United States General Accounting Office

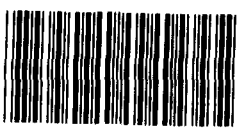
GAO

Fact Sheet for the Chairman, Committee on Labor and Human Resources, U.S. Senate

May 1992

FEDERALLY FUNDED HEALTH SERVICES

Information on Seven Programs Serving Low-Income Women and Children



GAO/HRD-92-73FS

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United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-246782

May 28, 1992

The Honorable Edward M. Kennedy
Chairman, Committee on Labor
and Human Resources
United States Senate

Dear Mr. Chairman:

Improving access to health services for pregnant women and children has been of increasing national, state, and local concern for the last several years. The health care situation for children is particularly troubling. According to recent reports, two-thirds of uninsured pregnant women fail to receive adequate prenatal care; 40 percent of children lack basic childhood vaccinations; 25 percent do not see a physician even once during the course of a year; and 31 percent of children in low-income families lack coverage under either private or public health insurance.

We discussed with your staff the Committee's concern about the many women and children who rely on public programs for health care. In response to your request, this fact sheet provides information on services, eligibility, and program interrelationships for seven programs that fund the delivery of health services to this population. The programs are the Preventive Health and Health Services block grant; Maternal and Child Health block grant; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) portion of Medicaid; Childhood Immunization Program; Childhood Lead Poisoning Prevention; Community Health Centers; and Migrant Health Centers.

Specifically, for these seven programs you asked us to compile information on federal and state responsibilities for administration, funding, target populations, program goals, numbers of people served, and services authorized. This is summarized in table 1 (see p. 2). In addition, you asked us to examine requirements for inter-program coordination and to identify instances in which such coordination did or did not take place. We found requirements were not well-defined. We found instances, however, based on our interpretation of the term coordination, in which coordination takes place and other instances in which it is lacking.

Table 1: Seven Programs: Goals, Administration, Funding, and Target Population

Program and authority	Program goals	Federal administrative agency	State administrative agency	Federal expenditures	Target population	Number served
Community Health Centers Grant (CHC) (section 330, Public Health Service [PHS] Act)	Support development and operation of community health centers, which provide primary health services, supplemental health services, and environmental health services to medically underserved populations	Bureau of Health Care Delivery and Assistance (BHCDA), Health Resources and Services Administration (HRSA)	None: individual grantees selected by BHCDA/ Department of Health and Human Services (HHS)	1990: $446.5 million	Residents of medically underserved areas	1989: 5.35 million (total), 1.78 million children approximately
Migrant Health Centers Grant (MHC) (section 329, PHS Act)	Support development and operation of migrant health centers and projects that provide primary health care services, supplemental health services, and environmental health services that are accessible to migrant and seasonal agricultural farmworkers and their families as they move and work	Bureau of Health Care Delivery and Assistance, HRSA	None: individual grantees selected by BHCDA/HHS	1990: $42.8 million	Migratory and seasonal agricultural workers and their families	1989: 500,000 (total), 166,667 children approximately

(continued)

Program and authority	Program goals	Federal administrative agency	State administrative agency	Federal expenditures	Target population	Number served
Maternal and Child Health Programs (M&CH) (title V, Social Security Act [SSA])	Enable states to maintain and strengthen their leadership in (1) planning, promoting, coordinating, and evaluating health care for mothers and children and (2) providing health services for mothers and children who do not have access to adequate health care	Bureau of Maternal and Child Health, HRSA	Generally, the state health agency	1990: $457.3 million[a]	Mothers and children, especially those with low income or limited access to health services	Not known: most states included in a recent survey had inefficient data collection systems The Omnibus Budget Reconciliation Act of 1989 included provisions to promote greater consistency in reporting
Childhood Lead Poisoning Prevention Program (Lead Contamination Control Act, 1988)	(1) Screen and identify large numbers of infants and young children for lead poisoning; (2) identify the possible sources of lead exposure; (3) monitor medical and environmental management of lead-poisoned children; (4) provide information on childhood lead poisoning, its prevention and management; and (5) encourage community-action programs directed to the goal of eliminating childhood lead poisoning	Centers for Disease Control, (CDC), Public Health Service	Individual grantees selected by CDC	1990: $2.8 million	High-risk children under 6 years of age a	Not known: reports were first required from grantees as of 12/90; according to CDC, these reports were of too poor quality to release; initial reports of adequate quality werenticipated by the end of fiscal year 1991

(continued)

Program and authority	Program goals	Federal administrative agency	State administrative agency	Federal expenditures	Target population	Number served
Childhood Immunization Program (section 317, PHS Act)	Assist states and communities in establishing and maintaining preventive health service programs to immunize children against vaccine-preventable diseases	Centers for Disease Control, PHS	Generally, the state health agency	1990: $156 million	All children	Not known: program does not provide direct services to children
Preventive Health and Health Services Block Grant (PHHS) (title XIX, part A of PHS Act)	Provide states with resources for comprehensive health services, including emergency medical services, health incentive activities, hypertension programs, rodent control, fluoridation programs, health education and risk reduction programs, home health services, services for rape victims, serum cholesterol control, chronic diseases, uterine and breast cancer services, immunization services, and maternal and child health services	Centers for Disease Control, PHS	State determined	1990: $81.3 million	State determined	Not known: during the 1988 reauthorization process, additional reporting requirements were added, including the numbers of persons served; in fiscal year 1990, additional funds were provided for direct operations to improve reporting; CDC is working with the states to meet these requirements

(continued)

Program and authority	Program goals	Federal administrative agency	State administrative agency	Federal expenditures	Target population	Number served
Medicaid/EPSDT (title XIX, SSA)	Provide a comprehensive process through which children are screened for health deficiencies, diagnosed, and then treated to the extent that medically necessary services are covered under Medicaid	Health Care Financing Administration (HCFA)	State determined	1989: $4.3 billion	EPSDT: needy children under 21[b]	1990: 11.5 million eligible, 1.2 million in continuing care

Note: Data are for federal fiscal years, and include most recent information available.

