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Feasibility Study To Develop A Medicaid Reciprocity Program For Migrant And Seasonal Farmworkers

FEASIBILITY STUDY TO DEVELOP A MEDICAID RECIPROCITY PROGRAM FOR MIGRANT AND SEASONAL FARMWORKERS

BACKGROUND PAPER

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Authors:

MATHEMATICA POLICY RESEARCH
George E. Wright
Nancy J. Fasciano
Hilary Frazer

HEALTH SYSTEMS RESEARCH
Ian T. Hill
Beth Zimmerman

THE URBAN INSTITUTE
Nancy M. Pindus

Submitted to:

Department of Health and Human Services
Health Care Financing Administration
324 East High Rise Building
6325 Security Boulevard
Baltimore, MD 21207

Attention: Sherrie Fried

Submitted by:

Mathematica Policy Research, Inc.
600 Maryland Avenue, S.W.
Suite 550
Washington, DC 20024

Project Director: George Wright

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Ann Miles and Sharon Clark took charge of producing this report and, with their good humor, minimized the last-minute confusion and turmoil.

CONTENTS

CONTENTS *(continued)*

CONTENTS *(continued)*

Chapter

TABLES

I. INTRODUCTION

This report addresses the need to improve Medicaid participation for one of the most underserved groups in the nation--migrant agricultural workers. Despite the eligibility of many of these vulnerable workers and their dependents for coverage under the numerous Medicaid expansions. their specific characteristics and high mobility have often prevented enrollment. In response to this problem and numerous calls for action, the Health Care Financing Administration (HCFA), in cooperation with the Office of Migrant Health of the Bureau of Primary Health Care of the Health Resources and Services Administration (HRSA), is supporting a feasibility study for a HCFA-sponsored demonstration. Specifically, the project will evaluate the feasibility of establishing a multi-state reciprocity agreement that would enable eligible migrants to maintain Medicaid coverage in the states through which they travel.

This background paper is the project's first report and is intended to initiate a systematic review of the numerous potential structural. procedural, and design issues that such a demonstration might confront. It offers a review of the major problem areas that should be evaluated in designing a demonstration. Note that the purpose at this point is not to specify critical issue areas or to offer definitive assessments of which states would be easiest to link in a demonstration. Rather, this paper seeks to identify those areas which can *potentially* influence the design and feasibility of interstate reciprocity agreements.

Following a review of this document by an expert advisory panel, the project team will initiate a series of site visits to state Medicaid officials and migrant health programs and then convene meetings of key personnel from interested states to discuss in detail the structure of a possible demonstration. The site visits and meetings will culminate in an issues paper, which will assess various options for interstate reciprocity agreements, state willingness to participate. and specific barriers to implementation. If HCFA personnel conclude that there is sufficient state interest in a

feasible demonstration, the project will move to a design phase, including the drawing up of a model interstate compact.

The remainder of this chapter reviews the health status of migrants, problems in delivering care, and limitations of the Medicaid program. It then discusses the policy background and objectives of a potential demonstration, and concludes with sections on the study methodology and the structure of this report.

A. HEALTH CARE AND MEDICAID ENROLLMENT FOR MIGRANT AND SEASONAL FARMWORKERS

1. Profile of Migrant Farmworkers

Definitive demographic data on migrant farmworkers are difficult to obtain because of their mobility, the rapid changes in size and structure of migrant labor, and the fact that demographic profiles vary with definitions of migrant farmworkers. (These issues will be discussed in more detail in Chapter III.) Although there is little hard data, most observers have noted rapid changes in the location, composition, and behavior of migrant labor. The introduction of technological innovations such as drip irrigation and double cropping is expanding the demand for farm labor on the East Coast; rapid increases in supply are creating spot surplus labor in other areas. According to the Department of Labor (1993), the profile of workers in newly Latinized migrant areas is quite different from that of the more established states of California, Texas and Florida. In addition, migrant status is difficult to define--a problem with important implications for eligibility in a Medicaid multi-state reciprocity demonstration, and consequently for the potential impact of a demonstration on Medicaid enrollment. The distinction to be made is between migrant and settled seasonal agricultural workers. Definitions of migrants, as opposed to seasonal workers, vary in terms of crops covered (nurseries, forestry, and livestock are often excluded), time in residence, number of months since previous move, distance traveled, and percentage of income from nonagricultural work.

As a result of differences in definition and lack of data, estimates of the number of migrant farmworkers and dependents range from 500,000 to 800,000[1] (National Migrant Health Program 1992; Mountain 1992; Slesinger 1992). The most recent and widely accepted estimates place the unduplicated number at around 600,000 migrant farmworkers and dependents (Pindus et al. 1992).

Most migrant farmworkers travel through one of the three major migrant streams which are based in home-base states: western stream (California and western states), midwestern stream (Texas, southwest, and midwest states), and eastern stream (Florida, mid-Atlantic, and eastern states). In terms of numbers of migrants, the eastern stream is roughly half the size of the midwestern stream and about one-third as large as the western stream.[2] More than 50 percent of migrant farmworkers and their families reside in the three home-base states of California, Texas, and Florida (National Migrant Health Program 1992).

A compilation of the most available data paints a picture of migrant and seasonal farmworkers as primarily young Hispanic workers living in poverty. A significant number of migrant farmworker families are women and children, the subpopulation most likely to be eligible for Medicaid. The profile of migrants can be summarized as follows:

- ***Latinization.*** The proportion of Hispanics appears to be rising rapidly. In the late 1980s, more than two-thirds were Hispanic (70 percent of whom were Mexican born), one-fourth were white, and 3 percent were black (Mines, Gabbard and Samardick 1992; Slesinger 1992; Mines, Gabbard and Boccalandro 1991). The most recent National Agricultural Workers Survey (NAWS) puts the Hispanic population at more than 90 percent (Mines, Gabbard and Samardick 1992).

- ***Poverty.*** Real agricultural wages have been falling and often are below minimum wage. The majority of farmworkers have incomes below the federal poverty level (Slesinger 1992).

- ***Predominantly Young.*** The population is disproportionately young with 38 percent under 14 years old. Among migrants there is a growing proportion of young.

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[1]Since individuals often live in multiple areas, counts of migrants from different states can result in duplication. Estimates of duplicated counts range from 1.6 million to more than 5 million.

[2]Duplicated counts for the eastern, midwestern and western streams are one million, more than two million, and more than three million, respectively.

unattached men who present social and behavioral problems. Most women are of childbearing age (National Migrant Resource Program 1992).

- *Predominantly Male.* Migrant farmworkers are predominantly male (82 percent); although most are married, the majority of male workers travel alone (Mines, Gabbard, and Samardick 1992).

- *Lack of Family Facilities.* Fifty-four percent of farmworkers have children, 80 percent of whom reside with parents at the work site (NAWS 1990); however, family housing is available to only 3 percent of migrants (Mines, Gabbard, and Samardick, 1992).

- *Lack of Education.* Fifty-one percent have been in the United States longer than eight years (NAWS 1990), but the average migrant farmworker has less than eight years of education, and less than half speak English (Slesinger 1992; Mines, Gabbard, and Boccalandro 1991).

- *Increasing Number of Women and Children.* Women and children are a growing subset of the migrant farmworker population, particularly since the passage of the Immigration Reform and Control Act of 1988 (IRCA), which increased the numbers of migrant farmworkers and their families with legal status (IRCA, P.L. 99-603). Increasing numbers of women and children may be traveling in the midwestern and eastern streams. Comparatively few women are divorced or separated; 85 percent of married migrant women travel with their spouses (unpublished communication from Department of Labor).

2. Prevalence of Unmet Health Needs

The lack of consistent health and socioeconomic data on migrant farmworkers generates inaccurate estimates of the size of the migrant population, as well as underreporting in the incidence of health problems (Mobed et al. 1992). It is generally agreed, however, that the health status of migrant farmworkers and their families is poorer than that of the general population.

- *Infant Mortality and Life Expectancy.* Infant mortality is 1.6 times higher than for the general U.S. population (Slesinger et al. 1990). The life expectancy of migrants is 49 years, compared with the national average of 75 years.

- *Infectious Diseases.* Migrants' death rates from influenza and pneumonia are 20 percent and 200 percent higher, respectively, than the national average (National Migrant Health Center 1992). Migrants are six times more likely to develop tuberculosis, and they suffer high rates of syphilis and HIV-1 infection.

- *Malnutrition.* Malnutrition is higher for migrants than for any other group in the country.

- *Alcoholism and Substance Abuse.* There are high rates of alcoholism (for men) and comorbid conditions of mental illness.

- *Chronic Conditions.* Migrants suffer higher rates of chronic conditions, particularly hypertension, and diabetes (Slesinger 1992).

- *Parasitic Infections.* Parasitic infection rates are estimated to be 11 to 59 times higher for migrants.

- *Dental Disease.* Migrants, including children, suffer high rates of dental disease (Dever 1991).

Migrant farmworkers also face a number of occupational hazards which pose health risks. These dangers include hazardous machinery, chronic and acute pesticide exposure, lack of toilets and clean drinking water, overcrowded vehicles, poor use of safety restraints, traveling long distances at night with little sleep for the driver, and traveling poorly paved country roads (Slesinger 1992). The risks are also high for heat stroke or cold shock and chronic back and joint trauma. These occupational dangers, combined with high rates of chronic conditions that require primary care, reflect a population with critical health needs.

3. Barriers to Care

Despite the evident need, migrant farmworkers face a number of barriers when trying to access the health-care system:

- *Lack of Insurance.* Migrants rarely have health insurance and only 5 percent of migrants thought they were covered by workers' compensation (Mines, Gabbard, Samardick 1993).

- *Lack of Transportation.* Migrant workers usually lack transportation to get to health appointments (many must rely on their crew leaders for transportation).

- *Poor Participation in Medicaid.* Many migrants who are eligible for Medicaid do not get enrolled due to fear, lack of information, inconvenient hours and location of state offices, and a cumbersome enrollment process.

- *Limited Provider Availability.* There is anecdotal evidence that providers, notably physicians, are unwilling to see migrant patients even if they are enrolled in Medicaid. Clinic hours often conflict with work hours, making it difficult for migrants to make appointments.

- *High Mobility*. Migrants' high mobility prevents them from establishing a relationship with a primary health-care provider.

- *Language Barriers*. Many migrant farmworkers do not speak or understand English; these limitations make it difficult for migrants to get clinic appointments and apply for public assistance, especially when most clinic staff speak only English, and most medical and public assistance forms are written only in English.

- *Cultural Barriers*. Because many migrants are new immigrants to the United States, they sometimes face cultural insensitivity (Slesinger, p. 232). Most health care workers have little or no knowledge of Spanish or different aspects of Hispanic customs (SSM Health Care System 1990).

Further, because migrant farmworkers work primarily in the agricultural sector, they work and reside primarily in rural regions, many of which face a declining supply of hospitals, physicians, nurses, and other licensed medical personnel. Financially weak, rural hospitals are not equipped to take on the burden of uncompensated care provided to uninsured migrants. Thus, migrant farmworkers also must deal with the systemic problems affecting rural areas, in addition to cultural and occupational barriers.

To improve access to care, federal policy has attempted to expand directly the number of providers serving migrants and their families. The major such initiative is Title 329 of the Public Health Services Act, under which Congress authorized annual grants to Migrant Health Centers (MHCs). HRSA's Office of Migrant Health currently funds 103 MHCs operating more than 400 satellite clinics in 43 states (National Migrant Health Program 1992). These centers reach out to farmworkers through extended hours, bilingual staff, outreach and mobile services (Zuvekas 1990). Table I.1 lists for selected key states the number of funded MHCs and the number of satellite clinics; the table also contains information on seven states that receive Section 329 grants to operate statewide programs. These statewide programs are small scale, often restricted to certain counties and feature limited voucher programs whereby migrants needing health care are screened and given a voucher to be presented to a community provider. The accompanying Table I.2 gives the number of reported migrants using these centers as well as total expenditures.

TABLE I.1

FEDERALLY FUNDED MIGRANT HEALTH CENTERS
AND OTHER SECTION 329 GRANTEES
(1993)

	Number of 329 Clinic Grantees	Number of Satellites	Number of Satellite Clinics in 329 Funded State Programs	Voucher Program	Direct Service
Eastern Migratory Stream					
Florida	12	27			
Georgia	1	16	16	✓	✓
Maine	1	0[d]			
Maryland	0	--[c]			
Mississippi	0	--			
New Jersey	2	2			
New York	3	7			
North Carolina	3	3	13	✓	
Pennsylvania	0	--	9	✓	
South Carolina	2	6	0[a]	✓	
Tennessee	2	2			
Virginia	0[b]	0[b]			
Midwestern Migratory Stream					
Arkansas	1	0			
Colorado	3	18	9	✓	✓
Illinois	2	0[e]			
Michigan	5	14	6	✓	
Minnesota	1	--			
Missouri	1	3	11	✓	
New Mexico	1	4			
North Dakota	0	0[f]			
Oklahoma	0[h]	--			
Ohio	2	3			
Texas	13	41			
Wisconsin	1	0[g]			

SOURCE: *The 1992 Migrant Health Centers Referral Directory*, The National Migrant Resource Program, Inc., Austin, Texas. Information supplied by Jack Egan, DHHS, Office of Migrant Health.

NOTES: [a]In South Carolina, the State Health Department refers migrants directly to private physicians and hospitals that have contracts with the Department. There are approximately 40-50 such contracts presently. (Communication from the South Carolina Office of Rural Health, Migrant Health and Primary Care)

TABLE I.1 (*continued*)

NOTES: [b]Virginia had a single 329 grantee listed in the 1992 directory, but it did not receive a grant for FY 1993. The Shenandoah Community Health Center in West Virginia and the Delmarva Rural Ministries, which has its headquarters in Delaware, receive 329 funds and have a satellite in Virginia.

[c]Although Maryland does not have any 329 grantees, the Delmarva Rural Ministries, a private non-profit organization located in Delaware that receives 329 funds, has two satellites in Maryland.(Communication from Gail Stevens at Delmarva Rural Ministries)

[d]Although the 329 Clinic Grantee in Maine does not have any satellites, it has a mobile unit and a voucher agreement with a private nonprofit health center. (Communication from Rural Health Centers of Maine)

[e]The 329 Clinic Grantee in Illinois provides its services on-site.

[f]Migrant Health Services, Inc., a private health provider in Minnesota, funds two satellites that are located in North Dakota. These satellites are seasonal and are open 2-4 months a year. (Communication from Migrant Health Services, Inc.)

[g]The 329 Clinic Grantee in Wisconsin provides many services on-site and has a voucher agreement with many private health care providers throughout the state. (Communication from Family Health/La Clinica Administration)

[h]Oklahoma used to have a 329 Clinic Grantee; however the clinic no longer receives 329 funds. Services are provided at local health centers funded by other federal and state money and private donations. (Communication from Oklahoma State Health Department)

TABLE I.2

MIGRANT CLINIC REVENUES AND USERS
SUPPORTED BY SECTION 329 and 330 GRANTS
(CY 1992)

	Total Revenue (000s)	Percent of Revenue from 329 Grants	329 Grants as a % of PHS Funding	Total Migrant Users	Percent of Users that are Migrants
Eastern Migratory Stream					
Florida	51,180	14.9	30.3	51,121	23.8
Georgia	557	78.7	100.0	2,434	94.1
Maine	3,885	3.9	15.0	317	2.1
Maryland	0	--	--	0	--
Mississippi	0	--	--	0	--
New Jersey	4,299	6.0	15.9	2,354	18.2
New York	308	19.7	23.4	5,594	17.0
North Carolina	6,438	33.6	58.3	18,255	57.2
Pennsylvania	814	76.8	100.0	5,526	96.1
South Carolina	72	19.3	19.3	2,456	19.5
Tennessee	3,409	9.5	16.0	612	9.7
Virginia	0	--	--	0	--
Midwestern Migratory Stream					
Arkansas	0	--	--	0	--
Colorado	15,430	17.0	35.3	16,098	26.5
Illinois	4,134	9.5	23.0	4,650	25.9
Michigan	8,849	22.3	52.2	24,720	53.9
Minnesota	1,435	73.5	100.0	10,233	99.0
Missouri	NA	--	--	775	6.8
New Mexico	2,272	3.5	7.0	396	5.4
North Dakota	0	--	--	0	--
Ohio	4,445	9.8	29.0	4,053	43.1
Oklahoma	0	--	--	0	--
Texas	46,502	12.4	21.9	28,441	16.3
Wisconsin	757	45.8	81.0	2,716	85.1

SOURCE: Calculated from data furnished by the Office of Migrant Health, Department of Health and Human Services. Percent of grants from Section 329 calculated on basis estimated grants for FY 94.

As illustrated by the two tables, the number and size of MHCs are extremely limited. By one estimate they serve less than 20 percent of the eligible migrant population (Mountain 1992). Improving Medicaid coverage for migrant workers and their families is therefore critical for increasing access to general providers. In addition, Medicaid enrollment will strengthen the capacity of MHCs. Traditionally, they have generated limited Medicaid revenue because of poor reimbursement and the few migrants enrolled in Medicaid. However, through the new Federally Qualified Health Center (FQHC) program, centers are now reimbursed at reasonable cost. As a result, providing continuous enrollment for migrant families would not only improve their financial access, it would strengthen the financial base of key facilities dedicated to serving all farmworkers in addition to Medicaid enrollees. (For details on the effect of the FQHC program, see Lewis-Idema et al. 1992.)

4. Barriers to Medicaid Coverage for Migrant Farmworkers

The Medicaid program targets health insurance specifically for low-income populations. Yet, despite their low incomes, migrant workers and their families face significant barriers to enrollment and coverage in the Medicaid program. Many workers simply are not eligible for Medicaid--either because they are categorically excluded, or because they do not meet Medicaid state residency requirements. Moreover, workers and family members who are eligible confront numerous administrative and logistical problems during the application and recertification processes. Because of language, cultural, and education barriers, many eligible workers are unaware of existing benefits, their eligibility for the program, or the steps necessary to complete the application process. Even successful enrollment in a state often is of little use to migrants once they leave their home state. Billing for services provided out-of-state is slow and cumbersome, and offers few incentives for providers to accept migrants as patients.

a. Overview of Medicaid Eligibility Requirements for Migrant Workers

In contrast to many uninsured working families in the United States who earn too much to qualify for Medicaid but not enough to afford private insurance, most migrant workers and their families are extremely poor and would qualify for Medicaid. The average annual personal income for all seasonal agricultural workers in 1991 was approximately $6,900, with newly arriving migrants who work for labor contractors earning only half the average (Mines, Gabbard, and Smardick 1993). In addition, many migrant workers spend at least part of each year unemployed. Those workers with families are even more likely to be poor (Slesinger 1992).

Despite migrants' poverty, current Medicaid eligibility rules permit interstate reciprocity agreements to cover only a relatively small portion of migrant farmworkers and families. First, workers must be legal permanent residents or qualify for Permanently Residing Under Color of Law (PRUCOL) status.[3]

The U.S. Department of Labor (1993) reports that the Special Agricultural Worker (SAW) provision of IRCA 1986 has substantially expanded the number of legal agricultural workers.[4] Under the Family Fairness and Family Unity Programs, family members of immigrants legalized under IRCA 1986 have PRUCOL status until they receive legal permanent residency status through the regular family visa petition process. Medicaid coverage under these programs may be limited to emergency services or extend to full coverage.

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[3] PRUCOL is a term used to define alien eligibility for certain public benefits. This concept was adopted for use in defining alien eligibility under the Medicaid program by regulation in 1982, and by statute in 1986. The term is not clearly defined, but generally includes refugees, asylees, conditional entrants, aliens paroled into the U.S., aliens granted suspension of deportation, Cuban-Haitian entrants, and applicants for registry. Congress intended PRUCOL to be broadly construed for Medicaid eligibility, using the same criteria as for Supplemental Security Income (SSI), which includes "any other alien residing in the U.S. with the knowledge and permission of the INS and whose departure....the [INS] does not contemplate enforcing." (Berger, 1985).

[4] SAWs are statutorily disqualified from receiving AFDC and certain Medicaid benefits for a five-year period beginning from the date the individual applied for temporary residency.

As discussed in more detail in Chapter II (p. 30), it is difficult to determine whether legal status is a major barrier to coverage under Medicaid. Statistics are uncertain. Anecdotal evidence suggests that even many "documented" workers might be unwilling to have their credentials examined, in part because the complexities of immigration law result in uncertainties regarding their own legal status or that of family members. This may account for some of the discrepancy in reported estimates.

A more significant barrier to coverage under Medicaid is that the majority of workers --being able-bodied, married men, or single men with no children--fail to meet categorical eligibility requirements. Very few of the men, who account for the majority of migrants, can be covered. Nonetheless, many migrant family members, children in particular, are potentially categorically eligible. Recent federal reforms mandating state eligibility expansions for pregnant women and infants; and eligibility provisions for children in poverty currently are being phased over the next decade. By the turn of the century, all children 18 or younger living in poverty will be eligible for Medicaid benefits. As a result of these recent reforms, children under age 10 represent the largest potential group of Medicaid eligibles among the migrant population. Migrant women also can be covered under the Medicaid expansions, but only if they become pregnant. Those relatively few migrant women who are single parents may qualify under Aid to Families with Dependent Children (AFDC) rules, depending on state income, asset, and residency requirements.

Income eligibility requirements vary from state to state, depending on category of eligibility. Federal Medicaid eligibility expansions, passed through budget reconciliation and other statutes in the late 1980s and early 1990s, mandated minimum income eligibility standards for several categories of potential Medicaid participants. All states are now required to provide Medicaid benefits for pregnant women and children (under age 10) in families with incomes up to 133 percent of the poverty line. Twenty-nine states have opted under the federal law to raise the income standard for pregnant women and infants up to 185 percent of the poverty line. Income eligibility requirements for other adults under AFDC and SSI rules are still at the discretion of states, and vary widely.

b. State Residency Requirements and Administrative Barriers to Enrollment

Even those migrant workers and their family members (primarily women and their children) who meet all categorical and income requirements for Medicaid eligibility still face significant eligibility and enrollment barriers in the form of state residency and other administrative requirements. As workers and families travel from state to state looking for employment, they are likely to encounter a number of problems in establishing residency in a given state. In 1979, the federal government removed some of these barriers by adding provisions which allow migrant families two residency options. Migrant families may establish a "home state" of residence where they intend to reside, but leave the state temporarily in search of work; or they may apply for Medicaid residency in whichever state they are currently seeking employment (National Advisory Council on Migrant Health 1992). States cannot discontinue Medicaid enrollment simply because migrant families have left the state temporarily.

Despite these provisions, the length of the enrollment process and requirements for recertification continue to make sustained participation in Medicaid difficult for eligible migrant family members. Migrant families that opt out of home-state residency must apply for Medicaid in each state where they seek employment. Families that choose the home-state option may find that their benefits have lapsed while they are out of state unless they recertify on a periodic basis, which varies from state to state. In addition, migrants may be unable to choose the home-state option when they become eligible out of state. For example, if a woman from Texas becomes pregnant in Michigan, it may be several months before she returns to her home state of Texas to apply for eligibility under her new category.

Administrative difficulties normally encountered during the Medicaid application process are further complicated by the seasonal travel patterns of migrant workers. Eligible families often do not stay in one state long enough to complete the application process. By the time the process (which can take up to 45 days) is completed, the family may have left the state. Although states

cannot deny applications because of a lack of permanent residence, follow-up communications during the application process can be hindered when migrant families do not have a permanent address in any state. In addition, many families lack documentation necessary for Medicaid enrollment.

c. Access to Out-of-State Providers for Migrant Families Enrolled in Medicaid

Migrant families continue to face difficulties when seeking care outside their state of eligibility, even if they are successfully enrolled in a state Medicaid program. The main barrier to accessing care is reluctance on the part of providers. Health-care providers face a number of administrative difficulties when attempting to bill for services provided for out-of-state Medicaid patients, particularly when patients come from distant states or those with which the provider has little experience. These include:

- Requirements that out-of-state providers enroll as Medicaid providers of that state before they are able to bill for services rendered.
- Billing forms and billing procedures vary with states, requiring that individual providers be familiar with the process required by each migrant's state of eligibility.
- The need for providers to be aware of the services covered by the program in order to avoid rejection of billed claims.
- Unfavorable out-of-state payment rates.
- Requirements for prior approval and complications introduced by Medicaid managed-care programs in many states.

In summary, a demonstration designed to improve the participation of migrant workers and families in Medicaid confronts four key characteristics: (1) limitation of coverage to pregnant women and children under 10 under existing eligibility categories; (2) a complex web of state-to-state variations in Medicaid enrollment, service coverage and payment policies; (3) substantial challenges in the outreach effort needed to enroll eligible migrants; and (4) even when migrants are enrolled, limited provider participation in Medicaid and further difficulties with provider willingness/ability

to treat migrants with limited English skills. All this suggests that a demonstration will require not only active cooperation among states. but communication and coordination between migrant health programs and Medicaid administrators within states.

B. PROPOSALS TO IMPROVE MIGRANT PARTICIPATION IN MEDICAID AND DEMONSTRATION OBJECTIVES

The issues underlying this study are hardly new, since the problem of improving migrants' access to Medicaid-financed care has been discussed among states, addressed by interest groups, and has been the subject of proposed legislation and public commission recommendations. As long ago as 1979. the Carter Administration published federal rules allowing a more flexible definition of state residency for migrant families. More recently, the National Advisory Council on Migrant Health (1992) recommended that "a national demonstration program be initiated which would annualize income and standardize eligibility criteria." Such a demonstration would be part of a broader effort to provide education and social services and respond to a call for "improving the coordination of farmworker programs at the federal. state, and local levels" (Commission on Agricultural Workers 1992).

Despite the widespread agreement that improvement in Medicaid-financed access to care is desirable. there are conflicting proposals on how this is to be achieved. Moreover. even within the structure of a limited interstate agreement, there are in fact differing objectives. The following sections discuss these two issues.

1. Proposals to Improve Migrant Participation in Medicaid

Because migrant farmworkers and their families have poorer health than the general population and face many barriers to care, a number of proposals have been made. One idea is to try to increase the number of migrants enrolled in Medicaid through multi-state Medicaid agreements. Under current law, states are allowed to engage in reciprocal Medicaid agreements (Office of the Federal Register. 42 CFR 431.52). Interstate Medicaid agreements or compacts coordinate differing

Medicaid administrative procedures from state to state and allow Medicaid services to be provided in one state but financed under another state's Medicaid plan. Such formal agreements, however, are not common.

Under the interstate agreement, two or more states in the same migrant stream could agree to honor one another's Medicaid eligibility determinations for migrant farmworkers (National Association of Community Health Centers 1990). Such an arrangement would avoid the barrier of repeated and cumbersome Medicaid application processes and should improve migrant access to Medicaid-financed care.

This mechanism of interstate Medicaid agreements has been formally proposed by the National Advisory Council on Migrant Health in its 1992 recommendations entitled "Farmworker Health for the Year 2000." This report recommends that Medicaid interstate reciprocity agreements for migrant farmworkers and their families be pursued at the administrative and legislative levels. The report also recommends that the federal government initiate a demonstration of reciprocity agreements that would include standardized Medicaid eligibility criteria.

Currently, no states have established interstate Medicaid agreements for migrant farmworkers, and only a few states have Medicaid reciprocity agreements covering other populations. One such model is between New York and Massachusetts, which have a Medicaid reciprocity agreement for nursing-home services. There also are existing models of interstate agreements for non-medical services. For example, interstate agreements exist in cases of institutionalized persons, children involved in interstate adoptions, and interstate foster-child cases (National Association of Community Health Centers 1990).

Congress also has expressed an interest in expanding services through Medicaid for migrant farmworkers and their families at the federal legislative level. In March 1991, Congressman Henry Waxman (D-California) introduced Medicaid amendments that included interstate compacts. Specifically, the amendments would "allow states to enter into interstate agreements to issue to low-

income migrant agricultural worker children, pregnant women, and their families Medicaid cards which will be recognized by all of the states that are parties to the agreement through which the child, pregnant woman, and his or her family move during the harvesting season" (H.R. 1392, Slattery-Waxman 1991). Congress did not pass this legislation, but a new version may be introduced this session.

An alternative to Medicaid interstate agreements has been proposed by the National Association of Community Health Centers (NACHC). The NACHC proposal is based on the idea that interstate agreements would be too difficult to implement because of states' competing interests and different Medicaid procedures. Rather, NACHC proposes federalizing the process by establishing a national set of services and single eligibility standard that would cover all migrant workers, particularly women and children. Providers would be reimbursed from a national fund financed by a "tax" on federal Medicaid matching payments. That is, all states would have a small percentage deducted from their federal Medicaid payment.

This approach is very different from one centered on interstate reciprocity agreements. Although the latter approach relies on existing programs and structures, it nonetheless presents a number of technical issues. The need to identify and define alternative approaches to these issues is the reason for first conducting a feasibility study.

2. Demonstration Objectives

The principal goal of an interstate reciprocity demonstration is to improve the health status of migrant workers and their families with increased access to Medicaid-financed care. In meeting this objective, however, such a system may impact the level and distribution of revenues and expenditures within and between states. This is due not only to the direct Medicaid financing provisions, but because an effective program will: (1) expand the demand for health services, and (2) substitute sources of payment for existing care. The emergency and obstetric services hospitals provide to migrants are often uncompensated. However, there is anecdotal evidence that hospitals already bill

the home states of migrants with Medicaid for high-cost services. Outside of inpatient care, the primary impact of a demonstration may be to reduce uncompensated care provided by hospitals and migrant health centers and expand primary care available from other providers.

Given potential changes in financial burden, the design of an interstate reciprocity demonstration or operational agreement may need to harmonize the different perspectives and objectives of the parties concerned. Examples of specific objectives that may conflict include:

- Federal Government
  - Limit financial commitment to the administrative costs of a demonstration
  - Limit program to current Medicaid program: no new eligibility categories
  - Support Migrant Health Centers and other Section 329 grantees
  - Avoid appearance of encouraging illegal immigration, a goal shared by many states
- State Government
  - Limit additional Medicaid expenditures under the mandated expansions
  - Use a demonstration to help support state migrant and other health programs
  - Transfer Medicaid costs to other states
  - Reduce costs in home states by encouraging increased primary care in upstream states
  - Avoid preferential treatment of migrant vis-a-vis other state residents
- Community Health Centers and MHCs
  - Increase FQHC revenues by enrolling as many of their clients as possible in Medicaid
  - Use additional revenues to strengthen financial base and expanded service capacity
- Other Providers
  - Reduce uncompensated care by enrolling as many migrants as possible in Medicaid

- Serve migrants enrolled in states with relatively generous reimbursement policies
- Minimize paperwork required for reimbursement

The importance of many of these possible objectives depends upon the size of the program. There is an obvious potential conflict between the goal of covering as many migrants as possible and the goal of limiting budgetary exposure. Any sizable program will require careful attention to interstate allocation of financial burdens.

C. METHODOLOGY

This section reviews the methodology and data sources for the study.

1. Study States

The states considered for a demonstration are limited. In response to initial inquiries, HCFA received no positive responses from western stream states (California, Oregon and Washington) and therefore drew up the scope of inquiry to include only states in the eastern and midwestern streams. The number of states from which statistical data are gathered is further limited. Given limited resources with which to catalogue Medicaid program characteristics, we have elected to focus data collection on the 24 states with the highest estimated number of migrants--those with more than 15,000 estimated migrant farm jobs. For this purpose we used the recent tabulations of the "Enumeration Project" sponsored by the Migrant Legal Action programs (Larson and Placencia 1993). The study states in the two streams are listed in Table I.1. Note that this targeting is for study purposes only and is in no way intended to limit the states that can participate in a future feasibility study or demonstration.[5]

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[5]The targeting strategy appears to include the most important states for migrant labor. In the eastern stream, only one of the excluded states has a federally funded Migrant Health Center (MHC). West Virginia and Delaware were excluded, but Delaware's MHC also serves Maryland which is included. In the Midwest, however, a larger number of potentially important states may have been excluded from the study list. That is, Idaho, Indiana, Iowa, Kansas, Montana, Nebraska. (continued...)

2. Data Sources

Given these study states, this report draws from a large variety of published and unpublished resources. Chapter II on Medicaid program characteristics draws from published compilations from the National Governors Association, HCFA, the Physician Payment Review Commission, and the Intergovernmental Health Policy Project. It also draws on published and unpublished data compiled by Health Systems Research, Inc. The detailed compilations of Medicaid program characteristics are presented in Appendix A.

In order to supplement these largely summary profiles, we also developed case studies for six states drawn from detailed interviews with Medicaid officials. These case studies focused on such operational specifics as the treatment of out-of-state claims, eligibility determination, and the recertification process.

The estimates of the number of potential Medicaid enrollees presented in Chapter III depend on state-by-state information drawn from the 1987 National Agricultural Census and on unpublished data from the Migrant Enumeration Project as provided by Dr. Alice Larson. These are supplemented by estimates of migrant characteristics drawn from published sources (Mines, Gabbard, and Samardick 1992), as well as custom tabulations provided by the Department of Labor from its annual National Agricultural Worker Surveys (NAWS).

