Department of Health Care Services
Utilization of Clinics

Report to the Legislature

July 2020

UTILIZATION OF CLINICS

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EXECUTIVE SUMMARY

Health and Safety Code (HSC) Section 124485, requires the Department of Health Care Services (DHCS) to prepare and transmit to the Legislature a report of the department's activities relating to the utilization of clinics to provide comprehensive health services pursuant to the following five programs:

- 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 also required to include a description of any grant funds expended and the resources allocated to the programs by the department, including staff and support services. The report must be transmitted to the Legislature by July 1, of 1992, and every fourth year thereafter. This report covers the period of July 1, 2016 through June 30, 2020

Clinics provide primary medical, dental, mental health, and substance use disorder services to targeted populations in underserved areas throughout the state. Data in this report shows an increase in the number of clinic visits and Medi-Cal reimbursement during the preceding years, from 2015-18. The report also describes DHCS activities related to provision of training, technical and financial assistance to clinics and organizations on issues impacting populations in the above listed programs.

INTRODUCTION

The SAMW, IHP, and RHSD programs are administered by the DHCS' Primary, Rural, and Indian Health Division (PRIHD). Combined, these programs support clinics providing health services for seasonal and migratory workers, American Indians, and rural residents and their families. DHCS' mission is to provide Californians with access to affordable, integrated, high-quality health care, including medical, dental, mental health, substance use treatment services and long-term care. PRIHD supports DHCS' mission to improve the health status of special, targeted population groups living in medically underserved urban and rural areas of California. The principal objective of the PRIHD is to improve and increase access to comprehensive primary and preventive health care services and other public health services for at-risk persons, including the medically uninsured or indigent, and those who would otherwise have either limited or no access to services due to cultural or language barriers.

The SAMW, IHP, RHSD, GIA, and CHSC programs were established in the late 1970s. Previously, most of the programs included funding for clinic infrastructure grants, technical assistance and training. Clinic grant funding was eliminated in Fiscal Year (FY) 2009-10 from the state budget. Subsequently, PRIHD focused efforts on development and implementation of clinic policies in the DHCS administered Medi-Cal program and training and technical assistance to SAMW, IHP, RHSD programs only between FYs 2016-20. The GIA program was designed to provide clinics with bridge funding when they were at risk for closure of services. Due to the elimination of funding, DHCS did not provide any training or technical assistance associated with this program, and has nothing to report on the GIA

program. Also, while there was never any funding for support and local assistance allocated for the CHSC program, PRIHD manages several programs established to increase the primary care workforce in underserved areas. Therefore, those activities are described in this report instead. PRIHD also administers the State Office of Rural Health, Small Rural Hospital Improvement Program, Medicare Rural Hospital Flexibility/Critical Access Hospital Program, J-1 Visa Waiver and Tribal Emergency Preparedness and Response programs with federal grant funding. PRIHD supports approximately 15 Full-Time Equivalent positions to focus efforts on the provision of training, technical assistance, research, and coordination to maintain the clinic primary care infrastructure in California. This staff also provides support in the development of Medi-Cal policies that directly impact clinics. This report covers the period July 1, 2016 through June 30, 2020

CLINIC MEDI-CAL PARTICIPATION

Primary care clinics that participate in Medi-Cal, serve populations targeted in the SAMW, IHP, and RHSD programs. Theses clinics are enrolled in Medi-Cal as Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and Indian Health Services/Memorandum of Agreement (IHS/MOA) Medi-Cal provider types per Federal Medicaid statutes. According to the DHCS' Audits and Investigations Division, there were 1,190 FQHCs (350 of which are located in rural counties), 227 RHCs, and 94 tribal IHS/MOA clinics enrolled in Medi-Cal as of July 1, 2019.

The following two tables display Medi-Cal claims paid, visits, and clinic users in FQHCs, RHCs, and IHS/MOA clinics for the period of July 1, 2015 - June 2018. This data set represents three full years of information during the period of this report.

Table 1: Medi-Cal Claims Paid by the Medi-Cal Fiscal Intermediary (FI), Visits, and Users of FQHCs and RHCs in Urban and Rural Counties from July 2015 - June 2018.

FY	Visits	Expenditures	Unduplicated Users
FY 2015-16	16,281,860	$2,557,356,663.62	3,544,925
FY 2016-17	16,627,289	$2,672,367,502.95	3,378,756
FY 2017-18	16,761,045	$2,786,612,539.56	3,312,469

Source: Claims data for all years retrieved from DHCS Management Information System/Decision Support System (MIS/DSS) data warehouse.

