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# UTILIZATION OF CLINICS

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California Department of Health Care Services  
Report to the Legislature  
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### EXECUTIVE SUMMARY

The Health and Safety (H&S) Code Section 124485, requires the Department of Health Care Services (DHCS) to prepare and transmit a report to the Legislature describing its activities relating to the utilization of clinics, which provide comprehensive health services pursuant to the following five programs:

- Health of Seasonal Agricultural and Migratory Workers and Their Families Program (SAMW);
- American Indian Health Services Program (IHP);
- Rural Health Services Development Program (RHSD);
- Grants-In-Aid to Clinic Program (GIA); and
- California Health Services Corps Program (CHSC).

The report is to be transmitted to the Legislature by July 1, 1992, and by July 1, every fourth year thereafter. The following report describes activities conducted by DHCS that maintain the primary care clinic infrastructure and assists clinics to participate in California's Medicaid Program (Medi-Cal). These activities ensure clinic services remain available to the populations targeted in the above programs.

### BACKGROUND

The programs listed above are administered by DHCS's Primary, Rural, and Indian Health Division (PRIHD), which also administers the State Office of Rural Health, Small Rural Hospital Improvement, Medicare Rural Hospital Flexibility/Critical Access Hospital, and J-1 Visa Waiver programs per federal authority. PRIHD supports 14 Full-Time Equivalent positions to focus on the provision of training and technical assistance to primary care clinics.

The mission of DHCS is to provide Californians with access to affordable, integrated, high-quality health care. PRIHD supports DHCS' mission to improve the health status of targeted population groups residing in medically underserved urban and rural areas of California. The principal objectives of PRIHD are to expand and increase access to comprehensive primary and preventive health care services, and other public health services, for vulnerable individuals. These individuals include the medically uninsured or indigent, and those who would otherwise have limited or no access to health care services due to cultural or language barriers.

From the late 1970's to 2010, PRIHD administered grants to clinics to provide infrastructure funding for the provision of primary care to targeted populations. The clinic grants were allocated to SAMW; IHP; RHSD, and GIA. The state budget eliminated local assistance infrastructure grant funding (general fund) between fiscal years (FY) 2008-2010, for RHSD, SAMW, IHP and GIA. It should be noted that funding for support and local assistance for CHSC was never appropriated in the state budget.

Consequently, this report will focus on activities relating to: 1) training and technical assistance provided to maintain the primary care clinic infrastructure; and 2) Medi-Cal

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operational activities provided to clinics that serve the populations previously targeted under the SAMW, IHP, and RHSD programs. The GIA program did not target a particular population as did the SAMW, IHP, or RHSD programs. Rather, GIA funds were used to provide short term supplemental funding to any eligible clinic that was at risk for immediate closure prior to the GIA elimination from the state budget in 2008-2010. Therefore, GIA activities are not detailed explicitly in this report because the training and technical assistance provided for the SAMW, IHP, and RHSD programs applies to the same clinics that may have been formerly funded by GIA.

## CLINIC FUNDING

Primary care clinics, which serve populations targeted in SAMW, IHP, and RHSD, participate in Medi-Cal. Medi-Cal reimbursement for provision of services to low income, underserved populations allows the clinics to maintain a comprehensive suite of primary care services and expand sites to increase access to care. These clinics provide primary care medical services, dental services, behavioral health, and substance use disorder services to low-income uninsured and Medi-Cal populations. They also provide important services to other populations in the DHCS programs, such as Genetically Handicapped Persons Program and California Children's Services.

The clinics participate in Medi-Cal as a variety of "provider types" including Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Indian Health Services (IHS)/Memorandum of Agreement (MOA) Clinics. FQHCs, RHCs and IHS/MOA Clinics are required to provide services to patients regardless of income or insurance status. There are 975 FQHCs of which 335 are in rural communities, 339 RHCs, and 66 tribal health clinics, which provide essential services to low income and medically underserved populations. Although SAMW, IHP, and RHSD infrastructure grants are no longer funded, DHCS continues to utilize these clinics as safety net providers in Medi-Cal.

