

MCHB/DCAFH
Medicaid Portability:
Eliminating Gaps in Health Care, Optimizing Oral Health,
for Migrant Children and their Families

March 18, 2009

PAMELLA VODICKA: Hello, everyone. Thank you for joining us today for our oral health webinar on Medicaid portability. This is Pamela Vodicka, senior public health analyst at the Oral Health Program at Maternal and Child Health. Before I get started on introducing the program for today I would like to go over a few housekeeping rules.

One, slides will appear in the center window and should advance automatically. The slide changes are synchronized with the speaker's presentations. You may want to adjust the timing of the slide changes to match the audio by using the slide delay control at the top of the messaging window. Two, we encourage you to ask the speakers requests -questions at any time during the presentation. Type your question, with the dropdown you will want to select question for speaker. You'll then hit send. Please include your state or organization in your message so we know where you're participating from. We'd also like to ask that you start your question with who you would like the question to be directed to. The questions will be relayed onto the speakers at the end of the broadcast. If we don't have the opportunity to respond to all your questions we'll email you answers afterwards. The answers will also be available in the archived version at the end of the presentation. Again, we encourage you to submit questions at any time during the broadcast and to know these questions will be asked at the end.

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Those of you who selected accessibility features will see text captioning. At the end of the broadcast you'll have the opportunity to fill out an online evaluation. Take a couple of minutes to do so. Your response will help us to plan future broadcasts in this series and improve our technical support. Again, I thank you for joining us today.

Our topic today is on Medicaid portability. We have four speakers for your presentation. The outcome of today's presentation, our objectives are to increase participant knowledge of Medicaid portability and its impact on the continuity of care for migrant workers and their families. To increase participant awareness of current Medicaid portability efforts and models and piloting a medicate portability project between Texas and Michigan. Dr. John Rossetti is lead oral health consultant. He'll be followed by Jana Blasi, from Austin, Texas. Following her will be Lynda Meade from Lansing, Michigan and could conclude. Will be Christine Farrell from the Michigan Department of Community Health, Lansing, Michigan. I would like to turn the event over to Dr. Rossetti beginning on slide three. You're on, Dr. Rossetti. Dr. Rossetti if you have your mute button can you please unmute?

JOHN ROSSETTI: Can you hear me?

>> Yes, Dr. Rossetti. Thank you very much.

>> Hello, America. What I would like to do today is provide a little overview regarding what we're going to do today. I would like to give you a little overview of what Medicaid

portability is, talk a little bit about some of the Medicaid efforts that have taken place, talk a little bit about the two models that we will discuss a little later, one in more detail than the other one called the interstate provider network model which we'll talk in detail from Michigan and Texas, and the other one is the multi-state Medicaid current model which we'll barely touch upon. What is Medicaid portability? Medicaid portability is really the ability to have Medicaid follow a child from state to state. In the case of Medicaid for migrant farm worker children, what it means there would not be a gap in Medicaid coverage as a farm worker child moved from state to state. Some of these children can move through three to six states a year and have to -- they would lose their coverage in between. If there were Medicaid portability, this would prevent that from happening. So Medicaid portability, once it's established means a farm worker child. We're talking farm worker children but I think in the future we could be talking a number of children outside of the migrant community. The child would have to dis-enroll in Medicaid in the state in which they were enrolled, the sending state. They would lose their coverage, they would go to a new state, have to reenroll and then the farm child would travel to the new state and lose his coverage. With Medicaid portability it means that the child could be in his home state, move to a new state, carry the coverage with him or her and the state from which the child was originally enrolled would provide the coverage.

Next slide. This sounds like a pretty simple process. But it really isn't. In fact, we'll hear today it's a somewhat cumbersome process and a very involved process but it sounds sort of -- very simple at the beginning. Actually Medicaid portability has been a possibility at least in the Medicaid legislation for over 30 years. But it has never occurred. Something simple, doable but never occurred. There have been several reports and several recommendations written over those 30 years as to how Medicaid portability at least for migrant children should be implemented but nothing ever became of that. There were only

a few organizations that were really following Medicaid portability because it was very important to them. Those organizations were the National Association of Community Health Centers, and a farm worker health group. They were the only two groups out there over the 30 years that were really following any type of Medicaid portability legislation. Although Medicaid portability is an important issue. It was pointed out a lot when we had Hurricane Katrina in Louisiana and many of these children went to other states, many were on Medicaid and they lost their coverage from the state where they were. They had to re-enroll and it was a cumbersome issue. If Medicaid portability were a reality that problem of those children going through a disaster and moving to another state would not have been a problem. There has really been nothing done in the legislation recently regarding Medicaid portability until the new CHIPRA act was enacted in 2009. In 2009 section 13 of that act, the new CHIPRA legislation called for the secretary to look at models of Medicaid portability and enrollment and coverage and to report back to the secretary on any progress or models that have been developed. Now, from my perspective and I think some of the perspective of the folks that were at the meeting that we're going to talk about a little later we'd like to think that some of the things we've come up with over the last year or so have done something to stimulate this broader Medicaid portability legislation. As many of you know, the Maternal and Child Health Bureau is a federal agency that is probably the only federal agency that comprehensively looks at the child health needs out there. It actually looks at the needs of a child, the needs of a family and it looks at a lot of the issues surrounding the health needs and specifically the oral health needs of children. Over the last three to four years the Maternal and Child Health Bureau has periodically looked at issues that were of what we call cutting edge issues. Those were issues that were issues that would have a large impact on the health of children. They were issues that were timely in that you have to address them within a short period of time to have any effect. And there were also issues these cutting edge

issues were issues that other organizations really didn't deal with. No one would really get into dealing with these issues and trying to resolve them. Over the course of the last two years the Maternal and Child Health Bureau has looked at several of these issues. One is oral health of children with special healthcare needs and convened groups of experts on issues of topical fluoride, we've look at the concept of a dental home, early childhood caries program and numerous others, cutting edge programs.

Now going to be on slide -- for those who have trouble following me I'm now on slide number 6. In 19 -- I'm sorry, in March of 2008, the Maternal and Child Health Bureau decided to look at Medicaid portability of Head Start migrant children of one of the cutting edge issues it wanted to look at. This reason it did this, the Maternal and Child Health Bureau had an agreement for several years. The issue had come up that migrant Head Start children were moving from one state to another and having difficulty getting into the Medicaid program. They would be in a community for such a short period of time that they were unable to enroll in the program and it was causing all kinds of -- all kinds of problems for the Head Start programs.

