Medicaid Portability

in the Context of Oral Health Care for Head Start-Enrolled Children in Migrant Farmworker Families

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Introduction

This analysis, prepared for a leadership conference on oral health care for young children receiving Migrant and Seasonal Head Start (MSHS) services examines opportunities and challenges in addressing Medicaid eligibility and enrollment for children of migrant and seasonal farmworkers. Specifically, this analysis examines the issue of portability, that is, the ability of Medicaid to "follow the child" from one state to another. Following a brief background, the analysis presents an overview of basic aspects of Medicaid eligibility and enrollment and then considers possible approaches to increasing Medicaid enrollment and coverage portability for migrant children receiving Head Start services, using MSHS programs as a mechanism for identifying and enrolling eligible children.

Background

Oral health is one of the most fundamental aspects of child health. Low income children generally are at significantly higher risk for poor oral health, whose effects can lead to impaired child development and a lifetime of disease and disability.[1] The Children's Dental Health Project, which advances policy to improve children's dental health, reports that tooth decay is the most widespread chronic disease in children.[2]

Among low-income children, no subgroup is at higher risk than children who are members of migrant and seasonal farmworker families, as a result of their extreme poverty and the transitory nature of their lives, which combine to act as ferocious impediments to basic health care access. In 2000, the median annual income for farmworker families stood at $6,250, one-seventh the median annual income for all families.[3] As with wages, health insurance coverage among migrant children and adults falls well below the national average, even when compared to other low income families. For example, in 2000, when 22 percent of low-income children lacked health insurance coverage, more than 90 percent of children in migrant and seasonal farmworker children were without any form of coverage.[4]

The extreme poverty, pervasive lack of health insurance coverage, and high mobility experienced by migrant and seasonal farmworker families result in enormous health care access barriers. Those families who are fortunate may live or work within range of a federally funded migrant health clinic or other community clinical care provider such as a public hospital, a local health agency, or a free clinic. But thousands of families face extreme barriers; indeed, one study reported that only 20 percent of migrant farmworkers reported receiving any health care in the previous 2 years.[5]

Dental health particularly underscores the pediatric health and health care complications caused by extreme poverty and isolation. According to one study, dental disease ranks among the top five health problems for migrant children and young adults.[6] One report notes that MSHS grantees ranked the lack of access to dental care as their most urgent concern for the children they assist.[7] At the same time, MSHS can play a vital role in the lives of young children in farmworker families because of their ability to identify and support families in their efforts to find adequate health care for their children. Thus, the 36,000 children served (as of 2002) by 26 MSHS grantees operating 475 centers in 37 states[8] potentially benefit not only from the educational and child development opportunities that they receive, but also from support to families in finding and maintaining health care.

Integral to the ability of Head Start grantees to assist families locate dental care (helping families locate a dental home is a basic program requirement) is ensuring that families have a means to pay for care, since Head Start programs lack the ability to finance pediatric dental care out of their own budgets. The MSHS Collaboration Office reports the following protocol that grantees are expected to follow:

- Center staff must determine whether each child has an ongoing source of continuous accessible health care, also known as a Medical Home. If a child and his or her family do not have a source of ongoing care in Michigan, center staff must assist the family in locating a local source of care.

- Staff are expected to encourage (and provide the necessary guidance to) the family to enroll and participate in Medicaid and must note in the child's record that an application is pending. Similarly, staff must record in the child's record evidence of Medicaid enrollment or some other source of coverage. Staff also are expected to document a family's refusal to apply for Medicaid as well as when the enrollment discussion took place.

Without question, the most important source of financial assistance with paying for health care is Medicaid. Making Medicaid work for this population, however, requires addressing two major challenges:

- The first challenge is enrolling children in Medicaid. Medicaid enrollment is more complex than simply advising the families. Forms must be completed and documentation must be collected. As will be discussed below, states in recent years have taken steps to make enrollment easier, but it is still a relatively complex undertaking. Making matters more complicated is that the process of eligibility determination and card issuance can take nearly 8 weeks, unless states have expedited procedures or, as discussed below, are willing to issue temporary cards through a process known as "presumptive" eligibility. Many health care providers, particularly community and migrant health centers, have added staff whose job is to assist in Medicaid applications.
- Second, coverage must be "portable." That is, to be of optimal use, the coverage must be movable from state to state without continuous re-enrollment, especially since so many weeks may elapse before a card is issued. Interstate compacts that effectively create a form of reciprocity among state Medicaid programs may be a means for addressing the portability problem. This approach can be seen as ensuring that "the money follows the child," a type of "demand-side" intervention. Another approach, discussed below, is to use "supply-side" strategies, that is, to create an informal network of providers who submit their claims to the issuing state for payment.

