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Moving Toward Inclusion: Access to Care Models for Uninsured Immigrant Children

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Policy Points:

- Models for access to care for uninsured immigrant children that mitigate structural and sociopolitical barriers to inclusive health care include funding structures (e.g., state-sponsored coverage) and care delivery systems (e.g., federally qualified health centers,).
- Although the quintessential model of access to care necessitates health coverage for all children regardless of immigration status or date of United States entry, incremental policy change may more realistically and efficiently advance equitable access to high-quality health care.
- Intentional advocacy efforts should prioritize achievable goals that are grounded in data, are attentive to the sociopolitical milieu, are inclusive of diverse perspectives, and would meaningfully impact health care access and outcomes.

Keywords: access to care, immigrant children, uninsured.

The United States is home to 44.9 million immigrants who contribute unique assets, economic stability, and rich lived experiences to communities across the nation.[1–4] Immigrant children, or those who are born outside of the United States, reside in all 50 states and the District of Columbia.[5] As the immigrant population in the United States reaches historic highs,[6,7]

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all communities benefit by ensuring immigrant children can fully participate in programs that support health, development, and well-being.

Health care coverage, i.e., health insurance, is associated with improved health care access and child health outcomes.[8–10] The long-term effects of improved health care coverage for children, assessed during Medicaid expansions, include lower adult mortality rates, increased college enrollment, lower teenage pregnancy rates, and increased wages especially for adult women.[11,12,13] Despite these benefits, 21% of documented and 34% of undocumented immigrant children remain uninsured.[14] Some populations of noncitizen children, including refugees and children of active duty military, are eligible for Medicaid in all states without a waiting period.[15] However, many states continue to impose a five-year waiting period on Medicaid access for children with other types of immigration status. These waiting periods were introduced through the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) in 1996.[15–18] Because the passage of the Affordable Care Act (ACA), the percent of immigrants who are uninsured fell from 32% in 2013 to 20% in 2017.[4] However, the approximately 11 million immigrants of all ages with undocumented status[4] remain excluded from state and federal programs, including enrollment in the ACA, in most states.[19,20] Only 11 states (California, Connecticut, Illinois, Massachusetts, Maine, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington) and the District of Columbia offer state-funded, comprehensive Medicaid-level coverage to children (with some state-based differences in ages covered) regardless of immigration status.[15,16] Additional states expand coverage to pregnant people regardless of their immigration status,[15,16] recognizing that their US-born children would constitutionally be US citizens and thus eligible for federal coverage.

Even among eligible immigrants, the chilling effect of restrictive immigration policies and xenophobic rhetoric is a pervasive deterrent for those attempting to access health care coverage.[21,22] Additional barriers to health care access that immigrant families may experience include inadequate language services, low health literacy, limited transportation, fear and uncertainty regarding immigration status, and health care's rising cost.[21–24] These social drivers of health significantly exacerbate insurance coverage barriers.

In the absence of universal coverage for children and recognizing the heterogeneity of health care delivery, it is imperative to understand existing models that improve access to and delivery of consistent care for immigrant children. In this paper, we categorize and describe models of funding and care delivery for uninsured immigrant children based on existing evidence and relevant operational experiences, highlighting opportunities to incrementally and meaningfully increase access to care. Although this characterization into models of funding and delivery is imperfect in that it cannot claim to be exhaustive, it offers a framework through which to explore policy-level and practical components that can support better access for this population.

Recognizing that access alone does not equate with improved outcomes, we also seek to identify successful models and gaps in current understanding that would inform policy and practice.

Models of Funding

Emergency Medicaid

Emergency Medicaid covers treatments that are considered lifesaving, including birthing services.[25] Funded with state dollars and federal matching based on average per capita income in the state, Emergency Medicaid is available to all immigrants regardless of immigration status and is a key component of reimbursement for urgent care delivered to uninsured immigrants.[25] Services covered by Emergency Medicaid, which vary by state, may incentivize use of emergency services rather than cost-effective nonemergency approaches, such as inclusive ambulatory care.[26] For instance, although Emergency Medicaid covers emergency dialysis, studies have demonstrated that providing scheduled outpatient dialysis improves patient outcomes and is more cost-effective.[27–29] Emergency Medicaid is essential for lifesaving strategies but is distinct from Medicaid, which provides comprehensive care for eligible individuals that is not limited temporally or to a specific medical condition. Overreliance on this strategy can be mitigated by more preventive models.

A few states, including California, New York, and Massachusetts, continue to use a designation called Permanently Residing Under the Color of the Law ("PRUCOL") to offer services to individuals who immigration officials are aware are living in the United States without authorization but that they do not plan to remove.[30] This status was previously more extensively used prior to the 1996 PRWORA. This designation grants benefits eligibility including to Medicaid and the state's child health insurance program if the individual meets other residential and income thresholds.[31,32] Coverage through PRUCOL may be state- or locally funded. Eligible immigrants may include people with Deferred Action for Childhood Arrivals (DACA) and asylum seekers whose asylum applications are submitted and whose cases are pending. Research has not specifically studied the economic and health impact of expanding coverage through PRUCOL.

Regional Coverage Models

Local and county-based coverage models funded through public–private partnerships may lay the foundation for broader inclusion. The Healthy Kids program, initiated in 2001 in Santa Clara County, was enacted under the Children's Health Initiatives (CHI) program to provide health care to all children regardless of immigration

status as a privately funded, county-based insurance program.[33,34] By 2006, 16 more California counties enacted programs.[34,35] Ultimately, these programs successfully provided children with a regular source of care and a medical home.[35,36] Stanford's health systems piloted referral of all uninsured children to San Mateo County's CHI, finding that over half of eligible children were connected with insurance.[37] Emergency department–based referrals to health insurance for undocumented and uninsured children, including Healthy Kids San Mateo, increased hospital revenue and decreased bad debt.[37] By using existing infrastructure to enroll children and modeling the program after the Children's Health Insurance Program (CHIP) known as Healthy Families, program enrollment improved.[38] The similarities to Healthy Families created parity with respect to access for mixed-status families enrolled in both programs.[33] The limited copays and low-cost premiums were arranged on a sliding scale[34] and accessible for most families who reported lower health costs than when uninsured. However, families of children with special needs were more likely to be concerned about the costs of the copays and premiums.[38] Of note, as Healthy Kids enrollment prices increased, participation in the program decreased by about 20% associated with the premium increases,[39] reflecting persistent inequities in who can take full advantage of such programs.

