Harvesting Solutions:
The Development and Implementation of State Models To Increase Farmworker Access to SCHIP and Medicaid

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I. ABSTRACT

Migrant farmworker access to Medicaid has been an issue of discussion at the federal and state levels for a little over 10 years, since first brought to the attention of the Health Resources Services Administration in a 1992 recommendation from the National Advisory Council on Migrant Health. In recent years, various recommendations for policy and procedural reforms have been made, and relevant issues have surfaced. This paper brings a new dimension to the challenge of improving access to needed health benefits by documenting initiatives underway in Wisconsin, and under development in California, Texas, and Michigan. In addition, it sets forth a series of definitions for frequently used terms, often subject to varying interpretations, in order to establish a standard vocabulary that will facilitate dialogues at the state and national levels.

II. INTRODUCTION

A. Purpose

Much has been written about the health risks of the migrant farmworker population, and the obstacles they and their families face in establishing eligibility for publicly funded health benefits and in accessing health services. In recent years, various recommendations for policy and procedural reforms have been made, and relevant issues have surfaced. This paper brings a new dimension to the challenge of improving access to needed health benefits by documenting initiatives underway in several states.

In the interest of facilitating constructive dialogue about prospects for operational reforms, this paper also defines terms frequently used in discussing potential models, i.e.: "reciprocity," "portability" and "presumptive eligibility."

The specific purpose of the paper is to promote improvements in eligible migrant farmworkers' access to Medicaid and/or State Children's Health Insurance Program (SCHIP) health services, through a broader awareness of:

- Current models under active development;
- Lessons learned from those efforts;
- Practical recommendations for facilitating and/or replicating operational models; and
- The prospects for constructive initiatives in today's environment.

The potential for practical initiatives focused on Medicaid/SCHIP coverage for a specific target population depends not only on local efforts of dedicated program managers, but on the attention and knowledgeable support from a broad array of policymakers, providers, advocates, stakeholders, grantmakers and researchers – at the state and federal levels, and in related social service and agricultural labor enterprises. This paper is oriented to that larger audience, to foster awareness of the contributions they can make, and the importance of their support in bringing workable solutions to fruition.

B. Content

Section III, *"Background and Recent Developments"* presents an overview of literature relevant to facilitating Medicaid/SCHIP coverage and health service access for migrant farmworker families. It summarizes recommendations made in that research and by national advisory councils, and discusses recent events and circumstances likely to influence the prospects for and the shape of viable reforms in the current environment.

Section IV, *"Current Models"* presents the different approaches underway in states that have taken the initiative to develop workable reforms. The models described include: the operational interstate reciprocity in Wisconsin's Medicaid/SCHIP eligibility determinations; intra-state portability and inter-state reciprocity under development in California (in collaboration with Washington and Oregon) and presumptive eligibility for SCHIP-eligible farmworker children migrating to California; creation of a multi-state migrant care provider network sponsored by Texas; and Michigan's expansive "Plan of Action for Improving the Health of Migrant and Seasonal Farmworkers." The defining characteristics and status of each model are described, as

well as the developmental strategies and operational methodologies being pursued in each model.

In addition, Section IV presents insights from the developmental experience to date, from the individuals working with each of the models and from the authors of this paper. Lessons learned specific to each model and involved state(s) are discussed, as well as observations applicable to any such initiatives, regardless of model type. Areas of emphasis include: approaches to collaboration with multiple parties and interests; significant or unanticipated challenges; environmental factors affecting the shape and pace of reforms; and prospects for replicability in other geographic areas or state programs.

Chapter V, *"Observations and Conclusions"* presents practical suggestions related to development, expansion or replicability of the alternative models, including:

- Defining realistic objectives and action plans;
- Setting priorities and monitoring progress;
- Raising awareness and garnering support from policymakers and stakeholders;
- Soliciting and maintaining effective collaborative relationships among key parties;
- Collecting critical data and information;
- Assessing cost-benefit and budgetary feasibility; and
- Establishing policies, administrative mechanisms or definitional clarifications that would foster successful initiatives to improve coverage and access for Medicaid/SCHIP-eligible migrant farmworkers and their families.

C. Caveats

This paper is not intended as a comprehensive analysis of all facets of migrant farmworker demographics, health status and risks, nor of data or budgetary considerations that would inform larger national policy or program reforms. The Bibliography and the Resources Appendix do, however, reference individuals, agencies and literature that can provide useful information and insights for such broader interests. Also, the numerous barriers migrant farmworkers continue to confront in trying to access Medicaid/SCHIP eligibility determinations and health services are described in detail in several of those resources.

Note also that the descriptions of models presented and the related "lessons learned" reflect the initiatives' status in the months prior to publication. Because each initiative is a dynamic and iterative process, readers are encouraged to contact the National Center for Farmworker Health and/or key individuals involved in each state to keep abreast of the evolving status of each model.

For purposes of this paper, the term "model" is used to describe different types of approaches or initiatives to increase farmworker access to Medicaid and SCHIP. As such, a model is considered to be a distinctive approach which may be in any stage of development: i.e, a conceptual idea; undergoing operational design and development; or fully operational. Although not operational at the time of this writing, three of the models (California, Texas and Michigan) are in developmental phases. They are actively being worked on through collaboration between

state primary care associations (PCAs), state agencies, and other parties as described in Section IV.

D. Definitions

Certain terms often subject to varying interpretations are defined below, as they are used for purposes of this paper.

The terms *"migratory agricultural worker," "seasonal agricultural worker" and "agriculture"* were defined in the Health Centers Consolidation Act of 1996, Section 330(g) (Public Law 104-299, October 11, 1996); i.e.:

"Migratory Agricultural Worker" means an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last twenty-four months, and who establishes a temporary abode for the purposes of such employment.

"Seasonal Agricultural Worker" means an individual whose principal employment is in agriculture on a seasonal basis, and who is not a migratory agricultural worker.

"Agriculture" refers to farming in all its branches, including:

(a) cultivation and tillage of the soil;
(b) the production, cultivation, growing and harvesting of any commodity grown on, in, or as an adjunct to or part of a commodity grown in or on the land; and
(c) any practice (including preparation and processing for market and delivery of storage or to market or to carriers for transportation to market) performed by a farmer or on a farm incident to or in conjunction with an activity as described in (b), above.

For purposes of this paper, ***"Migrant Farmworker (MFW)"*** encompasses low-income *migratory agricultural workers* and their dependents that travel with them. Seasonal agricultural workers, and dependents of migrant farmworkers, who remain in one home-base state or jurisdiction are subject to many of the same health care access barriers as migrant farmworkers are, but do not face some of the unique problems related to establishing health benefits eligibility, portability of coverage, and access to services that are experienced by migrant farmworkers.

"A State Resident" is defined in federal law (section 1902(b)(2) of the Social Security Act), regulations (42CFR431.52) and guidelines (State Medicaid Manual Section 4230), for purposes of Medicaid eligibility, as one who is living in the state with the intention to remain there permanently, or who entered with a job commitment or seeking employment.

"Presumptive Eligibility" refers to an expedited Medicaid/SCHIP eligibility determination for an applicant, based on streamlined documentation requirements, which grants immediate coverage for a temporary period of time pending full verification of eligibility for an extended period of coverage. Presumptive eligibility may be provided as a Medicaid and/or SCHIP state plan option limited to defined target groups of applicants, such as children under age 19, pregnant women (for ambulatory prenatal care only) and/or women diagnosed with breast or cervical cancer. The allowable period of presumptive eligibility coverage is generally limited to the time

from determination of presumptive eligibility by a state-designated qualified entity, to the date a full, formal Medicaid/SCHIP eligibility determination is made. However, if the individual fails to file a formal Medicaid/SCHIP application, presumptive eligibility is terminated at the end of the month following the month in which presumptive eligibility was determined.

"Continuous Eligibility" is another state plan option that can be offered to Medicaid/SCHIP-eligible children and/or pregnant women. Continuous eligibility can be useful to migrants who experience intermittent or seasonal fluctuations in income. Children under age 19 can be granted continuous eligibility for up to twelve months, even if there is a change in circumstances that would make the child ineligible, such as income or assets. States can designate an age level (up to age 19) and/or the period of time (up to twelve months) in electing the continuous eligibility option for children. Pregnant women may be granted continuous eligibility throughout the pregnancy and postpartum period, regardless of changes in income or assets. Continuous eligibility is only available to individuals who have been determined to be eligible for Medicaid/SCHIP; it is not available to those in presumptive eligibility status.

"Reciprocity" refers to policies of an individual state that recognize Medicaid/SCHIP eligibility determinations made by another state. For example, state A may accept state B's (or any other state's) currently active Medicaid card held by an applicant in determining eligibility for benefits in state A. Reciprocity may convey automatic eligibility in state A, or may be limited to acceptance of the other state's determination of financial eligibility, categorical eligibility, or other specific eligibility requirements. Even when limited, reciprocity expedites and simplifies the eligibility determination process in the applicant's current state of residence. Reciprocity can take two different forms:

> ***"Unilateral reciprocity"*** refers to a single state's policy of accepting eligibility determinations, in whole or in part, from other state(s), while not requiring cooperation or inter-state agreements for mutual acceptance of eligibility determinations among the participating state(s).
>
> ***"Inter-state Reciprocity"*** refers to an agreement among two or more states to accept each others' eligibility determinations, in whole or in part.

Note that ***"intra-state reciprocity"*** is required by federal law (Section 1902(a)(1) of the Social Security Act) and regulations (42CFR435.916 and 435.930), requiring that a state plan must be applicable statewide. As clarified in a December 4, 2000 "Dear State Medicaid Director" letter from CMS, an otherwise-eligible person who moves from one county to another may not be required to re-apply for coverage in the new county of residence, unless there is evidence indicating other changed circumstances that might affect eligibility status. Timely case record transfer and uninterrupted coverage is required between the affected counties.

