



# **PROVIDER TYPE SPECIFIC PACKET/CHECKLIST**

**(Louisiana Medicaid Program)**

# **EPSDT Health Services**

(Enrollment packet is subject to change without notice)

# EPSDT Health Services

## CHECKLIST OF FORMS FOR SUBMISSION

The following checklist identifies the necessary documents needed to enroll in Louisiana Medicaid (Fee-For-Service) as an EPSDT Health Services provider:

| Completed                   | Document  |
|-----------------------------|---|
| <input type="checkbox"/> *  | 1. Completed Entity/Business Louisiana Medicaid PE-50 Provider Enrollment Form.   |
| <input type="checkbox"/> *  | 2. Completed PE-50 Addendum – Provider Agreement Form.  |
| <input type="checkbox"/> *  | 3. Completed Medicaid Direct Deposit (EFT) Authorization Agreement Form.  |
| <input type="checkbox"/> *  | 4. Louisiana Medicaid Ownership Disclosure Information Forms for an Entity/business.  |
| <input type="checkbox"/>    | 5. <b>(If submitting claims electronically)</b> Completed Provider's Election to Employ Electronic Data Interchange of Claims for Processing in the Louisiana Medical Assistance Program (EDI Contract) Form <b>and</b> Power of Attorney Form (if applicable).   |
| <input type="checkbox"/>    | 6. Copy of voided check or letter from the bank on bank letterhead verifying the account and routing number for the account to which you wish to have your funds electronically deposited ( <b>deposit slips are not accepted</b> ).  |
| <input type="checkbox"/>    | 7. Copy of a pre-printed document received from the IRS showing both the employer identification number (EIN) and the official name as recorded on IRS records ( <b>W-9 forms are not accepted</b> ).   |
| <input type="checkbox"/> ** | 8. <b>Only for Charter Schools:</b> <ul style="list-style-type: none"> <li>• Completed Declaration of Charter School Status Form.</li> </ul>  |
| <input type="checkbox"/> ** | 9. Completed PE-50 EPSDT Provider Supplement Agreement C - School Board/Charter School Certification of Understanding.  |
| <input type="checkbox"/> ** | 10. Completed Amendment to the Provider Agreement Between LDH-BHSF and the appropriate Parish School Board/Charter School.  |
| <input type="checkbox"/> ** | 11. Completed Individual Clinician Form.  |
| <input type="checkbox"/>    | 12. Submit an online printout for each of the professionals/therapists listed on the Individual Clinician Form referenced above, in item 11. <ul style="list-style-type: none"> <li>• The license printout must contain the license number, the effective date of issuance, and the current status of the license.</li> </ul> |
| <input type="checkbox"/>    | 13. <b>Only for Type 1 and 3 Charter Schools in Orleans Parish:</b> <ul style="list-style-type: none"> <li>• Written approval from the Orleans Parish School Board that approval has been granted for the Charter School to act as its own local education agency.</li> </ul>   |
| <input type="checkbox"/>    | 14. On <b>Section A</b> of the <b>PE-50</b> Form, in the <b>Specialty Code</b> space write in '44' (Public Health) and leave the <b>Subspecialty Code</b> Space 'blank'.  |
| <input type="checkbox"/>    | 15. On <b>Section D</b> of the <b>PE-50</b> Form, in the <b>Provider Type Description</b> space write in "EPSDT Health Svcs" and in the <b>Provider Type Code</b> space write in '70'.  |

\*Forms are included in the Basic Enrollment Packet

\*\*Forms are included here

Original Signatures Required – Sign in Blue Ink

Submit all required documentation to:  
**Gainwell Provider Enrollment Unit**  
**PO Box 80159**  
**Baton Rouge, LA 70898-0159**

# Declaration of Charter School Status

1) Name of the enrolling Charter School:

\_\_\_\_\_

2) Below, identify the Type classification of this enrolling school:

\_\_\_\_\_ **Type 1** - New School – Local School Board/Charter School Authorized

---OR---

\_\_\_\_\_ **Type 1** - New School – Local School Board/Charter School Authorized- Under R.S. 17:3995(G)(2). Type 1 charter school that has obtained approval from the Orleans Parish School Board to act as its own local education agency for one of more funding purposes.

