IMPROVING HEALTH SERVICE ACCESS FOR MEDICAID-ELIGIBLE MIGRANT FARMWORKERS

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Executive Summary

Medicaid-eligible migrant farmworkers present an array of challenges in outreach, eligibility determination, access and continuity of care. This report presents a basic orientation to the health status and access problems facing migrant farmworkers, and the challenges of providing Medicaid and State Children's Health Insurance Program (SCHIP) coverage to farmworkers and their family members who travel across state lines. The report also: summarizes past research on and current prospects for multi-state reciprocity demonstrations; raises options and issues for public/private partnerships through insurance or managed care models; and notes a variety of short-term policy and operational alternatives.

Section I, "DEFINING THE POPULATION" discusses variations in defining "migrant farmworker" populations, including migrant vs. seasonal farmworkers, the scope of agricultural labor, and implications for family members who remain more or less settled in "homebase" areas.

Section II, "OBJECTIVES OF A BETTER HEALTH SYSTEM FOR MIGRANT FARMWORKERS" summarizes alternative sets of objectives framed in conferences and by the National Advisory Council on Migrant Health. Because migrants' health problems are highly linked to multiple aspects of daily life, objectives emphasize multi-faceted, integrated approaches – beyond "medical models" of health service delivery – that require intensive coordination among parties, programs and funding streams.

Section III, "CHARACTERISTICS OF MIGRANT FARMWORKERS: DEMOGRAPHICS, HEALTH STATUS AND GEOGRAPHIC MIGRATION PATTERNS" highlights findings from the literature on attributes and health problems of the migrant farmworker population. The migrant farmworker population is largely composed of minority-group young males, some of whom are accompanied by family members; most migrant women are of childbearing age. Although most have very low incomes, few have established eligibility for Medicaid, WIC or Food Stamps. Health problems reflect the risks and stresses of agricultural labor, including injuries, exposure to pesticides, inadequate living conditions and difficulty in accessing care for chronic conditions such as hypertension, diabetes and tuberculosis. Geographic migration patterns vary among those who travel greater or lesser distances along eastern, midwestern or western migrant "streams" and others who circulate within more circumscribed geographic areas.

Section IV, "MIGRANT HEALTH SERVICES TODAY" describes federally-funded migrant health centers and programs managed by the DHHS Bureau of Primary Health Care's Migrant Health Branch, and supportive services provided through private sector organizations such as the National Center for Farmworker Health and the Migrant Clinicians Network.

Section V, "ACCESS TO MEDICAID ENROLLMENT AND SERVICES" focuses on policy and operational constraints affecting the migrant farmworker population's ability to establish Medicaid eligibility, enroll in the program, and access health services in fee-for-service and managed care environments.

Eligibility policy constraints include: differences among states' eligibility policies; income computation methods that can disadvantage applicants with unpredictable, fluctuating income; documentation needed to verify eligibility; state residency requirements; and complex policies governing citizenship and immigration. Access to the Medicaid enrollment process is constrained by transportation and communication barriers, and lengthy processing times that can exceed the individual's stay in the local area. In many states, Medicaid eligibility also entails mandatory enrollment in managed care arrangements ill-suited to a migrant population, and managed care enrollment further complicates and extends the process of establishing eligibility.

Migrant farmworkers who do establish Medicaid eligibility face challenges in accessing services from Medicaid providers, due to conflicting work schedules, provider misunderstandings about new program restrictions on immigrant populations, and/or reluctance to treat out-of-state eligibles. Most managed care enrollees will not have access to their primary care physician or other network providers while engaged in migratory agricultural labor.

Section VI, "CONFRONTING THE BARRIERS" discusses conceptual approaches to improving health access for Medicaid-eligible migrant farmworkers, and raises relevant questions inviting further deliberation and model design work.

Subsection VI.A. summarizes a 1994 initiative to design a federally-sponsored inter-state reciprocity demonstration, including various models, issues and assumptions considered in that effort. The 1994 initiative did not generate sufficient commitment for a multi-state demonstration project. Prospects for inter-state reciprocity models in today's environment are discussed, emphasizing the difficulty of modifying multiple states' policy and operational program frameworks for a small population.

Subsection VI.B. presents opportunities through public/private partnerships, such as purchase of commercial indemnity insurance for a migrant population, modeled after health benefits for private sector employees. The potential for a public/private partnership model involving managed care organizations is also discussed, with particular interest in a preferred provider-type network that would span multiple states.

Subsection VI.C. notes a variety of short-term actions that could be pursued by individual states to relieve some access barriers.

Appendices to the report include a list of resource individuals and organizations, and a bibliography of the relevant literature.

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Table of Contents

Introduction

Medicaid-eligible migrant farmworkers present an array of challenges in outreach, eligibility determination, access and continuity of care. The Medicaid program framework does not easily lend itself to approaches requiring interstate reciprocity or intensive interagency collaboration, nor to operational/systems investments that address the needs of relatively small numbers of beneficiaries without a strong political voice or advocacy.

This report presents a basic orientation to the health status and access problems facing migrant farmworkers, and the challenges of providing Medicaid and State Children's Health Insurance Program (SCHIP) coverage to farmworkers and their family members who travel across state lines. The report also: summarizes past research on and current prospects for multi-state reciprocity demonstrations; raises options and issues for public/private partnerships through insurance or managed care models; and notes a variety of short-term policy and operational alternatives.

Throughout, three considerations are of particular interest in this study:

- the potential for developing viable inter-State reciprocity demonstration models;

  prospects for capitalizing on Medicaid managed care as a vehicle for continuity of care across State lines; and

- outreach and program management approaches that might facilitate eligible migrant families' access to Medicaid/SCHIP coverage and services.

There appears to be considerable research on the nature, incidence and causes of health risks and medical problems experienced by migrant and seasonal farmworkers. This report does not attempt to comprehensively summarize that information beyond presenting the more salient medical risks and health status patterns. Several of the resources noted in the Appendices offer rich linkages to more in-depth clinical information.

Systemic and socio-cultural access barriers to health service delivery are thoroughly addressed in the literature, with some attention to issues affecting health benefits coverage or insurability, including basic access barriers to Medicaid entitlement and services for eligible migrant farmworkers. Implications of the growth of managed care in general, and among State Medicaid programs, do not appear to have yet been subject to focused research.

Publications and organizations referenced in this report are listed in the Appendices, with additional source information. Several of the publications most heavily relied upon for this project contain extensive bibliographies. Many of the sources used in this report present information contained in several others, and publication dates are not always evident. Because it is difficult to determine which among multiple publications should be referenced for particular information, citations in the text are limited to primary sources that were clearly identifiable..

I. DEFINING THE POPULATION

An immediate concern in understanding Medicaid entitlement and health access needs of any special population is sensitivity to different criteria that may be used to define the population, among researchers, advocates and policy makers with somewhat different interests and perspectives.

The population addressed by this study is generally referred to in the text as "migrant farmworkers." It is important to note, however, that various definitions of somewhat different populations are in use among researchers, service organizations and assistance programs.

> Some definitions refer only to "migrants" while others include workers who engage in seasonal employment that may or may not be some distance from their regular residence. Such distinctions can be blurry, depending on the distance and frequency of travel, and considering the fact that most migrant workers have a home base to which they seasonally return and/or where family members may permanently reside.
>
> Definitions also differ based on the type of employment, generally limited to agricultural work rather than other types of intermittent industrial or manual labor. Definitions of "agricultural" also differ, depending on the type of crop or activity; e.g., whether work involving forestry, fish and livestock, landscaping and/or delivery and marketing of produce is included or not.
>
> And, definitions differ in whether or not family members who seldom or never travel with the worker, including young children and/or elderly dependents, are counted.

Legislation authorizing the federal Migrant Health Program (P.L. 104-299) defines a *migratory agricultural worker* as an individual who, during the past 24 months, has been principally employed in agriculture on a seasonal basis, and who establishes for the purpose of such employment a temporary abode.

The focus of this study is on low-income individuals and families whose livelihood is dependent on agricultural work of any kind which requires them to be in more than one State during a year – for ease of reference, "migrant farmworkers." Migrant farmworkers' dependents and seasonal workers who remain in one "homebase" State may suffer from many of the cultural access barriers experienced by migrant farmworkers , but do not face many of the health risks nor problems of establishing health benefits eligibility and portability of coverage experienced by inter-State migrants.

The literature and resources summarized in this report do, however, reflect data, studies and programs addressing the variety of definitionally different populations. Where possible, the appropriate phraseology is provided with the relevant text, such as "migrant and seasonal farmworkers" or "migrant workers and their families."

II. OBJECTIVES OF A BETTER HEALTH SYSTEM FOR MIGRANT FARMWORKERS

Through extensive deliberations in various forums, considerable attention has been devoted to defining objectives for improved health services for migrant farmworkers. Because migrants' health problems are highly linked to multiple aspects of daily life, objectives and system reforms often emphasize multi-faceted, integrated approaches – beyond "medical models" of health service delivery – that require intensive coordination among parties, programs and funding streams. .

The National Advisory Council on Migrant Health is legislatively mandated to advise the Secretary of Health and Human Services (HHS) on the health and well being of migrant and seasonal farmworkers (MSFWs) and their families and to increase the effectiveness of migrant health centers (MHCs). Fifteen members are appointed by the Secretary for four-year terms. The Advisory Council's Year 2000 Recommendations, summarized in *"Bridging the Gap: Working to Eliminate Barriers to Healthcare For Migrant and Seasonal Farmworkers in the 21st Century"* focus on:

Health Care Access: Recommendations to improve access highlight needs in the areas of:

Dental and Oral Health Services – Fund new oral health access points in MHCs, place more National Health Service Corps (NHSC) providers in areas with MSFWs, and offer incentives for dental schools to partner with MHCs and to recruit and train more bilingual/bicultural oral health providers.

Mental Health/Substance Abuse/Domestic and Family Violence Services – Develop joint initiatives between the Substance Abuse and Mental Health Services Administration and the Health Services and Resources Administration for MHC services, develop new adolescent mental health initiatives, define expectations for MHC mental health/substance abuse services, and provide incentives for MHCs to hire and train more bilingual/bicultural mental health staff.

