

Instructions for Completing the Local Educational Agency (LEA) Medi-Cal Billing Option Program Annual Report (AR)

These instructions were developed to assist Local Educational Agencies (LEAs) in completing the LEA Medi-Cal Billing Option Program Provider Participation Agreement (PPA) and Annual Report (AR).

The AR includes the LEA Medi-Cal Provider Enrollment Information Sheet, LEA Consortium Billing Sheet, Certification of State Matching Funds for LEA Services, Annual Report Financial Statement Data, and the Statement of Commitment to Reinvest. The PPA and AR are used to enroll LEAs in the LEA Medi-Cal Billing Option Program. LEAs must include the PPA when submitting the AR to DHCS.

✧ [LEA Website](#)

- ✧ DO NOT revise the forms as they are considered a legally binding contract.
- ✧ This is a fillable document; all information must be typed, except where specifically notated.
- ✧ Print the instructions and use them to help you navigate through tabs at the bottom of the page to assist with the completion of the Annual Report.
- ✧ **Failure to submit the PPA or AR by the due date of October 10, of each fiscal year, may result in claim reimbursement withhold in the LEA Medi-Cal Billing Option Program**

PAGE 1: LEA MEDI-CAL PROVIDER ENROLLMENT INFORMATION SHEET

- ✧ **Date:** The date will appear each time the document is opened.
- ✧ **Official LEA Provider Name:** Type the official name of your LEA as registered with California's Department of Education from the drop-down list.
 - ▶ **Note:** Once the Official LEA Provider Name is typed, it will auto populate throughout the document.
- ✧ **Update LEA Name:** If the Official LEA Name has changed, check this box and type the correct Official LEA Name in the designated field.
 - ▶ **Note:** If you update the Official LEA Name, you will need to submit a complete signed PPA.
- ✧ **Doing Business As (DBA):** Type the business name of your LEA if it differs from the Official LEA Name used for tax purposes on file with the IRS.
 - The business name should be listed as a DBA name on the Medi-Cal Provider Master File; however, the LEA name that is on file with the Department of Education is the Official LEA Name.
- ✧ **Check All that Apply:** Check all of the appropriate boxes that apply to your LEA.
 - **Charter School:** If the billing LEA is charter school, check this box.
 - **Consortium Billing:** If your LEA is a billing consortium, where several LEAs bill under the same NPI, check this box and complete the requested LEA information on the consortium billing page.
- ✧ **LEA Administrative Office Address:** Type the address from which your LEA will be preparing Medi-Cal claims and will maintain the Medi-Cal documentation related to the claims.
 - DO NOT use a post office box address.
- ✧ **Payment/Mailing Address:** Type the address to which your LEA will receive payment for service. Select "Same as Above" if it is the same as the Administrative Office Address.
 - ▶ **Note:** If you update the Payment/Mailing Address, you will need to submit a complete signed PPA.
- ▶ **Primary Contact Name/Title:** Type the name and title of the person within the LEA responsible for administering the LEA Medi-Cal Billing Option Program.
- ✧ **Telephone Number:** Type the telephone number of the office or contact person within the LEA responsible for administering the LEA Medi-Cal Billing Option Program.

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- ✧ **Email Address:** Type the email address of the office or contact person within the LEA responsible for administering the LEA Medi-Cal Billing Option Program.
- ✧ **Secondary Contact Name:** Type the name of the person within the LEA who assists with administering the LEA Medi-Cal Billing Option Program.
- ✧ **Secondary Email Address:** Type the email address of the contact person within the LEA who assists with administering the LEA Medi-Cal Billing Option Program.
- ✧ **Billing Agent/Vendor Information:** Select the Vendor/Billing Agent from the dropdown box. If the Vendor/Billing Agent is not listed, type the information in the designated field.
- ✧ **Telephone Number:** Type the Billing Agent/Vendor telephone number of the office or contact person responsible for the LEA Medi-Cal Billing Option Program.
- ✧ **Contact Person:** Type the name of the person responsible for administering the LEA Medi-Cal Billing Option Program for the Billing Agent/Vendor.
- ✧ **Email Address:** Type the email address of the office or contact person responsible for administering the LEA Medi-Cal Billing Option Program for the Billing Agent/Vendor.
- ✧ **California School Directory (CDS) Code:** Type the fourteen (14) digit California School Directory (CDS) Code as registered with the Department of Education.
 - This information can be found in the [CDS Directory](#)
- ✧ **Federal Employer Identification Number (EIN):** Type the nine (9) digit LEA Federal Employer Identification Number (EIN) on record with the IRS. It is imperative that the Official LEA Name and Federal EIN number are in accordance with the LEAs IRS records. Your Business Service/Fiscal Officer can provide the required IRS documentation that must accompany your enrollment application.
 - Check with your Business Service/Fiscal Officer to ensure that the EIN provided is not shared with a County Office of Education, Superintendent of Schools, or SELPA.
- ✧ **National Provider Identification (NPI) Number:** Type the unique, numeric identifier that all covered health care providers, health plans, and health care clearinghouses must use to process administrative and financial transactions.
 - ▶ **Note:** Please ensure that the NPI is correct, as this number will populate throughout the entire document.
 - The NPI Number is issued and obtained through the Centers for Medicare & Medicaid Services (CMS) National Plan and Provider Enumeration System (NPPES). If you have not already obtained an NPI Number, you must obtain one prior to applying to participate in the LEA Medi-Cal Billing Option Program. The NPI Number is a Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard that does not carry any information about healthcare providers such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions. For information on how to obtain an NPI Number please use the following resources:
 - Information on the web: [CMS Website](#)
 - Information via the NPI Enumerator Phone Line: 1-800-465-3203
 - Applying on the web: [NPPES Website](#)
- ✧ **Data Universal Numbering System (DUNS) Number:** Type the unique nine digit identification number for each physical location of your business. The DUNS number is the Data Universal Numbering System assigned and maintained by Dun and Bradstreet and issued and obtained at <http://fedgov.dnb.com/webform>.
- ✧ **Signature of Authorized Representative:** The person who has the authority to bind the LEA to the statements made on the LEA Medi-Cal Provider Participation Agreement, whose signature certifies