The following two tables display Medi-Cal claims paid to FQHCs, RHCs and IHS/MOA Clinics for the period July 1, 2012, through March 31, 2015, and estimated data from April through June 2015. This data includes per-visit code 18 payments ("wrap payments"), paid for services to Medi-Cal managed care members. As table 1 and table 2 demonstrate, the number of patients and health care visits and corresponding claims paid by Medi-Cal, increased significantly from July 2012, to March 2015. Notably, between FY 2013-14, and FY 2014-15, FQHC/RHC visits increased by 27 percent, expenditures increased by 26 percent and users increased by 44 percent. Between FY 2013-14, and FY 2014-15, IHS/MOA Clinic visits increased by 42 percent, expenditures increased by 50 percent and users increased by 51 percent.

The increases are likely due to Medicaid expansion to include childless adults consistent with the Affordable Care Act (ACA) and the simultaneous increase in clinic infrastructure funding for development of new clinic sites from the federal government to accommodate the increase in service demand by the new ACA eligible adults.

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**Table 1:** Medi-Cal Claims Paid by the Fiscal Intermediary (FI) to FQHCs and RHCs in Rural Counties July 2012 through June 2015.

Fiscal Year	Visits	Expenditures	Unduplicated Users
FY 2012-13	3,039,048	\$368,016,950	695,883
FY 2013-14	3,542,567	\$436,619,704	851,188
FY 2014-15*	4,485,208	\$548,605,948	1,229,935

\*Based on actual data from July 2014 – March 2015, and estimated data from April – June 2015

**Table 2:** Medi-Cal Claims Paid by the FI to IHS/MOA 638 Clinics in Urban and Rural Counties July 2012 through June 2015

Fiscal Year	Visits	Expenditures	Unduplicated Users
FY 2012-13	207,936	\$59,817,226	52,073
FY 2013-14	270,092	\$80,232,109	68,276
FY 2014-15*	384,489	\$120,389,212	102,903

\*Based on actual data from July 2014 - March 2015, and estimated data from April - June 2015

### **SEASONAL AGRICULTURAL AND MIGRATORY WORKERS (SAMW)**

SAMW, established in 1977, is governed by H&S Code Sections 124400 through 124440 and 124550 through 124570. SAMW previously provided clinic infrastructure grants, and requires DHCS to provide technical assistance to migrant clinics, which deliver primary care services and health education to seasonal agricultural and migratory workers and their dependents. Additionally, SAMW requires DHCS to examine and monitor the health status and health services of seasonal and agricultural workers and their dependents, and coordinate with similar federal and state programs and voluntary agencies.

#### **Local Assistance**

The local assistance funding for migrant health clinics was eliminated in FY 2009-2010, and subsequent years; however, the Health Services and Resources Administration (HRSA) provides federal infrastructure grants to migrant health centers in California.

#### **Training and Technical Assistance Activities**

PRIHD provided the following trainings and technical assistance to SAMW clinics from FY 2012-2013 to FY 2015-2016:

- Disseminated information regarding migrant health research findings, state legislative updates, state programs policy updates, and federal rulemaking;
- Distributed information on the availability of federal grants and loans, through an email listserv, which afforded migrant health clinics alternative funding opportunities;
- Provided technical support to migrant health clinics with HRSA federal grant applications;

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- Delivered outreach training regarding pesticide poisoning affecting seasonal and migrant workers in collaboration with the California Department of Public Health (CDPH) Office of Binational Border Health;
- Delivered health specific training webinars to clinicians and administrators regarding smoking cessation through the Medi-Cal Incentives to Quit Smoking Project, which teaches strategies to encourage Medi-Cal enrollees to quit smoking and provides incentives to quit smoking;
- Provided training and technical assistance on effective telemedicine networks and strategies to develop and maintain the healthcare workforce;
- Provided technical assistance and health education materials to migrant health clinics on issues including pesticide exposure;
- Provided trainings to administrators, clinicians, and clinic outreach workers/promoters on topics including best practices in recruiting and retaining rural health workforce, emergency preparedness;
- Provided trainings to administrators on the use of United States (U.S.) Department of Veteran Administration's Veteran's Choice Program for veterans to obtain services from safety net providers; and
- Compiled and disseminated research on seasonal agricultural and migratory workers and dependents health population status, rural population demographic information, insurance utilization, and migrant health resources.

