Improving Medicaid Enrollment Rates among Eligible Migrant Children

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Abstract

Many migrant children who are eligible for Medicaid are not enrolled in the public insurance program while residing in North Carolina. This qualitative study explores the barriers migrants face when enrolling children in Medicaid. The time involved in the enrollment process, difficulty obtaining proof of income and residency, and mistrust of government all create barriers to enrollment in Medicaid for the migrant population. This article discusses policy recommendations and evaluates the potential effectiveness of a rapid enrollment system based on presumptive eligibility.

Introduction

Many children of migrant workers who are eligible for public insurance are not enrolled in public insurance while in North Carolina for a variety of reasons. Migrant children lacking insurance is a problem because health insurance is associated with health benefits for children including higher utilization of medical care and lower mortality (Currie and Gruber 1996) and because the community health centers must shift the costs of uninsured care to other patients. Community health centers are required to provide services regardless of ability to pay and to charge uninsured patients a rate based on a sliding scale determined by family income, with families below 100 percent of the federal poverty level paying nothing and other poor families paying only a percentage of the fees ("Program Requirements"). When a patient is insured, the health center is able to be paid for the services provided, so it benefits the health centers (as well as the patients) when Medicaid-eligible children actually have the Medicaid insurance.

Research Question

The North Carolina Community Health Center Association wanted to investigate the policy question: *What measures can the North Carolina Community Health Center Association encourage to ensure that more Medicaid-eligible migrant children are enrolled in Medicaid while living in the state?* Therefore this study seeks to determine what the current barriers to enrolling eligible migrant children are. This study began with the following two research questions:

1) What are the barriers to enrollment in Medicaid for migrant children in North Carolina?

2) What measures would be successful in reducing the barriers?

Background and Literature Review

Current State of Affairs in North Carolina

A 2000 report estimated that North Carolina had 20,736 migrant children along with 63,000 migrant farmworkers (Larson 2000). More recent estimates using 2007 data state that approximately 28,536 children accompany the 59,672 migrant and seasonal horticultural workers that live in North Carolina (Fernández 2011). Unfortunately, the new data does not distinguish between the number of children with the migrant workers and the number of children accompanying the seasonal workers. The majority of the workers in North Carolina are Latino (with the majority from Mexico) and speak Spanish as a first language. Most of the migrant workers reported traveling along the east coast,

and North Carolina has the highest population of migrant workers in the mid-Atlantic region, which includes Delaware, Kentucky, Maryland, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia. The migrants coming to North Carolina tend to come from Florida, South Carolina, Texas or Mexico. The population of migrant and seasonal workers is the highest in North Carolina between March and October.

In 2011, community health centers in North Carolina served 53,855 migrant and seasonal workers and over 38,000 of those were classified as 330g grantees (eligible to receive funding specific to migrants) ("2011 North Carolina Report" 2011). Over 15 percent of patients at the community health centers were pediatric patients (under 12 years old) ("2011 North Carolina Data" 2011). According to the 2011 North Carolina Report, 52.1 percent of patients at the community health centers were uninsured.

Medicaid is administered at the state level, so parents must re-apply for their children when they move to a new state. In order to apply for Medicaid for children in North Carolina, the parents must provide proof of residency in North Carolina. They also must provide proof of income. The qualifying income level is based on family size and the age of the child. The maximum monthly income is higher for children aged 0-5 years than for older children. Applicants apply at the Department of Social Services in the county of residency (North Carolina Department of Health and Human Services).

North Carolina does not currently have policies in place that allow for a simplified application for Medicaid for migrant workers who were enrolled in Medicaid in another state or for Medicaid portability (being able to use state Medicaid in other states). Such policies are present in states like Wisconsin and Texas ("Medicaid Eligibility Handbook", "Outreach for Texas Migrant Care Network").

The Scope of the Problem: Disparities in Insurance and Healthcare Access

A clear disparity exists between access to insurance and healthcare for the children of migrant workers and for other US children. A study conducted in California (Goldman, Smith, and Sood 2005) found that 17 percent of native-born non-elderly US citizens lacked insurance at the time of the study, compared to 23 percent of foreign-born US citizens and 68 percent of undocumented immigrants. Chronic uninsurance rates, measured by the percentage of the population that was always uninsured in the two years prior to the study, showed a similar disparity between native-born citizens and the foreign-born. While only 12 percent of nonelderly adults who were native-born were chronically uninsured, 36 percent of those who were foreign-born were chronically uninsured (and even 18 percent of the US citizens among the foreign-born) (Goldman, Smith, and Sood 2005). This evidence suggests that naturalized US citizens are less likely to have insurance than native-born citizens. As many migrants are non-citizens, who are even less likely than naturalized citizens to have insurance, this indicates a clear problem for the migrant population.