"Portability" enables a Medicaid/SCHIP-eligible person to access health benefits while away from the state that issued the individual's Medicaid/SCHIP card. The issuing state retains responsibility for facilitating access to and reimbursement of out-of-area covered services, unless special arrangements have been made with other states. For example, states may enter into inter-state agreements governing the cost of such services, or to facilitate provider acceptance of out-

of-state eligibles or provider billing for services. Inter-state fiscal agreements might address, e.g., costs of out-of-state services not covered by the originating state, differences in participating states' provider payment rates, reconciliations based on utilization patterns and/or other such arrangements.

III. BACKGROUND AND RECENT DEVELOPMENTS

A. Summary of the Literature on Models and Prospects for System Reforms

This Section focuses on potential models surfaced in conjunction with past initiatives toward developing operational reforms to facilitate Medicaid/SCHIP coverage of migrant farmworkers and their families. Those initiatives have also generated specific recommendations for policy and administrative reforms, which are summarized in Section B., below.

Just over ten years ago, the federal government began serious deliberations toward a demonstration project to facilitate continuity of coverage across state lines for Medicaid-eligible migrant farmworkers. In response to a 1992 recommendation of the National Advisory Council on Migrant Health, and in collaboration with the Migrant Health Program of the Public Health Service's Health Resources and Services Administration (HRSA), the Health Care Financing Administration (HCFA; now the Centers for Medicaid and Medicare Services (CMS)) contracted with Mathematica Policy Research, Inc. (MPR) for a feasibility study of an interstate Medicaid reciprocity program.

In September 1993, MPR submitted an in-depth background paper entitled, "A Feasibility Study to Develop a Medicaid Reciprocity Program for Migrant and Seasonal Farmworkers." The study focused on problems inherent in the basic Medicaid framework, such as interstate variations in eligibility, benefit packages, provider reimbursement and claims processing. The background paper presented: profiles of the migrant population; their unmet health needs and barriers to care; state Medicaid program characteristics affecting access to enrollment and services; estimates of the number of Medicaid-eligible migrant farmworkers and expected demonstration program costs; and objectives, key issues and preliminary options for structuring a demonstration.

In February 1994, a subsequent MPR paper, "Options for a Demonstration to Improve Medicaid Coverage of Migrant Farmworkers and their Families" presented nine specific demonstration model options within three strategic approaches: cross-state agreements on eligibility (interstate reciprocity); single-state eligibility with portable benefits (portability); and purchase of non-Medicaid insurance or managed care. The nine potential models are summarized in a later report, "Improving Health Service Access for Medicaid-Eligible Migrant Farmworkers" (Kenesson, September 2000).

Based on discussions with the study's expert panel and with Medicaid program managers from six states in the eastern migratory stream, two models were proposed for further development as an operational demonstration: an "Interstate Eligibility Transfer" reciprocity model and "Purchase of Commercial Insurance," a public/private partnership portability model involving interstate cost sharing, and building on states' existing option to purchase commercial insurance

in lieu of standard Medicaid when it is cost-effective to do so. Those models are described in more detail in Section III.B. (3), below.

Although there was insufficient state interest to pursue a demonstration project, the MPR study clarified options, thoroughly examined the relevant issues, and framed basic guidelines reflecting the realities under which state Medicaid programs operate. For example, objectives of the demonstration design included: facilitated enrollment and service access; equitable financial liabilities among states; no expansions of eligibility or covered benefits; administrative simplicity and minimal administrative costs; and protections for states from Medicaid eligibility quality control errors and from significant unanticipated program cost increases (e.g., by capping participation).

Since the MPR feasibility study, a few states have taken the initiative, with assistance from the National Center for Farmworker Health (NCFH), to develop models that reflect the objectives and strategic approaches analyzed in that study. Those models are described in Section IV of this paper.

As the Medicaid environment has evolved, particularly with the expansion of mandatory managed care enrollment in most states and implementation of the 1997 SCHIP legislation nationwide, there has been a renewed interest in revisiting the prospects for facilitating Medicaid/SCHIP enrollment of migratory farmworkers and their families. In 2000, three papers presented fresh perspectives on the challenge.

In June 2000, the National Health Policy Forum (NHPF) in Washington, D.C. convened a group of forty-six experts in health care programs for needy families to discuss the problems in providing Medicaid and SCHIP coverage to migrant families and children. Observations from that session were published by NHPF in a paper, "Policy Options for Serving Migrant Children and Families under Medicaid and SCHIP." The range of options included: limited solutions to mitigate structural barriers within the existing Medicaid/SCHIP framework; intermediate approaches to facilitate broader enrollment through more creative arrangements; and major reforms for more universal coverage through systemic change.

- *Limited solutions included:* special arrangements for reimbursement of out-of-state providers; interstate compacts for demonstration waiver projects; streamlined eligibility policies and procedures such as presumptive eligibility and annualized income; and culturally-sensitive targeted outreach and outstationing of intake workers.

- *Intermediate approaches encompassed:* interstate reciprocity agreements; unilateral reciprocity such as Wisconsin's policy of accepting other states' eligibility determinations for migrant farmworkers; and various arrangements for linking migrant health center services across state lines, such as special billing practices or interstate provider networks.

- *Major reforms contemplated* were a national resource center to help states minimize interstate eligibility and access barriers, and/or federal policy reform to create a national Medicaid/SCHIP eligibility standard or program.

In October 2000, a memorandum, "Options for expanding publicly financed health coverage of migrant farmworkers and their families" was prepared for the National Association of Community Health Centers (NACHC) by Sara Rosenbaum, Director of the Center for Health Policy Research at the George Washington University School of Public Health. Following a summary of barriers to migrants' access to eligibility and out-of-state services, the memorandum posed three approaches:

- Encourage states to make maximum use of existing state plan provisions relating to coverage of residents and provision of out-of-state coverage, or to establish policies for interstate reciprocity in eligibility determinations, and to exempt migrant farmworkers from mandatory managed care enrollment.

- Encourage states to develop comprehensive multi-state migrant coverage demonstrations involving section 1115 waivers of federal Medicaid/SCHIP program requirements.

- Seek legislation to create a program of migrant family coverage in which states with high migrant populations could participate, probably involving a single fiscal intermediary for claims processing and an interstate migrant health network to facilitate access to care. Program costs could be capped through aggregate upper limits on authorized funds.

A September 2000 paper done for the Center for Health Care Strategies, Inc. (CHCS), "Improving Health Service Access for Medicaid-Eligible Migrant Farmworkers" (Kenesson, 2000), was prepared as a comprehensive, updated resource in light of changes in the Medicaid/SCHIP programs and environment since the MPR initiative. The scope of that paper includes: migrant farmworker demographics, health needs and access barriers; recommendations of national advisory councils and interested organizations; past research on multi-state reciprocity demonstrations; and opportunities for public/private partnerships through insurance or managed care models.

Considerations of particular interest in the Kenesson paper were the potential for viable interstate reciprocity models in a new environment, and prospects for capitalizing on Medicaid managed care as a vehicle for continuity of care across state lines. The overall conclusions from the paper are that:

- With respect to interstate reciprocity, the environment at the time of the MPR study was more conducive to innovation and investment in program reforms. States were, at that time, less concerned about budgetary constraints and more interested in outreach and/or program expansions for low-income working families. Also, with the advent of SCHIP, children who travel with their migrant farmworker parent(s) could be an attractive target group for interstate reciprocity, benefiting from the renewed emphasis on outreach, simplified enrollment and program design flexibility.

  Nonetheless, prospects for interstate reciprocity had been further complicated by increased structural variations among state programs. Examples of these state variations include: expanded state flexibility through demonstration waivers and SCHIP program design

options, as well as the prevalence of Medicaid managed care models for families and children.

- With respect to opportunities through public/private partnerships, there has not yet been sufficient developmental work to resolve design issues inherent in either a commercial insurance or a managed care network model. Critical design issues include: apportioning financial liabilities among participating states; defining a common benefit package or adjudicating claims for different states' coverage policies; setting premium or capitation rates for a population with unmet needs; establishing contracting provisions and conducting compliance monitoring; and defining eligibles and managing enrollments across state lines. Developing a viable model design would require intensive analyses and tailoring specific to the participating state(s) program policies and operations.

  Whether through purchase of commercial indemnity insurance or a multi-state network model, public/private partnership concepts offer a promising framework for improving access to health services for migrant farmworkers and their families. Despite the model design complexities, the effort could result in a workable model that is least disruptive to established state Medicaid/SCHIP program structures and that meets the health access and service needs of migrant farmworkers. The Texas Migrant Care Network initiative, described in Section IV.C., is an example of a public/private partnership to develop an inter-state managed care network model.

The Kenesson paper discusses the options and issues in depth, but does not present specific recommendations for systemic reform. It does, however, propose a variety of short-term actions that individual states could take to relieve some access barriers (summarized in Section III.B, below.)

A monograph produced by the NCFH for the National Advisory Council on Migrant Health, "Medicaid and the State Children's Health Insurance Program" (Arendale, 2001) discusses the dilemma created by the SCHIP program – expanded eligibility and streamlined enrollment complicated by increased interstate program variations due to SCHIP program design flexibility. This paper shares Kenesson's observation that a public/private partnership model may be a promising alternative to interstate reciprocity within the basic Medicaid/SCHIP program framework.