The expected values of Medicaid expenditures were developed from tabulations of Medicaid claims files for calendar year 1991 as provided by (1) SysteMetrics for the four states in the Tape-to-Tape Medicaid data project, and (2) 1992 tabulations provided by California's Medi-Cal program. The methodology used to estimate enrollment and expenditures is detailed in Appendix B.

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[5](...continued)
Utah, Wyoming all have MHCs but are not included as study states. Some of these states have expressed interest in participating in a demonstration.

D. ORGANIZATION OF REPORT

As a review of major problem areas that should be evaluated in designing a demonstration, this report presents key issue areas in four subsequent chapters. Chapter II addresses the problem of interstate differences in Medicaid program characteristics. Since an interstate compact will have to either reconcile or work around such differences, the degree to which states' programs differ can strongly influence the structure of a demonstration. Chapter III presents evidence on a key issue for states considering participation--state-by-state estimates of the number of individuals that could potentially be served by interstate compacts, as well as estimates of additional Medicaid expenditures. Chapter IV reviews demonstration objectives, key demonstration design issues, and the options for interstate reciprocity agreements.

CHAPTER II: STATE MEDICAID PROGRAM CHARACTERISTICS

The Medicaid program is administered and developed by the states in accordance with broad federal requirements and guidelines. This administrative structure has two important consequences for migrant families seeking Medicaid coverage. First, individuals must establish state residency to obtain coverage. Second, states vary considerably in terms of benefits offered, groups covered, income eligibility thresholds, and provider reimbursement levels.

In this chapter, we provide an overview of migrant families' current enrollment options and the complications created by interstate variation in Medicaid programs. Information was gathered from state plans, published national comparisons of plans, unpublished data on program characteristics collected by Health Systems Research, Inc., and interviews with Medicaid agency staff in six states: Florida, Georgia, North Carolina, New York, Texas, and Illinois. Although these states are not necessarily representative, they all host a large number of migrant workers and represent a variety of upstream and downstream circumstances. A review of their Medicaid plans highlights some of the challenges that must be faced in devising an interstate compact. Section A of this chapter reviews eligibility criteria applicable to migrants. Section B discusses some of the barriers migrants face in attempting to enroll in Medicaid. Section C discusses obstacles migrants face in obtaining care under the program. Section D provides an overview of difficulties current migrant coverage arrangements pose for providers and state agencies. Details of state program characteristics are presented in Appendix A.

A. MEDICAID ENROLLMENT

1. Eligibility Requirements

The complexities of Medicaid eligibility categories are well-known. Certain categories are required and seldom vary among states; others are optional. This section summarizes the

requirements and the degree to which they vary among states for major eligibility groups. Full details of this analysis are contained in Appendix A.

a. AFDC-Related Medicaid Eligibility

The categorical nature and stringent income eligibility standards of the AFDC program preclude most migrants from receiving Medicaid by qualifying for AFDC cash assistance. However, long periods of unemployment and high variations in earnings may, open this category for some. AFDC, AFDC-UP, and Ribicoff Children are the three primary eligibility categories related to AFDC.

AFDC. States are required to provide Medicaid coverage to families that receive cash assistance under the AFDC program but are allowed to set their own income-eligibility standards. Asset limits, however, are uniform across states. Families may own a home of any value, one automobile with an equity value of up to $1,500, and other real and personal property worth up to $1,000. For those few migrants traveling with their own automobiles, these asset limits may be problematic.

As shown in Table II.1, across the 12 midwest region states, the eligibility thresholds for a family of three range from a low of 18.6 percent of the federal poverty level (FPL) in Texas to a high of 55.6 percent of poverty in Michigan. In the 12 eastern region states, the variation across eligibility thresholds is somewhat less and ranges from 29.4 percent of the FPL in Virginia to 58.2 percent in New York.

AFDC-UP. Of greater significance to migrants, the Family Support Act of 1988 required states to extend AFDC cash payments and Medicaid coverage to two-parent families in which the principal wage earner is unemployed. Six months of coverage is federally mandated, with states having the option to extend this period to a full 12 months. In addition, states may also opt to extend Medicaid-only coverage for up to 12 months to families with unemployed parents even if they receive AFDC payments for only the mandatory 6 months.

In the midwest region, only 4 of the 12 states extend assistance to families for the full 12 months; 8 of 12 eastern region states extend the assistance period. Note that the two major home

TABLE II.1

AFDC-RELATED MEDICAID ELIGIBILITY

State	AFDC		Coverage of Families with Unemployed Parents (AFDC-UP)	
	Annualized Income Eligibility Threshold[a]	As a Percent of the FPL[b]	Cash Recipient Beyond Federal Minimum (in months)	Noncash Recipient
Midwestern Stream States				
Arkansas	$ 2,448	20.6	6	NA[c]
Colorado	$ 5,052	42.5	6	NA
Illinois	$ 4,404	37.0	N	NA
Michigan	$ 6,612	55.6	6	N
Minnesota	$ 6,384	53.7	N	N[c]
Missouri	$ 3,504	29.5	N	N
New Mexico	$ 3,888	32.7	N	Y
North Dakota	$ 4,812	40.5	N	N
Ohio	$ 4,092	34.4	N	N
Oklahoma	$ 5,652	47.5	6	NA
Texas	$ 2,208	18.6	N	Y
Wisconsin	$ 6,216	52.3	N	N
Eastern Stream States				
Florida	$ 3,636	30.6	N	Y
Georgia	$ 5,088	42.8	N	Y
Maine	$ 6,636	55.8	6	NA[c]
Maryland	$ 4,306	36.2	6	NA
Mississippi	$ 4,416	37.1	6	NA
New Jersey	$ 5,316	44.7	6	NA
New York	$ 6,924	58.2	6	NA
North Carolina	$ 6,528	54.9	6	NA
Pennsylvania	$ 5,052	42.5	6	NA
South Carolina	$ 5,280	44.4	6	NA
Tennessee	$ 5,112	43.0	N	Y
Virginia	$ 3,492	29.4	N	Y

SOURCES: Appendix A, Tables I.A and I.B. Data compiled by Health Systems Research, Inc., 1993.

NOTES: [a]For a family of three.
[b]The FPL for a family of three is $11,890.
[c]there are no noncash recipients in states which make AFDC payments to families with unemployed parents 12 months of each calendar year (6 required plus 6 optional months).

FPL = Federal poverty level.

states, Florida and Texas, cover unemployed families for 6 months with an option of Medicaid coverage for an additional 6 months. This could be a significant source of assistance for U.S.-based migrants.

Ribicoff Children. States are permitted to provide Medicaid coverage to "Ribicoff Children," i.e., those children living in families whose income and resources meet the state's AFDC income and resource standards, but who do not meet the AFDC definition of "dependent child" (e.g., children in two-parent families not qualifying for AFDC-UP). States may cover these children up to 18, 19, 20, or 21. Some states effectively limit this eligibility category to special needs children (e.g., foster or retarded). Among the 24 study states, 8 impose this limitation. In general, the importance of the Ribicoff Children provision will diminish over the remainder of the decade as a congressional mandate phases in Medicaid coverage of children under age 19 with family incomes below the federal poverty level.

b. Medically Needy Eligibility

States are permitted to cover "medically needy" persons who meet the categorical requirements for Medicaid coverage but not the income or resource standards for "categorically needy" eligibility. States set both income and resource standards for the medically needy population. The income eligibility threshold for medically needy coverage may not exceed 133⅓ percent of the state's maximum AFDC payment for a family of the same size.

Of the 12 midwest region states (see Table II.2), 8 have medically needy programs. Their income eligibility thresholds (for a family of three) range from a low of 26.9 percent of the FPL in Texas to a high of 71.6 percent of poverty in Minnesota. In the eastern region, all but two states have medically needy programs, with eligibility thresholds for a family of three ranging from a low of 25.2 percent of the FPL in Tennessee to a high of 77.4 percent of poverty in New York.

TABLE II.2

MEDICALLY NEEDY MEDICAID ELIGIBILITY

State	Medically Needy Program	Annualized Income Eligibility Threshold[a]	Percent of FPL[b]	Asset Limit for Family of Three
Midwest Region				
Arkansas	Y	$3,300	27.8%	$3,100
Colorado	N			
Illinois	Y	$5,904	49.7%	$3,050
Michigan	Y	$6,804	57.2%	$3,200
Minnesota	Y	$8,508	71.6%	$6,650
Missouri	N			
New Mexico	N			
North Dakota	Y	$5,220	43.9%	$6,025
Ohio	N			
Oklahoma	Y	$5,508	46.3%	$3,100
Texas	Y	$3,204	26.9%	$1,000
Wisconsin	Y	$8,268	69.5%	$3,300
Eastern Region				
Florida	Y	$3,636	30.6%	$6,000
Georgia	Y	$4,500	37.8%	$4,100
Maine	Y	$5,496	46.2%	$3,100
Maryland	Y	$5,004	42.1%	$3,100
Mississippi	N			
New Jersey	Y	$7,092	59.6%	$6,100
New York	Y	$9,204	77.4%	$4,350
North Carolina	Y	$4,404	37.0%	$2,350
Pennsylvania	Y	$5,604	47.1%	$3,500
South Carolina	N			
Tennessee	Y	$3,000	25.2%	$3,100
Virginia	Y	$4,296	36.1%	$3,100

SOURCE: Appendix A, Tables 2.A and 2.B. Data compiled by Health Systems Research, Inc., 1993.

[a]For a family of three.
[b]In 1993, the FPL for a family of three is $11,890.

FPL = federal poverty level.

c. Poverty-Related Eligibility

A series of congressional actions between 1986 and 1990, known collectively as the Medicaid expansions, greatly increased coverage for pregnant women, infants, and children. Although AFDC-linked Medicaid eligibility standards vary greatly by state, eligibility for pregnant women and children is much less variable. There are four principal components to these expansions:

- *Required for Pregnant Women and Children under Six.* States are required to provide Medicaid coverage to pregnant women and children under age six with family incomes up to 133 percent of the FPL.
- *Optional for Pregnant Women and Infants.* State are permitted to extend coverage to pregnant women and infants with incomes up to 185 percent of poverty.
- *Required for Children under 19.* States are required to provide Medicaid coverage to children born after September 30, 1983 with family incomes under the federal poverty level. All states currently cover children under age 10; the upper age limit of 19 will be reached by October 2001.
- *Optional Expanded Coverage of Children under Special Conditions.* Several states have expanded Medicaid coverage of children beyond the currently mandated level using either HCFA demonstrations or legislative authority as a basis for more liberal criteria for disregarding income than required by AFDC.

As shown in Table II.3, 6 of the 12 midwest region states cover pregnant women and infants at the required threshold of 133 percent of poverty. Of the six that exceed the minimum standard, 4 are at the maximum level permitted by law--185 percent. In the eastern stream, only 4 states exceed the minimum required coverage: Florida, Georgia, Maine, and Virginia. This diversity in eligibility thresholds is further complicated by the fact that some states such as Colorado and Florida have different thresholds for different counties within the state.

d. State-Funded Insurance Programs for Medicaid-Ineligible Persons

There are two primary ways in which states offer coverage without federal matching payments. First, some states offer entirely state-funded programs to provide coverage for children left uninsured despite the federally mandated expansions. One of the midwest region states, Minnesota,

TABLE II.3

MEDICAID COVERAGE OF PREGNANT WOMEN, INFANTS, AND CHILDREN

State	Coverage of Pregnant Women and Infants: Income Threshold as a Percent of the FPL	Coverage of Children: Age Range	Coverage of Children: Income Threshold as a Percent of the FPL
Midwest Region			
Arkansas	133%	under 10	100%
Colorado	133%	under 10 under 9	100%
Illinois	133%	under 10	100%
Michigan	185%	under 10 under 18	100%
Minnesota	185%	under 10	100%
Missouri	133%	under 10	100%
New Mexico	185%	under 10	100%
North Dakota	133%	under 10	100%
Ohio	133%	under 10	100%
Oklahoma	150%	under 10	100%
Texas	165%	under 10	100%
Wisconsin	155%	under 10 ages 2 through 5	100%
Eastern Regional			
Florida	186%	under 19	None
Georgia	185%	under 19	100%
Maine	185%	under 20	125%
Maryland	185%	under 10	100%
Mississippi	185%	under 10	100%
New Jersey	185%	under 10	100%
New York	185%	under 10	100%
North Carolina	185%	under 10	100%
Pennsylvania	185%	under 10	100%
South Carolina	185%	under 10	100%
Tennessee	185%	under 10	100%
Virginia	185%	under 10	100%

SOURCES: Appendix A. Tables 3.A and 3.B. Data compiled by Health Systems Research, Inc., 1983.

FPL = federal poverty level.

has taken this route and is phasing in a plan to cover all uninsured persons in the state. Under this program, children under 18 are covered up to 185 percent of the poverty line, a much higher income threshold than allowed for under the mandated Medicaid expansions. Other state-funded insurance programs for children are operated in New York, Pennsylvania, and Virginia.

Second, states may offer coverage through General Assistance programs. Most states fund and administer, on their own or with local governments, health care programs for the indigent that provide coverage for low-income individuals who are not eligible for Medicaid because they do not meet the program's categorical requirements. Eligibility for such health care programs is typically determined by income and disability status. Benefits vary greatly across programs, ranging from packages that are the same or similar to Medicaid benefits to much more limited packages that may, for example, provide only pharmacy, ambulatory, or inpatient hospital services. (Details are available in Appendix A.) One issue for designing an interstate reciprocity agreement is whether other states should recognize optional and state-only eligibility and coverage provisions.

e. Supplemental Security Income-Related Eligibility

The federal Supplemental Security Income (SSI) program provides cash assistance to needy aged, blind, and disabled individuals. States are required to provide Medicaid coverage to SSI recipients. Under SSI, the federal government sets uniform minimum income and resource eligibility guidelines. States may supplement the federal benefit standard by making additional payments to SSI recipients, thus effectively increasing the Medicaid income eligibility threshold; there are also provisions for more restrictive eligibility standards. As a result, income thresholds vary significantly across states, but as a practical matter, few migrants are likely to meet the disability standards, and if they did, neither they nor their disabled children would be likely to travel extensively.

2. Immigration Status

The large number of foreign-born migrants raises the issue of their legal status. Medicaid regulations clearly state that all citizens and many of those legally in the country are eligible for the program (Commerce Clearing House, Paragraph 14,341):

> U.S. citizens who meet a state Medicaid program's financial and categorical eligibility standards must be covered by Medicaid. Medicaid programs must also cover aliens who have been lawfully admitted for permanent residence or are permanently residing in the U.S. under color of law (PRUCOL) if they meet the state Medicaid program's financial and categorical eligibility standards.

In addition to standard immigration, visa, and work permit PRUCOL categories, there are two main legal criteria under which migrant workers and their dependents can receive Medicaid-financed care--PRUCOL status under IRCA 1986 and undocumented status.

a. Status Under IRCA Provisions

Many spouses and children of immigrants legalized under IRCA 1986 did not qualify for amnesty either because they did not enter the U.S. before the January 1982 cut-off date for the Section 245A program or because they did not perform the requisite hours of farm labor for the Section 10 (Special Agricultural Worker) program. The Family Fairness and Family Unity Programs provide protection for these family members until they receive legal permanent residency status through the regular family visa petition process. Persons granted Family Fairness status by the INS are eligible to receive the full range of services covered by Medicaid.

Section 301 of the Immigration Act of 1990 (P.L. 101-649) created the Family Unity Program, which is available to spouses and children of persons who were granted temporary or permanent residence under one of IRCA's legalization programs: the Cuban-Haitian Program (IRCA Sec. 202), the Seasonal Agriculture Worker (SAW) program (INA Sec. 210), and the pre-1982 amnesty

program (INA Sec.245A).[6] Medicaid coverage for family members under these three programs is as follows (assuming they meet the income, family status, and other eligibility criteria):

- Family members of those legalized under the Cuban-Haitian Program (IRCA Sec. 202) are eligible for full Medicaid services.
- The pre-1982 amnesty program included a five-year ban on eligibility for certain services for the family members of those receiving legal status. Since the applications for temporary residency first began to be approved by INS in May 1987, the five-year ban began to lift in May 1992, enabling those adults to become eligible for full Medicaid services.
- Family members of those legalized under the SAWs program (Sec. 210 or either Sec. 405A) are eligible for Medicaid as follows:
  - Children under 18: the aged, blind, and disabled as defined in the SSI program: and Cuban-Haitian entrants are eligible for full Medicaid services.
  - Other adults (family members as well as the legalized immigrant) are eligible for delivery services and emergency services only, because of IRCA's five-year ban on the receipt of certain services, counted from the temporary residency adjustment date of the amnesty spouse or parent.

Table II.4 summarizes the effect of these provisions on Medicaid eligibility.

We would expect that spouses and children affected by the 1990 Family Unity Program (Section 301) would be included in the demonstration in the same manner as other Medicaid-eligible migrant farmworkers. Section 301 went into effect in October 1991 so that some of those affected by these provisions may already be aware of their right to apply for Medicaid, and providers who serve substantial numbers of immigrants should also be aware of the potential Medicaid eligibility of workers and particularly of their dependents. Those who have already taken advantage of the Section 301 provisions and are enrolled in Medicaid would be subject to the same reciprocity arrangements as other participants in the demonstration (but any coverage limitations related to their immigration status would still apply).

[6]There was an additional program--Replenishment Agricultural Workers (RAWs)--that was never implemented; its authority was scheduled to end in September 1993.

TABLE II.4

MEDICAID ELIGIBILITY OF SPOUSES AND CHILDREN OF LEGAL ALIENS

INS Status/Program	Level of Medicaid Services	
	Full Services	Limited Services (Pregnancy/Emergency)
I. Amnesty Program		
A. Family Fairness (established 1987)	Yes	NA
B. Family Unity (enacted 1990)		
1. Cuban/Haitian Program (IRCA Sec. 202)	Yes	NA
2. Pre-1982 Amnesty (INA Sec. 245A) or SAW Amnesty (INA Sec. 210)	Yes for: • children under 18 • aged over 65 • blind/disabled	Non-aged or disabled adult relatives are limited to pregnancy/emergency services for five years after application by amnesty spouse or parent. This disqualification started to lift in May 1992 and is lifted whenever the relative becomes a legal permanent resident
II. Current SAWs	No	Limited services available on the same basis as any undocumented resident of the U.S.
III. Legal Permanent Resident	Yes	NA

SOURCE: Adapted from National Immigration Law Center. *Immigrants' Rights Manual.* Los Angeles, CA: 1990, with 1992 updates.

One implication of these provisions is that immigrants (including Section 301 immigrants) would need to be targeted in any outreach aspects of the demonstration. Family members of migrant farmworkers who are SAWs need specific information about Medicaid eligibility under Family Unity.

b. Undocumented Status

All undocumented immigrants who are otherwise eligible for Medicaid (i.e., they meet the income, family status, and other eligibility criteria) are eligible to receive limited services under Medicaid. The Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) (OBRA-86) allowed Medicaid coverage for treatment of an undocumented immigrant's "emergency medical condition," including emergency labor and delivery costs. An emergency medical condition is defined as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to seriously jeopardize the patient's health, or to result in serious impairment of bodily functions or serious dysfunction of any bodily organ or part. Although single men are not normally eligible for Medicaid, they can be covered for accidents, which account for a significant portion of their utilization.

c. Recent Changes

Any discussion of immigration status is necessarily incomplete because this area is, by nature, ambiguous in certain key respects. First, the proportion of migrant workers who are undocumented is uncertain. According to the National Agricultural Workers Survey, half of foreign-born respondents have SAW status, and only 17 percent are undocumented (Department of Labor 1993). A recent report by the General Accounting Office (1992, p. 24), however, reports that "Estimates of the percentage of the hired farmworker population who are undocumented aliens are as high as 50 percent." There is much anecdotal evidence of forged documents, and workers having such documents may be very reluctant to use them in a Medicaid application.

As discussed later in this chapter, a key issue for undocumented individuals is the definition of "emergency" care. States differ in the scope of services they provide under the rubric of emergency care (e.g., some states include prenatal care). Because the issue has been litigated, case law is also influencing the definition of required services.

Finally, Medicaid coverage for the foreign-born may change with the current national debate on immigration policy. The recent health reform proposal for Washington State aims for universal coverage for all residents, *except* agricultural workers. California has proposed that anyone with a second residence outside the state be ineligible for Medi-Cal. There is concern that the administration's national health reform proposal will offer universal health insurance to all except the undocumented, potentially leaving them in a worse position than under current Medicaid regulations (The Nation's Health 1993). In sum, the Medicaid eligibility of a large proportion of migrants may be subject to substantial changes.

3. State Residency Requirements

Because Medicaid is a state-administered program, individuals and families must establish state residency to obtain coverage. To prove residency, applicants usually must produce mortgage or rent bills; if an individual is living with a friend or family member, the agency may call to verify the arrangement. Whether procedures for establishing residency constitute a barrier to migrant enrollment will be further explored in the course of this study.

The basic residency rule set forth in the federal regulations defines an individual's state of residence as the state in which he or she is living "with the intention to remain there permanently or for an indefinite period." However, the regulations also permit an individual to claim residence in a state which he or she "entered with a job commitment or seeking employment" (Office of the Federal Register, 42 CFR 435.403). Migrant families seeking Medicaid coverage consequently have two options. They can either apply for Medicaid in a single state or in each or any state in which they travel for work. Under a "home state" arrangement, care provided elsewhere is billed to the

home state in accordance with specific provisions in the state plan. Provisions for out-of-state coverage vary from state to state. If a migrant family instead opts to obtain coverage in multiple states, care provided in a given state is billed to that state's Medicaid agency. In that case, the interstate variations of greatest concern to migrants are those in eligibility requirements and coverage.

The difficulties presented for families and providers by these two different enrollment options highlight issues that must be addressed in developing an interstate compact. Specifically, a compact that builds on current home-state arrangements must address the problems associated with maintaining eligibility while traveling; limitations on out-of-state coverage; provider enrollment requirements; and interstate variations in prior approval requirements, claims processing, and provider reimbursement. A compact that more closely resembles current arrangements for multiple-state enrollment must resolve problems associated with time-consuming application procedures; application-processing delays; and interstate variation in eligibility criteria and coverage.

B. ENROLLMENT PROCEDURES

Whether families enroll in the Medicaid plans of multiple states or in a single state's plan, many aspects of the enrollment process pose problems. For families who enroll in multiple states, the most difficult part of the process is apt to be the initial enrollment phase. For families who enroll in a single state, maintaining eligibility while travelling is more problematic. The following review of issues surrounding enrollment procedures is based on information gathered from state plans and interviews with Medicaid agency staff in six states: Florida, Georgia, North Carolina, New York, Texas, and Illinois.

1. Multiple-State Enrollment

In almost all states, Medicaid applicants must complete an application form and appear for an interview with an eligibility worker. How burdensome this process is for applicants depends to some

extent on whether the state has adopted federally approved streamlining strategies, many of which were designed to facilitate enrollment of children and pregnant women.

These strategies include the removal of asset tests, shortened application forms, outstationing of eligibility workers, and presumptive eligibility determination. (For more information, see Appendix A.) Ordinarily, states determine Medicaid eligibility on the basis of assets (e.g., home and car ownership, savings, and investments) as well as income. Asset tests may preclude some migrant families who own vehicles from obtaining coverage. However, OBRA-86 permitted states to disregard assets when determining eligibility for pregnant women and children. All six of the states we surveyed have dropped the asset test for pregnant women; only Texas has retained it for children. The removal of asset tests also allowed states to greatly simplify application forms for these applicants; some states have taken this opportunity to streamline the application used by all applicants. Of the six states we surveyed, all but Florida have shortened their application forms.

States have also tried to improve access by outstationing eligibility workers at sites where women and children receive health care services. All states place eligibility workers at federally qualified health centers (FQHCs) and hospitals that serve a disproportionate share of Medicaid patients (as required by legislation contained in the OBRA-90). Many states also place workers in other provider sites, such as local public health departments. Of our survey states, all but Illinois and New York outstation workers at sites in addition to those mandated by Congress.

Another strategy to improve access is presumptive eligibility determination. Under OBRA-86, states have the option of allowing certain qualified providers to make preliminary Medicaid eligibility determinations for pregnant women, thereby granting them immediate temporary coverage. In most states, however, clients must still file a formal application to obtain Medicaid coverage beyond the temporary coverage period of up to 60 days. All six survey states have presumptive eligibility policies.

Although these streamlining strategies can greatly improve migrants' access to Medicaid coverage, substantial obstacles remain. For families who attempt to enroll in states where they are temporarily employed, interview requirements and the typically lengthy turnaround time on application processing are apt to be serious impediments. Although a few states allow applicants to mail in eligibility forms, the vast majority still require a face-to-face interview with an eligibility worker. Of the six states we surveyed, all require interviews. While some local offices in some states are able to schedule same-day interviews, busier offices may require applicants to wait a week or more. (In New York, the wait may be as long as a month.)

Failure to supply all necessary documentation (rent bills, pay stubs, and the like) may further delay application processing. The need to formally document income, assets, expenses, legal status, and state residency precludes some families from obtaining coverage altogether: migrants may not carry all necessary financial and personal papers with them when they travel.

By federal law, the state has 45 days from the date of application to make a determination. Actual processing time varies. Although a few states expedite the processing of applications made by pregnant women (typically requiring that a determination be made within 5 to 10 days), none of the states we surveyed has instituted such a policy. Illinois processes applications in 30 days or less. In North Carolina, the average is about three weeks.

Given the difficulty of maintaining Medicaid eligibility in a single state while traveling (see the next section), it seems unlikely many migrants attempt to maintain eligibility in multiple plans while traveling from state to state. However, the issue of eligibility maintenance would obviously have to be addressed in any interstate compact that involves multiple-state enrollment.

2. Home-State Enrollment

Families who enroll in their home state face many of the same barriers as other migrants in applying for Medicaid. However, these families need to go through the process only once, and if they apply during an extended stay in their home state, application-processing delays should not

prevent them from getting coverage. For these families, the greatest challenge may be to maintain eligibility while traveling. The monthly issuance of cards and the biannual scheduling of recertification interviews--both standard practice in most states--pose obvious problems for recipients who move frequently and who are out of the state much of the year. The six states we contacted appear to be fairly flexible with regard to card issuance and recertification. However, because these states lack established policies and procedures to deal with the types of difficulties migrants encounter, these problems tend to be resolved on an ad hoc basis, usually at the discretion of a caseworker. It is not clear that either caseworkers or migrants are always apprised of the options available to them.

All six of the states we contacted mail Medicaid cards out of state. The client must write or call the local office (or, in Illinois, a statewide toll-free number) to request an address change. If the card has already been mailed out, the office may approve a duplicate or forward the original once it is returned. If a family has no mailing address at their out-of-state location, agency staff may even be willing to send the card to the closest welfare office. The use of outside vendors to produce and mail cards may complicate matters. If the local office does not notify the vendor in a timely fashion, or if the vendor does not make the change promptly, the card may be sent to the wrong address; by the time it is eventually forwarded, the family may have moved again.

Recertification requirements are another hurdle for families who enroll in a single state. Federal law requires that all Medicaid recipients be recertified at least annually. Many states require children covered under the Medicaid expansions to recertify every six months, as AFDC families do. Others require only annual recertification. All six of the states we contacted will make special arrangements for recipients who are unable to return to their local office for a recertification interview. Texas, Illinois, and North Carolina will conduct interviews over the phone and accept documentation submitted by mail. Florida permits recipients to authorize a friend or family member to represent them in the interview. Georgia will make arrangements for the interview to be

conducted by staff at the local office nearest the recipient, even if that office is out of state. New York will reschedule the six-month interview at any time within the year that is convenient for the recipient. Since all of these arrangements deviate from standard procedures, however, responsibility rests with individual caseworkers to ascertain what accommodations can be made. Procedural flexibility in a given state may therefore vary among local offices and even among caseworkers in a single office.

3. Implications for Demonstration Design

Any interstate compact that involves enrollment outside the migrant's home state will have to resolve the problems associated with multiple, time-consuming eligibility interviews that require migrants to produce documents they may not carry with them. One solution would be for states to recognize one another's eligibility determinations. Another problem that must be addressed is that of eligibility maintenance. The simplest solution might be to issue migrants annual cards and extend the recertification period for these families to a year. However, a demonstration waiver may be required for states to legally set different standards for a group of recipients based on the nature of their employment.

C. COVERAGE

Whether families enroll in one state Medicaid program or in several, they also face unique obstacles in actually obtaining care. These problems depend to a large extent on the enrollment option the family has chosen.

1. Multiple-State Enrollment

Although federal Medicaid regulations mandate the provision of certain basic services to certain recipients (the basic package varies depending upon the eligibility category), states are permitted substantial discretion in determining the additional benefits they offer (if any). The resulting

variation in state programs has important implications for migrant families who enroll in multiple states.

While some states cover many optional services, others cover very few. Of the 33 services states may offer at their option. New York covers 27, Georgia just 18. Among the services New York provides that Georgia does not are physical and occupational therapy; chiropractors' services; inpatient psychiatric care for individuals under age 21; and treatment for speech, hearing, and language disorders. The scope of services provided also varies across states. For example, five of the six states we surveyed cover some dental services beyond those mandated under EPSDT provisions. But while Illinois, New York, and North Carolina cover routine dental care for adults, Georgia and Florida do not. Restrictions and prior approval requirements also vary across states. Of the six states, North Carolina is the only one that requires prior approval for many dental services. New York is the only one of the six that limits the number of dental visits; the state reimburses a maximum of three visits per year. Coverage for other optional services may vary similarly.

2. Home-State Enrollment

Federal regulations require that state Medicaid agencies cover certain services furnished out-of-state to individuals enrolled in the state program. However, the mandated coverage is limited, and states may impose significant prior approval requirements for any services they do cover. Under the federal regulations, states must cover medical services in an emergency or if the recipient's health would be endangered if he or she were required to travel to his or her state of residence. States are also required to cover services provided out of state if these services are more readily available in the other state or if it is general practice for recipients in a particular locality to get care in another state. (Office of the Federal Register, 42 CFR 431.52).

Because many people who live near a state line ordinarily obtain care in the neighboring state, all six of the states we contacted permit nonresident providers operating within some set distance

of the states' borders to enroll as in-state providers. Medicaid recipients can obtain care from these providers as they would any provider actually located in-state. However, as shown in Table II.5, the definition of the border area varies from state to state. While North Carolina limits in-state enrollment to providers within 40 miles of the state border, Illinois extends the option to providers located anywhere within its neighboring states.

Of the six states surveyed, three cover services furnished by other out-of-state providers only under the conditions stipulated in the federal regulations. Prenatal care, children's check-ups, and other routine services furnished by out-of-state providers are not covered. However, states' interpretations of the federal regulations may permit both providers and the state agency staff charged with reviewing claims some flexibility in defining coverage, since it is difficult to specify what constitutes care an individual cannot reasonably be expected to return to his home state to obtain. Some states very narrowly define such care. Georgia, for example, will not pay for an out-of-state delivery after 35 weeks, on the grounds that the woman should have returned to the state when her due-date neared. States with less clearly defined policies may or may not be equally restrictive.

States that offer more generous out-of-state coverage may require providers to obtain prior approval for any nonemergency care (see Table II.6). Three states (Illinois, New York, and North Carolina) provide more than minimum coverage. Of these, North Carolina requires out-of-state providers to obtain prior approval for any nonemergency care. Whether the approval process poses an obstacle for migrants seeking care depends to a large extent on the state's willingness to approve services over the phone and the provider's willingness to deal with the "hassle" factor. North Carolina's requirements seem fairly manageable. The state requires surgery and other major procedures to be approved in writing as "medically necessary"; a determination is made within five days of receipt of the necessary paperwork. Other services can be approved over the phone.

Managed care arrangements of various sorts may constitute another stumbling block for migrants. Most of the states in the migrant streams have implemented one or more managed care

TABLE II.5

OUT-OF-STATE PROVIDER ENROLLMENT

	Florida	Georgia	Illinois	New York	North Carolina	Texas
Different enrollment procedures for in-state and out-of-state providers (Y/N)	Y	Y	Y	Y	Y	Y
Out-of-state provider enrollment limited to dates of service; re-enrollment required with each claim (Y/N)	N	Y	N	N	Y	N
Providers in state's border area enrolled as in-state providers (Y/N)	Y	Y	Y	Y	Y	Y
Definition of border area (in miles from border)	50	50	Contiguous states	Contiguous states[a]	40	
Number of active out-of-state providers[b]	NA[c]	NA	24,577	14,582[c]	NA	4,188
Number of out-of-state claims per week	629	NA	NA	NA	NA[c]	5,122[f]

[a]With same rate systems
[b]Definition may vary across states
[c]3,259 providers enrolled in first 8 months of 1993
[d]Have submitted a claim in the past few years
[e]50-60 out-of-state hospital claims per week
[f]23,051 in July 1993

TABLE II.6

OUT-OF-STATE COVERAGE AND PRIOR APPROVAL REQUIREMENTS

	Florida	Georgia	Illinois	New York	North Carolina	Texas
Different prior approval requirements for in-state and out-of-state providers (Y/N)	Y	Y	N	Y	Y	Y
Prior approval required for all out-of-state care, except emergency services (Y/N)	Y	Y	N	N	Y	Y
Out-of-state coverage limited to services mandated by federal regulations (Y/N)	Y	Y	N	N	N	Y

plans. These include capitated programs, in which a health plan receives a monthly fee for each covered recipient, and primary care case management (PCCM) programs, in which participating primary care physicians are paid a fee for each service rendered as well as a periodic case management fee to coordinate the delivery of the recipient's health care services. Programs may operate in selected areas or statewide. Participation may be voluntary or mandatory for certain groups of Medicaid recipients.

