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Medicaid Expansion for La Comunidad Latina in North Carolina: Community Health Workers' Role in Outreach

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Abstract

Purpose The Fostering Insurance Enrollment among Latinos in North Carolina (FIEL-NC) Project evaluated the experiences of Latino/a/e/x or Hispanic individuals (herein referred to as *la comunidad Latina*, as preferred by the community) with Medicaid enrollment following expansion in North Carolina (NC) to identify successes and areas for improvement.

Methods The study team recruited community members who self-identified as members of *la comunidad Latina* and have considered, attempted, or successfully enrolled in Medicaid post-expansion. We recruited community health workers (CHWs) who self-identified as members of *la comunidad Latina* and conducted insurance outreach post-expansion. Eligible participants completed a Spanish or English survey. Data was analyzed using chi-squared and Fisher's exact tests in STATA.

Results Results of this exploratory analysis demonstrate that among participating community members ($n=44$), 30% enrolled in Medicaid post-expansion, 36% attempted but were unsuccessful, and 34% did not attempt. Spanish-speaking, female, and foreign-born community members were more likely to have lower health knowledge and remain uninsured if not enrolled in Medicaid, compared to English-speaking, male, or U.S.-born counterparts. Half of community members reported limited health insurance knowledge. Among CHWs ($n=57$), 65% reported above average health knowledge, with more years of experience associated with increased health insurance knowledge. Almost all (98%) CHWs identified as Spanish-speaking, and 100% reported serving Spanish-speaking communities.

Conclusion Most community members had limited health insurance knowledge, which is a known barrier to enrollment. CHWs increase language concordance, trust, and engagement with health systems and resources. Expanding CHW health insurance training and CHW-led outreach can improve Medicaid enrollment among all eligible individuals.

Keywords Medicaid expansion · Insurance enrollment · Hispanic or Latino · Health equity · Community-based participatory research · Health policy/politics

Introduction

In December 2023, North Carolina (NC) expanded Medicaid, extending eligibility to more than 600,000 adults [1]. Evidence from other states demonstrates that Medicaid expansion improves access to preventive care, chronic disease management, and mental health services for newly eligible individuals [2–6]. Despite these gains, *la comunidad Latina* – a term identified by NC communities to reference Latino/a/e/x or Hispanic individuals [7] – continues to face substantial barriers to health insurance coverage [8–10]. Representing 11% of NC's population, *la comunidad Latina* has an uninsurance rate of 27.3%, markedly higher than both the statewide rate (9.2%) and the national average (8%) [11]. The disparity is most pronounced among NC adults aged 19–64, where *la comunidad Latina* reports an uninsurance rate of 38%, compared with 17% among Black individuals and 9% among non-Hispanic White individuals [11]. According to the NCDHHS Medicaid Expansion Dashboard, at the start of data collection for this study (December 2024), 589,222 individuals had enrolled in Medicaid

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following expansion. Of these enrollees, 55,628 (9.4%) identified as Hispanic, compared with 36.9% who identified as Black/African American and 57.2% as White/Caucasian [12]. Factors such as language barriers, low health literacy, and difficulty navigating healthcare systems contribute to lower enrollment among *la comunidad Latina* [4, 8, 9, 13].

During the COVID-19 pandemic, many in *la comunidad Latina* delayed seeking care due to lack of health insurance [14]. Key barriers included fears of disclosing immigration status, discrimination within insurance processes, and misinformation regarding the public charge rule [15]. Community health workers (CHWs) and community-based organizations (CBOs) played critical roles in mitigating these barriers [14]. As trusted members of the communities they serve, CHWs link marginalized populations to culturally appropriate services and interventions, yet remain underutilized in outreach, research, and policy development [16–19].

Project FIEL-NC (Fostering Insurance Enrollment among Latinos in NC) is an interdisciplinary initiative focused on increasing health insurance enrollment among eligible yet uninsured members of *la comunidad Latina* across the state. The project operates across three integrated pillars: (1) community education and training; (2) navigation and communication; and (3) policy research. Under the education pillar, the team has conducted focus groups and interviews to inform the development of culturally and linguistically tailored CHW health literacy training materials. The navigation and communication pillar enhances CHW outreach by building partnerships with CBOs and interest holders in NC counties with high concentrations of *la comunidad Latina* and elevated rates of uninsurance and poverty. The policy research pillar examines local, state, and federal health policies that influence community health outcomes.

Project FIEL-NC's outreach and research efforts rely on strong collaborations with CBOs, CHWs, and multisectoral coalitions that primarily serve *la comunidad Latina* in NC. A key partner is the Latinx Advocacy Team and Interdisciplinary Network for COVID-19 (LATIN-19), a multisectoral coalition of community, academic, healthcare, and policy interest holders formed to address healthcare barriers facing *la comunidad Latina* during the COVID-19 pandemic and beyond [7, 20].