Outreach Services – Define expectations and provide funding necessary for MHC outreach services reflecting the cultural and linguistic characteristics of MSFWs, and provide funding to expand successful lay health outreach models.

Recruitment, Retention and Training of Bilingual/Bicultural Staff – Provide incentives for recruitment and training in the health professions, identify strategies to attract and retain providers in migrant health, disseminate migrant health educational models for medical students, and insure priority placement of NHSC providers in areas with MSFWs.

Pharmaceuticals – Define expectations for pharmacy services provided by MHCs.

Patient Tracking/Continuity of Care – Encourage and fund systems that make it possible to track mobile patients.

Disaster Relief – Provide financial relief to MHCs for uncompensated care subsequent to natural disasters that did not merit a Federal disaster declaration but which did adversely affect MSFWs.

Medicaid and the State Children's Health Insurance Program (SCHIP): Investigate low participation of MSFWs in Medicaid and SCHIP, target joint HRSA/HCFA initiatives on MSFWs and their children, incorporate interstate reciprocity and portability in new initiatives, and preserve cost-based reimbursement for federally qualified health centers (FQHCs).

Environmental/Occupational Safety and Health: Implement a program to train health providers to identify and treat the effects of pesticides, using the Environmental Protection Agency's "Pesticides and National Strategies for Health Care Providers" model.

Appropriations: Pursue increased appropriations sufficient to raise base funding for the Migrant Health Program to $150 million for FY 2001.

Research: Fact-finding research is needed to document the number of farmworkers and their families, their health problems, birth and death rates, accident rates and other information necessary for planning budgets and program reforms.

The Advisory Council also emphasized its concerns in three areas which, although outside the purview of the DHHS Secretary, significantly impact the health and well-being of MSFWs:

Child Labor: Concern that MSFW children are exposed to the health hazards of the agricultural work place, due to the family's economic necessity and/or inability to afford daycare.

Housing: Concern that substandard living conditions and the disproportionate percentage of income that MSFWs must pay for shelter contribute to their poor health status. Remedies require combined efforts of the Departments of Agriculture, Labor, Housing and Urban Development and DHHS.

Guestworker Programs: Concern that "guestworkers" currently in the U.S. do not have adequate access to health services. In light of a recent General Accounting Office finding that there is a surplus of domestic MSFWs, the Advisory Council does not support further guestworker program expansion for such agricultural labor.

A 1992 Migrant Health and Migrant Clinical Issues Conference addressed the question, "What are the key elements of a viable migrant health care delivery system for the year 2000?" Their deliberations were summarized in a Migrant Clinicians Network monograph, *"Blueprint for Migrant Health: Health Care Delivery for the Year 2000."* There was general agreement that an ideal health system for migrant farmworkers must:

address all areas that affect farmworkers' health, including housing, immigration regulations, and workers compensation;

provide comprehensive health care services, including preventive care, mental health, and social services;

offer service delivery appropriate to farmworkers' culture and lifestyle, with sensitivity to cultural values, language and literacy, and access barriers, by, e.g., offering transportation, child care, and evening/weekend access and multiple service sites;

be developed from the ground up, based on documented needs and involving affected individuals and communities;

provide "one-stop" access through interagency coordination and integration of services, and ensure interstate reciprocity as farmworkers travel along the migrant stream;

aggressively recruit multilingual, multicultural health care providers, and provide services through multi-disciplinary teams;

use a centralized, standardized data base, for statistical information and transfer of medical records among service delivery sites; and

consolidate funding from among different sources, to minimize differing priorities and directives.

For the most part, such forums have focused on strengthening the specialized migrant health service delivery system upon which migrant farmworkers currently rely. Deliberations have acknowledged the difficulties migrants face in accessing Medicaid entitlement and services; coverage portability or interstate reciprocity are often included in lists of objectives. Nonetheless, the Medicaid program has not emerged as a preferred infrastructure for systemic reforms that require inter-agency coordination, portable coverage and some form of centralized data base or information exchange.

With implementation of the State Child Health Insurance Program (SCHIP), however, there appears to be increased attention to facilitating Medicaid/SCHIP coverage and encouraging interstate reciprocity for migrant farmworkers' children.

In its October 1997 publication, *"The Children's Health Initiative and Migrant and Seasonal Farmworker Children: The current situation and the available opportunities,"* the BPHC Migrant Health Program presented recommendations for SCHIP implementation to improve access for eligible migrant farmworker families and children:

allocation of SCHIP funds to outreach and enrollment assistance;
prioritizing SCHIP coverage based on income, which would encompass most migrant farmworker children.
presumptive eligibility, to minimize coverage delays;
income averaging, to maintain eligibility despite temporary periods of earnings above allowable levels; and
interstate reciprocity in accepting Medicaid cards issued in other state(s).

The prime effort to explore inter-State reciprocity to adapt the Medicaid program to migrant health system needs was a feasibility study undertaken in 1993 by Mathematica Policy Research, Inc., under a HCFA research grant in response to 1992 Advisory Council recommendations. That effort, and prospects for Medicaid as a framework for migrant health system reforms, are addressed in Section VI of this report.

III. CHARACTERISTICS OF MIGRANT FARMWORKERS: DEMOGRAPHICS, HEALTH STATUS AND GEOGRAPHIC MIGRATION PATTERNS

A. Demographics and Health Status

It is difficult to generate accurate estimates of the size, location and characteristics of the migrant farmworker population. In addition to definitional differences (see Section I, "Defining the Population"), different enumeration methods are used to estimate state-specific populations. The National Center for Farmworker Health (NCFH) reports that "upstream" (employment destination) states tend to use a "Demand for Labor" technique, reflecting the number of workers likely to be needed to harvest certain crops. Migrants who seasonally return to reside in "downstream" (homebase) states may be counted there, as well as in upstream states where they travel to work.

Through the Migrant Health Program, the NCFH contracted for enumeration profiles of migrant and seasonal farmworkers in ten states: Arkansas, California, Florida, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, Texas and Washington. Recently completed, the project includes data on farmworker children, useful for SCHIP and Medicaid program planning.

A review of various resources indicates that there may be more than four million migrant and seasonal farmworkers and family members in the U.S., about 40 percent of whom are *migrant* farmworkers and their family members. The migrant subpopulation is largely young males; most migrant women are of childbearing age.

Less than half of migrant farmworkers speak English and about 85 percent are minorities. About half of the migrant and seasonal farmworkers served by migrant health centers are Hispanic; 35 percent are African-American and the remaining 15 percent are Asian, White, or "other." Consequently, health services research on minority populations is particularly significant for the migrant population. For example: Black men are more likely to die from cancer than any other group in the United States; Hispanics have been found to have particularly high rates of high blood pressure, high cholesterol levels and diabetes; and Hispanic women exhibit a high rate of cervical cancer.

Through the National Agricultural Workers Survey (NAWS), the U.S. Department of Labor tracks farmworker demographics, legal status, education, family size and household composition, wages and working conditions. Although focused on farmworkers in field and orchard crop agricultural work, most of the NAWS data is <u>not</u> specific to *migrant* farmworkers. NAWS data does include some information about farmworkers' use of public benefit programs. The 1994-1995 surveys revealed that:

> Only about 15 percent of the estimated 1.6 million crop workers received Food Stamps and Medicaid; 47 percent of farmworker Medicaid recipients were foreign-born non-citizens.
>
> Only about 35 percent of farmworker families with dependent children with income below the poverty line who also were citizens or eligible immigrants received Medicaid.
>
> Farmworker families associated with unauthorized workers used few social services for which they might be eligible under some circumstances – only 7 percent of such families used Medicaid, WIC or Food Stamps.

The 1997-1998 NAWS provides some information specific to "migrant farmworkers," defined as individuals who travel more than 75 miles to obtain a job in U.S. agriculture. This group constitutes

about 56 percent of all hired farmworkers. The average age of such migrant farmworkers was about 26-27 years, and 42 percent maintained a home base outside the United States.

Many migrant farmworkers have less than an eighth grade education. Most migrant farmworkers' family income is below federal poverty levels; average annual income is less than $7500. Nonetheless, little is known about the numbers who might be eligible for Medicaid in various states nor about the extent to which those eligibles would pursue Medicaid coverage or use program services.

The 1997-1998 NAWS also collected data on citizenship status among all hired farmworkers About half of hired farmworkers lacked work authorization; 22 percent were U.S. citizens, 24 percent were legal permanent residents and 2 percent had temporary work permits. (Other studies noted below, however, have found most farmworkers to be U.S. citizens or legal residents.)

Eleven studies of various aspects of migrant farmworkers' economic, legal and health status have been summarized by the National Center for Farmworker Health in "*Facts About America's Migrant Farmworkers*," including findings that:

- Most migrant and seasonal farmworkers are citizens or legal residents of the United States. Although most earn less than the federal poverty level, few are able to secure public assistance such as Medicaid or food stamps, nor to document their entitlement to Social Security retirement benefits.

- Migrant Health Centers have the capacity to serve fewer than 20 percent of the nation's farmworkers. Less than 12 percent of MHCs' revenue is from Medicaid reimbursement.

- "Unsanitary working and housing conditions make farmworkers vulnerable to health conditions no longer considered to be threats to the general public. Poverty, frequent mobility, low literacy, language, cultural and logistic barriers impede farmworkers' access to social services and cost effective primary health care. Economic pressure makes farmworkers reluctant to miss work when it is available . . . they are not protected by sick leave, and risk losing their jobs if they miss a day of work. [Consequently, they] postpone seeking health care unless their condition becomes so severe that they cannot work [and then] must rely on expensive emergency room care."

  Health risks in agricultural labor include exposure to the elements, pesticides and dangerous equipment, resulting in a high incidence of falls, heat stress, dehydration and pesticide poisoning.

The NCFH also points out that agriculture is not subject to the degree of safety legislation that protects workers in other industries. Although OSHA requires that employers of eleven or more farmworkers provide toilet facilities and drinking water for workers in the field, sanitation violations were found in 69 percent of OSHA's 1990 field inspections. Worker Protection Standards requiring education about pesticide poisoning have been difficult to enforce. The Environmental Protection Agency estimates that at least 300,000 farmworkers suffer acute pesticide poisoning each year; additional cases probably go unreported because patients do not seek treatment or are misdiagnosed as having viral infections.