Before plunging into possible avenues for addressing both enrollment and portability, it is important to set out a brief overview of the program. Persons interested in more extensive reading on Medicaid may want to explore the rich array of materials that can be found at the Web site of the Kaiser Commission on Medicaid and the Uninsured (www.kff.org).

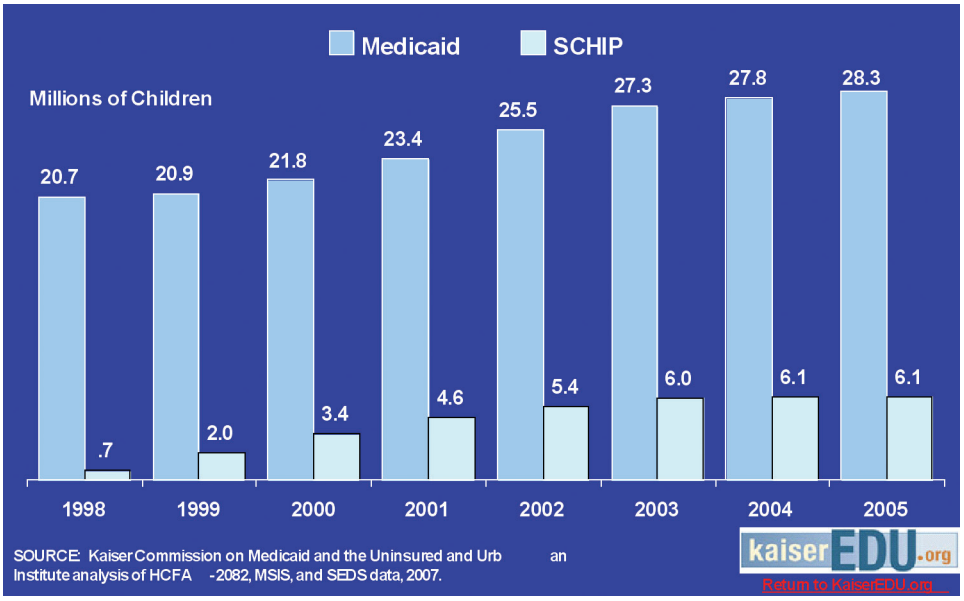
A Brief Overview of Medicaid

Medicaid is public health insurance that is administered by states and jointly funded by the federal government and participating states. A grant-in-aid program, Medicaid operates in accordance with numerous and complex federal requirements. At the same time, Medicaid gives states considerable flexibility over various phases of program administration, including eligibility and enrollment, coverage rules, and provider participation and claims payment.

Although state programs vary significantly in certain respects, Medicaid is much more uniform where children's coverage is concerned. This uniformity can be seen in eligibility standards for young children and in the level of coverage to which all eligible and enrolled children are entitled as a result of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

It is difficult to overstate the importance of Medicaid to the health care system. In 2005, the program provided coverage to more than 46 million persons, virtually all of whom would have been unable to qualify for private health insurance because of the cost of coverage, their health status, or both. Children comprise the single largest group of beneficiaries (49 percent in 2005) but account for only 18 percent of program spending.[9] In 2005, Medicaid covered more than 28 million children, with coverage of an additional 4 million children through its smaller companion State Children's Health Insurance Program (SCHIP).

