Migrant Farmworkers, Medicaid, and State Children Health Insurance Programs: Barriers to Enrollment, Lack of Portability and Possible Solutions

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This DRAFT issue paper does not represent any particular policy interest or recommendation of the DHHS or the Secretary of Health and Human Services. Issues and concepts described do not constitute recommendations or preferences on the part of the Department, but are intended to promote discussion among experts at a DHHS-convened meeting on December 2, 2003.

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November 24, 2003

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Foreword and Purpose of Study

Section 404 of Public Law 107-251, the "Health Care Safety Net Amendments of 2002", requires the Department of Health and Human Services (DHHS) to report to Congress with a study of problems experienced by migrant farmworkers and seasonal agricultural workers in obtaining health services from the State-administered Medicaid and State Child Health Insurances Programs (SCHIP). Section 404 requires that a "Study Regarding Barriers to Participation of Farmworkers in Health Programs" be conducted that will summarize information on barriers to enrollment and the lack of portability of the Medicaid and SCHIP programs. The statute also identifies different possible solutions and requires the study to examine them (See Attachment 1).

This paper is organized to reflect the outline in the legislative requirement. First, a background section describes issues of access and portability. Then, sections on each of the six possible solution categories are presented. Solution areas include: interstate compacts, demonstration projects, use of current law flexibility, national migrant family coverage, public/private partnerships and other.

The congressional mandate directs the Secretary to consult with experts that have different areas of knowledge regarding health care for farmworkers. Responding to the mandate, the Department is hosting a meeting on December 2, 2003 that will bring together experts in the field and seek their input on this topic. Panel participants and observers are being provided this paper in advance of the meeting so that it will help focus the discussion around the different possible solutions outlined in the statute. The meeting will be facilitated by Larry Bartlett, Ph.D. of Health Systems Research, Inc., a consultant to the Department. Selected observers will be available as resources for the panel.

Background on Medicaid and SCHIP: Barriers to Enrollment and Lack of Portability for Farmworkers

Migrant farmworkers and seasonal farm laborers provide labor for the compensation they receive from farmers and growers in the United States at farms that are planted, tended, and picked seasonally and/or annually. Many farmworkers change residency frequently as they move within and across the United States to perform this work. The agricultural economy is of critical importance to the U.S. economy. In 2002, $26 billion in cash farm receipts were reported annually in California alone.[1]

Farmworker employment may be of short duration and available to workers willing to travel almost all the time, contrary to most job arrangements. Most Americans consider farm work to be difficult, laborious, and low paying. As a result, farmworkers are drawn to this nation and arrive from Haiti, Jamaica, Asia, Central American nations and, especially, the Republic of Mexico. Although 58% maintain their home in the United States, only about 19 percent of all farmworkers are U.S.-born.[2] Many farmworkers migrate across States, often across recognized "migrant streams" along the Eastern seaboard, within the South, Mid-West, and mountain regions, and along the West coast.

Social and economic institutions in American society are organized around the concept of "place". Residence serves as a key factor for obtaining a social security number, registering for public education, and qualifying for innumerable private sector benefits including bank accounts, credit cards, and bank loans. However, social and economic institutions organized around an identifiable home address are not optimally designed for those without a home address or a home address in a far away State. Providing services for those eligible for public or private benefits, but with lives characterized by constant changes in residence, is a challenging problem.

Improving farmworker health is impacted by a large number of factors and does not rest solely with healthcare organizations working in a farmworker community and health insurance programs. These may be seen to include:

Nationalities and Ethnic Origins

The U.S. Department of Labor estimates that there are approximately 2.5 million U.S. agricultural workers.[3] A little over a quarter (28%) of these workers are engaged in beef, poultry, fish and other livestock production and the rest are engaged in crop production, including horticultural products, cash grains, fruits, nuts, and vegetables.[4] In fiscal year 1999-2000, 50 percent of those who engaged in crop production were migrants, 55 percent were unauthorized to work, and 85 percent were foreign born. Among the foreign born, 97 percent were born in Mexico. Approximately one third (31%) were citizens and legal permanent residents while two thirds (65%) lacked authorization to work in the U.S.[5] In addition to being largely foreign-born and undocumented, farmworkers are predominantly male. Only 20 percent of the farmworker workforce was female in 2001.[6]

Language and Culture

Foreign-born farmworkers usually know only their native language. Most are limited in their ability to speak, read, write, and understand the English language. The primary language of many agricultural workers is Spanish; only 12 percent speak English. In addition, most farmworkers possess only a few years of formal education. They average 6 years of education, but nearly three quarters (73%) completed their education in Mexico. An increasing number of migrants from Southern Mexico and Central American speak one of several indigenous languages and may or may not speak Spanish or English. By one standard of literacy, most farmworkers (85%) would have difficulty obtaining information from printed materials in any Language.[7] The ability of medical and/or other service personnel and farmworkers to understand each other is made even more complicated by the beliefs, attitudes and cultural philosophies of many farmworkers.[8]

Immigration Laws Enforcement and Labor Turnover Rate

The high number of undocumented farmworkers may reflect consequences of the Immigration Reform and Control Act of 1986 (IRCA) but also a high and possibly growing turnover rate among hired farmworkers. Despite IRCA's intent to curtail the entry of undocumented immigrants, enforcement of the law's employer sanctions provision may allow growers and labor contractors to continue using inexpensive undocumented workers. Low wages, poor benefits, and high incidence of injuries and accidents in agriculture contribute to a high turnover rate, which also contributes to an undocumented workforce. Nearly a third of foreign-born workers are newcomers who have arrived in the U.S. within the last two years and most (70%) lacked authorization to work. Considering that the average stay in agriculture for a worker is between five and six years, as older, experienced workers continue to leave agriculture, the quantity of undocumented workers is bound to increase.[9]

Labor Market Surplus and Outcomes

Despite a strong economy and increasingly widespread prosperity in the 1990s, farmworkers became economically worse off, and their health status failed to show improvement. For example, between 1989 and 1999, the gap between farmworker wages and those of all production workers widen, and real wages declined.[10] These outcomes are seen as symptomatic and indicative of a national oversupply of labor due to increasing numbers of undocumented immigrant workers. Labor supply shortfalls are one means of improving worker wages, fringe benefits, and living and working conditions. Although shortfalls develop through constricting grower access to foreign workers, foreign worker programs provide employers the means to remain economically competitive.[11]

