Access of migrant farmworkers and members of their families to Medicaid as a source of payment for covered health care services

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SECTION 1

DESCRIPTION OF THE PROBLEM

DESCRIPTION OF THE PROBLEM:

ACCESS OF MIGRANT FARMWORKERS AND MEMBERS OF THEIR FAMILIES TO MEDICAID AS A SOURCE OF PAYMENT FOR COVERED HEALTH CARE SERVICES

Numbers of Migrant Farmworkers

Estimates of the number of persons who migrate from locality to locality in order to participate in agricultural work vary widely, depending on the definition of a qualifying migration and on the definition of agricultural work. The legislation which authorizes the Migrant Health Program (contained in Section 329 of the Public Health Service Act) defines a "migratory agricultural worker" as "an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the past twenty-four months, and who establishes for the purpose of such employment a temporary abode". Using this definition the Migrant Health Program published in 1990 an atlas containing the estimates for each of 42 states.[1] At that time the duplicated estimates (counting migrants in each area where they temporarily reside) of migrant farmworkers and members of their families totaled over 1.6 million. The unduplicated count is estimated to be between 0.5 and 0.8 million.

Because some migrant farmworkers may settle out and reside in an area for several years, often engaging in seasonal farmwork during this period, then rejoin the migrant stream at some future time, the numbers of migrant and seasonal farmworkers may be more useful for estimating the potential numbers of such workers. The Migrant Health Program estimated about 2.5 million non-migrating seasonal farmworkers and members of their families in the 1990 report.

Neither national estimates of migrants nor estimates of the numbers of migrant farmworkers and family members who work in any given state are good predictors of the numbers who would receive services reimbursed by Medicaid if interstate eligibility were facilitated. Those migrant farmworkers who travel to and work in upstream states tend to be disproportionately young males, generally in good health. Although some bring one or more non-working family members with them, the disabled and those with severe chronic disorders tend to remain in the home state where the family spends the winter. Thus, there are no comprehensive data on the numbers of migrants who would use Medicaid in any given time period if they were eligible.

Health Problems of Migrant Farmworkers and Family Members

Migrant and seasonal farmworkers represent a heterogeneous population of

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[1] Migrant Health Program, An Atlas of State Profiles Which Estimate Number of Migrant and Seasonal Farmworkers and Members of Their Families, Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, Rockville, Maryland, March 1990.

Black, White, Hispanic and other racial/ethnic backgrounds. They endure substandard living conditions, labor in one of the nation's most dangerous occupations, and have limited access to primary health care. There are no current national data on the socio-economic status of migrants. In 1983, migrant farmworkers earned an annual average income of $5,921, with farm work accounting for $4,638. The median total family income of migrant farmworker families was significantly below poverty level -- $9,000 compared to the poverty threshold of $11,000 for a family of four. Nearly half (48 percent) of migrant farmworkers have less than a ninth grade education. The Migrant Health Centers which receive federal financial support under Section 329 of the Public Health Service Act report information on those migrant and seasonal farmworkers who use center services. The proportion of users with family incomes below the poverty level varies from about 39% to 100% of users, depending on the location of the health center, whether open year round or seasonally, and the mix of migrant versus non-migrant seasonal farmworker users. The median reported figure for 1988 was 80% of users were from families with income levels below the poverty threshold.

The health care problems of migrant and seasonal farm workers are more severe than those of most other Americans as a result of a combination of poor living conditions, low education levels and socioeconomic status, relatively poor healthcare habits and a lack of access to adequate medical care. According to a white paper prepared in 1987 for the Migrant Health Program[2]:

- The infant mortality rate for migrants is 125 percent higher than the national average.
- The life expectancy of a migrant farmworker is 49 years, as compared to the national average of 75 years.
- The rate of parasitic infection among migrants is estimated to be 11 to 59 times higher than that of the general U.S. population.
- The incidence of malnutrition among migrants is higher than among any other sub-population in the country.

In addition, migrant workers experience substantially higher rates than the general population of accidental injuries; mental health and substance abuse problems; and dental and oral disease.

