Monograph series

Migrant Health Issues

Medicaid and the State Children's Health Insurance Program

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Farmworkers are a mobile, high risk, working poor population thought to have the worst overall health status in the nation. The annual income of most farmworker families falls below 100% of the federal poverty level (Dever, 1991). For this reason, enrollment screening for the State Child Health Insurance Program (SCHIP) defaults most farmworkers to the Medicaid program. Eligible farmworkers underutilize the Medicaid and SCHIP as well as other social programs. "Looking at major programs … 20 percent used Medicaid and Food Stamps, 11 percent used WIC, and 5 percent received some kind of cash payment" (Mines, Gabbard, and Steirman, 1997, p. 30).

Over the last five years, the terms reciprocity, portability and presumptive eligibility have become part of the vernacular of advocates and agencies focusing on migrant health. However, the challenge of migrant and seasonal farmworker access to Medicaid has not changed significantly. "Regretfully, participation of eligible farmworkers continues to be impeded by the state-based structure of the system, by eligibility requirements which are not uniform, and by benefits which are not portable" (*Losing Ground*, 1995). In addition, the Personal Responsibility and Work Opportunity Act of 1996 with its resulting change to immigration laws, has added to the confusion on the issue of public charge, creating the perception that all immigrants are ineligible for publicly funded healthcare. This has discouraged qualified immigrant farmworkers from seeking coverage under Medicaid or the SCHIP enacted in 1997. It is also important to note that based on income, most migrant and seasonal farmworkers will default to the Medicaid program. However, farmworkers continue to be subject to the same barriers to participation they experienced 35 years ago.

In embracing SCHIP, states had options to create a separate program, expand Medicaid, or create a hybrid of the two (part separate/part Medicaid expansion). This has further compounded issues of potential reciprocity between states. The low rate of farmworker participation is attributed to health systems' problems in the regulation and administration of child health insurance programs. Despite the eligibility of many of these vulnerable workers [farmworkers] and their dependents for coverage under the numerous Medicaid expansions, their specific characteristics and high mobility have often prevented enrollment (Wright, Fasciano, Frazer, Hill, Zimmerman, and Pindus, 1993). Stated in different terms, "Many workers are simply not eligible for Medicaid – either because they are categorically excluded, or because they do not meet Medicaid state residency requirements" (Wright et al.).

Key concepts associated with the SCHIP are "simplification" and "streamlining enrollment." The Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration [HCFA]), has supported and encouraged Medicaid simplification as demonstrated by their section 1115 waivers under SCHIP. However, not many states are taking advantage of this. The §1115 of the Social Security Act "authorizes the Secretary of HHS to waive otherwise applicable requirements of federal law to permit demonstrations that further program objectives" (Rosenbaum, personal communication, October 20, 2000). Under

SCHIP, if the state adopts at least three of the proposed enrollment simplification or streamlining options it may apply for a §1115 waiver. These options include: the elimination of face-to-face interviews, elimination of the assets test, joint application for SCHIP and Medicaid, presumptive eligibility, 12-month continuous eligibility, and allowing self-declared income. This option is intended to simplify state Medicaid programs.

State regulatory policies often create barriers to farmworker participation by failing to accommodate the special access needs of farmworkers in their planning processes. Under Medicaid and SCHIP statutes, each state program has its own rules and standards, and is often subject to careful oversight by a variety of legislative, executive, and budget controls. In states where counties provide administrative direction of eligibility, an additional complexity is introduced. And in the case of families who move between and among states, the potential need to work with other states adds a special complexity (Moore, 2000).

Once farmworkers are successfully enrolled, their benefits must be made portable. Currently, out-of-state billing processes are slow and cumbersome, with risk of the provider not being paid at all, and offering little incentive for out-of-state providers to accept migrants as patients (Kenesson, 2000). Special efforts to overcome access barriers are required at the community, state and national levels if enrollment efforts are to be successful in allowing farmworker participation in both the SCHIP and Medicaid programs.

In 1995, the National Advisory Council on Migrant Health proposed two recommendations: 1) a nationally administered program to provide health care for farmworkers, which would preclude the problems occurring in the individually administered state programs; and 2) creation of a cooperative demonstration project sponsored by the Centers for Medicare & Medicaid Services and the Migrant Health Branch, Bureau of Primary Health Care (BPHC), Health Resources and Services Administration (HRSA), to facilitate interstate reciprocity of Medicaid benefits through the use of an interstate enrollment transfer model (Losing Ground, 1995). Six years later, neither of these recommendations have been implemented, although as of March of 2001 the California Primary Care Association has initiated a project to study the possibility of establishing the reciprocity model between California, Oregon and Washington. This demonstration project is based on the findings of the 1993 report: "Feasibility Study to Develop a Medicaid Reciprocity Program for Migrant and Seasonal Farmworkers," conducted by Mathematica Policy Research, Health Systems Research and The Urban Institute.

