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Geiger Gibson Program in Community Health Policy

rchn community health foundation

Geiger Gibson /
RCHN Community Health Foundation Research Collaborative

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About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the Milken Institute School of Public Health at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation is a not-for-profit foundation established to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the U.S. dedicated solely to community health centers, RCHN CHF builds on a long-standing commitment to providing accessible, high-quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at http://publichealth.gwu.edu/projects/geiger-gibson-program-community-health-policy or at rchnfoundation.org.

Executive Summary

Migratory and seasonal agricultural workers (MSAWs) provide essential labor for farming in all its branches in the United States. Between 2.4 and 3 million MSAWs live across the U.S. in every state but are clustered in areas dense with agricultural employment. As a population already susceptible to poor health outcomes because of poverty and work-related health risks, MSAWs depend on community health centers, especially those known as migrant health centers that receive additional migrant funding. Reporting data from a national survey of agricultural workers, as well as findings from analyses of data from the Uniform Data System (UDS) that covers all health centers, this analysis finds that:

- In 2014, health centers served approximately 892,000 migrant and seasonal agricultural workers and their dependents.

- Health centers in four states (California, Florida, North Carolina, and Washington state) served nearly 632,000 migrant and seasonal agricultural workers, accounting for 71 percent of all MSAWs served by health centers in 2014.

- Migrant and seasonal agricultural workers rely particularly on health centers that receive additional migrant funding (migrant health centers). In 2014, migrant health centers accounted for 9 in 10 agricultural worker patients served by federally-funded health centers nationally.

- Medicaid expansion appears to play a key role in expanding health insurance coverage at migrant health centers. Although migrant health centers in both Medicaid expansion and non-expansion states experienced significant decreases in their uninsured rates between 2013 and 2014, the decline was steeper in Medicaid expansion states. Migrant health centers in Medicaid expansion states also registered a statistically significant increase in the percentage of patients with Medicaid coverage between 2013 and 2014, while migrant health centers in non-expansion states did not.

- A closer, focused examination of 16 migrant health centers with the highest percentage of agricultural worker patients found that those served by migrant health centers located in Medicaid-non-expansion states were twice as likely to be uninsured in 2014 as those served by migrant health centers located in expansion states.

These findings suggest that the Medicaid expansion matters even to safety net clinics serving heavily uninsured populations. Medicaid may be reaching additional agricultural workers not only because of their deep poverty but also their growing tendency to work in the state in which they reside, thereby reducing the risk that they will lose Medicaid coverage when they move to another state temporarily for work reasons. At the same time, these findings also underscore the special importance of grant funding, given the high rates at which agricultural workers lack health insurance coverage.

Background

Migrant and seasonal agricultural workers (MSAWs) are essential to America's agriculture and agriculture-related industries, which in 2014 contributed $835 billion to the national GDP.[1] Between 2.4 million and 3 million[2,3] agricultural workers plant, cultivate, harvest, handle, package, and process crops, as well as feed and care for farm animals. Agricultural work is characterized by many occupational hazards, including sun and heatstroke, exposure to crop pesticides, and repetitive stress injuries, which lead to musculoskeletal and skin disorders such as back pain and dermatitis.[4,5] Multiple studies also highlight the extensive need for oral health care among MSAWs.[6,7,8] Gaining access to care can be difficult for this population, and poor health is common. Studies show that MSAWs lack access to care;[9,10,11] one survey of MSAWs in Colorado found that 17 percent did not know where to seek help for a medical problem, 55 percent did not know where to seek help for a mental health problem, and only 20 percent of workers with medical problems had sought care in the previous year.[12] A Georgia study found that lack of health care access caused MSAWs to delay seeking care for treatable conditions and diagnosing pregnancies.[13] Coupled with extreme poverty from low-wage employment arising from dependence on the harvest seasons, MSAWs represent an especially vulnerable population of the U.S. workforce.

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[1] United States Department of Agriculture- Economic Research Service. (2015). *Ag and Food Sectors and the Economy*. http://www.ers.usda.gov/data-products/ag-and-food-statistics-charting-the-essentials/ag-and-food-sectors-and-the-economy.aspx

[2] Farmworker Justice & The National Center for Farmworker Health. (2015). *Farmworkers' Health Fact Sheet: Data from the National Agricultural Workers Survey.* http://www.ncfh.org/uploads/3/8/6/8/38685499/fs-nawshealthfactsheet.pdf

[3] National Center for Farmworker Health. (2012). *Farmworker Health Fact Sheet: Demographics*. http://www.ncfh.org/uploads/3/8/6/8/38685499/naws_ncfh_factsheet_demographics_final_revised.pdf

[4] Feldman, S. R., Vallejos, Q. M., Quandt, S. A., Fleischer, A. B., Schulz, M. R., Verma, A., & Arcury, T. A. (2009). Health Care Utilization among Migrant Latino Farmworkers: The Case of Skin Disease. *The Journal of Rural Health, 25*(1), 98-103.

[5] Henning, G. F., Graybill, M., & George, J. (2008). Reason for Visit: Is Migrant Health Care that Different? *The Journal of Rural Health*, *24*(2), 219-220.

[6] Diaz-Perez, M. J., Farley, T., & Cabanis, C. M. (2004). A Program to Improve Access to Health Care among Mexican Immigrants in Rural Colorado. *Journal of Rural Health, 20*(3), 258; 258-264.

[7] Lukes, S. M., & Miller, F. Y. (2002). Oral Health Issues among Migrant Farmworkers. *Journal of Dental Hygiene: JDH / American Dental Hygienists' Association, 76*(2), 134-140.