In regard to children, evidence suggests that children who are citizens but whose parents are not citizens are less likely to have health insurance than children whose

parents are also citizens. One study examining immigrant families in the US using national data found that 34 percent of children who were born as US citizens but to noncitizen parents lacked health insurance at some point during the 12 months prior to the study (Huang, Yu, and Ledsky 2006). Only 15 percent of citizen children with citizen parents experienced the same. After controlling for various factors, the study found that citizen children of noncitizen parents were 1.6 times more likely to be uninsured than their citizen counterparts who were born to citizen parents. Children of noncitizen parents were also more likely to have no usual source of healthcare than those with citizen parents. This evidence indicates that children whose parents are not citizens are both less likely to have health insurance coverage and less likely to have a regular source of healthcare to depend on.

Other data confirms these findings. Evidence from a study with data from 13 states found that citizen children with noncitizen parents had almost an eight percentage point higher risk of being uninsured than a citizen child with citizen parents and almost a five percentage point lower probability of being enrolled in Medicaid (Ku and Matani 2001). This means that eligible children who are citizens but whose parents are not citizens are less likely to be enrolled in Medicaid than their counterparts who have citizen parents.

Looking specifically at migrant populations, the evidence is similar. A study of migrant families in eastern North Carolina (Diener-West, Minkovitz, Campo, and Weathers 2004) reported that 73 percent of children in the sample did not have health insurance. More strikingly, 34 percent of the children in the sample had never had a well-child examination. The researchers found that 53 percent of the children had a need for medical care that went unmet. It appears that migrant children in the state are unlikely to have insurance and often do not receive adequate healthcare.

Research on migrant populations nationwide also provides evidence that there is a disparity in health insurance access for migrant children. After examining data from the National Agricultural Workers Study, researchers found that 45 percent of migrant parents reported lack of insurance for their children compared to only 30 percent of nonmigrant parents (Rodríguez, Vestal, Suttorp, and Schuster 2008). They also suggested that being a resident of the southeast or southwest was significantly and positively correlated with the child lacking insurance. This suggests that the problem may be even greater in North Carolina, corroborating earlier evidence (Diener-West, Minkovitz, Campo, and Weathers 2004).

In addition to disparities in insurance and healthcare access, some evidence suggests that there is a disparity in healthcare quality. One study (Bustamante and Chen 2011) looking at a physician survey suggested that physicians whose patient population was majority Latino were more likely to say that they could not provide high quality care to patients, relative to physicians serving a predominantly white population due to communication difficulties and patients not following recommendations. While improved insurance access may not alter the quality of care, it is important to take note that inequalities in quality of care may also exist.

Barriers to Healthcare and Insurance for Migrants

While there are many barriers to healthcare and insurance for the general population, migrants also face barriers specific to their lifestyles. A 2011 report from the North Carolina Community Health Center Association named fear, finances, lack of knowledge, language, and transportation as barriers to healthcare access (Fernández 2011). Evidence from North Carolina migrant families suggests that high pressure on the child's caretaker to work is correlated with unmet medical need for the child (Diener-West, Minkovitz, Campo, and Weathers 2004). The main reasons parents gave for unmet medical need for the child were lack of transportation and not knowing where to go. The researchers suggested that the hours the clinics are open as well as their locations create barriers to healthcare access for migrants. Parents who feel a lot of pressure in their jobs do not feel like they can take any time off from work to take children for medical care. Also, parents often do not have access to personal transportation and the rural locations where they often live lack adequate public transportation. The lifestyles of migrant workers and their dependence on others for transportation therefore play a role in preventing migrant children from receiving needed healthcare.