Coordination of Migrant and Seasonal Farmworker Service Programs

Our nation's key worker protections like minimum wage, the forty-hour workweek, child labor provision, unemployment insurance, Social Security, and legal protections for union organizing, which came into existence with the New Deal legislation of the 1930's, specifically excluded farmworkers.[12] The plight of migrant farmworkers became a national concern in the 1960s leading to the creation of federal government service

programs to help meet their needs, and over time, many have come to serve non-migrant seasonal farmworkers as well. Today, farmworkers draw upon the assistance of approximately 10 migrant and seasonal farmworker specific service programs and numerous other general programs such as food stamps or Medicaid. In addition, farmworkers often qualify for other services provided by state and local government, or funded through private initiative, each governed by its own particular definition or eligibility standard. As with these state and local programs, each Federal program has its own definition of migrants and/or seasonal farmworker, intake procedures, as well as eligibility standards. The result is a potential for overlap of some services and gap in others. Moreover, because each agency has its own mechanism to generate program statistics and estimates of the target population, which vary widely in method and scope, there is a lack of reliable system for gathering data, which has led to varying pictures of the nation's population of migrant and seasonal farmworkers.[13]

Predominantly Male Workforce

The predominance of a male farm labor force has both increased health risks and hampered the use of health care services. In some cases, migrant labor camps are composed primarily of single males. This male workforce has hampered health care service use because, when compared to women, men seek less health care. For example, a statewide study of California farmworkers found that more than a third of women reported a medical visit within the previous five months and nearly 75% had a medical visit at some point in the prior two years. But among men, nearly a third, said they had never been to a doctor or clinic in their entire lives and just under half reported a doctor or clinic visit in the prior two years.[14] Also, very limited recreational facilities, social isolation, and cultural sanction of prostitution, has resulted in a high incidence of sexually transmitted disease in these camps. In the east coast stream, in particular, a high incidence of both prostitution and intravenous drug use has been observed within some farmworker communities.

Language and Cultural Barriers and Health Seeking Behavior

The language barriers faced by farmworkers in need of medical care and/or social services limit their ability to critical public health, hospitals and other medical and social services to which they are legally entitled. Many health and social service programs provide information about their programs only in English and rely on receptionists, eligibility workers, nurses, and doctors who only speak English. According to the Office of Civil Rights, persons with limited English proficiency (LEP) who are eligible for federally assisted health and medical care and social services are often excluded from programs, denied medical series, and suffer long delays in the receipt of health and social services. In addition, they can receive inaccurate or incomplete information or fail to receive notice of or fully understand what services are available to them. To help deal with this problem, the Office of Civil Rights has issued a Guidance Memorandum describing a variety of options to use by health and service providers in addressing the language assistance needs of LEP persons, and to ensure they are not discriminatorily denied equal access to or an equal opportunity to benefit from health and social services programs on the basis of national origin.[15]

Difficulties in communication between medical personnel and farmworkers due to language barriers is further complicated by the beliefs, attitudes and cultural philosophies of many farmworkers. Ointments, herbal remedies, and massages are typical solutions to a variety of injuries and illnesses. Indigenous peoples, in particular, such as the Mixtecs, hold serious reservations about visiting a health clinic even when health services are free, preferring instead to frequent a tribal doctor or midwife. In addition, farmworkers often understand chronic pain as a normal part of work and will seek care only when the pain becomes sever and disabling.[16]

Utilization of Health and Other Service Programs

Although typically in the most need, unauthorized workers are the least likely to seek out help. Because of their status, they frequently tolerate employer abuses and don't report injuries or illnesses. Despite the low annual incomes of farmworkers, few use contribution-based services or needs-based services. For example, in the case of contribution-based services, only a fifth used unemployment insurance, and only 1% used disability insurance or social security. In the case of needs-based services, such as temporary assistance to needy families, WIC, Medicaid, and public housing, just 17% of all farmworkers used needs-based services.[17] Women who are pregnant often do not inform their supervisors or employers about their pregnancy reasoning that they would be replaced with other unemployed workers. Even in the case of workers legally authorized to work in the U.S., fear of reprimand or retaliation by their employer may keep them from seeking help. In addition, most of their earned income goes to food, clothing and other necessities, so things like health care falls near the bottom of their personal priorities. In those instances when they do seek medical attention, many farmworkers cannot afford to return for follow-up care. Rather than seek health care, in many instances, farmworkers turn to home remedies or return to Mexico for treatment. Availability of and access to health care facilities also contributes to the low use of service programs. Health centers often are not open in the evening hours, and farmworkers are unwilling to lose wages to visit the center during the day. High clinic fees and the fact that many farmworkers do not own motor vehicles and must depend on others for transportation also contribute to low use of medical health services. Because of their migratory existence, farmworkers often are not aware of services available in the various locations where they work.[18]

Farmworker Housing and Living Conditions

Farmworker low household income and housing costs impact both the quality and quantity of housing. Not only is farmworker housing often very crowded, in many cases these units lack adequate sanitation and working appliances. Serious structural problems such as sagging roofs and porches are also prevalent. In addition, a significant proportion of farmworker housing is directly adjacent to pesticide treated fields. Crowded conditions are associated with increased incidence of infectious diseases such as tuberculosis and influenza. Lack of sanitary facilities contributes to hepatitis, gastroenteritis, and other conditions. Water leakage and broken windows expose residents to dust, mold, mosquitoes and other rodents and insects, which can contribute to poor health. Children are especially vulnerable to the health and safety risks posed by pesticides in the home, poor quality, and overcrowded conditions.[19 20]

Limited Knowledge of Government and Private Service Programs

Another area of concern regarding factors that impact farmworker health care is their limited knowledge of government and low cost private services. In part because of the high turnover rate, but also because of migration, poverty, limited English proficiency, and other factors, many farmworkers are unaware of laws to protect them. For example, farmworkers laws like Workers' Compensation Insurance, the Worker Protection Standard, and the Federal Field Sanitation Standard are often unknown to them. This lack of awareness, in combination with their demographic characteristics, keeps many hired farmworkers from reporting incidents or seeking aid for health problems.[21]

Immigration Laws and Climate of Confusion

Immigrant farmworkers face many of the barriers to health and health care as experienced by non-immigrant low-income individuals. Others are specific to immigrant populations, such as welfare reform, fear and confusion over benefit eligibility, and cultural and linguistic barriers. The lasting effects of The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996, for example, restricted Medicaid eligibility of legal immigrants, so that those entering in the country could not receive coverage during the first five years in residence, except in the event of an emergency. Prior to this, legal permanent residents and other legal immigrants were eligible for Medicaid benefits on the same terms as citizens. The lasting effect of PRWORA and other efforts created a climate of confusion where immigrants eligible for Medicaid benefits are likely to remain uninsured for fear of jeopardizing their citizenship status.[22]

Migrant Clinic Factors

It is estimated that migrant and rural outreach services provide services to 20 percent of the full population of hired farmworkers. Among the areas of concern are the lack of occupational medicine training among clinicians, financial burdens due to cutbacks in migrant clinic funding, and language and cultural differences between farmworkers and clinicians that makes communication with each other difficult.[23]

