Rural Health Care State Programs:

✓ Long-Term Care
✓ Physician Recruitment and Retention
✓ Rural Emergency Medical Services
✓ Migrant Farm Workers

A Selection of Papers by

Southern Rural Development Center
Rural Health Task Force

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Declining population, poor economic conditions, greater numbers of elderly and changes in the Medicare reimbursement policy have and are forcing changes in the rural health care delivery system. Changes range from closing a facility to creating an alternative delivery system. A staff report of the United State Senate Special Committee on Aging regarding rural health care reported in 1986 and 1987, rural hospital closures exceed urban closures, and estimated that as many as 600 rural hospitals face the prospect of closure in the next few years. From 1980 to 1988, 408 U.S. hospitals closed, and half of them were in rural areas. The prediction that 600 rural hospitals face closure possibilities appears to be coming true. Health Care Investment Analysts, Inc. (HCIA) analyses historical, financial and utilization data for most U.S. hospitals. In their analyses, HCIA defines a distressed hospital as one that has experienced substantial changes in utilization, paper mix, profitability, capital structures, and/or liquidity. These analyses are published quarterly. For the U.S. the number of distressed hospitals was 538 in July 1990 and increased to 918 by January 1991. The South appears hardest hit as the states with the highest number of distressed hospitals were Florida, Texas, and Oklahoma.

The dramatic changes and conditions in rural hospitals is and will have dramatic impacts on other health services. The subject of physician recruitment and retention will become increasingly important as hospital and community leaders seek to provide physician services to remain viable. Emergency medical services are extremely important under the current scenario. If hospitals close, the transportation element becomes even more critical. Health care needs of migrant farm workers is a serious problem and needs national and state attention.

Leadership in the Southern Rural Development Center (SRDC), having foresight of the emergency health issues, created a task force to address the problem. The SRDC not only supported the travel of the task force members but also was responsible for the publication of this document. A special thanks goes to H. Doss Brodax, director of SRDC for funding the project and to Bonnie Teater, Jacqueline Tisdale and Sandy Payne for preparation and publication of the document.

The task force identified projects which they worked to accomplish. These included:

1. create a booklet on rural health options for County Agents;
2. conduct a symposium on rural health issues at the Southern Rural Sociology Association and Southern Agricultural Economics Association meetings; and
3. create a publication which summarizes the actions that states have taken to address selected health issues.

This publication is a result of the last project which involved selected task force members writing chapters on specific rural health areas. Each author did a national search in an effort to find out what states were doing relative to legislature and assistance. The topics presented included long-term care, physician recruitment and retention, emergency medical services, and migrant farm workers.

The purpose of this publication is to share the innovative ideas with other states. It is hoped through ideas which have been successful in other states, insight can be gained and other states may better assist in delivering rural health care.

Endnotes


Long-Term Care: State Priority Issues and Rural Initiatives

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Introduction

The lack of a coordinated long-term care system continues to be the number one shortcoming in the health and social services systems (AARP, 1990). The long-term care aim is to equip the individual client with options among a spectrum of services, used individually or in partnership, that will diminish the limitations of severe illness, bolster as autonomous a life-style as is feasible, and halt additional difficulties of protracted health conditions (Koff, 1982). Such services may be progressively or sporadically needed, and include "medical and mental health care, nursing care, rehabilitative therapy, personal-care services and social services" (Daniels, 1988, p. 103). Long-term care services also sustain, rectify, or offset losses of natural functioning, and may be institutional or home-based. Hence, long-term care includes a range of personal, social and medical care services primarily designed to address the needs of chronically ill and disabled people of all ages.

Older people, however, represent about two thirds of the individuals who require long-term care (AARP, 1990). Thus, the aging of the population will force critical issues regarding our long-term care system. In fact, society will have to bolster its output of long-term-care-services from a contemporary approximate "base of 6.9 million daily units of long-term-care-services to 19.8 million units in 2040" (Daniels, 1988, p. 104). The challenge will not be that of just enhancing a premier of satisfactory delivery system but one of structuring a doable and sufficient system to manage existing and impending needs (Daniels, 1988). In this regard, Daniels (1988) notes that our moral clarity and political will to meet current long-term care needs is bereft and appalling. Because of this dearth in our commitment, the aging of society will eventually have to "push us into crisis" before we respond to the neglect of the long-term care system. Unfortunately, long-term care issues will dominate health and social policy and polarize society for the next 20 to 30 years (Daniels, 1988: Vogel & Palmer, 1982).

Rural areas have been unduly besieged with such concerns. In general, more poor people live in rural areas and these persons are more likely to be elderly (Shortland, 1986). When compared to urban areas, rural areas are marked by more deprivation, less acceptable housing and transportation, and lack a convenient and accessible spectrum of human services, thereby creating an abundance of unmet needs among all ages. The intent of this paper is to target current state long-term care priorities and initiatives in the reforming long-term care system, especially in rural areas.

Components of Long-Term Care

Functioning is the key indicator to long-term care. An emphasis on the concept of functioning reveals the progression of chronic disease or ill health, rather than underscoring of the disease itself (Kane and Kane, 1987). In short, the functionally impaired individual requires income, housing, health care, recreation and other human and social services. In fact, one of the most formidable challenges in long-term care is the translation of functional impairments and support needs into guidelines for discrete packages of services (Kane & Kane, 1987). In other words, it is the assumption of planners and policy makers that the functional disorder of an individual can be reshaped into a set of services analogous to the problems denoted. Various elements, however, circumvent the translation of such needs into viable service prescriptions, particularly since a good taxonomy of services and the technology
to translate these needs into services are unfortunately inadequate. Additionally, the goal for functioning (e.g., correction or prevention of functional disability), mix of services and service providers, duration and intensity (e.g., lifetime monitoring or intermittent services), and the nature of public sector involvement all contribute the amorphous framework and diversity of the long-term care system.

Long-term care, therefore, requires a diverse set of social, health, and personal care services. It is actually a hybrid of the human services system, that is, part health and part social service (Kane & Kane, 1987). Long-term care services, particularly regarding the elderly, can be divided into six service components (Laurie, 1987; Kane & Kane, 1987):

1. **Home help** (which includes personal care, checking, homemaker, administrative and legal, meal preparation, and continuous supervision).

2. **Medical help** (includes medical care, psychotropic drugs, supportive devices, nursing care, physical therapy, and mental health).

3. **Financial help** (includes financial, housing, groceries, and food stamps).

4. **Social/Recreational** (includes social/recreational activities).

5. **Assessment and Referral** (includes coordination, information, and referral; overall evaluation, and outreach).

6. **Transportation** (includes all types of transportation support).

Problems in the Long-Term Care Services Delivery System

Of the elderly needing or requiring long-term care women constituted a significant percentage. In fact, data show that approximately 75 percent of nursing home residents are women. Additionally, 66 percent of the six million people residing in the community with some type of functional limitation in activities of daily living are women (AARP, 1990). Thus, long-term care is fast becoming a problem for women.

The rapid increase in noninstitutional care and services has also posed problems for long-term care policymakers. Applebaum and Phillips (1990) have noted that there are six critical factors that "complicate efforts to assure quality including client and provider characteristics, fiscal constraints, inadequate regulation, lack of quality assurance methods, and lack of a coherent social policy for long-term care" (p.444). Federal programs that finance long-term care health and social services system include, Medicare, Medicaid, the Department of Veterans Affairs, the Social Services Block Grant Program and Title III of the Older Americans Act (AARP, 1990). The Social Services Block Grant Program and Title III of the Older American Act provided a small amount of the funds for home and community care services. Other concerns focus on the high cost of financing institutional long-term care. Medicare and private insurance paid about three percent of nursing home costs in 1987 (AARP, 1990). In fact, in 1987 more than fifty percent of such costs were paid by residents or their families, and remainder of costs were paid by Medicaid (42 percent).

Medicaid eligibility varies from state to state, because of this it is a prime contributor to the long-term care system's fragmentation. Moreover, "there is no nationally uniform list of nursing home services covered under Medicaid" resulting in extra charges for "items such as laundry and special menus" (AARP, 1990 p.23). Hence, the financial burden and spend-down under Medicaid has placed an enormous hardship on individuals requiring intensive long-term care services, with the average cost for nursing home care ranging from $25,000 to
$34,000 a year and for in-home care services, ranging from $50 to $200 per day (AARP, 1990). Data also indicate approximately 10 to 18 percent of nursing home residents impoverish themselves, and, therefore, must rely on Medicaid. Even after impoverishment, many middle income elderly may not be able to obtain Medicaid because their incomes may still exceed the allowable standards in 20 states (AARP 1990).

Medicare also contributes to the long-term care system fragmentation. It is chiefly an acute care support system for the elderly and disabled, and covers limited long-term care services (AARP, 1990). The services supported by Medicare are limited to coverage for care in a skilled nursing facility, home health care, and rehabilitative care. These services follow the "medical model" of care, in that, in most cases after confinement in an acute care setting (hospital) benefits can be obtained. Medicare does cover skilled nursing care for up to 100 days per episode providing the beneficiary spends at least three days in the hospital. It also covers home health care for a short period of time, that is, if the beneficiary is homebound and needs skilled care.

Additionally, ironhanded restrictions have been put on the extension of community care under the Medicaid waiver program, specifically home and community-based services. The intent of the waiver programs, which was enacted in 1982, was to give states the power to waive certain Medicaid provisions and to support a range of services, including case management and personal care.

Hence, the failure of federal and state long-term care policies to proffer channels that facilitate the integration of services and coordination of resources have resulted in our failure to provide optimal health, which is the essence of productive life (Ford, 1990).

