adebayo et al., 2018). CBOs are often designed to provide services, engage in advocacy, connect individuals to resources, and build community. CBOs are often nonprofit organizations (NPOs) and both aim to serve societal needs. However, CBOs typically focus on addressing specific concerns and representing the interests of a particular local community, whereas non-profit organizations may operate on a broader scale or target diverse issues.

Community-Based Organizations

Several theories attempt to explain the role of the nonprofit sector in filling in “gaps” in the provision of goods or services, such as healthcare. The market failure and government failure theories are relevant to the provision of health coverage and care for low-income immigrants. Market failure defines a situation where the free market fails to produce the demanded goods and services. In the nonprofit sector context, market failure is relevant when market prices for basic needs (such as healthcare or food) are priced too high to be affordable for some of the population (*Theories – Introduction to the Nonprofit Sector*). An example is the emergence of NPOs that provide basic or primary health care for those who cannot afford the market price of health insurance. The availability of public goods and services can also be impacted by government failure. Since the government aims to provide goods to the majority of the public, some goods

and services are left underprovided by the government. In the view of these two theories, NPOs and CBOs "fill in the gaps left behind by the inability of government and the market to provide to the public" (*Principles of Economics*, 2016). These local organizations are an essential part of the US public health system by serving those most in need and filling gaps in services left in healthcare systems (*CDC Foundation*).

Community-Based Organizations and Health

CBOs have long played a key role in the health sector. A 2001 World Health Organization report describes the role of civil society in health (Strategic Alliances: The Role of Civil Society in Health, 2001)The discussion argues for greater future research on the role of civil society organizations (synonymous with NPOs or CBOs) in health and the benefits of collaboration between states and CBOs. They fill roles in various health system functions such as health services, health promotion and information exchange, policy settings, resource mobilization, and monitoring the quality of care. In collaboration with states, CBOs can provide unique perspectives and a collective voice of the community. This increases the possibility of influencing health policy and counterbalancing commercial interests in building health priorities. Partnerships can increase service provision and implementation of public programs, particularly among marginalized communities. The discussion concludes "strategic alliances offer opportunities for enhancing the legitimacy of health policies and programmes, improving public outreach, advocacy of health goals, information exchange and increasing resource inputs to health programmes".

CBOs are positioned to address a variety of challenges in service provision or outreach that government bodies cannot. One study examining factors affecting the delivery of HIV/AIDS prevention programs by CBOs found that CBOs are equipped to deliver services to specific high-

risk populations (Chillag et al., 2002). Supporting the WHO's recommendations, CBOs are well-positioned to provide services to these populations because they understand the communities and are typically connected closely to the groups they serve. The study collected structural, sociocultural, organizational, and individual factors that created barriers to service. Relevant examples include legal and policy issues, stigma, distrust of social services, lack of resources, and documentation status. Along with these barriers, several facilitators emerged. CBOs can collaborate with partners in the community to create a larger resources network and greater advocacy impact. As CBOs aim to serve a specific community, they know cultural norms and are perceived as credible and trusted by the community. Chillag et al. found that preexisting ties in communities can be "tapped" to find creative solutions to resource strain. Strong leadership and staff connection to the issue can create and maintain motivation. Comprehensive services and attention paid to needs outside of HIV are emphasized as important to address all needs of individuals.

CBOs foster community health by harnessing the power of community engagement, solidarity, and advocacy. A qualitative study of youth civic groups and community-based organizations, in low-income communities in California connected the cultures of civic engagement and cultures of health (Bloemraad & Terriquez, 2016). The study focused on youth of color, especially those who are immigrants or whose parents were born outside of the United States. Bloemraad and Terriquez found three mechanisms: CBOs can 1) empower individuals both in individual and civic capacities, 2) foster solidarity by building networks, social identities, and share commitments, and 3) mobilize individuals to advocate for health-related policies and programming. Bloemraad and Terriquez argue that CBOs "can play an important role in generating, diffusing, and maintaining a culture of health and engagement that benefits

marginalized populations most at risk for poor health outcomes." While agreeing with other scholars about social networks and identifying factors as determinants of health, Bloemraad and Terriquez add to the conversation by highlighting the role of CBOs for individual and community health and wellbeing.

Community health workers (CHW), often employed at CBOs, are also vital resources for health care and public health. Wilkinson et al. examine three initiatives in Massachusetts in which state health departments have collaborated with CHWs, providers, and CBOs to develop and implement innovative policies. Wilkinson et al. recognize the demonstrated impacts CHWs can have in strengthening the engagement and health of diverse, vulnerable populations. Particularly, CHWs can help address "the needs of patients with costly, complex conditions that are often associated with racial and ethnic disparities" (Wilkinson et al.). Federal agencies and state governments are drawing on state innovations involving CHWs and allocating new resources to partnerships with CHWs to improve healthcare quality and economic efficiency. Reducing healthcare costs, reducing health disparities, and creative policy innovation are the main focuses for the increased interest in CHW partnership integration.

CBOs play an important role in both setting the groundwork for program implementation and enabling a successful implementation. Dulark and DuPre found strong evidence that the level of implementation directly affected outcomes in health promotion and prevention programs (Durlak & DuPre, 2008). Implementation was found to be affected by a variety of contextual factors related to communities, providers, innovations, and prevention support systems (such as training). Successful implementation depends on local context and sufficient capacity. Dulark and DuPre use two specific studies to illustrate this point. Engstorm et al. found that capacity, or community readiness, was a significant predictor of the implementation of youth tobacco control

programs. Kegler et al. found “the level of capacity achieved through the actions of community coalitions was significantly related to more effective implementation” (Kegler et al., 2012). This study supports Bloemraad and Terriquez’s findings about the roles of CBOs in successful local implementation while adding attention to the capacity of CBOs as part of this function.

Community-Based Organizations and Engagement with Immigrants

CBO leaders can utilize community and cultural ties to better navigate barriers clients with undocumented states face. The unique and complex stressors that migrants face “have resulted in distrust in community resources, uncertainty about future health benefits, delayed medical care, and adverse mental health outcomes” (Valentín-Cortés et al., 2020). Alwan, Kaki, and Hsia conducted a qualitative study investigating barriers and facilitators to accessing health services for people without documentation status (Alwan et al., 2021). They interviewed 24 individuals, a mix of healthcare providers and CBO leaders. The study was framed as a sociological model in an anti-immigration era. Alwan, Kaki, and Hsia found that fear, policies such as public charge rule, and anti-immigration rhetoric all were cited as barriers to service. Local expansion of health care coverage (Healthy San Francisco), “culturally concordant clinical sites, representation of the community in the provider pool, and resources to address social needs” all facilitated access to care. Fear was eased by trauma-informed navigators. The 2021 study concluded that within a region with expanded healthcare access, barriers and fear span multiple levels, from policy to individual. Community engagement and partnerships were found to have built trust and may continue to decrease barriers this population faces.

The engagement and work of CBOs during the COVID-19 pandemic provide novel insight into the strength and flexibility of CBOs. Coll et al. investigated the approach of Mujeres Unidas y Activas (MUA) in the San Francisco Bay Area, a CBO led by low-income, primary

Spanish-speaking immigrant women from Mexico and Central America (Coll et al., 2023). They found that local organizations that employ grassroots leadership are “critical resources for service providers, policymakers, and community-engaged scholar-educators” (Coll et al.). Attention to their critical role and sustained support is necessary. Coll et al. support Bloemraad and Terriquez connection between civic engagement and health, finding that “learning together in service to transforming social, legal, and economic structures that limit their flourishing are key components of individual and collective well-being.” Coll et al. found that MUA’s experience integrating service provision with community organizations allowed them to respond quickly to the pandemic. They also prioritized caring for staff and members' immediate needs during the pandemic. This encouraged resilience in their staff and community, enabling MUA to enact longer-term actions. Trust was formative to create deep relationships and systems of support among their staff and community. Coll et al. note that trust is especially important for working with survivors of trauma.

Scholarship illustrates the many positives and unique advantages of a CBO-focused approach to providing health-related services. As illustrated, partnerships between CBOs and local government can have multiplied positive impacts. However, CBOs and nonprofits also face a multitude of challenges in maintaining their staff and services. The literature also acknowledges the challenges nonprofits and CBOs face working in these partnerships.

Maintaining consistent funding is a challenge to the capacity and services of nonprofits, including CBOs. The 2023 Giving USA annual report shows a 10.5 percent decline in overall growth between 2021 and 2022, adjusted for inflation (Carlson, 2023). The Urban Institutes argues that declines in giving can particularly impact small organizations or those serving marginalized communities (*Nonprofit Trends and Impacts 2021 | Urban Institute*, 2021). In their

study, they also found the COVID-19 pandemic of 2020 "dramatically impacted nonprofits of all types and sizes" (same as above). Financial strains for nonprofits are not unique but disproportionally impact nonprofits serving communities of color. Several studies find that nonprofits led by or serving people of color (BIPOC) experience greater financial difficulties and lower giving (Kim & Li, 2023) (Dorsey et al., 2020). Kim and Li note the lack of research focused on BIPOC nonprofit leadership and organizations serving communities of color. Another study finds both underrepresentation and undercounts of immigrant-focused nonprofits in databases, suggesting more research needs to be done on this focus (Gleeson & Bloemraad, 2013).

Community-Based Organizations and Government Partnerships

More literature is being published about the benefits and challenges of nonprofits and CBOs working in partnership with the government. Much of the literature focuses on the impacts of government funding. A systematic review of challenges of collaboration between NPOs and government in healthcare services found several main challenges in these partnerships (Rajabi et al., 2021). These challenges include structural issues, process-related issues (bureaucracy), issues related to roles and responsibilities, trust and communication, and power relations. Identifying and acknowledging these challenges and using them to inform action and design can help promote sustainable collaboration between government and nonprofit partnerships. Carey and Braunack-Mayer investigate the effects of government funding on CBOs and their approaches to health promotion(Carey & Braunack-Mayer, 2009). The study describes "top-down" versus "bottom-up" approaches to health promotion. "Top-down" is typically understood as actions taken from a large, even national, government level. "Bottom-up" focuses on community-based, "grassroots" efforts. The work of CBOs can be categorized by a bottom-up, community-based

approach. Carey & Braunack-Mayers' study found in their case study that increased partnerships with the government, specifically related to government funding, can shift the focus from individuals to populations. For the government and community, this shift in focus may be considered an overall gain with resources and services reaching further and having a greater impact on health. However, staff stated concerns that a shift to a population approach may reduce the strength of networks and relations with community groups, becoming "not as personal as it used to be" (Carey & Braunack-Mayer, 2009). These studies weigh the benefits and challenges of increased government and CBO or nonprofit partnerships, arguing for expanded research to find a sustainable balance.

Community involvement is a key component of Healthier Oregon's design. This study aims to build upon the literature on partnerships between government entities and CBOs, the unique position CBOs have to promote health within their communities, and their specific role in the implementation of Healthier Oregon. The case study focuses on the role of community partners, the majority of whom work at CBOs across Oregon, gaining their perspective and experiences during the implementation process and first two years of the program.

Healthier Oregon

Two reports have been released to the public about the Healthier Oregon program, an implementation report by OHA in January of 2023 and an evaluation report for the Healthier Oregon Outreach and Healthcare System Navigation Grant in December of 2023. Published less than six months since the first rollout of the program (July 1, 2022), the Healthier Oregon implementation report provides an overview of the program, information about the Advisory Work Group (AWG), program design, outreach, early insights, and next steps. Focused on implementation, the report focuses on design and implementation (Oregon Health Authority,

2023). OHA collaborated with the Centers for Medicare and Medicaid Services (CMS) to integrate Healthier Oregon members into coordinated care organizations (CCOs) (the same system other OHP members receive care through) and claim federal matches for eligible services, stretching state dollars further. "Eligible services" include those that were previously covered by CWM before Healthier Oregon. OHA emphasizes that "Healthier Oregon members are OHP members with access to the same benefits and coordination, just with different funding sources" (Oregon Health Authority, 2023). HB 3352, Healthier Oregon's bill required the establishment of the Healthier Oregon AWG, a team made up of twelve members representing communities across the state. The AWG focused on advising OHA on the implementation of Healthier Oregon and advising and assisting OHA in the development of outreach, engagement, and enrollment. The report emphasizes an equity-focused, member-centered design that is flexible to adapt as the program expands to more age groups.

The implementation report finds that even with Oregon's uninsured rate decreasing between 2019 to 2021, disparities exist in coverage (Oregon Health Authority, 2023). Those who identify as white, not Hispanic or Latino/a/x/e saw a drop from 5.2% uninsured to 3.6% from 2019 to 2021 while those who identify as Hispanic or Latino/a/x/e, any race, saw a marginally smaller reduction from 11.6% uninsured to 10.8% during the same period. Of those enrolled in Healthier Oregon as of November 2022, 80.2% identify as Hispanic or Latino/a/x/e, 8.4% as Asian, 4.3% as white, 2.2% as Black or African American, and the remaining 4.9% as Middle Eastern, North African, Native Hawaiian, Pacific Islander, or multiple. Among the broader group of self-identified Hispanic or Latino/a/x/e, a Mexican identity was most common. Under the broader group of Asians, Chinese and Vietnamese are the most common identities. Other preliminary data from the report identifies most members as speaking English less than very

well, with 45% identifying as speaking English “not at all.” Spanish was the most common preferred language. Demographics find that nearly three in four members live in one of five counties, a quarter each in Multnomah and Washinton counties, 15% in Marion County, 6% in Clackamas County, and 5% in Jackson County. The report concludes with steps needed to prepare eligibility for all and expand program effects. As many Healthier Oregon members have limited or no familiarity with the US healthcare system, linguistically and culturally responsive outreach and engagement are crucial to helping members understand and use their benefits.