Illness and Participation in Insurance Arrangements

Similar to many other segments of our society living at or below the Federal Poverty Level (FPL), migrant farmworkers are at increased risk for illness and disease. Studies show that they suffer from higher serum cholesterol, high blood pressure, and obesity more than the general population.[24] They also have low participation rates in publicly funded health programs. The National Agricultural Workers Survey (NAWS) 2001-2002 indicates that five percent of farmworkers have publicly-funded health insurance.[25] The California Agricultural Workers Survey (CAWS), modeled on the NAWS and performed in 1999, reported seven percent of respondents covered by public-funded programs.[26]

In a survey of health service use by children of migrant farmworkers in North Carolina, 44 percent of children had visited a doctor in the preceding three months, of these, 11

percent had coverage by some form of insurance. Of the whole sample, 20 percent had Medicaid and 4 percent had SCHIP.[27] This survey found that "migrant children using health services are distinct from nonusers with regards to socio-demographic factors, enabling resources, and need for care". Users were more likely to be younger children and had lived in the area for six or more months.[28]

Interestingly, results from the 2001-2002 NAWS indicate significant differences in insurance coverage across three groups of migrant farmworkers defined as "settled", "migrant", and "newcomers". The more settled the worker, the more likely that the worker and family lived in the area and that family members had publicly-funded health insurance. This finding was consistent across the Eastern, Midwestern and Western migratory streams.[29] When considering possible solutions to barriers in enrollment in Medicaid and SCHIP and lack of portability, it may be useful to consider the very different characteristics across these three "length-of-residence" defined migrant and seasonal farmworkers.

Although these issues are not described further here, all these factors appear to contribute significantly to barriers in health insurance enrollment, and the lack of insurance portability as experienced by farmworkers and seasonal farm laborers, as defined by the Public Health Services Act.[i]

Barriers to Enrollment

Section 404(a) language: "Barriers to their enrollment, including a lack of outreach an outstationed eligibility workers, complicated applications and eligibility determination procedures, and linguistic and cultural barriers."

Medicaid is designed to provide health care benefits to certain categories of women, children, low-income families, and aged, blind and disabled individuals. SCHIP programs are available to income children with incomes higher than the Medicaid thresholds and certain adults in limited circumstances. Both these programs operate under Federal statute and regulations that define complex parameters of eligibility, coverage and payment. States, and often counties, are authorized to administer and implement these programs. Program variation greatly increases the complexity experienced by participants. This complexity is compounded further for migrant farmworkers across the multiple States where they live and work each year.

The consequence of the design and implementation of Medicaid and SCHIP programs is that "virtually every aspect of the current Medicaid/SCHIP policies and program

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[i] Section 404 specifies that a "farmworker" is a migratory agricultural worker or seasonal agricultural worker, as such terms and are defined in section 330(g) (3) of the Public Health Services Act (42 U.S.C. 254c (g) (3)), and includes a family member of such a worker. The PHS Act defines "migratory agricultural worker" as "an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode. A "seasonal agricultural worker" is "an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker."

structure makes access to enrollment and services difficult for eligible farmworkers and their families".[30] Given the cultural and lifestyle differences between migrant children and typical children, helping migrant children meet standard quality measures requires much work and coordination among providers.[31] There is a need for more case management, parent education, tracking efforts, and language services to help migrant children achieve positive health outcomes. A number of specific program barriers have been identified and portrayed in a taxonomy with corresponding statutory or regulatory sections identified, and possible program changes that might be attempted.[32] (See Table 1).

Barriers to migrant farmworkers' access to the Medicaid and SCHIP programs have been the subject of much study and discussion over the last couple of decades. The following barriers to access have been consistently identified by stakeholders:

Barriers Related to Citizenship and Immigration Status
Only United States citizens and nationals and qualified aliens are eligible for regular Medicaid and SCHIP coverage. Non-qualified aliens, a group which includes undocumented immigrants, are only eligible for emergency medical services under Medicaid, and only if they are otherwise eligible for Medicaid. They are not eligible for SCHIP. Therefore, migrant farmworkers who are undocumented immigrants are not eligible for Medicaid or SCHIP coverage.

Those migrant farmworkers who are nationals or qualified aliens who are not eligible for public benefit programs due to their immigration status may think they are also not eligible for Medicaid and SCHIP because they are not eligible for other public benefit programs due to their immigration status. Furthermore, migrant farmworkers who are nationals or qualified aliens might be reluctant to apply for Medicaid or SCHIP for fear that their receipt of public benefits might affect their immigration status.

Finally, migrant farmworkers who are citizens, nationals, or qualified aliens, but who have family members who are non-qualified aliens, might fear applying for Medicaid or SCHIP for fear that they will place those family members in legal jeopardy.

Categorical Eligibility Requirements
To be eligible for Medicaid, an individual or family must fit into an eligibility category or group. Generally, the eligibility categories are limited to low-income families, pregnant women, children, and aged and disabled individuals. Non-disabled, childless adults, or non-disabled adults living apart from their children, are not categorically eligible for Medicaid. Generally, SCHIP eligibility is limited to children. Thus, since many migrant farmworkers are single adults, or parents who live apart from their children, they are not categorically eligible for Medicaid or SCHIP.

Residency Requirements
Federal regulations define "residence" as either the state in which a person is living with the intention to remain there permanently or for an indefinite period or the state in which a person is working. Therefore, migrant farmworkers can apply for Medicaid in either

the state in which they make their permanent residence or in the state in which they are working at that time. If they receive Medicaid from their "home state," they might have difficulty receiving services in other states as the providers in those states might not be willing to accept out-of-state Medicaid cards. If they apply for Medicaid in their work state, they might have difficulty accessing its benefits as they might not be in that state long enough to complete the enrollment process or to receive medical services if they do complete the process. The SCHIP residency requirements are a little different than Medicaid. Section 457.320(d) allows states to establish whatever SCHIP requirements they want with the exception that states cannot impose a durational residency requirement. However, we have seen states require that applicants "intend to stay in the state" which could be harmful to migrant farmworkers.

Differences in States' Eligibility Policies
Because states have flexibility to establish eligibility groups and income and resource standards for Medicaid and SCHIP, migrant farmworkers and their families may be eligible for the program in one state, but not another, even if their income and resources and family composition remain constant.

Documentation Requirements
Medicaid, non-citizens applicants must provide proof of their immigration status. In SCHIP, states have the option to allow self-declaration of citizenship status. State Medicaid and SCHIP programs can impose other documentation requirements on applicants and recipients. In addition, all Medicaid applicants must provide the state with their Social Security Number, if the State chooses to require it. Migrants who travel frequently may not have immigration documents, social security cards, or other personal information in their possession; therefore, they may have difficulty completing the application process.

Income Computation Methods
Even if the migrant farmworkers families' annual income is below a state's income standard, the individual or family might not be income eligible for Medicaid or SCHIP because the state can calculate annual income based on income for a shorter period that exceeds the families' average monthly income.

