

# Developing an Oral Health Medicaid Portability Model for Migrant and Seasonal Head Start Children:

## An Expert Meeting

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## Meeting Summary Report

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Washington, DC



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## **Meeting Summary Report**

### **OVERVIEW**

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On March 10–11, 2008, an Oral Health Expert Meeting was held at Altarum Institute in Washington, DC, to discuss how Medicaid portability among states could enhance access to oral health care for children of migrant farmworkers in Migrant and Seasonal Head Start (MSHS) programs. The meeting was sponsored by the Maternal and Child Health Bureau with the support of the MSHS Collaboration Office. Meeting participants described models of Medicaid portability and agreed on two models for State pilot implementation. Subsequently, participants continue to work as part of both a Workgroup and a Steering Committee while the states of Texas and Michigan take steps toward pilot model implementation. The following report summarizes what transpired at the meeting and the follow-up activities that have taken place since. To put these efforts in context, a preliminary discussion of the challenges farmworkers face in accessing health care, particularly dental care, also is presented.

### **MEETING PURPOSE**

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#### **Meeting Rationale<sup>1</sup>**

Recognizing the dire oral health care needs, high incidence of dental decay and the lack of health care coverage of farmworker children, the Health Resources and Services Administration's (HRSA) Maternal and Child Health Bureau (MCHB) dedicated contract funds to help address the challenge of maintaining oral health care services for Medicaid-eligible MSHS children. In 2007–2008, using MCHB contract funds and supplemental sponsorship by the Migrant and Seasonal Head Start Collaboration Office, Altarum Institute spearheaded the

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<sup>1</sup> In response to concerns over Medicaid enrollment and participation barriers for farmworkers, Section 404 of the Health Care Safety Net Amendments of 2002 directed the U.S. Department of Health and Human Services (DHHS) to conduct a study in order to address portability and eligibility barriers that farmworkers and their families experience when participating in Medicaid and the State Children's Health Insurance Program (SCHIP). Those barriers include complicated applications, cultural barriers, and problematic mobility and portability. DHHS was asked to identify solutions in six areas, including interstate compacts and the use of current law flexibility. The outcome was a 2003 expert meeting resulting in a report to Congress published in 2006. The report detailed findings in five areas of possible solutions (the sixth area was "other possible solutions" and none were identified) around farmworkers and Medicaid. This report has served as a basis for ongoing discussion among farmworker advocates since its release in 2006.

coordination and planning of one in a series of Oral Health Expert Meetings. Broadly, the meeting aimed to address challenges in sustaining coverage which arise from enrollment timelines, and, primarily, from those challenges brought on by Medicaid's current inability to travel across state lines – something farmworker families must do to make a living. Without question, the most important source of financial assistance to pay for health care for children in MSHS is Medicaid. MSHS, as a payer of last resort, makes efforts to connect families with needed health care services and to find funds to cover oral health care services for children not otherwise covered. Enrolling eligible children in Medicaid not only enables MSHS programs to use their funds for other program needs,<sup>2</sup> but it also can provide children with a mechanism for accessing additional needed services and for continuity of care (as they travel, for example).

### ***Meeting Purpose and Desired Outcome(s)***

The meeting aimed to convene a diverse group of stakeholders in order to identify challenges and potential solutions across disciplines, build stakeholder rapport and collaboration, and begin to identify potential model components and possible pilot targets. In specific, the meeting's objectives<sup>3</sup> included:

- Highlight current promising practices in Medicaid portability
- Identify the challenges and potential solutions for Medicaid portability (demonstrated and forecasted)
- Identify provider network challenges and opportunities (licensure, fees, claims processing)
- Break down barriers, myths, and misunderstandings across the Medicaid, oral health, and MSHS communities
- Identify elements of a comprehensive Medicaid portability pilot model (through cross-discipline dialogue)
- Identify potential states and communities for pilot model implementation

Recognizing that various Medicaid portability movements have been under way for more than 30 years, planners and participants methodically and strategically focused on realistic goals for a 2-day meeting. Many believed that homing in on a precise target population and a specific health concern, as well as bringing together the “right” combination of participants at the “right time,” augured well for progress.

### ***Meeting Design and Format***

Altarum and MCHB's Lead Oral Health Consultant assembled a Planning Committee, which included key representatives from MSHS, Medicaid, and migrant health. Planning Committee members then designed a 2-day (March 2008) meeting aimed at identifying workable models that could be agreed upon and implemented (possibly by the meeting participants). Sara

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<sup>2</sup> Programs use their operational funds when the funds are not otherwise available through insurance or other means.

<sup>3</sup> Review of written evaluations, anecdotal feedback from the Planning Committee and individual meeting participants indicate successful achievement of all meeting objectives.

Rosenbaum, a nationally recognized Medicaid expert who has worked on Medicaid portability and farmworker issues for over thirty years, crafted a comprehensive background paper (see Appendix A) outlining the fundamental considerations and challenges surrounding Medicaid portability in the context of oral health access for MSHS Children.

The meeting was conducted as a full group discussion with no breakout sessions. The first day focused on cross-discipline learning, enabling participants to increase their understanding of the perspectives each group brought to the table. Three panel presentations on the Head Start environment, the Medicaid environment, and the oral health environment (which addressed Medicaid and Early and Periodic, Screening, Diagnosis and Treatment (EPSDT), the migrant and community health perspective, and the oral health provider perspective) were followed by facilitated group discussions. These panel discussions are summarized below.

The second day was less structured and provided room for creativity, open analysis, and facilitated dialogue around model development. The objective was to build rapport across stakeholders and, more concretely, to reach some agreement on a pilot model or models.

In addition to Professor Rosenbaum's background paper, circulated to participants prior to the onsite meeting, a number of resources were made available onsite. Those and additional resources are listed in Appendix B.

### ***Meeting Participants***

The March 2008 meeting brought together 27 federal, national, state, and local program-level participants from Medicaid, MSHS, migrant health, and oral health. Participants were carefully selected based on an intentional design of number, discipline, and geographic representation. An additional number of key stakeholders with a longstanding role and investment in Medicaid portability efforts also were included. States with a likely interest in serving as pilot sites also were considered. See Appendix C for a full Participant List.

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## **MEETING PANEL PRESENTATIONS AND GENERAL DISCUSSION**

### ***Meeting Assumptions***

In early discussions, participants agreed to some key assumptions for the purpose of focusing meeting dialogue.

- **Population focus:** Participants agreed to focus discussion on Medicaid eligible, MSHS-enrolled children who are from both migrant and seasonal farmworker families (with an emphasis on migrant) (see Figure X for MSHS eligibility criteria). Discussions focused on Medicaid-eligible children enrolled in MSHS, not on a Medicaid expansion for undocumented children (New York is currently the only state that offers Medicaid/SCHIP coverage to undocumented children) and not currently on siblings or adults in those families. In an attempt to quantify the target population, one meeting participant said, "Roughly half of [the 36,000 children] need treatment, and they all need prevention."

However, since seasonal farmworker families comprise such a small portion of MSHS, discussions still involved the universe of MSHS families.

- ***Health topic focus: This meeting specifically focused on oral health care.*** While planners and participants recognize that, ultimately, increased access to and continuity of other health care services may be a welcomed additional benefit, discussions focused on oral health.
- ***Medicaid enrollment:*** It was suggested that while enrollment barriers and strategies are essential to the success of any portability model, until children are enrolled in Medicaid there is nothing to make portable. Planners and implementers must work closely and inclusively with farmworker-serving providers such as MSHS and Migrant and Community Health Centers (M/CHCs), at a minimum, to ensure that farmworker families are reached and hear accurate messages about Medicaid and portability. However, enrollment strategies, such as outreach, outstationing, and other facilitated enrollment strategies were beyond the direct scope of this meeting.

Though participants agreed to the above assumptions, they maintained that a number of issues remain to be considered. In particular, issues such as provider availability (capacity is a fundamental concern, and Federally Qualified Health Centers (FQHCs) are not immune to the recruitment and retention issues their surrounding communities face), Medicaid enrollment and outstationing, and the potential “ripple effect” of a successful Medicaid portability model focused on MSHS children likely will require additional exploration and discussion.

## ***Panel Presentations and Discussions***

Three panel presentations and their ensuing discussions provided participants with a common understanding of the three key topics at the center of the meeting and the model development effort: Medicaid, MSHS, and oral health. The meeting agenda in Appendix D details presenters included in each panel. A brief summary of panel presentations and their discussions follows.

### **MEDICAID ENVIRONMENT**

While federally funded farmworker-serving programs – such as M/CHCs, MSHS, and Migrant Education – can help alleviate some of the health access issues that farmworkers face, having health care coverage, ideally through insurance, is important. Furthermore, while some farmworker families live within range of a federally funded migrant health clinic or other community clinical care provider, a study showed that only 20 percent of farmworkers received care in the preceding 2 years. Furthermore, farmworkers have higher rates of uninsurance than the general population.

*In 2000, 22 percent of low income children lacked health insurance coverage, yet more than 90 percent of migrant and seasonal farmworker children were without any form of coverage.<sup>1</sup>*

Effective Medicaid enrollment can help address coverage issues, especially for children. Medicaid (and SCHIP), public health insurance for low-income individuals in the United States, is a state-administered program with a federal funding match. Enrollment procedures, which require proof of eligibility and forms completion vary across states. In many cases, procedures have been improved to facilitate enrollment for children.



All Medicaid recipients under age 21 are entitled to benefits under EPSDT services. Federal law requires that Medicaid programs inform families about EPSDT, assist families in locating health care providers, outline basic services to be provided, and specifically outline details that a dental examination must be provided no later than age 3. However, states vary in their EPSDT services provision, as federal law does not specify which provider(s) should deliver services, and some states outline services beyond federal requirements. EPSDT requires that any medical condition uncovered through an EPSDT screen must be covered by Medicaid, regardless of whether it is routinely covered under state Medicaid benefits. Under EPSDT, states must cover all medically necessary dental services for children and cannot limit their dental services or spending for children (in addition, cost sharing is not permitted for EPSDT services). Medicaid coverage has widespread benefits, especially for children who need not only preventive oral health care services, but for those needing treatment and follow-up care.

While Medicaid providers can register as health care providers with more than one state, children cannot enroll in more than one state at a time. It is a federal requirement that a Medicaid beneficiary drop out of Medicaid in one state before applying in another. Medicaid is not set up to provide coverage outside state bounds, except in the case of emergency care or in “situations in which it is customary to seek care across state lines.” As such, even when successfully enrolled (considering varying state eligibility requirements and other administrative barriers), Medicaid benefits “stop at the border” – making Medicaid an unsustainable form of continuous coverage for mobile children.

Many state Medicaid regulations and enrollment procedures are inconsistent with farmworker lifestyle and circumstances. However, one potential challenge – residence – is no longer an issue. In 1979 Medicaid law was amended to address and accommodate “residence.” As a state-administered program, eligibility is partially dependent on state residence. As of 1979, there are now two definitions of “residence:” domicile is established if the individual intends to reside there permanently and also can be the state where an individual is living while working or seeking employment.