More recently, NCFH prepared a paper for the Farmworker Health Access Committee, "Farmworker Access to Safety Net Insurance Programs: Harvesting Solutions to a Thirty-Seven-Year Old Issue" (Kapeller, 2003). Following a summary of past research and program developments, this paper presents current efforts underway in Wisconsin, Texas, California, Michigan, Virginia and North Carolina. Those initiatives are described in Chapter IV, below. The paper concludes that the challenge faced by high migrant impact states is not in lack of will to find solutions, but rather in the financial and administrative realities of state Medicaid and SCHIP programs, and that national and federal attention and support of these efforts is critical to their success.

B. Past Recommendations

Recommendations for improving health access for migrant farmworkers and their families have been raised in conference discussions and by the National Advisory Council on Migrant Health, which is legislatively mandated to advise the Secretary of Health and Human Services (HHS) on improving the health status of migrant farmworkers and their families and increasing the effectiveness of migrant health centers (MHCs).

Many recommendations have focused on the basic health and social service needs of migrant farmworkers and on strengthening the specialized migrant health clinic system. Deliberations have acknowledged the difficulties migrants face in accessing Medicaid/SCHIP eligibility and services, and portable coverage or interstate reciprocity were usually included in lists of objectives. Nonetheless, the Medicaid program did not emerge as a preferred infrastructure for systemic reforms. Since enactment of SCHIP, however, with increased attention being placed on outreach and streamlined eligibility processes for all low-income children, recommendations relevant to migrants have included facilitating access to Medicaid/SCHIP coverage for eligible migrant children.

Recommendations not specific to the Medicaid/SCHIP programs generally include:

- Strategies and incentives for recruitment, retention and training of bilingual/bicultural health service providers;
- Research and provider education in migrant farmworker occupational health risks, especially the effects of pesticides on farmworkers and their children, as well as substandard living conditions, workers' compensation and exploitation of child labor;
- Development of systems to facilitate access to and continuity of care for mobile populations, such as automated eligibility and/or medical records databases; and
- Expansion of services most needed by migrant farmworkers, primarily through increased funding for MHC capabilities, such as dental and pharmacy services, mental health, substance abuse and family counseling, and outreach services tailored to the needs of migrant farmworkers.

With the implementation of SCHIP, an October 1997 publication by HRSA's Migrant Health Program, "The Children's Health Initiative and Migrant and Seasonal Farmworker Children: The Current Situation and the Available Opportunities" presented recommendations oriented to the Medicaid/SCHIP program framework; i.e.:

- Allocation of SCHIP funds to outreach and enrollment assistance;
- Prioritizing SCHIP coverage based on income to encompass most migrant farmworker children;
- Presumptive eligibility to expedite access to benefits and continuity of care;
- Income averaging, to maintain eligibility despite temporary periods of earnings above program eligibility levels; and
- Interstate reciprocity in accepting Medicaid/SCHIP cards issued by other states.

Recommendations specific to Medicaid/SCHIP entitlement and service delivery also emerged from the model options and proposals described in the literature summarized in Section III.A

above. That research represents in-depth analyses of approaches to improving access within the Medicaid/SCHIP program frameworks. Recommended initiatives can be summarized within four basic approaches:

(1) Single-state administrative program enhancements. Individual states can implement a variety of improvements within existing authority for program administration, or through relatively minor state plan amendments. Actions that have been proposed include:

- *Facilitating access to enrollment by:* recruiting and training culturally/linguistically appropriate individuals to help with Medicaid/SCHIP outreach and enrollment; outstationing intake workers at workplaces, housing areas and/or health providers frequented by migrant farmworkers; offering outreach and enrollment at convenient times such as evenings and during inclement weather that precludes field work; and joining forces with other service programs' outreach activities (such as Food Stamps and/or Head Start).

- *Facilitating eligibility determinations by:* offering presumptive and/or continuous eligibility to encourage applications for migrant children and pregnant women; averaging countable income to consider seasonal or intermittent earnings; exempting migrant farmworkers from mandatory managed care enrollment; assuring state residency policies comport with federal regulations and are understood by intake workers; and developing simplified application forms and minimizing documentation and verification requirements.

- *Improving access to services and continuity of care by:* educating Medicaid/SCHIP providers and their staff about eligibility provisions specific to migrant farmworkers (including residency and immigration status); implementing requirements and/or incentives for providers to serve migrant farmworkers at convenient times and locations; arranging for transportation to community Medicaid/SCHIP providers; arranging for interpretation/translation services to help with patient/provider encounters and to assure the patient understands follow-up care instructions; using culturally/linguistically-appropriate lay health providers for health education; fully implementing basic statutory requirements to pay for out-of-state care; exempting migrant farmworkers from mandatory managed care enrollment; supporting linkages with referral resources to identify Medicaid/SCHIP participating providers; and participating in multi-state data systems that track migrant farmworker service use or medical records.

Most of those administrative measures could be implemented in conjunction with the more complex or expansive program reforms summarized below.

(2) Single-state initiatives for reciprocity and/or portability of benefits. Individual states can pursue larger initiatives involving more complex program reforms, requiring more significant state plan amendments and/or demonstration waivers. Recommended approaches have focused on:

- *Unilateral reciprocity* to accept other state(s) Medicaid/SCHIP eligibility determinations, either to confer automatic eligibility in the new state or to facilitate enrollment by relying on another state's verification of specific financial and/or categorical entitlement and/or citizenship status. The operational model in Wisconsin is described in Section IV.A. below.

- *Public/private partnerships for portable benefits* such as contracting with a third-party administrator, commercial insurer or managed care plan to create a multi-state provider network and handle provider payments, as is done with other group health insurance products. The approach being pursued by Texas is described in Section IV.C. below.

(3) Models requiring cooperation among multiple states. Variations in Medicaid/SCHIP eligibility, coverage and administrative mechanisms among the states make multi-state models more complex. Such models can be implemented through formal inter-state agreements, although some aspects may require federal demonstration waivers or significant changes in participating states' Medicaid/SCHIP state plans and state statutes and regulations. Two approaches that were recommended for further development in discussions of the MPR feasibility study were:

- *Portability through a public/private partnership with multi-state cost sharing.* MPR recommended a multi-state portability model involving purchase of commercial insurance, with cost sharing among states where the insurer's network was established. Building on states' existing option to purchase commercial insurance in lieu of standard Medicaid when it is cost-effective to do so, eligible migrant farmworkers would choose to enroll in regular Medicaid for coverage within that state or in a portable basic benefit package administered by a commercial insurer.

  The enrolling state would pay the monthly premium, subject to an annual cost sharing process among participating states to reconcile the authorizing state's aggregate premium payment amounts with other states' provider claims payment liabilities. Providers in any of the participating states would choose whether to accept the commercial coverage, and be paid by the insurer per its fee schedule.

  The migrant-specific commercial insurance package commonly available in all participating states would offer only basic benefits (i.e., mandatory Medicaid services plus prescription drugs, but excluding long-term care) counterbalanced by greatly enhanced access. Some optional Medicaid services important to migrant health needs, such as dental care, might not be covered.

- *Inter-state Eligibility Transfer* offers an inter-state reciprocity model with designated enrollment sites convenient to migrant farmworkers that would authorize twelve-month coverage for Medicaid-eligible migrant farmworkers and dependents. Upon entering another participating state, those individuals would present their out-of-state Medicaid cards along with proof of agricultural work to designated intake offices in the new state.

Following a simplified intake process relying primarily on the initial state's determination, the individual would be issued either a regular Medicaid card or, at state option, a presumptive eligibility card (pending further authorization and/or mailing of a regular card) from the new state. Each state's own benefit package, coverage limitations, and provider reimbursement would remain in place, and providers would treat migrant workers as any other in-state Medicaid eligible.

Variations on those approaches have been recommended (Rosenbaum, 2000):

- Portability and reciprocity could be based on existing authority for states to enter into inter-state agreements and regulatory requirements governing payment for out-of-state care. Participating states would accept another state's Medicaid/SCHIP eligibility determinations, issue an in-state card to facilitate access to care, and bill the state that originally determined eligibility (the individual's state of residence) for costs of out-of-state care. This model, like other approaches to inter-state reciprocity, raises issues of inter-state variations in eligibility, benefits and payment rates, as well as shared financial liabilities among participating states.

- Portability and reciprocity could also be implemented through multi-state demonstration waivers to establish common coverage, provider compensation and administrative provisions specific to migrant farmworkers, possibly incorporating an inter-state managed care network.

(4) Broader, systemic reforms requiring federal legislation. Federal legislative remedies could address or supplant the complexities involved in designing viable multi-state models. Recommendations for new legislative authorities could expand on, or be modeled after, the flexibility built into the SCHIP program. For example, payment incentives might be offered to encourage states to participate in a new migrant coverage program. Through a collaborative process among states, experts in migrant health and other stakeholders, the Secretary of HHS could frame legislative proposals for migrant-specific multi-state eligibility, coverage and payment policies. Such a program could be administered through a federally-contracted fiscal intermediary to establish an inter-state provider network and handle all claims processing for enrolled migrants. Increased federal matching funds coupled with aggregate upper limits on authorized funds could protect states from unmanageable expenditures and encourage state program participation. However, pressures for similar tailored programs for other special needs groups (such as homeless persons and families) could lead to a plethora of proposals that might discourage congressional interest. (Rosenbaum, 2000)

C. Recent Developments at the National Level

The most significant recent development at the national level was enactment of a statutory mandate for a federal study and report to Congress on approaches to improving access to Medicaid/SCHIP health coverage for migrant farmworkers. The mandate was defined in Section 404 of Public Law 107-251, the "Health Care Safety Net Amendments of 2002". In May of

2003, responsibility for the study and report was officially assigned to the D/HHS Centers for Medicare and Medicaid Services (CMS).

