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Using a Voucher System to Extend Health Services to Migrant Farmworkers

SYNOPSIS

FAMILY HEALTH/LA CLINICA de los Campesinos, Inc., is a federally funded migrant health clinic in the heart of Wisconsin's farmland that has offered outpatient health care since 1973 and an accompanying "voucher" program since 1988.

The charges for outpatient care are based on the ability to pay. The clinic issues vouchers not only to migrant workers living and working in remote parts of the State but also to patients needing services the clinic does not offer.

Between 1 April 1992 and 30 March 1993, 677 participants submitted 1,794 vouchers that provided for $83,833 in partial health care payments. La Clinica paid a median amount of $22 for each voucher, its reimbursement value ranging from $1 to $979.

Hospitals received the highest median payment and pharmacies the lowest. Voucher payments generally covered 60% of the bill, but dentists commanded a higher percentage (70%) and clinics and medical groups a lower one (42%). Most vouchers paid for procedures and services La Clinica could not provide.

This program shows how a health care provider in one location, with a patient population scattered throughout a sizable geographic area, can coordinate services not offered at its facility. With the national spotlight on health care reform, the concept of vouchers for people in outlying or underserved regions deserves further investigation.

Early in the development of American agriculture when private farmlands grew too large for individual families to work, day workers, field hands, and migrant workers were hired to plant and harvest crops. Although these populations are essential to agriculture, seasonal and migrant workers earn modest incomes, endure substandard living conditions, and often live in poverty. Safety nets available to most of the urban and rural poor usually are unavailable to migrant workers[1], and they rank among the most disadvantaged, medically underserved populations in the United States.

About 4 million people in the United States are hired farmworkers[2]. Most are seasonal employees, distinct from migrant workers in several ways. Seasonal and migrant farmworkers often perform the same tasks, but seasonal workers live at home year-round, while migrant workers travel the country searching for work. Most seasonal workers use their income from farm labor to supplement other income; migrants depend on farm labor for most of their annual income. Seasonal employees are hired individually; migrants usually travel in groups and often are paid as family units. In 1985, about 6% of the paid farm labor

force were migrant workers[3].

The migrant workers' transient lifestyle makes it difficult for them to obtain health care. Few carry private health insurance because they rarely work for the same employer long enough to qualify for coverage. Although their income levels and household sizes qualify them for State medical assistance programs, they seldom stay in one State or county long enough to satisfy the 30-day residence requirement. Because of these circumstances, a federally funded system to subsidize migrant health care has evolved.

The Public Health Service Act, Section 329, supports health facilities that serve migrant and seasonal farmworkers and supplements the cost of existing clinic care. However, with mobility a factor, the needs of these migrant workers cannot be met adequately by the 106 grantees at 370 clinics (figures provided by the Migrant Health Program, Bureau of Primary Health Care, Health Resources and Services Administration). In fact, the National Advisory Council on Migrant Health estimates that migrant health clinics spend about $100 per user, per year, but reach only 12% of the migrant population[4].

In 1987, The Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, Public Health Service tried to reverse this low rate. It issued a memorandum describing a new program for migrant health services that said in part, "In agricultural areas without Community or Migrant Health Centers but with substantial numbers of migrant and seasonal farmworkers (MSFWs), a voucher program may be appropriate as a means for supplementing access to primary care. Generally, these areas will have too few MSFWs, or the period in which the migrants are present is too short to warrant establishing a traditional clinic. Vouchers are to be used to fill in gaps in access to primary care services, and there are a wide variety of appropriate models. Voucher programs represent a viable solution only in locations where there is adequate primary care capacity but financial and other barriers impede access by MSFWs[5]."

In an examination of the published literature[7] and in discussions with Jack Egan, Deputy Director of the Migrant Health Program, Bureau of Primary Health Care, Health Resources and Services Administration, we found no formal national evaluation that determined whether the voucher program was successful. Egan noted that, in 1993, 15 organizations in 13 States received "voucher" funds. Although vouchers are mainly for primary care, each organization may use different approaches to allocate the funds. To serve the migrant worker, some organizations supplemented community health center funds, while others, when necessary, paid bills for migrant health care. In our study, we analyzed how Family Health-La Clinica allocated the funds it received for fiscal year 1992.

La Clinica Voucher Program

La Clinica in Wild Rose, Wisconsin, provides on-site primary care and coordinates Wisconsin's health care voucher program. It issues the vouchers, and each migrant worker must register with the clinic before receiving one. La Clinica staff members, outreach workers, mobile clinic personnel, and camp health aides visit camps throughout the State to register individuals and families; some public health nurses, school clinic workers, and United Migrant Opportunity Services offices (a private nonprofit corporation that serves migrant and seasonal farmworkers) also enroll prospective patients. The reason for registration, a simple procedure, is to set up a file before medical care is required.