Understanding the community's experiences with Medicaid expansion is essential to enhancing outreach and enrollment in Medicaid, Affordable Care Act (ACA) marketplace plans, and other public benefits. Findings from this study provide evidence-based guidance to CBOs, CHWs, and government agencies to create culturally and linguistically responsive resources that promote equitable enrollment for all eligible populations. While prior research has examined insurance barriers among *la comunidad Latina* at the national level [10, 21–24], few studies have investigated post-expansion enrollment experiences in NC or incorporated CHW perspectives.

To address this gap, Project FIEL-NC conducted a survey to assess post-expansion Medicaid enrollment experiences among CHWs and members of *la comunidad Latina*. For community members, we hypothesized that demographic factors – including gender, age, race, country of birth, country of origin, length of residence in the United States (U.S.), level of education, and language(s) spoken – may influence health knowledge and Medicaid enrollment outcomes. For CHWs, we assessed how similar demographic factors, along with CHW-specific characteristics such as certification status and years of experience, shape health knowledge.

Methods

Eligibility for community members included: ages 19–64 years; residency in NC; self-identification as Latino/a/e/x or Hispanic; ability to speak and understand Spanish and/or English; and having considered, attempted, or successfully enrolled in Medicaid following expansion. Eligibility criteria for CHWs included: ages 18 years or older; residing and working in NC; self-identification as Latino/a/e/x or Hispanic; ability to speak and understand Spanish and/or English; and participation in NC Medicaid outreach efforts after expansion.

To recruit study participants, Project FIEL-NC contacted 82 NC organizations, including CBOs, multisectoral coalitions, and state-level organizations – such as the NC Navigator Consortium and NC Department of Health and Human Services (NCDHHS) – 45 federally qualified health centers (FQHCs), 100 public health departments, and 12 churches throughout NC, requesting that research information be shared in newsletters and listservs. Bilingual and bicultural research members presented study details at seven in-person recruitment events held at trusted community sites. Additionally, the study team contacted 95 Spanish-speaking CHWs who had either completed FIEL-NC's health insurance training or participated in its activities, inviting them to enroll and disseminate study information within their communities.

Study information was also shared through social media channels. The team posted two announcements on trusted community partner Facebook pages, reaching approximately 539 users (which includes groups and individuals) and circulated information via closed WhatsApp groups, reaching approximately 279 recipients. The Qualtrics survey incorporated security measures – including reCAPTCHA and BallotBoxStuffing detection – to identify and prevent bot-generated responses.

Data Collection and Analysis

Separate survey instruments were developed for community members and CHWs to gather demographic data and assess experiences with NC Medicaid expansion. Additional CHW-specific questions explored their roles in promoting health insurance enrollment through community outreach. Surveys were available in Spanish and English, with bilingual team members conducting translation and back-translation to ensure linguistic accuracy. Data collection occurred from December 2024 – April 2025.

To detect potential bot-generated responses, two team members independently reviewed and flagged entries presenting more than two of the following indicators: (1) atypically brief survey completion times; (2) duplicate IP addresses; (3) geolocation coordinates from outside NC, particularly those outside the U.S.; (4) short answer responses with repetitive patterns; and (5) low ReCAPTCHA and BallotBoxStuffing scores recorded by Qualtrics. One original reviewer and two additional team members resolved classification discrepancies through consensus discussion. The research protocol was approved by the Duke University Institutional Review Board under protocol Pro00111973.

Survey data were analyzed using STATA to identify correlations and group differences. Chi-squared and Fisher's exact tests assessed associations between demographic characteristics, health literacy, and insurance outcomes among community members and CHWs.

Results

Study Sample

A total of 132 community members and 129 CHWs accessed the survey. Survey respondents were screened out based on eligibility criteria. As shown in Fig. 1, the final sample included 29 eligible community members and 63 eligible CHWs. Responses from partially completed surveys were included in the analysis, resulting in variation in the number of respondents across survey items.

Table 1 summarizes the demographics of community members and CHWs who completed the survey. The majority of community members (70%, $n=19/27$; n=responses/total respondents to question) and CHWs (86%, $n=49/57$) identified as female. Community members were more commonly between 26 and 40 years old (54%, $n=14/26$) while CHWs were more likely to be aged 41–50 years (35%, $n=20/57$). U.S.-born respondents comprised 33% ($n=8/24$) of community members and 8% ($n=4/53$) of CHWs. For those born outside of the U.S., the majority of community members (44%, $n=7/16$) and CHWs (84%, $n=41/49$) reported residing in the U.S. for more than 10 years.