The Maternal and Child Health Bureau, next slide, decided to convene as part of these cutting edge meetings decided to take a closer look at the issue of Medicaid portability for Head Start children. As I mentioned earlier, the issue of Medicaid portability had been around for a long, long time. Never really being addressed because it was such a broad issue to address. It sounds simple but the issue is so broad that it's very difficult to get a handle on it and to -- and to understand it. What the bureau thought in order to address the issue, we had to sort of focus our attention on an issue that could be solved. The bureau decided to focus, as I said earlier, on access to care for Head Start migrant children. So as I said, in March of 2008, the bureau convened a panel of 30 to 40 experts.

These are experts and people who have worked with Head Start, worked with Medicaid, worked with community health centers, worked with advocacy groups and others. It was a very, very unique group and the Maternal and Child Health Bureau, along with the migrant and seasonal Head Start collaboration office who co-sponsored this meeting with the Maternal and Child Health Bureau pulled together a very, unique very group of people. They pulled together people who probably had thought about, talked about, tried to address the problem of Medicaid portability but had never met each other. There was a meeting when we went around the room and introduced each other, we found that all these people, about half the people in the room, had never met the other person or even had associations with the programs that these people ran. But we knew if we convened the right people and we were focused in our attention, we could hopefully come up with some type of model which would look at Medicaid portability. We had folks from as I say Texas, Michigan. You'll hear a little later we had community health center reps. As I said, Head Start reps and just a very, very broad group of people and the attitude was at the meeting if we got the right people and we had a can-do attitude, we would be able to at least begin the process of trying to address the issues.

Next slide, please. We're on slide number 8. As I mentioned earlier, there were two basic models we could look at for Medicaid portability and that would help a child carry that coverage from state to state. One was the interstate provider model and the other one was the multi-state Medicaid model. The interstate provider model seemed more appropriate to the audience that we had at that meeting to implement the Medicaid, the multi-state Medicaid card with a little broader concept and it was something that that very focused group that we had would not be able to address. But the interesting provider model we had the right people in the room at the right time to sit down to see if we could come up with addressing the Medicaid portability issue. You will note there is a reference

in the webcast or there will be a reference document by Sarah Rosenbaum of George Washington University who discusses a little historical perspective of Medicaid portability and also defines to a bigger degree the interstate provider network model and the multi-state Medicaid card model and I suggest that if you are interested, go back to that, read that entire reference document and I think it would provide a lot of perspective on what we're talking about here today. As I said, both models are doable under current law. The idea is we never really sat down and tried to implement it but this is all within the legislative acts of Medicaid, but something that was never done until we find out how it is being done and being implemented and in the process of being implemented by the states of Texas and Michigan. And I think you will hear some very good things from the next two presenters who Pam will introduce. Thank you.

>> Thank you, Dr. Rossetti.

Now on to the next slide. Slide 9. We'll be talking further about the Texas/Michigan partnership. I didn't mention at the beginning of the presentation there were in addition to the slides, there were the document that Dr. Rossetti mentioned. There was also another resource page that will further provide information on what the speakers that follow will provide if you did not download that, be sure and go back and get it to have for your resource packet. Our next on the list of speaking is again Jana Blasi from Texas, please, Jana, you can begin starting with slide 10.

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JANA BLASi: Great. Thank you, Pam. Good afternoon. As Pam said my name is Jana Blasi, we are the there are PCAs representing every state in the country. They represent community, migrant and health centers called federally qualified health centers and you'll

hear me and the following presenters talk about FQHCS, a little background on the alphabet soup you are about to here. I'm excited to be here to tell you about the progress we made in actually implementing Medicaid portability here in the State of Texas.

Targeting migrant and seasonal farm workers' families and children. And as John alluded to, the high cost of healthcare and lack of insurance coverage really creates major challenges and barriers for many of our migrant families to be able to access healthcare services when they're out of state. It's really difficult for these families to have to try to reenroll in different state Medicaid programs every time they change locations while they're accessing employment. And they often don't have the necessary verifications that are necessary to enroll in a different state program. They also don't know where to go.

There is also transportation barriers, linguistic and cultural barriers so we know in our experience working with this population that is not a viable approach. Past strategies have been discussed over the years to address portability and many of these strategies have not panned out for Texas. This is in large part due to the varying eligibility levels and categories, benefits and reimbursement rates provided among the different state Medicaid programs. So just overcoming all those differences between different state programs has made other options not as viable and attractive certainly for Texas and for a lot of other states.

The next slide, please. So back in 1998, Texas began to look at Medicaid portability and specifically the interstate network model and we're calling it the Texas Migrant Care Network. So we started looking at this model and instead of having the burden be on the families to try to re-enroll in different state programs the focus of our program is to build networks with out of state providers who provide care to our Texas migrant and those out of state providers, once enrolled as Texas Medicaid providers, would serve our Texas families in their state and they could bill Texas Medicaid to be reimbursed. And this model

really mirrors what many of us who are commercially insured experience when we go out of town on a business trip, we don't have to try to re-enroll in a different health insurance program. We can go ahead and use our card. It's the same philosophy and it takes the burden off the patient and the other really important point about what Texas is doing, we've been allowed to do this all along. You could enroll in a different state Medicaid program if you were a provider, if you follow through the enrollment processes. However, there are policies and procedures that would create barriers for those providers to actually bill and get reimbursed for services and provide that care to the Texas families when they were out of state. Those are such things as prior approval requirements, a lot of states have primary care provider referral policies that would make it very difficult for a family to go to a non-primary care provider that they had selected in their home state.

Next slide, please. Slide 12. Back in -- we've been working on this for about ten years.

After the meeting that John talked about with the Maternal and Child Health Bureau, which I think was really one of the catalysts to get the state moving in this direction and really deciding to fully implement this portability model, we were contacted in late March by Texas Medicaid and were asked to help identify out of state providers, especially federally qualified health centers that would be interested in enrolling in Texas Medicaid to create the Texas Migrant Care Network. The goal of this program is to facilitate the access not only to medical care but dental care, behavioral health services and to provide that continuous coverage to our migrant families both in and out of state. As John said, a lot of times there are gaps in coverage with our children as they move from state to state. And so this model is really designed to make sure that they have access continuously to any services that they need that are covered by Texas Medicaid. And one lesson that we've learned in implementing this program and getting out of state providers interested in enrolling in Texas Medicaid, especially federally qualified health centers, instead of picking

out one service like oral health saying we want you to go through the hassle of getting enrolled in Texas Medicaid so you can get reimbursed for any dental services you're providing, we now know that really it's much more effective and a greater incentive to cover all of those services covered by Texas Medicaid. So if a provider provides medical, dental, pharmacy, oral health, they can get reimbursed for those services through Texas Medicaid.