[8] Lukes, S. M., & Simon, B. (2006). Dental Services for Migrant and Seasonal Farmworkers in US Community/Migrant Health Centers. *Journal of Rural Health, 22*(3), 269-272.

[9] Arcury, T. A., & Quandt, S. A. (2007). Delivery of Health Services to Migrant and Seasonal Farmworkers. *Annual Review of Public Health, 28*(1), 345-363.

[10] Villarejo, D. (2003). The Health of U.S. Hired Farm Workers. *Annual Review of Public Health, 24*(1), 175-193.

[11] Diaz-Perez, et al., op. cit.

[12] Ibid.

[13] Bail, K. M., Foster, J., Dalmida, S. G., Kelly, U., Howett, M., Ferranti, E. P., & Wold, J. (2012). The Impact of Invisibility on the Health of Migrant Farmworkers in the Southeastern United States: A Case Study from Georgia. *Nursing Research and Practice,* 760418. doi:10.1155/2012/760418

Through special grants, community health centers have long played a critical role in health care for agricultural workers and have worked extensively to tailor their services to overcome population-specific barriers including the lack of insurance, transportation, and language. The average agricultural worker family income hovers at or below the U.S. poverty rate ($17,500-$19,999 in 2011-2012,[14] when the poverty rate for a family of three was $19,090[15]). Their poverty is compounded by the fact that 57 percent of agricultural workers report speaking little to no English.[16]

In 2014, 1,278 federally-funded community health centers across the U.S. served nearly 892,000[17] migratory and seasonal agricultural workers and their families (this brief uses MSAWs to refer to both workers and their dependents). Among all health centers, 172 health centers receive additional grants to serve agricultural workers and are referred to as migrant health centers. Although not all community health centers receive dedicated migrant funding, health centers are a source of care for medically underserved community residents generally, who may include agricultural workers and their spouses and children. This report examines the experiences of all health centers serving agricultural workers and their families, including migrant health centers.

Methodology

The purpose of this study was threefold: to bring to light changes in population characteristics of migrant and seasonal agricultural workers and their dependents, to examine changes over time in the MSAW population served by health centers since our previous brief, which used 2002 data to examine the experience of agricultural workers,[18] and to examine how the implementation of the Affordable Care Act (ACA) has affected migrant health centers. For this analysis, researchers used data from the Uniform Data System (UDS), which includes all federally-funded community health centers, and reported data from the National Agricultural Workers Survey (NAWS), which has provided population trend data on crop workers for over a quarter century. The NAWS, which is administered and managed by the Department of Labor, gathers information nationwide through a random-sample survey of currently employed agricultural workers (both seasonal and migratory). We combined the most recently available NAWS survey findings with earlier data to identify changes in health insurance coverage, health care utilization, and migratory behavior over the 2000-2012 time period.

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[14] Farmworker Justice. (2014). *Selected Statistics on Farmworkers.* https://www.farmworkerjustice.org/sites/default/files/NAWS%20data%20factsht%201-13-15FINAL.pdf

[15] ASPE. (2012). 2012 HHS Poverty Guidelines. https://aspe.hhs.gov/2012-hhs-poverty-guidelines

[16] Farmworker Justice, 2014, op. cit.

[17] Bureau of Primary Health Care, Health Resources and Services Administration. (2015). National 2014 Health Center Data. http://bphc.hrsa.gov/uds/datacenter.aspx?q=tall&year=2014&state=

[18] Rosenbaum, S. & Shin, P. (2005). *Migrant and Seasonal Farmworkers: Health Insurance Coverage and Access to Care.* Kaiser Commission on Medicaid and the Uninsured. http://kff.org/medicaid/report/migrant-and-seasonal-farmworkers-health-insurance-coverage/

The UDS data that has become available since our previous health center study allowed us to examine the growth in the agricultural worker population at health centers, as well as the impact of the ACA on health centers with additional migrant health funding.

Findings

Growth of the migrant and seasonal agricultural worker population served and the number of health centers receiving dedicated migrant funding

Health centers served approximately 892,000 migrant and seasonal agricultural workers and their dependents in 2014 (**Table 1**). Since 2003, the number of MSAWs served by health centers grew by 28 percent, an increase of almost 200,000 MSAW patients. **Table 1** also shows that health centers with dedicated migrant funding, referred to as migrant health centers, served approximately 9 in 10 MSAWs who sought care from all health centers throughout 2003-2014.

Table 1: Growth in migrant health centers and the migrant and seasonal agricultural worker population served by health centers, 2003-2014

Year	Number of federally-funded health centers	Number of migrant health centers	MSAWs served by all health centers	MSAWs served by migrant health centers	Percentage of MSAWs served by migrant health centers
2003	890	125	694,040	656,014	94.5%
2004	914	131	726,813	680,151	93.6%
2005	952	135	776,668	729,460	93.9%
2006	1,002	140	807,153	755,408	93.6%
2007	1,067	153	826,977	775,106	93.7%
2008	1,080	155	834,006	769,305	92.2%
2009	1,131	156	864,996	803,821	92.9%
2010	1,124	156	862,775	799,382	92.7%
2011	1,128	160	862,808	792,702	91.9%
2012	1,198	166	903,089	801,720	88.8%
2013	1,202	169	861,120	788,139	91.5%
2014	1,278	172	891,796	809,633	90.8%

Source for patient numbers: Bureau of Primary Health Care. (2004-2015). 2003-2014 National Uniform Data System Reports. Health Resources and Services Administration. Source for number of health centers: GW analysis of 2003-2014 UDS datasets, Health Resources and Services Administration.

