

medicaid
and the **uninsured**

**Migrant and Seasonal Farmworkers:
Health Insurance Coverage and Access to Care**

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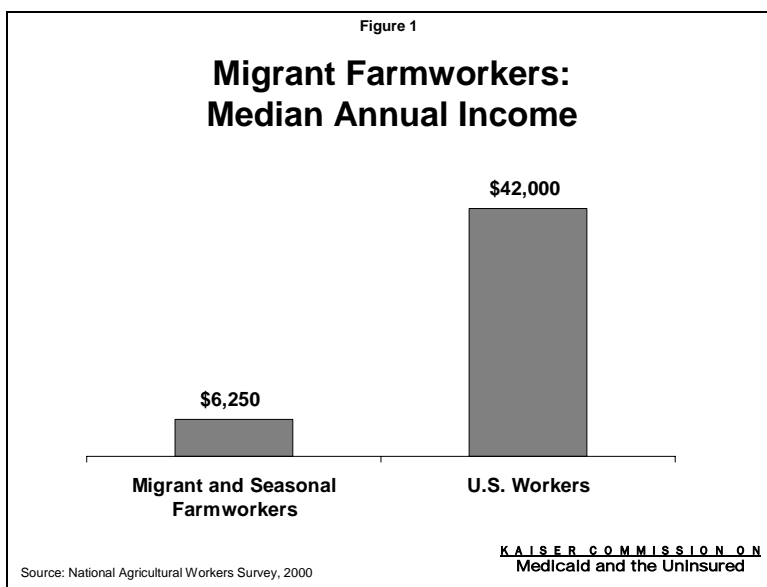
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EXECUTIVE SUMMARY

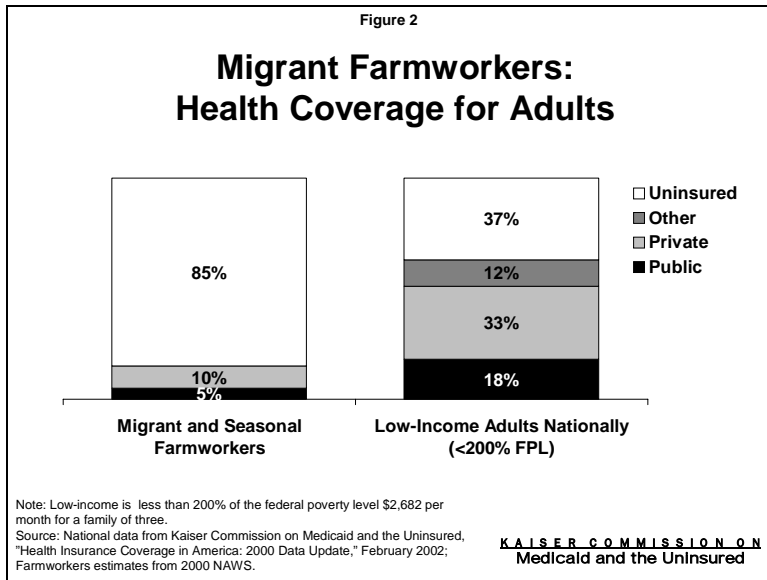
Migrant and seasonal farmworkers are an integral support to the nation's agricultural industry. Nearly three million workers earn their living through migrant or seasonal farm labor. Migrant and seasonal farmworkers and their families confront health challenges stemming from the nature of their work, their extreme poverty and mobility, and living and working arrangements that impede access to health coverage and care. This brief provides an overview of migrant and seasonal farmworkers and the health challenges they face and considers options for improving their health coverage and access to care.

Overview of Farmworkers and their Health Coverage and Care

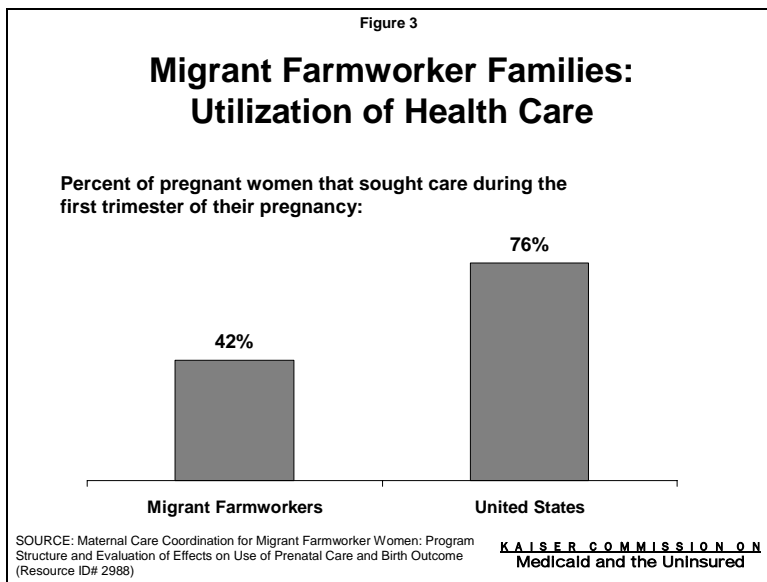
Almost all migrant and seasonal farmworkers are foreign-born with only 6% reporting being born in the United States. The majority (70%) permanently reside in the United States. Although concentrated in certain areas of the country, migrant and seasonal farmworkers reside in all states. They travel frequently between states for their employment. As a group, migrant and seasonal farmworkers face significant language barriers—about 9 in 10 say they read and speak little or no English. They are predominantly male (88%), over half are married (52%), and over four in ten have children (44%). Even though migrant and seasonal farmworkers report working five to six days a week, they are extremely poor. In 2000, the median income for migrant and seasonal farmworkers was \$6,250, compared to \$42,000 for U.S. workers overall (Figure 1).



Migrant and seasonal farmworkers and their families are overwhelmingly uninsured. In 2000, 85% of migrant and seasonal farmworkers were uninsured, compared to 37% of low-income adults nationally (Figure 2). Further, nine in ten children in migrant and seasonal farmworker families were uninsured compared to less than a quarter (22%) of low-income children nationally.



Reflecting their low levels of coverage, migrant and seasonal farmworkers and their families use very little health care compared to other low-income people. In 2000, only 20% of migrant and seasonal farmworkers reported using any healthcare services in the preceding two years. Further, one study found that only 42% of women in farmworker families reported seeking early prenatal care compared to over three-quarters (76%) nationally (Figure 3). Data show a nearly one in four incidence of undesirable birth outcomes and elevated rates of low birthweights and pre-term births among the farmworker population.



The low utilization patterns among farmworkers are not a reflection of limited health care needs. Migrant and seasonal farmworkers are often in poor health and they are at elevated risk for an enormous range of injuries and illnesses due to the nature of their jobs. The two most significant reported barriers to care among migrant and seasonal farmworkers are cost and language.

Health Centers Serving Farmworkers

Federally funded health centers are a key source of care for migrant and seasonal farmworkers. In 2002, 125 of the nation's 843 federally funded health centers received funds specifically targeted to meet migrant health needs. These centers serviced some 670,000 migrant and seasonal farmworkers and their families. An additional 247 health centers, which did not receive a specific migrant subsidy, served another 39,000 migrant and seasonal farmworkers and their families.

The vast majority of health centers that receive migrant funding also rely on general health center grants and serve the overall low-income population. Because they serve both farmworkers and other community residents, they are similar to health centers that do not receive special migrant funding in terms of the insurance distribution of both their patients and their revenues—Medicaid covers about 35% of patients and accounts for over a third of revenues, and about a quarter of revenues comes from federal grants. Centers that receive migrant funding do differ from other centers in that they often offer services tailored to migrant and seasonal farmworkers families' needs, such as outstationed services.

In 2002, some 15 health centers were funded exclusively with migrant grant funding and did not receive general health center grants. These centers tend to be far smaller than other health centers, and, because the overwhelming majority of their patients are uninsured (92%), their revenues primarily come through their federal grants (80%).

Medicaid Coverage Barriers

Migrant and seasonal farmworkers face a number of barriers to obtaining Medicaid coverage. Some of these problems affect the low-income population generally, but many of them are exacerbated by the characteristics of migrant and seasonal farmworkers, such as their immigrant status, their fluctuating incomes, and their migratory patterns.