\_\_\_\_\_ **Type 2** - BESE Authorized

\_\_\_\_\_ **Type 3** - Conversion School – Local School Board/Charter School Authorized

---OR---

\_\_\_\_\_ **Type 3** - Conversion School – Local School Board/Charter School Authorized- Under R.S. 17:3995(G)(2). Type 1 charter school that has obtained approval from the Orleans Parish School Board to act as its own local education agency for one of more funding purposes.

\_\_\_\_\_ **Type 3B** - Former Type 5 Charter School transferred from RSD back to local school system

\_\_\_\_\_ **Type 4** - New or Conversion School - Local School Board/Charter School Authorized

\_\_\_\_\_ **Type 5** - BESE – Authorized – Recovery School District (RSD)

**NOTE: Only Types 2, 3b, and 5 Charters Schools are eligible for Medicaid enrollment. Type 1 and Type 3, are only eligible for Medicaid enrollment with the appropriate documentation under RS 17:3995(G)(2).**

Signature of Authorized Representative \_\_\_\_\_

Printed Name of Authorized Representative \_\_\_\_\_

Date of Signature \_\_\_\_\_

Title of Authorized Representative \_\_\_\_\_

Name of Enrolling Provider: \_\_\_\_\_

**PE-50 EPSDT PROVIDER SUPPLEMENT AGREEMENT C  
SCHOOL BOARD/CHARTER SCHOOL CERTIFICATION OF  
UNDERSTANDING**

**(APPLICABLE ONLY TO HEALTH SERVICES PROVIDED TO CHILDREN WITH SPECIAL  
NEEDS, FORMERLY REFERRED TO AS SCHOOL HEALTH SERVICES)**

The Provider School Board/Charter School acknowledges that this Certification of Understanding is required by the U.S. Department of Health and Human Services, Center for Medicare and Medicaid Services, as part of the Bureau of Health Services Financing's assurance in accordance with the Title XIX State Plan that local parish School Board/Charter School funds are available to the Medicaid Program to be matched with the federal share in the reimbursement of EPSDT services provided by the School Board/Charter School to children with special health care needs.

1. The Provider School Board/Charter School understands, certifies and assures it does have the state and/or local match funds available to draw down the federal share for the EPSDT health services provided to children with special needs by the School Board/Charter School.
2. The Provider School Board/Charter School understands, certifies, and assures that in participating in this program and qualifying for matching funds herein, no federal funds received by or available to the School Board/Charter School will be used in recapturing federal dollars.
3. The Provider School Board/Charter School assures that adequate records and an audit trail to support the above assurances will be maintained for the individual check writes and will be made available to the U.S. Department of Health and Human Services and the Bureau of Health Services Financing and its designees for review.
4. The Provider School Board/Charter School understands that this Certificate of Understanding is not applicable to EPSDT screening services.

\_\_\_\_\_  
BHSF Director Signature Date

\_\_\_\_\_  
Print BHSF Director Name

\_\_\_\_\_  
Superintendent Signature Date

\_\_\_\_\_  
Print Superintendent Name

\_\_\_\_\_  
School Board/Charter School Member Signature Date

\_\_\_\_\_  
Print Board/Charter School Member

AMENDMENT to the PROVIDER AGREEMENT BETWEEN  
the LOUISIANA DEPARTMENT OF HEALTH (LDH), BUREAU  
OF HEALTH SERVICES FINANCING (BHSF)

AND

Parish School Board/Charter School, by the Name of:

---

The Louisiana Department of Health, Bureau of Health Services Financing, hereinafter called BHSF, and the \_\_\_\_\_ Parish School Board/Charter School, a government entity, hereinafter called Local School Board/Charter School; hereby make this Amendment to the Provider Agreement in order to implement the Medicaid State Plan under Title XIX of the Social Security Act (Medicaid).