Nonetheless, a farmworker still may be asked to provide proof of residence. While in most cases proof, such as a letter from a grower, may be a reasonable request, in some cases it can still present a barrier to enrollment.

#### ORAL HEALTH ENVIRONMENT<sup>4</sup>

Migrant farmworkers and their families are characteristically poor and highly mobile and work long hours. Work and travel schedules, poor health care coverage, and health care access barriers often make it difficult for migrant farmworkers to address health care needs.

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<sup>4</sup> The issue of provider availability was raised, but participants agreed that that was not the meeting’s focus. One of the most widespread challenges is a lack not only of pediatric oral health care providers (general dentists are often less amenable to delivering services to children under age 3) but of any oral health care providers in the community, especially those who accept Medicaid and will see children under age 3. Other issues, such as reimbursement rates, claims submission, and payment delays also were raised. For these reasons, FQHCs, an already farmworker- and child-friendly provider, became the initial target providers for pilot programs.

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, with potential effects that can lead to impaired child development and a lifetime of disease and disability.<sup>5</sup> Migrant populations have three times the incidence of dental decay as the general population.<sup>6</sup> Considering common practices brought on either by custom, lifestyle, or circumstances – such as toothbrush sharing, brushing without paste, and reliance on baby bottle at bedtime – coupled with often-delayed oral health care, migrant farmworker children often present with multiple, complex oral health care needs requiring ongoing treatment and follow-up.

## MSHS ENVIRONMENT

Since 1969, MSHS has been funded primarily by the Federal Government to serve low-income families who are working in agriculture with children ages 0–5. MSHS eligibility criteria are outlined in Figure 1. It provides preschool programs in some of the most rural areas of the United States to meet the emotional, health, nutritional, and psychological needs of children and their families. As of 2002, MSHS grantees served 36,000 (approximately 3 percent are seasonal and 97 percent are migrant)<sup>7</sup> farmworker children across 475 centers operated by 26 MSHS grantees in 37 states.<sup>8</sup> MSHS staff can play a role in reaching and comfortably establishing rapport and trust with farmworker families. They are typically sensitive to farmworker lifestyle and culture, typically provide language appropriate services, and generally are able to establish rapport and trust with farmworker families.

MSHS is an important resource for farmworker families and, in many cases, serves as an advocate and primary support as families navigate the health system. In fact, MSHS integrates the EPSDT requirement to provide a dental exam (starting at least at age 3), with its own requirement that its programs help families locate a “dental home” and a “medical home.” MSHS staff members are expected to encourage families to enroll in Medicaid and provide the necessary support throughout that process for families who choose to apply. However, this is where the administrative and regulatory challenges addressed earlier in this report truly manifest themselves in practice. In addition to an overall lack of oral health providers who accept Medicaid, the Head Start performance standard dictating that all enrolled children have an initial assessment within 30 days proves particularly challenging, considering the mobility of Migrant Head Start families and Medicaid enrollment policies.

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<sup>5</sup> The George Washington University School of Public Health and Health Services, Pediatric Dentistry. How can dental care for low-income children be improved? Available at: <http://www.gwumc.edu/sphhs/about/rapidresponse/Pediatric%20Dentistry.cfm>. Accessed January 25, 2008.

<sup>6</sup> McFarland J. *A Community Health Center (Migrant Health Center) Oral Health Care Perspective*. Presentation at the Oral Health Expert Meeting, Washington, DC; March 10, 2008.

<sup>7</sup> National Migrant and Seasonal Health Start Association. Available at: <http://nmshsa.org/About%20Us>. Accessed September 12, 2008.

<sup>8</sup> Academy for Educational Development. *Migrant and Seasonal Head Start: 25 Years in the Making*. Unpublished, May 2003.



**Figure 1.**

<b>MSHS Eligibility Criteria</b>	
<b>Income:</b>	<ul style="list-style-type: none"><li>▪ Falls within poverty guidelines (100–130 percent federal poverty guidelines)</li><li>▪ 50 percent of annual family income must come from agricultural work</li></ul>
<b>Farmworker status:</b>	<ul style="list-style-type: none"><li>▪ Must work with field crops<ul style="list-style-type: none"><li>• <u>Migrant farmworkers</u>: move within 2 years</li><li>• <u>Seasonal farmworkers</u>: have stayed to work in the same location for more than 2 years</li></ul></li></ul>
<b>Age:</b>	<ul style="list-style-type: none"><li>▪ Serves children from birth to mandatory school age</li></ul>

### **Key Considerations and Opportunities: Developing a Successful Medicaid Portability Model**

During the meeting, Professor Rosenbaum led a discussion about the key components that might contribute to a successful Medicaid portability model and about the present-day conditions that are more supportive of it than conditions of years ago. The section below further details some of these considerations and components.<sup>9</sup>

A few key considerations include:

- *Perspective/Type of Model*: Models and components can address *demand for coverage* (e.g., enrolling children with portable cards) or can focus on the *supply side*, which centers around the providers themselves and enrolling providers in other state Medicaid programs.

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<sup>9</sup> It is worth noting other valuable efforts under way to explore or address portability. For example, since 1997, Wisconsin has been accepting Medicaid enrollments from other states as part of its Badger Care<sup>9</sup> (state Medicaid) program. Accepting other states' eligibility determinations is one possible portability solution. Another example is the demonstration project funded by the Health Resources Services Administration (HRSA)'s Bureau of Primary Health Care to explore the feasibility of reciprocity arrangements across Oregon, Washington State, and California. A final example is the neighboring state reciprocity (e.g., cross-state payments) already common in many areas across the country that accommodates people living close to state borders who cross the state borders for care. For example, Wisconsin and Michigan accept Medicaid patients from across their borders. In the past, Wisconsin was also involved in reciprocity discussions with Texas.

- *Medicaid Structural Issues:* Medicaid both supports and hinders portability:
  - Medicaid is not designed to be portable health insurance.
  - Eligibility varies across states (e.g., while “residence” is federally defined, “income” is state defined). A few states allow presumptive eligibility which, if eligibility is apparent, assumes a child eligible in order to receive services immediately without waiting to reenroll upon arrival from another state.
  - Reimbursement rates vary across states.
  - Enrollment procedures vary across states (most states allow application without a face-to-face interview).
  - Medicaid is a federal entitlement program with federal regulations.
  - Medicaid is state administered with state-defined services, requirements, innovations, and reforms, but with necessary federal compliance or approval.
- *Provider Issues:* Provider considerations include state variations in licensure, fees, and authorization to provide services.
- *Definitions:* Migrant health, migrant education, and MSHS “farmworker” definitions differ slightly. It is important to note that when working with farmworker populations, slight variations in federal program definitions and criteria could create confusion and discrepancy in eligibility.
- *Other Considerations:*
  - Managed care plays a large role in modern-day Medicaid. However, managed care is not likely to work well with mobile populations and is rare in the oral health world.
  - Technology (e.g., electronic medical records, electronic billing) is available to support and enhance portability arrangements, and considerations should be made to pilot the appropriate technology as well.
  - A number of challenges to Medicaid portability include provider willingness (to participate and to complete the process to become a Medicaid provider in another state), state variation in Medicaid reimbursement rates, administrative burden, and managing out-of-state claims. The most fundamental solutions offered included focusing on FQHCs as the target provider group and strategic stakeholder building and careful negotiation across states.

A number of opportunities or models also were discussed and include:

- *Interstate Compacts:* An interstate compact (a formal agreement) between two or more states allows states to turn their programs into multi-state 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. Interstate compacts were one potential solution identified in 2006 when the Centers for Medicare and Medicaid Services (CMS) reported to congress on options for making Medicaid coverage more available to farmworker families.<sup>1</sup>

While states may not have the authority to negotiate reimbursement rates and fees, under an inter-State compact, they could agree to uniform benefits and coverage; establish third-party administration (interoperability), such as the third-party biller Texas has set up to enroll out-of-state providers; and manage claims. During the meeting, Professor Rosenbaum suggested a closer look at the interstate foster care adoption model to learn what has made that arrangement successful.

- *Taking Advantage of Existing Regulations:* Federal regulations allow for states to pay out-of-state claims, both in an emergency and when it is “customary” (not defined) to travel.
- *Eligibility Criteria:* Eligibility varies less from state to state now than it did 30 years ago. Furthermore, while some states have additional assets tests, when looking at income alone, most farmworkers (especially migrant farmworkers) easily meet income criteria because of their typically low wages nationally.

Other opportunities take the form of key potential partners and key stakeholders who can help prepare for and implement a Medicaid portability pilot model. Some of those partners follow:

- *FQHCs:* FQHCs are federally funded<sup>10</sup> entities that exist in every state Medicaid plan. Some FQHCs receive funding specifically to serve migrant and seasonal farmworkers and may already be accustomed to receiving farmworker families and to delivering culturally and linguistically appropriate care. Furthermore, federal statutes require that FQHCs receive a higher Medicaid reimbursement rate than private providers.
- *MSHS:* MSHS programs are essential for reaching farmworkers and sharing accurate messages about Medicaid portability. Thus, MSHS staff members often have established relationships of trust with farmworkers, providing an excellent opportunity for outreach. State MSHS Collaboration Directors also may be potential stakeholder partners.

## **Discussion of Medicaid Portability Models**

In her background paper and meeting presentation, Professor Rosenbaum outlined the two most plausible Medicaid portability models. She underscored that to be successful, at a minimum, a model should: use existing policy and process as much as possible, be achievable without legislative action, be simple for providers and farmworkers, and involve little administrative cost. The two models, which are described in greater detail below and in Figure X, are:

- **Interstate Provider Network Model** (a “provider-side” model)
- **Multistate Card Model** (a “coverage-based” model)

One meeting participant offered that “there is no silver bullet” and, therefore, space was afforded for creativity in the event that participants decided to weave a patchwork of key components, rather than adopt a single full proposed model. After discussing the two models that Professor Rosenbaum presented, participants were invited to brainstorm and offer

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<sup>10</sup> Note: FQHCs are generally only partly federally funded.

alternate models. The result was a total of five models that the full group actively considered and, in the end, voted on. The three models not selected for pilot implementation are described briefly in Appendix E. A detailed description of the two Medicaid-based models presented by Professor Rosenbaum and selected by the group for further investigation and piloting are detailed in Table I.

### ***Pilot Implementation***

There was debate about where to pilot. Arguments were made in support of targeting states with lower farmworker populations initially in order to “start small” and increase initial likelihood for successful implementation. Obvious reasons for targeting more commonly identified “farmworker states,” such as California included the bigger impact that could be realized.

Michigan (represented by their Primary Care Association, Medicaid representative, MSHS grantee, an individual FQHC Executive Director, and the former Migrant Health Specialist of the Department of Human Services) offered to serve as a pilot site.