- **Many migrant and seasonal farmworkers are not eligible for Medicaid.** One significant barrier is that, under current law, states cannot provide Medicaid coverage to non-disabled low-income adults without dependent children. Further, since 1996, recent immigrants, including legal immigrants, have been excluded from Medicaid for the first five years they reside in the United States. From a financial eligibility perspective, some states use monthly budgeting rules and have restrictive asset tests, which make it difficult for low-income workers with fluctuating incomes and assets needed for employment (e.g., a truck) to qualify.
- **Eligible migrant and seasonal farmworkers can have difficulty enrolling in Medicaid.** Migrant and seasonal farmworkers who are eligible for Medicaid may have difficulty completing the application and enrollment process. Given their limited English skills, it can be very difficult for them to complete long application forms or meet extensive verification requirements, particularly if there is limited availability of language assistance. Inaccessible site locations can also impede enrollment.
- **Because of their frequent movement among states for work, migrant and seasonal farmworkers also face state residency barriers to Medicaid coverage.** Medicaid is a state-based program. It recognizes state residency among people who live in a state for work-related purposes and states also are required to provide out-of-state coverage for their

residents to permit travel, but this coverage can be very limited. Accordingly, migrant and seasonal farmworkers can seek to apply for Medicaid each time they change their state residence, but they may encounter enrollment barriers such as those mentioned above. On the other hand, farmworkers can travel with a Medicaid card from the state in which they permanently reside but may find that they are only covered for emergency situations and/or have difficulty identifying out-of-state providers willing to honor the card.

Options to Improve Coverage and Access to Care

Over the years, a few states, including Wisconsin and Texas, have attempted to improve Medicaid's ability to serve farmworkers. From these state experiences, we have learned that Medicaid can be made more accessible through rapid enrollment, accessible enrollment locations, acceptance of out-of-state enrollment cards, and payment for a broad range of services provided out-of-state. Federal efforts could be undertaken to improve states' willingness to pursue these initiatives and to improve their effectiveness. The federal government also could pursue broader efforts to address farmworkers' coverage challenges:

- **Improving access to Medicaid.** A number of actions could be taken to facilitate farmworkers' ability to enroll in and utilize Medicaid coverage.

Facilitating eligibility reciprocity across states. The model of accepting an out-of-state enrollment card can work well but is hindered by varying eligibility standards across states. It could be facilitated by federal guidelines for implementing a fast track enrollment option, changing existing eligibility criteria, and identifying health centers and other programs to serve as enrollment sites. It could be further encouraged by allowing states to establish separate eligibility standards for farmworkers and their families that could be consistent across states.

Improving "traveling Medicaid card" models. The model of paying for out-of-state services requires efforts to identify out-of-state providers willing to participate and a claims administration intermediary. Federal efforts could encourage and improve this model. For example, if a regional intermediary were identified, it could enable processing of out-of-state claims, creation of provider networks, and outreach and education for traveling families. Costs for this effort would appear to be directly related to state Medicaid administration and, thus, eligible for reimbursement.

- **Creating a new federal coverage program for farmworkers and their families.** While these initiatives may help encourage enrollment and access among eligible farmworkers, they will not be able to overcome the barriers stemming from Medicaid's exclusion of adults without dependent children and recent immigrants. A broader solution for farmworkers and their families might be to couple Medicaid access efforts with a federal coverage program that could enroll farmworkers and their families on a nationwide basis, thereby permitting interstate movement and portable benefits.

The health needs of farmworkers are considerable, but their numbers are relatively modest. The evidence reviewed in this analysis suggests the importance of addressing their needs and presents a range of viable options, including efforts through Medicaid and other programs to complement Medicaid's reach. Such efforts might help surmount the major challenges farmworkers and their families face in terms of securing health coverage and accessing needed care.

I. INTRODUCTION

An estimated three million workers earn their living through migrant and seasonal farm labor, traveling the nation to support an agricultural industry which yielded \$28 billion in fruit and vegetable business in 2001 alone.¹ Forty-five years ago, farm labor was the subject of *Harvest of Shame*,² a classic documentary which chronicled the devastating conditions under which migrant laborers worked. Much has changed over the past four and a half decades where workplace safety and healthcare access are concerned; at the same time, migrant and seasonal farmworkers continue to confront unique health and healthcare challenges arising from the hazardous nature of their work, their extreme poverty and mobility, and living and working arrangements which serve to make access to health insurance and health care especially difficult.

As part of the 2002 reauthorization of the health centers program, Congress mandated a study to examine “the problems experienced by migrant and seasonal farmworkers (including their families) under Medicaid and SCHIP.”³ Congress sought an analysis of Medicaid enrollment and portability barriers as well as options for possible solutions, both within the current limits of Medicaid and SCHIP and through use of Section 1115 demonstration authority and public-private partnerships to develop coverage alternatives.

This policy brief begins with a review of the health and healthcare environment in which migrant and seasonal farmworkers and their families live and work, as well as the challenges faced by the nation’s federally funded health centers serving the farmworker population. It then reviews the literature on farmworker healthcare coverage and considers policy options for improving health insurance coverage and healthcare access for farmworkers.

II. STUDY APPROACH

A. Data Sources

The information used to develop this analysis comes from a review of the literature as well as two data sources: the 2000 National Agricultural Worker Survey (NAWS), a periodic national survey of farmworkers conducted by the United States Department of Labor; and the Uniform Data System (UDS) maintained on federally funded health centers by the United States Department of Health and Human Services, Health Resources and Services Administration. Although other data sources exist for describing the migrant labor force, only these two data sets provide information on migrant health status and health care access.⁴ (In January 2005, the Department of Labor announced that it was discontinuing NAWS, thereby ending access to specialized economic, living arrangement, and health insurance coverage information about farmworkers.)

¹ National Center for Farmworker Health, *Facts About Farmworkers* (Accessed September 6, 2004) www.ncfh.org.

² Walter Goodman, “New Harvest, Old Shame” NY Times (1990) Accessed at <http://www.galaninc.com/press/prharvest.phtml> (September 6, 2004)

³ §404, Pub. L. 107-251 (107th Cong., 2d Sess.)

⁴ Although the monthly Current Population Survey provides detailed information on the labor force, it does not specifically target migrant workers. The Department of Agriculture conducts two surveys, the Farm Labor Survey (FLS) every 4 months and Census of Agriculture every five years, for the purpose of tracking wage rates and production.

Several years of NAWS data were examined in this study. The 2000 NAWS data are based on interviews with more than 3,500 randomly selected workers who perform various agricultural services. The survey excludes secretaries and mechanics, as well as workers who are non-immigrants working in the U.S. under a temporary visa issued pursuant to the Immigration and Nationality Act.⁵ The NAWS analysis is based on a sub-sample of approximately 1,400 workers who identified themselves as migrant farmworkers.

The UDS includes tabulated patient data and select encounter information from all federally-funded health centers. The UDS identifies migrant and seasonal farmworkers, including their dependents. In 2002, 372 out of 843 federally funded health centers (44%) served 708,611 persons identified as migrant and seasonal workers and family members. Among this broader group of grantees receiving both general and migrant health center funding, 15 health centers received migrant and seasonal farmworker grants exclusively and served a total of 58,350 patients. The UDS analysis provides information on this small grantee subset as well as the broader universe of migrant health centers.

B. Defining the population

As with any analysis of population characteristics, an examination of farmworkers and their families begins with a discussion of definitions. Two separate sets of policies – those which are a part of labor law, and those which govern the provision of migrant healthcare – are relevant.

Department of Labor definitions: The Migrant and Seasonal Agricultural Worker Protection Act⁶ (MSAWPA) extends protections to individuals currently employed as farmworkers and reaches two distinct classes of farmworkers: migrant agricultural workers and seasonal agricultural workers.

A “*migrant agricultural worker*” is an individual who is

employed in agricultural employment of a seasonal or other temporary nature, and...is required to be absent overnight from his permanent place of residence.⁷

The term “*seasonal agricultural worker*” means

an individual who is employed in agricultural employment of a seasonal or other temporary nature and is not required to be absent overnight from his permanent place of residence: (1) When employed on a farm or ranch performing field work⁸ related to planting, cultivating, or harvesting operations; or (2) When employed in canning, packing, ginning, seed conditioning or related research, or

⁵ For more details on the survey methodology, see the Department of Labor's *The National Survey of Agricultural Workers* at <http://www.dol.gov/asp/programs/agworker/naws.htm>.

⁶ 29 U.S.C. §1801 et., seq.

⁷ 29 C.F.R. §500.20. The NAWS survey notes that a 75 mile travel distance is used to measure “required”.