State-Sponsored Coverage

Currently, the most comprehensive models offer access to state-sponsored health care coverage regardless of immigration status. Although regional programs demonstrated that providing accessible insurance to children increases care access and reduces cost burdens on health care systems, concerns persisted regarding the financial sustainability of the private, county-funded program.[33,34,38,40] In 2016, California passed SB-75, granting all income-eligible children residing in California access to Medi-Cal regardless of immigration status.[41] State-funded coverage for undocumented immigrant children is associated with significant improvements in uninsurance rates and has public health benefits.[42,43] Although the direct economic impact of providing insurance coverage to undocumented children is not well studied and warrants further investigation, experts have suggested that expansion may facilitate cost savings to hospitals on uncompensated care spending and direct saving through reduced dependency on Emergency Medicaid.[40,44] Of note, despite concerns that state-sponsored coverage would increase migration of eligible families to those states, changes in migration have not been observed.[45]

For children and pregnant people with an authorized immigration status in the United States, the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) option provides Medicaid and CHIP coverage without a five-year waiting period. Funding is provided through a combination of state funds and federal

matching based on this policy option.[25] As of May 2023, 34 states and the District of Columbia have utilized the CHIPRA option to cover immigrant children with an authorized immigration status.[16]

The most inclusive models of state-sponsored coverage offer provision of care to the entire family regardless of immigration status. Insuring low-income adults results in fewer barriers than child-only coverage and increases the likelihood of a child receiving routine medical care.[46–48] Only the District of Columbia, California, and Illinois have extended coverage to some undocumented adults beginning in 2022 (Table 1).[49–51] Additionally, the Massachusetts Health Safety Net is a noninsurance program offering limited benefits for all individuals below 300% of the federal poverty line regardless of immigration and insurance status.[52] Although the Health Safety Net may not include all inpatient services, such as some physician consultations and/or services provided by private companies,[52] it offers a structure for states seeking to incrementally expand coverage.

As children with medical complexity account for disproportionate health care expenditures, particularly for inpatient, mental health, and pharmacy services, this special population receives unique consideration.[53] Some states offer select state-sponsored coverage for uninsured children with significant medical complexity, funded in part through Title V Maternal and Child Health Services Block Grant Program.[54] Coverage varies by state; in Maryland, coverage prioritizes specialty care,[55] and in Texas, services also include primary care, mental health care, and dental care.[56] Additional research is needed to understand the impact in terms of health outcomes and costs of the various programs that prioritize children with medical complexity.

Models of Care Delivery

In settings where public insurance coverage is not available to undocumented children, models of health care delivery are heterogeneous in structure, with varied strengths and opportunities for improvement.

Free/Low-Cost Clinics and Mobile Clinics

Charity care from stationary and mobile clinics can provide varied services, including prenatal, dental, vision, well-child visits, vaccinations, and screenings, for children and their families.[52–57] Mobile clinics can reach geographically isolated communities, and stationary clinics provide a consistent location to access health care services without requiring families to travel to different locations based on unit movements. Many clinics provide free care, and some use sliding-fee scales. A large portion of the

Table 1. Models for Care Delivery for Uninsured Immigrant Children

Models of Funding Structures	
Emergency Medicaid	• Available to all immigrants regardless of immigration status • Key component of reimbursement for urgent care delivered to uninsured immigrants
County-sponsored care	• May lead to expansion to state-funded coverage (e.g., California)
State-funded coverage	• State-sponsored health care coverage regardless of immigration status and Medicaid and CHIP coverage for children and pregnant people with an authorized immigration status in the United States • California, Connecticut, Illinois, Massachusetts, Maine, New Jersey, New York, Oregon, Rhode Island, Vermont, and Washington
Models for Care Delivery	
FQHCs	• Provision of federally funded comprehensive care using a sliding-scale model of payment
Free/low-cost clinics and mobile clinics	• Community safety net medical entities • Provide a range of free health care services sponsored by various entities such as academic centers, foundations, or faith-based organizations
Practitioner- or health care system–driven donated care	• Referral-based model to provide low-cost and free health care to qualified children, prioritizing those with medical complexity or subspecialty needs • May be supported by health system or philanthropically
Regional/local government models for donated care	• Tier-based financial assistance to eligible residents regardless of immigration status • Allows access to affordable health care services within the network to reduce uncompensated medical care • Health departments across states cover a variety of communicable illnesses including tuberculosis treatment, COVID-19 vaccinations, and HIV-related care

Continued

Table 1. (Continued)

	Models for Care Delivery
School-based care	• Use of the school system, particularly the school nurse, to connect students to health resources and/or school-based health centers that are satellite clinics of larger health clinics and systems
Children of migrant farmworkers	• Hybrid delivery strategies given unique needs of this population
Comprehensive needs	• Strategies to offer dental, vision, and mental health care as part of comprehensive care

Abbreviations: CHIP, Children's Health Insurance Program; FQHC, federally qualified health center.

free/low-cost clinics are run by nursing, medical, and other professional school students and exist within the infrastructure of academic medical centers.[57–63] To optimize use, community needs assessment must inform the timing, services, and format of both mobile and stationary clinics.[64] Successful programs can adopt a process for continuous quality improvement to meet the evolving needs of immigrant families.

Free clinics may be supported fully or partially through academic-community partnerships.[57,58,60,64,65] Partnerships with major health systems or academic medical centers provide an avenue for coordinated primary and specialty care needs for patients with medical complexity. Charity care in the context of an academic-community partnership provides additional access points for free or low-cost medical care to patients and encourages students to consider how systems must be redesigned to meet the needs of underresourced communities.[57,58,60,61,65] Merging medical education with charity care programs offers developmental opportunities and can also present ethical questions, including a demand for careful oversight of students.[66] However, partnerships between health systems and free clinics may create other challenges for both parties, including liability for health systems and decreased autonomy for free clinics.

Federally Qualified Health Centers

Federally qualified health centers (FQHCs), funded federally and supplemented with grants and other modalities, provide a comprehensive and accessible model of care provision to immigrant children and their families.[67] FQHCs use a sliding-scale model of payment. Many offer multiple collocated services, including dental care,[68] mental health, low-cost prescription drugs, and enrollment in public programs such as the Special Supplemental Nutrition Program for Women, Infants and Children. Challenges may include consistent access to coordinated pediatric subspecialty care, after-hours access, and lack of coverage for inpatient or surgical needs. Although FQHCs are more likely to exist within communities in greater need such as those with high rates of poverty and uninsurance even after the passage of the ACA, FQHCs remain less accessible in rural areas.[69]

Some FQHCs partner with hospitals, health systems, and/or local donated care networks to reduce these barriers. Similar to vertical integration of free clinics, such partnerships may also create some challenges for both parties, including misalignment of missions and increased administrative burden.

Donated Care: Health Care Practitioners and Systems

The provision of donated care, when health care practitioners and/or health care systems provide care without charging for the services provided, is quite heterogenous in structure. Models range from discrete service such as student-run clinics at academic medical centers[70] to "brokered access" that is centrally administered, such as

comprehensive voucher programs.[64,71] Some level of sustainability is inherent, as hospitals' and health systems' nonprofit status requires the provision of donated care, i.e., charity care, in exchange for exemption from taxes.[72]

Additionally, hospitals that care for a disproportionate percentage of patients with low income or uninsurance are recognized as "disproportionate share hospitals" (DSHs) and receive additional payments from Medicaid and Medicare to support uncompensated care.[73] With passage of the ACA, DSH funding was reduced under the premise that hospitals would not need to provide as much uncompensated care.[73] With the exclusion of undocumented immigrants from the ACA, DSH funding cuts inequitably impact undocumented people and those hospitals seeking to offer inclusive care.