Migrant Health Centers in upstream states report seeing few elderly and treat few with chronic degenerative diseases. Acute episodic illness and accidental injuries have a high incidence rate in this population, and there is great need for perinatal and pediatric services. In those states where migrants winter over (home base states) there are many former migrant farmworkers who no longer migrate due to age or disability. Also, family members with conditions which prevent travel or work in the fields may settle out or remain behind with

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[2] Georgetown University, "White Paper on Nutrition", unpublished paper, dated 1987.

relatives during the agricultural season. It is this latter group, the elderly, the disabled, and those with serious diseases or conditions who represent the high cost users and who ultimately qualify and obtain Medicaid eligibility in their home base state. However, those who migrate today and need but do not receive timely care for perinatal conditions, minor acute problems, and accidental injuries are at high risk of becoming tomorrow's severely ill and disabled.

Migrant Worker Barriers to Medical Care

Migrant patients encounter major barriers in obtaining access to health care services. Migrant families often do not have readily available transportation (frequently depending on their crew leader for rides), because of moving from area to area they often cannot wait for a scheduled appointment, are not available for appointments during traditional office hours without missing a day of work, and they are not able to pay the cost of health care as it is delivered today. Because publicly funded health care resources in the rural areas where migrants work are either absent or severely limited in their capacity, and because the private sector health care providers are reluctant to treat a large influx of patients who are unable to pay for services, migrants tend not to have timely access to mainstream primary health care. Furthermore, because of the special health problems of this group, language and cultural barriers, and lack of funds for prescriptions or referrals, health care services when provided are often less effective for migrants. Research has suggested that the high rates of dental disease and chronic diseases, such as hypertension, tuberculosis, anemia and parasitic infections, are a direct result of the migrant population's lack of access to appropriate and culturally sensitive primary health care.

Federally supported primary care services are provided by migrant Health Centers, funded under Section 329 of the public health services act. However, because of limited funds migrant health centers are only located in areas with the largest concentrations of migrant and seasonal farmworkers. Currently less than 15 percent of the Migrant Health Program target population receives services through these health centers each year. Even when migrant workers do have access to and use primary care services at migrant health centers or community health centers, obtaining required specialty care and hospital care can be a major problem if migrant workers are not covered by insurance programs.

Barriers to Participation in Medicaid

Migrant and seasonal farmworkers represent a medically underserved population because of their migrant work pattern, language and cultural barriers, relatively low income and socioeconomic status, and lack of adequate third party financing under private health insurance and government sponsored health benefit programs. The Federal and State financed Medicaid program, authorized under Title XIX of the Social Security Act, is the primary publicly sponsored health benefit program for the poor. Despite the fact that migrant and seasonal farmworkers are among the lowest income occupational groups, with only a small proportion being covered under employer-sponsored health benefit programs, they

are largely uncovered by state Medicaid programs. Their lack of Medicaid coverage does not represent an intended public policy decision, but an unfortunate circumstance resulting largely from a combination of their employment experience and residential status. From a health care coverage perspective, they truly have fallen through the cracks -- the holes in the "safety net" designed to insure all U.S. residents the basic necessities of life.

Medicaid coverage for pregnant women, infants, and children has been expanded and income limitations eased under a federal mandate which has resulted in Medicaid coverage for a sizeable proportion of these individuals in migrant families. All states must now cover pregnant women and infants residing in families with income levels up to 133% of the poverty level, and have the option of extending this limit up to 185% of the poverty level. Further, twenty-three states have extended temporary Medicaid eligibility to pregnant women through the "presumptive eligibility" option. This program is particularly helpful for migrant workers because it shortcuts the administrative requirements for initial Medicaid coverage for services. However, the administrative barriers in the application process for migrants seeking Medicaid represent a formidable barrier to those seeking primary care services in communities without presumptive eligibility. The administrative barriers of particular concern to migrants are:

- locations at which applications must be made are often some distances from migrant labor camps or other places where migrants reside --- this is a particular problem in rural areas without public transportation

- welfare offices are only open during the working hours when migrants work in the fields, thus posing the difficult tradeoff of choosing between working to provide food for the family or not working in order to apply for Medicaid