Concentration of the agricultural worker population

While agricultural workers are employed in every state, in 2012, an estimated one-quarter (24 percent) of all workers engaged in agricultural labor were concentrated in California, and an additional 23 percent of the workforce was in Washington, Texas, Florida, and Oregon, reflecting the availability of agricultural work, shown in **Table 2.**[19]

Table 2: Percentage of crop and animal production workers employed in each state, 2012

State	Percentage of total crop production workers	Percentage of total animal production workers	Percentage of total U.S. agricultural workers
California	31.13%	5.38%	23.93%
Washington	10.49%	1.95%	8.10%
Texas	3.67%	13.30%	6.37%
Florida	5.48%	2.82%	4.74%
Oregon	4.27%	1.88%	3.60%
Total	55.06%	25.33%	46.74%

Source: National Center for Farmworker Health. (2012). Migratory & Seasonal Farmworker Population Estimates. http://www.ncfh.org/population-estimates.html

In turn, migrant health centers are similarly geographically clustered in California, the South, and the Northwest (**Table 3**). The distribution of the MSAW patient population served by all health centers, not just those with additional migrant funding, shows that health centers in four states (California, Washington, Florida, and North Carolina) served nearly 632,000 MSAWs and accounted for 71 percent of all MSAWs served in 2014. Nearly half (48 percent) of the total MSAW health center patient population was served by health centers in California.

[19] National Center for Farmworker Health. (2012). Migratory & Seasonal Farmworker Population Estimates. http://www.ncfh.org/population-estimates.html

Table 3: State distribution of migrant and seasonal agricultural worker patients served by all health centers, 2014

State	Total MSAWs served by all health centers in 2014	State percentage of MSAW patients served by health centers in 2014	State	Total MSAWs served by all health centers in 2014	State percentage of MSAW patients served by health centers in 2014
AL	12,002	1.3%	MT	3,243	0.4%
AK	499	0.1%	NE	625	0.1%
AZ	11,545	1.3%	NV	335	0.0%
AR	1,291	0.1%	NH	327	0.0%
CA	424,201	47.6%	NJ	12,369	1.4%
CO	10,037	1.1%	NM	16,674	1.9%
CT	294	0.0%	NY	21,120	2.4%
DE	291	0.0%	NC	47,756	5.4%
DC	138	0.0%	ND	365	0.0%
FL	58,524	6.6%	OH	3,917	0.4%
GA	20,005	2.2%	OK	953	0.1%
HI	776	0.1%	OR	19,853	2.2%
ID	9,994	1.1%	PA	5,329	0.6%
IL	10,213	1.1%	PR	17,235	1.9%
IN	2,529	0.3%	RI	163	0.0%
IA	1,316	0.1%	SC	8,051	0.9%
KS	6,823	0.8%	SD	256	0.0%
KY	1,520	0.2%	TN	4,768	0.5%
LA	2,399	0.3%	TX	9,083	1.0%
ME	2,489	0.3%	UT	9,442	1.1%
MD	1,279	0.1%	VT	468	0.1%
MA	2,744	0.3%	VA	5,216	0.6%
MI	15,126	1.7%	WA	101,091	11.3%
MN	2,498	0.3%	WV	1,254	0.1%
MS	842	0.1%	WI	928	0.1%
MO	1,350	0.2%	WY	232	0.0%
			U.S.	891,796*	100.0%

*This number includes 5 and 13 MSAWs served by health centers 2014 in Guam and the Virgin Islands, respectively (not shown). Source: GW analysis of 2014 UDS data, HRSA

Characteristics of migrant health centers

In comparison to other health centers, those health centers that receive additional migrant funding have higher average percentages of patients who are children, are racial/ethnic minorities, are best served in a language other than English, and are low-income, with incomes at or below 200 percent of the federal poverty level (**Table 4**). Despite having significantly lower ratios of full-time equivalent (FTE) physicians, mid-level providers, and medical workers, health centers with migrant funding outperformed other health centers on quality measures related to cervical cancer screening, asthma care, and low birth weight births. (Migrant health centers' significantly lower rate of depression screening may be explained by their lower ratio of mental health workers or linguistic and cultural barriers.)[20]

Table 4: Comparison of Uniform Data System variables by health center type, 2014

UDS variables	Not a migrant health center	Migrant health center
N	1,106	172
Location of health centers*		
Rural	51.2%	75.6%
Urban	48.8%	24.4%
Patient population		
Percent of patients who are children age 0-17*	26.1%	30.2%
Percent of elderly patients age 65 and older	8.7%	8.2%
Percent of patients who are female	57.0%	56.8%
Percent of patients who are racial/ethnic minorities*	53.5%	62.5%
Percent of patients best served in a language other than English*	16.4%	31.3%
Percent of patients who are poor (at or below 100% FPL)	67.8%	70.1%
Percent of patients who are low-income (at or below 200% FPL)*	91.1%	93.7%
Health insurance		
Percent of patients who are uninsured*	29.9%	36.4%
Percent of patients with Medicaid coverage	40.9%	39.4%
Percent of patients with Medicare coverage*	10.0%	8.4%
Percent of patients with other public insurance coverage	1.3%	1.1%
Percent of patients with private insurance coverage*	18.2%	15.3%
Staffing variables		
Physicians per 10,000 patients*	5.0	4.2
Total mid-level providers (NPs, PAs, CNMs) per 10,000 patients*	5.4	4.1
Total medical FTEs per 10,000 patients*	28.6	25.4

[20] National Center for Farmworker Health. (2014). *A Profile of Migrant Health: An Analysis of the Uniform Data System, 2010*. http://www.ncfh.org/uploads/3/8/6/8/38685499/aprofileofmigranthealth.pdf

