MIGRANT HEALTH PROGRAM

MIGRANT HEALTH CENTERS

Signed into law on September 25, 1962, by President John F. Kennedy, the Migrant Health Act established the authorization for delivery of primary and supplemental health services to migrant farmworkers. The Migrant Health Program is currently funded under the Consolidated Health Care Act of 1996 and administered by the Bureau of Primary Health Care, in the Health Resources and Services Administration, Department of Health and Human Services.

There are 177 federally funded migrant health center grantees. Most of the migrant health centers are private not-for-profit corporations owned and operated by community-based organizations, (CBOs), and some are operated by governmental entities such as state and local health departments.

Seventeen (17) of these grantees are also known as "Voucher Programs." The current list of Voucher Programs can be found here. Migrant Health Voucher Programs (MHVPs) are designed to operationalize and support their ability to increase access to comprehensive and integrated quality primary health care for migratory and seasonal agriculture workers (MSAWs). MHVPs receive Public Health Service 330 funds to coordinate, facilitate, and provide access to primary health care for MSAWs by purchasing some or all of the primary care required under Section 330. These programs serve a unique and diverse population of agricultural workers, utilizing a combination of service delivery models which include providing enabling and direct health care services and providing vouchers for primary health care with private providers. The voucher service delivery model increases access to care for MSAWs in areas with short agricultural seasons, limited agricultural activity and/or a widely dispersed MSAW population.

Collectively these health centers operate more than 2,480 satellite service sites and comprise a loosely knit network of independent organizations serving migratory and seasonal farmworkers. The satellite service sites can range in size and location. Some are located in frontier and rural areas serving small groups of farmworkers that are in the area for as short as 6 weeks and provide services through the use of payment vouchers that authorize care to be provided by local area private providers. Other sites are large jointly funded Community and Migrant Health Centers in high migrant impact areas with tens of thousands of farmworkers served within one health center corporation. Because all farmworkers deserve access to care, regardless of whether they live in densely or sparsely populated areas, it is required that all health centers provide services appropriate to the needs of their communities.

BACKGROUND

For almost 60 years, health centers in the United States have delivered comprehensive, high-quality primary health care to patients regardless of their ability to pay. Health center grantees have established a tradition of providing care for people underserved by America's health care system: the poor, uninsured, and homeless; minorities; migratory and seasonal farmworkers; public housing residents; and people with limited English proficiency. One unique feature of the Community and Migrant Health

Center legislation that has made the network so strong and enduring is the mandate that the governing boards of these entities be composed of a 51% majority of consumers of the health center's services. With the passage of the Migrant Health Act in 1962 federal support funded medical and support services for migratory and seasonal farmworkers and their family members. Two years later, the Economic Opportunity Act of 1964 provided Federal funds for two "neighborhood health centers," which were launched in 1965 by Jack Geiger and Count Gibson, physicians at Tufts University in Boston.

Those first two centers created an innovative new model of community-based, comprehensive primary health care that focused on outreach, disease prevention and patient education activities. The early centers also promoted local economic development, job training, nutritional counseling, sanitation, and social services. Most importantly, they established one of the enduring principles of the program: respect for patients and communities and their involvement in the operation and direction of health centers.

In the mid-1970s, Congress permanently authorized neighborhood health centers as “community health centers” and “migrant health centers” under sections 329 and 330 of the Public Health Service Act. Congress expanded the health center system in the later years of the 20th century. In 1987, the Health Care for the Homeless program was created by the McKinney Homeless Assistance Act and 3 years after that the Public Housing Primary Care program was established by the Disadvantaged Minority Health Improvement Act of 1990. Passage of the Health Centers Consolidation Act of 1996 brought authority for all four primary care programs – community (section E), migrant (section G), homeless (section H), and public housing (section I) -under section 330 of the PHS Act. (Source: The Bureau of Primary Health Care)

MIGRANT AND COMMUNITY HEALTH CENTER LEGISLATION

Health Centers Consolidation Act of 1996

Public Health Service Act (Sections 1-330) as amended through 2004

Health Care Safety Net Act of 2008

The Public Health Service Act is part of the U.S. Code. Section 330 was the numbering for the health centers section when the Public Health Services Act was a stand-alone document. The term "Section 330" is still used today. However, as part of the U.S. Code, it has been renumbered. Title 42 of the U.S. Code, Chapter 6A is the Public Health Service Act, and section 254b is the equivalent of Section 330. It is available online.