State Initiatives in Long-Term Care

At one time long-term care services were considered tantamount with nursing home care (Justice, 1986). Medicaid became the prime federal and state funding source, which limited community services options and established an institutional based delivery system. Recently, a remarkable policy revolution has taken place with states moving away from institutional based delivery of long-term care to community based care. The institutional significance, however, of the formal long-term care system is still apparent (Applebaum & Phillips, 1990). For example, estimates of annual nursing home expenses are still 10 times higher than home care expenditures (Crystal et al., 1987). Nevertheless, varying elements have contributed to the states' current shift in policy direction. One factor is the contemporary budgetary environment, which has forced states to examine the complex factors involved in caring for the frail elderly. The structuring of alternatives to institutionalization has become a dominant marshalling call among researchers, policymakers, partitioners, and consumers (Applebaum & Phillips, 1990).

In-home care is fast becoming the cornerstone of the long-term care program (National Conference of State Legislatures, 1991). More than 8.4 billion was spent on home care in 1989, and approximately nine thousand home health agencies are currently operating in the US. Data show that states have shifted to a community care approach to providing long-term care while attempting to control costs and use resources efficiently. States are also placing special emphasis on program coordination (Justice, 1986).

Recent state efforts in organizing community long-term care delivery systems focus on the development of alternatives to institutional care. State priority issues for 1991 include four major areas: in-home care; community-based care; adult day care; and respite care (National Conference of State Legislatures, 1991). Figure 1 depicts the ranking of elderly and long-term care priorities by the states. What is clear is that the majority of the states responding to the survey conducted by the National Conference of State Legislatures (NCSL) (i.e., survey of state legislatures in 49 states, Puerto Rico and the District of Columbia in September 1990) were concerned with the financing and development of alternatives to institutional care. Forty-four percent of the respondents ranked alternatives to institutional care as the number one legislative priority. Long-term care (including funding mechanisms,
community services, and access/availability issues); nursing homes and related services; health insurance, and financial assistance and subsidies all ranked as the number two priority for thirty-seven percent of the states responding to the NCSL survey. The states appear to be concerned with cost controls and quality of care.

Speciality care, which includes such sub-issues as rural health care, mental health care, Alzheimer's disease, and frail elderly, was ranked as the number three priority long-term care issue. It should be noted that only 18 percent of the responding states indicated that rural health was a priority issue within the area of speciality care concerns (Table 1). Legal rights and protection, financial protection, and crime prevention compensation were all ranked as the number four priority issue for the states responding to the NCSL survey of legislatures. The NCSL also noted the top priorities nationally included alternatives to institutional care; long-term care; nursing home and services, and health insurance. Health insurance was considered to be a top national issue. According to NCSL sixty-seven percent of the respondents considered this a top priority issue for 1991 for the states. Long-term care insurance, Medicare/Medicaid coverage, and regulation of Medicare supplement plans will dominate the policy issues for the states.

Regional Issues: A Special Focus on Five States

Five states were singled out for further analysis. These include Alabama, Georgia, Mississippi, Tennessee and Florida, and are located in the geographical area of concern of the Southern Rural Health Task Force. Key long-term care leaders were contacted in each state and asked to identify the top long-term care priority issues for rural areas in their respective states. The predominance of these issues were that long-term care issues primarily affected the elderly and that policy planning was not divided along urban and rural lines. Each respondent forwarded a copy of their aging plan. Alabama was the only exception, in that, the state has recently established an Office of Rural Health. Key rural long-term care issues over the past two years for Alabama includes the following (Alabama Dept. of Public Health, Rural Task Force, 1989):

- Allowing rural hospitals to provide respite care, domiciliary care and transitional care.
- Securing Medicaid reimbursement for hospitals which provide adult day care.
- Changing hospital licensing standards to facilitate alternate uses of hospital beds such as conversion of existing hospital beds to nursing home beds.

The primary rural health care problems in Alabama are reimbursement factors (i.e., changes from the traditional cost-based system to the prospective payment or per diem system according to the third party payer); demographic factors (i.e., outmigration of the younger population to more populated areas); utilization factors (i.e., decline in use of health care services); and insufficient physician supply (Alabama State Health Planning and Development Agency, 1988-91). Because of the rapid increase in nursing home costs, Alabama adopted a restrictive bed need methodology, and a moratorium was placed on additional nursing home beds from 1984 to 1986. Currently, Alabama needs an additional 205 nursing home beds. The state has recently adopted a new long-term care need methodology which focuses on assurance and continued availability, accessibility, and affordability of quality nursing home care (Alabama State Health Planning and Development Agency, 1991).

In Fiscal Year 1990, the average occupancy for the 216 nursing facilities was approximately 96 percent. The planning and development office feels that the 216 facilities are geographically distributed and accessible to the majority of the elderly long-term care population. In fact, every county except one has at least one nursing home. The Alabama State Plan on Aging for Fiscal years 1991-1994 addresses the following service needs: access; community based; housing; legal assistance; advocacy; education and training; in-home care; and long term care and ombudsman. These service needs are consistent to those embraced
by the Older American Act. The Georgia Office of Aging (1991) indicated that a top policy priority is to continue to support the Community Care Services Program (CCSP), which provides a full range of community-based services—a safeguard to unnecessary institutionalization. This key priority is consistent with the Georgia FY 1989-1990 State Plan on Aging objective that is, "to develop and maintain a comprehensive, coordinated service delivery system for older Georgians" (Georgia Office of Aging, 1991). The CCSP includes the following services: assessment, case management, home delivered services, adult day rehabilitation, alternative living services, respite care, homemaker aide, and emergency response services. The various services provided under the CCSP are reimbursed by the Georgia Medicaid program funds coupled with state matching funds through a federal Medicaid waiver for Home and Community-Based Services. Other priorities in Georgia include: installation of a statewide toll-free information line, which includes a voice and telecommunication device for the deaf; reduction of budget requests caused by recent budget reductions, which may impact FY 91 improvement requests such as funding and development of Alzheimer's program in every planning and service area; completion of the computerization of the Title III reporting system; and the reductions in human services because of economic woes (Georgia Dept. of Human Services, Office of Aging, 1990). Additional initiatives being developed or explored by the Georgia Office on Aging are: intergenerational programs; literacy programs; minority issues; programs for the developmental disabled; and multicultural programs.

The Mississippi Council on Aging indicated that the major activities and initiatives for the 1990 Fiscal Year included system improvements in the departmental organizational structure. These improvements included enhancement of the management information system and the development of quality assurance standards for all aging services. Additionally standardized administrative assurance standards were implemented in October 1990. These standards will replace the minimum standards that regulate services (Mississippi Council of Aging, 1990).

Service delivery also remains a high priority in Mississippi. During the 1990 Fiscal Year, funds provided under the Medicaid Waiver Program, Older American Act, and the Social Services Block Grant are currently being used to support non-institutional and community-based services such as in-home and community services, including congregate and home delivered meals; homemakers; day care; transportation; ombudsmen; legal assistance; case management; information and referral; training; and others (Mississippi Council on Aging, 1990). Mississippi, like other states in the region, face fiscal constraints with many of the long-term care service networks operating with reduced budgets. The Mississippi policymakers will be driven by activities which serve to bolster local networks. Future efforts in Mississippi will include efforts that enhance service, administration, systems development, service delivery, promotion of elder rights and advocacy.

The Tennessee Commission of Aging (1991) targeting policies include identification of individuals in "greatest economic and social need" who require services. Emphasis will be placed on low income minorities, which constitute 4.6 percent of the elderly population; and rural elders, which constitute 37.4 percent of elderly. The Tennessee Commission supports the development of a senior citizens center or nutrition center in each county. These efforts are encouraged to ensure that transportation, congregate and home-delivered meals, information and referral, ombudsman services, legal assistance, health screening, and volunteer opportunities are available in each of the counties in the state. Tennessee's focus is on improvement and expansion of its ability to reach and serve low-income minority and rural elderly. In FY 1991 the Tennessee Commission also adopted a new intrastate funding formula. The purpose for the implementation of the new funding formula is to add a factor for increased allocation of funds for low-income minorities and rural elderly.

The Florida State Plan on Aging (1990) outlines seven policy initiatives which will be pursued during the next four years. The seven
priority initiatives as outlined by the plan are (Florida, Dept. of Health and Rehabilitation Services, 1990):

1. Development of comprehensive and flexible services to meet the needs of elderly and caregivers.

2. Improvements in coordination between public, private, voluntary and religious organizations and all components of the aging service system.

3. Improvement in access of services, particularly to those in greatest social or economic need.

4. Enhancement of the quality of services provided to the elderly.

5. Increased availability of community-based services for the frail elderly.

6. Development of a comprehensive system of mental and physical health promotion and preventative care for the elderly.

7. Development of a consolidated comprehensive and automated computer system for outreach, information and referral, assessment, care planning and management.

Florida like most states is interested in the development and support of community-based long-term care. Moreover, the state of Florida like Tennessee will be concerned with the continued support and concerted efforts to provide services to special populations of the elderly, including those that reside in the rural areas.

Discussion

Access, cost controls and quality care issues appear to dominate the focus of current long-term care policy initiatives at the state and local levels. Alabama is concerned with issues facing its rural hospitals and access to long-term care services. Alabama has made an attempt to assume a larger role in the provision of long-term care. Recent efforts relative to rural long-term care have been to initiate legislation that authorizes the establishment of swing beds (use of inpatient beds for skilled nursing or intermediate care services to Medicare or Medicaid beneficiaries), hospital-based respite care and adult day care programs. Such efforts in Alabama are consistent with national rural human service concerns. One national issue facing the rural hospital is the need to change its structure and service products. Such a change is necessary in order for the hospital to survive in its rural environment. For example, data suggests that rural swing-bed patient days account for an average of 25 percent of the patient days reported by participating hospitals (Coward and Cutler, 1989).