On the other hand, a state's use of average annual income to determine income eligibility might hurt migrant farmworkers' families in the months in which they are not working if their average monthly income is higher than their income for that month.

Barriers to Completing an Application
Migrant farmworkers may have difficulty getting to a Medicaid or SCHIP office to complete an application due to a lack of transportation, or due to office hours that are limited to typical business hours in which a farmworker would be in the field. They might also not have access to technology, such as telephones, fax machines, or computers, that would enable them to file or complete an application without having to

travel to an office. And if they can get to a Medicaid or SCHIP office or get an application, they might confront language barriers that make it difficult to complete the application process.

Barriers to Receiving Services
Migrant farmworkers might have difficulty accessing providers due to a lack of transportation and demanding work schedules that overlap with physicians' office hours. Futhermore, many providers might be reluctant to treat migrant workers because of an unwillingness or inability to provide language assistance services, to accept an out-of-state Medicaid card, and/or to establish a short-term relationship with a patient.

Farmworkers who receive Medicaid in a mandatory managed care environment might have even more difficulty accessing providers. First, they might have difficulty understanding how to select and enroll in a managed care plan. Second, they might have difficulty finding a plan provider, particularly a specialist, in a rural area.

Lack of Portability

Section 404(a) language: "The lack of portability of Medicaid and SCHIP coverage for farmworkers who are determined eligible in one State but who move to other States on a seasonal or other periodic basis."

States routinely pay out-of-state Medicaid/SCHIP claims based-on third party billing arrangements in emergencies, for services across State lines, or under foster care arrangements. However, they are generally not organized or able to facilitate portable health insurance coverage. Program variations make administrative coordination and efficient operation across programs difficult. The different configurations of Medicaid and SCHIP both State-only SCHIP, and Medicaid-combined programs further exacerbate interstate program complexity.[33]

Three basic portability models have been proposed. First is a "State-based" model in which beneficiaries enroll in one State program where they work. Second a "portability" model would enable farmworkers and family members to receive coverage in their home state (especially Florida, Texas, and California) and then carry that coverage to receiving States (such as Michigan, New York, and Washington). Third, a range of "hybrid" options from multi-state cards to individual interstate reciprocity arrangements have been considered and/or partially developed.[3435] The modified Taxonomy below at Table 1 portrays barriers and potential solutions across these models.[36]

Table 1: Eligibility & Portability Taxonomy

Barriers	Current Statute or Regulation	Goal & Change Mechanism
General Eligibility		
Categorical eligibility restrictions that preclude coverage of non-disabled childless adults	1902(a)(10)	Farmworkers as an optional eligibility group: • §1115 demonstration; or • Statutory change
Financial eligibility barriers: • Low financial eligibility standards • Restrictive methods for calculating financial eligibility • Budgeting systems that create problems for persons with fluctuating income.	Sections 1931 and 1902 (r)(2) authorize less restrictive standards and methodologies for determining applicants' countable income and resources.	Establish less restrictive methodologies for counting income received on a contractual or intermittent basis • Latitude defined in program guidelines.
No special recognition of farmworkers as a distinct eligibility group or groups: • Newcomers • Migrants • Settled	§§1902(a) (1) and (17) (statewideness and comparability) would appear to be satisfied by eligibility criteria that might most benefit farmworkers.	Establish special eligibility category: • By statute (e.g., breast and cervical cancer patients). • Program guidance clarifying flexibility not violating comparability or statewideness • To include flexible treatment of itinerant labor income, tools for farm work, etc.
Citizenship, national, or qualified alien status necessary for full versus emergency coverage only (all other conditions of eligibility being met).	1903(v)	**Basic coverage for otherwise eligible non-qualified aliens:** • **§1115 demonstration; or** • **Statutory change**
State Based Model		
The eligibility determination time period is long in relation to farm worker travels (45 days). • Enrollment delays resulting from limited enrollment sites, • limited assistance in a primary language, • limited access to	Current law sets reasonable promptness test. (§1902(a)(8)). Outstationed enrollment a requirement at all FQHCs (§1902(a)(55) and presumptive eligibility permissible for women and children. (e.g.,§1902(a)(47)). Medicaid is subject to LEP	Facilitate eligibility determination adapted to farm worker residency: • Program guidance and clarification on state options in presumptive eligibility for

Barriers	Current Statute or Regulation	Goal & Change Mechanism
application process by individuals whose residency is brief and based on temporary employment	guidelines as a condition of Title VI of the 1964 Civil Rights Act.	farmworkers and families;
Inaccurate application of Medicaid residency test	42 CFR 435.403 addresses residency linked to work or job seeking.	Assure accurate application of Medicaid residency test: • Program guidance on farm worker eligibility and options; • Assess and monitor consistency of residency determinations.
Absence of immediate disenrollment and re-enrollment provisions as residency changes & absence of efficient verification processes	Current law bars more than one state Medicaid enrollment at a time. Current law permits the elimination of virtually all required proof except immigration status.	Facilitate State-to-State verifications and transfer of eligibility: • Implement electronic enrollment & disenrollment and interstate information exchange; • Develop a multi-state cards; • Exercise limited verification requirements, use self-declaration, honor (but verify) out-of-state cards.
<u>Portability Model</u>		
Brief enrollment periods and frequent redetermination that precludes long duration enrollment	Current regulation permits states to establish longer enrollment time periods (up to 12 months) and less restrictive income methodologies for those with intermittent income.	Enable longer enrollment and modified verification procedures: • Program guidance on comparability and budgeting periods for those with intermittent income.
Lack of clarity regarding which services can be covered on an out of state basis and under what conditions	Current rules at 42 CFR 431.52 allow out of state payment when the need is urgent or out of state usage is customary.	Clarify that interstate travel makes out of state usage of primary care customary: • Program guidance encouraging this for farmworkers.
Lack of access to out of area providers willing to accept out of state cards	(§1902(a)(16)) requires states to have procedures for providing medical assistance to absent state residents.	Encourage states to develop prompt payment and administratively simplified arrangements:

Barriers	Current Statute or Regulation	Goal & Change Mechanism
	Current law also uses "urgency" and "custom" to guide out of state payment policies.	• Deem all migrant health centers that are FQHCs as qualified providers for all state Medicaid programs for purposes of out-of-state billing through one application; • Modify payment principles to pay for translation services in accordance with Title VI requirements.
Lack of prompt payment for interstate claims	Current law requires prompt payment of clean claims (§1902(a)(37))	• Encourage sending and receiving states to develop special provider and intermediary outreach and education.
Absence of Managed care portability beyond home states.	Current law (§1932) requires coverage of emergency care, and states are permitted to pay for customary out-of-area care.	• Program guidance on out-of-area coverage requirements; • Interstate compact for health plans.
Multi-State Hybrid Model		
Inability to enroll quickly as farmworkers travel from one state to another.	None	Facilitate multi-state eligibility and enrollment: • Interstate compacts on eligibility; • Web-based technologies accessible by States, providers, payers, and Farmworkers or their representatives; • §1115 demonstration allowing uniform cross-state eligibility standards for a subclass of individuals (farmworker families), enrollment in any one state, and a multi-state card that provides for payment by state in which treatment is rendered.
Reciprocal Model		
Inability to make use of an out-of-state card because of provider non-acceptance	None	Facilitate interstate reciprocity: • Interstate compact permitting immediate issuance of in-state card

Barriers	Current Statute or Regulation	Goal & Change Mechanism
		by work-related residency • Agreement on use of one application or eligibility determination, so long as the applicant has a valid and current card from state of origin.

