May 29, 1990

ACCESS OF MIGRANT AND SEASONAL FARMWORKERS TO MEDICAID COVERED HEALTH CARE SERVICES

There are between 3 and 5 million migrant and seasonal farmworkers in the United States, including non-working family members. Migrant and seasonal farmworkers represent a medically underserved population because of their migrant work pattern, language and cultural barriers, relatively low income and socioeconomic status, and lack of adequate third party financing under private health insurance and government sponsored health benefit programs. The Federal and state financed Medicaid program, implemented under Title XIX of the Social Security Act, is the primary publicly sponsored health benefit program for the poor. Despite the fact that migrant and seasonal farmworkers are among the lowest income occupational groups, with only a small proportion being covered under employer-sponsored health benefit programs, they are largely uncovered by state Medicaid programs. Their lack of Medicaid coverage does not represent an intended public policy decision, but an unfortunate circumstance resulting largely from a combination of their employment experience and residential status. From a health care coverage perspective, they truly have fallen through the cracks -- the holes in the "safety net" designed to insure all U.S. residents the basic necessities of life.

Who are Migrant and Seasonal Farmworkers?

Migratory agricultural workers, local seasonal agricultural workers, and members of their families represent the target population for the Migrant Health Program. The legislation which authorizes the Migrant Health Program (contained in Section 329 of the Public Health Service Act) defines a "migratory agricultural worker" as "an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the past twenty-four months, and who establishes for the purpose of such employment a temporary abode". A seasonal agricultural worker is defined as "an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker".

There is no reliable national figure for the number of migrant and seasonal farmworkers and their families. Estimates of the number of migrant and seasonal farmworkers by state, developed during the 1987-89 period, are provided in Table 1. The sum of estimated numbers of migrant and seasonal farmworkers in each state, which includes some double counting of migrants within and among states but also excludes 8 states, is 4.2 million. The true figure for an unduplicated count is likely to be between 3 and 5 million. The states which have the largest number of migrant and seasonal farmworkers are California, Florida, Texas and North Carolina. However,

migrant and seasonal farmworkers are employed in all states and, in a majority of states, number at least 10,000 during peak farmworker employment periods.

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

The health care problems of migrant and seasonal farm workers are more severe than those of most other Americans as a result of a combination of poor living conditions, low education levels and socioeconomic status, relatively poor healthcare habits and a lack of access to adequate medical care. According to the "White Paper on Nutrition" completed by Georgetown University in 1987:

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

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

Migrant Worker Barriers to Medical Care

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

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

The primary barriers to migrant workers obtaining access to Medicaid financed services relate to Medicaid eligibility rules in general, and to the different rules, interpretations of rules and administrative practices under each state's Medicaid program. Eligibility for Medicaid in most states depends on being able to answer "yes" to the following basic questions:

- Does the patient fit into one of the federally recognized eligibility categories, and does the patient meet the financial eligibility tests that apply to his or her particular eligibility category?

- Is the patient a resident of the state in which he or she is applying for benefits?

- Is the patient lawfully present within the United States (either a citizen or a lawfully present alien)?

Only the first two requirements are addressed here. It is assumed that most migrant farmworkers and their families are lawfully present, but even those born in the U.S. may continuously be asked to prove it.

Many migrant workers and their families meet the criteria of one or more of the many categories of needy individuals to whom states must extent Medicaid benefits, i.e., the categorically needy. Medicaid coverage for pregnant women, infants, and children has been expanded and income limitations eased under a federal mandate which could result in Medicaid coverage for a sizeable proportion of these individuals in migrant families. Twenty-three states have extended temporary Medicaid eligibility to pregnant women through the "presumptive eligibility" option. This program is particularly helpful for migrant workers because it shortcuts the administrative requirements for initial Medicaid coverage for services.

Because Medicaid is a state-administered program, persons who wish to enroll must be residents in the states in which they are applying. Residency requirements are the most troublesome barrier faced by otherwise eligible migrant workers. In general, the barriers that residency requirements create can be overcome only if the state Medicaid agency actively steps in to help, with convenient, swift enrollment procedures and retroactive payment.

The basic residency rule for Medicaid eligibility requires intent to reside in the state, and eligibility may not be denied because a person failed to reside in a state for a specific period of time. A person can fulfill the Medicaid residency requirements as soon as he or she enters the state with the intent of remaining indefinitely. The applicant need not have a fixed home or mailing address in the state, although not having a mailing address complicates communication between the state Medicaid agency and the migrant seeking eligibility. A special rule was adopted under federal Medicaid law to facilitate migrant workers and their families who otherwise meet Medicaid eligibility requirements to satisfy Medicaid residency requirements.

> An individual involved in work of a transient nature or who goes to another state seeking employment has two choices: The individual can establish residence in the state in which he/she is employed or seeking employment, or the individual may wish to claim one particularly state as his/her domicile or state of residence, provided he/she satisfies the rules set forth in this section.
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> Example 1: A migrant worker who resides in state A enters the migrant stream in state A and returns to state A every year. He may choose to retain state A as his residence or may change his state of residence as he goes from state to state.

(42 USC Section 3230.3B)

In addition, states may enter into written agreements to resolve cases of disputed residence.

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

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

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

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

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

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

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

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

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

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

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

Expanding Access to Medicaid Covered Services

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

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

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

Providers should generally not experience special problems in obtaining Medicaid payment on claims for migrant workers in the provider's own state, assuming no problem exists with recipient eligibility. However, a number of problems may occur if the migrant worker is enrolled in another state's Medicaid program. Assuming the provider has obtained a provider number from other states' Medicaid programs, payment delays or denials may occur as a result of incorrect service descriptions or procedure codes, not using the designated claims forms, changes in claims submission procedures which out of state provider may not be aware of, and for other reasons. For providers with a small volume of claims to a specific state's Medicaid program, the cost of billing and collection may exceed the value of the claims. Billing and collection problems may cause providers to refuse to treat Migrant workers who are enrolled in out-of-state Medicaid programs.

Efforts to overcome some of these barriers to Medicaid coverage for Migrant workers will generally require cooperation of two or more state medicaid programs. States do have authority to enter into interstate agreements regarding residency. However, a more comprehensive approach may be required. Outlined below is a proposal for a reciprocity program among multiple state Medicaid programs. It's objectives are to remove barriers to eligible migrant workers obtaining Medicaid coverage for medical care services while at the same time reducing administrative and cost burdens to the recipients, to providers and to the state Medicaid programs. Federal Medicaid law specifically permits such interstate agreements.

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

- joint recognition of eligibility. If an individual is Medicaid eligible in one state's Medicaid program, he or she can be covered for (specified) medical services in each of the participating states.

- use of a special eligibility card for migratory workers participating in the program, or unique identifier on each state's existing Medicaid eligibility card.

- Automated or phone access to eligibility records of all participating states' eligibility files

- Each Medicaid program pays its own state providers, for all participating states' migrant workers' claims using its own claims forms, payment rates, and claims processing rules and procedures.

- Participating programs agree on procedures and criteria to determine and monitor continued recipient eligibility.

- Participating programs agree on formulas for inter-program reimbursement of claims costs for migrant workers.

The reciprocity program for migrant workers will require extensive planning, and modifications in each state's claims processing system and Medicaid Management Information System (MMIS). Several states may be able to join together to implement a reciprocity program for facilitating and improving the administration of Medicaid coverage for Migrant farm workers. However, this type of program is particularly well suited for implementation as part of a HCFA sponsored demonstration project. In this way, the reciprocity program can be more carefully evaluated to determine its suitability for more widespread implementation, with or without refinements or modifications.