Next slide, please. To make this work, it takes a lot of effort not only on the provider's side, the family's side but also on Texas Medicaid's side and they have actually assigned specific staff to work with out of state providers to help facilitate the enrollment of out of state providers who would serve our Texas migrant families. And so that's really been critical. That's another lesson learned. When we first started identifying providers, we didn't have one person at Texas Medicaid to refer them to. And so we've learned that they really need that warm handoff so their enrollment is facilitated. Now, the focus of this project is on migrant children who are currently enrolled in Texas children's Medicaid and that's very logical considering that Texas is one of the largest sending states in the country. We have an estimated 200,000 to 300,000 migrant seasonal farm workers. At least 100,000 of those are children. Any Medicaid recipient, whether they're a migrant or not, if they go to an out of state provider that's enrolled in Texas Medicaid, they can -- their coverage will work as well. You don't have to be a migrant. This is purely a Medicaid program.

Next slide, please. But keeping in mind that we are really focusing on migrant children in the migrant family, in this program we -- there are three major eligibility groups that are covered under Texas Medicaid that would be most likely to travel out of state for

temporary employment, and that would be children, pregnant women and women of childbearing age.

So on this slide we have the eligibility criteria for these three groups. But it's important to note that Texas Medicaid offers more eligibility categories. Those other Medicaid recipients are less likely to travel out of state for employment. So these are the three groups that would most likely present for care when out of state. And it's also important to note that due to the low income levels of the vast majority of our migrant farm workers and their families, most of them are going to be eligible for Texas Medicaid and would fall under the asset and income level requirements of our state program.

Next slide, please. There are three very important policy issues related to the Texas Migrant Care Network that I think should be highlighted. Currently this program is only Medicaid and CHIP is not included. However, due to the recent provision in the CHIPRA. We hope CHIP will be added to the Texas Migrant Care Network. Certainly due to our experience in Medicaid portability, we think it would be fairly easy for us to expand this to CHIP. The second really important issue that John also talked about is that we are using existing Medicaid law. We didn't create -- we didn't expand the Texas Medicaid program to do this. We didn't create a new eligibility category in Texas Medicaid. This is just a Medicaid program and if you're eligible for Medicaid whether you're a migrant or not, you would be able to access care out of state and your insurance would be portable. In fact, to help facilitate this and really speed up this process, the implementation process, Texas is following the current provisions in our state Medicaid plan so we don't have to go through an often-times lengthy process with CMS to make amendments to our state plan. We're following current state regulations and policies and procedures that have been approved by CMS to implement this program. Now, another challenge for us, though, is that the

family members have to be enrolled in Texas Medicaid before they leave the state. We're not trying to get out of state providers to enroll Texas families into Texas Medicaid when they are in Ohio, for example. It's really critical we get them enrolled before they leave and advise them to maintain their coverage. This is very challenging for Texas, as most of you are probably aware. We have one of the largest uninsured populations in the whole country. One out of four Texans is uninsured, which is 5.6 million people in our state. Of those 1.5 million are children and of those, it's estimated that 750,000 of those uninsured children are income-eligible for Medicaid and CHIP. So we have a huge outreach in enrollment effort underway to try to correct that situation. But we do have a lot of uninsured children so we're working hard on our end through our community health centers and other partners in the state to identify these families that are uninsured. Get them enrolled in Medicaid before they leave.

Next slide, please. Texas Medicaid recognizes that federally qualified health centers are a primary provider for this special population. And, in fact, FQHCs serve many farm workers nationally. Texas Medicaid knew we needed to target them to build the out of state networks. Other private providers, other health departments, other clinical departments that provide services the migrant farm workers and they're welcome to participate, enjoy and get involved in the Texas migrant care network. We're not interested in just primary care. That's the first step. We also envision these networks as being fully comprehensive in terms of specialty care. Oral health services, hospital care, pharmacy. So those are going to be the next step. We're just trying to build the backbone of the networks with good primary and preventive healthcare providers. Now, the state -- how is the state reimbursing these providers? Well, federally qualified health centers will get their perspective payment system rate, PPS rate, which will cover their cost of providing care, which has been one of the barriers to implementing other models in the past where you

had -- where rates may be different from one state to the other. Every FQHC is going to have a PPS rate that's specific to their health center regardless of what state they're in. Texas is saying if you're an Ohio health center and you have a PPS rate we'll pay you your PPS rate. Now, if it's another type of provider they would be paid their fee-for-service rates under the Texas Medicaid program. Next slide, please. As John also said this sounds simple but it has been incredibly challenging to implement and we're learning new challenges every day as we move forward in this program. One of the biggest challenges is really figuring out way our Texas migrant families are going for work. There has really not been any -- we have anecdotal information but there has been no formal study of the migratory patterns of migrant farm workers from Texas making it hard to figure out where they're going and what providers they go to try to target for enrollment in Texas Medicaid. That has been a little bit tricky. The other thing with migrant seasonal farm workers in the past there has been a belief that migrant farm workers from Texas typically just went to Midwestern states and certainly they do. But we've learned in working over the last year that our migrant farm workers go everywhere. They go to all states. They go to the east coast and the west coast and up and certainly in the Midwestern states as well. So we are really targeting a variety of states but we're very open to the fact that they really do go everywhere. The final really serious difficult challenge to implementation is just the misperception that migrants have to drop their Texas Medicaid before they leave and that I've even heard some providers to tell me it's illegal for them to carry their Texas coverage out of state. That's not correct. We have a huge educational effort not only with our migrant families. They're used to doing that. We're educating them to keep their coverage and out of state providers that it's okay to keep their Texas Medicaid coverage and we're even having to do a huge educational effort with our out-station eligibility workers and eligibility workers at Texas Medicaid. They're used to telling people to drop their Texas

Medicaid coverage. We have three big outreach efforts underway to try to change that misperception.

