STUDY BY THE STAFF OF THE U.S.

General Accounting Office

Problems In The Structure And Management Of The Migrant Health Program

This study discusses the status of the Department of Health and Human Services' Migrant Health program and the program's relationship to other Federal efforts to provide health services to the medically underserved. It also discusses the Department's practice of jointly funding health centers with Migrant Health funds and Community Health Center program funds together with reasons for consolidating aspects of these programs. This study also provides insight into the access-to-health-care barriers faced by migrant farm workers, which current Federal efforts have not completely overcome.

The study explores several alternatives for structuring and funding the Migrant Health program, including the administration's proposal to consolidate the program into a health block grant to the States.

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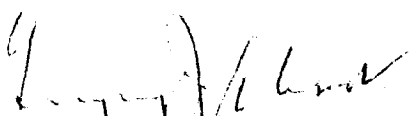
PREFACE

This study was undertaken because of the concerns expressed by the House Committee on Interstate and Foreign Commerce and the Senate Committee on Labor and Human Resources about the Department of Health and Human Services' practice of combining Migrant Health program funds with Community Health Centers program funds. The Committees were concerned that migrant farmworkers might not receive needed services or full benefits of the funds directed to jointly funded health centers.

The study discusses management problems associated with combined funding, particularly difficulties in accounting for migrant funds. It also discusses similarities and differences between the Migrant Health program and the Community Health Centers program and their respective beneficiaries. Underlying these issues is the question of how and whether the Migrant Health program should be continued, given the number of other Federal health efforts aimed at medically underserved groups. Several alternatives for structuring and financing the program are explored.

This information should be useful to the Congress as it considers whether to reauthorize the Migrant Health program legislation, which expires in September 1981, or to put the program into a block grant, as proposed by the administration.

We received oral comments on a draft of this study from representatives of the Department's Health Services Administration. We incorporated their comments in the staff study as appropriate.



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ABBREVIATIONS

BCHS	Bureau of Community Health Services
CHC	Community Health Center
HHS	Department of Health and Human Services

CHAPTER 1

INTRODUCTION

When the local labor supply is insufficient to meet the peak seasonal demands of American agriculture, migrant farmworkers are hired to fill the gap. The American agricultural economy depends on the availability of migrant and seasonal farmworkers. These workers provide an essential service for Americans: they till, plant, reap, sort, and pack the fruits and vegetables we eat.

Despite their importance to our agricultural economy, migrant and seasonal farmworkers remain an underprivileged group. Generally, they are poor, undereducated minorities living in substandard conditions. Many of these socioeconomic factors, as well as special demands of migratory life, influence poor health. This study discusses the structure and management of selected Federal programs aimed at improving migrants' health status. It also addresses congressional concerns about the effects of the Department of Health and Human Services' (HHS') efforts to combine funds earmarked for migrant health care with other Federal funds to operate health centers serving other medically underserved groups.

WHO THEY ARE

Expressed simply, migrant farmworkers move to find work while seasonal farmworkers do not. However, distinguishing between the groups is not so simple because migrants may settle in a community for a time becoming seasonal farmworkers and seasonal farmworkers may later migrate to find work. There is no standard definition for these groups covered by Federal programs. However, for migrant health care programs, Public Law 94-63, enacted in 1975, defined the groups as follows:

--A migratory agricultural worker is an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes a temporary abode for the purposes of such employment.

--A seasonal agricultural worker is an individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker.

Estimates of the numbers of migrant and seasonal farmworkers vary considerably because of the fluctuating nature of the work force, nonstandard definitions, and the groups' mobility. Estimates indicate that there are about 800,000 migrant workers and about 1.9 million seasonal farmworkers in the United States. 1/