Health systems, through donated care, may engage in systems-level responses to mitigate coverage gaps. A more comprehensive, systems-level donated care effort to expansion of Medi-Cal coverage to all children in California, Kaiser Permanente launched the Child Health Plan in 1998 to cover uninsured children who were at that time excluded because of exceeding the state's income requirements. The Child Health Plan was initially funded as a feasibility study through The California Endowment.[74] Kaiser Permanente also launched efforts to undocumented people who were at the time not eligible for Medi-Cal or Healthy Families. Most children utilizing Kaiser Permanente's Child Health Plan were transitioned to more comprehensive Medi-Cal coverage beginning in 2016 with the expansion of state-funded Medicaid coverage for low-income and undocumented children, shifting costs from Kaiser Permanente back to the state.

Other regions offer programs to expand access that, although not providing true insurance, do offer free or low-cost access. For instance, multiple nonprofit providers in North Carolina participate across five counties in the Healthcare Access program.[75] Participating providers and systems essentially pool their services that are donated as charity care to provide a broad range of primary and subspecialty medical care. Eligible patients have the dignity of being able to show an ID card to identify their eligibility for these services and pay a token copay per service visit. However, particularly in regions and states that not as inclusive of undocumented people, donated care programs are often not widely advertised, and immigrant families may worry that accessing such programs will accumulate bad debt or prompt immigration enforcement. Furthermore, donated care is often limited in scope because of enrollment restrictions,[71] exclusion of some services (e.g., anesthesia or surgical facility fees), and a lack of participating physicians in the program.

Donated Care: Regional/Local Government Models

City or county hospitals or clinics and/or local health departments offer access to care through federal, state, county, and/or municipal funds. For certain conditions, local health departments offer completely or partially funded care, such as treatment of

communicable diseases, e.g., tuberculosis[76,77] and sexually transmitted infections.[77] Health departments may also foster collaboration with other publicly-funded programs, such as public health nurse participation at FQHCs.[78] In some states, local health systems provide free or discounted health services to uninsured adults and children that reside within the city or county.[79–83] For instance, Access Medical provides medical services through a local nonprofit organization such that recipients who live or work in Nevada can receive discounted health services for a small monthly membership fee.[83] These local programs provide access to preventive health care services, medical home clinics, and emergency and specialty care services.

School-Based Care

School-based delivery models that connect families to resources is an essential access point for many immigrant children.[64] School nurses and school-based clinics can offer medical care that mitigate use of the emergency department, act as case managers for immigrant children, and provide a connection point with medical homes.[64]

School-based health services extend beyond basic medical care. As many immigrant children have experienced significant trauma, schools can both identify students in need of mental health services and provide these services on site or through school-linked programs.[84–86] One such model integrated school-based mental health services, including screening, referral, and treatment, within a school-based health center administered by an FQHC.[87] Public school systems also provide a platform to connect students with dental care.[65,88] One challenge is that clinics that exist within school systems may be limited in the scope of services they can offer (e.g., reproductive and sexual health care) depending on state and local laws. Some systems navigate this through incorporating school-linked clinics that often do not have the same restrictions.[89] One other consideration is that school-based clinics by their nature exclude younger children who are not yet in school or are too young to seek care without the presence of a parent or caregiver.

Comprehensive Care Needs: Dental, Vision, and Mental Health Care

Systems-level approaches to providing preventive dental, vision, and mental health care to immigrant children are limited. Immigrant children are less likely to receive preventive dental care and more likely to have restorative and surgical care.[68,90,91] Immigrant children may also be identified as failing vision screens but may not have access to appropriate ophthalmologic follow-up care.[92] Even among children with coverage, it may not be made clear that public insurance includes eye care.[92] With respect to mental health, immigrants are, in aggregate, equally or more likely

to have mental health needs, including stress-related disorders, and uninsured and undocumented immigrants are less likely to access services.[93,94] However, the magnitude of the effect varies greatly based on country of origin and age of immigration. For example, children who immigrate at younger ages are more likely to experience psychiatric illness than immigrant children who arrive after age 14.[95] Given the intimate association among dental health, vision, mental health, and overall physical, psychological, and socioeconomic well-being,[84,93–98] efforts to expand care delivery must intentionally include strategies to improve access in these key service domains. School-based services, described above, may offer a promising area for prioritization of dental, vision, and mental health screening and connection to and/or delivery of care.

Special Population: Children of Migrant Farmworkers

A significant body of literature around models of care delivery for immigrant children focuses on migrant farmworkers and their families. Migrant health programs are often funded from a variety of sources, including federal funds, community–academic partnerships, and faith-based organizations.[57,60,65,68,99–101] The federal government funds clinics that provide care for nearly 800,000 migrant farmworker families every year.[102] Migrant farm workers and their families face unique health challenges, including high rates of work-related injuries[59] and risk for occupational exposures.[103] Because the majority of migrant farmworkers are undocumented immigrants,[104] children of migrant farmworkers may face a multitude of barriers to health care access, including fear of deportation for themselves or their parents.

Student-run clinics and partnerships with academic institutions often offer medical care, mental health services, and public health outreach to migrant families.[60,61,100] Because follow-up care is often difficult as families move, the Migrant Student Record Transfer System, a nationwide computerized information network, permits the transfer of health information collected primarily by school nurses.[61] Organizations such as the Migrant Clinicians Network mitigate barriers to continuity with a virtual case management system for patients and an educational and technical support network for clinicians.[105] Providing paper medical record copies to families may offer a good solution for those who relocate and/or cannot reliably access the internet, and therefore their electronic health record, even if the family remains in the same community.[100]

Discussion

Our categorization and description of models of coverage and models of care delivery for uninsured immigrant children delineate the patchwork that comprises the health care safety net for uninsured immigrant children in the United States depending on their geographic location, health conditions, immigration status, and

availability of community-based resources. In the absence of universal coverage, single solutions are often not feasible in all settings. Rather, incremental policy change that is responsive to the sociopolitical milieu may in itself be the best practice.

Existing immigration laws and policies at state and local levels[106,107] can inform tailored advocacy priorities. For instance, in more restrictive states, advocates may strategically prioritize efforts to expand access for documented immigrants, such as state-level advocacy to support use of the CHIPRA option to immediately provide Medicaid and CHIP coverage to children and pregnant women with an authorized immigration status in the United States. Such efforts have been successful for several states in recent years, including Arkansas, Nevada, and South Carolina, and are ongoing in other states, such as Georgia.[108,109] In states with more inclusive policies but budget restrictions, reimagining Emergency Medicaid to include all US Preventive Services Task Force grade 'A' and 'B' preventive services may be more affordable than focusing only on comprehensive coverage for all children.[110] Although this may not include all essential pediatric services, such expansion would certainly include enhanced provision of preventive care and mitigation of preventable emergency care. However, this would also necessitate federal matching to support these state-led efforts.