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that the information provided is true, accurate, and complete. This must be signed in [blue ink](#) by the Superintendent, Assistant Superintendent or Authorized Business Services/Fiscal Officer.

- ✧ **Name and Title of Authorized Representative:** Type the name and title of the person who signed the LEA Medi-Cal Provider Enrollment Information Sheet.

PAGE 2: LEA CONSORTIUM BILLING PAGE

This form is only required if the LEA is part of a billing consortium where more than one LEA bills under the same NPI number.

- Include all LEAs claiming under the same NPI on this sheet.
- **Do Not** include each LEA within a district.
 - ▶ **Note:** The LEA that is directly linked to the NPI is responsible for making sure that the funds for all LEAs in the consortium are included in the annual report.
- ✧ **Official LEA Provider Name:** Type the official name of your LEA as registered with California's Department of Education.
- ✧ **National Provider Identification (NPI) Number:** Type the unique, 10-digit, numeric identifier that all covered health care providers, health plans, and health care clearinghouses must use to process administrative and financial transactions.
 - The NPI will auto populate from the Medi-Cal Provider Information Sheet.
- ✧ **LEA Name:** Type the LEAs name as registered with the Department of Education for each LEA in the consortium.
 - If the LEA Name was selected from the drop-down list on the Provider Enrollment Information Sheet, the consortium information on file with DHCS will auto populate in this section.
 - ▶ **Note:** This information may be edited by selecting the cell and typing the correct information.
- ✧ **CDS Code:** Type the fourteen (14) digit CDS code for each LEA in the consortium.
- ✧ **LEA District:** Type the school district the LEA is located in, if it is different than the claiming LEA.
 - This information can be found in the CDS Directory
- ✧ **Charter:** Select yes or no if the LEA is a charter school.

PAGE 3 - ATTACHMENT 1: CERTIFICATION OF STATE MATCHING FUNDS FOR LEA SERVICES

- ✧ **Line 1:** Type the official name of your LEA as registered with California's Department of Education.
 - This field will auto populate.
- ✧ **Line 2:** Type the amount your LEA has budgeted in the current fiscal year to fund the activities covered by the LEA Medi-Cal Billing Option Program. This line must include a dollar figure greater than \$0.
 - ▶ **Note:** To estimate the dollar amount to include on the Certification of State Matching Funds for LEA Services, add up the costs of employees who provide health services (wages, benefits, administrative costs), and any contracted health services. (Exclude any employees who are 100% federally funded from the calculation, but include all other nurses, counselors, psychologists, etc.)
- ✧ **Signature of Authorized Representative:** The person who has the authority to bind the LEA to the statements made on the Certification of State Matching Funds for LEA Services (Attachment 1) and whose signature certifies that the information provided is true, accurate, and complete must sign this form in [blue ink](#). This should be the Superintendent, Assistant Superintendent, or Business Services/Fiscal Officer.

