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What Portion of Medi-Cal Primary Care Visits Are Provided by Health Centers?

An Analysis by Region, Race, and Ethnicity

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About the Authors

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About the Foundation

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DESIGN BY DANA KAY DESIGN

Introduction

The Medicaid program constitutes an important and growing source of health care coverage for the country as a whole and for California in particular. The percentage of the population covered by Medicaid/CHIP programs increased in California from 15.2% in 2008 (13.4% in the US) to a high of 27.2% in 2016 (20.8% in the US). It increased again in 2020 due in part to the adverse economic consequences of the COVID-19 pandemic and the concomitant participation of additional states in the Medicaid expansion.[1] In 2019, Medicaid/CHIP accounted for 17.4% of all health care expenditures in the US, and Medi-Cal (the Medicaid/CHIP program in California) accounted for over 33% of the total California budget.[2]

This report seeks to enhance stakeholder understanding of the role of FQHCs as Medi-Cal providers by offering a reliable estimate of the contribution of Federally Qualified Health Centers and related types of health centers to primary care visits for Medi-Cal enrollees. This analysis resulted from a collaboration with the California Department of Health Care Services' Data Management and Analytics Division (DMAD) in response to a request in accordance with the Public Records Act.[3]

Federally Qualified Health Centers (FQHCs) and similar community health centers are an important component of the health care safety net. Annual reporting by FQHCs and FQHC Look-Alikes (LALs) to the Human Resources and Services Administration (HRSA) indicates these clinics provided services to over 5.5 million Californians in 2019, at least 65% of whom were Medi-Cal enrollees.[4] Although these clinics report to both HRSA and the Department of Health Care Access and Information (formerly the California Office of Statewide Health Planning and Development), limitations on utilization data by payer source make it difficult to assess the attribution of specific services delivered by FQHCs and related clinics.[5] Consequently, it is difficult to assess, for example, what percentage of primary care visits by the Medi-Cal population are provided by FQHC and related clinics.

Administrators, policymakers, health professional groups, and many others are interested in better understanding what influences Medicaid spending in order to contain health care expenditures and to improve the value realized for those expenditures. Additionally, analysis of the utilization of health services (i.e., benefits) supports those goals by providing information about service demand, whether the population's service needs are met, whether resources are allocated appropriately, the quality and effectiveness of those services, and the relative influence of various services on Medicaid spending.

Methodology

The primary data source used for this analysis was the Management Information Systems / Data Support System (MIS/DSS) maintained by DMAD. The MIS/DSS contains information from over 30 different sources including the Medi-Cal Eligibility Data Systems; paid and unpaid claims from multiple sources (e.g., fee-for-service, dental, pharmacy, behavioral health claims); encounter data from managed care and County Organized Health System plans; the Family PACT program; aggregated episode-of-care data from a product called Symmetry; and a variety of reference data sets, such as International Classification of Diseases, 10th revision (ICD-10) and Current Procedural Terminology (CPT) codes.

The target category of service providers for this analysis is a subset of what are commonly referred to as "community health centers," of which there are over 2,000 service delivery sites in California.[6] For several reasons, mostly having to do with unique program requirements and payment

methodologies, this analysis focuses on FQHCs, LALs, and Rural Health Centers (RHCs), as explicitly defined by HRSA.[7] Using those definitions, the analysis in this paper includes 1,667 FQHCs and LALs plus 501 RHC clinics that define the numerator, and for the denominator, adds to those additional outpatient primary care and licensed clinics that are not federal health center program grantees or designated as Look-Alikes. Descriptive statistics for these organizations are including in Table 1.[8]

Table 1. Clinic Types Included in the Analysis

Denominator Clinics and Practices	**16,889**
Indian Health Services (includes 638 clinics)	61
Cost-based reimbursement clinics	26
Other outpatient clinics and providers	14,634
Numerator clinics	2,168
▸ FQHC and FQHC Look-Alikes	1,667
▸ Rural Health Centers	501

Note: *FQHC* is Federally Qualified Health Center.

For the purposes of this analysis, primary care services were defined by service type, service location, and provider specialty codes. The study was further limited to those services provided on an outpatient basis and distinguished from those documented on inpatient, long-term care, other institutional, and pharmacy claims. Dental, behavioral health, and substance use treatment claims were also excluded. This filter yielded nearly 72 million outpatient visits by over 31 million enrollees between October 2017 and December 2019.

The percentage of primary care services delivered by FQHCs, LALs, and RHCs was ultimately determined by dividing the number of primary care claims and encounters meeting analytic criteria and provided in FQHC, LAL, and RHC clinics (the numerator) by the number of primary care claims and encounters meeting analytic criteria and provided in any outpatient primary care settings meeting analytic criteria (the denominator). The appendix includes further detail about the methodology and business rules developed for this analysis.

Findings

Federally Qualified Health Centers, Look-Alikes, and Rural Health Centers provide a significant portion of primary care visits to Medi-Cal enrollees. On average, FQHCs, LALs, and RHCs delivered 43.7% of all primary care visits provided to Medi-Cal enrollees from October 1, 2017, through December 21, 2019. Moreover, there was a small but steady increase in the percentage of Medi-Cal primary care visits attributable to those clinics from a low of 42.9% in the last quarter of 2017 to a high of 45.1% in the second quarter of 2019. Those data are summarized by year and quarter in Table 2.

Table 2. Medi-Cal Primary Care Visits Provided by FQHCs/LALs/RHCs, October 1, 2017 to December 21, 2019

		PRIMARY CARE VISITS PROVIDED BY FQHC, LAL, AND RHC CLINICS	
YEAR/QUARTER OF VISIT	TOTAL PRIMARY CARE VISITS	NUMBER	PERCENTAGE
2017	—	**3,267,321**	—
▸ Q4	7,608,464	3,267,321	42.9%
2018	—	**13,767,414**	—
▸ Q1	8,522,608	3,608,149	42.3%
▸ Q2	7,914,841	3,415,669	43.2%
▸ Q3	7,762,313	3,380,153	43.5%
▸ Q4	7,748,107	3,363,443	43.4%
2019	—	**14,395,004**	—
▸ Q1	8,424,567	3,705,064	44.0%
▸ Q2	7,982,667	3,597,584	45.1%
▸ Q3	7,998,462	3,573,635	44.7%
▸ Q4	7,893,450	3,518,721	44.6%
TOTAL	**71,855,479**	**31,429,739**	**43.7%**

Note: *FQHC* is Federally Qualified Health Center, *LAL* is Look Alike, *RHC* is Rural Health Center.

Source: California DHCS MIS/DSS data warehouse, March 26, 2021.