To the extent that participation is mandatory, managed care arrangements may pose problems for migrant families who seek services while traveling. Unless home states are willing to waive or freely interpret the requirement that services be approved by the recipient's primary care physician, for example, coverage for certain services may be denied to migrants while they are out of state.

States' so-called "bundling" of services may also pose problems for migrants. Under bundling arrangements, the Medicaid agency pays a provider a global fee to furnish an entire package of services; pregnancy services (delivery, pre-, and postnatal care) are among those most commonly bundled. Several of the states we contacted bundle pregnancy services. However, all of these states will unbundle the package and reimburse each visit on a fee-for-service basis, if necessary.

3. Implications for Demonstration Design

To ensure continuous coverage for migrant families, an interstate compact that calls for each state to cover services furnished within its borders must resolve the problems associated with of interstate variation in coverage and restrictions imposed by managed care arrangements. Since migrants may be unlikely to pursue in several different settings those services that require continuity of care, interstate variation in coverage of such services as substance abuse treatment and mental health care may not pose a serious problem. However, variation in coverage of services such as dental care may be a concern.

A compact that requires migrants' home states to pay for care furnished elsewhere may require participating states to relax restrictions on coverage of out-of-state services. A demonstration waiver

may be necessary for states to make this accommodation only for migrants. States will also have to consider how migrants' special needs can be accommodated within managed care programs.

D. PROVIDER REQUIREMENTS

Migrants' participation in Medicaid through a home-state arrangement may create substantial administrative burdens for out-of-state providers and for home-state Medicaid agencies. Providers who furnish services to a Medicaid recipient from another state must enroll in that state's Medicaid program and almost always face different prior approval requirements than they do in their own state. Claims processing is apt to be more cumbersome, and reimbursement levels may be lower. Whether providers consider it worthwhile to enroll and submit a claim may depend on the efficiency of their billing operations and the expected amount of reimbursement. This section reviews the relevant requirements and restrictions that affect providers who may potentially serve migrant workers and discusses the implications these requirements have for a demonstration design.

1. Relevant Requirements and Restrictions

Providers' concerns about furnishing services to individuals covered by another state's Medicaid plan are likely to focus on eligibility verification, provider enrollment procedures, prior approval requirements, service limits, claims processing, reimbursement levels, and copayments.

a. Eligibility Verification

Most states issue Medicaid cards on a monthly basis. Although a state may terminate a recipient's coverage mid-month, a provider can usually assume that a recipient with a current monthly card is covered by the issuing state. A few states have recently replaced the standard paper cards issued monthly to recipients with permanent, plastic cards; several other states plan to follow suit. Florida, for example, has introduced magnetized plastic cards in 14 counties and plans to phase in the new cards in the rest of the state over the course of the year. The magnetized cards allow providers equipped with point-of-sale (POS) terminals (mainly pharmacies) to instantaneously verify

clients' eligibility. Out-of-state providers, however, are unlikely to have a computer linkage to Medicaid agencies in other states and therefore gain nothing from the new technology. Since the plastic cards have no expiration date, providers who do not have POS terminals must call the Medicaid agency to verify clients' eligibility. Anecdotal evidence indicates this can be a time-consuming and frustrating experience.

b. Provider Enrollment

In all six of the states surveyed, out-of-state providers must enroll in the home state's Medicaid plan to be reimbursed for services. The process is ordinarily fairly simple. Upon receipt of a claim from an unenrolled provider, the state agency contacts the provider to obtain in writing such basic information as documentation of licensure, the provider's IRS number, and rate schedule. Providers may be asked to complete a short application form or simply to submit proof of enrollment in their own state's Medicaid plan. (Texas, for example, recently limited its requirements to proof of enrollment in another plan.) States may set different enrollment policies depending upon the amount of the claim. Illinois, for example, requires no formal enrollment for first-time claims of $150 or less; agency staff simply call the provider to collect the information necessary to approve a limited enrollment.

By federal mandate, states have 10 days to review a provider's application and make a determination or request more information. However, some states take longer; one of those we surveyed requires 30 days to process an application. All six states surveyed permit nonresident providers to enroll and submit claims up to a year after the date of service. Typically, out-of-state providers seek enrollment only if they have a claim to submit. Some states, such as Florida, will enroll nonresident providers only under these circumstances. States may also limit the period of enrollment to the dates of service, requiring providers to re-enroll with each new claim.

c. Prior Approval Requirements

As described above, a given state may set different prior approval requirements for services furnished in- and out-of-state. Prior approval requirements for out-of-state services also vary *among* states. Georgia, for example, requires in-state providers to obtain prior approval for all inpatient admissions, physician visits in excess of 12 per year, cosmetic surgery, and some outpatient procedures. Out-of-state providers must obtain approval for *any* nonemergency services; approval is granted only under the conditions described in the federal regulations. Illinois, on the other hand, requires prior approval for no services and for only a small number of medical products (some medical supplies, pharmaceuticals, leg braces, and eyeglasses after the first pair). The state's policy is the same for both in- and out-of-state providers.

Whether states set especially restrictive prior approval requirements for out-of-state providers or simply expect them to conform to those set for in-state providers, these requirements make it more difficult for physicians, hospitals, pharmacies, and clinics to serve Medicaid recipients from other states. To ensure reimbursement, providers must either maintain a library of state regulations or call each patient's state agency for guidance on prior approval requirements before providing services.

d. Service Limits

States also vary in terms of the limits they place on covered services. Some states cover only a limited number of emergency room visits, days of inpatient hospital care, or physician visits. Florida, for example, covers a maximum of 45 days per year of inpatient hospital services. Georgia limits the number of physician visits to 12 per year. In both cases, the limit can be exceeded only with prior approval. For providers to be certain that a visit or stay will be reimbursed, they must contact the state Medicaid agency to find out whether a recipient has depleted his or her coverage. Providers in states that do not limit services may not be aware that this is necessary.

e. Claims Processing

States also vary in terms of claim forms used and the amount of time required to process a claim and issue reimbursement. As the claims process becomes increasingly computerized, procedures for handling in-state and out-of-state claims are bound to further diverge.

Of the six states we contacted, four use standard claim forms (the HCFA 1500 and UB82). Illinois and New York have their own claim forms. If an out-of-state provider submits a claim on a different form, Illinois staff transfer the claim to the Illinois form and send it to the provider for approval and signature. New York sends providers a certification letter to sign giving the state permission to transfer the claim to another form. As shown in Table II.7, processing time varies considerably, from a low of 7 days in Texas to a high of 125 days in Illinois. In both Illinois and New York, the lag is attributable to budget shortfalls that preclude prompt payment of providers, rather than to processing delays.

States are increasingly turning to POS and other electronic claims processing technology to facilitate eligibility verification and claims submission. In Texas, for example, almost 50 percent of all claims are processed electronically. In Illinois, 80 percent of pharmaceutical claims are processed this way, and the state has begun to computerize physician billing. In Illinois, electronic claims are processed instantaneously, while paper claims take an estimated three days to process. Some agency staff believe electronic processing also reduces errors.

Currently, a standard electronic format exists only for the widely used HCFA 1500 physician claim form. Because the states have yet to agree on standard electronic formats for other claims, providers cannot easily submit claims electronically to Medicaid agencies in other states.

f. Reimbursement Levels

State Medicaid plans vary not only in terms of the methodology used to determine reimbursement for different kinds of services, but in how they reimburse out-of-state claims. Insofar

TABLE II.7

CLAIMS PROCESSING AND PROVIDER REIMBURSEMENT

	Florida	Georgia	Illinois	New York	North Carolina	Texas
State uses standard claims forms (Y/N)	Y	Y	N	N	Y	Y
Out-of-state physicians reimbursed at in-state rates (Y/N)	N	N	Y	Y	Y	Y
Out-of-state hospitals reimbursed at in-state rates (Y/N)	Y[a]	N	N	N	N	Y[b]
Reimbursement for intermediate physician visit (CPT 99213)	$25.00	$30.26	$17.10	$11.00	$26.53	$26.87
Average lag time for reimbursement (in days)	20	60	25-125	90	30	7

[a]Florida pays the lesser of the amount charged or the average per diem rate for Florida hospitals.
[b]Texas uses the median standard dollar amount for Texas hospitals to calculate DRG-based reimbursement.

as states pay nonresident providers what they pay in-state, rate disparities among states are an important issue for out-of-state providers.

All six of the states we contacted reimburse in-state physicians according to a statewide CPT-based fee schedule. As shown in Table II.7 physician reimbursement varies widely. Payment for an intermediate office visit ranges from $11 in New York to $30.26 in Georgia. Texas, Illinois, North Carolina, and New York pay out-of-state physicians what they pay in-state physicians. Florida pays out-of-state physicians the lesser of its rate or the physician's charge. Georgia pays the lesser of the *other* state's rate or 65 percent of the physician's charge.

Inpatient hospital reimbursement is more complicated. Two of the six states (Florida and North Carolina) reimburse in-state inpatient hospital services on a per diem basis. Three (New York, Texas, and Illinois) use a diagnosis-related group (DRG) system. One (Georgia) pays a flat rate per case. In all cases, fees are established by the state on the basis of reported costs and are specific to an individual hospital or group of hospitals. States' policies on reimbursement for out-of-state impatient hospital care differ. New York and North Carolina ordinarily pay out-of-state hospitals whatever the hospitals' own state agencies pay. Georgia pays the lesser of the other state's rate or 65 percent of the hospital's charge. Florida and Texas base reimbursement on their own Medicaid payment schedules. Florida pays the lesser of the amount charged or the average per diem rate for its hospitals. Texas uses the median standard dollar amount for its hospitals to calculate DRG-based reimbursement for out-of-state hospitals.

Paying providers according to the rates established by their own state Medicaid agency involves a good deal of work for the home state. In New York, agency staff charged with handling out-of-state claims contact the Medicaid agency in the other state to obtain the appropriate rates for a given service. Since the basis for reimbursement varies across states, New York staff often must convert the rates provided by other states to a format the New York system can process. If a provider is ordinarily paid a certain percentage of charges, for example, the total amount must be

divided by the number of days to obtain a per discharge rate. Because of the additional processing involved, all out-of-state claims must be routed to a special unit in the state Medicaid agency, rather than submitted directly to the contractor that processes all other claims for the state.

g. Copayments

Federal regulations permit states to impose fees, premiums, copayments, and other cost sharing charges on Medicaid recipients who are not categorically needy. Four of the six states we surveyed set copayments for certain services. Since collection of a copayment is the responsibility of the provider (the amount is simply deducted from the provider's reimbursement), and providers are federally prohibited from refusing service to an individual who cannot pay, the copayment may come out of the provider's pocket more often than the recipient's. Copayments are unlikely to be an issue for providers who treat Medicaid-eligible migrants, however, since the federal regulations prohibit cost-sharing for any services provided to individuals under 18, (19, 20, or 21, at the state's option), for family planning services and supplies, for emergency services, or for pregnancy services (or any services provided to pregnant women, at the state's option).

2. Implications for Demonstration Design

An analysis of provider requirements under current home-state provisions suggests that a demonstration modeled on this arrangement must address several thorny issues. Current experience suggests that enrolling in another state's plan is not especially burdensome for providers unless they are required to do so each time they file a claim. Eligibility verification, however, threatens to become a major problem; as states move to computerized cards, verification will become increasingly difficult for out-of-state providers. Electronic claims processing may also make filing out-of-state claims relatively much more difficult than filing in-state. Unless states adopt a uniform electronic claim form, providers who are accustomed to filing electronically will still be obliged to fill out paper claims for out-of-state

clients. (This is apt to be more of an issue for any future interstate compact than for a short-term demonstration.)

Variations in coverage and prior approval requirements also create disincentives for providers to serve out-of-state clients. But what most imperils the success of an interstate compact on the home-state model is interstate variation in reimbursement levels. This will be particularly problematic if home states such as Texas and Florida are known to pay less than upstream states.

III. NUMBER OF MIGRANTS AND EXPECTED MEDICAID EXPENDITURES

Determining the impact of an interstate reciprocity agreement on Medicaid enrollment and expenditures is not an easy task. Nevertheless, state participation in a demonstration may well depend on the projected fiscal impact of the program, and demonstration design may be influenced by the relative flows of migrants between states. To assess states' potential exposure, this chapter develops state-by-state estimates of the number of migrants potentially eligible for Medicaid and projects program expenditures under the assumption that all those eligible enroll. The estimates, however, must be treated only as an initial approximation due to a lack of precise data and the simplifying assumptions employed. The analysis is intended to inform a feasibility assessment, not to serve as an actuarially sound cost estimate. Nevertheless, the results and the issues raised through the estimation process are valuable because they shed light on the limitations of the Medicaid program in serving migrant farmworkers. Developing quantitative estimates is complicated by the fact that the migrant farmworker population is a fluid one. It is difficult to measure a mobile population that also has a high proportion of members who are not proficient in English and without legal status. In addition, migrants' travel patterns change quickly; and the boundaries between the definitions of migrant farmworker, seasonal nonmigrant agricultural worker, and the unemployed often are vague (Lukomnik 1993). Therefore, to estimate the number of migrant farmworkers as the basis for projecting Medicaid expenditures, we address in this chapter the question of how migrant status should be defined. (The number of migrants and the potential cost of a demonstration are sensitive to this definition.) We then review existing estimates and present new state-by-state estimates of the number of migrants potentially eligible for Medicaid. We use these eligibility numbers to project total Medicaid expenditures, and conclude the chapter with a discussion of the estimates' limitations.

A. DEFINITIONS OF MIGRANT WORKERS

The definition of migrant agricultural workers is relevant not only for the survey design and the collection of statistics. It also determines eligibility for the several federal programs targeted at the specific needs of migrants. Table III.1 summarizes the definitions of a migrant seasonal farmworker (MSFW) that have been developed by the following seven federal programs:[7]

- *Migrant Education.* Authorized under Title I of the Elementary and Secondary Education Act of 1965, the program gave $286 million in grants to states in FY 1991 to fund a wide variety of specialized education programs. $9 million in grants to coordinating centers, including the Migrant Student Record Transfer System, and $9 million to colleges and nonprofits for the HEP/CAMP programs for high school equivalency and college support.

- *Migrant Health.* Authorized under Section 329 of the Public Health Service Act and administered by the Office of Migrant Health of the Public Health Service. In FY 1991 its appropriation of $52 million was used largely in grants to 102 Migrant Health Centers operating some 400 clinic sites.

- *Migrant Head Start.* Operated as a component of the Head Start Program administered by the Administration for Children and Families, this program was appropriated close to $74 million in FY 1991. The program offers unique features including full day centers, enhanced transportation, services for infants and toddlers, and flexible operating seasons which shift with weather patterns.

- *Job Training for Migrant and Seasonal Farmworkers.* Known as JTPA 402, the program is administered by the Department of Labor's Office of Special Targeted Programs with a FY 1991 budget of $70 million. The program offers competitive flexible grants (typically one to each state) to help train migrants who want to work outside farm labor or who need skills to augment agricultural income.

- *Special Supplemental Food Program for Women, Infants, and Children (WIC).* This program provides direct food assistance for pregnant and postpartum women as well as children under five. There is no special set-aside for migrants, but the regulations make special provision for expedited service for MSFWs; the program also pioneered the use of portable eligibility cards.

- *Housing Construction and Rehabilitation.* Under Sections 514 and 516 of the Housing Act of 1959, the Department of Agriculture provides subsidized loans to farmers, states and private nonprofit agencies to construct or rehabilitate housing for farm labor. Grants are available to cover housing costs. Total funding is $27 million.

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[7]These brief program profiles are drawn from descriptions in Martin and Martin 1992.

TABLE III.1

MIGRANT DEFINITIONS USED TO DETERMINE PROGRAM ELIGIBILITY

Name of Program	Definition of Farmworker	Definition of Agriculture	Definition of Migratory	Look-back Period[a]
Migrant Education	Works in agriculture on a seasonal or temporary basis	Field crops, dairy products, poultry, livestock, trees, fish	Has moved from one school district to another with the intent of doing farmwork	Up to 6 years with consent of parents
Migrant Health	Employed in agriculture on a seasonal basis within the past 24 months as "principal" employment	Any commodity grown in or on the land (including processing if performed by a farmer or on a farm in conjunction with growing or harvesting)	Establishes temporary abode for the purpose of doing farmwork	24 months
Migrant Head Start	Family income comes "primarily" from agriculture	Field crops and trees	Has moved from one geographic location to another for the purpose of doing farmwork	12 months
Job Training Partnership Act	Employed at least 25 days in farmwork over a consecutive 12-month period or has earned at least $400 in farmwork. In addition, 50 percent of earnings or work hours must be in farmwork	Crops, livestock (excluding veterinary services, landscape, and horticultural services)	Work prevents person from returning to permanent place of residence within the same day	24 months
WIC	Worked in agriculture as a "principal" employment within the 24-month period preceding application	No formal definition	Establishes temporary abode for the purpose of doing farmwork	24 months
Section 514 and 516 Housing Loans and Grants	"Substantial proportion" (50 percent of federal income limit for region) of income comes from performing farm labor employment, or an average of 110 whole days per year spent in agriculture	Cultivating soil for any agricultural commodity; catching, netting, or handling, preserving, storing in unmanufactured state, or delivering to market any agricultural commodity	Temporary residence at one or more locations not within a day of permanent home for the purpose of doing agricultural work	

TABLE III.1 (*continued*)

Name of Program	Definition of Farmworker	Definition of Agriculture	Definition of Migratory	Look-back Period[a]
HEP/CAMP (High School Equivalency/ College Assistance Migrant Programs)	Has spent a minimum of 75 days during the past 24 months doing seasonal work in agriculture on a farm, ranch, or similar establishment	Field crops, dairy products, poultry, livestock, trees, fish	Work prevents person from returning to permanent place of residence overnight	
Legal Services	Works in agriculture[b]	Any agricultural commodity; trees, horticulture, dairy, poultry, livestock, or bees; processing if integrated with fieldwork	Work prevents person from returning to permanent place of residence overnight	

SOURCES: David Martin and Philip Martin, Coordination of Migrant and Seasonal Farmworker Service Programs. Washington, DC Administrative Conference of the United States, 1992.

Migrant Education, Migrant Head Start, HEP/CAMP - Jim English, Office of Migrant Education, Department of Education.

Job Training Partnership Act - Paul Mayrand, Special Targeted Programs, Department of Labor.

WIC - Doris Dvorscak, WIC, Supplemental Foods, Department of Agriculture.

Section 514 and 516 Housing Loans and Grants - John Pentecost, Multifamily Housing Processing Division, Farmers Home Administration, Department of Agriculture.

Legal Services - Legal Aid Bureau in Salisbury, MD.

[a] Period of time after a qualifying move during which a person is still considered to be a migrant.

[b] The definition of terms such as "agriculture" differs from state-to-state, for migrant legal services. Many states follow the definitions found in The Fair Labor Standards Act and the Agriculture Labor Protection Act. Many states have added minimum travel requirements and strict limitations to the minimum number of months previously employed.

- *Migrant Legal Services.* As part of the Legal Services Corporation, the program has a special line-item appropriation to assure the continuation of services targeted to migrants in 46 states. With a FY 1992 appropriation of $11 million, the program restricts full legal services are restricted to farmworkers with legal immigration status.

Although these programs are intended to serve the same population, the definitions they use vary significantly, and people counted as migrant farmworkers by one program may be excluded from another. For example, while the children of a family might meet the eligibility criteria for the Migrant Education program, the adults in the same family might not be defined as migrant farmworkers according to the requirements for JTPA 402. Similarly, a family that is defined as an MSFW family by Migrant Health might have a young child who is not eligible for Migrant Head Start. A recent Urban Institute report on services for migrant children concluded that:

> Depending on the definition of migrant farmworker used, the migrant population could have a very different demographic profile, a very different geographic distribution, and would constitute a very different percentage and number of the farmworker population nationally (Pindus et al. 1993).

One source for the differences in the eligibility requirements for these programs is the definition of agricultural work that each employs. Similarly, the programs vary in their definitions of what constitutes a migratory work pattern and a qualifying move, and in regard to the amount of time within which the family must have moved to find farm work. Specific variations among different programs are outlined in Table III.1, which summarizes definitions of migrant status used to determine program eligibility. Federal programs differ significantly in the way they define agriculture, farmwork, and migration.

The 1992 Administrative Conference of the United States on the Coordination of Migrant and Seasonal Farmworker Service Programs recommended the development of a core definition of migrant seasonal farmworker. The definition proposed by the Conference would require consistency on the following parameters: (1) the type of farm work included, (2) the number of days employed

per year in qualifying work. (3) the definition of migration, and (4) the length of time one is considered a migrant after a qualifying move (Martin and Martin 1992). Although ultimately this core definition would prove useful in ensuring better coordination among different service programs, the recommendation's most immediate effect would be in helping to develop a single reliable federal estimation system for migrant farmworkers, separate from any of the current federal programs that generate program-specific estimates. To date, no such estimate of the total U.S. migrant population exists.

B. EXISTING ESTIMATES OF MEDICAID-ELIGIBLE MIGRANTS

Statistics on migrants and their dependents are difficult to generate. Migrant farmworkers are hard to locate for survey interviews. Additionally, language barriers and a general reluctance to answer questions pertaining to residency status may impede representative data collection. The transitory and far-ranging nature of migrant work opportunities also makes it difficult to get an accurate count of migrant farmworkers.

The most common form of migrant estimation is a "bottom-up" approach which compiles local counts of seasonal farmworkers adjusted by the estimated proportion of migrants and their dependents. In contrast, "top-down" procedures begin with aggregate data on total farm employment or production and then adjust these published statistics using estimated proportions of migrant and seasonal farmworkers. Both approaches have potential problems. In the case of bottom-up estimates, the main concern is data collection error; the major argument against the top-down procedure is its inevitable reliance on arbitrary assumptions to differentiate between subsets of the MSFW population (Martin and Martin 1992).

1. Nonprogram Generated Estimates

Current nonprogram-generated data sources for migrant population estimates are (1) wage and employment data from the Quarterly Annual Labor Survey (QALS), (2) the 1987 Census of

Agriculture, and (3) the National Agricultural Workers Survey (NAWS). The NAWS is a randomized national survey consisting of detailed one-hour interviews with farmworkers. It is the research successor to the defunct Hired Farmworkers Force data from the Current Population Survey. The 1990 NAWS estimated the number of migrant workers engaged in perishable crop work to be approximately 42 percent of the total U.S. crop farmworker labor force, or approximately 840,000 to 940,000 migrants. The NAWS classifies as a migrant anyone who travels 75 miles or more during the year in search of farm work; it excludes all data on livestock and farm service workers.

The NAWS has not published state estimates of the migrant farmworker population. In fact, the survey's use of site area sampling to obtain a nationally representative cross-section of MSFWs cannot support state-level estimates, except for California and Florida (Aguirre International 1993).

A 1993 Department of Labor report, *U.S. Farmworkers in the Post-IRCA Period*, which is based on data from 1989, 1990, and 1991 NAWS, provides valuable regional demographic information pertaining to seasonal workers, albeit limited detail on migrants. A series of new reports on migrant farmworkers based on the NAWS is forthcoming.

2. Program-Generated Estimates

The Migrant Education and Migrant Health Center federal programs collect data on the farmworker families who receive services, and these have been used to estimate the size of the U.S. migrant population. In addition, a third migrant population estimate, The Migrant Enumeration Project, was conducted recently for Migrant Legal Services.

a. Migrant Education

The source of Migrant Education's population estimates is the program's Migrant Student Record Transfer System. The MSRTS stores academic, health, and other educational records on migratory children participating in the Migrant Education program. Because of the way the MSRTS generates its FTE counts, even when MSRTS records show that a student has withdrawn from a

school system. she remains within that state's database until she is picked up by a system in a different state and the state notifies MSRTS of the enrollment there. In the past, this slow removal from a state's MSRTS counts worked to the advantage of "stopover" states with aggressive ME outreach programs. since many of the children signed up in such states were never picked up by another state system (Martin and Martin 1992). The MSRTS also may include double counting of children with access to services in more than one state. Other criticisms of MSRTS-based migrant population estimates are: (1) states vary in their requirements for completion of MSRTS; (2) MSRTS counts will not include migrant children who attend schools not enrolled in the Migrant Education Program: and. (3) the increasing complexity of MSRTS reporting procedures has reduced the timeliness and accuracy of the system's migrant children estimates (Pindus et al. 1993).

b. Migrant Health

The Office of Migrant Health collects information on farmworkers and their family members who receive services. since funding allocations for approved Migrant Health Centers under sections 329 and 330 of the Public Health Service Act are made based on the number of migrants in a clinic's "catchment area." The major drawback of migrant estimates compiled using data from grant applications as well as patient and utilization data from the Bureau of Community Health Services Common Reporting Requirement system, is that they include only those migrants who have visited 329- and 330-funded official Migrant Health Centers (Pindus et al. 1993).

In 1990 the Office of Migrant Health published, "An Atlas of State Profiles Which Estimate Number of Migrant and Seasonal Farmworkers and Members of Their Families." The Atlas is a compilation of state-based estimation efforts that rely on a variety of enumeration methodologies.

c. Migrant Legal Services

The 1993 Migrant Enumeration Project (MEP) is a national state-by-state estimate of migrants undertaken to help Migrant Legal Services allocate funds proportionate to the migrant populations

in each state (Larson and Plascencia 1993). The study defines migrants as "anyone who, while employed in seasonal agricultural labor during the last year, cannot return to his/her normal residence at night."

The MEP uses data from the Quarterly Annual Labor Survey, the National Agricultural Workers Survey, as well as Migrant Health and Migrant Education program-generated data. These and other secondary source materials were supplemented with selected interviews. The MEP targets migrant workers in the following areas: field agriculture, forestry, nurseries and greenhouses, processing activities. cotton gins, and crops under cover. Seasonal laborers in fishing, dairies, poultry or eggs or working with other animals are excluded from the counts. In each state, the researchers identified counties with migrant labor, gathered crop and labor specific data, and developed field agricultural summaries for each county based on demand-for-labor estimates for specific agricultural tasks. Because the MEP methodology does not adjust for interstate or intrastate duplication, its resulting estimated total migrant labor pool includes an unquantified amount of duplication. The duplication problem is exacerbated by the estimate for dependents, which was created by multiplying the unadjusted migrant labor pool estimates by coefficients developed from data reported by Migrant Health, Migrant Education, and the NAWS. The resulting total number of migrants and dependents is 3,036,432.

C. NEW ESTIMATES OF MIGRANT POPULATIONS BY STATE

Given the wide variability in existing estimates of the number of migrants, as well as the estimates' potential upward bias and lack of focus on the specific issue of Medicaid eligibility, we have generated independent estimates for major migrant states in the eastern and midwestern streams. A fully accurate estimate would require access to more current data (particularly the 1992 Census of Agriculture and the 1992 NAWS, which are not yet available) and a detailed simulation of the many possible eligibility categories outlined in Chapter II. Since our intention at this point

is to generate an initial rough estimate of the potential impact of improved enrollment in Medicaid and resulting program expenditures. we have made several significant simplifying assumptions.

- Medicaid eligibility for migrants will be limited to pregnant mothers and children. Although some migrants will be eligible under other categories, the bulk will be enrolled through the Medicaid expansions. Few migrants are single mothers eligible under AFDC.
- All children under the age of 15 are eligible. This assumption is required by the definition of children in the NAWS and is a compromise between the current cut-off of 10 and age 18, which will be the mandatory limit when the expansions are fully phased in.
- All migrants meet every state's income. residence and asset criteria. The transitory nature of many migrant families' income may remove eligibility for a time (particularly if eligible under AFDC-UP).
- All eligible migrants are enrolled for the entire 12 months of a year. This may not be possible for women, who are limited to pregnancy and 60 days post-partum under the expansions. In 1991, such women averaged 5.8 months of enrollment, and their children averaged 7.1 months.[8]
- Migrants by the NAWS definition are (1) only those working on field and orchard crops (livestock. dairy, fishing, forestry and processing activities are excluded), who (2) work at least 75 miles from home.

Given these assumptions. the number of Medicaid-eligible migrants is generated in three steps. (Details of the methodology are described in Appendix B.) First, the total demand for farm labor in each state is derived from the 1987 Census of Agriculture, which gives the total wages reported by growers by crop. The number of agricultural jobs in each state is estimated by dividing total labor costs first by regional wages for farmworkers, then by the average hours worked per week. and finally by the average time in state for migrant and seasonal workers. The result of this first step is an estimate of the number of farmworkers in each state. Table III.2 compares these estimates with those generated by the Migrant Enumeration Project (Larson and Plascencia 1993). The latter approach estimated total labor demand starting with crop tonnage and acreage reported in the 1987

[8]Based on Medicaid enrollment data for the four Tape-to-Tape states of California. Georgia, Michigan, and Tennessee. The estimates are an unweighted average calculated from unpublished tables supplied by the Tape-to-Tape contractor, SysteMetrics, Inc.

TABLE III.2

COMPARATIVE ESTIMATES OF MIGRANT POPULATIONS BY STATE
(EXCLUDING ADJUSTMENTS FOR DOWN TIME)

Target States	Migrant Enumeration Project Estimates		MPR Estimates Based on Labor Cost Labor and NAWS		Migrant Health Program[d]
	Number of Farm Labor Jobs	Total Migrant Workers and Dependents[a,b]	Number of Farm Labor Jobs	Total Migrant Workers and Dependents[b,c]	Total Migrant Workers and Dependents
Midwestern Migratory Stream States:					
Arkansas	17,774	15,978	32,928	35,068	--
Colorado	35,676	37,719	31,684	29,086	20,220
Illinois	22,635	32,470	64,092	68,258	17,508
Michigan	121,886	151,668	60,661	64,604	59,831
Minnesota	30,850	45,686	41,342	44,029	11,965
Missouri	15,902	19,387	29,667	31,595	1,343
New Mexico	27,518	19,945	13,711	12,587	6,706
North Dakota	19,343	30,613	26,639	24,455	9,000
Ohio	16,995	25,089	46,696	49,731	9,058
Oklahoma	14,736	15,014	13,232	12,146	--
Texas	208,547	220,548	73,072	67,080	281,778
Wisconsin	10,311	14,428	31,722	33,783	7,792
Total	636,767		465,446		
Alabama	14,634	7,667	16,730	17,817	4,083
Florida	246,478	228,423	199,886	183,495	182,790
Georgia	93,585	100,462	36,488	38,859	28,081
Maine	26,525	17,908	10,256	10,923	5,580
Maryland	23,504	23,332	13,797	14,694	1,416
New Jersey	36,930	30,184	29,251	31,153	6,377
New York	23,260	70,778	48,478	51,629	19,209
North Carolina	141,092	140,225	44,348	47,231	44,062
Pennsylvania	37,001	35,504	59,229	63,079	14,734
South Carolina	42,543	51,514	20,700	22,046	10,760
Tennessee	12,229	15,147	21,247	22,628	2,894
Virginia	34,342	39,739	14,514	15,457	5,731
Total	732,123		514,924		
Total in Midwestern and Eastern Migratory Stream States	1,368,890		980,370		

[a]The numbers in this column assume that each migrant holds only one job in each state. Estimates from Larson and Plasencia (1993).
[b]The total migrant labor pool hours in Texas and Florida are not adjusted for downtime in home states. Estimates are for all migrants regardless of legal status.
[c]MPR estimates from Appendix Table B.1.
[d]Department of Health and Human Services, Migrant Health Program (1990).

Census of Agriculture and using average coefficients for the labor required to grow and harvest these crops. This methodology results in 40 percent more farm labor than the MPR estimate derived from wage costs. Particularly large differences are evident in the agricultural centers of Texas, North Carolina, and Georgia. Note that these estimates are limited to field crops and that in some states (e.g. Illinois) the demand for labor in nurseries and seasonal processing plans forms a relatively large proportion of migrant employment. As noted previously, the exact definition of migrant labor influences the estimates.