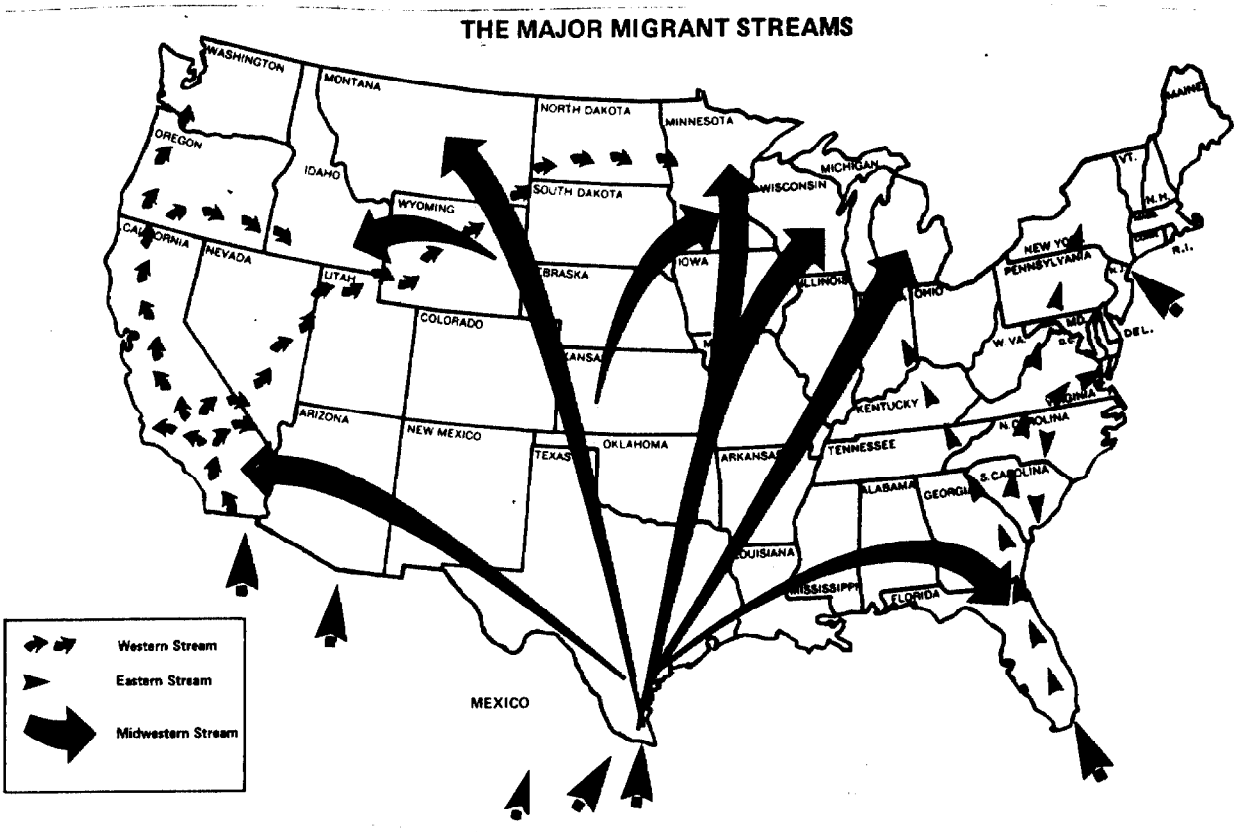
1/Numbers of migrant and seasonal farmworkers used throughout this study include their families.

HOW AND WHY THEY MOVE

Migratory workers travel because of economic necessity. For some workers, the amount of farmwork available locally is limited; for others, migratory work is a way of obtaining higher wages. Migratory farmworkers move from home base locations, where they reside when they are not working (usually during the winter), to "upstream" communities, where they reside temporarily to obtain work. In home base areas, migrants are indistinguishable from their nonmigratory neighbors, who are usually of the same ethnic or racial group. As the growing season changes, the migrant travels by almost any means possible, usually paying his own way, to find work.

The farmworkers' migration patterns once consisted of three distinct and predictable streams from California, Texas, and Florida. The three classic migration streams were the Western Stream, including California, Washington, Oregon, and the Rocky Mountain States; the Midwestern Stream, which begins in Mexico and Texas and extends northward into Illinois, Wisconsin, and Michigan; and the Eastern Stream extending from Florida northward along the eastern U.S. seaboard.

While the established streams remain constant, migrant movement now crisscrosses between streams. Changes in the migration patterns have resulted in part from advanced agricultural technologies and competition for available work. Because of its long growing seasons, California now serves as a year-round location for resident seasonal farmworkers. Midwestern Stream migrants and coastal migrants now mingle in new patterns. The following map illustrates recent agricultural migration patterns.



WHY MIGRANT HEALTH BECAME A NATIONAL ISSUE

The seriousness of the migrants' health conditions, the inadequacy of the health services available to them, and the interstate nature of the migrant problem compelled national action. In 1961 and 1962 congressional hearings, migrants' health needs were recognized as among the greatest of any group in the United States. Despite their needs, health services were not generally available to migrants. Providing these services for a transient group required health providers to work together.

Agricultural migrants and their families suffer the usual health problems of their socioeconomic groups. However, these problems are compounded and magnified by migrants' mobility. Early studies showed that migrants had high infant mortality rates, high communicable disease rates, low prenatal care rates, high premature birth rates, high accident rates, low immunization levels, and a serious need for dental care. Their socioeconomic status contributed to these health problems. Poverty, lack of health knowledge, cultural differences, language barriers, and mobility limit migrant access to medical services.

Federal involvement stemmed from the realization that migrants' health needs could not be met by one community, State, or region working alone. Despite an economic dependence on migrant farmworkers, communities had frequently overlooked or excluded them from health service. Migrants often fail to qualify as legal residents in their temporary work communities and thus are frequently excluded from community services available to other indigents. Furthermore, the linking of health services along the path of migration is essential to provide continuity of care.

THE MIGRANT HEALTH PROGRAM

With the enactment of the Migrant Health Act (Public Law 87-692) in 1962, the Congress initiated a Federal grant program to make health care accessible to migrants. Funding, services, and eligible groups have expanded dramatically since the program began in 1962 with a $750,000 appropriation. In fiscal year 1980, the migrant health appropriations reached $39.7 million, funding clinics, hospitalization, and other migrant health-related activities. In addition, other Federal assistance is used to serve migrant and seasonal farmworkers' health needs.

