

## Medi-Cal Reimbursement Splits

Medi-Cal is reimbursed using both state and federal funds. The percentages that are reimbursed by different funding sources are determined by AID codes. Each distribution type listed below is adjudicated and reimbursed separately. Because of this we ask that Providers batch each type of medi-cal separately. This will significantly reduce the time spent on claims reconciliation for both the provider and county.

**Mandated Medi-Cal:** Sometimes we also refer to this as “traditional” Medi-Cal. Mandated Medi-Cal refers to any client who is eligible for Medi-Cal under the pre-ACA Medi-Cal eligibility definitions regardless of when they become eligible. Mandated Medi-Cal clients are paid 50% federal Medi-Cal and 50% state realigned Medi-Cal distribution rate.

**Enhanced Medi-Cal:** Enhanced Medi-Cal is for the Affordable Care Act expanded Medi-Cal population. It is most often AID codes M1 or L1. Enhanced Medi-Cal is paid for 100% federal

Providers must assign Medi-Cal clients to one of the above listed Medi-Cal Payor Group Enrollment plans based on their AID code. Please refer to the Master Aid Code list included in the Provider Manual for more information.

Go to CLAIM BATCH LIST. For each batch select [profile](#). Click on [send to clearinghouse](#). At this point the batch is submitted. Please email your program manager and copy [kmartin@marincounty.org](mailto:kmartin@marincounty.org) to let them know that you have submitted your medi-cal batches. Claims are due on the 10<sup>th</sup> of the month following the month in which the service was provided. You must submit your Medi-Cal Claim submission form before the County can upload your invoices to the state. Failure to submit this document in a timely fashion may result in non-payment of services.