### **Medi-Cal Operational Activities**

There are currently 30 migrant health clinics funded by HRSA. PRIHD was responsible for the following list of Medi-Cal operational functions in regards to migrant clinics from FY 2012-2013 to FY 2015-2016:

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- Researched and analyzed Medi-Cal billing services information rendered by migrant health clinics;
- Interpreted federal and state policies regarding FQHCs, and updated the Medi-Cal Provider Policy Manual, prepared Operating Instruction Letters to the Medi-Cal FI to amend FQHC policies or payments;
- Prepared and submitted the cost of inflation Medicare Economic Index (MEI) rate to the Medi-Cal FI. The MEI rate is applied to the FQHC payment, which is adjusted annually based on federal law;
- Prepared analyses on proposed legislation regarding FQHC benefits provided to Medi-Cal enrollees, provider payments, and provider services; and
- Provided information to clinic executive directors on Medicaid rate setting procedures for new clinic sites.

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### **INDIAN HEALTH PROGRAM (IHP)**

IHP, established in 1976 by H&S Code 124575 through 124595, directs DHCS to maintain a program for American Indians and their families. To meet these mandates, DHCS provides technical assistance and training to American Indian health clinics, and coordinates with similar programs of the federal government, other states, and voluntary programs and conducts studies on the health and health services available to American Indians and their families throughout the state per the statute. Additionally, IHP administers the American Indian Infant Health Initiative (AIIHI) and manages a Tribal Emergency Preparedness program through an interagency agreement with the CDPH Emergency Preparedness Office.

#### **Local Assistance**

- Provided \$2.096 million (Federal Title V) in grants to four Indian health clinic corporations for the administration of AIIHI from FY 2012-2013, through FY 2015-2016. AIIHI provides home visitation support services and health care instruction to high risk pregnant and parenting American Indian families in five counties: Humboldt, Riverside, Sacramento, San Bernardino, and San Diego; and
- Provided oversight and monitoring of grant deliverables to ensure compliance with state and federal requirements.

#### **Training and Technical Assistance Activities**

PRIHD provided the following trainings and technical assistance to Indian health clinics from FY 2012-2013 to FY 2015-2016:

- Provided training and technical assistance through onsite visits, webinars, and phone consultation to clinics on licensing requirements, provider enrollment, annual claims reconciliations, etc.;
- Conducted two annual regional trainings for AIIHI personnel on subjects such as: Hepatitis C and Injection Drug Use, Working with Drug-Impaired Families, Adolescent Pregnancy Prevention, Women and Co-Dependency, Fetal Alcohol Spectrum, Children's Oral Health, Methamphetamine Use in Native Communities, Resilience and Cultural Factors, Car Seat Safety, Childhood Lead Poisoning, Sudden Infant Death Syndrome, Domestic Violence, Breastfeeding, Native Women and Historical Trauma, Perinatal Mental Health, and Adverse Childhood Experiences;
- Transitioned existing AIIHI grantees to the Family Spirit (FS) Home Visitation model. The FS model is an evidence-based, culturally tailored home-visiting program of the Johns Hopkins Center for American Indian Health. FS promotes optimal health and wellbeing for high-risk American Indian mothers and their children through the use of paraprofessionals who provide support and health education;
- Provided on-site technical assistance to maintain grant compliance and orientation of new AIIHI staff;
- Completed an annual emergency preparedness and response needs assessment survey of Indian health clinics of which the results were used to determine training and technical assistance needs for the clinics;

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- Based on results of the survey, PRIHD provided emergency preparedness training and on-site technical assistance to Indian Health clinics and communities on active shooter training, community mental health first aid, preparing for emergency and disasters, and continuity of operations incident command systems;
- PRIHD hosted two regional emergency preparedness trainings. Topics covered included: working with local public health departments during an emergency, preparing for ongoing drought impact, building a strong tribal health clinic preparedness program, working effectively with tribal governments, developing individual clinic emergency plans, working with the Federal Emergency Management Agency, and how to address cultural, spiritual, physical, and mental health needs during a community emergency; and
- PRIHD worked with consultants on the development of the DVD, "From the Ashes," which focused on resilience and collaboration with county services during a fire disaster. The DVD was provided to all Tribal health programs to encourage collaboration with local health departments and first responders.