Alabama and Tennessee legislators and policymakers are making special efforts to provide access and quality care to rural elderly requiring long-term care services. As noted earlier, thirty-seven states will most likely pursue legislative issues concerning delivery of services to rural elderly. Such actions denote that a political process is fundamental in expediting change within community health and social service systems, especially the long-term care system. States appear to be moving away from the expensive "medical model" of care and seeking ways to fund and provide alternative long-term care services. This current trend appears to be pushed by economic and budgetary needs as well as access and quality care concerns. It also appears that states are equating good quality care with cost-effectiveness, which is critical for public confidence and continued support.

The issue of funding continues to pose a problem for the states. Health insurance and financial protection and assistance ranked as the number two priority issues for 1991 (National Conference of State Legislatures, 1991). Strong emphasis have been placed on avoiding unnecessary nursing home placement, especially since such efforts aid in the reduction of Medicaid costs. The Georgia CCSP is a good example of such statewide efforts to reduce unnecessary institutionalization as well as saving Medicaid dollars. It is clear from this research that the states are becoming innovators in the
design of the long-term care system. Developing a viable and efficient system for long-term care is still one of the most important social issues facing public policymakers.

Conclusion
Current data suggest that state initiatives in long-term care are concerned with the provision of a comprehensive and cost efficient network for community-based long-term care. The current legislative approach to defining community-based and comprehensive long-term care system suggests that if the states are successful in developing statewide human service delivery networks for the frail and functionally dependent persons, the issue of access and availability in rural areas would be moot, in that, all residents requiring such services would have equal opportunity to access such care.

References


Figure 1
National Priority Ranking of Top Long-Term Care Issues by State Percentages

Table 1
States Indicating Rural Health Care as a Major Long-Term Care Subissue for 1991

<table>
<thead>
<tr>
<th>State</th>
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<tbody>
<tr>
<td>CALIFORNIA</td>
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<tr>
<td>FLORIDA</td>
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<td>GEORGIA</td>
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<td>HAWAII</td>
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<td>KANSAS</td>
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<td>ILLINOIS</td>
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<td>INDIANA</td>
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<td>LOUISIANA</td>
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<tr>
<td>MISSISSIPPI</td>
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<td>MONTANA</td>
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<td>MINNESOTA</td>
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<td>NORTH DAKOTA</td>
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<tr>
<td>NEVADA</td>
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<tr>
<td>NEW YORK</td>
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<tr>
<td>OHIO</td>
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<tr>
<td>SOUTH DAKOTA</td>
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<tr>
<td>UTAH</td>
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<tr>
<td>WISCONSIN</td>
</tr>
</tbody>
</table>
The maldistribution of physicians is more a matter of concern than the supply of physicians, although there may also be a concern in the supply of primary care physicians. In the past, many states relied more on the National Health Service Corp (NHSC) scholarship physicians to fill the void in underserved areas, formerly called Health Manpower Shortage Areas (HMSA), now called Health Professional Shortage Areas, where physicians were badly needed. During the Reagan Administration, the NHSC scholarship program had its funding reduced substantially. In addition, the Reagan Administration policy of increased state responsibility for programs changed the course for many states in addressing this health issue. Many of the actions taken by state legislatures were in the 1980s. There are over 90 separate programs in approximately 37 states that address the rural physician shortage. The following information is an attempt to categorize programs that various states have implemented in this regard.

Loan Repayment (Forgiveness) Programs

There are thirty states that have either passed or proposed legislation whereby states either payoff or forgive loans of physicians. In return for payoffs or forgiveness, a physician is obligated to work in an underserved rural area. Most states provide one year of forgiveness for one year of service. The amount of forgiveness or payment of loans varies from a low of $5,000 a year in Indiana, Maine and West Virginia to $25,000 in Michigan and Pennsylvania. There are six states that offer a $10,000 loan repayment and six states that offer $20,000 (See Table 1).

In the South, eight states offer such programs: Tennessee and Virginia $20,000; Georgia and Alabama $10,000; Texas $9,000; North Carolina $7,500; Oklahoma $6,000 - $8,000; and Mississippi $6,000. In New Jersey and South Dakota, a specified amount per year of service is not identified in the legislation.

In addition to the specified amounts per year of service, most states require a minimum of two or three years of service. In some states like Oklahoma, Maryland and Utah, the dollar amount per year will increase per year with extended periods of service. Alabama, Texas, Washington and Wisconsin extend periods up to five years of service for physicians.

Penalties provisions have been specified in legislation in sixteen states if physicians do not complete their obligations. In two states, Arkansas and South Dakota, there is no penalty. Ohio and three Southern states (Georgia, Alabama and Tennessee) have a penalty of three times the amount of the loan. Penalties of two and one-half times the amount of the loan have been cited in five states. Texas, North Carolina and Virginia, along with nine other states, did not have specified penalties in their legislation. This does not mean that penalties will not be established. In some states penalties may be a decision that will be made in the regulatory process.

Scholarships

In general, those states with loan repayment programs, also have scholarship programs. In most cases, state scholarship programs were created before the loan repayment programs. In essence, some states followed the federal initiative by offering scholarships and loan repayment programs. In the South, Georgia, Alabama and Virginia have both scholarships and loan repayment programs. Other states having both include: Illinois, Massachusetts, Missouri, South Dakota, Utah and Washington (See Table 2).

Monetary provisions vary from state to state and are generally lower than the loan
### Table 1. Loan Repayment Provision

<table>
<thead>
<tr>
<th>State</th>
<th>Loan Amount</th>
<th>Penalty**</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Southern States</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alabama</td>
<td>$10,000</td>
<td>3 Times Loan</td>
</tr>
<tr>
<td>Arkansas</td>
<td>$12,000</td>
<td>No Penalty</td>
</tr>
<tr>
<td>Georgia</td>
<td>$10,000</td>
<td>3 Times Loan</td>
</tr>
<tr>
<td>Mississippi</td>
<td>$6,000</td>
<td>Other Penalty</td>
</tr>
<tr>
<td>North Carolina</td>
<td>$7,500</td>
<td>Loan + Interest</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>$6,000 - 8,000</td>
<td>Loan + Interest</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$20,000</td>
<td>3 Times Loan</td>
</tr>
<tr>
<td>Texas</td>
<td>$9,000</td>
<td>Not Identified</td>
</tr>
<tr>
<td>Virginia</td>
<td>$20,000</td>
<td>Not Identified</td>
</tr>
<tr>
<td><strong>Other States</strong></td>
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<td></td>
</tr>
<tr>
<td>Idaho</td>
<td>$20,000</td>
<td>Loan + Interest</td>
</tr>
<tr>
<td>Illinois</td>
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</tr>
<tr>
<td>Indiana</td>
<td>$15,000</td>
<td>2 Times Loan</td>
</tr>
<tr>
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<td>$5,000</td>
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<td>$12,500</td>
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</tr>
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<tr>
<td>Minnesota²</td>
<td>$10,000</td>
<td>Loan + Interest</td>
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<td>Missouri</td>
<td>$20,000</td>
<td>Other Penalty</td>
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<td>New Jersey</td>
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<td>New Mexico</td>
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<td>Other Penalty</td>
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<tr>
<td>New York</td>
<td>$10,000</td>
<td>2 Times Loan</td>
</tr>
<tr>
<td>Ohio³</td>
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<td>3 Times Loan</td>
</tr>
<tr>
<td>Oregon</td>
<td>$7,500</td>
<td>Other Penalty</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>$25,000 - 35,000</td>
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</tr>
<tr>
<td>South Dakota</td>
<td>Not Specified</td>
<td>No Penalty</td>
</tr>
<tr>
<td>Utah</td>
<td>$10,000</td>
<td>2 Times Loan</td>
</tr>
<tr>
<td>Washington</td>
<td>$10,000 - 15,000</td>
<td>2 Times Loan</td>
</tr>
<tr>
<td>Wisconsin⁴</td>
<td>$5,000 - 50,000</td>
<td>No Penalty</td>
</tr>
<tr>
<td>West Virginia</td>
<td>$5,000</td>
<td>Other Penalty</td>
</tr>
</tbody>
</table>

* A loan amount is usually the maximum per year for each year of service. Amount may vary with years of service. Minimum years of service is usually two but does vary with states.