⁸ The concept of field work as it relates to seasonal and migratory farmwork encompasses planting, cultivating or harvesting operations and “includes all farming operations on a farm or ranch which are normally required to plant, harvest or produce agricultural or horticultural commodities, including the production of a commodity which normally occurs in the fields of a farm or ranch as opposed to those activities which generally occur in a processing plant or packing shed. A worker engaged in the placing of commodities in a container in the field and on-field loading of trucks and similar transports is included.”

processing operations, and transported, or caused to be transported, to or from the place of employment by means of a day-haul operation.⁹

The term “*agricultural employment*” means agricultural work within the scope of the Fair Labor Standards Act and the Internal Revenue Code. It includes service activities involving

the handling, planting, drying, packing, packaging, processing, freezing, or grading prior to delivery for storage of any agricultural or horticultural commodity in its unmanufactured state.¹⁰

“*Agricultural commodities*” encompass products “of the soil that are planted and harvested by man.”¹¹

The definition of migratory and seasonal farmworkers under the MSAWPA does not include individuals who are temporary non-immigrants authorized to work in agricultural employment under the Immigration and Nationality Act.¹² NAWS provides data on both farmworkers employed in their communities as well as those who travel for work as defined under the law.

Health centers program definitions: The definition of “migrant and seasonal farmworker” which is used in the health centers program actually is somewhat broader than that found in U.S. labor law.

Under the Public Health Service Act, a “*migratory agricultural worker*” means

An individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes for the purposes of such employment a temporary abode.¹³

A “*seasonal agricultural worker*” means an individual “whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.”¹⁴

Unlike the more narrowly circumscribed Department of Labor (DOL) definition, the Public Health Service definition recognizes individuals and families for whom migrant labor is their principal, although potentially not their only, form of labor, as well as persons who were farmworkers in the recent past (presumably and sensibly in order to allow for transitional health care within a health center). In addition, the Public Health Service Act does not contain distinctions based on legal or immigrant status.

As with the DOL definition, the term “agriculture” under the health centers program focuses on farming the land, as well as preparation and processing performed either by a farmer or on a farm

⁹ 29 C.F.R. §500.20

¹⁰ Id.

¹¹ 29 C.F.R. §780.12

¹² 29 C.F.R. §500.20

¹³ 42 U.S.C. 254(g)

¹⁴ Id.

for the purpose of market and delivery to storage.¹⁵ The Public Health Service Act does not distinguish between immigrants and non-immigrants who perform farm labor duties.¹⁶

These definitional differences mean that the potential eligible migrant and seasonal farmworker population at migrant health centers may be larger than the population counted as farmworkers by the DOL. This population would include temporary non-immigrants, as well as citizens and legal residents for whom migrant farm labor is a principal (but non-exclusive) occupation. The eligible population also could include families with a member who worked as a migrant or seasonal farmworker within the preceding 24 months but does not do so at the present time. Despite these distinctions, experts in migrant health care view NAWS as providing an accurate portrait of migrant and seasonal farmworkers for purposes of designing health care services.¹⁷

C. Counting Farmworkers

Simply calculating the size of the migrant and seasonal farmworker population presents a challenge. Because NAWS is a sample-based study, it does not offer a population census. According to the Bureau of Primary Health Care within HRSA, which administers the health centers program, the most recent national population estimates of migrant and seasonal agricultural workers are found in the 1993 “Atlas of State Profiles which Estimate [the] Number of Migrant and Seasonal Farmworkers and Members of their Families.”¹⁸ The Bureau initiated an update of this census in the late 1990s, but the latest estimates are available only for a 10-state subset;¹⁹ as a result, the most recent national census data are over ten years old. The 1993 Atlas enumeration reports slightly over three million migrant and seasonal farmworkers. This figure is below the four million worker census from 1990; however, the estimation methods changed between the two time periods, making accurate trend examination impossible.²⁰

III. A PROFILE OF FARMWORKERS AND THEIR FAMILIES

A. Residential Patterns and Demographics

Residential Patterns. Although concentrated in certain areas of the country, migrant and seasonal farmworkers are found in all states. Figure 4, drawn from the 1993 enumeration shows, that 68 % of all migrant and seasonal farmworkers were concentrated in 8 states that year: California, Florida, Georgia, Michigan, North Carolina, Oregon, Washington State, and Texas.²¹

¹⁵ Id.

¹⁶ Programs of the Public Health Service Act, and specifically health centers, are not considered public benefits whose use is restricted under the Immigration and Nationality Act.

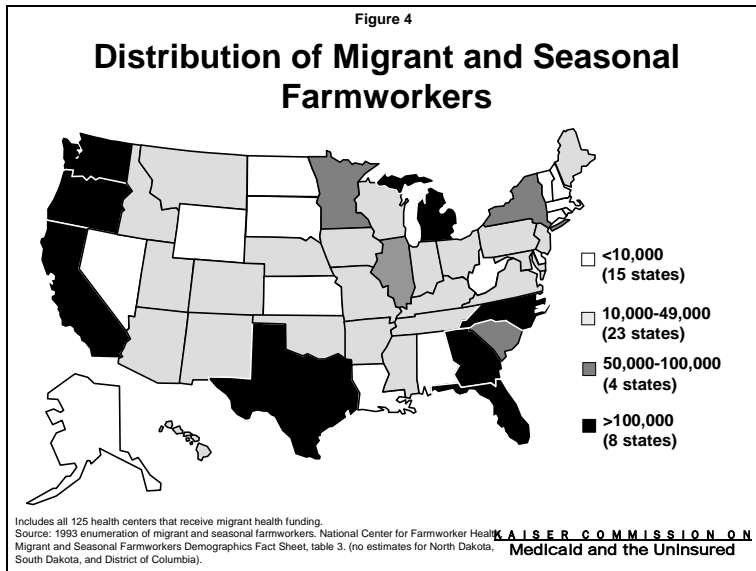
¹⁷ For an excellent source of information on farmworkers in a health and healthcare context, see the National Center for Farmworker Health, www.ncfh.org.

¹⁸ National Center for Farmworker Health, Migrant and Seasonal Farmworkers Demographics Fact Sheet <http://www.ncfh.org/docs/fs-Migrant%20Demographics.pdf> (Accessed September 6, 2004).

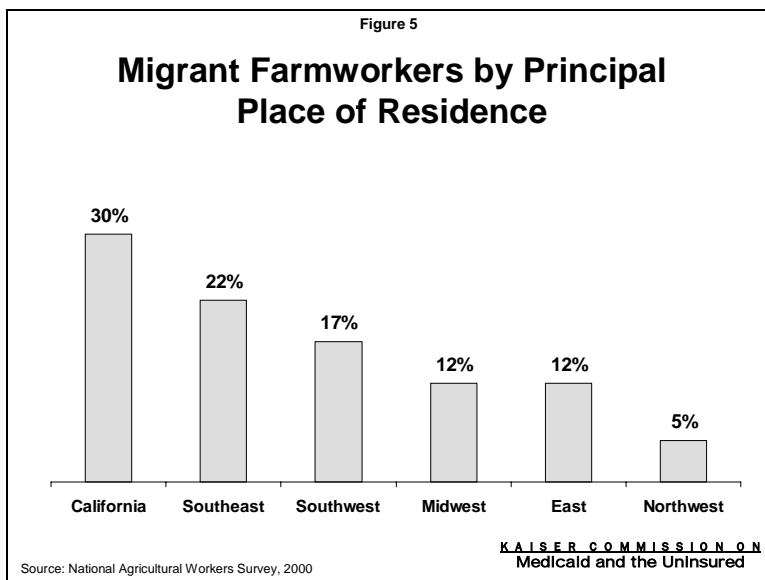
¹⁹ State level analyses were completed in 2000 for Arkansas, California, Florida, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, Texas and California. They can be viewed at <http://bphc.hrsa.gov/migrant/Enumeration/EnumerationStudy.htm> (Accessed September 6, 2004)

²⁰ National Center for Farmworker Health, Migrant and Seasonal Farmworkers Demographics Fact Sheet <http://www.ncfh.org/docs/fs-Migrant%20Demographics.pdf> (Accessed September 6, 2004)

²¹ Id. Table, p. 3.