Specifically, the study is to address:

(1) Barriers to enrollment, including lack of outreach and outstationed eligibility workers, complicated applications and eligibility determination procedures, and linguistic and cultural barriers.

(2) Lack of health coverage portability for farmworkers who are determined eligible in one state but who move to other states on a seasonal or other periodic basis.

(3) Possible solutions to increase enrollment and access to health benefits for farmworkers, and the associated costs of each of the possible solutions. Possible solutions to be examined include:

(a) Interstate compacts for portability and reciprocity and potential financial incentives for states to enter into such compacts;
(b) Demonstration projects involving multiple states for comprehensive migrant coverage;
(c) Use of current flexibility in Medicaid/SCHIP law relating to coverage of residents and out-of-state coverage;
(d) National migrant family coverage programs in which states could participate;
(e) Public-private partnerships with incentives to develop private coverage alternatives for farmworkers;
(f) Other possible solutions the D/HHS Secretary deems appropriate.

In conducting the study, the legislation required the federal government to consult with:

- Migrant farmworkers affected by the lack of portability of coverage under Medicaid or SCHIP;
- Individuals with expertise in providing health care to farmworkers, including national and local organizations representing migrant health centers and other providers;
- Others with expertise in health care financing;
- Foundations and other nonprofit entities that have conducted or supported research on farmworker health care financial issues;
- Federal agencies involved in providing or financing farmworker health care, including CMS and HRSA;
- State governments;
- The farm and agricultural industries; and
- Labor organizations representing farmworkers.

On December 2, 2003, CMS convened a meeting of 23 panelists and 17 observers to seek their input to the study. Before the meeting, participants received a November 2003 CMS background paper, which summarized current knowledge on barriers to enrollment and lack of portability, and described various approaches to potential solutions within five categories:

- Under current Medicaid/SCHIP program authority;
- Through interstate compacts;
- Under section 1115 research and demonstration waiver authority;
- Through public-private partnerships; and
- Through national provisions for migrant family coverage.

Those five categories shaped the agenda for the meeting. A lively, informative discussion elicited perspectives and ideas from all the panelists and observers, including considerations relevant to each general approach and pros and cons of specific potential solutions. New approaches, such as the potential for internet-based mechanisms and information technology to facilitate models for improving access, were also surfaced.

At this writing, the study report is under preparation in CMS. The report to Congress will provide a valuable resource for moving the dialogue, and the prospects for constructive approaches, forward.

IV. CURRENT STATE MODELS

Farmworker access to SCHIP and Medicaid has been the topic of various papers and meetings as discussed in Section III. Previous works presented theoretical models looking at long and short term solutions to access barriers. This section offers the first summary of models currently being developed and implemented by individual states. The models presented here include a unilateral reciprocity model, an inter-state reciprocity model, a portability model, and a state-based model. The background, description, challenges, and lessons learned are presented for each state model currently under development. These efforts represent the first state efforts in improving farmworker access to SCHIP and Medicaid.

Wisconsin's unilateral reciprocity model is the only state model to be fully implemented, a variation of the MPR Interstate Eligibility Transfer Option. California's reciprocity effort, led by the California Primary Care Association (CPCA), focuses on establishing intra-state portability and inter-state reciprocity with Washington and Oregon. Texas' portability model, led by the Texas Association of Community Health Centers (TACHC), explores a public/private partnership that would result in a multi-state network. The Michigan state-based model, led by the Michigan Primary Care Association (MPCA), capitalizes on the use of current state flexibility in the administration of SCHIP and Medicaid at a state level, and policy change at the state level if needed.

A. Wisconsin's Model

Background of the Wisconsin Model

Following the release of the MPR study, CMS (known as HFCA at that time) and MPR held a meeting with several states in 1994 to discuss prospects for a demonstration project to address migrant farmworker access to Medicaid. In response, in May of 1995 Wisconsin Medicaid implemented a change to eligibility determination procedures for migrant families seeking

Medical Assistance (MA) in Wisconsin. The new policy (1) automatically grants MA to migrant families that have valid Medicaid eligibility in another state until the end of the certification period on the card, and (2) calculates MA eligibility using annualized income.

Description of the Wisconsin Model and Results

The 1995 Wisconsin State Notification of Policy Change (NPC) divides migrant families into two categories, those with out-of-state MA eligibility and those without. These categories are defined as follows:

- *Migrant families with out-of-state MA eligibility* are defined as those migrant families that have at least two months (the length of Wisconsin eligibility/application process) of live Medicaid eligibility from another state, or "had MA eligibility in Wisconsin certified through months 1 and 2 of the current application that ended only because the family left the state." (1995 NPC). In addition, the household must be the same size or smaller in Wisconsin as that listed on the out-of-state MA eligibility or Medicaid card. These families would complete a simplified application. The simplified application for migrant families with current out-of-state coverage:

  - Requires non-financial information only,
  - Provides the family with a re-determination date that matches that of their current out-of-state MA eligibility,
  - Ensures that migrant families are not enrolled in managed care,
  - Requires the migrant family to complete a regular Wisconsin MA eligibility determination upon the expiration of their presumptive eligibility period. At that time, financial and non-financial information is reviewed, income is annualized to off-set the seasonal nature of migrant income, and a 12 month re-determination date is set.

  Income averaging only allows the family to take the earnings they receive from seasonal employment and average that income over the 12 month time period. The family is not certified for 12 months of continuous coverage; i.e., they must report changes in household composition or other non-financial circumstances, and whenever they get a new non-seasonal job or a new source of unearned income.

  With respect to children in migrant families who are only eligible for SCHIP, Wisconsin has not elected the federal option to extend expedited eligibility to SCHIP eligible children. Income averaging, however, is applied in determining their financial eligibility.

- *Migrant families without out of state MA eligibility* are defined as those migrant families that have less than two months live MA eligibility in another state, do not have out-of-state MA eligibility, or whose household composition is larger in Wisconsin than as listed on their out-of-state MA eligibility. These migrant families must apply for eligibility through the regular Wisconsin MA eligibility and application process. Both financial and non-financial information are reviewed, income is annualized, they are not enrolled in managed care, and families determined to be eligible are enrolled in the Wisconsin fee-for-service MA program for a 12 month period.

This model is a unilateral reciprocity model. Wisconsin accepts Medicaid eligibility for migrant farmworkers from all states, although no other state accepts Wisconsin MA eligibility determination. To date, this is the only state reciprocity model to increase farmworker access to Medicaid across state lines that has been fully implemented.

Lessons Learned

When looking at the Wisconsin model, other states have noted that because Wisconsin MA financial eligibility criteria are relatively generous, a migrant family who qualifies for eligibility in another state is likely to also qualify in Wisconsin. In addition, some other states do not utilize annualized income, or determine eligibility for a 12 month period. Therefore, although unilateral presumptive eligibility can reduce administrative costs and streamline access to coverage, states with relatively low financial eligibility limits would risk providing Medicaid services to individuals who would not otherwise be eligible in the state.

B. California's Model

Background of California's Project

In 2001, the California Primary Care Association (CPCA), along with its project partners, the Oregon Primary Care Association (OPCA), the Washington Association of Community & Migrant Health Centers (WACMHC), and the Northwest Regional Primary Care Association (NWRPCA), embarked on a project to study the portability barriers faced by migrant farmworkers with Medicaid coverage and to advocate for solutions. The following activities were completed during the two-year project period:

- Successfully advocated for policy changes in California's inter-county transfer process to ensure compliance with the federal requirement of statewideness (federal law Section 1902(a)(1) of the Social Security Act and regulations 42CFR 435.916 and 435.930).
- Utilized the framework developed by the MPR study to determine the feasibility of establishing portable Medicaid coverage for migrant farmworkers between all or some of the states.
- Contracted with the California Institute for Rural Studies to conduct a cost-benefit analysis of providing portable Medicaid coverage to migrant farmworkers.
- In partnership with the Northwest Health Law Advocates, analyzed the differences between the California, Oregon, and Washington Medicaid programs.
- Researched and advocated for various policy options for addressing the problem.
- Educated policymakers regarding the barriers and potential solutions.
- Successfully achieved presumptive eligibility for all children, including those in migrant farmworker families.

Description of California's Project Results

- *Intra-State Portability:* California's Medicaid program, called Medi-Cal, often delegates administrative functions to the county level. When beneficiaries move from one county to another, an inter-county transfer process occurs to ensure a beneficiary's case file is properly

sent to the new county. As California Primary Care Association (CPCA) began its project looking at barriers between California, Oregon, and Washington, it was discovered that migrant farmworkers were facing difficulties in retaining Medi-Cal coverage when they moved to another county within the state of California. There were reports that the inter-county transfer process often involved terminations, interruptions in coverage, and it placed the burdens on beneficiaries to prove they remained eligible for Medi-Cal.

The CMS recognized these problems and released a State Medicaid Director Letter on December 4, 2000 to address the problems faced by beneficiaries in county-based Medicaid programs. Federal law, Section 1902(a)(1) of the Social Security Act, requires that the Medicaid program must be in effect statewide in all counties of the state. The letter states, "In a county-administered Medicaid program, when a family moves within the State, the State and the counties are responsible for transferring the case record from the old county of residence to the new county of residence so that Medicaid can continue without interruption. The State cannot require the family to reapply for Medicaid or comply with a Medicaid re-determination solely based upon a move to a new county."

In response to the advocacy of CPCA and other interested parties, the California Department of Health Services (DHS) established a work group to address the barriers with the inter-county transfer process. As part of this work group process, CPCA succeeded in advocating for a revised All County Welfare Directors Letter, outlining the prohibition of terminating Medi-Cal coverage for beneficiaries simply due to a move to another county.