Considering Texas-Michigan migratory patterns and a strong focus within Texas Medicaid on promoting enrollment among farmworkers, Texas was a logical pilot partner for the Interstate Provider Network Model and agreed to pilot (this was discussed as a one-way relationship for the time being, wherein Michigan FQHC providers would enroll in Texas Medicaid, but not visa versa).

### ***Workgroup and Steering Committee***

Eight meeting participants volunteered to serve on a Steering Committee to lead the postmeeting follow-up efforts, in collaboration with Altarum Institute and MCHB’s Lead Oral Health Consultant. All meeting participants will serve as part of a broader Workgroup that will have input into follow-up and implementation efforts. The Workgroup has envisioned a shorter implementation timeline for the Provider Network model, whereas more preparation and planning would likely be required for implementation of the Multistate Medicaid Card model.

Participants underscored the importance of federal interagency support of ongoing Medicaid portability pilot efforts and included HRSA and the Office of Head Start as necessary partners. MCHB offered hope for future funding for similar efforts but was forthcoming about a definite current gap in funding (after the current contract sunsets in September 2008), at a minimum, from October 2008 to September 2009. A foundation present at the meeting expressed an interest in considering this initiative for future funding, without commitment. Altarum Institute offered to explore sponsorship of continued efforts in the absence of immediate funding while fundraising is under way.

Table I. Selected Medicaid Portability Models

	Description	Key Strengths	Key Challenges
<p><b>MODEL I</b></p> <p><b>Interstate Provider Network Model</b></p>	<p>Providers enroll in another state’s (sending state) Medicaid program, agree to see children with out-of-state Medicaid, and bill the other state’s Medicaid program. This model is similar in practice to private insurance with regional coverage and benefits. Children are considered “out-of-state” for “in-state” providers, who are actually out-of-state providers who have enrolled as in-state providers for the sending state.</p>	<ul style="list-style-type: none"> <li>▪ Avoids re-enrollment upon migration: children maintain Medicaid enrollment in their home (sending) state and only have to go through recertification.</li> <li>▪ Leverages FQHC potential (easier to work with FQHCs because of higher reimbursement rates and willingness).</li> <li>▪ Creates a potential relationship among FQHCs across states, most importantly for purposes of continuity of care.</li> <li>▪ Already occurs for a number of providers near state borders.</li> <li>▪ Does not require legislative action or any formal interstate agreement, though some formality might ensure a smoother process.</li> <li>▪ Can be agreed upon and implemented at the state level.</li> </ul>	<ul style="list-style-type: none"> <li>▪ May not work as well for farmworker families without a “home” state (e.g., those who migrate from state to state, not necessarily between two states).</li> <li>▪ Requires a great deal of coordination within each state (across Medicaid, MSHS, and FQHCs), as well as coordination across states. States likely have nuanced administrative and provider enrollment processes, too.</li> <li>▪ Relies also on priority arrangements made between the sending state’s Medicaid enrollment and claims agency and the out-of-state provider; otherwise, enrollment and reimbursement for the out-of-state provider may be cumbersome and slow.</li> <li>▪ Electronic billing was previously (and may still be) an issue, but under the Health Insurance Portability and Accountability Act (HIPAA) there may be some standardization.</li> </ul>

## MODEL 2

### Multistate Medicaid Card (based on interstate compact)

Description	Key Strengths	Key Challenges
<p>A group of states agree to accept a portable, universal card. There are two possible payment arrangements. Participating states would decide among themselves either that the state rendering services pays the provider and then gets reimbursed by the sending state (Option 1 below) or that the place of service treats the newly arrived child as “one of their own” and assumes all the cost (Option 2 below). Children are essentially considered “in-state” as long as they are within one of the participating state’s borders.</p> <p><i>Option 1:</i> Participating states agree to accept each other’s Medicaid rate. For example, a child enrolls in Medicaid and then moves from (sending) state A to (receiving) state B. State B sees the child, bills state A, and accepts state A’s reimbursement rate/payment. This option, across two states, looks similar to the Interstate Provider Model, but takes on more of a multistate nature once families move on to additional states.</p> <p><i>Option 2:</i> Participating states enter into a universal reciprocity agreement across states, accepting a child’s enrollment, regardless of the state where they enroll. In this option, the sending state enrolls the child, and the receiving state sees the child and pays for the service without billing the sending state at all.</p>	<ul style="list-style-type: none"> <li>▪ Avoids re-enrollment upon migration (easier for farmworkers and for MSHS staff).</li> <li>▪ Administratively more simple (and has the potential for administrative cost-savings).</li> <li>▪ Providers do not need to enroll in other states’ Medicaid programs.</li> <li>▪ Once farmworker families are provided with the message about the “new” agreement, the multistate card can be easier for families and enable them to move around more freely with respect to health coverage.</li> <li>▪ Does not require legislative action.</li> <li>▪ Can be agreed upon and implemented at the state level.</li> <li>▪ If eligibility can be agreed upon across states at 130 percent of poverty, all MSHS automatically meet the income requirement by nature of having met the MSHS criteria (and generally have few to no assets).</li> </ul>	<ul style="list-style-type: none"> <li>▪ Requires extensive stakeholder building and more detailed interstate compacts.</li> <li>▪ Likely to involve longer periods of planning and piloting.</li> <li>▪ Electronic billing was previously (and may still be) an issue, but under HIPAA, there may be some standardization.</li> </ul>



## FOLLOW UP TO MEETING

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In the 4 months subsequent to the March meeting, the Medicaid Portability Initiative continues to thrive and demonstrate important outcomes and updates in a variety of areas.

### ***Steering Committee and Workgroup Engagement:***

The Steering Committee and Workgroup have met via conference call approximately four times since March. In addition to information imparted on calls, some participants have exchanged email messages and phone conversations to share information. Committee and Group members also provide each other with updates about related efforts (e.g., Delaware farmworker advocates were asked to brief their Governor about Medicaid portability options; California, in the aftermath of the March meeting, planned to conduct discuss across migrant health, MSHS, and Medicaid).

### ***Marketing Materials and Information Dissemination Efforts:***

In response to Steering Committee suggestions to generate materials that could be used to inform potential stakeholders and other public audiences about this initiative, Altarum Institute drafted an informational document (see Appendix F) that includes a description of the two pilot models and Web links to the Michigan Primary Care Association (MPCA) Web Site and to the Texas Association of Community Healthcare Centers (TACHC) Web site.

Abstracts on this Medicaid Portability Initiative have been submitted to two conferences:

- Migrant Education Resource Center: National Identification and Recruitment Forum, October 2008 (accepted)
- Association of Maternal and Child Health Programs, February 2009 (submitted)

### ***Preparation for Medicaid Portability Pilot Implementation:***

A number of efforts have been achieved or are under way in support of the Texas/Michigan Interstate Provider Network Model.

In the spring of 2008, map overlays were created (by GIS mapping and by hand) of Michigan and Texas, in order to visually represent where M/CHC sites and MSHS centers are located (Appendix H). This was helpful in identifying programs in close proximity of one another.

#### *Michigan*

Michigan has been able to identify and establish a champion for Michigan's efforts to prepare for and pilot this model. The MPCA has created numerous informational materials and other learning opportunities through their Web site and ongoing meetings. Within their already-established Migrant Health Workgroup, they have

launched a Medicaid Portability Workgroup, including representatives from the MPCA (immunization outreach, migrant health), the new Director of Migrant Affairs, and a number of FQHCs. The group has met four times since May. Jana Blasi (TACHC) also provided an overview at one meeting.

The MPCA, the Michigan Medicaid Office, and Telamon Corporation continue to collaborate. (The workgroup that they formed will meet again in September; the MPCA Migrant Health Network discussed this Initiative at their July 30 meeting. There are two TACHC Webcasts in August.)

Approximately 13 Michigan FQHCs have expressed interest in enrolling as Texas Medicaid providers. As of July 31, 2008, none successfully completed enrollment: some FQHCs are still in a process of Board approval of the effort; some FQHCs have applied and have been asked for additional information. Texas would pay FQHCs the same reimbursement rate they currently receive in their own state, even as out-of-state providers.

Michigan and Texas have been collaborating to engage Michigan providers in Texas-sponsored Webcasts on out-of-State billing and other relevant topics that can facilitate the process.

Both Texas and Michigan have developed a number of informational materials, primarily for providers, which are available on their respective Web sites.

#### *Texas*

Opportunities present in Texas have generally facilitated preparation for and implementation of this pilot model as well. In 1997, the state of Texas was mandated to take corrective action in response to a class action suit filed for not meeting the requirements of EPSDT under Medicaid (See Appendix G for a description of *Frew v. Hawkins*). As such, the state is receptive to opportunities that will increase access to services for Medicaid-eligible children.

Texas Health and Human Services Commission (the state's Medicaid office) is collaborating with the TACHC, the Texas Migrant Council, and the MPCA.

As of July 31, 2008, the Texas Migrant Council has identified 1,900 MSHS children who are enrolled in Medicaid. The Texas Health and Human Services Commission and the Texas Migrant Council continue exploring ways to exchange that data while ensuring confidentiality. The Texas Health and Human Services Commission continues work on a complicated file exchange with the Texas Education Agency. The Texas Education Agency has identified 66,000 migrant children, but their definition of a "migrant child" is broader than the definition employed by the Texas Migrant Council and by the Texas Health and Human Services Commission.

### ***Progress on the Multistate Medicaid Card***

As anticipated after the March meeting, much emphasis in the short term has been placed on successfully staging pilot implementation of the Interstate Provider Network Model and, as such, little dialogue has centered around the Multistate Medicaid Card. Discussions that have occurred at the Steering Committee level have underscored the importance of gaining additional stakeholder support for this model. To that end, the development of materials such as a PowerPoint presentation and an informational document (already developed) are next steps.

In order to make informed decisions about which states to target, the Steering Committee identified GIS mapping as a useful tool. As with the Michigan and Texas mapping efforts, overlaying M/CHC sites (not just headquarters) and MSHS sites (not only grantee's central locations) will be helpful. To that end, the MSHS Collaboration Office and the National Center for Farmworker Health have provided Altarum Institute with electronic databases for cleaning and mapping. Beyond the scope of the current contract, mapping remains a future activity.

### ***Other Topics Identified by the Steering Committee and Workgroup***

Continue to discuss the potential ripple effect of this initiative, as well as opportunities for partnership beyond current stakeholders. Migrant education, for example, could be a beneficial partner even with the current target population, considering their ability to promote a consistent Medicaid portability message among farmworker families who also have MSHS-age children.

## **CONCLUSION**

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This Expert Meeting aimed to begin development of a Medicaid Portability model. Commitment, excitement, and available expertise abounded, resulting in exceeded expectations. We achieved two very successful outcomes: (1) a cohesive, sustainable interdisciplinary stakeholder group and (2) a hybrid pilot model comprising two distinct models, which two states willingly engaged for immediate pilot implementation. Pilot implementation is now in its initial stages. Given successful meeting outcomes and initial pilot steps, this is a critical and unique opportunity for follow-up and action after 30 years of Medicaid portability groundwork.