How migrant health programs developed

The migrant program evolved from a limited assistance effort aimed at State and local health agencies for treatment of migrants to much-expanded services covering migrants and seasonal farmworkers' health needs. Because the original funding was limited, it was used to support ongoing preventive health programs, such as

immunization, health education, and environmental safety programs conducted by State and local health agencies. Migrant health legislation received increased funding when the Community Health Services Extension Amendments of 1965 (Public Law 89-109) provided broader authority and increased authorization, which permitted support of projects designed specifically for migrants.

Other legislative changes specified the target groups and the focus for migrant funding. Until 1970, this assistance was directed exclusively at migrants and their families. However, in 1970, Public Law 91-209 broadened the migrant coverage to include seasonal farmworkers and their families, who shared many of the migrants' health needs. Not until 1975 did Public Law 94-63 formally define these eligible groups. In 1978 Public Law 95-626 extended services to former migrants who had become aged and disabled.

In 1975 the Congress directed funds into high migrant impact areas as a priority. A 1971 Community Change, Inc., study entitled "Evaluation Design and Analyses of Migrant Health Delivery Systems" recommended this change to correct problems with the ineffective and fragmented use of migrant health funds. Public Law 94-63 defined high-impact areas as places where no fewer than 6,000 migrant and seasonal farmworkers reside for more than 2 months of the year. These areas were redefined by Public Law 95-626 in 1978 to encompass no fewer than 4,000 eligibles for at least 2 months annually.

The Migrant Health program today

In fiscal year 1979, the Migrant Health program provided about $33 million for ambulatory or in-hospital care. In addition, the program provided about $1.5 million for other migrant health-related activities. The major program components, together with their fiscal year 1979 funding levels, follow:

	Amount
Personal health services:	
Ongoing projects and centers	$28,472,585
Hospitalization program	2,018,114
Entitlement program	2,470,006
Migrant assurance program	77,625
Other migrant health programs:	
Migrant referral system	447,000
Sanitation program	263,133
Technical assistance	399,537
Evaluation	377,000
	$34,525,000

HHS estimated the migrant program served about 557,000 persons. However, using data from the Bureau Common Reporting Requirements, from hospital admissions, from enrollments reported in an evaluation of entitlement programs, and from user estimates for the Migrant Assurance program, we estimate that the Migrant Health program served about 421,000 migrant and seasonal farmworkers in fiscal year 1979. Program officials believe the major reason for this discrepancy is due to underreporting of seasonal farmworkers within the number of total users. In fiscal year 1980, the Migrant Health program was increased by 15 percent to $39.7 million. Following is a brief description of the program components.

Projects and centers

The largest program component consists of grant awards to health centers and projects that provide ambulatory care to eligible migrants and seasonal farmworkers and their dependents. Some clinics offer complete, comprehensive ambulatory care, including dental, preventive, sanitation, social, and welfare services on a 24-hour-a-day, 7-day-a-week schedule. Smaller clinics provide mostly referral and counseling services at least during the off-season for migration. In fiscal year 1979, 123 grantees received migrant health care funding for centers and projects.

Hospital demonstration program

Twelve of these 123 grantees participate in another program segment--the Migrant Hospital Demonstration program. They refer eligible patients to hospitals located near the clinics if inpatient care is required. In fiscal year 1979, 19 hospitals participated, receiving reimbursement through fixed-price per diem contracts.

Entitlement programs

In this program segment, four entitlement programs allow migrants to obtain care from private physicians, hospitals, and public clinics. HHS sponsored these entitlement demonstration projects to provide comprehensive health services to migrants both in the home base and while migrating. The four projects are the El Valle Community Health Plan of Harlingen, Texas, a health maintenance organization-type project; the Laredo-Webb County Migrant Health Project of Laredo, Texas; the East Coast Entitlement Program of Palm Beach County, Florida; and the Collier Health Services, Inc., Migrant Program of Immokalee, Florida. The Laredo project purchases Blue Cross/Blue Shield coverage for its enrollees; the two Florida projects use Blue Cross/Blue Shield as their fiscal intermediary.

Assurance program

The fourth service delivery segment is the East Coast Migrant Health Assurance Program. This program provides outpatient services in Alabama, Georgia, and South Carolina, where migrants are without definable access to health care. These areas are not typically high impact, and although health resources exist, they are often not financially accessible to migrants. An authorization voucher is used for outpatient ambulatory services on a fee-schedule basis.

Other program activities

In addition to the personal health service segments, the Migrant Health Referral System has been established to transfer medical information for migrant patients as they travel throughout the Nation. Its objectives are to provide continuity of care and to avoid duplication of care for migrants. The major components include personal health cards, migrant referral forms to obtain treatment for migrants in need of continuing care, the migrant medical information service (a telephone credit card number for migrant health providers to obtain migrant medical information), and the National Migrant Health Service Directory, a comprehensive list of health care programs in areas where migrants and seasonal farmworkers work or live.