Registrants may obtain a voucher in several ways. First, they can receive vouchers for referrals or prescriptions when they visit La Clinica. Second, La Clinica's outreach staff members and mobile medical units will telephone the clinic to make voucher arrangements for patients in outlying areas. Third, if migrant workers are too far away to be reached by outreach workers or by the mobile medical unit, public health nurses, camp health aides, or local providers will telephone the clinic for vouchers. La Clinica administrative staff members handle these calls and authorize the use of vouchers. Many of the voucher recipients in fiscal 1992, incidentally, needed specialized care that La Clinica does not provide.

La Clinica's staff members inform health care providers who agree to accept vouchers of the administrative and reimbursement procedures and payment rates. For fiscal year 1992, La Clinica used the reimbursement schedule found in the box. How much participating providers expect for com-

1992 Reimbursement Schedule for La Clinica

Outpatient care	
Office visit	$15 maximum
Prescription	$5 maximum
Laboratory service	$15 maximum
Dental visit	$35 maximum
Emergency room visit	75% of total cost
X-ray	75% of total cost per X-ray
X-ray interpretation	75% of total cost per X-ray
Inpatient Care	
Hospital charges	60% of charges per admission, $500 maximum
Physician charges	50% of charges per admission, $250 maximum
One-day surgical procedures	
Hospital charges	60% of charges per admission, $400 maximum
Physician charges	50% of charges per admission, $200 maximum

pensation varies. Some medical organizations bill La Clinica for only a portion of the cost, absorbing part of the expense for the specialized or hospital care. Other providers bill migrant patients directly for amounts exceeding La Clinica's voucher limits. According to La Clinica policy, patients are responsible for additional costs. Once issued, vouchers are valid for 15 days and for one visit or one prescription. Patients must obtain new vouchers for subsequent visits or refills.

Methods

La Clinica staff members update a computerized data base when vouchers are submitted for payment. Since these vouchers reflect no diagnostic or treatment information, only the following data are recorded: clinic and patient identification numbers, birth date and sex, county of patient's residence and provider's location, issue date of voucher and date of medical service, codes for types of service and provider, amount of the bill, and amount of voucher reimbursement.

We converted all voucher information for fiscal year 1992, received in an unformatted file, to WordPerfect. After editing the text, we uploaded the file to a computer and processed and analyzed the information using SPSS statistical software.

Results

Voucher data. Between 1 April 1992 and 30 March 1993, 1,794 vouchers were issued from La Clinica to 677 registrants. Thirty-nine percent used one voucher, 46% used two to four vouchers, 13% used five to nine vouchers, and 2% used 10 to 31 vouchers. As expected, hospitalized and surgical patients who underwent multiple medical procedures received more vouchers than other voucher recipients. As summarized in table 1, most recipients lived in the La Clinica nine-county service area; only about 21% lived outside this area.

To calculate billing information for this article, we used only records that included entries for charges and payments. Of the 1,794 vouchers issued, 1,578 records were complete. La Clinica vouchers paid $83,833 toward provider fees. We excluded a few vouchers from the analysis because they were ultimately paid by Workers' Compensation or the Salvation Army.

Each "case" in this analysis is an individual voucher rather than an individual patient or voucher user. All numbers and percentages in the tables and charts refer to vouchers, not to patients.

Patient sex, age, and location. Of the 1,794 vouchers, women received 55%, and men received 45%. This contrast may signify a sex difference in overall use of health care or in the proportion of men and women in the migrant population. Likewise, numbers of vouchers issued to patients in various age groups may reflect the age distribution of all migrant workers: ages 18 to 64 used 77% of the vouchers, younger than age 18 used 22%, and ages 65 and older used less than 1% (table 2). The percentages for vouchers issued to men and women were about the same in each age group.

Most of the migrant workers receiving vouchers live and work in the southern and central parts of Wisconsin. Of the 1,794 vouchers issued, La Clinica received 1,015 (56%) from providers practicing in the same counties in which their patients lived. Cited as the camp or resident county, Waushara County where La Clinica is located, appeared on about 40% of all vouchers. Likewise, for services rendered, Waushara County providers submitted 41.9% of the vouchers. These percentages reflect both the county's large concentration of migrant workers and La Clinica's role as their primary health care institution.