UDS variables	Not a migrant health center	Migrant health center
Total dental FTEs per 10,000 patients	6.2	6.3
Total mental health FTEs per 10,000 patients*	3.9	2.3
Total substance abuse FTEs per 10,000 patients*	1.0	0.3
Total vision FTEs per 10,000 FTEs	0.2	0.2
Total enabling services FTEs per 10,000 patients	9.9	9.1
Quality measures		
Female patients aged 24-64 who had at least one Pap test performed*	50.8%	54.5%
Patients aged 5 through 40 diagnosed with asthma who have an acceptable pharmacological treatment plan*	81.2%	84.7%
Patients aged 12 and older who were (1) screened for depression with a standardized tool and if screening was positive (2) had a follow-up plan documented*	39.4%	33.7%
Percent of births that were low or very low birth weight*	8.3%	7.2%

* Indicates a significant group difference at the p<0.05 level; Source: GW analysis of 2014 UDS data

Health insurance coverage of migrant and seasonal agricultural workers

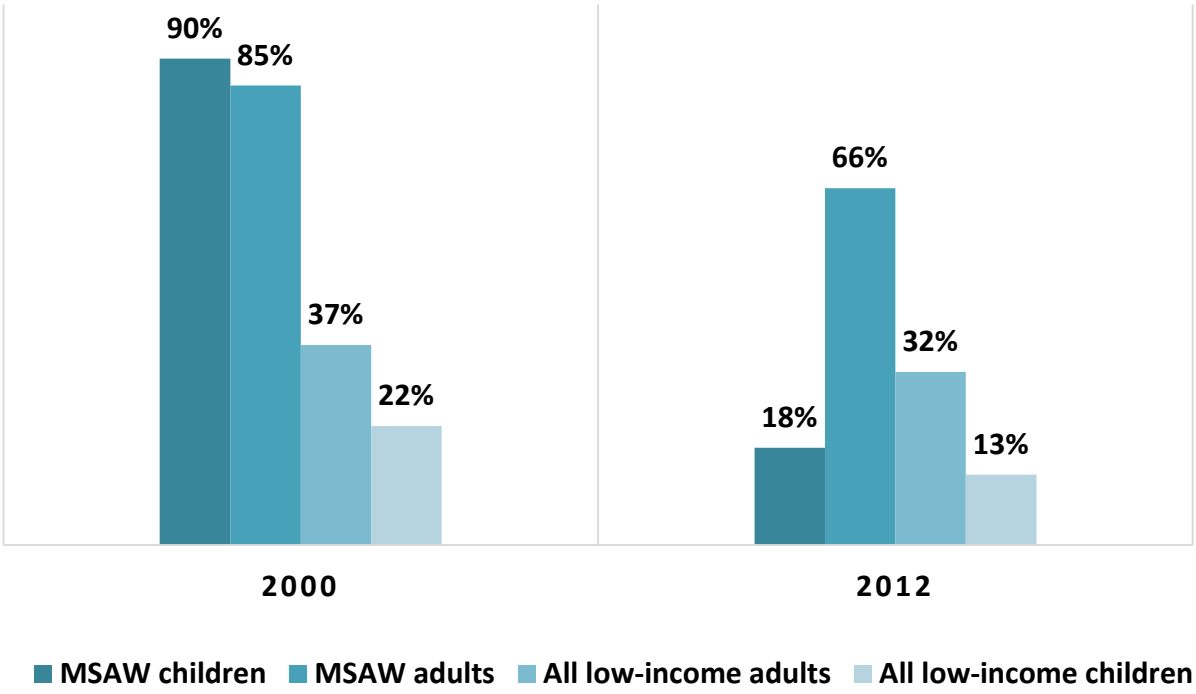
From 2000-2012, the proportion of uninsured agricultural workers declined from 85 percent to 66 percent nationally.[21] While uninsured rates among MSAWs declined faster than the decline over the same time period among all low-income adults (those below 200 percent of the FPL; 37 percent in 2000 compared to 32 percent in 2012), in 2012, agricultural workers remained more than twice as likely to be uninsured as other low-income adults[22] (**Figure 1**). Among children, the changes in coverage were even more dramatic: while 90 percent of MSAW children were uninsured in 2000, by 2012 the proportion without insurance coverage had declined to 18 percent, a decrease of 80 percent.[23] However, compared to other low-income children, who had an uninsured rate of 13 percent, children living in MSAW families lacked health insurance at a substantially higher rate in 2012.

[21] Rosenbaum & Shin, 2005, op. cit.; Farmworker Justice & The National Center for Farmworker Health, 2015, op. cit.

[22] The 2000 uninsured rate is reported in Rosenbaum & Shin, 2005, op. cit. The 2012 uninsured rate is derived from: US Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2013. http://www.census.gov/cps/data/cpstablecreator.html

[23] Rosenbaum & Shin, 2005, op. cit.; Farmworker Justice & The National Center for Farmworker Health, 2015, op. cit.

Figure 1: Uninsured rates among migrant and seasonal agricultural workers and their children, compared to all low-income adults and children, 2000-2012



Source: Rosenbaum & Shin, 2005, op. cit.; Farmworker Justice & The National Center for Farmworker Health, 2015, op. cit.; US Census Bureau Current Population Survey, Annual Social and Economic Supplement, 2013, op. cit.