The second step in estimating the enrollment impact is to use the total number of jobs as a basis for estimating the number of working migrants and their dependents eligible for Medicaid, i.e. estimating the number of legal pregnant women and children. This is done by using demographic coefficients estimated as the average of the 1989-1991 NAWS. Most of these coefficients are unpublished and generously calculated for us by the Office of Program Economics of the Department of Labor. These coefficients for the specific migrant population are very important, since published data from the NAWS tends to cover all seasonal workers, and not specifically migrants, who differ from seasonal agricultural workers in important respects.

We adjusted for the following factors:

- Migrants as a percentage of all seasonal workers, many of whom are settled
- Percentage of migrant workers with legal immigration status
- Percentage of migrant workers who are female
- Percentage of migrant females pregnant during the year
- Number of children under 15 traveling with migrant workers

The third step is to calculate an unduplicated count of pregnant women and children who return during the non-crop season to the home states of Florida and Texas. This number is augmented by an estimate of the number of pregnant women and children who remain in the home state while the

husband/father travels for work. These estimates take into account two important characteristics that significantly limit the number of migrants potentially affected by an interstate reciprocity agreement. First, two-thirds of migrants do not follow the crops. Instead they are exclusively "shuttle migrants;" i.e., they travel back and forth between a home base (where they do no farm work) and one farm work location.[9] Second, more than 80 percent of shuttle migrants are based in foreign countries (primarily Mexico). While most of these shuttle migrants report legal Special Agricultural Worker status, including them in Medicaid is an outreach problem for their primary target state. Since these workers move primarily between a foreign base and a single state, an interstate compact will not affect them and their families.

In addition to adjusting for demographic status, the state-by-state estimates attempt to model movement between states and make allowance for down time in the home state. This required the following simplifying assumptions:

- All migrants spend down time in a single home state (Texas or Florida).
- Migrants minimize state-to-state travel and stay in one state for the duration of the peak growing season.
- All married migrant women are migrants and are counted in the labor force.
- The demographic profile of migrants in upstream states is constant across all states.
- Workers in Florida and Texas have identical demographic profiles.
- Workers divide the weeks spent in nonagricultural work equally between their home state and upstream states.

The results of this estimation process are summarized in Table III.3. It is clear that relatively few individuals will be added to the Medicaid rolls for most upstream states. The real issue appears to be for the home states of Florida and Texas. The down time adjustment generates a significant

[9]An additional 14 percent of migrants both move from crop-to-crop and are also classified as "shuttle migrants" -- they travel back and forth between a home base and different U.S. crop locations.

TABLE III.3

MPR MIGRANT LABOR COST DERIVED ESTIMATES

	Number of Seasonal Agricultural Labor Hours (thousands)	Number of Legal Migrant Workers	Number of Potentially Eligible Pregnant Women	Nummber of Potentially Eligible Number of Children	Number of Pregnant Women and Children in Homes State	Total Number of Medicaid Eligibles
Midwestern Migratory Stream States:						
Arkansas	30,031	17,067	769	8,533		9,302
Colorado	19,647	14,714	702	10,300		11,002
Illinois	40,762	33,219	1,497	16,609		18,106
Michigan	38,580	31,441	1,416	15,720		17,137
Minnesota	26,293	21,427	965	10,714		11,679
Missouri	18,868	15,376	693	7,688		8,381
New Mexico	12,192	6,367	304	4,457		4,761
North Dakota	16,519	12,371	590	8,660		9,250
Ohio	29,698	24,202	1,090	12,101		13,191
Oklahoma	11,766	6,145	293	4,301		4,595
Texas	82,075	33,935	1,619	23,754	62,607	25,373
Wisconsin	20,175	16,441	741	8,221		8,961
Eastern Migratory Stream States:						
Alabama	15,258	8,671	253	4,336	69,288	4,589
Florida	224,512	92,827	2,706	69,288		136,973
Georgia	33,277	18,912	551	9,456		10,007
Maine	6,523	5,316	155	2,658		2,813
Maryland	8,775	7,151	208	3,575		3,783
New York	30,832	25,126	732	12,563		13,295
New Jersey	18,604	15,161	442	7,580		8,022
North Carolina	40,445	22,986	670	11,493		12,163
Pennsylvania	37,670	30,699	895	15,349		16,244
South Carolina	18,879	10,729	313	5,364		5,677
Tennessee	19,377	11,012	321	5,506		5,827
Virginia	13,237	7,523	219	3,761		3,980

number of potential eligibles. Many of these, however, may already be enrolled in the home state's Medicaid program. As a result, the estimates overstate the potential increase in a state's Medicaid enrollment. We have, however, no data on the proportion of migrants currently covered by Medicaid. If the order of magnitudes are correct, the demonstration will not by itself significantly increase Medicaid enrollment or impact most states. In Georgia for example, Table III.3 projects 10,308 enrollees, which comprise only pregnant women and children under 15. This respresents an estimated 30.8 thousand person months, a fairly marginal effect compared with the 8,593.0 thousand person months of enrollment in the state's Medicaid program in 1991.[10]

D. EXPECTED MEDICAID EXPENDITURES

Given the wide-ranging estimates of eligible migrants and a lack of data, it is difficult to confidently project expenditures per enrollment month. There is some evidence that the average utilization of migrants is very low. In particular, since the mid 1970s the federal government has sponsored a series of demonstrations that paid for some portion of the health expenditures of migrants enrolled at selected Migrant Health Centers (Pindus et al. 1977). Utilization and expenditures have been modest. For example, a program operated out of The Gateway Community Health Center in Laredo, Texas. issues to enrolled migrants Blue Cross/Blue Shield cards that are valid in all areas except the home-base area. In the past decade, the cost per month has averaged less than $20 (Travino, 1993). Observers suggest that poor access to care and unwillingness to forego limited work opportunities make migrants reluctant to take the time and effort to seek medical care when they are traveling.

Available Medicaid data, however, suggest that we should treat the hypothesis of low utilization with some caution. The population enrolled in the Laredo demonstration is a cross-section of workers with predominantly young, healthy men who have few medical problems beyond

[10]Data on total person months of enrollment from unpublished tabulations of the Tape-to-Tape project furnished by SysteMetrics Inc. The estimate of migrant person months is from Table III.5.

emergencies. In contrast, women can become eligible for Medicaid primarily if they are pregnant and therefore are certain to have a relatively high-cost hospitalization.

Table III.4 displays Medicaid expenditures per month for four states and compares expenditures for patients eligible through AFDC to those enrolled under the poverty-related status mandated by the Medicaid expansions. The latter is the eligibility category most likely to be relevant for migrants. In most cases, children and pregnant women are considerably more costly. Moreover, data from California's two special programs for foreign-born Medicaid enrollees support the hypothesis of relatively high cost. The category "IRCA Aliens" aggregates adults and children with several types of legal immigration status under IRCA 86. The largest component group are those with SAW designation, the category relevant for migrants. The monthly expenditure per person for this group of $213 is similar to the average across the four states for all adults and children with poverty related eligibility. (The 12.7 percent difference between Medi-Cal monthly expenditures for poverty-related and IRCA alien eligibility group is partially accounted for by inflation between 1991 and 1992.) It is safest to assume that the experience with poverty-related groups rather than AFDC is relevant to migrants. We will assume the four-state average monthly per-person expenditures for adults and children under poverty-related eligibility.

In addition to expenditure per month, projected Medicaid expenditures are highly sensitive to the assumed average length of enrollment. Rather than assume a full twelve months of enrollment, we have used the Tape-to-Tape data (not shown) for the four states on actual enrollment periods under the Medicaid expansions. For children and pregnant women these run relatively consistently at 7.1 and 5.8 months respectively. As explained in more detail in Appendix B, we adjust these average enrollment periods depending on travel or home state down time status.

The final rough estimates of potential Medicaid expenditures are summarized in three sections of Table III.5: the potential number of eligible migrants, person-months of Medicaid enrollment, and Medicaid expenditures. The first two columns summarize the earlier estimates of the numbers

TABLE III.4

COMPARISON OF AVERAGE MEDICAID MONTHLY EXPENDITURES BY ELIGIBILITY CATEGORY FOR TAPE-TO-TAPE STATES

Eligibility Category	California	Georgia	Michigan	Tennessee	Four-State Average
AFDC (1991)[a]					
Adult	$130	$139	$137	$170	144
Child	44	60	63	75	60
Total	70	84	91	106	88
Poverty Related (1991)					
Adult	325	567	307	327	381
Child	93	130	140	93	114
Total	189	258	198	142	198
IRCA Aliens (1992)[b]					
Total	213	NA	NA	NA	NA
OBRA Aliens (1992)[b]					
Total	224	NA	NA	NA	NA

SOURCES:

[a]Calculated from unpublished tabulations from the Tape-to-Tape database furnished by SysteMetrics. Inc.

[b]Calculated from tabulations of Medi-Cal data furnished by the California Department of Health, Division of Medical Care Statistics. The IRCA and OBRA categories combine several eligibility categories covered under the two legislative mandates.

TABLE III.5

ESTIMATED MEDICAID EXPENDITURES

Target States	Number of Migrant Pregnant Women Potentially Eligible	Total Migrant Children Potentially Eligible	Medicaid Eligible Person-Months for Pregnant Women	Medicaid Eligible Person-months for Migrant Children	Medicaid Expenditures for Women at $381 per Month	Medicaid Expenditures for Children at $114 per Month	Total Estimated Medicaid Expenditures
Midwestern Migratory Stream States							
Arkansas	769	8,533	10,487	26,580	3,995,649	3,030,116	7,025,766
Colorado	702	10,300	11,544	22,373	4,398,193	2,550,564	6,948,757
Illinois	1,497	16,609	19,262	36,079	7,338,645	4,112,963	11,451,609
Michigan	1,416	15,720	18,230	34,147	6,945,814	3,892,800	10,838,614
Minnesota	965	10,714	12,424	23,272	4,733,731	2,653,032	7,386,764
Missouri	693	7,688	8,916	16,700	3,396,889	1,903,795	5,300,684
New Mexico	304	4,457	5,229	13,883	1,992,262	1,582,701	3,574,963
North Dakota	590	8,660	9,706	18,811	3,697,904	2,144,458	5,842,363
Ohio	1,090	12,101	14,033	26,286	5,346,746	2,996,598	8,343,344
Oklahoma	293	4,301	5,046	13,398	1,922,657	1,527,404	3,450,061
Texas	4,692	83,288	28,950	461,218	11,030,134	52,578,811	63,608,945
Wisconsin	741	8,221	9,533	17,857	3,632,190	2,035,671	5,667,861
Total	13,751	190,593	153,362	710,605	58,430,815	81,008,914	139,439,730
Eastern Migratory Stream States							
Alabama	253	4,336	4,978	13,504	1,896,564	1,539,500	3,436,064
Florida	5,107	121,533	73,665	617,737	28,066,414	70,422,018	98,488,432
Georgia	551	9,456	10,857	29,453	4,136,426	3,357,666	7,494,093
Maine	155	2,658	2,933	5,773	1,117,299	658,179	1,775,478
Maryland	208	3,575	3,945	7,767	1,503,007	885,392	2,388,398
New Jersey	442	7,580	8,364	16,466	3,186,579	1,877,151	5,063,730
New York	732	12,563	13,861	27,289	5,281,044	3,110,959	8,392,004
North Carolina	670	11,493	13,196	35,798	5,027,492	4,080,972	9,108,463
Pennsylvania	895	15,349	16,935	33,341	6,452,302	3,800,924	10,253,226
South Carolina	313	5,364	6,159	16,709	2,346,671	1,904,866	4,251,537
Tennessee	321	5,506	6,322	17,151	2,408,640	1,955,169	4,363,809
Virginia	219	3,761	4,319	11,716	1,645,386	1,335,611	2,980,997
Total	9,867	203,175	165,532	832,705	63,067,823	94,928,408	157,996,231
Total in Midwestern and Eastern Migratory Stream States		393,769		1,543,310	121,498,639	175,937,322	297,435,961

of migrant pregnant women and children under 15 potentially eligible for Medicaid. The totals include estimates both of those traveling while working, and of those with down time in the home state. Note that we do not report totals, since the state numbers are not an unduplicated count of individuals. The next two columns estimate the number of person months of Medicaid enrollment for these potentially eligible migrants. These are calculated using NAWS data on average number of weeks in agricultural work, nonagricultural work and unemployed in upstream and downstream states. They also reflect the assumptions on average length of enrollment discussed above. (For details of assumptions and estimates see Appendix B.) Columns 5 and 6 estimate total Medicaid expenditure by multiplying person months for adult women and children by the estimated average expenditures per month of $381 and $114 respectively.

For the 24 study states in the midwest and eastern streams, full coverage of migrants would potentially generate an estimated $297 million in Medicaid expenditures. Roughly half of this would be paid for by the federal government. (The federal match rate varies from state to state.) Given the simplifying assumptions of this simulation, more than 50 percent of total expenditure would occur in the home states of Texas and Florida.

These figures are clearly first estimates and sensitive to many assumptions. In particular, agricultural payroll data may significantly underestimate labor utilization. We have rerun the estimation using the recent and higher labor estimates developed by Larson and Plascencia (1993) for the Migrant Enumeration Project. The results of the two estimates are compared in the first two columns of Table III.6. The higher labor demand figures raise the overall estimated cost for the 24 study states by 33 percent and significantly change the distribution by increasing the share of the home states.

How much are these estimated expenditures in relation to the current Medicaid program? Table III.6 compares the estimated figures with total Medicaid expenditures reported for 1991. In all except three upstream states, the proportions are well under 1 percent. Only the home states of

TABLE III.6

ESTIMATED MEDICAID EXPENDITURES OF MIGRANTS
AS A PROPORTION OF TOTAL EXPENDITURES

	Estimated Spending on Migrants (in $ millions)		Total 1991 Medicaid Expenditures[c] (in $ millions)	Estimate as % of Total	
	Based on Payroll Data[a]	Based on Production Data[b]		Based on Payroll Data[a]	Based on Production Data[b]
Midwestern Stream States					
Arkansas	7.0	3.8	688	1.0	.1
Colorado	6.9	7.8	673	1.0	1.1
Illinois	11.4	4.0	2,731	.4	.1
Michigan	10.8	21.8	2,540	.4	.9
Minnesota	7.4	5.5	1,561	.4	.3
Missouri	5.3	2.8	1,118	.5	.2
New Mexico	3.6	7.2	342	1.0	2.1
North Dakota	5.8	4.2	227	2.6	1.8
Ohio	8.3	3.0	3,653	.2	.1
Oklahoma	3.4	3.8	814	.4	.5
Texas	63.6	102.2	3,532	1.8	2.9
Wisconsin	5.7	1.8	1,471	.4	.1
Total	139.4	167.9	19,350	.7	.9
Eastern Stream States					
Alabama	3.4	3.0	755	.4	.4
Florida	98.5	132.7	2,944	3.3	4.5
Georgia	7.5	19.2	1,799	.4	1.1
Maine	1.8	4.6	536	.3	.1
Maryland	2.4	4.1	1,292	.2	.3
New Jersey	5.1	6.4	2,725	.2	.2
New York	8.4	4.0	13,728	.1	*
North Carolina	9.1	29.0	1,788	.5	1.6
Pennsylvania	10.2	6.4	3,436	.3	.2
South Carolina	4.2	8.7	910	.5	1.0
Tennessee	4.4	2.5	1,485	.3	.2
Virginia	3.0	7.0	1,218	.2	.6
Total	158.0	227.6	32,616	.5	.7

[a]Congressional Research Service, Medical Source Book: Background Data and Analysis (1993 Update). Report to the Committee on Energy and Commerce, U.S. House of Representatives. Washington, DC: CRS, 1993. Table II-9, pp.116.

[b]See Table III.5, column 7.

[c]Rerun of estimation model using agricultural labor.

Florida and Texas appear to be liable for a significant expenditure, and some portion of migrants are already enrolled in those states. In sum, upstream states appear to be able to join a demonstration without running to run the risk of a large potential increase in expenditures.

E. LIMITATIONS OF THE ANALYSIS

Although these estimates have greatly benefited from the use of unpublished NAWS data on migrants (as opposed to seasonal agricultural workers), they represent only an initial effort to gauge the size and distributive effects of a fully implemented system of interstate reciprocity agreements. While the estimation can be improved with more recent data and more detailed simulations, a basic lack of information on state and local conditions will unavoidably limit the accuracy of estimated effects in individual states. The following are the most notable limitations of the current estimates:

- *Inadequate Data on Total Numbers of Migrants.* The estimates have had to rely on the 1987 Census of Agriculture, data which do not represent recent changes, particularly in the eastern and midwestern states. The 1992 Census will not be fully available until 1994.

- *Uncertain Bias in the Use of Payroll Data.* More work needs to be done on how much underreporting occurs with the use of grower reported payrolls as the basis for estimating total numbers of agricultural jobs.

- *Need for Disaggregated Data on Upstream and Downstream States.* The NAWS data allow disaggregation of results for migrants in home states versus upstream states. The assumption that the profile of migrants is the same in all non-home states is in error. Those in North Carolina or Georgia may have different characteristics from those in Maine or New York.

- *Lack of Detailed Modeling of Shuttle Patterns.* The majority of migrants do not move from state to state but shuttle between a home base and a single state of work. This pattern is inadequately accounted for and may greatly influence the number of migrants benefiting from an interstate reciprocity agreement.

- *Need for More Complex Simulation of Medicaid Eligibility.* We have assumed that migrants will be eligible only under provisions of the Medicaid expansions. Estimates would be improved by taking into account all relevant eligibility categories, and simulating their provisions more exactly. Incorporating state-to-state differences would be desirable.

- *Uncertainty Over Average Length of Enrollment.* We have not assumed that all migrants will be enrolled 12 months a year. The enrollment period data are based

on only four states. More important, the timing of care will have a large impact on the interstate distribution of costs. Some 55 percent of pregnant women's costs are deliveries which could be focused on the home state (Howell and Brown 1989).

- *Uncertainty over legal status.* We have assumed in these simulations that the pregnant wives and children of migrants declaring themselves legal are eligible for full Medicaid coverage. This is most certainly an overestimate since many workers have SAW status under which their family members are not legal. Better data on legal status may significantly effect estimated eligible population.

- *Inaccurate Estimate of Average Monthly Medicaid Expenditures.* The wide range of estimated monthly expenditures indicates the need for more detailed analysis. State-specific averages would be desirable.

- *Lack of Information on Current Participation in Medicaid.* In order to evaluate the net impact on state Medicaid expenditures, we need information on the proportion of migrants currently enrolled in Medicaid. In particular, many of the deliveries may already be covered.

The importance of such an expanded modeling effort to this evaluation of the feasibility of a demonstration cannot yet be determined. The utility depends in part on the proposed structure, the number of participating states, and the need for more accurate estimates in state and federal decision making.

IV. ISSUES AND OPTIONS FOR DEMONSTRATION DESIGN

We have identified a number of issues that must be considered in designing a demonstration to test the feasibility of an interstate Medicaid reciprocity agreement for migrant farmworkers. They include the numerous barriers migrants face in obtaining health care, the problems of sharing financial risk and burden among states, the substantial state-to-state variations in key Medicaid program characteristics, the small numbers of migrants potentially eligible under existing Medicaid policy, and the lack of existing models for interstate reciprocity agreements. In this chapter, we review the objectives of an interstate agreement, the key issues raised in this report that are most likely require the greatest attention in designing a demonstration, and the basic options for the core dimensions of a demonstration design.

A. DEMONSTRATION OBJECTIVES

The purpose of the interstate compact under consideration is to facilitate state and federal government efforts to include farmworkers and their families under the Medicaid program. Ensuring access and coverage for migrant farmworkers and their families under Medicaid is not a new mandate. In fact, "migrant farmworkers precisely fit the profile of the population the Medicaid program was designed to protect" (National Advisory Council on Migrant Health 1992). In a very real sense, the purpose of reciprocity agreements is to "expand the Medicaid expansions."

As a result of expanded Medicaid participation, an interstate reciprocity agreement would meet two indirect objectives: (1) improved access to care for migrants and (2) the development of more cost-effective patterns of care due to better primary and preventive care. In achieving the first goal, we anticipate that the most significant impact of interstate compacts or other demonstration models that facilitate Medicaid coverage for migrant farmworkers and their families will be in the area of outpatient primary care services--particularly preventive, prenatal, and well-child services. Migrants who are hospitalized, chronically ill, or disabled are most likely to have Medicaid coverage if they

are otherwise eligible, either categorically or by virtue of their income. Migrants who are hospitalized are more likely to be walked through the application process by a hospital social worker in order to ensure reimbursement to the hospital and are more likely to remain in the state for the period required for the application process to be completed. Migrant farmworkers or their family members who are chronically ill or disabled are unlikely to travel with their families.

Given the limited proportion of migrants currently served by MHCs, a further goal of a demonstration is to increase access to other providers. From this perspective, operational details such as ease in obtaining prior authorization and establishing provider reimbursement procedures will be critical to a demonstration's success. This is particularly true if utilization will increase primarily for less costly services.

In achieving the second goal--more cost-effective patterns of care--we anticipate that home states that enroll migrants in Medicaid could benefit if upstream coverage was encouraged and primary care was not postponed. Moreover, a successful demonstration has the potential to generate longer term benefits. Since states have been moving to increase the number of EPSDT providers who are then eligible for Medicaid reimbursement, an interstate reciprocity agreement would facilitate treatment of children identified as having particular deficits. Preventive care, prenatal care, and earlier treatment of illness and injury may actually result in a decrease in more expensive hospital utilization. In addition, public health benefits will be realized through increases in services such as immunization and tuberculosis screening, and treatment for migrant farmworkers and their families.

B. KEY ISSUES FOR THE DEMONSTRATION DESIGN

Five main issues must be addressed by a demonstration to assess the feasibility of an interstate Medicaid reciprocity agreement for providing coverage to migrant workers:

1. ***Definition of Migrants Covered.*** Given the host of definitions under which migrant programs operate, how shall eligibility for the program be specified?

2. *Standards for Eligibility and Scope of Services.* Should migrants meet the same eligibility standards in all states and receive a consistent scope of services?

3. *Program Organization.* How should an interstate reciprocity agreement be administered, and who should be responsible for eligibility determination and payment?

4. *Requirements for Outreach and Coordination.* Should a demonstration impose additional conditions of participation such as outreach programs to enroll migrants?

5. *Benefits of a Demonstration.* Do the benefits of a demonstration justify the associated effort and expense?

The way we choose to address these five issues will structure the design of an interstate compact and a demonstration to test its effectiveness.

1. Definition of Migrants Covered

The answers to several questions feed into a definition of migrant workers. Who should be covered by a demonstration? Do we need a special program for migrants or simply an agreement to simplify interstate processing of claims for all Medicaid enrollees? Limiting the demonstration to migrants has the advantage of confining the potential financial liability of states. Moreover, a program for migrants would focus increased attention on their unique access needs.

A program limited to migrants does, however, raise the issue of defining the eligible population. Key components of a definition include the "look-back period" since the last move for agricultural work, how recently an individual must have moved across state borders, and the proportion of income or work hours connected with agricultural labor. Which of the several definitions already drawn up for other migrant programs should be adopted? An expansive definition such as the one used by migrant education would qualify far more individuals than the restrictive one employed by Migrant Head Start. In addition, equity issues are involved in improving access to care for some depending upon occupation. Why shouldn't the family of an unemployed carpenter moving for work have the same status as that of one who ordinarily works in the fields? There are also administrative

issues. What documentation would be required? Who would administer the eligibility tests? Introducing a special category of "migrant" will be complicated by the need to train eligibility workers and ensure uniformity in dealing with what would be, for most, a "rare event."

There is an additional potential issue of states' ability to enter into a formal agreement that covers and benefits only some enrollees. Although the ability of states to generate side agreements is not in doubt, restrictive agreements may require formal HCFA waivers. Application for waivers would be facilitated by a demonstration, but would greatly complicate an operational program.

2. Standardized Benefits and Eligibility

One implication of state-to-state variations in Medicaid program characteristics is that migrants eligible for coverage in one state with an eligibility threshold of 185 percent of poverty, for example, would be ineligible in another state with a 133 percent of poverty eligibility threshold. While both states would presumably recognize the other's eligibility determination under an interstate reciprocity agreement, enrollment would depend on the state in which a migrant pregnant mother or her children first applied. For states with restrictive Medicaid eligibility criteria, an interstate compact would confer benefits on some migrants that are not available to its other low-income citizens. An additional issue is whether states should recognize each others' state-only programs. such as General Assistance.

While we have concluded that with the exception of dentistry, differences in covered services seldom include those services most likely to be used by migrants, there are major differences in service limitations (number of hospital days or visits), managed care, and prior authorization requirements that would affect migrants. For example, there are likely to be problems with pharmacy claims, since states now have the authority to reintroduce restrictive formularies, have differing prior approval requirements, and are increasingly requiring POS electronic eligibility verification. These developments pose problems for migrants who need a refill for a prescription issued in another state. Given the problems created by this variation, should a demonstration

require a uniform set of eligibility standards and service requirements? While uniformity would improve the consistency of care as migrants move from state to state, deciding upon a single set of standards could prove difficult. Moreover, it would again leave some states with different rules for different classes of beneficiaries.

If, on the other hand, program characteristics remain unique to each participating state, a real issue is the degree to which such differences place providers at risk of claim denial. Different payment and coverage regulations may complicate participation particularly for rural providers who are often in the best position to serve migrants.

3. Program Administration

The different state Medicaid programs and administrative procedures will have to be coordinated in a system of interstate agreements. These operational details are not only necessary for states' Medicaid programs, they can have an important effect in discouraging or encouraging provider participation. Among the issues to be addressed are:

- ***Enrollment Cards.*** Will participating states issue special enrollment cards to migrants, maintain existing cards that will be deemed valid in all states, or issue portable certifications as are used in the WIC program, which would guarantee enrollment in participating states without repeating an eligibility determination process?

- ***Recertification Process.*** Which state will be responsible for recertifying migrant enrollees? How will recertification be communicated to other states? Will all states recognize the same recertification requirements?

- ***Current Enrollment Verification.*** Will providers be responsible for verifying the eligibility of migrants? If so, with which state will they check?

- ***Exceptions for Managed Care Requirements.*** For states with mandatory managed care and/or case management provisions, what will be the exceptions process for migrants staying only a brief while?

- ***Procedures and Liability for Utilization Controls.*** Will providers in all states be required to check with the home state to see if particular utilization limits have already been met or prior authorization is required? How will they know who to contact? Which state's regulations will be in effect?

- *Reimbursement Policy.* Will providers be paid according to their own state's standards or some other set? Who will be responsible for the collection of patient copays required by some states and not others?

- *Cost Sharing Among States.* If either claims or administrative costs are disproportionately shared among states, is a financing pool required? If so, how should it be organized?

4. Additional Requirements for Outreach and Provider Participation

The issue of outreach and coordination requirements is fundamentally an issue of additional conditions of participation. That is, how much would be accomplished if the administrative structure of an interstate reciprocity agreement were put in place without a significant effort to inform and recruit migrants and physicians?

The problem with requiring states to have specific plans that would facilitate provider participation and migrant enrollment is that it may discourage them from joining a demonstration. In the current fiscal climate, states may be very nervous about taking on any new Medicaid obligations. Additional requirements may only compound the recruitment problem. This is particularly true since HCFA has made clear its intention to fund only the limited administrative costs associated with a demonstration. There are currently no plans for providing additional funding that would cover activities such as expanded outreach.

5. Benefits from a Demonstration

The final major issue in developing a demonstration design is whether the benefits from a demonstration will justify the associated effort and expense. States can develop cooperative agreements without federal interference. Under a HCFA-sponsored demonstration, participating states would have to negotiate mechanisms for recognizing or harmonizing the substantial differences in Medicaid program characteristics. Moreover, such states as South Carolina, North Carolina, and Georgia have already expressed considerable interest in the project. For these states, a formal

demonstration process could delay, rather than encourage, the implementation agreements to facilitate migrant participation in Medicaid.

A real advantage of a HCFA-sponsored demonstration would be funding for administrative costs, a focus for the extensive planning effort needed, and a ready mechanism for granting waivers. The complex issues we have identified require a special kind of leadership to identify and work out solutions--an ideal federal role. Planning and implementation of agreements will require effort and resources; in a time of tight state budgets, even limited federal grants could be an incentive.

C. OPTIONS FOR STRUCTURING A DEMONSTRATION

There are at least four ways to organize an interstate compact, each with its advantages and disadvantages. The differences between them relate to who makes eligibility determinations and who is responsible for paying claims.

1. Expand the Current Home-State System

The simplest structure would be to continue to allow each state to determine eligibility, but to have services billed back to the home state issuing the card. Out-of-state providers would be subject to the limitations and payment systems of the home state. A demonstration would seek to facilitate the interstate flow of claims, but not to disrupt the present system.

The advantages of this structure are that states would not be required to alter their eligibility determinations, and they would retain a measure of control over expenditures. This simple expansion is inexpensive to administer and minimizes risk to states uncertain about joining a demonstration.

The basic disadvantage is that providers would be placed at risk for claim denials and, confronting a welter of conflicting reimbursement procedures and requirements, would face the considerable burden of verifying out-of-state current eligibility. Given the huge apparent discrepancy between the numbers of migrants in the home states of Florida and Texas, and those in the upstream

states. such a process would tend to generate a one-way flow of payments from these two home states to providers in the other upstream states.

2. Mutually Recognized Eligibility Determination

This structure would allow each state to determine eligibility of migrants as they apply through established procedures, but all participating states would recognize one anothers' determinations. Coverage and payment policy, however, would be made by each state to its own providers. Providers would recognize an out-of-state card, but would bill only their own state's Medicaid office using familiar approval and billing procedures.

The advantage of this option is that it does not require a major reorganization of the current system. It also avoids all the difficulties out-of-state providers face in submitting claims. States would not have to adjust coverage or payment policy; all classes of beneficiaries continue to receive the same treatment.

The disadvantage is that the scope of covered services would shift as the migrant moves from state to state. The state would be at risk in that it is financially liable for eligibility determined in another state. States with restrictive programs would risk having more liberal states expand Medicaid enrollment to those who would otherwise not be eligible. The process by which providers would verify the current validity of an out-of-state enrollment card could be cumbersome.

3. Independent Central Administration

In this option, a demonstration administrator would issue special interstate cards and process all claims billed to those cards. The Medicaid office of a participating state could contract for this role. This option has the advantage of highlighting the special status and problems of migrant health. It would abstract from the conflicting coverage, payment, and eligibility provision of different states. A single point of contact would minimize bureaucratic "hassle" for providers. and a single authority would enable the demonstration to offer a single standard for enrollment, coverage, and

reimbursement. On the other hand, a specialized authority would add a new and expensive layer--that may not even operate efficiently--to a bureaucratic organization. A centralized authority would also require a funding mechanism and a formula for cost sharing among states. Achieving agreement among participating states on standards for enrollment, coverage, and reimbursement might prove difficult. States would be at risk, since they would have little control over expenditures.

4. Hybrid Central Authority

A fourth option would be to combine elements of the previous models. For example, one could contract with MHCs in each state to administer eligibility determination for all migrants in the state. This would provide the necessary expertise and cultural sensitivity. Each state's providers would continue to bill their own Medicaid agencies.

The advantages of this structure are that states would retain control over expenditures, and providers would continue to deal with familiar utilization controls and reimbursement procedures. A specialized role for MHCs would expand upon the current outstationing of eligibility workers through the FQHC program. By centralizing eligibility, it would be possible to issue cards on which the identity of participating states stamped on the back would not have to be permanent. As a result, if a particular patient were not eligible in another state, that state could be excluded.

However, most MHCs would not be receptive to making Medicaid eligibility determinations. Moreover, it is not clear how they would administer a statewide program from a few limited sites. Retaining in-state claims submission has the same disadvantage to the patients as in the second option--the scope of covered services would shift as the migrant moves from state to state.

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APPENDIX A

KEY MEDICAID PROGRAM CHARACTERISTICS

A. INTRODUCTION

In considering the feasibility of establishing a multi-state Medicaid reciprocity demonstration for migrant workers and their families, a critical first step is to examine the degree to which state Medicaid programs vary across key program characteristics and policies. The identification of those program areas which are relatively similar across states, as well as those which are widely discrepant, is needed to guide the development, and to evaluate the implications for states, of interstate Medicaid compacts for the migrant population.

This chapter describes several categories of key Medicaid program characteristics for states in the migrant streams. The three major policy areas addressed are: eligibility, services, and managed care arrangements. In addition, information is provided on the number of federally-supported Community and Migrant Health Centers in each state which provide primary care services to medically underserved populations.

Data were compiled from a range of secondary data sources. These included:

- *Medicaid spData System*, U.S. Department of Health and Human Services, 1992;
- *Medicaid Source Book*, Congressional Research Service, 1993;
- *MCH Updates*, July 1992 and January 1993, National Governors' Association:
- *A Review of State Indigent Care Programs*, Intergovernmental Health Policy Project, George Washington University, 1992;
- *Creating Systems of Care for Substance-Using Pregnant Women and their Children*, National Governors' Association, 1993;
- *National Summary of State Medicaid Coordinated Care Programs*, Medicaid Bureau, Health Care Financing Administration, June 1992; and
- *Access to Community Health Care: 1993*, National Association of Community Health Centers.