** No penalty, other penalty or not identified may be loan + interest.

¹Passed legislation in 1990 but unable to fund properly.
²Passed in 1990 but unable to implement in 1991; amendments are now in legislative action.
³Did not pass in 1990 legislation.
⁴Passed in 1990. Range is either a specific amount or a percent of outstanding loan - each graduated by years of service.
Table 2

<table>
<thead>
<tr>
<th>Southern States</th>
<th>Scholarships</th>
<th>Penalty</th>
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<tbody>
<tr>
<td>Alabama</td>
<td>$10,000</td>
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</tr>
<tr>
<td>Georgia</td>
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<td>3 Times Scholarship</td>
</tr>
<tr>
<td>Virginia</td>
<td>$10,000 or less</td>
<td>Not Identified</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Other States</th>
<th>Scholarships</th>
<th>Penalty</th>
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</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>$10,000 or less</td>
<td>Scholarship + Interest</td>
</tr>
<tr>
<td>Illinois</td>
<td>$12,000 - $25,000</td>
<td>3 Times Scholarship</td>
</tr>
<tr>
<td>Kansas</td>
<td>$10,000 - $15,000</td>
<td>Scholarship + Interest</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>$10,000 or less</td>
<td>2 Times Scholarship</td>
</tr>
<tr>
<td>Missouri</td>
<td>$10,000 or less</td>
<td>Scholarship + Interest</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Tuition</td>
<td>Not Identified</td>
</tr>
<tr>
<td>Utah</td>
<td>Not Identified</td>
<td>2 Times Scholarship</td>
</tr>
<tr>
<td>Washington</td>
<td>$10,000 - $15,000</td>
<td></td>
</tr>
</tbody>
</table>

Many of the states that have scholarship programs and loan repayment and forgiveness programs also establish certain service areas within the state where physicians fulfill their obligations. Arkansas, Georgia and Mississippi have established state criteria for the determination of their service areas for their loan repayment program. Texas and Tennessee use a combination of state criteria and Health Professional Shortage Area (HPSA) criteria. Virginia uses the HPSA criteria. In Alabama, North Carolina and Oklahoma the service areas were not specified in the legislation. Most of the states that have scholarship programs use their own criteria for underserved areas. The only state outside the Southern Region using a combination of HPSA and state criteria is Massachusetts. Funding for both programs usually consist of state appropriations, penalty payments or cash "buy outs." In some states, like Indiana, Maryland, Missouri, New Mexico, Oklahoma, South Dakota and Texas, a combination of state appropriations and community matching grants is used.
Federal/State Loan Repayment Program

In 1987 under the Public Health Service Amendments Act, a new initiative was created to address health power problems in underserved areas. The loan repayment program involves a 75:25 federal/state match. Health care professionals eligible to participate include: allopathic and osteopathic family practice, general practice, obstetric/gynecology, internal medicine, general pediatrics, nurse practitioners (OB, FP, and Pediatric) and nurse midwives. There is a minimum two-year service obligation.

Under the federal/state program, in combination with the state repayment programs, a physician may have up to $25,000 - $35,000 forgiven in a year. The federal/state program is the only program in Florida and South Carolina; whereas in other states there exists a state program plus the federal/state program. With the combination of both programs the amounts of forgiveness increases. Penalty provisions for nonfulfillment of obligation are applied in all cases except two, North Carolina and Texas. The funding of state and federal programs vary. The federal dollars for Texas was $400,000. In New Mexico, the state match was actually more than the federal monies. Generally speaking, the state matches were 25 percent of federal money awarded.

More and more states are applying for the funds to implement this program. Florida, Maine, New Mexico, North Carolina, South Carolina, Texas and West Virginia received grants initially. In addition to those states, recently Georgia, Utah, Michigan, Louisiana, Connecticut, Massachusetts, and Missouri received funding. Grant money ranged from $90,000 to $347,195. Michigan, which initiated a state program, has now combined its efforts into one program. Georgia has also combined the program to enable it to now offer larger loan repayment sums. In the coming year, the federal/state match for funding will change from 75:25 to 50:50.

Other Strategies

In an effort to encourage medical students to establish rural practices, five states—Illinois, New Mexico, Pennsylvania, Texas and South Dakota—have established new medical resident-
State Legislation for Funding of Rural Emergency Medical Services

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Gerald A. Doeksen
Regents Professor, Department of Agricultural Economics
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Introduction

Investment in infrastructure has an enormous impact on the economic development of a community. Today, leaders in the United States are concerned about the poor condition of infrastructure throughout the country. A 1988 study by the National Council of Public Works Improvement\(^1\) concludes that U.S. infrastructure is barely adequate to meet current demands. To compound the problem, state and federal funding has decreased.

A Southern Rural Development Center task force was created to research state legislation that provides funding mechanisms for health care services: hospitals, emergency medical services (EMS), etc. This paper looks at state legislation that provides funding mechanisms for EMS.

The purpose of this paper is to share the information on funding mechanisms with others. It is hoped that through this sharing of information, leaders in other states may gain insights into alternative ways of funding EMS systems. Before presenting the results, the method of obtaining information will be discussed.

Methodology

A survey letter with four major points was sent to the EMS Directors of each state. The first point was an explanation of the project: the Southern Rural Development Center Health Task Force is reviewing state legislation that provides funding mechanisms for health care services. The second point provided the example of Oklahoma legislation that allows special EMS districts to levy a special assessment tax (up to six mills) on their constituents. The letter then requested information on legislation in other states that provides funding mechanisms for EMS: specifically, a copy of the legislation, a summary of the legislation, and an assessment of the effectiveness of the legislation. The fourth point concluded the letter with an explanation of the publication that is planned as a result of this project.

Fifty-five letters were sent to EMS Directors: one to each state EMS director and one to the EMS Directors in the American Samoa, District of Columbia, Guam, Puerto Rico, and the Virgin Islands. Forty responses were received; the respondents include Alabama, Alaska, Arizona, California, Colorado, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Dakota, Texas, Utah, Vermont, Virginia, Virgin Islands, Washington, West Virginia, and Wyoming. The responses are summarized in this report.

Legislation for Funding Mechanisms

Information from the survey respondents was divided into nine categories of funding: ad valorem tax districts, vehicle registration/driver’s license fees, traffic violation fees, EMS service/vehicle license fees, civil penalty fees, excise tax, tobacco tax, and other funding. Table 1 shows the categories of funding and lists the states using each type. All categories will be discussed below.
Ad Valorem Tax Districts

Fifteen of the forty respondents (Alaska, Florida, Iowa, Kentucky, Mississippi, Missouri, New York, North Carolina, North Dakota, Oklahoma, South Dakota, Texas, Utah, Washington, and Wyoming) reported legislation that enables local communities to organize and tax themselves to provide emergency services. Typical tax assessments were 1 to 3 mills; legislation in North Dakota allows assessments of not more than 5 mills. Table 2 shows specific assessments and unique features of each state's legislation on ad valorem tax districts.

Common procedures in all the states include a petition for an ambulance district and then a vote of the people. If a district is established, members of a board are elected or appointed to organize, establish, equip, maintain, and supervise an ambulance service for the district. To manage and conduct the business affairs of the district, the board may purchase or lease ambulances and equipment, other supplies, real and personal property; make and execute contracts; incur indebtedness; establish an equitable fee schedule; employ personnel and determine compensation for said personnel; apply for and receive funding from the state and federal governments to maintain or improve EMS service in the district; issue bonds for the purchase of real property, improvements, and equipment; establish sinking funds; sue and be sued; impose and collect taxes; accept and receive donations; etc.

Assessments of the effectiveness of the legislation range from partially successful to very successful. The major advantage of this type of legislation is that the EMS district has a stable source of funding. Another plus for volunteer organizations is that the volunteers spend less time and energy on fund-raisers.

Traffic Violation Fees

Seven of the forty respondents (Arizona, Florida, Indiana, Minnesota, Mississippi, Rhode Island, and Utah) reported legislation in which EMS funding comes from fines for certain traffic violations (Table 3). Fines are imposed for failure to wear a seat belt, speeding, reckless driving, any hazardous moving traffic violation, accidents causing damage to vehicles or property, and alcohol- or drug-related traffic offenses. In Indiana, drunk drivers are fined for uncollectible EMS expenses when they cause motor vehicle accidents. Among the services paid for by this fund are EMS training, testing, and certification programs, EMS provider grants, purchase of equipment and ambulances, and staff support and administrative expenses.

In Utah, $3.50 is added to the EMS fund for each reportable traffic violation where a fine is imposed or bail is forfeited. Three percent of these funds are to provide staff support and cover other expenses incurred in administration of these funds. Of the remaining funds, 42.5 percent is available to prehospital EMS providers in the form of block grants: to fund EMS training, testing, and certification programs and to purchase EMS equipment used for patient care, transportation, or communications purposes. Another 42.5 percent is distributed to grant applicants through contracts and the remaining 15 percent is for high school EMS training programs.

In Minnesota, the $10 fine for not wearing a seat belt is distributed equally among the eight regional EMS systems in the state. The annual fund totals $350,000 to $400,000 or $40,000 to $50,000 per region.

In Arizona, the fines for convictions of speeding and driving under the influence garner $2 million per year. Ninety percent of these funds are deposited in the EMS operating fund and pay for rural training programs, EMS provider grants, rural ambulance placement/replacement and functions of the state EMS office. The remaining ten percent of these monies is placed in the general fund of the state.

The respondents concluded that this source of funding should be supplemented by another source. This type of funding is subject to variables such as the effectiveness of seatbelt use campaigns, level of enforcement, etc. Predictions of the level of future funding are not extremely accurate.

Vehicle Registration/Driver's License Fees

Five respondents (Colorado, Florida, Idaho, New Mexico, and Virginia) reported EMS funds were obtained from vehicle registration or driver's license fees. This
legislation, often referred to as "$1 for life", is the addition of $1 to all motor vehicle registration fees. Idaho adds an additional $.25 to support EMS in the county of origin while the $1 goes into the state EMS fund. Idaho also adds $2 to driver's license fees to support EMS. In Colorado, 60 percent of the monies raised are distributed as grants to local EMS providers; 20 percent of the fund is distributed to the counties for planning and coordination of EMS services in the county and the remaining 20 percent is used for direct/indirect costs of planning, developing, implementing, maintaining, and improving the statewide EMS system. In Florida, $0.10 is added to vehicle registration fees to fund the administration of the trauma care program. In New Mexico, the money from this fund is distributed on the basis of need to those local EMS units that apply for aid.

In Virginia, the "$1 for life" was increased to "$2 for life" in 1990. Twenty-five percent of the monies collected is returned to the locale in which the vehicle is registered and is used for equipment, supplies, and training. The remaining monies are distributed between the Virginia Association of Volunteer Rescue Squads (2.5 percent), the Virginia Rescue Squad Assistance Fund program for matching grants (31.75 percent), the statewide program for support of regional EMS councils and the Division of EMS activities (27.25 percent), and training, recruitment, retention, public awareness, and technical assistance programs (13.5 percent).