It is important to highlight that one state took the lead in farmworker access to Medicaid as a result of the study conducted by the Mathematica Policy Research, Health Research Systems and the Urban Institute. In May of 1997, the Wisconsin legislature passed a bill creating a model program for migrant farmworkers, by accepting out-of-state Medicaid cards for this population. "Farmworkers in Wisconsin will simply show their out-of-state Medicaid card along with proof of agricultural work" (National Conference of State Legislatures (NCSL), 1997). Their rationale being "Although many farmworkers and their families are eligible for Medicaid, time-consuming procedures, lack of reciprocity among states and other barriers prevent enrollment" (NCSL, 1997).

Other organizations working towards continuity of care for farmworkers continue to work on creative solutions such as a national federally administered program, while at the same time taking advantage of the SCHIP and the CMS support for simplification processes as a partial solution towards that overall goal. One creative idea includes the Texas Association of Community Health Center's effort to develop a portable private provider (PPO) model. The Texas PPO model will be piloted between Texas and four other states (to be determined) as a result of the passing of Texas House Bill (HB) 1537. HB 1537 was signed into law by Texas Governor Rick Perry on June 11, 2001 with an effective date of September 1, 2001. In this model the state of Texas would pay the Texas Medicaid fee for service rates to providers enrolled from the selected pilot states.

The latest and most complete piece of research on this topic, "Improving Health Service Access for Medicaid-Eligible Migrant Farmworkers," by Mary S. Kenesson of Health Policy Crossroads for the Center for Health Care Strategies, Inc. (September 2000), discusses

potential options to solve the problems at hand. One of these options is the highly discussed inter-state reciprocity model. This model gained popularity with the 1993 *Mathematica Study*. Six years later, Kenesson notes that there is a growing realization that reciprocal eligibility, coverage and payment arrangements among two or more state Medicaid programs would be an extremely problematic approach to addressing policy and access barriers for migrant farmworkers. In addition, the advent of SCHIP and the federal and state emphasis on simplified enrollment, outreach, and program design has led to a greater variety in state programs, which seems less conducive to reciprocity models that rely on negotiated commonalities in eligibility, benefit packages, payment structures and administrative processes among multiple states, and/or that would need a strong federal presence in program design and operations (Kenesson, 2000).

Another proposed alternative to farmworker access issues includes the purchase of commercial indemnity insurance. In this scenario, states enrolling eligible migrant farmworkers or their dependants into Medicaid would pay a premium to a commercial insurance company, which would issue an enrollment card and pay all claims regardless of the patient's state of origin or the service delivery location. States already have the authority to do this when it is proven to be cost effective.

Whether through purchase of commercial indemnity insurance or a multi-state network model, public/private partnership concepts offer a promising framework for a viable approach to improving access to care and service delivery for Medicaid/SCHIP-eligible migrant farmworkers and their families. While the design challenge may be complex, the outcome could well be a workable model that is least disruptive to established state Medicaid program structures and that meets the health service needs of migrant farmworkers (Kenesson, 2000).

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Copies may be obtained through the following sources:

National Center for Farmworker Health, Inc., Buda TX
Phone: (512) 312-2700
http://www.ncfh.org

Migrant Health Branch, Bethesada, MD
Bureau of Primary Health Care
Phone: (301) 594-4300
http://bphc.hrsa.gov/migrant/

References

Dever, G. E. (1991). *Migrant Health Status: Profile of a Population with Complex Health Problems. MCN monograph series*. Austin, TX: National Migrant Resource Program, Inc.

Kenesson, M.S. (2000). *Improving Health Service Access for Medicaid-eligible Migrant Farmworkers*. Princeton, NJ: Center for Health Care Streategies, Inc.

Losing Ground: The Condition of Farmworkers in America. (1995). Editors: Dailey C.Y., Ryder, E.R., Barnett, J, Dockrey, W.N. National Advisory Council on Migrant Health. Austin, TX: National Migrant Resource Program, Inc.

Mines R., Gabbard, S., and Steirman A. (1997). *A Profile of U.S. Farmworkers Demographics, Household Composition, Income and Use of Services*. Office of Program Economics, Research Report #6. U.S. Department of Labor, Office of the Assistant Secretary for Policy.

Moore, J.D. (2000). *Policy Options for Serving Migrant Children and Families under Medicaid and SCHIP*. National Health Policy Forum. Unpublished.

National Council of State Legislatures (1997). Wisconsin Hopes to Improve Farm Workers' Health.

Rosembaum, S. (2000, October 20). "Options for Expanding Publicly Financed Health Coverage of Migrant Farmworkers and Their Families." Personal communication to the National Association of Community Health Centers' Migrant Work Group. Unpublished memorandum.

Wright, G. E., Fasciano, N. J., Frazer, H., Hill, I. T., Zimmerman, B., and Pindus, N. M. (1993). *Feasibility Study to Develop a Medicaid Reciprocity Program for Migrant and Seasonal Farmworkers*. Washington, DC: Mathematica Policy Research, Inc.