In addition, data from the Social Security Administration as well as selected data previously collected by Health Systems Research, Inc. were used in the development of several tables. Effective dates for the data are noted in footnotes on each of the tables.

B. ELIGIBILITY POLICIES

Of the major policy areas for which data were collected, eligibility criteria are probably the most critical to the design of an interstate compact demonstration. Several eligibility policy characteristics for states in the migrant streams were collected for this study. These include:

- AFDC-related income eligibility thresholds and coverage policies (AFDC, AFDC-UP, and Ribicoff Children);
- Poverty-related coverage[1] of pregnant women and children;
- Strategies to streamline the eligibility process for poverty-related groups;
- Redetermination periods and interim reporting requirements for children covered through both poverty-related and AFDC eligibility categories; and
- Income eligibility thresholds under the Supplemental Security Income (SSI) and Medically Needy programs.

1. AFDC-Related Medicaid Eligibility AFDC.

States are required to provide Medicaid coverage to families that receive cash assistance under the Aid to Families with Dependent Children (AFDC) program. AFDC eligibility is based on both income and resources. States set their own income eligibility standards, as described below. Resource limits, however, are uniform across states. The Omnibus Budget Reconciliation Act of 1981 set resource limits as follows: families may possess a home of any value, one automobile worth up to $1500, and other real and personal property essential for day-to-day living worth up to $1000.

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1 Poverty-related coverage refers to the expanded Medicaid eligibility categories for pregnant women and children established in federal law during the late 1980s.

Tables 1-A and 1-B present the Medicaid eligibility thresholds for the states in the midwest and eastern migrant streams, respectively. Under AFDC, the term "threshold" refers to that income limit that truly drives program eligibility. In most states, this is the payment standard. However, in several of the migrant states (noted in the footnotes on the tables), the threshold is the state's more generous need standard. In these states, the payment standard is actually significantly lower than the Medicaid eligibility income threshold.

As shown in Table 1-A, the twelve midwest region states have rather restrictive AFDC income eligibility thresholds. Across the twelve states, the eligibility thresholds for a family size of three range from a low of 18.6 percent of the federal poverty level (FPL) in Texas to a high of 55.6 percent of poverty in Michigan.

In the twelve eastern region states (see Table 1-B), the degree of variation across the states' AFDC-related Medicaid eligibility thresholds is less than in the midwest region. The thresholds range from 29.4 percent of the FPL in Virginia to 58.2 percent in New York. Furthermore, nine of the twelve states' thresholds cluster between 29.4 and 44.7 percent of the FPL.

AFDC-UP. The Family Support Act of 1988 required states, as of October 1, 1990, to extend AFDC cash payments to two-parent families in which the principal wage earner is unemployed. Assistance must be provided for six out of every thirteen months, and may be provided for seven through twelve months. Medicaid coverage also must be provided to families receiving such cash assistance. However, states may also opt to provide Medicaid-only coverage to families with unemployed parents who do not receive AFDC payments for a full twelve months of each year, but who continue to meet the AFDC requirements for receipt of cash payments ("non-cash recipients"). Coverage of non-cash recipients is of importance, therefore, in states which do not provide cash assistance after the required six month period.

In the midwest region states (see Table 1-A), eight of the twelve states provide assistance to families only for the mandatory six month time period. The remaining four states provide an

Table 1-A
AFDC-RELATED MEDICAID ELIGIBILITY
Midwest Region States

STATE	AFDC (a) (1) Annualized Income Eligibility Threshold*	AFDC (a) (1) As a Percent of the FPL	Coverage of Families with Unemployed Parents (AFDC-UP) (2) Cash Recipient Beyond Federal Minimum (in months) (c)	Coverage of Families with Unemployed Parents (AFDC-UP) (2) Non-Cash Recipient	Coverage of Ribicoff Children (b) (3) All Under Age	Coverage of Ribicoff Children (b) (3) Limited to Specified Reasonable Categories Under Age
Arkansas	$ 2,448	20.6%	6	NA**	18 (d)	21
Colorado	$ 5,052	42.5%	6	NA	--	21
Illinois	$ 4,404	37.0%	N	NA	18 (d)	21
Michigan	$ 6,612	55.6%	6	N	21	--
Minnesota	$ 6,384	53.7%	N	N***	21	--
Missouri	$ 3,504	29.5%	N	N	--	18/21 (e)
New Mexico	$ 3,888	32.7%	N	Y	--	18
North Dakota	$ 4,812	40.5%	N	N	21	--
Ohio	$ 4,092	34.4%	N	N	21	--
Oklahoma	$ 5,652	47.5%	6	NA	21	--
Texas	$ 2,208	18.6%	N	Y	--	18/19
Wisconsin	$ 6,216	52.3%	N	N	19 (f) (4)	21 (4)

NOTES:

States in bold letters have 30,000 or more migrants.

FPL = The federal poverty level. The 1993 federal poverty level for a family of three is $11,890.

* For a family of three. Under AFDC, the term "threshold" refers to that income limit that truly drives program eligibility. In most states, this is the Payment Standard. In Colorado, Michigan, and Oklahoma, the threshold is the state's Need Standard. In these states, the threshold that appears on the table is not what the state pays to AFDC recipients. These states' Payment Standards are actually significantly lower than the eligibility threshold.

** There are no non-cash recipients in states which make AFDC payments to families with unemployed parents twelve months of each calendar year (six required plus six optional months).

*** Pending state amendment as of March 1992.

(a) AFDC-related Medicaid eligibility is based on both income and resources. The states set income thresholds (see table). The Omnibus Budget Reconciliation Act of 1981 created uniform resource limits for all the states. Under the legislation, families can possess a home of any value, one automobile worth up to $1,500, and other real and personal property essential for day-to-day living worth up to $1,000.

(b) Ribicoff children are under 21 (or at state option, under 20, 19, or 18) who would be eligible for AFDC if they met the definition of dependent child.

(c) States are required to provide AFDC benefits, and therefore Medicaid coverage, for 6 out of 13 months.

(d) State covers all children under age 18 and some reasonable categories under age 21.

(e) State covers one or more reasonable categories of children under age 18 and one or more reasonable categories of children under age 21.

(f) State covers all children under age 19 and children housed in institutions for mental disease (IMD) under age 21.

Sources:
(1) MCH Update, National Governors' Association, January 1993. (Data effective as of January 1993.)
(2) Medicaid spData System, U.S. Department of Health and Human Services, May 1992. (Data effective as of March 11, 1992.)
(3) Medicaid Source Book, Congressional Research Service, 1993. (Data effective as of September 1992.)
(4) Personal communication, Wisconsin Office of Welfare Reform, August 1993.

Data compiled by Health Systems Research, Inc., 1993.

Table 1-B
AFDC-RELATED MEDICAID ELIGIBILITY
Eastern Region States

STATE	AFDC (1)		Coverage of Families with Unemployed Parents (AFDC-UP) (2, 3)		Coverage of Ribicoff Children (4) (b)	
	Annualized Income Eligibility Threshold *	As a Percent of the FPL	Cash Recipient Beyond Federal Minimum (in months) (c)	Non-Cash Recipient	All Under Age	Limited to Specified Reasonable Categories Under Age
Florida	$ 3,636	30.6%	N	Y	--	18/21 (d)
Georgia	$ 5,088	42.8%	N	Y	--	18
Maine	$ 6,636	55.8%	6	NA**	21	--
Maryland	$ 4,308	36.2%	6	NA	21	--
Mississippi	$ 4,416	37.1%	6	NA	18 (e)	21
New Jersey	$ 5,316	44.7%	6	NA	21	--
New York	$ 6,924	58.2%	6	NA	21	--
North Carolina	$ 6,528	54.9%	6	NA	21	--
Pennsylvania	$ 6,052	42.5%	6	NA	21	--
South Carolina	$ 5,280	44.4%	6	NA	18/19 (f)	21
Tennessee	$ 5,112	43.0%	N	Y	--	21
Virginia	$ 3,492	29.4%	N	Y	--	21

NOTES:

States in bold letters have 30,000 or more migrants.

FPL = The federal poverty level. The 1993 federal poverty level for a family of three is $11,890.

* For a family size of three. Under AFDC, the term "threshold" refers to that income limit that truly drives program eligibility. In most states, this is the Payment Standard. In Georgia, Maine, Mississippi, South Carolina and Tennessee the threshold is the state's Need Standard. In these states, the threshold that appears on the table is not what the state pays to AFDC recipients. These states' Payment Standards are actually significantly lower than the eligibility threshold.

** There are no non-cash recipients in states which make AFDC payments to families with unemployed parents twelve months of each calendar year (six required plus six optional months).

(a) AFDC-related medicaid eligibility is based on both income and resources. The states set income thresholds (see table). The Omnibus Budget Reconciliation Act of 1981 created uniform resource limits for all the states. Under the new legislation, families can now possess a home of any value, one automobile worth up to $1,500, and other real and personal property essential for day-to-day living worth up to $1,000.

(b) Ribicoff children are under 21 (or at state option, under 20, 19, or 18) who would be eligible for AFDC if they met the definition of dependent child.

(c) States are required to provide AFDC benefits, and therefore Medicaid coverage, for 6 out of 13 months.

(d) State covers one or more reasonable categories of children under age 18 and one or more reasonable categories of children under age 21.

(e) State covers all children under age 18 and some reasonable categories under 21.

(f) State covers children under age 18, except that children under 19 may be covered if in secondary school.

Sources:
(1) MCH Update, National Governors' Association, January 1993. (Data effective as of January 1993.)
(2) Medicaid spData System, U.S. Department of Health and Human Services, May 1992. (Data effective as of March 11, 1992.)
(3) Personal communication with state officals. (Data effective as of August 1993.)
(4) Medicaid Source Book, Congressional Research Service, 1993. (Data effective as of September 1992.)

Data compiled by Health Systems Research, Inc., 1993.

additional six months of cash assistance. Of the eight states that provide just six months of cash assistance, two states provide Medicaid-only coverage to families with unemployed parents who continue to meet the AFDC requirements for receipt of cash payments (non-cash recipients).

In the eastern region states, as shown in Table 1-B, many more states have extended assistance periods. Eight states provide assistance for an additional six months beyond the mandatory time period. Of the four states that do not, all provide Medicaid-only coverage to non-cash recipients.

Ribicoff Children. States are permitted to provide Medicaid coverage to "Ribicoff Children," i.e., those children living in families whose income and resources meet the state's AFDC income and resource standards, but who do not meet the AFDC definition of "dependent child" (e.g., children in two-parent families not qualifying for AFDC-UP). States may cover these children up to age 18, 19, 20, or 21. States may cover all such children or limit coverage to subgroups of children who fall under certain "reasonable categories." These categories may include children in foster care, in intermediate care facilities for the mentally retarded, or children receiving active treatment as inpatients in psychiatric facilities. The importance of this category will diminish over the next decade as states, under Congressional mandate, phase in Medicaid coverage of children under age 19 with family incomes below the federal poverty level. Some states may, however, continue to use this option to cover children up to age 21, as the Medicaid phase-in will cover children only up to age 19.

As illustrated in Table 1-A, all of the states in the midwest region provide coverage to Ribicoff children. However, there is considerable variance across the states' specific eligibility standards. Five of the twelve states provide coverage to all Ribicoff children under age 21. Three states cover all children under a lower age limit (18 or 19) but extend coverage to older children who fall under specified reasonable categories. The remaining four states cover only those Ribicoff children who fit into reasonable categories, with age limits varying across states as well as within states which have different age limits depending on the eligibility category.

As shown in Table 1-B, six states in the eastern region cover all Ribicoff children under age 21. Two states cover all children under age 18 or 19 and older children under 21 who fall into reasonable categories. Four states cover only those children, up to varying age limits, who fall under specified reasonable categories.

2. Medically Needy Eligibility

States are permitted to cover "Medically Needy" persons who meet the categorical requirements for Medicaid coverage but do not meet the income or resource standards for Categorically Needy eligibility. States set both income and resource standards for the Medically Needy population. The income eligibility threshold for Medically Needy coverage may not exceed 133 1/3 percent of the state's maximum AFDC payment for a family of the same size.

Of the twelve midwest region states (see Table 2-A), eight have Medically Needy programs. Their income eligibility thresholds (for family size of three) range from a low of 26.9 percent of the FPL in Texas to a high of 71.6 percent of poverty in Minnesota. All but three states' thresholds, however, are less than 50 percent of the FPL. The asset limits (for family size of three) for these states span a considerable range but most cluster around $3000; five states have asset limits between $3000 and $3300. Two states have limits between $6000 and $7000. As well as having the most restrictive income threshold, Texas, the home state of many migrant workers, has the lowest asset limit of the group at $1000.

Table 2-B shows Medically Needy coverage by states in the eastern region. All but two states in this region have Medically Needy programs. The eligibility thresholds for a family size of three range from a low of 25.2 percent of the FPL in Tennessee to a high of 77.4 percent of poverty in New York. Of these ten states, however, the eligibility thresholds for all but two states fall between 25.2 and 47.1 percent of the FPL. Asset limits for family size of three in these states vary

Table 2–A
MEDICALLY NEEDY MEDICAID ELIGIBILITY THRESHOLDS
Midwest Region States

STATES	Medically Needy Program (1)	Annualized Income Eligibility Threshold (a) (1)	Percent of FPL (b)(1)	Asset Limit for Family of Three (2)
Arkansas	**Y**	**$ 3,300**	**27.8%**	**$ 3,100**
Colorado	N			
Illinois	**Y**	**$ 5,904**	**49.7%**	**$ 3,050**
Michigan	Y	$ 6,804	57.2%	$ 3,200
Minnesota	**Y**	**$ 8,508**	**71.6%**	**$ 6,650**
Missouri	N			
New Mexico	**N**			
North Dakota	Y	$ 5,220	43.9%	$ 6,025
Ohio	**N**			
Oklahoma	Y	$ 5,508	46.3%	$ 3,100
Texas	**Y**	**$ 3,204**	**26.9%**	**$ 1,000**
Wisconsin	Y	$ 8,268	69.5%	$ 3,300

NOTES:

States in bold letters have 30,000 or more migrants.

(a) For a family of three.

(b) FPL = Federal poverty level. In 1993 the FPL for a family of three is $11,890.

Sources:

(1) MCH Update, National Governors' Association, January 1993. (Data effective as of January 1993.)

(2) Medicaid Source Book, Congressional Research Service, 1993. (Data effective as of March 1992.)

Data compiled by Health Systems Research, Inc., 1993.

Table 2–B
MEDICALLY NEEDY MEDICAID ELIGIBILITY THRESHOLDS
Eastern Region States

STATE	Medically Needy Program (1)	Annualized Income Eligibility Threshold (a) (1)	Percent of FPL (b) (1)	Asset Limit for Family of Three (2)
Florida	Y	$ 3,636	30.6%	$ 6,000
Georgia	Y	$ 4,500	37.8%	$ 4,100
Maine	Y	$ 5,496	46.2%	$ 3,100
Maryland	Y	$ 5,004	42.1%	$ 3,100
Mississippi	N			
New Jersey	Y	$ 7,092	59.6%	$ 6,100
New York	Y	$ 9,204	77.4%	$ 4,350
North Carolina	Y	$ 4,404	37.0%	$ 2,350
Pennsylvania	Y	$ 5,604	47.1%	$ 3,500
South Carolina	N			
Tennessee	Y	$ 3,000	25.2%	$ 3,100
Virginia	Y	$ 4,296	36.1%	$ 3,100

NOTES:

States in bold letters have 30,000 or more migrants.

(a) For a family of three.
(b) FPL = Federal poverty level. In 1993 the FPL for a family of three is $11,890.

Sources:

(1) MCH Update, National Governors' Association, January 1993. (Data effective as of January 1993.)

(2) Medicaid Source Book, Congressional Research Service 1993. (Data effective as of March 1992.)

Data compiled by Health Systems Research, Inc., 1993

considerably, from $2350 to $6100. However, similar to the case in the midwest region, asset limits for the eastern regions states commonly range between $3100 and $3500.

3. Poverty-Related Eligibility

Coverage of Pregnant Women, Infants, and Children. Although AFDC-linked Medicaid eligibility standards vary greatly by state, eligibility for pregnant women and children is much less variable. This consistency can be attributed to the passage of several federal laws between 1986 and 1990 that established uniform minimum eligibility standards for the maternal and child population. These laws extended Medicaid coverage to thousands of pregnant women and children not receiving cash assistance who were previously ineligible for coverage. The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) required states to provide Medicaid coverage to pregnant women and children to age six with family incomes up to 133 percent of the FPL. States were also permitted by OBRA-87 to extend coverage to pregnant women and infants with incomes up to 185 percent of poverty. Legislation passed in 1990 mandated states to phase in Medicaid coverage of children up to age nineteen with family incomes under the federal poverty level according to an annual phase-in schedule. States are currently required to cover children under age 10; the upper age limit of nineteen will be reached by October 2001. Additionally, several states have expanded Medicaid coverage of children beyond the currently mandated level. For example, several states have used the authority of Section 1902(r)(2) of the Social Security Act to expand coverage of children using Medicaid funding. This provision allows states to determine Medicaid financial eligibility using more liberal methods for disregarding income and resources than those used for the AFDC program. Other states have used Health Care Financing Administration demonstration authority to finance expansions for children with Medicaid funds.

As shown in Table 3-A, six of the twelve midwest region states cover pregnant women and infants at the required threshold of 133 percent of poverty. Of the other half which exceed the

minimum standard, four are at the maximum level permitted by law: 185 percent. However, when Missouri increases its income standard from 133 to 185 percent in January 1994, there will be five states in this region at the maximum coverage level. Of the twelve eastern region states (see Table 3-B), eleven have adopted the maximum allowed 185 percent coverage level for pregnant women and infants.

Most of the states in both regions are phasing in Medicaid coverage of children at the mandated pace. In the midwestern region (see Table 3-A), however, three states (Colorado, Michigan, and Wisconsin) exceed the required coverage level for children. The programs in Colorado and Michigan are funded jointly by Medicaid funds and private donations. Michigan's program is statewide; however, Colorado's operates in only two counties in the State. Wisconsin's expanded coverage is for a limited group of children ages of two through five in families with incomes between 133 and 155 percent of poverty.

As shown in Table 3-B, four states exceed the minimum required coverage of children under Medicaid: Florida, Georgia, Maine, and Virginia. Both Florida's county-specific expanded Medicaid program and Maine's statewide program operate with demonstration funds from the federal Health Care Financing Administration. Georgia and Virginia have expanded Medicaid coverage to children using the authority of Section 1902(r)(2) of the Social Security Act.

Strategies to Streamline the Medicaid Eligibility Process. To complement the removal of financial barriers to eligibility achieved by the Medicaid expansions for pregnant women and children, most states have adopted a range of strategies to reduce the complexity and length of the Medicaid application process. The strategies discussed below are primarily directed at maternal and child populations.

- *Dropping the Assets Test.* OBRA-86 gave states the option to disregard all assets, when determining Medicaid eligibility for pregnant women and children. States which have simplified the Medicaid eligibility process by not considering assets (e.g. home and car ownership, savings, and investments) base eligibility determinations

Table 3–A
MEDICAID COVERAGE OF PREGNANT WOMEN, INFANTS, AND CHILDREN
Midwest Region States

STATE	Coverage of Pregnant Women and Infants (1)	Coverage of Children (1) (2)	
	Income Threshold as a Percent of the FPL (a)	Age Range (b)	Income Threshold as a Percent of the FPL
Arkansas	133%	under 10	100%
Colorado	133%	under 10 under 9 (c)	100% 185%
Illinois	133%	under 10	100%
Michigan	185%	under 10 under 18 (d)	100% 185%
Minnesota	185%	under 10	100%
Missouri	133% (e)	under 10	100%
New Mexico	185%	under 10	100%
North Dakota	133%	under 10	100%
Ohio	133%	under 10	100%
Oklahoma	150%	under 10	100%
Texas	185%	under 10	100%
Wisconsin	155%	under 10 ages 2 through 5	100% 133% to 155%

NOTES:

States in bold letters have 30,000 or more migrants.

FPL = Federal poverty level.

(a) OBRA–89 mandated states to cover pregnant women and infants up to 133% of the FPL. States, however, have the option of covering this population up to 185%of the FPL.

(b) According to OBRA–89, states are mandated to phase in coverage of children up to age 19 with family incomes below the FPL. Currently, states are covering children under age 10.

(c) The program in Colorado is not statewide and only operates in two counties. The program is also administered by the state and funded by a combination of philanthropic donations and federal Medicaid dollars authorized under special waiver authority.

(d) Michigan's program is funded by both Medicaid demonstration funds under HCFA demonstration authority and Blue Cross/Blue Shield of Michigan.

(e) The income threshold for pregnant women and infants in Missouri will increase to 185% of the FPL effective January 1, 1994.

Sources: (1) MCH Update, January 1993, National Governors' Association (NGA), (data effective as of January 1993), and personal communication with Missouri Medicaid official, September 1993.
(2) Health Systems Research, Inc. (Data effective as of December 1992.)

Data compiled by Health Systems Research, Inc., 1993.

Table 3–B
MEDICAID COVERAGE OF PREGNANT WOMEN, INFANTS, AND CHILDREN
Eastern Region States

STATE	Coverage of Pregnant Women and Infants (1) Income Threshold as a Percent of the FPL (a)	Coverage of Children (1) (2) Age Range (b)	Income Threshold as a Percent of the FPL
Florida	185 %	Under 19 (c)	None
Georgia	185 % (d)	Under 19 (e)	100 %
Maine	185 %	Under 20 (c)	125 %
Maryland	185 %	Under 10	100 %
Mississippi	185 %	Under 10	100 %
New Jersey	185 %	Under 10	100 %
New York	185 %	Under 10	100 %
North Carolina	185 %	Under 10	100 %
Pennsylvania	185 %	Under 10	100 %
South Carolina	185 %	Under 10	100 %
Tennessee	185 %	Under 10	100 %
Virginia	133 %	Under 19 (e)	100 %

NOTES:

States in bold letters have 30,000 or more migrants.

FPL = Federal poverty level.

(a) OBRA–89 mandated states to cover pregnant women and infants up to 133% of the FPL. However, states have the option of covering this population up to 185% of the FPL.

(b) According to OBRA–89, states are mandated to phase–in coverage of children up to age 19 with family incomes below the FPL. Currently, states are covering children under age 10.

(c) Florida and Maine operate programs under HCFA demonstration authority. Maine's program operates statewide but Florida's program covers only children enrolled in the Volusia County school district.

(d) Georgia increased the income threshold for pregnant women and infants up to 185% in July 1993.

(e) Georgia and Virginia have expanded Medicaid coverage to children using the authority of Section 1902(r)(2) of the Social Security Act.

Sources: (1) MCH Update, January 1993, National Governors' Association (NGA) (data effective as of January, 1993) and personal communication with NGA staff, August 1993.
(2) Health Systems Research, Inc. (Data effective as of December 1992.)

Data compiled by Health Systems Research, Inc., 1993.

on income alone. As shown in Table 4-A, ten of the twelve midwestern states have dropped assets tests for pregnant women, and eight of the states have dropped assets tests for children. The eastern region states (shown in Table 4-B) have all dropped assets tests for both pregnant women and children.

- *Presumptive Eligibility for Pregnant Women.* States were also permitted by OBRA-86 to allow certain qualified providers to make preliminary Medicaid eligibility determinations for pregnant women, thereby granting them immediate temporary coverage. This strategy can improve access to care by moving the initial eligibility intake point to the provider site and by providing same-day insurance coverage for prenatal care services. In most states, however, clients must still file a formal application to obtain Medicaid coverage beyond the temporary coverage period, which lasts up to sixty days.

  In the midwest region, eight of the twelve states offer presumptive eligibility for pregnant women. In the eastern region states, nine states have adopted this policy. Two eastern region states, New York and Pennsylvania, have further simplified the process by using the presumptive eligibility application form for determining formal Medicaid eligibility.

- *Expedited Eligibility for Pregnant Women.* Given the importance of early prenatal care in promoting healthy births, several states have adopted policies which place priority on processing Medicaid applications made by pregnant women. In these states, regulations require that these applications be processed more quickly than under normal circumstances, typically within five to ten days. This is a vast improvement over the forty-five day processing period allowed by federal rules.

  As indicated in Tables 4-A and 4-B, few states have adopted expedited eligibility policies for pregnant women -- two in the midwest region and one in the eastern region. This is due to the fact that states adopting a range of simplification strategies have tended not to have both expedited and presumptive eligibility policies for pregnant women, as both provide quicker access to Medicaid coverage. As indicated in the above discussion, most states have adopted presumptive eligibility policies.

- *Shortened Applications for Pregnant Women and Children.* The removal of assets tests from the eligibility determination process for pregnant women and children provided states with an opportunity to greatly simplify and shorten application forms. Since the late 1980s, many states have created special shortened application forms that typically range from one to ten pages in length. Building on this idea, other states have streamlined the application used by all Medicaid applicants.

  Table 4-A indicates that eleven of the twelve midwest region states have reduced their Medicaid application forms, eight by creating special forms for the maternal and child population and three by shortening the general application form. Of the eastern region states, as shown in Table 4-B, nine states have shortened their application forms; six states created special forms for pregnant women and children, and three states shortened the general application form.

- *Mail-In Eligibility for Pregnant Women and Children.* Another strategy used by several states to streamline the Medicaid eligibility process is to allow applicants to

Table 4–A
STRATEGIES TO STREAMLINE MEDICAID ELIGIBILITY
Midwest Region States
January 1993

STATE	Dropped Assets Test for Pregnant Women	Dropped Assets Test for Children	Presumptive Eligibility for Pregnant Women	Expedited Eligibility for Pregnant Women	Shortened Application for Pregnant Women and Children	Mail–In Eligibility for Pregnant Women and Children	Outstationing (a)
Arkansas	N(b)	N (b)	Y	N	A	N	Y
Colorado	Y	N (c)	Y	N	Y	Y	N
Illinois	Y	Y	Y	N	Y	N	N
Michigan	Y	Y	N	N	Y	Y	Y
Minnesota	Y	Y	N	Y	Y	N	N
Missouri	Y	Y	Y	N	Y	N	Y
New Mexico	Y	Y	Y	N	Y	N	N
North Dakota	N(d)	N (d)	N	N	N	Y	N
Ohio	Y	Y	N	Y	Y	Y	Y
Oklahoma	Y	Y	Y	N	A	N	Y
Texas	Y	N (e)	Y	N	A	N	Y
Wisconsin	Y	Y	Y	N	Y	N	N
TOTAL Y =	10	8	8	2	11	4	6

NOTES:

States in bold letters have 30,000 or more migrants.

A = Shorter form used by all Medicaid applicants, not just pregnant women and children.

(a) OBRA–89 required states to allow pregnant women and children to apply for Medicaid at Federally Qualified Health Centers and disproportionate share hospitals. The states indicated as outstationing do so in sites beyond those required by OBRA–89, including local departments, WIC clinics, and other hospitals.

(b) Arkansas dropped the assets test for pregnant women and children in 1988 but reinstated it in 1992. The asset limits are $3000 for a family of 2, $3100 for a family of 3, $3200 for a family of 4 and $100 for each additional person. (Pregnant woman = family of 2 in Arkansas).

(c) Colorado uses the federal AFDC resource standards for poverty–related coverage of children. (See table 1–A, footnote a.)

(d) Asset limits in North Dakota are $3000 for 1 person, $6000 for a family of two, and $25 for each additional person. (Pregnant woman = family of 1 in North Dakota.)

(e) Texas has a resource limit of $2,000 for poverty–related children, as compared to the $1,000 AFDC resource limit.

Source: National Governors' Association, January 1993.

Data compiled by Health Systems Research, Inc., 1993.

Table 4-B
STRATEGIES TO STREAMLINE MEDICAID ELIGIBILITY
Eastern Region States
January 1993

STATE	Dropped Assets Test for Pregnant Women	Dropped Assets Test for Pregnant Children	Presumptive Eligibility for Pregnant Women	Expedited Eligibility for Pregnant Women	Shortened Application for Pregnant Women and Children	Mail In Eligibility for Pregnant Women and Children	Outstationing (a)
Florida	Y	Y	Y	N	N	N	Y
Georgia	Y	Y	Y	N	A	N	Y
Maine	Y	Y	Y	N	N	Y	Y
Maryland	Y	Y	Y	N	Y	N	Y
Mississippi	Y	Y	N	N	Y	N	Y
New Jersey	Y	Y	Y	N	Y	N	N
New York	Y	Y	Y	N	A	N	N
North Carolina	Y	Y	Y	N	Y	N	Y
Pennsylvania	Y	Y	Y	N	N	N	Y
South Carolina	Y	Y	N	N	Y	Y	Y
Tennessee	Y	Y	Y	N	A	N	N
Virginia	Y	Y	N	Y	Y	Y	Y
TOTAL Y =	12	12	9	1	9	3	9

NOTES:

States in bold letters have 30,000 or more migrants.

A = Shorter form used by all Medicaid applicants, not just pregnant women and children.

(a) OBRA-89 required states to allow pregnant women and children to apply for Medicaid at Federally Qualified Health Centers and disproportionate share hospitals. The states indicated as outstationing do so in sites beyond those required by OBRA-89, including local departments, WIC clinics, and other hospitals.

Source: National Governors' Association, January 1993.

Data compiled by Health Systems Research, Inc., 1993.

mail in their eligibility forms without requiring a face-to-face interview with an eligibility worker. This policy facilitates access to coverage for persons who, for example, do not possess a means of transportation to and from a welfare office.

Four states in the midwest region and three states in the eastern region have adopted this strategy.

- *Outstationing Eligibility Workers.* Placing eligibility workers at sites where women and children receive health care services rather than at welfare offices, a strategy known as "outstationing," is aimed at making the eligibility system more accessible. The Omnibus Budget Reconciliation Act of 1990 required states to place eligibility workers at federally qualified health centers (FQHCs) and hospitals that serve a disproportionate share of Medicaid patients to ensure that pregnant women and children could apply for coverage at these provider sites. However, most states outstationed eligibility workers before the OBRA-90 requirement, and many continue to place workers in provider sites beyond those mandated by Congress, such as local public health departments.

  Tables 4-A and 4-B indicate that six states in the midwest region and nine in the eastern region outstation eligibility workers at provider sites beyond Federally Qualified Health Centers and disproportionate share hospitals.

- *Recertification Periods and Reporting Requirements.* Some states require less frequent recertification of children eligible under poverty-related criteria than of those eligible under AFDC. As shown in Tables 5-A and 5-B, Maryland, Mississippi, North Carolina, and Missouri all set recertification periods of 12 months for the poverty-related Medicaid expansion group, compared with 6 months for the AFDC group. Although Colorado requires *less* frequent recertification of the AFDC group, it also requires that these families report monthly. Other states also require more frequent interim reporting by families eligible under AFDC. In New York, for example, families with earned income who are eligible for Medicaid under AFDC must report every three months; there is no such reporting requirement for families eligible under the Medicaid expansions.

4. State-Funded Insurance Programs for Medicaid-Ineligible Persons

State-Funded Insurance Programs for Children. Although federal Medicaid provisions included in the various reconciliation acts passed during the late 1980s have been the primary vehicle used by states to expand insurance coverage of children, entirely state-funded programs have also been created to provide coverage for children left uninsured despite these expansions.

One of the midwest region states, Minnesota, has taken this route (see Table 6-A). Children are one of the groups covered under the "MinnesotaCare" plan which is being phased in to cover all

Table 5-A
RECERTIFICATION PERIOD AND REPORTING REQUIREMENTS (a)
Midwest Region States
January 1993

STATE	POVERTY-RELATED ELIGIBILITY		AFDC ELIGIBILITY	
	Eligibility Period In Months	Reporting Required	Eligibility Period In Months	Reporting Required
Arkansas	6	N	6	Every 3 months
Colorado	6	N	12	Monthly
Illinois	12	N	12	Every 6 months
Michigan	12	Monthly if income fluctuates	12	Every 6 months or monthly with earned income
Minnesota	12	Every 6 months	12	Monthly with earned income
Missouri	12	N	6	N
New Mexico	6	N	6	N
North Dakota	12	N	12	Monthly
Ohio	6	N	6	N
Oklahoma	6	N	6	N
Texas	6	N	6	N
Wisconsin	6	N	6	N

NOTES:

States in bold letters have 30,000 or more migrants.

(a) Applies to recertification criteria for children.

Source: National Governors' Association, January 1993.

