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Medicaid and migrant farmworker families : analysis of barriers and recommendations for change

MEDICAID AND MIGRANT FARMWORKER FAMILIES:

ANALYSIS OF BARRIERS AND RECOMMENDATIONS FOR CHANGE

National Association of Community Health Centers

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INTRODUCTION AND OVERVIEW OF FINDINGS

For 30 years, Americans have watched television images of migrant workers and their children laboring in farm fields under untenable conditions, denied of even the most basic forms of subsistence. Over those 30 years there have been significant improvements in the living conditions of migrant farmworker families. But overall, farmworkers and their children continue to lead lives of grievous poverty and deprivation as they perform the tasks which virtually no one else will undertake (Table 1). And because of both their mobility, and barriers grounded in prejudice and language and cultural isolation, migrant families continue to be denied essential health and family supports.

This report examines how the nation's more than 4 million members of migrant and seasonal farmworker families fare under the Medicaid program, the nation's largest source of health care financing for the poor. It finds that recent program expansions which should have provided major benefits to millions of migrant children and women of childbearing age, as well as other family members, are bypassing large numbers of eligible migrants because of the unique problems they encounter in obtaining and keeping Medicaid.

Medicaid's failure to reach eligible migrant families means that they remain disproportionately uninsured, even compared to all poor persons and even when clearly eligible for coverage. Their extreme poverty and lack of health insurance (compounded by the inadequate number of federally funded migrant health centers to provide affordable primary health care as they travel) intensify the already serious health risks migrant families face.

To examine the Medicaid barriers faced by migrant women, children and families, the National Association of Community Health Centers, with the assistance of the Children's Defense Fund, undertook a Medicaid survey of the nation's 102 federally funded migrant health centers in the spring of 1991. In 1990 migrant health centers, located in 43 states and Puerto Rico, provided comprehensive basic health care to more than 340,000 migrant workers and family members, out of a total population of 500,000 migrant and seasonal farmworkers; and assisted them in obtaining other essential health benefits. These health centers are familiar with both their patients' health needs and the difficulties they encounter in securing health care.

Fifty centers, representing 49 percent of all migrant health centers and 54 percent of all migrant patients served nationally, responded to the survey. Responses were received from nine out of ten regions of the nation. The survey revealed that:

- Virtually all health centers report that their potentially eligible patients seek Medicaid for themselves and their children, and virtually all health centers assist their migrant patients in doing so.

- Eighty-eight percent of responding health centers reported that migrant families encounter significantly greater problems in securing Medicaid than their non-migrant patients.

- The reasons for denial of Medicaid coverage for potentially eligible migrant applicants indicate that thousands of eligible patients, including clearly eligible pregnant women, infants, and children are being denied coverage for reasons other than their inability to satisfy program eligibility requirements. Only 27 percent of health centers reporting significantly greater Medicaid eligibility barriers for their migrant patients indicated that excess income was a problem, and only 23 percent reported that too many resources were a problem. However, mobility, language barriers and inability to furnish needed documentation were listed as

disproportionately severe problems for migrants by 43 percent and 77 percent, respectively, of all respondents.

- Denials for reasons unrelated to eligibility were common even in the case of women and children. This is particularly disturbing given the major expansions in Medicaid coverage for pregnant women and children enacted in recent years and the extreme poverty of migrant families. In the case of pregnant women and children, only 23 percent of respondents reporting greater problems for migrants indicated that excess income was a problem, only 7 percent identified excess resources as a problem, and only 16 percent identified categorical ineligibility. But mobility and language, as well as documentation-related difficulties, were identified by 59 percent and 66 percent respectively, of all respondents.

- When asked about the major health problems encountered among their maternity and pediatric patients, respondents most commonly identified conditions and illnesses which can readily be controlled through regular medical care and for which comprehensive Medicaid coverage is in fact available. Conditions included malnutrition, anemia, hypertension, gestational diabetes and infections among pregnant women. Among children, the most commonly reported conditions were the lack of immunizations, routine exams, dental care, developmental disabilities, dysentery, malnutrition, general infections, infectious and parasitic disease, skin disorders, hypertension, fever, measles, and anemia.

The burden of Medicaid enrollment will always present especially great problems for migrant families. The fact that even those migrant families who do receive assistance from health centers continue to face major barriers to Medicaid enrollment is of serious concern, given the large numbers of migrant families who do not have access to the support that health centers and other community based programs can offer.

Reforms in the procedures states use to enroll individuals in Medicaid could significantly ameliorate the problems migrants face. Some of these reforms, such as out-stationed enrollment, simplified enrollment procedures, a use of community-based bilingual staff, and (in certain cases) reciprocal agreements among states through which migrants travel, can all be carried out under current law. However, to improve Medicaid's performance for migrant families, Congress should enact legislation introduced by Representatives Slattery, Waxman and others, which would give states the authority to develop reciprocal, interstate arrangements for migrant families. Under these arrangements, states could eliminate migrants' need to continuously re-enroll in Medicaid each time they move to a new state and could extend to migrant families minimum enrollment periods to protect them from arbitrary disenrollment during their travel periods.

Such agreements would dramatically reduce the frequency with which families traveling from state to state would be forced to face the rigors of the Medicaid enrollment process. Through more stabilized and continuous enrollment, migrants would be better assured of adequate health care. In turn, the migrant health centers and other community providers that care for migrant families, would be better able to provide and arrange for the health care their patients need.

I. MEDICAID AND MIGRANT FARMWORKERS: AN OVERVIEW

Medicaid is one of the most important yet most complex of all public assistance programs for the poor. For the families who are able to obtain it, Medicaid plays a major role in securing access to essential health services. Medicaid has a significant impact on access to health care, especially care for the management of complicated but preventable health conditions (such as high

risk pregnancies), and primary and preventive health services for children.[1]

Medicaid not only provides direct access to health services but equally important, better enables health providers serving the poor to furnish and arrange for a broad array of services. Without Medicaid, it is far more difficult to serve poor women, children and other family members, since the lack of insurance coverage greatly limits providers' ability to secure timely and appropriate care and services for their patients, particularly the services of specialists or admission to hospitals in the case of patients with substantial health problems or with maternity-related needs. For example, arranging for hospital admission for a pregnant woman in labor or with severe hypertension is fraught with problems when the mother is both poor and uninsured.

In recent years Medicaid eligibility standards have been substantially improved for certain categories of low income persons, especially children and pregnant women. Many of these improvements hold great promise for migrant families, because of who migrant families are. Migrant and seasonal farmworkers and their families are among the poorest and most medically vulnerable of all low income Americans. Statistics from the United States Public Health Service show that migrant and seasonal farmworker families are overwhelmingly young, minority, deeply impoverished, vulnerable to major health risks, and uninsured.[2]

Some 1.6 million members of migrant farmworker families (from a total of 4.1 million) reside in the U.S. These families are disproportionately members of racial and ethnic minority groups: 50 percent are Latino, and 35 percent are black. They are also extraordinarily poor. Ninety percent of all migrant family members have family incomes below 100 percent of the federal poverty level, and the per capita income level in communities heavily populated by migrant families is half the U.S. average.[3]

As with agricultural workers generally, migrant families are disproportionately uninsured. They are also extremely young. A remarkable 38 percent of all migrant family members are children under age 14 -- a figure roughly twice the U.S. average. Twenty-eight percent are women of childbearing age.[4]

The Medicaid reforms enacted in the late 1980's remove the eligibility limitations that historically have confined program coverage to children and relatives living in single-parent families who are not in the work force and who rely on Aid to Families With Dependent Children (AFDC). Because migrant families tend to include two parents with young children and spend all or much of the year working, the expansions are of particular importance for them.