Other incremental efforts may prioritize special populations of uninsured immigrant children. For instance, the only current federal coverage of undocumented immigrant children is for unaccompanied children while they are in the custody of the federal government via the Office of Refugee Resettlement (ORR).[111,112] However, on release to sponsors, eligibility for coverage is contingent on local and state policies in their geographic areas.[111,112] Using federal funding to extend eligibility for coverage to unaccompanied children on release from ORR custody would offer an opportunity to pilot expansion in a population who has already been under the care of a federal agency and would provide platform to investigate the health and fiscal impact of such expansion. Similarly, extending eligibility for state-sponsored, federally matched Medicaid coverage to undocumented children in foster care would offer similar focused opportunities for impact and evaluation.

Community-based, family-centered strategies are fundamental to translating policy change into meaningful access and improved outcomes. For instance, community health workers (CHWs) can serve as trusted liaisons among immigrant families, community-based services, and health care systems.[58,100] One example, the Individualized Management for Patient-Centered Targets CHW model, includes an eight-step framework to develop and sustain at CHW intervention at an academic medical center.[113] Other strategies incorporate professional advocates, social workers, and/or health navigators to act as health care brokerage agents.[23,57] A novel approach incorporates the US Centers for Disease Control and Prevention's Whole School, Whole Community, Whole Child model with medical anthropology to strategically engage

school employees to improve health.[23] Such multidisciplinary approaches are promising and warrant further investigation.

Policies impacting eligibility for services intersect closely with other factors that impact use. Considering language access as an example, programs that receive federal funds are required to provide language access, and states have the option to claim Medicaid reimbursement for the cost of interpretation services,[114] so access to this fundamental service often depends on where people are able to obtain care. Specifically, there is significant variation in the use of interpreting services in particular geographic areas, across different specialties, and within certain clinical contexts (e.g., emergency services, non–federally funded safety net emergent medical clinics), with nonprofessionals often interpreting during emergencies in the field and in settings where trained medical interpreters are not required by law.[115,116] As more states expand state-sponsored Medicaid coverage to children regardless of immigration status,[15,16] research that investigates reimbursement for medical interpretation may intersect with the impact of expanded coverage on health care use, patient outcomes, and state finances.

Given the heterogeneity of models of funding and delivery among uninsured immigrant children, multisite and population-level data would support policy-level action. For instance, research that categorizes use of Emergency Medicaid by undocumented children within and across states, including assessment of typical diagnoses and chronic medical needs, would inform policy-level prioritization of services and/or special populations. Such data could inform efforts to expand state use of Title V funding for undocumented children with medical complexity.

Discussions of models of care delivery must also address who will deliver care to our increasingly diverse communities and where this care will be delivered. Projected national physician workforce shortages in both primary and specialty care are expected to be exacerbated for minoritized and underresourced populations.[117,118] Foreign-born physicians, who often serve minoritized and underresourced communities,[119,120] represented 26% of physicians practicing in the United States, with varied distribution across states.[119] In areas with high poverty rates, nearly one-third of the physicians are foreign-trained, and in areas where at least three-quarters of the population are people of color, more than one-third of the physicians are foreign-trained.[119] Yet, barriers for foreign-born and foreign-trained physicians prevail. Although there are a variety of temporary and permanent visa categories that may offer foreign-born physicians an opportunity to work in the United States, the United States has not historically prioritized recruitment of foreign-born physicians.[118] In fiscal year 2021, only two percent of H-1B Visas (for those in specialty occupations) went to physicians and surgeons.[118] To mitigate physician shortages and advance equitable access to care for immigrant children, policymakers should prioritize opportunities to include foreign-born and foreign-trained physicians in the health care workforce.

Legislative solutions have historically been a challenge, with shifting policy that mostly restricts federal access and varies at state and local levels. Yet, drawing from the California experience, incremental change can lead to sustained and comprehensive solutions. What began in California at the county level and with one major health system built the foundation for California to become the first state to cover all children regardless of immigration status. As other communities and systems consider implementation of similar local solutions, it will be essential to evaluate investments through both qualitative, experience-based data (including stories that motivate messaging) with outcomes and fiscal data to justify larger-scale investments. Quantitative outcomes measures may include emergency room and hospital use data.

Understanding the economic impact of widespread access is only one aspect of this discussion, which also includes considering human rights and the ethics[121] of limiting health care for a population. This ideological dialogue transpired around ACA eligibility for people with DACA, with this group ultimately not being granted eligibility. New efforts through federal rulemaking that would expand health coverage eligibility to people with DACA were underway at the time of writing of this paper.[122]

The current patchwork model likely reflects the difficulty that well-intentioned people experience in navigating restrictive immigration policies, variations of local and state sociopolitical milieus, complex viewpoints on the connection between immigration reform and health, and the conflation of immigration status with access to health care. Furthermore, even proposed legislation to provide a pathway to citizenship for undocumented youth typically specifies eligibility in terms of arrival to the United States before the passage of the legislation. As a result, this need will recur cyclically, requiring pediatricians and health care institutions to continually develop local and regional pathways to access care.[101]

Moving beyond good intentions, practitioners, researchers, and policy experts should implement multipronged and multidisciplinary approaches to advance policy change. Community-based participatory research inherently incorporates both research and action,[123] honoring community expertise and creating a platform for people who are often discounted by systems to be part of the solution to change them. Furthermore, engaging communications scientists to frame policy-level messaging and facilitate translation of scientific evidence can facilitate sustainable change in understanding of both policymakers and the public.[124] For instance, the evidence-based metaphor of "toxic stress"[125] has been effectively incorporated in legislative advocacy regarding harmful immigration policies, including family separation. Incorporation of multidisciplinary perspectives, engagement of diverse stakeholders, and consideration of sociopolitical factors are essential to create the political will to change policies that will enhance health care access for uninsured immigrant children.

Conclusion

Numerous and heterogenous models of care provide immigrant children access to health care services in a variety of ways; however, expansion and optimization of these models of funding structures and health care delivery is urgently needed. The most quintessential model of access to care necessitates funding health coverage for all children regardless of immigration status or date of entry into the United States. However, realizing the aspirational nature of this assessment, for the foreseeable future, many immigrant children will remain uninsured, and inequities will persist depending on the local and regional availability of health care coverage. Until universal coverage can be achieved, health care professionals, researchers, and policymakers must engage simultaneously in incremental and visionary change management that is grounded in evidence and centered in advancing health equity for uninsured immigrant children.