As with the fees collected from traffic violations, respondents concluded that fees from vehicle registration should be supplemented by another source of revenue. Furthermore, the difficulty in predicting future levels of revenue is also far from accurate.

EMS Service/Vehicle License Fees

Florida, Maine, Massachusetts, New Mexico, and Oklahoma were the only states that reported the return of fees for EMS service licenses (basic life support, advanced life support, air ambulance service), EMT licenses, and ambulance licenses to the EMS fund. These fees are used for training, salaries, and the expenses incurred to implement and enforce the legislation. This source of funding in Florida was supplemented by collection of traffic violation fees, vehicle registration fees, and civil penalty fees; the Director of EMS felt the combination of funding mechanisms was very effective.

Civil Penalty Fees

Florida was the only state to report EMS funding from civil penalties received by county courts. Two dollars from every civil penalty is paid to the Department of Health and Rehabilitative Services. Of the remainder, 25 percent goes into the EMS Trust Fund. The effectiveness of this legislation was considered in conjunction with the other fees collected by the state of Florida: all of the fees together provide an effective source of funding.

Excise Tax

New Mexico was the only state reporting EMS funding from an excise tax: "the majority of the members elected to the board of county commissioners may enact an ordinance imposing an excise tax on any person engaging in business in the county area for the privilege of engaging in business." The rate of the tax is one-eighth to one-fourth of one percent of the gross receipts of the business. However, this tax cannot be imposed on gross receipts arising from transmission of messages or transporting persons/property from inside the county area to outside the county area.

The ordinance goes into effect after a simple majority of the qualified electors of the county area vote in favor of imposing the excise tax. The tax is imposed for not more than five years from the effective date of the ordinance imposing the tax. Up to three percent of the revenue from this tax may be collected as a charge for the administrative costs of collection; this amount is deposited in the state general fund. The remaining 97 percent of the fund minus any disbursements for tax credits, refunds, and the payment of interest applicable to the tax is transferred back to the county of origin. The resulting revenue is dedicated for "financing the operational expenses, ambulance services or capital outlay costs of independent fire districts or ambulance services provided by
the county" and is disbursed through the county board of commissioners to the county fire or ambulance districts of the county. This legislation was termed "helpful" by the Director of EMS and supplements the "$1 for life" program in New Mexico.

**Tobacco Tax**

In 1988, California residents voted to raise the state tobacco tax, effective in 1989. A portion of the annual appropriation of this revenue source is distributed to the counties for deposit in their Physician Services Account. These funds are used to reimburse physicians and surgeons (up to 50 percent) for the uncompensated care that they provide to emergency patients.

**Other Funding**

**Federal Funds.** States also receive monies for EMS from federal funding programs such as Public Health Service Block Grants, Preventive Health and Health Services Block Grants, or NHTSA 402. Federal funds are used to establish and maintain regional EMS councils, evaluate statewide EMS systems, provide public information, support state EMS offices, establish statewide trauma registries, develop a prehospital patient care report system, etc. Although a majority of survey respondents did not mention this type of funding, we can assume that federal monies help support EMS in most states.

**State Appropriations.** Appropriations for EMS from the state’s general fund is a common funding mechanism. These funds are used to train personnel, to replace ambulances, to purchase essential equipment, to provide education programs for schools, to provide travel funds for county medical directors, etc. The funds may be dispersed through competitive or non-competitive grants or through matching grants (50 percent state funds and 50 percent local funds in Iowa, Kentucky, North Carolina, and North Dakota; 25 percent state funds and 75 percent local funds in Indiana).

In Utah, approximately $900,000 is reported to be distributed annually to local EMS providers: $400,000 in grants distributed on a formula basis, $400,000 in competitive grants, and $100,000 for a high school training program on "what to do until the ambulance arrives." In North Carolina, about $550,000 is distributed in noncompetitive grants to 18 local government led organizations and $590,000 in noncompetitive, matching grants to eligible rescue and EMS squads.

Funding through state appropriations was assessed as very effective in Hawaii; elsewhere, it was assessed as completely inadequate to meet the growing needs of EMS providers because of its dependence on legislative whims.

**Local Funding.** Funding at the local level includes donations, patient care/transport revenues, pull-tab gambling, subsidies, subscriptions, EMS fairs, direct solicitation, third-party payments (Medicare, Medicaid, insurance), pie suppers, bake sales, bean suppers, games nights, community fish fries, dances, etc.

**Summary**

Fifty-five survey letters were sent to EMS directors; forty responses were returned. Types of funding discussed by the respondents were ad valorem tax districts, traffic violation fees, vehicle registration/driver’s license fees, EMS service/vehicle license fees, civil penalty fees, and excise and tobacco taxes. Federal funding, state appropriations, and local funding were also mentioned. The major theme running through a majority of the responses was that more than one type of funding is necessary to keep pace with the needs of EMS providers. The most stable type of funding is obtained through the ad valorem tax districts; the other types are dependent on promotion campaigns, legislative whims, law enforcement, etc.

The purpose of the study was to provide an overview of funding mechanisms for EMS systems. If users of the study desire detailed information from any state, the respondents are listed in Appendix A. Hopefully, this publication will aid state decision makers as they adopt or create legislation to adequately fund EMS.
Responding State Directors of Emergency Medical Services

**Alabama**

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<table>
<thead>
<tr>
<th>Funding Type</th>
<th>States</th>
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<tbody>
<tr>
<td>Ad Valorem Tax</td>
<td>Alaska, Florida, Iowa, Kentucky, Mississippi, Missouri, New York, North Carolina, North Dakota, Oklahoma, South Dakota, Texas, Utah, Wyoming</td>
</tr>
<tr>
<td>Traffic Violation Fees</td>
<td>Arizona, Florida, Indiana, Minnesota, Mississippi, Rhode Island, Utah</td>
</tr>
<tr>
<td>Vehicle Registration/Driver’s License Fees</td>
<td>Colorado, Florida, Idaho, New Mexico, Virginia</td>
</tr>
<tr>
<td>EMS Service/Vehicle License Fees</td>
<td>Florida, Maine, Massachusetts, New Mexico, Oklahoma</td>
</tr>
<tr>
<td>Civil Penalty Fees</td>
<td>Florida</td>
</tr>
<tr>
<td>Excise Tax</td>
<td>New Mexico</td>
</tr>
<tr>
<td>Tobacco Tax</td>
<td>California</td>
</tr>
<tr>
<td>Telephone Tax</td>
<td>Missouri, Virginia</td>
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</tbody>
</table>

*Most states also receive funding from federal, state, and local governments.
<table>
<thead>
<tr>
<th>State</th>
<th>Amount of Millage</th>
<th>Other Unique Features</th>
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<tbody>
<tr>
<td>Alaska</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Florida</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Iowa</td>
<td>40.5¢/$1,000 assessed value to 67.5¢/$1,000; additional 20.25¢/$1,000</td>
<td>township trustees may credit to reserve account up to 10¢/$1,000 assessed value annually for purchase or replacement of supplies and equipment</td>
</tr>
<tr>
<td>Kentucky</td>
<td>up to 10¢/$100 of assessed value</td>
<td>board of directors appointed by fiscal courts and city legislative bodies</td>
</tr>
<tr>
<td>Mississippi</td>
<td>not to exceed 2 mills of county ad valorem tax on all assessable property in the county between 1/2 and 1 mill for air ambulance service district</td>
<td>--</td>
</tr>
<tr>
<td>Missouri</td>
<td>30¢ on $100 assessed value additional tax not to exceed 3¢ per $100 assessed value for central dispatching</td>
<td>ambulance district board elected by district residents</td>
</tr>
<tr>
<td>New York</td>
<td>--</td>
<td>appoint or elect board ambulance commission the town board</td>
</tr>
<tr>
<td>to advise</td>
<td>--</td>
<td>the board of county commission defines an ambulance service district</td>
</tr>
<tr>
<td>North Carolina</td>
<td>--</td>
<td>up to 10% of annual operating budget may be set aside to dedicated ambulance service fund for replacement ambulance and equipment</td>
</tr>
<tr>
<td>North Dakota</td>
<td>not to exceed 5 mills on taxable property in district</td>
<td>board is appointed by county commissioners</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>up to 3 mills for operating costs up to 3 mills for capital costs</td>
<td>--</td>
</tr>
<tr>
<td>State</td>
<td>Amount of Millage</td>
<td>Other Unique Features</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>South Dakota</td>
<td>not to exceed 1 mill on taxable property in district</td>
<td>tax rate may be reduced by petition and election</td>
</tr>
<tr>
<td></td>
<td>no tax in excess of 1 mill/$1 of taxable valuation on the property</td>
<td>may contract for law enforcement services</td>
</tr>
<tr>
<td>Texas</td>
<td>up to 10¢/$100 valuation</td>
<td>may adopt, change the rate of, or abolish a sales and use tax</td>
</tr>
<tr>
<td>Utah</td>
<td>per county resolution</td>
<td>counties may assess mill levy, if approved by a majority of county voters</td>
</tr>
<tr>
<td>Washington</td>
<td>0.25¢/$1,000 assessed valuation of property</td>
<td>six-year levies</td>
</tr>
<tr>
<td>Wyoming</td>
<td>not to exceed 2 mills on $1 of assessed valuation of property (rural health care districts)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>not to exceed 3 mills on each $1 of assessed valuation of property (hospital districts)</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Amount of Fine Imposed</td>
<td></td>
</tr>
<tr>
<td>------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Arizona</td>
<td>$30 on every fine, penalty, and bail forfeiture imposed and collected by the courts for driving under the influence $5 on every fine, penalty, and bail forfeiture imposed and collected by the courts for other penalty assessments</td>
<td></td>
</tr>
<tr>
<td>Florida</td>
<td>$5 driver damaging vehicle or property $5 reckless driving $25 DUI civil penalties: 30% of (Total-$2)</td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>drunk driving offenders pay for uncollectable EMS expenses from motor vehicle accidents in which they were involved</td>
<td></td>
</tr>
<tr>
<td>Minnesota</td>
<td>$10 for failure to wear seat belt</td>
<td></td>
</tr>
<tr>
<td>Mississippi</td>
<td>$5 from each person fined or forfeiting bail for any hazardous moving traffic violation</td>
<td></td>
</tr>
<tr>
<td>Rhode Island</td>
<td>$1 for each motor vehicle violation</td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td>$3.50 for each reportable traffic violation when a fine is imposed or bail is forfeited</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Amount of Fine Imposed</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
</tbody>
</table>
| Colorado         | $1 per vehicle registration  
                  | 60% of fund distributed as grants to local EMS providers  
                  | 20% of fund for distribution to counties for planning and coordination of EMS services in the country  
                  | 20% for direct/indirect costs of planning, developing, implementing, maintaining, and improving state wide EMS system |
| Florida          | $0.10 per vehicle registration to fund administration of trauma care program                                                                            |
| Idaho            | $1.25 per vehicle registration  
                  | $1 to state and $0.25 to county of origin  
                  | $2 per driver’s license                                                                                         |
| New Mexico       | $1 per vehicle registration distributed on the basis of need to those local EMS units that apply for aid                                              |
| Virginia         | $1 per vehicle registration  
                  | 25% returned to locality in which vehicle is registered                                                           |
A Review of State Programs for Delivering Health Care Services to Migrant Farmworkers