Other migrant health funds were spent for supplementing State sanitation inspection and enforcement efforts, for providing technical assistance to migrant health centers and projects, and for performing program evaluation.

Program management

Within HHS' Public Health Service, the Office of Migrant Health of the Bureau of Community Health Services (BCHS) has overall responsibility for the Migrant Health program. Program management is decentralized to the regional level, where it is the responsibility of the Regional Health Administrators.

OTHER FEDERAL ASSISTANCE TO MIGRANTS

Other Federal programs, many of which began after passage of the Migrant Health Act, also afford health assistance to migrants. Community Health Centers (CHCs), established under section 330 of the Public Health Service Act in 1975, also serve migrants and seasonal farmworkers. These farmworkers may qualify for assistance under Medicaid if they meet State eligibility requirements. Migrants may also qualify for hospitalization under the former Hill-Burton program (now title XVI of the Public Health Service Act) and are eligible for other categorical programs, such as family planning.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our objective was to review the design of the migrant health care delivery system and to discuss alternatives. Congressional committees had expressed concern about the appropriateness of combining migrant funds with funds for the medically underserved under the CHC program to operate integrated centers. Because of these concerns, we examined the reasons for the integrated operations and the impact of combined funding.

Information for this report was gathered from several sources--legislation, visits to health centers and regional offices, interviews, program documentation, and questionnaires. We reviewed the legislative history of the migrant program and other programs offering health benefits to migrants.

Since most migrant health money is used to operate migrant health centers and projects, our study focused on the operations of these centers and projects, and we visited 23 of the 123 grantees. We also interviewed HHS program officials, migrant health officials at six HHS regional offices, officials at the migrant health projects and centers, and officials from a national farmworker organization to obtain information on program management and operations. We reviewed program documentation, including studies on migrant health needs and use of services and reports on program administration and operations.

Using a questionnaire, we polled migrant health center and project grantees for information on their funding sources; other health services in the area; their evaluation of migrants' use of health services compared to that of other poor people; the importance of certain selected services such as outreach or transportation; and their experience with various elements of the Migrant Health program. From the 122 questionnaires mailed to grantees (Hawaii was excluded at the suggestion of BCHS), 100 replies were received.

The methodology we used to select sites was aimed at obtaining broad coverage of the program. We chose two HHS regional offices in each of the migratory streams and attempted to select one region in the home base area and the other upstream. According to a migrant health official, for administrative purposes HHS defines Regions II, IV, VI, IX, and X as home base. The other five are considered upstream. However, BCHS originally informed us that Region X was upstream, so we included Seattle as the upstream region. The following regions were selected for review.

Stream	Region	Regional office
Western	IX	San Francisco (home base)
	X	Seattle (home base)
Midwestern	VI	Dallas (home base)
	V	Chicago (upstream)
Eastern	IV	Atlanta (home base)
	III	Philadelphia (upstream)

To select the 23 grantees visited out of the 123 total, we sought to include geographically dispersed centers with varying types of funding, including both home base and upstream locations and those that participated in special programs.

We used the most recent data available at the time of our fieldwork. Consequently, the funding analysis and program descriptions used fiscal year 1979 data. We did not update the information because of the additional time it would have required.

CHAPTER 2

REASONS TO RECONSIDER THE CURRENT MIGRANT HEALTH CARE STRATEGY

A distinct health program to serve migrants and seasonal farmworkers operates alongside the CHC program for the medically underserved. These programs are similar, and their funds are often combined to serve both groups at individual centers. There are good reasons for integrating these program operations. These reasons also argue for further program consolidation.

First, migrants and seasonal farmworkers qualify for assistance under both programs, and the programs offer similar benefits. Second, as recognized by BCHS, using one center to serve migrant and seasonal farmworkers and other medically underserved persons in an area is more economical and efficient than operating two separate centers. Third, migrants, seasonal farmworkers, and the rural poor have similar health needs and do not generally require different health services.

Finally, joint funding, with its attendant problems of assuring migrant funds are spent only for migrants, adds weight to the argument that aspects of the Migrant Health and CHC programs can be consolidated. BCHS has had difficulty matching migrant funds with levels of services at consolidated centers. This problem could be alleviated by using CHC program funds to serve all eligible users of these centers.

Although there are several ways in which the migrant and CHC programs can be consolidated, some special efforts for migrants may be necessary. Because they are mobile, migrants have a problem--finding and qualifying for health care--that seasonal farmworkers and the rural poor do not have. Programs such as Medicaid, Hill-Burton, and Migrant Health Referral System have not totally overcome this obstacle.