Next slide, please. So we're doing a lot to try to fix that. So we're working very closely with our health center outreach staff in migrant representatives to get out into the migrant communities, talk to advocacy groups, other providers to get the word out about this program and that for them to keep their Texas Medicaid coverage. We have a website that is on my presentation, www.tahcorg where we have a webpage where we've archived a lot of our training and outreach materials we're using in this program that you're welcome to download and use yourself. So we've developed outreach materials for providers as well as families and we have those materials in English and in Spanish. Currently we're targeting health centers in Michigan, Ohio, Illinois, Indiana, Washington state, Oregon, Florida, Georgia, North Carolina, South Carolina, Maryland, New Mexico, Arkansas, California, Colorado, the list goes on and on. I just got a call from a center in Idaho yesterday. I didn't realize we had any migrants in Idaho but we do. We're really open to the fact we need to do enrollment outreach efforts pretty much in every state to figure out where our migrants are going. Currently we have FQHC sites around the country who see significant Texas migrant populations in their practices.

Next slide, please. So we're doing a lot of training, a lot of informational sessions, you know, provider enrollment has been a big focus of ours but we're also now getting into billing and coding for out of state providers and are trying to put together and have done some trainings on that. Other major policy issues that we're working with the state on are recertification of our children when they're out of state. How do we get them recertified. What happens if it's a Texas Medicaid mom. And she delivers the baby out of state. How do we get that newborn enrolled in Texas Medicaid and some of those issues? So it is a

very complex program, different policy issues and implementation issues are coming up and we are working hard to address all of those.

Next slide, please. We also, you know, in addition to information and trainings, we act as a liaison between the out of state providers and advocacy groups and families and Texas Medicaid to try to work out any of these issues that they're having because it's in our best interest and our center's best interest and in our Texas families' best interest to make this program work. We're working very hard to troubleshoot any of those issues and are learning quite a few lessons along a way. We've had tremendous success in working with Michigan in particular. And I think one of the reasons we've been so successful in getting Michigan federally qualified health centers and other migrant groups and the Michigan Medicaid program to be so supportive of this is the work that the Michigan Primary Care Association has been doing in working with their centers and with their state partners to help us implement this program. And so with that I'd like to turn it over to Lynda Meade. She'll be on slide 21.

LYNDA MEADE: Thanks, Jana, this is Lynda with the Michigan Primary Care Association and I'll talk a little about the efforts that we've been working on here in Michigan both relating to the request of the national workgroup that met last March as well as the opportunity that was given to us through Texas. We are a large receiving state.

On slide 21 you can see a little bit of information about Michigan. We have six health centers that are designated to serve migrant workers and family members. And we did an enumeration study in the summer of 2006. Michigan is receiving 90,000 workers and over 45,000 family members or dependents. You can see a break down of where those kids are. A very large number of children are migrating up to Michigan. Our season runs

primarily may through October with some workers already in the state. We have some early crops and work that's done in April. So we're already seeing some of the workers. The numbers of those served in our community health centers in 2007 you can also see on this slide.

We served over 20,000 migrant seasonal farm workers and family members. One thing that Michigan does have is we have a very strong network and a very connected network of migrant and community health centers and they work very closely with the PCA. We've done a lot of work. We have a migrant health network and we're frequently in contact with our health centers so that established network has really been a benefit to doing this work. Just one other note on the data that we have here that I didn't put on the slide. We're working very closely with migrant Head Start run by a corporation here in Michigan. Migrant Head Start has over 1,400 kids in their program each season. Our migrant education program run through the Michigan Department of education has over 8,700 children in their program. And our Department of Human Services supports over 4,000 children through childcare support and stuff like that so we have a nice audience and we have a nice connection to our state agencies.

Slide 22, please. On this slide you can see the result of our study done in 2006. It shows you the density of our migrant workers and family members when they are in Michigan. And we've also done an overlay here. The gray stars that you see are the locations of our current migrant health centers and those that are the dots are our other community health centers that also see some migrant workers but the vast majority of those are seen in our migrant health centers.

Next slide, please. As a result of the meeting in March of 2008 and we just have to keep reminding ourselves it's only been a year. I think there has been a lot of really great progress done due to a lot of work that was done prior to that meeting. But this really again, like Jana said, was the impetus to get us up and going. We had really strong representation at that meeting in Washington, D.C. And as a result of that, we came back to the State of Michigan and within just over a month we convened the Michigan Medicaid portability workgroup. That was comprised of all of our members that our migrant health centers, the health centers seeing migrant workers, the primary care association we were asked to take a lead guidance role in that. Migrant Head Start. Our Medicaid policy office, which Chris is the representative on our Michigan as well as the national workgroup and she'll talk just after me. Then we have -- we're fortunate to have migrant health promotion here in the State of Michigan so they came to our table and have been a great asset to that program. And then our Department of Human Services has also been involved. We've met five times in the last year and we've been a lot of email communications as our health centers have been doing the enrollment process. We've formed an enrollment sub group so they can talk to each other, work out some of the issues that they're having in enrollment and get advice from each other. So we've been working on that with the purpose of that workgroup is to share information, problem solving and I think that will continue through this implementation phase. The support of each other and finding out what each other is doing and kind of encouraging each other along the way and then, of course, to keep our options open to other portability efforts that are out there. And I do need to give kudos out to our migrant health centers and our health centers. When we first talked about this program and we had the very narrow focus of migrant children in migrant Head Start around oral health services that number really would have been quite a small number. And there was a question about the actual cost benefit but to the benefit of the folks that sat around that first meeting, it was decided that this might not have a cost

benefit to us but it's not the only reason we need to do this. We need to do this because it's the right thing. We've been asked to do this. We'll learn a lot from this and down the road it will benefit our health centers but let's focus on those families and children so they've done a really incredible job in that work.

Next slide, please. 24. Aside from the Medicaid portability workgroup there has been other key partners that I think have set up Michigan to really get on the fast track in doing this. We're very fortunate that we have a couple structures in the state that connect those key partners. We have the opportunity to meet on a monthly basis on a statewide group that is called the interagency migrant services committee that is coordinated through our Department of human services and we have a director of migrant affairs in that position. We also, as a side to that, have a child task force, a housing task force and a data task force. Again, we do meet monthly about 25 people attend those meetings. And you can see the list. I'm not going to go through it but you can see the partial list of those key partners on the side and it's been critical to opening doors to administrative staff, policy staff as well as field staff. I just want to again give kudos to the people who had the foresight to put it together and it benefits us in many ways but it certainly has been part of the success that we've seen here in Michigan.

Slide 25, please. On this slide you can see a little bit about the efforts that we're making here in Michigan as a receiving state. We're using some of the material that was developed in Texas.