References

1. Sherman A, Trisi D, Stone C, Gonzales S, Parrott S. Immigrants Contribute Greatly to U.S. Economy, Despite Administration's "Public Charge" Rule Rationale. Center on Budget and Policy Priorities. August 15, 2019. Accessed June 3, 2022. https://www.cbpp.org/research/poverty-and-inequality/immigrants-contribute-greatly-to-us-economy-despite-administrations
2. Wolla SA. The Economics of Immigration: A Story of Substitutes and Complements. Economic Research Federal Reserve Bank of St. Louis. May 2014. Accessed June 3, 2022. https://research.stlouisfed.org/publications/page1-econ/2014/05/01/the-economics-of-immigration-a-story-of-substitutes-and-complements/
3. Hirschman C. The contributions of immigrants to American culture. *Daedalus*. 2013;142(3). https://doi.org/10.1162/DAED_a_00217
4. Batalova J, Hanna M, Levesque C. Frequently Requested Statistics on Immigrants and Immigration in the United States. Migration Policy Institute. February 11, 2021. Accessed June 3, 2022. https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states-2020
5. Who Are Children in Immigrant Families? Annie E. Casey Foundation. October 21, 2021. Accessed June 3, 2022. https://www.aecf.org/blog/who-are-the-children-in-immigrant-families?gclid=Cj0KCQjw4uaUBhC8ARIsANUuDjXfv01QqRu3s-KQPSURVvdsn5BtSimnQoMHXQHtlAvtZuEYN42IDSIaAsF4EALw_wcB
6. Ward N, Batalova J. Frequently Requested Statistics on Immigrants and Immigration in the United States. Migration Policy Institute. March 17, 2022. Accessed April 6, 2022. https://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states

7. Budiman A. Key Findings about U.S. Immigrants. Pew Research Institute. August 20, 2020. Accessed June 3, 2022. https://www.pewresearch.org/fact-tank/2020/08/20/key-findings-about-u-s-immigrants/
8. Morriss FH. Increased risk of death among uninsured neonates. *Health Serv Res*. 2013;48(4):1232-1255. https://doi.org/10.1111/1475-6773.12042
9. Swartz JJ, Hainmueller J, Lawrence D, Rodriguez MI. Expanding prenatal care to unauthorized immigrant women and the effects on infant health. *Obstet Gynecol*. 2017;130(5):938-945. https://doi.org/10.1097/AOG.0000000000002275
10. Flores G, Lin H, Walker C, et al. The health and healthcare impact of providing insurance coverage to uninsured children: a prospective observational study. *BMC Public Health*. 2017;17(1):553. https://doi.org/10.1186/s12889-017-4363-z
11. Brown DW, Kowalski AE, Lurie IZ. Long-term impacts of childhood Medicaid expansions on outcomes in adulthood. *Rev Econ Stud*. 2020;87(2):792-821. https://doi.org/10.1093/restud/rdz039
12. Miller S, Wherry LR. The long-term effects of early life Medicaid coverage. *J Hum Resour*. 2019;58(3):785-824. https://doi.org/10.3368/jhr.54.3.0816.8173R1
13. Boudreaux MH, Golberstein E, McAlpine DD. The long-term impacts of Medicaid exposure in early childhood: evidence from the program's origin. *J Health Econ*. 2016;45:161-175. https://doi.org/10.1016/j.jhealeco.2015.11.001
14. Health Coverage of Immigrants. Kaiser Family Foundation. Updated March 30, 2023. Accessed June 3, 2022. https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/
15. Medical assistance programs for immigrants in various states. National Immigration Law Center. Updated July 2023. Accessed May 30, 2023. https://www.nilc.org/issues/health-care/medical-assistance-various-states/
16. Health Care Coverage Maps. National Immigration Law Center. April 2023. Accessed May 30, 2023. Available at: https://www.nilc.org/issues/health-care/healthcoveragemaps/
17. Hirota S, Garcia J, Silber R, Lamirault I, Penserga LJ, Hall MB. Inclusion of immigrant families in U.S. health coverage expansions. *J Health Care Poor Underserved*. 2006;17:81-94. https://doi.org/10.1353/hpu.2006.0006
18. Coverage for Lawfully Present Immigrants. US Department of Health and Human Services. Accessed June 3, 2022. https://www.healthcare.gov/immigrants/lawfully-present-immigrants/
19. Wilson F. Federal and state policies affecting immigrant access to health care. *JAMA Health Forum*. 2020;1(4):e200271. https://doi.org/10.1001/jamahealthforum.2020.0271
20. Immigration Status and the Marketplace. US Department of Health and Human Services. Accessed June 3, 2023. https://www.healthcare.gov/immigrants/immigration-status/
21. Haley JM, Kenney GM, Bernstein H, Gonzalez D. One in Five Adults in Immigrant Families with Children Reported Chilling Effects on Public Benefit

Receipt in 2019. Urban Institute. June 18, 2020. Accessed June 3, 2022. https://www.urban.org/research/publication/one-five-adults-immigrant-families-children-reported-chilling-effects-public-benefit-receipt-2019#:~:text=One%20in%20five%20adults%20in%20immigrant%20families%20with%20children%20(20.4,percent%20of%20those%20without%20children

22. Capps R, Fix M, Batalova J. Anticipated "Chilling Effects" of the Public-Charge Rule Are Real: Census Data Reflects Steep Decline in Benefits Use by Immigrant Families. Migration Policy Institute. December 2020. Accessed June 3, 2023. https://www.migrationpolicy.org/news/anticipated-chilling-effects-public-charge-rule-are-real
23. Campbell-Montalvo R, Castañeda H. School employees as health care brokers for multiply-marginalized migrant families. *Med Anthropol*. 2019;38(8):733-746. https://doi.org/10.1080/01459740.2019.1570190
24. Jacquez F, Vaughn L, Zhen-Duan J, Graham C. Health care use and barriers to care among Latino immigrants in a new migration area. *J Health Care Poor Underserved*. 2016;27(4):1761-1778. https://doi.org/10.1353/hpu.2016.0161
25. Khullar D, Chokshi DA. Challenges for immigrant health in the USA – the road to crisis. *Lancet*. 2019;393(10186):2168-2174. https://doi.org/10.1016/S0140-6736(19)30035-2
26. Khullar D, Chokshi DA. Immigrant health, value-based care, and emergency Medicaid reform. *JAMA*. 2019;321(10):928-929. https://doi.org/10.1001/jama.2019.0839
27. Cervantes L, Tuot D, Raghavan R, et al. Association of emergency-only vs standard hemodialysis with mortality and health care use among undocumented immigrants with end-stage renal disease. *JAMA Intern Med*. 2018;178(2):188-195. https://doi.org/10.1001/jamainternmed.2017.7039
28. Nguyen OK, Vazquez MA, Charles L, et al. Association of scheduled vs emergency-only dialysis with health outcomes and costs in undocumented immigrants with end-stage renal disease. *JAMA Intern Med*. 2019;179(2):175-183. https://doi.org/10.1001/jamainternmed.2018.5866
29. West J, Chan HK, Molony DA, Robinson DJ, Foringer JR, Wang HE. Insurance status and emergency department visits associated with hemodialysis in Texas. *JAMA Netw Open*. 2020;3(2):e1921447. https://doi.org/10.1001/jamanetworkopen.2019.21447
30. Broder T, Lessard G. Overview of Immigrant Eligibility for Federal Programs. National Immigration Law Center. Updated March 2023. Accessed May 17, 2023. https://www.nilc.org/issues/economic-support/overview-immeligfedprograms/
31. Immigrants: Qualified Aliens/PRUCOL Aliens. New York City. Accessed February 12, 2023. https://www1.nyc.gov/assets/ochia/downloads/pdf/prucol_information.pdf
32. Major Benefit Programs Available to Immigrants in California. National Immigration Law Center. October 2021. Accessed July 14, 2023. https://www.nilc.org/wp-content/uploads/2015/11/cal-benefits-table.pdf