Jeffrey Alwang
Department of Agricultural Economics
Virginia Tech

Introduction
Statistics on the number of migrant farmworkers in U.S. agriculture are notoriously unreliable, yet most estimates put the total somewhere around 200,000, roughly 8-10 percent of the total hired workforce (Whitener, Smith, and Coltrane). Migrant workers put stress on existing health care delivery systems since they tend to concentrate in particular agricultural regions for short periods of time; they generally receive lower incomes and are less likely to have health insurance than most other rural residents; they have fewer connections to the local community and less information about service providers; and they work in a dangerous occupation. Because of these factors, federal, state, and local policymakers, along with non-governmental organizations, have developed health care service delivery programs for migrant farmworkers.

The purpose of this article is to provide information comparing state programs/policies for the delivery of health services to migrant farmworkers. As a point of departure it is noted that the federal government has taken the lead in providing funds for these services. Because of this, various federal programs are described first. A survey of states regarding their programs is then described. This is followed by a broad description of types of state programs which tend to supplement and support these federal efforts. Then, specific state programs are described. Finally, a list of contacts in various states is provided.

Agricultural producers are generally exempt from any obligation to provide health insurance or health services to their workers, and migrant workers and their products move from state to state. Because of this, the federal government has maintained lead responsibility for providing for the health needs of migrants. This support comes in two broad forms: public health insurance, and national systems support. The public health insurance program, Medicaid, is usually available to migrant citizens of the U.S. and some non-citizens since they generally meet income guidelines for eligibility.

Federal Programs
The most important federal program for migrant health services comes through section 329 and 330 of the Public Health Service Act, which provides grants for migrant (MHCs) and community (CHCs) health centers, respectively. The Act is administered by the Bureau of Health Care Delivery and Assistance (BHCDA) of the U.S. Department of Health and Human Services. MHCs and CHCs provide primary care services that augment medicaid reimbursable services. In addition, the centers can provide primary care services for non-citizens who meet certain guidelines. Both MHCs and CHCs are designed to provide a broad range of services to migrants.

The centers encourage migrants to apply for medicaid, WIC, and other programs, and help facilitate the transfer of health records. MHCs and CHCs are the most prominent source of health care for migrant workers. Notice that section 329 and 330 grants are federal dollars; in many states they represent the only source of health care for migrants. Other states provide direct and indirect support for these centers.

The Section 329, Migrant Health Program, funds 105 grantees found in 39 states and Puerto Rico. Primary Health Care Associations in various states and nationally exist to promote the MHC/CHC movement and represent the MHCs and CHCs and the people they serve. These associations tend to be very active in rural health care issues.

State Health Departments often receive federal funds for indirect support to the MHCs
and CHCs. This support comes in the form of Cooperative Agreements with BHCPA and provides funds for things such as physician or provider recruitment, and planning and development, training, needs assessments, etc., but not for primary health care services.

As a part of the Immigration and Reform Act of 1986, State Legalization Impact Assistance Grants (SLIAG) are block grants to assist states in meeting the needs of newly legalized residents. SLIAG money is allocated according to the number of legalizations approved for state residents, and is destined for three broad areas: education, health, and welfare.

Although the federal government takes lead responsibility for providing health services to migrants, states with significant migrant populations generally provide additional support or have separate programs. States with MHCs and CHCs at times provide facilities and other state support for the centers. Many states administer pass-through federal dollars earmarked for indigent health care which reaches migrants, since they usually meet eligibility requirements.

Survey of States

In order to determine the policies/programs of individual states in meeting migrant health needs, letters were sent to contact people in each state. Follow up letters were sent, when necessary, to individuals whose names and addresses were provided by respondents to the initial letters. In some cases, telephone interviews were conducted. Representatives of 42 states responded. A list of respondents is provided at the end of this section. Those states that are not included in the following state-by-state summary were not included because it was impossible to elicit a response from the contacts. At least two attempts at the contact were made for each state.

The letters requested information on state assistance for health services for migrant workers. It was first asked whether line-item state funds for migrant health exist. Then, questions were asked about state policies/programs specifically designed for migrant workers. Next, information about state financial or other support for MHCs or CHCs for migrant health care was requested. Finally, questions were asked about contracting mechanisms for the delivery of services to migrants.

Individual State Activities

In general, state programs tend to augment federal programs, and these state programs vary widely. Support ranges from none, or complete reliance on the existing indigent delivery system, to coordinated auxiliary services for migrant workers. States with significant migrant populations tend to be more active in providing support for the medical needs of migrants. These states also frequently form cross-agency coordinating committees which are needed because migrant funds come from different federal and private sources and are handled in the states by different agencies. The following sections summarize the results state-by-state.

Innovative mechanisms for service delivery to migrant workers exist. Some states (e.g., North Dakota, Virginia) do not have Section 329 grantees and contract with grantees in neighboring states to provide services to migrants. Other states (Pennsylvania, Kansas, etc.) contract with MHCs to provide services for which the entire indigent population is eligible. This contracting helps ensure delivery to the migrant portion of the targeted population.

California

The Seasonal Agricultural and Migratory Workers Program (SAMWP), administered by the Primary Health Care Systems Branch of the California Department of Health Services, provided $1,038,000 in FY 1990-91 for health services for migrant farmworkers. Some of these funds are allocated directly from the state general fund to nine clinics who are able to demonstrate commitment to serving seasonal and migrant farmworkers and can show that a minimum of 60 percent of the services provided under these funds are destined for these workers. The SAMWP is also charged with conducting studies of the adequacy of health care services for migrants, and coordinating with similar federal programs. Migrant workers are eligible for other services funded by the $60 million state budget allocation for local health assistance.
The Seasonal Agricultural and Migratory Workers Advisory Committee advises the State Department on levels of resources, priorities, and guidelines necessary to provide health services to migrants. It is composed of 15 members including consumer advocates, health service providers, representatives of state or local agencies, health professionals, and private citizens.

**Colorado**

About 43,000 migrant and seasonal farmworkers live or work in Colorado. These workers’ health care needs are largely met by the state’s four Migrant Health Program grantees. One of these, the Colorado Migrant Health Program (CMHP), operates as a section of the Colorado Department of Health. CMHP provides health services to some 6,000 medical and 3,000 dental patients. The state provides office space for the CMHP.

State support for migrants includes the Medically Indigent Program (MIP), which provides inpatient services for migrant farmworkers who are U.S. citizens or legal residents. The MIP (also called the Colorado Residence Discount Program) reimburses 23-30 percent of inpatient costs and is designed to pick up after Medicaid benefits have been exhausted. These benefits are available to all indigent residents; no special programs for migrants exist. Inpatient services for newly legalized aliens may be funded through SLIAG grant funds.

**Florida**

Because such a large number of migrant farmworkers live and/or work in Florida, health care for them has been a major concern of the state government. The most recent estimate is that there are nearly 270,000 migrant farmworkers and their families traveling to and around Florida.

There are 12 MHCs in Florida, and these received approximately $7 million from the federal government in 1987-88. In 1986, these clinics served a combined total of 279,000 patients. The Florida legislature passed the Health Care Access Act in 1984, and $30 million has been appropriated to counties to defray parts of the cost of establishing and providing care for low-income persons. This legislation has been extended under an indigent health care law to establish primary care facilities in most counties. Migrants are eligible, in general, to use the services of these facilities.

The Governor’s Advisory Council on Farmworker Affairs examines issues related to migrant labor and makes recommendations to the governor for improvements. In 1989, the Health Care Subcommittee addressed issues such as pesticide exposure, nursing shortages, shortages of funding for community health centers, and access to normal low income services. Hospital cost reimbursements were studied by the State of Florida’s Health Care Cost Containment Board, which issued its final report in February 1989. It estimated that in 1987, approximately $59.5 million in gross unreimbursed hospital charges were registered by migrants. The Board made recommendations on funding these services including: 1) improved documentation on use of services by migrants; 2) increased state funding for hospital reimbursement; 3) strengthening existing indigent care funding; 4) exploring the feasibility of health insurance models.