In December 2023, the evaluation report for the Heathier Oregon Outreach and Healthcare System Navigation Grant Program was published by a team of researchers at Oregon State University in partnership with OHA (Phibbs, 2023). The Healthcare System Navigation Grant was designed to provide financial assistance to 22 community partner organizations across the state to support system navigation. The mixed methods evaluation’s goal was to “describe the effectiveness of navigation services in helping new members access care through their OHP benefits. In particular… address how the program increased access, utilization, and successful navigation of healthcare services for Healthier Oregon members in the OHP within the first year of implementation (July 1, 2022 - June 30, 2023)” (Phibbs, 2023). The evaluation included interviews with community partners and a survey for members distributed through community partners. A general summary of findings indicates that survey participants’ understanding of how to navigate the healthcare system improved, access to healthcare improved, and the number of services used increased. Barriers to accessing care or using benefits included: language access, discrimination, public charge concerns, appointment availability, lack of transportation, and some individual factors. Navigation assistance, interpreting, and transportation benefits helped members use their benefits and were highly satisfied with the benefits and navigation services.

Navigators themselves valued training, resources, and regional outreach provided by the OHA team.

Based on evaluation results, three recommendations were made to the OHA Healthier Oregon team: improvements in language access, improvements in transportation support, and greater appointment availability (Phibbs, 2023). They also recommended continuing communications about eligibility to reduce confusion and more financial support for community partners to provide outreach, enrollment assistance, and navigation.

This report is the only publicly available evaluation of the Healthier Oregon program, offering many valuable insights into the program so far. Working in partnership with OHA, this formal evaluation was conducted by a credible research team from OSU. Concluding as my data collection was starting, the grant evaluation had several similarities to my study. Both studies conducted interviews with OHP-certified community partners to gain insights about the Healthier Oregon program. However, the OSU evaluation was also able to get feedback from program enrollees through community partner-distributed surveys. The main distinction between our two studies is that the OSU-authored report was a grant evaluation conducted by a professional team whereas my study was designed to gain insight into the implementation of the Healthier Oregon program as a case study. In the OSU evaluation limitations, it was noted that participants may have been more hesitant to discuss negative aspects of the program due to the association of the research team with OHA. I hope that as a student researcher, the power imbalance could be reduced. I also interviewed some community partners that were not part of the grant program.

Literature Review: States

A Complicated Policy History

Barriers to accessing social welfare services in the US, such as public health insurance for immigrants with unqualified or undocumented statuses reflect the broader policy context for this population. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) is a welfare reform bill that greatly restricted Medicaid access for recent immigrants. PRWORA created a five-year waiting period from when an immigrant gains lawful permanent residency to when one can access federal means-tested public benefits (TANF, Medicaid, CHIP) (*Summary of Immigrant Eligibility Restrictions Under Current Law*, 2009). Means-tested state and federal programs measure a family's income against the federal poverty line (*Means Test*). PRWORA effectively created two categories of immigrants; "qualified immigrants" and "not qualified immigrants." "Qualified immigrants" generally include legal permanent residents (green card holders) who arrived in the US on or after August 1996, asylees, those serving in the Armed Forces, and some survivors of severe human trafficking or battery (see full list in Appendix A) (*8 U.S. Code § 1641 - Definitions*). "Nonqualifying immigrants" include all other immigrants, including those that are undocumented, non-immigrants (temporary residents on time-limited visas to work, study, or travel), asylum-seeking immigrants (who have yet to be granted asylum status), and other immigrant groups that do not meet the definition of a "qualifying immigrant" (*Overview of Immigrant Eligibility for Federal Programs*). Qualifying immigrants are subject to the 5-year bar. Non-qualifying immigrants are barred from enrollment in means-tested programs, so the rule is not applicable.

PRWORA created significant barriers for immigrants accessing social services. One report investigating the scope and impact of PRWORA found that this welfare reform act

“represented a major departure from prior policy by making citizenship more central to the receipt of benefits” by granting immigrant eligibility determinations to the states rather than the federal government. This marks a distinction between immigrants arriving before and after the enactment of PRWORA on August 22nd, 1996. (*Scope and Impact of Welfare Reform’s Immigrant Provisions*, 2002). Other reports found that PRWORA’s restrictions and eligibility criteria may prevent mixed status familiar from seeking benefits from means-tested programs (*Immigrants Have Been Waiting 25 Years for the LIFT the BAR Act*). The five-year bar created additional barriers that harm immigrants' access to education, health, and well-being. Zhou claims the five-year bar is “based on racist narratives that immigrants come to this country to take advantage of public benefits. In reality, these federal public benefits are services that immigrant help pay for through their taxes” (*Immigrants Have Been Waiting 25 Years for the LIFT the BAR Act*). PRWORA's enforcement not only reshaped immigrant benefit eligibility but also created obstacles that impede this population's access to vital services, rooted in false narratives and xenophobia.

The PRWORA’s implementation limited immigrant participation in the state’s Temporary Assistance for Needy Families (TANF) programs. Undocumented immigrants remained ineligible. In 2003, an article examining the impact of the bill stated that though it was “intended to serve as a tool for reducing illegal immigration and protecting public resources, federal restrictions on undocumented immigrants' access to publicly financed health services unduly burden health care providers and threaten the public's health” (Kullgren, 2003). A combination of a direct impact of PRWORA and the stigma of immigrants being “undeserving” to benefit from welfare programs has led to reduced usage of these programs, even if a person was eligible (DuBard & Massing, 2007).

More recent federal legislation has given states the option to ease restrictions for certain immigrant groups. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) gave states the option to eliminate the 5-year waiting period for Medicaid and CHIP for recent legal resident children or pregnant women (*Medicaid and CHIP Coverage of Lawfully Residing Children & Pregnant Individuals*). The new law included provisions to include a state option to provide dental insurance and higher family income limits ("Children's Health Insurance Program Reauthorization Act of 2009," 2009).

The 2010 Affordable Care Act (ACA) and the rollout of reform expansions in 2014 significantly increased enrollment in health insurance programs and expanded Medicaid eligibility. Under the ACA, naturalized citizens hold the same access and benefits as US-born citizens. Lawful Present Immigrants (LPIs) are eligible for limited benefits that vary by state. Undocumented immigrants have no federal coverage and are not allowed to enroll in private or publicly funded coverage with the exemption of emergency services for low-income immigrants ("Immigrants and the Affordable Care Act (ACA)"). Limited investigation into the impacts of the ACA expansion on immigrants of varying documentation status has been conducted. One California study found that the ACA had led to major coverage gains for legal permanent residents and "modest gains" for undocumented immigrants (Porteny et al., 2022). The increase in coverage for undocumented immigrants is largely attributed to expanded eligibility for California's Emergency Medicaid programs, such as My Health LA (Porteny et al., 2022). The subsequent expansion of the ACA and options for immigrant groups varies from state to state, depending on their individual expansion policy choices. 41 states, including Washington DC, have expanded Medicaid (DuBard & Massing, 2007). Among states that have expanded coverage, very few have identical policies or program options available to immigrants.

Low-income immigrants who do not qualify for Medicaid due to their immigration statuses are eligible for treatment of emergency medical conditions under Emergency Medicaid (EM) (Park et al., 2023). EM is a federally funded, state-run health program that leaves flexibility for states to use discretion to widen what each state defines as a "medical emergency". This has resulted in variations between states in what services, procedures, or conditions are covered and what are not (Santos et al., 2023).

The few studies that have examined the use of Emergency Medicaid by immigrants have found rising costs and utilization, primarily among pregnant women, the elderly, and chronic diseases. One study conducted in North Carolina analyzed all claims reimbursed under EM criteria between 2001 and 2004 (DuBard & Massing, 2007). The objective of the study was to "describe Emergency Medicaid use by recent and undocumented immigrants including patient characteristics, diagnoses, and recent spending trends in North Carolina" as the state sees a rapidly increasing population of undocumented immigrants." During these four years, a total of 48,391 individuals received services under EM. The patient profile was found to be majority undocumented, Hispanic, female, and in the 18 to 40 age group. From 2001 to 2004, total spending increased by a third. Childbirth and pregnancy complications accounted for most of the EM spending. However, rates of increase are highest among elderly and disabled patients. The study found that EM is "primarily filling 3 gaps in the health care needs of this population: childbirth-related costs, emergency care of sudden-onset problems, and emergency care for severe complications of chronic disease." EM for chronic disease reveals the lack of primary or preventive care available to this population and assesses the scope of EM to stabilize or treat conditions. The study concludes that the economic efficiency of public health dollars can be improved by improving the health status of this population and reducing the need for expensive

emergency care by increasing access to comprehensive, preventative, and managed care. Studies replicating the one conducted in North Carolina are needed provide more up-to-date information to further understand who is utilizing EM, how they are using it, and if there are more effective ways to keep people healthy while reducing costs to states.

Medicaid Expansion in Oregon

In 2008, Oregon Health Authority decided that Oregon Health Plan's Standard program could accommodate 10,000 new enrollees after being closed to new enrollment since 2004 (Allen et al., 2013). Anticipating a larger demand than slots available, a lottery randomly selected 30,000 to fill out an application (about 30% enrolled) out of 75,000 who signed up. Researchers took advantage of this experiment, conducting the first randomized evaluation on the impact of Medicaid (Allen et al., 2013). Tracking health measures of OHP enrollees from this cohort and comparing against the control group, those not selected in the lottery, The Oregon Health Insurance Experiment found several outcomes. Medicaid coverage increased healthcare use (preventative services and emergency department visits), reduced financial strain, reduced depression, and improved self-reported health. However, Medicaid coverage had no statistically significant improvements in measures of physical health or affect employment. Allen et al. note that long-term effects on health may differ from those found over this shorter experiment period due to the time it takes medication to take effect. The study found that having Medicaid increased the use of recommended preventative care services with self-reported access to and quality of care also improving. The effects of increased use of preventive services are likely to be more long-term results than what was captured in this study.

The Oregon Health Insurance Experiment data prompted other research investigating the impacts of increased Medicaid coverage. A welfare analysis applied to the dataset found that

Medicaid can be separated into “a subsidized health insurance product for low-income individuals and a transfer to external parties who would otherwise subsidize medical care for the low-income uninsured” (Finkelstein et al., 2019). The study estimates that 60 cents of each dollar of Medicaid spending transfers to the referred external parties. Hospitals in the US may find themselves as one of these “external parties” subsidizing medical care costs. As US hospitals are federally required to provide emergency medical care to the uninsured (such as Emergency Medicaid), studies find that each additional uninsured person costs hospitals approximately $800 each year (Garthwaite et al., 2018). Increased Medicaid coverage helps subsidize costs of care for the uninsured that hospitals would otherwise be fronting. Medicaid helps reduce cost burdens both through increased uptake of preventative care (which in turn helps reduce costly emergency or preventable procedures) and subsidizing costs of emergency care for the uninsured.

A significant finding from the Oregon Health Insurance Experiment dataset was that Medicaid increased emergency department (ED) visits by 40% in the first 15 months (Finkelstein. et al., 2016). This finding prompted surprise because of the widespread belief that expanding Medicaid coverage to the uninsured would reduce ED use by uptakes of primary care services. Researchers found that increased demand was sustained for at least two years after gaining Medicaid. Possible explanations include those that use more care and those that seek care across multiple settings including the ED and primary care offices. It is also a possibility that increasing the use of primary care may result in greater use of emergency care as primary care physicians may encourage patients to seek ED care. These results are constrained by a short-term analysis and numerous factors and explanations influencing where and how often Medicaid patients may seek care. The findings from the Oregon Health Insurance Experiment, the first of its kind, demonstrate the need for additional analysis to understand service use patterns for those

recently insured. The economics of health insurance coverage are incredibly complicated and are impacted by a variety of factors that differ from population to population. An analysis of several Oregon Health Insurance Experiment studies argues the benefits of widening eligibility for public health insurance on individuals and populations' health will be limited unless access to primary care is improved (Heintzman et al., 2014). The article frames bolstering primary care infrastructure as a "necessary companion" to health reform efforts and insurance expansion.

States that Offer Coverage to Undocumented Immigrants

In states and territories that have opted to extend some version of coverage for low-income immigrants, coverage varies in depth and access from state to state. Most rollouts occur on a tiered approach, first expanding coverage to children and pregnant women, some adult groups, and finally all adult groups. As of March 2024, 12 states and D.C. offer coverage to children who meet income eligibility requirements, regardless of immigration status. Most states have taken up CHIPRA options to expand coverage to LPI children and pregnant women (A. Pillai et al., 2024). Six states (California, Colorado, Illinois, New York, Oregon, Washington) plus Washington D.C. provide full state funding coverage to at least some groups of income-eligible adults regardless of status. A few have also expanded fully state-funded coverage to some income-eligible adults regardless of immigration status. In this section, details about several state options are provided. Only information about federal or state-funded programs for low-income immigrants (who do not have naturalized statuses) is included (several states such as Colorado have implemented private coverage plans).