The new All County Welfare Directors Letter contains language that specifies that:

- Counties must ensure all Medi-Cal cases remain active, with no interruption in benefits, when beneficiaries move to another county;
- Medi-Cal is a statewide program;
- Counties may not terminate Medi-Cal benefits or ask beneficiaries to re-apply for benefits when a beneficiary moves to another county;
- Counties may not re-determine a beneficiary's eligibility for Medi-Cal because of a move to another county; and
- Beneficiaries who are temporarily away from their home county are not required to undergo the inter-county transfer process. They can continue to receive benefits without having their case files transferred.

This revised policy will greatly improve Medi-Cal retention for beneficiaries who move between counties, either permanently or temporarily. Migrant farmworkers who move to another county within the State, will no longer be subject to having their coverage terminated or their eligibility re-determined as they move between counties. Access to Medi-Cal coverage will be sustained.

- *Inter-state Reciprocity:* The CPCA's project utilized the model developed by the MPR study and consisted of a multi-pronged approach. The research phase consisted of three components: 1) performing a study looking at health care needs and the benefits of coverage; 2) conducting an analysis of the three state Medicaid programs; and 3) analyzing

potential policy solutions. Utilizing the research results, CPCA engaged various state and federal officials to promote solutions to improve portability of Medicaid coverage for migrant farmworkers.

CPCA contracted with the California Institute for Rural Studies to investigate the costs and benefits of improving Medicaid portability. The study's findings also demonstrated how migrant farmworkers severely lack access to health care, and highlighted specific areas of disparity when comparing migrant health to the general population. Migrant farmworkers exhibit high percentages of obesity, more than twice the percentage of the general U.S. population, and exhibit higher risk for other health conditions such as diabetes, anemia, and musculoskeletal pain. Breast and cervical cancer screenings showed that 7-13% of farmworker women had abnormal test results. The study indicated that a third of the migrant workers have never visited a doctor or clinic their entire lives, and almost half of those who did receive care had to pursue health care outside their local area. Despite these disparities in risk factors and health conditions, migrant farmworkers lack access to health care.

The CPCA sponsored study also developed an estimate of the numbers of migrant farmworkers and dependents leaving California for work in other states that are likely to be eligible for Medicaid. Using a conservative estimate of the population of California's crop workers – (approximately 500,000) - the data from the National Agricultural Workers Survey (NAWS) showed that about 10 percent or 50,000 people leave the state to do farm work elsewhere. Of these 50,000 workers, about 27% (13,000) have children, with an average family size of between two and three children per household. Two-thirds of all U.S.-resident farmworker children were born in the United States, which translates to 21,000 citizen children, at a minimum, being affected by barriers to retaining coverage as their families migrate across state lines. A significant number of documented adults with children would also qualify. For those 50,000 interstate adult migrants who travel to some other state, about 21.5% have children and are documented. This implies that at minimum, another 10,750 migrant adults are also eligible for Medicaid. Unfortunately, the number of migrant farmworkers and dependents traveling into California could not be estimated because researchers were unable to access the needed data.

For the second component of research, CPCA, in partnership with Northwest Health Law Advocates, analyzed the differences between the three Medicaid programs of California, Oregon, and Washington. Areas examined included: income eligibility, resource tests, categorical eligibility, covered benefits, and residency requirements. The results illustrated that because the migrant farmworker population lacks income and assets; many farmworkers who are eligible for a Medicaid program in one state based on income and assets would most likely be eligible in another. The major differences between the states occurred with categorical eligibility requirements. California provides coverage for recent legal immigrants within their first five years of arrival while Washington and Oregon do not. Oregon's program covers childless adults up to 100% of the federal poverty level while California and Washington do not. However, the childless migrant farmworker adult population tends to be more recent immigrants and thus, it is anticipated that few childless migrant farmworker adults in Oregon would qualify due to the immigration restrictions.

Finally, CPCA analyzed policy options that had been outlined in the MPR study, utilizing information gathered from the first two components regarding farmworker demographics and health care needs and the differences between the three state Medicaid programs. Based on this information, each policy option was assessed for its impact on portability and costs. In 2002, a convening of various stakeholders from the three states was held to further discuss and debate the various policy options. What emerged from the discussion was an agreement on the most feasible models to pursue during the advocacy phase. These models were: 1) streamlined Medicaid enrollment processes for farmworkers; 2) state reciprocity in covering farmworker access to health care services among Federally Qualified Health Centers if they have Medicaid coverage from another state; and 3) state reciprocity in providing Medicaid coverage to farmworkers with Medicaid coverage from other states.

In summary, the following were the highlights of the research phase results:

- Migrant farmworkers face tremendous health care needs. They exhibit higher rates of certain health conditions, yet severely lack access to health care or insurance coverage.
- A significant number of farmworkers and dependents migrate from California to other states for agricultural work and are likely eligible for Medicaid. The conservative estimate of 31,000 farmworkers and children does not include the numbers of farmworkers migrating from other states into California.
- California's Medicaid eligibility levels generally are broader than the other two states of Oregon and Washington. Because of the demographic characteristics of the farmworker population, it appears that the vast majority of migrant farmworkers with Medicaid coverage from Oregon and Washington would also qualify for Medicaid in California.
- Stakeholders identified advocacy efforts that should focus on certain policy options such as streamlining enrollment processes or creating state reciprocal eligibility for farmworkers with Medicaid.

In response to the research, CPCA began meeting with allies, state officials, and other policymakers to discuss solutions for improving Medicaid portability for migrants. Unfortunately, the beginning of the advocacy phase of the project occurred just as states around the country began to experience deep fiscal crises. California, Oregon, and Washington all suffered dramatic budget deficits, creating challenges in advocating for improved access to Medicaid coverage for migrant farmworkers. In an environment of proposals to cut health care programs severely, it was politically infeasible to discuss any solutions that could be perceived as having a cost attached.

- *Presumptive Eligibility for Children:* Out of this period of crisis in California, however, arose an incredible opportunity for improving access to health care for children. In 2002, California's governor proposed to eliminate the Child Health & Disability Prevention (CHDP) program, which provides basic health screenings, including dental and vision, to every child in the state regardless of whether they have Medi-Cal or Healthy Families (California's Medicaid and SCHIP programs respectively). The entire health care community, represented by providers, hospitals, health centers, and consumers, mobilized an outpouring of support to prevent the elimination of this important benefit for all children. CPCA, in collaboration with other allies, advocated for presumptive eligibility and simplified

enrollment processes to improve the CHDP program so that it could facilitate enrollment of children, including those in migrant families, into the Medi-Cal or Healthy Families programs.

According to estimates by the California DHS, approximately 760,000 of the 1.1 million children in the CHDP program are eligible for Medi-Cal or Healthy Families. Because California receives federal matching funds for Medi-Cal and Healthy Families beneficiaries, presumptive eligibility to improve enrollment of eligible children in Medi-Cal or Healthy Families is a cost-effective approach for drawing down federal funds. CPCA and other advocates successfully utilized arguments illustrating the cost-effectiveness of providing preventive health care for all children and of increasing the amount of federal funds distributed to the state.

In addition, because California's eligibility levels for children in the Medi-Cal and Healthy Families programs are broader than Oregon, Washington, and many other states, the success in achieving presumptive eligibility ensures that migrant farmworker children from other states with Medicaid coverage will become eligible for Medi-Cal or Healthy Families via an expedited process. This streamlined process with presumptive eligibility is called the CHDP Gateway Program.

The CHDP Gateway Program requires health care providers to utilize an electronic application that enrolls children and provides them with presumptive Medi-Cal coverage for up to two months. Children with incomes below 200% of the federal poverty level are eligible. As part of this electronic application, parents can request a Medi-Cal or Healthy Families application, and children can continue to receive health care services for up to two months while their application form is completed and processed. Children in migrant farmworker families benefit tremendously by being deemed presumptively eligible for Medi-Cal so that they can start receiving health care immediately. For those children with Medicaid coverage from other states, this CHDP Gateway allows them to access services and connects them to be enrolled in Medi-Cal or Healthy Families, of which they are likely eligible. Even for those children who are not eligible for Medi-Cal or Healthy Families, they can continue to receive health screenings according to a specified periodicity schedule.

Although California has greatly improved access to Medi-Cal and Healthy Families coverage for children, CPCA will be continuing to advocate for improved enrollment processes and solutions for the migrant farmworker adult population.

Challenges

The main challenge to establishing improved Medicaid coverage for migrant farmworkers has been the fiscal crisis that has plagued numerous states throughout the country. After several years of surpluses and growth, the sudden and dramatic decline in state revenue created significant budget deficits. The timing of our project occurred at a time when advocacy for improved Medicaid coverage became difficult. All three states in the project had a political climate where discussions of cutting Medicaid eligibility, services, and provider rates occurred, making it extremely challenging to broach the subject of improved access for migrant farmworker beneficiaries.

An additional challenge was the differences in political culture and environment among the three states. Having one model for all three states proved to be difficult because each state had a very different political environment and culture. California has a long history and association with the farmworker movement. Many of the state's political leadership, including the strong Latino Legislative Caucus, are highly supportive of this population and are open to comprehensive approaches. However, the other two states have a political environment that necessitates more limited options.

Lessons Learned

California's achievements in improving Medicaid coverage of migrant farmworkers could not have succeeded without the support of the larger health care advocacy community. CPCA recognized that numerous solutions to eliminate barriers for migrant farmworkers were also solutions for other low-income populations with access to health care challenges. Because of the overlap, CPCA mobilized a broad range of health advocacy organizations, including those representing low-income and Latino communities, and worked collaboratively with partners on these issues. The mobilization of support among a broad range of stakeholders proved critical to CPCA's successes.