Additionally, migrant parents may not be familiar with the processes for enrolling children in insurance. A study using national data reported that having a parent who had lived for five years or fewer in the US was correlated with a child lacking health insurance (Rodríguez, Vestal, Suttorp, and Schuster 2008). The researchers suggested that time in the US may be a proxy for acculturation and that those who have not acclimatized to the US culture may be more likely to have children without insurance. Another study using data from multiple states suggested that parents' fears may explain part of why even citizen children of noncitizen parents are less likely to be enrolled in Medicaid than children with citizen parents (Ku and Matani 2001). Therefore, parents who are not accustomed to the US system and bureaucracy or who do not feel secure may not enroll their children in health insurance.

There is conflicting evidence regarding whether a parent's citizenship status actually plays a role in determining a child's insurance status. One study found that a parent's citizenship status was correlated with a child's insurance status. Nonetheless, the authors noted that this may be a result of the parent's time spent in the US rather than citizenship status alone (Huang, Yu, and Ledsky 2006), which is more consistent with the other literature (Rodríguez, Vestal, Suttorp, and Schuster 2008).

There may also be a disparity in the quality of care received due to communication problems. Physicians serving a majority Latino patient population reported not being able to provide quality care for reasons such as difficulty communicating with the patients, not having sufficient time with the patients, patients lacking the ability to pay, and patients not complying with the treatment recommendations (Bustamante and Chen 2011).

The Benefits of Having Children Insured

Research suggests that having insurance provides increased healthcare usage and health benefits to the population. A study of migrant children in North Carolina (Weathers, Minkovitz, O'Campo, and Diener-West 2003) found that migrant children who had visited a doctor in the three months prior to the study were much more likely to report having insurance than those who had not visited a doctor recently. Other research suggests that health insurance is positively correlated with better access to regular ambulatory health care (Ku and Matani 2001). This evidence suggests that children with health insurance have better access to healthcare than children who lack insurance. Other evidence suggests that insurance has beneficial impacts on children's health. A study on Medicaid eligibility changes found that increasing Medicaid eligibility led to an increased use of medical care along with a decrease in child mortality (Currie and Gruber 1996).

In addition to benefits of insurance to the patients themselves, Federally Qualified Health Centers benefit when patients have health insurance. Federally Qualified Health Centers charge rates for services based on the patient's ability to pay ("What is a Health Center?" 2012). When the patient is insured, the centers are able to charge more for the services and cover expenses. The health centers themselves therefore benefit from patients having insurance.

There also appear to be benefits to patients who use the community health centers. A study conducted in Colorado (Rothkopf, Brookler, Wadhwa, and Sajovetz 2011) found that Medicaid patients who used a community health center as their primary source of care were less likely to experience a preventable hospital admission as well as less likely to visit the emergency department than Medicaid patients seeing private providers, suggesting a benefit to the services community health centers can provide.

Conclusions from the Literature

More than 28,000 children of migrant and seasonal workers come through North Carolina each year (Fernández 2011). Overall the literature suggests that barriers such as lack of parent understanding of processes (Rodríguez, Vestal, Suttorp, and Schuster 2008) and practical issues such as lack of transportation (Diener-West, Minkovitz, Campo, and Weathers 2004) may prevent migrant children who are eligible for Medicaid from being enrolled. Latino children in general may not be receiving as high quality care as other children for various reasons, such as communication difficulties and patients not following treatment instructions (Bustamante and Chen 2011). Having insurance benefits the families as well as the community health centers (Ku and Matani 2001, Weathers, Minkovitz, O'Campo, and Diener-West 2003, "What is a Health Center?" 2012). The need to address the disparity in Medicaid enrollment is obvious.

Methods

Data Collection

The research strategy included interviewing migrant outreach workers at the Migrant Health Clinics in North Carolina including Blue Ridge Community Health Services, Carolina Family Health Centers, CommWell Health Center, Gateway Community Health Centers, Goshen Medical Center, Greene County Health Care, High Country Community Health, Kinston Community Health Center, NC Farmworker Health Program, and Roanoke Chowan. The original sampling frame included the outreach workers at the 11 Migrant Health Clinics in North Carolina. The contact information was provided by the North Carolina Community Health Center Association (Bakersville Community Medical Clinic is also a Migrant Clinic in addition to the 10 listed previously, though the NCCHCA did not yet have an outreach contact). However, a few of the outreach workers said they did not see migrant children in their area and I was unable to get responses from several others. Therefore only three of the interviews were conducted with respondents from the original sampling frame. I then went beyond my sampling frame and contacted outreach workers through the North Carolina Farmworker Health Program, which collaborates with agencies throughout the state to provide healthcare for farmworkers in areas with lower densities of farmworkers than areas with freestanding clinics. Five more interviews were completed through these contacts.