CURRENT HEALTH STRATEGY-- A SEPARATE MIGRANT PROGRAM USING INTEGRATED CENTERS

The Migrant Health program remains a categorically separate health program, but its service delivery is often integrated with the CHC program for the medically underserved. Legislative changes have broadened the program's scope to include seasonal farmworkers and have given priority for migrant funds to areas where migrants and seasonal farmworkers reside for the longest periods. Other legislation was passed to offer similar benefits to the medically underserved. BCHS decided to integrate service delivery for these groups whenever possible by consolidating migrant funds and CHC

funds to operate centers. As a result, over half of the migrant funds are used in support of integrated health center operations for the medically underserved.

Migrant Health program broadened to include seasonal farmworkers

As new legislation was enacted, the Migrant Health program shifted from a migrant emphasis to include both seasonal and migrant agricultural workers, with funds concentrated in the home base. The initial Migrant Health Act provided special benefits to migrant families only. Later legislation extended the benefits to seasonal farmworkers who are home based year-round. About 2 million seasonal farmworkers were added to the program by Public Law 91-209. Migrants totaled only about 650,000 at that time. 1/ As a result, migrant funds covered a much broader, more stable group.

Through other legislation, Migrant Health program funds became concentrated in home base areas. The Special Health Revenue Sharing Act of 1975 specified that high-impact areas--those where at least 6,000 migrants and seasonal farmworkers reside for more than 2 months in any calendar year--would receive priority assistance for migrant health center grants. The highest priorities were assigned to areas where the greatest numbers of migrants and their families resided. With the Health Services and Centers Amendments of 1978 (Public Law 95-626), the Secretary of HHS was given responsibility for determining the highest priorities for assistance. High-impact areas continued to receive priority assistance but were redefined to include no fewer than 4,000 migrant and seasonal farmworkers. These high-impact areas generally coincide with home base rather than upstream locations. Consequently, the legislation evolved from a migrant-only focus to a concentration of assistance for migrant and seasonal agricultural workers in the home base.

CHC program for medically underserved parallels Migrant Health program

Section 330 of the Public Health Service Act offered benefits similar to the Migrant Health program and also covered the migrant and seasonal farmworker. When section 330 was added to the Public Health Service Act in 1975, medically underserved areas and groups became eligible for assistance under the CHC program. Medically underserved means an area with a shortage of personal health services or a group suffering from health service shortages.

Legislation for the CHC and Migrant Health programs mandates virtually identical benefits except for the following services unique to the Migrant Health program:

1/BCHS estimate in 1973.

--Hospitalization and environmental programs, which represented 7 percent of the $34.5 million fiscal year 1979 budget.

--Migrant health center requirements to screen for infectious and parasitic disease and conduct accident protection programs if appropriate.

--A migrant health center mandate to provide bilingual services that the CHC program offers only as supplemental health services.

Furthermore, these programs often serve the same areas and groups. Virtually all migrant centers and projects are located in areas designated by HHS as medically underserved. In addition, high migrant impact areas, where concentrations of migrants reside for longer periods, have priority for grants under the migrant and CHC programs. Under the CHC program, priority grant consideration is given to an area or group meeting three of the following four criteria:

--Is a high migrant impact area.

--Is medically underserved.

--Has a health manpower shortage.

--Has high infant mortality.

Jointly funded centers integrate programs

Recognizing the overlap of target areas and groups between migrant programs and programs for the medically underserved, BCHS decided it would be more economical and efficient to have one comprehensive health center in a community than to serve migrants separately. HHS funded these consolidated centers with both migrant and CHC (section 330) funds. BCHS believes its integration of CHC and Migrant and Appalachian Health activities under the administratively established Rural Health Initiative has been successful.

By 1979, 78 of the 123 grantees (63 percent) that received migrant health care funds to run centers and projects also received section 330 funds. About $20.5 million (72 percent) of the $28.5 million used for migrant health centers and projects is channeled to consolidated centers.

SOME REASONS TO CONSIDER ALTERNATIVE STRATEGIES

Several factors argue for reconsidering of the strategy for providing health care to migrants. First, trying to manage the programs separately may not be worthwhile because migrants, seasonal farmworkers, and the rural poor have essentially the same health needs, receive similar benefits, and use the same health centers. Second, at jointly funded centers, limited attention was being given to matching the level of funding and level of services for migrants, and procedures for verifying migrant eligibility were not strictly enforced.

Migrant health needs similar to those of the rural poor

As early as 1970, several congressional reports recognized that the needs of migrants and seasonal farmworkers were similar to other disadvantaged sectors of the population. Several studies prepared for BCHS corroborated this conclusion. In a 1976 National Health Insurance Household Survey, an HHS contractor found that migrants displayed the same approximate response patterns as comparable groups of other rural residents when asked about their perceived health status. InterAmerica Research Associates' 1976 report on migrant and seasonal farmworkers concluded that migrants and the rural poor share many of the same barriers to receiving adequate health care.