Table 5--B
RECERTIFICATION PERIOD AND INTERIM REPORTING REQUIREMENTS (a)
Eastern Region States
January 1993

	POVERTY-RELATED ELIGIBILITY		AFDC ELIGIBILITY	
STATE	Eligibility Period In Months	Reporting Requirement	Eligibility Period In Months	Reporting Requirement
Florida	6	N	6	N
Georgia	12	Every 6 months	12	Every 6 months
Maine	6	N	6	N
Maryland	12	N	6	N
Mississippi	12	N	6	Monthly with earned income
New Jersey	6	N	6	N
New York	12	N	12	Every third month with earned income
North Carolina	12	N	6	N
Pennsylvania	12	N	12	Monthly with earned income
South Carolina	12	N	12	Every 6 months
Tennessee	6	N	6	N
Virginia	12	N	12	Every 6 months

NOTES:

States in bold letters have 30,000 or more migrants.

(a) Applies to recertification criteria for children.

Source: National Governors' Association, January 1993.

Data compiled by Health Systems Research, Inc., 1993.

uninsured persons in the State. Under this program, children under 18 are covered up to 185 percent of the FPL, a much higher income threshold than allowed for under the mandated Medicaid expansions. As shown in Table 6-B, three states in the eastern region have state-funded insurance programs for children: New York, Pennsylvania, and Virginia.

General Assistance Programs. Most states fund and administer, on their own or with local governments, indigent health care programs that provide coverage for low-income individuals who are not eligible for Medicaid because they do not meet the program's categorical requirements. Eligibility for such programs is typically determined based on income and disability status. Benefits vary greatly across programs, ranging from packages that are the same or similar to Medicaid program benefits to programs with much more limited benefits, e.g. ambulatory or inpatient hospital services only. As shown in Tables 6-A and 6-B), nine of the midwest region states and seven of the eastern region states have general assistance programs.

5. Supplemental Security Income-Related Eligibility

The federal Supplemental Security Income (SSI) program provides cash assistance to needy aged, blind, and disabled individuals. In general, states are required to provide Medicaid coverage to SSI recipients. Under SSI, the federal government sets uniform minimum income and resource eligibility guidelines. States may supplement the federal benefit standard by making additional payments to SSI recipients, thus effectively increasing the Medicaid income eligibility threshold. However, utilizing authority granted in Section 209(b) of the Social Security Act, several states use more restrictive eligibility standards than the current federal standards as long as they are not more restrictive than those which were in effect in 1972 when SSI was enacted. This study looked at Medicaid income eligibility thresholds for disabled SSI recipients (rather than for the aged or blind recipient populations).

Table 6–A
STATE FUNDED INSURANCE PROGRAMS FOR MEDICAID–INELIGIBLE PERSONS
Midwest Region States

STATE	State Funded Insurance Program for Children	Age Range	Income as Percent of FPL *	Other Statewide General Assistance State–Only Program	Eligibility
Arkansas	N			N	
Colorado	N			N	
Illinois	N			Y	County administered, except for the program in Chicago, which is state administered.
Michigan	N			Y	Family and state disability assistance clients who are ineligible for other publicly– or privately–sponsored coverage. In addition, other state residents who meet the income and resource standards for the state disability assistance program.
Minnesota	Y (a)	Under 18	185%	Y	Income limits for persons with dependent children: Individuals $464, Couples $583, Family of 3 $709, Family of 4, $828. Without dependent children: Individuals $420, Couples $524; Asset limit $1000.
Missouri	N			Y	Unemployable for 90 days and ineligible for federal programs or providing home care for an incapacitated family member.
New Mexico	N			Y	County administered.
North Dakota	N			Y	County administered.
Ohio	N			Y	General assistance: single, unemployed persons and families not receiving other assistance. Disability assistance: persons 18 and under, persons 60 and older, pregnant women, persons meeting the SSI disability guidelines or determined medication dependent.
Oklahoma	N			Y	< 100% of the FPL.
Texas	N			N (b)	
Wisconsin	N			Y	Income limit $175/month, asset limit $200 cash ($1500 car and house is exempt).

NOTES:

States in bold letters have 30,000 or more migrants.

* FPL = Federal poverty level

(a) The State's program, called MinnesotaCare, also covers parents and dependent siblings of covered children.

(b) No statewide program but 140 of 254 total counties have indigent care programs for persons categorically eligible for Medicaid who cannot meet the AFDC income and resource standards.

Source: A Review of State Indigent Care Programs: 1992, Intergovernmental Health Policy Project, George Washington University. (Data from 1992.)

Data compiled by Health Systems Research, Inc., 1993.

Table 6-B
STATE FUNDED INSURANCE PROGRAMS MEDICAID-INELIGIBLE PERSONS
Eastern Region States

STATE	State Funded Insurance Program for Children	Age Range	Income Limit as Percent of FPL *	Other Statewide General Assistance State-Only Program	Eligibility
Florida	N			N	
Georgia	N			N	
Maine	N			Y	Adults <100% of the FPL. Children <125% of the FPL.
Maryland	N			Y	Same as state's Medicaid income and resource standards.
Mississippi	N			N	
New Jersey	N			Y	New Jersey has two programs: 1) General Assistance: Individuals -- $140 (employable) $210 (non-employable) Couples -- $193 (employable) $289 (non-employable) 2) AFDC Non-Federal: Families who do not meet the federal AFDC standards for unemployment.
New York	Y	Under 13	None (a)	Y	Basic need standard plus a shelter component that varies from county to county. Asset limits -- $1000. (In NYC, the limit is $352/month per individual.)
North Carolina	N			N	
Pennsylvania	Y	Under 6 (b)	235% (c)	Y	General assitance Categorically Needy: Identical to AFDC resource limits. Resource limits are $250 for one person and $1000 for all other family sizes. General assistance Medically Needy: Determined by 6 month income period. Individual: Income $2550, Resources $2400 Couple: Income $2650, Resources $3200 Family of 3: Income $2800, Resources $3500 Family of 4: Income $3400, Resources $3800
South Carolina	N			Y	Under 200% of the FPL. Asset limit -- $500 in liquid assets and $6000 person property and equity value of real property not exceeding $36,000.
Tennessee	N			N	
Virginia	Y	Under 1	200%	Y	County administered.

NOTES:

States in bold letters have 30,000 or more migrants.

* FPL = Federal poverty level.

(a) No cost sharing if income under 160% of FPL, $25/child/year if income is between 160% and 222%, and full premium payment is required if family income exceeds 222% of FPL.
(b) Pennsylvania is also phasing in coverage for children ages 13-19 up to 100% of the federal poverty level.
(c) No cost sharing if under 185% of FPL, half of premium subsidized if income is up to 235% of poverty.

Source: A Review of State Indigent Care Programs: 1992, Intergovernmental Health Policy Project, George Washington University. (Data from 1992.)

Data compiled by Health Systems Research, Inc., 1993.

As shown in Table 7-A, seven of the midwestern region states provide Medicaid coverage to disabled SSI recipients based on the federal benefit standard (74.7 percent of the FPL for individuals and 81.9 percent of the FPL for couples in 1993). Two states, Michigan and Oklahoma, supplement the federal payment amount, raising the eligibility thresholds for these states to 77.1 and 85.1 percent, respectively. There are six 209(b) states in the midwest region, three of which have income thresholds that are more restrictive than the federal standard. More restrictive standards range from 48.7 to 72.3 percent of the FPL.

As shown in Table 7-A, seven of the midwestern region states provide Medicaid coverage. Of the twelve eastern region states (see Table 7-B), seven use the federal benefit level as the Medicaid eligibility threshold. Four states supplement the federal SSI payment, thereby raising the Medicaid eligibility threshold above the federal level for these states to between 76.4 and 89.5 percent of poverty. One of the two 209(b) states in this region (North Carolina) uses a more restrictive income eligibility threshold than the federal standard; the eligibility threshold in North Carolina is equal to 41.7 percent of the FPL.

C. POLICIES RELATING TO SERVICE COVERAGE

A second policy area critical to the consideration of interstate compacts is coverage of services. In this section, we discuss coverage of mandatory and optional services, as well as limitations on selected mandatory services.

1. Coverage of Mandatory and Optional Services

States are required under Medicaid to cover a broad range of federally-defined services in order to receive federal matching payments. The following "mandatory services" must be provided for the Categorically Needy population:

- Inpatient hospital services;

Table 7–A
SUPPLEMENTAL SECURITY INCOME (SSI) MEDICAID ELIGIBILITY THRESHOLDS
MIDWEST REGION STATES
January 1993

STATE	Annualized Income Eligibility Threshold for Disabled Individuals	As a Percent of the FPL (a)	Annualized Income Eligibility Threshold for Disabled Couples	As a Percent of the FPL (a)	"209(b)" (*) State
Arkansas	$5,208 (b)	74.7%	$7,724 (b)	81.9%	N
Colorado	$5,208	74.7%	$7,724	81.9%	N
Illinois	$3,396	48.7%	$4,296	45.6%	Y
Michigan	$5,376	77.1%	$8,076	85.6%	N
Minnesota	$5,040	72.3%	$6,240	66.2%	Y
Missouri	$5,208	74.7%	$7,724	81.9%	Y
New Mexico	$5,208	74.7%	$7,724	81.9%	N
North Dakota	$5,208	74.7%	$7,724	81.9%	Y
Ohio	$4,488	64.4%	$7,824	83.0%	Y
Oklahoma	$5,928	85.1%	$8,544	90.6%	Y
Texas	$5,208	74.7%	$7,724	81.9%	N
Wisconsin	$5,208	74.7%	$7,724	81.9%	N

NOTES:

States in bold letters have 30,000 or more migrants.

(*) Section 209(b) of the Social Security Amendments of 1972 (P.L. 92–603) permitted states, at their option, to continue using the financial standards and definitions for disability they had in effect in January 1972 to determine Medicaid eligibility for their aged, blind and disabled residents, rather than making all SSI recipients automatically eligible for Medicaid. Often the financial and categorical standards used by 209(b) states are more restrictive than SSI's.

(a) FPL = Federal poverty level. The 1993 FPL for a family of one is $6,970, and $9,430 for a family of two.
(b) The federal SSI Medicaid eligibility threshold for disabled individuals is $5,208 and for disabled couples is $7,724.

Source: Social Security Administration, January 1993.

Data compiled by Health Systems Research, Inc., 1993.

Table 7-B
SUPPLEMENTAL SECURITY INCOME MEDICAID ELIGIBILITY
EASTERN REGION STATES
January 1993

STATE	Annualized Income Eligibility Threshold for Disabled Individuals	As a Percent of the FPL (a)	Annualized Income Eligibility Threshold for Disabled Couples	As a Percent of the FPL (a)	"209(b)" (*) State
Florida	$5,208 (b)	74.7%	$7,724 (b)	81.9%	N
Georgia	$5,208	74.7%	$7,724	81.9%	N
Maine	$5,328	76.4%	$8,004	84.9%	N
Maryland	$5,208	74.7%	$7,724	81.9%	N
Mississippi	$5,208	74.7%	$7,724	81.9%	N
New Jersey	$5,580	80.1%	$8,124	86.2%	N
New York	$6,240	89.5%	$9,060	96.1%	N
North Carolina	$2,904	41.7%	$3,816	40.5%	Y
Pennsylvania	$5,592	80.2%	$8,412	89.2%	N
South Carolina	$5,208	74.7%	$7,724	81.9%	N
Tennessee	$5,208	74.7%	$7,724	81.9%	N
Virginia	$5,208	74.7%	$7,724	81.9%	Y

NOTES:

States in bold letters have 30,000 or more migrants.

(*) Section 209(b) of the Social Security Amendments of 1972 (P.L. 92-603) permitted states, at their option, to continue using the financial standards and definitions for disability they had in effect in January 1972 to determine Medicaid eligibility for their aged, blind and disabled residents, rather than making all SSI recipients automatically eligible for Medicaid. Often the financial and categorical standards used by 209(b) States are more restrictive than SSI's.

(a) FPL= Federal poverty level. The 1993 FPL for a family of one is $6,970 and $9,430 for a family of two.
(b) The federal SSI Medicaid eligibility threshold for disabled individuals is $5,208 and for disabled couples is $7,724.

Source: Social Security Administration, January 1993.

Data compiled by Health Systems Research, Inc., 1993.

- Outpatient hospital services;
- Rural health clinic services;
- Federally qualified health center services;
- Other laboratory and x-ray services;
- Nursing facility (NF) services for individuals 21 or older;
- Early and periodic screening, diagnostic and treatment (EPSDT) services for individuals under age 21;
- Family planning services;
- Physicians' services;
- Home health services for any individual entitled to NF care;
- Nurse-midwife services (to the extent nurse midwives are authorized to practice under state law or regulation); and
- Services of certified nurse practitioners and certified family nurse practitioners (to the extent these individuals are authorized to practice under state law or regulation).

If a state elects to have a Medically Needy program, it must at minimum provide certain services to Medically Needy beneficiaries. These services include:

- Prenatal and delivery services for pregnant women;
- Ambulatory services for individuals under 18 and individuals entitled to institutional services;
- Home health services for individuals entitled to NF services; and
- Several additional services if the state provides coverage for Medically Needy persons over age 65 or under age 21 in institutions for mental disease or coverage for the Medically Needy in intermediate care facilities for the mentally retarded.

States may also cover a range of additional services, known as "optional services," for Medicaid recipients. As described in Tables 8-A and 8-B, transportation, prescription drugs, rehabilitation, and substance abuse services (both inpatient and outpatient) are covered by nearly all states in the

Table B–A
COVERAGE OF OPTIONAL MEDICAID SERVICES
Midwest Region States

STATE	Mental Health Clinics (1)	Substance Abuse – Inpatient (2) (a)	Substance Abuse – Outpatient (2) (a)	Physical Therapy (3)	Occupational Therapy (3)	Speech Hearing and Language Disorders (3)	Private Duty Nursing (3)	Inpatient Psychiatric Care (3) (c)	Personal Care (3)	Respiratory Care (3)	Emergency Room Services (3)	Rehabilitation Services (3)	Prescription Drugs (3)	Transportation (3)
Arkansas	C	C	C	B	B	B	B	B	C	B	B	B	B	B
Colorado *	C	C	C/21 (b)	N	N	N	C	C	N	N	C	C	C	C
Illinois	B	C	C	B	B	B	B	B	N	N	B	B	B	B
Michigan	B	C	C	B	B	B	N	B	B	B	B	B	B	B
Minnesota	B	C	C	B	B	B	B	B	B	N	B	B	B	B
Missouri *	C	C	C	N	N	N	N	C	C	N	N	C	C	C
New Mexico *	N	C	C	C	C	C	N	N	N	N	C	N	C	C
North Dakota	N	C	C	B	B	B	B	B	N	N	B	B	B	B
Ohio *	C	C	C	C	C	C	C	N	N	N	C	C	C	C
Oklahoma	N	C	C	N	N	N	N	B	B	N	N	B	B	B
Texas	N	C	C	B	N	N	N	N	B	B	B	B	B	B
Wisconsin	B	C	C	B	B	B	C	C	B	B	B	C	B	B

NOTES:

States in bold letters have 30,000 or more migrants. C = Covered service for Categorically Needy population. B = Covered service for both Categorically and Medically Needy populations.

* State has no medically needy program.

(a) Coverage refers to the Categorically Needy population. Information on whether these services are provided also to the Medically Needy population was not available.

(b) C/21 = Services provided only for patients below age 21.

(c) Under age 21 only.

Sources: (1) Medicaid spData System, U.S. Department of Health and Human Services, May 1992. (Data effective as of March 11, 1992.)

(2) Creating Systems of Care for Substance–Using Pregnant Women and their Children, National Governors' Association 1993. (Data effective as of March 1993.)

(3) Medicaid Source Book, Congressional Research Service, 1993. (Data effective as of October 1991.)

Data compiled by Health Systems Research, Inc., 1993.

Table 6-B
COVERAGE OF OPTIONAL MEDICAID SERVICES
Eastern Region States

STATES	Mental Health Clinics (1)	Substance Abuse – Inpatient (2) (a)	Substance Abuse – Outpatient (2) (a)	Physical Therapy (3)	Occupational Therapy (3)	Speech, Hearing and Language Disorders (3)	Private Private Duty Nursing (3)	Inpatient Psychiatric Care (3) (c)	Personal Care (3)	Respiratory Care (3)	ER Services (3)	Rehabilitation Services (3)	Prescription Drugs (3)	Transportation (3)
Florida	N	C	C	B	B	B	B	N	B	B	B	B	B	B
Georgia	B	N	C	N	N	N	N	N	N	N	N	N	B	B
Maine	N	C	C	B	B	B	B	B	B	N	N	B	B	B
Maryland	B	C	C	B	N	B	B	B	B	N	B	N	B	B
Mississippi	N	C	C/21 (b)	C	C	C	N	N	N	N	C	C	C	C
New Jersey	B	C	C	B	B	B	N	C	C	N	C	B	B	C
New York	B	C	C	B	B	B	B	B	B	N	B	B	B	B
North Carolina	B	C	C	N	N	N	B	B	B	N	N	B	B	B
Pennsylvania	B	C	C	N	N	N	N	B	N	N	B	B	C	B
South Carolina *	C	C	C	C	C	N	N	C	N	N	C	C	C	C
Tennessee	B	C	C	N	N	N	N	B	N	B	B	B	B	B
Virginia	B	C	N	B	B	B	N	N	N	N	B	B	B	B

NOTES:

States in bold letters have 30,000 or more migrants. C = Covered service for Categorically Needy population. B = Covered service for both Categorially and Medically Needy populations.

* = State has no Medically Needy program.

(a) Coverage refers to the Categorically Needy population. Information on whether these services are provided also to the Medically Needy population was not available.

(b) C/21 = Services provided only for patients below age 21.

(c) Under age 21 only.

Sources: (1) Medicaid spData System, U.S. Department of Health and Human Services, May 1992. (Data effective as of March 11, 1992.)

(2) Creating Systems of Care for Substance-Using Pregnant Women and their Children, National Governors' Association 1993. (Data effective as of March 1993.)

(3) Medicaid Source Book, Congressional Research Service, 1993. (Data effective as of October 1991.)

Data compiled by Health Systems Research, Inc., 1993.

migrant streams. Other services covered by a significant portion of the states include: mental health clinic services; physical therapy; occupational therapy; therapy for speech, hearing and language disorders; inpatient psychiatric care; and emergency room services. Respiratory care, personal care, and private duty nursing are covered by relatively few of the states in the migrant streams.

2. Limitations on Selected Services

States are permitted to set limits on the amount, duration, and scope of services in the program. In evaluating the feasibility of interstate Medicaid compacts, the degree to which service limits and other utilization controls vary across states, particularly for physician and hospital services, is an important consideration.

Limitations on Physician Service Coverage. Physician service limits are typically based on the location of the visit. For example, a state may choose to limit the number of office-based visits, the number of physician visits during an inpatient hospital stay, or the number of visits per month during residence in a long term care facility. Furthermore, a state may set an overall limit on the number of visits in a specified time period regardless of the setting in which they occur.

Tables 9-A and 9-B describe the physician limits that states in the midwest and eastern regions have established. In the midwest region, six states limit the number of physician visits during inpatient hospital stays, and seven states limit physician visits in long term care facilities. Only four states, however, limit the number of office visits; these limitations, furthermore, are relatively minor. This is significant as a major intention of interstate Medicaid coverage of migrants is to improve migrants' access to office-based care. Four states impose limits for combinations of visits in different sites. Three states in this region (Colorado, Illinois, and Texas) do not limit physician services.

A similar pattern of physician limits is seen in the eastern region states. Six states limit inpatient hospital physician visits, five states limit visits in long term care facilities, three states limit the number of office-based physician visits, and four states limit some combination of physician visits. One state

Table 9 - A

LIMITS ON PHYSICIAN SERVICE COVERAGE BY LOCATION OF PHYSICIAN VISIT
MIDWEST REGION STATES
January 1991

STATE	Inpatient hospital visits	Long Term Care Facility Visits	Office Visits	Combination of Visits
Arkansas	1/day; 25/FY/per physician			12/CY noninpatient visits in any combination of office, home, long term care facilities, and outpatient hospital visits. Also, physician consultations are limited to 2/CY if provided in a physician's office, patient's home or hospital. (a)
Colorado				
Illinois				
Michigan		1/30 days		
Minnesota		1/30 days (b)	1/day/physician (b)	7/7day period
Missouri		1/month		
New Mexico	2/day/provider provider group	2/day	1/day (c)	
North Dakota	1/day	1/month; more allowed if medically necessary.		
Ohio	10/month; 1 critical care visit/day	24/CY		24/CY for all providers of physician services including outpatient hospital visits. (a)
Oklahoma	1/day; additional visits are allowed for individuals under 21	2/month	4/month; additional visits may be allowed in connection with an acute physical injury, family planning and EPSDT.	4/month in any combination of physician, office, home, organized out-patient hospital, clinic and any other physician visits except nursing home, inpatient hospital, and inpatient psychiatric. Exceptions are treatment for acute physical injury, family planning, or EPSDT.
Texas				
Wisconsin	1/day	1/month for routine visit	1/year only applies to the procedure code for annual checkup.	

NOTES:

States in bold letters have 30,000 or more migrants.

CY = Calendar Year

FY = Fiscal Year

(a) Additional visits are available if medically necessary. Physician visits are usually conducted by the physician providing ongoing care for the patient. A consulting physician may only bill at the consultation fee for a particular patient one time; physicians must bill subsequent as a visit.

(b) More visits are available with prior authorization.

(c) New Mexico limits office visits to one per day unless referred to another physician or if the claim documents a change in the client's condition.

Source: Medicaid Source Book, Congressional Research Service, 1993.

Data compiled by Health Systems Research, Inc., 1993.

Table 9-8

LIMITS ON PHYSICIAN SERVICE COVERAGE BY LOCATION OF PHYSICIAN VISIT
EASTERN REGION STATES
January 1991

STATE	Inpatient Hospital Visits	Long Term Care Facility Visits	Office Visits	Combination of Visits
Florida	1/day with the exception of emergencies	1/month	1/provider/day is allowed for supervision of chronic illness	
Georgia	1/day; critical visits are unlimited if medically necessary.	12/FY (a)	12/FY (a)	
Maine				
Maryland				
Mississippi	1/day; 30/FY. Exception made to the limit for intensive or coronary care units, 2/day.	36/FY		12/FY in any combination of physician office visits and rural health clinic visits.
New Jersey				
New York				
North Carolina				24/year in any combination of physicians office, hospital outpatient (emergency rooms excluded), free standing clinics, podiatric, optometric, and chiropractic visits. Exempt are EPSDT, pregnancy-related services, life threatening conditions (hemophilias, unstable diabetes, and cancer therapy). State also covers 1 adult health screening (preventive) exam/year for beneficiaries 21 years and older.
Pennsylvania	$1,000/stay/hospitalization/ physician service; also 2 consultations/specialty/hospitalization			Outpatient: $500/day on all physician services. 1/provider/day for hospital, home office, emergency room, clinic, inpatient care, nursing home, or screening visits.
South Carolina		5/month		18/year for beneficiaries age 21+ in any combination of physician office, podiatric, dental, chiropractic, opthomology, and psychiatric evaluation. Exceptions are patients with cancer, allergies, AIDS, on dialysis or insulin, or using psychiatric services.
Tennessee	1/day	1/month for Level I care; 4/month for level II care	24/FY	
Virginia	1/day; for adults 21+, 21 visits/60 day period for the same diagnosis.			

NOTES:

States in bold letters have 30,000 or more migrants. FY = Fiscal Year CY = Calender Year

(a) More visits are available with prior authorization.

Source: Medicaid Source Book, Congressional Research Service, 1993.

Data compiled by Health Systems Research, Inc., 1993.

in the region (Pennsylvania) imposes dollar limits on physician services rather than limitations on the number of visits. Four states in the eastern region (Maine, Maryland, New Jersey, and New York) do not restrict physician services.

Limitations on Hospital Services. States place limits on both inpatient and outpatient hospital services. For inpatient hospital services, states often restrict length of stay, typically through the use of day limits. Outpatient hospital service limitations are typically in the form of visit limits, emergency room visit limits, and prior authorization requirements.

Of the midwest region states (see Table 10-A), four have placed limitations on the number of allowable inpatient hospital days (either per fiscal year or per spell of illness). Two states (Arkansas and Missouri) have percentile length of stay limitations. Seven states have no restrictions on inpatient hospital length of stay. Of the twelve eastern region states (see Table 10-B), five have day limits, and seven states have no limitations on length of stay.

Outpatient hospital limitations are also described in Tables 10-A and 10-B. In both regions, prior authorization requirements are the most common form of outpatient hospital restriction; eight states in the midwest region and seven in the eastern region have prior authorization requirements under certain circumstances. Relatively few states (three in the midwest region and four in the eastern region) impose limits on the number of outpatient visits. Only one state in each of the midwest and eastern regions limits emergency room use.

One state in each region (North Dakota in the midwest region and Maine in the eastern region) has no limitations on outpatient services.

D. MANAGED CARE ARRANGEMENTS

Increasingly, states are implementing managed care programs for all or portions of their Medicaid populations in an attempt to both improve access to services and contain rising Medicaid costs. A variety of managed care models are being used by states, including:

Table 10–A
LIMITATIONS ON HOSPITAL SERVICES *
Midwest Region States

	Inpatient Hospital Length of Stay Restrictions (1)		Outpatient Hospital Services (2)			
STATE	Limits	Number of Days	Limits	Visit Limits	ER Limits	Prior Authorization
Arkansas	Y (a)	25/FY	Y	12 visits/ year (b)	N	Y B
Colorado	N	N	Y (c)	N	N	N
Illinois	N	N	Y	N	N	Y B
Michigan	N	N	Y	N	N	Y B, C, E
Minnesota	N	N	Y	N	N	Y B, C, D
Missouri	Y (a)	N	Y	2 visits/ month	Y	Y B, D
New Mexico	N	N	Y	N	N	Y B, E
North Dakota	N	N	N	N	N	N
Ohio	Y	30/spell of illness	Y	N	N	Y B, D
Oklahoma	Y	20/FY for individuals 21 and older; 60/FY for individuals under 21.	Y	4 visits/ month	N	N
Texas	Y	30/spell of illness	Y (d)	N	N	N
Wisconsin	N	N	Y	N	N	Y B, D

NOTES:

States in bold letters have 30,000 or more migrants.

* The data refer to the categorically needy population. CY = Calendar Year FY = Fiscal Year

(a) Arkansas and Missouri also impose an indirect length of stay restriction by placing an upper limit on days that is equal to 50 and 75 percent, respectively, of the average length of stay in that region of the country with the same, or similar, diagnosis and/or operation.

(b) Arkansas : Data based on pending state plan amendment.

(c) Colorado : Limits = Exclusion of (unspecified) procedures.

(d) Texas : Limits = Exclusion of cosmetic surgery.

(A) Dollar threshold. (B) Procedure (C) Extension of Benefits (D) Out–of–state provider (E) Other

Sources: (1) Medicaid Source Book, Congressional Research Service, 1993 (Data effective as of January 1991.)
(2) Medicaid spData System, U.S. Department of Health and Human Services, May 1992. (Data effective as of March 11, 1993.)
(3) Personal communication, Missouri Division of Medical Services, August 1993.

Data compiled by Health Systems Research, Inc., 1993.

Table 10-B
LIMITS ON HOSPITAL SERVICES *
Eastern Region States

	Inpatient Hospital Length of Stay Restrictions (1)		Outpatient Hospital Services (2)				
STATES	**Limits**	**Number of Days**	**Limits**	**Visit Limits**	**ER Limits**	**Prior Authorization**	
Florida	Y	45/FY for beneficiaries 21 years and older	Y	N	N	Y	A
Georgia	Y	30/admission; psychiatric only	Y	N	N	Y	B
Maine	N	N	N	N	N	N	
Maryland	N	N	Y	N	N	Y	B
Mississippi	Y	30/FY; beneficiaries under age 21 in disproportionate share hospitals are exempt from limits	Y	6 visits/year	N	N	
New Jersey	N	N	Y	N	N	Y	D, E
New York	N	N	Y	N	N	Y	E
North Carolina	N	N	Y	24 visits/year	N	Y	B, C, D
Pennsylvania	N	N	Y	12 visits/year	N	N	
South Carolina	N	N	Y	N	N	Y	D
Tennessee	Y	For transplants: heart 43/FY, liver 67/FY, bone marrow 40/FY	Y	30 visits/year	Y	N	
Virginia	Y	21/admission for coverage within a 60 day period for the same diagnosis, beginning with the first admission. Children under 21 are exempt.	Y (a)	N	N	N	

NOTES:

States in bold letters have 30,000 or more migrants.

* Data refers to the categorically needy population.

CY = Calendar Year FY = Fiscal Year ER = Emergency Room

(a) Exclusion of experimental surgeries.

(A) Dollar threshold (B) Procedure (C) Extension of benefits (D) Out-of-state provider (E) Other

Sources: (1) Medicaid Source Book, Congressional Research Service, 1993. (Data effective as of January 1991.)
(2) Medicaid spData System, U.S. Department of Health and Human Services, May 1992. (Data effective as of March 11, 1992.)

Data compiled by Health Systems Research, Inc., 1993.

- *Capitated Programs.* Under capitation arrangements, a health plan receives a monthly fee for each covered beneficiary. Plans may be either fully or partially capitated:

  Fully capitated plans are at-risk for providing all health care services required by enrollees within the monthly capitation rate.

  Partially capitated plans receive a fixed monthly payment per beneficiary for a more limited range of services (e.g. physician services and referrals for specialty and diagnostic services).

- *Primary Care Case Management (PCCM) Programs.* Participating primary care physicians in PCCM programs are paid a fee for each service rendered as well as a periodic (typically, monthly) "case management" fee to coordinate the delivery of the beneficiary's health care services.

Most states have targeted their managed care programs to the AFDC and AFDC-related populations, as these groups are likely to be similar to existing primary care physicians' patients and not require the same specialized health care as the SSI population.[2] However, SSI and SSI-related beneficiaries are also included under several states' managed care arrangements.

States may depend on a variety of managed care arrangements to serve Medicaid recipients. Participation may be voluntary (i.e. the recipient may choose between a fee-for-service and managed care option), or states may utilize federal waiver authority to mandate that certain groups of Medicaid beneficiaries participate in a managed care plan (although recipients may choose among managed care plans).

As described in Tables 11-A and 11-B, most of the states in the midwest and eastern migrant streams have implemented one or more managed care plans. Furthermore, most of the states now without programs are in the process of implementing managed care arrangements on either a statewide or more limited basis.

In the midwest region, eight of the twelve states have managed care programs in place. Of these, three states have fully capitated plans only, one state only operates a primary care case management

2 U.S. General Accounting Office. Medicaid: States turn to managed care to improve access and control costs. March 1993. GAO/HRD-93-46.

Table 11-8
MANAGED CARE PROGRAMS
EASTERN REGION STATES

STATE	Medicaid Managed Care Programs (1)	Target Populations (1,2) AFDC	AFDC Related	SSI	SSI Related	Geographic Location (1,2)	Comments (2)
Florida	F CAP	X	X	X (a)	X (a)	Four major areas: Jacksonville vicinity, Tampa/St. Petersburg, Orlando, and Miami/Ft. Lauderdale/Palm Beach.	Voluntary program.
	PCCM	X	X			Four counties in the Tampa/St. Petersburg area.	Mandatory program.
Georgia	NONE						A PCCM program will be instituted in in three counties by October 1, 1993.
Maine	NONE						A pilot program will be in place by fall 1994; it will enroll AFDC and AFDC-related populations.
Maryland	F CAP	X	X	X	X	HMO services at primary care sites in Baltimore City and Anne Arundel County.	Voluntary program.
	PCCM	X	X	X	X	PCCM program is statewide.	Mandatory program.
Mississippi	NONE						
New Jersey	F CAP	X	X	X	X	3 HMOs participate in 10 of 33 counties.	Mandatory by 1998.
New York	F CAP	X	X	(b)		22 of 62 counties in New York State have operational plans, representing a geographical catchment area of more than 1/3 of the state.	Voluntary programs throughout the state, except in Brooklyn, where the programs are mandatory.
	PCCM	X	X	(b)			
North Carolina	F CAP	X	X	X	X	HMO program in 3 counties (Durham, Mecklenberg, and Wake.) out of 100.	Voluntary program.
	PCCM	X	X	X	X	Program operates in 16 counties. May be statewide in a few years.	Mandatory program. (c)
Pennsylvania	F CAP	X	X	X	X	HMO program operating in 12 of 67 counties.	Voluntary program.
	F CAP	X	X	X	X	Fully capitated program in Philadelphia.	Mandatory program.
South Carolina	F CAP	(See comments.)				Program operates in 8 of 46 counties.	Voluntary program that serves only the Medicaid mentally ill.
Tennessee	F CAP	X				Operates in 22 of 95 counties.	Voluntary program.
Virginia	PCCM	X	X			Operates in 8 sites (mostly counties) out of 95 counties.	Mandatory program.

NOTES:

States in bold letters have 30,000 or more migrants.

HMO = Health Maintenance Organization
F CAP = Fully capitated program.
PCCM = Primary care case management program.