You can see on this slide in the upper right-hand corner you can see just a partial snapshot of one of the three posters that Texas has done. They've done two that are focused on the family. One in English, one in Spanish. They also did one for providers.

We widely distributed this to like in the list that's on that same slide, we've widely distributed this to health centers, Head Start, a system of migrant resource counsel we have in Michigan. Multi-county entities make up of all the service folks. We have eight of those in Michigan. We're working through the growers also. And then we did the post cards that you see on there. One side is English, one side is Spanish. We distributed 4,000 of these through the same distribution list and then some. The purpose of those post cards was really to get the information out to the workers before they left the state in the fall. We got those out in September so we probably missed some but those that got them in their hands at least when they go back to Texas will say maybe you heard a little bit about this when I was in Michigan. It gives them important information, phone numbers and thanks them for coming to Michigan and stuff like that. That was one of the tools that we developed along with Texas, with the migrant health promotion helped us with that. We've been doing a lot of this. We know this is key and we know this is going to follow on the heels of what is being done in Texas. It's a large state that we need to communicate with and a lot of different pockets of growers and workers and agencies but we think we have a good start on it last fall and have continued that through the went and now have geared up again for this spring season, which is right around the corner.

Slide 26, please. Now as Jana said talking about some of the challenges they found in Texas, we as a receiving state are also finding some challenges that we're trying to work through as part of a pilot and part of a model. We're doing as much as we can to document some of these challenges and how they were resolved which I think is part of our charge again from that national group and it is going to help others as well as us as a state. It is a challenge, as Jana said, to communicate with migrant seasonal farm workers for a lot of different reasons even with a system and structure as strong as we have here in Michigan, we still have many workers and family members that may not be accessing

services through some of the partners that I mentioned earlier, so we need to continue that outreach. I think it is going to be something that will be happening from here on out is that communication. When they come to the state, as Jana said earlier, too, they're used to dropping their coverage in Texas before coming up to Michigan and that's their routine. Here in Michigan we have a lot of different options for Medicaid and I think Chris is going to talk a little bit about that so I won't go into that. Determining what their best plan for coverage is based on their family composition, where they are going to be working, what health center or dentist or wherever they're going to be going for their services. It is a little bit of education for all of us to figure out what that best plan for coverage would be. The third bullet. The stuff I mentioned is changing their routine. The other thing that we're working that I think again will resolve over time is not all of our health centers are enrolled in Texas Medicaid. Right now we have two agencies that have completed the enrollment. That makes up about eight different delivery sites. We have two more that are almost completed with the process. I think when those two are done we'll have 20 delivery sites. Here in the State of Michigan we have a total of 160 delivery sites between our migrant and our community health centers. We need to work to close that gap. I think over time we will indeed do that but there will be some confusion as to where they need to go to use their Texas Medicaid but we're doing as much as we can to mitigate that before the season starts. There has been efforts to train the staff that work in the health center and I think Texas has done an outstanding job and so has the farm worker health services has done an outstanding job at providing resources, webcast, support documents. I, too, have put a webpage together that has links to all of this information to make it easy to find here in Michigan. But we're working on training and we're going to hopefully have one more training for general information before this season and then I think we are probably going to need another billing training that will just talk to the Michigan folks with the Texas folks and try to mitigate as many problems as we can to make that successful. Of course, the

challenge of change. Change anywhere is always a bit of a challenge but we're trying to make it as painless as possible. I think through the partners we're doing a pretty good job of that.

Slide 27, please. Now that we're enrolled, we're working with Texas in really thinking about the implementation issues at a health center level. We've done some policy stuff. We've done some administrative stuff but what is it that they'll need to know when they come into a health center? The health center staff? What questions will they need to ask, very simple questions, how do we recertify if they're from out of state or if there is a new baby born, how do we verify and handle immunizations, registry and all that stuff. We posed all those questions to Texas and have that before we get into our season. That's part of our documentation and our continued technical assistance that we're providing across the states. Again we're doing a preseason call with Texas, Jana has been kind enough to join us for several of our workgroup calls and has been able to answer questions, so has a few other staff there in Texas, some folks that have expertise in billing as well as those that know enrollment and Jana that knows FCHCs, that's been an encouraging part of the plan. If our health centers call and have questions they'll get some body that is familiar with the project and are going to know where to go for the answers if they don't have them themselves. That will reduce the frustrations that our health centers could have if they just get thrown into a general call center. So they've done a great job of doing that. Now, we're getting a lot of information to enrollment and outreach staff. Chris is going to talk about that at the end of this presentation. We've had a couple meetings with staff in the state office that works with the outreach and field staff and we're putting together the tools they need to be able to answer the questions and make the right referrals so there is just not confusion on our end. I think we're pretty much on target to have that ready for them. One of the commitments that Head Start made when they were in Washington, D.C. a year ago

was to really be a strong partner with this project and Head Start is really focusing on shifting their contracts for services for all of their children to health centers, migrant health centers or any other provider that is enrolled in Texas Medicaid. We thought we had about half of the kids that come to the state from Texas and half from Florida. And some of our numbers support that and some of them are incomplete datasets. By shifting that over, that's going to provide some of the benefits of the Texas Migrant Care Network by having continuity of care and coverage. It will be a cost saver for Head Start and I think that they can go to agency or a site that has good quality care. So that's an important part of our success and again of our documenting the successes for replication. We're asking everyone to have patients and understanding in year one. Please let us know what questions you have. What can you anticipate. What do you have in realtime so we can help with that? We're going to gather data on the usage and other challenges that can be resolved at the time of the issue or if it's something that needs to be taken care of kind of with what is a little more off season. If we need to work on policies or get some other kind of support material together, that we'll be able to do that to make it as smooth as possible. We're very committed to reaching the goals of the national workgroup, which is again our migrant Head Start children in oral health and we're still very focused on that. The Texas Migrant Care Network has allowed us to make an easier sell. We're trying to stay true to both programs and doing a good job with the documentation so it can hopefully spread to other states and everyone can learn from us. The next presenter on this webcast is Chris Farrell. Chris is with the Department of Community Health that works on Medicaid policy and I think I skipped a slide but I think I covered everything on there. I apologize for that. I'll turn it over to Chris starting slide 29.on