CPCA also learned that persistence is key to achieving results. Although the state budget environment made it appear that improvements would be difficult to achieve, our successes occurred because we continually talked about the barriers faced by migrant farmworkers in a variety of settings. It is often difficult to know when a particular issue may move due to timing or opportunity, and it is critical to raise the issue of improved health care access for migrant farmworkers continually in various discussions.

C. Texas' Model

Background on Texas' Project

On June 15, 2001, Texas Governor Rick Perry signed Texas House Bill (HB) 1537, with an effective date of September 1, 2001. HB 1537 is a piece of legislation designed to study the feasibility of establishing a SCHIP and Medicaid portability pilot that would provide coverage for Texas migrant farmworker children ages 0-19.

HB 1537 required that the Texas Health and Human Service Commission (Texas HHSC) establish a Workgroup, conduct a feasibility study regarding the establishment of a migrant care network for migrant children ages 0-19 currently enrolled in SCHIP and Medicaid, and report its findings and recommendations to the Texas Legislature. The Workgroup was established and led by the Texas HHSC and the Texas Association of Community Health Centers (TACHC). The Workgroup included members from the National Center for Farmworker Health (NCFH), Migrant Health Promotion, the Texas Department of Health, and the Texas Department of Human Services.

The draft feasibility study, submitted to the Texas Legislature for review in October of 2002 included:

- The definition of migrant children;
- Current policy on coverage options for enrolled migrant children while out of state;
- An estimate of the number of migrant children currently enrolled in SCHIP and Medicaid;
- Destination states of Texas migrants;
- Efforts to provide SCHIP and Medicaid coverage to migrant farmworkers in Wisconsin and California;
- Migrant population health care preferences;
- Texas migrant children health care utilization patterns; and
- Options and fiscal impact of options.

Description of Texas' Project Results

Under current Texas policy, Texas SCHIP and Medicaid may enroll out-of-state providers. According to the Medicaid claims administrator, in state fiscal year (SFY) 1999, 533 physicians from 32 states, and 44 hospitals from 23 states were identified as enrolled in the Texas Medicaid program. The majority of enrolled providers were in group practice settings while many of the enrolled hospitals were children's hospitals providing specialty care.

At the time the feasibility study was conducted, Texas Medicaid did not have a unique migrant identifier and did not track migrant status. Consequently, the HHSC was unable to determine the number of migrant children ages 0-19 currently enrolled in Medicaid and SCHIP, or their service utilization patterns. In order to estimate the number of Texas migrant children currently enrolled in SCHIP or Medicaid, hence eligible for participation in a pilot, Texas HHSC and the workgroup looked at data and studies in the three following categories:

- Data sources containing Texas migrant farmworker children numbers;
- Studies on farmworker income levels; and
- Studies noting the rate of farmworker utilization of needs-based services.

Using the "Migrant and Seasonal Farmworker Enumeration Study" (Larson, 2000), data from the Department of Labor (DOL), and Texas Education Agency 2000-2001 data, which includes Head Start figures, the workgroup estimated that there are between 50,000 and 76,000 migrant and seasonal farmworker children in Texas. Farmworker income data from various studies was used and compared to the 2002 Federal Poverty Level for a family of four ($18,000), resulting in Texas HHSC estimating that 100% of Texas migrant farmworker families would qualify for SCHIP or Medicaid. In a previous study, the DOL estimated farmworker utilization of needs-based services at 13%. This percentage was applied to the number of migrant farmworker children determined by the workgroup, resulting in an estimate of between 6,408 and 9,966 migrant children currently enrolled in Texas SCHIP or Medicaid.

Establishing migrant children's health care utilization patterns was also challenged by the lack of a migrant specific identifier in SCHIP, Medicaid and most health care settings. In order to estimate utilization patterns, a sample was obtained from four federally qualified health centers (FQHCs) in the Rio Grande Valley area of Texas, which is estimated to have the largest concentration of migrants in the State. (FQHCs receiving federal dollars for provision of services for migrant farmworkers have unique identifiers for this population.) The sample

consisted of 517 unduplicated migrant Medicaid clients for SFY 1999 and 2000 combined (SFY 1999 consisting of 416 unduplicated counts and SFY 2000, 479.) Data analysis results showed that the top two procedure codes were for diabetes supplies, and oral lab work/diagnostic procedures. The data suggests that migrant children currently enrolled in Texas Medicaid are primarily seeking services for chronic conditions in a hospital setting.

In the draft report, the Texas HHSC recommended that the legislature approve the portability pilot for implementation, and that contrary to standard Texas practice, that the pilot be conducted using all Texas counties versus one to two. The justification for this pilot implementation exception was the result of the small number of migrant children estimated to be currently enrolled in Texas SCHIP or Medicaid (6,408 to 9,966), and upstream provider impact and receptivity to the pilot if some Texas farmworker children qualified for the pilot and others did not. Once the migrant farmworker travels out of state they are viewed by other states as Texas migrants, not as Texas migrants from "X" county.

A possible portability model, the Migrant Care Network (MCN), was conceptualized and structured through collaboration between the state and TACHC, with funding from the Robert Wood Johnson Foundation. The model is a managed care network model, which represents a new approach with the farmworker population.

The goal of the MCN is to establish SCHIP and Medicaid portability for migrant farmworker children ages 0-19 between Texas and five target pilot states. Target pilot states were identified as a result of a feasibility study conducted by the Texas HHSC and the workgroup it formed as directed by Texas House Bill 1537. Target states were identified based on rate of migration from Texas to these states, and in order include: Michigan, Minnesota, Florida, New Mexico, and California.

Through the MCN model, Texas SCHIP and Medicaid would become portable for migrant children between the ages of 0-19, including newborns. A request for proposals to managed care organizations (MCOs) was released December 30, 2002 to develop a network of in-and out-of-state providers, conduct outreach and for program administration.

Basic aspects of the MCN model design, as presented in the RFP, included:

- The contractor would establish a 1-800 nurse advice and member services line, staffed 24 hours a day, 7 days a week, to provide enrollees assistance with health care questions and referral services to an MCN network provider.
- Established Medicaid and SCHIP programs' eligibility policies and enrollment mechanisms would remain in place. The MCN contractor could perform outreach and education.
- The state's separate benefit packages for Medicaid and SCHIP would remain in place, with separate Medicaid and SCHIP capitation rates. Per member per month costs would be estimated, based on SFY 2000 data plus a medical inflation factor, for each Medicaid and SCHIP risk group; i.e.: for Medicaid, TANF children, federal mandate children and expansion group children; and for SCHIP, by age group (0 – 1, 1 – 5, 6 – 14 and 15 – 18)
- Risk sharing between the contractor and the state, with the state assuming risk for aggregate medical claims costs between 100% and 110% of targeted amounts, and the contractor to

assume risk for aggregate medical claims costs above 110%. Aggregate targets and risk sharing would be computed and assessed separately for Medicaid and SCHIP enrollees.
- The contractor would be expected to establish statewide provider networks in more than one of the targeted upstream states prior to implementation. Out-of-state provider networks should encompass all Texas-covered Medicaid/SCHIP services; mandatory services offered to mandatory populations would be essential and the state would work with the contractor to coordinate benefits that may be difficult to provide out-of-state, such as dental, vision, pharmacy and behavioral health services.
- Texas and out-of-state providers enrolled in the contractor's managed care network would receive Texas fee for service rates and bill in accordance with Texas Medicaid and SCHIP policies.

The contract was to be awarded for a 36-month period, subject to extension by mutual agreement of the parties.

The only proposal received was non-responsive to the state's specific RFP requirements, thus the state did not approve the proposal. The state was assuming a full financial risk HMO model in the RFP. The proposal received by the state did not assume full financial risk. The TACHC is currently:

- Seeking federal congressional support to address the start-up costs of the model.
- Working at the congressional level to establish a federal enhanced Medicaid match (90%-10%) for states participating in the model. Senator Jeff Bingaman is supporting this effort.
- Working with target state Primary Care Associations, SCHIP and Medicaid offices in states with higher reimbursement rates to cover the wrap-around in service costs and benefit packages.

Challenges

One of the greatest challenges to this project is the lack of concrete data on migrant and seasonal farmworkers in order to assess the financial risks, and to determine the costs of implementing and operating a portability pilot. Due to the mobile nature of this population, we know anecdotally that they have unique health care needs. However, not having unique identifiers, we cannot determine with certainty their health care preferences and utilization patterns.

Some of the key challenges to the MCN model itself are due to administrative barriers that are inherent in both SCHIP and Medicaid, such as the difference between these programs from state to state. Other barriers relate to program implementation. Examples of these barriers include:

- Out-of-state provider participation – given differences in states' reimbursement rates (especially in states with higher fee schedules) and the complexities of different billing practices
- Variance in benefit packages provided from state to state.
- Health centers in upstream states are concerned about receiving the wrap-around costs for providing services.
- States are concerned about who would receive credit with the SCHIP/Medicaid encounter since Texas would be paying for the services.

- Start up costs for the pilot.

Lessons Learned

Especially for managed care type solutions, it is critical to know the numbers and demographics of migrant farmworkers, number of Medicaid eligible and percentages by categorical eligibility type, health service use, etc. This information is necessary for managed care rate setting and for health plans to be able to submit rate bids from a knowledge base. Health plans must be sure there are enough eligible "lives" to support a risk-based health plan.

Solutions or models pursued must be sensitive to how the migrant farmworker population actually accesses health care services. The lack of health care preference and utilization rates of this population is critical. Texas had to create a unique identifier for migrants, in order to know how many there were, what services they use, etc. This was very costly to do, and the State is still having problems getting migrant farmworkers to self-identify as migrants, and getting caseworkers to use the identifier.