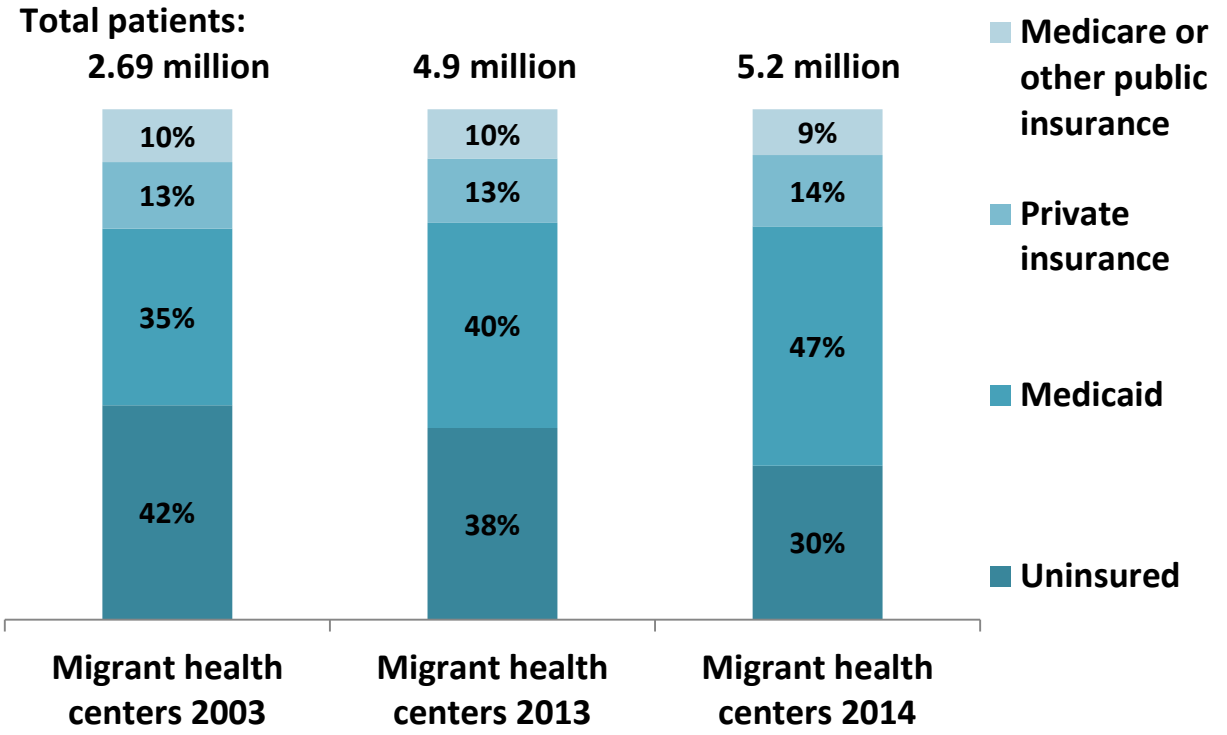
Not surprisingly, health centers with migrant funding have a significantly higher mean percentage of uninsured patients than those which do not receive dedicated migrant funds (**Table 4**). Migrant health centers also report significantly lower percentages of patients covered by private insurance or Medicare compared to health centers that do not receive such funding.

The Affordable Care Act has led to a decline in the uninsured rate for patients served by health centers receiving migrant funds

Patients served by migrant health centers have gained coverage under the ACA, but because insurance status is not reported in the UDS by MSAW status, it is not possible to measure gains in coverage specifically for agricultural worker families. **Figure 2** shows that, in 2003, more than four in ten patients at health centers receiving migrant funds were uninsured; this percentage had declined to 3 patients in 10 by 2014. **Figure 2** also underscores the importance of the ACA even at health centers whose mission specifically includes care for the low-income MSAW population, whose lack of

health insurance is much higher than that among the low-income population generally. This decrease in the uninsured rate is largely attributable to increasing Medicaid coverage, as the proportion of patients at migrant health centers covered by Medicaid increased from 35 percent in 2003 to nearly half (47 percent) of all patients in 2014.

Figure 2: Insurance Coverage of Patients Served at Migrant Health Centers: 2003, 2013, and 2014

