Medi-Cal
Electronic Health Record
INCENTIVE PROGRAM

Understanding Medi-Cal and Needy Individual Encounters
With 2013 Updates

For the purposes of the Medi-Cal EHR Incentive Program DHCS has developed guidance on what constitutes a Medi-Cal or other needy individual encounter. This is based on federal regulations and specific characteristics of health care programs and billing practices in California. This guidance will assist hospitals, groups, clinics and providers in determining their eligibility for the Medi-Cal EHR Incentive Program. This updated document incorporates changes in federal regulations that become effective for the 2013 program year but cannot be applied to the 2012 or earlier program years.

One Provider/One Day

Multiple encounters with the same provider on the same day can only be counted as one encounter. Encounters with different providers on the same day do count as different encounters. Supervising providers can personally count encounters delivered by the clinical staff they supervise if such supervision is required by law or regulation. For example, supervising physicians can count the encounters of nurse practitioners or medical interns they supervise because those provider types are required by law to have such supervision. If the supervised provider is an EP, they can also count the same encounter for the purposes of establishing eligibility for incentive payments. Supervision provided for other reasons, such as quality improvement or utilization review, cannot be counted as encounters by supervising providers.

Medi-Cal Must Pay Some Portion

For an encounter to be considered a Medi-Cal encounter, Medi-Cal must have paid some portion of the cost. Medi-Cal does not have to have paid all of the cost, only some portion. This can include payment in part or whole of an individual's premiums, co-payments, and cost sharing. Thus, Medicare encounters for some "dually eligible" Medi-Cal patients can be included if Medi-Cal has paid the patient's Part B Medicare deductible. In general, Medi-Cal pays the Part B Medicare premiums for dually eligible beneficiaries except those in the aid codes listed below with an unmet share of cost. If the unmet share of cost has been "certified" by the provider, DHCS will pay the Medicare Part B premium for the certified month only.

17 – Aged/MN	1Y - MSSP	27 – Blind/MN	37 – AFDC/MN
67 – Disabled/MN	6R – SB87	6W – DDS Waiver	6Y – IHO Waiver
83 – MI-C	87 – MI-CP	8V – CHDP Infant	

For a complete list of dually eligible aid codes see Appendix 1 at the end of this document.

2013 Update: Beginning in 2013 program year encounters for Medi-Cal covered services by Medi-Cal enrolled patients can be counted as "Medicaid" regardless of whether Medi-Cal paid for or was billed for any portion of the services. For this reason, all Medi-Cal covered services provided to "dually eligible" patients can be counted as "Medicaid" beginning in program year 2013. Hospitals can utilize this policy when determining the Medicaid Volume Percentage, but not in determining the Medicaid Inpatient Bed Days. Medicaid Inpatient Bed Days must still be paid for in some manner by Medi-Cal.

Encounters Paid in Part by Medi-Cal's 1115 Waiver Count as Medi-Cal Encounters
According to federal regulations services paid for through a state's 1115 waiver count as Medi-Cal encounters for the purposes of the EHR Incentive Program. In 10 counties in California (Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura) this includes services provided through Safety Net Care Pool. Also, indigent services delivered by Designated Public Hospitals using Safety Net Care Pool funding can be considered Medi-Cal encounters.

Other Needy Individual Encounters
Providers in FQHC's, FQHC look-alikes, RHCs, and Indian Tribal Clinics can also count services to other needy individuals in addition to Medi-Cal patients. According to federal regulations these encounters can include: Healthy Families, sliding-scale or reduced cost services, and no cost services. If the total of these encounters plus Medi-Cal encounters equals or exceeds the 30% threshold providers who practice predominantly in these clinics are eligible for the Medi-Cal EHR Incentive Program. However, providers who do not practice predominantly (at least 50% of their encounters in a 6 month period in the 12 months prior to attestation or in the last calendar year) in these clinic types are not eligible on this basis.

AID Codes for Medi-Cal Encounters
Professional services delivered to patients in most AID codes can be counted as Medi-Cal encounters for the purposes of the Medi-Cal EHR Incentive Program. However, services provided to patients in the following AID codes, which do not include any federal financial participation, cannot be counted as Medi-Cal encounters for the purposes of the Medi-Cal EHR Incentive Program.

2V—Trafficking and Crime Victims Assistance Program (TCVAP)
4V—TCVP—RMA
65—Katrina Evacuees
7M, 7N, 7P, 7R—Minor Consent Programs
71—Medi-Cal Only Dialysis Program
73—Total Parenteral Nutrition Program

2013 update: Beginning in the 2013 program year services delivered to Medi-Cal enrolled patients (except those in the AID codes above) can be counted if they are covered by Medi-Cal regardless of whether they have been billed or paid for by Medi-Cal. This includes services delivered to patients who are dually eligible for Medicare and Medi-Cal.

Except in the counties of Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura and in Designated Public Hospitals, encounters provided under the following AID codes also cannot be counted as Medi-Cal encounters.

OR, OT—Breast and Cervical Cancer Treatment Program
53—Medically Indigent, Long Term Care Services
81—Medically Indigent, Adult Aid Paid Pending.

Healthy Families Encounters
The Healthy Families program will begin transitioning patients to Medi-Cal in 2013. When patients transition into Medi-Cal their future encounters can be counted as "Medicaid." However, encounters delivered prior to their transition cannot be counted as "Medicaid" retrospectively. For this reason, Healthy Families encounters will not begin to contribute to the eligibility of providers not practicing in FQHCs or RHC until the 2014 program year. DHCS will issue further instructions about this issue as the transition of patients from Healthy Families to Medi-Cal progresses in 2013.