Washington DC

Washington D.C. covers all age groups for eligible individuals, regardless of immigration status. Income-eligible Washington DC Residents under 21 are covered by the Immigrant Children program, regardless of immigration status (*Immigrant Children's Program*). Those who meet the same qualifications and are over 21 are covered by the DC Health Care Alliance (*Health Care Alliance*). Once enrolled, each participant is assigned a primary care physician, and all medical services are free ((*Know Your Rights! DC Healthcare Alliance*). The Health Care Alliance requires a recertification process every 6 months.

Illinois

Illinois offers three state-funded programs to cover income-eligible immigrants (including those who are undocumented) for age groups up to 18 and groups 42 and older. First, the All Kids program began in 2006 and covers those up to age 18 with comprehensive health coverage (*Illinois' All Kids: Progress Report*). The Health Benefits for Immigrant Adults program covers eligible adults ages 42 to 64, expanding this age group in the past few years (*IDHS*, 2022). Finally, those 65 and older may qualify for the Immigrant Seniors Program which offers benefits comparable to Medicare (*IDHS*, 2021).

California

California was among the first states to offer full-scope coverage for low-income immigrants without qualifying statuses. In the past several years, California has worked to extend coverage through a series of age-restricted waves. In 2016, low-income, undocumented children under 18 became the first to be eligible to enroll in Medical, California's Medicaid program. The Young Adult Expansion was enacted by Governor Gavin Newsom in 2020, providing Medical access for low-income adults under 26, regardless of immigration status (Sosa, 2022). The next phase, The Older Adult Expansion, was implemented in May of 2022 and expanded eligibility to those ages 50 and above. The final wave closes the final gap of ages 26 to 49 beginning on January 1st, 2024. Individuals enrolled in emergency-only coverage were automatically enrolled in Medi-Cal once coverage was expanded.

The UC Berkeley Labor Center predicts once the policy is implemented, California's uninsured population will decrease to 2.57 million (7.9% of the population) under age 65 (Dietz et al., 2023). Through these various expansions, nearly one million Californians without verified documentation status will have access to Medi-cal. Undocumented Californians are still

ineligible to enroll in Covered California, the state's health exchange marketplace due to federal policy. They are also barred from receiving federal premium subsidies to make care more affordable (Dietz et al., 2023). Unqualified immigrants can purchase private health insurance outside of Covered California. Some coverage options may also vary by county (*Information for Immigrants*). However, coverage costs remain high with no federal support.

New York

New York currently covers children ages 19 and younger, regardless of immigration status, through Child Health Plus. Individuals who may not qualify for federal Medicaid requirements can purchase private health insurance coverage at full cost and may be eligible for employee-sponsored coverage (*OCHIA*). NYC Care is a health access program that offers low-cost or free services offered by NYC Health + Hospitals to eligible New Yorkers, regardless of immigration status ("About NYC Care"). It is important to note that NYC Care is not a health insurance program and is only available to residents who live in one of the 5 boroughs of NYC. Originally included but eventually left out in the 2022-2023 state budget, the NY Department of Health sought a federal waiver to expand the Essential Plan to cover undocumented immigrants ages 19-64 (*NYSDOH Office of Health Insurance Programs*). There likely will be a push for this expansion again in the future (Mellins, 2023).

Maine

Full MaineCare (Maine's Medicaid program) is available for US Citizens, refugees and asylees, LPRs who have had their green card for more than 5 years, Haitian or Cuban entrants, survivors of domestic violence who have been in the US for more than 5 years, and parolees who have been in the US for more than 5 years (*Maine Equal Justice*). Maine has not eliminated the

5-year bar so immigrant groups must wait 5 years before accessing benefits (with some exceptions).

As of July 1, 2022, individuals with qualifying income who are under 21 or individuals who are pregnant are eligible to receive full MaineCare benefits, regardless of their immigration status (*Maine Equal Justice*). Pregnant people who qualify for the federal Children's Health Insurance Program (CHIP) are eligible. Effective January 1, 2024, Maine extended coverage of the CHIP Unborn Child Option population to cover 12 months postpartum. This includes pregnant people otherwise not eligible for Mainecare due to their immigration status (*Maine MaineCare*). Those already enrolled in Emergency MaineCare and are eligible under new guidelines are automatically enrolled in the new full coverage.

Advocates and legislators in Maine have long called for further coverage for immigrant groups. In July 2023, an emergency bill (LD 199) proposed by House Speaker Rachel Talbot Ross (D- Portland) to expand MaineCare coverage for all low-income Maine residents, regardless of immigration status failed after a vote of the Legislative Council (Popp, 2023; *Summary of LD 199)*. This is the second bill to try and reinstate previously extended benefits for immigrants in Maine after then-Governor LePage barred immigrants from accessing means-tested programs in 2011 (Popp, 2023). The previous effort in 2021 (LD 718) also failed (cite). Prior to the 2011 ban, Maine had implemented these programs (MaineCare, food assistance, and TANF) for immigrants as a reaction to 1996's PRAWA (Neumann, 2019).

Vermont

In Vermont, people with eligible immigration statuses who have been in the US more than 5 years are eligible for Medicaid coverage. Green Mountain Care is Vermont's Medicaid program. If a person is under 21 or pregnant, they are eligible for Medicaid without the 5-year

requirement (*Information for Non-Citizens*). Immigrant groups are not eligible for Vermont's "Dr. Dynasaur" program. Dr. Dynasaur is low-cost or free health coverage for ages under 19. To address this gap, the Vermont state legislature passed House Bill 430 in July of 2021. The act created a "new, state-funded health care program for pregnant individuals and children who have an immigration status for which Vermont Medicaid is not available" (*Information for Non-Citizens | Department of Vermont Health Access*). The act determined to create "Dr. Dynasuar-like coverage" for immigrants that do not qualify for Dr. Dynasuar (*33 V.S.A. § 2092*). This program, called the Immigrant Health Insurance Plan (IHIP) was available for enrollment on July 1st, 2022. IHIP covers doctor visits, prescriptions, dental care, hospital stays, and may also cover non-emergency medical transportation (*Department of Vermont Health Access*). All other Vermont residents that do not have an immigration statuses eligible for Dr. Dynasaur, Medicaid, or qualifications for IHIP are eligible for Emergency Medicaid (*Immigrants and Health Care Coverage*).

Washington State

A 2022 supplemental budget allowed Washington to provide "Medicaid equivalent coverage to uninsured adults who do not meet the immigration requirements for federal assistance" (*Apple Health Expansion*). This expansion comes in the form of the Apple Health Expansion, named for Washington State's Medicaid program, Apple Health. The Apple Health Expansion coverage will start July 1st, 2024 (*Apple Health Expansion*). Individuals may qualify for this program if they are Washington residents age 19 or older, don't qualify for other Apple Health programs based on immigration status, or are not eligible for other qualified health plans. Before the July 2024 rollout, immigrants who do not have a qualifying immigration status may be covered for emergency services only under the Alien Medical Program (AMP) (*DSHS*). AMP

is Washington state's Emergency Medicaid program. The population eligible for this program includes anyone who has a qualified immigration status has not met the 5-year bar or is not exempt from the 5-year bar, nonpregnant nonqualified immigrant status, and individuals with undocumented statuses.

Individuals who are under 19 may qualify for Washington's CHIP program Apple Health for Kids (HCA). Those that are pregnant or have been in the past 12 months may apply for Apple Health for Pregnant Individuals or After-Pregnancy Coverage (APC) (*Apple Health Expansion*). Those that had been enrolled in Apple Health coverage during pregnancy will automatically be transferred to APC once their pregnancy ends.

Rhode Island

Immigrant groups that qualify for Rhode Island's Medicaid, RIte Care include LPRs (Green Card holders) (after 5 years), refugees, asylees, victims of trafficking, and certain victims of violence. Lawfully present individuals (those that "have not been admitted to live in the U.S. on a permanent basis but have a status that allows them to live here") are not eligible for Rite Care but may be eligible if they are under 19 or pregnant (*RIte Care*).

In July 2022 "Cover All Kids" passed in Rhode Island, allowing all low-income children to qualify for the state's RIte Track program, regardless of immigration status. Cover All Kids allows children under 19 to enroll in Rite Care (*State of Rhode Island General Assembly*, 2022)

Colorado

Colorado, like other states, has an Emergency Medicaid program available for immigrants who do not qualify for Health First Colorado (Colorado's Medicaid program). The program covers emergency services, family planning services such as contraceptives and basic

fertility services, and family planning related services such as diagnosis and treatment of sexually transmitted infections, cervical cancer screening and prevention, and related evaluations(“Emergency Medicaid,”). In 2025, Colorado will expanded health coverage for pregnant people and children under a new program known as “Cover All Coloradans” (*Cover All Coloradans: Health Benefits for Children and Pregnant Persons*). Children up to 18 and pregnant people for 12 months after pregnancy will be covered under Health First Colorado, regardless of immigration status.

Colorado also has an innovative program, OmniSalud, that allows undocumented Coloradoan’s and DACA recipients to apply for a Colorado Option plan through the state Marketplace exchange (*OmniSalud | DORA Division of Insurance*). A section 1332 waiver allows the state to use state funds to provide Marketplace coverage with premium subsidies for individuals who meet certain income eligibility requirements regardless of immigration status (A. Pillai et al., 2024).

Oregon: Healthier Oregon

Oregon previously provided two pathways for those who would qualify for the Oregon Health Plan (Oregon’s Medicaid program) if not for their immigration status. The programs were Citizen/Alien-Waived Emergency (CAWEM, later referred to as Citizen Waived Medical (CWM)) and Cover All Kids (CAK). First, CAWEM was only used to cover emergency medical services. To be eligible, applicants must meet all other criteria for the Oregon Health Plan (OHP) eligibility, except for immigration status. Emergency medical services are defined as a sudden onset of a medical condition that requires immediate treatment. CAWEM Plus, beginning October 1st, 2013, also offers expanded services to pregnant people, including prenatal care and birth services (*CAWEM Program Manual*; McDonald, 2013). Next, Cover All Kids passed as SB

558 in 2017 to expand the benefits for those under 19, regardless of immigration status. After meeting eligibility income criteria, children and teens who are DACA recipients or are undocumented can receive full OHA benefits (*Oregon Health Plan (OHP) Benefits*; *Oregon Health Plan (OHP) Covers Me!*).

As of July 1, 2022, Oregonians with any immigration status between 19 and 26 and over 55 are eligible to enroll in the Oregon Health Plan (OHP). This includes those who are not US citizens, do not have a green card or have had a green card for less than five years, and those who have Deferred Action for Childhood Arrivals (DACA) status. This new program, formally Cover All People, is now "Healthier Oregon." Those enrolled in CWM or CWM Plus (Oregon's EM programs) will automatically change to full OPH benefits. Instead of only covering emergency services or those related to pregnancy (CWM and CWM Plus), Healthier Oregon will open access to full OPH benefits and coverage. This includes "many health care services like medical, mental health, dental, eye exams, prescriptions, tests, x-rays and hospital care" (Oregon Health Authority). Additionally, OHP may also provide transportation to services for those who lack transportation options(*Oregon Health Plan (OHP) and Travel Help*). Healthier Oregon is intended to slow the growing health disparities that exist for immigrant populations. The policy creates a pathway for those without citizen or green card immigration statutes to access OHP, gain consistent health coverage, and improve community health outcomes.

Healthier Oregon is funded by the state of Oregon and includes no federal assistance. Federally funded Medicaid restricts the use of funds for ineligible immigrants so the coverage that people eligible for Healthier Oregon will be state-funded. Federally approved services, like those formally included in EM, are expected to be matched by federal Medicaid funding (*Healthier Oregon*). The bill also helps reduce unnecessary healthcare costs by reducing

emergency room visits, encouraging preventative care, and increasing employment. When the program launched, the system automatically switched those who were previously only eligible for Emergency Medicaid (EM) to Healthier Oregon, the highest tier of benefits available. EM programs, in contrast, are an inefficient use of healthcare dollars. EM is associated with high average costs as it covers only emergency procedures which tend to be very expensive (DuBard and Massing, 2007). Full OHP benefits and preventive care will help individuals address issues closer to the root of the problem and mitigate high-cost, invasive procedures. Healthier Oregon can also help strengthen the state's economy. In a comment that Healthier Oregon will reduce healthcare costs in Oregon, Governor Brown stated that states that expand health coverage have outpaced other states in terms of job growth, explaining that "expanding quality healthcare coverage is linked to individuals obtaining and maintaining employment, benefiting the economy" (Jones, 2021). Healthier Oregon and its implementation will help reduce health disparities, reduce unnecessary healthcare costs, and increase health outcomes for all by widening eligibility criteria for state Medicaid coverage.

Healthier Oregon is an important piece in Oregon's healthcare reform efforts. It is a step closer to the goals of Measure 111, to "ensure that every resident of Oregon has access to cost-effective, clinically appropriate and affordable health care as a fundamental right" (Templeton, 2021). The policy creates a pathway for those without citizen or green card immigration statutes to access OHP, gain consistent health coverage, and improve community health outcomes. It emphasizes the importance of covering and providing quality care for all who live in Oregon. Already, after the program had been live for under six months, November 2022 data shows that over 14,300 adults had enrolled in Healthier Oregon (Oregon Health Plan).

Methods

This study was granted Human Subjects research approval
by the University of Oregon institutional review board.