[a]Represents the portion of the block grant allotted among the states; excludes various set-asides.

[b]Children aged 6 months to 5 years whose family income is not above 133 percent of the federal poverty level; children born after September 30, 1983 whose family income is not above 100 percent of the federal poverty level; and children to age 21 whose family income and resources qualify them for federal cash assistance programs such as Aid to Families With Dependent Children (AFDC).

This fact sheet expands on briefings that we gave to your office during 1991: see section 1 on background, section 2 on eligibility and services, and section 3 on program coordination requirements and practices. Appendix I lists the services available under each of the seven programs, and our methodology is described in appendix II.

We carried out our work between March and October 1991 in accordance with generally accepted government auditing standards. We did not obtain written agency comments on this fact sheet, but we did discuss its contents with knowledgeable HHS officials and have incorporated their suggestions as appropriate.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this fact sheet until 30 days from the date of this letter. At that time, we will send copies to the administering federal agencies and other interested parties. If you have any questions, please call me at 512-7118. Other major contributors to the report are listed in appendix III.

Sincerely yours,

Mark V. Nadel

Mark V. Nadel
Associate Director, National and
Public Health Issues

Contents

Figures

Abbreviations

BHCDA	Bureau of Health Care Delivery and Assistance
CDC	Centers for Disease Control
CHC	Community Health Centers Grant
CIP	Childhood Immunization Program
CLPPP	Childhood Lead Poisoning Prevention Program
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
M&CH	Maternal and Child Health Block Grant
MHC	Migrant Health Centers Grant
PHHS	Preventive Health and Health Services Block Grant
PHS	Public Health Service
SSA	Social Security Act
WIC	Women, Infants, and Children Program

Background

Programs and Objectives

All seven programs are authorized to address the health care needs of women, children, or both, but each targets a slightly different population, and the type of services available under each program varies. The programs and their objectives are shown in table 1.1.

Table 1.1: Programs and Objectives

Community Health Centers Grant (CHC)	This program provides preventive and primary health care services and case management of other services to medically underserved populations;[a] each CHC must demonstrate the capability to serve all age groups, and should be able to identify populations in its service area with special health care needs
Migrant Health Centers Grant (MHC)	This program provides preventive and management of other services to migrant and seasonal farmworkers and their families; in defining its appropriate role, each center assesses the needs of its target population
Maternal and Child Health Block Grant (M&CH)	This block grant program seeks to improve the health of mothers and children who do not have access to adequate health care,[b] particularly those from low-income families: direct services include preventive and primary care for children, prenatal care and delivery services, and postpartum care, but this funding also helps to support the state service delivery infrastructure; other services must also be provided for children with special health care needs
Childhood Lead Poisoning Prevention Program (CLPPP)	This program provides states with resources to establish and expand programs to prevent childhood lead poisoning: program activities may include screening for lead poisoning, referral for medical treatment and environmental intervention, follow-up, and education about lead poisoning
Childhood Immunization Program (CIP)	This program provides states with resources to establish and maintain programs to immunize children against vaccine-preventable diseases; CIP funds may be used for the planning and implementation of immunization programs, for vaccine purchase, and for assessment of immunization status

(continued)