33. Stevens GD, Rice K, Cousineau MR. Children's health initiatives in California: the experiences of local coalitions pursuing universal coverage for children. *Am J Public Health*. 2007;97(4):738-743. https://doi.org/10.2105/AJPH.2006.088690
34. Frates J, Diringer J, Hogan L. Models and momentum for insuring low-income, undocumented immigrant children in California. *Health Aff (Millwood)*. 2003;22(1):259-263. https://doi.org/10.1377/hlthaff.22.1.259
35. Howell E, Trenholm C, Dubay L, Hughes D, Hill I. The impact of new health insurance coverage on undocumented and other low-income children: lessons from three California counties. *J Health Care Poor Underserved*. 2010;21(2 suppl):109-124. https://doi.org/10.1353/hpu.0.0293
36. Stevens GD, Cousineau MR, Pickering TA, Lee P. Healthy Kids insurance and experience of medical home quality for vulnerable children. *Med Care*. 2011;49(4):828-833. https://doi.org/10.1097/MLR.0b013e318215d0ef
37. Acosta C, Dibble C, Giammona M, Wang NE. A model for improving uninsured children's access to health insurance via the emergency department. *J Healthc Manag*. 2009;54(2):105-115.
38. Hill I, Dubay L, Kenney G, Howell E, Courtot B, Palmer L. Improving coverage and access for immigrant Latino children: the Los Angeles Healthy Kids Program. *Health Aff (Millwood)*. 2008;27(2):550-559. https://doi.org/10.1377/hlthaff.27.2.550
39. Cousineau MR, Tsai KY, Kahn HA. Two responses to a premium hike in a program for uninsured kids: 4 in 5 families stay in as enrollment shrinks by a fifth. *Health Aff (Millwood)*. 2012;31(2):360-366. https://doi.org/10.1377/hlthaff.2011.0734
40. Gardner A, Kahn J. Increasing access to care for the uninsured: considering the options in California counties. *J Health Care Poor Underserved*. 2006;17(4):830-850. https://doi.org/10.1353/hpu.2006.0123
41. SB 75 – Medi-Cal for All Children. California Department of Health Care Services. Accessed June 3, 2023. https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SB75Children.aspx
42. Lipton BJ, Nguyen J, Schiaffino MK. California's Health4All Kids Expansion and health insurance coverage among low-income noncitizen children. *Health Aff (Millwood)*. 2021;40(7):1075-1083. https://doi.org/10.1377/hlthaff.2021.00096
43. Gostin LO. Is affording undocumented immigrants health coverage a radical proposal? *JAMA*. 2019;322(15):1438-1439. https://doi.org/10.1001/jama.2019.15806
44. Rao P, Girosi F, Eibner C. Expanding insurance coverage to undocumented immigrants in Connecticut. *Rand Health Q*. 2022;10(1):3.
45. Yasenov VI, Lawrence D, Mendoza FS, Hainmueller J. Public health insurance expansion for immigrant children and interstate migration of low-income immigrants. *JAMA Pediatr*. 2020;174(1):22-28. https://doi.org/10.1001/jamapediatrics.2019.4241
46. Guendelman S, Wier M, Angulo V, Oman D. The effects of child-only insurance coverage and family coverage on health care access and use: recent findings

among low-income children in California. *Health Serv Res*. 2006;41(1):125-147. https://doi.org/10.1111/j.1475-6773.2005.00460.x

47. Venkataramani M, Pollack CE, Roberts ET. Spillover effects of adult Medicaid expansions on children's use of preventive services. *Pediatrics*. 2017;140(6):e20170953. https://doi.org/10.1532/peds.2017-0953
48. DeVoe J, Crawford C, Angier H, et al. The association between Medicaid coverage for children and parents persists: 2002–2010. *Matern Child Health J*. 2015;19(8):1766-1774. https://doi.org/10.1007/s10995-015-1690-5
49. Immigrant Children's Program and DC Health Care Alliance. DC Action. Accessed June 3, 2023. https://www.wearedcaction.org/healthalliance
50. Gutierrez M. California expands Medi-Cal, offering relief to older immigrants without legal status. *Los Angeles Times*. July 27, 2021. Accessed June 3, 2022. https://www.latimes.com/california/story/2021-07-27/medical-expansion-immigrants-budget-california-newsom-legislature
51. Bruce G. Illinois Is First in the Nation to Extend Health Coverage to Undocumented Seniors. Kaiser Health News. January 7, 2022. Accessed April 20, 2022. https://khn.org/news/article/illinois-is-first-in-the-nation-to-extend-health-coverage-to-undocumented-seniors/
52. Health Safety Net for Patients. Massachusetts Government. Accessed June 7, 2022. https://www.mass.gov/service-details/health-safety-net-for-patients
53. Kuo DZ, Hall M, Agrawal R, et al. Comparison of health care spending and utilization among children with Medicaid insurance. *Pediatrics*. 2015;136(6):e1521-1529. https://doi.org/10.1542/peds.2015-0871
54. Title V Maternal and Child Health Services Block Grant to the States Program: Guidance and Forms for the Title V Application/Annual Report – Appendix of Supporting Documents. U.S. Department of Health and Human Services. December 1, 2020. Accessed June 3, 2022. https://www.hhs.gov/guidance/document/title-v-maternal-and-child-health-services-block-grant-states-program-guidance-and-forms-2
55. Children's Health Services. Maryland Department of Health. Accessed June 3, 2022. https://health.maryland.gov/phpa/genetics/Pages/CMS_Program.aspx
56. Children with Special Health Care Needs Program. Texas Department of Health and Human Services. Accessed June 3, 2022. https://www.hhs.texas.gov/services/disability/children-special-health-care-needs-program
57. Luque JS, Castañeda H. Delivery of mobile clinic services to migrant and seasonal farmworkers: a review of practice models for community-academic partnerships. *J Community Health*. 2013;38(2):397-407. https://doi.org/10.1007/s10900-012-9622-4
58. Sherrill WW, Crew L, Mayo RM, Mayo WF, Rogers BL, Haynes DF. Educational and health services innovation to improve care for rural Hispanic communities in the USA. *Educ Health (Abingdon)*. 2005;18(5):356-367. https://doi.org/10.1080/13576280500312850
59. Luque JS, Reyes-Ortiz C, Marella P, et al. Mobile farm clinic outreach to address health conditions among Latino migrant farmworkers in Georgia. *J Agromedicine*. 2012;17(4):368-397. https://doi.org/10.1080/1059924X.2012.713837