Using various mortality rates for comparison, a 1977 GEOMET, Inc., study, "Migrant Farmworkers' Health Status," concluded that migrants and their dependents do not have poorer health status than the more general population of rural low-income residents. Comparing various mortality indices in 21 high migrant impact counties with 42 reference counties having few or no migrants gave no convincing evidence that migrants and their dependents had a poorer health status. The disease-specific indices indicated a higher migrant rate for cirrhosis of the liver but not for the other seven leading causes of death.

Information from our review generally corroborated these studies. Most officials at 15 health facilities we visited where migrants, seasonal farmworkers, and the rural poor were all served said these groups have essentially the same health care needs. Officials at the six HHS regional offices visited also said there was no difference in health needs between the groups. For virtually all the services offered, most health grantees reported that migrant and seasonal farmworkers' use of health care services was about the same or less than that of the needy poor, according to results from our questionnaire. Only transportation and translation services were reported by most respondents as used more often by migrants than by the poor.

In summary, migrants and seasonal farmworkers have the same health needs as the rural poor, they are eligible for similar benefits under both the migrant program and the CHC program, and they often use the same health centers as the rural poor.

Migrant funds do not always match level of service

The allocation of migrant health funds to operate jointly funded centers did not always match the population served. Ten of the 15 jointly funded centers visited during our review served fewer migrants than their migrant health funding ratio indicated. For example, a Florida center had 62 percent migrant funding, but migrants made up only 43 percent of its patient load in 1979. Similarly, at a Texas center the patient load was 49 percent migrant, but migrant funds amounted to 80 percent of the total funds allocated. In one region, migrant funds were used to offset a decrease in section 330 funds even though services to migrants did not change.

Some centers and projects may have used migrant funds to serve other than migrant and seasonal farmworkers and their families. During fiscal year 1979, 40 BCHS health centers and projects received migrant funds but no section 330 funds, yet about 10 percent of the patient load was nonmigrant. Half of these 40 centers served in total about 15,000 users who were neither migrant nor seasonal farmworkers. At several centers, the percentage of nonmigrant, nonseasonal users was above 30 percent.

In fiscal year 1979, one region received $2.4 million less in CHC funds and $1.7 million more in migrant funds than was allocated in fiscal year 1978. The additional migrant funds were used to offset the decrease in section 330 funds, and there was no change in migrant services. In its jointly funded centers, the region attempted to make the funding level equal to the proportion of migrant and seasonal users. As a result, six facilities that received no migrant health funds in fiscal year 1978 received such funds in 1979. In addition, one jointly funded facility saw its migrant funds jump from $175,000 in fiscal year 1978 to over $920,000 in 1979. Although the funding sources changed, there was no corresponding increase in service to migrants or in migrant and seasonal farmworkers' use of the centers. The same replacement of section 330 funds with migrant health funds occurred in two other regions we visited, although less money was involved.

In other cases, migrant and seasonal farmworkers were served by centers that received section 330 funds but no migrant funds. About 7,850 migrant and seasonal farmworkers (4 percent) used these centers in 1979.

Differences between funding and user levels in jointly funded centers resulted partially from the absence of a cost-accounting

system to link migrant services to migrant reimbursements. BCHS and the regions allocate funds but do not match actual migrant use of services with center allocations and third-party reimbursements. Controlling migrant funds accurately would require accounting for (1) actual use of services by eligible individuals, (2) cost of services, and (3) extent of reimbursements received by the center on behalf of migrants and seasonal farmworkers.

These controls were not always in place. Migrant health care charges generally did not correspond with actual costs of services, as required by HHS regulations (42 C.F.R. 56.303(f)). Only 5 of the 23 centers we visited had fee schedules based on actual costs. Most of the others based their fees on prevailing rates. Furthermore, BCHS' funding allocation procedure did not consider third-party reimbursements or self-payments from migrants or seasonals because BCHS assumed that such reimbursements or payments were rarely made for or by migrants or seasonals.

Eligibility and verification procedures not enforced

Health centers and projects receiving migrant funds did not have a consistent, adequate practice for determining patient eligibility. Eight of the 23 health centers we visited were using variations of the migrant and seasonal farmworker definitions specified in the migrant health legislation. As a result, some centers with broad definitions were inappropriately classifying some of their patients as migrants; others with overly restrictive definitions may have failed to classify migrants appropriately.

Some centers required strict verification of patient information, while others only interviewed the patient. According to our questionnaire responses, 6 centers or projects (5 percent of the total 123 grantees) did not have a process for determining patient eligibility, and another 40 (33 percent) interviewed the patient but did not verify eligibility. HHS officials agreed that definitions were not strictly enforced or verified. They believe there is already selective screening for migrants by the placement of centers in high-impact areas.

SOME REASONS TO RETAIN A SEPARATE MIGRANT EFFORT

Because they are mobile, migrants face access-to-health-care barriers. Finding and qualifying for medical assistance is more difficult for migrants than for the more stable seasonal farmworkers and the rural poor. Cultural and language differences may be further obstacles to obtaining services from health providers. Programs, such as Medicaid and Hill-Burton, and other efforts, such as the Migrant Health Referral System, have not totally overcome these access difficulties.