Figure 1:
SCHIP and Medicaid Enrollment of Children (FY 1998 – FY 2005)



Medicaid Eligibility Criteria

Medicaid's eligibility requirements are complex, although more simple in certain respects where children are concerned, as a result of child coverage reforms that began in the 1980s and that were phased in over time. In the case of children, Medicaid's "conditions of eligibility" can be summarized as follows:

- The child is a "poverty-level" child. This means that the child has "countable" family income (as determined by the state) that falls below the state's financial eligibility standard, which at a minimum is 133 percent of the Federal Poverty Level[10] for children under age 6. Numerous states set financial eligibility standards for young children at a higher level, as shown in Table 1 in the accompanying report by Donna Cohen Ross and Laura Cox for the Kaiser Commission on Medicaid and the Uninsured, *Resuming the Path to Health Insurance Coverage for Children and Families*.
- The child's family assets (in states that consider resources such as a car or work equipment as well as income) fall below the state's eligibility standards. As of 2007, 46 states and the District of Columbia disregarded assets entirely when evaluating children's eligibility.[11]
- The child is a citizen or legal U.S. resident (children who are recent legal resident arrivals would be eligible only for emergency coverage and must wait 5 years before full coverage begins). Both citizenship and legal residency must be shown with documentation.
- The child is a resident of the state in which coverage is sought.
- The family complies with certain rules related to the disclosure of other forms of health insurance coverage (including potential sources of coverage through child support).

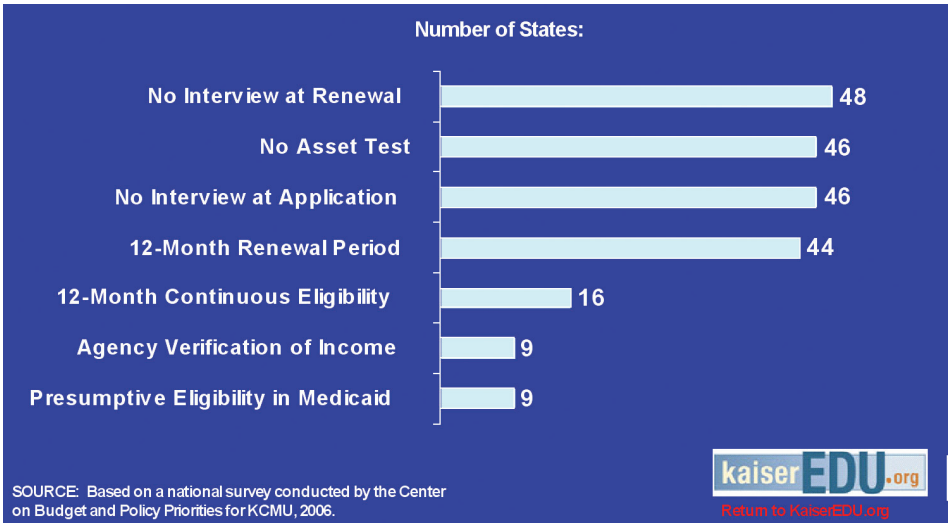
Procedures for Enrolling in and Maintaining Medicaid Coverage

States have considerable discretion where enrollment is concerned, as well as in terms of the procedures used to renew coverage. As of 2007:

- 46 states did not require a face-to-face interview in order for families to enroll their children (although submission of documents is typically required)
- 44 states allowed children to enroll annually, as opposed to requiring re-enrollment on a more frequent basis[12]
- 12 states provided for continuous eligibility – that is, the continuation of eligibility for a full year regardless of fluctuations in family income[13]
- 9 states provided for "presumptive eligibility" – that is, temporary eligibility for children whose family finances indicate eligibility[14]

Figure 2, which shows recent data, summarizes information on state enrollment and simplification practices for children.

Figure 2:
Simplifying Enrollment and Renewal. Strategies States Are Using in Children's Health Coverage Programs (July 2006)



Benefits for Medicaid-Enrolled Children

All children enrolled in Medicaid are entitled to comprehensive coverage as a result of the EPSDT benefit, which provides comprehensive coverage for children.[15] EPSDT benefits are the broadest ever conceived under any health insurance program, public or private. Not only are the classes of benefits comprehensive, but coverage is very broad as a result of the special medical necessity test that governs EPSDT. Essentially EPSDT requires health care at the earliest possible point, with the emphasis on health interventions that promote child development and ameliorate physical and mental conditions.[16] **Figure 3** lists the major classes of EPSDT services, which are available on a *periodic* basis in accordance with pediatric professional standards as well as *inter-periodically* (as needed).