The change in sample may have introduced bias into the results. As the outreach coordinators through the NC Farmworker Health Program work in lower density areas, the issues the migrants face may be slightly different than those workers in higher density areas. Nonetheless, many of the problems these outreach workers mentioned were also mentioned by the outreach workers in the original sampling frame. I therefore have reason to believe that the results are still valid and representative of the Medicaid enrollment issues that are present throughout the state.

In total I conducted eight in-depth interviews with outreach workers from various parts of the state including the western, central, and eastern parts. The geographic range gives a breadth of experience with different groups of migrants. Interviews lasted approximately 20 to 25 minutes. Three of the interviews were completed in person as was preferred for the study. The other five were completed by phone according to the interviewee's preference or time constraints. I was the sole interviewer and therefore did not need to take measures to ensure uniformity across interviewers. The interviews were recorded and transcribed.

The Interview Instrument

The interview instrument (which can be seen in the Appendix) consists of four modules. Module 1 is designed to gauge what type of migrant population the respondent works with and to ascertain the scope of the problem. Module 2 considers the barriers to healthcare migrant children face. There are questions that elicit open-

ended answers as well as questions that ask the respondent to consider specifically whether insurance status plays a role in whether migrant children receive healthcare. Module 3 directs outreach workers to explain the barriers to health insurance for this population. Questions consider general barriers but ask respondents to focus on the barriers for children who are eligible for public insurance but are not enrolled. The questions in Module 4 ask respondents to describe practices that have already been tried and to discuss their successes or lack thereof.

I piloted the interview instrument with two professionals who work with the migrant community in North Carolina before beginning the interviews that would be transcribed and analyzed. Based on the results of piloting, I reworded questions to make them clearer and eliminated questions that seemed repetitive or unanswerable.

Data Analysis

The interviews were transcribed using a professional transcription service. I reviewed the interview transcripts for emerging themes. I developed a working codebook containing codes for the themes that appeared in the first two interviews. I then began coding each interview after transcribing it. I used the NVivo 10 software package for coding and analysis.

In addition to coding the data, I evaluated each interview transcript for the quality of data obtained and noted any major concerns or biases that appeared. I conducted exploratory analysis of the coded data using inductive techniques. I then evaluated the data looking for trends and similarities among what the respondents said.

Results

Barriers to Healthcare

The outreach workers mentioned many barriers to healthcare for the migrant population. These included language barriers, limited access to transportation, difficulty in being able to go to a clinic during normal operational hours, and fear of appearing unhealthy in front of the workers' bosses. One outreach worker recounted the following story:

> …Sometimes people are just scared that if they are seen as ill or you know they have an injury that they might be sent home and lose their pay for their family, so we've heard stories of people, there was a guy last summer who broke his foot in Benson just outside Benson, North Carolina. And he continued to work on his foot for almost a full week, until he knew the clinic would be open on a Thursday night, our farm worker clinic. So, by the time he actually got seen, he

> was in excruciating pain, he hadn't told his employer and it was, he needed surgery.

The outreach workers also mentioned that migrant workers rarely have access to personal transportation and often depend on their employers for transportation for healthcare and other needs. This complicates healthcare access.

Barriers to Enrolling Eligible Children in Medicaid

In addition to barriers to receiving healthcare, migrants face many barriers specific to enrolling children in Medicaid. Outreach workers named numerous potential barriers, including the time and effort it takes to apply, trouble obtaining proof of income and residency, and mistrust in the government.

1) Time and Effort

Many of the outreach workers stressed that the time and effort required to enroll children in Medicaid is often not worth it for the migrants. Since many migrants do not remain in North Carolina for more than five months, they often do not want to go through the enrollment process.

One outreach worker in eastern North Carolina said:

> They're here three or four months. They're here usually a little while before they start working or, you know, they're here, then it's two or three weeks before they really get their first check.
>
> So then at that point, that's when they go and usually do the application because that's when they have proof of income. And then it's a four to six week process, may or may not get it or they might say okay we need this other form, come bring that in, then you know, it's another two or three weeks they're waiting, they get it or don't get it, then they leave in three weeks.
>
> So I think what we've seen is for a lot of them it's not worth the effort with what they're having to do or come up with in the short amount of time they're here.