Community Partner Interviews

Research Question:

> What are the key roles, challenges, and successes experienced by community partners involved in the implementation of the Healthier Oregon program, particularly in terms of barriers to outreach, enrollment, and service navigation for individuals with undocumented statuses?

Participants

To address my first research question focused on the key roles, challenges, and successes experienced by community partners involved in the implementation of the Healthier Oregon program for undocumented populations, I reached out to community partners who engage in outreach, assist with enrollment, and promote access to services within this community. I collected primary data by conducting interviews with staff who have worked on Healthier Oregon and "OHP-certified community partners" who worked with Oregon Health Authority (OHA) during the implementation of Healthier Oregon. Contact with OHA informed the selection of community partners as potential participants. OHP certified community partners are trained individuals, (affiliated with designated organizations) who help individuals understand eligibility, enrollment, and use their benefits (*Oregon Health Plan Certified Community Partners*).

Community partners and nonprofit organizations have unique insight into the implementation of this bill and its local outcomes for multiple reasons. First, these organizations

have existing relationships with the communities they serve. Typically, each organization assists with enrollment, navigation, and case working for Oregon social service programs, including OHP. Second, these existing connections with the community promote trust with community members. Trust is especially important in communities that may include individuals without qualifying immigration status who are prone to fear of deportation or in any way diminishing their chances of becoming a citizen or verified immigrant. Community partner organizations work directly with clients and can hear firsthand about their experiences. Some employees may share a cultural or immigration background with the clients they serve. Third, community partner organizations are a key component of implementing the policy on a local level. They have a more in-depth understanding of the target population, their needs, and the local healthcare system. It is because of this knowledge and established expertise that the role of community partner organizations is written into the bill of Healthier Oregon to assist with elements of implementation such as outreach, navigation, and case management. Together, these components emphasize the importance of community partners in implementing Healthier Oregon and call for an in-depth investigation of their experiences. Community partners are one of the many links between state policy and individuals reaping the benefits.

The inclusion criteria were defined as "an individual who is employed by a healthcare or social service organization, may or may not be an OHP certified community partner, and a significant part of their role includes assisting with enrollment, navigation, outreach, or other access to services for Healthier Oregon specifically." Interviews with local nonprofits that work closely with the population Healthier Oregon serves but are not OHP-certified community partners were also included. Many of my participants ended up also being Community Health

Workers (CHW) alongside their official roles. It was not included in my interview questions to inquire about being CHW but six participants mentioned they were CHWs.

Position titles varied and included positions ranging from Director of Patient Support Services to Resource Navigator, as well as positions that focused specifically on helping those who are OHP-eligible. Participants' roles generally focused on outreach, community engagement, enrollment/ services navigation, or director positions. However, many participants "wore many hats" and were involved in a variety of roles. Seven participant roles were directly related to enrollment/ service navigation, six were directly related to outreach, four held director or program manager roles, and one participant worked within patient support services, managing a call center (note that some participants had multiple titles and were listed twice, one interview had two participants). Participants commented on multiple role areas, sharing information from coworkers who have different roles in their organization as well. For example, if an individual's role was related to enrollment and service navigation, they may directly assist with enrollment and help set up appointments but also provide insight into the outreach areas of their organizations as well. All participants were asked about multiple areas of focus such as outreach and enrollment, even if they were not directly involved.

Out of 15 participating interviews, seven worked at organizations that received a grant from the Healthier Oregon Outreach and Healthcare System Navigation Grant Program. Grants were awarded to community-based organizations to support the implementation of Healthier Oregon, specifically to support organizational activities specific to outreach, application assistance, and healthcare system navigation locally.

Procedure

Community partners or potential interviewees were contacted via email. Emails were found on OregonHealthCare.gov under a "find help" page by county. A recruitment message was sent to these email addresses (see Appendix B). This message was often forwarded to other employees or community partners as suggested in the recruitment message. A portion of emails provided were personal email addresses and the others were for the organizations that community partners are employed at (community partner organizations). Most community partner organizations are nonprofit organizations. Recruitment was conducted via email based on the organization's geographic location to ensure geographic and population diversity. Various waves of emails were sent out based on responses, locations that hadn't been represented, and locations with higher immigrant populations. Snowball sampling, asking participants if they knew of anyone else who works with this population and would be interested in participating, was also used to get additional contact emails.

According to data from the Healthier Oregon Implementation Report, the majority of current enrollees identified with a group that can be categorized as Hispanic or Latino/x (Healthier Oregon: Better Care for More People). The community partner organization population naturally had a large share of Latinx-focused organizations and I made sure to include these in my outreach efforts. I also selected geographically diverse organizations, with special attention to the counties that have a high percentage of enrollees. The Implementation Report noted that nearly three-quarters of enrollees lived in Multnomah, Clackamas, Marion, and Jackson counties (cite). Variation in geographic location was intended, varying from urban counties to rural countries. Other intentional outreach included organizations that were immigrant-serving and healthcare-specific organizations, Health Navigation Grantees, and those

who have not received any program-specific grants. Table 2 shows that five organizations were from the Portland Metropolitan Area, while another five were from the Willamette Valley. I also interviewed two organizations from Central Oregon, two from Eastern Oregon, and one from the Colombia Gorge region.

Fifteen total community partner interviews were completed. In one instance, two individuals completed an interview together. Due to the information gathered, this interview will be counted as one community partner interview. Five organizations had two community partners complete separate interviews. Because each interviewee, even if from the same organization, held different positions or worked in different office locations, these interviews were kept in the data set since they understood the process from a different perspective. Organization names have been removed from the dataset to ensure interviewees remain anonymous.

Community Partner	Region	Type of Organization	Focus of Organization	Health Navigation Grant Recipient
A	Portland Metropolitan Area	Non profit organization	Immigrant & Refugee	Yes
B	Portland Metropolitan Area	Non profit organization	Immigrant & Refugee	Yes
C	Portland Metropolitan Area	Non profit organization	Latino/x Health	No
D	Portland Metropolitan Area	Non profit organization	Latino/x Health	No
E	Portland Metropolitan Area	Non profit organization	Community Development	No
F	Willamette Valley	Non profit organization	Latino/x Community	Yes
G	Willamette Valley	Non profit organization	Latino/x Community	Yes
H	Willamette Valley	Non profit organization	Community Health	No
I	Willamette Valley	Non profit organization	Healthcare	Yes
J	Willamette Valley	Non profit organization	Healthcare	No
K	Central Oregon	Non profit organization	Healthcare	Yes
L	Central Oregon	Non profit organization	Healthcare	Yes
M	Eastern Oregon	Non profit organization	Community Health	No
N	Eastern Oregon	Non profit organization	Community Health	No
O	Columbia Gorge	County Health Department	Public Health	No

Table 1 Types of nonprofit organizations that participated in this study

Interview Materials

Interview questions for community partners were developed to investigate the achievements and challenges of the OHP expansion while incorporating each organization's unique perspectives. Questions include community partners' role in the implementation of Healthier Oregon (enrollment, outreach, case working), where gaps in outreach and enrollment may be, positive impacts of the bill, what challenges they have encountered during the implementation of the bill, suggestions for improvement, and finally provided opportunities for open comments.

All interviews were conducted in English even though not all participants were fluent. This did not impact the quality of the interview. For the length of the interview (45 minutes) and the depth of information, the community partner interviewees were financially compensated ($40 Visa egift cards). During the 45-minute interview, typically 10-15 questions and follow-up questions were asked. The interviews were scheduled using Calendly and conducted remotely and recorded over Zoom. At the start of each interview, I read a script about the purpose of the research, intention, and summary of the current interview setup. Before the interview questions were asked, I asked consent questions about participation in the interview for research purposes, and audio recording for transcription purposes. I also included a notice of audio recording in the Calendly sign-up. Audio recording began once both consent questions were answered. I then used Otter.ai to transcribe the audio file for each interview. Transcripts were each reviewed for accuracy and manual edits were made to correct mistakes, remove non-interview-related communication, and increase clarity. Dedoose was used to code each interview transcript.

Analysis

Coding: A codebook of six codes was created based on research questions. Coding was completed using Dedoose. 10 codes were applied to the data, six parent codes and four child

codes. Codes were categorized in the following: Succesess, Outreach, Enrollment, Service Navigation (Translation/language, Transportation, Wait time), Barriers (Cultural barriers), and Partnership with OHA). A few other excerpts with interesting information were tagged “Blank.” Please see the full codebook and definitions in Appendix C.

State Comparison Interviews

Research Question:

> How does the Healthier Oregon program compare with other state programs that offer healthcare coverage for low-income populations with undocumented statuses, in terms of breadth, challenges, and effectiveness?

Participants

To address my second research objective of looking at the larger national state of health coverage for undocumented populations, I interviewed personnel from different state programs that covered portions of low-income immigrant groups under their state Medicaid programs. This includes states with more comprehensive coverage programs such as Oregon as well as states that have made significant traction to provide coverage. Participants were chosen based on whoever was deemed "best fit" for an interview on this topic by each state health department. I asked a person who regularly consults with these states to distribute my interview request in addition to cold-emailing public health departments (please see more details in *Procedure* below). Inclusion criteria include roles such as policy analysts, program managers, directors, or any staff both familiar with their state's program and available to be interviewed.

Materials

Interviews were semi-structured, following questions generally. Interview questions focused on the state's program, understanding the kinds of coverage available to whom and under what circumstances, assessing the successes and challenges those programs may be experiencing, and what next steps (if any) the state is focusing on. There were also opportunities for open comments. Interviews were primarily to understand how programs operate as the information

available is limited. These interviews lasted on average 20 to 25 minutes and included 5 to 10 questions and follow-up questions were asked. Similar to my interviews with community partners, interviews were conducted remotely and recorded using Zoom.

Procedure

States were selected based on available information about state healthcare coverage programs for individuals without qualifying immigration statuses. California, Colorado, Oregon, New York, Vermont, and Washington State were reached out to and interviewed. Illinois declined the interview request. Washington DC was reached out to but did not reply. Participants were recruited based on interview request emails. Each state was typically reached out to from their respective DHS email address unless a more specific address for the program could be located. For Oregon, I was referred to an individual who works closely with Healthier Oregon by an OHA contact. The recruitment message requested that it be forwarded to an individual best fit to answer the questions as described in the message (Appendix D). These interviewees were conducted voluntarily.

Five interviews were recorded over Zoom. One interview took place over Microsoft Teams and was not able to be recorded, however, extensive notes were taken. At the start of each interview, I read a script about the purpose of the research, intention, and summary of the current interview setup. I asked consent questions about participation in the interview for research purposes, and audio recording for transcription purposes. I also included a notice of audio recording in the Calendly sign-up. Audio recording began once both consent questions were answered for all Zoom interviews. I then used Otter.ai to transcribe the audio file for each interview, in the same manner as the community partner interviews. The interview guide can be found in Appendix E.

Analysis

Interviews were transcribed using Otter.ai, an artificial intelligence software for transcription. Transcripts were each reviewed for accuracy and manual edits were made to correct mistakes, remove non-interview-related communication, and increase clarity. Due to the shorter nature, fewer interviews, and one interview not having a transcript, this set of interviews was analyzed using thematic analysis. Main themes were located throughout transcripts and excerpts were collected. These themes included barriers, system complexity, community engagement, claiming, program details, and successes.

Community Partner Interview Findings

Successes	• **Access to Healthcare**: Increased eligibility allowed many, including entire families, to receive regular care and reduced fears related to healthcare costs. • **Community-Based Organizations (CBOs)**: Effective coordination with CBOs facilitated outreach, enrollment, and service navigation due to their preexisting community connections. CBOs were crucial for local program implementation. • **Visibility and Collaboration**: Improved visibility of immigrant populations and enhanced networking among service providers and organizations.
Outreach	• **Awareness Levels**: Awareness of the program varied, with some communities well-informed and others needing more targeted outreach. • **Outreach Methods**: Effective methods included word of mouth, letters, flyers, social media, radio, TV ads, and community events, with tailored strategies for different populations. • **Trust**: Trust in CBOs was critical for successful outreach, as information from trusted sources was more likely to motivate enrollment.
Enrollment	• **Enrollment Assistance**: Flexible assistance from community partners, provided both over the phone and in-person, was essential, especially for those needing language or additional support.
Service Navigation	• **General Navigation**: Assistance included understanding benefits, setting up appointments, and accessing additional resources. • **Translation/Language**: Language barriers were significant. Significant need for improved translation and interpretation services, particularly in mental health care. • **Transportation**: Issues included unreliable services and long travel distances, hindering access to care. • **Wait Times**: Long wait times for appointments due to a shortage of healthcare providers caused delays in receiving care.
Barriers	• **Immigration Status and Fear**: Fears of jeopardizing immigration status and potential costs deterred some from seeking care. • **Language Barriers**: Persistent language barriers affect the quality of care and access to services. • **Income Guidelines**: Strict guidelines and fluctuating incomes led to confusion and ineligibility, particularly for seasonal workers. • **Cultural Barriers**: Lack of diversity among healthcare providers and need for culturally competent education about the importance of routine preventive care.
Partnership with OHA	• **Communication and Training**: Training and communication with OHA were appreciated, but there was a need for more input from and better understanding by OHA.