60. Wilson AH, Wold JL, Spencer L, Pittman K. Primary health care for Hispanic children of migrant farm workers. *J Pediatr Health Care*. 2000;14(5):209-215. https://doi.org/10.1067/mph.2000.104098
61. Gwyther ME, Jenkins M. Migrant farmworker children: health status, barriers to care, and nursing innovations in health care delivery. *J Pediatr Health Care*. 1998;12(2):60-66. https://doi.org/10.1016/s0891-5245(98)90223-1
62. Smego RA, Costante J. An academic health center-community partnership: the Morgantown Health Right free clinic. *Acad Med*. 1996;71(6):613-621. https://doi.org/10.1097/00001888-199606000-00012
63. Bauer S. Community clinic offers access to care. A system and a city collaborate to care for an immigrant population. *Health Prog*. 1993;74(8):42-44.
64. Blewett LA, Casey M, Thiede Call K. Improving access to primary care for a growing Latino population: the role of safety net providers in the rural Midwest. *J Rural Health*. 2004;20(30):237-245. https://doi.org/10.1111/j.1748-0361.2004.tb00034.x
65. Connor A, Rainer LP, Simcox JB, Thomisee K. Increasing the delivery of health care services to migrant farm worker families through a community partnership model. *Public Health Nurs*. 2007;24(4):355-360. https://doi.org/10.1111/j.1525-1446.2007.00644.x
66. Shah S. How should academic medical centers administer students' "domestic global health" experiences? *AMA J Ethics*. 2019;21(9):E778-787. https://doi.org/10.1001/amajethics.2019.778
67. Saloner B, Wilk AS, Levin J. Community health centers and access to care among underserved populations: a synthesis review. *Med Care Res Rev*. 2020;77(1):3-18. https://doi.org/10.1177/1077558719848283
68. Chaffin J, Pai S, Bagramian R. Cost-efficiency of a community dental delivery program for migrant children. *J Dent Child (Chic)*. 2003;70(1):47-50.
69. Behr C, Hull P, Hsu J, Newhouse J, Fung V. Geographic access to federally qualified health centers before and after the Affordable Care Act. *BMC Health Serv Res*. 2022;22(1):385. https://doi.org/10.1186/s12913-022-07685-0
70. Simpson SA, Long JA. Medical student-run health clinics: important contributors to patient care and medical education. *J Gen Intern Med*. 2007;22(3):352-356. https://doi.org/10.1007/s11606-006-0073-4
71. Taylor Fries E, Cunningham P, McKenzie K. Community approaches to providing care for the uninsured. *Health Aff (Millwood)*. 2006;25(3):w173-182. https://doi.org/10.1377/hlthaff.25.w173
72. Bai G, Yehia F, Anderson GF. Charity care provision by US nonprofit hospitals. *JAMA Intern Med*. 2020;180(4):606-607. https://doi.org/10.1001/jamainternmed.2019.7415
73. Bioethics in Community Health: Undocumented Immigrants in the United States: U.S. Health Policy and Access to Care. The Hastings Center. Accessed January 29, 2023. https://community.thehastingscenter.org/immigrant-health/undocumented-immigrants-in-the-united-states-u-s-health-policy-and-access-to-care/

74. Frates J, Diringer J, Hogan L. Models and momentum for insuring low-income, undocumented immigrant children in California. *Health Aff (Millwood)*. 2003;22(1):259-263. https://doi.org/10.1377/hlthaff.22.1.259
75. HealthCare Access. Accessed January 29, 2023. http://www.hcaccess.org/
76. Cole B, Nilsen DM, Will L, Etkind SC, Burgos M, Chorba T. Essential components of a public health tuberculosis prevention, control, and elimination program: recommendations of the Advisory Council for the Elimination of Tuberculosis and the National Tuberculosis Controllers Association. *MMWR Recomm Rep*. 2020;69(17):1-27. doi:10.15585/mmwr.rr6907a1
77. Menu of Suggested Provisions for State Tuberculosis Prevention and Control Laws. Centers for Disease Control and Prevention. Accessed June 3, 2023. https://www.cdc.gov/tb/programs/laws/menu/costs.htm
78. Vest JR, Caine V, Harris LE, Watson DP, Menachemi N, Halverson P. Fostering local health department and health system collaboration through case conferences for at-risk and vulnerable populations. *Am J Public Health*. 2018;105(5):649-651. https://doi.org/10.2105/AJPH.2018.304345
79. Beck TL, Le TK, Henry-Okafor Q, Shah MK. Medical care for undocumented immigrants: national and international issues. *Physician Assist Clin*. 2019;4(1):33-45. https://doi.org/10.1016/j.cpha.2018.08.002
80. My Health LA (MHLA). Los Angeles County Health Services. Accessed June 7, 2022. https://dhs.lacounty.gov/my-health-la/my-health-la2/
81. Harris Health System. Accessed June 7, 2022. https://www.harrishealth.org/
82. About NYC Care. NYC Health and Hospitals. Accessed June 3, 2022. https://www.nyccare.nyc/
83. We Are Here to Help You Get the Care You Need at a Price You Can Afford. Access Medical. Accessed June 3, 2022. https://www.accesstohealthcare.org/services-for-individuals/medical-discount-program/
84. DeSocio J, Elder L, Puckett S. Bridging cultures for Latino children: school nurse and advanced practice nurse partnerships. *J Child Adolesc Psychiatr Nurs*. 2008;21(3):146-153. https://doi.org/10.1111/j.1744-6171.2008.00147.x
85. Cleary SD, Snead R, Dietz-Chavez D, Rivera I, Edberg MC. Immigrant trauma and mental health outcomes among Latino youth. *J Immigr Minor Health*. 2018;20(5):1053-1059. https://doi.org/10.1007/s10903-017-0673-6
86. Pumariega AJ, Jo Y, Beck B, Rahmani M. (2022). Trauma and US minority children and youth. *Curr Psychiatry Rep*. 2022;24(4):285-295. https://doi.org/10.1007/s11920-022-01336-1
87. Schapiro NA, Gutierrez JR, Blackshaw A, Chen JL. Addressing the health and mental health needs of unaccompanied immigrant youth through an innovative school-based health center model: successes and challenges. *Child Youth Serv Rev*. 2018;92:133-142. https://doi.org/10.1016/j.childyouth.2018.04.016
88. Herman NG, Rosenthal M, Franklin DM. Delivery of comprehensive children's dental services using portable dental clinics in NYC public schools. *N Y State Dent J*. 1997;63(4):36-41.