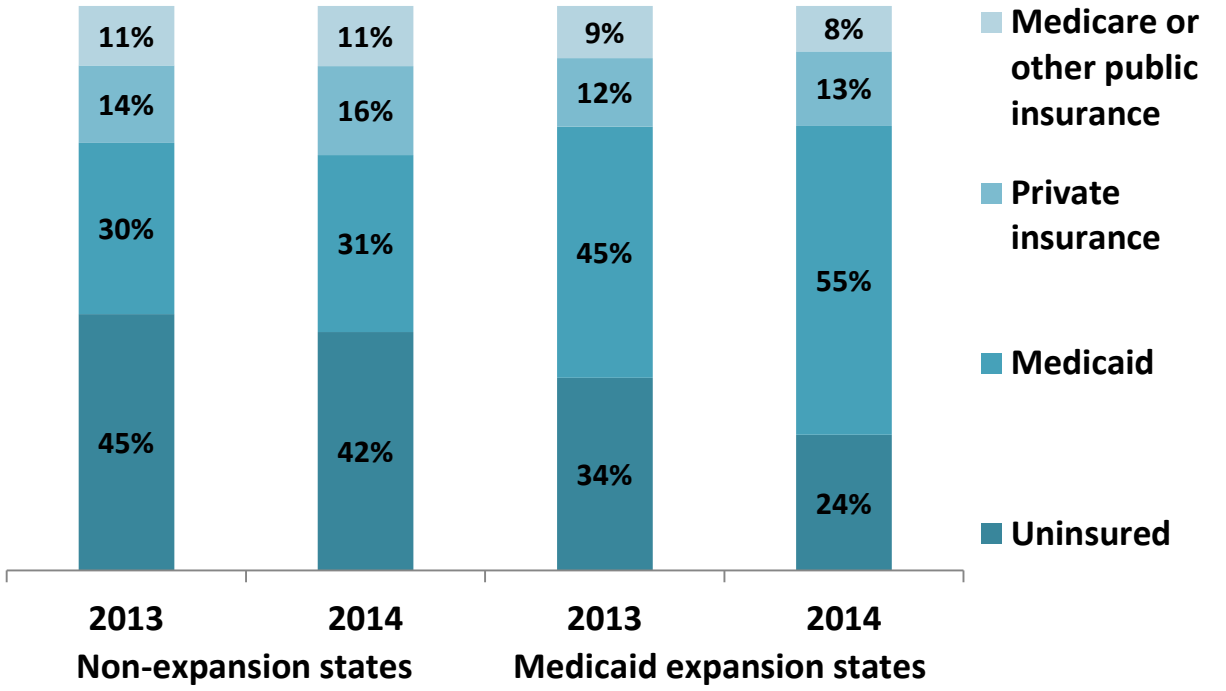


Source: GW analysis of 2003, 2013, and 2014 UDS data

As with health centers generally,[24] states' decisions regarding whether to expand Medicaid carry major implications for health centers serving migrant patients. **Figure 3** shows that patients at health centers receiving migrant funding and located in expansion states were substantially more likely than those served by migrant health centers in non-expansion states to show gains in coverage between 2013 and 2014 and had far lower rates of patients without health insurance.

[24] Shin, P., Sharac, J., Zur, J., Rosenbaum, S., & Paradise, J. (2015*). Health Center Patient Trends, Activities, and Service Capacity: Recent Experience in Medicaid Expansion and Non-Expansion States.* The Kaiser Commission on Medicaid and the Uninsured. http://kff.org/medicaid/issue-brief/health-center-patient-trends-enrollment-activities-and-service-capacity-recent-experience-in-medicaid-expansion-and-non-expansion-states/

Figure 3: Insurance profile of patients served by health centers receiving migrant funding, by state Medicaid expansion status, 2013-2014



Source: GW analysis of 2013 and 2014 UDS data

Table 5 shows changes in health insurance status among patients served by migrant health centers between 2013 and 2014. Overall, the proportion of uninsured patients at migrant health centers in Medicaid expansion states decreased from 34 percent to 24 percent, while the proportion of uninsured patients at migrant health centers in non-expansion states, which was 45 percent in 2013, fell to only 42 percent in 2014. In California, Washington, Florida and North Carolina, the four states that served the highest proportions of MSAW health center patients, the effects of Medicaid expansion on the insurance profile of patients served at migrant health centers are readily apparent. In California and Washington, both Medicaid expansion states, the uninsured rates dropped by nine and eleven percentage points, respectively, while the uninsured rate at migrant health centers in Florida and North Carolina, both of which are non-expansion states, dropped by only four and three percentage points, respectively, from 2013-2014. Conversely, the percentage of patients with Medicaid at migrant health centers grew by ten percentage points in California and twelve in Washington, but by only one percentage point in Florida and remained the same in North Carolina between 2013 and 2014.

Table 5: Insurance coverage at migrant health centers (MHCs) by state, 2013-2014

State	Expanded Medicaid in 2014	Percentage of MHC Uninsured Patients 2013	Percentage of MHC Uninsured Patients 2014	Percentage of MHC Medicaid Patients 2013	Percentage of MHC Medicaid Patients 2014	Percentage of MHC Private insurance Patients 2013	Percentage of MHC Private insurance Patients 2014
AL	No	47%	47%	27%	27%	15%	15%
AR	Yes	42%	20%	25%	33%	19%	33%
AZ	Yes	25%	23%	44%	46%	22%	24%
CA	Yes	34%	25%	49%	59%	8%	10%
CO	Yes	35%	22%	39%	53%	13%	14%
DE	Yes	35%	31%	40%	41%	20%	22%
FL	No	42%	38%	40%	41%	8%	11%
GA	No	75%	74%	14%	14%	5%	6%
IA	Yes	94%	96%	5%	2%	0%	1%
ID	No	50%	42%	22%	25%	19%	22%
IL	Yes	22%	15%	44%	53%	22%	21%
IN	No	34%	27%	50%	53%	9%	13%
KS	No	74%	71%	24%	26%	2%	3%
KY	Yes	46%	29%	21%	41%	23%	23%
LA	No	27%	37%	55%	42%	12%	15%
MD	Yes	21%	17%	37%	41%	32%	31%
MA	Yes	98%	78%	1%	15%	0%	2%
ME	No	91%	93%	5%	3%	4%	4%
MI	Yes	36%	28%	46%	52%	10%	11%
MN	Yes	95%	93%	4%	7%	1%	0%
MO	No	36%	31%	37%	39%	18%	19%
MT	No	63%	62%	11%	12%	16%	17%
NC	No	56%	53%	16%	16%	17%	20%
NE	No	56%	49%	24%	29%	12%	15%
NJ	Yes	43%	29%	40%	54%	12%	11%
NM	Yes	49%	36%	31%	44%	8%	8%
NY	Yes	38%	32%	37%	44%	14%	14%
OH	Yes	36%	23%	44%	47%	14%	24%
OK	No	40%	35%	48%	51%	8%	10%
OR	Yes	39%	22%	45%	62%	9%	9%
PA	No	22%	21%	22%	22%	44%	44%
SC	No	32%	33%	40%	40%	17%	17%
TN	No	35%	33%	36%	36%	17%	17%
TX	No	57%	52%	19%	19%	13%	16%