Service code, provider type, and provider location. La Clinica records include two related codes for determining service information. One denotes types of health service for which the vouchers are used, and the other distinguishes types of health care providers. Not only is there substantial

Table 2. La Clinica voucher users by age and sex

			Men		Women	
Age category (years)	Total	Percent	Number	Percent	Number	Percent
Younger than 5	161	9.0	78	9.6	83	8.5
5–17	238	13.3	107	13.2	131	13.4
18–34	649	36.2	271	33.3	378	38.5
35–64	734	40.8	354	43.7	380	38.7
65 and older	11	0.6	2	0.2	9	0.9
Unknown	1	0.1	1	0.1	0	0.0
Totals	1,794	100.0	813	100.0	981	100.0

Table 1. La Clinica's voucher users and registrants by service area

	Voucher users		Total registrants		Percent received
Area	Number	Percent	Number	Percent	voucher
Inside nine-county service area	534	78.9	4,182	73.0	33.5
Outside service area	143	21.1	1,547	27.0	25.3
Total	677	100.0	5,729	100.0	31.3

overlap between "service code" and "provider type" (dental care in dental offices), but also, in some cases, health care providers—hospitals or large clinics—offer a wider range of services than other providers. Consequently, a voucher used at a hospital for laboratory work will be coded "hospital" for "provider type" and "laboratory" for "service code." Conversely, some services commonly associated with hospitals—obstetric and gynecologic care—are available through individual or group practices. Since most service and provider codes are closely associated, we are reporting only service codes.

As shown in figure 1, the difference between how men and women use the vouchers is slight. The largest proportion were used for hospital services, then for physician or clinic office visits and prescriptions. A total of 43.8% of the vouchers paid for hospital services, including X-ray and ultrasound (23.6%), emergency room care (16.2%), inpatient hospital services (3.5%), and physician services (3.5%) (table 3). All but the oldest group used most of their vouchers for hospital services, then for physician and clinic services (fig. 2). Older patients used their vouchers mainly for physician (primary care) services, then for prescriptions.

We analyzed the data to determine whether vouchers submitted by different types of providers were used in the resident or camp counties or in other counties. For all types of providers, more than half of the vouchers were used in the resident or camp county. The highest proportion of vouchers used outside the patient's county paid for dental care.

Amount of bill and amount paid by voucher. The voucher program uses Federal funds to subsidize migrant health care throughout Wisconsin. Because these funds are limited, La Clinica establishes annual guidelines to set payment ceilings for different kinds of health care. In most health service categories, these limits are somewhat lower than the prices health care practitioners normally charge. Providers are informed about the reimbursement schedule when they agree to take part in the program; their fees, however, are not prescribed. Since voucher records show that most providers submit a bill for more than the reimbursement schedule, the clinic's payments invariably do not cover the billed charges.

Table 3. Detailed service code for La Clinica voucher users

Code	Number	Percent
Hospital	839	43.8
Emergency room services and physician	291	16.2
Inpatient hospital	63	3.5
Physician services	63	3.5
X-ray	197	11.0
X-ray interpretation	184	10.3
Ultrasound	41	2.3
Physician, group clinic	472	26.2
Dentist	64	3.6
Pharmacy	264	14.7
Laboratory	154	8.6
Unknown	1	0.1
Totals	1,794	100.0

The median amount per bill during fiscal 1992 was $47; the amount for all bills totalled $226,867. The median amount paid was $22; the partial reimbursement for all vouchers equalled $83,833. The amount paid for a single voucher ranged from $1 to $979. On the average, La Clinica paid 60% of each bill. Hospital bills and corresponding payments tended to be the largest, and pharmacy bills and payments were the lowest. Dentists received the highest proportion (70%) of the amounts they billed, and clinics and medical groups received the lowest (42%).

Differences in the proportions paid for various services and to various providers may reflect the practitioner's way of coping with the program's limited resources. Some billed for only the amount they expected to receive. Others, particularly dentists, scheduled two appointments for necessary work, submitting separate bills for each procedure (personal communication by Edward Pflug, La Clinica Director, April 1994).