EPSDT also requires that state Medicaid programs inform families about EPSDT and provide assistance in helping families locate sources of health care, including dental care. EPSDT informing is typically done annually, but a request for assistance can be made at any time on behalf of enrolled children. In this respect, EPSDT is very different from Medicaid for adults, in that its obligations extend beyond the payment of bills and include the provision of actual support services in helping families obtain care and providing transportation to necessary care.[17]

Figure 3: EPSDT Benefits

- A comprehensive health care examination conducted on a periodic basis that meets professional pediatric standards and consisting of:
  - An unclothed physical examination
  - A developmental assessment to measure growth and development
  - All immunizations recognized by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention
  - All recommended laboratory tests
  - Nutritional assessment including assessment of obesity risk
- Comprehensive dental care to restore teeth, address emergencies, and maintain dental health, conducted on a periodic basis that meets professional pediatric standards
- Comprehensive vision care, including eyeglasses, conducted on a periodic basis that meets professional pediatric standards
- Comprehensive hearing care, including hearing aids, conducted on a periodic basis that meets professional pediatric standards
- All medically necessary diagnostic and treatment services that are recognized under federal Medicaid law for the treatment of physical or mental conditions that are uncovered during a periodic or interperiodic screen

All EPSDT services also must be made available on an interperiodic basis. States must inform families about EPSDT and provide scheduling and transportation services to ensure that children actually receive covered medical and dental benefits.

EPSDT coverage is without cost sharing in the case of poverty level children, although some states do require copayments for certain services in the case of near-poor children.

Access to Medicaid-Covered Health Care

Children can receive Medicaid-covered health care through any participating provider unless they are enrolled in Medicaid in a state that restricts access to enrollment in a managed care arrangement that uses provider networks. Most states today use some form of managed care. But as a practical matter, low provider participation in Medicaid means that it would be rare to find a significant provider of Medicaid-covered primary health care services that is not available to Medicaid patients.

While low provider participation in Medicaid is a problem generally, the crisis is particularly serious in the case of dental care providers. A 2000 U.S. Government Accountability Office report found that in 26 states, less than 25 percent of dentists reported treating at least 100 Medicaid patients.[18] As dental care providers increase, use rates also appear to rise.[19]

Medicaid providers can register as health care providers with more than one state. Many states pay participating providers furnishing care out of state, with coverage and payment determined by the state that makes the payment. Cross-state payments are common in the case of residential services and hospitals located close to state borders that serve persons who cross state lines. Out of state payments are permissible in the case of emergency care as well as in situations in which it is customary to seek care across state lines.

Community and migrant health centers are a major source of dental care. All health centers serve all patients in their catchment areas, but a proportion receives special grants that support services to farmworkers. Data from the Uniform Data System, an annual, health center-based reporting system, show the relative availability of preventive and restorative dental care at health centers through direct provision, payment and referral, or a combination of the two.

Figure 4: Health Centers and Dental Care	
Federally Funded Health Centers	Health Centers That Provide or Refer and Pay for Preventive and Restorative Dental Care*
Total 1,002	Preventive 894, Restorative 871
Centers Receiving Farmworker Health Grants 140 (14%)	Preventive 140, Restorative 141*
*The same center may both provide and refer and pay for care. Source: Uniform Data System (2006). Calculations by the George Washington University.	

Options for Promoting Medicaid Enrollment and Portability

Facilitating Enrollment

As noted, states can do much to ease enrollment by:

- Removing financial barriers
- Lengthening the period of coverage
- Adopting continuous eligibility, thereby eliminating the need to report changes in circumstances during the period of continuous coverage, which can be as long as 12 months
- Eliminating documentation and in-person interview requirements
- Making applications available online
- Placing applications in outstationed locations and training staff at these locations in providing families with assistance in completing the applications
- Identifying a specific individual to work with persons who provide application assistance in order to assure that they are properly trained and have someone who can receive and process the applications in a timely fashion
- Adopting presumptive eligibility
- Expediting the eligibility determination process

States also can facilitate access to care by furnishing an EPSDT hotline service that can help families locate health care providers (including dentists) and arranging transportation.

A Special Note on Outstationed Enrollment at Migrant Head Start Programs

No information is currently available on the extent of involvement by MSHS programs in outstationed enrollment. However, this information presented in this analysis suggests that the vast majority of states have done away with in-person interviews where Medicaid enrollment of children is concerned. Therefore, there is an important opportunity to enhance the involvement of MSHS programs in outstationing.