These clinics provide a substantial percentage of primary care Medi-Cal visits regardless of race or ethnicity, with White and Latino/x enrollees having the highest utilization. Table 3 lists the Medi-Cal primary care visits attributable to FQHC, LAL, and RHC clinics by race and ethnicity. For the visit dates included in this analysis, the percentage of primary care visits attributable to these clinics was highest for those identifying as Other, White, or Latino/x (46.3%, 45.3%, and 45.2%, respectively). The lowest utilization occurred among consumers identifying as Black, American Indian and Alaska Native, or Asian, Native Hawaiian, and Pacific Islander, who received 38.1%, 37.2%, and 35.6% of their respective Medi-Cal primary care visits from FQHC, LAL, and RHC clinics.[9] It is difficult to draw conclusions about the reasons for these differences, given that a trend analysis was not performed by race/ethnicity. There is, however, considerable literature describing the relatively and persistently low utilization of primary care as a usual source of care for Black populations in the United States and a need for more focused research to facilitate a better understanding of the many and complicated factors that influence primary care utilization among people of color.[10] Additionally, there is a need to understand where people of color not going to FQHC, LAL, and RHC clinics are accessing primary care. For example, based on the makeup of the provider network in Los Angeles, a moderately high percentage of people are accessing care at community-based private, nonprofit hospitals and other practitioners who are not part of the traditional core safety net and instead constitute a "hidden safety net" of providers caring for low-income and vulnerable populations.

Table 3. Medi-Cal Primary Care Visits Provided by FQHCs/LALs/RHCs, by Race/Ethnicity, 2017–19

	NUMBER	PERCENTAGE
American Indian and Alaska Native	315,313	37.2%*
Asian, Native Hawaiian, and Pacific Islander	6,961,458	35.6%*
Black	4,662,697	38.1%*
Latino/x	36,835,139	45.2%
Other	5,151,802	46.3%†
Unknown	4,974,625	43.0%
White (non-Latino/x)	12,954,445	45.3%
TOTAL	**71,855,479**	**43.7%**

* Indicates $p < .0001$.

† Indicates $p < .002$.

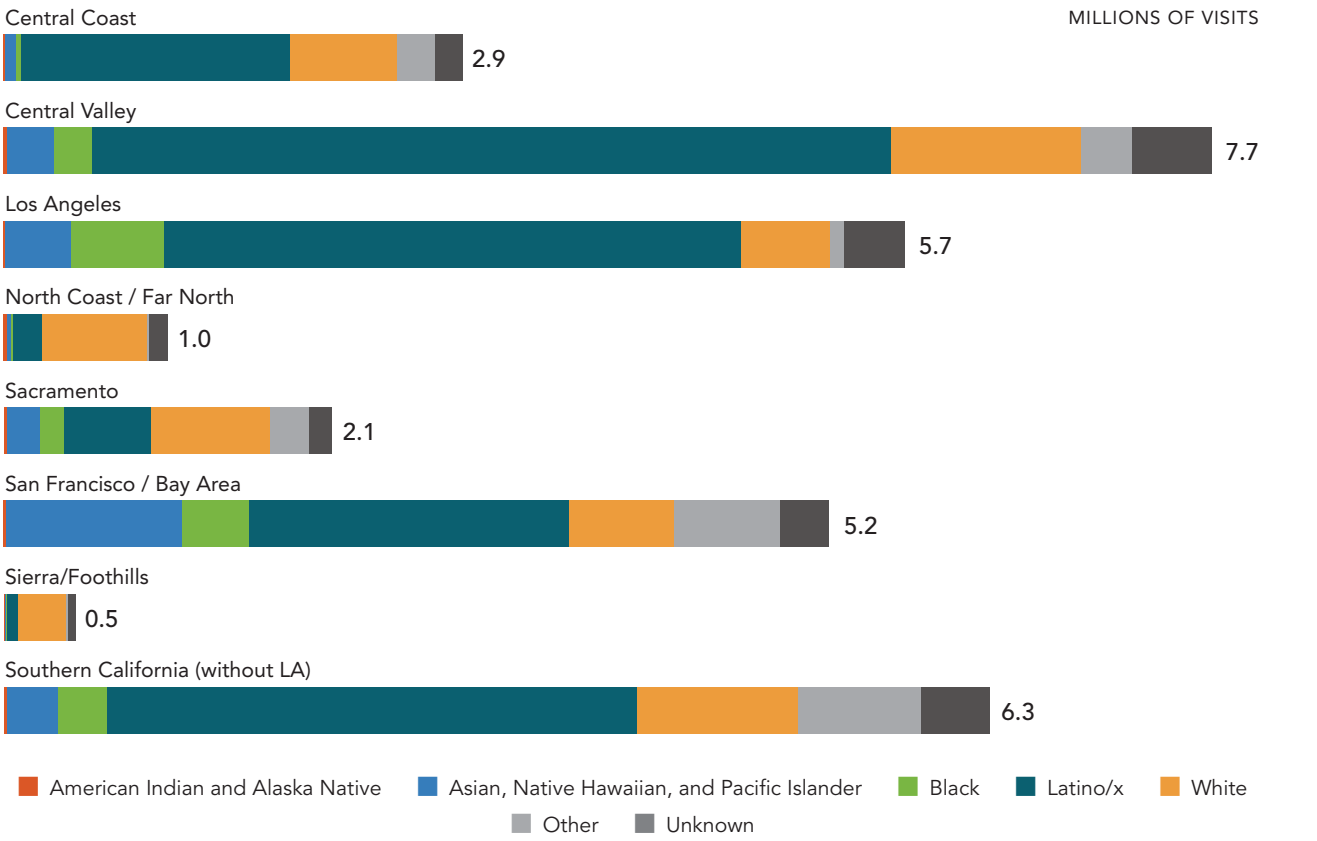
Notes: Survey respondents self-identified as *African American / Black*, *Asian / Other Pacific Islander*, *Hispanic*, and *White* (*non-Hispanic*). *FQHC* is Federally Qualified Health Center, *LAL* is Look Alike, *RHC* is Rural Health Center.

Source: California DHCS MIS/DSS data warehouse, March 26, 2021.

The percentage of primary care visits attributable to these clinics is highest in the North Coast / Far North and Central Valley market regions. Using the California Health Care Foundation regional market designation of California counties leads to greater understanding about the influence of geography on the source of primary care visits.[11] For example, the Los Angeles and Southern California regional markets each registers nearly 19 million primary care visits for Medi-Cal enrollees. Although the Central Valley region comes in third with nearly 14 million primary care visits, Figure 1 demonstrates that the Central Valley region has the highest total number of primary care visits attributable to FQHC, LAL, and RHC clinics (7,686,592, or 55.2% of all Medi-Cal primary care visits).