Medicaid Enrollment Outcomes

Survey responses from community members ($n=44$) revealed that 30% reported successful Medicaid enrollment as shown in Table 2. An additional 20% considered and 16% attempted to enroll in Medicaid after expansion but were unsuccessful. The remaining 34% had not considered or attempted to enroll. Among those who considered or attempted, but ultimately did not enroll, community members most commonly reported remaining uninsured (38%, $n=5/13$) or obtaining coverage through Medicare (23%, $n=3/13$).

No significant associations were found between demographic factors and Medicaid enrollment ($p>.05$; Fisher's exact test). Among community member respondents, however, gender was significantly associated with insurance status – women were more likely than men to remain uninsured if not enrolled in Medicaid ($p=.002$; Fisher's exact test). For respondents who did not successfully enroll in Medicaid, women were more likely to enroll in an ACA health plan and men were most likely to be covered by Medicare ($p=.002$, Fisher's exact test).

Language Preferences

Table 1 demonstrates that Spanish was the most spoken language by 88% of community members and 98% of CHWs. Half ($n=12/24$) of community members and 84% ($n=48/57$) of CHWs preferred to read Medicaid-related materials in Spanish. Among 57 CHWs, 100% reported serving Spanish-speaking communities (see Table 3). Despite the prominence of Spanish language needs, no significant associations were found between language and Medicaid enrollment among community members. Community members who speak primarily Spanish at home and preferred Spanish health materials, however, were more likely to report lower health insurance knowledge ($p=.010$ and $p=.030$; Fisher's exact test) and remain uninsured if not enrolled in Medicaid compared to English-speaking community members ($p=.009$; Fisher's exact test).

Health Literacy

Health literacy was measured as self-reported knowledge of health insurance topics. Among 26 community member respondents, half ($n=13$) reported limited knowledge. In contrast, 9% of CHWs ($n=5/57$) reported limited knowledge. Seventy-seven percent ($n=10/13$) of community members reported knowing the number of people in their

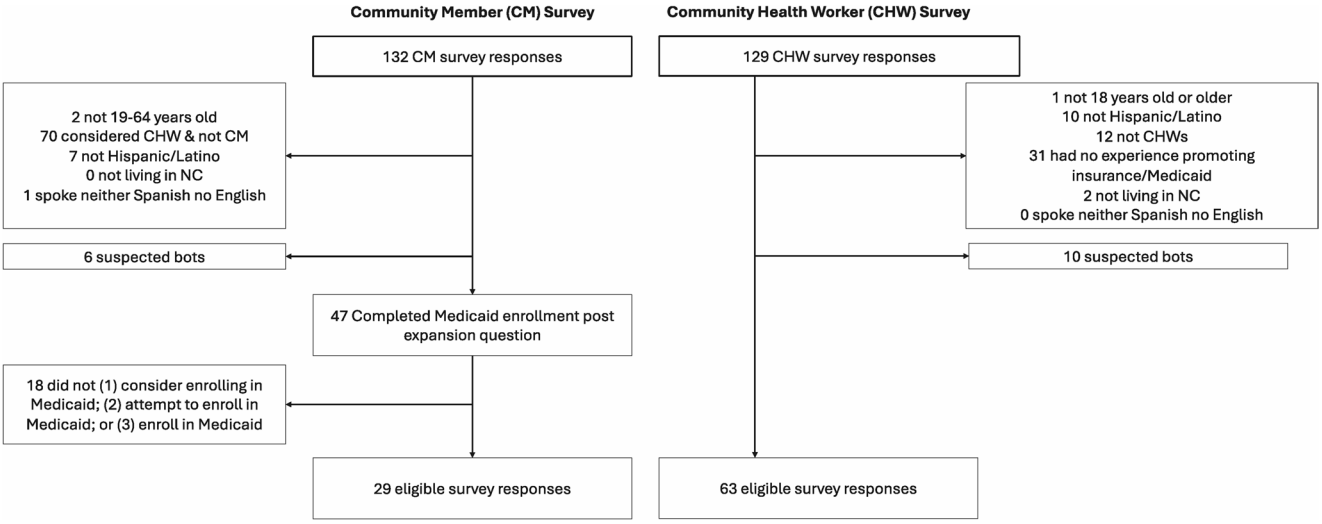

Fig. 1 Participation eligibility screening flow diagram for community member and CHW surveys

nuclear family eligible for Medicaid, with a mean family size of 4.33 individuals. Community members who identified as male or born in the U.S. were significantly more likely to report higher health insurance knowledge (p=.005; Fisher's exact test). Among CHWs, there was no statistically significant associations between demographics and health literacy, or between health literacy and Medicaid enrollment (p>.05; Fisher's exact test).

CHW Interactions

Seventy-three percent (n=8/11) of community members reported receiving assistance from a CHW, and among those, 88% (n=7/8) expressed that a CHW "helped me a lot." Collectively, CHW respondents reported serving the local communities in every NC county. Furthermore, we examined associations between demographic factors, education, years of experience, CHW certification, and health literacy among CHWs. Years of experience as a CHW was the only variable significantly associated with health insurance knowledge, with greater years of experience corresponding to higher levels of health insurance knowledge (p=.031; Fisher's exact test). Survey data available upon request.