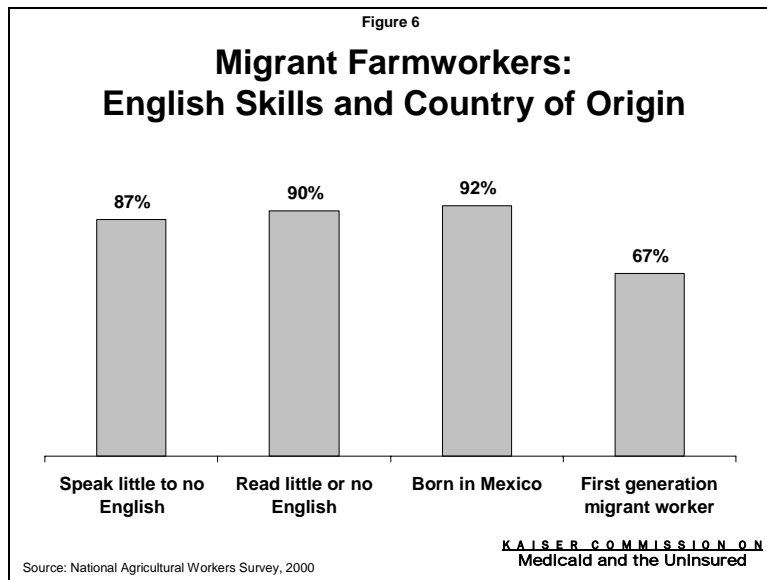
Approximately 70% of migrant and seasonal farmworkers permanently reside in the US. Figure 5, drawn from the 2000 NAWS, shows the states in which migrant and seasonal farmworkers tend to be domiciled (i.e., reside permanently). As Figure 5 indicates, California is the largest domicile state, representing 30% of all farmworkers. Twenty two percent of respondents report a domicile in a southeastern state, 17% report a southwestern state domicile, 12% report a Midwestern state domicile, 12% report an eastern state domicile, and 5% a northwestern domicile.²² These residential patterns underscore that domiciles differ markedly from the states in which workers reside for relatively brief periods of time as they travel for employment reasons.



²² East includes DE, KY, MA, ME, NC, NJ, NY, PA, TN, and WV; Southeast includes AL, AR, FL, GA, LA, and MS; Midwest includes IA, KS, IL, IN, MI, MN, MO, NE, OH, SD, and WI; Southwest includes AZ, OK, and TX; and Northwest includes CO, ID, OR, WA. California is the only state that is reported separately.

Work Patterns. The NAWS data indicate that among migrant and seasonal farmworkers, 24% indicate they had at least two farm jobs more than 75 miles apart. The remaining 76% report that they shuttle to two or more crop locations at least 75 miles from their residence.

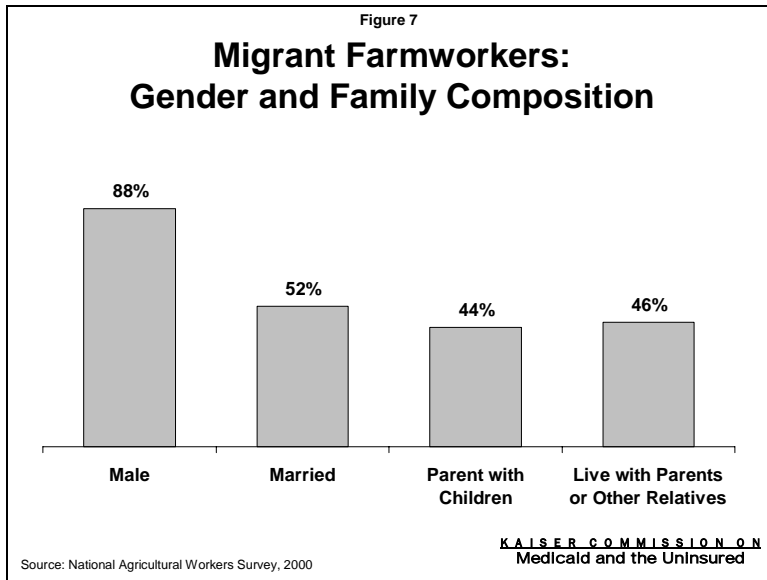
Demographic Characteristics. Figure 6 shows that migrant and seasonal farmworkers are overwhelmingly foreign-born and as a group tend to speak and read little or no English. Six percent of NAWS respondents identify themselves as U.S. born, while 67 percent identify themselves as first generation farmworkers.²³



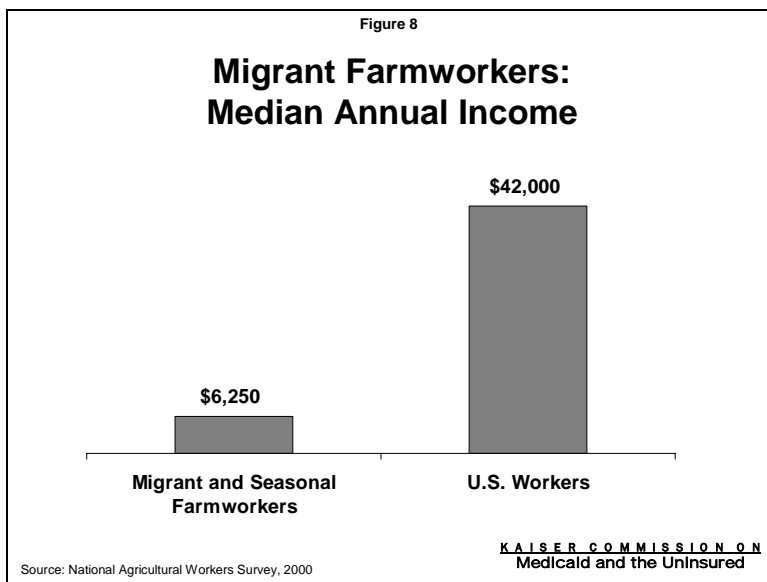
Most migrant and seasonal farmworkers are male, and 52% are married (Figure 7). Somewhat fewer than half of all migrant and seasonal farmworkers have children, while about half live in households with parents and other family members. Among migrant and seasonal farmworkers with children, 66% migrate with their children and an estimated 250,000 children migrate with their parents each year.²⁴

²³ First generation migrants report parents did no farm work.

²⁴ National Center for Farmworker Health, *Maternal and Child Health Fact Sheet* (Buda Texas) (Accessed September 6, 2004 at <http://www.ncfh.org>)



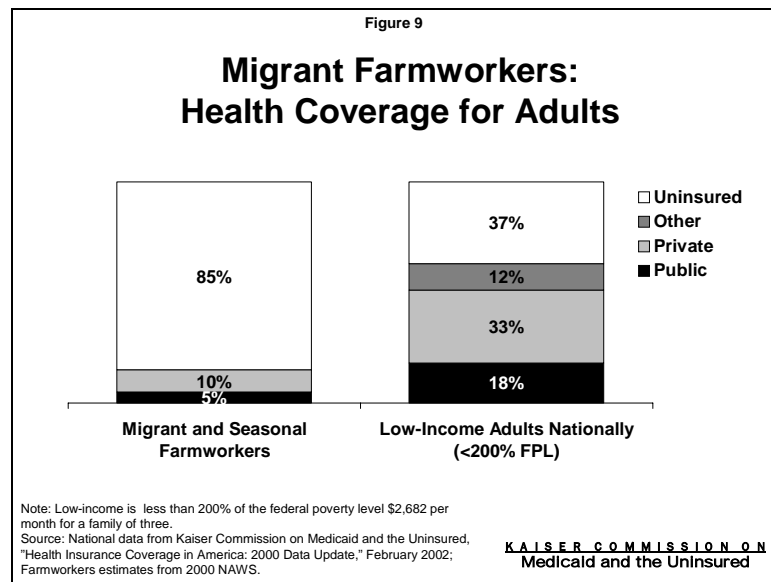
Poverty among migrant and seasonal farmworker families is very deep. In 2000, U.S. workers earned a median annual income in excess of \$42,000.²⁵ Figure 8 shows that the 2000 median income of migrant and seasonal farmworkers stood at \$6,250, even as they reported working 5 to 6 days a week. Further analysis of income data show that 91% of migrant and seasonal farmworkers reported annual income below \$15,000 in 2000, while 56% reported earnings lower than \$5,000. Income trends drawn from NAWS data show the proportion of migrant and seasonal farmworkers with annual family incomes below the federal poverty level increased from 51% in 1993 to 76% in 1998, falling back to 59% in 2000.