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- ✧ **Name of the Authorized Representative:** Type the name of the person who signed the Certification of State Matching Funds for LEA Services.
 - ✧ **Title of the Authorized Representative:** Type the title of the person who signed the Certification of State Matching Funds for LEA Services.
 - ✧ **Date:** Type the signature date of the document.
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PAGE 4 - ATTACHMENT 1A: FINANCIAL STATEMENT DATA SHEET

Financial Statement July 1, 2014 – June 30, 2015: Summarize revenues received, if any, from the LEA Medi-Cal Billing Option Program during the prior fiscal year for which you are reporting and list how your LEA has reinvested those revenues in expanded health and social services.

- ✧ **Official LEA Provider Name:** Type the official name of your LEA as registered with California's Department of Education. This field will auto populate.
 - ✧ **National Provider Identifier:** Type the unique, 10-digit, numeric identifier that all covered health care providers, health plans, and health care clearinghouses must use to process administrative and financial transactions.
 - This field will auto populate from page 1.
 - ✧ **Line A:** Enter the total LEA revenue received from the LEA Medi-Cal Billing Option Program for the 2014-2015 fiscal year.
 - ✧ **Line B:** Enter the total LEA revenue carried over from the LEA Medi-Cal Billing Option Program from previous fiscal year(s). This should be a positive number.
 - ✧ **Reinvestment Expenditures:** Using the check-boxes on the document, list your LEA's reinvestment of its unexpended revenue. This usage may be similar to the anticipated service priorities for the next fiscal year. The plan for future use of unexpended revenue may also be based on anticipated service priorities decided by the LEA Collaborative for the reporting Fiscal Year.
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PAGE 5 - ATTACHMENT 2: STATEMENT OF COMMITMENT TO REINVEST

The LEA Collaborative may be a newly established or existing collaborative interagency human services group at the county or sub-county level. This group makes decisions regarding the reinvestment of LEA Medi-Cal Billing Option Program funds.

- ✧ **Line 1:** Type the official name of your LEA as registered with California's Department of Education.
 - ✧ **Description of LEA Medi-Cal Collaborative:** Describe the role of the collaborative by answering how reinvestment decisions are made, and the planned frequency of meeting.
 - ▶ **Note:** If the collaborative has not yet developed an infrastructure, please do so in order to answer these required questions. Leaving this area blank or answering "not applicable" is not an acceptable response.
 - ✧ **Anticipated Service Funding Priorities:** List the top service funding priorities for your LEA for the upcoming school year.
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PAGE 6 - ATTACHMENT 2A: STATEMENT OF COMMITMENT TO REINVEST – LEA COLLABORATIVE PARTNERS

The LEA Collaborative may vary according to community needs. However, the collaborative should include representation from the school, a major public agency serving students and families (including health, mental health, social services, juvenile justice, courts, civic and business leadership), the advocacy community, parents and/or guardians, current safety net and traditional health care providers,

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and the LEA fiscal business office. LEA Collaborative consisting of at least three representatives from differing agencies/interests will best serve the needs of the collaborative decision making process.

- ✧ **Names/Titles of the Collaborative Partners:** Type the name and title of the persons who signed the Statement of Commitment to Reinvest, and all others who are part of the LEA Collaborative.
- ✧ **Organizations of the Collaborative Partners:** Type the affiliated organizations of the persons who signed the Statement of Commitment to Reinvest, and all others who are part of the LEA Collaborative.
- ✧ **Signatures of the Collaborative Partners:** The persons who have the authority to bind the LEA to the statements made on the Statement of Commitment to Reinvest (Attachment 2A) must sign this form, and all others who are part of the LEA Collaborative.
 - ▶ ALL LEA Collaborative partners are required to provide signatures on this document in **blue ink**.
- ✧ **Date:** Type the signature date of the document.

SUBMISSION INSTRUCTIONS

❖ **The AR may be submitted to DHCS by one of three ways:**

1. Complete the document online using electronic signatures and email as a PDF file
 - Save the file using the following naming convention on the document and in the subject line:
 - *14-15AR.NPI Number.LEA Name.Date of Submission*
 - Example for New Haven Unified School District:
14-15AR.2233445566.NewHaven.10-01-2015
 - Email to LEA.AnnualReport@dhcs.ca.gov
2. Complete the document online and print, hand sign, scan and email as a PDF file
 - Save the file using the following naming convention on the document and in the subject line:
 - *14-15AR.NPI Number.LEA Name.Date of Submission*
 - Example for New Haven Unified School District:
14-15AR.2233445566.NewHaven.10-01-2015
 - Email to LEA.AnnualReport@dhcs.ca.gov
3. Complete the AR online and print, sign (**in blue ink**) and mail a hard copy, **including a signed copy of the 10-page PPA** to:

California Department of Health Care Services
Safety Net Financing Division
Attn: Dmitry Terlesky/Admin Support/LEA Program Unit
1501 Capitol Avenue, MS 4603
Sacramento, CA 95899-7436