Other outreach workers echoed those sentiments. They suggested that migrants do not want to go through the process each time they move to a new state. In order to enroll in North Carolina, they would have to cancel their benefits in their home state. Some migrants are therefore fearful of giving up the benefits in the state where they spend most of the year.

2) Proof of Income and Residency

The outreach workers also mentioned that it can be difficult for migrant workers to provide the necessary proof of income and residency. The Medicaid application requires proof of residency, such as a utility bill with a North Carolina address, and proof of income, such as a pay stub ("Family and Children's Medicaid", "What is Medicaid?"). If the parents are undocumented, the employers are often hesitant to provide proof of income since that indicates that the employer is employing illegal immigrants. One outreach worker stated:

> …Most of them are not legally able to work here so most of them get paid cash, and some of the growers are skeptical about giving them anything with their names on it, because of course that's the proof of employment and they really shouldn't be employing them, so they don't want to give them maybe a letter of proof or sometimes they actually don't even know who their boss is. They work through crew leaders and the crew leaders themselves really don't give them the access to talk to their farmers who would be providing the income…

Additionally, many migrants live in migrant camps with other workers or families. Their housing is often not registered in their name and the workers do not have a lease with their name on it. The electricity bills are mostly not in the names of the migrants. This makes proving residency difficult.

3) Trust in Government

Outreach workers also mentioned that migrants sometimes mistrust the government or do not have adequate information to trust the government. As many of the parents are in the country illegally, they are hesitant to put their information on government forms. One outreach worker mentions that she reminds the migrants that they are applying for their child, who is eligible. She said she tells hesitant applicants who may be afraid to seek government services:

> Always remember that you are not applying for yourself, you are applying for your kid.

Another outreach worker suggested that if the parents are undocumented, they may fear potential "repercussions" from filling out formal government paperwork.

4) Additional Barriers

In addition to the three main barriers listed above, outreach workers highlighted a variety of other barriers that migrants face in regard to enrolling children in Medicaid. Outreach workers mentioned that migrants sometimes do not know how to fill out the

forms and get bad advice if they are not accompanied by someone who speaks Spanish and is familiar with the process. Additionally, some migrants are hesitant to enroll an eligible child if they have another child who is not eligible. Unfamiliarity with social services and lack of information can also be barriers to enrollment according to the outreach workers.

Addressing the Barriers

Some of the outreach workers have taken steps to address these barriers. Some mentioned that they have developed relationships with the employers so that they are able to approach them to ask for help in providing proof of income. Once a trusting relationship with the employer is formed, the outreach worker can then explain to the employer what they need to provide that will serve as proof of income for the migrant worker. Outreach workers also mentioned that they themselves sometimes write a letter providing proof of income that the employer can then simply sign. Many outreach workers said obtaining proof of income can be a large barrier to enrolling migrant children in Medicaid. Encouraging the employer to provide the proof or actually writing proof that the employer can sign helps minimize this barrier.

Nonetheless, this effort to aid in providing proof of income or residency is not always sufficient. One outreach worker in western North Carolina expressed frustration that his letter of proof of residency was not always adequate for the Medicaid application. The Medicaid office can still ask for further proof. He felt that if he were vouching for the migrant and saying that the migrant lived in the state that should be sufficient for the Medicaid application. The Medicaid office, however, does not always agree.

Outreach workers also mentioned that they work to ensure that the migrant workers are well-informed. This includes advising them about which children may be eligible for Medicaid and making sure the parents know that they should still apply for the child even if the parents themselves are undocumented.

Many of the outreach workers said that they provide transportation in their personal vehicles and that the migrants have the outreach worker's cell phone number in order to reach them with questions or to ask for transportation. This can help the migrant workers and their children get to the Department of Social Services to apply for Medicaid and also to get access to healthcare.

One outreach worker said that developing relationships with the migrants is also key to ensuring access to Medicaid and healthcare:

> As far as Medicaid specifically, I think it probably just helps to have a relationship established, so trust is a big part of that, so our outreach workers will often visit families more than once. You know, it depends on the needs of the family but, you know, there are some sites that we'll visit, you know

> we'll see people all year-round, and just continue to visit them, so I think developing a trusting relationship is key and then, yeah, helping them with the forms, providing transportation when they need it, and interpretation.