Developing an  
**Oral Health Medicaid Portability Model  
for Migrant and Seasonal Head Start Children**  
An Expert Meeting

**APPENDIX A:**

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**Background Paper: “Medicaid Portability  
in the Context of Oral Health Care for  
Head Start-Enrolled Children in Migrant  
Farmworker Families”**



# Medicaid Portability

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

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**Prepared for an Oral Health Expert Meeting**

**Sponsored by the Maternal and Child Health Bureau, and  
the Migrant and Seasonal Head Start Collaboration**

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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.<sup>1</sup> 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.<sup>2</sup>

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.<sup>3</sup> 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.<sup>4</sup>

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.<sup>5</sup>

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.<sup>6</sup> One report notes that MSHS grantees ranked the lack of access to dental care as their most urgent concern for the children they assist.<sup>7</sup> 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<sup>8</sup> 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.



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- 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](http://www.kff.org)).

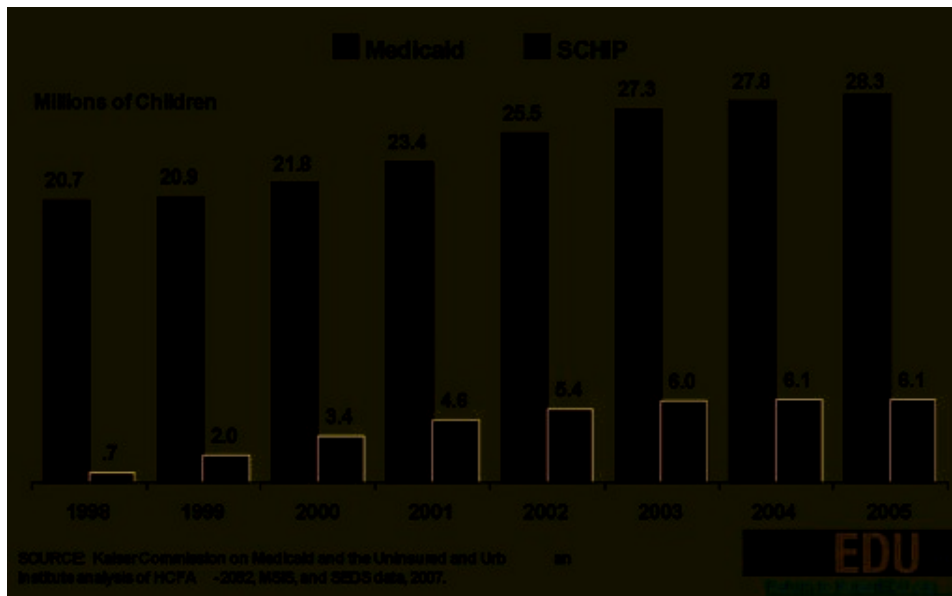
## A Brief Overview of Medicaid

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.<sup>9</sup> 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<sup>10</sup> 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.<sup>11</sup>
- 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).

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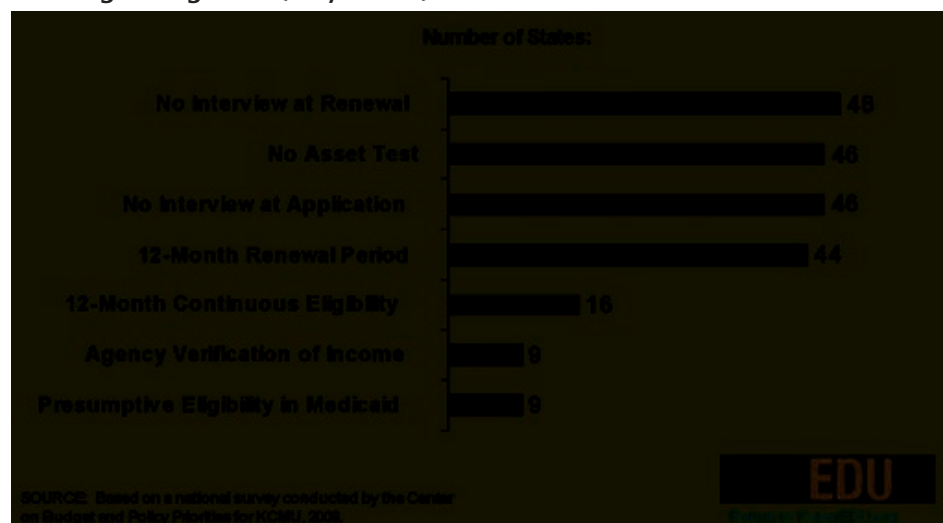
## Procedures for Enrolling in and Maintaining Medicaid Coverage

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<sup>12</sup>
- 12 states provided for continuous eligibility – that is, the continuation of eligibility for a full year regardless of fluctuations in family income<sup>13</sup>
- 9 states provided for “presumptive eligibility” – that is, temporary eligibility for children whose family finances indicate eligibility<sup>14</sup>

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.<sup>15</sup> 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.<sup>16</sup> 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.<sup>17</sup>

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### 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.<sup>18</sup> As dental care providers increase, use rates also appear to rise.<sup>19</sup>

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.

<b>Figure 4: Health Centers and Dental Care</b>	
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 outstationing, 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,

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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 outstated 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<sup>20</sup> 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.<sup>21</sup> 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.



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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*,<sup>22</sup> 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.

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## 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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- 12 Ibid. AK, GA, MN, OR, PA, and TX do not allow annual enrollment periods for Medicaid.
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Developing an  
**Oral Health Medicaid Portability Model  
for Migrant and Seasonal Head Start Children**  
An Expert Meeting

**APPENDIX B:**

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**Background Resources**

## Background and Resources

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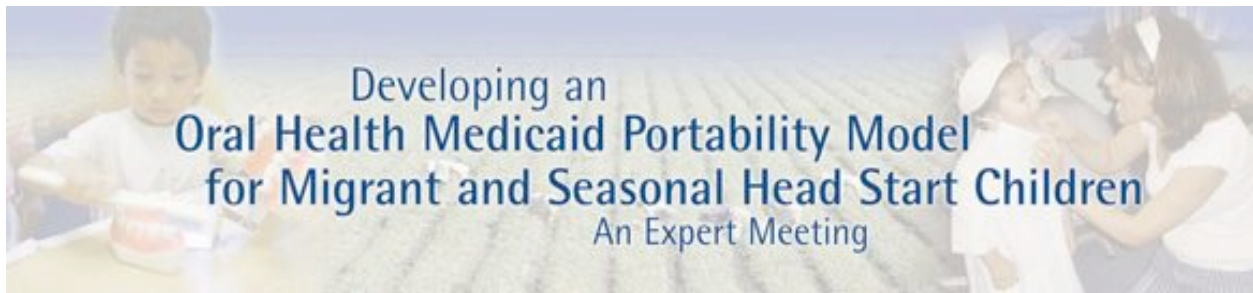


Developing an  
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for Migrant and Seasonal Head Start Children**  
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**APPENDIX C:**

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**Participant List**



## Participant List

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Developing an  
**Oral Health Medicaid Portability Model  
for Migrant and Seasonal Head Start Children**  
An Expert Meeting

**APPENDIX D:**

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Meeting Agenda



**Meeting Objectives:** (Specific to Migrant and Seasonal Head Start children where possible)

- Highlight current promising practices in Medicaid portability
- Identify challenges of and potential solutions for Medicaid portability (demonstrated and forecasted)
- Identify provider network challenges and opportunities (licensure, fees, claims processing)
- Break down barriers, myths, and misunderstandings across the Medicaid, oral health, and Migrant and Seasonal Head Start communities
- Identify elements of a comprehensive Medicaid portability pilot model (through cross-discipline dialogue)
- Identify potential states and communities for pilot model implementation

### **Agenda**

**Monday, March 10, 2008**

8:30–9:00 a.m. **Continental Breakfast**

9:00–10:00 a.m. **Welcome, Introductions, Meeting Overview**

Remarks by:

- John Rossetti, Lead Oral Health Consultant, Maternal and Child Health Bureau (MCHB)

Establishing meeting ground rules, general logistics, and overall panel introduction

- Naomi Tein, Altarum Institute

10:00–11:15 a.m. **Head Start Environment (Panel 1)**

*Facilitated Discussion Led by Yvette Sanchez*

- Federal Migrant Head Start perspective
  - Sandra Carton, Office of Head Start
- Program level perspective (Migrant/Seasonal Head Start Programs)
  - José Martinez, Riverside County Office of Education (CA)
  - Criselda Cuevas, United Migrant Opportunity Services Child Development Programs (WI)
  - Suzanne Orozco, Telamon Migrant Corporation, Inc. (MI)



Developing an  
**Oral Health Medicaid Portability Model  
for Migrant and Seasonal Head Start Children**  
An Expert Meeting

**Agenda**

**Monday, March 10, 2008 (Continued)**

- 11:15–11:30 a.m. **BREAK**
- 11:30 a.m.–12:30 p.m. **Review of Background Paper**  
Presentation by:
- Sara Rosenbaum, JD, Hirsh Professor and Chair, Department of Health Policy, George Washington University School of Public Health
- 12:30–1:00 p.m. **Lunch (on your own)**
- Time to visit area establishment (list provided in folder) and bring lunch back
- 1:00–1:30 p.m. **Informal Networking/Question-and-Answer Session**
- 1:30–2:30 p.m. **Medicaid Environment (Panel 2)**  
*Facilitated Discussion Led by Christine Farrell*
- William Clark, Centers for Medicare and Medicaid Services
  - Olga Garcia, Texas Medicaid Program
- 2:30–3:00 p.m. **Participant Questions and Comments**
- 3:00–3:15 p.m. **BREAK**
- 3:15–4:15 p.m. **Oral Health Environment (Panel 3)**  
*Facilitated Discussion Led by John Ruiz*
- State oral health perspective and EPSDT
    - Christine Farrell, Michigan Department of Community Health
  - Community Health Center perspective
    - John McFarland, Salud Family Health Center
  - Oral health provider perspective
    - Jim Crall, National Oral Health Policy Center
- 4:15–4:45 p.m. **Participant Questions and Comments**





Developing an  
**Oral Health Medicaid Portability Model  
for Migrant and Seasonal Head Start Children**  
An Expert Meeting

### **Agenda**

#### **Monday, March 10, 2008 (Continued)**

4:45–5:30 p.m. **Preview of Day 2 (laying groundwork for pilot model development)**

Remarks by:

- John Rossetti, Lead Oral Health Consultant, MCHB
- Roger Rosenthal, Migrant Legal Action Program

### **Agenda**

#### **Tuesday, March 11, 2008**

8:00–8:30 a.m. **Continental Breakfast**

8:30–9:00 a.m. **Review of Panel Discussions and Questions/Comments**

- Facilitated Discussion

9:00–10:30 a.m. **Beginning to Develop a Model [Facilitated by Roger Rosenthal]**

- Assess elements of the two Medicaid portability models
- Steps necessary in developing a model
  - What the law requires
  - How states will implement
  - Practical considerations
  - Stakeholders and other resources
  - Challenges and barriers
  - Opportunities

10:30–10:45 p.m. **BREAK**

10:45 a.m.–12:30 p.m. **Beginning to Develop a Model (continued)**

12:30–1:30 p.m. **Lunch (on your own)**

1:30–3:00 p.m. **Putting together the pieces (of the model)**

3:00–3:45 p.m. **Next Steps**

3:45–4:00 p.m. **Final Remarks**

- Closing Remarks by: John Rossetti, Lead Oral Health Consultant, MCHB





Developing an  
**Oral Health Medicaid Portability Model  
for Migrant and Seasonal Head Start Children**  
An Expert Meeting

**APPENDIX E:**

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**Alternate Medicaid Portability Models**

## Alternate Medicaid Portability Models

During the meeting, it was agreed that the three brainstormed models were not as appropriate for the agreed-upon target population within the context of this discussion. Meeting participants agreed to move forward with the original two models, in large part because they are Medicaid-based (with a funding source) and doable, and also because at least one could be applied in the very short term.