²⁵ U.S. Census Bureau. <http://www.census.gov/hhes/income/income00/inctab1.html> (Accessed September 2004)

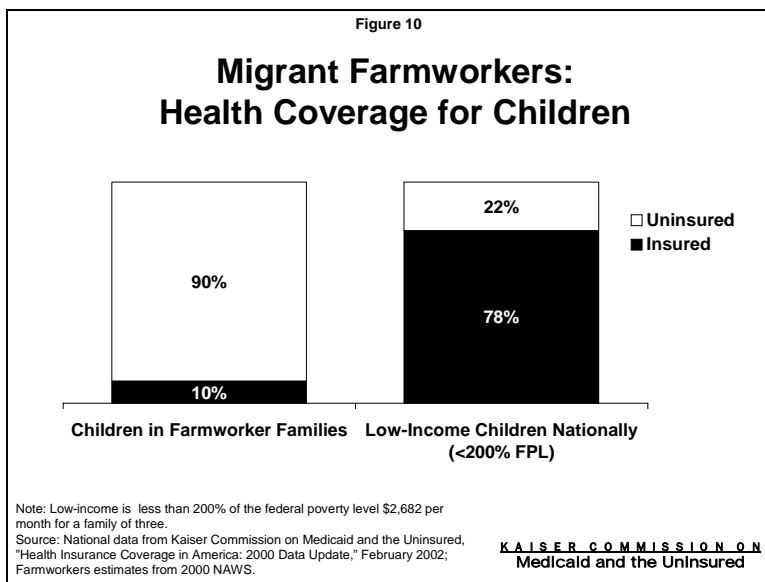
B. Health Coverage, Utilization, and Status

Health Coverage. Compared to workers generally, migrant and seasonal farmworkers and their families are overwhelmingly uninsured. Figures 9 and 10 illustrate the extent to which farmworkers and their families lack coverage. In 2000, 85% of migrant and seasonal farmworkers were completely uninsured, compared to 37% of all low-income adults nationally (i.e., adults with family incomes at or below 200% of the federal poverty level).²⁶ Ten percent of migrant and seasonal farmworkers reported private coverage, while 5% reported coverage through Medicaid. Children of migrant and seasonal farmworker families similarly were pervasively uninsured compared to low income children nationally; nearly 90% were completely uninsured in 2000, compared to 22% of all low-income children that year.²⁷ Trends over time, as shown in the NAWS data, suggest that despite the advent of major Medicaid reforms for children, Medicaid coverage among children in migrant and seasonal farmworker families remains very low, although Medicaid represents the dominant form of health insurance for migrant and seasonal farmworker children.



²⁶ U.S. Department of Labor, "National Agricultural Workers Survey"(Release 3.0) and Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2000 Data Update," February 2002.

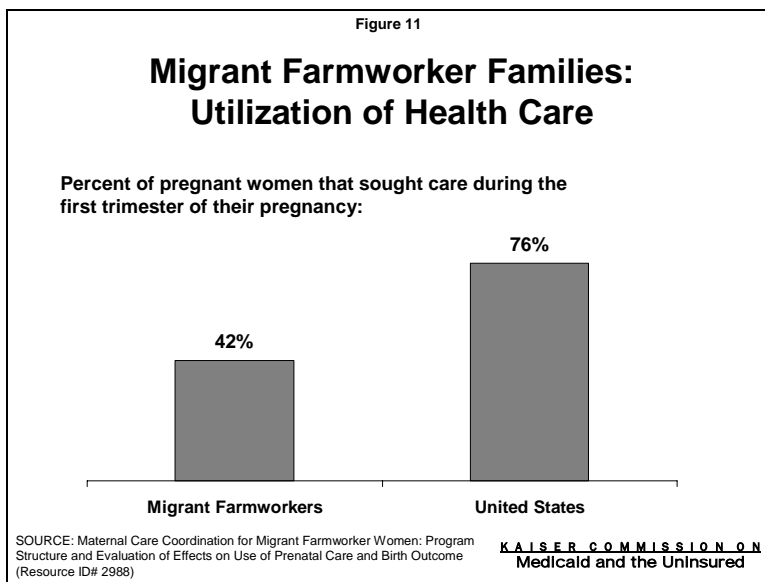
²⁷ U.S. Department of Labor, "National Agricultural Workers Survey"(Release 3.0) and Kaiser Commission on Medicaid and the Uninsured, "Health Insurance Coverage in America: 2000 Data Update," February 2002.



Utilization of Health Care. Migrant and seasonal farmworkers and their families use very little health care compared to other low-income people. The 2000 NAWs data indicate that only 20% of migrant and seasonal farmworkers reported the use of any healthcare services in the preceding 2 years. Although the NAWs does not inquire about related reasons for use or nonuse of services, it does ask about barriers. Survey respondents identified cost and language as the two most significant barriers to care, as borne out by smaller studies of farmworkers in selected states.²⁸ Additionally, one study found that only 42% of farmworker women reported early prenatal care (i.e., within the first 3 months of pregnancy) compared to 76% nationally (Figure 11). Researchers have noted that even where services are available, extreme mobility means that families may leave an area before treatment is furnished.²⁹ Extreme mobility leaves families at particularly great risk for limited and interrupted health care.

²⁸ M. Perez, G. Reuben, H. Pinzon, "Northern California Hispanic migrant farm workers health status: a case study," *Migration World Magazine*, 26(1-2), 1998.

²⁹ Gina R. Lombardi, "Dental/Oral Health Services" *Migrant Health Issues* (National Center for Farmworker Health (Accessed September 6, 2004 at <http://www.ncfh.org>) 2001.



Health Status. The limited use of health services by migrant and seasonal farmworkers cannot be attributed to a low need for health care. Indeed, by virtue of their extreme poverty, their mobility in search of work, and hazardous living and housing conditions under which they work, migrant and seasonal farmworkers have an extraordinary need for health care. Farmworkers are at elevated risk for an enormous range of injuries and illnesses. According to a review of data from the Bureau of Labor data, while agriculture-related employment comprised only 2% of overall employment, agricultural and livestock-related production, along with agricultural services, comprised 13% of all occupational deaths over a 1994-1999 time period.³⁰ Risks arise as a result of work-related conditions, the use of equipment, and exposure to chemicals, with resulting elevated rates of chronic conditions, musculoskeletal injuries, serious disabilities, and fatalities.

More than 40% of all workers reported leaving or changing jobs as a result of chronic pain.³¹ Respiratory illnesses such as asthma and bronchitis are relatively common, as are skin problems, exposure to infectious diseases such as tuberculosis and parasites, and diseases related to unsanitary and close living conditions in substandard housing.³² Higher rates of cancer are suspected, as are elevated rates of eye and vision problems.³³ Pesticide exposure and its consequences represent one of the best documented risks, although experts believe that there are insufficient studies examining the effects of multiple pesticide exposure.³⁴

The families of farmworkers also appear to have poor health status and to be at high risk for illness. Exposure to chemicals can result in contamination, which, in turn, is brought home to

³⁰ Alice Larson, Environmental/Occupational Safety and Health, “*Migrant Health Issues Monograph Series* (National Center for Farmworker Health, Buda Texas, 2001) (Accessed September 6, 2004 at <http://www.ncfh.org>)

³¹ Id.

³² Id. See also Christopher Holden, “Housing,” *Migrant Health Issues* (National Center for Farmworker Health, Buda Texas, 2001) (Accessed September 6, 2004 at <http://www.ncfh.org>)

³³ Id.

³⁴ Id.

the children of migrant and seasonal farmworkers.³⁵ Research has documented a rate of self-reported fair-to-poor health status among farmworker mothers that stands at more than triple the rate for the general population.³⁶ Data from a special CDC data system which measures pregnancy nutrition among the population found diminished weight gain, a nearly one-in-four incidence of undesirable birth outcomes, elevated rates of low birthweights and preterm births among farmworkers.³⁷

Health problems among farmworker children are extensive, with studies showing a high incidence of intestinal parasites, severe asthma, chronic diarrhea, Vitamin A deficiency, chemical poisoning, and continuous ear infections.³⁸ Despite their greater health risks, depressed access to care means that farmworker children are delayed in their immunization schedules.³⁹ Migrant children also have been found to exhibit “striking” levels of mental illness such as anxiety, depression, and disruptive behaviors. Researchers have attributed these risks to the psychological impact of the extreme poverty, separation, and dislocation experienced by children in farmworker families.⁴⁰ Dental problems among migrant and seasonal farmworkers and their families rank among the top five health problems for individuals ages 5 through 29; children of farmworkers experience a rate of decay twice that for children in the general population.⁴¹

IV. A PROFILE OF HEALTH CENTERS SERVING FARMWORKERS

In 2002, 125 of the nation’s 843 federally funded health centers received funds specifically targeted to meet migrant health needs; these centers served 670,000 migrant and seasonal farmworkers and their families. Another 247 health centers, which do not receive a specific migrant subsidy, served an additional 39,000 farmworkers and family members. That year, 44% of all health centers served migrant and seasonal farmworkers and some 25% of all migrant and seasonal farmworkers reported in the 1993 Enumeration received health care at a health center. These statistics capture the central importance of health centers to farmworker healthcare access. Figure 12 shows the relative distribution of health centers receiving migrant grants.