The NCFH also summarized findings from eighteen sources in a "*Basic Health Fact Sheet*" about migrant farmworkers, highlighting problems such as:

high rates of work-related injuries, including toxic chemical injuries;

alcohol and drug abuse;
inadequate fresh water and toilet facilities at workplace and housing sites;
high incidence of urinary tract infections, diarrhea, parasitic infections, heat stress, dehydration, and parasitic infections, and high death rates from influenza and pneumonia;
vaccine-preventable illnesses, and lack of timely vaccinations among the majority of pre-school age children;
high-risk pregnancies and low rates of first trimester prenatal care; and
an infant mortality rate twice the national average.

The NCFH has also issued Fact Sheets on disease-specific research, such as the incidence of HIV/AIDS and tuberculosis among migrant farmworkers:

> Various studies of the incidence of HIV among migrant farmworkers between 1987 and 1992 found HIV-positive rates up to eight times the national rate, and that prevalence of HIV had increased among migrant populations tested during those periods.
>
> Migrant farmworkers appear less well-informed about the risk factors and symptoms of HIV/AIDS than the general population, and many rely on nontraditional therapies such as self-treatment with folk medicines and/or access to uncontrolled injectible drugs available outside the U.S. Thus, HIV infection may not be diagnosed, and may be spread unknowingly, before AIDS-related disorders appear. Also, condom use is perceived by many Hispanic migrants as unacceptable for religious and cultural reasons, including a subtle association between condom use and promiscuity.
>
> Various studies of the incidence of tuberculosis among migrant farmworkers during 1987-1992 found rates of asymptomatic TB infection of 44 percent, with rates as high as 62 percent among U.S.-born Blacks, 76 percent among Haitians and 37 percent among Hispanics.
>
> Tuberculosis in migrant farmworkers presents special problems because it is easily spread within crowded living and workplace situations and because it is difficult to maintain lengthy treatment regimens given the transient nature of migrant agricultural work.

A study of health status and service use among migrant and seasonal farmworkers in migrant homebase areas of Texas, and in non-homebase areas of Michigan and Indiana, (Dever, 1991) found that more than half of households in migrant homebase areas lived below national poverty levels. Their overall health status was significantly worse than that of the general U.S. population, or of farmworkers in non-homebase migrant areas. Over 40 percent of farmworkers who visited Migrant Health Center clinics exhibit multiple health problems. Reasons for clinic visits, by age group, indicate that:

- Clinic visits for young children are mostly for infectious diseases and nutritional health problems. Dental disease is the number one health problem for patients aged 10-14, and for males through age 19.

- Pregnancy is the number one health condition among females aged 15-19. Females age 20-29 visit clinics mostly for pregnancy or reproductive problems, diabetes and the common cold. Males in that age group exhibit contact dermatitis, strep throat and scarlet fever, and dental problems.

- Diabetes and hypertension are the most common cause of clinic visits among older adult males and females; nearly half of all clinic visits for men and women aged 45-64 are for diabetes, hypertension or arthropathies. Among the elderly, over 60 percent of clinic visits by males and 80 percent by females are for diabetes and hypertension.

Following implementation of the State Child Health Insurance Program, the federal Migrant Health Program published a paper on *"The Children's Health Initiative and Migrant and Seasonal Farmworker Children: The current situation and the available opportunities."* A profile of children served by MHCs noted that approximately 70% of migrant and seasonal farmworkers' children live below the federal poverty line and nearly 73% have no health insurance. In addition to the above-cited health problems of migrant children, the report noted that migrant children who work and play in the fields are more susceptible than adults to the toxic effects of pesticides due to their lower weight and higher metabolism.

B. Geographic Migration Patterns

Traditionally, migrant farmworkers' geographic migration patterns have been thought of in terms of three inter-State streams, with homebase locations in Florida (eastern stream), Texas (midwestern stream) or southern California (western stream).

> Eastern stream migrants travel and work throughout the mid-Atlantic states to New England; some follow a parallel route through Georgia and Alabama to Tennessee, Kentucky, Ohio, Indiana and as far north as Michigan.
>
> Subsets of midwestern stream migrants cover the largest geographic area, along numerous intertwining stream branches from Texas through or to nearly all of the states west of the Mississippi River; some migrate to the east, through the Gulf coast states and into Florida.
>
> Western stream migrants travel mostly along the Pacific coast, through California to Washington and Oregon; some work and travel primarily in the southwestern states of California, Arizona and New Mexico.

An atlas of 42 States' profiles prepared by the Migrant Health Program in 1990 identified the States with the largest concentrations of migrant farmworkers and their family members, in approximate order, as: California, Texas, Florida, Washington, Puerto Rico, Oregon, Massachusetts, Idaho and North Carolina.

More recently, the Migrant Clinicians Network's web site portrayed geographic migration patterns in terms of three different types of migration, i.e.:

> *Restricted circuit* – Seasonal travel within a relatively small geographic area, such as the Central Valley in California, along Interstate 80 in Nebraska, and around the El Paso/Las Cruces/Cuidad Juarez area.

- *Point-to-Point* – Seasonal travel to the same places along a round-trip route. Similar to the seasonal stream concept, these migrants tend to establish homebase areas in Florida, Texas, Mexico, Puerto Rico or California. Multiple such point-to-point migration patterns include up and down the Atlantic and Pacific coastal areas, and from Texas to the southern Atlantic states.

- *Nomadic* – Longer-term travel away from home for a period of years, often covering great distances to follow changing demands for farm labor. Some nomadic migrants may settle in areas to which they have migrated, while others eventually return to their home base. Home base areas tend to be in Mexico, south Texas and the Caribbean Islands.

The Department of Labor NAWS data also distinguishes among migrant farmworkers based on migration patterns. "Shuttle migrants" are defined as those who reside more than 75 miles from their farm jobs, and who work at one or more sites within a limited geographic area (similar to "restricted circuit" migrants). About half as many are defined as "follow the crop" migrants, who have at least two farm jobs that are more than 75 miles apart and at least 75 miles from their home base.

Variations in migration patterns among sub-groups of migrant farmworkers would be useful to consider in developing models for health system reform For example, inter-state reciprocity might best be tested between two states with common borders within a restricted circuit pattern, or between the destination and home-base states of seasonal point-to-point (stream) patterns.

It would also be interesting to know the extent to which there are differences (if any) in the demographic and health status attributes of farmworkers who pursue particular migration patterns – e.g., if migrant farmworkers with young children are less likely to follow nomadic patterns.

IV. MIGRANT HEALTH SERVICES TODAY

At the federal level, migrant health services are managed through the Migrant Health Program of the Bureau of Primary Health Care (BPHC), in the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (DHHS). Under Section 330(g) of the Public Health Service Act, the federal Migrant Health Program (MHP) provides grants to over 120 public and private nonprofit organizations, supporting about 390 Migrant Health Clinics (MHCs) and Migrant Health Programs (MHPs) in 35 states and Puerto Rico. Appropriations increased from slightly over $70 million for FYs 1997 and 1998 to $78 million in FY 1999 and $80.7 million in FY 2000.

MHCs serve about 600,000 migrant and seasonal farmworkers and family members each year. However, it is estimated that MHC funding covers only about 20 percent of farmworkers who need access to care. MHC services generally include primary and preventive care, dental and pharmaceutical services, environmental health programs, outreach and transportation. MHCs use lay outreach workers, bilingual, bicultural health personnel, and culturally appropriate protocols developed by the Migrant Clinicians Network (see below). Children's preventive services include immunizations, well baby care and developmental screenings.

In addition to direct service delivery, Migrant Health Program funds can be used for planning, development and operation of MHCs (including acquisition and modernization of buildings), for program management training and environmental health studies or projects, and for grants to support local Migrant Health Programs.

In geographic areas where there are insufficient numbers of migrant farmworkers to support a MHC, Section 330(g)-funded Migrant Health Program grantee organizations conduct health education, outreach and service coordination, relying to a greater degree on referrals to local health resources for medical service delivery. Although historically such local Migrant Health Program initiatives have been characterized as "voucher" programs, there are a variety of models. For example, rather than issuing vouchers to migrant farmworkers in need of care, Farmworker Health Services of Colorado enters into formal arrangements with medical, dental and pharmacy providers, who agree to accept the Program's reimbursement rates, and to obtain prior authorization for emergency dental services and specialty care. Because many of Colorado's migrant farmworkers and their families tend to remain within the state throughout the season, they can be enrolled in the program, carry a membership card, and access services without having to obtain service-specific vouchers.

The BPHC Migrant Health Branch establishes Migrant Stream Coordinators in conjunction with regional host agencies, to enhance the visibility of farmworker health issues, identify gaps in services, and promote inter-state cooperative efforts for health service delivery. Conferences on migrant and seasonal farmworker issues and regional forums engaging representatives of the three migrant geographic streams have been held for many years. The Migrant Health Branch also provides staff support to the National Advisory Council on Migrant Health. The Advisory Council's recommendations are discussed in Section II, above.

The Migrant Health Program relies on a variety of collaborative linkages to support and augment MHC services. At the federal level, the MHP works closely with education and Head Start programs, and WIC supplemental food programs for migrant farmworkers and their children. The MHP establishes cooperative agreements with State agencies and State and regional Primary Care Associations, and fosters partnerships between MHCs and State and local health departments and health and social service providers.

Significant supportive services are provided by the National Center for Farmworker Health and the Migrant Clinicians Network, both of which offer informative internet web sites (see *Bibliography and Resources* in the appendices to this report.)

The National Center for Farmworker Health (NCFH) is a private, non-profit corporation based in Austin, Texas, which provides a broad range of services, including:

- promoting public awareness of farmworker health needs, for consideration in larger policy discussions;
- networking and collaboration to improve access to services through partnerships with other organizations;
- a Resource Center to meet the information needs of migrant constituencies;
- support for Migrant Health Center operations; and
- stream coordination, to improve access to health and social services for farmworkers in the Midwest Stream.