The three models that were brainstormed on site were not detailed thoroughly. Nevertheless, a brief description of each is provided below. With additional time, research, and discussion, it is possible that these models could become pilots.

- ***Managed Care Multistate Provider Model:***

This model relies on a Third Party Administrator (TPA), a centralized entity that would enroll providers and farmworker children in a managed care plan. It builds on the widespread presence of managed care, especially in Medicaid. The model involves devoting time and resources to negotiated contracts and incurring the additional expense of a TPA. Participants questioned whether managed care would work in an oral health context.

- ***Public-Private Partnership Model:***

Similar in function to the “TPA model,” this non-Medicaid-based model relies on a partnership of employers who pool funds that are tied to workers. Farmworkers would be expected to provide a small copayment. While this model encourage growers to play a collaborative role, the portability element is lost on a model tied to employers. In addition, much negotiation among and across States and providers would be required in order to generate that pool of money that would be tapped when farmworkers move from State to State. Furthermore, even a low copayment might be prohibitive for farmworkers.

- ***National Medicaid Pilot Model:***

This model is essentially a Medicaid carve-out for a small population of children age 0–5 in MSHS. It would involve crafting a special pilot for these children, and moving toward persuading Medicaid to recognize Head Start as a provider. There was a question among participants about whether legislative action would be required, considering that discretionary funds would be used for the pilot.

Participants brainstormed and questioned alternate ideas and model components. There was, for example, discussion around whether MSHS could be billed as a provider and then reimbursed. This idea was explored and initially determined not to be viable, but it resurfaced under the brainstormed “National Medicaid Pilot Model.”



Developing an  
**Oral Health Medicaid Portability Model  
for Migrant and Seasonal Head Start Children**  
An Expert Meeting

**APPENDIX F:**

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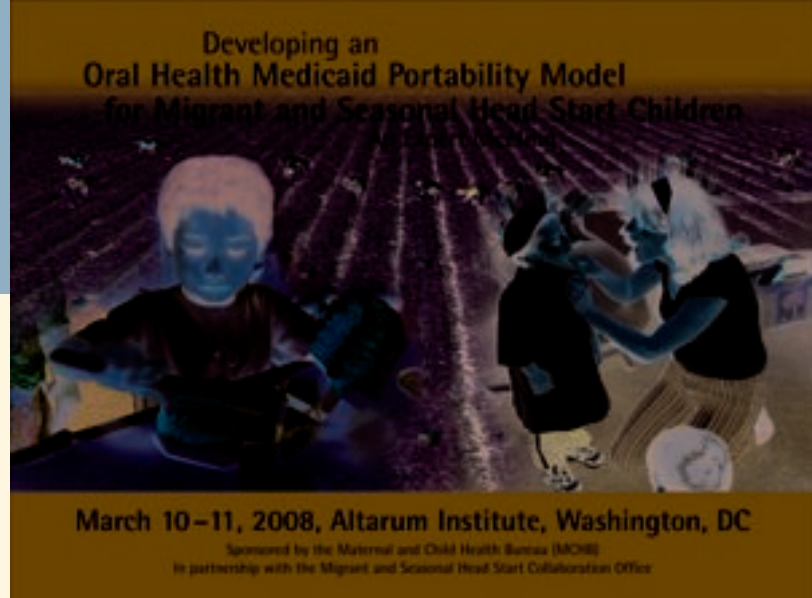
**Medicaid Portability Project Overview**

## Medicaid Portability Initiative: Medicaid Portability Models to Increase Access to and Continuity of Oral Health Care Services for Medicaid-Eligible Migrant and Seasonal Head Start Children

### Background

In 2007-2008, through contract funding provided by the U.S. Maternal and Child Health Bureau (MCHB) and supplemental sponsorship by the National Migrant and Seasonal Head Start Collaboration Office, Altarum Institute is coordinating efforts and has convened key stakeholders in an effort to resolve issues and challenges in accessing and maintaining oral health care services for Medicaid-eligible Migrant and Seasonal Head Start (MSHS) children that arise from fundamental parameters around Medicaid enrollment and the current lack of portability. This Initiative aims to identify and implement a mechanism to support Medicaid's ability to "follow the child."

Altarum and the MCHB Lead Oral Health Consultant assembled a Planning Committee, comprising an MCHB Lead Oral Health Consultant and key representatives from each of the following three areas: MSHS, Medicaid, and Migrant Health. Together, Planning Committee members designed a two-day March 2008 meeting that aimed to identify a model or models likely to succeed that could be agreed upon and implemented by the meeting participants. Professor Sara Rosenbaum, a nationally-renowned Medicaid expert working on Medicaid portability and farmworker issues for over thirty years, crafted a comprehensive background paper outlining fundamental considerations and challenges surrounding Medicaid portability in the context of oral health access for MSHS children.



### March 2008 Meeting Participants, Content and Outcomes

The March 2008 meeting brought together twenty-seven Federal, national, state, and program-level participants from Medicaid, MSHS, Migrant Health, and Oral Health. Panelists were asked to provide an overview and basic challenges around Medicaid, MSHS, and Oral Health. In addition to an overall lack of oral health providers who accept Medicaid, the Head Start performance standard dictating that all enrolled children have an initial assessment within 30 days proves additionally challenging considering the mobility of Migrant Head Start families and Medicaid enrollment policies.

After discussions of challenges and opportunities, meeting participants introduced and analyzed pros and cons of five possible models. As a state-administered program with a Federal match, models identified involve some level of inter-state collaboration and coordination. Participants prioritized and agreed to pursue two models that avoid the need for children to re-enroll in Medicaid each time a new residence is established. The two models are described on page 20.

Eight meeting participants volunteered to serve on a Steering Committee to lead post-meeting follow up efforts in order to ensure progress and ultimately implementation of the two identified models. All meeting participants will now serve as part of a broader Work Group that will have input into follow up and implementation efforts. The Work Group has envisioned a shorter implementation timeline for the Provider Network model, whereas more preparation and planning will likely be required for implementation of the Multi-state Medicaid Card model.

## Post-Meeting Progress and Update

Steering Committee and Work Group members continue to meet via conference call.

Immediately following the March 2008 meeting, Texas and Michigan launched efforts toward implementation of the Provider Network Model. Each state has been working to identify interested Federally Qualified Health Centers (FQHC) receiving Migrant Health funding. Texas has started enrolling Michigan's Federally Qualified Migrant and Community Health Centers. The Texas Medicaid Commission has also formed more active partnerships with the Texas Association of Community Health Centers and with the Texas Migrant Council (which operates Texas Migrant and Seasonal Head Start programs), and has started to enroll the other state's FQHC providers in their own Medicaid program.

Steering Committee members and Altarum are mapping all Migrant/Community Health Centers (including satellite site) and MSHS centers through GIS mapping in order to create a visual understanding of where the overlap is.

### Model A: Interstate Provider Network

This model is based on the premise that 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 states. 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. Migrant families in turn would remain residents of their home state (their domicile state), even when traveling for work. This would permit dental professionals in any of the stream states to bill the state of residence.

Under this model, the provider bills the state in which the child is enrolled in Medicaid.

### Model B: Multi-State Medicaid Card

An interstate compact is the cornerstone to this multi-state model. Centers for Medicare & Medicaid Services (CMS) reported to congress on options for making Medicaid coverage more available to farmworker families. 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 this model, unlike the Provider Network model where providers are enrolled in their own state's and receiving states' Medicaid programs, providers serving MSHS children remain enrolled only in their own state's Medicaid program. Consider an example where a child enrolled in State A's Medicaid program travels with their family to State B for farm work reasons. There are two possible scenarios for payment. Either State A will pay State B (at State A's reimbursement rate) for treating the child. A second option is for State B to recognize the child as its "own" and reimburse the State B provider at their own rate, even though the child was originally screened for eligibility and enrolled in State A's Medicaid program.

Under this model, the provider bills the provider's own state, who reimburses the provider directly. Depending on the version of this model states agree on, the receiving/treating state might consider the child as its "own" Medicaid enrollee and use their own state Medicaid funds to reimburse their own provider. Alternatively, the receiving/treating state might then turn to the "sending" state where the child originally enrolled in Medicaid, requesting that the sending state reimburse the receiving/treating state for the state portion of the Medicaid payment.

*continued on page 3*

## Next Steps

Steering Committee members continue to discuss strategies for moving forward with the Multi-state Medicaid Card model, and to identify appropriate states for implementing the Multi-state Medicaid Card Model, as well as additional states for Provider Network Model implementation.

The Medicaid Portability Initiative is eager to identify additional partners and stakeholder with an interest in and opportunity for supporting one or both of the Medicaid portability models.

Altarum continues to work with Michigan's key stakeholders in this effort, championed by the Michigan Primary Care Association, and to work with Texas to strengthen collaboration among key stakeholders and to identify mechanisms for sustainability there.

Altarum will continue to monitor challenges and successful elements of both models, in order to identify common minimum elements that should be included in the Medicaid portability models as the Initiative move forward. These Medicaid portability models have promise of replicability not only across other states, but of great significance, with other populations, such as individuals and families experiencing homelessness and other mobile populations such as construction workers.

## Information

Additional information may be found on the Michigan Primary Care Association Web site: <http://www.mpca.net/migranthealth/migrantworkgroup.htm>. The MPCA has formed a network of migrant health partners to better understand and respond to the needs of migrant and seasonal farmworkers in Michigan. Michigan FQHC's that work with farmworkers have been extended an invitation to enroll in Texas Medicaid so that when they see farmworker children in Michigan with Texas Medicaid cards, the children can be seen and the Michigan providers can be reimbursed by Texas Medicaid. Learn more here: <http://www.mpca.net/migranthealth/MCNProviderFlyer6-2008.pdf>. Information on the Texas Migrant care Network may be found here: <http://www.mpca.net/migranthealth/MCNProviderFlyer6-2008.pdf>.