Given low levels of Medicaid/SCHIP program enrollment and/or service use among migrant children at the outset, intensive outreach and education is needed to assure sufficient enrollment to support a risk-based managed care model. When the size of the enrollee population will only support one risk plan, the federal requirement of choice of health plans becomes a problem. With voluntary enrollment, it may be possible to offer Medicaid/SCHIP eligibles a choice of enrolling in a single MCN plan or remaining in fee-for-service.

Not enough time was allowed under the request for proposals put out by the State of Texas for MCOs to build networks in the state, much less out of state, given out-of-state provider reimbursement and recognition challenges. Once implemented, a managed care plan can help with access to care with out of state providers by setting up call centers for locating network providers, and nurse advice lines.

In creating solutions it is also important to consider the changing demographics of the migrant population, which according to the National Agricultural Workers Survey (NAWS) is a decrease in families and an increase in young solo-males from areas in Mexico where Spanish is not the primary language. The Texas model focuses strictly on children ages 0 to 19.

D. Michigan's Model

Background on Michigan's Project

In 2001, the Michigan Primary Care Association (MPCA) launched an initiative to improve the health status of migrant and seasonal farmworkers. The initiative was guided by an interagency coalition including partners from the MPCA, Community Action Agency, state agencies (Family Independence Agency (FIA) and Michigan Department of Community Health), federally qualified health centers (FQHCs) (Family Medical Center, Health Delivery, Inc., InterCare Community Health Network, and Northwest Michigan Health Services, Inc.), and national organizations (Migrant Health Promotion, and NCFH). The charge of the coalition was to

develop and implement a *Plan of Action for Improving the Health of Migrant and Seasonal Farmworkers*.

The *Plan of Action for Improving the Health of Migrant and Seasonal Farmworkers*, completed in August of 2002, addresses the most critical health issues for migrant and seasonal farmworkers in Michigan. Along with the literature review and expertise of coalition members, a series of focus groups with Camp Health Aids was held to ensure that the farmworker input was included in the development of the plan. As a result, seven priority areas were identified and addressed in the plan:

- Increase access to health care.
- Increase access to publicly funded health insurance programs.
- Address continuity of care within Michigan and across the country.
- Develop a cultural and linguistic responsiveness improvement strategy.
- Decrease adverse health outcomes from environmental and occupational causes.
- Develop a comprehensive approach to outreach and eligibility services.
- Elevate the status of migrant and seasonal farmworkers in policy discussions and program development.

Due to the focus of this paper, the only item of the plan that will be discussed further is increasing access to publicly funded insurance. More information on the *Plan of Action for Improving the Health of Migrant and Seasonal Farmworkers* can be found on the internet at MPCA's web site at www.mpca.net.

Description of Michigan's Project and Results

The issues surrounding farmworker access to public health insurance are larger than any single given state. Learning to navigate the public health insurance system to establish eligibility and services in one state is challenging enough. Factor in migrant farmworker mobility and the result is that a migrant family may leave a state before they attain coverage and will have to begin the eligibility and enrollment process again in a different state. In addition, migrant farmworkers face added challenges such as cultural, linguistic and literacy barriers. The combination of these challenges and barriers make the process of seeking Medicaid/SCHIP coverage very difficult on migrant families.

Approximately 67% of Michigan's farmworkers migrate from Texas every year (*Plan of Action for Improving the Health of Migrant and Seasonal Farmworkers*, 2002.) MPCA and the interagency coalition agree that ensuring continuity of care is critical to improving the health status of this population. Participation in the Texas MCN would facilitate continuity of care for Texas migrant children (ages 0-19) enrolled in the MCN, and would reduce Michigan program costs in providing services to them. While implementation issues remain, MPCA and the interagency coalition see the MCN as a positive step toward increasing collaboration on behalf of migrants and their families.

Through the *Plan of Action for Improving the Health of Migrant and Seasonal Farmworkers*, the MPCA and their interagency coalition developed a two-pronged approach to address farmworker access to SCHIP and Medicaid: a state-based strategy and a collaborative strategy. The state-

based strategy aims at increasing farmworker access to publicly funded health insurance programs to all SCHIP/Medicaid eligible migrant farmworkers coming to work in Michigan. Specifically, plan objectives include:

- To encourage Michigan providers to participate in the Texas MCN pilot when it is implemented, in order to promote continuity of care for participating Texas migrant farmworkers.
- To advocate for presumptive eligibility of migrant farmworkers in Medicaid and MIChild (Michigan's SCHIP program).
- To promote migrant farmworker enrollment in Medicaid and MIChild.
- To advocate for modifying existing Medicaid policy to carve-out migrants from the managed care program.
- To work to increase access to primary, mental and oral healthcare services for migrant and seasonal farmworkers.

- *State Based Strategy:* The state based strategy involves the MPCA working the Michigan Department of Community Health (MDCH), the FIA, and state policymakers in order to explore state options to increase farmworker participation in SCHIP, Medicaid and other publicly funded insurance programs. Options being explored under this strategy include administrative changes ranging from enrollment simplification to "carving-out" migrants from the Medicaid managed care system.

  At a state policy level, MPCA is working to promote interest in farmworker issues, and support legislative changes that will provide farmworkers with immediate access to SCHIP and Medicaid upon entering the State of Michigan. As a result, MPCA expects to see migrant and seasonal farmworkers "carved-out" of the Medicaid managed care program during the next contract re-bid. The MDCH is also considering the possibility of presumptive eligibility for farmworkers. Due to current administration support of the coalition's efforts, MPCA does not see a need to pursue any policy requests legislatively.

  If the Texas MCN pilot is implemented, the state based approach would be applied to all eligible farmworkers migrating to Michigan with the exception of those enrolled in the Texas MCN.

- *Collaborative Strategy:* The collaborative strategy, which supports Michigan participation in the Texas MCN pilot, aims at maintaining continuity of care for farmworker children ages 0-19 migrating to Michigan from Texas. Participation in the pilot would allow migrant farmworker children enrolled in Texas SCHIP or Medicaid to receive SCHIP/Medicaid services in Michigan without having to cancel their Texas coverage, apply for Michigan SCHIP or Medicaid, or learn the SCHIP/Medicaid programs and system in Michigan. TACHC has shared the MCN model with MPCA, and MPCA has responded with potential barriers to implementation as identified by Michigan migrant health centers, providers, and the interagency coalition members. The challenges portion of this section will address these in detail.

Challenges

- *Challenges to the State Based Strategy:* Challenges to the state-based strategy of Michigan's project are primarily related to the state SCHIP and Medicaid budgets, and to the choice to enroll in a managed care plan. As in all states, budget neutrality is the key for state support of any changes to current administrative procedures.

  In Michigan, migrants are currently given an option to enroll in a managed care plan or to receive services on a fee-for-service basis. If they do not elect the fee-for-service option, enrollment automatically defaults to enrollment in a managed care plan. Many farmworkers do not understand the implications of the choice they are given, and consequently do not select the option to receive services on a fee-for-services basis. Hence they are enrolled in a managed care plan, which is problematic for this population due to its mobility within the state.

- *Challenges to the Collaborative Strategy:* Challenges to the collaborative strategy of the plan deal primarily with the fundamental differences between the Texas and Michigan SCHIP and Medicaid programs, and with provider reimbursement issues. Specific concerns expressed by Michigan migrant health centers, providers and interagency coalition members include:

  - Provider reimbursement rates – Michigan SCHIP and Medicaid pay higher rates than Texas rates.
  - Differences between Texas and Michigan SCHIP and Medicaid benefit packages.
  - Uncertainty for referrals and access to specialists. The Texas MCN does not specify the inclusion of specialists within the network. In Michigan, migrant and community health centers and other providers have arrangements with specialists to which they can refer their Medicaid patients. Currently, access to specialty care is a challenge for migrant farmworkers enrolled in Michigan Medicaid. If the Texas MCN does not include specialists in the network access to them would become even more difficult.
  - Additional administrative burdens and paperwork for Michigan providers.

  A major concern for Michigan federally qualified health centers (FQHCs) is the issue of credit for encounters and wrap-around payments for services provided to migrants participating in the Texas MCN. There is a question of which state would receive credit for the Medicaid encounter. According to Michigan Medicaid, if Texas is pays for the services, the encounter would be a Texas encounter. What this means is that Michigan FQHCs would not receive Michigan wrap-around payments for encounters provided to patients participating in the Texas MCN pilot, which would result in loss of revenue to the Michigan FQHCs serving them. This is a barrier that the Texas project is working to overcome prior to pilot implementation.

Lessons Learned

Managed care plans are problematic for migrant farmworkers because they are a highly mobile population, not only between states but also within any given state. As Michigan does not have a statewide MCO, farmworkers enrolled in Medicaid and MIChild that move from one part of the

state to another would have to disenroll and re-enroll as they migrate within the State of Michigan.

In considering the composition of the MCN in Michigan, the importance of non-health center providers does not seem to have been properly assessed. As a result, Michigan provider support of the MCN is not guaranteed. Michigan FQHCs do not work in isolation and often have well developed networks, which include other providers and specialists, to provide all necessary services for their patients.

Challenges to the collaborative strategy might have been reduced through earlier intensive deliberations between the TACHC and the MPCA during the development of the Texas MCN design. In addition, significant discussions between Michigan and Texas Medicaid programs regarding the Texas MCN pilot specifics and design need to take place in order to reduce barriers and clarify administrative and programmatic specifics that could jeopardize implementation, and make pilot participation more attractive to providers.