Table 2: Community Partner Interview Main Findings Summarized

Successes

The success code was defined as elements going well with Healthier Oregon, successful program outcomes, or implementation process outcomes. Within the data, 40 excerpts were coded as successes. The main successes found in the data set were access to healthcare generally, the ability for entire families to be covered, reduced fear of cost, barrier of immigration status removed, increased trust in the program, visibility for underserved communities, and success in the role of CBOs.

Overwhelmingly, participants found one of the most successful elements of the program to be that more people were eligible to apply and have health coverage. This theme emerged 31 times among all 15 recipients mentioning this as a success. Along with coverage, participants also highlighted the ability of entire families to be covered, to receive regular care, and to reduce barriers related to the fear of cost. Several community partners mentioned that this was the first time that many of their clients were able to access care and see a doctor for the first time. Some participants even mentioned that some of their clients hadn't been able to go to a doctor for upwards of 20 years:

> *"For some, they're actually able to get health care. Whereas otherwise, they would go without which then, depending on like their job, let's say they get an injury, and they don't feel like they can go because they don't have insurance. Or they go [to the doctor], and they get this huge bill and people are less likely to go for minor or serious things. And so [Healthier Oregon] has given people an option to say, I'm sick, I have the opportunity to go to the doctor, and I can go to the doctor."*

Nine participants mentioned also mentioned the coordination of CBOs as another success. Participants felt that using CBOs to help implement this program and provide enrollment and navigation assistance significantly helped with the rollout of Healthier Oregon. CBOs established ties with the communities of focus and laid the groundwork for Healthier Oregon to be best received, navigated, and utilized. Trust was highlighted as particularly

important, and participants noted that CBOs were essential to establishing trust within the community.

A handful of participants also mentioned the ability to connect and collaborate with other CBOs in their area. One grant-receiving organization was able to apply for the grant with local partners taking advantage of this opportunity as they "had never had the resources to compel us or to enable us to [partner] in such a robust way." Another found they were able to refer clients to other organizations that could help them get non-healthcare-related support such as access to air conditioning or heating.

> *"Because we've educated our community so well, the people that are in contact with these populations have helped us make it so that it was easy for them to feel like they could accomplish this. Because I think if OHA would have just bounced in there, the community would have still been more hesitant."*

The third main success was a sense of increased visibility for immigrant populations with various statuses in the community among both providers and community members. One participant also expressed that the visibility of their organization increased with their local Coordinated Care Organization (CCO) and OHA.

> *"Agencies like OHA, or in this case one of our CCOs in this region, they know us better, and they know that they can connect people through us. I think that more networking and more connection between agencies, I think this is a plus is something that I can see. They weren't able to see before. I know, so I feel more comfortable calling agencies here or OHA people to say, 'Hey, this is happening'. So connections, communication."*

Outreach

The outreach code was defined as community outreach performed by community partner organizations, OHA, or other parties aiming to spread awareness, information, or updates about Healthier Oregon. The first main theme identified was a general awareness of the program for those who may be eligible to apply. Awareness of the program was mentioned 19 times by 12

participants. The interviews provided mixed findings on levels of awareness that varied from the perspectives of each community partner. Out of ten interviews that mentioned awareness levels, three expressed low awareness levels, four expressed some or mixed awareness, and three expressed high awareness levels within the target population. For example, one participant noted regarding health coverage information: *"I feel like unless you're out searching for that information, you're not going to just be told about it."*

The second outreach theme is the ability to reach out to communities using various methods. This was mentioned 35 times in 14 separate interviews. All 15 organizations engaged in outreach for Healthier Oregon. The most common means of outreach included word of mouth, letters (from OHA or others), flyers, online posting (social media), radio, TV ads, and pulling from existing organization databases. Outreach took place at a variety of locations, schools, stores (especially cultural grocery stores), churches, community events, organization events, health fairs, farms, and the organization itself. Participants found that different populations, cultural identities of immigrants, and age played a major role in the kinds of outreach received and engaged with. There were also different preferences noted based on geographic location (rural versus urban) and occupation (working hours, seasonal work).

The concept of strategizing to meet people where they are at was emphasized especially among rural populations, seasonal workers, and especially vulnerable groups of immigrants. Several participants emphasized language and translated materials as critical to outreach. Also, being able to receive outreach from trusted sources was expressed as extremely influential in motivating those eligible to pursue enrollment for themselves and their families. This logic is why word-of-mouth, and trusted organizations were considered the best ways to distribute

information about the program. Some participants also expressed a need for increased widespread outreach and more avenues to conduct outreach:

> *"Bringing the community together for a joyful year and moment, distributing Christmas gifts, capturing memorable photos, and providing valuable information about our services and programs. This initiative not only strengthened ties with the community but also provided invaluable input to enhance our rich efforts and deliver relevant information for their well-being."*

> *"Have that information offered in a space the community finds safe and that they have some kind of respect."*

Enrollment

The enrollment code was defined as enrollment into the Healthier Oregon program. This includes the full enrollment process, from questions of eligibility to the actual enrollment in the program, including assistance in this process. Enrollment was coded 15 times across 9 participant interviews. The main finding is the importance of flexible enrollment assistance provided by community partners. Many organizations offer assistance over the phone and/or in person. The experience of community partners is that enrollment assistance for the Healthier Oregon program transitions to serving clients as a resource navigator, first, contact if issues come up, and an opportunity to provide clients with additional resources. Some participants noted that the enrollment process has become more user friendly while others said clients still found it confusing, especially regarding eligibility criteria. One participant who reported they had been tracking their enrollment numbers since July 2023 found that they helped 30-35 clients each month, about half of whom needed Spanish translation services. Another participant also mentioned the need for more individuals to assist with enrollment, especially in a variety of languages.

> *"Making sure that folks are up to date with knowing what a community health worker is, who are they, what do they do, and that clients or individuals know that those are available as a resource to them so that they can provide this medical terminology and information in a simpler language easy to understand and that comes from a place of understanding, you know like, being bicultural by literal and bilingual, I think would be a good benefit"*

Service Navigation

The service navigation code was defined as Navigation of Healthier Oregon benefits, setting up appointments, CCO navigation, locating providers, and other services including transportation or language assistance. The general theme is understanding how to utilize services after enrollment. Three child codes existed under service navigation. The child codes were translation/language, transportation, and wait times. Generally, participants explained the breadth and depth of service navigation. Participants reported that they help clients with a variety of navigation including questions about their benefits, setting up initial appointments, switching doctors when requested, notifying clients of other resources and programs, notifying clients of transportation and language benefits, and other needs related to accessing resources or benefits.

Translation/language

The first child code was translation/language. In relation to navigating translation services or language. Spanning all 15 participant interviews, 40 excerpts were tagged. First, relating to translation services, participants noted clients felt intimidated to enroll due to language barriers and a low awareness that interpreter services were available free of charge. When interpreters were available, clients generally preferred them in person. Several participants reported that clients often found difficulty getting their true meaning across through an interpreter and in some cases would simplify their issue or downplay symptoms to make things easier. Participants noted that interpretive services and translations related to mental health care were especially limiting for clients. A few participants reported a desire to see more diverse and

bilingual providers available. Translated documents and materials also came up several times. Several reported that documents, materials, and letters (primarily those from OHA) even when translated into a secondary language were often difficult and frustrating for clients to understand. Two participants stated that the reading level of the material was too difficult as many of their clients have limited education and/or are unfamiliar with complicated healthcare-related vocabulary. Another participant who primarily worked with Vietnamese immigrants reported that letters from OHA translated into Vietnamese were incorrectly or unclearly translated. The participant noted that this has also been the case with other materials translated into Burmese, Somali, and Arabic. Another community partner reported the difficulty in helping clients who speak indigenous languages.

> *"We really advocate for families who don't speak English as their first language. We know it's intimidating. We know that you haven't had insurance for a while. So we'll take the initial step to make your medical and dental appointment. We'll ask them. Do you prefer mornings? Do you prefer a female doctor? Do you prefer this area? We really, really commit to doing that as that extra step."*

> *"Sometimes interpreters at the moment could say something different than what it is, so they don't get your message across how it's supposed to. So sometimes it's important for someone to speak your language to be understood. So I think that could be one of the biggest things."*

> *"There's definitely variation in the quality of interpretation. And I know they have worked to expand the certification process. But, we just have some concerns about some of the quality of the communication if you can't communicate in the language anyway, if you have low communication skills, speaking in a second language is not going to necessarily help. And a lot of our patients have lower educational levels. And so they need things not just translated, because a lot of times doctors will speak at a high school or college level, and our patients need more like a third or fourth grade level. And so breaking some of those really, higher level concepts down into simpler language is another piece of it."*

Transportation

The second child code was transportation. Transportation was defined as non-emergency medical transportation as provided by OHA and general transportation to access services. Less

than half (6) participants mentioned transportation, but all acknowledged it was a major barrier to accessing care Transportation services were noted by one participant to be unreliable, communicating poorly with clients or failing to pick them up altogether. Another participant spoke of an unhoused client who was placed with a primary care provider over 40 minutes away and found transportation to be a major barrier. Lastly, CBOs in rural to remote areas reported that transportation was a major issue because of a shortage of drivers, especially those who were familiar with the client population or were bilingual.

Wait Times

The third child code was "wait times". The wait times code referred to any mention of wait times for clients to see providers or access other covered services. Wait times came up in 16 excerpts and were brought up by 9 participants. It should be noted that those who did discuss wait times elaborated on the topic and spoke passionately about it. Participants reported the time it took to establish care for clients and appointment wait times were lengthy. Reported wait times for an appointment ranged from 1 to 6 months. A shortage of providers was noted by participants as a primary reason. Several participants explained how if a client had something that needed immediate attention and may only be able to get an appointment months out, they may decide not to seek care or go to urgent care or the emergency room. Two participants mentioned the inability to see a doctor within a reasonable amount of time as a contributor to extended emergency room wait times. Another described the influx of newly eligible Healthier Oregon recipients creating a "bottleneck" phenomenon within an already stressed healthcare system. Mentions of wait times were not exclusive to urban or rural regions. Both urban and rural areas found shortages of doctors and extended wait times to see providers. However, a few participants did not mention wait times or did not find a shortage in their area.

> *"They'll get an appointment, it'll be three or four months out, and we work with them and say, Okay, go ahead and take that appointment Because you don't know what three or four months is going to bring, go ahead and take it. And hopefully, you'll be able to follow through with it. But what we're finding is, the offices themselves are calling to reschedule and sometimes 2,3,4 times. Our patients don't have a lot of control over their schedules. To be able to rearrange things for one visit and have that change multiple times is a little unnerving for them. And then after a while, people just give up, they're like, this is just too hard. Why am I going to even try? I'll just go to the emergency room."*

Barriers

The barriers code was defined by barriers to accessing coverage or care. Barriers can be both systemic or individual and function to deter or prevent someone from accessing coverage or care. These can occur before or after enrollment. There were 83 excerpts tagged "barriers" and were mentioned by all 15 participants.

A variety of barriers were brought up. First, the lingering fear and stigma of immigration status continue to be a barrier. Specifically, fears related to "public charge" or anything that may risk an individual or their family's status or ability to remain in the US were prevalent. Community partners emphasized how risk-averse this population is when it comes to jeopardizing their ability to remain in the country or impacting their chances of obtaining a green card. Many clients were said to be hesitant to share certain pieces of information about themselves or their families. An additional fear of possible costs incurred by using healthcare was also mentioned. One community partner commented on the significance even small seeming barriers may be: *"I think it's important for research to understand that those little things may discourage people from using the services again."*

Language was cited by multiple participants as a significant, if not the largest barrier to accessing care. Hours to accessing care were mentioned by two participants, explaining that hours of medical offices or assisting programs were not available outside of work hours. Many individuals in this population do not have control over their working hours and missing work

may mean losing valuable pay. Community partners that had experiences working with seasonal workers or day laborer populations especially noted this.

Income guidelines were cited as a significant barrier by six participants. Income tables were said to be "too low" or not an accurate assessment of individuals who have variable pay. Many participants explained that because many individuals of immigrant populations participate in seasonal work, their income varies month to month, qualifying for OHP one month and not the next. This led to confusion, frustration, and fears of cost. Stigma was also brought up as a barrier, especially concerning stigmas against accessing mental health care or substance abuse treatment.

> *"Make sure that also the people that are assisting with this program, that they have capacity, that they're not understaffed But what if they get an elderly, illiterate, dialect speaking client, to fill out this paperwork. Then you have to take into consideration an interpreter. And to make it so that the clients don't feel rushed. A lot of these people already are feeling like they've already had so many life stressors, so many social determinants of health are affecting their lives. And I'll tell you, the Latino community, when we have to ask for something, it's kind of degrading, humiliating, and we feel bad, we feel embarrassed. Somebody new to this country, and they don't want to be a burden, that's just our culture. And so, to make sure that these people are culturally literate give them some training on empathy and compassion, and, and that to serve the community, because, you know, it's not just a dollar sign that's associated with that appointment that we're going to do."*

Cultural barriers were brought up as barriers to care in two ways. First, a lack of diversity within the healthcare sector was perceived as a barrier for clients who prefer to interact with a doctor who looks like them. Participants expressed that it was important to have patients feel more comfortable because of a shared background and to receive more culturally appropriate care. Many interviewees commented that routinely going to the doctor even when nothing may be "wrong" (such as a checkup with a primary care doctor) is not a standard practice in many enrollees' cultures. Patients may wait to seek care until the issue has become more severe.