A quarterly newsletter, *Migrant Health Newsline* (available through the NCFH web site) provides conference news, updates on national policy and local initiatives and best practices. The NCFH supports special initiatives and conferences on migrant health issues, and promotes communication among health entities along the U.S.-Mexico border. The NCFH also maintains a database of all Migrant Health Centers and clinics that provide services to farmworkers, which is used for the BPHC's *Migrant Health Centers Referral Directory*. With state-specific listings and locater maps, the directory helps health center staff refer migrating clients to sources of follow-up care.

The Migrant Clinicians Network (MCN) is a private non-profit corporation established in 1984 to promote farmworker health through:

opportunities for networking and professional development among health care providers serving migrant farmworkers;
- research and development of clinical tools appropriate to migrant farmworkers' health needs; and

serving as a national and international locus for leadership, advocacy and partnerships with collaborating agencies.

The MCN is sustained through voluntary efforts of primary care providers and organizations concerned with the health status of farmworkers. Governed by an eight-member Board of Directors, the MCN has over a thousand clinician members in the U.S. The MCN provides a variety of publications, studies and practice guidelines on health problems and issues affecting migrant farmworkers, such as diabetes, tuberculosis, hypertension, stress, eye care, HIV/AIDS, violence and family planning. To promote continuity of care for conditions frequently found in migrant farmworkers, the MCN's prototype chronic care guidelines address cultural, linguistic, environmental/educational and follow-up needs, known as the "CLEF" model.

V. ACCESS TO MEDICAID ENROLLMENT AND SERVICES

This Section focuses on the more relevant policy and operational constraints affecting the migrant farmworker population's ability to establish Medicaid/SCHIP eligibility, complete program enrollment, and access health services in fee-for-service and managed care environments.

Virtually every aspect of the current Medicaid/SCHIP policies and program structures makes access to enrollment and services difficult for eligible migrant farmworkers and their families. Many of these constraints are attributable to the flexibility state governments enjoy within the Medicaid framework, and thus are relevant to any transient low-income population.

A. Establishing Medicaid Eligibility

"Basic" Medicaid eligibility has always been notably complex and confusing for applicants, even for U.S. citizens with stable residency in a single State. Migrant farmworkers have been especially affected by inter-state eligibility policy differences and recurring issues affecting State residency and immigration requirements. Despite provisions to preserve, expand and/or simplify access to health coverage, statewide Medicaid waiver programs and recent legislative reforms have increased program complexity and inter-state variations. For example:

> Uninsured low-income children ineligible for Medicaid can be covered through SCHIP, with higher income limits, provisions for presumptive eligibility and simplified application processes in many states, but eligibility criteria and program structures vary among the states.
>
> Welfare reform legislation (the Personal Responsibility and Work Opportunity Act of 1996; P.L. 104-193 (PRWORA)) preserved traditional Medicaid eligibility criteria, and allowed states to liberalize Medicaid eligibility income limits and computation methodologies which could benefit uninsured adults (under a new section 1931 of the Social Security Act.) But misperceptions that PRWORA's new restrictions on cash assistance eligibility would affect Medicaid eligibility, and administrative fragmentation of intake processes, may have deterred eligible persons from seeking Medicaid – especially those with cultural/language barriers and/or immigration status concerns.
>
> Eligibility expansions in statewide section 1115 demonstration waivers were generally coupled with mandatory enrollment in managed care plans. The Balanced Budget Act provided six months guaranteed eligibility for managed care enrollees. But managed care, whether through MCOs or PCCM programs, is ill-suited to a transient population.

1. Eligibility Policy Constraints

Beyond the core intricacy of Medicaid eligibility policy, migrant families face additional policy-related complexities and constraints. Aspects of Medicaid eligibility policy that are particularly problematic for migrant farmworkers include:

(a) Differences Among States' Eligibility Policies

Migrant farmworkers' children, at least, are likely to be categorically eligible for Medicaid or SCHIP in most states today. However, income levels for Medicaid and SCHIP eligibility vary greatly among the states. For example, a three-person migrant farmworker family with one

wage-earner who traveled along the midwest labor stream in 1998 would encounter widely different Medicaid eligibility annual income limits – ranging from about $4,300 in their home base state of Texas to over $37,000 while working in Minnesota.

(b) Income Computation Methods

Even if the migrant farmworker families' annual income is low enough to qualify the family, or at least the children, for Medicaid or SCHIP, they may not qualify during periods of seasonal employment in states that count earnings on a less than annual basis.

Annual income averaging could help many low-income migrant families with fluctuating seasonal income. Determining anticipated annual income is difficult for migrant farmworkers, however, due to the uncertainties of climate and labor demands, whether locally or in other states. Income averaging can disadvantage families whose prior year income was too high to qualify, but who will not sustain that level of earnings in the current year.

Income averaging may also disadvantage migrants who choose to go through the eligibility determination process in their homebase state, where they spend enough time to attend to their healthcare needs while not working intensively. Most of the homebase states where such families spend the winter months are in the south, with relatively low eligibility income levels. The family may not qualify in such states if months of prior earnings are averaged in with months of unemployment.

Wisconsin implemented annual income averaging in conjunction with a 1997 initiative for migrant farmworkers who had established eligibility in another state (described in Section VI.C.2, below). Based on the prior twelve months' earnings, estimated prospective annual income is equalized for each of the subsequent twelve months, subject to adjustment if the prior year's income is not likely to be indicative of the coming year's earnings.

(c) Eligibility Documentation

Verifying family eligibility can be a problem if key documentation is carried by the head of household who is working elsewhere, or if the family simply does not have basic documentation such as a Social Security number (SSN) or a drivers' license. Although states may not require a SSN from non-applicant family members as a condition of the child's eligibility for SCHIP, failure to provide a SSN can complicate and delay income verification in determining eligibility.

(d) State Residency

Under federal policies (section 1902(b)(2) of the Social Security Act and regulations at 42CFR 431.52) and guidelines (State Medicaid Manual Section 4230), Medicaid is available to otherwise eligible persons who reside in the state in which they apply; i.e. "who are living in the state with the intention to remain there permanently or for an indefinite period" or who "entered with a job commitment or seeking employment."

Durational residency requirements cannot be imposed, and eligibility cannot be denied based on an applicant's failure to document a permanent abode or fixed address in the state. Special provisions for migrant or other transient eligibles offer two options: to apply in each or any state where they are working or seeking employment; or to apply in a single "home" state.

A "home state" arrangement, however, does not guarantee that providers in other states will accept the migrant's home state Medicaid card (see Section V.B.1, below on access to out-of-state services.)

Although states may enter into inter-state reciprocity agreements to recognize Medicaid eligibility granted by another state, such arrangements have generally been limited to service areas overlapping state borders, or to facilitate out-of-state adoption placements, or in individual cases of disputed residency. The complexities inherent in inter-state reciprocity for a migrant population, especially when more than two states are involved, are discussed in section VI.A., below.

(e) Citizenship and Immigration

Laws affecting the status of immigrant farmworkers and their families for purposes of receipt of public benefits are extremely complex, and have changed in recent years. Although many migrant farmworkers are U.S. citizens or legal residents, they are likely to be confused about their own and their family's eligibility status for Medicaid and/or SCHIP. Non-citizens who do remain eligible for Medicaid and/or SCHIP may fear that applying for benefits could affect their immigration status or expose them to deportation.

Medicaid coverage has traditionally been available to otherwise eligible persons who are U.S. citizens or who have been lawfully admitted for permanent residence or are permanently residing in the U.S. under color of law, known as "PRUCOL" status. The Immigration Reform and Control Act of 1986 increased the number of migrant farmworkers with legal PRUCOL status, under the Special Agricultural Worker (SAW) provision. For family members of individuals legalized under SAW, full Medicaid benefits were authorized for otherwise-eligible children under 18 and the aged, blind and disabled, as well as Cuban-Haitian entrants.

In 1996, changes in immigration laws and enactment of the PRWORA welfare reform legislation imposed more stringent and more complex restrictions on immigrants' eligibility for public benefits. Essentially, PROWRA limited coverage to "qualified aliens," defined as those who are lawfully admitted for permanent residence under specific sections of the Immigration and Nationality Act (including: an asylee, a refugee, an individual who has been paroled into the U.S. for a period of one year, or an individual who has had his/her deportation withheld, and who has been granted conditional entry.)

Under PROWRA, states must verify citizenship and immigration status of applicants for public benefits, although non-applicant parents need not disclose their status when filing a Medicaid or SCHIP application for a child. PRWORA did not change longstanding law that any child born in the United States is a citizen; such children, regardless of their parents' legal status, are entitled to Medicaid and SCHIP under the same criteria as any other U.S. citizen.

PROWRA and the 1997 Balanced Budget Act provided special protections for certain public benefits, including Medicaid, for specified groups – primarily young, elderly and disabled immigrants who were in the country at the time the welfare bill was enacted. (Additional protections specific to aliens eligible for Medicaid as SSI recipients are too complex for summary in this paper.) For purposes of Medicaid and SCHIP eligibility, groups *exempted* from PROWRA restrictions are:

> all legal immigrant children who were in the U.S. before August 22, 1996;
> refugees, asylees and certain Cuban, Haitian and Amerasian immigrants;

unmarried, dependent children of veterans and active duty service members of the Armed forces; and
legal immigrants arriving on or after August 22, 1996, and in continuous residence for 5 years.

Under PRWORA, immigrants legally entering the United States after August 1996 were barred from coverage for their first five years in the country. The earliest eligibility date for this group is August 22, 2001. Their sponsor's income and resources may be taken into account in determining eligibility. Two bills pending in congress as of December 1999 would restore Medicaid and SCHIP benefits for "post-enactment" pregnant women and children. Several states currently use state-only funds to provide health benefits to at least some of the "post-enactment" pregnant women and/or children who are legal immigrants but were barred from coverage by the 1996 legislation (e.g., California, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, Minnesota, Nebraska, New York, Pennsylvania, Rhode Island, Texas, Virginia and Washington.)