The above data demonstrates the number of visits and reimbursements to FQHC and RHC clinics increased between FYs 2015-18, while number of unduplicated users decreased slightly. This suggests an overall increase in utilization by clinic users.

Table 2: Medi-Cal Claims Paid by the Medi-Cal FI, Visits, and Clinic Users in Tribal IHS/MOA Clinics in Rural Counties from July 2015 - June 2018:

FY	Visits	Expenditures	Unduplicated Users
FY 2015-16	429,941	$139,000,070.48	145,353
FY 2016-17	456,560	$152,343,319.00	153,954
FY 2017-18	489,849	$185,848,698.05	223,496

Source: Fee For Service Claims data for all years retrieved from DHCS MIS/DSS data warehouse. Managed care data for year 2018 retrieved from DHCS Capitation Payment Management System (CAPMAN).

The above data demonstrates a steady increase in the number of visits, reimbursements, and unduplicated users at IHS/MOA clinics between FYs 2015-18.

The remainder of the report will describe SAMW, IHP, RHSD, and CHSC related activities completed by PRIHD from 2016-20.

SEASONAL AGRICULTURAL AND MIGRATORY WORKERS

Established in 1977, the SAMW program was authorized by HSC Sections 124400-124440 and Sections 124550-124570. The SAMW program previously provided clinic infrastructure grants, requiring DHCS to provide technical assistance to migrant clinics for the delivery of primary care services and health education to seasonal agricultural and migratory workers and their dependents. Additionally, DHCS was required to examine and monitor the health status and available health services in coordination with similar federal and state programs as well as voluntary agencies.

As stated previously, state local assistance infrastructure grant funding of migrant health clinics was eliminated in FY 2009-10 and subsequent years. However, the federal Health Services and Resources Administration (HRSA) provides infrastructure funding to 30 migrant health clinics in California through the federal HRSA clinic “Health Center" program. These clinics participate in Medi-Cal as FQHCs. Federal HRSA also funds PRIHD’s State Office of Rural Health (SORH) through its “Federal Office of Rural Health Policy” program. SORHs are required to deliver training and technical assistance activities to rural providers including migrant health clinics. During 2016-20, SORH completed the following training and technical assistance:

- Disseminated information regarding migrant health research findings, state legislative updates, state program policy updates, and federal rulemaking at least monthly;
- Distributed bi-monthly information on the availability of federal grants and loans, which afforded migrant health clinics alternative funding opportunities through an email listserve;
- Provided annual grant writing workshops;
- Provided technical support to migrant health clinics with HRSA federal grant applications, as requested;
- 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 (OBBH);
- Delivered annual outreach training to Promotores/Promotoras that offers relevant health education and resources to seasonal, agricultural, migrant workers, and rural residents;
- Delivered health specific training webinars to clinicians and administrators regarding smoking cessation through the Medi-Cal Incentives to Quit Smoking Project, which encouraged Medi-Cal enrollees to quit smoking and provided incentives to quit smoking;
- Provided training and technical assistance on effective telemedicine networks and strategies to develop and maintain the healthcare workforce in partnership with the California Telehealth Resource Center (CTRC);
- Provided technical assistance and health education materials to migrant health clinics on issues including anti-microbial resistance, diabetes prevention, and use of pesticides;
- Provided trainings to administrators, clinicians, and clinic outreach workers/promotores on topics including best practices in recruiting and retaining rural health workforce and emergency preparedness;
- Provided trainings to administrators on the use of United States Department of Veteran Administration's Veteran's Choice Program for veterans to obtain services from safety net providers; and
- Disseminated research on seasonal agricultural and migratory workers and dependents health population status, rural population demographic information, insurance utilization, and migrant health resources.

Completed Medi-Cal Operations Activities including:
- FQHC Medi-Cal Provider Policy Manual updates
- Provided FQHC provider enrollment assistance
- Facilitated FQHC annual rate adjustments

INDIAN HEALTH PROGRAM (IHP)
Established in 1976, DHCS maintains a program for American Indians and their families, pursuant to HSC Sections 124575-124595. To meet these mandates, PRIHD provides technical and financial assistance and training to American Indian health clinics while coordinating 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.