- because of short duration of residence in any one location while working on harvests, the eligibility determination process may not be completed by the time the migrant moves on, thus requiring the entire application process to be repeated at the next location

- language barriers for many migrants may interfere with proper completion of the application

- lack of payroll, tax, or other records, including proof of citizenship may interfere with timely eligibility determination

- lack of a permanent address may interfere with correspondence and other communications with the state concerning the eligibility application process

Migrants who are hospitalized generally qualify for Medicaid, and the hospital has an economic incentive to assist with the eligibility process in order to recover at least a portion of the costs of care. It is hypothesized that the requirement for hospital inpatient care of migrants is often made necessary, or more costly, because of the lack of access to primary care due to

financial barriers. Access to the full range of medical care services could be substantially improved if migrant workers and family members were to have access to Medicaid through a single application process and which would then cover services and providers in all of the states in which they work.

Even when migrants can overcome the access barriers of transportation, hours of operation, language, and records, other regulatory barriers remain. The principal regulatory barrier for a migrant worker seeking access to Medicaid relates to Medicaid eligibility rules in general, and to the different rules, interpretations of rules and administrative practices under each state's Medicaid program. Eligibility for Medicaid in most states depends on being able to answer "yes" to the following basic questions:

- Does the applicant fit into one of the recognized eligibility categories, and does the applicant meet the financial eligibility tests that apply to his or her particular eligibility category?
- Is the applicant a resident of the state in which he or she is applying for benefits?
- Is the applicant lawfully present within the United States (either a citizen or a lawfully present alien)?

Only the first two requirements are addressed here. It is assumed that most migrant farmworkers and their families are lawfully present, but even those born in the U.S. may be repeatedly required to produce documentation to prove it. The migrant lifestyle contributes to occasional loss of records, and thereby may delay eligibility when a migrant moves into a state, even when still possessing an out-of-date Medicaid card from another state.

Many migrant workers and their families meet the criteria of one or more of the many categories of needy individuals to whom states must extent Medicaid benefits, i.e., the categorically needy. Because Medicaid is a state-administered program, persons who wish to enroll must be residents in the states in which they are applying. Residency requirements are the most troublesome barrier faced by otherwise eligible migrant workers. In general, the barriers that residency requirements create can be overcome only if the state Medicaid agency actively steps in to help, with convenient, swift enrollment procedures and retroactive payment.

The basic residency rule for Medicaid eligibility requires "intent to reside" in the state, and eligibility may not be denied because a person failed to reside in a state for any specific period of time. A person can fulfill the Medicaid residency requirements as soon as he or she enters the state with the intent of remaining indefinitely. The applicant need not have a fixed home or mailing address in the state, although not having a mailing address complicates communication between the state Medicaid agency and the migrant seeking eligibility.

A special rule was adopted under federal Medicaid law to facilitate migrant workers and their families who otherwise meet Medicaid eligibility requirements

to satisfy Medicaid residency requirements. This rule allows the migrant to either establish residence in the state in which he/she is seeking employment or to keep one particular state as his/her state of residence while moving from state to state for employment purposes (42 USC Section 3230.3B). In addition, states may enter into written agreements to resolve cases of disputed residence.

Despite the migrant workers' option of enrolling in the state of residency or the state of current employment, problems remain in obtaining Medicaid coverage while outside of his or her state of residency. If Medicaid eligibility is sought in the state of residency (rather than the state of employment) the following problems may be encountered:

- The migrant's home state Medicaid eligibility may have lapsed by the time medical care is required in another state. Neither the patient nor the provider may be aware of this lapse.

- Because the provider treats few persons with Medicaid eligibility in any particular distant state, the provider may not have obtained a provider number in the migrant's state of residency, nor have the appropriate billing forms and information to submit a proper claim for payment.

- The provider has the added burden of trying to obtain payment for out-of-state claims, may incur substantial costs in communicating with the other state agency, and may not be able to recontact the migrant if additional information is needed in order to obtain payment.