In Figure 2, it is noteworthy that despite the high total number of Medi-Cal primary care visits, the two largest regional markets, represented by the metropolitan Southern California region (excluding Los Angeles) and Los Angeles County itself, have the lowest percentages of primary care visits attributed to FQHCs, LALs, and RHCs (33.5% and 30.4%, respectively). That is not surprising given the plethora of health care options in these regional markets. Among the five counties in the Southern California regional market, Imperial stands out as a county whose Medi-Cal enrollees heavily utilize these clinics for primary care services (65.6% of primary care visits in Imperial County are attributable to FQHC/LAL/RHC clinics).

Figure 1. Total Medi-Cal Primary Care Visits Provided by FQHCs/LALs/RHCs, by Race/Ethnicity in Regional Markets

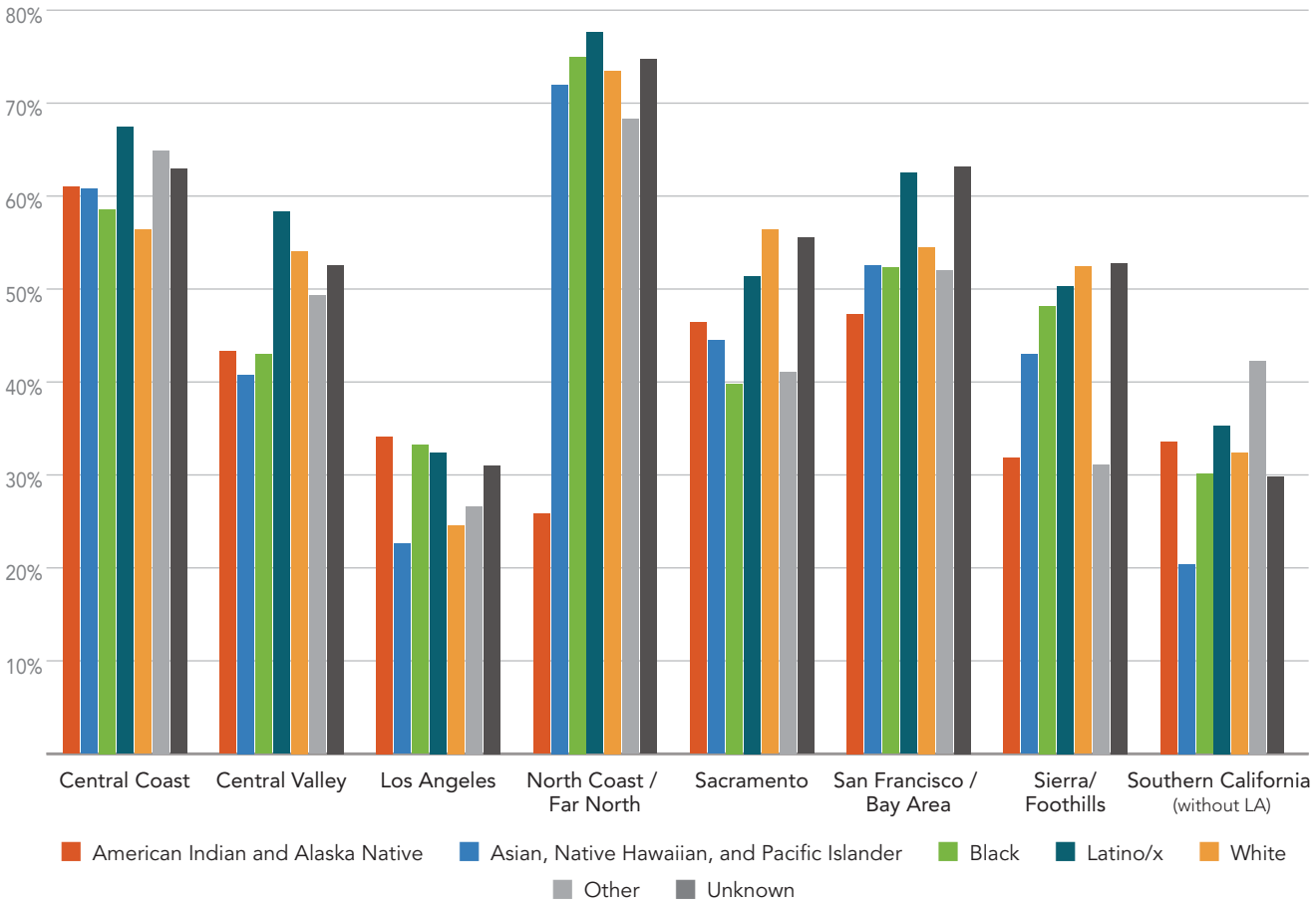


Note: Source uses *Asian / Other Pacific Islander*, *Black / African American*, and *Hispanic*.

Source: California DHCS MIS/DSS data warehouse, March 26, 2021.

Although the North Coast / Far North regional market has a relatively low overall number of Medi-Cal primary care visits (1,458,041), Figure 2 shows that the region boasts the highest percentage of primary care Medi-Cal visits attributable to FQHC/LAL/RHC clinics (71.5%) across the eight counties that make up that market. Within that region, Modoc and Mendocino Counties have the largest attribution of primary care visits to those clinics (79.9% and 79.0%, respectively). The North Coast / Far North regional market is followed closely by the Central Coast region, where 63.8% of its nearly 4.6 million Medi-Cal primary care visits are attributable to these clinics. Indeed, in nearly all the remaining regional markets, except the Los Angeles and the Southern California markets, at least half of the Medi-Cal primary care visits are provided by FQHC/LAL/RHC clinics (49.9% in the Sacramento Valley, 50.4% in the Sierra/Foothills, 55.2% in the Central Valley, and 56.9% in the San Francisco / Bay Area market).

Figure 2. Share of Medi-Cal Primary Care Visits Provided by FQHCs/LALs/RHCs, by Race/Ethnicity in Regional Markets



Note: Source uses *Asian / Other Pacific Islander*, *Black / African American*, and *Hispanic*.

Source: California DHCS MIS/DSS data warehouse, March 26, 2021.

Populations identifying as Latino/x and those identifying as American Indian / Alaska Native have the highest and lowest utilization, respectively, across all regions. People identifying as Latino/x have the highest total number of primary care visits (36.8 million) and, as seen in Figure 1, the highest number attributable to FQHC/LAL/RHC clinics (16.7 million) across the state and across all market regions excepting North Coast / Far North, Sierra/Foothills, and the Sacramento Valley. In those regions, people identifying as White dominate both total and FQHC/LAL/RHC-attributable primary care visits. Conversely, those identifying as American Indian / Alaska Native (AIAN) have the lowest numbers of primary care visits overall and in the FQHC/LAL/RHC clinics. That is most probably due to the more common utilization of Indian Health Services (IHS) or IHS-contracted clinics by this population.