As shown in figure 3, bill and payment amounts vary for the different age

Figure 1. Percentage distribution of service code by sex of patient

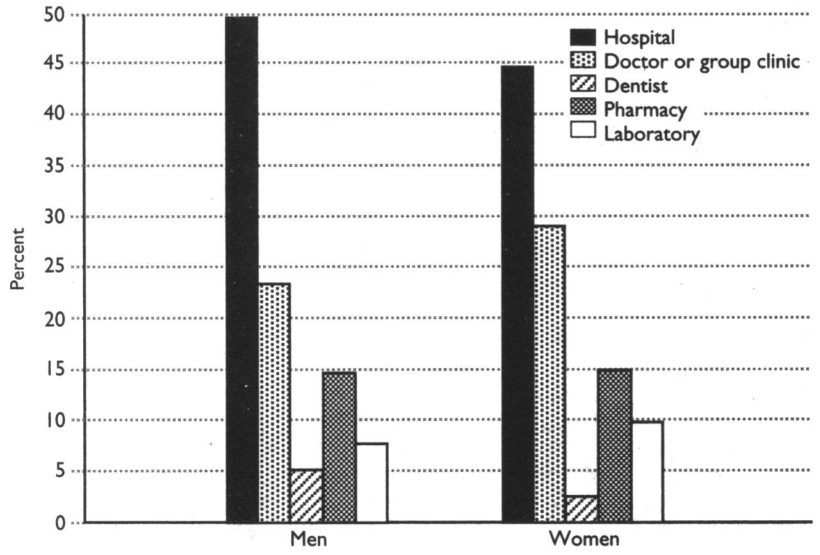
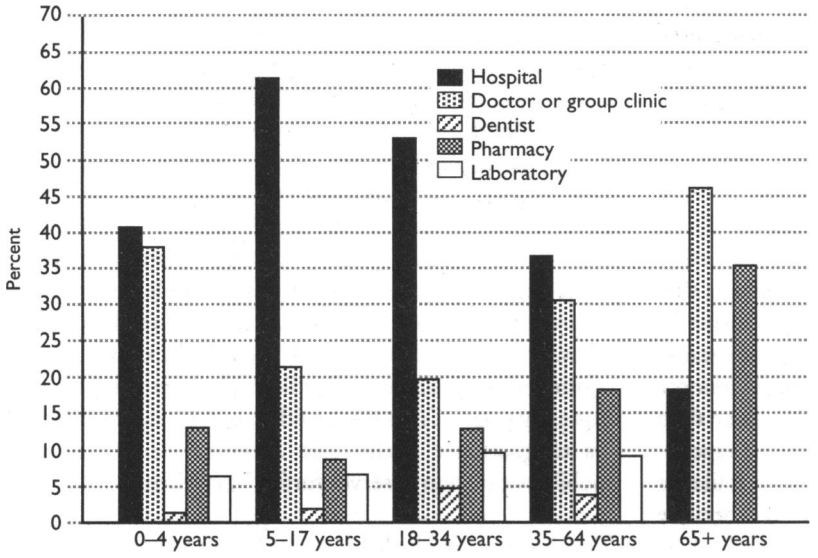


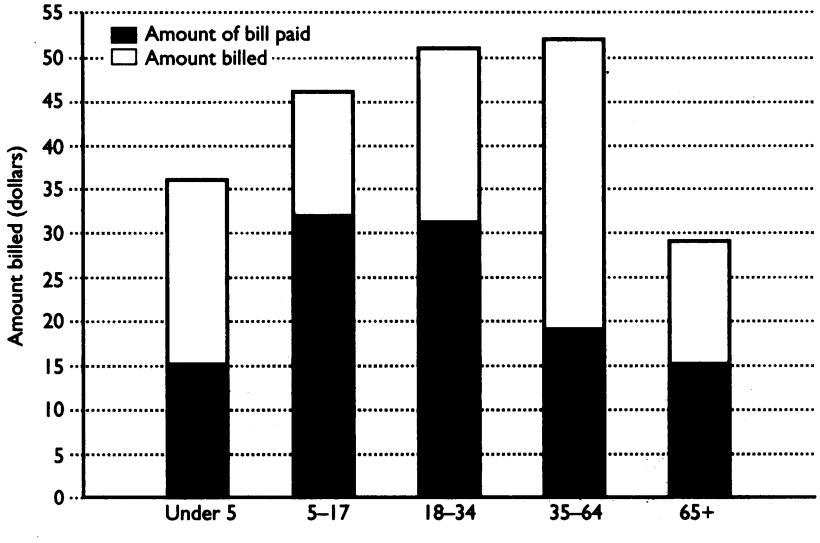
Figure 2. Percentage distribution of service code by age of patient



groups. Based on median amounts billed and paid, a sizable portion was allotted for ages 5 to 17—$32, the median amount paid for a median bill of $46. Median reimbursement amounts for ages 35 to 64 were considerably less—$19 for a median bill of $52.

The median amounts billed are almost equal for men and women, but the proportion of payment was higher for men (57%) than for women (42%). Location also influenced payment. Waushara County providers received substantially higher proportions (70.4%) than their counterparts in other counties (51.5%). Nearly half of all vouchers used in Waushara county covered hospital services, which generally cost more and are paid at a relatively high rate. Hospitals averaged 65% of the amount billed compared with 60% for all bills together. Waushara County providers, who have treated La Clinica patients for many years, probably adjusted their billing procedures to parallel more closely La Clinica's official reimbursement limits.