Discussion

This study provides one of the first post-expansion assessments of Medicaid enrollment experiences among *la comunidad Latina* in NC, integrating perspectives from both community members and CHWs. Overall, exploratory findings reveal that the majority of CHWs demonstrated above-average knowledge of health insurance topics and were embedded within the communities they serve, frequently sharing the same language. In contrast, most community members possess minimal or no health insurance knowledge, thereby restricting their ability to navigate Medicaid enrollment. Although the community member sample size was too small to draw definitive conclusions, trends align with prior research indicating that low health insurance knowledge can hinder enrollment, particularly among Spanish-speaking individuals [9, 13]. The high proportion of respondents (73%) who received assistance from CHWs may have helped bridge knowledge gaps, potentially influencing the absence of a statistically significant association in our results.

Based on our data, enrollment outcomes remain suboptimal: 36% of participating community members considered or attempted to enroll, but did not succeed, and an additional 34% did not attempt enrollment at all. The lack of association between enrollment status and demographic factors suggests that barriers to access may exist across groups, highlighting systematic challenges in reaching Medicaid-eligible individuals who lack information on how to apply, contributing to under-enrollment despite expanded eligibility.

Certain demographics – specifically gender, preferred language, and country of birth – were associated with lower health insurance knowledge. Gender and preferred language also correlated with uninsured status. These compounding barriers faced by Spanish-speaking women born outside of the U.S. may reflect cultural and traditional gender roles as well as structural inequities in healthcare access [9, 22, 23, 25, 26]. These patterns reinforce evidence that insufficient culturally and linguistically tailored resources impede navigation of health insurance enrollment and utilization [8, 13].

Table 1 Participant demographics and characteristics

	Community Members ($n=29$)	Community Health Workers ($n=63$)
Age		
18–26	1 (4%)	3 (5%)
27–40	14 (54%)	14 (25%)
41–50	8 (31%)	20 (35%)
51–64	3 (12%)	19 (33%)
65+	0	1 (2%)
Prefer not to respond	0	0
Gender		
Woman	19 (70%)	49 (86%)
Man	8 (30%)	8 (14%)
Transgender Man	0	0
Transgender Woman	0	0
Non-binary / non-conforming	0	0
Other[a]	0	0
Race		
White	15 (58%)	29 (51%)
Black or African American	1 (4%)	0
Indigenous American or Native of Alaska	1 (4%)	2 (4%)
Asian	0	0
Other[b]	9 (35%)	26 (46%)
Country of birth		
Colombia	2 (8%)	1 (2%)
Ecuador	0	1 (2%)
El Salvador	2 (8%)	2 (4%)
Guatemala	0	2 (4%)
Honduras	2 (8%)	3 (6%)
Mexico	8 (33%)	36 (68%)
Nicaragua	1 (4%)	1 (2%)
United States	8 (33%)	4 (8%)
Venezuela	1 (4%)	3 (6%)
Family's country of origin		
Colombia	2 (8%)	1 (2%)
El Salvador	2 (8%)	0
Spain	0	1 (2%)
Guatemala	1 (4%)	2 (4%)
Honduras	3 (12%)	3 (5%)
Mexico	9 (35%)	41 (72%)
Nicaragua	1 (4%)	1 (2%)
United States	3 (19%)	0
Venezuela	1 (4%)	0
Multiple countries	1 (4%)	8 (14%)
Other[$]	1 (4%)	0
Years in the United States		
Less than 1 year	0	0
1–3 years	6 (38%)	1 (2%)
4–10 years	3 (19%)	6 (12%)
More than 10 years	7 (44%)	41 (84%)
Prefer not to respond	0	1 (2%)
Highest level of education		
Some Elementary school	1 (4%)	0
Elementary school	0	2 (4%)
Some middle school	1 (4%)	1 (2%)
Middle School	0	1 (2%)
Some high school	6 (23%)	8 (14%)

Table 1 (continued)

	Community Members ($n=29$)	Community Health Workers ($n=63$)
High school or GED	2(8%)	12 (21%)
Associates degree	0	12 (21%)
Bachelors degree	11 (42%)	14 (25%)
Masters, doctorate, or post-doctorate	5 (19%)	3 (5%)
Other[b]	0	4 (7%)
Knowledge of health insurance topics		
No knowledge	2 (8%)	0
Minimal knowledge	11 (42%)	5 (9%)
Average knowledge	8 (31%)	15 (26%)
Adequate knowledge	3 (12%)	33 (58%)
Superior knowledge	2 (8%)	4 (7%)
Prefer not to respond	0	0
Languages spoken (all)[c]		
English	14 (58%)	35 (39%)
Náhuatl	1 (4%)	0
Quechua	0	1 (2%)
Spanish	21 (88%)	56 (98%)
Other	0	3 (5%)
Prefer not to respond	0	1 (2%)
Primary language spoken at home		
English	8 (33%)	7 (12%)
Spanish	16 (67%)	48 (84%)
Other	0	2 (4%)
Preferred language for reading information related to Medicaid/insurance		
English	12 (50%)	9 (16%)
Spanish	12 (50%)	48 (84%)

[a]includes Other, Prefer not to respond, and Don't know.