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Developing an  
**Oral Health Medicaid Portability Model  
for Migrant and Seasonal Head Start Children**  
An Expert Meeting

**APPENDIX G:**

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Frew v. Hawkins



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**Frew v. Hawkins**

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Originally filed against the State of Texas in 1993, *Frew v. Hawkins*, challenges the State's provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to its Medicaid population. The EPSDT Program is a federally mandated health care program of prevention, diagnosis, and treatment for Medicaid recipients from birth through age 20. Through EPSDT, States must offer health and developmental assessments, vision, dental, and hearing services to these Medicaid recipients. In addition to screening services, EPSDT includes diagnostic and treatment services necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. Services are provided in accordance with Title XIX of the Social Security Act as amended, and program requirements are contained in 42 United States Code §1396d(r) and defined and codified at 42 Code of Federal Regulations §440.40 and §§441.56-62.

In Texas, the EPSDT Program is known as the Texas Health Steps (THSteps) Program. The Texas Department of State Health Services, a Health and Human Services agency, collaboratively administers THSteps with Health and Human Services Commission (HHSC), the State Medicaid agency. HHSC's rules for the program are contained in Title 25, Chapter 33 of the Texas Administrative Code relating to Early and Periodic Screening, Diagnosis, and Treatment.

*Frew v. Hawkins* was certified by the federal court as a class action lawsuit. Currently, the Plaintiff class comprises approximately 2.5 million children enrolled for benefits under THSteps. The lawsuit does not affect the Children's Health Insurance Program.

The State reached agreements with Plaintiffs in the lawsuit, including a 1996 Consent Decree and corrective Action Orders in 2007.



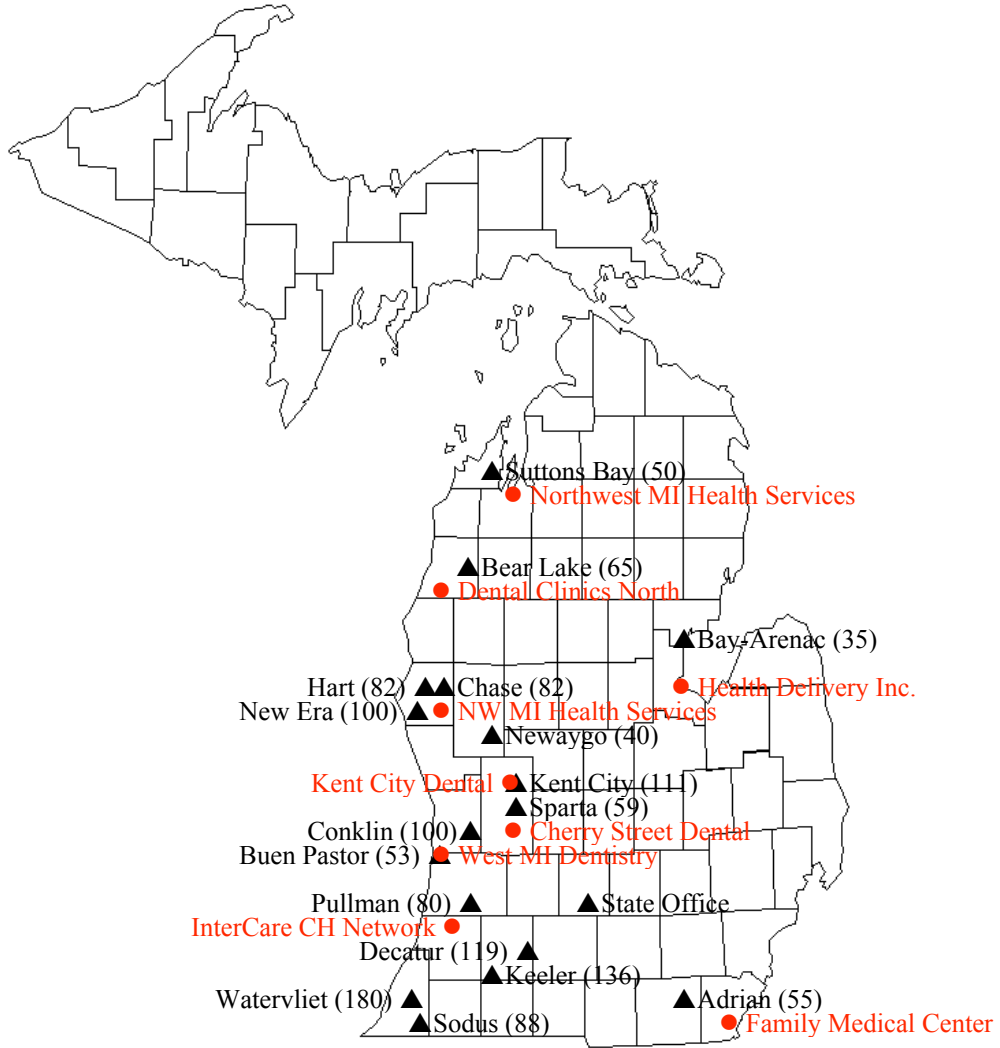
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for Migrant and Seasonal Head Start Children**  
An Expert Meeting

**APPENDIX H:**

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**Michigan and Texas Overlay Maps (GIS)**

## TELAMON - MICHIGAN MIGRANT HEAD START WITH HEALTH CENTER OVERLAY



Dental Provider	Center	Duration of Operation	# Children Planned Enrollment (over course of entire season with drops/adds)	Planned Age Groups		
				Infants	Toddlers	Preschool
Cherry Street Dental	Conklin	17 weeks June-October	100	12	36	40
	Sparta	15 weeks July-October	59	13	22	20
Family Medical Center	Adrian (including satellite site in Manchester)	9 weeks June-August	55	16	24	40
	Decatur (including satellite site in Bangor)	18 weeks June-October	119	16	24	60
InterCare Community Health Network (includes a mobile unit)	Keeler	21 weeks May-October	136	16	24	60
	Pullman	16 weeks June-October	80	8	16	60
Kent City Dental – Michael Watkins DDS	Sodus	20 weeks June-October	88	16	16	40
	Watervliet (including satellite site in South Haven)	23 weeks May-October	180	40	40	80
Health Delivery, Inc (has mobile unit)	Kent City	15 weeks July-October	111	24	32	58
	Bay-Arenac	9 weeks July-September	35	8	16	20

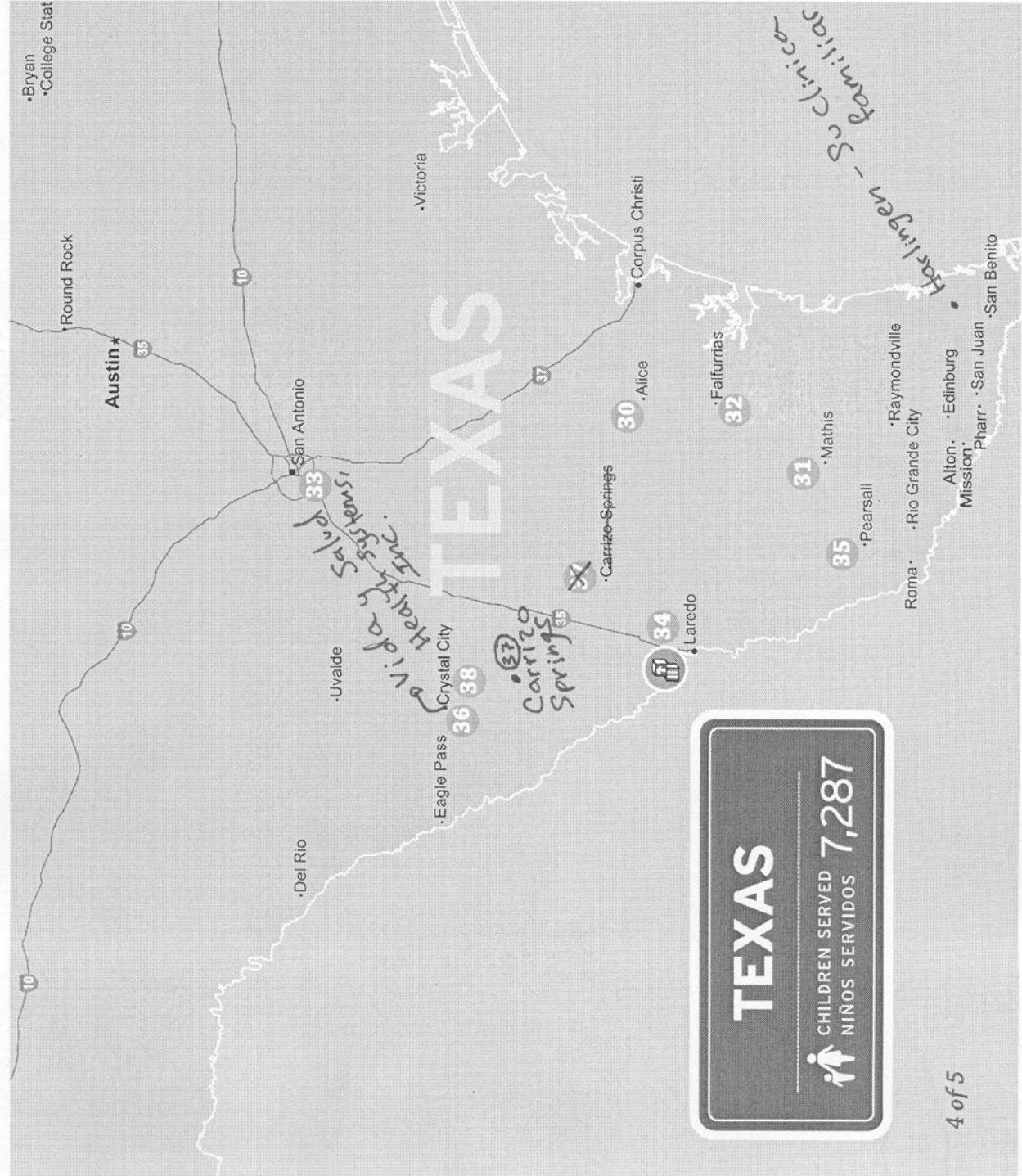
Northwest MI Health Services, Inc (Shelby Clinic)	Chase	27 weeks May-November	82		8	16	40
	Hart	22 weeks May-October	82		8	8	40
	New Era	22 weeks May-October	100		16	32	40
Northwest MI Health Services, Inc. (Traverse City Clinic)	Suttons Bay	15 weeks May-October	50		16	16	18
	Bear Lake	14 weeks July - October	65		8	16	40
Note: Dental Clinics North also serves Bear Lake but no contract on file to date							
InterCare Community Health Network (delegate manages agreement with provider)	Buen Pastor (Delegate)	10 weeks June-August	53		8	8	37
Family Health Care (delegate manages agreement with provider)	Newaygo (Delegate)	12 weeks July-September	40		8	16	18