Chief among the most important Medicaid improvements potentially affecting migrant families are eligibility expansions for pregnant women and children and improvements in coverage of unemployed two-parent families. Legislation enacted in recent years provides for coverage by all states of pregnant women, infants and young children under age 6 with family incomes below 133 percent of the federal poverty level, phased-in coverage of all poor children ages 6 to 19, optional coverage of all pregnant women and infants with family incomes below 185 percent of poverty, and

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1 Karen Davis and Cathy Shoen, Health and the War on Poverty, (Brookings Press, 1977); Rosenbach, Mar.90, "The Impact of Medicaid on Physician Use by Low-Income Children" AJPH 79:0 1220 - 1226 (1989)

2 Unpublished data, Calendar Year 1989 - 1990, Bureau Common Reporting Requirements (BCRR), Bureau of Health Care Delivery and Assistance, HRSA

3 A Migrant Health Status: Profile of a Culture With Complex Health Problems" National Migrant Resource Program, Inc. (undated) Austin, TX

4 BCRR, op. cit.

coverage of two-parent families in which the principal wage earner is unemployed.[5]

Despite Medicaid's potential to aid migrant families, however, the program's basic structure works against them in a number of ways. First, and most importantly, in order to qualify for Medicaid, individuals or families not only must meet the program's categorical and financial eligibility requirements but also must be residents of the state in which they apply for benefits. The very nature of their employment, which requires frequent movement from state to state, means that migrant farmworker families historically have had difficulty establishing state residency.

Second, migrant families' mobility means that they have great difficulty completing the application process before they move and retaining coverage once they receive benefits. Migrant families frequently enter states only for short periods of time. Under even the best of circumstances the Medicaid application process is lengthy. Even when families can show that they are residents of a particular state, they may be ready to move on before their applications have been processed (by law, states can take up to 45 days from the time an application is filed to determine eligibility). Moreover, for those families who do gain eligibility for Medicaid, the task of remaining enrolled is a major one. Families may have moved out of an area by the time their periodic redetermination notices arrive.

Third, the Medicaid application process is extraordinarily cumbersome, as many studies have shown[6]. It creates particularly severe problems for working families such as migrants, who often cannot take even a half day off without losing their jobs and who are strangers in a community, without relatives or other sources of social support to help them. The application process requires extensive documentation of everything from family income to children's birth dates. Families may not travel with much of the needed documentation. Moreover, other documentation (such as verification of family income) simply may be unattainable in certain cases, since obtaining it depends on the time and good will of employers. The procedure also can require repeated trips to the welfare office for families who cannot afford to lose work during a growing season.

The burdens created by the Medicaid application process and its intricate eligibility criteria thus tend to be intensified in the case of migrant families. In addition to the normal problems caused by poverty, these families often are strangers in the states in which they labor -- absolutely essential to the local economies in which they work, but frequently unwelcome and resented except by a handful of public and community providers. Migrant families frequently are weighed down by language and cultural isolation and by barriers which flow from prejudice and discrimination.

While migrant and seasonal farm workers are overwhelmingly United States citizens or lawful residents of the U. S., anecdotal evidence indicates that they are repeatedly treated as if they were not. Many are fluent and literate only in Spanish. Application forms commonly are available only in English, and families frequently are expected to navigate these forms at welfare offices in which no one speaks Spanish.

For some time the federal government has recognized and has attempted to specifically remedy some of the unique Medicaid enrollment problems faced by migrant families. These efforts have focused on improving migrants' ability to establish state residency. In 1979, in order to lessen barriers created by Medicaid's definition of state residency, the Health Care Financing

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5 P.L. 101-508 (Omnibus Budget Reconciliation Act of 1989); P.L. 101-2391 (Omnibus Budget Reconciliation Act of 1990); P.L. 100-485 (Family Support Act of 1988); P.L. 100-203 (Omnibus Budget Reconciliation Act of 1987).

6 See, e.g. Sarah Shuptrine Associates, "The Relationship of the Reasons for Denial of AFDC/Medicaid Benefits to the Uninsured in the United States (Columbia, SC, 1988)

Administration (HCFA) adopted new and more appropriate standards for migrant families. Under pre-1979 law an individual could be considered a resident and therefore eligible for Medicaid only if he or she intended to remain in a state either permanently or indefinitely[7]. By definition this standard excluded migrant families who frequently intended to remain in any given state only for a few weeks. The 1979 HCFA regulations established a new residency standard for migrant families which permits them, at their option, to claim residency in any state in which they are present for work-related reasons[8]. It was anticipated that this reform would eliminate the most significant barrier to migrants' Medicaid eligibility.

However, this change did not achieve the desired result. The restrictive residency definition, while the single greatest barrier to eligibility, is only one of many reasons why migrant families cannot obtain or keep their coverage. Moreover, the employment-related residency test has tended to introduce new problems, since as migrants' residency now rapidly changes from state to state, they frequently leave their work state before the eligibility determination process can be completed. Anecdotal evidence over the years has revealed major barriers to eligibility, with migrants caught in a continuous cycle of Medicaid ineligibility created by ever changing residence, as well as mobility, barriers and procedural impediments.

The impact of these barriers can be seen in Public Health Service data showing source of revenue for community and migrant health centers. Nationally, in 1990 18 percent of all revenues generated by health centers came from Medicaid. For migrant health centers, however, only 12 percent of patient revenues where derived from Medicaid. Most migrant health centers also care for non-migrant poor families who reside in their communities. Thus even this depressed level of Medicaid funding at migrant centers would be lower still, were centers' patients exclusively migrant.

The cumulative impact of migrant's high poverty, low level of insurance, mobility, lack of access to health care, and high-risk employment can be seen in their health status. Compared to the general population, migrant farmworkers suffer more infectious diseases and have higher rates of such conditions as diabetes, hypertension, skin ailments, malnutrition and generalized body infections[9]. Migrant family members, particularly infants and older adults, are more likely than other Americans to suffer multiple health problems. Yet migrant family members have significantly fewer health encounters annually than the general population[10].

II. SURVEY OF MIGRANT HEALTH CENTERS

In order to determine whether the major Medicaid eligibility improvements enacted in recent years have had an impact on migrants' eligibility for benefits, in the spring of 1991 the National Association of Community Health Centers (NACHC), with the assistance of the Children's Defense Fund (CDF), undertook a study designed to determine the impact of recent eligibility reforms. Because migrant farmworkers are not described or tracked by state Medicaid programs as a discreet Medicaid eligibility category it was felt that the best (and only) way to measure eligibility barriers would be through a survey of the nation's 102 migrant health centers.

Located in 43 states and Puerto Rico, migrant heath centers receive funding by the federal government to provide comprehensive health services to low income and medically underserved

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7 42 CFR 435.403 (1978)

8 42 CFR 435.403 (i) (ii) (1990)

9 "Migrant Health Status", op.cit.

10 Ibid

migrant and seasonal farm workers. These families live in what is known as "high impact" areas with large numbers of farmworkers. In 1990 migrant health centers served more than 340,000 of the estimated 4.1 million migrant and seasonal farmworkers and their family members[11]. Established in 1962 in response to the widespread attention given the plight of migrant farm workers, these clinics are known for the comprehensiveness of the primary health services they furnish. By and large migrant health centers also receive federal community health center funding to serve other low income families in their communities. Centers are located within the three principal "streams" which migrant families travel (Table 2A-C) and furnish care to migrant families on both a year-round and seasonal basis.

A more-than-30-percent decline in real-dollar funding levels for both the community and migrant health centers programs during the 1980's means that the clinics can reach only a fraction of the farmworker families who need care. Where there are no health centers, families must rely on health services offered by employers or charitable care offered by local medical societies, church organizations and other voluntary associations.