Migrants face access-to-health-care barriers

Although peculiar health care needs have not surfaced, migrants can be distinguished from seasonal farmworkers and the rural poor by their mobility and cultural differences. As a mobile group, migrants face the difficulty of finding medical services in an unfamiliar area. Their transience often effectively disenfranchises them from such programs as Medicaid, where the requirements and the time it takes to verify eligibility limit the benefits to migrants as compared to other more stable rural poor. Also, because of their mobility, migrants with chronic illnesses face problems getting continuing care.

Cultural and language differences further complicate a migrant's ability to get needed health care. Health providers may be inexperienced in dealing with farmworkers, particularly migrants. They may discriminate against migrants because they are poor, minorities, or nonresidents. Finally, language differences may prevent a migrant from adequately describing his symptoms or conditions to the health provider.

Current efforts have not overcome migrant access problems

Federally sponsored health programs have not totally overcome the migrants' access difficulties. Migrants still face problems taking advantage of general programs, such as Medicaid and Hill-Burton hospitalization benefits. Furthermore, the Migrant Health Referral System, designed to provide continuity of care for migrants, has not been consistently effective.

Medicaid

Migrants still face problems qualifying for Medicaid and proving their eligibility despite recent changes liberalizing State residency requirements. Medicaid's coverage was expanded to include temporary residents in a State for purposes of employment, making it possible for migrants and itinerant workers with families to receive benefits if they are otherwise eligible. However, another provision allows a State to deny or terminate Medicaid eligibility if another State has determined a person to be a resident for Medicaid purposes. Consequently, migrants traveling across State lines may lose Medicaid benefits.

Other nonresidency requirements are often obstacles for a migrant needing Medicaid assistance. Verifying Medicaid eligibility may take longer than a migrant's stay in an area. Consequently, a migrant may leave an area or a State before eligibility is recognized. In other cases, some migrants who travel as a family are not eligible for assistance in States that give Aid to Families

with Dependent Children only to single-parent families. Not recognizing that a migrant's duration of employment is usually for some fraction of a year, States may use a migrant's most recent earnings to determine projected annual income, overstate actual yearly earnings, and consequently refuse a migrant assistance.

Hill-Burton

The Hill-Burton Act, requiring hospitals receiving Federal funds to provide care for indigent patients, has not been consistently successful in helping migrants and seasonal farmworkers receive needed inpatient services. Only 39 percent of 96 questionnaire respondents that provided information on their experiences with this program said they had used Hill-Burton, although several responded to open-ended questions that inpatient care was a very important and/or critically unmet need of migrants. Several respondents who had had marginal or little success with Hill-Burton commented that hospitals decide who will receive assistance, find excuses not to use Hill-Burton, or actually refuse assistance.

Migrant Health Referral System

Participation in the migrant referral system has been limited, and communication between clinics has been infrequent. Although some centers we polled rated the system to be very important, most centers we visited reported the referral system to be ineffective and cited examples of when they unsuccessfully tried to use it.

Health centers often did not participate in the migrant referral system. Only 59 percent of the centers responding to our questionnaire reported using the system. Furthermore, in 1979 an HHS task force found that communication between health centers in different areas was infrequent.

Sixteen of the 23 centers we visited reported that the migrant referral system was not used or had limited effectiveness. In one region, all five upstream projects complained they were unable to establish contact with the service providers at the migrants' previous abodes, which generally were in the home base. This type of system breakdown results in loss of continuity of care. Another upstream clinic reported that it had only one referral from downstream during the entire 1979 season. When this same clinic referred patients to downstream clinics, the referral documents were sometimes returned with a notation that the downstream clinic was unable to locate the migrants in question. However, these migrants later told the referring clinic that they had returned to the downstream clinic's catchment area.

A referral system was regarded by 47 percent of our questionnaire respondents as marginally important to very unimportant. An HHS task force recently reported that the toll-free number and

personal health cards used to link migrant health care at different centers had worked in certain cases.

There is some evidence that the system is improving. Two clinics reported some improvement in the system but said it previously had not worked. Another upstream clinic improved its own referral system by charting the home base for each migrant, thereby giving the clinic a way to track down home base providers.

CHAPTER 3

ALTERNATIVE PROGRAM STRATEGIES

Legislation authorizing the Migrant Health program expires in September 1981. The administration has proposed consolidating the program into a block grant program that would include CHCs and several other health service delivery programs administered by HHS. In considering the Migrant Health program, the Congress has several alternatives, such as reauthorizing the program as it currently exists, reauthorizing it with changes, or consolidating it with the CHC program or a block of health programs.

If the Congress decides to reauthorize a separate Migrant Health program, improvements will be needed to resolve the problems discussed in chapter 2. If the Congress decides to consolidate the migrant program with the CHC program or with several health programs, as a minimum some monitoring may be necessary to ensure that the special access-to-health-care problems of migrants resulting from their interstate movements are addressed. Following is a discussion of several funding and service delivery alternatives relevant to providing health services to migrants to help overcome their access-to-care problems.