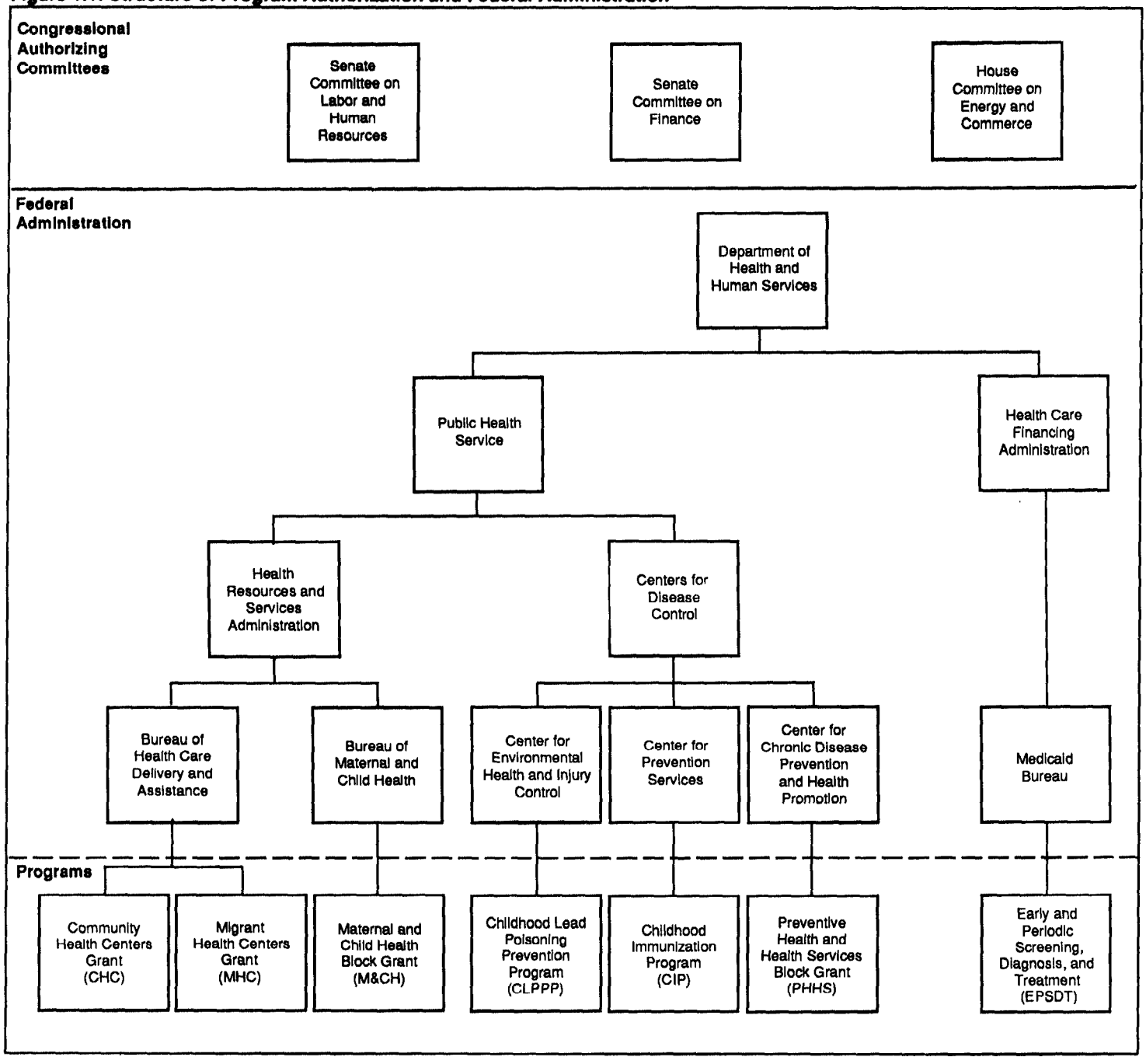
Preventive Health and Health Services Block Grant (PHHS)	This block grant program provides states with resources for comprehensive preventive health services
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	This program seeks to diagnose physical and mental problems in low-income children and to provide treatment to correct any conditions found

[a]Medically underserved populations are designated by the Department of Health and Human Services (HHS) according to the percentage of population with income below the poverty level, percentage of population 65 years of age and over, infant mortality rate, and physicians per 1,000 population.

[b]The Maternal and Child Health Block Grant provides both grants to states and funding for set-aside programs. In this fact sheet, we are reporting only on the grants to states.

The seven programs are administered by different organizational units within the U.S. Department of Health and Human Services (HHS). The congressional committees and HHS components that authorize and administer the programs are shown in figure 1.1 (see p. 12). Various other committees also share responsibility for funding or for other considerations. Administrative responsibility for the programs is discussed in section 3.

Figure 1.1: Structure of Program Authorization and Federal Administration



Funding Characteristics

Funding for the seven programs varies in three ways: amount, method of distribution, and flexibility in use of funds. Funding distribution and flexibility are both influenced by program type.

Program Type Affects Both Distribution and Flexibility of Funds

The seven programs may be categorized as block grants, project (discretionary) grants, or entitlement programs.

- Maternal and Child Health (M&CH) and Preventive Health and Health Services (PHHS) are block grant programs; under these programs, federal funds are allotted to state agencies in accordance with a prescribed distribution formula and may be passed on to local agencies. The PHHS program does not require a state match for federal funds, but states receiving M&CH funds must contribute $3 for every $4 in federal funds that they receive. Block grants were designed to fund activities of a continuing nature that are not confined to a specific project. States receiving these grants may fund programs, within general functional areas, addressing the needs of their citizens.
- The Childhood Immunization Program (CIP), Childhood Lead Poisoning Prevention Program (CLPPP), Community Health Centers (CHC) and Migrant Health Centers (MHC) programs are called project (discretionary) programs. Applications for funding are submitted to the appropriate federal administrative body. Funding is established for a fixed period of time, and is intended for use on a specific project or for the delivery of specific services or products. None of the four project programs requires state matching of federal funds.
- The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program is part of Medicaid, an entitlement program, under which benefits are provided to all who qualify. Those who meet the categorical,[1] income, and resource criteria are entitled to medically necessary services, which may be rendered by any participating provider, but must be covered under the state Medicaid plan.

The EPSDT program consists of a set of services that must be provided, as necessary, to participating Medicaid-eligible children up to the age of 21; unlike regular Medicaid services, services needed by EPSDT-participating children are not necessarily limited to those usually covered under the

[1]Eligibility for Medicaid has historically been linked to participation in cash assistance programs such as Aid to Families With Dependent Children (AFDC). Thus, applicants for Medicaid have had to meet welfare program requirements, such as membership in a family with dependent children (a categorical requirement), in addition to income and resource requirements. Recent changes in the Medicaid program have extended eligibility to certain groups of pregnant women, as well as their children, who meet resource and income requirements, regardless of participation in cash assistance programs or family composition.

state plan for other Medicaid participants.[2] In addition to financing services, states are required to facilitate successful participation through outreach activities. States are entitled to federal matching funds for outlays on covered services.