### **Medi-Cal Operational Activities**

PRIHD was responsible for the Medi-Cal operational functions for 69 primary care clinic sites in California serving American Indians including, 11 FQHCs and 58 IHS/MOA Clinics, for FY 2012-2013 to FY 2015-2016:

Activities included:

- Provided information and sought input from Tribes and American Indian health clinics on proposed changes to Medi-Cal as required by the American Recovery and Reinvestment Act of 2009, utilizing various communication methods including written notifications, webinars, face-to-face meetings, and teleconferences;
- Maintained listserv of Tribes and Indian health clinic designees for dissemination of information and funding opportunities;
- Researched and analyzed Medi-Cal services and billing policies for compliance with federal and state guidelines for IHPs;
- Responsible for Medi-Cal administrative functions including assisting in the development of Medi-Cal policies affecting IHPs, review of Medi-Cal provider manual updates, Medi-Cal system changes, bill analysis, and annual tribal health clinic rate changes;
- Researched and developed Indian health clinic Medi-Cal utilization profile;
- Provided presentations on Indian health related Medi-Cal and DHCS activities to IHPs, tribal stakeholders, and federal partners; and
- Researched and developed training to provide DHCS staff with information to effectively implement federal and state provisions of Medicaid regulations that affect Indians and IHPs in California.

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### **RURAL HEALTH SERVICES DEVELOPMENT (RHSD)**

RHSD, established in 1977, is governed by H&S Code Sections 124600 through 124785. RHSD requires DHCS to provide infrastructure grants and technical assistance to primary care clinics to ensure the maintenance of adequate health services and resources for medically underserved populations living in rural areas of the state.

#### **Local Assistance**

The local assistance funding for primary care clinics was eliminated in FY 2009-2010, and subsequent years; however, HRSA provides federal infrastructure grants to community health centers in California.

#### **Training and Technical Assistance Activities**

PRiHD provided the following trainings and technical assistance to RHSD clinics from FY 2012-2013 to FY 2015-2016:

- Disseminated information regarding rural health population research findings, state legislative updates, state programs policy updates, and federal rulemaking;
- Distributed information on the availability of federal grants and loans through an email listserv, which afforded RHCs optional funding opportunities;
- Provided technical support to rural primary care clinics with HRSA and US Department of Agriculture federal grant applications;
- Coordinated with federal, state, and stakeholder groups, such as HRSA, Federal Office of Rural Health Policy, Bureau of Health Workforce, Office of Statewide Health Planning and Development, California State Rural Health Association, California Primary Care Association, California Association of Rural Health Clinics, Statewide Area Health Education Center Program, California Telehealth Resource Centers, and CDPH in the dissemination of information regarding health prevention strategies, health care delivery models, quality improvement models, and federal policy and/or regulation updates to rural primary care administrators;
- Provided funding for the California annual rural health conferences;
- Provided technical assistance and trainings to administrators on topics including, but not limited to: effective telemedicine networks and strategies to develop and maintain a rural healthcare workforce; strategies for successful Health Information Technology (HIT) adoption; federally mandated HIT requirements and financing (including the implementation of electronic health records); Medicare's Physician Quality Reporting System requirements; preparation for federal health care reform; expansion of managed care in rural counties; best practices in recruiting and retaining rural health workforce; navigating veteran health services in rural counties; implementing effective quality improvement programs and evaluation of such programs; managing challenges in a rural primary care clinic; ACA provider screening and enrollment requirements; and community level emergency preparedness; and
- Compiled and disseminated research on rural health population status, rural population demographic information, insurance utilization, and rural health resources.

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### **Medi-Cal Operational Activities**

There are currently 674 rural primary care clinics enrolled as either FQHC or RHC Medi-Cal providers. PRIHD was responsible for the Medi-Cal operational functions in RHSD clinics from FY 2012-2013 to FY 2015-2016 as follows:

- Researched and analyzed Medi-Cal billing information regarding services rendered by rural primary care clinics;
- Provided information on Medicaid rate setting requirements, change in scope of service, auditing, Medicaid waivers, state plan amendments, dental services, mental health services, podiatry services, chiropractic services and optometry services for new clinic sites;
- Interpreted federal and state policies regarding FQHCs and updated the Medi-Cal Provider Policy Manual, prepared Operating Instruction Letters to the Medi-Cal FI to amend FQHC/RHC policies or payments, and prepared analyses of state legislation regarding FQHC/RHC policy;
- Prepared and submitted the cost of inflation MEI rate to the Medi-Cal FI. (The MEI rate is applied to the FQHC/RHC prospective payment rate, which is adjusted annually based on federal law); and
- Prepared analysis on the impact of legislation and state plan changes regarding FQHC/RHC benefits provided to Medi-Cal enrollees, provider payments, and provider services.
- Compiled and disseminated information pertaining to the expansion of managed care
- Provided responses to rural primary care providers on managed care services, enrollment procedures, and billing processes.