[b]includes Other and Prefer not to respond.

[c]Participants could select more than one response so percentages total more than 100%.

CHWs, with their higher overall health insurance knowledge and trusted role within Spanish-speaking communities, remain central to addressing these gaps. Since March 2022, CHWs may pursue certification acknowledging their lived and prior experience through the Legacy Track. Although we did not directly assess Legacy Track recognition, we accounted for CHWs' experience by measuring years worked with *la comunidad Latina* and included this in our analysis. Notably, only years of CHW experience, not certification status, was significantly associated with health insurance knowledge, underscoring the need for continued investment in CHW education and training.

Our findings also affirm that *la comunidad Latina* is not a monolith, but a diverse mosaic of countries of origin, languages, and cultural contexts. These variations shape levels of health literacy and influence the specific barriers to and facilitators of enrollment. Outreach and education strategies must therefore reflect this diversity. CHWs can lead such efforts by fostering language concordance, building trust, and encouraging community engagement with healthcare systems.

Several recently expanded states, such as Connecticut and California, have begun to model culturally and linguistically responsive enrollment strategies by formalizing partnerships with CBOs through Medicaid transformation initiatives [27–29]. These efforts include providing dedicated funding for multilingual outreach, building community trust, and addressing persistent misinformation. Yet across many Medicaid-expanded states, culturally and linguistically responsive insurance outreach strategies—and the literature evaluating their effectiveness—remain limited [27].

Several limitations affect interpretation of these findings. Despite employing evidence-based recruitment strategies – through partnerships with LATIN-19 and other CBOs, outreach at trusted community venues, and bilingual, bicultural recruitment [19] –survey participation from community members was low generally and compared to CHWs. Thus, findings among community members remain exploratory and are not powered for inferential analyses; significant results should therefore be interpreted cautiously.

Similar limitations apply to our sample of CHWs. As of December 2025, the North Carolina Community Health

Table 2 Community member responses

	n = 44
Medicaid enrollment following expansion	
I considered enrolling but did not enroll	9 (20%)
I attempted to but did not enroll	7 (16%)
I successfully enrolled	13 (30%)
None of the above [a]	15 (34%)
	n = 29
Current insurance for those who did not successfully enroll in Medicaid (*n* = 16)	
No insurance	5 (38%)
ACA health plan (Obamacare)	2 (15%)
Job-based insurance	2 (15%)
Medicare	3 (23%)
Private health insurance	1 (8%)
Have you received help from a CHW?	
Yes	8 (73%)
No	2 (18%)
Don't know/prefer not to respond	1 (9%)
Experience with CHWs (*n* = 8)	
The community health worker(s) helped me a lot	7 (88%)
The community health worker(s) helped me a bit	1 (13%)
The community health worker(s) did not help me	0
Do you know how many are eligible for Medicaid in your nuclear family?	
Yes	10 (77%)
No	3 (23%)
Prefer not to respond	0
Indicate the number eligible for Medicaid in your nuclear family (*n* = 13)	
Mean (SD)	4.33 (1.22)

[a]These participants were excluded from all other questions.

Table 3 Community health worker responses

	n = 63
CHW Certification at community college	
Yes	41 (72%)
No	13 (23%)
Prefer not to respond	3 (5%)
Languages spoken by community served[a]	
Spanish	57 (100%)
English	23 (40%)
Náhuatl	1 (2%)
Other	5 (9%)
Years as a CHW working with *la comunidad Latina* in NC	
Less than 1 year	4 (7%)
1–5 years	31 (53%)
6–10 years	7 (12%)
11–15 years	7 (12%)
16–20 years	3 (5%)
More than 20 years	5 (8%)
Prefer not to respond	2 (3%)
Participated in FIEL_NC opportunities before	
Yes	30 (53%)
No	24 (42%)
Prefer not to respond	3 (5%)

[a]Participants could select more than one response so percentages total more than 100%.

Worker Association has awarded 1,370 Community Health Worker certifications statewide [30]. Although the exact number of CHWs who engage with *la comunidad Latina* is unknown, we acknowledge that the 63 eligible CHWs included in this study represent a small subset of this larger workforce. Accordingly, CHW findings should also be interpreted as exploratory.