The seven programs provide funding to three different types of grantees. The grantee may be a state, as is the case for the block grants; a local government, as is the case for CLPPP; or a nonprofit organization, permitted for CHC and MHC. See figure 1.2 for a list of eligible grant applicants for the seven programs.

Figure 1.2: Eligible Applicants by Program

Program	State government	Local government	Nonprofit organization
CHC	◒[a]	◒[a]	●
MHC	◒[a]	◒[a]	●
M&CH	●		
CLPPP	●[b]	◒[c]	
CIP	●[d]	●[d]	
PHHS	●[b]		
EPSDT[e]	●		

● Eligible applicant.

◒ Eligible applicant, with restrictions. For example, see footnotes a and e.

[a]Although public organizations may apply for CHC and MHC funding, legislation significantly limits the amount of funding awarded to public entities (for example, state and local governments).

[b]Federally recognized Indian tribal governments may apply.

[c]Local government agencies serving jurisdictional populations greater than 500,000 may apply.

[d]Other public entities may apply.

[e]As part of Medicaid, EPSDT is an entitlement program. All states that participate in the Medicaid program are required to provide EPSDT services.

[2]The states are required to provide any service, which they are permitted to cover under Medicaid, necessary to address conditions or problems discovered during EPSDT screenings, regardless of whether that service is otherwise included in the state Medicaid plan.

Funding Varies by Program

Annual funding for the seven programs ranges from $4.3 billion for EPSDT to $2.8 million for CLPPP (see table 1.2).

Table 1.2: Federal Program Expenditures (Fiscal Year 1990)

Dollars in thousands

Program	California	Massachusetts	North Carolina	United States[a]	Percentage of U.S. total expenditures on seven programs
CHC	$34,042	$ 8,511	$12,731	$ 446,533	8.11
MHC	5,999	139	1,958	42,772	0.78
M&CH[b]	28,775	10,429	15,044	457,282	8.30
CLPPP	0	450	0	2,840	0.05
CIP	18,508	4,015	3,347	155,971	2.83
PHHS	5,951	2,408	2,407	81,258	1.48
EPSDT[c]	96,218	17,948	8,531	4,320,128	78.45
				$5,506,784	

Note: EPSDT data are expenditures; CLPPP data are award amounts; and all other program data are obligations.

[a]The data for the United States include the 50 states and the District of Columbia.

[b]The data represent the portion of the block grant allotted among the states, and exclude various program set-asides.

[c]Data are for fiscal year 1989, the most recent year for which they are available. The Medicaid program (including EPSDT) is financed jointly with federal and state funds. Data cited here are for federal expenditures only, as reported by the states to the Health Care Financing Administration (HCFA). HCFA officials cautioned that the quality of EPSDT expenditure data is poor.

For the three states to which site visits were made—California, Massachusetts, and North Carolina—the same three programs received the highest level of funding: EPSDT, CHC, and M&CH. This pattern is consistent with the average funding in the 50 states and the District of Columbia for the seven programs.

The relative funding per program, however, varied by state. For example, in California, EPSDT expenditures were much higher than funding for any of the other programs; in North Carolina, EPSDT expenditures were lower than funding for the CHC program and the M&CH program. However, states vary in the extent to which they differentiate EPSDT expenditures from other Medicaid expenditures.

Eligibility and Services

Program Eligibility

The seven programs target different groups, but the populations served have considerable overlap. For example, three programs serve children only:

- CIP targets all children, without specifying age. However, there may be implicit age restrictions based on generally accepted immunization schedules.
- EPSDT targets low-income children to the age of 21.
- CLPPP targets infants and children—from 6 months of age to 5 years—who are at risk for lead poisoning.

Four programs serve both children and adults: CHC, MHC, M&CH, and PHHS.

Eligible participants for each program are shown in figure 2.1.

Figure 2.1: Program Coverage by Age

	Children			Women aged 21+			Men aged 21+
Program	0-1	2-6	7-20	Pregnant	Children	No children	
CHC	●	●	●	●	●	●	●
MHC	●	●	●	●	●	●	●
M&CH[a]	●	●	●[b]	●	●	●	
CLPPP	●	●					
CIP	●	●	●				
PHHS[c]	●	●	●	●	●	●	●
EPSDT[a]	●	●	●				

[a]May be income-dependent.

[b]State-determined upper age limit.

[c]State determined.

Services Authorized

The services authorized under the seven programs may be designated as optional or mandatory. Some programs prohibit use of funds for specific services. In addition, some programs designate a certain percentage of funds to be spent on particular services (see fig. 2.2).

Figure 2.2: Restrictions on Services

	Mandatory services		Prohibited services	
Program	None	Some	None	Some
CHC		●	●	
MHC		●	●	
M&CH		●[a]		●
CLPPP	●[b]			●
CIP	●[b]		●	
PHHS		●		●
EPSDT		●[a]	●	

[a]For M&CH and PHHS, a minimum amount or percentage of funds must be allocated to specific categories of care. M&CH grantees must allocate (1)at least 30 percent of the grant amount for preventive and primary care services to children and (2)an additional 30 percent for services to children with special health care needs. PHHS recipients must reserve a portion of grant funds for the provision of services to the victims of sex offenses and for related services.

[b]The authorizing legislation for these programs does not designate specific mandatory services. However, CLPPP recipients are restricted to screening, referral, and education services. CIP recipients are similarly restricted to a few services designated to promote childhood immunization.