Potential Solutions Under Current Medicaid and SCHIP Program Authority

Section 404 (b) language: "Use of current law Medicaid and SCHIP State plan provisions relating to coverage of residents and out-of-State coverage."

Rather than pursue initiatives subject to intensive review and approval, many States discover innovative ways to change their Medicaid and SCHIP programs through the broad discretion allowed in the design of the Medicaid/SCHIP State Plan, and program changes available through sections 1915 (a), (b), (c), and (d). In addition, inter-state compacts may be developed under current authority so that multiple States can work together, if they can agree on a common set of goals, criteria, and plan for implementation. Some strategies for developing solutions using current law authority are:

Begin with the concept and examine how it may be implemented, what changes would be necessary and whether sufficient flexibility can be found such that the initiative maintains original goals under current limits;

- Assess all the relevant enabling resources available to solve a problem, determine an optimal configuration for achieving a policy goal, examine alternative ways under current authority that may hold promise, select the optimal method for implementation;

When a preferred goal may not be attained under current authority, determine whether modifying the approach in order to fit within current authority would result in an acceptable design such that desired outcomes may be achieved sufficient to avoid the section 1115 demonstration process.

The following model options are provided to illustrate how these strategies may be utilized in the development of a program change.

Coordinated and Enhanced Outreach and Consumer Education for Migrant Farm Worker Women and Children

Option:

Assure that migrant farm worker families, especially women and children, are made aware of their potential Medicaid/SCHIP program eligibility through improved coordination of existing program resources where it may be expected that these families will have contact as they change employment and residency status.

Maximize program efficiency and cost-effectiveness through improved coordination and collaboration of resources and improved health outcomes for program beneficiaries.

Possible Activities:

- Identify community programs and health services now required or likely to serve migrant women and children:
    - Hospital Emergency Departments, birthing units, clinics, and social services/discharge staff;
    - National Health Service Corps physicians and other Pediatricians, obstetricians, nurse practitioners, physician assistants and promotoras de salud;
    - Migrant education programs;
    - Mobile health units;
    - Women, Infants, and Children Nutrition Programs;
    - Migrant Health Clinics;
    - Food Stamp programs;
- Determine reasonable and achievable steps whereby the identified range of program resources may collaborate on a plan, and then implement local-level improvements;
  Target particular geographic areas defined as "hard to reach" in the 2000 United States Census and/or Health Manpower Shortage Areas for community health and education services and information;
  Adopt a one-step application/enrollment process;
  Meet with employers to share information and resources;
- Cross-train staff from various programs to facilitate referrals, staff communication and program knowledge and understanding;
- Develop coordinated beneficiary information and education materials for use in community and beyond i.e. print, Radio/TV, web-based, and 800 phone;
- Add scoring weight for program coordination in Public Health Services Act section 330 grant awards;
  Coordinate with private foundations that work on SCHIP and Medicaid outreach, e.g. the Robert Wood Johnson Foundation, California Endowment, and the Kaiser Family Foundation, to target migrant farmworkers and their families.

Considerations:

This example is presented as an initiative that may involve very few, if any, statutory or regulatory barriers. Rather, implementation prospects may vary depending on the ability and willingness of local, County, State, and Federal agencies and staff to work together to improve and fund current practices that would result in better outreach and access.

Migrant Farm Worker Medicaid/SCHIP Primary and Secondary Coverage Model

Option:

Develop and implement portable Medicaid coverage across multiple States;

Concept:

Using an inter-state or multi-state compact, establish common features as may be necessary and appropriate under current Medicaid fee-for-service, 1915(a) pre-paid health plan or 1915(b) managed care authority as may include: presumptive eligibility, annualized income (or other treatment of income), length of guaranteed eligibility, arrangements for home-state primary payment, and processes for receiving state secondary payer arrangements through fiscal intermediaries and/or pre-payment arrangements;

Possible Project Activities:

- Examine package of desired features that may be incorporated within current law i.e. wider use of existing self-declaration of residency rules etc.;
- Negotiate agreements with other States (or among counties) as feasible;
- Determine exact responsibility of each State in their primary and/or secondary payer role in the initiative;
- Consider improvements in carrier-to-carrier coordination;
- Assess financial requirements necessary and available to start-up prospective arrangements;
  Develop provider contracts to develop service networks, operational capacity, operational protocols and implement initiative; and
- Develop information resources i.e. print, web-based, and 800 numbers

Considerations:

This scenario is based, if only in part, on the concept developed as a request for contract in Texas by the Health and Human Services Commission that was attempted under current authority in 2002. Although not implemented, as yet, the model serves as an excellent example of innovation based on current program authority.

Mandated Enrollment Health Plan Portability Model

Several States mandate mandatory enrollment for Medicaid recipients in Statewide health reform initiatives under section 1115 or 1915(b) waivers. Arizona, California, and Oregon are often cited as examples. Exceptions to managed care enrollment may exist in rural areas, for migrant farmworkers and other Medicaid-eligible populations, or depending on variations of county systems. This model is designed to be an example of a potential solution under these broad health reform initiatives.

Option:

To facilitate continuous eligibility and portability within/across health plans and States for Medicaid/SCHIP eligible and participating enrollees.

Concept:

Using inter-state or multi-state compacts, States agree to facilitate the continuous managed care coverage for migrant farmworkers enrolled in managed care organizations. As workers migrate across a stream of States, continuous coverage would be provided through a network of affiliated health plans, specially contracted to accept and serve migrant farm worker enrollees.

Potential Activities:

- Payment apportionment and processing responsibilities of managed care organizations and States would be negotiated in the compacts and health plan contracts;
- Specified presumptive eligibility and facilitated eligibility determination processes may be tied to documented changes in residency status in collaboration with employers;
- Employer contributions may enhance supplemental benefits made available to enrollees, perhaps transportation or on-site delivery of specified primary and preventive services;
- The same corporate or non-profit plan may be available to the enrollee as that entity operates separate contracts in different states;
- Managed Care contracts may be designed whereby contractors will accept bona fide enrollees from other plans or other states for specified periods of time, with appropriate verification from the plan and State of origin;
- Migrant Health Centers could contract with range of managed care contractors.