Survey Methodology

In the spring of 1991 a written survey instrument was developed by NACHC and CDF and sent to all 102 migrant health centers. A total of 50 responses were received for a response rate of 49 percent. The 50 respondents were located in nine out of ten regions of the United States (as defined by the United States Department of Health and Human Services) and served a total of 184,000 migrant patients (54 percent of all migrant patients served by health centers) (Table 3).

Information was sought regarding both the Medicaid enrollment barriers faced by migrant farm worker family members and the health problems presented by pregnant women and children, the two categories of persons most likely to have been helped by the recent Medicaid eligibility expansions.

The vast majority of respondents (96 percent) indicated that migrant patients actively seek out Medicaid, with an even greater number (98 percent) reporting that they furnish Medicaid application assistance to migrant family members who desire benefits (Table 4). These numbers indicate that migrant farmworker families are eager for the health insurance benefits offered by Medicaid and are willing to undertake the application process. These numbers also tend to at least indirectly confirm that migrant farmworkers are overwhelmingly United States citizens and lawful U.S. residents who do not avoid public support services out of fear of being discovered. This is a common problem confronting undocumented workers.

Forty-four out of 50 respondents (88 percent) indicated that among their patients, migrant farmworker families were significantly more likely to encounter application-related problems. Those which did not indicate greater problems reported that special on-site enrollment initiatives undertaken in cooperation with their local welfare agencies significantly reduced barriers to enrollment. Respondents were least likely to report barriers related to actual ineligibility for benefits. For example, only 27 percent reported excess income problems and 23 percent, excess resource problems. Eighty-two percent reported that failure to satisfy categorical requirements was a concern (Table 4), but this is not unexpected given the large numbers of two-parent migrant families and Medicaid's failure to cover adults in poor two parent families who are employed.

However, respondents far more reported problems unrelated to patients' ability to satisfy program eligibility requirements. Forty-three percent reported mobility-related problems, another

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11 Unpublished BCRR data, op.cit.

43 percent, language barriers, and 77 percent, documentation problems.

For pregnant women and children the responses were particularly disturbing. With the elimination of categorical eligibility limitations on coverage of pregnant women and children and the liberalization of financial eligibility requirements, nearly all pregnant women and children in migrant families should be able to meet Medicaid eligibility standards and avoid grave application barriers. Yet the responses show otherwise. In the case of pregnant women and children, only 23 percent of respondents reported income barriers, only 7 percent, resource barriers, and only 16 percent, categorical-related barriers (presumably in the case of older children not yet reached by the phased-in expansions for poor children over age 6). However, 59 percent reported mobility problems, 59 percent, language problems, and 66 percent, documentation problems (Table 4).

Many health centers reported problems in addition to the specific areas for which information was sought by the survey. The most common types of problems noted were related to migrants' inability to comply with welfare agencies' face-to-face interview requirements, states' failure to honor the federal employment-related residency standard for migrants, (and their continued requirement of permanent residency) states' misapplication of federal alienage standards resulting in the denial of benefits to lawfully resident migrants, and substantial bureaucracy barriers, such as a shortage of workers at local welfare offices to meet the additional needs of migrant workers during harvest times, lack of evening and weekend hours, and the lack of accessible eligibility determination locations. Numerous respondents noted generally discriminatory treatment of migrant families as a problem.

Most disturbing of all, perhaps, were the types of health problems reported by respondents among their maternity and pediatric patients. Virtually without fail, the problems most frequently noted were ones that could be readily addressed through ongoing health care and for which comprehensive Medicaid coverage is available. For pregnant women, the most frequently reported problems were infections, hypertension, gestational diabetes, malnutrition, and other medical risks complicating pregnancy. Among children, the most common conditions were anemia, generalized infections, infectious and parasitic disease, dysentery, malnutrition, lack of immunizations, measles, fever, and lack of access to basic medical and dental care.

The responses to the survey are cause for serious concern. It is evident that despite the active assistance furnished by health centers, large proportions of Medicaid eligible patients are being denied benefits, not because they have actually been found ineligible but because they cannot navigate the application process or because of their mobility. Moreover, given the extremely large number of migrant families who have no access to the active assistance of community based, highly skilled, and well trained providers such as migrant health centers, one can assume only that in areas not served by health center the incidence of inappropriate Medicaid denials is far greater than this survey indicates.

RECOMMENDATIONS FOR REFORM

State Medicaid programs could take a number of steps to begin tackling the exclusion of eligible migrant farmworker families from Medicaid. Some of these steps build on reforms enacted by Congress in recent years which are designed to make Medicaid more accessible to eligible persons. Others make use of long-standing state administrative options. All of these activities are ones for which federal Medicaid funding is available on a 50 percent matching basis to assist states carry out their administrative responsibilities under the program.

Outstationed enrollment: Chief among recently enacted reforms that hold promise for migrant families are 1990 amendments to Medicaid which require states to provide for the receipt and initial processing of applications for Medicaid by pregnant women and children at all "federally qualified

health centers". These centers include the nation's federally funded community and migrant health centers, as well as disproportionate share hospitals. Federal guidance regarding the program can be found at Appendix A.

Using this new "outstationing" program state Medicaid agencies could develop enrollment initiatives with migrant health centers specifically targeted at migrant and seasonal farmworkers at all clinics and satellite locations. Initiatives could involve all programs that large numbers of migrants use, such as local health agencies, WIC clinics and migrant Head Start programs. These initiatives could provide for:

- o on site screening of all potentially eligible migrant family members, in addition to pregnant women and children;

- o on-site application receipt and processing, using specially trained bilingual clinic workers familiar with migrant families and equipped to assist them deal with English-language forms, documentation tasks, and other activities (all of which can be done at outstationed locations according to the new guidance);

- o on-site eligibility determinations using traveling welfare office caseworkers authorized to make a final determination or by using technology designed to make local welfare office accessible to remote migrant sites. For example, through computers and facsimile machines, all completed applications could be immediately transferred to a local welfare office for final verification and determination;

- o fast-track determinations for migrant family members so that final eligibility decisions are made within days, not weeks. Notification can be given to migrant clinics on patients' behalf so that they can inform their patients, assure they receive appropriate identification cards and help them comply with redetermination requirements;

- o presumptive (i.e., temporary) eligibility for pregnant migrant women so that each migrant health clinic can issue Medicaid cards on the spot for all ambulatory pregnancy-related care (currently only half of all states have taken the option to offer presumptive eligibility to pregnant women).

- o arrangements with hospitals and birthing centers performing deliveries of migrant women to enroll newborns into Medicaid prior to discharge and provide them with temporary identification cards. All infants born to Medicaid eligible women are entitled to one year of automatic coverage without reapplication as a result of amendments enacted to Medicaid in 1990[12]. However, as a practical matter this entitlement is without utility unless families are given evidence of their babies' coverage so that providers can bill the program. All infants, including those born to migrant families, could be issued at least a temporary Medicaid card upon hospital discharge to show their enrollment until a final and permanent card is furnished by the agency.

All of these recommendations are designed to make the application process more accessible, and all build on the 1990 outstationing mandate for pregnant women and children. All are reimbursable by the federal government at normal Medicaid matching rates for administrative activities. Numerous states now collaborate with health centers to improve Medicaid enrollment,

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12 42 USC 1396a(a)(55) as added by P.L. 101-508.

and as of July 1, 1991, all will have to maintain so-called "out-stationing" programs. Modifying these programs to take the specific needs of migrant families into account makes sense, particularly in areas in which large numbers of migrant families are present only for short time periods, thereby making permanent additional local welfare agency staff an inefficient remedy.