89. Fothergill K, Ballard E. The school-linked health center: a promising model of community-based care for adolescents. *J Adolesc Health*. 1998;23(1):29-38. https://doi.org/10.1016/s1054-139x(98)00012-3
90. Okunseri CE, Rota K, Okunseri E, et al. Dental service utilization and immigrant family structure. *J Public Health Dent*. 2021;81(3):198-205. https://doi.org/10.1111/jphd.12432
91. Mulligan R, Seirawan H, Faust S, Habibian M. Mobile dental clinic: an oral health care delivery model for underserved migrant children. *J Calif Dent Assoc*. 2010;38(2):115-122.
92. Dotan G, Truong B, Snitzer M, et al. Outcomes of an inner-city vision outreach program: Give Kids Sight Day. *JAMA Ophthalmol*. 2015;133(5):527-532. https://doi.org/10.1001/jamaophthalmol.2015.8
93. Derr AS. Mental health service use among immigrants in the United States: a systematic review. *Psychiatr Serv*. 2016;67(3):265-274. https://doi.org/10.1176/appi.ps.201500004
94. Rousseau C, Frounfelker RL. Mental health needs and services for migrants: an overview for primary care providers. *J Travel Med*. 2019;26(2):tay150. https://doi.org/10.1093/jtm/tay150
95. Alegría M, Álvarez K, DiMarzio, K. Immigration and mental health. *Curr Epidemiol Rep*. 2017;4:145-155. https://doi.org/10.1007/s40471-017-0111-2
96. Mertz E. The dental-medical divide. *Health Aff (Millwood)*. 2016;35(12):2168-2175. https://doi.org/10.1377/hlthaff.2016.0886
97. Wilson FA, Wang Y, Stimpson JP, Kessler AS, Do DV, Britigan DH. Disparities in visual impairment by immigrant status in the United States. *Am J Ophthalmol*. 2014;158(4):800-807.e.5. https://doi.org/10.1016/j.ajo.2014.07.007
98. Stein BD, Kataoka S, Jaycox LH, et al. Theoretical basis and program design of a school-based mental health intervention for traumatized immigrant children: a collaborative research partnership. *J Behav Health Serv Res*. 2002;29(3):318-326. https://doi.org/10.1007/BF02287371
99. de Jesus Diaz-Perez M, Farley T, Martin Cabanis C. A program to improve access to health care among Mexican immigrants in rural Colorado. *J Rural Health*. 2004;20(3):258-264. https://doi.org/10.1111/j.1748-0361.2004.tb00037.x
100. Watkins EL, Larson K, Harlan C, Young S. A model program for providing health services for migrant farmworker mothers and children. *Public Health Rep*. 1990;105(6):567-575.
101. Luque JS, Martinez Tyson D, Markossian T, et al. Increasing cervical cancer screening in a Hispanic migrant farmworker community through faith-based clinical outreach. *J Low Genit Tract Dis*. 2011;15(3):200-204. https://doi.org/10.1097/LGT.0b013e318206004a
102. Migrant Health Program. National Center for Farmworker Health, Inc. Accessed June 3, 2022. http://www.ncfh.org/migrant-health-centers.html
103. Hargreaves S, Rustage K, Nellums LB, et al. Occupational health outcomes among international migrant workers: a systematic review and meta-analysis. *Lancet Glob Health*. 2019;7(7):e872-e882. https://doi.org/10.1016/S2214-109X(19)30204-9

104. Agricultural Worker Demographics. National Center for Farmworker Health, Inc. Accessed June 3, 2022. http://www.ncfh.org/agricultural-worker-demographics.html
105. Our Story. Migrant Clinicians Network. Accessed June 3, 2022. https://www.migrantclinician.org/about/our-story
106. Samari G, Nagle A, Coleman-Minahan K. Measuring structural xenophobia: US state immigration policy climates over ten years. *SSM Popul Health*. 2021;16:100938. https://doi.org/10.1016/j.ssmph.2021.100938
107. Perreira KM, Pedroza JM. Policies of exclusion: implications for the health of immigrants and their children. *Annu Rev Public Health*. 2019;40:147-166. https://doi.org/10.1146/annurev-publhealth-040218-044115
108. Pham O. Arkansas and Nevada Latest to Eliminate 5-Year Waiting Period for Lawfully Residing Children. Center for Children and Families. August 16, 2017. Accessed June 3, 2022. https://ccf.georgetown.edu/2017/08/16/arkansas-and-nevada-latest-to-eliminate-5-year-waiting-period-for-lawfully-residing-children/
109. Harker L. Five-Year Waiting Period is a Barrier to Immigrant Health Care Access. Georgia Budget and Policy Institute. October 21, 2019. Accessed June 3, 2022. https://gbpi.org/five-year-waiting-period-barrier-immigrant-health/
110. Park JK, Chokshi DA. Toward a new standard of health for immigrants in the United States. *Lancet Reg Health Am*. 2022;10:100238. https://doi.org/10.1016/j.lana.2022.100238
111. Linton JM, Griffin M, Shapiro AJ; Council on Community Pediatrics. Detention of immigrant children. *Pediatrics*. 2017;138(4):e20170483. https://doi.org/10.1542/peds.2017-0483
112. Beier J, Fredricks K. A Path to Meeting the Medical and Mental Health Needs of Unaccompanied Children in U.S. Communities. Migration Policy Institute and American Academy of Pediatrics. April 2023. Accessed May 10, 2023. https://migrationpolicy.org/research/medical-mental-health-needs-unaccompanied-children
113. Morgan AU, Grande DT, Carter T, Long JA, Kangovi S. Penn Center for Community Health Workers: step-by-step approach to sustain an evidence-based community health worker intervention at an academic medical center. *Am J Public Health*. 2016;106(11):1958-1960. https://doi.org/10.2105/AJPH.2016.303366
114. Translation and Interpretation Services. Centers for Medicare & Medicaid Services. Accessed May 9, 2023. https://www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html
115. Lundin C, Hadziabdic E, Hjelm K. Language interpretation conditions and boundaries in multilingual and multicultural emergency healthcare. *BMC Int Health Hum Rights*. 2018;18(1):23. https://doi.org/10.1186/s12914-018-0157-3
116. Denson VL, Graves JM. Language assistance services in nonfederally funded safety-net medical clinics in the United States. *Health Equity*. 2022;6(1):32-39. https://doi.org/10.1089/heq.2021.0103

117. Complexities of Physician Supply and Demand Projections from 2018 to 2033. Association of American Medical Colleges. June 2020. Accessed September 1, 2022. https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf
118. Masri A, Senussi MH. Trump's executive order on immigration - detrimental effects on medical training and health care. *N Engl J Med*. 2017;376:e39. https://doi.org/10.1056/NEJMp1701251
119. Foreign-Trained Doctors Are Critical to Serving Many U.S. Communities. American Immigration Council. 2018. Accessed May 12, 2023. https://www.americanimmigrationcouncil.org/research/foreign-trained-doctors-are-critical-serving-many-us-communities
120. Batalova J. Immigrant Health-Care Workers in the United States. Migration Policy Institute. April 7, 2023. Accessed May 12, 2023. https://www.migrationpolicy.org/article/immigrant-health-care-workers-united-states#Number_Share
121. Harbut RF. AMA Policies and *Code of Medical Ethics*' opinions related to health care for patients who are immigrants, refugees, or asylees. *AMA J Ethics*. 2019;21(1):E73-77. https://doi.org/10.1001/amajethics.2019.73
122. Department of Health and Human Services. Clarifying eligibility for a qualified health plan through an exchange, advance payments of the premium tax credit, cost-sharing reductions, a basic health program, and for some Medicaid and Children's Health Insurance Programs. *Fed Reg*. 2023;88(80):25313-25335. Accessed May 16, 2023. https://www.govinfo.gov/content/pkg/FR-2023-04-26/pdf/2023-08635.pdf
123. Minkler M. Linking science and policy through community-based participatory research to study and address health disparities. *Am J Public Health*. 2011;100(suppl 1):S81-S87. https://doi.org/10.2105/AJPH.2009.165720
124. What We Do. FrameWorks. Accessed May 30, 2023. https://www.frameworksinstitute.org/about/what-we-do/
125. Kendall-Taylor N, Levitt P. Beyond hat in hand: science advocacy is foundational for policy decisions. *Neuron*. 271;94(4):708-712. https://doi.org/10.1016/j.neuron.2017.04.039

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