State	Expanded Medicaid in 2014	Percentage of MHC Uninsured Patients 2013	Percentage of MHC Uninsured Patients 2014	Percentage of MHC Medicaid Patients 2013	Percentage of MHC Medicaid Patients 2014	Percentage of MHC Private insurance Patients 2013	Percentage of MHC Private insurance Patients 2014
UT	No	63%	61%	21%	21%	11%	14%
VA	No	29%	27%	22%	23%	32%	33%
WA	Yes	32%	21%	45%	57%	14%	15%
WI	No	43%	40%	46%	48%	8%	9%
WV	Yes	23%	14%	34%	45%	30%	28%
WY	No	78%	92%	22%	8%	0%	0%
Total for MHCs in expansion states		**34%**	**24%**	**45%**	**55%**	**12%**	**13%**
Total for MHCs in non-expansion states		**45%**	**42%**	**30%**	**31%**	**14%**	**16%**

Source: GW analysis of 2013 and 2014 UDS data

Table 6 compares changes in insurance status for patients served at migrant health centers located in Medicaid expansion and non-expansion states in 2013 and 2014. Migrant health centers in both expansion and non-expansion states showed statistically significant declines in the average percentage of patients who were uninsured and significant increases in the average percentage of patients with insurance coverage. However, migrant health centers in Medicaid expansion states showed a statistically significant increase in the average percentage of patients with Medicaid coverage, while migrant health centers in non-expansion states showed a statistically significant increase in the average percentage of patients with private insurance coverage, suggesting in these states the importance of subsidized marketplace coverage, which, in non-expansion states, commences at 100 percent of the federal poverty level.

Table 6: Changes in the proportion of insured patients at migrant health centers (MHCs), 2013-2014

	2013	2014
Migrant health centers in non-Medicaid expansion states (n=76 for 2013-2014 paired MHCs)		
Uninsured rate*	51.6%	47.8%
Percentage of patients with insurance*	49.1%	52.9%
Percentage of patients with Medicaid	25.4%	26.2%
Percentage of patients with private insurance*	13.8%	16.4%
Migrant health centers in Medicaid expansion states (n=84 for 2013-2014 paired MHCs)		
Uninsured rate*	38.1%	28.3%
Percentage of patients with insurance*	61.9%	71.7%
Percentage of patients with Medicaid*	39.1%	49.3%
Percentage of patients with private insurance	13.7%	14.2%

*Indicates a statistically significant change from 2013-2014 at the p<0.05 level
Source: GW analysis of 2013 and 2014 UDS data

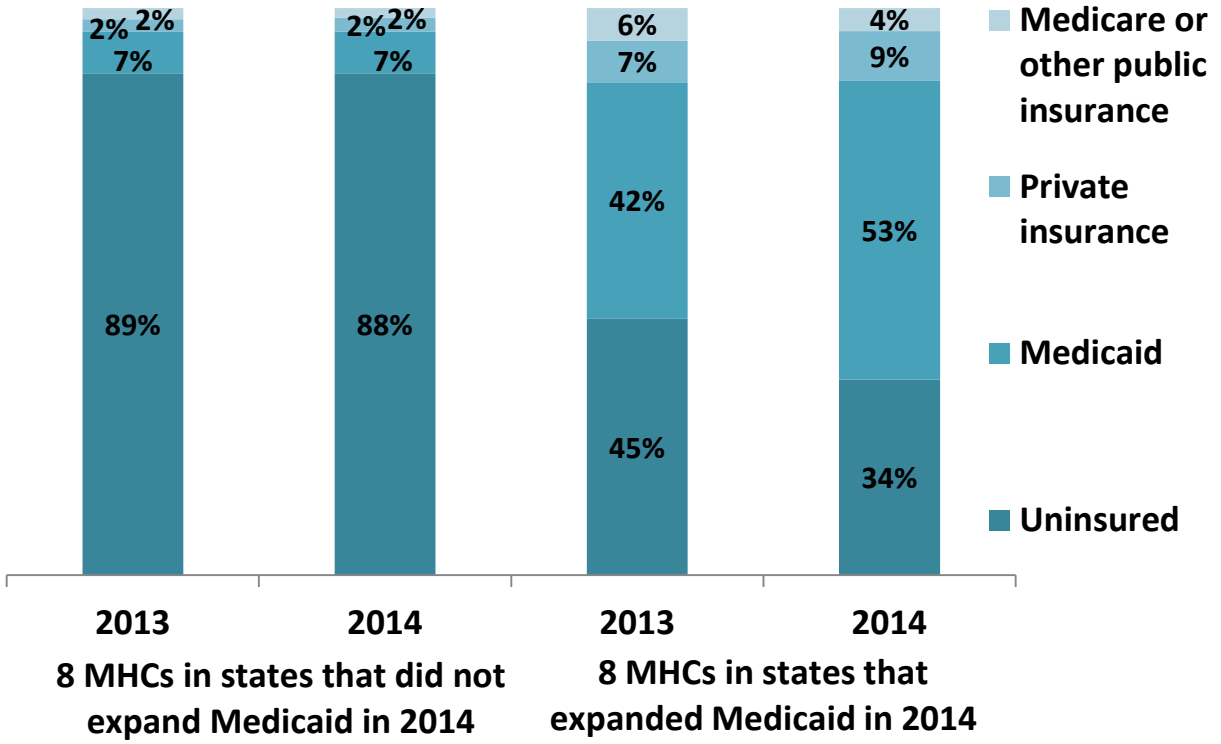
Impact of the ACA's Medicaid reforms on migrant health centers serving high numbers of migrant and seasonal agricultural workers and their families

Looking only at those health centers with the highest proportion of migrant and seasonal agricultural worker patients, the importance of the ACA becomes even more pronounced. **Figure 4** depicts health insurance rates for a group of 16 health centers receiving migrant funding and serving the highest proportion of agricultural worker patients (ranging from 56 percent to 100 percent of their total patient population). It shows that even prior to the Medicaid expansion, patients at a group of eight health centers receiving migrant funds and located in states that did not expand Medicaid were twice as likely to be uninsured as those served by eight migrant health centers in states that would expand in 2014. **Figure 4** also shows that, following the expansion, health centers with high percentages of migrant patients and located in expansion states made notable gains in the proportion of insured patients, while those serving patients in non-expansion states showed virtually no gain.