Federal regulations break outstationing into two phases. The first is the initial receipt and processing of applications, while the second involves further enrollment assistance, including final determinations of coverage. Very few states engage in full oustationing, but most may be willing to involve social service and childcare programs in initial outreach. Therefore, it would be wise to have the MSHS program engage state Medicaid directors in a dialogue about use of MSHS workers in outstationing. Activities would include identification of potentially eligible children, assistance in gathering necessary documentation, presentation of documents to the local welfare agency,

which processes applications, and further assistance to families as documentation is completed and eligibility is determined. The cost of such assistance is considered an allowable administrative cost, with 50 percent of the cost of training and support to MSHS programs payable by the Federal Government. State governments could, if they so elected, provide MSHS programs with outstationed enrollment assistance contracts to help defray the cost of such assistance.

Creating Portable Medicaid Coverage

As noted, Medicaid is a state-administered program, and therefore, state residence is a basic eligibility requirement. For purposes of Medicaid eligibility, federal regulations[20] define residence in two ways. An individual is a resident of a state if the state is the individual's *domicile* – that is, if the individual intends to reside there permanently. Alternatively, residence can be a state in which an individual is living while working or seeking employment. This change dates back to 1979, when Medicaid was amended to assure that intent to make a state a domicile would not determine eligibility for migrant families. (Families that migrate throughout a single state, as is the case in large states such as California, would meet the domicile test.) The state of residence is part of the eligibility determination process, and states may require proof, which in the case of migratory families might be a letter from a grower showing evidence of a job in the state.

Families that attempt to enroll each time they enter a new state for work purposes may encounter serious barriers, since the enrollment process can take weeks. While, as noted, some states do offer presumptive eligibility (which allows for on-the-spot coverage for ambulatory services), the number of states offering on the spot coverage is low and simply permits temporary access while the eligibility determination is being completed.

Because continually re-enrolling in Medicaid each time the state of residence changes is so difficult, solutions have focused on the creation of multi-state coverage or a multistate provider network of providers all of whom participate in the Medicaid program offered in the state of residence:

- *A multistate Medicaid card; using interstate compact flexibility.* In 2006, the Centers for Medicare & Medicaid Services (CMS) reported to congress on options for making Medicaid coverage more available to farmworker families.[21] CMS identified interstate compacts as one option. An interstate compact (a formal agreement) between two or more states allows states to turn their programs into multistate insurance arrangements, much like Medicare, which, in its traditional form, operates on a nationwide basis. The interstate compact option permits states to formally align their programs, with reciprocal recognition of eligibility and procedures for payment of out of state providers. Such agreements do not require federal approval as a general rule and can cover arrangements for reciprocal payments.

  Under an interstate compact arrangement, State A could agree to repay State B its "state share" (the portion of the payment to the participating Medicaid provider that comes from state funds) when children covered by State A's Medicaid program receive EPSDT dental services from a participating provider in State B. Conversely, each state in the compact could extend reciprocity – that is, recognize eligible children in any of the participating states as if their eligibility had been determined in the state in which they are living.

  CMS notes that the Interstate Compact on Adoption and Medical Assistance serves as a model for such arrangements, which in turn help facilitate out of state adoption placements. The effect of an interstate compact in the case of migrant children would be to create a multistate card that is good during a period of enrollment in any of the states that are parties to the compact. Since EPSDT benefits are uniform, and since all states uniformly cover poor children, this is probably the optimal model, because it eliminates the burdens that can fall on providers that attempt to get paid for services furnished to out of state residents and also eliminates the need for continuous re-enrollment by families as they change state residence.

- *Creating an interstate provider network for state residents who travel.* As noted, federal Medicaid law permits states to pay for health care furnished to residents who are out of state in both emergency situations and cases in which it is customary to seek care in another state.

Because it is the custom of migrant families to travel, it could be considered customary for migrant families who are residents of one state, to seek care for their children when traveling for work purposes to another state.