The outreach workers tended to agree that there is sufficient sharing of best practices between health centers across the state. Forums as well as individually reaching out to nearby outreach workers keep communication open.

The outreach workers had mixed opinions as to whether a rapid enrollment system based on presumptive eligibility would be effective. The system would not address the problem of having to cancel benefits in the home state to enroll in North Carolina, but may address the time barrier. One outreach worker in western North Carolina said:

> I think it would help, but, like I said, each case is so different and pretty complicated and each family has their reasons for, you know, wanting to apply here because they think they are going to stay or not wanting to apply here because they really feel like they are going to move back very soon.

Discussion

Clearly the application process serves as a barrier to enrollment. The limited amount of time that migrants spend in one place makes the lengthy application process less worthwhile. Reducing the time required to apply would benefit this population and minimize one of the largest barriers to Medicaid enrollment.

Nonetheless, the outreach workers were uncertain as to whether a rapid enrollment system based on presumptive eligibility would be effective. Presumptive eligibility would mean that children who had been enrolled in Medicaid in another state would be presumed to be eligible for Medicaid in North Carolina and therefore enrolled more quickly but would still have to cancel benefits in their home state. Some of the outreach workers said that the migrants did not want to enroll in North Carolina because they did not want to give up the benefits in their home state. These outreach workers felt that some of the migrants would not enroll their children regardless of the time required to complete the application process.

If this is the situation for many of the migrants, a rapid enrollment system based on presumptive eligibility would not fully address the problem. In this case, portable Medicaid may be more effective. Texas currently allows for Medicaid portability but other states do not. As many of the migrants coming to North Carolina arrive from Florida, North Carolina would need to join forces with Florida to encourage a portable Medicaid program.

Nonetheless, plenty of migrants do choose to enroll their children in Medicaid while in North Carolina. As a portability system is probably a distant possibility, North Carolina should work toward creating a system based on presumptive eligibility. This would reduce the time barrier that migrant parents who do choose to enroll their children in Medicaid face. It would also encourage parents who choose not to do so because of the drawn-out process to reconsider. While outreach workers said a rapid enrollment system would not be enough to encourage all migrants to cancel benefits in their home states in order to enroll, none of the outreach workers thought the system was a bad idea.

In the absence of Medicaid reform, outreach workers can continue to address barriers by working with the employers to facilitate access to proof of insurance. Several of the outreach workers felt fairly successful in writing letters with proof of income that the employer simply had to sign. Outreach workers across the state should work to streamline this process so that employers become more familiar with the procedure. The North Carolina Community Health Center Association can aid in this streamlining process and in distributing information on the Medicaid enrollment process to outreach workers. Making sure all outreach workers are aware of the proof of income and residency as a barrier and providing guidance to outreach workers on how to help migrants obtain these proofs would also be an effective measure in facilitating Medicaid enrollment for migrant children.

Additionally, one outreach worker mentioned that Medicaid officers have some discretion in expediting applications and in processing the application with a single proof of residency. Developing relationships with local Medicaid offices may be useful so that the Medicaid officers will trust the proof of residency provided by the outreach workers.

The North Carolina Community Health Center Association can continue to support outreach workers and to facilitate the sharing of best practices. Creating a streamlined letter as proof of income could also be useful. Additionally, while a rapid enrollment system may not be completely effective, it is certain that reducing the application time for migrants would improve enrollment rates to at least some extent. The NCCHCA could collaborate with the Medicaid offices to encourage more use of discretion for migrants who come with the support of a local outreach worker.

Conclusion

Many migrant children who are eligible for Medicaid are not enrolled while living in North Carolina. Outreach workers suggest that the time and effort required to enroll a child can often be overwhelming to migrant parents. Additionally, proof of income and residency can be hard to obtain for migrants who live in camps provided by their employers. Some migrants are hesitant to fill out government paperwork if they are undocumented.

Outreach workers have already taken steps to minimize barriers to enrolling eligible children in Medicaid. They often provide transportation or help with obtaining proof of income and proof of residency. Systematic changes in Medicaid, such as a presumptive eligibility system for those who already have Medicaid in another state or portable Medicaid, could help further reduce the barriers. However, in the absence of such changes, the North Carolina Community Health Center Association could encourage outreach workers to continue working with families to help facilitate enrollment. Outreach workers should continue to help provide proof of residency and proof of income. Additionally, best practices should be shared with outreach workers across the state.