The services authorized under each program are not necessarily the services available to the targeted populations. The extent to which services are available depends on several factors in addition to what is authorized, for example:

- Resource limitations may result in fewer services than those authorized being made available.
- When services are authorized as optional—for example, hospital services for community health centers and migrant health centers—they may not be available.
- Services authorized for the block grants, M&CH and PHHS, may not be available because of the great latitude provided to grantees. The grantees may choose the services that will be provided with these funds, so services provided by one grantee may not be provided by another.

For example, a 1989 survey of local health departments, the primary provider for many of the underinsured and uninsured, indicates that certain services may be available in only limited locations. The survey found, for example, that only 38 percent of local health departments are "active in" dental care; 60 percent, in family planning; 59 percent, in prenatal care; and 20 percent, in obstetrical care.[1] In Pennsylvania, an advocate group is suing the state, charging that it has enrolled less than 25 percent of eligible children in the EPSDT program; the group claims that program participation rates are uniformly low across the United States. A 1991 GAO report found that access to health services for pregnant women was also affected by factors such as awareness of the need for care, its availability, and ready access to provider sites.[2]

Because all the programs serve the health care needs, to some degree, of low-income women or children or both, the potential for overlap exists; similar services may be available to the same population through more than one of the seven programs, for example:

- Children may benefit from various immunization supplies and services funded under CHC, MHC, M&CH, CIP, PHHS, or EPSDT.
- Pregnant women may receive prenatal care through CHC, MHC, or M&CH.

In practice, however, duplication of services may be limited by budgetary constraints and, in some instances, by coordination between providers.

All seven programs permit the use of program funds for specific services that are not expressly health care services, for example:

- Transportation assistance for the purpose of receiving medical care is a reimbursable service under EPSDT.
- Each state receiving M&CH funds must provide for the operation of a toll-free telephone number, which gives information about provider availability.

[1]National Profile of Local Health Departments, National Association of County Health Officials (July 1990). The survey authors note that standard definitions for these services were not provided; the interpretation was left to the respondent. Similarly, the local health departments were asked whether or not they were "active in" the listed functions and services, but no definition was provided for the term "active in."

[2]Medicaid Expansions: Coverage Improves but State Fiscal Problems Jeopardize Continued Progress (GAO/HRD-91-78, June 1991).

A list of the services permitted under each program, as described in the authorizing legislation, has been included as appendix I. In some cases, the legislation specifically defines the services that may be provided; in other cases, the services are stated in broad language rather than specific, standard medical terms.

health services. In addition, Medicaid plans must provide for the entry of the state agency responsible for EPSDT into agreements with any agency, institution, or organization receiving payments under M&CH.

- Under CLPPP, as a prerequisite for receiving a grant, federal law requires grant recipients to coordinate with state activities funded under Medicaid or M&CH.
- Under M&CH, the federal administrators are required to promote coordination with administrators of other health block grants and categorical health programs, such as immunizations, and especially with EPSDT. State agencies that administer M&CH also are required to participate in the coordination of activities with related federal grant programs.
- Under CIP, federal guidelines require grantees to maintain close liaison specifically with EPSDT, but also with other federal, state, and local health programs.

Program Coordination

As noted above, there is no consensus across the seven programs regarding the nature or the purpose of coordination efforts. Regulations for the M&CH program say that coordination with EPSDT is necessary "to ensure there is no duplication of effort." EPSDT regulations call for cooperative agreements between state agencies to seek "maximum utilization of health services."

In the absence of a legislative or regulatory definition, we interpreted coordination to include any formal or informal interaction between agencies or individuals involved in any way with the seven programs or with the delivery of services funded by the programs. We sought evidence that such activities were taking place, and found varying degrees of federal, state and local coordination among the programs.

Federal Coordination

On the basis of information that the agencies responsible for the seven programs provided to us, we found three arrangements that could help to enhance coordination among the programs:

- Two federal agencies (HHS and the Department of Housing and Urban Development) agreed to promote cooperation and coordination among state and local providers of federal program services, including health services, to help low-income families.
- BHCDA, which administers both CHC and MHC, entered into an agreement with the Bureau of Health Professions (which, like BHCDA, is part of the

Health Resources and Services Administration [HRSA].)[1] The agreement sought to improve the coordination of federal and state resources, particularly concerning the supply of primary care physicians for community and migrant health centers.

- The Health Care Financing Administration (HCFA) and BHCDA entered into an interagency agreement,[2] approving Medicaid reimbursement for medical services provided by community or migrant health centers or similar facilities.

Several interagency task forces include some representatives from the seven programs, for example:

- All agencies within HHS, as well as the Department of Agriculture's Women, Infants, and Children Program (WIC), are represented on the Interagency Committee on Infant Mortality. Its Workgroup on Access and Service Integration looks for ways to coordinate HHS services to pregnant women and infants, including those served by M&CH, CHC, MHC and Medicaid/EPSDT.
- There is an Interagency Committee on Immunization—which includes policy-level representation from a variety of Public Health Service (PHS) agencies and offices, as well as other HHS agencies—charged with designing a plan to improve access to immunization services through improved coordination of federal health and related programs. Of immediate relevance to our study is the participation of program representatives from the Centers for Disease Control (CDC), HRSA, and HCFA.
- HCFA works with a Medicaid Maternal and Child Health Technical Advisory Group composed of state Medicaid and M&CH directors. The group's focus is on the process of federal and state collaboration between these two programs.