Because the regional markets are made up of a number of counties (except the Los Angeles County region), details about racial/ethnic utilization across the regions may get obscured. Some of the notable findings from this analysis about primary care utilization across the regions and by race/ethnicity include the following (see Figure 2):

- While those identifying as Asian / Other Pacific Islanders (AOPI) appear to make limited use of Medi-Cal or FQHC/LAL/RHC sites for primary care, there are a few counties where utilization is higher among this group. In particular, there are counties within the North Coast / Far North, Sierra Foothills, and San Francisco / Bay Area regions where AOPI populations have higher attribution of primary care to the FQHC/LAL/RHC clinics. For example, in Calaveras County, 76.2% of the 527 primary care visits for this population were attributable to FQHC/LAL/RHC clinics, while 72.4% of the 7,800 visits in Humboldt and 64.7% of the 2,300 visits in Del Norte were attributable to these clinics. In Marin (San Francisco / Bay Area region), 87.2% of the 14,000 visits and in San Francisco County, 74.8% of the 18,900 visits for that population occurred in FQHC/LAL/RHC clinics.
- People identifying as Black / African American (BAA) appear to have the highest FQHC/LAL/RHC primary care utilization in Modoc and Lake Counties (both in the North Coast / Far North region) even though the total number of primary care visits is lower in those counties than in other counties or regions. In Modoc County, 77.8% of the nearly 2,100 primary care visits are attributable to FQHC/LAL/RHC sites, and in Lake County 77.9% of the 2,000 visits were provided in these clinics.

A downloadable data file with detailed race/ethnicity data is available at **www.chcf.org/publication/portion-medi-cal-primary-care-provided-health-centers**.

There is significant variation in primary care visit attribution by Medi-Cal aid code. The percentage of primary care visits attributable to FQHC, LAL, and RHC clinics varies across Medi-Cal aid codes from a low of 33.3% of primary care visits to people in the "Adoption Assistance" aid code group, to a high of 84.9% of primary care visits to people in the "Other_1" aid code group. The "Other_1" group includes enrollees who qualify as medically indigent adults, for refugee resettlement or minor consent services, and codes for those impacted by human trafficking, along with other smaller categories. Those in the "Pregnant Women" aid code and those qualifying under "Presumptive Eligibility" codes receive over 50% of their primary care visits from these clinics (53.8% and 51.0%, respectively). Almost half (45.1%) of primary care visits for those qualifying under the numerous "Low Income Families" aid codes were attributable to FQHC, LAL, and RHC clinics (there are over 60 Low Income Families aid codes). Table 4 lists the Medi-Cal primary care visits attributable to FQHC, LAL, and RHC clinics by aid code group.

Table 4. Medi-Cal Primary Care Visits Provided by FQHCs/LALs/RHCs, by Aid Code Group, 2017–19

	TOTAL PRIMARY CARE VISITS	PRIMARY CARE PROVIDED BY FQHC, LAL, AND RHC CLINICS
ACA Expansion Adults age 19–64	18,881,328	46.6%
Adoption Assistance	245,028	33.3%*
Aged/Blind/Disabled	12,883,799	42.6%
Children	14,170,871	41.0%
Former Foster Youth	70,717	43.7%
Foster Care	450,006	37.5%*
Low Income Families	17,203,203	45.1%
MCHIP	5,798,932	37.3%*
Other_1	41,935	84.9%*
Other_2	37,968	42.7%
Pregnant Women	1,040,909	53.8%*
Presumptive Eligibility	878,080	51.0%*
SCHIP	152,701	44.6%
TOTAL	**71,855,477**	**43.7%**

*Indicates $p < .01$.

Note: *FQHC* is Federally Qualified Health Center, *LAL* is Look Alike, *RHC* is Rural Health Center.

Source: California DHCS MIS/DSS data warehouse, March 26, 2021.

Data Limitations

Potential data challenges may have arisen due to the methodology, data sources, or the unique billing processes in FQHC, LAL, and RHC clinics. In the absence of a simple definition of primary care that can be operationalized for analysis, it is possible the business rules the authors used to define primary care services may not have been complete enough to capture all the services others might consider primary care. Variability in coding accuracy, completeness (especially for managed care encounters), and claims runout periods may have affected data quality. While the definitional choices could conceivably introduce some systematic gaps, one would expect challenges with coding and the claims cycle to affect the numerators and denominator equally. Claims runout should not be an issue, given the last year for data analysis was 2019.

The unique billing and payment mechanisms for FQHC, LAL, and RHC clinics introduce other, well-known challenges when analyzing activities based on claims or encounters. First, the prospective payment system method introduces distinctive billing and coding practices including unique codes for fee-for-service (FFS) and capitated visits. In particular, the use of a differential rate or wraparound code (code 18) reimburses an estimated amount payable to these providers on an interim basis for services to Medi-Cal enrollees in managed care plans (and for which an annual reconciliation process is required). Although mechanisms are in place at the state level, and the business rules included steps to avoid this, it is possible that these complexities could result in duplicated claims/encounters or dropped services. Additionally, because these clinics are generally prohibited from submitting more than one claim or encounter on a given day for a given location, regardless of how many providers were seen by a Medi-Cal enrollee, there is likely some undercounting of primary care services attributed to FQHC, LAL, and RHC clinics.[12]

Conclusion

The analysis conducted for this issue brief suggests that between the end of 2017 and the end of 2019, FQHC, LAL, and RHC clinics in California delivered nearly 44% of primary care visits to the Medi-Cal population.

There are two important conclusions to draw from this work. The first and most obvious is the indisputable contribution of FQHC, LAL, and RHC clinics to the safety net for Californians with low incomes, and more specifically, to comprehensive primary care services for the Medi-Cal population. Some of the variation in primary care utilization is predictable. For example, there was tremendous variation in the percentage of primary care visits attributable to these clinics among aid code groups, with pregnant women (53.8%), enrollees presumptively eligible (51.0%), and those with codes in the "Other_1" aid code group (84.9%) having the highest rates, while enrollees in the "Adoption Assistance" aid code group had the lowest percentage of primary care visits attributable to these clinics. While gender and age did not yield any significant variation, there was variation by race and ethnicity. Enrollees identifying as Black (38.1%), American Indian and Alaska Native (37.2%), and Asian, Native Hawaiian, and Pacific Islander (35.6%) had a lower percentage of primary care visits attributable to FQHC, LAL, RHC clinics than did White (45.3%) and Latino/x (45.2%) enrollees.