³⁵ Id.

³⁶ National Center for Farmworker Health, *Maternal and Child Health Fact Sheet* (Buda Texas) (Accessed September 6, 2004 at <http://www.ncfh.org>)

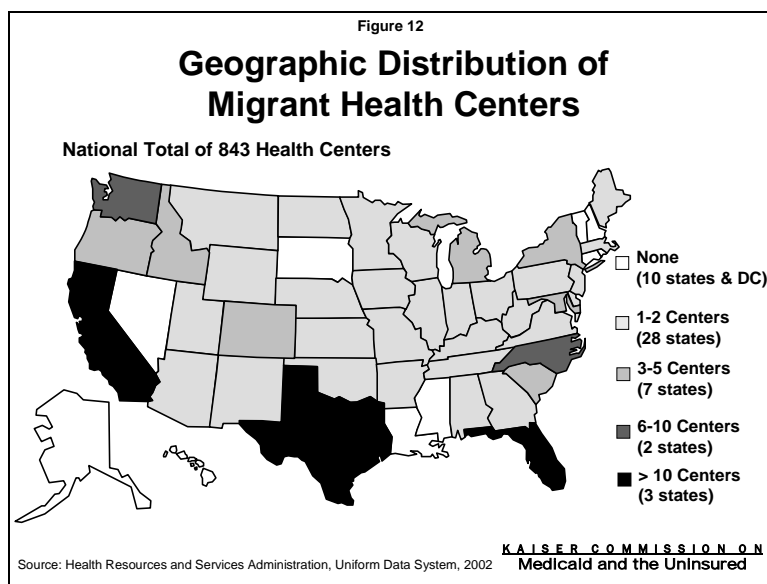
³⁷ National Center for Farmworker Health, *Maternal and Child Health Fact Sheet* op. cit.

³⁸ Id.

³⁹ Id.

⁴⁰ Joseph D. Hovey, “Mental Health and Substance Abuse” *Migrant Health Issues* (NCFH, Buda Texas, 2001) Accessed September 6, 2004 at <http://www.ncfh.org>.

⁴¹ Gina R. Lombardi, “Dental/Oral Health Services” *Migrant Health Issues* (National Center for Farmworker Health (Accessed September 6, 2004 at <http://www.ncfh.org>) 2001.



The vast majority of health centers receiving migrant funding (110 out of 125 in 2002) are “mixed grant” centers; that is, they also receive general health center grants. This dual status permits health centers to serve the general population, as well as furnish continuing care to families after they leave farm labor. Approximately 27% of patients served at “mixed grant” centers nationally are migrant and seasonal farmworkers and their family members. In terms of both insurance distribution of patients and revenue distribution, these “mixed grant” health centers resemble those that do not receive migrant grants. At the same time, mixed grant health centers also offer services which are tailored to migrant and seasonal farmworker families, in particular, outstationed services in accessible locations, Medicaid enrollment assistance, and services which are geared to addressing the unique health conditions and needs of migrants (see text box on next page).

Some 15 migrant health centers were funded exclusively as migrant health centers, that is, without mixed grants. These 15 health centers were located in Alabama, Georgia, Iowa, Illinois, Kansas, Kentucky, Massachusetts, Maine, Michigan, Minnesota, Montana, New York, North Carolina, South Carolina, and Wyoming. Although these centers are as likely as their “mixed grant” colleagues to be located in rural areas and provide similar services, the 15 migrant health centers tend to be far smaller. Approximately two-thirds reported fewer than 5,000 patients and only one exclusively migrant health center reported serving more than 10,000 patients.

Farmworker Services in a Michigan Community Health Network

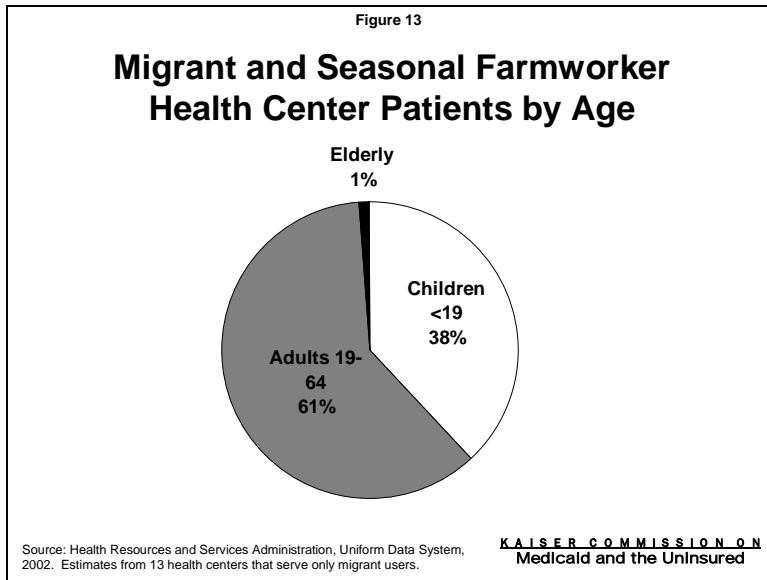
The Intercare Community Health Network has served farmworkers and community residents throughout western and southwestern Michigan for more than 30 years. From its beginnings as a modest community clinic for farmworkers and local area residents, Intercare has grown into a six-site health network serving more than 40,000 patients. More than one in four Intercare patients is a member of a migrant or seasonal farmworker family. Intercare's services parallel those found at many health centers: comprehensive primary medical care; dental care; prenatal and obstetrical care; maternal and infant support services; breast and cervical cancer screening and testing; health education and outreach; and behavioral health care. More than 80% of Intercare's patients have family incomes below 100% of the federal poverty level, 45% are uninsured, and 38% are insured through Medicaid. Although 11% of Intercare's patients have private health insurance, among Intercare's pregnant patients, the figure is far lower; of 300 pregnant women who received care in 2004 at one site, only 10 (3%) had private health insurance.

For more than a decade, Medicaid application assistance has been a central feature of Intercare's patient support services. Farmworker families are included in this support effort, with particular emphasis placed on pregnant women and children. Medicaid coverage is enormously important to the success of Intercare's obstetrical program: 98% of all pregnant applicants qualify for help (either full coverage or emergency Medicaid and state-funded medical assistance for expectant mothers who cannot satisfy Medicaid's legal status test).

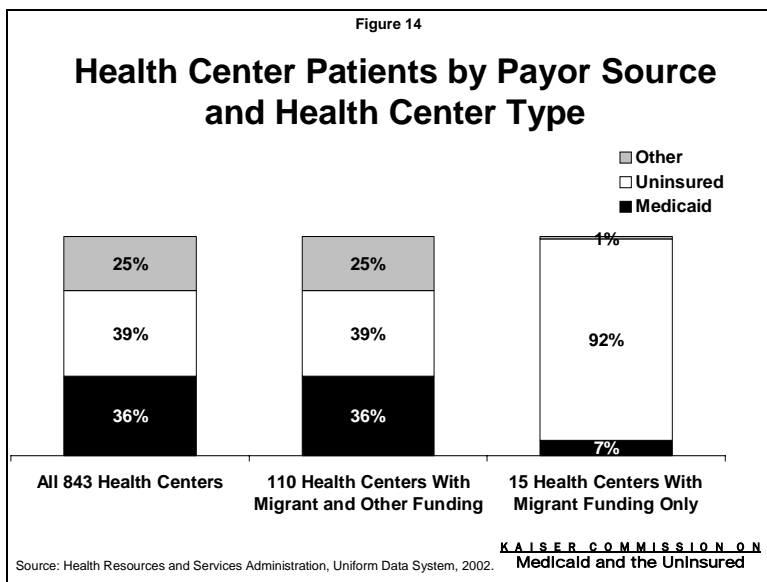
Intercare acts as a "bridge" into Medicaid for its patients, assisting with completion of the applications, assembly of necessary documents related to eligibility determinations, and ensuring that applicants are able to get to local welfare offices to complete the enrollment process. The state requires in-person appearances by all applicants and does not outstation eligibility workers at health centers. Intercare's services also include assistance with the enrollment of newborns and children. The state's financial aid to support Intercare's outreach efforts ceased in 2004, and Intercare now provides these services with its own health care revenues.