Considerations:

The number of migrant farm worker and seasonal laborer families currently enrolled in Medicaid managed care plans is not known, but may be estimated. As managed care continues to evolve as the dominant Medicaid and SCHIP financing mechanism across the United States, portability options within existing managed care health plan and provider networks may be consistent with overall State program policy goals.

Via, Vouchers, Primary Care Case Management, Provider Networks, and Migrant Health Centers

Option:

Optimize resource value through strategies attempt to integrate program authorities so as to facilitate enrollment, access, and portability of insurance for Medicaid/SCHIP eligible migrant farmworkers.

Concept:

Through existing program authorities, combine the resources of Medicaid and Migrant Health Centers (MHC) and new technologies that enhance portability options.

Possible Activities:

- Migrant Health Center, or other, physicians would contract with State Medicaid agencies as Primary Care Case Managers (PCCM) under the authority of 1915(b);
- Physicians would serve as medical homes for farmworkers. Enrollees could qualify for extended eligibility provisions afforded under 1915(b);
- Monthly payment to physicians would be for primary care, care coordination, pharmacy management, translation services, and to serve as medical home when and wherever the enrollee travels for work.
- Payment rates might be risk-adjusted reflecting variation between settled, migrant, or newcomer status of the enrollee;
- Employer contributions could be sought to enhance the PCCM benefit package available to their employees, perhaps including sufficient funds for VIA web-based systems operations or 800 phone numbers;
- Physicians, nurse practitioners, promotoras de salud, eligibility specialists, and "in-stream" coordinators could facilitate PCCM functions, provide required translation services perhaps with partial support for staffing through Public Health Services Act grant funds;
- PCCM could manage prior authorization of Medicaid services, and provide a link to other physicians and providers across the participating stream States and MHCs;
- PCCM functions could include maintaining and updating VIA migrant farm worker web-based information, designed to contain essential diagnostic and program eligibility information. Summary medical and program eligibility information could be available immediately for providers from the PCCM and others given access to this secured information by consenting migrant farmworkers;

An interstate compact representing agreements made by multiple States to offer the PCCM option per 1915 (b) and other features such as measures to expedite eligibility determinations, provisions for presumptive eligibility, and specified Medicaid/SCHIP state plan services payment arrangements and processes, and coordination information and outreach could be developed;

- Coordinated information for WIC, Medicaid, SCHIP, Migrant Education and other programs could be disseminated by print, the internet, 800 phone number; and

  Vouchers, as are available through the Public Health Services Act, could be provided as necessary and appropriate under current rules as workers moved up and down migrant stream States, and across counties in some states. Medicaid could be payer of last resort for eligible beneficiaries requiring services beyond that which vouchers could cover assuming appropriate approval by the PCCM.

Considerations

The options and concepts described above, serve as examples of possible solutions to barriers to enrollment and lack of portability in health insurance. They illustrate how Federal, State, local and private sector programs may be reconfigured and coordinated at the local level. Until specific details were developed, it could not be determined whether current State Plan authority exists to accomplish a particular goal.

Potential Solutions Through Interstate Compacts

Section 404(b) language: "The use interstate compacts to establish eligibility reciprocity and service portability for Medicaid and SCHIP and provide potential financial incentives for States to enter into such compacts."

Concepts:
An interstate compact is an agreement between states that provides the framework for formalized interstate cooperation. By establishing and joining an interstate compact on medical assistance to migrant farmworkers, states can more readily recognize each other's eligibility determinations and to reimburse out-of-state providers; therefore, they can provide more seamless Medicaid coverage to migrant farmworkers. Financial incentives might encourage states to join such a compact.

Potential Activities:

- CMS could enter into a cooperative agreement with a grantee to administer the interstate compact and will provide ongoing technical assistance to the grantee;
- The grantee would establish relationships with state Medicaid agencies and organizations representing providers and migrant farmworkers, could help collect statistics on the number of interstate migrant farmworker cases and the nature and costs of services provided them, conduct an annual meeting with states, develop communications vehicles to share relevant policy information, act as a liaison to the CMS regarding unresolved issues, and provide public awareness and training regarding interstate Medicaid for migrant farmworkers;
- CMS could develop a policy for providing financial incentives to states to provide Medicaid coverage to migrant farmworkers who move between states;
- State-to-State compacts may not require Federal approval depending on the nature of the agreement.

Considerations:
This model has been effectively employed, in the form of the Interstate Compact on Adoption and Medical Assistance (ICAMA), mandated by Congress, to provide more seamless Medicaid coverage to interstate adoption cases. Since ICAMA was established in 1986, 45 states have become members.

The CMS might need Congressional authority and/or appropriations to enter into a cooperative agreement and provide a financial incentive to states. Once CMS has the authority to provide financial incentives, it will most likely need to develop regulations to provide them. States might have difficulty tracking migrant farmworkers' Medicaid cases because, unlike in the case of adopted children, special eligibility groups do not exist for them.

Congress and the States might not be as motivated to facilitate interstate Medicaid coverage for migrant farmworkers as they have been to facilitate coverage for adopted children.

Potential Solutions Under Section 1115 Research and Demonstration Waiver Authority

Section 404 (b) language: "The use of multi-state demonstration waiver projects under section 1115 of the Social Security Act (42 U.S.C. 1315) to develop comprehensive migrant coverage demonstration projects."

Background:
Research and demonstration waivers under section 1115 of the Social Security Act offer the Federal and State governments broad authority to examine changes in the health care service delivery and financing systems that serve Medicaid and SCHIP participants. Special Federal Project Funds (SFPF), may also be authorized for use under this authority as special financial match.

Many aspects of Medicaid and SCHIP may be waived through section 1115 that are not easily altered under existing State Plan authority. Examples are included below both to illustrate how a variety of program changes may be combined into an innovative program design and as potential solutions for consideration.

Only States may apply for waivers of section 1115. Providers and others interested in forming a demonstration initiative may work with States in the development of initiatives. These requests are submitted to CMS for a substantial and comprehensive review of programmatic and budgetary impacts. Applicants are generally advised to consider a section 1115 waiver only when no other existing authority may be used to accomplish the desired outcome.

Option: Changes in Benefits and Coverage

Innovative demonstrations involving Section 1115 waivers may include changes in benefits and coverage for defined eligible groups with less than state-wide application. These include waivers of amount, duration and scope and statewideness.