**Georgia**

Approximately 28,100 migrant farmworkers and their dependents are found in the state. During 1990-91, the Georgia Division of Public Health (DPH) received $377,000 in federal funds, $25,000 in state funds, and $25,000 SLIAG allotment to provide health care to approximately 1,775 migrant farmworkers. In addition to normal primary care services, nurse practitioners, nurses, and bilingual outreach workers in the DPH assist migrants in gaining access to health care and receiving services such as food stamps, education, etc. Nurse practitioners provide primary health care directly and also give referrals for physicians and dentists.

Local migrant health advisory councils meet throughout the state. A state council meets quarterly to advise the various agencies involved in providing services, to identify problems and collectively seek solutions.
Indiana

There were approximately 7,000 migrant workers in Indiana during 1990, with the largest concentration in the north-central portion of the state. There are a total of 11 community/migrant health care centers (CMHCs) in the state. In addition to the normal services provided by these centers (see the Migrant Health Centers Referral Directory), WIC, Medicaid, and free immunizations are available to these workers.

The Indiana State Board of Health provided $89,000 in 1990 for migrant health and dental care. Over $67,000 was spent on the Migrant Nurse Program which pays expenses for 16 registered nurses to make visits to migrant labor camps. County boards of health determine the type and amount of services. The Migrant Dental Program provides screenings, oral hygiene instruction, prophylaxis, and other basic dental care to migrant children aged 1-19. The Indiana Board of Health budgeted $22,000 additional in salaries, and the Division of Dental Health absorbed the remaining costs.

The Task Force on Migrant Affairs meets monthly to advise the governor, provide information, and coordinate programs. The Task Force includes representatives of people from various state agencies, migrant advocates, and health centers organizations.

Kansas

The number of migrant workers in the state is subject to debate, but the pattern of migrant employment changed in recent years. Prior to 1984, large numbers of migrants (10,000-12,000) were employed in the Western Kansas sugar beet industry. The beet processing plants were closed in 1984, and subsequently far fewer migrants are used in the region. The health care delivery system had to be restructured to adjust for this change.

Because of the changing pattern of migrant populations, a task force developed a statewide plan for migrant health care delivery which combined and coordinated the services of Migrant Education, the two MHCs in the state, the Hunter Health Clinic, county public health departments and Harvest America (a non-profit organization). This consortium applied for a $298,000 federal (329) grant which will be supplemented by $51,000 in in-state funds. The project is expected to reach 2,200 users in its first year.

Migrant Education, Harvest America, and the local health departments will certify migrants, who can then visit six statewide contractors or receive vouchers for additional services. A key element of the plan is to identify the number of migrants eligible for service in order to provide improved needs documentation for subsequent years.

Maryland

Migrants are used in hand labor crops in all regions of the state, the Eastern Shore being the major agricultural area. The Department of Health and Mental Hygiene’s Migrant Health Program coordinates delivery of health services. The central office staff works with local health departments and other service providers. The program awards supplemental grants (5 in 1989) to counties with high migrant populations. The grants are monitored by on-site evaluation visits to local health departments, telephone contacts, and visits to the migrant labor camps by the program chief. Migrant health services in non-grant counties are also monitored.

County health departments provided services to migrants as they were needed. Services included: visits to migrant camps for health and nutrition screening, immunizations, family planning, communicable disease counseling, drug and alcohol services, maternity and prenatal care.

The state provided small amounts of financial assistance to the two MHCs which serve Maryland migrants: the Shenandoah Community Health Center and Delmarva Rural Ministries.

Michigan

There are an estimated 40,000-50,000 migrant workers Michigan. Five MHCs delivered health services to approximately 25,000 migrants in 1989. The Michigan Department of Public Health contributes to these centers by funding or passing through federal funding for many services, such as WIC, a
Medical Screening Program for minors, and others. In addition, the Department of Public Health funds two programs directly targeted at migrants. The Camp Health Aid Program trains women who live in camps to serve as health resources to camp residents, and the Migrant Health Program funds outreach nursing services to increase immunization levels among migrant children as well as for dental screening and preventative treatment.

There is some state support for migrant programs. The Migrant Hospitalization Program (MHP) pays for essential inpatient hospital services. To be eligible, the migrant family must also be eligible for Medicaid. The Non-resident Hospitalization Program supports inpatient hospitalization for migrants who do not meet the requirements of the MHP. It is available to non-citizens and individuals who do not have legal alien status. The Department of Social Services reimburses counties for these services.

**Minnesota**

In addition to programs such as WIC and Medicaid which target all residents in need, the State of Minnesota, mostly through Migrant Health Services, Inc., an MHC, offers some health and social services to migrant workers. The Department of Health provides funds for hemoglobinopathy screening and a mobile health unit (funding from the State was $108,000 in 1990). The Department of Human Services helps fund a chemical dependency education program ($28,000), and the Department of Corrections provides services for battered women ($47,350). Finally, the Department of Education provides $52,000 for health screening for migrant children. In 1987, almost 9,000 migrants in Minnesota and North Dakota received health care through Migrant Health Service, Inc.

**Missouri**

There is no state funding for migrant health services. Some state agencies do pass through federal funds to provide services to migrants. This funding is processed through three nonprofit groups: the Southeast Migrant Education Program, the Southwest Migrant Education Program and Rural Missouri, Inc. The money is used for eye exams, glasses, and emergency medical care for migrant children. Rural Missouri, Inc. uses its funds for housing, transportation and emergency medical treatment for migrants.

There is one MHC funded exclusively by the federal government. It provided services to approximately 1,000 migrants in 1990, all in southeast Missouri. This MHC is attempting to coordinate migrant health care delivery, though it receives little active support from the state government.

**Montana**

Montana is typical of many states in that while there are a number of migrant workers and a federally funded health center, the state is mainly involved in administering the transfer of federal funds to the center. Thus, the state contributes few resources for health services to its 7,000-7,500 migrants.

The Montana Migrant Council, Inc., an MHC provides migrant health services in Montana, and in 2 counties in northwestern North Dakota. The state of Montana provides some funds for WIC, nursing, maternal and child health services for which migrants are eligible. Funds provided by the federal government are distributed to the counties. The state also helps distribute vaccines purchased with federal funds to migrant children.

**New York**

New York has an estimated 26,500 migrant workers and dependents. In addition to the three MHCs and their satellite clinics, the New York State Department of Health (through the Maternal and Child Health Services Block Grant—MCHSBG) and the State Education Department specifically fund health care for migrants and their dependents. In 1986 the MCHSBG provided $100,000 in grants for migrant health. The largest was $30,000 to fund nursing services at 20 day care centers. The remaining grants were allocated to six programs providing medical diagnosis and treatment programs, maternal and child health services, and dental services.
The Department of Education’s Tutorial Outreach Program helps provide children of migratory workers with medical and dental health care. In addition, the Education Department funds the Migrant Student Record Transfer Service which provides information on education and health that is forwarded when the children move to new day care centers or public schools.

The Department of Education also contracts with the Cornell Migrant Program (CMP) to provide and subcontract for health care of migrant children. In 1986 CMP spent $64,457 for health care. CMP also administers a modified case-managed voucher program for school-aged migrant youth not served by health centers.

The Interagency Workgroup on Migrant Health Care was convened in 1987 to address issues of health care specific to migrant farmworkers. They found that though numerous agencies and bureaus fund migrant health services, services remained largely uncoordinated; this lack of coordination tended to diminish the efficiency of the programs. The workgroup identified transportation and mobile health teams as critical to the needs of migrants. It suggested that budgets and evaluation forms be standardized among providers, and the existing health care network be strengthened. The workgroup also suggested the creation of a statewide coordinator of migrant and farmworker health services to foster interagency coordination. Providers of services were urged to designate a coordinator to deal with the various state and federal agencies.

North Carolina

North Carolina has three MHCs serving migrant workers. In addition, the Migrant Health Program (MHP), of the North Carolina Department of Human Resources’ Division of Adult Health, receives Section 329 funding. The state supplements the $750,000 in federal money for this program with $250,000. These state funds pay for inpatient hospital services for migrants; the $750,000 in federal funds are for reimbursements for services provided by doctors. The state recently streamlined its billing and payment programs; providers can now directly bill the MHP for services, whereas previously they had to get approval from local health centers. Streamlining has increased efficiency and helped centralize data collection for program reviews. The MHP also maintains contracts with county health departments to provide limited health services to migrants.

North Carolina has two committees to recommend action on migrant issues. The North Carolina Farmworker Council is a cabinet-level group of state agencies and political appointees designed to advise the governor on state policies. The Farmworker Services Coordinating Committee is an informal group of state and federal agency representatives and farmworker and farmer advocacy groups. The committee meets bimonthly to share information and seek opportunities to coordinate programs. A special task force of the North Carolina Farmworker Council will report in July 1991 on health care needs and services available to migrant workers.

The state also has a $120,000 SJIAG and uses some of these funds to subcontract with health centers to provide health services to aliens involved in the legalization process.

Ohio

An estimated 8,000-11,000 migrants work in hand-labor operations, orchards, and in other specialized occupations in Ohio. The principal sources of migrant health care services in Ohio are two MHCs and their corresponding satellite clinics. These centers and satellite clinics operate on a voucher nursing and medical model. Nursing visits lead to immediate treatment, the issuance of vouchers for off-site medical services, or an appointment with a clinic physician. Though these centers are funded largely with section 329 federal dollars, the state provides some support and assistance. The state funds facility maintenance, data collection, administration, medical director, and nursing services for the center in northwest Ohio where the majority of migrant workers is located. Facilities and support for the WIC program, Medicaid invoicing, and some well-child services are also funded by the state at this center.
The Ohio Department of Health contracts with all the out-of-clinic service providers. State level migrant policy is coordinated by the Governor's Committee for Migrant Affairs. In addition, there is an agricultural ombudsman within the Ohio Bureau of Employment Services who coordinates migrant affairs and operates a migrant hotline.