Language barriers were also relevant. This theme was especially relevant for mental health treatment as receiving care for mental health is already stigmatized in many cultures.

> *"I work with a local nonprofit; I refer my clients there for mental health. And why is that? Because there are therapists, counselors, and doctors that look like us. That's like us, and probably has some kind of common factor in our lives."*

In general, desires for increased cultural competence and respectful care were expressed. Second, cultural perception of when and how often to seek care was perceived as a barrier. Participants reflected that in many of their own or their client's cultures, it is not a norm to seek care for many ailments. They expressed a need for education to encourage Healthier Oregon recipients to engage in preventive care and seek care for minor to major issues.

> *Interviewer: "Would you say a percentage of people that have insurance or not, they're not used to going to the doctor, or that's not something that they're doing is like preventative? Or even if they had access, they still wouldn't use those services?*
>
> *Participant: "Oh, yeah. It's a huge amount of people. Yes. Because they only normally go to the doctor when something is wrong, and taking care of themselves is not part of their culture. And even if they don't have time, or it's something that it's a waste of time when you feel okay."*

Partnership with OHA

This code was defined by comments related to partnering with OHA for this program. Related to communication, training, or feedback. The code came up in 19 excerpts and was mentioned in 10 interviews. Participants commented on the current relationship and communication between their organization with OHA. Several commented on the training provided by OHA related to enrollment and other services navigation. These were found to be plentiful and contain helpful information. Two participants commented that they enjoyed their relationship with their coordinator within OHA, finding that contact useful. One grant-receiving organization reported routine meetings with OHA representatives provided opportunities to provide feedback and solve issues. Although their experience with their representative was

"great," they still viewed OHA as a "big black box," and were not sure where their feedback was going and if it was ever heard by others at OHA. Other participants echoed this, expressing a desire to have more input in the program and still feeling some lack of communication. Some participants expressed that they don't feel like OHA understands the extent of work organizations are doing and are not seeing the full picture and effects of policy directly like organizations do.

> *"I see that the OHP people have great ideas, but sometimes they don't adapt these ideas to the population. So, for them, it makes sense, but not for the people. Even if it's a great idea, it's not the thing that they need, or it's not the way that we need to do things. So, our role in these organizations is to translate that all into information the people can understand."*
>
> *"They don't pay what we work. Honestly, they don't. I hope they can understand the value of this, of the work we do. This is the dark side."*

Additional Tagged Excerpts

During coding, additional excerpts were collected but not categorized under a predetermined code. These provide supplementary or anecdotal results deemed significant enough to include. Several different points were emphasized.

Low income tables were cited as a barrier. Several participants expressed a need for them to be adapted to variable income and other options for those that n=done qualify or qualify only every few months.

> *"With this population, you either make a certain amount of income and qualify or you don't, and there are very limited options."*
>
> *"We run into situations too where I hate seeing folks sacrifice, I can barely afford to pay my rent, and I can't have health insurance, or I should just quit my job get on health insurance, but now I have no income to pay for my housing. So just this very delicate balance and, you know, sacrifices that folks need to make that. I just wish it wasn't like that."*

Second, as discussed under “successes,” many participants stated in their interviews it was good for entire families, regardless of age or immigration status to be covered. Participants found it was important to emphasize the prevalence of mixed-status families and understand how different policies affect them.

Third, participants emphasized the importance of trust and how more work needs to be done to build and maintain trust with communities.

> *I think they need to know their audience. And not just sit around the table and figure out what they think but they need to know the audience that they're going to serve and they need to bring them into the picture to you know, I'm not saying ask everybody that you want to, but bring some of them who have had experience with this to the table and help make sure that that their voices heard as well.*

A few participants were unclear on what happened to CWM (Oregon’s Emergency Medicaid program) once Healthier Oregon launched. Some participants noted the influx of people going into emergency rooms. They were concerned that more education was needed to help enrollees understand where they should receive what kinds of care.

Community Partner Interview Discussion

A significant lack of scholarship exists on the implementation or use of expanded coverage programs for low-income immigrant populations. To my knowledge, few publicly available reports examining the implementation of these programs exist. Existing literature focuses on barriers immigrant populations face and specific service use of Emergency Medicaid. Other scholarship exists related to CBOs serving immigrant populations, government – CBO partnerships, and the strength of these connections. However, limited literature illustrates the complex relationships between policies designed to improve immigrant health by expanding coverage, the partners involved in implementation, and factors that contribute to successful implementation and improved healthcare access.

This study finds original results that can be applied to future program rollouts and strengthen health systems to better serve immigrant communities. The study examines the rollout of Healthier Oregon through the perspective of community partners who were key partners with Oregon Health Authority in assisting with local level policy implementation. The main goal of this innovative policy was to expand health coverage to those eligible for OHP who were barred due to their immigration status. Based on a sample of 15 interviews with community partners, this study investigated community partners' key roles, experience in outreach, enrollment, and services navigation as well as their overall perceived challenges and successes of the program implementation. I find significant successes from Healthier Oregon, including increased access to healthcare, successful coordination with community-based organizations, and improved visibility for underserved communities. However, notable barriers such as fears related to immigration status, language and cultural obstacles, challenges with income guidelines, and

stigma surrounding healthcare-seeking behaviors underscore the need for targeted interventions to ensure equitable access to healthcare services among those who are undocumented.

The results yielded several main findings about the Healthier Oregon program implementation. First, community partners highlighted that more people were eligible to apply for and receive health coverage, which community partners considered a significant success of the program. Community partners noted the importance of their statewide network due to their instrumental role in outreach, enrollment, and service navigation for Healthier Oregon enrollees. They were uniquely positioned for these roles because of their existing connections with local communities, being seen as a trusted source by immigrant populations, and the dedication of community partner organizations and staff to address the health and wellbeing of Healthier Oregon enrollees. This is in line with other studies, such as that by Chillag et al., which found that CBOs are well-positioned to provide such services as they have a preexisting connection with the populations they serve. Like Chillag et al.'s findings, CBOs addressed the needs of the population outside of the program criteria, helping not only with Healthier Oregon outreach and enrollment but also in-depth health service navigation, other programs OHP recipients may be eligible for, and addressing unique community needs.

Many community partners who participated in the study also were community health workers (CHWs). The intended population of Healthier Oregon recipients is low-income individuals who do not have qualifying immigration. This population in Oregon faces barriers at multiple levels and fits as a group that according to Wilkinson et al, CHWs are best poised to positively impact. The diverse makeup of CHWs and CBOs follows Alwan et al.'s findings that community and cultural ties can be used to better navigate barriers that immigrants, including those without documentation status, face in accessing health services.

The integration of community partners in the Healthier Oregon program was an integral part of the program's successful planning and implementation.

The same advantage of utilizing community partners was apparent in program outreach as facilitated by CBOs. Outreach took place in various locations and utilized different methods tailored to different populations, emphasizing the importance of meeting people where they were at to notify them about Healthier Oregon and any eligibility changes. Locations the target population frequented and trusted were key to well-received outreach. While some community partners expressed low awareness levels, various methods were used to spread awareness of the program, including word of mouth, letters, flyers, and online postings. Outreach was conducted at churches, schools, ethnic grocery stores, job sites, and trusted community spaces. For this population, it was important for information to be perceived as reliable, accurate, and most motivating to enroll that it comes through a trusted source. Word of mouth was considered by community partners as being the most motivating source for individuals to take the step to apply. While some community partners expressed low awareness levels, various methods were used to spread awareness of the program, including word of mouth, letters, flyers, and online posting.

Trust was a significant theme in the findings as found in the research of Valentín-Cortés et al, Chillag et al., Alwan et al., Coll et al, and Rajabi et al. Trust was key in several dimensions of implementing health programming, partnerships between CBOs and government agencies, and working with a vulnerable population such as low-income immigrants. As Coll et al. found in their CBO of focus, trust was formative to establishing dynamic partnerships and relationships. The role of trust in relationships was found at multiple levels between the translation of policy to people. Trust was integral to the

relationships between OHA and CBOs/ community partners and especially between CBOs/community partners and potential or existing Healthier Oregon enrollees. Established trust was key to better understanding potential barriers existing or potential enrollees may face and is a first step to figuring out how to minimize or mitigate them. Additionally, bringing community partners and program enrollees into the conversation allows agencies to not only hear directly from community voices but also foster a sense of participation in directing the health of their communities.

Community partners repeatedly highlighted the need for improved translation and language services to overcome language barriers, especially in mental health care. Translation services, both for physical material and interpretive services, are a pressing need for immigrant communities. Translations must be accurate and use simple vocabulary for complicated medical or health system vocabulary. Interpretive services should be available in a variety of languages. Study results suggest a reexamination of interpretive services available to OHP recipients, finding a variety of quality and effectiveness among community partner perspectives. Community partners also noted that ideally patients would be able to access services in their native language, calling for increased diversity in Oregon's healthcare system.

System capacity of the healthcare system in Oregon impacted the access to healthcare for Healthier Oregon enrollees. The stress of an overloaded healthcare system was seen in the lengthy wait times for patients to establish care or be seen by a doctor. Access to primary care has worsened nationwide with physician shortages and long wait times for appointments resulting in worse health outcomes for Americans ("The Health of US Primary Care"). In Oregon, hospitals report that they are in "crisis" and have not recovered from the COVID-19

pandemic (*Oregon Hospitals in Crisis*, 2022). System-wide shortages are impacting access to basic and specialized care, hindering the successful implementation of programs aiming to improve health access. Some community partners noted that an increase of individuals covered and able to use services and higher ER use have also played a role in system capacity. Further research needs to be done on increasing coverage for immigrant groups, services use, and impacts on system capacity.

Healthier Oregon expanded healthcare services covered from basic Emergency Medicaid to comprehensive care. Community partner findings inform that additional education is needed around when individuals should seek care and routine preventative care. Many interviewees commented that routinely going to the doctor even when nothing may be "wrong" (such as a checkup with a primary care doctor) is not a standard practice in many enrollees' cultures. This finding suggests that additional, culturally competent education remains a need to increase routine preventive service use. Education to help communities establish health care routines can help improve uptake up preventive care services, reduce necessity of costly emergency services, and encourage improved health outcomes in the long run.

It is blatant that the anti-immigration rhetoric in politics, policy, news, and everyday life has impacted current immigrants in Oregon. This is especially true for those that hold non-legal immigration statuses. "Public charge" fears were brought up by community partners multiple times, demonstrating the lingering fear of jeopardizing ones' or their family members' immigration statuses or even deportation. Trust, in general, has been diminished within migrant populations, affecting interactions with government bodies and larger systems such as healthcare. Individuals working with immigrant communities or engaging with

outreach should be aware of this complex and discriminatory history and the impact on immigrant communities trust of government and healthcare.

The repeated challenges with income guidelines especially for individuals with variable pay or seasonal work suggest that there is a need for increased access for those who may qualify one month but not another. Additional considerations may need to be made to address the unique needs of immigrants who do farm or seasonal work.

State Interview Findings

States that offer various health coverage to immigrant populations each strategize unique ways to extend coverage or benefits to fit their population's needs. From six state interviews, top themes, challenges, and strategies have been identified. The results offer insights into the strategies employed by states to extend healthcare coverage, along with the overarching trends and lessons learned from their experiences. Top themes identified from the data set include: 1) community engagement and partnerships, 2) overcoming barriers to access, 3) maximizing federal funding, 4) navigating complex systems, and 5) continuous improvement and equity advancement.

Top Themes	Details
Community Engagement and Partnerships	• **Collaboration with Community Partners**: States emphasized the vital role of community partners in outreach, enrollment, and navigating benefits. Several states credited their success to these strong local partnerships and long-standing advocacy efforts. Community partners were crucial in establishing and maintaining trust with immigrant communities. • **Advisory Work Groups**: States like Oregon used interdisciplinary teams and diverse advisory groups to shape program rollouts and ensure community involvement.
Barriers to Access	• **Awareness and Language**: Providing materials in multiple languages and user-testing them were key, yet language barriers and interpretive services remained significant challenges. • **Fear and Distrust**: Fear of deportation and distrust of government agencies persisted as major barriers. Clear communication about policies like public charge helped alleviate some concerns. • **Perceived Deservingness**: Some potential enrollees felt undeserving of benefits, creating additional hurdles for enrollment.
Navigating System Complexity	• **Federal Matching**: States were motivated to claim federal matching for qualifying services and cover non-qualifying services with state funds. • **Step-by-Step Coverage Expansion**: States expanded coverage in phases, starting with children and pregnant women, then older adults, and eventually all age groups. This gradual approach helped manage budgets and implementation challenges. • **Emergency Medicaid Flexibility**: States like Colorado used broad definitions for emergency services, while others like New York streamlined enrollment by pre-qualifying individuals for emergency coverage.
Claiming Complexity	• **Multiple Funding Streams**: Navigating multiple funding streams for different services created administrative burdens. States faced challenges in distinguishing funding sources and managing back-end claiming systems. • **Managed Care Plans**: Transitioning from fee-for-service to managed care plans improved access to care and streamlined services but required careful planning and implementation.
Continuous Improvement and Equity Advancements	• **Commitment to Improvement**: States showed a commitment to continuous improvement and equity. Feedback from partners and members was integral to planning and refining programs. • **State Collaboration**: Communication and sharing program strategies between states is helpful for other state expansions. California, for example, shared its expertise with other states to improve their claiming processes. • **Equity in Coverage**: Ensuring that immigrant coverage was identical to general Medicaid was a priority to avoid discrimination and ensure equal treatment

Table 3: State Interview Findings Summarized

Community Engagement and Partnerships

Most states emphasized the importance of collaboration with community partners and advocates in implementing healthcare expansion programs. Compared to the information collected from community partner interviews, efforts from states were more general. The outreach explained included sending out mail notices of program changes or expanded eligibility for individuals enrolled in EM coverage. States had a similar strategy of working with community partners to ensure target populations were both aware of new coverage and understood how to enroll.