Interstate agreements: Federal Medicaid law authorizes states to develop interagency agreements to facilitate administration of their plans and to resolve residency related matters[13]. Using this authority, states that currently employ identical eligibility criteria for sub-classes of migrant family members could enter into agreements that permit each state to honor currently valid evidence of Medicaid enrollment.

Table 2A-C shows those states within each principal migrant "stream" that currently use identical criteria for pregnant women and young children. Given the uniform minimum criteria for coverage of pregnant women, infants and young children which now exists, current federal residency regulations appear to permit states that use these minimum standards to enter into agreements that honor coverage on a reciprocal basis. Under such an agreement, eligible pregnant women and children, for example, could enroll in any state and be able to use a currently valid card in all states in which the agreement is in effect. Such agreements, in combination with outstationing programs aimed at persons not yet enrolled in any state, would help remove some of the most serious barriers to eligibility. These types of interstate agreements are used to aid in the administration of states' Title IV-E and Medicaid long-term care programs, both of which involve interstate travel of Medicaid-eligible persons[14].

A good example of states which might develop such an agreement are Idaho, Montana, New Mexico and Oregon. All are located in the Western Migrant stream (Table 2C). All use identical criteria for pregnant women, infants and children under six. Therefore,all conceivably could agree to honor a valid Medicaid card for these women and children without a need for reapplication if the card has been issued by any of the states which are parties to an agreement.

Further legislative reform: Even with these changes, however, further legislative reforms are needed to permit more effective coverage of migrant families. More flexibility is required in order to permit interstate agreements among states that use non-identical eligibility criteria and to permit enrollment of migrant families without interruption for their entire travel period. As Table 2 shows, eligibility criteria fluctuate for families from state to state within any given stream. They even fluctuate slightly for pregnant women and infants, since some states have elected to use slightly higher eligibility levels for pregnant women and infants than those required by federal law.

Federal amendments further expanding state flexibility to develop interstate reciprocal arrangements for migrants would help in a number of ways. First, the added flexibility would allow migrants to establish coverage in one state and to be deemed covered in **all** states in which they reside for employment related purposes without continuous reapplication. Currently migrants are caught in an impossible situation. If families elect to take advantage of the employment-related residency test to which they are entitled, they can find themselves constantly "in-between" eligibility determinations in the various states in which they reside.

On the other hand, if families elect to establish a residency in one state and travel with an

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13 42 CFR 435.403 U.

14 Most states in fact maintain one or more types of interstate Title IV-E on nursing home agreements. A recent NACHC survey of 16 states indicated that at least 10 would be interested in developing interstate agreements for some or all members of migrant families. The surveyed states included AZ, CO, FL, ID, OR, PA, MD, ME, MI, NH, NY, RI, SD, TX, UT, VT.

out-of-state card, other problems develop. Current federal rules governing coverage of benefits for Medicaid beneficiaries traveling out of state restrict out-of-state coverage only to emergency or urgent care[15]. Thus, were a pregnant woman with Medicaid coverage from Texas to travel to Iowa, current rules governing Medicaid coverage for persons traveling out-of state would limit her coverage to emergency services only. Moreover, it is difficult to find providers who will accept out-of-state cards. Were the woman to travel with an out-of state card issued by Texas, it would be nearly impossible for her to find providers willing to accept her benefits.

All pregnant women and infants under age 1 are now entitled to continuous Medicaid coverage without interruption regardless of changes in income eligibility. But changes in their state of residence could, without further reforms, either cause an interruption in coverage or limit them only to services available to Medicaid enrollees who travel out of state.

To permit the development of truly transportable Medicaid cards for migrant families that allow continuous and uninterrupted enrollment as they travel, further legislation is required. H.R. 1392, recently introduced by Representatives Waxman, Slattery and others would permit two or more states to develop interstate agreements for migrant families that contain the following essential features:

- Agreements would have to cover at least pregnant women and children under age 6 but could be extended to any potentially eligible migratory agricultural worker and his or her spouse and minor children;

- Under an agreement, a state would be able to fully honor the Medicaid eligibility certification extended by any other participating state which is a party to the agreement, regardless of whether both states eligibility criteria are identical. Coverage could be extended without reapplication for benefits, just as if enrollment had been effectuated in every state honoring the agreement.

- Minimum enrollment periods of not less than 6 months and not more than 12 months could be utilized. During this time the migrant family members covered by the agreement would be eligible for coverage without the need to redetermine eligibility and regardless of any modest changes in economic circumstances.

Such agreements would have the effect of permitting all states within (or across) the three principal streams to develop programs of truly transportable benefits for migrants. Under these programs, enrollment for covered migrant family members would need to occur only once per 6-to-12 month enrollment period. Cards could be issued that indicate on their face all of the states in which they are to be honored, and there would be no need for continuous reapplication as migrant beneficiaries move from state to state. The state in which the migrants are residing for employment related purposes would treat beneficiaries covered by the agreement as if they had been found eligible by the participating state and were carrying an in-state card.

While the Slattery/Waxman bill would have a potentially enormous and beneficial impact on migrants, its cost would be modest. First, the legislation's importance will be felt only by migrant workers who travel interstate. A significant proportion of migrant families travel intra-state and therefore do not encounter residency-related problems. This is particularly true with California-based migrant families, who comprise approximately 20 percent of all U.S. migrant farmworkers.

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15 42 CFR 431.52

Second, the proposal does not add any new classes of eligible persons to the program. It simply makes coverage more accessible. Original estimates underlying the 1989 and 1990 Medicaid expansions assumed eligibility for poor migrant family members as well as other poor persons and also assumed that these persons would in fact enroll in the program. Therefore, the changes proposed by the Waxman/Slattery legislation would simply make effective for migrant workers those benefits to which they are already entitled and whose costs have already been assumed in the broader cost estimates prepared for recent legislation.

If implemented by states, the proposed legislation would result in Medicaid eligibility in the case of some migrant family members in states in which, in the absence of an agreement, such members would not be eligible. For example, if California and Oregon entered into a reciprocal agreement covering pregnant women and infants, pregnant women with family incomes up to 185 percent of poverty level who enrolled in California would be deemed eligible in Oregon, which in the absence of such an agreement, ordinarily covers women only up to 133 percent of poverty.

However, these slight eligibility expansions are modest compared to the large numbers of completely eligible migrant family members who now are being denied the coverage to which they are entitled. Moreover since all pregnant women and infants under age one are now eligible for Medicaid regardless of changes in income levels, such flexible reciprocity honoring slightly higher eligibility levels has sound precedent. Finally, the cost to states of not assuring continuous coverage for pregnant women, children and other high risk populations far outweighs the slightly greater outlays that such continuous interstate coverage could cause.

CONCLUSION

In the absence of a national health insurance plan that eliminates state residency requirements, families that move from that to state for work related reasons will inevitably encounter barriers to coverage. These barriers are particularly severe in the case of migrant families because of their poverty, heightened health needs and social and cultural isolation. However, a considerable amount might be done under current law to ease migrants' plight, and pending federal legislation would significantly increase state flexibility to begin to address the extraordinary health needs of this population.