<b>Dental Provider:</b>	<b>Notes:</b>
Cherry Street Dental 550 Cherry Street SE, Grand Rapids, MI 49503 (616) 235-7289	<b>Services provided – Working to establish contract</b>
Dental Clinics North (service location) 449 River Street, Manistee, MI 49660 231-398-9305  Attn: Patricia Ulrich, RDH email: <a href="mailto:p.ulrich@nwhealth.org">p.ulrich@nwhealth.org</a> 220 W. Garfield, Charlevoix, MI 49720 (231) 547-6523 FAX: (231) 547-6238	<b>Services provided for Bear Lake – Working to establish contract</b>
Family Medical Center Attn: Marcia Deiley 8765 Lewis Ave., Temperance, MI 48182 (734) 847-3802 FAX: (734) 847-3418 <a href="mailto:mdeiley@familymedical.org">mdeiley@familymedical.org</a>	<b>Contract on file</b>
Health Delivery, Inc. (has mobile unit) Attn: Becky Demers or Dr. Robert Dennison 3605 Davenport, Saginaw, MI 48602 (989) 792-2115 ext. 233	<b>Contract on file</b>
InterCare Community Health Network (has mobile unit) Attn: Sharon Kloosterman, Dental Director P O Box 130, Bangor, MI 49013 (269) 427-7937 ext. 104 <a href="mailto:SKLOOSTERMAN@InterCare.org">SKLOOSTERMAN@InterCare.org</a>	<b>Contract on file</b>
Kent City Dental - Michael Watkins, DDS Attn: Kathy 52 S. Main Street, PO Box 300, Kent City, MI 49330 (616) 678-4040 FAX: (616) 678-5194	<b>Direct pay contract on file – he does not accept Medicaid (he bills us below Medicaid rate and gives in-kind to match our grant)</b>
Northwest MI Health Services, Inc. Attn: Ann Avery 1067 Traverse Hwy., Suite B, Traverse City, MI 49684 (231) 947-1112	<b>Contract on file</b>
West Michigan Dentistry (for follow-up work only) Robert Sterken, DDS, MS 844 Washington Ave, Ste 4100 Holland, MI 49423 616-392-2381 FAX: 616-392-3748	<b>Contract on file</b>  <b>Follow-up Services for Conklin, Decatur, Keeler, Pullman, Sodus, Watervliet, Buen Pastor</b>





TEXAS MIGRANT COUNCIL, INC. ( )  
5215 McPherson Ave.  
Laredo, TX 78041-7325  
Telephone/Teléfono: (956) 722-51



**TEXAS**

CHILDREN SERVED 7,287  
NIÑOS SERVIDOS

CITY CIUDAD	CENTER NAME NOMBRE DE CENTRO
<b>WINTERGARDEN REGION - LAREDO</b>	
30 ALICE	Alice
31 MATHIS	Mathis
32 FALFURRIAS	Falfurrias
33 SAN ANTONIO	San Antonio
34 LAREDO	Laredo Infant/ Toddler Center
35 PEARSALL	Pearsall
<b>WINTERGARDEN REGION - CRYSTAL CIT</b>	
36 CRYSTAL CITY	Wintergarden Region - Crystal City
37 CARRIZO SPRINGS	Carrizo Springs
38 CRYSTAL CITY	Crystal City





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CITY  
CIUDAD

CENTER NAME  
NOMBRE DE CENTRO

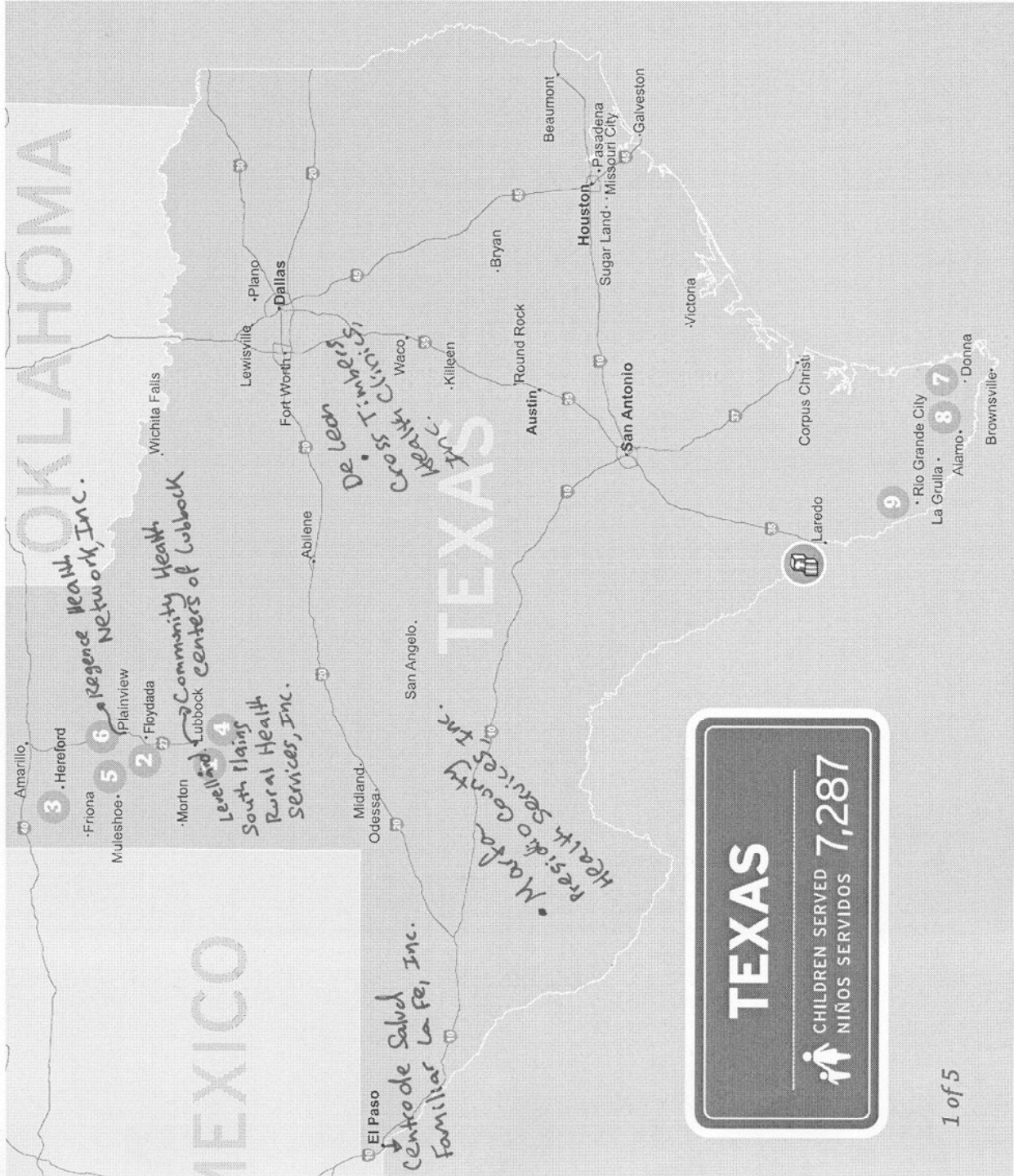
WESTERN REGION - PANHANDLE

- 1 LUBBOCK Western Region - Panhandle
- 2 FLOYDADA Floydada
- 3 HEREFORD Hereford
- 4 LUBBOCK Lubbock
- 5 MULESHOE Muleshoe
- 6 PLAINVIEW Plainview

RIO GRANDE VALLEY REGION

- 7 DONNA Rio Grande Valley Region
- 8 ALAMO Alamo
- 9 RIO GRANDE CITY Alto Bonito

For up-to-date print  
<http://www>



**TEXAS**

CHILDREN SERVED 7,287  
NIÑOS SERVIDOS

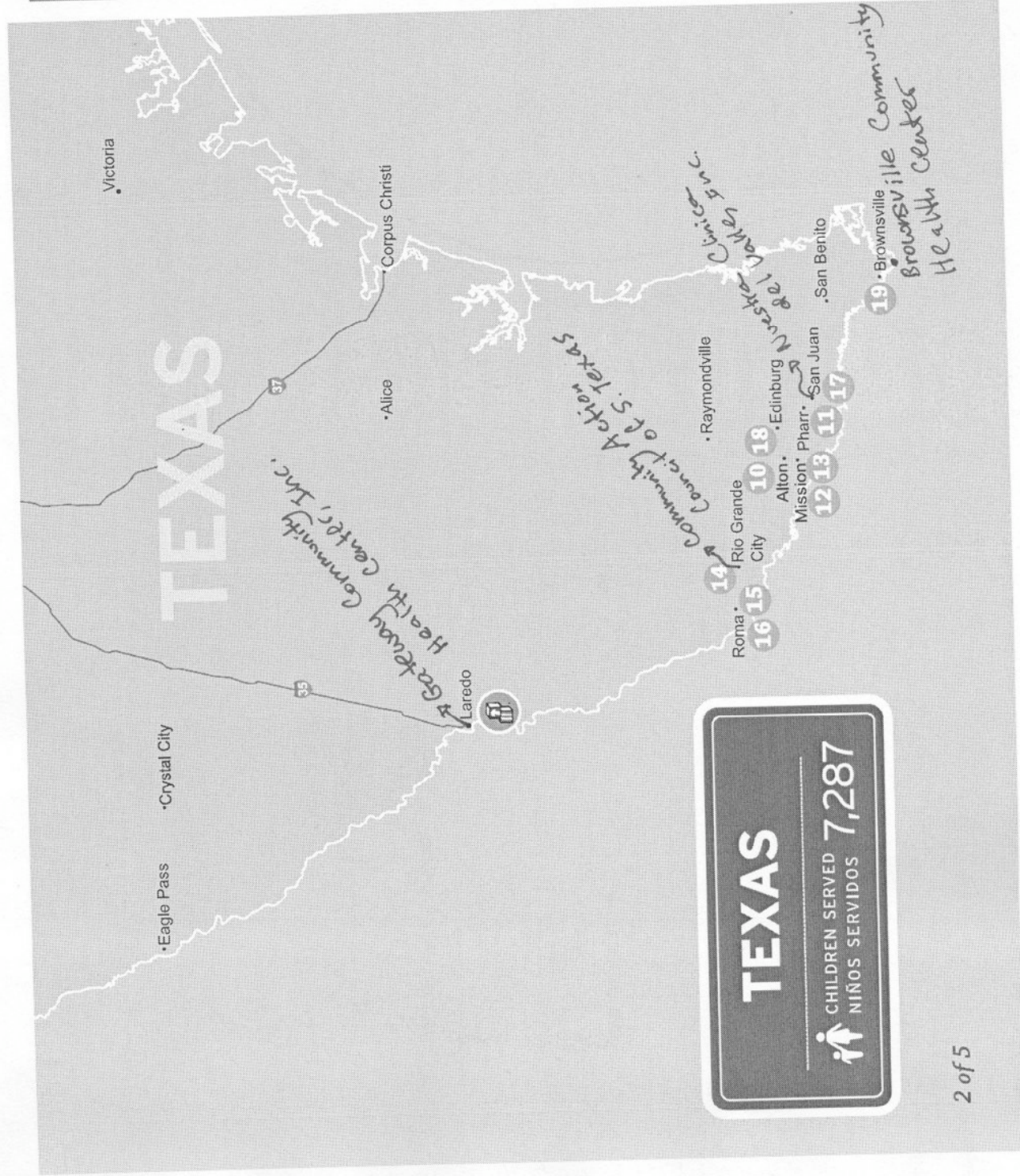




TEXAS MIGRANT COUNCIL, INC. (C)  
5215 McPherson Ave.  
Laredo, TX 78041-7325  
Telephone/Teléfono: (956) 722-51