Medicaid coverage for emergency services only (including labor and delivery) remains available to undocumented aliens if they would otherwise be Medicaid eligible. (Section 1903(v) of the Social Security Act.) However, some states have defined the scope of "emergency services" more broadly than others; and/or have issued service-limited Medicaid cards to eligible immigrants who apply, while others determine eligibility only after the individual has received emergency services.

Although Medicaid and SCHIP are included in the definition of "federal public benefits" subject to PROWRA eligibility restrictions, migrant health services were not included in the list of applicable programs, indicating that Migrant Health Center clinic services may be provided without regard to citizenship or immigration status.

Another provision in immigration law, the "public charge" determination, is intended to prevent entry or naturalization of immigrants likely to be, or become, dependent on government assistance. In the May 26, 1999 *Federal Register*, however, the Immigration and Naturalization Service (INS) defined "public charge" as an alien who is, or is likely to become, primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance or institutionalization for long-term care at government expense. Non-cash benefits such as vouchers or direct services for health are considered supplementary support rather than subsistence. An immigrant will not be considered as a "public charge" based on receipt of food stamps, Medicaid or SCHIP.

It is no wonder that any non-citizen would be confused about their eligibility for public benefits in general and health benefits in particular, and fearful about how pursuing an application might affect their immigration status. As reported in the September 13, 1999 issue of *State Health Notes*, a 1998 Urban Institute study of Los Angeles County found that approved applications for welfare and Medi-Cal benefits for families headed by non-citizens fell over fifty percent since 1996; no decrease was noted for families headed by citizens. Migrant farmworkers present a special challenge in outreach and education for eligible non-citizens. Some promising outreach models are noted in Section VI, below.

2. Access to the Medicaid Enrollment Process

The states and the federal government have mounted considerable efforts to educate potential eligibles about Medicaid protections under PROWRA and about SCHIP program expansions for

children, and to facilitate access through streamlined enrollment processes. The migrant farmworker population, however, presents special challenges for the outreach, communication and processing necessary to secure coverage for eligible individuals.

Transportation and communication barriers inhibit access to eligibility intake offices, as do the business hours of the intake process – generally during weekday daylight hours when the head of household is likely to be at work in the fields. Intake offices in rural areas may not have multi-lingual workers, or sufficient staff to take applications in the evenings or outside the office. When eligibility staff are outstationed in community clinics or Migrant Health Centers, they may only be on-site intermittently. Because Medicaid reimburses Migrant Health Centers on a reasonable cost basis, MHCs have a financial incentive to serve larger numbers of Medicaid eligible migrant farmworkers, and to facilitate access to the enrollment process.

Even if the intake worker is accessible, it may be difficult to encourage migrant farmworkers to discuss Medicaid or SCHIP. At a health center, the farmworker may need to return to the fields immediately after treatment for a minor injury, or see no need to pursue Medicaid/SCHIP coverage while receiving free or affordable care at the health center.

When migrant families apply for public assistance, they may decide not to pursue health coverage if they cannot access "one stop shopping" for cash assistance, food stamps and Medicaid/SCHIP benefits. States have increasingly designated different agencies, with different processes in different locations, to take applications for cash assistance, Medicaid and/or SCHIP. The most needy families are likely to seek cash assistance and food stamps first, and not pursue health coverage if the process presents an additional access or paperwork burden.

For migrant families who do pursue health coverage, streamlined applications and provisions for presumptive eligibility are helpful. The longer it takes to process an application, procure and verify documentation, effectuate coverage on automated systems and provide a "live" enrollment card, the more likely it is that the family will have migrated to another jurisdiction before completing enrollment. This can be a problem even within some states where the eligibility intake process is controlled by individual counties. A lengthy application and card issuance process may be futile for families who routinely migrate among multiple jurisdictions.

Processing time is less of a problem when establishing eligibility in the family's homebase state. When working elsewhere, however, those who have established home state eligibility may fail to receive enrollment cards that are mailed monthly, or miss required recertification interviews.

3. Managed Care Enrollment

Expansion of Medicaid managed care has further altered states' program structures, generally through federal waivers authorizing states to implement mandatory enrollment in managed care organizations (MCOs) and/or primary care case management (PCCM) systems.

For many Medicaid eligibles, the length of the enrollment process – from filing an application to receiving a "live" Medicaid card – now requires additional time to select a managed care plan and/or primary care provider, be registered on that plan's and/or provider's caseload record, and be issued a health plan membership card designating the individual as enrolled with that plan and/or provider. An extended enrollment process, coupled with constraints on accessing health services through managed care arrangements (see B.2. below), make managed care seem ill-suited to a migrant population.

Nonetheless, categorical eligibility as a family with dependent children, or as a Medicaid/SCHIP-eligible child, would subject migrant farmworkers and their family members to mandatory managed care enrollment in most states. As young adults able to work, they would not qualify for mandatory enrollment exemptions generally allowed for the aged, disabled or other SSI or Medicare-eligible populations.

Some states provide mandatory enrollment exemptions for "homeless" individuals, though not with a migrant farmworker population in mind. New York's mandatory enrollment program exempts individuals expected to be Medicaid eligible for less than six months, which does allow seasonal agricultural workers to pursue coverage under the statewide fee-for-service program. In its reciprocity initiative (described in Section VI, below), Wisconsin provided for an automatic exemption from mandatory enrollment for all migrant farmworker applicants, and designated a special Medicaid enrollment identifier code for them in the fiscal agent's computer system.

Opportunities for facilitating migrant farmworkers' access to enrollment in managed care plans are discussed in Section VI.B, below.

B. Accessing Medicaid Health Services

1. Access to Medicaid Providers

Migrant farmworkers who do establish Medicaid eligibility face challenges in accessing services from Medicaid-participating providers, both within the state of eligibility as well as while seeking out-of-state services.

In addition to the language and socio-cultural access barriers experienced by minority populations, migrant farmworkers are more likely to find it difficult to access community providers, even in the state where they have a Medicaid card. Except during periods of inclement weather, their daylight work schedules overlap with most physicians' office hours, and migrants cannot reliably anticipate when they might be free to keep an appointment. Transportation may also be an impediment. The family and the worker may depend on others for transportation; if they do have a car, the worker may need it to get to the fields during the day.

When migrants do seek out private sector health providers, they may encounter resistance for several reasons. Due to the complexity and nature of recent welfare reform and immigration laws, providers may not know who is eligible for what, or assume that only citizens remain eligible for Medicaid. Providers may be reluctant to treat persons with presumptive eligibility status, especially if the individual might not remain in the community long enough to complete the process to confirm eligibility. Providers may also be reluctant to make appointments that might not be kept, or to treat patients who may have difficulty following treatment regimens or returning for follow-up care.

Migrants face additional barriers in accessing Medicaid providers outside the state where they established Medicaid eligibility.

Federally-mandated out-of-state coverage is limited to: services needed in an emergency or if the person's health would be endangered if he or she were required to travel to the state of residence; or where services are more readily available in another state or it is general practice for recipients in a particular locality to get care in another state (section 1902(a)(16) of the Social Security Act and 42CFR 431.52). The latter two conditions have generally been applied when there is a shortage of a particular service in the state of residence and/or within communities spanning state borders. States must also have procedures to facilitate furnishing of services to persons who are Medicaid-eligible in

another state, but this has not been applied as a mandate for expansive inter-state reciprocity arrangements. States may establish broader reciprocity agreements, but efforts to do so have not yet been productive, as explained in section VI.A, below.

Providers are likely to be even more reluctant to treat migrant farmworkers carrying an out-of-state Medicaid card. Absent a well-crafted arrangements for out-of-state payment, providers may not know if they must have a provider agreement with the originating state, nor what that state's billing practices, payment rates or coverage limitations are. The burden and cost of billing for out-of-state reimbursement, and the risk of not being paid at all, may well outweigh a provider's positive inclination to care for migrant farmworkers.

The migrant farmworkers, too, may consider it futile to seek out community Medicaid providers while away from the state of eligibility. They can rely on accessible Migrant Health Center clinics for primary and urgent care that will be affordable or free, with culturally-sensitive providers and without concerns about immigration status queries.

However, the extent to which eligible migrant farmworkers do not seek, or cannot get, eligibility and services from Medicaid programs and providers will have an adverse impact on the public health centers they do use. As culturally-sensitive, accessible providers, increased Medicaid revenues would help these clinics devote limited grant dollars to serve larger numbers of migrant workers and their families.

2. Access through Managed Care Organizations

Medicaid managed care remains structurally grounded in restricted provider network models. Although states do require networks to have sufficient numbers of providers to offer enrollees choices among accessible and culturally sensitive primary care providers (PCPs) and specialists, "open network" arrangements with options to use out-of-network providers are largely limited to private sector plans. Also, some Medicaid MCOs' networks encompass fairly small sub-state service areas, such as in urban communities where lots of Medicaid eligibles reside.

Even private sector health plans do not readily accommodate enrollees who may want to access non-emergency out-of-state (or service area) providers. Inter-state MCOs do not automatically recognize enrollees from another state, unless there are pre-established contractual and administrative arrangements to do so in specified service areas.

Other aspects of managed care, such as reliance on each enrollee's PCP for referrals to specialist providers and requirements that some services be pre-authorized by the health plan, present additional constraints on migrant farmworkers' access to care through managed care programs.

Medicaid managed care in rural areas is often through PCCM programs rather than the more cohesive primary, specialty and institutional provider networks of risk MCOs. PCCM programs, however, pose many of the same problems for migrant farmworkers, in that care must be provided or authorized through a designated PCP. And, an individual PCP may rely on affiliated hospitals and specialty providers within a smaller geographic area than that served by a large MCO network. Such PCPs may be reluctant to accept patients who are likely to seek follow-up care from specialty providers outside the PCP's familiar service area.

Prospects for developing managed care arrangements tailored to migrant farmworkers health access needs are discussed at Section VI.B.2. below.