Sources

"2011 North Carolina Data." US Department of Health and Human Services, http://bphc.hrsa.gov/uds/view.aspx?year=2011&state=NC.

"2011 North Carolina Report." US Department of Health and Human Services.

Brickhouse, Tegwyn H., R. Gary Rozier, and Gary D. Slade. "The Effect of Two Publicly Funded Insurance Programs on Use of Dental Services for Young Children." Health Services Research 41, no. 6 (2006): 2033-53.

Bustamante, A. V., and J. Chen. "Physicians Cite Hurdles Ranging from Lack of Coverage to Poor Communication in Providing High-Quality Care to Latinos." Health Affairs 30, no. 10 (2011): 1921-29.

Currie, Janet, and Jonathan Gruber. "Health Insurance Eligibility, Utilization of Medical Care, and Child Health." The Quarterly Journal of Economics 111, no. 2 (1996): 431-66.

Diener-West, Marie, Cynthia Minkovitz, apos, Patricia Campo, and Andrea Weathers. "Access to Care for Children of Migratory Agricultural Workers: Factors Associated with Unmet Need for Medical Care." [In English]. Pediatrics 113, no. 4 (2004/04): 898.

"Distribution of Revenue by Source for Federally-Funded Federally Qualified Health Centers, 2010." The Henry J. Kaiser Family Foundation, http://www.statehealthfacts.org/comparemaptable.jsp?ind=428&cat=8.

Fernádez, Magdalena. "2011 Migrant Health Profile Mid-Atlantic." North Carolina Community Health Center Association, 2011.

Goldman, Dana P., James P. Smith, and Neeraj Sood. "Legal Status and Health Insurance among Immigrants." [In English]. Health Affairs 24, no. 6 (2005): 1640-53.

Huang, Zhihuan Jennifer, Stella M. Yu, and Rebecca Ledsky. "Health Status and Health Service Access and Use among Children in U.S. Immigrant Families." American Journal of Public Health 96, no. 4 (April 2006): 634-40.

Ku, Leighton, and Sheetal Matani. "Left Out: Immigrants' Access to Health Care and Insurance." Health Affairs 20, no. 1 (January 1, 2001): 247-56.

Larson, Alice C. "Migrant and Seasonal Farmworker Enumeration Profiles Study: North Carolina." (September 2000): 21.

"Medicaid Eligibility Handbook." State of Wisconsin Department of Health Services, http://www.emhandbooks.wisconsin.gov/meh-ebd/policy_files/25/meh_25.8_migrant_workers.htm.

NC Department of Health and Human Services. “Family and Children's Medicaid MA-3335 STATE RESIDENCE.” http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/man/ma3335-01.htm.

NC Department of Health and Human Services. "What is Medicaid?." http://www.ncdhhs.gov/dma/medicaid.

"North Carolina Migrant Health Fee-for-Service Program Guidelines." edited by North Carolina Farmworker Health Program, 2010.

"Outreach for Texas Migrant Care Network." Texas Association of Community Health Centers, http://www.tachc.org/programs-services/outreach/outreach-for-texas-migrant-care-network.

Pati, Susmita, and Shooshan Danagoulian. "Immigrant Children's Reliance on Public Health Insurance in the Wake of Immigration Reform." [In English]. American Journal of Public Health 98, no. 11 (2008): 2004-10.

Pourat, N., and L. Finocchio. "Racial and Ethnic Disparities in Dental Care for Publicly Insured Children." Health Affairs 29, no. 7 (2010): 1356-63.

Rice, Jennifer L., and James A. Thornton. "Does Extending Health Insurance Coverage to the Uninsured Improve Population Health Outcomes?" [In English]. Applied Health Economics and Health Policy 6, no. 4 (2008/10//: 217+.

Rodríguez Rl, Elliott M. N. Vestal K. D. Suttorp M. J. Schuster M. A. "Determinants of Health Insurance Status for Children of Latino Immigrant and Other Us Farm Workers: Findings from the National Agricultural Workers Survey." Archives of Pediatrics & Adolescent Medicine 162, no. 12 (2008): 1175-80.