Oregon
Health services for migrants are provided through the four MHCs in the state. The Ad Hoc Committee on Migrant and Seasonal Farmworkers Health Concerns, a group of state agencies and other providers of health services to farmworkers, meets monthly to discuss migrant health issues, but there are no specific state policies.

Several Divisions within the Department of Human Resources provide health services for which migrants are eligible. Though these services are not specifically targeted for migrant workers, migrant residents are eligible. The Office of Alcohol and Drug Abuse Programs has SLIAG funds for alcohol treatment.

Texas
Texas has 14 MHCs to serve its large migrant population. Despite this, there are no line item programs in the state budget strictly for migrant workers. To avoid political opposition, migrant advocates included migrants in the broader issue of rural and indigent health care. State support for the 329 centers has come mostly through the Primary Health Care Act. In addition, the Maternal Infant Health Improvement Act provides state support.

Virginia
Estimates of migrant workers and their dependents in Virginia range from 8,000 to 19,000. Migrants work in vegetable crops on the Eastern Shore, tobacco and vegetables in Southside, and in fruit orchards in the Shenandoah Valley.

There are two MHCs and one CHC providing medical services to migrant workers. The state provides a $250,000 line item specifically for migrant care which goes to a hospital on the Eastern Shore as reimbursement for services provided to migrants. Two coordinating councils in the state government exist: the Interagency Migrant Policy Committee, and the Migrant and Seasonal Farmworkers Board.

Washington
Washington has five MHCs providing health services to migrant workers. All of these are jointly funded CHCs and receive Section 330 dollars. Several other CHCs in the state provide health services to migrants. The state supports these MHC/CHCs in a number of ways. First, the Department of Health provides Primary Health Care Program (PHCP) grants to these centers to assist and enhance the delivery of prescribed services. PHCP grants allow some Health Centers to provide dental services. Mental health services are also provided in two of the Health Centers.

The State Office of Parent Child Health Services (PCHS) funds maternity services for migrant women. Funds for these services are provided as grants to the MHCs which provide prenatal and delivery services. This program began in 1989 and was funded at $700,000 in 1990-1991. The Migrant Education Program provides health insurance and health care for children in school. Women who fall within 185 percent of the official poverty level are eligible for special maternity care assistance through the State First Steps program. These services include pre- and post-natal care and other support services. The program extends Medicaid eligibility and, though not entirely geared toward serving migrants, includes a large number of migrant participants.

There is no specific state agency designated to coordinate migrant health policy, but a number of agencies and committees are actively involved in migrant affairs.
<table>
<thead>
<tr>
<th>State</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>No state programs exist.</td>
</tr>
<tr>
<td>Arizona</td>
<td>No line item state programs. The two MHCs received money from the Arizona Department of Health Services to provide dental care to migrant children. This funding ended in 1991, and the clinics now receive no support from the state. The state has begun to coordinate the delivery of health services to migrants by forming a Migrant Coordinating Council comprised of the two MHCs, social service agencies, growers, and some state agencies.</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Few migrants in state. No state programs exist. The New England Farmworker Council (see Massachusetts) has a satellite clinic in Hartford.</td>
</tr>
<tr>
<td>Delaware</td>
<td>No line-items specifically for migrant services. A multi-agency group reviews problems and refers them to the proper state agency. Migrants are served through one MHC, various CHCs, and State Service Centers.</td>
</tr>
<tr>
<td>Hawaii</td>
<td>No programs exist.</td>
</tr>
<tr>
<td>Idaho</td>
<td>State has two MHCs. The state provides no assistance to these clinics, nor are there state line item programs to provide health services to migrants. Some private organizations improve health delivery to migrants. The Idaho Migrant Council has health funds for emergency care, and also provides transportation services. Western Idaho Community Action operates headstart programs and has some funds for physical and dental care. Some local schools coordinate dental screening as part of their migrant education program. Finally, the Southwest Idaho Dental Project provides dental screenings for migrants.</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Few migrants in state. Numbers may be growing, so there is increasing interest. No identifiable programs. No MHCs exist.</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Few migrants in state, estimated at 2,475. No special programs or policies directed at migrants. No MHCs exist.</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>No state programs for migrant workers. The New England Farmworkers Council, an MHC, has its main office in Springfield, MA. This center has satellite clinics around New England.</td>
</tr>
<tr>
<td>Nebraska</td>
<td>The Nebraska Migrant Health Project, an MHC, facilitates access to medical care on a fee-for-service basis through contracts with providers. There are no state policies/programs specifically for migrants in the state. There are approximately 4,000-5,000 migrants and 1,000 seasonal workers in Nebraska agriculture.</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>No state programs exist.</td>
</tr>
</tbody>
</table>
New England  Farmworkers Council (see Massachusetts) has a satellite clinic in Manchester.

New Jersey  No specific migrant programs. Two MHCs are found in southern New Jersey, serving approximately 4,000 users at the centers, three satellite sites and through mobile medical teams visiting the migrant camps. Migrants also have access to normal low income programs (WIC, etc.) and services provided by local health departments such as STD and TB clinics, HIV counseling and testing, immunizations and child health conferences. The department of Health convenes a NJ farmworkers taskforce quarterly to discuss issues of concern such as pesticide exposure and access to primary care.

Nevada  No programs. No MHCs exist.

North Dakota  No programs. Approximately 1,500-2,000 migrants work in sugar beet industry in western North Dakota. No MHCs exist. The state contracts with providers in Minnesota and Montana. In 1990, the North Dakota Department of Education provided $15,000 dollars for health screening of migrant children by the Migrant Health Service, Inc. in Minnesota.

Oklahoma  The State Department of Health formerly received a federal Migrant Health grant. This grant was discontinued in 1990, and the Migrant Health Program was discontinued. Migrants are eligible for services from county health departments. No specific state support for migrant health services exist.

Pennsylvania  No specific state programs. Pennsylvania Rural Opportunities (PARO), an MHC, provides health services through its numerous satellite clinics. PARO contracts with various state agencies to deliver specific services to migrants. Generally this money is part of a statewide thrust (such as AIDS education), with PARO providing access to the migrant community.

Rhode Island  Fewer than 20 migrants. No MHCs exist, but the New England Farmworkers Council (see Massachusetts) has a satellite clinic in Pawtucket.

South Carolina  No line item state programs exist. The state provides personnel support for an MHC. This center, the South Carolina Migrant Health Project, received in 1989 an $85,000 grant from the federal government, and supported services for 1,100 users and 2,600 encounters. In addition, three CHCs exist to serve migrants in the state.

South Dakota  Few migrant workers. No specify programs for migrant policies. No MHCs exist.

Tennessee  Tennessee has two MHCs. In addition, several CHCs also provide significant health services to migrants (eg., Rural Community Health Services, Inc., a CHC provided health services to 1,100 migrants in 1990). There are no state programs designated strictly for
migrant workers, though the state agencies work closely with the MHCs and CHCs to ensure that state services are made available to migrant workers. There is a state Interagency Networking Committee, made up of state agencies and migrant advocates that addresses local migrant needs.

Utah

One MHC exists. There are no state line-items. The Health Department has a cooperative agreement with BHCSA to provide some support for the 329/330 Centers. Health service delivery to migrants is coordinated by the Migrant Farmworkers Coordinating Council. The Council is developing a strategic plan for health service delivery to migrant and seasonal farmworkers.

Vermont

No programs. No MHCs exist.

West Virginia

There is one MHC to provide services to an estimated 1,440 migrant farmworkers. Migrants are eligible for several programs offered by the State Department of Health and Human Resources (WIC, food stamps, etc.); there is, however, no specific state entity that is responsible for migrant programs or policies. A portion of the state appropriation for primary health care is used to support migrant activities.

Wisconsin

One MHC exists. Migrants are eligible for health care services funded by the State Maternal and Child Health Block Grants, but no state programs specifically targeted for migrant health care exist.

Wyoming

No specific programs. Two MHCs with associated satellite clinics are found in the state.

Resources

The 1990 Migrant Health Centers Referral Directory

This directory lists nationwide migrant health facilities and a brief overview of the types of services each facility provides. The facilities are funded by the Migrant Health Program of the U.S. Department of Health and Human Services. In addition to the facilities, complete with maps and locations of satellite clinics, the directory contains: names, addresses, and phone numbers of federal and regional Migrant Health Program officials, of Migrant Health Program grantees, of state and regional primary care associations, state health departments, members of the National Advisory Council on Migrant Health, and members of the National Association of Community Health Centers’ Migrant Health Subcommittee.
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References

Indiana State Board of Health, "Indiana Plan for Health, Sixth Edition."


Endnotes

1 Migrant Health Centers are community-based non-profit organizations with at least 51 percent of their boards of directors coming from the client (migrant farmworkers) group.

2 These grantees are mostly MHCs, though some state health departments receive 329 funds and use them to reimburse doctors for primary health care provided to migrant workers. The locations of the grantees and the services they provide are cataloged in The 1990 Migrant Health Centers Referral Directory.
The SRDC is one of four regional rural development centers in the nation. It coordinates cooperation between the Research (Experiment Station) and Extension (Cooperative Extension Service) staffs at land-grant institutions in the South to provide technical consultation, research, training, and evaluation services for rural development. For more information about SRDC activities and publications, write to the Director.

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