A broader finding relates to the difficulty and complexity of undertaking a utilization analysis to answer the relatively straightforward research question at the heart of this analysis: What percentage of Medi-Cal primary care visits take place in Federally Qualified, Look-Alike, and Rural Health Center Clinics? Fortunately, the Centers for Medicare & Medicaid Services (CMS) has been working with states on the Transformed Medicaid Statistical Information System (T-MSIS), which should improve

the accessibility and usability of basic claims and encounter data for Medicaid programs across the country.[13] Key California stakeholders are also continuing their own efforts to improve the quality of data in the MIS/DSS, including an encounter data improvement initiative that began in 2017.[14]

While the information gleaned from this analysis is helpful in affirming long-held beliefs about the significant role these safety-net clinics play in serving the Medi-Cal population, ready access to more comprehensive and timely utilization data would facilitate the answers to even more actionable questions, such as these:

- What have been the trends in the contribution of safety-net clinics to Medi-Cal primary care services over the past 10 to 15 years (encompassing passage of the Affordable Care Act in 2008 and the Medicaid expansion in January 2014)?
- Are there significant differences by race, ethnicity, clinic type, size, or region?
- Are safety-net clinics coding comprehensively enough to effectively support value-based payment arrangements?

Some of these questions have taken on additional significance in recent months, given the obvious health disparities related to the COVID-19 pandemic and the appropriate inquiries about which determinants contributed to them and what interventions can best be leveraged to eliminate them.

These are important questions that should be far easier to answer than they are at present. Continued work on the data reporting initiatives described above is necessary if analyses, such as the one described and others contemplated in this brief, are to be completed more easily in the years ahead.

Appendix. Business Rule for Clinic Primary Care Service Analysis

Once Medi-Cal eligibility and the delivery system were verified (i.e., fee-for-service vs. Medi-Cal managed care), the methodology employed a series of filters to facilitate identification of primary care visits using a combination of service type, service location, and provider specialty codes. Subsequently, a high-level summary of the study criteria, sequential steps in the analysis, and analytic rules (i.e., filters) related to clinic place of service and primary care providers categories were established.

The next filter was based on service location. The service locations included in the numerator were only those for FQHCs, LALs, and RHCs (Table A1, row 3). The denominator included additional service locations such as Indian Health Services clinics, Tribal 638 clinics, community primary care clinics, private offices, non-hospital-based clinics, hospital outpatient clinics, school-based health centers, and retail clinics. Excluded from this analysis were services at a number of specialty, ambulatory surgery, rehabilitation, dental, behavioral health, imaging, end-stage renal disease, and other facilities at which primary care services were unlikely to be provided. Additional details of inclusion and exclusion criteria are provided in detail in Table A2 on page 14.

A final filter based on provider type was then constructed using provider taxonomy codes deemed by the authors to be consistent with primary care.[15] The sequence of provider identification began with the use of taxonomy codes for the rendering provider, if available. If the taxonomy data were missing, the rendering provider name was matched to provider taxonomy from the CMS database (i.e., the National Uniform Claim Committee code set list) based on the provider's National Provider Identifier (NPI) number (providers are

Table A1. Study Criteria and Related Analytic Rules

CLAIMS-BASED QUERY CRITERIA	RELATED BUSINESS RULES
Is the Medi-Cal enrollee eligible for managed care or fee-for-service during the months of service covered in the analysis?	▸ Claim type is Medi-Cal FFS or managed care ▸ Enrollees are eligible for month of service included in the analysis period
Is the service an outpatient medical service?	▸ Claim type is outpatient medical ▸ Claims exclusions: inpatient, long-term care, pharmacy, dental, mental/behavioral health
Is the place of service a primary care setting?	▸ Place of service codes (for denominator) include FQHCs, LALs, RHCs, IHS and Tribal 638 facilities, mobile clinics, retail clinics, independent clinics, private offices, etc. ▸ Place of service code exclusions: ambulatory surgery centers, adult day care facilities, birthing centers, critical access hospitals, emergency departments, dental offices, imaging centers, oncology clinics, SUD treatment programs, and others as detailed in the appendix
Is the service provider a primary care provider?	▸ Rendering provider taxonomy code is consistent with primary care, or (if rendering provider data unavailable) billing provider taxonomy code is consistent with primary care ▸ Deduplication of claim detail based on rendering provider taxonomy

Notes: *FFS* is fee for service, *FQHC* is Federally Qualified Health Center, *IHS* is Indian Health Service, *LAL* is Look Alike, *RHC* is Rural Health Center, *SUD* is substance use disorder.

Source: California DHCS MIS/DSS data warehouse, March 26, 2021.

required to select a taxonomy code describing their medical classification and specialty when applying for an NPI number). If rendering provider information was missing, the authors proceeded with the same sequence using the billing provider data.

Table A2. Detail for the Claims-Based Query Criteria, *continued*

1. Limit by Claim Type
Outpatient Service and Medical/Allied (FFS) or Medical/Physician (MC)

INCLUDED	EXCLUDED
▸ Medical, outpatient	▸ Inpatient, LTC (long-term care), pharmacy/drug ▸ Dental ▸ Mental/behavioral health, SUD (substance use disorder)

2. Limit by Care Settings / Place of Service
For Outpatient and Medical/Allied (FFS) or Medical/Physician (MC) claims types, include/exclude based on whether Care Settings are considered to be Primary Care Services — *FI_Prov_Type_CD, POS, other*

INCLUDED	EXCLUDED
Numerator for Public Records Act (PRA) request ▸ Federally Qualified Health Centers ▸ Look-Alikes ▸ Rural Health Clinics **Denominator for PRA request** (the above facility types and these): ▸ Community/primary care clinics ▸ Hospital-based outpatient clinics ▸ Indian Health Service outpatient ▸ Non-hospital-based clinics ▸ Non-hospital physician offices ▸ Public health clinics ▸ Retail clinics ▸ School-based services Telehealth is okay for above settings; exclude telehealth visits for behavioral health	▸ Adult day health/day care facility ▸ AIDS – Waiver Services ▸ Ambulatory surgical centers ▸ Ambulance ▸ Birthing center ▸ Clinic/center: critical access hospital ▸ Clinic/center: medical specialty ▸ Clinic/center: medically fragile infants and children day care ▸ Clinic/center: multi-specialty ▸ Community mental health centers ▸ Dental offices ▸ Emergency department visits ▸ ED visits that result in hospital admission ▸ End-stage renal disease facilities ▸ Home health care ▸ Hospice/palliative care ▸ ICF-DD (intermediate care facilities – developmentally disabled) ▸ Imaging centers ▸ Laboratories ▸ Long-term care ▸ Mental/behavioral health clinics ▸ Oncology clinics ▸ Outpatient rehabilitation facilities ▸ Physical therapy centers ▸ Rehabilitation centers ▸ Respite care ▸ Substance abuse clinics ▸ Urgent care centers