As with the other clinic programs, infrastructure grant funds were eliminated in the IHP in FY 2009-10. However, PRIHD continues to administer grants to targeted clinics for maternal and child health related activities in response to the comparatively low maternal, child health status of American Indians. PRIHD is also responsible for coordinating the Medi-Cal operations functions for 107 Indian health clinics delivering primary care services throughout California, which includes:
- 94 Tribal IHS/MOA clinic sites
- 13 Urban Indian FQHC clinic sites

DHCS administers the maternal and child health program through an Interagency Agreement with CDPH. Grant funding was allocated through Title V of the Social Security Act in the amount of $1,312,500 to four Indian health clinic corporations for the implementation of the American Indian Infant Health Initiative (AIIHI) program from FYs 2016-2018. Through AIIHI grant funding, home visitation support services were conducted to provide health care instruction to high-risk pregnant and parenting American Indian families in five counties: Humboldt, Riverside, Sacramento, San Bernardino, and San Diego. PRIHD AIIHI activities included:

- Conducted annual regional trainings for local clinic AIIHI personnel on subjects such as: Intimate partner violence, Breastfeeding, Native Women and Historical Trauma, Ages and Stage Child Development Screenings, Oral health, Perinatal Mental Health, and Adverse Childhood Experiences; and
- Provided ongoing technical assistance to clinic personnel on AIIHI program specific issues

The AIIHI program was phased out in 2018 pursuant to a needs assessment completed by DHCS, which included extensive data analysis, and stakeholder input. (Notably, three of the four former AIIHI clinics secured alternative funding to maintain AIIHI services.) DHCS subsequently allocated $1,069,000 in Social Security Act Title V grant funding to four Indian health clinics for the administration of the American Indian Maternal Service and Supports (AIMSS) program in 2019. The AIMSS program is designed to support perinatal case management and home visitation services to improve American Indian perinatal outcomes in Fresno, Humboldt, Placer, and Shasta counties.

Through the AIMSS program, assistance to pregnant American Indian women during pregnancy and 6 weeks post-delivery provides a wide range of services such as care coordination, health care monitoring, education, emotional support, and referrals. Also, $127,500 in perinatal training funds was provided to ten Indian health clinics within the same year. These funds were used to train clinic staff on an evidence-based home visitation curriculum and/or training on maternal health education topics such as, substance use disorders and maternal/fetal health, maternal and infant nutrition, lactation, and maternal behavioral health,

Both the AIIHI and AIMSS programs utilized the “Family Spirit” (FS) model curriculum. The FS model is an evidence-based, culturally tailored home-visit program from 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.

In addition to the maternal and child health program related activities, DHCS is responsible for compliance activities related to American Indian Medicaid provisions in the American Recovery and Reinvestment Act of 2009 (ARRA). ARRA requires the DHCS to facilitate development of Medi-Cal policies affecting Indian health clinics based on input from tribes and designees of Indian health programs (clinics). To accomplish this, PRIHD provides regular presentations on Medi-Cal and DHCS activities to Indian health clinic representatives, tribal representatives, and federal partners. During the reporting period activities included quarterly written notices and webinars and two meetings annually.

Other Medi-Cal Operations Activities completed were:

- Provided training and technical assistance through onsite visits, webinars, and phone consultation to clinics on licensing requirements, provider enrollment, Medi-Cal managed care policies annual claims reconciliations;
- Completed Medi-Cal provider manual updates;
- Facilitated annual tribal health clinic rate changes;
- Provided presentations on Indian health related Medi-Cal and DHCS activities to tribal representatives and federal partners; and
- Provided technical support throughout the Medi-Cal program on issues of implementation of Medicaid regulations that affect American Indians and Indian health programs in California.

RURAL HEALTH SERVICES DEVELOPMENT

Established in 1977, RHSD is authorized by HSC Sections 124600-124785 to provide infrastructure grants and technical assistance to primary care clinics to assist in the maintenance of adequate health services and resources for medically underserved populations living in rural areas within the state. Similar to the SAMW program, local assistance funding for primary care clinics through RHSD was eliminated in FY 2009-10. Federal HRSA provides funding through the PRIHD's SORH program to deliver various activities related to rural primary care clinics.

During 2016-20, SORH completed the following training and technical assistance activities:

- Disseminated bi-monthly information regarding rural health population research findings, state legislative updates, state programs policy updates, navigating veteran health services in rural counties, and federal rulemaking;
- Distributed bi-monthly information regarding 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 U.S. Department of Agriculture federal grant applications as requested;
- Coordinated with federal, state, and stakeholder groups, such as HRSA's, Federal, Bureau of Health Workforce, California 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 Center, and CDPH in the dissemination of information regarding health prevention strategies, health care delivery models, quality improvement models, and federal policy and regulation updates to rural primary care administrators;
- Awarded funding for the Annual California Rural Health Conference;
- Supported technical assistance and trainings to administrators on topics including effective telemedicine networks, strategies to develop and maintain a rural healthcare workforce, 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.