VI. CONFRONTING THE BARRIERS – APPROACHES AND PROSPECTS

Renewed interest in the policy and access barriers affecting Medicaid-eligible migrant farmworkers led to two initiatives in June and September 2000. Supported by the Robert Wood Johnson Foundation's "Covering Kids" program, on June 14, 2000 the National Health Policy Forum (NHPF) held an invitational working session, *"Medicaid and SCHIP Portability Issues: How to Provide for the Children of Migrant Workers."* A subsequent paper by Judith D. Moore, Co-Director of the NHPF, *"Policy Options for Serving Migrant Children and Families under Medicaid and SCHIP"* summarized a variety of limited solutions, intermediate approaches and comprehensive reforms. On September 5th and 6th, with support from the Milbank Memorial Fund and in cooperation with HRSA and HCFA, the Refoming States Group held a meeting on *"Portable Continuity of Care and Coverage for Medicaid Eligible Migrant workers and their Families."* That meeting explored short, medium and long-range policy options, and specific experiences and concerns of several states.

Those initiatives surfaced a broad array of potential approaches to lifting policy and access barriers, all of which merit further consideration. To help inform future dialogue, this Section focuses on two conceptual approaches:

A. *Inter-state reciprocity* modifications to the basic Medicaid program framework, because this approach is often raised as a potential panacea; and

B. *Public-private partnerships* involving health insurors or managed care organizations, entities increasingly evident in Medicaid programs and strategies.

As systemic reforms that would affect multiple states, those approaches entail complex political, design and developmental challenges. Subsection C. highlights some of the *simpler, readily available approaches* that could be implemented on a local or state-specific basis.

A. Using the Medicaid Framework: Inter-State Reciprocity

There is a growing realization that reciprocal eligiblity, coverage and payment arrangements among two or more state Medicaid programs is an extremely problematic approach to addressing policy and access barriers for migrant farmworkers. Nonetheless, inter-state reciprocity often surfaces as a conceptually appealing approach. The intensive design work and feasibility analysis that has been done should be considered in any future discussions of prospects for inter-state reciprocity.

1. Federal Efforts to Develop a Demonstration Design

In response to a 1992 recommendation of the National Advisory Council on Migrant Health, in June 1993 the Health Care Financing Administration (HCFA) contracted with Mathematica Policy Research, Inc. (MPR) to develop a multi-state Medicaid reciprocity demonstration for migrant farmworkers and their families. Although that initiative did not lead to implementation of a demonstration, MPR explored multiple constraints and a range of options toward framing viable approaches to inter-state reciprocity.

The HCFA/MPR study was not designed to explore models that would entail Medicaid eligibility expansions, but rather to improve access for migrant farmworkers within the basic Medicaid framework. The study focused on problems stemming from inter-state variation in eligibility policies, benefit packages, reimbursement rates and claims processing,

In consultation with an Expert Panel and the BPHC Migrant Health Program, nine potential demonstration models were considered, within three basic strategies. The following chart summarizes those models and the key issues related to each approach.

Summary of Options for a Demonstration to Improve Medicaid Coverage of Migrant Farmworkers and their Families

(Based on a February 11, 1994 discussion paper prepared by George E. Wright, Mathematica Policy Research, Inc.)

NOTE: "State" refers to states that would voluntarily agree to participate in a demonstration.

MODELS	ISSUES
Strategy A: Cross-State Agreements on Eligibility	
Option 1: Inter-State Eligibility Transfer Initial annual Medicaid enrollment in any state, using that state's policies and process. Other states allow simple local enrollment, accepting initial state's determination of basic eligibility criteria, for expedited issuance of state-specific Medicaid card. *(Similar to approaches in the WIC program for migrants and in Medicaid coverage for adopted children.)*	– Does not address barriers to establishing initial eligibility and accessing enrollment processes. – Difficulty of determining/verifying annual income. – Need to train all states' eligibility workers in special procedures for migrants.
Option 2: Reciprocal Eligibility Determination States would fully recognize other states' eligibility determinations. Either: issue a "universal" Medicaid card (with no need to re-enroll in other states); or other states automatically issue state-specific cards at application.	– Does not address barriers to establishing initial eligibility and (unless a "universal" card is used), accessing enrollment in each state. – If a "universal" card is used, need to educate providers. – Variation among states' eligibility standards, and intra-state equities when migrants granted eligibility under another state's more liberal criteria. – Information systems and data transfer if "universal" card is used. – Responsibility for redeterminations and maintenance of case records across states.
Option 3: FQHC-Centered Reciprocal Eligibility FQHCs in all states would accept other states' Medicaid cards. FQHC services (only) would be billed to each FQHC's own state as Medicaid encounters. For non-FQHC services (specialists and inpatient), either: migrants must apply under routine Medicaid process in each state; or FQHCs could contract with other providers.	– Barriers to specialist and inpatient services likely to remain. – Is there sufficient access to FQHCs (and migrant health centers)? Should all rural health centers be included?
Option 4: Central Eligibility Clearinghouse A multi-state migrant eligibility roster and data base, to facilitate re-enrollment in each state and/or provider verification of eligibility.	– What entity to operate the clearinghouse? – Implementation cost and operational financing? – Use clearinghouse data to grant presumptive eligibility in other states after initial eligibility determination?

Continued on next page.

Strategy B: Single-State Eligibility with Portable Benefits

Option 1: Improve Out-of-State Claims Processing Eligibility and payment liability retained in state where eligibility initially determined. States agree to relaxed, more uniform policies for payment of out-of-state claims.	– Disproportionate financial burden on "home" states. How to apportion costs among states more fairly? – Need to educate providers and encourage acceptance of out-of-state Medicaid cards and payments. – Monthly and/or paper cards some states use are not durable or valid for extended periods of time.
Option 2: Claims Processing Clearinghouse A commercial insuror or TPA would issue Medicaid cards and process claims for payment by the state where the migrant enrolled in Medicaid – i.e., to facilitate payment of out-of-state claims. Providers would recognize the cards as commercial coverage, but payment liability remains with the state of enrollment. The entity could also operate an eligibility clearinghouse per Option A..4.	· Likely to increase the disproportionate financial burden on "home" states. How to apportion costs among states more fairly? · Implementation cost and operational financing? Cost-effectiveness for such a small population? · Migrants and providers subject to home state's coverage and payment limitations. · Would commercial carriers/TPAs want to do this, if their name were on the card?

Strategy C: Purchase of Non-Medicaid Insurance or Managed Care

Option 1: Purchase of Commercial Insurance Each state that enrolls a migrant farmworker would pay a fixed premium to the insurance company, which would issue a card and pay all claims regardless of the service delivery location.	– How to set rates, without historical use and cost data for the population? – How to apportion costs among states? – Need to define multi-state benefit package and payment rates.
Option 2: Establish a Migrant HMO Each state would administer its own eligibility system and issue its own enrollment cards. Enrollees would also have an HMO card to access services through an inter-state provider network. The network would include migrant health centers and other providers currently serving large numbers of migrants.	– FQHCs/migrant health centers are not prepared to sponsor the managed care entity. A commercial sponsor is needed to assume financial risk and meet multiple states' licensing standards. – How to set premium rates? – Who would provide risk protection for an experimental HMO? – How would FQHC network providers be paid? – Could a common benefit package and payment rates be authorized among multiple states?

The two options selected for further development – "Inter-State Eligibility Transfer" (i.e., reciprocity) and "Purchase of Commercial Insurance" – are discussed in more detail below and in Subsection VI.B, respectively. The option to "Establish a Migrant HMO" was not pursued in the demonstration initiative, but is also discussed further at Section VI.B.

In considering the desirability of each of those models, the Expert Panel framed some basic guidelines for a demonstration, i.e.:

Facilitate Enrollment and Access to Care – Simplify the process of enrolling from state to state, and issue Medicaid cards that are recognizable and acceptable by each state's providers.

Equitable Cost Sharing Among States – Each state should pay its own providers, possibly under a common multi-state benefit package and rate schedule.

No Expansion of Eligibility – Only migrant farmworkers currently eligible for Medicaid could participate.

Non-discrimination in Benefits – No new benefits would be offered. Participation would be voluntary, with an option to enroll in each state's traditional Medicaid program.

Administrative Simplicity – Avoid re-training of all eligibility workers, extensive provider education, and creation of new administrative structures.

Administrative Costs – Minimize start-up and operating costs, especially due to modifications of automated eligibility and claims processing systems.

Protection from Liability for QC Errors – Exempt participating states from errors attributable to demonstration experience.

Limit States' Financial Liability – Allow each participating state to cap the number of demonstration participants.

The design framework limited participation to migrant farmworkers and dependents as defined by U.S. Public Health Service standards; itinerant workers in non-agricultural industries, and non-migratory seasonal agricultural workers, would not be included. Non-migratory family members would be expected to access Medicaid benefits in their homebase state.

Implications of different types of geographic migration patterns (discussed in Section III.B above) were apparently not fully considered in defining demonstration models, nor the special problems of individuals with homebase areas outside the U.S. or those who follow erratic migration patterns. Migrants who travel within fairly restricted areas might be able to establish Medicaid eligibility within the one or two States they visit. "Point-to-point" migrants cover multiple states, but in fairly predictable patterns. An additional challenge, therefore, lies in tailoring a demonstration design to migration-pattern subsets of individuals who are difficult to identify.

Option A.1, "Inter-State Eligibility Transfer" involved simplified processes for migrant farmworkers to establish eligibility in each state following an initial full eligibility determination in any one of the participating states. Design assumptions for such an inter-state reciprocity model included:

Eligibility would be authorized for twelve months before a full redetermination was required.

At each new state, the individual would present his/her out-of-state Medicaid card, with proof of agricultural work in the new state and a local "residence" or point of contact – which might be the FQHC or migrant health center nearest the area where they are working. Such local enrollment information would be entered in a statewide data base, linked to that state's Medicaid eligibility system.

Designated enrollment sites convenient to migrant farmworkers would minimize caseworker training and allow targeted oversight of the specialized intake process.

Each state would issue its own Medicaid card to demonstration participants. At state option, presumptive eligibility could be authorized upon application, and/or a pre-printed enrollment sticker affixed to the state's more durable plastic card. Demonstration participants would be exempted from any requirements for mandatory enrollment in managed care programs.

Providers would accept their own state's Medicaid card and verify eligibility under existing procedures. Each participating state's own benefit package, coverage limitations and reimbursement rates would remain in place for migrants accessing that state's services.