These problems represent a strong deterrent to the primary care physician in private practice or to the small rural hospital which provides an occasional outpatient service to migrants from each of a number of other states. A related complication is that Medicaid eligibility is usually not sought nor even available until a specific medical problem or need arises (e.g., pregnancy). A woman may be several hundred miles from her state of residency when she first requires care related to pregnancy.

If Medicaid eligibility is sought in the state of current employment, the following problems may arise:

- Migrant workers must enroll in each state in which they work and in which there is a reasonable likelihood of their requiring medical care.

- Slow eligibility determination procedures may result in Medicaid coverage not being obtained before the migrant worker leaves the state.

- States have little information on which to base decisions on continued eligibility after the migrant worker leaves the state.

- Some states may discourage Medicaid enrollment by migrant

workers who have only recently arrived in the state and who may leave after only a few months (e.g., requiring in-person application at county offices at locations a substantial distance from migrant worker employment sites, inconvenient office hours, long waits for service, lack of translation services, and the use of long and complex application forms).

- Administrative costs to the states and lost time costs to the migrants will be high if a sizeable number of migrant workers who are eligibility for Medicaid seek to enroll in Medicaid in each state in which they work.

SECTION 2

COMPARISON OF SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS

COMPARISON OF SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS

Because Medicaid is a state administered program jointly funded by the federal and state governments, there are large differences from state to state in many provisions of the programs. Although states must cover certain eligibility categories (those receiving Supplemental Security Income, SSI, and Aid for Dependent Children, AFDC, with the exception of certain states, designated as 209(b) states). Unlike SSI which is a federal program, each state can set the income requirements for AFDC. Since AFDC is the category most likely to apply to members of a migrant farmworker family, it is of concern that income requirements for AFDC and Medicaid eligibility vary widely from state to state in which migrants are employed.

For purposes of discussion, Exhibit 2-1 displays selected characteristics of Medicaid programs in Florida, Georgia, Maryland, New York, North Carolina, and South Carolina. These states are representative of those in which migrants working the east coast stream may be employed. The first row displays the income level, expressed as the percent of the poverty level, below which a family of three could qualify for AFDC and Medicaid in July 1988. Note that the percentages varied from a low of 32.9 percent (North Carolina) to a high of 66.7 percent (New York). The income thresholds change from year to year and by state and undoubtedly differ today from those displayed here. However, these figures illustrate the differences which could interfere with an interstate compact among these states to provide reciprocity in eligibility.

States have the option of also covering the medically needy in their Medicaid programs. Medically needy eligibility income levels represent the remaining income after large medical bills required for Medicaid eligibility for individuals or families. States may set income levels for medically needy eligibility at up to 133 percent of their AFDC levels. As of September 1989 thirty five states and the District of Columbia offered Medically Needy programs. The second row in Exhibit 2-1 illustrates that five of our sample of six eastern migrant stream states offered a medically needy program. The third row indicates the income threshold for eligibility under the Medically Needy program as a percent of the poverty level.

Although federal requirements mandate that all states provide Medicaid coverage to pregnant women and infants with family incomes up to 133 percent of the poverty level, states have the option of extending eligibility up to 185 percent of poverty. Row 4 in Exhibit 2-1 indicates that for our six sample states one used 133% of poverty as of April 1990, two used 150%, and three used 185%. Row 5 indicates that five of the six states have implemented presumptive eligibility for pregnant women. This does not mean that a pregnant woman can just walk into any provider and be welcomed as a Medicaid recipient, since the state may only contract with selected providers to serve as presumptive eligibility contractors. Row 6 indicates that all six of the sample of states offer continuous eligibility throughout pregnancy once a pregnant woman has been determined to be eligible. Thus, if the woman's family income increases, she need not worry about loss of eligibility until after she delivers.