Tables and Appendix

Table 1

Adjusted State Profiles (Farmworkers Plus Dependents)

STATE	MIGRANT	SEASONAL	TOTAL MSFW POP.
ALABAMA	4,083	2,400	6,483
ALASKA			
ARIZONA	21,189	10,606	31,795
ARKANSAS	426,831	935,703	1,362,534
CALIFORNIA	20,220	29,127	49,347
COLORADO	4,756	4,665	9,421
CONNECTICUT	1,651	3,746	5,397
DELAWARE	182,790	252,583	435,373
FLORIDA	28,081	65,523	93,604
GEORGIA			
HAWAII	44,513	75,455	119,968
IDAHO	17,508	3,332	20,840
ILLINOIS	6,506	1,210	7,716
INDIANA	1,728	32,502	34,230
IOWA	5,460	13,073	18,533
KANSAS			
KENTUCKY	5,580	3,080	8,660
LOUISIANA	1,416	2,851	4,267
MAINE	4,721	3,092	7,813
MARYLAND	59,831	7,396	67,227
MASSACHUSETTS	11,965	1,379	13,344
MICHIGAN			
MINNESOTA	1,343	18,981	20,324
MISSISSIPPI	10,417	2,609	13,026
MISSOURI	4,030	14,726	18,756
MONTANA			
NEBRASKA	526	200	726
NEVADA	6,377	7,145	13,522
NEW HAMPSHIRE	6,706	2,549	9,255
NEW JERSEY	19,209	11,602	30,811
NEW MEXICO	44,062	300,882	344,944
NEW YORK	9,000	6,000	15,000
NORTH CAROLINA	9,058	2,563	11,621
NORTH DAKOTA			
OHIO	89,412	39,152	128,564
OKLAHOMA	14,734	9,977	24,711
OREGON	99,046	132,843	231,889
PENNSYLVANIA	281	178	459
PUERTO RICO	10,760	7,800	18,560
RHODE ISLAND			
SOUTH CAROLINA	2,894	3,677	6,571
SOUTH DAKOTA	281,778	218,360	500,138
TENNESSEE	7,220	1,763	8,983
TEXAS	1,515	270	1,785
UTAH	5,731	9,348	15,079
VERMONT	175,595	266,849	442,444
VIRGINIA	-	-	
WASHINGTON	7,792	407	2,700
WEST VIRGINIA	5,560	1,240	8,199
WISCONSIN			6,800
WYOMING			
TOTAL	1,661,875	2,506,844	4,171,419

Source: U.S. Public Health Service

Table 2A

Eastern Migrant Stream (Home Base and Receiver States)
Medicaid Financial Eligibility Levels, Selected Populations (Jan. 1991)

State	Pregrant Women and Infants	Eliminated Assets Tests	Children[1] Born Prior to October 1, 1983
Alabama	133%	Yes	13%
Florida	150%	Yes	31%
Georgia	133%	Yes	45%
Illinois	133%	No	39%
Indiana	133%	Yes	31%
Maine	185%	Yes	70%
Massachusetts	185%	Yes	62%
Michigan	185%	Yes	63%
Minnesota	185%	Yes	57%
New Hampshire	133%	Yes	55%
New Jersey	133%	Yes	45%
New York	185%	Yes	62%
North Carolina	185%	Yes	29%

Source: National Governor's Association; calculations by NACHC

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1 All children under age 6 with family incomes below 133% of the federal poverty level must be covered. All children born on Oct. 1, 1983, or thereafter and who have attained age 6, must also be covered if their family incomes are below 100% of the federal poverty level. Eligibility standards for children born prior to Oct. 1, 1983 also apply to single parents and unemployed two-parent families.

Table 2A - Con't

Eastern Migrant Stream (Home Base and Receiver States)
Medicaid Financial Eligibility Levels, Selected Populations (Jan. 1991)

State	Pregnant Women and Infants	Eliminated Assets Test	Children[1] Born Prior to October 1, 1983
Ohio	133%	Yes	36%
Pennsylvania	133%	Yes	45%
South Carolina	185%	Yes	47%
Virginia	133%	Yes	31%
West Virginia	150%	Yes	26%
Wisconsin	155%	Yes	55%

Source: National Governor's Association; calculations by NACHC

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1 All children under age 6 with family incomes below 133% of the federal poverty level must be covered. All children born on Oct. 1, 1983, or thereafter and who have attained age 6, must also be covered if their family incomes are below 100% of the federal poverty level. Eligibility standards for children born prior to Oct. 1, 1983 also apply to single parents and unemployed two-parent families.

Table 2B

Central Migrant Stream (Home Base and Receiver States)
Medicaid Financial Eligibility Levels, Selected Populations (Jan. 1991)

State	Pregnant Women and Infants	Eliminated Assets Test	Children[1] Born Prior to October 1, 1983
Alabama	133%	Yes	13%
Arizonia	140%	Yes	31%
California	185%	No	74%
Colorado	133%	Yes	45%
Florida	150%	Yes	31%
Georgia	133%	Yes	45%
Idaho	133%	Yes	33%
Illinois	133%	No	39%
Indiana	133%	Yes	31%
Kansas	150%	Yes	41%
Louisiana	133%	Yes	20%
Michigan	185%	Yes	63%
Minnesota	185%	Yes	57%
Missouri	133%	Yes	31%
Montana	133%	Yes	39%
Nebraska	133%	Yes	39%
New Mexico	133%	Yes	33%
New York	185%	Yes	62%

Source: National Governor's Association; calculations by NACHC

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1 All children under age 6 with family incomes below 133% of the federal poverty level must be covered. All children born on Oct. 1, 1983, or thereafter and who have attained age 6, must also be covered if their family incomes are below 100% of the federal poverty level. Eligibility standards for children born prior to Oct. 1, 1983 also apply to single parents and unemployed two-parent families.

Table 2B - Con't

Central Migrant Stream (Home Base and Receiver States)
Medicaid Financial Eligibility Levels, Selected Populations (Jan. 1991)

State	Pregnant Women and Infants	Eliminated Assets Test	Children[1] Born Prior to October 1, 1983
North Dakota	133%	No	43%
Ohio	133%	Yes	36%
Oklahoma	133%	Yes	50%
Oregon	133%	Yes	47%
South Carolina	185%	Yes	47%
Texas	133%	No	19%
Washington	185%	Yes	67%
Wisconsin	155%	Yes	55%

Source: National Governor's Association; calculations by NACHC

[1] All children under age 6 with family incomes below 133% of the federal poverty level must be covered. All children born on Oct. 1, 1983, or thereafter and who have attained age 6, must also be covered if their family incomes are below 100% of the federal poverty level. Eligibility standards for children born prior to Oct. 1, 1983 also apply to single parents and unemployed two-parent families.

Table 2C

Western Migrant Stream (Home Base and Receiver States)
Medicaid Financial Eligibility Levels, Selected Populations (Jan. 1991)

State	Pregnant Women and Infants	Eliminated Assets Test	Children[1] Born Prior to October 1, 1983
Arizona	140%	Yes	31%
California	185%	No	74%
Colorado	133%	Yes	45%
Idaho	133%	Yes	33%
Montana	133%	Yes	39%
New Mexico	133%	Yes	33%
Oregon	133%	Yes	47%
Washington	185%	Yes	67%

Source: National Governor's Association; calculations by NACHC

[1] All children under age 6 with family incomes below 133% of the federal poverty level must be covered. All children born on Oct. 1, 1983, or thereafter and who have attained age 6, must also be covered if their family incomes are below 100% of the federal poverty level. Eligibility standards for children born prior to Oct. 1, 1983 also apply to single parents and unemployed two-parent families.