CHRIS FARRELL: Hello, good afternoon, I'm Chris Farrell from the Michigan Department of Community Health and I'm with the state Medicaid program. And I am -- I work on

dental policy issues and I also work on the FQHC issues so it's been a pleasure working with Lynda and the primary care association and then getting to know Jana from Texas on this issue. Before I get started, I just want to also give you a quick overview of the Michigan Medicaid program, just a quick for funding the number of eligibles that we have in our state and the administration of the program. Currently for fiscal year 2009 Michigan Medicaid is a \$10 billion program. We cover mandatory and optional populations in eligible categories include children 0 to 18, 19 and 20-year-olds, parents, caretaker relatives, childless adults, elderly and disabled. Some the same categories as Texas Medicaid that Jana had on an earlier slide. So it does -- those same children would be covered under Medicaid in Michigan and for right now depending on which -- if you do it currently, depending on if you stayed in Michigan Medicaid and Texas Medicaid. If they come into Michigan now they would probably stay under Texas Medicaid. In Michigan we have seen growth in our Medicaid caseloads. Actually quite a bit of caseload growth since 2001. In 2001 we had 1.1 million Medicaid eligibles including children and adults. January 2009 we saw over 1.6 million Medicaid eligibles. We have a state population of 10 million residents. We are by far the state with the highest unemployment rate, 11.6 and probably climbing. So we do see a lot of Medicaid eligibles in our state right now. Two of our priorities for fiscal year 2009 is to provide healthcare coverage for children and improving the quality of care for children and pregnant women.

Next slide. This just depicts enrollees of Michigan Medicaid eligibles from fiscal year 2008. A disproportionate number of children are enrolled in Medicaid. 54%. In 2008 there were 1.1 million children enrolled in Medicaid or my child, the S-CHIP program statement. We think Michigan Medicaid has a special responsibility to provide the best possible start in life.

Next slide. This is just about on slide 31 on administration of the Michigan Medicaid. And we have two different departments involved in the administration of Medicaid. The Department of Human Services determines the eligibility. They have the responsibility for the beneficiaries. The Department of Community Health, which is the area that I work in, we administer the health benefits, determine coverage and enroll providers. But we work closely and collaboratively across the agencies on both of these issues. We get our enrollment files on a nightly basis from DHS so we know who our Medicaid beneficiaries are. And we have also worked collaboratively on this Medicaid portability issue and because it concerns both enrollment into Medicaid and then providers and payment of claims. And you already have heard that Michigan role right now is that we're the receiving state and we have migrants coming primary from Texas and Florida. You've heard that from Lynda also. In this initiative, though, in terms of this partnership with Texas, DHS, the Department of Human Services, would play the major role regarding eligibility at this point. We would play, Department of Community Health would play a minor role because the Michigan providers are the ones enrolling in Texas Medicaid and Texas will reimburse the claim. At this point in time we aren't working on reciprocity in having Texas providers enroll in Michigan Medicaid. It's only a one way stream at this point. We both attended the expert meeting in March of 2008. Martha Gonzalez was the representative and I was the DHS representative last year.

Next slide. And as mentioned, Medicaid portability has been around for 30 years and Michigan has participated in this issue for a number of years. At the state government level. Lynda also mentioned this, too, we have an interagency migrant services committee, DCH and DHS are partners on it. Within that committee is a migrant child task force and Medicaid and public health representatives are also on that participant. And this task force has its own mission, to promote the well-being of Michigan migrant children

through the education of their caregivers, advocacy for effective public policy and collaboration with community partners. So this task force and interagency committee has been aware of this initiative. Within the Department of Human Services, they also have a distinct section for special populations and one is the Office of migrant affairs.

Unfortunately the position had been vacant for almost a year, Martha had left. Since the start of 2009 a new director of migrant affairs has been hired and her name is Mars Lena SAVALEA. She will play a vital role in the future plans on this initiative. She's listening on the call today. As mentioned by both Linda and Jana one of the challenges for the migrant office is reliable data collection and review of migrant patterns so we know who is coming into the state and where the migrants are coming and settling. Within county offices, we have migrant program specialists and fiscal year 08 there were staff. Due to budget problems fiscal year 09 we have 64 designated staff in the 24 counties that will work specifically on migrant issues.

Next slide. As mentioned, communication regarding this initiative is the main topic.

Communication and outreach. And we are looking at developing one consistent message for the participation and why we should be part of this and the message is access to healthcare by providing seamless coordination of Medicaid eligibility. And you've heard MPCA -- and other partners regarding enrollment into Texas Medicaid as a provider. Where as the Department of Human Services' role is going to be communicate with eligibility, outreach staff and the beneficiary regarding the continuation of their Texas medical eligibility while in Michigan. So we are trying to work on that seamless coordination. And Lynda and I met with the DHS staff yesterday, including Mars Lena regarding information that what we'll need to develop for field staff and one of the reasons we've done this in a two-prong approach is we needed to at least have providers here in Michigan enrolled in Texas so we could tell beneficiaries if you come into Michigan you

have providers you can see. There was no use telling them to stay enrolled in Texas Medicaid if we didn't have health providers for them to see. We also want to coordinate one message within the field operations, the migrant or the Medicaid policy unit and the migrant affairs. In the Office of migrant affairs will be coordinating questions from the field so there will be one message going out regardless of where the contact comes back in through state government.

Next slide. So we're also looking at resources and tools for our DHS staff. MPC a working on tools and resources for their migrant community healthcare staff and we'll probably use the same information. We cannot have too much information. We want to provide workers with a question and answer guidance. We also want to give them a list of migrant and community health centers in Michigan that participate in Texas Medicaid and we want to, you know, because basically the workers are going to have to reassure Texas beneficiaries that if they're in Michigan, they can continue to keep their Texas Medicaid. We want to also provide them with contact information for Texas Medicaid if they need to contact -- if they need to contact someone and they're concerned about what they should do. Also Department of Human Services is gathering a list of questions that they would like Texas Medicaid to answer for their field staff regarding eligibility enrollment. This question and answer will not only just -- we're looking at a question and answer tool for beneficiaries but we also want a question and answer for the eligibility workers here in Michigan so that they can provide the information in one consistent theme. The Office of migrant affairs also will play a role in this and coordinating these questions.

Next slide. Our challenges are for Michigan Medicaid is disseminating information in a timely manner. As Lynda mentioned, the growing season is right around the corner and some workers are already starting to come up. We -- unfortunately this initiative is

competing with other priorities and initiatives going on. Where it falls we hope to continue with it but it does compete with other priorities. And then the challenge is also to coordinate and review Texas and Michigan Medicaid coverage so that the workers, the Michigan DHS workers can assist the families in making an informed decision. At a minimum, DHS workers would like ways to confirm Texas eligibility and contacts for them to call, too. So if there is specific numbers and dedicated staff, we would appreciate that information, too. DHS has probably within internally will have their own future meetings to discuss this issue and come up, like I said, with other questions and answers, questions that they might have. And another challenge would be to review the impact on the other programs when the family comes in, what is helping them make their best informed decision on whether or not to stay in Texas Medicaid and why it would be beneficial for them to stay in the continuity of having -- one program.