EXHIBIT 2-1

COMPARISON OF SELECTED STATE MEDICAID PROGRAM CHARACTERISTICS

		STATE					
		Florida	Georgia	Maryland	New York	North Carolina	South Carolina
1.	Income for AFDC Family of 3 as % Poverty (7/88)*	34.1	46.6	46.7	66.7	32.9	49.9
2.	States with Medically Needy Program (as of 9/89)**	Yes	Yes	Yes	Yes	Yes	No
3.	Income for Medically Needy Family of 3 as % Poverty (as of 7/88)*	45.4	45.4	54.7	78.5	44.3	--
4.	Income for Pregnant Women and Infants as % Poverty (as of 4/90)**	150	133	185	185	150	185
5.	States with Presumptive Eligibility (as of 4/90)**	Yes	No	Yes	Yes	Yes	No
6.	Continuous Eligibility for Pregnant Womem (4/90)**	Yes	Yes	Yes	Yes	Yes	Yes

* Source: National Governors' Association, July 1988

** Source: A Medicaid Resource Guide To Migrant Health Centers, National Association of Health Centers, Inc., Washington, DC, August 1990.

SECTION 3

EXAMPLES OF HOW OTHER PROGRAMS ADDRESS THE PROBLEM OF INTERSTATE MOBILITY

EXAMPLES OF HOW OTHER PROGRAMS ADDRESS THE PROBLEM OF INTERSTATE MOBILITY

1. Women, Infants and Children (WIC) Supplemental Food Program

This program, funded by the Department of Agriculture is administered by each state, usually through contracts with local agencies. WIC serves essentially the same population as are eligible for Medicaid under the recently expanded eligibility provisions for pregnant women, infants, and children (e.g., pregnant women, infants, and children up to age five with incomes up to 185% of poverty and who are determined to be at nutritional risk). WIC program regulations requires that states and local agencies operating WIC clinics must make special efforts to improve the accessibility of WIC to migrant populations.

State agencies administering WIC are required to give special attention to funding local agencies to serve through conveniently located service outlets special populations in need, particularly migrants. For example, states are encouraged to co-locate WIC at migrant health centers. States must also institute plans which accommodate the special problems and needs due to migrant influx during certain times of the year. Migrants certified for WIC in one jurisdiction must receive expedited certification when moving into another jurisdiction. A Verification of Certification (VOC) has been developed by USDA to assist in implementation of this regulation. States must issue VOCs and must assure that local agencies accept VOCs for certification. No further information is required for WIC eligibility.

Because migrant families may enter and leave jurisdictions quickly, expedited processing of applications is required. Regulations require that pregnant migrant women and infants under six months of age be certified within 10 days. Those migrants arriving with a VOC must be placed at the top of a waiting list, if such a list is maintained, otherwise the VOC must be accepted for certification in order to assure continuity of services.

If a significant proportion of the population served is non-English speaking, bilingual staff or interpreters are required for WIC sites.

The Bureau of Health Care Delivery and Assistance (BHCDA) which administers the Migrant Health Program requires that its migrant health center grantees become or establish linkages with WIC program clinics.

2. Medicare

Because Medicare is a federal program, eligibility and enrollment is established based on national standards and, once enrolled, applies regardless of mobility of the beneficiary. Health care providers, however, submit claims to state specific fiscal intermediaries (FIs) for services covered under Part A, and to designated Carriers for services covered under Part B. The Health Care Financing Administration maintains a central data bank and query system through which FIs and Carriers may confirm eligibility

and the status of the recipient in terms of meeting deductibles. Because the FIs and Carriers cover most providers in specific geographic areas, they are able to administer a provider specific payment rate system.

3. Supplemental Security Income Recipient Medicare Part B Buy-In Program

Because states must cover Supplemental Security Income (SSI) recipients in their Medicaid programs, states must enroll eligible SSI recipients in Part B of Medicare. In addition to the paperwork of the enrollment, states must then pay the Part B premium for these Buy-In enrollees. Federal regulations prohibit states from claiming federal financial participation for any bill paid by a state Medicaid agency which should have been paid by Medicare.

Because SSI is a federally administered program, States have the option of requesting that Social Security Administration automatically enroll SSI recipients in the state's Medicaid program and automatically enroll those SSI eligible recipients in Part B, and advise HCFA to bill the state for the premium. SSI recipients who move from one state to another may have Medicaid and Medicare handled automatically, or may have to reapply for Medicaid in the new state -- then the state must enroll the individual in Part B.

In the case of SSI beneficiaries the Social Security Administration maintains the central data file and provides states with monthly data tapes which can be used for enrollment transactions. States may also query SSA or HCFA concerning Medicare eligibility for any recipient.