Several factors may have limited survey participation. Initially created as screening tools for focus groups, the surveys were later expanded yet only included individuals who had attempted or considered Medicaid enrollment. This approach excluded individuals who may have been eligible but unaware of the expansion or hesitant to apply. While excluded individuals were asked to share reasons for not attempting enrollment, none provided reasons. Additionally, several community members also identified as CHWs. These individuals were therefore excluded from the community member survey and instead guided to the CHW survey to avoid duplicate data across surveys. Heightened fear and mistrust of government – shaped by recent anti-immigrant policies, deportations, and political rhetoric – likely further limited participation. Thus, despite efforts to ensure participants that information gathered was anonymous and secure, many potential respondents may have been hesitant to complete a survey. As in many self-reported surveys, perceived health literacy may have been over- or underestimated, introducing potential bias. These limitations may obscure relationships between health literacy and enrollment outcomes.

To address these gaps, Project FIEL-NC is incorporating qualitative methods to capture more nuanced experiences within *la comunidad Latina*, better understand intra-group differences, and identify additional enrollment barriers and facilitators. Future research should include not only those who have attempted enrollment, but also eligible individuals who remain unaware or skeptical of Medicaid and other public benefits. Expanding the scope in this way may strengthen outreach strategies to reach marginalized populations more effectively.

Policy Implications

North Carolina's Medicaid expansion aimed to improve access to health coverage, yet our findings show that significant enrollment barriers persist for *la comunidad Latina*. These barriers require targeted, culturally-responsive, and community-centered strategies to ensure expanded eligibility translates to actual coverage. Based on the data, we

recommend three actions for CBOs, CHWs, policymakers, and state agencies.

1. **Tailor health literacy efforts to cultural and linguistic diversity**. Spanish language preference – whether spoken or written – was associated with both lower health insurance knowledge and higher likelihood of remaining uninsured, compared to English-speaking respondents. Spanish-speaking women born outside the U.S. experienced compounded barriers, including lower health literacy and reduced enrollment rates. These findings underscore the need for outreach materials that are culturally appropriate, linguistically accurate, and accessible regardless of education, employment, or literacy level. In particular, Spanish-language resources must go beyond translation to incorporate cultural relevance and trust-building elements.
2. **Center CHWs in outreach and enrollment strategies.** Our results and existing literature confirm the pivotal role CHWs play in overcoming language barriers, improving health literacy, and countering institutional mistrust [16–18]. As trusted members of their communities, CHWs can translate complex processes into actionable guidance, assist individuals with enrollment, and connect individuals to local resources. Their embedded presence within communities positions them as essential conduits for culturally and linguistically appropriate assistance. Therefore, strengthening their role in Medicaid outreach offers an immediate pathway to improving enrollment outcomes.
3. **Sustain and expand investment in CHW capacity and programming.** Effective CHW-led outreach requires consistent funding, robust training, and updated resources to deliver accurate, culturally sensitive health insurance education. Strengthening CHW capacity ensures that outreach can be proactive rather than reactive, enabling CHWs to reach eligible individuals before gaps in coverage lead to unmet health needs.

Together, these recommendations address the persistent barriers documented in this study and support equity-driven enrollment strategies. By pairing linguistically- and culturally-tailored education with sustained CHW-led outreach, NC can improve Medicaid participation among *la comunidad Latina* and extend the impact to other public benefit programs. Such approaches not only promote equitable access within immigrant and marginalized populations, but also advance statewide goals for preventive care, chronic disease management, and overall community health.

Conclusion

This study offers one of the first post-expansion analyses of Medicaid enrollment experiences within *la comunidad Latina* in NC, incorporating both community member and CHW perspectives. Findings of this exploratory analysis reveal persistent barriers to enrollment despite expanded eligibility, particularly among Spanish-speaking, foreign-born women, and underscore the critical role of CHWs in bridging health literacy, language, and trust gaps. Strengthening culturally and linguistically tailored outreach and CHW-led initiatives can directly address structural and informational barriers that perpetuate inequities in health coverage. In today's everchanging policy environment—marked by heightened institutional mistrust, anti-immigrant sentiment, and policy uncertainty—community-driven, evidence-based approaches are indispensable. Sustained investment in trusted community infrastructure, cross-sector partnerships, and culturally grounded health communication will be vital to ensuring that existing public benefits achieve their intended goals and contribute to population health.

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Author Contributions Natalie Sanchez Farez, Kristin Podsiad, Paulina A. Ruiz, Lauren Hart, Pedro Gomez Altamirano, Viviana Martinez-Bianchi, and Gabriela Plasencia contributed to the study conception and design. Material preparation and data collection were performed by Natalie Sanchez Farez, Kristin Podsiad, Paulina A. Ruiz, Lauren Hart, Pedro Gomez Altamirano, Viviana Martinez-Bianchi, and Gabriela Plasencia. Data analysis was performed by Natalie Sanchez Farez, Kristin Podsiad, and Lauren Hart. The first draft of the manuscript was written by Natalie Sanchez Farez and Kristin Podsiad. All authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

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Declarations

Ethics Approval This study was granted an exemption by the Duke University Health System Institutional Review Board (Pro00116231).