Many details of such a demonstration would need to be defined and tailored to participating states' programs. Budgetary considerations were a significant constraint, including concern about accepting service-reimbursement liability for persons found eligible by another state, and the possibility that the demonstration would encourage large numbers of migrants to enroll in either the homebase state(s) or in states with more liberal eligibility criteria. Also, at that time, many states were developing new Medicaid managed care initiatives and/or broader demonstrations to expand coverage to their own low-income uninsured populations, and/or were concerned with implications of the national health reform debate. Although some states expressed preliminary interest, the complexity of the issues and other priorities of the time prevented further development and implementation of a demonstration.

An alternative "reciprocity" model which can be implemented by a single state and is operational in Wisconsin, is described in Subsection VI.C, below.

2. Prospects for Inter-State Reciprocity in Today's Environment

Some of the barriers to inter-state reciprocity have faded with recent changes in the Medicaid environment. States are less concerned about budgetary constraints and more interested in outreach and/or program expansions for low-income working families. Most states have progressed beyond the difficult initial stages of managed care implementation, and national health reform no longer threatens the basic state/federal Medicaid infrastructure.

Perhaps the most promising development is the advent of SCHIP benefits for children of the working poor and related opportunities for their parents to become Medicaid eligible through the section 1931 state plan option. With SCHIP, there is also a renewed federal and state emphasis on outreach, simplified enrollment and program design flexibility. Children who travel with their migrant farmworker parent(s) represent an attractive target group for inter-state reciprocity in Medicaid and SCHIP programs, especially since migrant children born in the U.S. will have citizenship status. Further research is needed to determine the extent to which Medicaid/SCHIP-eligible children do travel with their migrant parents and whether they are, in fact, not currently enrolled or receiving the health services they need.

Nonetheless, prospects for inter-state reciprocity may not be significantly better today than in the mid-1990s. Expanded state flexibility through statewide demonstration waivers and the SCHIP legislation have increased structural variations among state programs, and reflect states' interests in tailoring their own programs for their own populations. Overall, the current environment 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.

Apart from environmental changes, the basic structural constraints on migrant farmworkers' access to Medicaid eligibility and services, and on inter-state reciprocity agreements, remain. A "lesson learned" from the earlier effort is that the most viable model will be one which relies least on cooperative program adaptations among multiple states. The more promising approaches are likely to be state-specific initiatives to make their own Medicaid programs more accessible (see Subsection C.,

below), and/or inter-state models that can be driven by entities other than state Medicaid agencies (discussed in Subsection B., below).

The objective, of course, is not necessarily to enroll migrant farmworkers and their dependents in Medicaid, but rather to improve their access to the types of health services they most need. Consequently, it is important to consider prospects for reform in a larger context than solely inter-state reciprocity among Medicaid programs.

B. Opportunities through Public/Private Partnerships

A public/private partnership arrangement between state Medicaid agencies and a commercial health insuror or managed care organization might facilitate portable Medicaid coverage for migrant farmworkers. The MPR feasibility study surfaced options for purchase of commercial indemnity insurance and for creation of a "migrant HMO."

1. Purchase of Commercial Indemnity Insurance

In this model, each state enrolling a Medicaid-eligible migrant farmworker or dependent 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. Each state would retain its own eligibility criteria, and providers would respond to a widely-recognized health insurance company card. States are already authorized to purchase private health insurance for Medicaid eligibles when it is cost-effective to do so.

This approach is modeled after health benefits for private sector employees. Although private health insurance plans often limit out-of-state coverage to emergency services, employers can purchase benefits through multi-state insurance companies that can coordinate payment for services provided through affiliated plans in other states. For example, Blue Cross and Blue Shield (BC/BS) operates a National Account Association to which providers in any state can send claims for adjudication.

A similar model for migratory farmworkers in Texas operated for many years with BPHC grant funding to the Gateway Health Center, which purchased health insurance coverage from BC/BS for migrant farmworkers who enrolled in Webb County, Texas. Recently, however, enrollment was not sufficient to support financial viability given premium costs and limited grant funds.

Some of the issues and assumptions about a commercial health insurance model that were raised in the MPR study included:

> *How the insuror would adjudicate and pay claims despite variations in states' benefit packages, coverage limitations and payment rates.* It was assumed that participating states would agree on a basic benefit package and fee schedule. The benefit package would be limited to mandatory Medicaid services (except for long-term care) plus primary dental care for migrant children and prescription drugs. EPSDT-related benefits beyond the basic benefit package would be paid on a non-risk cost basis.
>
> *How to limit enrollment to migratory farmworkers, given the difficulty of identifying who will, and will not, "follow the crops" in the coming year.* It was assumed that by giving all seasonal farmworkers an option to enroll in their current state's traditional Medicaid program, or in the commercial insurance program with more limited benefits, only those likely to be out-of-state for extended periods of time would choose commercial insurance.

How to set premium rates without a relevant actuarial base. It was assumed that premiums based on historical use and cost data for migrants would be lower than for a demographically similar but geographically "stable" Medicaid population, so would not adequately reflect unmet need or the new-demand costs of portable coverage. Prospective premium amounts would be adjusted semi-annually based on actual payment experience during the first two years of the demonstration, and annually thereafter, based on the previous 18 months' experience. Premiums would include an industry-standard add-on for administrative overhead.

How to apportion costs among the states. It was assumed that the state that granted eligibility would pay the monthly premium for the period of enrollment. Because this could place an unfair liability on homebase states and be a financial disincentive for any state to facilitate enrollment, an annual reconciliation process would be necessary. States whose premium payments were less than amounts paid to that state's providers would either reimburse the over-paying states or have their premium contribution adjusted upward in the coming year.

There was also concern about the impact of this model on health centers that serve large numbers of migrant farmworkers and which are paid by state Medicaid agencies on a cost reimbursement basis.

In addressing the above issues, two variations on the model were considered. One modification would exclude the state of Medicaid enrollment, which would issue its regular Medicaid card for services rendered by providers in that state. Migrants presenting that Medicaid card upon application for benefits in other states would be offered the indemnity insurance enrollment option without undergoing a redetermination of eligibility. This would reduce premium costs (for a limited benefit package of only out-of-state services), facilitate out-of-state enrollment and foster receptivity among out-of-state provides. An alternative approach would be to have a commercial entity act as a non-risk-bearing fiscal agent to process multiple states' claims for services to migrants during the first two years, after which risk-based premium rates could be based on that actuarial data.

2. Contracts with Medicaid Managed Care Organizations

In the MPR feasibility study, an option to "Establish a Migrant HMO" (see the chart at VI.A.1, above) received only cursory attention. At that time, many state Medicaid agencies were less experienced with managed care arrangements and were focused on building mandatory enrollment programs for their own core Medicaid populations. Most states were not ready to craft a portable multi-state model for a small, special population.

Today, managed care is fairly well established in most state Medicaid programs, and state staff have become quite adept at program design and contracting. Nonetheless, difficult issues remain in contemplating managed care as a viable approach to improving health services for Medicaid-eligible migrant farmworkers.

Conceptually, managed care seems well-suited to the health and access needs of migrant farmworkers. A true managed care plan: assures access to care through its provider network; promotes preventive and primary services; and emphasizes continuity and coordination of care through each member's primary care provider (PCP). A good managed care organization could offer multi-lingual, round-the-clock member services and nurse advice toll-free hotlines, outreach, wellness and health education programs, and automated case management systems with provider access to centralized medical records information – unfettered by geography or political boundaries.

In reality, however, most managed care organizations (MCOs) are no more oriented to serving mobile enrollee populations than are traditional state Medicaid programs. Even MCO entities with affiliated plans in multiple states generally do not allow members to access out-of-state provider networks, except in emergencies or with prior authorization for a specific service. For any MCO risk plan, differences among states' administrative authorities and licensing, quality assurance and reporting requirements preclude offering a truly portable managed care product. Medicaid-specific Inter-state variations add to complexities for Medicaid managed care organizations (MMCOs).

However, regulatory and contracting requirements are generally somewhat less prescriptive for non-risk preferred provider organizations (PPOs) and, to some extent, for point-of-service (POS) plans that allow enrollees to use non-network providers (often subject to higher out-of-pocket costs.) Unlike risk MCOs that rely on tight control of closed, geographically cohesive provider networks, PPO entities are oriented toward building widely accessible provider networks. A PPO-type entity could offer a multi-state provider network, and administrative capability for e.g., member services, provider relations and claims adjudication. A migrant-specific network could improve culturally-sensitive access to services they most need, and could be built with active participation from health centers and other providers who currently serve large migrant populations. Prospects for a PPO- or POS-type managed care model for migrant farmworkers have not yet been fully explored, although the Texas Association of Community Health Centers has begun framing potential approaches.

A public/private partnership involving state contracting with a multi-state provider network designed to serve migrant farmworkers merits further consideration in today's Medicaid managed care environment. Some questions to consider in framing such a model include:

Whether a single state or multiple states would contract with the entity? Should the contract and related administration and oversight be the sole responsibility of a single (homebase) state within the PPO network's multi-state service area? Or, should all states within the service area contract with the entity and somehow share or delegate management responsibilities? If multiple states are involved, what licensing requirements would apply?

Whether a single state or multiple states should have financial liability for startup, operations and health services? If shared, how should costs be apportioned among the states and how should reconciliations be effectuated?

Whether the entity would be paid on a risk basis or not? Should there be a risk-bearing "parent" such as an indemnity insuror or risk MCO? If so, how would premium rates be set and financial solvency assured?

How to define a benefit package and provider payment rates? Should benefits and/or provider payments be specific to the migrant network product, or as per the Medicaid program of the contracting state(s), the state(s) of enrollment or the states where services are rendered?

Whether enrollment could occur in a single state or multiple states? If all enrollments were through a single contracting state, how could eligibility be maintained during extended periods of absence? Would migrants who are seldom or never in that state be excluded? If so, would people relocate to the contracting state to access enrollment there? If enrollment could occur in any participating state, how should that influence cost allocations among the states? Would migrants seek enrollment in states with more liberal eligibility criteria?