4. Blue Cross/Blue Shield National Accounts

If an individual enrolled in Blue Cross of Maryland seeks medical care while visiting in Arizona, the Arizona provider (if he or she accepts assignment) sends the bill to Blue Cross of Maryland, who then pays the bill. BC of Maryland may consult BC of Arizona concerning payment amounts if there are questions. Providers accept this arrangement and generally have a sufficient volume of out-of-state BC/BS business to be familiar with it. However, reimbursement rates tend to be much closer to charges than is the case for out-of-state Medicaid, verification of eligibility is easy and, for physician bills, if there are questions the patient can pay the bill and be subsequently reimbursed by the home state BC/BS plan.

Employers who have facilities in multiple states may wish to offer BC/BS to all employees, but only want to contract with a single state plan. For these purposes a number of BC/BS plans have established a National Account Association (NAA) to which providers in any state send claims. NAA knows the benefit structure and has access to eligibility and claims history files to permit adjudication of the claims.

6. Other

Although not interstate, many state Medicaid agencies administer the eligibility system through county welfare offices. In such states the recipient may be assigned an ID number which is specific to the county of

residence. If the recipient moves to another county, the recipient must notify the welfare office and arrange for new eligibility cards to be sent to his or her new address. There need not be a break in eligibility however, and usually the state Medicaid eligibility system maintains a permanent computer ID number for the individual, even though the recipient may periodically change Medicaid ID numbers which appear on his or her Medicaid card.

To the medical care service provider the change from one county to another by the recipient is totally transparent. Claims are still sent to the same address, charges and coverage limitations remain the same, etc.

SECTION 4

DEVELOPMENT OF A PROTOTYPE SYSTEM FOR EXPANDING ACCESS BY MIGRANT FARMWORKERS TO NEEDED HEALTH CARE SERVICES

DEVELOPMENT OF A PROTOTYPE SYSTEM FOR EXPANDING ACCESS BY MIGRANT FARMWORKERS TO NEEDED HEALTH CARE SERVICES

Expanding Access to Medicaid Covered Services

Potentially successful approaches to expanding access of migrant workers to Medicaid covered service need to address existing barriers related to eligibility standards, the process of enrollment, maintenance of eligibility, and acceptance by providers of patients with out-of-state Medicaid cards (barriers are related to achieving provider status in multiple states and the submission and processing of claims). Optimal approaches will reduce or remove barriers in all of these areas.

The issues of eligibility and enrollment are interrelated. States with different eligibility requirements represent barriers to some migrant workers as do differences among states in how "intent to reside" is defined, interpreted and applied. While some states recognize the migrant worker's option of enrolling in Medicaid in the current state of employment and may even facilitate enrollment, other states may place barriers (inadvertently or intentionally) to migrant workers enrolling in their Medicaid program. Administrative barriers include inconvenient enrollment locations, long lines and delays at the enrollment locations, requiring enrollees to return for a second or third day to complete the enrollment process, complex application forms, absence of bilingual eligibility workers, delays in determining eligibility and excessive denial rates based on technicalities which could have been remedied at time of application.

Once Medicaid eligibility is determined, the state Medicaid program must periodically revalidate the enrollee's eligibility. This may be done as frequently as monthly or as infrequently as every six months, depending on the state and the specific eligibility category. For migrant workers, the revalidation process is problematic because migrant workers may lack a fixed address for much of the year. These problems occur both in situations where migrant workers become Medicaid eligible in their state of residency or when eligibility is obtained in the state of current employment.

Providers should generally not experience special problems in obtaining Medicaid payment on claims for migrant workers with a current Medicaid eligibility card issued by the provider's own state. However, a number of problems may occur if the migrant worker is enrolled in another state's Medicaid program. Assuming the provider has obtained a provider number from other states' Medicaid programs, payment delays or denials may occur as a result of incorrect service descriptions or procedure codes, not using the designated claims forms, changes in claims submission procedures which out of state provider may not be aware of, and for other technicalities. For providers with a small volume of claims to a specific state's Medicaid program, the cost of billing and collection may exceed the value of the claims. This is particularly true for physician services where the allowed reimbursement amount may be a fraction of the amount charged. Billing and collection problems may cause providers to refuse to treat Migrant workers who are enrolled in out-of-state Medicaid programs.