CITY CIUDAD	CENTER NAME NOMBRE DE CENTRO	S	D
10 ALTON	Alton	3	
11 PHARR	Las Milpas	2	
12 MISSION	Mission	3	P.
13 MISSION	Palmview Infant/ Toddler Center	4	M
14 RIO GRANDE CITY	Rio Grande City	5	P.
15 ROMA	Roma I	1k	
16 ROMA	Roma II	4	P.
17 SAN JUAN	San Juan	2	P.
18 EDINBURG	Edinburg	4	
19 BROWNSVILLE	Brownsville	6	P.

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<http://www>



**TEXAS**  
CHILDREN SERVED 7,287  
NIÑOS SERVIDOS



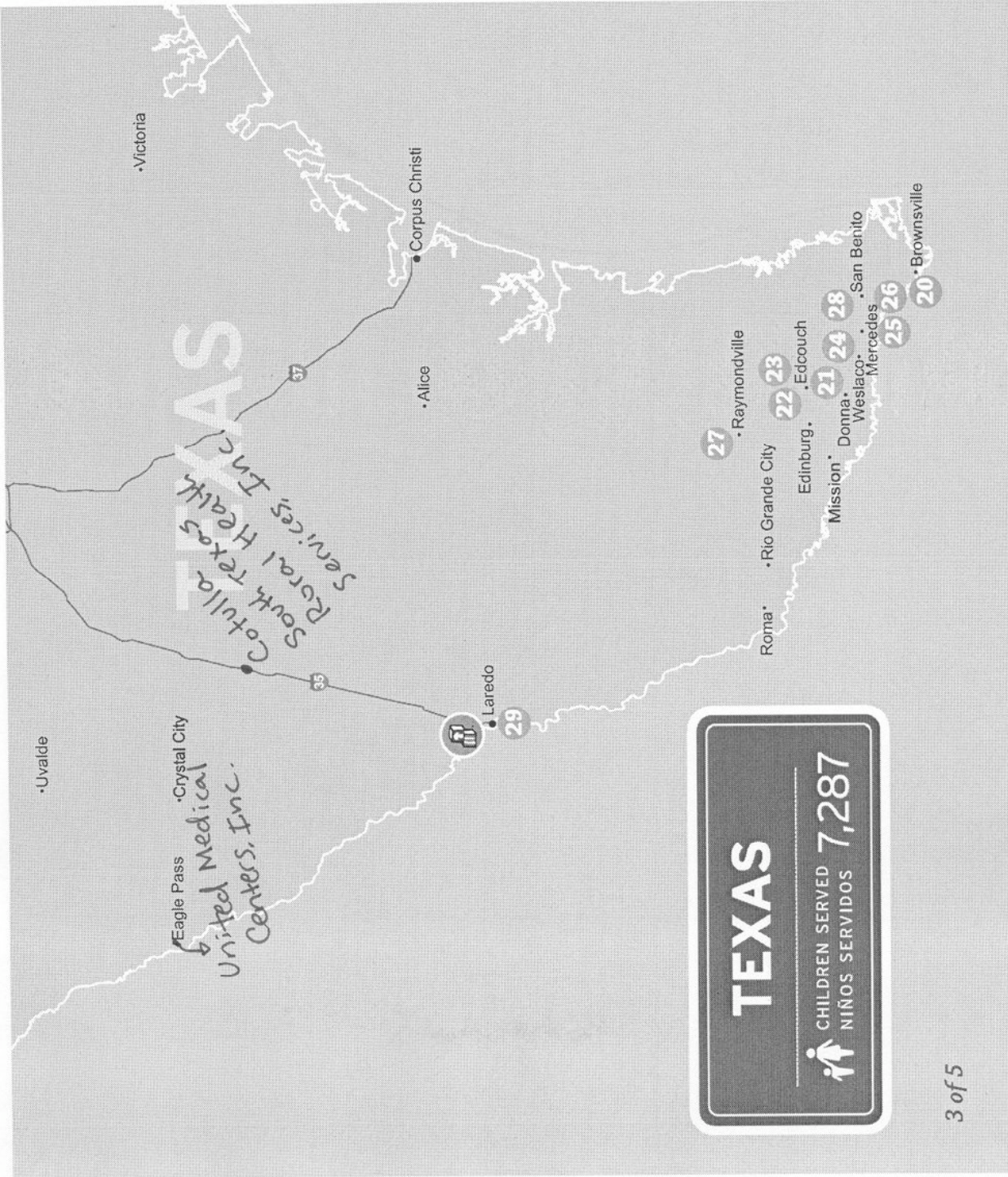
**MIGRANT AND SEASONAL HEAD START  
DIRECTORIO DEL LOCALIZADOR DEL HEAD START**



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5215 McPherson Ave.  
Laredo, TX 78041-7325  
Telephone/Teléfono: (956) 722-51

CITY CIUDAD	CENTER NAME NOMBRE DE CENTRO
20 BROWNSVILLE	Brownsville I/T
21 DONNA	Donna
22 EDCOUCH	Edcouch I
23 EDCOUCH	Edcouch II
24 MERCEDES	Mercedes I
25 WESLACO	Progreso
26 WESLACO	Weslaco Infant/ Toddler Center Raymondville
27 RAYMONDVILLE	
28 SAN BENITO	San Benito (La Paloma Center)
29 WINTERGARDEN REGION - LAREDO	Wintergarden Region - Laredo

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<http://www>



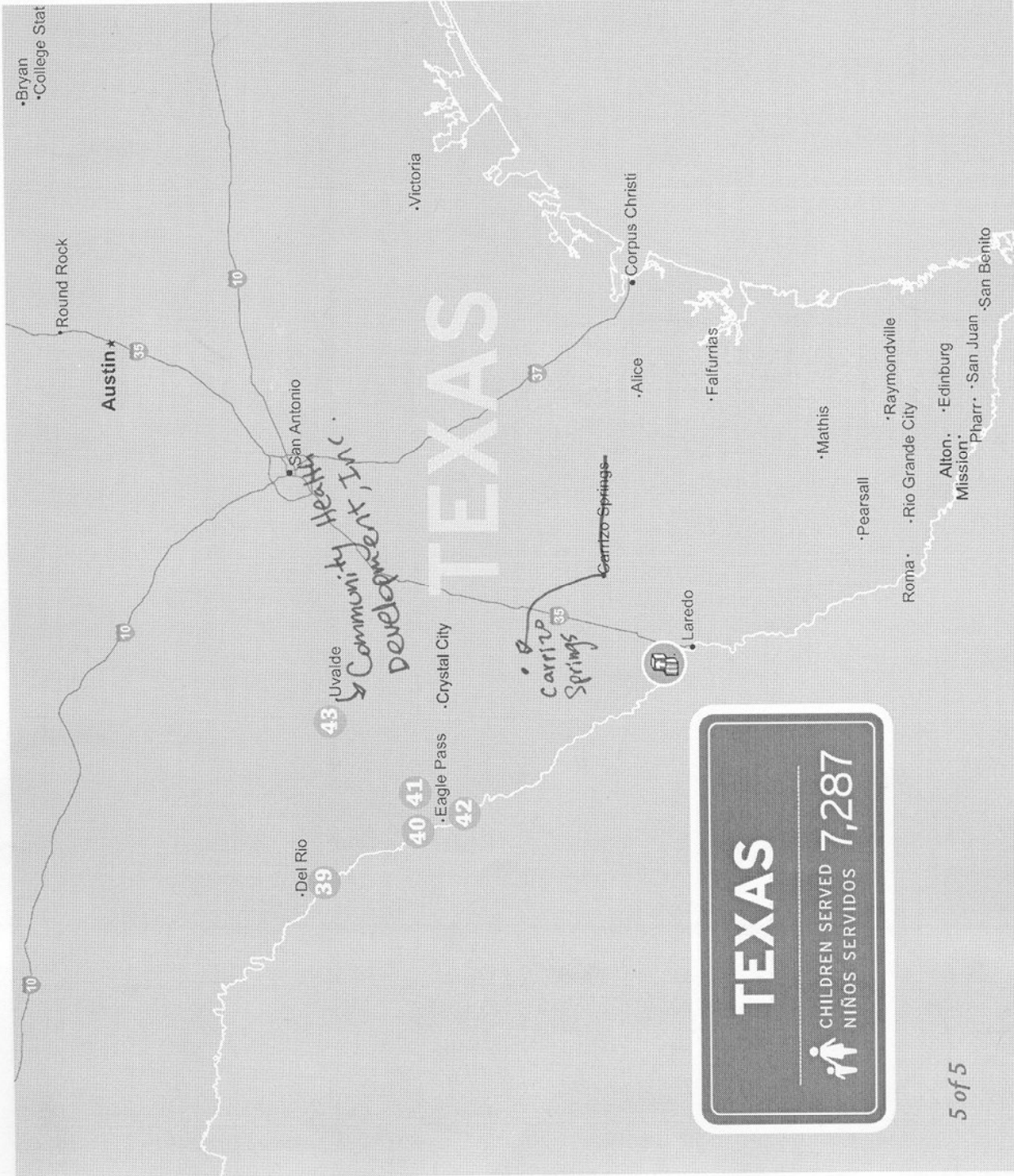
**TEXAS**  
CHILDREN SERVED  
NIÑOS SERVIDOS 7,287



MIGRANT AND SEASONAL HEAD START  
DIRECTORIO DEL LOCALIZADOR DEL HEAD START



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Laredo, TX 78041-7325  
Telephone/Teléfono: (956) 722-51



CITY CIUDAD	CENTER NAME NOMBRE DE CENTRO	F
39 DEL RIO	Del Rio	F
40 EAGLE PASS	Eagle Pass I	F
41 EAGLE PASS	Eagle Pass II	F
42 EAGLE PASS	Eagle Pass Infant/ Toddler Center	F
43 UVALDE	Uvalde	F

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