Next slide. But we do see this as an opportunity. We're definitely willing to partner with Texas regarding this. We see this also as another positive to possibly maybe workload reductions or cost savings to our Michigan program if the beneficiaries are staying within Texas Medicaid program. We do expect this momentum to be slow for the first year and we want to capitalize on the lessons learned with Texas. This one state so it can be replicated. Like we mentioned before, other states migrant farm workers are coming from other states, Florida is probably the other major state that we have workers coming from. So we are willing to partner with other states because we're in a receiving role and we want to develop -- we see this as a way of developing seamless coordination of Medicaid portability and we also want to continue to partner and collaborate with our MPCA our Michigan Primary Care Association on this and other migrant issues and any other health-related issues we work with them. So in terms of also looking at -- besides Medicaid portability this initiative could be helped with other developments also going on nationally.

I was looking at electronic health record development and interoperability of systems development and that not only would there be possibility of the eligibility continuing but their health record, providers here could see what has happened in Texas and -- this is in the future, that we could be dialed in to see what their health record and health status is. Some resources could help towards this in the CHIPRA bill that was mentioned earlier.

Next slide. At this point this concludes our presentation on this issue and if one thing that you come away with from this presentation is that the main topic is definitely communication and outreach is vital. And especially for the first year in getting the message out. Thank you.

>> Hello, this is Pam again. I would like to thank you all for joining us. We now move on to our questions and as you have questions, please be sure while we have these last few minutes left on our presentation, I can pull them off of the screen. For now I'll refer to the ones I've already received. Some from what I can tell with the questions, some of them have already had a bit of the answer provided. But we'll go ahead and see if there is any more to share. Let's look at what happens if the migrant worker does not return to its home state? It was made reference there is data being collected in tracking the worker themselves in the state. But is there -- for those workers who don't return to their home state is there a time limit of coverage and then can you speak more on the tracking system. I believe this would be directed both maybe to all three but Jana, I'll let you start and we'll move down the line.

>> Okay. In terms of what Texas Medicaid is wanting to see with our migrant families, if they are not going to be out of Texas for more than six months and do plan to return to the state, then we want to maintain them on Texas Medicaid. If they are going to be out of the

state longer than six months or don't plan to return, they need to drop their Texas Medicaid and if they're in Michigan, get enrolled in Michigan Medicaid.

>> So if they've left the state and then have only decided they aren't going to return, is there some mechanism that is an automatic drop or should they still be responsible for contacting you?

>> At this point they would be responsible. If they don't plan to return, if the client doesn't plan to return, they would need to contact Texas Medicaid and drop their coverage.

>> Okay. And then you said for a six-month period of time. At six months if they're still out of the state, and something was to happen in that 7th month period would they automatically not get coverage?

>> At this point the state isn't able to track exactly how long they're out of state so it's up to the patient to contact Texas Medicaid and let them know they're not planning to return or they're out of the state longer than six months. But for some of the -- for children currently in children's Medicaid in Texas, eligibility is only good for six months. If the child is out of the state for longer than six months their eligibility would lapse.

>> Lynda or Chris, would you like to add?

>> This is Chris. Basically it depend on the redetermination date is kind of Jana has alluded to. Texas has six months of continuous eligibility and then they would have to reapply for Texas Medicaid. That was one of the challenges that we noted as having the

worker try to contact Texas Medicaid to make sure that they get re-enrolled and stay in Texas Medicaid. If they're going to stay in Michigan or not go back to Texas, what happens now is that they would end up having to come to the Michigan Medicaid, one of the local offices or something and to that worker tell them that they had Texas Medicaid, the worker has to contact Texas Medicaid, make sure that's closed and then they would apply for Michigan Medicaid. So, you know, it can be closed and it can be opened in a new state.

>> Continuing on the theme of the relationship between Texas and Michigan a question came in are the reimbursement rates different between the two states?

>> Yes.

>> Yes.

>> But as mentioned, the FQHCs would get their PPS rate for that state so the Michigan FQHCs will get their rate that has been negotiated here with Michigan Medicaid and Texas is going to pay that rate. They don't have to go through the process of developing a separate Texas PPS rate for this Michigan FQHC. It's the -- regardless of FQHCs, from my experience or from what I can see, regardless of who they're seeing are going to get their rates. The Texas Medicaid fee-for-service rates and the Michigan Medicaid fee-for-service rates are different.

>> Okay. Speaking about rate then takes us to the providers. How do private providers and FQHCs actually enroll as Texas Medicaid providers if they're from another state.

>> This is Jana. They should contact me and I will refer them over to my contact at Texas Medicaid that is in provider enrollment and then that staff member works closely with them to answer any questions and get the information necessary to complete a provider enrollment application. It's important to go through us because if they contacted Texas Medicaid directly, they wouldn't necessarily be in contact with the appropriate person that knows that they're an out of state provider that sees migrant children and so their application will be facilitated and they'll get extra assistance if they work through the PCA.

>> Okay. Thank you. Next question. Let's go back to the idea of data. Having spoke of the cost benefit or the proposed cost benefit there was mention of data being collected or the plan to collect data. When would you think that you can draw conclusion from such data to reckon that there is cost benefit? Or is that already ongoing?

>> I think this is an experiment. I don't think we have the data yet at all. This is our first year of enrollment. First year of sending people out and receiving it. So we're -- it probably will be a couple years in terms of collecting any data. We don't have any -- we can only tell you right now who is enrolled but we don't even know -- I don't believe that they've actually treated and saw a Texas migrant person yet. Lynda might be able to answer that question but I don't -- we're just starting this. This is our really first year of implementation.

>> The idea of collecting data to make such analysis is forthcoming?

>> Yes.

>> This is Linda. We will be collecting information. One of the key things with that we'll be able to pull some data from this and billing data but we'll also have a postseason meeting

with all of our health centers to ask them about how it went and how many did they see and stuff like that. We've also been asked to hold a focus group or two during the summer to talk to the families to ask them how it went for them and if they can share information about their experiences and how they were communicated with in Texas and Michigan. We'll collect that information, too.