Efforts to overcome some of these barriers to Medicaid coverage for Migrant workers will generally require cooperation of two or more state medicaid programs. The two basic alternatives for such cooperations involve states either extending reciprocity in eligibility or reciprocity in the payment mechanism (e.g., accept claims made by in-state providers for a Medicaid migrant enrollee from another state). Variations on these alternatives could include merely expediting enrollment for migrants, expediting enrollment of migrants with evidence of recent enrollment in another state, exchange of eligibility information to expedite and simplify enrollment in another state, offering a centralized regional claims processing and eligibility clearinghouse for a new category of enrollee to be covered in several states, etc.

States already have authority to enter into interstate agreements regarding residency. However, a more comprehensive approach may be required. Although there are many alternatives for addressing the problems described above, we have outlined below one of these, a proposal for a reciprocity program among multiple state Medicaid programs. It's objectives are to remove barriers to eligible migrant workers obtaining Medicaid coverage for medical care services while at the same time reducing administrative and cost burdens to the recipients, to providers and to the state Medicaid programs. Federal Medicaid law specifically permits such interstate agreements.

Outline of a Demonstration

Medicaid Reciprocity Program. A number of states among which there is an annual flow of migrant farmworkers may agree to test and demonstrate a reciprocity program regarding Medicaid eligibility, claims processing and payment. This may be used for a small number of eligibility categories (e.g., pregnant women and infants) or a larger number of categories. The program would include all or several of the following features.

- joint recognition of eligibility. If an individual is Medicaid eligible in one state's Medicaid program, he or she can be covered for (specified) medical services in each of the participating states.
- use of a special eligibility card for migratory workers participating in the program, or unique identifier on each state's existing Medicaid eligibility card.
- Automated or phone access to eligibility records of all participating states' eligibility files
- Each Medicaid program pays its own state providers, for all participating states' migrant workers' claims using its own claims forms, payment rates, and claims processing rules and procedures.
- Participating programs agree on procedures and criteria to determine and monitor continued recipient eligibility.
- Participating programs agree on formulas for inter-program

reimbursement of claims costs for migrant workers.

The demonstration of a reciprocity program for migrant workers will require extensive planning, and may require some modifications in each state's claims processing system and Medicaid Management Information System (MMIS). Several states may be able to join together to implement a reciprocity program for facilitating and improving the administration of Medicaid coverage for Migrant farm workers. However, if waiver of any federal requirements, or if federal financial participation (FFP) is sought for payment of claims which would otherwise not be paid under the HCFA approved state plan, this type of program should be implemented as part of a HCFA sponsored demonstration project. Preparation of the waiver application and request for FFP or other funding will be time consuming. Moreover, any waiver project must include an evaluation component to not only assure objective measurement of the achievement and costs of the demonstration, but also to assess suitability for more widespread implementation. Separate funding for the evaluation may be requested.

The detailed mechanics of such a reciprocity compact, including the legal, economic, and administrative barriers which would need to be removed, are complex. They have not yet been studied, much less put in place. To fill the void, this paper proposes a three-phase effort for designing, implementing, and testing a prototype system which would expand, through Medicaid reciprocity, access to needed health care services by migrant farmworkers in the states of Florida and South Carolina (the proposal could be expanded to include any number of states, but is easiest to describe within the context of a simple two state system).

Phase I involves the development of a plan for conducting a 4 to 6 month feasibility study of such a system. Phase II is the actual conduct of the feasibility study, the product of which is a detailed plan, including any required waiver applications, for a demonstration with concurrent evaluation. Phase II is essentially an investigation of a variety of issues of a systems, legal, economic, and/or administrative nature, resulting in the development of a prototype system which would then be implemented and tested in Phase III. In addition, Phase II will identify factors related to occupation (work schedule and housing conditions) and race which affect access to care.