The role of local organizations and community partners was important to implementation in many states. Some states, like California, explicitly named relationships with counties or community partner organizations as vital to local implementation. The California interviewee explained that "from our side, whenever we implement policy, it is really just a system piece of it" and working with community partners is vital for the implementation side of the program. States mentioned the role of community partners in outreach, enrollment assistance, and helping enrollees navigate their benefits. Local organizations were also key in the advocacy essential to get programs to expand coverage passed. In the cases of Vermont and Oregon, the state interviewees explicitly credited the passage of each expansion program to decades of advocacy from their communities. Local involvement is important at the birth and the rollout of these programs.

Outreach was noted as a vital role of community partners. Spreading information about the program on a local level in clear, approachable, and engaging ways. Outreach efforts by community partners were credited with "getting people in the door." States mentioned the

importance of providing materials, both direct letters from the state and materials to disseminate to community partners. Two states mentioned user-testing materials with the community before distribution. User-testing involves distributing materials to a limited group with the objective of getting feedback on the quality, ease of understanding, and any other comments before widespread distribution. Several states brought up community partners' role in establishing and maintaining trust with communities. Two grant receiving community-based organizations in Vermont were highlighted as responsible for much of the state's outreach. The representative noted that the organizations also met people where they were to conduct successful outreach.

> *"[The organizations] put together a bunch of like outreach stuff, and they also do farm visits. So they're frequently out in the community for migrant workers and I'm guessing that a lot of the folks that this is really aimed at are on dairy farms in Vermont. It's a very rural state."*

Oregon credited the success of its program to an interdisciplinary team and community partners. Their team was made up of policy specialists, system analysts, community partner strategists, and others who helped lead the work, desiring to bring together silos. A diverse advisory work group was established to shape the program and was instrumental in deciding what age groups should be included in each rollout.

> *"[The advisory work group] and the community partners that they support have been super helpful and forming communities about Healthier Oregon and the benefits are really ensuring and helping members understand everything about their benefits and the letters that they receive. They also help members make appointments, and a lot of other activities that really help the gap between being covered and receiving care which I think is so important."*

Barriers to Access

States recognized the numerous barriers that this population faces to accessing care. States that expanded on barriers to accessing coverage and care expressed the importance of understanding the experiences of potential and current enrollees. These experiences are as central

to understanding barriers they face to assessing care. General barriers that came up across states included awareness of the program, language and translation, transportation, lingering fears or distrust, wait times for appointments, individuals not feeling serving of benefits, and "getting people in the door" or effectively motivating people to enroll.

States that mentioned language and translations highlighted their efforts to provide materials in various languages. The variety of languages that materials were offered was highlighted. As part of their work on outreach language, one state user tested their materials to ensure clarity. Despite these efforts, language continued to have remained a top barrier to access. Most that expanded into language and interpretive services mentioned that interpreters are a resource but language still is a significant barrier. One state mentioned the feedback received about interpretive services for their EM enrollees. Not all providers were as willing to provide or accommodate these services.

> *"[interpretive services] are not explicitly mentioned but as part of a registered Medicaid, language services are requirement I believe, because they're [providers] are accepting federal funds. But I definitely know that we've had members complained that some providers are not helpful in that sense."*

Fear and distrust remain a high-level barrier in many states. Distrust of the government and fear of deportation or other repercussions for accessing benefits create hesitation to enroll. One state representative noted that fear remained an issue, especially during the implementation of coverage for children. In most states that have expanded coverage, children are among the first group to gain coverage. Parents were fearful of enrolling their children due to public charge rules or other repercussions. Regarding public charge, some states found it still an issue whereas others found that clear communication regarding public charge reduces stress.

> *"Now that there's kind of clear guidance on public charge, and how a public charge will not apply to Medicaid benefits, that's definitely helped with our latest*

expansion, kind of dispelling a lot of fears and barriers that we were experiencing with this population wanting to access Medicaid."

A final barrier highlighted was the notion that potential enrollees don't feel deserving the benefits that they are offered. Two states explicitly mentioned this as a barrier.

> *"We found that members are still feeling like they aren't deserving of the benefits that they now receive. I would say that's pretty similar to a culture shock, and not being accustomed to what they are entitled to. And so a lot have that feeling, we feel like maybe discourages them to seek those benefits."*

Maximizing Federal Funding

A significant challenge that showed up in a variety of state interviews was navigating claiming systems. As immigrants with nonqualifying statuses are barred from receiving federal Medicaid dollars, care outside the scope of emergency services (e.g., Emergency Medicaid) must be covered by state dollars. States with more expanded coverage for immigrants ensure that the coverage immigrant enrollees receive is nearly identical to general Medicaid coverage. States can receive federal matching for services that do qualify and must cover those that do not with state funds. Overall, the desire to maximize federal matching is consistent across states. Having established coverage for this population among the first in the nation, California reflected that they had spent a considerable amount of time on this issue and had learned how to address it. The interviewee from California said their state had been collaborating with other states struggling and offering guidance and advice on how to best maximize federal dollars.

> *"So we've met with quite a few other states who have been over the years that are also, you know, looking to implement various pieces of this. And one of the largest kind of things that states want to ask us is how you do the claiming the claiming part is a big thing for states because it's really trying to figure out how to appropriately shift these folks over to state-funded and making sure that you're identifying the correct population."*

Navigating System Complexity: Step-by-Step Approaches

When expanding eligibility, states offer coverage in waves by age group. Budgets constrain states from extending coverage to all at once and instead often cover children and pregnant women first since this group is eligible for more federal funding. From there, states often expand to older age groups above 65 before eventually rolling out the program to all ages. Many states that have expanded coverage find themselves somewhere along this process with varying eligibility by age group until finally expanding to all. The Oregon representative noted that their first expansion, Cover All Kids in 2018, comes out of decades of community advocacy to expand healthcare access. This program was a "foundational stepping stone" for the Healthier Oregon program. Healthier Oregon itself started with a more limited age group and expanded to cover everyone eligible in its second year. Each state interviewed and researched demonstrated the same step by step pattern. The California representative also commented on this approach their state has taken. They described a push for coverage since the early 2000s, slowly covering each group. The representative commented:

> *"That's kind of how we have these programs stacked. Firstly, the legislation approved the kids, and then we went to the young adults, and then the older adults, so now we're doing just the last middle [age] group. So, you know, it has taken us eight years to get fully implemented."*

Navigating System Complexities: Emergency Medicaid

Other states have not expanded state Medicaid coverage past Emergency Medicaid (EM) coverage. Colorado, for example, only has emergency medical coverage available for low-income immigrants who are unable to qualify for Medicaid due to their immigration status. Despite this limited coverage, Colorado has taken advantage of the flexibility of the EM statute. Instead of having a list of preapproved procedures that qualify as "emergency," Colorado leaves

emergency determination up to the physician. While a broad definition allows for more services to be covered, the Colorado interviewee also described it as a “doubled-edged sword.” and physicians can be subject to audits and don’t want to authorize incorrect claiming, leaving some to apply a broad definition with strict scrutiny.

> *Depending on the provider, things like rural versus urban and the stigma around the population, [the broad definition of emergency] can either increase access to care or it can decrease that because providers want to be prescriptive and the guidance they get from us, they want to say yes, you covered this, this and this. But each case is so personal that we can't over guide as risk of reducing access for others.”*

While New York now has coverage beyond Emergency Medicaid, their EM program was “done differently from other states.” They allowed applicants with statuses that do not qualify to apply directly to Medicaid and are “put up with emergency coverage only.”

> They explain, *“Our system that plays our claims would only pay for services that are emergency. So the physician's office or hospital, when they submit a claim, they have to attest that that's an emergency. It will pay that claim. So this way, we don't have to enroll them at the time of emergency, the way we used to do it.”*

The New York representative explained that this process was much less burdensome than enrolling people at the time of emergency. If an individual already was enrolled, the claiming system would automatically kick in and pay for the care if it was deemed emergency. This reduced the time and resources to enroll the person at time of emergency and less retroactive coverage.

New York, as well as Oregon and California, added that their states transitioned all EM program enrollees over to the new comprehensive programs once their age group was eligible. This auto-enroll process removed the barrier of enrollees needing to separately apply for the new expanded coverage.

New York: *"We had these 18,000 people already on emergency Medicaid, and we flipped their coverage to this new coverage, sent them a letter telling them changes are coming... It was those initial people that were on emergency Medicaid, because they were they were already sitting there that we could just flip. We didn't need a new application for them."*

Claiming Complexity

Distinctions in claiming and multiple funding streams bring many challenges. Navigating what programs and services are paid for by what funding takes time, resources, and practice. Some states explained that this can create a complicated insurance claiming system. With multiple streams of funding covering one individual, the "backside" claiming systems were described as "complicated and confusing." Each state has a different claiming system, and each cited it as a complicated, often time-consuming process. Some states expressed that they had in the past or currently were missing out on federal matching simply because they didn't have the ability to work out how to distinguish funding for programs from the backend and instead just used state funding. Other states expressed the challenge of navigating these already complicated systems when expanding coverage to a new population or transitioning current enrollees from EM limited plans to fuller coverage plans.

New York, for example, had two separate systems for two groups that fell under that low-income immigrant umbrella. They were able to transition one group to the other program internally and simplify their organization. However, "the challenge is our new consumers that want to apply. They cannot apply directly to the marketplace." The same application tests that were waived for the transferred population could not be waived for new enrollees. Instead, the New York interviewee states:

"they have to go through a local Department of Social Services. They have to be determined eligible for Emergency Medicaid because that's the only thing that's programmed in our local Department of Social Services, and then they have to be transferred to our new system…So we have a process, but it's not smooth. And I

just say that's a challenge. Even though we're using the existing process. I have to monitor that no one gets lost. Yeah. And it will take time for those new people to enroll before they are in a managed care plan. It is the only way I can implement this."

The majority of states had in place or transitioned to managed care plans for their members instead of relying on fee for service. This was in part to save money and offer a more streamlined system of care. (Note, it was not explicitly asked if this transition to fee for service was for all Medicaid enrollees in each state or just non-qualifying immigrant groups.) About the above section, some added complexity for states was figuring out what services could be covered under managed care plans and what must be fee for services. States often wanted to offer coverage for things like pharmaceutical drugs but had to pay separately for those services.

"Shifting everybody over from fee for service to managed care, which provides them better access to care. So with that, that greatly impacts our expansion populations, because it is getting them better access to care, and getting them into those resources for mental health and more."

A few states noted that actual enrollment numbers were higher than planned. This, however, was expected. It is understood that immigrant populations are chronically undercounted. Enrollment numbers from states proved this to be true.

Continuous Improvement and Equity Advancements

Each state interviewed demonstrated a commitment to continue improvement and advancements to increase equity. States emphasized a consistent emphasis on improving outreach with each coverage wave. Many expressed a desire and "wishful thinking" to cover all populations. Feedback from partners and members was integral to planning and improvements. A few states emphasized that coverage offered to their immigrant was as identical as possible to the state's general Medicaid plans. This is important to the state and to members to ensure that

they are being treated the same as general Medicaid members and not excluded from benefits or equal treatment due to their immigration status.

California expressed that their last expansion had been the most successful. This was credited to years of implementation, mistakes, and learning from past slip ups. These were all incorporated into their most recent rollout.

> *"We made a lot of mistakes. So, we learned from those and then moving forward. I do think that we're pretty good now...this last extension has been our most successful. We've learned a lot...we knew all the steps and there weren't any huge hiccups or anything like that. So we've actually been very successful."*

Overall, these common themes reflect the shared goals of expanding healthcare coverage, improving access to care, and addressing disparities through collaborative efforts, innovative strategies, and continuous adaptation to changing circumstances.

State Interviews Discussion

As more states continue to expand their state Medicaid program to provide coverage for categorically excluded immigrants, states will face challenges and complexities in policy design and program implementation. For states that desire to expand coverage to these populations, program expansion and implementation may require a several-year process to pass measures at the policy level, organize planning and strategies labor, ensure community engagement, and implementation and evaluation. Three main topic areas emerged from the state interview group. First, trust must be established and maintained with immigrant communities through clear guidance, coverage stability, and messaging of deservingness. Second, dramatic variation exists between state programs as well as internal system complexities. Third, increased investments in strong partnerships with community partners and the establishment of diverse workgroups can help increase local and overall program success.

Findings indicate varying levels of trust among immigrant populations that shape hesitancy to enroll and access services. Literature tells us that fear among immigrant communities is shaped by political and social anti-immigration rhetoric. Politics and policy, such as the public charge rule, influence this fear by attaching a sense of instability and impermanence to social programs targeted toward immigrants. Despite general messaging, hesitancy remains. To address this hesitance, trust in immigrant communities must be established and maintained. Clear guidance, stability of benefits, follow through on promises, and messaging of deservingness may improve trust within communities. California, for example, has dispelled many public charge fears through intensive messaging and communication. They no longer find public charge concerns as a primary barrier. States may opt to include messaging related to deservingness of care in messaging about the program. Taking a page out of immigrant rights

and health advocates' book, states should center this messaging on the right to healthcare for everyone.