Medi-Cal and Needy Encounters by Payer Source
Using the payer sources collected by the Office of Statewide Health Planning, DHCS has classified payer sources as Medi-Cal, Needy, or Neither. See footnotes below the list for further information.

- Medicare (Medi-Cal if dually eligible)

- Medicare Managed Care (Medi-Cal if dually eligible)
- Medi-Cal (Medi-Cal)
- Medi-Cal Managed Care (Medi-Cal)
- County Indigent/ CMSP/ MISP (Needy)[1]
- Healthy Families (Needy/Medi-Cal)[2]
- Private Insurance (Neither)
- Self-Pay/ Sliding Fee (Needy)
- Free (Needy)
- Breast Cancer Programs (Needy)[1]
- Child Health and Disability Prevention Program (Medi-Cal)
- EAPC (Expanded Access to Primary Care) (Needy)
- Family PACT (Medi-Cal)
- PACE Program (Medi-Cal)
- LA County Public Private Partnership (Medi-Cal)
- Alameda Alliance for Health (Medi-Cal)
- Other County Programs (Neither)
- All Other Payers (Neither)

[1] Counted as Medi-Cal in the counties of Alameda, Contra Costa, Kern, Los Angeles, Orange, San Diego, San Francisco, San Mateo, Santa Clara, and Ventura and in Designated Public Hospitals.
[2] May be counted as "Medi-Cal" for encountered delivered to patients in 2013 after they transition to Medi-Cal.

Appendix 1—Dual Eligible Aid Codes

2013 Update: This appendix should not need to be used for 2013 and later program years. Beginning in the 2013 program year all encounters for "dually eligible" patients should be counted as "Medicaid" regardless of whether Medi-Cal has paid for Medicare Part B premiums or any portion of the services provided.

Full-Scope Medi-Cal (no share of cost) Aid Codes
DHCS pays the Medicare Part B premiums for these Medi-Cal aid codes.

01 – RCA	02 – RMA	03 – AAP/Federal	04 – AAP/AAC
06 – AAP/OOS	07 – AAP/IV-E	08 – EAC	10 – Aged/SSI
ON - BCCTP	OP - BCCTP	14 – Aged/MN	16 – Aged/Pickle
1E – Aged/SB87	1H – Aged/FPL	1X - MSSP	20 – Blind/SSI
24 – Blind/MN	26 – Blind/Pickle	2E – Blind/SB87	2H – Blind/FPL
30 – CalWORKs	32 - TANF	33 - CalWORKs	34 – AFDC/MN
35 - CalWORKs	36 – Disabled/Cobra	38 – Edwards/Kizer	39 - TMC
3A – CalWORKs	3C – CalWORKs	3D – CalWORKs	3E - CalWORKs
3G - CalWORKs	3H – CalWORKs	3L - CalWORKs	3M - CalWORKs
3N – AFDC/1931	3P - CalWORKs	3R – CalWORKs	3U - CalWORKs
3W - TANF	40 – AFDC/FC	42 – AFDC/FC	43 – AFCD/FC
45 - FC	46 – FC/OOS	49 – AFCD/FC IV-E	4A – OOS/AAP
4C – Foster Care	4F - KinGAP	4H – CalWORKs/FC	4L – FC/1931
4M – Former FC	4N - CalWORKs	4P – CalWORKs FR	4R – CalWORKs FR
4S – KinGAP NMD	4T – KinGAP IV-E	4W – KinGAP NMD	54 – Four Month C
59 - TMC	5E – HF AER	5K – EA FC	60 – Disabled/SSI
64 – Disabled/MN	66 – Disabled/Pickle	6A – DAC/Blind	6C – DAC/Disabled
6E – Disabled/SB87	6G – 250% WDP	6H – Disabled/FPL	6J – SB87
6N – SSI/Appeal	6P - PRWORA	6V – DDS Waiver	6X – IHO Waiver
72 – 133% Citizen	7A – 100%/Child	7J - CEC	7T – Express E
7X – Medi-Cal to HF	82 – MI/C	86 – MI/CP	8E – Accel/Children

8P – 133% Property	8R – 100%/Child	8U – CHDP Deemed	8W – CHDP Gateway

Medi-Cal Share of Cost (SOC) Aid Codes
DHCS does not pay the Medicare Part B premiums for clients who have a Medi-Cal SOC. Exception to this rule - If the unmet SOC has been certified by the Provider, DHCS will pay the Medicare Part B premium for the certified month only.

17 – Aged/MN	1Y - MSSP	27 – Blind/MN	37 – AFDC/MN
67 – Disabled/MN	6R – SB87	6W – DDS Waiver	6Y – IHO Waiver
83 – MI-C	87 – MI-CP	8V – CHDP Infant	

Long Term Care (LTC) Aid Codes
DHCS pays the Medicare Part B premiums for these Medi-Cal aid codes.

13 – Aged LTC	23- Blind LTC	63 – Disabled LTC

Medicare Savings Programs
DHCS pays the Medicare Part B premiums for these aid codes, regardless if the client has an unmet Medi-Cal SOC.

80 – Qualified Medicare Beneficiary (QMB)	8C – Specified Low-Income Medicare Beneficiary (SLMB)	8D – Qualified Individual (QI-1 Program)