Concepts:

- Groups of States might agree to develop and implement a standard benefit package targeted for eligible migrant and seasonal Farmworkers and families. Participating states would agree, through Interstate Compact, to offer a standard fully capitated basic health plan and/or primary care case management (PCCM) option. Under this arrangement enrolled farm worker members and families may be provided the opportunity to access the same set of benefits across those states participating in the agreement;
- Specific services may be offered that may not otherwise be approved under a State Plan. For example, States may seek pay for, promotoras de salud community workers or a 1-800 phone number for coordinated program information targeted to farmworkers;

- Because State Medicaid and SCHIP programs vary, coverage in individual states could be modified to achieve the standard benefit package. States above median benefits might be expected to maintain current level of efforts by offering additional benefits and services while those below may bring benefit coverage up to the agreed upon standard through subsidies by employers and/or other Federal, State, private, or in-kind funding sources;
- If fee-for-service Medicaid approaches were to be considered, services and benefits not approved in the State Plan could be offered through a demonstration waiver;
- Disease/Pharmacy management and care coordination services could be demonstrated and evaluated. Many proven and effective disease management strategies could be made more widely available to farmworkers with enhanced care coordination to include inter-State coordination and referral;
  Rural and field-based mobile health units and telemedicine initiatives could be tested;
- Federally and State funded health centers and Medicaid programs could work in tandem to examine and test specific strategies expected to enhance farm worker access and portability in a cost-efficient manner. For example, many years of migrant health center experience with promotoras de salud provide a potential platform to test the provision of such services through Medicaid waiver demonstration with approved provider arrangements;
  Public/Private and employer/employee initiatives could be attempted that might otherwise not be possible under Medicaid State Plan authority.

Option: Changes in Eligibility and Enrollment

Section 1115 authority enables changes in eligibility in Medicaid and SCHIP.

Concepts:
Some changes that States might want to test include:

In combination with other section 1115 waivers, presumption of eligibility strategies could be tested that verified and determined eligibility in one State so as to confer immediate presumption of eligibility in other States per Interstate Compacts and operational implementation. Time limitations on the length of the presumption period could be made subject to State discretion;

- States could consider using WIC eligibility and portability features as a template for Medicaid and SCIP programs;
  Streamline State eligibility processes through the use of the Internet and/or other proposed communication technologies; (Higher Federal match can be provided for improvement of State administrative data systems). Through these changes, some of which may require section 1115 authority, States could agree to develop cross-program interfaces facilitating migrant farm worker access and portability;
- Eligibility changes to assure access to standard benefit package. If a number of states agreed to provide a standard benefit package, eligibility changes that a

particular state might want to make in association with changes in coverage and payment could be tested;

- Eligibility policies and procedures. Some States may want to test the effectiveness of changes in the length of time between re-determining program eligibility. Also changes in methods of, and periods for, calculating recipient income and assets could be examined.

  Streamlined eligibility procedures and operations among States, counties, and health plans may be developed to test systems to facilitate improved access to health care and portability of coverage.

Option: Payment

In combination with Section 1115 waiver authority to changes per section 1902, payment changes are permitted through Section 1903 of Title XIX . Recent changes in Medicaid regulations that require actuarial certification of Medicaid managed care payment rates and the development of comprehensive diagnosis-based risk adjustment payment methodologies now in use by Medicare and other payers may serve as examples of financing demonstration strategies for consideration.

Concepts:

- A standard benefit package may be priced for actuarial Equivalence state-by-state so the each State's cost for the benefit may be determined vis-à-vis the cost for the same package across all other states in a compact. States with financing needs necessary beyond the means for Medicaid to provide the standard package may seek to combine public/private funding sources to achieve adequate financing under a demonstration waiver. Actuarial certification may make apportionment of public and private financing responsibilities more standardized, negotiable, and predictable such that variations of cost-sharing and, in some instances, beneficiary co-insurance may be tested across payers and geographic areas;
- In association with disease/pharmacy management initiatives and capitated payment demonstrations, application of comprehensive risk adjustment payment systems could be tested across payers and geographic areas. Payments based on clinical complexity could be demonstrated and evaluated. For example, States with diagnosis information for a farm worker could assess the expected cost to provide a standard benefit package, or any other defined benefit package based on the costs of those with similar diagnosis scores within the State. Although such payment approaches are now utilized by Medicare with the Medicare + Choice, other payers may be interested to apply these increasingly accurate methodologies in their financing systems;
- Voucher payments for eligible farmworkers to use with designated providers. Under the Public Health Service Act, community health programs may issue vouchers to farmworkers for them to access health services where no community health center is available. In some states all community health services available per the Health Resource Services Administration programs are now paid through

voucher arrangements. Medicaid and SCHIP services paid for in a similar manner could be examined under the demonstration waiver authority;

- Limited Special Federal Project Funds may be applied in support of any of the above examples, with approval. If budget resource allocations enable it, additional matched funds would be available. With the small amount of funds available through this authority, program investment based on this strategy must necessarily be of limited scope.

Considerations

As mentioned above, by law, only States may apply to test Medicaid and SCHIP demonstration concepts under Section 1115 authority. States may work with external partners in the development of initiatives. Many States use Section 1115 authority for broad health care reform initiatives i.e. Arizona, and Oregon. However, States, working with CMS, have used this authority for more modest initiatives over many years.

Demonstration waivers sought by the States are subject to review and approval by the Department of Health and Human Services. Of crucial importance is the budget neutrality of each proposal. Budget neutrality is required under Section 1115 authority and implemented per the budget policies of the Office of Management and Budget. In the case of SCHIP demonstrations, including HIFA demonstrations, proposals must demonstrate allotment neutrality. It is difficult to emphasize enough the significance of implementing budget neutral or budget saving proposals. Generally, considerable time, effort and expertise is required in order to develop, seek approval for, and implement demonstration initiatives. These initiatives are generally required to include research evaluation plans and strategies. So as to emphasize through repetition: Section 1115 waivers are to be sought by States only when no other means may accomplish the goal under current Medicaid and SCHIP program authorities.

The examples provided above do not represent any particular policy interest of the Department of Health and Human Services or the Secretary of Health and Human Services or the Centers for Medicare & Medicaid Services. They are presented only as a means to illustrate how specific types of Medicaid and SCHIP changes may be made under the demonstration authority.

Potential Solutions Through Public-Private Partnerships

Section 404 (b) language: "The provision of incentives for development of public-private partnerships to develop private coverage alternatives for farmworkers."

Option
States could develop premium assistance programs with employers of farmworkers and use a commercial insurance plan to provide the coverage. The federal government or foundations could help provide the incentives to develop these programs by financing initial start-up costs for states.

Concept
Premium assistance is a concept where public funds, such as Medicaid dollars, are used to help workers pay the premiums necessary to enroll in employer-sponsored health insurance. There are two different types of premium assistance:

- The traditional approach is where the state or Medicaid agency checks to see if an applicant has access to employer coverage when they are applying for public coverage. If the applicant has access to employer-sponsored coverage, the state pays the employee share of the premium and the applicant enrolls in the employer-sponsored coverage.
- Alternative approaches use public funds, such as Medicaid matching dollars, to encourage expansion of employment-based coverage for low-income workers and their families. A few counties in Michigan have used this approach to provide coverage to low-income workers. In these counties, employers, employees, and the county governments split the premium cost three ways. In general, premium assistance helps provide coverage of workers, promotes cost savings from the states' perspective by accessing employer contributions, encourages job stability and attachment to the workforce.