Consent to Participate Informed consent was obtained from all individual participants included in the study.

Consent to Publish In the study we are only presenting de-identified and aggregate data, participants did consent to publication of the de-identified and aggregate data.

Competing interests G.P. and V.M.B. are Executive Board Members of the Latinx Advocacy Teamwork and Interdisciplinary Network for COVID-19 (LATIN-19). Executive Board Members do not receive any direct financial remuneration for their involvement in LATIN-19. Other individuals listed as authors on this manuscript certify that they have NO affiliations with or involvement in any organization or entity with any financial interest (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements), or non-financial interest (such as personal or professional relationships, affiliations, knowledge or beliefs) in the subject matter or materials discussed in this manuscript.

References

1. An Update on ACA Medicaid Expansion: What to Watch in North Carolina and Beyond. 2018. https://www.kff.org/policy-watch/an-update-on-aca-medicaid-expansion-what-to-watch-in-north-carolina-and-beyond/
2. Jiang GY, Urwin JW, Wasfy JH. Medicaid Expansion Under the Affordable Care Act and Association With Cardiac Care: A Systematic Review. Circ Cardiovasc Qual Outcomes Jun. 2023;16(6):e009753. https://doi.org/10.1161/CIRCOUTCOMES.122.009753.
3. Sommers BD, Blendon RJ, Orav EJ, Epstein AM. Changes in utilization and health among low-income adults after medicaid expansion or expanded private insurance. JAMA Intern Med. 2016;176(10):1501–9. . https://doi.org/10.1001/jamainternmed.2016.4419
4. Guth M, Ammula M. Building on the evidence base: studies on the effects of medicaid expansion, February 2020 to March 2021. KFF. 2021.
5. Mazurenko O, Balio CP, Agarwal R, Carroll AE, Menachemi N. The Effects Of Medicaid Expansion Under The ACA: A Systematic Review. Health Aff (Millwood) Jun. 2018;37(6):944–50. https://doi.org/10.1377/hlthaff.2017.1491.
6. Carlson MJ, DeVoe J, Wright BJ. Short-term impacts of coverage loss in a Medicaid population: early results from a prospective cohort study of the Oregon Health Plan. Ann Fam Med Sep-Oct. 2006;4(5):391–8. https://doi.org/10.1370/afm.573.
7. Martinez-Bianchi V, Maradiaga Panayotti GM, Corsino L, et al. Health and Wellness for Our Latina Community: The Work of the Latinx Advocacy Team & Interdisciplinary Network for COVID-19 (LATIN-19). N C Med J Jul-Aug. 2021;82(4):278–81. https://doi.org/10.18043/ncm.82.4.278.
8. Rudowitz R, Tolbert J, Damico A. A closer look at the remaining uninsured population eligible for medicaid and CHIP. KFF. 2024;Uninsured.
9. Huguet N, Valenzuela S, Marino M, et al. Following Uninsured Patients Through Medicaid Expansion: Ambulatory Care Use and Diagnosed Conditions. Ann Fam Med Jul. 2019;17(4):336–44. https://doi.org/10.1370/afm.2385.
10. Guerrero EG, Legnick-Hall R, Andrews C. Underlying challenges of public health insurance enrollment and use among Latino adults: insights from the largest safety-net institution in Los Angeles. Public Health Nov. 2017;152:47–50. https://doi.org/10.1016/j.puhe.2017.06.006.
11. Data from: 2022 American Community Survey 1-year estimates. 2023. Washington (DC).
12. North Carolina Department of Health and Human Services. Medicaid Expansion Enrollment Dashboard. In: NC Medicaid Reports and Dashboards. 2025. https://medicaid.ncdhhs.gov/reports/medicaid-expansion-dashboard Accessed 12 Dec 2025
13. Ghaddar S, Byun J, Krishnaswami J. Health insurance literacy and awareness of the Affordable Care Act in a vulnerable Hispanic population. Patient Educ Couns Dec. 2018;101(12):2233–40. https://doi.org/10.1016/j.pec.2018.08.033.
14. Plasencia G, Gupta R, Kaalund K, Martinez-Bianchi V, Gonzalez-Guarda R, Thoumi A. Systemic Racism Affecting Latinx Population Health During the COVID-19 Pandemic and Beyond: Perspectives of Latinx Community Health Workers and Community-Based Organization Leaders. Health Equity. 2023;7(1):715–21. https://doi.org/10.1089/heq.2023.0193.
15. Thoumi A, Plasencia G, Madanay F, et al. Promoting Latinx health equity through community-engaged policy and practice reforms in North Carolina. Front Public Health. 2023;11:1227853. https://doi.org/10.3389/fpubh.2023.1227853.
16. Perry HB, Zulliger R, Rogers MM. Community health workers in low-, middle-, and high-income countries: an overview of their history, recent evolution, and current effectiveness. Annu Rev Public Health. 2014;35:399–421. https://doi.org/10.1146/annurev-publhealth-032013-182354.
17. Ignoffo S, Margellos-Anast H, Banks M, Morris R, Jay K. Clinical Integration of Community Health Workers to Reduce Health Inequities in Overburdened and Under-Resourced Populations. Popul Health Manag Apr. 2022;25(2):280–3. https://doi.org/10.1089/pop.2021.0376.
18. Coulter K, Ingram M, McClelland DJ, Lohr A. Positionality of Community Health Workers on Health Intervention Research Teams: A Scoping Review. Front Public Health. 2020;8:208. https://doi.org/10.3389/fpubh.2020.00208.
19. Plasencia G, Kaalund K, Thoumi A. Training Latinx Community Health Workers as Clinical Research and Health Care System Navigators. Am J Public Health Nov. 2023;113(11):1157–9. https://doi.org/10.2105/AJPH.2023.307418.
20. Maradiaga Panayotti GM, Martinez-Bianchi V, Corsino L, et al. LATIN-19: A Grassroots Coalition to Mitigate the Effect of COVID-19 on the Latinx Community in North Carolina. Prog Community Health Partnersh. 2022;16(2S):33–8. https://doi.org/10.1353/cpr.2022.0036.
21. Rivera-Gonzalez AC, Roby DH, Stimpson JP, et al. The impact of Medicaid funding structures on inequities in health care access for Latinos in New York, Florida, and Puerto Rico. Health Serv Res Dec. 2022;57(Suppl 2):172–82. https://doi.org/10.1111/1475-6773.14036.
22. Huguet N, Kaufmann J, Holderness H, et al. Medicaid Eligibility Expansion Regardless of Immigration Status and Insurance Coverage Among Latinos Seen in Community Health Centers, 2018–2023. Am J Public Health Jun. 2025;115(6):900–9. https://doi.org/10.2105/AJPH.2025.308052.