Rothkopf, J., K. Brookler, S. Wadhwa, and M. Sajovetz. "Medicaid Patients Seen at Federally Qualified Health Centers Use Hospital Services Less Than Those Seen by Private Providers." Health Affairs 30, no. 7 (2011): 1335-42.

Weathers, Andrea, Cynthia Minkovitz, Patricia O’Campo, and Marie Diener-West. "Health Services Use by Children of Migratory Agricultural Workers: Exploring the Role of Need for Care." Pediatrics 111, no. 5 (May 1, 2003: 956-63.

"What Is a Health Center?". US Department of Health and Human Services, http://bphc.hrsa.gov/about/.

Appendix

Interview Instrument

Warm-up

1) What do you think are the main health issues for migrant children?
   Intent: Obtain a general understanding of the respondent's experience with health issues of migrant children.

Module 1: The Population Served

1) In your position as _____, how do you serve migrants, particularly the children?
   Intent: Understand how the respondent interacts with the migrant population.

2) How long do the migrants that come to your Health Center tend to stay in the area?
   Intent: Gain an understanding of the time constraints that each respondent faces when serving the migrant population.

3) How frequently do you work with migrant children who are eligible for Medicaid but not enrolled in North Carolina?
   Intent: Discover the scope of the problem.

Module 2: Barriers to Healthcare

1) What are the main barriers to healthcare access that migrant workers in your area face?
   Intent: Get respondent to share reasons that prevent the general migrant population from getting healthcare.

2) What are the major barriers to healthcare access specifically for the children of migrant workers in your area?
   Intent: Obtain an understanding of what problems are specific to the children of migrants.

3) To what extent does insurance status determine whether migrants seek healthcare?
   Intent: Ascertain whether the respondent believes health insurance is a determinant of healthcare access.

4) Do you think migrant workers know where to go for care? Why or why not?
   Intent: Confirm whether knowledge is a key barrier to care as the literature suggests may be the case.

Module 3: Barriers to Insurance

1) What are the major barriers to insurance that the children of migrant workers in your area face?
   Intent: Direct consideration to the things that prevent children from having insurance (in general, not specific to children who are eligible for public insurance).

2) What are the major barriers specific to the children who are eligible for Medicaid?
   Intent: Understand the reasons that children who are eligible for public insurance remain uninsured.

3) What role, if any, does the time required for Medicaid paperwork play in preventing access to Medicaid?

Intent: Ascertain whether the bureaucratic issues (given time limits in one state) of public insurance prevent migrant children from being enrolled in Medicaid.

4) What role, if any, does the language barrier play in preventing access to Medicaid?
Intent: Obtain an understanding of whether the language gap plays any role in limiting insurance access.

5) Does the parents' legal status play any role in determining whether a child has health insurance? Why or why not?
Intent: Confirm whether respondents believe that legal status of the parents determines insurance status of children. Literature suggests that this may be the case but the idea is contradicted in other literature.

Module 4: Innovative Approaches

1) What efforts have you made or seen others make that have been successful in getting migrant children better access to healthcare?
Intent: Ascertain what the respondent thinks can be useful in helping minimize barriers to healthcare access.

2) What efforts have you made or seen others make that have been successful in getting eligible migrant children enrolled in Medicaid?
Intent: Ascertain what the respondent thinks can be useful in helping minimize barriers to health insurance.

3) What steps have been tried that have been unsuccessful? Why do you think they were unsuccessful?
Intent: Ascertain what approaches the respondent thinks are not useful in minimizing barriers.

4) To what extent are best practices shared between outreach workers at the various health centers in North Carolina or other states?
Intent: Obtain an understanding of whether mechanisms are in place to share successful ideas.

5) Do you think a coalition between Community Health Centers, rural clinics, Migrant Health Centers, and hospitals would be useful in addressing the problem?
Intent: Ascertain whether a coalition in the respondent's area would be feasible and effective.

6) Do you think having portable Medicaid, in which children remain enrolled in their home state's Medicaid program and can use that Medicaid in the states that they travel to, would address the barriers that children of migrant workers in North Carolina face?
Intent: Understand whether respondent thinks a policy minimizing paperwork and time would lead to more children being insured.

Cool-down

1) Is there anything else you would like to add about specific characteristics of the migrant population you serve or about ways to minimize barriers to healthcare and health insurance?
Intent: Give the respondent the opportunity to add additional information that has not been covered.