In addition, there has been collaboration between some programs on nonservice functions. The Omnibus Budget Reconciliation Act of 1989 required HHS (in consultation with the Secretary of Agriculture) to develop, publish, and disseminate a model application form for use in enrolling a pregnant woman or child under the age of 6 for a number of maternal and child assistance programs. These included four programs in our study: Medicaid, M&CH, CHC, and MHC.[3] A Federal Interagency Work Group was

[1]The programs of the Bureau of Health Professions support efforts to ensure minorities and the disadvantaged equal access to health services and health careers.

[2]This was characterized as an interagency agreement by HHS, even though both HCFA and BHCDA are part of HHS.

[3]The others were Health Care for the Homeless, Head Start, and WIC.

established for this purpose, composed of representatives of the responsible agencies and of the Association of Maternal and Child Health Programs. The resulting model application form was published in December 1991.

CIP and PHHS staffs at CDC collaborated on creating a standardized form so that states could report their activities relating to prevention and control of vaccine-preventable diseases. Similarly, PHHS collaborated with federal M&CH staff at HRSA to create a standardized form so that states could report the incidence of infant mortality and adolescent pregnancy.

Federal agencies have also made arrangements to facilitate coordination among state agencies. For example, BHCDA supports cooperative agreements with entities of state governments in 48 states, focusing on primary care for the medically indigent. These entities are expected to plan for primary care services, prevent overlap and duplication, promote coordination, and assist community-based providers of care to underserved populations.

State and Local Coordination

The extent of state and local coordination is unclear. In Pennsylvania, advocates have brought suit in U.S. District Court, alleging that the coordination required under EPSDT regulations is lacking.[4] The complaint also cites "extensive experiences in many places across the country," however, where "thoughtful and real interagency cooperation" does occur. An example of close inter-program coordination is the use of M&CH or CHC funds to pay for the administration of vaccines provided under CIP.

In the three states we visited, we found instances of coordination involving state and local administrators and service providers. Coordination at these locations was absent, however, for the most part, between two major sources of care for the low-income population—community health centers and local health departments. A 1989 nationwide survey of 130 "pairs" of local health departments and community or migrant health centers with overlapping service areas found that 28 percent of the pairs reported a high degree of interaction and 30 percent reported moderate interaction.[5] Almost half the centers reported collaborating with the local health departments on prenatal care. The

[4]Scott v. Snider, No.91-CV-7080, Eastern Division, Pennsylvania. As of January 1992, no date had been set for the court hearing.

[5]National Association of County Health Officials, Report on the Nature and Level of Linkages Between Local Health Departments and Community and Migrant Health Centers (Washington D.C., Dec. 1990).

extent of such coordination reported by the local health departments was somewhat lower.

Responsibilities for the Seven Programs Are Vested in Many Institutions

There are so many institutions and other entities involved in legislation and oversight, program administration, and service delivery that coordination is complex and difficult. Three congressional committees authorize the seven programs. Others provide funding or share overlapping concerns. Six units within HHS share in federal administration. (See fig. 1.1 on p. 12). For state and local administration, the identity and number of institutions involved, as well as their relationships, vary from location to location.

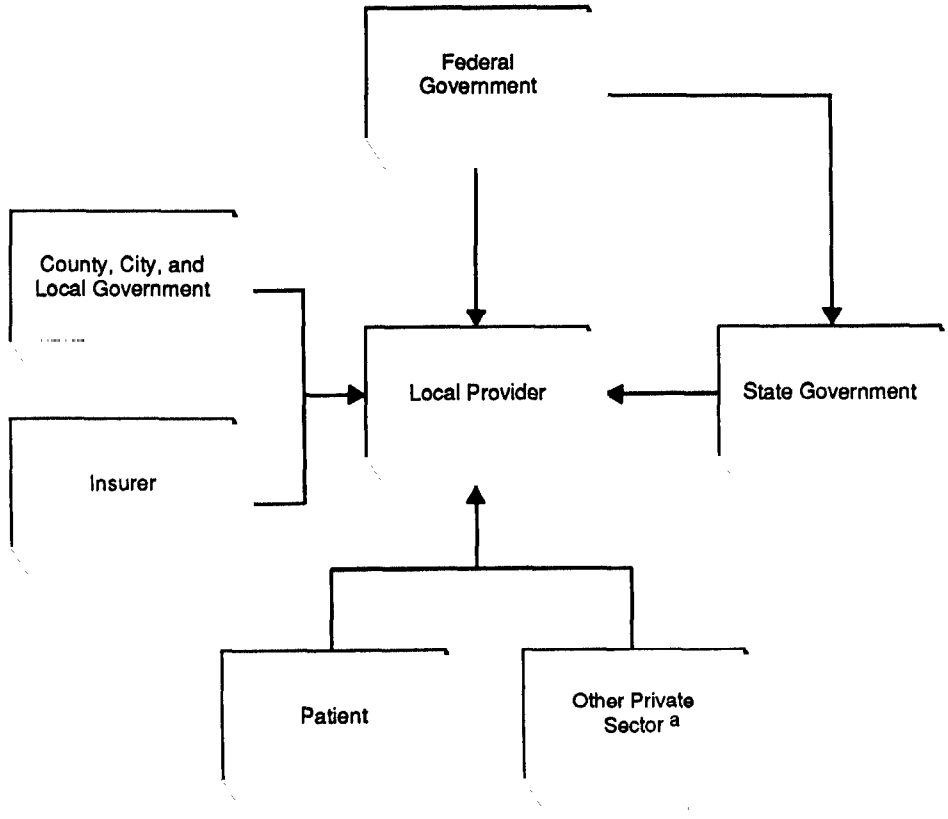
- The 10 HHS regional offices distributed across the country are involved to varying degrees in program monitoring.
- Except for CHC and MHC, administrative responsibilities below the federal level generally fall to two or more agencies in each state. For each site visited, multiple units in two departments were directly involved in program administration.
- Locally, many individuals and institutions are responsible for the delivery of services and, thus, have a potential interest in service coordination. The low-income population makes heavy use of local health clinics or, where they exist, community or migrant health centers. Hospitals and private physicians also directly provide health care and may participate in coordination activities. The same applies, although more peripherally, to organizations such as the Area Health Education Centers, for example, which primarily contribute by fostering the supply of health professionals available to serve in rural areas.[6]