Table 3

Overall Response to Health Center Survey

Total number of currently funded migrant health centers, U.S.	102
Total number of patients served by currently funded centers	342,985
Number and percentage of centers responding to survey	50 (49.0%)
Number and percentage of patients served by respondents	184,014 (53.6%)

Source: National Association of Community Health Centers, Migrant Medicaid Survey, 1991

Table 4

Medicaid Application Patterns and Barriers among Patients Served by Responding Health Centers

A.	Total respondents	50
B.	Number and percentage of respondents reporting Medicaid application by migrant patients	48 (96.0%)
C.	Number and percentage of respondents offering application assistance	49 (98.0%)
D.	Number and percentage of of respondents reporting greater application barriers for migrant patients	44 (88.0%)
	Application barriers affecting migrant patients identified by 44 respondents	
a. Excess income		12 (27.3%)
b. Excess resources		10 (22.7%)
c. Family mobility		19 (43.2%)
d. Language barriers		19 (43.2%)
e. Documentation problems		34 (77.3%)
f. Failure to meet categorical standards		36 (81.8%)
	Application problems affecting migrant pregnant women and children identified by 44 respondents	
a. Excess income		10 (22.7%)
b. Excess resources		3 (6.8%)
c. Family mobility		26 (59.1%)
d. Language barriers		26 (59.1%)
e. Documentation problems		29 (65.9%)
f. Failure to meet categorical standards		7 (15.9%)

Source: National Association of Community Health Centers, Migrant Medicaid Survey, 1991

state medicaid manual
Part 2 — State Organization and General Administration

Department of Health and Human Services
Health Care Financing Administration

ADVANCE COPY OF FINAL ISSUANCE

Transmittal No 71

Date JUNE 1991

REVISED MATERIAL	REVISED PAGES	REPLACED PAGES
Table of Contents		
Chapter 2	2-1 - 2-2 (2pp.)	2-1 - 2-2 (2pp.)
	2-5 - 2-6 (2 pp.)	2-5 - 2-7 (3 pp.)
Sec. 2104 - 2106.2	2-82.5 - 2-82.8 (4 pp.)	2-82.5 - 2-82.8 (4 pp.)
Sec. 2905-2911	2-397 - 2-397.2 (3 pp.)	

NEW MATERIAL EFFECTIVE DATE: July 1, 1991

Section 2104, Waiver of State Plan Requirements, explains that States may not waive certain requirements of §1902 of the Act under §1915(b) freedom of choice waiver programs as required by §§4604 and 4704 of OBRA 1990.

Section 2105, Categories of Waivers Under §1915(b), requires States to pay providers under a §1915(b)(4) waiver program on a timely basis in the same manner as health care practitioners must be paid under §1902(a)(37)(A) of the Act as required by §4742 of OBRA 1990.

Section 2106.1, General Requirements, requires States to submit waiver requests to HCFA central office at the same time the request is submitted to the HCFA regional office. It also clarifies that a new 90 day period begins when HCFA receives the State's response to HCFA's additional information request.

These instructions implement the provisions of §4602 of OBRA 1990. This statutory change provides for acceptance of, and initial processing of, applications for Medicaid by children and poverty level pregnant women at locations other than those used by the AFDC program. This provision is effective July 1, 1991 without regard to whether regulations have been published.

Section 2905, Outstationing of Eligibility Workers, sets forth the statutory requirements for outstationing.

Section 2906, Outstation Locations, provides the minimum criteria for outstation locations.

Section 2907, Staffing at Outstation Locations, provides the criteria for coverage of outstation locations by eligibility workers.

Section 2908, Guidelines for Outstationing and Providing Application Assistance at Low Use Locations, provides a mechanism for targeting outstationing efforts to those locations where the State finds the greatest need and for the most effective utilization of outstationed staff.

Section 2909, Limitations on Outstationing Workers, describes those activities which non-State agency eligibility workers may perform and what actions they are prohibited from taking.

Section 2910. Application Process, describes and defines initial processing and further processing and the effect of these definitions on outstation activities.

Section 2911. Applications, describes the types of application forms which may be used at outstation locations.

Section 2912. Compliance With Federal Regulations, directs you to comply with all regulations concerning due process, confidentiality of applicant information, authority of the single State agency, and conflict of interest when outstationing workers at locations other than agency offices.

Section 2913. FFP for Outstationing, describes the rate at which FFP is available for outstation administrative expenses whether the outstationed worker is a State employee, or a provider employee or contractor.

2905. OUTSTATIONING OF ELIGIBILITY WORKERS—GENERAL

Section 1902(a)(55) of the Act provides for the receipt of, and initial processing of, applications for Medicaid from mandatory and optional poverty level pregnant women and children under age 19, at locations other than welfare offices. These covered groups are defined in §§1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) of the Act. While you may make eligibility determinations at outstation locations, subject to §§2909 and 2910, it is not required.

2906. OUTSTATION LOCATIONS

At a minimum, at least each disproportionate share hospital and each Federally Qualified Health Center (FQHC) that participates in the State's Medicaid program must have a person qualified, as described in §2909, to take applications and assist applicants with the application process. In meeting the requirements of this section:

- Include as outstation locations, Indian Health Service clinics operated by a tribe or tribal organization which are included in the definition of rural health clinics; and

- Enter, at your option, into reciprocal agreements with adjoining States to assure that the target population, living in border areas of your State, has the opportunity to apply for Medicaid at the health care locations they normally frequent when those facilities are in another State.

- When an FQHC or disproportionate share hospital has more than one site, assure that applications for Medicaid can be taken at all sites. At locations where children and pregnant women seldom receive services, see §2908 for options in receiving applications and initial processing of applications. You may also provide eligibility workers at locations other than FQHCs and disproportionate share hospitals to the extent deemed appropriate.

2907. STAFFING AT OUTSTATION LOCATIONS

When outstationing eligibility workers, you must assure that staff is available at the outstation locations during the hours your offices are normally open to accept applications and assist applicants with the application process except as provided in §2908. For these purposes, outstationed eligibility workers do not have to be employees of the SA, but must be trained to assist applicants in filing applications and to answer accurately questions applicants may have or to refer such questions to the SA for an answer. At a minimum, applications meeting the requirements of §2910 must be available at all FQHCs and disproportionate share hospitals and someone must be available to assist applicants in completing the forms. The State plan must include a description about how this provision will be met.

2908. GUIDELINES FOR OUTSTATIONING AND PROVIDING APPLICATION ASSISTANCE AT LOW USE LOCATIONS

Where you encounter outstation locations at which children and pregnant women are seldom provided services, you may use any of the following practices to assure that such individuals are provided an opportunity to apply for Medicaid at the outstation location. You may use volunteers, provider employees, telephone assistance, or your own staff. When using State staff you may assign an agency employee to assist applicants at several outstation locations on a rotating basis. When any of these eligibility workers are not available, a

notice is prominently displayed at the location advising potential applicants about when such eligibility workers are available. This notice provides a telephone number which the applicant can call for assistance with initial processing of an application. Have copies of the Medicaid application available at all locations where children and women receive services.

2909. LIMITATIONS ON OUTSTATIONED ELIGIBILITY WORKERS

When taking applications at outstation locations, the following conditions and restrictions apply:

A. State Employees Who Are Outstationed.--These employees may perform any tasks in connection with the receipt of, and processing of, an application for Medicaid at an outstation location which the employee could perform at the offices of the State agency, including the eligibility determination. In those States which are county administered any reference to State employees is considered a reference to county employees.

B. Provider or Contractor Employees.--These individuals when employed at outstation locations to receive and perform initial processing of applications, including any required interview, may take all actions except evaluating the information provided on the application and supporting documentation, and/or making an eligibility determination. When contractor or provider employees, including provider contractors, perform outstation activities you must assure, whether by contract or other means, that they adhere to State and Federal confidentiality provisions concerning applicant and recipient information and adhere to all conflict of interest prohibitions. (See §2912.)

