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DRAFT FORM

Memorandum: Options for Expanding Publicly Financed Health Coverage of Migrant Farmworkers and their Families

Memorandum

To: Migrant work group

Fr: Sara Rosenbaum

Re: Options for expanding publicly financed health coverage of migrant farmworkers and their families

Date: October 20, 2000

Cc: Dan Hawkins, John Ruiz, and Heather Mizeur, NACHC

Introduction

This memorandum sets forth a series of options for improving publicly funded health coverage for migrant farmworkers and their families. After a brief background, I describe three basic approaches to the problem, setting out the strengths and limitations of each approach.

Background

For many years, policy makers, health professionals, policy analysts, advocates, and others have recognized that, because of their mobility, migrant and seasonal farmworker families face particularly serious barriers to coverage under state-based public programs such as Medicaid and SCHIP. Mobility creates two separate problems: an inability to successfully enroll in programs in the state of residence; and insufficient portability of coverage.

Enrollment-related problems. Mobility intensifies enrollment-related barriers Enrollment sites may be inaccessible in the remote areas in which migrant families may live and work. Because of unique language and cultural needs, families may have additional problems navigating the application process even when they have physical access to it. Families may lack the necessary documents that some states require because

they are on travel.[1] Finally, families may have to move before the eligibility determination process is complete and assistance is made available.

Portability-related problems: Even assuming that a family is able to enroll in Medicaid or SCHIP (where applicable) and gains coverage for the amount of time allowed under the state plan, (e.g., 3, 6 or 12 months) the utility of the coverage is severely limited once the family moves out of the state during the period of eligibility. Medicaid requires states to provide coverage for out-of-state services.[2] The categories of need that are recognized under the out-of-state service coverage requirement are quite broad: [3]

- Medical emergencies;
- Situations in which an "individual needs medical services and the recipient's health would be endangered if he were required to travel to his State of residence;"
- Cases in which "the state determines on the basis of medical advice that the needed medical services, or necessary supplementary resources, are more readily available in [another] state;"
- It is "general practice for recipients in a particular locality to use medical resources in another state."

Furthermore, a state Medicaid plan must provide that the state will "establish procedures to facilitate the furnishing of medical services to individuals who are present in the state and are eligible for Medicaid under another state's plan."[4]

Despite these comprehensive out-of state coverage and cooperation requirements, their effectiveness is unclear. Many states may be unfamiliar with the scope of the requirements. Even though the requirements could be interpreted to allow a state to justify coverage for virtually any covered benefit out of state (not just emergency or urgent care), many states may resist out-of-state payment arrangements with the exception of persons institutionalized out of state. Furthermore, even where a state is willing to reimburse for out-of-state care, it may be virtually impossible to find a health care provider willing to accept out-of-state coverage. Finally, of course, if coverage lapses while the family is out of state, the entire process must begin again.

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[1] Under federal Medicaid regulations, eligibility determinations must be completed for families with children within 45 days of application. The rate of mobility during the growing season may outstrip this time period, and many states may in fact take a longer time period to determine coverage.
[2] §1902(a)(16) of the Social Security Act; 42 C.F.R. §431.52
[3] 42 C.F.R. §431.52(b)
[4] 42 C.F.R. §431.52(c)

Many states have adopted certain application-related reforms (particularly for pregnant women and children), such as outstationed enrollment, presumptive (i.e., temporary) eligibility, expedited coverage determination procedures, and streamlined enrollment procedures. But even if these reforms reduce barriers (and their actual effectiveness for migrant enrollment has not been measured), these reforms alone cannot overcome the additional portability-related problems that migrant families face.

For these reasons, many persons have recommended the adoption of reforms that would provide portable coverage to migrant families, with full coverage available regardless of the state in which the family resides. Analysts also have recommended that portability reforms be accompanied by simplified eligibility standards and reforms in both outreach and enrollment procedures. The result would be a program that as a practical matter is national or regional in scope and operation.

Options for improving public coverage for migrant families

Over the years various options for improving public health coverage for migrant families have been discussed. These options range from improvements in current state plan operations (which could be done within the confines of current law), federal demonstrations that are broader in scope than what would be permitted under normal state plan operations, and federal legislation.

1. Encourage states to make maximum use of existing state plan provisions relating to coverage of residents and out-of-state coverage

Federal regulations provide that individuals are residents of the state in which they either intend to reside indefinitely or in which they are present for work-related reasons.[5] The work-related residency standard was added to the rules by the Carter Administration in 1979 specifically in order to foster coverage of migrant families.[6] In addition, federal regulations give states the option to enter into "interstate agreements" that provide for a modified definition of residency[7] and that set forth procedures for determining residency and resolving disputes. The rule specifies that "states may use interstate agreements to *** facilitate administration of the program."[8]

The interstate agreement authority, when combined with federal regulations related to payment for out-of-state care, would appear to authorize states to enter into a broad

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5 42 C.F.R. §433.403 (h)(3) adopts for Medicaid residency purposes the work-related residency standard in the AFDC program.

6 The change was contained in the original Child Health Assurance Plan legislation of the late 1970s. When the legislation died, the Administration separately issued the liberalized residency standards as a regulation, in order to ease access for migrant children and families.

7 42 C.F.R. §435.403(d)(2). Presumably, a state could only modify the federal definition to make it more liberal than the minimum federal standard would require.