Some program funds—those for community and migrant health centers—are awarded directly to grantees who provide or contract for service delivery. For the most part, these funds bypass the state governmental structure because grantees are primarily private nonprofit agencies. These grantees are responsible for planning and executing the delivery of health services and for administering grant funds responsibly, sometimes with technical assistance or other support from state or regional primary care associations or entities within the state government that have cooperative agreements with BHCDA. In North Carolina, for example, a small state agency (the Office of Rural Health) provides such assistance, but is not involved in program administration.

[6]They may also provide some care, though not funded under these seven programs.

Locally, financing from one or more of the seven programs may be comingled with that from other federal sources, state and local governments, and the private sector (see fig. 3.2). Typically, federal financing for these programs (excluding Medicaid) constitutes a small, largely indistinguishable portion of the provider's total service budget.[7]

Figure 3.2: Multiplicity of Funding Sources



[a]For example, the U.S. Conference of Mayors, the March of Dimes, and other foundations.

[7]For example, at one local health department in North Carolina, total state funding including federal pass-through money under these programs amounted to only 17 percent of the local health department's annual budget (excluding Medicaid). County funds accounted for a further 51 percent. The remainder was made up of other federal funds—primarily Medicare—and private pay (insurance and out-of-pocket). Despite this, the categorical nature of funding is preserved, the county health director said, and alternative sources embodying greater flexibility are used in a supplementary role.

Health Care Services Authorized for Seven Programs

I. Community Health Centers (CHC)

Primary Health Services

Physician services
Services of physician assistants and nurse clinicians
Diagnostic laboratory and radiologic services
Preventive health services, including
- Eye exams and vision screening for children
- Ear exams and hearing screening for children
- Perinatal services
- Well-child services
- Family planning

Emergency medical services
Transportation services as required for adequate patient care
Preventive dental services
Pharmaceutical services as appropriate

Supplemental Health Services

Hospital services
Home health services
Extended care facility services
Rehabilitative services, including
- Physical therapy

Long-term physical medicine
Mental health services
Dental services
Vision services
Allied health services

Therapeutic radiologic services
Public health services, including
- Counseling
- Referral for assistance
- Follow-up services

Ambulatory surgical services
Health education, including
- Nutrition education

Other services appropriate to meet the health needs of the population served

Referral to Providers of Supplemental Health Services and Payment for Their Provision of Services

Environmental Health Services, including

Detection and alleviation of unhealthful conditions associated with

Water supply
Sewage treatment
Solid waste disposal

Rodent and parasitic infestation
Field sanitation
Housing

Information on the Availability and Proper Use of Health Services, including

Translation services

Patient Case Management Services, including

Outreach
Counseling

Referral
Follow-up services

Note: All primary health services are required, as are patient case management services and information on the availability and use of health services, including translation services. All other services are supplemental, and should be provided as appropriate.

II. Migrant Health Centers (MHC)

Primary Health Services

Physician services
Services of physician assistants and nurse clinicians
Diagnostic laboratory and radiologic services
Preventive health services, including
- Eye and vision exams for children
- Ear and hearing exams for children
- Perinatal services
- Well-child services
- Family planning

Emergency medical services
Transportation services as required for adequate patient care
Preventive dental services
Pharmaceutical services as appropriate

Supplemental Health Services

Hospital services
Home health services
Extended care facility services
Rehabilitative services, including
- Physical therapy

Long-term physical medicine
Mental health services
Dental services
Vision services
Allied health services
Therapeutic radiologic services
Public health services, including
- Counseling
- Referral for assistance
- Follow-up services

Ambulatory surgical services
Health education, including
- Nutrition education

Other services appropriate to meet the health needs of the population served

Referral to Providers of Supplemental Health Services and Payment for Their Provision of Services

Environmental Health Services, including

Detection and alleviation of unhealthful conditions associated with

Water supply
Sewage treatment
Solid waste disposal
Rodent and parasitic infestation
Field sanitation
Housing

Infectious and Parasitic Disease Screening and Control

Accident Prevention Programs, including

Prevention of excessive pesticide exposure

Information on Availability and Proper Use of Health Centers and Services to Facilitate Optimum Use of Health Services, including

Translation services

atient Case Management Services, including

each
seling
Referral
Follow-up services

ll primary health services are required, as are patient case management services and information on the availability and alth services, including translation services. All other services are supplemental, and should be provided as

III. Maternal and Child Health Block Grant (M&CH)

Maternal and child health services for mothers and children

Immunizations

Health assessments

Diagnostic services

Treatment services

Preventive and primary care for low-income children[1]

Prenatal care, delivery, and postpartum care for low-income, at-risk pregnant women

Rehabilitative services for certain categories of children under 16 who are disabled

Provision and promotion of family-centered, community-based, coordinated care for children with special health care needs, including
- Care coordination services

Health services and related activities, including
- Planning
- Administration
- Education
- Evaluation
- Expenses for national health service corps personnel

Toll-free telephone number for information about providers

[1]Agency officials noted that adolescents are permitted to receive these services.