It is not possible to discern from UDS data what proportion of patients gaining coverage under the Medicaid expansion were themselves agricultural workers, but because MSAWs overwhelmingly meet the eligibility criteria for Medicaid in expansion states (very poor adults along with their children), this shift toward insurance coverage at high-impact migrant health centers located in expansion states suggests the importance of the expansion to agricultural workers, just as it has been important for other low-income populations. In expansion states, the proportion of uninsured patients served by this group of health centers dropped from 45 percent to 34 percent, while in

non-expansion states, the proportion of patients who were uninsured remained at an astonishing 88 percent. This enormous differential points not only to the impact of the expansion but also to the fact that non-expansion states were more likely to have offered Medicaid coverage for adults even prior to the ACA expansion.

Figure 4: Changes in health insurance coverage among patients served by 16 high migrant-service health centers, by state Medicaid expansion status, 2013-2014



Note: Percentages may not sum to 100 due to rounding. Source: GW analysis of 2013 and 2014 UDS data

Utilization

While migrant and seasonal agricultural workers have historically used only limited health services, utilization has shown a noteworthy increase over the past decade. In 2000, only 1 in 5 agricultural workers (20 percent) reported using any health care services in the previous two years; the most recent NAWS data from 2011-12 show that figure has increased, with more than three in five agricultural workers (61 percent) reporting use of health care services. This change in utilization may be the result of shifting labor patterns among agricultural workers generally since 2000. The NAWS data indicate that the proportion of agricultural workers who migrate has

declined, from 42 percent in 2001 to 17 percent in 2012.[25] As agricultural workers increasingly remain in stable locations, Medicaid coverage may be easier to maintain, since it eliminates the longstanding portability problems encountered by agricultural workers who travel and attempt to maintain their Medicaid coverage while temporarily out of state. (Anecdotal evidence suggests that attempts to address the Medicaid portability issue through streamlined enrollment and out-stationing at migrant health centers, as well as by allowing workers to use their coverage out-of-state by recognizing certain providers as qualified to bill the home state of residence, have met with limited success.) In addition, lower rates of travel also may promote continuity of care. Further, research has shown that agricultural workers who have family support systems are more likely to seek health care;[26] with declining migratory travel, health care utilization may be expected to increase.

Discussion

This analysis shows that the Medicaid expansion matters, not only to low-income populations generally, but also to agricultural worker populations most at risk for low rates of coverage and care. Migrant health centers located in Medicaid expansion states showed an increased rate of insurance coverage among their patients, while those located in non-expansion states showed significant but smaller gains. For migrant health centers in states that did not expand Medicaid, what gain there is tends to be in the proportion of patients with private health insurance, likely a testament to the importance of subsidized marketplace coverage. The modest nature of these gains is not surprising: the depth of agricultural worker poverty, coupled with language barriers, makes Medicaid expansion particularly important for agricultural workers, especially as they begin to settle in states and migrate less, thereby increasing the likelihood that they will be able to maintain Medicaid coverage over time, once enrolled.

This analysis also underscores the important health care implications of demographic shifts that have led to greater state-based stability among agricultural worker families. As agricultural worker families increasingly become continuous residents of single states, the need for dedicated grant funding also increases so that health centers can strengthen their capacity and better align their services with the health needs of a population that, even in the wake of watershed health reform legislation, continues to lack health insurance at high rates.

In addition, rising rates of health insurance among patients served by health centers also could reflect the fact that most health centers that receive migrant funding also serve populations in the community who are not MSAWs. Since the UDS data do not link insurance and employment status of patients, it is not possible to know whether

[25] Farmworker Justice, 2014, op. cit.

[26] Garcia, D., Hopewell, J., & Liebman, A.K., & Mountain, K. (2012). The migrant clinicians network: Connecting practice to need and patients to care. *Journal of Agromedicine, 17*(1), 5-14.

the increasing rate of insurance coverage seen at migrant health centers is occurring among patients who are members of the MSAW population or those who are not.

The expansion of insurance coverage at migrant health centers suggests a major opportunity for health centers to maximize the health and wellbeing of agricultural workers. As noted, studies have documented the health risks and disease burden faced by agricultural workers and their difficulty in knowing where to access medical, dental, and mental health care. Health centers, and migrant health centers in particular, have demonstrated success in serving the agricultural worker population. Research suggests that health centers in Medicaid expansion states are more likely to provide enhanced access to services. A recent survey of the nation's community health centers found that health centers in Medicaid expansion states were significantly more likely than those in non-expansion states to report increased mental health and dental care service capacity since the ACA was fully implemented, likely because increased insurance revenues allowed for investment in expanding services.[27] The challenges of improving access for the agricultural worker population in non-expansion states are apparent and underscore the importance of sustained grant funding and continuous efforts to expand Medicaid for the poor populations of these states.

[27] Shin, et al., 2015, op. cit.