V. OBSERVATIONS AND CONCLUSIONS

This Section presents the perspectives of the authors on states' efforts, now and in the future, to facilitate migrant farmworkers' access to Medicaid/SCHIP eligibility and services. Observations from the viewpoint of the states whose models are described in Section IV, above, are presented in the "Lessons Learned" sections of those model descriptions. Specific recommendations to support federal and/or state initiatives have previously been made in the literature, and the report to Congress under development by CMS will present new recommendations for consideration. Consequently, the concluding Section of this paper is oriented to observations the authors believe are applicable to any state's efforts, regardless of the type of model to be pursued.

The focus of these observations is on the importance of laying the groundwork for a new initiative, before model design and operational decisions are made, to improve the prospects for success. The underlying conclusion is that the scope and approach of preliminary research and collaboration is a critical factor in developing an initiative that will be accepted and that will work.

In general, the three aspects of such groundwork entail: fact-finding; coalition-building; and communicating in a common language.

A. Fact-Finding: Documenting the Scope and Impact of Program Change

Medicaid/SCHIP programs are virtually always facing budgetary constraints, and the next several years do not promise significant relief. With expiration of the temporary 2.95 % federal match increase in June 2004, year 2005 state budgets will have to account for two years of program cost inflation as they return to previous matching rates. Even when funds are available for program expansions, states face competing demands from health care providers for rate increases and from advocates for the multiple special populations served by Medicaid/SCHIP.

In such an environment, compelling arguments, supported with convincing data, are essential to successful proposals for even small changes in program policy or operations that are perceived to increase costs.

Migrant farmworkers are particularly vulnerable to perceptions on the part of some policymakers that facilitating their enrollment in Medicaid/SCHIP entails significant, or unnecessary, cost increases. Without actual data, some likely perceptions are that:

- Most migrant farmworkers would qualify because they are so poor;
- They would consume a disproportionate amount of service dollars because of their health status and risks of injury or illness related to agricultural work;
- Opening the door to migrant farmworkers would expose the state to a "new" population or that the state might become a magnet for those who postpone care until they arrive;
- Migrant farmworkers are not really the state's responsibility (despite federal residency requirements); and/or that
- Medicaid/SCHIP programs are not adaptable to migrant farmworkers or that it would be too expensive to make major operational changes for a small, temporary population.

Convincing data is needed to confront such perceptions. Even if policymakers have no pre-conceived notions, they are likely to ask legitimate questions about the real scope and impact of whatever program change is proposed. Most states do not know how many migrant farmworkers enter and/or leave the state, how long they stay or how many "settle out" within the state, whether they would qualify for Medicaid/SCHIP, nor the type and cost of health services they use, or need.

For example, recent NAWS data indicates that the demographics of the migrant farmworker population are changing, and that new entrants are more likely to be men traveling without dependents (and thus not likely to be eligible for Medicaid/SCHIP). The existing NAWS data may not be sufficient to support estimates of the numbers and characteristics of potentially eligible migrant farmworkers in the majority of states, which have relatively small numbers of migrant farmworkers. Data that is collected on a national basis needs to be readily available to individual states in a usable format for state-specific and cross-state analysis.

To support collection of new or different data, a person-specific identifier is needed, that: collects information on the migration patterns of migrant farmworkers in and out of each state and that can be linked with public health and Medicaid/SCHIP service utilization data bases. There is a need to explore how such an identifier might be framed, how to encourage migrant farmworkers to identify themselves and their family members as migrants, how the identifier should be recorded in health provider records, and how utilization data could be transmitted and maintained. Migrant health centers do collect migrant farmworker specific encounter data, but other providers, such as hospitals and private physicians, do not.

The data elements necessary to document the impact of Medicaid/SCHIP access models for migrant farmworkers have not been clearly defined. A research project to define essential data and develop a guideline for states on what questions are likely to be raised, what information is

needed to answer those questions, what data is available and how to access it, how missing data might be obtained or estimated, and how to analyze the data, would be extremely useful.

For example, to support initiatives for multi-state reciprocity or presumptive eligibility based on other states' eligibility determinations, it is important to do an in-depth comparison of the other affected state(s)' eligibility criteria. Financial eligibility criteria may be more or less liberal depending on definitions of income/assets, how income is defined and counted and allowable disregards, as well as the basic dollar thresholds. To estimate cross-state cost impacts, it is necessary to compare benefit packages, benefit-specific limits and utilization controls, and cost-sharing provisions.

When the critical data has been compiled and analyzed, it can be used for determining, or refining, what access improvement approaches might be most effective, and the potential impact on the program. When the preferred model is proposed, strategies for presenting the information in a readily understood and compelling way, tailored to different audiences, should be developed.

Initiatives involving program changes that conflict with federal Medicaid regulations, such as changes in eligibility policy or benefit packages not available as a state plan option, may require waivers from CMS. Basic approaches to inter-state reciprocity, however, can be implemented through inter-state compacts that formalize cooperative arrangements. For example, two states might agree to accept each other's eligibility determination, in whole or in part, and document the specific eligibility provisions and types of individuals affected, in a written inter-state compact. As a particular approach begins to take shape in collaboration among two or more states, CMS staff should be consulted to determine if state plan amendments or waivers are needed, and the related impact on the developmental process.

B. Coalition-Building: Starting with a broad base of support

Chances for success depend on mobilizing support from a broad base of individuals and organizations, including: those likely to be affected by the initiative; those who might have similar interests or objectives; and those whose support would be especially influential. Initiatives involving other states need to solicit collaboration with colleagues and affected parties in the other state(s) as well as locally.

Most individuals likely to initiate state migrant health access improvement projects are familiar with colleagues who share their interests, such as migrant health center staff, BPHC regional coordinators and migrant farmworker advocacy group representatives. Engaging others in the deliberations, however, may require reaching out to individuals who are not familiar with migrant health issues; some preliminary informational presentations may be necessary to spark their interest and understanding. For example, state Medicaid/SCHIP directors, state budget officials and governors' staffs may have little or no awareness of migrant populations, how their demographic characteristics relate to potential Medicaid/SCHIP eligibility, or the health services they have and need. Even state public health officials may not have focused on the importance of migrant farmworker health in safeguarding the quality of the food supply.

Advocates for other special populations can be mobilized to support a migrant farmworker access improvement initiative if they recognize that migrant farmworkers and their families represent particularly vulnerable members of their own constituencies. For example, advocates and foundations devoted to maternal and child health, or Hispanic and other ethnic groups, or low-income uninsured populations, can be oriented to the relevance of migrant farmworkers to their priority interests. Such organizations can bring resources and established relationships with policy-makers to bear on behalf of a migrant farmworker population that otherwise might lack a sufficient voice to gain attention.

It is also important to understand the dynamics of policy-making in the state, and to identify individuals in the community, in the health industry and in government who are particularly effective in promoting change. Among those individuals might be one or more who can be engaged as vocal and influential "champion(s)" of a new initiative to benefit migrant farmworkers.

And, if managed care is likely to be a factor (such as in proposing a carve-out for migrant farmworkers or developing a migrant farmworker-friendly managed care provider network), input from health plans that serve Medicaid/SCHIP populations in the affected state(s) can be informative and useful.

Collaboration and broad-based support should be solicited in the earliest stages of the effort. Single-state initiatives will improve their chances for success if broad-based support for the objectives and conceptual approach of the project are secured early and nurtured throughout the developmental process. When other states are involved, their early involvement in data collection, analysis, and deliberations on shaping the access improvement model is particularly important.

A broad-based coalition mobilized around a shared objective can be valuable in accessing a wider range of resources and creating a more audible voice for reform. Coalition members can also help with awareness of related interests and initiatives in other states and at the national level, as well as in identifying and pursuing grant-funded support from charitable foundations.

C. Common Understanding: Talking the same language

The terminology used among state and local Medicaid/SCHIP program staff is technical, program-specific and often linked to particular federal or state regulatory policies. For example, terms like "presumptive eligibility," "continuous eligibility" or even "income" and "family" have specific meanings in the Medicaid/SCHIP context. Some Medicaid/SCHIP terminology is defined in federal law or regulations; other terms may be defined differently among different states, but are always specific to the Medicaid/SCHIP programs.

Terminology used among migrant farmworker service organizations and advocacy groups tends to be less well-defined or commonly understood. Terms like "reciprocity" or "presumptive eligibility" or even "migrant farmworker" may mean different things to different individuals. Section II.D. of this paper attempts to clarify some frequently-used terms for common understanding.

An important first step in doing the groundwork for a new initiative and in securing a coalition of support is to understand the language of each interest group, and clarify terms to assure communications are clearly and accurately understood by all.

D. Some Final Observations

Each state is different, in the economic and political climate, the migrant farmworker demographic characteristics, and the Medicaid/SCHIP policies, operations and supporting systems. A model well suited to one state cannot be readily transplanted to another state without intensive analysis and tailoring. Achieving success in implementing an access improvement model is a process – one that takes time and persistence.

Be attentive to, and capitalize on, opportunities to get your message out and across. Armed with data analysis, be prepared to inject compelling facts into state legislative budget hearings, the press, and any other forum that will expand awareness of the need for improving health service access for migrant farmworkers.

A broad-based coalition is a key element of a successful strategy, to raise awareness, ensure sensitivity to varied perspectives and interests, surface and resolve questions that will increase the chances of designing a workable model, and to access available funds or other resources. Early coalition-building might reach out to influential individuals among, e.g.: health and social service agencies; State Medicaid/SCHIP officials; executive and legislative policymakers and their staffs; private sector provider and managed care organizations; providers that work with the farmworker population; and local, state, and national advocates for special populations.

Any model to improve migrant farmworker access to Medicaid and SCHIP requires structural and process changes to programs that were not designed for mobile populations. Creating system changes takes resources and time, and the effort must be prompted and sustained by a broad base of common interests. Martial your forces, collaborate, do your homework, get your message across, be persistent, and be patient. These are the seeds to harvesting solutions.

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