Notes: (1)The M&CH block grant funds various set-asides in addition to the grants to states. The services listed above are those authorized to be provided with the funding allotted to the states. Different services are authorized for the set-aside programs. (2)Recipient states must use at least 30 percent of the grant amount for child preventive and primary care services and at least 30 percent of the grant amount for services to children with special health care needs. Furthermore, all recipient states must use M&CH funding to provide for the operation of a toll-free telephone number for parents to access information about provider availability. States are not permitted to use more than 10 percent of their allotment for administration. (3)Block grant funds may not be used for the provision of inpatient services, except to children with special health care needs, high-risk pregnant women and infants, or as approved by the Secretary of Health and Human Services (HHS).

IV. Childhood Lead Poisoning Prevention Program (CLPPP)

Initiation and expansion of community childhood lead poisoning prevention programs, which will

Educate the following groups about childhood lead poisoning
- Parents
- Educators
- Local health officials

Screen infants and children for elevated blood lead levels
Refer for medical treatment and environmental intervention

Note: Grant awards may not be expended for medical care and treatment or for environmental remediation of lead sources. However, there must be an acceptable plan to ensure that these program activities are appropriately carried out.

V. Childhood Immunization Program (CIP)

Establishment and maintenance of immunization programs

Research into the prevention and control of diseases that may be prevented through vaccination

Demonstration projects for the prevention and control of such diseases

Public information and education programs for the prevention and control of such diseases

Education, training, and clinical skills improvement activities in the prevention and control of such diseases for health professionals (including allied health personnel)

Vaccine may be provided in lieu of cash

Note: Grants for research, demonstration projects, public information and education programs, and education, training, and clinical skills improvement activities must be limited to 10 percent of the total amount appropriated for any fiscal year.

VI. Preventive Health and Health Services Block Grant (PHHS)

Preventive Health Service Programs

Rodent control
Chronic disease reduction
Community-based and school-based fluoridation
Hypertension prevention/detection/referral
Cholesterol prevention/detection/referral
Uterine cancer prevention/detection/referral
Breast cancer prevention/detection/referral
Community-based demonstration programs
Risk reduction/health education
Deterrence of smoking and use of alcoholic beverages by children and adolescents

Comprehensive Public Health Services

Immunizations

Establishment of Home Health Agencies (no provision of services)

Emergency Medical Systems Services

Feasibility studies and planning
Establishment
Expansion and improvement (not operation of system)

Sex Offense Victim Services and Prevention

Notes: (1)Grant funds may be used for related planning, administrative, and educational activities; however, not more than 10 percent of the funds allocated may be used for administrative costs. (2)A portion of the funds granted to each state is reserved for the provision of services for sex offense victims. (3)Inpatient services may not be provided with PHHS grant funds.

VII. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

Outreach to EPSDT-Eligible Individuals or Their Families

Medical Screening, including

Mental health
- History
- Assessment

Physical health
- History
- Assessment

Comprehensive unclothed physical exam
Immunizations, as appropriate
Laboratory tests, including
- Blood lead level assessment

Health education, including
- Anticipatory guidance

Vision services, including
- Diagnosis and treatment for defects in vision, including
- Eyeglasses

Hearing services, including
- Diagnosis and treatment for defects in hearing, including
- Hearing aids

Dental Services, including

Relief of pain and infection
Restoration of teeth
Maintenance of dental health

Other, such as

Diagnostic services

Treatment (or Referral) Necessary to Correct or Ameliorate All Defects/Illnesses/Conditions Discovered by Screening

Note: Medical, dental, hearing and vision screening, and services shall be provided as medically necessary, as well as at reasonable intervals.

Note: The legislation for all 7 programs describes authorized services as (1) service categories that may be supported with program funding and (2) specific services that should be included in each category. The service categories and the specific services are listed here just as they are in the legislation. We have interpreted the lists of services to be exhaustive unless the word "including" precedes the list. In that case, it is our interpretation that additional services, beyond those specifically mentioned in the legislation, may be supported with program funding.

Source: Title 42, United States Code Annotated (1991), The Public Health and Welfare.

Scope and Methodology

Because the time for data gathering was limited, we elected to focus on information available at the national level, as well as three localities selected to provide as much geographic and demographic diversity as possible in so small a sample.

Our methodology included the following five steps: (1) We obtained program specifics from the cognizant executive agencies and bureaus. (2) We consulted a medical expert to assist in our interpretations of terminology employed in federal authorizing legislation and regulations. (3) We conducted an extensive literature review of program interrelationships throughout the human services area. (4) We interviewed federal agency officials and representatives of national associations and interest groups to obtain relevant documents and ascertain their perceptions regarding program interrelationships. (5) In order to obtain information on state and local administration of the programs and their interrelationships at state and local levels, for our target localities —Asheville (N.C.), Boston, and Los Angeles—we visited officials and service providers in North Carolina, Massachusetts, and California.

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