C. Volunteers.--Volunteers may be employed to provide the same assistance as provider or contractor employees at outstation locations. The same provisions apply to volunteers as apply to provider employees concerning adherence to State and Federal confidentiality provisions and conflict of interest prohibitions. (See §2912.)

2910. APPLICATION PROCESS

A. Initial Processing.--Initial processing means taking applications, assisting applicants in completing the application, providing information and referral, obtaining required documentation needed to complete processing of the application, assuring completeness of the information contained on the application, and conducting any interviews. Initial processing does not mean evaluating the information contained on the application and the supporting documentation nor making a determination of eligibility or ineligibility.

The date the application is completed and signed at the outstation is the application date for purposes of timely processing under 42 CFR 435.911 and determination of retroactive eligibility under 42 CFR 435.914. In States which require a face-to-face interview before determining eligibility, the interview may be conducted at the outstation location.

B. Further Processing.-- Further processing means examining and verifying information provided on the application, and making the eligibility determination. It also means conducting follow up interviews when additional information is required but was not obtained during initial processing.

C. Outstation Activities.—Perform initial processing and, at your option, further processing of applications at outstation locations. You may complete processing of eligibility, including determining eligibility, at the outstation location only if the outstation location is staffed with State agency personnel with the authority to make determinations of eligibility. As provided by 42 CFR 431.10(c) and (e), only Medicaid agency officials or the other agencies specified in this section may make determinations of eligibility for Medicaid.

2911. APPLICATIONS

The application form(s), including computerized applications, used at outstation locations may be an application designed for the target population, an application already used by Medicaid for applicants seeking Medicaid only, or a combined programs application where only that information appropriate for the Medicaid program by the target population is obtained.

The sole application form used at outstation locations may not be the AFDC application form as provided by §1902(a)(55) of the Act. Where a multi-program form is used, the person assisting the applicant and the form itself must make clear that only the information pertinent to Medicaid eligibility for the groups described in §2905 needs to be completed. The application used includes all of the questions which the applicant must answer in order to become eligible.

2912. COMPLIANCE WITH FEDERAL REGULATIONS

The SA must assure that all outstation activities are subject to compliance with the instructions in §2910 and the following regulations, no matter who is authorized to perform outstation activities:

- 42 CFR 431.10 requires that the single State agency must not delegate to others the authority to make eligibility determinations except as permitted by 42 CFR 431.10;

- 42 CFR 431.200-250 requires that all applicants who are denied eligibility or whose application is not acted upon with reasonable promptness are provided notice and due process;

- 42 CFR 431.300-307 requires that the confidentiality of applicant and recipient information be protected and that all persons with access to such information are subject to standards of confidentiality applicable to SA officials; and

- 42 CFR 447.10 prohibits certain actions by providers and their agents, including contractors. Such activities are also subject to all other State and Federal laws concerning conflict of interest.

2913. FFP FOR OUTSTATIONING

FFP is available as an administrative match for costs incurred by the State to implement and provide outstationing of eligibility workers. Such workers may be State employees, provider employees, volunteers, or provider contractors. HCFA pays for necessary administrative costs such as salary, fringe benefits, travel, training, equipment, and space directly attributable to the outstationing of eligibility workers.

102D CONGRESS
1ST SESSION

H. R. 1392

To amend title XIX of the Social Security Act to improve access to basic health care services for needy children.

IN THE HOUSE OF REPRESENTATIVES

MARCH 12, 1991

Mr. SLATTERY (for himself, Mr. WAXMAN, Mr. SCHEUER, Mr. MARKEY, Mrs. COLLINS of Illinois, Mr. SYNAR, Mr. WYDEN, Mr. RICHARDSON, Mr. SIKORSKI, Mr. BOUCHER, Mr. BRUCE, Mr. ROWLAND, Mr. TOWNS, Mr. STUDDS, Mr. KOSTMAYER, Ms. PELOSI, Mr. MCDERMOTT, Mr. FRANK of Massachusetts, Mr. PAYNE of New Jersey, Mr. LEVINE of California, Mr. BERMAN, Mr. RANGEL, Mr. DURBIN, Mr. BEILENSON, and Mr. DWYER of New Jersey) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend title XIX of the Social Security Act to improve access to basic health care services for needy children.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid Child Health Amendments of 1991".

SEC. 2. OPTIONAL COVERAGE OF CHILDREN UP TO AGE 19 WITH INCOME BELOW 185 PERCENT OF THE POVERTY LINE.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by the Omnibus Budget Reconciliation Act of 1990, is amended—

(1) in subclauses (VI) and (VII) of subsection (a)(10)(A)(i), by inserting "minimum" before "income level",

(2) in subsection (l)(2)(B), by striking "133 percent" and inserting "a percentage (established by the State, which is not less than 133 percent and not more than 185 percent)", and

(3) in subsection (l)(2)(C), by striking "100 percent" and inserting "a percentage (established by the State, which is not less than 100 percent and not more than 185 percent)".

(b) FLEXIBILITY ON AGE.—Section 1902(l) of such Act is amended—

(1) in paragraph (1)—

(A) by striking "and" at the end of subparagraph (C),

(B) by inserting "and" at the end of subparagraph (D), and

(C) by adding at the end the following:

Appendix B

"(E) at the option of the State, children born before October 1, 1983, who have attained 6 years of age but have not attained 19 years of age or a lesser age as selected by the State,";

(2) in paragraph (2)(C), by striking "subparagraph (D)" and inserting "subparagraph (D) or (E)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1992, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 3. EXTENSION OF MEDICAID TRANSITION COVERAGE.

(a) OPTIONAL ADDITIONAL 12-MONTH EXTENSION.—Section 1925(b) of the Social Security Act (42 U.S.C. 1396s(b)) is amended—

(1) in the heading, by striking "6-MONTH";

(2) in paragraph (1), by striking "the succeeding 6-month period" and inserting "the succeeding period of 6 months (or, at the State option as specified by the State, of 9 months, 12 months, 15 months, or 18 months)";

(3) in paragraph (2)(A)(ii), by inserting "(and, if applicable, 6th, 9th, 12th, and 15th month)" after "3rd month";

(4) in paragraph (2)(B)(ii), by inserting "(and, if applicable, 7th, 10th, 13th, and 16th month)" after "4th month";

(5) in paragraph (3)(A), in the matter before clause (i), by striking "6-month";

(6) in paragraph (3)(A)(iii), by striking "of the 6-month period" and inserting "(or, if applicable, the 7th, 10th, 13th, or 16th month) of the period"; and

(7) in paragraph (5)(D)(i), by striking "of the 6-month additional extension period" and inserting "(or, if applicable, the 7th, 10th, 13th, or 16th month) of the additional extension period".

(b) REPEAL OF SUNSET PROVISION.—Subsection (f) of section 1925 of such Act is repealed.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on January 1, 1992, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 4. EXTENSION OF PAYMENT PROVISIONS FOR MEDICALLY NECESSARY SERVICES IN DISPROPORTIONATE SHARE HOSPITALS TO CHILDREN UNDER 19 YEARS OF AGE.

(a) COVERAGE OF MEDICALLY NECESSARY SERVICES FOR CHILDREN.—(1) Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended, in the subdivision (X) following subparagraph (E), by striking "under one year of age" and inserting "under 19 years of age".

(2) Section 1902(s) of such Act, as added by section 4604 of the Omnibus Budget Reconciliation Act of 1990, is amended by striking "6 years" and inserting "19 years".

(b) ASSURING ADEQUATE PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR CHILDREN IN DISPROPORTIONATE SHARE HOSPITALS.—Section 1923(a)(2) of such Act (42 U.S.C. 1396r–4(a)(2)) is amended by adding at the end the following new subparagraph:

"(D) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1992, the State must submit to the Secretary by not later than April 1,

1992, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1992, involving exceptionally high costs or exceptionally long lengths of stay for individuals one year of age or older, but under 19 years of age.".