Phase I. - Plan Development

This phase will set the framework for the Phase II feasibility study. It will identify the issues to be studied, outline the manner in which they are to be examined, and establish a suitable time schedule. It will entail, among other things, a memorandum of agreement between the two states followed by coordination between their respective Medicaid agencies to assure that all impediments, real or potential, toward achieving the goal of this project are fully aired and explored. The experience of other states in implementing compacts of a similar nature involving Medicaid-eligible women and children (under WIC) or Medicare buy-ins for SSI eligibles will be studied as well.

To achieve as broad a perspective as possible, close coordination will be maintained with the National Migrant Referral Project, the National Migrant

Advisory Committee, the Migrant Clinicians Network, the National Association of Community of Health Centers, and the National Rural Health Association. This phase of the project will result in a detailed work plan, including funding recommendations, for the next phase of this effort.

Phase II. - Feasibility Study

Building on the work plan developed in Phase I, this phase will address such issues as:

- o Definitions of eligibility
- o Range of services to be covered
- o Utilization and costs
- o Restrictions and exclusions, if any
- o The role of Migrant Health Centers and state health departments
- o Special issues relating to specialty, inpatient hospital, and skilled nursing care
- o Administrative procedures and systems relating to eligibility (e.g., special eligibility card recognized in both states, on-line access to each other's eligibility files, etc.)
- o Administrative procedures and systems relating to adjudication of claims and issuing of payments
- o Responsibility for monitoring continued eligibility
- o Preparation of waiver applications, if needed, and budgets
- o Design for an independent evaluation

Alternative options for handling each of these issues will be defined and studied. Should, for example, providers who treat out-of-state farmworkers file for reimbursement from the other state using the other state's forms, or should all providers in a given state be reimbursed by that state with an end-of-year (or end-of-quarter) adjustment as necessary? To the extent practicable, actuarial study of the impact of these options on utilization will be performed. Legislative or other legal barriers, include the need for waivers or legislative amendments that may stand in the way of implementing a particular option will be examined.

The output of phase II will be the formal design of a prototype system which could serve as the basis for a HCFA funded (or other agency) demonstration. The products would also include any HCFA waiver applications needed, and the detailed budget required for implementation of the design in Phase III. Because of the

prototype nature of the system and the possibility that it might serve as a model for replication by other states, the design will include an evaluation component.

Phase III. - Conduct of the Demonstration

This phase involves implementing and testing the design developed in Phase II. A two- to three-year demonstration period is envisioned, during which time data will be collected on:

- o Systems and Procedures. - What systems and procedures were developed or modified from pre-existing Medicaid systems? What were the costs of such modifications?

- o Utilization. - The increased use of health care services in State A by migrants originally from State B.

- o Cost. - The cost to the state of implementing and administering the program, subdivided according to:

  (1) Claims payments which would not have been made in the absence of reciprocity[3]

  (2) The cost of developing and implementing the necessary systems (a one-time cost)

  (3) Cost of staffing and running the program (recurring)

- o Benefits. - The imputed benefits to the individual and to society resulting from the increased utilization of health care resources (e.g., reduced infant mortality, reduced acute and chronic morbidity, reduced rates of costly hospitalization, reduced absenteeism, etc.)[4]

It is anticipated that for the two states, Florida and South Carolina, the number of Medicaid eligible migrants who would utilize the reciprocity system would range from 200 to 800 per year. Many of these would have applied for and received eligibility in each state without the waiver (those with the most serious conditions requiring hospital inpatient care). Through the independent

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[3] It must be kept in mind that not every out-of-state visit by a migrant farmworker is an added cost to the nation's health bill. Some visits would have been made in any event, with or without the benefit of reciprocity. Other visits would have simply been deferred (perhaps to the detriment of the individual's health) until the worker returned to his or her home state.

[4] As with so many programs of this nature, the cost of its implementation and administration will, at least initially, be starkly evident and the benefits virtually unnoticed. The benefits are there, however; skillful evaluation design will be needed to assure that they are not overlooked.

evaluation the experience provided by this demonstration will be documented and the feasibility and costs of scaling up the system to include all states in the eastern migrant stream assessed.