Figure 3. Median amount billed and paid by age of patient



Discussion

We learned from the La Clinica voucher records how the clinic distributes voucher payments statewide, how age and sex influence the use of vouchers, and how the system disburses funds for various migrant health care services. We found that La Clinica issues most vouchers for procedures and services not provided at its facility. Although the program is designed to improve access to health care for migrant workers outside the nine-county primary service area, only 20% of all 1992 vouchers were used for care in outlying counties. La Clinica issued more than 80% for medical care within its primary service area, where most of the State's migrant workers live. Since La Clinica is still a main source for migrant primary care, offering vouchers for health care in other counties augments rather than replaces the clinic's work.

The number of vouchers issued has increased in the past few years. According to data from a 1989 Migrant Health Survey[7,8], migrant workers were relatively unfamiliar with the novel practice of paying for health care with La Clinica vouchers. Some migrant workers who received vouchers had difficulty dealing with the private practitioners mainly because of linguistic and cultural differences. But the number of vouchers issued still grows each season. In fiscal 1991, La Clinica processed 1,012 vouchers; in fiscal 1992, La Clinica processed nearly 1,800 vouchers. Presumably, migrant workers and private practitioners are more familiar with the program.

This basic voucher information by itself, however, does not allow us to analyze important qualitative questions about the effectiveness of the voucher program or about ways it may be changing the provision of health care to migrant workers in Wisconsin. Rural health care providers are often unprepared to meet the special needs of migrant workers, especially in matters of language, literacy, and cultural

understandings of health and health care. Voucher programs theoretically could encourage local providers to address these special needs.

The Bureau of Primary Health Care, which regulates funding for migrant programs, requires staff members involved in the voucher program to develop "a plan for increasing the sensitivity of local providers to the health problems of migrant workers"[9]. La Clinica's outreach staff members work with the providers, but we do not know whether such efforts are effective. We know that there are problems. In its 1990 grant application, La Clinica questioned whether the voucher system could overcome traditional problems that impose barriers for migrant workers. Not being fluent in English, not being literate, and not having adequate transportation, migrant workers might be served better by remote clinics staffed with Spanish-speaking personnel rather than by a voucher system that uses predominantly English-speaking providers. When funds permit, La Clinica uses a trailer or mobile medical unit to reach migrant workers who otherwise might be overlooked. Nurse practitioners, not medical or dental personnel, usually staff the unit, which often is used for preventive screening, not urgent care.

In addition, there are concerns that the voucher program may divert migrant families from migrant health clinics if workers who develop relationships with local practitioners want to continue these associations or if La Clinica patients equate subsidized care with "welfare" and use their vouchers for private care to avoid the perceived stigma of clinic care.

Further research into these more qualitative questions would help Wisconsin providers and health care administrators and could affect health care far beyond State boundaries. Based on what we have learned, we recommend more research on two aspects of Wisconsin's voucher system: migrant worker usage and satisfaction and private practitioner experience with the program.

To explore the effectiveness of voucher programs, we recommend collecting comparative data from both Wisconsin and other State or regional migrant health programs. Comparing the data will help researchers and administrators devise improved national and State health care for underserved and indigent populations. Voucher programs can be considered experimental in partly exposing to the mainstream a group whose access to private practitioners has been too limited.

Carefully planned and executed voucher programs could be extended to benefit other groups. Such programs could become an integral part of medical care systems that serve Native American communities, whose clinics now serve only registered tribal members on and near the reservations. Community health or public health clinics serving geographically large rural areas also could extend their services to eligible residents in these outer regions. Where patients live more than 100 miles from a community health clinic, the voucher program could subsidize visits to nearby health care providers for emergency health care or for monitoring chronic illnesses.

With health care reform under debate, a closer look at voucher programs could be beneficial. We know that health maintenance organizations (HMOs), alliances of health providers, and other managed care systems do not cover all medical contingencies when subscribers need out-of-town care. Young retirees not yet eligible for Medicare often spend several months of the year in warmer climates. For coverage during this temporary migration, they must make complex arrangements for intermediate health care because the HMOs pay for only off-site emergencies or life-threatening illnesses. A voucher program carefully planned to complement these health care schemes would supplement any breach in coverage. Also, with a program that included a centralized recordkeeping system, HMOs could track and guarantee continued medical care, regardless of where it is received. In this early stage of national health care reform, offering vouchers to guarantee health care coverage for an increasingly mobile population deserves further investigation.

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