How to maintain coordination and continuity of care? Migrant enrollees would not always have face-to-face access to a designated PCP for their primary care and for referrals to specialty providers. Should the migrant's PCP use telecommunications to maintain a care management role wherever the migrant might be, or would PCPs be wary of authorizing specialty or hospital care by unfamiliar providers without first seeing the patient? Should the MCO/PPO entity assume such PCP-like responsibilities when the migrant is away from his/her PCP, or would this be too expensive or questionable from a quality of care standpoint? Should all PCPs in the multi-state network be expected to collaborate with a designated homebase PCP in managing the care of a migrant enrollee? Would PCPs be willing to do this, and how much more would it cost?

While those questions, and other managed care-related issues may appear daunting, there has not yet been an initiative to assess the feasibility of a multi-state, public/private partnership model.

C. Simpler, Readily Available Approaches

Systemic approaches such as inter-state reciprocity and managed care arrangements require lengthy and complex policy, political and operational development, with uncertain outcomes. More immediate, practical approaches can address some of the access barriers discussed in Section V. above and can be implemented within individual states. The following examples of potential approaches and existing models are offered to encourage further refinement or replication..

1. Facilitate Access to Enrollment

Tailor outreach and education about Medicaid and SCHIP eligibility, enrollment processes and service delivery to migrant farmworkers' particular interests and concerns. Guidelines and materials for outreach initiatives oriented to migrant farmworkers are being developed by BPHC's Migrant Health Branch.

Bring the enrollment opportunity to the applicant, with outstationed intake workers and enrollment sites in clinics, emergency rooms, housing centers, commercial areas and workplaces frequented by migrant farmworkers.

Provide education and enrollment opportunities at convenient times, such as evenings, mealtimes, and days when inclement weather precludes field work.

Join forces with Food Stamps and/or Head Start outreach, education and enrollment activities.

Recruit and train culturally/linguistically appropriate individuals to help with outreach, education and one-on-one enrollment assistance. Employ migrant family members, community volunteers, and/or utilize contracted outreach and enrollment entities. Outreach workers and/or care coordinators affiliated with local MHCs can identify individuals likely to be eligible for Medicaid or SCHIP, help them apply and following-up on eligibility determinations.

Farmworker Health Services Inc. (FHSI) is a BPHC/MHP grantee that establishes outreach programs in partnerships with MHCs and other providers serving migrant farmworkers and provides training and technical assistance on farmworker health issues. FHSI recruits and trains outreach workers who are placed with partner agencies and who are expected to relocate every six months to follow farmworkers as they migrate within 17 eastern stream states

The Redlands Christian Migrant Association (RCMA) supports MHCs in Florida with bilingual outreach teams that identify farmworker infants, children and adolescents who have been unable to access health, education or social services. Outreach focuses on health and dental screening, immunizations and TB testing, and identification of disabled children.

The Outreach NETwork, a grassroots initiative started by outreach workers in North Carolina, allows outreach workers throughout the country to communicate with each other via email.

2. *Streamline Eligibility Determinations*

Develop a simplified application form reflecting migrant-specific streamlined eligibility determination policies and processes.
Implement income averaging for migrant farmworker applicants. (See V.A.1.(b) above for methods, models and considerations.)

Exempt migrant farmworkers from mandatory enrollment in Medicaid managed care. (See V.A.3. above, regarding exemption approaches in New York and Wisconsin.)

Define migrant-specific criteria to authorize presumptive eligibility.

Assure state residency policies comport with federal regulations and are understood by intake workers, so individuals without a permanent abode and/or who have entered the state seeking employment are not inappropriately denied coverage.

Minimize documentation and verification requirements and processes. With the applicant's consent, query and accept documentation on file in other Medicaid/SCHIP jurisdictions.

Wisconsin implemented a single-state "reciprocity" approach in 1997, for migrant farmworkers who were in the state for ten months or less. Those with a Medicaid card from another state are determined eligible without further verification of financial eligibility. If at least two months' eligibility remains on the out-of-state card, individuals who meet Wisconsin's non-financial eligibility criteria are guaranteed eligibility in Wisconsin until the date that redetermination would be required by the originating state. At that time (and for new applicants without at least two months' eligibility remaining from another state) Wisconsin would conduct a full eligibility determination, with financial eligibility based on estimated prospective annual income, with redetermination after twelve months.

3. *Improve Access to Services and Continuity of Care*

Educate Medicaid/SCHIP providers/staffs about eligibility provisions specific to migrant farmworkers and their families. Assure providers are not misinformed about, e.g., immigration and state residency policies, presumptive eligibility, managed care exemptions, etc.

Implement requirements and/or incentives for providers to serve migrant farmworkers at convenient times and locations, to make service delivery culturally/linguistically appropriate and/or to support local migrant health centers.

Arrange for transportation for migrants to access community Medicaid/SCHIP providers.

Arrange for translation services to help with patient/provider encounters, and to assure the patient understands the provider's instructions for follow-up care.

Use culturally/linguistically appropriate lay health providers for health education, preventive care and to bridge the gap between health and social service providers and migrnt communities.

Since 1985, the Michigan-based "Migrant Health Promotion" (MHP) program has trained migrant farmworkers in several states as Camp Health Aides who provide peer health education, service information, support, translation and basic first aid. Training is also focused on HIV/AIDS, maternal and child health, tuberculosis and managed care.

A "Traveling Lay Health Advisor (TLHA)" program, implemented by NCFH in 1994, provides health education, outreach and referrals (emphasizing screening and treatment for breast and cervical cancer) through *consejeras de salud*, health counselors recruited from among farmworker women. Based in Texas and New Mexico, the *consejeras* receive intensive training and guidance through the program Director in Texas and coordinators at five upstream health centers.

Implement basic arrangements to pay for out-of-state care, such as in jurisdictions within predictable "restricted circuit" or "point-to-point" migration patterns. Identify and inform key Medicaid/SCHIP providers in those areas and establish a telephone and/or internet contact point for eligibility verification and billing assistance.

Implement or establish linkages with referral resources to foster continuity of care.

The NCFH "Call for Health" program offers a toll-free line for bilingual information and referrals for migrant farmworkers and migrant health clinic staff throughout the country. Referrals might be to the nearest migrant health clinic, local health department, bilingual physician and/or social services resources. Call for Health also pursues voluntary donations and specialty surgery on a case-by-case basis. The NCFH also produces a pocket directory of health centers which serve farmworkers, for the farmworkers themselves to carry and use.

Develop and support cross-state health data systems targeted to migrants' priority treatment needs.

With funding from the Migrant Health Program and the Texas Department of Health, the Migrant Clinicians Network operates the binational Migrant Tuberculosis Tracking and Referral Network (TBNet) to transfer TB treatment data to a 50-clinic network of TB care providers in the U.S. and Mexico.

Facilitate portability of migrants' medical records. Require Medicaid/SCHIP providers to give migrant patients a copy of their medical record documents. Arrange for migrants to have a durable, weatherproof carrier for their medical records and eligibility documentation.

With support from the BPHC's Migrant Branch, Collier Health Services, Inc. is testing applicability of the HEART FAX™ system to migrant farmworkers' medical records. HEART FAX was developed to access medical records of cardiac patients who spend part of the year in Florida. In the migrant farmworker application pilot, HEART FAX serves as a medical record clearinghouse, accessible 24 hours a day through a toll-free telephone number. Each migrant farmworker who enrolls carries a membership card with the 800 number, an access code and a PIN. When contacted by a clinician treating the individual at any location, the HEART FAX system transmits the individual's medical record data to the caller's fax machine. Collier Health Services reports (in the May/June 1999 issue of *Migrant Health Newsline*) that they are working to expand the initiative through health centers in the Eastern and Midwestern Streams.

4. Promote and Support State and Local Initiatives

Individual state Medicaid/SCHIP programs could implement or cooperate in many of the "simpler, readily available" approaches noted above. Given the scope of concerns and other special populations that Medicaid/SCHIP programs must attend to, special initiatives for migrant farmworkers need impetus and support from federal agencies and interested organizations. The following "sponsorship" activities could prompt and support state and local initiatives.

Focus attention on the need, and possibilities, for action. Use forums and publications that reach Medicaid/SCHIP program managers to educate them about –

migrant farmworker health status, Medicaid/SCHIP access barriers, and the limitations of current service delivery systems; and

specific actions they can take, on their own initiative within their own states.

Support state and local initiatives with –

constructive policy guidance specific to migrant farmworker issues (such as citizenship, state residency, eligibility streamlining and payment for out-of-state services);

"how to" documentation of operational approaches; and

technical assistance and resources to implement or replicate promising models.

Sponsor evaluations of operational models, with particular attention to the implications for Medicaid/SCHIP program operations, costs and benefits.

Conclusion

Systemic reforms and "simpler, readily available" approaches are not mutually exclusive. In fact, intensive short-term initiatives might foster the level of attention, knowledge of the technical challenges and possibilities, and commitment to eroding access barriers that would be needed to pursue larger, more innovative solutions.

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.

The immediate challenge entails martialing the forces critical to a constructive design process – the public and private sector policy-makers, advocates and potential players who could devise a promising model and make it succeed.

The alternative is to again assert that the challenge is too great, and the population too small and too silent, to justify critically-needed health system improvements for those individuals and for the larger public health of the country.

Resources: Organizations and Individuals

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www.bphc.hrsa.dhhs.gov/mhc

National Advisory Council on Migrant Health
Judy Rodgers, BPHC/MHB Staff Contact
(301) 594-4304

National Center for Farmworker Health, Inc.
PO Box 150009
Austin, Texas 78715
Bobbi Ryder, CEO
(512) 312-2700
www.ncfh.org

Migrant Clinicians Network
2512 South IH-35, Suite 220
Austin, Texas 78704
Karen Mountain, Executive Director
(512) 447-0770
www.migrantclinician.org

Immigrant Policy Project of the State and Local Coalition on Immigration
National Conference of State Legislators
Ann Morse, Director
(202) 624-8697
www.ncsl.org/programs/immig

Texas Association of Community Health Centers
2301 South Capitol of Texas Highway Bldg. H
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Migrant Legal Action Program, Inc.
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