8 42 C.F.R. §435.403 (k)

agreement under which, for Medicaid (and SCHIP)[9] purposes, families who meet the eligibility criteria of any participating state would be eligible for full coverage by that state for all covered care and services received in any of the states. Any family with a valid out of state card could be issued an in-state card to facilitate access to care, and the state issuing the in-state card would in turn bill the state of residence for care. While the coverage of the temporary state might differ slightly from that of the state issuing the temporary card, differences would probably be minimal. For example, pediatric coverage is essentially identical in all states. All states cover prescribed drugs, FQHC and RHC services, physician and hospital services, laboratory and x-ray services, and other services typically used by adults. All states cover pregnancy-related care.

Strengths: This proposal could be implemented by states with no change in current law. The out-of-area payment rules, coupled with the interstate agreement authority, would permit any state to agree to extend full out-of-state coverage to any state resident who is a member of a migrant farmworker family and who is working in one of the other states involved in the agreement. States that are members of the agreement could issue covered families who have valid cards from another partner state with additional identification to reduce the potential for providers to reject the card. Federal law would cover the costs of administering the interstate agreements at normal FFP administration rates.

Limitations: The rules do not allow states to waive comparability in order to adopt uniform eligibility rules and coverage standards for migrant families. Thus, there is the potential for variable eligibility standards and benefit levels. Without shared standards, the state in which the migrant resides could not automatically grant him or her full in-state coverage automatically and without a separate application. In addition, this model would require careful development in order to ensure proper identification of families eligible to participate and interstate payment procedures. States might be unwilling to devote the time needed to develop this state-administered model.

Furthermore, states might fear that in the event of denial of payment by another state, they would be stopped from denying financial liability to the provider that furnishes care on the strengths of the state's representation of payment. If the individual who receives the care is not enrolled in the state program and would not be eligible for enrollment, then the state would not qualify for FFP.

Finally, in states that mandate managed care as a condition of enrollment, the state from which the family receives Medicaid would have to adopt special standards for its MCO and PCCM contractors to authorize full out-of-state coverage for eligible enrolled families. Given the problems with MCO payments to non-network providers, providers in other states might be unwilling to participate. (A state could of course exempt migrants from managed care enrollment altogether, and a number do so.)

[9] There are no SCHIP regulations. However, the statute gives states the authority to establish residency as well as other eligibility standards.

2. Encourage states to come together under a broader §1115 demonstration authority to develop comprehensive migrant coverage demonstrations

Section 1115 of the Social Security Act authorizes the Secretary of HHS to waive otherwise applicable requirements of federal law to permit demonstrations that further program objectives. Using this authority, the Secretary could, in collaboration with states that wish to participate and experts and stakeholders, develop a multi-state migrant coverage demonstration under both Medicaid and SCHIP. The demonstration authority would permit the states to address those eligibility and coverage issues that cannot be reached through the interstate residency agreement rules alone.

Strengths: Under a §1115 demonstration, states could overcome the eligibility and coverage problems that would otherwise be present in order to design a program that is truly identical in all participating states with respect to coverage, provider compensation, and other administrative variables. Depending on the nature of the migrant health systems in the partner states, the states could even develop an interstate managed care program that would ensure access to care through an interstate network.

Limitations: Federal support for such a plan would be at the regular Medicaid/SCHIP payment rates and states therefore would have to devote financial resources, just as they would under the state plan option. In addition, greater enrollment by eligible families and better coverage through portability could increase program costs to both the state and federal government.

3. Seek legislation that would create a program of migrant family coverage in which states with high migrant populations could participate

Much attention has been focused on expanding SCHIP to cover families. Because the program is so elastic in structure, it might be possible to add new authority for greatly enhanced payments to encourage states to participate in a migrant coverage program. The program authority could permit states, experts in migrant health, and other stakeholders to come together with the Secretary to fashion eligibility, coverage and payment rules. In addition, the program could authorize the selection of a fiscal intermediary who would handle all claims arising from the program as well as the creation of an interstate migrant health network to facilitate access to care. Payments could be controlled through aggregate upper limits on authorized funds.

Strengths: This model offers the greatest flexibility and may increase the potential for state participation for a number of reasons. First, FFP rates could be set high Second, the coverage would be on a non-federal-entitlement basis, which might encourage more states to try the model. Third, states could agree to use a single shared intermediary in order to reduce the administrative burden of the program.

Limitations: New program authority and financing would be required. Both of the other models can be done without new legislation, and expenditures would be part of

the Medicaid and SCHIP baselines. Furthermore, other groups interested in specially tailored insurance programs for their particular constituencies (e.g., homeless persons and families) might decide to pursue similar strategies, leading to a Christmas Tree effect and Congressional disinterest.

Recommendations

I would recommend serious and simultaneous exploration of options 2 and 3. Option 1 might make a good starting point for a couple of states but the lack of authority to develop common eligibility and coverage criteria might prove to be a major deterrent for states already concerned over administrative complexity. The model also probably would not work as well for families as totally portable coverage. Since 2 and 3 both permit states to address these other matters, they seem preferable.

It is at least worth noting that HCFA could be more insistent regarding state adherence to the out-of-state payment rules, the outstationed enrollment rules, the eligibility determination timelines, and all other aspects of Medicaid that affect the quality of its performance for migrant families. But it is not clear what this would achieve or why HCFA would single out one subgroup of families. Moreover, recent interest in the problem suggests that a good deal more might be achieved through collaboration as opposed to aggressive enforcement.