>> I had a second question in regard to the state to state communications in regards to a provider identifying themselves as getting set up with like the opposite state's Medicaid system. So Jana, you said they need to contact me. Can you reiterate again who you are and how you would -- where you actually would be contacted at? And how is this publicized to private providers and FQHCs as to who to contact and when?

>> Well, we're conducting -- we're doing presentations at national conferences, at migrant conferences, at federally qualified health start conferences and we've been doing informational calls as well and working through health center and migrant advocacy groups to get the word out to these different providers. By saying we're targeting federally health centers, private providers are welcome to participate and we're hoping through migrant advocacy groups that they'll have better information about who the private providers are. Our contacts are geared more toward federally qualified health center centers but we're willing to help any provider serving and providing services to our families. They contact me, Jana Blasi at the Texas Association of Community Health Centers and my phone number is 512-329-5959. And if they go to that website address that is in my presentation, there is a Texas Migrant Care Network link. They can click on that link and it also provides information on how to contact me and how to get enrolled as a provider in Texas Medicaid as well as an archived training, a webcast on how to build Texas Medicaid if you're a federally qualified health center. That's the process for

contacting me and there is certainly some good resources that could be disseminated to provider groups as well as advocacy groups on this program and where providers should go to get further information.

>> Okay. And Lynda or Chris, would you want to offer the same?

>> In terms of--

>> In regards of contacting. If someone from another state wanted to contact you in regards to next step.

>> At this point in time Michigan Medicaid is not really enrolling out of state providers.

>> I see, okay.

>> Our policies are similar in terms of when we discussed this whole process last year, Texas was looking at enrolling the providers. And they wanted us to for our beneficiaries -- their beneficiaries not to enroll them in Michigan Medicaid. Michigan Medicaid, our policies have to do on out of state providers currently deal with prior approval and whether or not they're emergency services. So at this point in time we don't -- we have not changed our policies on out of state providers.

>> Okay.

>> I will add to that, though, Pam, there has been some discussion and that's not off the table. We just didn't want to tackle too much at one time and we also need to do a little bit

of an assessment to see what the benefit -- how many of our workers or residents that we have traveling that would benefit from that program. I think within the next few years there will be a lot more discussion around that.

>> It's kind of a stay-tuned topic.

>> It is.

>> Okay. And just as in having communicate with the providers, how will my migrant workers find out where they can go and find out more and how they are to maneuver with the information once they go from their home state to another?

>> This is Jana from Texas. There is an 800 number that they can call that will connect them to Texas Medicaid and they can let the person -- the operator know where they are, what state they're in, what community they're in. There is a database that the operator will use to identify the nearest Texas Medicaid provider to that family.

>> Okay. And going to a more broader question about the whole process of Medicaid portability. Someone asked, where can one find the actual Medicaid portability language in the Social Security act? Anyone know that off the top of their head?

>> No, I don't. I don't know it.

>> We can include the answer to that in our questions that are provided for the archived--

>> John mentioned this, but Sarah Rosenbaum wrote a terrific background paper on Medicaid portability and I'm sure it cites specific statutes. So that would be a good resource for that information.

>> Just a reminder that report is provided as a download when you first signed on. It will be available in the archived division. We have a few more minutes and we have a few more questions. There are some quite interested in just the availability of this interaction within their own state. One question is, has California been involved at all? If so, who and how?

>> In terms of the expert meeting in March of 2008, there were some representatives from California and there were some health centers and I'm not sure who all the attendees were. There was -- there is a report that is, I think, has been just published on that meeting and it would give you the list of attendees. Pam, you might have it.

>> Yes, that reports that is sponsored by the Maternal and Child Health Bureau, specifically anything oriented the oral health can be found at the national Maternal and Child Health oral health Resource Center. You can go there and find this document.

>> So there were some representatives from California at that meeting. I think at that meeting there were definitely representatives from Texas and there was a wide representative from Michigan and I think pretty much when we decided when we were talking about that interstate provider network, it was kind of like well, which two states would be willing to do this? And Texas and Michigan had had relationships in the past on this issue so it was kind of like all right, we kind of raised our hands and said all right, we'll work on this together. Not that other states weren't unwilling. But there wasn't -- but I think

that's why Texas and Michigan said okay, we've worked on this before. We'll, you know, we'll -- we get buyout from our management we'll work on this together.

>> Okay. And my partner here has just brought me the report and actually for the one who participant who is interested in the California connection it was the director of the migrant Head Start in EL SANTRO. It can be found at the oral health Resource Center online.

>> We had other invite east from California but I don't think they were willing -- they were unable to attend at that meeting. I remember having a list. We had gone through a list of trying to figure out who to invite and we were looking at people from Washington state, California, Florida, a lot ---pretty much the large five or six states that had large migrant populations.

>> And I think since we have just a few minutes I'll leave with the concluding question and answer. The answer has already been given throughout all of your questions but it is how big is this target population? And so I think in concluding I think you can reflect on that and recognize that the portability -- Medicaid portability has its benefits because the target population is so large.

>> Actually, also depends on the state. We are one of the -- we are a large receiving state and Lynda kind of mentioned that. But not only -- but they aren't just coming from Texas straight to Michigan. They probably are going through and could be stopping through other states. Ohio might have some, but it could be the same family coming up and from -- I've only been involved in this for a short time. Linda and Jana could talk about it more but there seem to be dedicated streams that people tend to go each year. There are probably certain states that certain families go to and there is an east coast stream and a west

coast stream. So there are probably more states -- there are certain states that get affected more than some states.

>> Texas is one of three large home states or sending states. There is Texas, California and Florida are probably the biggest sending states and then -- there is -- the trick here is there is very -- data is very difficult with this population. Nobody really knows how many migrant and seasonal farm workers there are. It is estimated that in Texas we have 200,000 to 300,000 migrant seasonal farm workers and I don't know the numbers for California and Florida. But it is a significant population.

>> This is John. It's well over a million but the reason we chose

>> If we had a broader population -- I commend them for their work.

>> Thank you, doctor, a concluding statement the portability language in the act is found in section 213. So with that said I would like to remind all participants that there are those additional handouts not only the Power Point slides but the farm worker quick facts sheet. It's a two-pager that gives more of this data information that was shared. And to know in the archived version I will draw down all the questions that have been asked and will share with the speakers for them to reflect on and offer up additional answers should they wish to expand on what they've already shared. So I thank you for your participation. I thank the speakers once again for their time and I hope you've enjoyed our webcast today. Take care. Have a good day.