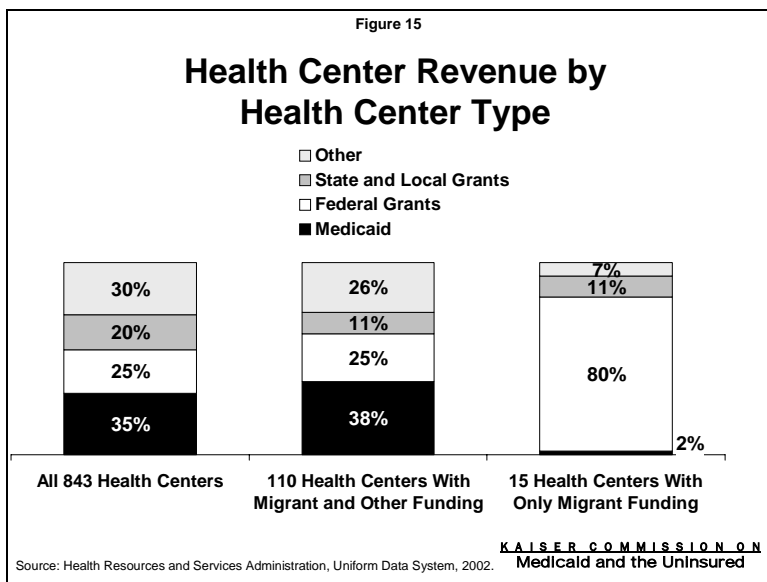
Another one of the clinic's most important types of Medicaid support is advocating with local agencies on behalf of migrating farmworker families who are inadvertently enrolled in managed care. Because of confusion that surrounds Medicaid enrollment, farmworker families incorrectly assume that they must enroll in managed care plans, even though the plan networks are not accessible as they follow the harvest. Thus, as they migrate north to follow the harvest and leave their plans' service areas, families can encounter significant health care access barriers, even for serious health care needs. Intercare provides key assistance by helping families disenroll from managed care and reenroll in the basic Medicaid fee-for-service system before leaving the area.

Figure 13 shows the age distribution of farmworkers and their family members served at health centers. Because adults are more likely to travel and work, a large proportion of migrant health center patients are working-age adults. However, the proportion of migrant and seasonal farmworkers served by migrant health centers who are working age adults is only slightly higher than the proportion of patients in health centers that do not receive migrant grants (61% versus 57%).



Health centers that do not rely solely on migrant health grants report that approximately 35% of their total patients receive Medicaid. The picture is much different at health centers funded solely by migrant health center grants. As Figures 14 and 15 show, health centers receiving migrant-only grants are far more likely than health centers generally to report uninsured patients, and experience vastly reduced levels of Medicaid revenues. In health centers that receive both general and migrant grants, migrant and seasonal farmworkers comprise 27% of the total registered patient population; this relatively low presence helps explain why “mixed grant” health centers continue to register relatively high proportions of Medicaid patients. Other factors may be the greater likelihood of “mixed grant” health centers to see Medicaid-eligible migrants and the resulting greater level of assistance furnished in Medicaid enrollment.





Reflecting their patient distribution, health centers receiving only migrant grants are more dependent on federal funding to care for a largely uninsured migrant and seasonal farmworker population. Figure 14 shows that, in 2002, health centers operating exclusively as migrant health centers reported that only 2% of their operating revenues came from Medicaid. In contrast, other health centers reported Medicaid accounted for more than one-third of their operating revenues. Unlike health centers generally, for whom Medicaid is the largest source of financing, migrant-only health centers exist virtually exclusively on grants; their modest size offers a further suggestion of the role played by Medicaid in permitting health centers to grow and expand their services.

V. BARRIERS TO MEDICAID COVERAGE

Reforming Medicaid to improve its performance for migrant and seasonal farmworkers and their families has been a program focus for some 30 years. The literature on farmworkers and Medicaid⁴² points to a set of problems which are related, specific, longstanding, and well-

⁴² See, e.g., Mary Kennesson, *Improving Health Service Access for Medicaid-Eligible Migrant Farmworkers* (Center for Health Care Strategies, Princeton N.J., 2000); National Health Policy Forum, *Policy Options for Serving Migrant Children and Families Under Medicaid and SCHIP* (The George Washington University, Washington D.C., 2000); Sara Rosenbaum, *Options for Expanding Publicly Financed Health Coverage of Migrant Farmworkers and their Families*, (National Association of Community Health Centers, Washington D.C. 2000); Elizabeth Kapeller, *Farmworker Access to Safety Net Insurance Programs: Harvesting Solutions to a Thirty-Seven Year Old Issue*, (National Center for Farmworker Health, Buda TX, 2003); E. Gallardo and V. Huang, *Expanding Access to Health Care Services: A Policy Brief* (California Primary Care Association, Sacramento, CA 2002); National Immigration Law Center, *Guide to Immigrant Eligibility for Federal Programs*, 4th ed. (Los Angeles, CA, 2002); Judith Moore, *Policy Options for Serving Migrant Children and Families Under Medicaid and SCHIP* (National Health Policy Forum, Washington D.C. 2000). In addition, the Congressionally mandated National Advisory Council on Migrant Health, the Migrant Clinicians Network (a special network of health center clinicians who specialize in farmworker healthcare), and others have recommended changes. In addition, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services (CMS) commissioned a study in the early 1990s to examine the feasibility of Medicaid reforms. The results were published in 1993. George E. Wright, Nancy Fasciano and Hilary Frazer (Mathematica Health Policy), Ian Hill and Beth Zimmerman (Health Systems Research), and Nancy Pindus (Urban Institute), *Feasibility Study to Develop a Medicaid reciprocity*

recognized. Although there are few systematic studies of farmworker Medicaid eligibility and enrollment barriers, information gathered by researchers, as well as repeated and widespread anecdotal evidence supplied over nearly four decades by a legion of health care providers and analysts, point to a series of problems which combine to cause exclusion. Some of these problems are present among many low-income populations excluded from Medicaid, but what is striking is how migratory farmwork serves to elevate and intensify their effect, while adding others attributable to barriers created by legal status and frequent changes in state residence. In short, classic Medicaid eligibility and enrollment barriers appear to combine with particular force in the case of migrant and seasonal farmworkers.

General problems that are particularly problematic for migrant and seasonal farmworkers.

One problem is the lack of categorical eligibility for certain groups of low-income people, in particular, childless working-age adults without disabilities. A second problem is financial eligibility barriers. States have considerable discretion in how they define and count income and resources. Use of monthly budgeting rules and restrictive asset tests are financial eligibility rules that tend to penalize itinerant and fluctuating work income (relatively high in relation to Medicaid eligibility rules one month, and then extremely low in the next month) and that fail to recognize work implements (e.g., tools, a truck) as a permissible asset. A third major barrier is legal status requirements that prohibit all but emergency Medicaid coverage of otherwise eligible legal U.S. residents who recently immigrated into the U.S. This barrier is the result of 1996 welfare reform legislation that eliminated Medicaid eligibility for otherwise-eligible recent legal immigrants.⁴³ A final barrier arises from application and enrollment barriers such as inaccessible site locations, long application forms, extensive verification requirements, and limited to no language assistance.

Barriers related to the lack of state residency. Medicaid is a state-based program; state residency requirements, coupled with the problems described above, can lead to nearly insurmountable Medicaid access problems for farmworkers. State residency problems arise in one of two ways. Medicaid recognizes state residency among persons who live in a state for work-related purposes. However, anecdotal evidence from advocates and health centers suggests that the work-related test may be honored only in the breach and that many state and local welfare agencies continue to deny enrollment to individuals and families who enter communities to work but do not intend to reside indefinitely. Medicaid also requires states to provide out-of-state coverage for their residents to permit travel. However, state policies may limit out-of-state coverage to persons whose out-of-state travel is related to institutional placement, the use of services located in nearby regional facilities (e.g., a regional children's hospital), or to persons who travel for brief periods of time and face emergency health care needs.

Federal regulations appear to require states to pay for medical care furnished out of state where it is a general practice for residents of certain state localities to use services furnished in another

Program for Migrant and Seasonal Farmworkers (Cont. No. 500-92-0037, Task 2). The National Association of Community Health Centers has been extensively involved in this issue over the years and from time to time has compiled information on the problem and options for reform. See, e.g., *Migrant and Seasonal Farmworker Access to Health Care Services and Insurance Coverage: Summary Report on Issues, Resources and Potential Solutions* (NACHC Washington D.C., 2003).