Completed Medi-Cal Operations Activities including:

- FQHC and RHC Medi-Cal Provider Policy Manual updates;
- Prepared Operating Instruction Letters to the Medi-Cal Fiscal Intermediary to amend FQHC policies or payments as necessary;
- Provided FQHC and RHC provider enrollment assistance; and
- Facilitated Annual FQHC/RHC rate adjustment

CALIFORNIA HEALTH SERVICES CORPS

Established by Senate Bill 1117 in 1983, CHSC was intended to serve as a healthcare workforce program by utilizing available health professionals to serve 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 enactment of SB 1117; however, PRIHD addresses the intent of the legislation through the administration of three federal Exchange Visitor Visa Waiver programs and one Medi-Cal program:

- California Conrad 30 J-1 Visa Waiver Program;
- U.S. Department of Health and Human Services (HHS) J-1 Visa Waiver Program;
- National Interest Waiver Program; and
- Teaching Health Center Graduate Medical Education (THCGME) Program

The federal programs recommend placement of physicians in California clinics that have a history of recruitment challenges as they are located in federally designated Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas.

Conrad 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 practice. Federal legislation allows each state's Department of Health (or equivalent) to annually sponsor up to 30 foreign medical graduate waivers in lieu of the two-year home residency requirement of a physician's J-1 Visa. Approved J-1 Visa waiver applicants are required to work full-time in a federally designated, medically underserved area, for a minimum of three years. In accordance with this mandate, J-1 Visa physicians may apply for a waiver of the two-year home residency requirement upon completion of their graduate medical education, with a recommendation from DHCS. From FYs 2016-20, DHCS assisted in the placement of 120 foreign-born primary care physicians in California to serve in medically underserved areas. Approximately 45 were placed in clinic settings.

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 have completed their postgraduate 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 Conrad 30 J-1 Visa Waiver Program slots have been filled.

A physician who is granted a HHS J-1 visa waiver must agree to deliver services for a minimum of 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 (42 U.S.C. §254b)
- A RHC as defined under Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).; 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 FYs 2016-20, PRIHD assisted in the placement of 44 primary care physicians in California to serve in clinics in HPSAs, by recommending foreign medical post-graduates to the U.S. 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 federal Attorney General to waive the job offer requirement placed on immigrants when the federal Attorney General determines the physician's services will be of the national interest.

A physician who submits a waiver application must agree to work 40 hours per week in a clinical practice for a period of five years, within 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 U.S. Department of Labor. Federal law requires states to verify certain facts presented in the application prior to recommending the foreign medical graduates to the U.S. Citizenship and Immigration Services for National Interest Waivers. From FYs 2016-20, PRIHD assisted in the placement of 84 primary care physicians in California to serve in HPSA-located clinics.

Teaching Health Center Graduate Medical Education Program
The federal and state THCGME programs provide funding to support the training of residents in a new or expanded primary care residency training program in rural and underserved communities. While other residency programs base training out of hospitals, THCGME programs focus training in settings such as FQHCs, RHCs, or health centers operated an Indian tribe or an urban Indian organization tribal health program. There are nine FQHCs accredited as graduate medical education institutions. The Centers for Medicare and Medicaid approved a California State Plan Amendment in April 2018 to allow Medi-Cal reimbursement under the clinic Prospective Payment System methodology for services performed by qualifying THCGME primary care residents physicians at participating clinics.

TRIBAL EMERGENCY PREPAREDNESS AND RESPONSE PROGRAM
PRIHD through the Tribal Emergency Preparedness and Response Program (TEPRP) provides emergency preparedness and response trainings and technical assistance to tribal health clinics and tribes. TEPRP assists clinics and tribes to develop emergency

operation plans and provides trainings as needed. During FYs 2018-19, TEPRP assisted 28 tribal health clinics and 32 tribes for program-specific activities, including:

- Technical assistance and trainings in the development of emergency operations plans and mitigation planning; and
- Annual emergency preparedness workshops with a focus on Incident Command Systems, active shooter training, mitigation analysis and planning, promotion and collaboration between tribes and counties.

CONCLUSION

DHCS continues to offer resources directly to clinics. DHCS delivers trainings and technical assistance on emergent health issues and system changes, and supports Medi-Cal operational activities to clinics serving populations targeted in the SAMW, IHP, and RHSD programs. These efforts assist with strengthening primary care services delivery to Californians in rural and underserved populations. DHCS will submit the next report to the Legislature in July 2024 covering program activities from 2020-24.