AFDC = Aid to Families with Dependent Children
SSI = Supplemental Security Income

(a) All but three HMO plans serve the SSI population.
(b) While the population served varies by contract within each program, all serve the AFDC population.
(c) The program is also mandatory for Medicaid Indigent Children (MIC); and Aged, Blind and Disabled. (Excluded are individuals in mental hospitals, long term care facilities, personal care homes, foster care or subsidized adoption, domiciliary care facilities and refugees.)

Source: (1) National Summary of State Medicaid Coordinated Care Programs, Medicaid Bureau, Health Care Financing Administration, June 1992. (Data effective as of June 30, 1992.)

(2) Health Systems Research, Inc. (Data effective as of July 1993.)

Data compiled by Health Systems Research, Inc., 1993.

program, and four states have implemented both fully capitated and PCCM plans (one of the four states also has a partially capitated plan). In general, the capitated programs in these states tend to have voluntary participation whereas the PCCMs tend to be mandatory for certain populations. Only two programs, the primary care case management plans in Colorado and Michigan, are statewide. Most other programs operate in a relatively small number of counties. It is significant to note that Texas, a major home state for the migrant population, is one of the four states which has not implemented a managed care program (the others are Arkansas, North Dakota, and Oklahoma).

Nine states in the eastern region have managed care arrangements in place for some or all of their Medicaid populations. Of these, four states have fully capitated plans only (in South Carolina, however, the program just covers the mentally ill), one state has only a primary care case management program, and four states have both fully capitated and PCCM plans. Again, the capitated plans are generally voluntary and the PCCM plans are generally mandatory for certain populations. In all cases, the programs are limited to a relatively small number of counties. Only one managed care program in this region (Maryland's PCCM program) is statewide. It is noteworthy that Georgia, which borders the large migrant home state of Florida, is one of three states in the region which does not have a managed care plan in place (the state is, however, implementing a PCCM program in three counties beginning October 1993).

E. PRIMARY CARE RESOURCES

The federal government, with funds provided under Section 329 of the Public Health Service Act, supports health centers targeted specifically to meeting the health care needs of the migrant population. Other federally-supported clinics serving medically underserved populations include Community Health Centers (Section 330 grantees) and Health Care Centers for the Homeless (Section 340 grantees).

Tables 12-A and 12-B provide information on 329 and 330 grantees in the migrant stream states. Of the midwest region states, ten have migrant health centers. The number of health center sites per state in the region ranges from one in Missouri to forty-eight in Wisconsin. (Texas has the second largest number of sites after Wisconsin.) Arkansas and North Dakota are the only states in the region that do not have any Section 329 grantees or sites. Community health center (Section 330) funding is provided to all but one state (North Dakota) in the midwest region. These centers are significantly more numerous than the Section 329 centers, with the number of sites ranging from three in Oklahoma to seventy-one in Texas. In all but three of the states, Medicaid applications are taken on-site at certain health centers; the portion of centers reporting on-site Medicaid eligibility intake ranges from 17 percent in Wisconsin to 57 percent in Colorado.

All states in the eastern region, with the exception of Mississippi, have Section 329 Migrant Health Center clinics. The number of Section 329 health centers in the eastern region ranges from two in Virginia to thirty-eight in Florida. Section 330 Community Health Centers are present in every state in the region, with the number of clinics ranging from twenty-one in New Jersey to eighty-two in New York. All states also report a significant portion of centers providing on-site Medicaid eligibility intake ranging from 38 percent in Tennessee to 67 percent in Maryland, New Jersey, New York, and North Carolina.

F. CONCLUSION

The Medicaid program characteristics data presented in this chapter indicate that the development of interstate compacts for states in the midwest and eastern migrant streams would require policymakers to confront and overcome several significant challenges. Yet, the data also identify certain areas where program characteristics are relatively similar across states, thereby facilitating the development of such compacts.

Table 12-A
FEDERALLY-SUPPORTED PRIMARY HEALTH CARE PROGRAMS
Midwest Region States

STATES	Number of 329 Grantees (a) (1)	Number of 329 Sites (a) (1)	Number of 330 Grantees (a) (1)	Number of 330 Sites (a) (1)	Percent Reporting on-site Medicaid Eligibility Intake (b) (2)
Arkansas	0	0	8	27	0%
Colorado	4	21	11	24	57%
Illinois	2	10	15	42	20%
Michigan	5	22	18	39	40%
Minnesota	1	9	5	9	NA
Missouri	1	1	12	36	50%
New Mexico	3	7	9	42	20%
North Dakota	0	0	0	0	NA
Ohio	2	6	11	56	43%
Oklahoma	1	5	3	3	50%
Texas	14	47	28	71	53%
Wisconsin	1	48	6	27	17%

NOTES:

States in bold letters have 30,000 or more migrants.

NA = Not available.

(a) Section 329 refers to Health Care Centers for Migrant and Seasonal Workers and Section 330 refers to Health Care Centers for the Indigent and Medically Underserved.

(b) Including Section 329, 330 and 340 (Health Care for the Homeless) Centers.

Source: (1) Access to Community Health Care: 1993, The National Association of Community Health Centers, Inc. (Data effective as of 1992.)

(2) Access to Community Health Care: 1993, The National Association of Community Health Centers, Inc. (Data effective as of 1991.)

Data compiled by Health Systems Research, Inc., 1993.

Table 12-B
FEDERALLY-SUPPORTED PRIMARY HEALTH CARE PROGRAMS
Eastern Region States

STATES	Number of 329 Grantees (a) (1)	Number of 329 Sites (a) (1)	Number of 330 Grantees (a) (1)	Number of 330 Sites (a) (1)	Percent Reporting On-site Medicaid Eligibility Intake (b) (2)
Florida	15	38	27	70	46%
Georgia	1	5	15	30	50%
Maine	1	3	7	27	57%
Maryland	0 (c)	3	9	25	67%
Mississippi	0	0	20	40	53%
New Jersey	2	4	8	21	67%
New York	4	8	37	82	67%
North Carolina	4	7	18	33	67%
Pennsylvania	1	9	26	74	46%
South Carolina	4	20	15	41	44%
Tennessee	3	7	19	60	38%
Virginia	0 (c)	2	18	25	45%

NOTES:

States in bold letters have 30,000 or more migrants.

(a) Section 329 refers to Health Care Centers for Migrant and Seasonal Workers and Section 330 refers to Health Care Centers for the Indigent and Medically Underserved.

(b) Including Section 329, 330 and 340 (Health Care for the Homeless) Centers.

(c) Although Maryland and Virginia have no 329 grantees, they both have 329 Sites. The grantee for these sites is a non-profit (Delaware Rural Ministries) located in Dover, Delaware.

Source: (1) Access to Community Health Care: 1993, The National Association of Community Health Centers, Inc. (Data effective as of 1992.)
(2) Access to Community Health Care: 1993, The National Association of Community Health Centers, Inc. (Data effective as of 1991.)

Data compiled by Health Systems Research, Inc., 1993.

Eligibility policies for AFDC and SSI-related groups vary considerably across states. However, due to the passage of federal legislation during the 1980s establishing uniform minimum eligibility standards for pregnant women and children, the development of interstate compacts is more feasible today than would have been possible several years ago. In fact, because of the recent statutory changes, pregnant women and children represent the most probable target populations for an interstate Medicaid demonstration.

Service coverage for the Medicaid population is not a major barrier to the development of interstate compacts, as coverage of a broad range of benefits is mandated by the federal government. Furthermore, those optional services of particular interest to the migrant population such as transportation, prescription drugs, and emergency room services are covered by a large majority of states in the migrant streams. The major service-related barrier to the development of interstate compacts is likely to be related to the varying limits imposed on physician and hospital services by the different states within each region.

The existence of Medicaid managed care programs presents several challenges to the successful development of interstate Medicaid compacts. The challenges presented by managed care, however, are mitigated by the fact that there are very few states in the midwest and eastern migrant streams which currently have statewide managed care plans. On the other hand, most states are rapidly phasing in statewide programs. This trend indicates that managed care arrangements may present one of the more significant future, if not current, obstacles to the successful implementation of interstate Medicaid compacts for the migrant population. Problems which are likely to be encountered include:

- Under capitated arrangements, recipients are required to obtain care from their primary care provider or provider organization. This basic tenet of capitated arrangements conflicts with the need of migrant workers to be able to obtain care from a variety of providers in the various locations in which they work.

- Typical PCCM programs rely on assigning one provider (the "primary care physician") responsibility for delivering, or at least coordinating, each beneficiary's care. Physicians are likely to be highly resistant to accepting responsibility for coordinating care for migrant workers who may seek care in other states, especially since case management fees are low, typically in the range of three to five dollars per month.

- The potential exists for migrant workers to be locked out of health care systems in states whose Medicaid programs are dominated by managed care plans. For instance, a state in which a migrant worker is temporarily residing may not allow migrants to enroll in their managed care plans due to their transient status. Furthermore, visiting migrant workers may have limited "on demand" access to care if managed care providers limit services only to enrollees and/or require prior approval from another primary care physician before rendering services.

APPENDIX B

ESTIMATION OF MIGRANTS POTENTIALLY ELIGIBLE FOR MEDICAID

This appendix presents the methodology used to derive state-by-state estimates of the number of migrant workers and their dependents potentially eligible for Medicaid. Part A of the appendix provides background information on currently available migrant counts from federal programs, as well as migrant-specific and migrant-related information from other national enumeration efforts. Part B explains in detail the methodology used in this report to estimate the number of migrant workers in individual states potentially eligible for Medicaid and the total annual expenditure states could experience. This exposition focuses on three spreadsheets that detail our migrant estimates; explanatory text provides the assumptions underlying the estimates.

A. CURRENT MIGRANT POPULATION ESTIMATES

No universal consensus exists on the best method for classifying U.S. migrant workers and their dependents. Nor is there a single accepted method for calculating their number and distribution. Different estimates of the U.S. migrant population vary greatly because of these definitional and methodological gaps. The preferred sources for migrant counts are objective federal data rather than statistics generated by individual federal migrant assistance programs (Martin and Martin 1992). Unfortunately, even federal data sources are likely to be inaccurate because of migrant-specific data collection problems. Migrant farmworkers are difficult to find at work or at home for survey interviews. Additionally, the transitory and far-ranging nature of migrant work opportunities makes it easy to count individual migrant farmworkers more than once.

The most common form of migrant estimation is a "bottom-up" approach based on local counts of migrant and non-migrant seasonal farm workers adjusted to estimate migrants and their dependents. In contrast, "top-down" procedures begin with the total number of farmworkers or some other related labor statistic and then adjust downward to isolate a particular subset of migrant and seasonal farmworkers (MSFWs). Both approaches have potential problems. In the case of bottom-up estimates, the main concern is data collection variability; the major argument against top-down procedures is their inevitable reliance on arbitrary assumptions to differentiate between subsets of

the MSFW population (Martin and Martin 1992). Most federal migrant program-generated estimates are of the bottom-up variety (Pindus, Nancy et al. 1993).

1. Federal Migrant Program Data Sources

The four major federal programs specifically designed to assist migrant farmworker families are: Migrant Health, Migrant Education, Migrant Head Start, and Job Training for Migrant and Seasonal Farmworkers (JTPA 402). Of these four major federal programs, only the JTPA 402 allocates state funds on the basis of external, non-program generated estimates of migrant farmworkers family members. Each program defines migrant in terms of its eligibility boundaries. Thus, many people counted as migrants by one program are excluded from another program's migrant count.

a. Job Training and Partnership Act (JTPA)

Job training programs for migrant and seasonal farmworkers originated in the Office of Economic Opportunity in 1964. In 1973, the Department of Labor took over MSFW job training and employment programs. Six months after moving to the DOL's jurisdiction, MSFW training programs were subsumed in umbrella legislation for federal job training and employment programs known as the Comprehensive Employment and Training Act. CETA expired in 1982 and Congress enacted a new framework for federal job-training programs, the Job Training Partnership Act (JTPA). The current national program for seasonal and migrant farmworkers is mandated in Section 402 of the JTPA.

JTPA 402 funds are allocated to states on the basis of the relative size of decennial Census of Population (COP) state migrant estimates. Current state funding allocations for the JTPA are based upon migrant estimates from the 1980 Census of Population. The 1980 migrant data were adjusted in the late 1980s to account for farmworkers legalized under an amnesty program for certain undocumented workers in the 1986 Immigration Reform and Control Act (IRCA). JTPA 402 funding allocations for fiscal year 1994 will be based on migrant estimates from the 1990 Census of

Population (Oral communication from the Office of Special Targeted Programs. Department of Labor). JTPA 402 eligibility is determined based on a two-year retrospective employment and income history.

The Census of Population's current data collection approach is not well-suited to an accurate estimate of the number of migrants in each state. The COP only counts persons working in agriculture at the time of the census polling in late March. Since there are few seasonal farm labor jobs in March, the COP underestimates the total number of seasonal and migrant farmworkers by as much as two-thirds and distorts migrant state residency estimates in favor of home-base states rather than the states to which migrants travel during the growing and harvesting season (Martin and Martin 1992).

b. Migrant Education

When Congress passed the Elementary and Secondary Education Act in 1966 it included a special program for migrant education. Unlike basic Chapter I federal funding for educating the disadvantaged, which provides grants through the states for aid to local education agencies, Section 1201 grants for migrant education place primary responsibility at the state educational agency level. In 1991, 49 states received some portion of a total Section 1201 appropriation of $285.6 million. In addition to the 1201 grants, section 1203 of the statute provides for additional grants to improve coordination among state and local educational agencies' educational programs available for migratory students.

Migrant Education funds are allocated to states on the basis of full-time equivalent (FTE) in-state population counts drawn from the Migrant Student Record Transfer System, rather than that percentage of a state's FTE migrant student population that actually receives ME services. The MSRTS stores academic, health, and other educational records on migratory children participating in the Migrant Education program. Children are eligible for Migrant Education services and remain in the MSRTS for up to six years after a family makes a program-qualifying household move.

Because of the way the MSRTS generates its FTE counts, even when MSRTS records show that a student has withdrawn from a school system, she remains within that state's database until she is picked up by a system in a different state and the state notifies MSRTS of the enrollment there. In the past, this slow removal from a state's MSRTS counts worked to the advantage of "stopover" states with aggressive ME outreach programs, since many of the children signed up in such states were never picked up by another state system (Martin and Martin 1992). The MSRTS also may include double counting of children with access to services in more than one state. Other criticisms of MSRTS-based migrant population estimates are: (1) states vary in their requirements for completion of MSRTS, (2) MSRTS counts will not include migrant children who attend schools not enrolled in the Migrant Education Program, and (3), the increasing complexity of MSRTS reporting procedures has reduced the timeliness and accuracy of the system's migrant children estimates (Pindus, Nancy et al. 1992).

c. Migrant Health

The Migrant Health Program is a branch of the Division of Primary Care Services in the Department of Health and Human Services. Oldest of the major federally funded migrant service programs, in 1970 Congress expanded the Migrant Health program to serve seasonal farmworkers as well. The bulk of the annual appropriation for Migrant Health goes to approved Migrant Health Centers. Migrant Health collects information on farmworkers and their family members who receive services, since funding allocations for approved Migrant Health Centers under sections 329 and 330 of the Public Health Service Act are made based on the number of migrants in a clinic's "catchment area." The major drawback of the resulting migrant estimates, which are compiled into aggregate patient profile and utilization data under the Bureau of Community Health Services Common Reporting Requirement system, is that they include only those migrants who have visited 329- and 330-funded official Migrant Health Centers (Pindus, Nancy et al. 1992). Like JTPA 402, Migrant Health eligibility is based on a family's preceding two years of employment and income history.

In 1990 the Office of Migrant Health published, "An Atlas of State Profiles Which Estimate Number of Migrant and Seasonal Farmworkers and Members of Their Families." The goal of the Atlas was to facilitate planning for services for MSFWs by providing state migrant population estimates. The Atlas is a compilation of state-based estimation attempts that rely on a variety of enumeration methodologies.

d. Migrant Head Start

Migrant Head Start began in 1965 as one component of Project Head Start in the Office of Economic Opportunity. The program is now administered by the Head Start Bureau in the Administration for Children and Families housed within the Department of Health and Human Services. In fiscal year 1990, Migrant Head Start received $60.4 million in federal funds. which was distributed to 23 Migrant Head Start grantees in 33 states. Funding allocations to MHS grantees are made on the basis of detailed performance reviews set out in contracts between MHS grantees and Head Start officials. In direct contrast to Migrant Education, MHS does not serve children of seasonal agricultural workers (Martin and Martin 1992). To qualify for MHS, family incomes must come primarily from the harvesting of tree and field crops and families must have moved within the last 12 months. Thus, MHS estimates of the migrant children it serves are based on a much narrower definition of migrant farmworker than that employed by Migrant Education. Another problem with using estimates from the Migrant Head Start program is that only a small portion of those families who qualify for the program actually receive MHS day-care and educational services. Most MHS programs operate on a first-come, first-serve basis and maintain waiting lists for children from qualified families.

e. Migrant Legal Services' Migrant Enumeration Project

Migrant Legal Services sponsored the 1993 Migrant Enumeration Project (MEP) for two major reasons: (1) to help determine how to re-apportion MLS funding among states with migrant legal

services programs, and (2) to increase Congressional funding generally for migrant legal services programs. The study, headed by Drs. Alice C. Larson and Luis Plascencia, defines migrants as, "anyone who, while employed in seasonal agricultural labor during the last year, cannot return to his/her normal residence at night." The MEP estimates the total number of U.S. migrants and their dependents to be approximately 3,036,432.

The MEP relies on data from the USDA's Quarterly Annual Labor Survey, the National Agricultural Workers Survey, as well as Migrant Health and Migrant Education program-generated data. The MEP supplemented these and other secondary source materials with some research and field review. The MEP targets migrant workers in the following areas: field agriculture, forestry, nurseries and greenhouses, good processing, cotton gins, and crops under cover. Seasonal laborers in fishing, dairies, poultry or eggs or working with other animals are excluded from the counts.

In each state, the researchers identified counties with migrant labor, gathered crop and labor specific data, and developed field agricultural summaries for each county based on demand for labor estimates of specific agricultural tasks. The MEP demand for labor formula is:

$$DFL = A \times H / W \times S$$

Where: A = crop acreage, H = hours needed to harvest one acre of the crop, W = work hours per farmworker per day during peak activity, and S = season length for peak activity.

Other aspects of the MEP approach included calculating a statewide migrant percentage by which to multiply the state total DFL migrant and seasonal farmworker estimates, determining the number of migrant households with non-working dependents and multiplying households by the number of non-working dependents per household. Migrant percentage estimates were an average of state migrant patient/client enrollment in Migrant Health and Migrant Education programs for 1990 and 1991. No Department of Labor employment statistics were available for some states. In these states, the survey team had to rely solely on state migrant program counts supplemented with field research. Results from the 1990 NAWS were used to determine the percent of migrants

accompanied by family members, with states grouped by USDA Farm Labor Region. NAWS was also the basis for state averages of dependents in migrant households.

One serious drawback of the MEP estimates is their reliance on program-generated data and other secondary sources. Additionally, the study's estimates are inflated by some amount of both interstate and intrastate duplication. The study's duplication problem is compounded by applying generous coefficient estimates of the numbers of migrant spouses and numbers of dependents per migrant dependents.

2. Non-Program Data Sources

a. Wage and Employment Data from the Quarterly Annual Labor Survey

The Quarterly Agricultural Labor Survey (QALS) is conducted by the U.S. Department of Agriculture every quarter for the purpose of tracking farm labor data. The QALS, which surveys five to ten thousand employers of farmworkers, estimates a total of 1.5 million farmworkers peak season (Pindus et al. 1993).

b. The National Agricultural Workers Survey (NAWS)

The annual National Agricultural Workers Survey (NAWS) generally is considered the best data set for examining farm labor supply fluctuations and demographic migrant and seasonal farmworker information (Pindus, Nancy et al. 1993). The NAWS is a top-down estimation effort based on Census of Agriculture (COA) and Quarterly Agricultural Labor Survey (QALS) data. A randomized national survey consisting of detailed approximately hour-long interviews with farmworkers, the NAWS is the research successor to the defunct Hired Farmworkers Force data from the Current Population

Survey.[1] The 1990 NAWS estimated the number of migrant workers engaged in perishable crop work to be approximately 42% of the total U.S. crop farmworker labor force, or approximately 840,000 to 940,000 migrants. (Note that the survey excludes livestock and farm service workers.) NAWS classifies as a migrant anyone who travelled 75 miles or more during the year in search of farm work.

Two major drawbacks of the NAWS results published to date are: (1) the information does not distinguish between migrants and nonmigrant seasonal farmworkers, and, (2) the survey's use of site area sampling to obtain a nationally representative cross-section of MSFWs obviates a statistically defensible way of examining the data at the individual state level, with the exception of California and Florida, states with very large migrant populations. The survey does offer extremely useful regional farm migrant labor pattern characterizations, but the sample size is inadequate to generate estimates for most of the NAWS regions illustrated in Figure B.1. A 1993 report from the Department of Labor based on data from the 1989, 1990, and 1991 NAWS, *U.S. Farmworkers in the Post-IRCA Period*, provides valuable regional demographic information pertaining to migrants. This information was substantially augmented with the assistance of Dr. Rick Mines, Office of Program Economics, Department of Labor, and Bea Boccalandro, Research Associate, Aguirre International. Unpublished migrant-specific regional estimates combining surveys for 1989, 1990 and 1991 are included and cited in our tables of state migrant estimates presented in the following section. Note that the limited sample size of the NAWS means that we have limited disaggregation to: (1) Eastern versus Midwestern streams, and (2) Texas and Florida versus all other "upstream" states.

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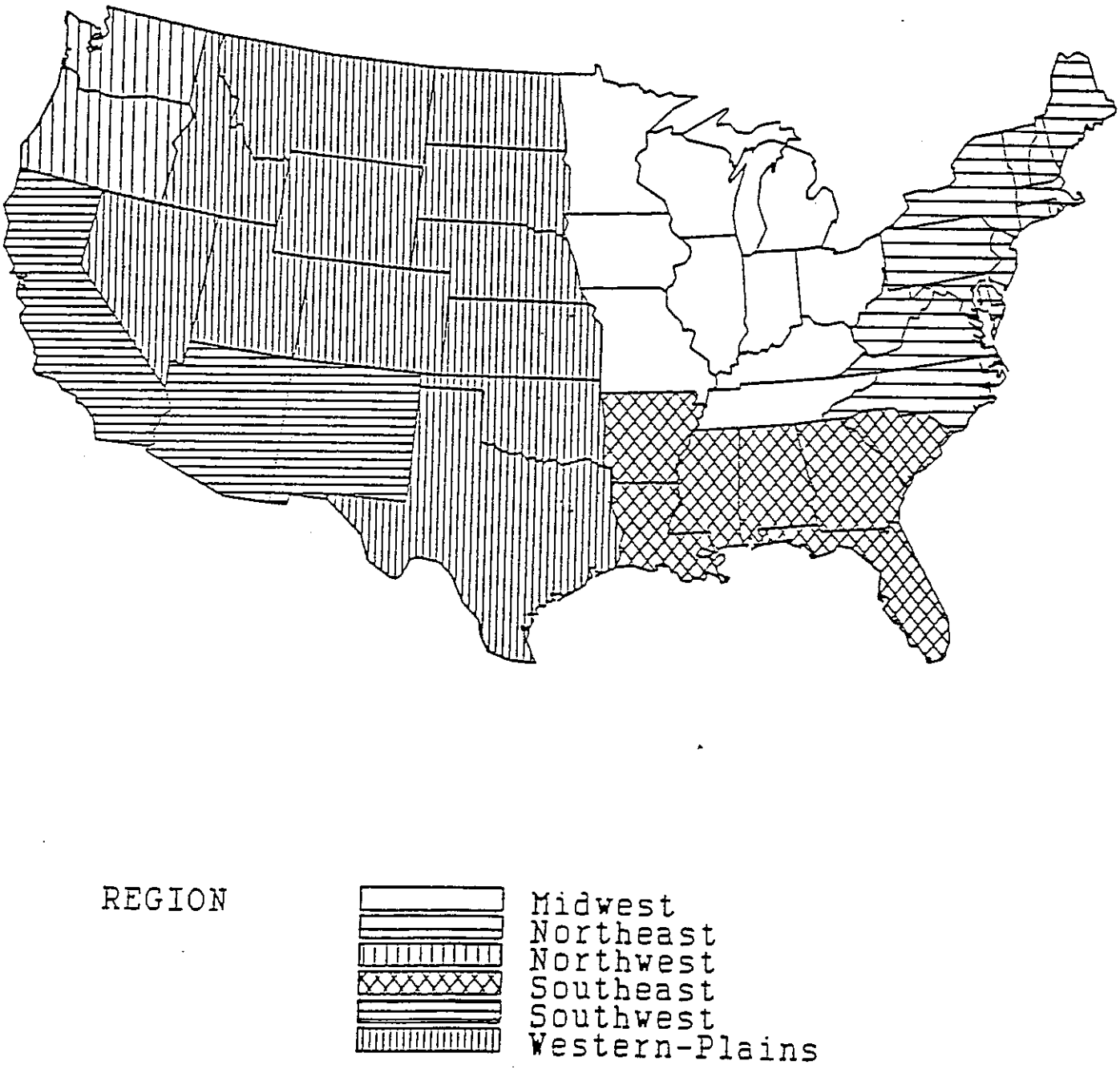
[1] Most labor data come from the monthly Current Population Survey, which interviews about 60,000 households. However, the CPS is not considered a reliable estimate of the migrant and seasonal farmworker populations because it is based on the assumption that each of the 80 million housing units in the United States has an equal probability of being in the sample, and does not take into account the non-traditional housing arrangements of migrant and seasonal farmworkers (Martin, David A. et al. 1992).

FIGURE B.1

NAWS REGIONS



SOURCE: U.S. Department of Labor. "Findings From the National Agricultural Workers Survey (NAWS) 1990." July 1990, pg. 95.

B. ESTIMATION METHODOLOGY

Given the fact that estimates of the number of migrants vary widely, contain a potential upward bias, and do not focus on the specific issue of eligibility for Medicaid, we have generated independent estimates for major migrant states. The core assumption is that Medicaid eligibility will be limited to pregnant mothers and children. For simplicity, we are assuming that all migrants meet every state's income eligibility criteria and that the Medicaid expansions are fully phased in thereby covering all children under 19. The basic approach is to start with the demand for migrant labor derived from the 1987 Agricultural Census and adjust these numbers using demographic and behavioral coefficients from the average of the 1989-1991 National Agricultural Worker Survey. Most of these coefficients are unpublished and calculated for us by the Department of Labor. These coefficients for the specific migrant population are very important, since published data from the NAWS tends to cover all seasonal workers, and not specifically migrants, who differ from seasonal agricultural workers in important respects.

The estimation is generated in three steps. First, the total number of migrant jobs in field agriculture is estimated for each state; these figures are adjusted to limit the count to the number of pregnant women and children with legal status. The second step is to calculate an unduplicated count of pregnant women and children who return and stay for the non-crop season in the home states of Florida and Texas. Finally, the results of the first two steps are added, adjusted to generate enrollee months and multiplied by an estimate of expenditure per enrollee month, a key figure drawn from the 1991 and 1992 Medicaid expenditures of four states. These three steps are discussed in detail in the following sections.

1. Total Medicaid Eligibles from Active Migrant Workers

The estimate of the number of agricultural jobs is presented in Table B.1. Rather than attempt to calculate the number of jobs from crop tonnage or acreage, we use the total agricultural payroll reported for field and seasonal crops. (This excludes dairy, livestock, forestry, fishing, and nursery

TABLE B.1

TOTAL ESTIMATION POTENTIAL STATE ENROLLMENT OF MEDICAID ELIGIBLE MIGRANT FAMILIES AND DEPENDENTS (NET OF HOME STATE DOWN TIME)

Target States	1 Total 1987 Farm Labor Expenditures (000)	2 Average Hourly Field Wage by QALS Region for 1987	3 Relative 1987 QALS Field Wage Estimates (col2/4.69)	4 NAWS Average Hourly Field Wage for Farmworkers in 1989	5 Ratio of 1987 to 1989 QALS Field Wages	6 Estimated NAWS Field Wage for Farmworkers in 1987 (col4/col5)	7 1987 NAWS Farmworker Wages Adjusted by QALS Regional Data (1987) (col6*col3)	8 Estimated Number of Farmworker Hours (000) (col1/col7)	9 Avg. Agricultural Work Hours per Week
Midwestern Migratory Stream States:									
North Dakota	74,556	4.45	0.95	5.19	1.0917	4.75	4.51	16,519	39
Minnesota	121,491	4.56	0.97	5.19	1.0917	4.75	4.62	26,293	40
Wisconsin	93,220	4.56	0.97	5.19	1.0917	4.75	4.62	20,175	40
Michigan	178,264	4.56	0.97	5.19	1.0917	4.75	4.62	38,580	40
Colorado	88,675	4.45	0.95	5.19	1.0917	4.75	4.51	19,647	39
Missouri	87,181	4.56	0.97	5.19	1.0917	4.75	4.62	18,868	40
Illinois	188,346	4.56	0.97	5.19	1.0917	4.75	4.62	40,762	40
Ohio	137,224	4.56	0.97	5.19	1.0917	4.75	4.62	29,698	40
New Mexico	53,388	4.32	0.92	5.19	1.0917	4.75	4.38	12,192	39
Texas	370,429	4.45	0.95	5.19	1.0917	4.75	4.51	82,075	39
Oklahoma	53,103	4.45	0.95	5.19	1.0917	4.75	4.51	11,766	39
Arkansas	119,632	3.93	0.84	5.19	1.0917	4.75	3.98	30,031	40
Eastern Migratory Stream States:									
Maine	31,143	4.71	1.00	5.19	1.0917	4.75	4.77	6,523	40
New Jersey	88,821	4.71	1.00	5.19	1.0917	4.75	4.77	18,604	40
New York	147,201	4.71	1.00	5.19	1.0917	4.75	4.77	30,832	40
Pennsylvania	179,848	4.71	1.00	5.19	1.0917	4.75	4.77	37,670	40
Maryland	41,894	4.71	1.00	5.19	1.0917	4.75	4.77	8,775	40
Virginia	63,197	4.71	1.00	5.19	1.0917	4.75	4.77	13,237	40
Tennessee	77,192	3.93	0.84	5.19	1.0917	4.75	3.98	19,377	40
North Carolina	193,099	4.71	1.00	5.19	1.0917	4.75	4.77	40,445	40
Alabama	60,781	3.93	0.84	5.19	1.0917	4.75	3.98	15,258	40
Georgia	132,564	3.93	0.84	5.19	1.0917	4.75	3.98	33,277	40
South Carolina	75,206	3.93	0.84	5.19	1.0917	4.75	3.98	18,879	40
Florida	894,382	3.93	0.84	5.19	1.0917	4.75	3.98	224,512	39

TABLE B.1 *(continued)*

Target States	10 Avg. Weeks Spent Working in State	11 Avg. Work Hours per Peak Harvest Season (col9*col10)	12 Total Number of Fieldworkers (col8/col11)	13 Estimated Pct. of Migrants based on NAWS Data	14 Number of Migrant Fieldworkers (col12*col13)	15 Pct. of Legal Migrant Workers by Latinization Region (NAWS)***	16 Number of Legal Migrant Workers*** (col14*col15)	17 Pct. of Migrant Workers Who are Women	18 Number of Migrant Workers Who are Women based on NAWS Data**** (col16*col17)	19 Traveling Children of Legal Migrants	20 Number of Children Present in Households (col16*col19)
Midwestern Migratory Stream States:											
North Dakota	15.9	620	26,639	0.54	14,385	0.86	12,371	0.18	2,227	0.7	8,660
Minnesota	15.9	636	41,342	0.71	29,353	0.73	21,427	0.17	3,643	0.5	10,714
Wisconsin	15.9	636	31,722	0.71	22,522	0.73	16,441	0.17	2,795	0.5	8,221
Michigan	15.9	636	60,661	0.71	43,069	0.73	31,441	0.17	5,345	0.5	15,720
Colorado	15.9	620	31,684	0.54	17,110	0.86	14,714	0.18	2,649	0.7	10,300
Missouri	15.9	636	29,667	0.71	21,063	0.73	15,376	0.17	2,614	0.5	7,688
Illinois	15.9	636	64,092	0.71	45,505	0.73	33,219	0.17	5,647	0.5	16,609
Ohio	15.9	636	46,696	0.71	33,154	0.73	24,202	0.17	4,114	0.5	12,101
New Mexico	22.8	889	13,711	0.54	7,404	0.86	6,367	0.18	1,146	0.7	4,457
Texas	28.8	1,123	73,072	0.54	39,459	0.86	33,935	0.18	6,108	0.7	23,754
Oklahoma	22.8	889	13,232	0.54	7,145	0.86	6,145	0.18	1,106	0.7	4,301
Arkansas	22.8	912	32,928	0.71	23,379	0.73	17,067	0.17	2,901	0.5	8,533
Eastern Migratory Stream States:											
Maine	15.9	636	10,256	0.71	7,282	0.73	5,316	0.11	585	0.5	2,658
New Jersey	15.9	636	29,251	0.71	20,768	0.73	15,161	0.11	1,668	0.5	7,580
New York	15.9	636	48,478	0.71	34,419	0.73	25,126	0.11	2,764	0.5	12,563
Pennsylvania	15.9	636	59,229	0.71	42,053	0.73	30,699	0.11	3,377	0.5	15,349
Maryland	15.9	636	13,797	0.71	9,796	0.73	7,151	0.11	787	0.5	3,575
Virginia	22.8	912	14,514	0.71	10,305	0.73	7,523	0.11	827	0.5	3,761
Tennessee	22.8	912	21,247	0.71	15,085	0.73	11,012	0.11	1,211	0.5	5,506
North Carolina	22.8	912	44,348	0.71	31,487	0.73	22,986	0.11	2,528	0.5	11,493
Alabama	22.8	912	16,730	0.71	11,878	0.73	8,671	0.11	954	0.5	4,336
Georgia	22.8	912	36,488	0.71	25,906	0.73	18,912	0.11	2,080	0.5	9,456
South Carolina	22.8	912	20,700	0.71	14,697	0.73	10,729	0.11	1,180	0.5	5,364
Florida	28.8	1,123	199,886	0.54	107,938	0.86	92,827	0.11	10,211	0.7	64,979

TABLE B.1 *(continued)*

Target States	21 Total Number of Pregnant Migrant Women (.265*col18)	22 Avg. Months of In-State Residency (col10/4.33)	23 Pregnant Women Potentially Medicaid Eligible Person-Months In-State (col21*col22)*.483	24 Children Potentially Medicaid Eligible Person-Months In-State (col20*col22)*.592
Midwestern Migratory Stream States:				
North Dakota	590	3.67	1,046	18,811
Minnesota	965	3.67	1,711	23,272
Wisconsin	741	3.67	1,313	17,857
Michigan	1,416	3.67	2,510	34,147
Colorado	702	3.67	1,244	22,373
Missouri	693	3.67	1,228	16,700
Illinois	1,497	3.67	2,652	36,079
Ohio	1,090	3.67	1,932	26,286
New Mexico	304	5.26	772	13,883
Texas	1,619	6.65	5,196	93,462
Oklahoma	293	5.26	745	13,398
Arkansas	769	5.26	1,954	26,580
Eastern Migratory Stream States:				
Maine	155	3.67	275	5,773
New Jersey	442	3.67	783	16,466
New York	732	3.67	1,298	27,289
Pennsylvania	895	3.67	1,586	33,341
Maryland	208	3.67	369	7,767
Virginia	219	5.26	557	11,716
Tennessee	321	5.26	816	17,151
North Carolina	670	5.26	1,703	35,798
Alabama	253	5.26	642	13,504
Georgia	551	5.26	1,401	29,453
South Carolina	313	5.26	795	16,709
Florida	2,706	6.65	8,686	255,661

operations.) Total labor expenses are divided by the average wage for seasonal agricultural workers to estimate the number of labor hours. The number of workers is then estimated by using the average number of weeks workers are working outside their home state. The estimated number of migrant jobs are duplicated, in that the same person can hold jobs in several states. For simplicity we assume that migrants minimize travel and remain their entire travel time in one upstream state. These counts are then adjusted for migrants as a percent of all seasonal agricultural workers, the percent of migrants with legal status, the percent who are women, the probability that women are pregnant and the number of traveling children per migrant.