THREE FUNDING ALTERNATIVES

During our review, we considered the following three alternative strategies for consolidating programs for migrants, seasonal farmworkers, and the medically underserved.

1. Eliminate seasonal farmworkers from the Migrant Health program and incorporate them into the CHC program.

2. Discontinue using Migrant Health program funds at consolidated centers and serve all eligible users of CHCs with section 330 funds. Use Migrant Health program funds in those areas without CHCs or for special access-to-care problems migrants face, such as access to in-hospital care.

3. Consolidate the Migrant Health program and the CHC program for the medically underserved.

Option 1 is based on the rationale that seasonal farmworkers are not mobile and could be as effectively served by the CHC program as by migrant health. It recognizes that seasonal farmworkers should be able to qualify for residency-based programs and should be more knowledgeable about health care systems in the area. It would result in a separate program for migrants and, as such, would be a limited consolidation of programs in that funding for seasonals would be combined with CHC program funds.

Option 2 would consolidate program funding to recognize the practicality of integrated service. It avoids attempting to separately control migrant and CHC funds at consolidated centers and eliminates confusion about funding because of program overlaps.

Option 3 would eliminate any further special program efforts directed at migrant or seasonal farmworkers since they apparently have no unique health needs, only access problems.

All of these options have the advantage (to varying degrees) of eliminating unnecessary program distinctions among migrants, seasonal farmworkers, and the medically underserved with similar health needs. They also (to varying degrees) avoid the problems caused by trying to manage separate programs within individual centers.

Each option also has disadvantages. One general drawback noted by a national farmworker association and by BCHS officials is that, without a separate funding source, migrants and seasonal farmworkers may lose their leverage for obtaining services at integrated centers. However, we noted no attempt to discriminate against farmworkers at jointly funded centers. Strengthened administrative controls could achieve the same special interest aims of separate funding.

Participation by farmworkers or persons representing migrant interests on governing boards is one way to help assure that the migrants' concerns are considered. However, interpretations of the required governing board composition varied, and migrants often were not adequately represented. Eighteen percent of the 65 centers required to have governing boards had neither migrant nor seasonal farmworkers represented on the board, according to questionnaire responses.

A drawback of the first option, which attempts only limited program consolidation, is that joint funding and its attendant problems would continue although the farmworker group to be served would be limited to migrants and thus be smaller. If migrants were put under the CHC umbrella (or under a block grant) as the third option suggests, they could lose some unique benefits, such as hospitalization and sanitation programs. Furthermore, some migrant projects are in areas where no section 330 centers have been established and which may not qualify as medically underserved. Complete consolidation would require consideration of how differences between the CHC and migrant programs could be resolved, without eliminating benefits migrants need.

CONSOLIDATION INTO A HEALTH BLOCK GRANT

The President's fiscal year 1982 budget proposes to consolidate the Migrant Health program and several other health service

programs into a block grant to the States. At issue is the ability of general, consolidated health programs to overcome migrants' access-to-health-care needs.

In 1968, when the Congress reconsidered the need for continued migrant health care legislation, the Senate Committee on Labor and Public Welfare anticipated that, at some future time, general health services might be sufficiently available to migrants that a separate migrant health initiative could be increasingly a supplement to other health programs. The number of health programs for which migrants are eligible--such as Medicaid, Maternal and Child Health, Family Planning, and the CHC program--points to increased health care opportunities. However, as we discussed in chapter 2, some efforts--such as Medicaid, Hill-Burton, and the Migrant Health Referral System--have not been consistently successful in serving migrants. The access-to-health-care problem remains.

A health block grant would give States greater flexibility in using funds for health services. States could use this flexibility to expand health services for migrants. States could also use it to avoid or overcome the types of problems discussed in chapter 2 or to develop a variety of approaches for providing health services to migrants.

On the other hand, States could shift funds currently benefiting migrants to other population groups. The incentive for doing this would appear to be greatest in upstream areas, where migrants work for short periods. It was the lack of adequate health services for migrants in many of these areas that initially prompted the Federal Migrant Health program.

Therefore, if the Congress chooses to consolidate the Migrant Health program into a block grant, the migrants may still have access-to-care problems caused by their mobility. This may leave one important question unanswered: Should a provision be incorporated into the block grant legislation that would provide assurance that the migrants' access-to-care needs would receive adequate consideration?

HEALTH SERVICE DELIVERY OPTIONS

Most migrant health funds have, heretofore, been directed to centers and projects. HHS has tested and continued to fund other service delivery options using demonstration projects for (1) hospitalization to provide inpatient hospital services to migrants who have no other means of obtaining hospital care, (2) health care entitlement programs, (3) an assurance program to provide access to services not otherwise available to migrants in low-impact areas, and (4) a migrant referral system. However, HHS has apparently not determined which service delivery approaches

offer the most cost-effective solutions for meeting migrant health care needs. If a separate Migrant Health program is continued, such a determination will be necessary.

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