Table A2. Detail for the Claims-Based Query Criteria, *continued*

3. Primary Care Based on Provider Taxonomy Code / Specialty

INCLUDED	EXCLUDED
Rendering service provider (with a primary care specialty taxonomy, listed below) ▸ Advanced practice midwife ▸ Clinical nurse specialist (w/ primary care specialty) ▸ Nurse practitioner ▸ Physician ▸ Physician assistant ▸ Prevention professional **Primary care specialists in a clinical setting** ▸ Adult health ▸ Allopathic and osteopathic ▸ Cardiology* ▸ Chiropractic providers ▸ Community health / public health ▸ Endocrinology* ▸ Family medicine (all specialties) ▸ Gastroenterology* ▸ General practice ▸ Gerontology ▸ Holistic ▸ Internal medicine (all specialties) ▸ Migrant health ▸ Obstetrics and gynecology ▸ Perinatal ▸ Pediatrics (all specialties) ▸ Preventive medicine† ▸ School ▸ Women's health **Billing providers with these specialties** ▸ Clinic/center: community health ▸ Clinic/center: corporate health ▸ Clinic/center: health service ▸ Clinic/center: migrant health ▸ Clinic/center: primary care ▸ Clinic/center: public health, federal ▸ Clinic/center: public health, state or local ▸ Clinic/center: student health	▸ Acupuncture ▸ Behavioral/mental health ▸ Dental ▸ Dermatology ▸ Elective/same-day surgery ▸ Endoscopy ▸ Eye/vision services ▸ Hearing and speech ▸ Laboratory/x-ray ▸ Occupational medicine ▸ Oncology/radiology ▸ Ophthalmology ▸ Pain medicine ▸ Pharmacy/drug ▸ Physical medicine and rehabilitation ▸ Podiatry ▸ Sports medicine

*Cardiology, endocrinology, and gastroenterology should all be included if billing provider is a Federally Qualified Health Center (FQHC) / Rural Health Clinic (RHC) / Indian Health Service (IHS) because these providers must all be trained in internal medicine before they can pursue these specialties. If they are employed by or working in FQHCs/LALs, they are likely operating mainly as primary care providers (PCPs) and occasionally as specialists.

† In the years since this became a specialty, the dominant employment for these specialists has been as PCPs, or in settings where they are delivering administrative services (which would likely not be the case in FQHCs/LALs).

Note: For certain clinic types (FQHC, FQHC-LAL, RHC, IHS, Cost-Based Reimbursement Clinic [CBRC]), in the absence of an appropriate taxonomy code, researchers used revenue and procedure codes to determine PCP type.

Table A2. Detail for the Claims-Based Query Criteria, *continued*

4. Business Rules Used in Programming

Enrollee Business Rules

- Include record if AKA_CIN's "Month of Eligibility" = month of "service from date."

Claims-Based Business Rules: General

- Claim header and claim detail records are joined on RECORD_ID.
- Paid Claims = Paid, last paid claim indicator not equal to "No", claim status flag not equal to "Q."

Claims-Based Business Rules: First Limit to Outpatient Claims/Encounters

```
(
        /* Medi-Cal FFS – Outpatient and Medical/Allied */
        (SRC_CD = '19'
        AND (FI_CLAIM_TYPE_CD = '04' OR (FI_CLAIM_TYPE_CD = '05' AND
ORIG_POS_CD IN ("05" "06" "07" "08" "11" "15" "17" "18" "19" "22" "49" "50" "71" "72" "99"))))
        /* Medi-Cal MCE – Outpatient and Medical/Physician */
        OR
        (SRC_CD = '80'
        AND (CLAIM_TYPE_CD = '1' OR (CLAIM_TYPE_CD = '4' AND
ORIG_POS_CD IN ("05" "06" "07" "08" "11" "15" "17" "18" "19" "22" "49" "50" "71" "72" "99"))))
)
```

ORIGINAL POS CD — LIMITED TO PRIMARY CARE OUTPATIENT CODES

Value	Description
05	Indian Health Service Free-Standing Facility
06	Indian Health Service Provider-Based Facility
07	Tribal 638 Free-Standing Facility
08	Tribal 638 Provider-Based Facility
11	Office
15	Mobile Unit
17	Walk-In Retail Health Clinic
18	Place of Employment-Worksite
19	Off Campus-Outpatient Hospital
20	Urgent Care Facility
22	On Campus-Outpatient Hospital
49	Independent Clinic
50	Federally Qualified Health Center
71	Public Health Clinic
72	Rural Health Clinic
99	Other Place of Service

Table A2. Detail for the Claims-Based Query Criteria, *continued*

4. Business Rules Used in Programming, *continued*

Claims-Based Business Rules: First Limit to Outpatient Claims/Encounters, *continued*

```
/* Exclude Behavioral Health (Medi-Cal & Short-Doyle) and Medi-Cal Dental
Length exclude_flag $1.;
      if (SRC_CD = "21"                    /* SHORT-DOYLE and MHSD */
      OR CLAIM_TYPE_CD = "5"               /* Dental */
      OR SUBSTR(PROC_CD,1,1) = "D"         /* Dental */
      OR PROC_CD="00003"                   /* Dental Services (RHC/FQHC) */
/* AG-Primary Physician, AH-Clinical Psychologist, AJ-Clinical Social Worker, HR-Family/Couple with Client Present */
      OR TOOTH_OR_MODIFIER_1 IN ("AH","AJ","HR")
      OR TOOTH_OR_MODIFIER_2 IN ("AH","AJ","HR")
      OR TOOTH_OR_MODIFIER_3 IN ("AH","AJ","HR")
      OR TOOTH_OR_MODIFIER_4 IN ("AH","AJ","HR")
/* AG when reported with T1015 for FQHC services relates to behavioral/mental health */
      OR (PROC_CD = "T1015" AND (TOOTH_OR_MODIFIER_1 = "AG" OR TOOTH_OR_MODIFIER_2 = "AG" OR TOOTH_OR_MODIFIER_3
= "AG" OR TOOTH_OR_MODIFIER_4 = "AG")))
      Then exclude_flag = "Y"; else exclude_flag = "N";
/*EXCLUDES MH/SUDS Diagnoses*/
primary_diag_cd_icd10 not in (F1010-F99)
```