(c) EFFECTIVE DATES.—(1)(A) The amendments made by subsection (a) applies (except as provided under subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1992, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional require-

ment before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(2) The amendment made by subsection (b) shall take effect on the date of the enactment of this Act.

SEC. 5. REQUIRING "SECTION 209(b)" STATES TO PROVIDE MEDICAL ASSISTANCE TO DISABLED CHILDREN RECEIVING SSI BENEFITS.

(a) IN GENERAL.—Section 1902(f) of the Social Security Act (42 U.S.C. 1396a(f)) is amended—

(1) by inserting "paragraph (2) of this subsection and" after ", except as provided in",

(2) by striking "(1)" and "(2)" and inserting "(A)" and "(B)", respectively,

(3) by inserting "(1)" after "(f)", and

(4) by adding at the end the following new paragraph:

"(2) A State shall provide medical assistance to any individual under 19 years of age with respect to whom supplemental security income benefits are payable under title XVI.".

(b) EFFECTIVE DATE.—(1) The amendments made by subsection (a) apply (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1992, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation authorizing or appropriating funds) in order for the plan to meet the additional requirement imposed by the amendments made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 6. MANDATORY CONTINUATION OF COVERAGE FOR CHILDREN OTHERWISE QUALIFIED FOR BENEFITS UNTIL REDETERMINATION.

(a) IN GENERAL.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following new paragraph:

"(12) With respect to an individual who has not attained the age of 19, who is receiving medical assistance under this title, and who is determined to be no longer eligible for such assistance, the State may not discontinue such assistance until the State has determined that the individual is not eligible for assistance under this title on any basis.".

(b) CONFORMING AMENDMENT TO QUALITY CONTROL.—Section 1903(u)(1)(D) of such Act (42 U.S.C. 1396b(u)(1)(D)) is amended by adding at the end the following new clause:

"(vi) In determining the amount of erroneous excess payments for quarters beginning on or after July 1, 1992, there shall not be included any erroneous payments which are attributable to individuals described in section 1902(e)(12) who are determined to be no longer eligible for assistance but whose assistance has not been discontinued because a determination on other bases for such assistance has not been made.".

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective with respect to eligibility determinations for medical assistance under title XIX of the Social Security Act on or after July 1, 1992, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

SEC. 7. OPTIONAL MEDICAID COVERAGE FOR FOSTER CHILDREN.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

(1) in subsection (a)(10)(A)(ii)—

(A) by striking "or" at the end of subclause (X),

(B) by inserting "or" at the end of subclause (XI), and

(C) by adding at the end the following new subclause:

"(XII) who are described in subsection (z)(1);";

(2) in subsection (a)(17), by striking "and (m)(4)" and inserting "(m)(4), and (z)(1)"; and

(3) by adding at the end the following new subsection:

"(z)(1) Individuals described in this paragraph are individuals for whom a public agency assumes full or partial financial responsibility—

"(A) who have not attained the age of 19,

"(B) who reside in a foster home, group home, or private institution, and

"(C) whose incomes do not exceed 100 percent of the income official poverty line (as defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of one.

"(2) Notwithstanding subsection (a)(17), for individuals who are eligible for medical assistance because of subsection (a)(10)(A)(ii)(XII)—

"(A) no resource standard or methodology shall be applied,

"(B) the income standard to be applied is the income standard described in paragraph (1)(C), and

"(C) income for these individuals shall be determined in accordance with a methodology which is no more restrictive than the methodology employed under the State plan under part E of title IV.".

(b) EFFECTIVE DATE.—The amendments made by this section shall become effective with respect to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1992, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

SEC. 8. OPTIONAL MEDICAID COVERAGE OF MIGRANT CHILDREN, PREGNANT WOMEN, AND THEIR FAMILIES.

(a) IN GENERAL.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 7(a) of this Act, is amended—

(1) in subsection (a)(10)(A)(ii)—

(A) by striking "or" at the end of subclause (XI),

(B) by adding "or" at the end of subclause (XII), and

(C) by adding at the end the following new subclause:

"(XIII) who are covered under an interstate agreement described in section 1902(aa)(1) (relating to migrant agricultural workers);", and

(2) by adding at the end the following new subsection:

"(aa)(1)(A) A State (which is 1 of the 50 States or the District of Columbia) may enter into an agreement

with 1 or more other such States under which each State agrees that it will treat, as entitled to medical assistance under its plan under this title, regardless of whether (in the absence of such an agreement) the individuals would otherwise be eligible for assistance from the State, and without the need to reapply for benefits, one or more categories of individuals described in paragraph (2) (including at least pregnant women and children under 6 years of age) who are residing in the State temporarily.

"(B) An individual covered under such an agreement shall be treated under this title as a resident of the State in which the individual is residing temporarily.

"(2) With respect to an agreement among States under paragraph (1), an individual is described in this paragraph if the individual—

"(A) is a migratory agricultural worker, as defined in section 329(a)(2) of the Public Health Service Act, or the spouse or child of such a worker or other family member under 19 years age of such a worker, and

"(B) has been determined by a State that is a party to the agreement to be eligible to receive medical assistance under the State's plan as an individual described in subsection (a)(10)(A).

"(3) Each agreement under paragraph (1) shall specify the period, of not less than 6 months nor more than 12 months, during which individuals described in paragraph (2) shall remain eligible for medical assistance without the need to redetermine such eligibility.

"(4) In the case of an individual covered under such an agreement and for whom an identification card has been issued by a State, such identification shall specify (A) the time period for which coverage without reapplication is in effect under the agreement, and (B) the States in which the agreement is in effect.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1992, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

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Appendix C

NACHC/CDF
Survey of Migrant Health Clinics
Regarding Barriers to Medicaid Eligibility
and Health Status of Migrant Worker Family Members

Name of Clinic _____ BCRR# _____

Name of Person Completing
Questionnaire _____

Date Completed _____

1. To the best of your knowledge, do migrant worker family members apply for Medicaid when they are living in your service area?

   yes ____ no ____

2. Does your clinic or program assist migrant family members who apply for Medicaid?

   yes ____ no ____

3. Are Migrant family members who apply for Medicaid more or less likely than other families served by your clinic to encounter difficulties in obtaining benefits?

   more ____ less ____

4. If the answer to #3 is 'more', please check all applicable reasons for these difficulties.

   a. ____ too much income

   b. ____ too many resources (car, personal property, etc.)

   c. ____ families move out of area before the eligibility determination process is completed

   d. ____ language problems

   e. ____ inability to provide needed documentation

   f. ____ members who apply who do not fall into a required eligibility category (e.g., children, pregnant women, single adults with children)

5. Do children under age 8 and pregnant women encounter difficulties in obtaining benefits?

6. If the answer to 5 is 'yes', please check all applicable reasons for these difficulties.

a. _____ too much income

b. _____ too many resources (car, personal property, etc.)

c. _____ families move out of area before the eligibility determination process is completed

d. _____ language problems

e. _____ inability to provide needed documentation

f. _____ members who apply who do not fall into a required eligibility category (e.g., children, pregnant women, single adults with children)

g. _____ other (please explain)

_____

_____

7. Do children and pregnant women arrive at your clinic with medical problems requiring treatment?

yes _____ no _____

8. If the answer to 7 is 'yes', please indicate 3 most common child health problems.

_____

_____

_____

3 most common pregnancy related problems

_____

_____

_____

9. Has your local welfare agency instituted any special applicant assistance programs for migrant worker/children?

yes _____ no _____