### **CALIFORNIA HEALTH SERVICES CORPS (CHSC)**

CHSC, established by Senate Bill 1117 in 1983, was intended as a healthcare workforce program. The purpose was to utilize available health personnel in rural areas designated as medically underserved. CHSC members were to be assigned to health providers or facilities in rural areas. CHSC was never funded after the passage of the legislation which authorized it; however, PRIHD addresses the intent through the administration of three federal Exchange Visitor Visa Waiver programs: the California Conrad 30 J-1 Visa Waiver Program; the U.S. Department of Health and Human Services (HHS) J-1 Visa Waiver Program; and the National Interest Waiver Program. These federal programs recommend placement of physicians in California clinics, where they provide primary care and mental health services in Health Professional Shortage Areas (HPSAs) or medically underserved areas.

### **Conrad State 30 J-1 Visa Waiver Program**

Federal law requires that foreign physicians seeking to pursue graduate medical education or training in the U.S. must obtain a J-1 Visa as a foreign visitor. Upon completion of their studies, physicians must return to their home country for at least two years before they can return to the U.S. to live and work. Federal legislation allows each state's Department of Health to annually sponsor up to 30 foreign medical graduates for waiver of the two-year home residency requirement of a physician's J-1 Visa. An

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approved J-1 Visa waiver applicant is required to work full-time in a federally designated, medically underserved area, for at least three years. This law permits J-1 Visa physicians to apply for a waiver for the two-year home residency requirement upon completion of their graduate medical education, with a recommendation from DHCS. From ,FY 2012-2013 to FY 2015-2016: by recommending foreign medical post-graduates to the U.S. Department of State for J-1 Visa Waivers, PRIHD assisted in the placement of 120 foreign primary care physicians in California to serve in clinics in HPSAs.

### **HHS J-1 Visa Waiver Program**

Similar to the Conrad 30 J-1 Visa Program, the HHS J-1 Visa Waiver Program accepts applications from physicians who received a J-1 Visa and completed their post graduate medical education and are requesting a waiver of the two-year foreign residency requirement. The physician applies directly to HHS. Federal law requires states to verify facts presented in the application. This program allows the physician to apply for the waiver even if California's 30 slots are filled.

A physician, who is granted a HHS J-1 visa waiver, must agree to deliver services for at least three years in a health care facility located in a HHS-designated primary care or mental health HPSA. Additionally, the facility must be one of the following: a FQHC as defined under Section 330 of the US Public Health Service Act, a RHC as defined under Sections 1102 and 1871 of the Social Security Act, or a Native American/Alaskan Native tribal medical facility as defined by the Indian Self-Determination and Education Assistance Act (P.L. 93-638).

From FY 2012-2013 to FY 2015-2016, PRIHD assisted in the placement of 24 primary care physicians in California to serve in clinics in HPSAs, by recommending foreign medical post-graduates to the US Department of State for J-1 Visa Waivers.

### **National Interest Waiver Program**

The Immigration and Nationality Act (INA), Section 203, authorizes the allocation of preference visas for employment based immigrants. Specifically, the 1999 Nursing Relief for Disadvantaged Areas Act permits a visa waiver, filed by a physician to provide health care in a HPSA. The INA allows the Attorney General to waive the job offer requirement placed on immigrants when the Attorney General determines the physician's services will be in the national interest.

A physician, who submits a waiver application, must agree to work 40 hours a week in a clinical practice for a period of 5 years in a medically underserved area/population, Mental Health Shortage Area or Veterans' Administration facility. It relieves the petitioner from fulfilling the labor certification requirement as administered by the US Department of Labor. Federal law requires states to verify certain facts presented in the application.

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From 2012 through 2016, PRIHD assisted in the placement of 77 primary care physicians in California to serve in clinics in HPSAs, by recommending foreign medical graduates to the US Citizenship and Immigration Services for National Interest Waivers.

## **CONCLUSION**

PRIHD continues to offer resources directly to clinics, although local assistance funding for SAMW, RHSD, and IHP programs were eliminated by 2010. PRIHD provides trainings and technical assistance on emergent health issues and system changes, and supports Medi-Cal operational activities for these programs to ensure adequate primary care services to Californians in rural and underserved populations.