Claims-Based Business Rules: Rendering Provider

1. If Rendering Provider Taxonomy codes are missing, get from CMS_PROV_TAXOMONY where PROV_PRIM_TAXON_SWITCH_CD = Yes and first.NPI.
2. Records are grouped into primary care buckets based on rendering provider taxonomy code, in this order:

```
      if FINAL_TAX_REND in ("207Q00000X" "207QA0000X" "207QA0505X" "207QG0300X" "207R00000X" "207RA0000X"
"207RG0300X" "207V00000X" "207VG0400X" "207VX0000X" "208000000X" "2080A0000X" "2083P0500X" "2083P0901X"
"208D00000X" "2080N0001X")
      then Rend_Taxon_group = "1_Individual Providers";
      else if FINAL_TAX_REND in ("363LA2200X" "363LC1500X" "363LF0000X" "363LG0600X" "363LP0200X" "363LP1700X"
"363LP2300X" "363LS0200X" "363LW0102X" "363LX0001X" "364SA2200X" "364SC1501X" "364SF0001X" "364SG0600X"
"364SH1100X" "364SP0200X" "364SP1700X" "364SS0200X" "364SW0102X" "367A00000X" "405300000X" "163WS0200X"
"163WP0200X" "163WW0101X")
      then Rend_Taxon_group = "2_Assistant/Nurse";
      else if FINAL_TAX_REND in ("261QC1500X" "261QC1800X" "261QH0100X" "261QM1000X" "261QP0904X" "261QP0905X"
"261QP2300X" "261QS1000X")
      then Rend_Taxon_group = "3_Facility";
      else if FINAL_TAX_REND in ("261QC0050X" "261QM1300X" "261QM2500X" "261QM3000X")
      then Rend_Taxon_group = "4_Facility_SP";
      else if FINAL_TAX_REND in ("261Q00000X" "261QF0400X" "261QR1300X")
      then Rend_Taxon_group = "5_Facility_NOS";
      else if FINAL_TAX_REND in ("163W00000X" "363A00000X" "363AM0700X" "363L00000X" "364S00000X")
      then Rend_Taxon_group = "6_Assistant/Nurse_NOS";
      else if FINAL_TAX_REND in ("207QB0002X" "207RA0002X" "207RB0002X" "207RC0000X" "207RE0101X" "207RG0100X"
"207RH0000X" "207RH0003X" "207RH0005X" "207RI0008X" "207RI0200X" "207RN0300X" "207RP1001X" "207RR0500X"
"207RX0202X" "207VB0002X" "207VF0040X" "207VM0101X" "2080B0002X" "2080P0202X" "2080P0205X" "2080P0206X"
"2080P0207X" "2080P0208X" "2080P0210X" "2080P0214X" "2080P0216X" "2080S0010X" "2083B0002X" "207QH0002X")
      then Rend_Taxon_group = "7_NOT_PC_1";
      else Rend_Taxon_group = "8_NOT_PC_2";
```

Table A2. Detail for the Claims-Based Query Criteria, *continued*

4. Business Rules Used in Programming, *continued*

Claims-Based Business Rules: Billing Provider

1. If Billing Provider Taxonomy codes are missing, get from CMS Provider Table where PROV_PRIM_TAXON_SWITCH_CD = XX and first.NPI.
2. Records are grouped into primary care buckets based on billing provider attributes, in this order:

   Variable = claim_flag, length = $15.

   a. PC_CBRC — CBRC facilities are identified first, to ensure they are not included in FQHC counts. CBRCs are identified by NPI.

   b. PC_IHS — Indian Health Service facilities based on primary care revenue codes and procedure codes.

   c. PC_IHS_2 — Indian health service facilities based on (FI_PROV_TYPE_CD = "075"), without primary care revenue and procedure codes.

   d. PC_FQHC/RHC — FQHC/RHC based on primary care revenue codes and procedure codes.

   e. PC_School — Place of service = school with primary care procedure codes.

   f. PC_rendTAX – Billing provider = outpatient care and rendering service provider ("1_Individual Providers" "2_Assistant/Nurse" "3_Facility")
   but billing provider taxonomy code is not in:
   and FINAL_TAX_BILL not in ("261QC0050X" "291U00000X" "225100000X" "1223G0001X" "103G00000X" "122300000X" "103T00000X" "225X00000X" "251T00000X" "213E00000X" "213ES0103X" "152W00000X" "111N00000X" "302F00000X" "225XH1200X" "282NC0060X" "173000000X" "133V00000X" "261QA1903X" "246XS1301X" "273R00000X" "1223P0221X" "237600000X" "251F00000X" "103TB0200X" "252Y00000X" "213ES0131X" "2251X0800X" "235Z00000X" "231H00000X" "213EP1101X" "225400000X" "261QP2000X" "293D00000X" "171100000X" "171W00000X" "261QB0400X" "213ES0000X" "1041C0700X" "246W00000X" "170100000X" "284300000X" "283Q00000X" "1223S0112X" "152WV0400X" "101YM0800X" "2471B0102X" "251B00000X" "183500000X" "173F00000X" "133NN1002X" "2471S1302X" "2471C3402X" "251E00000X" "103TC1900X" "282E00000X" "261QS0132X" "171M00000X" "225000000X" "176B00000X" "1223P0700X" "106H00000X" "261QR0400X" "174H00000X" "2471V0106X" "103TC0700X" "1835P0018X" "146D00000X" "103TC2200X" "146M00000X" "273Y00000X" "103TP0016X" "101YA0400X" "246ZE0600X" "156FX1700X" "247200000X" "237700000X" "225XP0200X" "231HA2400X")

   g. PC_FQHC/RHC_2 — FQHC or RHC based on (VENDOR_CD = "77" or FI_PROV_TYPE_CD = "035" or (FINAL_TAX_BILL in ("261QF0400X" "261QR1300X")) or (BILL_TYPE_CD in ("0770" "0771" "0772" "0773" "0774" "0775" "0777" "0778")))
   (without primary care revenue or procedure codes)

   h. NOT_PC_1 = if Rend_Taxon_group = "7_NOT_PC_1".

   i. Facility = if Rend_Taxon_group = "3_Facility" (facilities with primary care taxonomy codes)

   j. NOT_PC_2 = all other records.

Table A2. Detail for the Claims-Based Query Criteria, *continued*

4. Business Rules Used in Programming, *continued*

COUNTER: Business Rules

Unique_Visit_Key = Visits are counted as a unique combination of member ID, billing provider number, and date of service.