Under this model, dental providers in migrant stream states could formally or informally agree to seek provider participation in all of the states in which their migrant families reside. That is, providers all would seek status as out of state providers of care. Migrant families in turn would remain residents of their home state (their domicile state), even when traveling for work. Family members could receive out-of- state care for medical emergencies, but each of the states could recognize out of state providers when the service is dental care for children. This would permit dental professionals in any of the stream states to bill the state of residence. Again, since dental care is uniformly covered for young children and all low-income young children are entitled to Medicaid coverage, the one remaining hurdle would be recognition of out-of-state pediatric dental providers for children as a matter of health care practice custom for migrant families.

Concluding Thoughts

This policy brief has identified two possible options for resolving the financial barriers that impede access to oral health services among migrant children receiving Head Start services. One model effectively creates a multistate card for children through the establishment of an interstate compact arrangement into which multiple states would enter. The alternative is the creation of a multistate provider network, with out-of-state payments permitted by state Medicaid agencies in view of the custom of their migrant families to travel out of state for employment purposes. Both options would make Medicaid coverage more useful to children during their periods of enrollment and would offer alternatives to constantly having to re-enroll in Medicaid as the state of residence changes. These changes, combined with outstationing expansion efforts at MSHS programs, could be expected to have a considerable impact on the proportion of MSHS children enrolled in Medicaid and positioned to be able to secure dental care regardless of the state in which their parents are living and working. In this regard, a good resource is the Southern Institute on Children and Families Primer on *Understanding Policy and Improving Eligibility Systems*,[22] which details strategies for making enrollment into Medicaid easier through outstationed assistance.

Leadership from CMS and Head Start would be important in advancing either model. In this case leadership would entail the development of detailed criteria and guidance for each model and the dissemination of information about the models to states. Because of the large number of health centers that offer pediatric dental care, one might expect enthusiastic participation from the Health Resources and Services Administration within the U.S. Department of Health and Human Services. In addition, the longstanding interest in the health of migrant children among pediatric health professionals could be expected to garner support from organizations such as the American Academy of Pediatrics, the American Academy of Pediatric Dentistry, and the America Dental Association.

This type of initiative can be expected to result in minimal costs given the modest numbers of children in migrant Head Start programs as well as the low rate of dental care use as a result of access limitations such as geographic, language, or cultural isolation, low health literacy, and low provider participation in Medicaid. At the same time, such an initiative would target the most prevalent of all pediatric health problems and would make a major contribution to child health improvement.

Appendix A

Checklist of Medicaid "Best Practices" for Children

1. Setting income eligibility at 200 percent FPL
2. Elimination of the asset test
3. Elimination of the face-to-face interview
4. Elimination of documentation requirements to the maximum extent possible (citizenship and legal status documentation cannot be eliminated)
5. Enrollment periods of 12 months
6. Twelve-month continuous enrollment without the need to report changes in income or assets
7. Outstationed enrollment to ensure assistance in filing applications, with training for outstationed assistants and a clearly identifiable person with whom outstationed staff can work in filing the application
8. Online filing of applications
9. Expedited enrollment (within 10 days of submission of the completed application) and card issuance
10. Presumptive (temporary) eligibility during the waiting period for formal enrollment
11. An EPSDT "hotline" to provide immediate assistance in finding health care providers and arranging transportation
12. Payment for EPSDT services furnished out of state by participating Medicaid providers who are given a billing identifier from the issuing state
13. Interstate compacts under which each state gives reciprocal status to the other state's eligibility determination (in essence, each state treats the compact states' determinations as if they were those of the state

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10 Under U.S. Department of Health and Human Services poverty criteria, this level would equal $23,408 for a family of three in 2008.

11 Oregon, Texas, Utah, and South Carolina use an asset test. Only in Texas is the test set as low as $2,000. For a comprehensive survey of state policies regarding eligibility and coverage of children, see this source: Ross DC, Cox L. *Resuming the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP*. Washington: Kaiser Commission on Medicaid and the Uninsured; January 2007. Available at: http://www.kff.org/medicaid/upload/7608.pdf. Accessed February 2, 2008.

12 Ibid. AK, GA, MN, OR, PA, and TX do not allow annual enrollment periods for Medicaid.

13 Ibid. AL, AZ, CA, ID, IL, KS, LA, ME, MI, MS, NJ, NY, NC, SC, WA, WV, and WY do not allow annual enrollment periods for Medicaid. Note that considerably more states permit annual enrollment than the number that guarantee that, once it occurs, enrollment will last for an entire year regardless of changes.

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