⁴³ §401, Personal Responsibility and Work Opportunity Act of 1996 (P. L. 104-193)

state.⁴⁴ These rules seemingly could apply to farmworkers who live in certain localities of a state and who customarily travel to certain other states for work purposes. In the absence of this “portability” provision, farmworker families appear to be caught between two diametrically opposed problems. On the one hand, farmworkers seeking to apply for Medicaid as they change their state of residence for work related reasons may encounter numerous barriers including the absence of a rapid enrollment system, inaccessible points of entry, extensive verification requirements, and inadequate application support. On the other, farmworkers traveling with a valid Medicaid card issued by the state in which they permanently reside may find that coverage is denied for all but dire emergencies. Compounding this restriction is the fact that few if any out-of-state providers, other than programs such as migrant health centers that are accustomed to traveling patients, will honor the card.

Migrant health concerns have been a feature of public policy for more than four decades, beginning with the 1962 passage of the Migrant Health Act⁴⁵ and continuing with the legislative establishment of the Health Centers Program in 1975, which contained specific authority for grants to serve migrant and seasonal farmworkers.⁴⁶ In 1979, the Carter Administration promulgated regulations which revised the definition of state residence for Medicaid and cash welfare assistance purposes to require states to recognize as residents workers and their families who were present in a state for employment related reasons (either with a job or seeking one). No interpretive guidelines applying out-of-state coverage and payment rules to travel related coverage for farmworkers ever have been issued.

No systematic evaluation of the impact of the 1979 rule ever has been conducted, but its limited effect appears to be evident in the statistics on Medicaid enrollment and revenues from the UDS, as well as the results of our NAWS analysis. Anecdotal evidence from the literature and from persons familiar with farmworker issues suggests widespread failure on the part of local welfare agency staff to consistently recognize this expanded definition of residency. Furthermore, community health providers frequently report that even where employment-related residence is recognized, the application process poses such serious problems that the residency change alone has little impact.

Moreover, there is evidence that residency-related problems are *intrastate* as well as interstate, with documented barriers in states such as California,⁴⁷ where migration is significantly in-state, and where county government agencies appeared to require reapplication and submission of new proof of eligibility with each move. Following the 2000 issuance of a State Medicaid Directors

⁴⁴ Federal rules require payment for residents, including residents who are absent from a State. 42 C.F.R. §435.403(a). States must pay for covered services furnished out-of-state services to residents in medical emergencies, where services are needed and travel would endanger the patient’s health or where the state determines on the basis of medical advice that necessary health care is more readily available in another state. In addition, states must pay for services furnished in another state if “it is general practice for recipients in a particular locality to use medical resources in another state.” 42 C.F.R. §431.52 (b)(4)

⁴⁵ P. L. 85-61 (85th Cong., 2d Sess.)

⁴⁶ P.L.

⁴⁷ California Primary Care Association, *Policy Options Related to the Medicaid Portability for Migrant Farmworkers Project* (Sacramento, CA, 2002)

letter clarifying that such procedures violate Medicaid statewideness requirements,⁴⁸ along with sustained advocacy, California officials issued a directive to county officials clarifying their obligations to allow county-to-county movement by Medicaid-enrolled farmworkers.⁴⁹

VI. OPTIONS FOR IMPROVING COVERAGE

Over the years, a few states have attempted to improve Medicaid program performance for farmworkers. Wisconsin is particularly notable for having developed a reciprocal rapid enrollment system, which automatically extends coverage to any family with a valid out-of-state enrollment card, using a shortened application process. Enrollment lasts until the date on which the out-of-state enrollment expires, at which time families who continue in-state reapply for benefits using normal in-state procedures. Wisconsin also has adopted an income eligibility calculation methodology that permits families to annualize their income in order to avoid months of ineligibility as a result of fluctuating earnings.⁵⁰

While Wisconsin has pursued a reciprocal rapid in-state enrollment approach, Texas attempted an initiative that mirrors the Wisconsin method and applies the out-of-state coverage option to promote continuous access to coverage even during periods of work. In 2001, the Texas legislature enacted legislation to study an out-of-state portability demonstration project for migrant farmworker children. Under the demonstration, the state assured coverage on an out-of-state basis when migrant farmworker children traveled, signing up out-of-state providers and compensating them for customary, not merely emergency services.⁵¹

The pilot project achieved significant “upstream” participation by out-of-state physicians and hospitals in several dozen states and involved only a small, manageable number of children. State efforts to take the model “to scale” for all migrant farmworker children failed when no satisfactory full-risk contractor could be identified.⁵² The effort also revealed small but important state-to-state variations in children’s eligibility and benefit packages, program management problems created by the lack of a unique farmworker identifier, and challenges in making out-of-state provider payment systems work smoothly. During the pilot phase, Texas and Michigan (more than three-quarters of whose migrant farmworkers come from Texas) prepared for an expanded collaboration; however, the failure of the Texas program to achieve full implementation has set back a collaborative effort.

From these state experiences, certain lessons can be gleaned. The first is that there are indeed handles for making Medicaid work better for eligible farmworkers and their families. Whether a

⁴⁸ State Medicaid Director from Timothy Westmoreland, <http://www.cms.hhs.gov/states/letters/smd12400.asp> (Dec 4, 2000)

⁴⁹ Harvesting Solutions, *op. cit.*

⁵⁰ *Id.*

⁵¹ Federal rules on payment for out of state care allow states to honor such out of state claims for covered services in numerous circumstances beyond documented medical emergencies. Out of state payments may be made when “it is the general practice for recipients in a particular locality to use medical resources in another state” or when “medical services are needed and the recipient’s health would be endangered if he were required to travel to his State of residence,” or when “the state determines on the basis of medical advice that the needed medical services or necessary supplementary resources are more readily available in another state.” 42 C.F.R. §431.52(b).

⁵² *Id.*

state uses the Wisconsin approach or the Texas strategy, there are ways to facilitate farmworkers' access to Medicaid coverage. Wisconsin relies on fast-track access to enrollment in strategic locations (e.g., migrant health clinics, programs serving farmworkers), coupled with the adoption of a "card swap" rule. Texas has attempted, at least in the case of children, to operationalize a "traveling Medicaid card" through broader standards for out-of-state coverage and active efforts to identify and enroll participating providers.

At the same time, the limits are clear. The Wisconsin model of simply exchanging an in-state card for an out of state card for the duration of eligibility is hindered by varying eligibility and asset rules across the states. The Texas model requires an active effort to identify out-of-state providers and a claims administration intermediary.

Were HHS to spearhead an active collaboration between the Centers for Medicare and Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA), both approaches would be more feasible. CMS and HRSA could embark on a "Wisconsin" strategy for states that opt to fast-track enrollment and adopt eligibility standards suitable to families whose incomes are derived through seasonal agricultural work. Guidelines explaining a fast track enrollment option, options for altering existing eligibility criteria, and identifying health centers and other farmworker programs to serve as enrollment sites, all might provide a useful stimulus.

In order to facilitate the Texas model, CMS and HRSA could identify a regional intermediary capable of processing out-of state claims for participating states, arranging networks of participating migrant health centers and other providers; arrange for the provision of information for traveling families; and issue guidelines explaining the expanded use of the out-of-state coverage option. Costs associated with such an expanded effort would appear to be directly related to state Medicaid administration and thus eligible for reimbursement.

Were CMS and HRSA to engage in such a coordinated strategy, states would have two feasible approaches to easing entry into Medicaid and better coverage during periods of enrollment. Well thought out strategies, coupled with greater attention to the problem of coverage, could be expected to have some impact over time.

In the long run, however, it is evident that problems of legal status, categorical Medicaid barriers, and frequent movement combine to make the potential for improved Medicaid coverage for this especially vulnerable slice of the low-income population limited at best. A more long term solution might be to couple Medicaid access and enrollment improvement efforts with a federal insurance program, administered by a national intermediary, that would enroll and cover families on a nationwide basis, thereby permitting interstate movement, portable benefits and strategically accessible means of enrollment.

VII. CONCLUSION

For over 40 years, the health of migrant and seasonal farmworkers has received national attention. The latest effort to address the needs of migrant and seasonal farmworkers can be found in the Congressional study mandate enacted in 2002. The health needs of farmworkers are considerable, but their numbers are relatively modest. The evidence reviewed in the analysis presented here suggests the importance of an intervention and a range of viable options, including more energetic Medicaid interventions and other programs to complement Medicaid's reach. More active attention to overcoming Medicaid barriers, coupled with a national program that uses a nationwide intermediary to bring benefits to families, would help surmount the inherent difficulties for this population created by state borders and state-based healthcare programs. It is also evident that additional data would greatly inform any effort to expand insurance coverage for migrant and seasonal farmworkers.

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