Deduplication of claim header–claim detail is based on final Rend_Taxon_group, in this order (1 = type of claim detail that is kept first):

1_Individual Providers

2_Assistant/Nurse

3_Facility

4_Facility_SP

5_Facility_NOS

6_Assistant/Nurse_NOS

7_NOT_PC_1

8_NOT_PC_2

9_NULL

Claims are *excluded* if:

- Rend_Taxon_group in ("4_Facility_SP" "8_NOT_PC_2")
- claim_flag in ("9_NOT_PC_2")

SUMMARY SHOWING HOW CLAIMS ARE EXCLUDED, BY REND_TAXON_GROUP

claim_flag	1_Individual Providers	2_Assistant / Nurse	3_Facility	4_Facility_SP	5_Facility_ NOS	6_Assistant/ Nurse_NOS	7_NOT_PC_1	Null Rendering Provider	8_NOT_PC_2
PC_CBRC	Include	Include	Include	Exclude	Include	Include	Include	Include	Exclude
PC_FQHC/ RHC	Include	Include	Include	Exclude	Include	Include	Include	Include	Exclude
PC_FQHC/ RHC_2	Include	Include	Include	Exclude	Include	Include	Include	Include	Exclude
PC_IHS	Include	Include	Include	Exclude	Include	Include	Include	Include	Exclude
PC_IHS_2	Include	Include	Include	Exclude	Include	Include	Include	Include	Exclude
PC_School	Include	Include	Include	Exclude	Include	Include	Include	Include	Exclude
PC_rendTAX	Include	Include	Include	Exclude	Include	Include	Include	Include	Exclude
Facility	Include	Include	Include	Exclude	Include	Include	Include	Include	Exclude
NOT_PC_1	Include	Include	Include	Exclude	Include	Include	Include	Include	Exclude
NOT_PC_2	Exclude	Exclude	Exclude	Exclude	Exclude	Exclude	Exclude	Exclude	Exclude

Source: California DHCS MIS/DSS data warehouse, March 26, 2021.

Endnotes

1. "**February 2021 Medicaid & CHIP Enrollment Data Highlights**," Centers for Medicare & Medicaid Services, last modified April 2, 2021. The Patient Protection and Affordable Care Act (Pub. L. No. 111-148 [2010], as amended), was passed in 2008, and the Medicaid expansion language included therein became effective on January 1, 2014. Data on health care expenditures are derived from ***U.S. Health Care Coverage and Spending*** (PDF), Congressional Research Service, last updated January 6, 2021. Data on Medi-Cal as a percentage of health insurance coverage for the total population are derived from "State Health Facts," KFF.
2. "**State Health Facts: Build a Custom State Report**," KFF, accessed July 16, 2021.
3. California Public Records Act is pursuant to **Gov't Code § 6250 et seq.**, accessed on April 5, 2021.
4. "**Health Center Program Uniform Data System (UDS) Data Overview**," Human Resources and Services Administration (HRSA), accessed August 1, 2020. These data are aggregated from clinic submissions through UDS.
5. Office of State Health Planning and Development reporting also requires the inclusion of type-of-clinic license, and encounters by principal diagnosis (ICD-10 codes) and procedure type (CPT codes).
6. A community clinic in California is legally defined as "a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds, or contributions that may be in the form of money, goods, or services." A clinic may have multiple licensed sites. That broad definition may include FQHCs, LALs, RHCs, and tribal clinics as well as free clinics and independent practitioners who refer to their practice sites as community health centers because they may be located in medically underserved areas.
7. "**What Is a Health Center?**," HRSA, accessed August 20, 2020. The HRSA Health Center Program website provides general definitions for FQHCs, LALs, and RHCs. FQHCs are explicitly defined in the Social Security Act, as amended, 42 U.S.C. 1396d(l)(2)(B)(i) and (ii) §§ 1905(l)(2)(B)(i) and (ii), and RHCs are defined in the Social Security Act, 42 U.S.C. 1395x(aa)(2) § 1861(aa)(2)..
8. Because the state of California regulates many different types of health care facilities and, as part of that regulation, licenses individual sites, the analysis was based on the number of outpatient primary care sites that met numerator or denominator criteria rather than at the level of the parent entity.
9. Survey respondents self-identified as *African American / Black*, *Asian / Other Pacific Islander*, *Hispanic*, and *White (non-Hispanic)*.
10. Mawusi J. Arnett et al., "**Race, Medical Mistrust, and Segregation in Primary Care as Usual Source of Care: Findings from the Exploring Health Disparities in Integrated Communities Study**," *Journal of Urban Health* 93, no. 3 (June 2016): 456–67; and Mohsen Bazargan, Sharon Cobb, and Shervin Assari, "**Discrimination and Medical Mistrust in a Racially and Ethnically Diverse Sample of California Adults**," *Annals of Family Medicine* 19, no. 1 (Jan. 2021): 4–15.
11. Beginning in 2008, the California Health Care Foundation (CHCF) commissioned a regional market study analysis to gain insights into the organization, financing, and delivery of care in communities across the state and over time. The seven regional markets — Northern / Far North, Sacramento Valley, Bay Area, Central Valley, Central Coastal, Southern California (excluding Los Angeles), and Los Angeles — represent a range of economic, care delivery, and demographic conditions. The analysis of the limited county-level data available for this project is organized according to the CHCF regional markets, which are collections of counties as follows:
    - **North Coast / Far North:** Del Norte, Humboldt, Lake, Mendocino, Modoc, Shasta, Siskiyou, Trinity
    - **Sierra/Foothills:** Alpine, Amador, Calaveras, El Dorado, Inyo, Lassen, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Tuolumne
    - **San Francisco / Bay Area:** Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma
    - **Sacramento Valley:** Butte, Colusa, Glenn, Sacramento, Sutter, Tehama, Yolo, Yuba
    - **Central Valley:** Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare
    - **Central Coast:** Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
    - **Los Angeles County**
    - **Southern California (excluding Los Angeles):** Imperial, Orange, Riverside, San Bernardino, San Diego
12. ***Medi-Cal Provider Manual: Part 2 – Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)*** (PDF), California Dept. of Health Care Services, last updated May 2021. The "Qualifying Visits" section details the same-day qualifying visit rules as well as the exceptions (e.g., for dental visits or when, after a first visit, a patient suffers an illness or injury that requires another health diagnosis or treatment).
13. For more information, please visit "**Transformed Medicaid Statistical Information System (T-MSIS)**," CMS.
14. Health Net, "**Encounter Data Improvement Program: Improving Medi-Cal Care & Reducing Health Disparities**," press release, March 10, 2021.

15. Taxonomy codes are unique 10-character alphanumeric administrative codes required for claim documentation as part of the original Health Insurance Portability and Accountability Act to enable uniform identification of provider category (i.e., license type), classification (i.e., certification specialty), and specialization (i.e., subspecialty, if applicable). In some instances, the authors utilized taxonomy codes plus place of service to determine consistency with primary care. For example, a provider with a taxonomy code consistent with a specialty such as oncology or cardiology, but who operated only out of an FQHC with a regular schedule of patients, was acknowledged as a primary care provider.