23. Heintzman J, Bailey SR, DeVoe J, et al. In Low-Income Latino Patients, Post-Affordable Care Act Insurance Disparities May Be Reduced Even More than Broader National Estimates: Evidence from Oregon. J Racial Ethn Health Disparities Jun. 2017;4(3):329–36. https://doi.org/10.1007/s40615-016-0232-1.
24. Foiles Sifuentes AM, Robledo Cornejo M, Li NC, Castaneda-Avila MA, Tjia J, Lapane KL. The Role of Limited English Proficiency and Access to Health Insurance and Health Care in the Affordable Care Act Era. Health Equity. 2020;4(1):509–17. https://doi.org/10.1089/heq.2020.0057.
25. Hatch B, Hoopes M, Darney BG, et al. Impacts of the Affordable Care Act on Receipt of Women's Preventive Services in Community Health Centers in Medicaid Expansion and Nonexpansion States. *Womens Health Issues*. Jan-Feb. 2021;31(1):9–16. https://doi.org/10.1016/j.whi.2020.08.011.
26. Ye W, Rodriguez JM. Highly vulnerable communities and the Affordable Care Act: Health insurance coverage effects, 2010–2018. Soc Sci Med Feb. 2021;270:113670. https://doi.org/10.1016/j.socscimed.2021.113670.
27. Podsiad K, Kukoyi O, Efird-Green L, Thoumi A, Plasencia G. How states can improve Medicaid outreach among unenrolled and eligible Latiné populations. Health Aff (Millwood) Forefr. 2025 Aug;4. https://doi.org/10.1377/forefront.20250804.740700.
28. Hang K, Sabatoni M, Zemel S, Bates H, Chan–Sawin L. Medi–Cal health navigator project: lessons learned in Medi–Cal outreach and enrollment in rural Northern California. In: The Center at Sierra Health Foundation. 2022. https://www.shfcenter.org/wp-content/uploads/2022/02/Medi-Cal_Health_Navigator_Project_Report_January_2022.pdf. Accessed 10 Dec 2025.
29. Connecticut Health Foundation. Grants for trusted messengers to support changes in health coverage. In: Connecticut Health Foundation Latest News & Press Releases. April 4, 2023. https://www.cthealth.org/latest-news/news-releases/trusted-messengers/. Accessed 10 Dec 2025.
30. North Carolina Community Health Workers Association. Home. In: NCCHWA.org. North Carolina Community Health Workers Association, Inc. 2025. https://ncchwa.org. Accessed Dec 13, 2025.