The federalist design of healthcare in the United States has left powers related to health to be determined up to each state. This allows states to implement their own Medicaid systems as they see as best fit to promote their resident's health and well-being. Varying policies and coverage for immigrant groups from state-to-state result. An individual may find themselves entitled to completely different care from state to state and from provider to provider. In each state, diverse systems and programs lead to system complexities regarding the management and insurance claiming systems for immigrant benefits. States have taken on creative and innovative strategies to manage this complexity, ensure quality care, and maximize federal funding. However, these system complexities can also leave states vulnerable to missed federal matching opportunities and absorb more time and resources to maintain, all at the cost of healthcare quality. States have addressed these issues with two main patterns. First, most states with broad expansions have transitioned to managed care plans to maintain care. Not all services in each state or program are covered under these plans, leaving some states to also have certain services under fee-for-service plans. This trend may be useful information for any other state developing expansion programs for their Medicaid programs. Second, collaboration and communication between states is key to developing and maintaining programs that extend coverage to this population. States that have had programs established for several years expressed long learning processes throughout development, implementation, and especially claiming systems. Nationally, many states already engage in communication for this purpose, sharing advice and gaining information about other successful initiatives. This may contribute to the ability to maximize

federal matching, economic and labor efficiency, and increased innovation, resulting in improved quality of care.

Finally, continued partnerships and collaboration between state agencies and regional and community partners are essential. Increased investment into strong partnerships with community partners and diverse workgroups can help increase program success on the local level and best address health equity. More successful programs drive forward more allocated funds and resources to these programs. Workgroups enable state agencies to hear directly from experts and community stakeholders. Two-way communication pathways between agencies and community advocates are imperative to successful programs by promoting feedback. States may consider extra support such as grants to local organizations and community partners during the implementation process. Several states have integrated this approach during each rollout.

Limitations

This study has several limitations. First, regarding the state interviews, not all states that had developed programs for immigrants responded to emails and were unable to be included in the interviews. The interview sought to find an employee best suited to answer my questions but this determination was constrained by availability and understanding of the interview purpose. It can also be assumed that not all relevant state program information is updated and publicly available. A more in-depth review of all state policies is necessary to make the most accurate conclusions about the state of health programs for immigrants in the US. This study focused on Medicaid expansion for immigrant groups but several states have implemented Marketplace options with subsidies for low-income immigrants which were not included (except Colorado). Additional research must be done regarding the use and challenges of these programs.

Regarding community partner interviews, the sample was limited based on response rate and snowball sampling. A diverse sample was intentionally sought but cannot fully represent all community partners or CBO experiences. All interviews were conducted in English but English was not all interviewee's preferred language. Bilingual interviews could have allowed participants to more accurately get their point across.

Conclusion

Health coverage remains a significant determinant of health outcomes. Categorically excluded from Medicaid, low-income immigrants without qualified statuses face numerous barriers to accessing healthcare services. Many state programs, like Healthier Oregon, that expand state Medicaid benefits to immigrants who would otherwise qualify if not for their immigration status can help reduce uninsurance rates among this population. Expanding coverage that includes preventive care is both a better method to improve health outcomes and is more cost efficient than Emergency Medicaid programs. The research finds a growing trend for states to expand state Medicaid programs to improve access for at least the most vulnerable of these populations such as children and pregnant women. However, eligibility for health coverage does not equal increased health access or positive health outcomes. The case study of Healthier Oregon underlines the need to improve access to these programs and services. Healthier Oregon also demonstrates the vital role of community partner networks across the state in implementing the program, taking on outreach, enrollment assistance, and services navigation roles.

Increased research on this topic is essential. With growing numbers of immigrants coming into the US and socioeconomic gaps widening, more investigation around programs that expand state coverage to low-income immigrants must be completed. More data related to program enrollment, service use, roles of community partners or community-based organizations, managed care plan integration, patient and physician perspectives, and more related areas is needed. The impact of the influx of additional individuals on health system capacity is also a topic for continued research.

This is essential to develop a more comprehensive understanding of coverage options for states looking to begin or improve expansion, barriers immigrants face to accessing services, and improving health and wellbeing outcomes for all. After all, healthcare is a human right.

Appendix

Appendix A: US Immigration Status Categories

8 U.S. Code § 1641 – Definitions
Retrieved from Cornell Law School

(a)In general
Except as otherwise provided in this chapter, the terms used in this chapter have the same meaning given such terms in section 101(a) of the Immigration and Nationality Act [8 U.S.C. 1101(a)].

(b)Qualified alien
For purposes of this chapter, the term "qualified alien" means an alien who, at the time the alien applies for, receives, or attempts to receive a Federal public benefit, is—
(1)an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act [8 U.S.C. 1101 et seq.],
(2)an alien who is granted asylum under section 208 of such Act [8 U.S.C. 1158],
(3)a refugee who is admitted to the United States under section 207 of such Act [8 U.S.C. 1157],
(4)an alien who is paroled into the United States under section 212(d)(5) of such Act [8 U.S.C. 1182(d)(5)] for a period of at least 1 year,
(5)an alien whose deportation is being withheld under section 243(h) of such Act [8 U.S.C. 1253] (as in effect immediately before the effective date of section 307 of division C of Public Law 104–208) or section 241(b)(3) of such Act [8 U.S.C. 1231(b)(3)] (as amended by section 305(a) of division C of Public Law 104–208),
(6)an alien who is granted conditional entry pursuant to section 203(a)(7) of such Act [8 U.S.C. 1153(a)(7)] as in effect prior to April 1, 1980,
(7)an alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980), or
(8)an individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in section 1612(b)(2)(G) of this title, but only with respect to the designated Federal program defined in section 1612(b)(3)(C) of this title (relating to the Medicaid program).
(c)Treatment of certain battered aliens as qualified aliens
For purposes of this chapter, the term "qualified alien" includes—
(1)an alien who—
(A)has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented to, or acquiesced in, such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and
(B)has been approved or has a petition pending which sets forth a prima facie case for—
(i)status as a spouse or a child of a United States citizen pursuant to clause (ii), (iii), or (iv) of section 204(a)(1)(A) of the Immigration and Nationality Act [8 U.S.C. 1154(a)(1)(A)(ii), (iii), (iv)],
(ii)classification pursuant to clause (ii) or (iii) of section 204(a)(1)(B) of the Act [8 U.S.C. 1154(a)(1)(B)(ii), (iii)],
(iii)suspension of deportation under section 244(a)(3) of the Immigration and Nationality Act [8 U.S.C. 1254(a)(3)] (as in effect before the title III–A effective date in section 309 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996).[1]

(iv)status as a spouse or child of a United States citizen pursuant to clause (i) of section 204(a)(1)(A) of such Act [8 U.S.C. 1154(a)(1)(A)(i)], or classification pursuant to clause (i) of section 204(a)(1)(B) of such Act [8 U.S.C. 1154(a)(1)(B)(i)]; [2]

(v)cancellation of removal pursuant to section 240A(b)(2) of such Act [8 U.S.C. 1229b(b)(2)];

(2)an alien—

(A)whose child has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse or parent's family residing in the same household as the alien and the spouse or parent consented or acquiesced to such battery or cruelty, and the alien did not actively participate in such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B)who meets the requirement of subparagraph (B) of paragraph (1);

(3)an alien child who—

(A)resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B)who meets the requirement of subparagraph (B) of paragraph (1); or

(4)an alien who has been granted nonimmigrant status under section 101(a)(15)(T) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(15)(T)) or who has a pending application that sets forth a prima facie case for eligibility for such nonimmigrant status.

Appendix B: Community Partner Interview Recruitment Message

Email recruitment message for interview participants:

Student Interview Request – Healthier Oregon (HB 3352)

Hello,

My name is Megan Tuleya, a student at the University of Oregon, and I am reaching out to invite you to participate in my research study about the recent bill Healthier Oregon (HB 3352), which allows anyone, regardless of immigration status or age, to enroll in health coverage in the State of Oregon.

The purpose of the research is to investigate the state of healthcare access for immigrants without valid immigration statuses in the United States, focusing on healthcare coverage. This research will include a case study of the implementation of Oregon's policy, Healthier Oregon (HB 3352), which expands state healthcare coverage to individuals regardless of immigration status, to further understand the successes, and challenges of such policy expansions on a local level.

I am conducting interviews with community partners to learn more about understanding the program, and the challenges and successes that the program has encountered over a year after its implementation. Interviews will be approximately 40 minutes in length and will be conducted virtually, over Zoom. After the interview is conducted, you will be compensated with a $43 Visa egift card ($2.95 activation fee) for taking the time to talk with me.

Interviews will be anonymous and all identifiable information will be removed from the dataset. Please note that the audio from interviews will be recorded for transcription purposes.

Please respond to this email if you are interested in participating in this research study and willing to dedicate 40 minutes of your time to an interview. Your knowledge is valuable in informing the implementation of programs like Healthier Oregon and increasing access to health coverage! Feel free to relay this message and my contact information to other individuals who may be interested in this opportunity.

Please let me know if you have any questions or concerns.

Thank you,

Megan Tuleya

mtuleya@uoregon.edu

503-360-5532

University of Oregon

Appendix C: Community Partner Codebook

Code (Parent codes)	Global Definition	Subsections/ child codes
Successes	Elements going well with Healthier Oregon, successful program outcomes or implementation process outcomes.	
Outreach	Community outreach performed by community partner organizations, OHA, or other parties aiming to spread awareness, information, or updates about Healthier Oregon.	
Enrollment	Enrollment into the Healthier Oregon program. This includes the full enrollment process, from questions of eligibility to the actual enrollment in the program, including assistance in this process.	
Service Navigation	Navigation of Healthier Oregon benefits, setting up appointments, CCO navigation, locating specialists, and other services including transportation or language assistance. The general theme is understanding how to utilize services after enrollment.	A. Translation/Language B. Transportation C. Wait time
Barriers	Barriers to accessing care or coverage. Barriers can be both systemic or individual and function to deter or prevent someone from accessing coverage or care. These can occur before or after enrollment.	A. Cultural barriers
Partnership with OHA	Comments related to partnering with OHA for this program. Related to communication, training, or feedback.	

Appendix D: State Interview Recruitment Message

Student Interview Request – Healthier Oregon (HB 3352)

Hello,

My name is Megan Tuleya, a student at the University of Oregon, and I am working on a research study about Healthier Oregon for my Honors thesis. The purpose of the research is to investigate the state of healthcare access for undocumented immigrants in the United States, focusing on healthcare coverage. My larger research question is investigating the implementation of Healthier Oregon, looking at the success and challenges of the implementation, looking specifically at Lane Country. I hope to situate Oregon in the larger national context by talking to several states that have similar policies that expand their state Medicaid to all migrant groups or have attempted to pass similar legislation. I am conducting interviews both within Oregon and with other states, engaging in 20-minute online interviews with individuals who played a role in the creation or implementation of these programs. I hope to find information about Healthier Oregon's implementation that went well/ things that are still barriers and situate Oregon's experience with this type of policy expansion in the larger national context.

If you could please forward this email or my contact information to the best contact to discuss [state]'s healthcare programs for immigrant populations. I would be very interested to learn more about the work [state] has done in this area. Please let me know if there is anyone who would be willing to do the 20-minute interview with me. I am looking for individuals from Oregon, and generally (but not limited to), California, Colorado, Illinois, Maine, New York, DC, Vermont, and Washington. You can contact me (the Primary Investigator) at mtuleya@uoregon.edu with any interest, comments or questions.

Thank you,
Megan Tuleya
mtuleya@uoregon.edu
503-360-5532
University of Oregon

Appendix E: State Interview Guide

Healthier Oregon Study: State Comparisons

Hi, my name is Megan Tuleya and I am an undergraduate student at the University of Oregon. I am conducting research to fulfill my honors thesis about the state of healthcare for immigrants (specifically those without lawful status) in the US. I specifically am examining the implementation of Oregon's recent policy Healthier Oregon which opens up Oregon's Medicaid to all age groups, regardless of immigration status. As part of my research, I aim to place Oregon in the national context of healthcare access for all immigrant groups. I am asking you questions today during our interview to learn more information about your state's program and to better understand the successes and challenges of programs that provide healthcare regardless of immigration status in a variety of states.

This interview is designed for research purposes to gain more information about state Medicaid programs that expand state Medicaid access regardless of immigration status. The research investigates Healthier Oregon and aims to frame Oregon's program in a national context.

Before we get started, I have some consent-related questions for you:

Do you consent to this interview, knowing it is for research purposes and your name will remain anonymous unless you indicate otherwise?

Second, do I have your permission to record this interview for transcription purposes only? The recording is encrypted and will be deleted after transcription has occurred.

Interview Questions:

1. How was the program in [X state] implemented?

2. How has the program itself been successful in increasing access to coverage and care?

3. What challenges has the program encountered?

4. What barriers remain between individuals being covered and receiving care?

5. Looking ahead, what are the next steps for improving healthcare access and health outcomes for individuals without qualifying immigration statuses and their families in [X state]?

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