The data in Table B.1 are drawn from the following sources:

U.S. Department of Agriculture, Bureau of the Census, Census of Agriculture, 1987; USDA Quarterly Annual Labor Survey; U.S. Department of Labor, National Agriculture Workers Survey; Dr. Rick Mines, Office of Program Economics, Department of Labor; Dr. Philip A. Martin, UC Davis; and, Dr. Susan Gabbard and Bea Boccalandro of Aguirre International. In addition, length of enrollment on Medicaid estimates are drawn from unpublished tabulations furnished by SysteMetrics, Inc. from four states in HCFA's Medicaid Tape-to-Tape database (California, Georgia, Michigan, and Tennessee).

The assumptions and data sources for each of the 24 columns in Table B.1 are as follows:

Column 1: Farm labor expenditure amounts in Column 1 come from 1987 Census of Agriculture labor expenditures of crop farms in each state. Reported expenditures include gross wages or salaries paid to hired workers and supervisors, bonuses, social and other payroll taxes, and expenditures for fringe benefits. This column also includes what is paid to farm labor contractors.

Column 2: The average hourly field wages in Column 2 are taken from Quarterly Annual Labor Survey for 1987 which contains regional estimates for field workers.

Column 3: The relative regional wages of field workers in 1987 reported in Column 3 were determined by dividing each regional QALS wage estimate (Column 2) by the national average hourly wage of $4.69.

Column 4: The estimated 1989 average hourly field worker wage in Column 4 comes from *U.S. Farmworkers in the Post-IRCA Period*, Research Report No.4., U.S. Department of Labor, 1992 p. 44. That report shows the NAWS-reported overall "real" wage for all farm workers to be $5.19 per hour.

Column 5: The 1987 to 1989 QALS field wage ratio is reported in "Farm Employment and Wage Rates 1910-1990," U.S. Department of Agriculture, National Agricultural Statistics Service, Statistical Bulletin Number 822.

Column 6: Since the NAWS was not conducted in 1987, the estimated 1987 NAWS field wage was found by dividing the average NAWS reported 1989 hourly field work wage (Column 6) by the wage ratios of the QALS relative regional field wage estimates (Column 3).

Column 7: The estimated NAWS field wages for 1987 in Column 7 were adjusted by QALS relative regional field wage estimates.

Column 8: The total number of field workers in Column 8 was derived by dividing total 1987 farm labor expenditures for each state (Column 1) by 1987 regionally adjusted NAWS field wage estimates (Column 7).

Column 9: The average number of agricultural hours worked per week in Column 9 came from migrant-specific information from the NAWS provided to MPR by Rick Mines, Office of Program Economics, Department of Labor and Bea Boccalandro, Aguirre International.

Column 10: The average number of weeks spent working in a state reported in Column 10 came from migrant-specific information from the NAWS provided to MPR by Rick Mines, Office of Program Economics, Department of Labor and Bea Boccalandro, Aguirre International. The estimate of 28.8 weeks is specific to U.S. based migrants in home states only. The estimate of 15.9 weeks is the average number of weeks per year spent in the north. The estimate of 22.8 weeks is the average number of weeks per year spent in the south.

Column 11: Average work hours per peak harvest season in Column 11 were estimated by multiplying average agricultural worker hours per week (Column 9) by the length of the peak harvest season in each state (Column 10).

Column 12: Estimates of the total number of field workers in each state in Column 12 were derived by dividing the estimated number of farmworker in each state (Column 8) by the estimated average work hours per peak harvest season (Column 11).

Column 13: The estimated percentages of each states' labor supply that is migrant in Column 13 comes from the proportions of migrants in the established Latinization region (.54) and the recent Latinization region (.71) reported in "U.S. Farmworkers in the Post-IRCA period," DOL, p.20.

Column 14: The proportion of field workers who are migrants was determined by multiplying each state's estimated total number of field workers (Column 12) by the estimated migrant percentage (Column 13).

Column 15: Estimates of the percentage of migrant workers who are legal (these estimates include SAWs) in Column 15 came from migrant-specific information from the NAWS provided to MPR by Rick Mines at the Department of Labor, and Bea Boccalandro from Aguirre International.

Column 16: Proportions of migrants who work in each state who are legally residing in the U.S. were developed by multiplying the estimated number of migrant field workers for each state (Column 14) by the corresponding percentage of migrants who are in the U.S. legally (Column 15).

Column 17: The estimated coefficients of .18 for the established Latinization region and .17 for the recent Latinization region came from migrant-specific information from the NAWS provided to MPR by Rick Mines at the Department of Labor and Bea Boccalandro at Aguirre International. For the Eastern region, the estimate is 11 percent compared to the national average of 18 percent.

Column 18: The number of legal migrant workers who are women in each of the target states was developed by multiplying each state's estimated number of legal migrant workers (Column 16) by the estimated percentage of migrant workers who are women (column 17).

Column 19: The average number of children per household for migrants with legal status (0.7 for the established Latinization region; 0.5 for the recent Latinization region) came from migrant-specific information from the NAWS provided to MPR by Rick Mines at DOL and Bea Boccalandro at Aguirre International.

Column 20: The total estimated number of children present in migrant households was developed for each state by multiplying the number of legal migrant workers (Column 16) by the average number of children in migrant households with legal status (Column 19).

Column 21: The total number of Medicaid-eligible pregnant women is estimated by multiplying the total number of legal migrant women in column 18 by .265. This coefficient is drawn from Bureau of the Census, *Fertility of American Women: June 1992*, series P20-470, June 1993, Table 4 Part D. An average of 124.8 per 1000 Hispanic women between the ages of 15 and 29 gave birth the previous year. This coefficient was increased by 27.2 percent to take into account the fact that the rate for poor Hispanic women with incomes below $10,000 was 1.272 times the average for all Hispanic women. The number pregnant is larger than the number giving birth by a factor of 8/12 months. The proportion pregnant is therefore estimated as .1248 * 1.272 * 1.667.

Column 22: The number of months migrants are in a state is calculated by dividing the number of weeks in column 10 by the average number of weeks per month, 4.333.

Column 23: The column calculates the number of person months that migrant pregnant women are enrolled by multiplying the number of individuals by the average number of months in residency. The number is then discounted by .483, which is the ratio of 5.8 months to 12 months. The 5.8 figure is the average length of enrollment for women eligible through poverty-related status in four Tape-to-Tape states for 1991.

Column 24: The final column for migrant children mirrors the calculation for pregnant women in column 23. The discount factor of .592 is the quotient of the average length of enrollment of children eligible through poverty-related status for the Tape-to-Tape states (7.1 months) divided by 12 months.

2. Determination of Migrant Women and Children Down Time in Home States

The series of calculations presented in Table B.2 were performed to account for the fact that migrant workers and their dependents return to their home states during down time, a factor that will

TABLE B.2

DETERMINATION OF MIGRANT WOMEN AND CHILDREN DOWN TIME IN HOME STATES

States	col1 Legal Pregnant Women Migrant Workers in State (col21,Table1)	col2 Pct. of Migrants that have U.S. Home Base	col3 Women and Children Crop-to-Crop (Non-Shuttle) Legal Migrant Workers (col1*col2)	col4 Avg. Weeks Spent in State	col5 Number of Weeks Traveling Outside Home State	col6 Proportion of Travel Time in State (col4/col5)	col7 Unduplicated Number of Pregnant Women Returning to Home State (col3*col6)	col8 Pct. of Traveling Migrants with Spouse in Home State
Midwestern Migratory Stream States:								
North Dakota	590	0.36	212	15.9	32.3	0.49	105	0.01
Minnesota	965	0.36	348	15.9	32.3	0.49	171	0.06
Wisconsin	741	0.36	267	15.9	32.3	0.49	131	0.06
Michigan	1,416	0.36	510	15.9	32.3	0.49	251	0.06
Colorado	702	0.36	253	15.9	32.3	0.49	124	0.01
Missouri	693	0.36	249	15.9	32.3	0.49	123	0.06
Illinois	1,497	0.36	539	15.9	32.3	0.49	265	0.06
Ohio	1,090	0.36	393	15.9	32.3	0.49	193	0.06
New Mexico	304	0.36	109	22.8	32.3	0.71	77	0.01
Texas	1,619	0.36	583	28.8	0	0.00	0	0
Oklahoma	293	0.36	106	22.8	32.3	0.71	74	0.01
Arkansas	769	0.36	277	22.8	32.3	0.71	195	0.06
Total	10,678	0.36	3,844				1,711	
Eastern Migratory Stream States:								
Maine	155	0.30	46	15.9	32.3	0.49	23	0.06
New Jersey	442	0.30	133	15.9	32.3	0.49	65	0.06
New York	732	0.30	220	15.9	32.3	0.49	108	0.06
Pennsylvania	895	0.30	268	15.9	32.3	0.49	132	0.06
Maryland	208	0.30	63	15.9	32.3	0.49	31	0.06
Virginia	219	0.30	66	22.8	32.3	0.71	46	0.06
Tennessee	321	0.30	96	22.8	32.3	0.71	68	0.06
North Carolina	670	0.30	201	22.8	32.3	0.71	142	0.06
Alabama	253	0.30	76	22.8	32.3	0.71	54	0.06
Georgia	551	0.30	165	22.8	32.3	0.71	117	0.06
South Carolina	313	0.30	94	22.8	32.3	0.71	66	0.06
Florida	2,706	0.30	812	28.8	0	0.00	0	0
Total	7,466	0.30	2,240				852	

TABLE B.2 *(continued)*

States	col9 Number of Legal Migrant Workers (col16,Table1)	col10 Number of Wives Left in Home State (col8*col9)	col11 Avg. Number of Children per Migrant Worker Left in Home State	col12 Number of Children Left in Home State (col9*col11)	col13 Total Pregnant Women Left in Home State (col10*.265)	col14 Unduplicated Number of Pregnant Women Left in Home State (col6*col13)	col15 Avg. Number of Months in Home State for Traveling Dependents	col16 Enrollment Months for Traveling Pregnant Women in Home State (col7*col15)
Midwestern Migratory Stream States:								
North Dakota	12,371	124	0.10	1,237	33	16	4.4	460
Minnesota	21,427	1,286	0.20	4,285	341	168	4.4	753
Wisconsin	16,441	986	0.20	3,288	261	129	4.4	578
Michigan	31,441	1,886	0.20	6,288	500	246	4.4	1,104
Colorado	14,714	147	0.10	1,471	39	19	4.4	547
Missouri	15,376	923	0.20	3,075	244	120	4.4	540
Illinois	33,219	1,993	0.20	6,644	528	260	4.4	1,167
Ohio	24,202	1,452	0.20	4,840	385	189	4.4	850
New Mexico	6,367	64	0.10	637	17	12	4.4	340
Texas	33,935	0	0.10	3,393	0	0	0.0	0
Oklahoma	6,145	61	0.10	614	16	11	4.4	328
Arkansas	17,067	1,024	0.20	3,413	271	192	4.4	860
Total	232,706	9,946		39,188	2,636	1,363		7,526
Eastern Migratory Stream States:								
Maine	5,316	319	0.20	1,063	85	42	4.4	101
New Jersey	15,161	910	0.20	3,032	241	119	4.4	287
New York	25,126	1,508	0.20	5,025	400	197	4.4	476
Pennsylvania	30,699	1,842	0.20	6,140	488	240	4.4	581
Maryland	7,151	429	0.20	1,430	114	56	4.4	135
Virginia	7,523	451	0.20	1,505	120	84	4.4	204
Tennessee	11,012	661	0.20	2,202	175	124	4.4	299
North Carolina	22,986	1,379	0.20	4,597	365	258	4.4	624
Alabama	8,671	520	0.20	1,734	138	97	4.4	236
Georgia	18,912	1,135	0.20	3,782	301	212	4.4	514
South Carolina	10,729	644	0.20	2,146	171	120	4.4	291
Florida	92,827	0	0.10	9,283	0	0	0.0	0
Total	256,111	9,797		141,940	2,596	1,549		3,749

TABLE B.2 *(continued)*

States	col17 Enrollment Months for Pregnant Women Remaining in Home State (col14*5.8)	col18 Total Enrollment Months for Traveling and Resident Pregnant Women (col16+col17)	col19 Number of Traveling Children (col20,Table1)	col20 Unduplicated Count of Children Returning to Home-State (col19*col2*col6)	col21 Total Enrollment Months of Traveling and Returning Children (col20*col15)+(col12*7.1)	col22 Total Enrollment Months for Traveling and Resident Women Allocated to Home State (Totals for col18 allocated to FL and IX)	col23 Total Unduplicated Count of Women Returning to Home State (Total col7+ Total col14 allocated to home state)	col24 Total Enrollment Months for Traveling and Resident Children Allocated to Home State (Totals for col 21 allocated to FL and IX)
Midwestern Migratory Stream States:								
North Dakota	94	554	8,660	1,535	15,536	0	0	0
Minnesota	973	1,725	10,714	1,899	38,781	0	0	0
Wisconsin	746	1,324	8,221	1,457	29,757	0	0	0
Michigan	1,427	2,532	15,720	2,786	56,903	0	0	0
Colorado	111	659	10,300	1,825	18,478	0	0	0
Missouri	698	1,238	7,688	1,362	27,829	0	0	0
Illinois	1,508	2,675	16,609	2,943	60,122	0	0	0
Ohio	1,099	1,949	12,101	2,144	43,803	0	0	0
New Mexico	69	409	4,457	1,133	9,504	0	0	0
Texas	0	0	23,754	0	24,094	15,429	3,073	367,756
Oklahoma	67	394	4,301	1,093	9,172	0	0	0
Arkansas	1,111	1,971	8,533	2,168	33,776	0	0	0
Total	7,903	15,429	131,060	20,346	367,756	15,429	3,073	367,756
Eastern Migratory Stream States:								
Maine	241	342	2,658	393	9,276	0	0	0
New Jersey	688	975	7,580	1,119	26,454	0	0	0
New York	1,141	1,617	12,563	1,855	43,842	0	0	0
Pennsylvania	1,394	1,975	15,349	2,267	53,566	0	0	0
Maryland	325	460	3,575	528	12,478	0	0	0
Virginia	490	694	3,761	797	14,187	0	0	0
Tennessee	717	1,016	5,506	1,166	20,768	0	0	0
North Carolina	1,496	2,121	11,493	2,434	43,348	0	0	0
Alabama	564	800	4,336	918	16,353	0	0	0
Georgia	1,231	1,745	9,456	2,002	35,665	0	0	0
South Carolina	698	990	5,364	1,136	20,233	0	0	0
Florida	0	0	64,979	0	65,907	12,734	2,401	362,076
Total	8,985	12,734	146,621	14,615	362,076	12,734	2,401	362,076

TABLE B.2 *(continued)*

States	col 25 Unduplicated Count of Children Returning or Left In Home State (Total for col20+col12)
Midwestern Migratory Stream States:	
North Dakota	0
Minnesota	0
Wisconsin	0
Michigan	0
Colorado	0
Missouri	0
Illinois	0
Ohio	0
New Mexico	0
Texas	59,534
Oklahoma	0
Arkansas	0
Total	59,534
Eastern Migratory Stream States:	
Maine	0
New Jersey	0
New York	0
Pennsylvania	0
Maryland	0
Virginia	0
Tennessee	0
North Carolina	0
Alabama	0
Georgia	0
South Carolina	0
Florida	56,554
Total	56,554

have a major impact on the number of individuals potentially eligible for care. This calculation assumes that all migrants use either Texas or Florida as a home state. It starts with the number of eligible children and pregnant women calculated in Table B.1 and reduces their number by the percent who shuttle back and forth from Mexico or another foreign country. (Only 29 percent use a U.S. home base.) The table estimates an unduplicated count of the number of migrants who return to their home base, which is calculated using the ratio of the number of weeks spent in each state to the total number of weeks travelling from crop to crop. Table B.2 then estimates the number of pregnant women and children left behind in the home state while the fathers travel. The total in each stream of these two calculations are then allocated to either Texas or Florida as the host home state.

Table B.2 relies on the following sources:

U.S. Department of Agriculture, Bureau of the Census, Census of Agriculture, 1987; USDA Quarterly Annual Labor Survey; U.S. Department of Labor, National Agriculture Workers Survey: Rick Mines, Office of Program Economics, Department of Labor; Dr. Philip A. Martin, UC Davis; and, Susan Gabbard and Bea Boccalandro of Aguirre International; Bureau of the Census, *Fertility of American Women: June 1992* P20-470 June 1993, Table 4, Part D. In addition, length of enrollment on Medicaid estimates are drawn from unpublished tabulations furnished by SysteMetrics, Inc. from four states in HCFA's Medicaid Tape-to-Tape project (California, Georgia, Michigan, and Tennessee).

The assumptions and sources used for each of the columns in Table B.2 are as follows:

Column 1: Numbers are from Column 21 of Table B.1 (Total Estimated State Medicaid Exposure Assuming Enrollment of Medicaid Eligible Migrant Families and Dependents).

Column 2: This percentage is based on migrant-specific information from the NAWS provided to MPR by Rick Mines at DOL and Bea Boccalandro at Aguirre International. Roughly 71 percent of all migrants surveyed by the NAWS report that their home base region is outside of the United States. This proportion is estimated to be 70 percent in Eastern stream and 75 percent in the Western stream. We have interpolated the 64 percent for the Midwest.

Column 3: The number of crop-to-crop legal migrant workers was estimated by multiplying the estimates in Column 1 by the estimates in Column 2.

Column 4: The average number of weeks spent working in a state (also reported in Column 10 of Spreadsheet 1) came from migrant-specific information from the NAWS provided to MPR by Rick Mines, Office of Program Economics, Department of Labor and Bea Boccalandro, Aguirre International. The estimate of 28.8 weeks is specific to U.S. based migrants in home

states only. The estimate of 15.9 weeks is the average weeks per year spent in the north. The estimate of 22.8 weeks is the average weeks per year in the south.

Column 5: This estimate came from migrant-specific information from the NAWS provided to MPR by Rick Mines, Office of Program Economics, Department of Labor and Bea Boccalandro, Aguirre International. The 32.3 weeks is the sum of 27.1 weeks a year U.S.-based migrants spent in farm work and one half the 10.4 weeks they spent in non-farm work. Note that both Texas and Florida have an estimated zero amount of travel time in state because they are major home-base states.

Column 6: The proportion of travel time in state was developed by dividing the average weeks spent working in a state (Column 4) by the average number of weeks spent traveling outside of the home state (Column 5).

Column 7: The unduplicated number of pregnant migrant women returning to the home state was estimated by multiplying the non-shuttle legal counts of migrant women and children per state (Column 3) by the estimated proportion of in-state travel time (Column 6).

Column 8: Estimates of the percentage of migrants with legal status with a spouse residing elsewhere in the U.S. for both the recent (0.06) and established (0.01) Latinization regions came from migrant-specific information from the NAWS provided to MPR by Rick Mines, Office of Program Economics, Department of Labor and Bea Boccalandro, Aguirre International.

Column 9: The numbers of legal migrant workers in each state are the same as those reported in Column 6 of Spreadsheet 1: Total Estimated State Medicaid Exposure Assuming Enrollment of Eligible Migrant Families and Dependents.

Column 10: The number of migrant wives left in the home state was estimated by multiplying together the number of legal migrant workers (Column 9) and the percent of traveling migrants with a spouse in the home state (Column 8).

Column 11: The average number of children per migrant workers left in the home state was determined from NAWS results. The average number of children per migrant worker is 0.1 for established regions of Texas and Florida, and 0.2 elsewhere. We have assumed that all such children are in the home state.

Column 12: The total number of children left in a home state was estimated by multiplying together Column 9 and Column 11.

Column 13: The total number of pregnant women left in the home state was determined by multiplying Column 10 (the number of wives left in the home state) by the fertility rate of .265. This coefficient is the same as used In Table A.1, column 21.

Column 14: The unduplicated number of pregnant women left in the home state was determined by multiplying together Columns 6 and 13.

Column 15: The estimated average number of months in home state for traveling dependents came from the NAWS, according to which migrants with a home base in the U.S. spent 14.1 weeks not working. We have added to this half the 10.4 weeks working in non-farm jobs and divided the sum by the average number of weeks per month, 4.33.

Column 16: Total enrollment months are calculated by multiplying the number of traveling eligible individuals (Column 7) by the number of months they spend in the home state (Column 15).

Column 17: For those remaining in the home state while husbands travel, we estimated total eligible months by multiplying the number of individuals by 5.8, the average length of enrollment for poverty-related pregnant women enrollees in four Tape-to-Tape states, 1991.

Column 18: The number of months for eligibles who remain in the home state is added to the number of months for those who return for down time to estimate the total number of eligible months that need to be allocated to the home state.

Column 19: The numbers are from Table B.1 column 20.

Column 20: To arrive at an unduplicated count of traveling children returning to home base, column 19 is multiplied by the percent with a U.S. home base in column 2 and by the proportion of time working in each state in column 16. This calculation duplicates the procedure for pregnant women in column 7.

Column 21: Total potential enrollment months is the sum of: (1) an unduplicated count of children returning home in column 20 times number of months in the home base (column 15)), and (2) the number of children left in the home base (column 12) times the average number of months enrolled (7.1) from the four Tape-to-Tape states for 1991 for poverty-related Medicaid-eligible children.

Column 22: The total for each stream in Column 18 is allocated to either Texas or Florida. Texas is underestimated because some important migrant states are not included in the table.

Column 23: The total number of eligible individuals is estimated as in Column 19.

Column 24: The allocation to the home state for children's eligible months repeats the process in column 22.

Column 25: The allocation to the home state for an unduplicated count of eligible children repeats the process in column 23.

3. Calculation of Potential Medicaid Expenditures

Table B.3 brings together the results of Tables B.1 and B.2 to calculate potential Medicaid expenditures. To obtain state-by-state estimates, we multiplied the total number of eligible months for each state by an estimate of the average monthly expenditure per enrollee. Estimated expenditures are highly sensitive to assumed length of Medicaid enrollment of eligible migrants. We examined 1991 Medicaid data for four states in the Tape-to-Tape files maintained by SysteMetrics, Inc. under contract to HCFA. For pregnant women and children eligible under the poverty-related

TABLE B.3

ESTIMATED MEDICAID EXPENDITURES

Target States	Total Number of Migrant Women and Children	Number of Migrant Women and Children Returning or Left in Home State	Total Migrant Dependents Potentially Eligible	Medicaid Eligible Person-months of Workers in State	Enrollment Months for Traveling and Resident Dependents Allocated to Home State	Total Potential Enrollment Months	Estimated Medicaid Expenditure (dollars)
Midwestern Migratory Stream States							
North Dakota	9,250	0	9,250	33,941	0	33,941	7,229,362
Minnesota	11,679	0	11,679	42,853	0	42,853	9,127,712
Wisconsin	8,961	0	8,961	32,881	0	32,881	7,003,690
Michigan	17,137	0	17,137	62,878	0	62,878	13,393,111
Colorado	11,002	0	11,002	40,368	0	40,368	8,598,418
Missouri	8,381	0	8,381	30,751	0	30,751	6,549,975
Illinois	18,106	0	18,106	66,435	0	66,435	14,150,579
Ohio	13,191	0	13,191	48,403	0	48,403	10,309,744
New Mexico	4,761	0	4,761	25,050	0	25,050	5,335,575
Oklahoma	4,595	0	4,595	24,174	0	24,174	5,149,160
Arkansas	9,302	0	9,302	48,944	0	48,944	10,425,063
Texas	25,373	37,747	63,120	168,633	317,927	486,560	103,637,379
Total				625,311	317,927	943,238	200,909,768
Eastern Migratory Stream States							
Maine	2,897	0	2,897	10,631	0	10,631	2,264,453
New Jersey	8,263	0	8,263	30,321	0	30,321	6,458,306
New York	13,695	0	13,695	50,250	0	50,250	10,703,202
Pennsylvania	16,732	0	16,732	61,394	0	61,394	13,077,013
Maryland	3,898	0	3,898	14,301	0	14,301	3,046,175
Virginia	4,100	0	4,100	21,573	0	21,573	4,595,147
Tennessee	6,002	0	6,002	31,581	0	31,581	6,726,724
North Carolina	12,528	0	12,528	65,918	0	65,918	14,040,513
Alabama	4,726	0	4,726	24,867	0	24,867	5,296,624
Georgia	10,308	0	10,308	54,235	0	54,235	11,551,993
South Carolina	5,848	0	5,848	30,768	0	30,768	6,553,658
Florida	69,407	36,436	105,843	461,288	320,190	781,478	166,454,764
Total				857,128	320,190	1,177,317	250,768,573
Total in Midwestern and Eastern Migratory Stream States				1,482,438	638,117	2,120,556	451,678,341

criteria (i.e., the recent Medicaid expansions rather than the traditional AFDC or medically needy categories), the average length of enrollment was only 5.8 and 7.1 months respectively. The short period for pregnancy-related care is not surprising and probably related to high average expenditure per month due to the near certainty of hospitalization for delivery. Given these data and the probability that a high proportion of pregnant mothers would not elect to give birth while traveling, the assumptions used to calculate eligibility months (see Table B-1 columns 23 and 24 and Table B-2 columns 17 and 21) are as follows:

- Pregnant women returning to their home states will remain enrolled for the entire 4.4 average months of downtime indicated in the NAWS.
- Traveling pregnant women will on average be eligible for Medicaid in any state for only a fraction of the time in residence. (Months are reduced by the ratio of 5.8/12).
- Pregnant women not traveling with the husbands but staying at the home state will be eligible for 5.8 months.
- Children's eligibility will follow the same pattern as that for pregnant women except that an average enrollment period of 7.1 months rather than 5.8 will be operative.

The estimates for Medicaid cost per enrollment month are also drawn from Tape-to-Tape files maintained by SysteMetrics Inc. Problems determining an appropriate monthly expenditure coefficient are discussed in detail in Chapter III, Section B. Note that the high cost per month is related to the short eligibility period, particularly for pregnant women who incur the costs of delivery. Previous research on Medicaid data indicates that approximately 55 percent of the cost of pregnancy and post-partum care is generated by delivery (Howell and Brown 1989). Extending the assumed eligibility period, would require sharply lower assumptions on Medicaid expenditures per month.

Medicaid expenditure data have known sources of error and probably underestimate the actual expenditures. Lags in submitting and paying claims mean we do not have a record of all services provided in a year, and will result in an understatement if the number of enrollees is increasing (as is the case for poverty-related eligibles). The division of claims between mothers and their newborn

children is inexact and varies from hospital to hospital and state-to-state and is an important cost factor for premature infants. Moreover, states differ significantly in the degree to which they code recipients into the new eligibility categories created by the expansions - creating an unknown potential bias. Finally, expenditures exclude disproportionate share adjustments and "voluntary taxes" paid by hospitals.

The calculation of total expenditures in Table b-3 is straight forward. The first four columns repeat the results from Tables B.1 and B.2. Total eligible months are then multiplied by $114 for children and $381 for pregnant women to generate the estimates of total potential Medicaid expenditures per year per state.

APPENDIX C

REVENUE AND USERS OF ALL 329 GRANTEES (CY 1992)

APPENDIX C.1

REVENUE AND USERS OF ALL 329 GRANTEES
(CY 1992)

Eastern Migratory Stream States:	Total Revenue ($)	Pct. of Revenue from Grants	Total Migrants	Pct. of Users that are Migrants	Pct. of Agricultural Workers that are Migrants	Revenue from Services for Migrants ($)
Eastern Migratory Stream States						
Florida	51,179,548	49.33	51,121	23.79	75.72	12,175,071
North Carolina	6,438,191	57.67	18,255	57.21	89.55	3,683,607
Georgia	557,173	78.68	2,434	94.09	94.09	524,221
New York	308,032	84.41	5,594	16.99	82.51	52,327
South Carolina	72,045	100.00	2,456	19.51	97.50	14,059
Pennsylvania	814,360	76.76	5,526	96.10	96.10	782,635
Virginia	0[a]	–	0	–	–	–
New Jersey	4,298,786	37.87	2,354	18.15	91.35	780,091
Maryland	0	–	0	–	–	–
Maine	3,885,272	26.27	317	2.11	100.00	82,043
Tennessee	3,408,782	59.33	612	9.70	100.00	330,666
Mississippi	0	–	0	–	–	–
Midwestern Migratory Stream States						
Texas	46,502,261	56.59	28,441	16.32	76.99	7,590,033
Michigan	8,848,789	42.65	24,720	53.89	94.60	4,768,843
Illinois	4,133,530	41.54	4,650	25.89	73.32	1,070,207
Minnesota	1,435,259	73.50	10,233	99.01	99.01	1,421,094
Colorado	15,429,601	48.23	16,098	26.46	67.41	4,082,807
Ohio	4,444,937	33.85	4,053	43.13	100.00	1,917,136
North Dakota	0	–	0	–	–	–
Wisconsin	756,691	56.54	2,716	85.11	92.48	644,053
Missouri	–[b]	–	775	6.80	82.45	–
New Mexico	2,271,725	50.59	396	5.35	72.93	121,650
Arkansas	0	–	0	–	–	–
Oklahoma	0	–	0	–	–	–

Source: Tabulations furnished by the DHHS Office of Migrant Health from the Bureau of Common Reporting Requirments (BCRR) Analysis Data

a) Communication from Jack Egan, Office of Migrant Health.

b) This information was not provided to the Office of Migrant Health.

MATHEMATICA
Policy Research, Inc.

P.O. Box 2393
Princeton, NJ 08543-2393
(609) 799-3535

600 Maryland Avenue S.W., Suite 550
Washington, DC 20024-2512
(202) 484-9220