

Instructions for Completing the Local Educational Agency (LEA) Medi-Cal Billing Option Program Provider Participation Agreement (PPA)

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 PPA is a 9-page agreement signed by authorized representatives of the LEA, Department of Health Care Services (DHCS) and California Department of Education (CDE). The PPA contains two exhibits: Exhibit A - HIPAA Business Associate Addendum (BAA), and Exhibit B – Data File Description. In addition to complying with the terms listed in the PPA, all LEAs must abide by the terms listed in the BAA. The purpose of the BAA is to guard the privacy and security of protected health information and personal information that may be created, received, maintained, transmitted, used or disclosed pursuant to the PPA, and to comply with certain standards and requirements of HIPAA regulations. Exhibit B is a description of the data provided to the LEA via data tape match. **LEAs do not need to sign or return Exhibits A and B to DHCS.**

LEAs must include the AR when submitting the PPA to DHCS. Please see the AR Instructions posted on the [LEA Medi-Cal Billing Option website](#) for more information.

- ✧ 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.
- ✧ **Failure to submit the PPA or AR by the due date of October 10 may result in claim reimbursement withhold in the LEA Medi-Cal Billing Option Program.**

PAGE 1 - PROVIDER PARTICIPATION AGREEMENT

Official LEA Provider Name: Type the official name of your LEA as registered with California's Department of Education. This field will auto populate in the rest of the document.

PAGE 9 - ARTICLE VI - EXECUTION

- ✧ **Official LEA Provider Name:** Type the official name of your LEA as registered with California's Department of Education.
 - This field will auto populate.
- ✧ **Name of the Authorized Representative(s):** Type the name of the person who is authorized to bind contracts for the LEA.
- ✧ **Title of the Authorized Representative(s):** Type the title of the person who is authorized to bind contracts for the LEA.
- ✧ **Signature of the First Authorized Representative:** The person who has the primary authority to contractually bind the LEA to the statements in the LEA PPA and whose signature certifies that the information provided is true, accurate, and complete must sign this form. By signing the LEA PPA, the First Authorized Representative, on behalf of the LEA, agrees to comply with all LEA Medi-Cal Billing Option Program requirements, restrictions, and procedures; including, but not limited to: following Medi-Cal procedures, submitting required reports, and reinvesting Medi-Cal reimbursements as specified in the PPA. This should be the Superintendent or Assistant Superintendent.

Instructions for Completing the Local Educational Agency (LEA) Medi-Cal Billing Option Program Provider Participation Agreement (PPA)

- ✧ **Signature of the Second Authorized Representative:** The person who has secondary authority to contractually bind the LEA to the statements in the LEA PPA and whose signature certifies that the information provided is true, accurate, and complete must sign this form. By signing the LEA PPA, the Second Authorized Representative, on behalf of the LEA, agrees to comply with all LEA Medi-Cal Billing Option Program requirements, restrictions, and procedures; including, but not limited to: following Medi-Cal procedures, submitting required reports, and reinvesting Medi-Cal reimbursements as specified in the PPA. This should be the Business Services/Fiscal Officer.
- ✧ **Date:** Type the signature date of the document.
- ✧ **Signature of the CDE Authorized Representative:** (DO NOT complete this portion of the agreement. This portion is for California Department of Education use only.)
 - The staff person from the California Department of Education, who has the authority to review, approve, and certify the information provided by the LEA on the PPA is true, accurate, and complete, must sign this form. By signing the LEA PPA, the CDE Authorized Representative, on behalf of the California Department of Education, confirms the LEAs agreement to comply with all LEA Medi-Cal Billing Option Program requirements, restrictions, and procedures; including, but not limited to: following Medi-Cal procedures, submitting required reports, and reinvesting Medi-Cal reimbursements as specified in the PPA.
- ✧ **Signature of the DHCS Authorized Representative:** (DO NOT complete this portion of the agreement. This portion is for California Department of Health Care Services use only).
 - The staff person from the California Department of Health Care Services, who has the authority to review, approve, and certify the information provided by the LEA on the PPA is true, accurate, and complete, must sign this form. By signing the LEA PPA, the DHCS Authorized Representative, on behalf of the California Department of Health Care Services, confirms the LEAs agreement to comply with all LEA Medi-Cal Billing Option Program requirements, restrictions, and procedures; including, but not limited to: following Medi-Cal procedures, submitting required reports, and reinvesting Medi-Cal reimbursements as specified in the PPA.

SUBMISSION INSTRUCTIONS

The PPA may be submitted to DHCS by one of three ways:

- (1) Complete the PPA online using electronic signatures and email as a PDF file;
- (2) Complete the PPA online and print, hand sign, scan and email as a PDF file;

For options (1) and (2), save the file using the following naming convention on the document and in the subject line: *2016.PPA.LEA Name.NPI Number.pdf*

- Example: *2016.PPA.NewHaven.198765432.pdf*

For options (1) and (2), email the documents to LEA.AnnualReport@dhcs.ca.gov

- (3) Complete the PPA online and print, sign (**in blue ink**) and mail a hard copy, **including a signed copy of the AR** to:

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

Instructions for Completing the Local Educational Agency (LEA) Medi-Cal Billing Option Program Provider Participation Agreement (PPA)

FINAL CHECKLIST

❖ Please ensure:

- ❖ You are submitting the correct version of the PPA: **DHCS 07/01/16**
- ❖ You **DO NOT** revise the PPA or any of the annual report attachments as these documents are considered a legally binding contract any altered document(s) will be considered invalid and the entire submission packet will be denied.
- ❖ A complete LEA Medi-Cal Billing Option Program enrollment packet includes:
 - Complete (9 Pages) Provider Participation Agreement (PPA)
 - Article VI – Signature Execution
 - Medi-Cal Provider Enrollment Information Sheet
 - Consortium Billing (If Applicable)
 - Current Year Certification of State Matching Funds (Attachment 1)
 - Annual Report Financial Data (Attachment 1A)
 - Statement of Commitment to Reinvest (Attachment 2)
 - LEA Collaborative Partners (Attachment 2A)
- ❖ All pages are single sided.
- ❖ All required signatures on the documents are original and are in **blue ink**.
- ❖ All information is printed or typed, except where specifically notated.
- ❖ Attachments 1 and 1A include dollar amounts, where applicable.
- ❖ You make a copy of the entire Enrollment Package to keep on file with your LEA. These forms describe your program responsibilities as a Medi-Cal provider. If a copy of this PPA is needed in the future, please forward your request to PEDCorr@dhcs.ca.gov. Please include the NPI number, LEA Name, and fiscal year of the PPA that is being requested.
- ❖ You send the enrollment package, with original signatures, to the email address or mailing address listed above.