This option focuses on the possibilities of applying the alternative premium assistance approach to provide coverage to farmworkers. In this case, a group of states could work with growers and other employers of farmworkers to pool their financial resources to pay for coverage of employees. Employees could contribute a nominal amount in the form of co-payments. Employers and a consortium of states could agree to what the employer contribution should be. It could be a fixed amount or a fixed percentage of the premium. Then the states could subsidize the remainder of the premium. In order to address portability issues, the employers and states could select a commercial insurance carrier with business in these states to provide the coverage.

Considerations:
In order to develop a premium assistance program for farmworkers, certain issues have to be considered. Some of the issues include the legal authority, benefits, financing, a service delivery system, and the "provision of incentives" outlined in the statute.

Provision of Incentives

The congressional mandate indicates that this option should include the "provision of incentives" to help develop public private partnerships for private coverage of farmworkers. There are two questions associated with this issue: Who provides the incentives? And, what type of incentives should be provided.

- Who provides the incentives?
  This could be the federal government, state governments, foundations or others with an interest in seeing farmworkers get health coverage. No matter who provides the incentives, there has to be the political will to offer the incentives, as well as the financial capacity to deliver them.

  What type of incentives?
  The incentives could be grants, tax credits, or other sorts of funding to help pay for development of public-private partnerships. If the premium assistance model is used, the incentives could help pay for states' start-up costs in getting these programs off the ground.

Legal Authority

If Medicaid funds are to be used, the states could use Medicaid's current statutory authority, or section 1115 waiver authority for greater flexibility on benefits and program design.

Current statutory authority requires that premium assistance programs be cost-effective relative to the cost of providing direct coverage. Some states have developed premium assistance programs for their Medicaid beneficiaries using the current authority. Using this approach would be administratively simpler for states since they would not have to submit and receive approval of an 1115 waiver. However, if this approach is used, states are restricted in their ability to design a premium assistance program in terms of benefits and eligibility.

Alternatively, a consortium of states could use 1115 waiver authority and submit a waiver simultaneously. By using an 1115 waiver, the states and employers would have more ability to design the premium assistance program how they wish. For example, an 1115 waiver would allow states to create different benefit packages, and extend coverage to childless adult male farmworkers who are not normally eligible for Medicaid. The use of section 1115 waiver authority requires that the waiver being proposed is budget neutral. Evidence that the program will not spend more than it would in the absence of the waiver is required in the approval process. Using employer contributions for coverage could be included to make this approach budget neutral.

The Administration has initiated a new type of 1115 waiver called the Health Insurance Flexibility and Accountability (HIFA) initiative. HIFA waivers give states more flexibility on benefits and cost sharing, while encouraging partnerships with the private sector through premium assistance programs. This type of waiver could be used to extend premium assistance coverage to farmworkers. A benefit of using a HIFA waiver

is that states can use both their Medicaid and SCHIP funds to pay for coverage under the waiver. If SCHIP funds are used in a waiver, states can only spend up to the allotment, which is a capped amount of money.

Benefits

States and employers could develop one standard benefit package across the participating states or have different benefit packages in each state.

If states keep their existing benefit packages and offer different benefit packages across the states, they would not need a waiver to do this. Different benefit packages would make the premium assistance program more difficult to administer from an insurer's perspective, and more difficult for the beneficiary, but it would be easier for states in the short-term since they would not have to re-define benefit packages.

Alternatively, states could standardize their benefits for farmworkers across the states. If standardizing benefits made the package different than that for its regular Medicaid population, then states would have to submit an 1115 waiver. States cannot provide different benefit packages to Medicaid enrollees unless they have a waiver.

Financing

States and employers could contribute to the cost of insurance premiums. The employer contribution could be a fixed dollar amount or a percentage of the premium. States could subsidize the remaining portion with Medicaid or SCHIP funds. If the states were interested in finding additional financial partners, they could turn to foundations or other organizations interested in seeing this population covered.

Service Delivery

States and employers would have to find a commercial insurance product that would cover health services in rural, farming communities and have business in participating states. This most likely form of coverage would be either an indemnity insurance product or a preferred provider organization (PPO). Health maintenance organizations typically do not have established networks in rural areas. States and employers, through the premium assistance program, could contract with one insurer or possibly multiple insurers that would be willing to offer coverage.

Some issues need to be considered when thinking through the use of a premium assistance model to extend coverage to farmworkers:

Premium assistance programs are not easy to administer;
It may be difficult to get states and employers to finance this initiative because of the costs and time involved;

- If states choose to submit a waiver together to adjust benefit packages, the waiver process can take time to navigate, even though the Department has made strides in making the process move more quickly.

Potential Solutions Trough National Migrant Family Coverage

Section 404 (b) language: "The development of programs of national migrant family coverage in which States could participate."

Option:
Create through Federal legislation a new program to provide insurance coverage for migrant farmworkers and their families, with national eligibility standards and coverage rules.

Concepts:
Under this option, there would exist a single federal eligibility standard for migrant farmworkers and their families applicable across States that would allow them access to a standard package of benefits. A single fiscal agent could process all program claims and access to care could be facilitated through development of a delivery network which could use existing migrant health centers as key primary care delivery sites.

There are various ways this option could be financed, with differing degrees of State involvement. At one extreme, this program could be entirely Federal, structured as an entitlement, a capped entitlement like SCHIP, or a discretionary program. Alternatively, the SCHIP program could be modified to allow States to participate in a national migrant program, with enhanced SCHIP FFP, or an independent new program could be created, structured somewhat like SCHIP (match could be enhanced to encourage State participation), in which States could participate at their option. Finally, a Medicaid eligibility category for migrants and their families could be created. States could choose to participate if this were an optional category; or be required to participate if the category were mandatory.

Considerations:
A "national" approach would address many of the current problems associated with differing cross-State eligibility standards and portability.

This approach would pose difficult but not insurmountable questions in terms of what national standard would be used for eligibility, the content of the benefit package, and establishing an adequate delivery network.

The thorniest question, however, would be financing. No matter how this program would be structured, it would require new Federal legislation and some level of new Federal funding. Unless it were structured as an entirely Federal program (an unlikely scenario), it would also require State buy-in. To the extent States did not buy in, some of the same problems of portability would continue.

Current budget constraints at the national and State level make new categorical coverage unlikely. Also, opponents might argue that establishing a new category of coverage for this group could lead to other special populations seeking similar benefits.

Other Possible Solutions

Section 404 (b) language: "Such other solutions as the Secretary deems appropriate."

For the purposes of discussion it may be helpful to include a number of topic areas for which specific solutions may relate to possible solutions identified in the other areas. Such categories may include:

- Definitions of "migrant farmworkers"
- Technological Innovation
- Research and Data
- Bi-National Issues

End Notes

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