**I. GENERAL RESPONSIBILITY**

- A. BHSF recognizes the unique relationship that the Local School Board/Charter School, and the affiliated entities operating under contract or memorandum of understanding with it, has with its Medicaid eligible clients and its unique abilities to provide IDEA School- Based Health Services to Medicaid eligible students. BHSF, in order to take advantage of this expertise and relationship and to promote objectives of the State Medicaid Plan, has entered into this Amendment to the Provider Agreement with Local School Board/Charter School.
  
- B. BHSF and Local School Board/Charter School makes this Amendment with full recognition of all Agreements that BHSF has developed for services to Title XIX eligible clients living in Louisiana and which are currently included in the Title XIX State Plan approved by the federal Centers for Medicare and Medicaid Services.

**II. IDEA SCHOOL-BASED DIRECT HEALTH SERVICES**

- A. BHSF agrees to:
  - 1. Claim for federal financial participation (FFP) under Title XIX the actual and reasonable expenditures of the Local School Board/Charter School for IDEA School- Based Direct Health Services provided to Medicaid eligible children by its staff or by staff in agencies with which it has subcontracted for direct medical services under its Provider Agreement.
    - a. Actual and reasonable expenditures by the Local School Board/Charter School shall be determined by the same time accounting system which is utilized in Louisiana's Medicaid Allowable Costs approved Title XIX State Plan amendment which adhere to the provisions of OMB Circular A-87 and 45 CFR Parts 74 and 95.
    - b. This system will allocate the expense and equipment costs necessary to collect data, disseminate information and carry out the staff functions outlined in this Agreement.

- c. BHSF agrees to reimburse the Local School Board/Charter School no less than eighty-five percent of the FFP (“federal share”) received for the expenditures so claimed and reserves the right to retain up to fifteen percent of the FFP for BHSF’s own costs of administering the IDEA School-Based Health Services program, including monitoring compliance and quality of the program and providing technical assistance to Local School Board/Charter Schools.
- d. Reimbursement will be claimed in accordance with State Plan documents as approved by the Centers for Medicare and Medicaid Services (CMS).
- e. Changes in any federal regulation affecting costs eligible for federal match, which become effective subsequent to the execution of this Agreement, will be applied herein as provided in such changes in applicable federal regulations.

2. Designate an employee to act as liaison with Local School Board/Charter School for issues concerning this Agreement.

B. Local School Board/Charter School agrees to:

1. Perform or coordinate its subcontractors’ performance of IDEA School-Based Health Services activities on behalf of BHSF.
2. Account for the allowable activities of staff providing IDEA School-Based Health Services in accordance with the provisions of OMB Circular A-87 and 45 CFR Part 74 and 95, on forms issued by BHSF, according to Medicaid’s written instructions.
3. Avoid duplicate and unnecessary EPSDT services.
4. Participate in EPSDT services provider training.
5. Submit by or on behalf of the provider of any claim shall be certification that the specific EPSDT services for which the payment is claimed were provided to the person identified as the recipient.
6. Submit Medicaid claims within 1 year of the date of service electronically.
7. Promptly refer any suspected child abuse, neglect, and/or sexual abuse of recipients under the age of 21 promptly to the Office of Community Services in the parish where the recipient resides.
8. Participate in EPSDT recipient outreach activities including seeking out recipient and informing recipients of the benefits of EPSDT services, informing them of assistance, including transportation services, available and helping them use EPSDT services effectively.
9. Bill for IDEA School-Based Health Services based on the most current BHSF instructions for billing for these services.

10. Provide BHSF the expenditures information in the annual cost report it submits to BHSF, or its designee, in the manner prescribed by BHSF by no later than September 1st of each year and maintain related documentation for five years from date of payment.
11. Budget sufficient local and/or state funds, in an amount sufficient to equal anticipated total costs to provide IDEA health services to Medicaid eligible students, which shall subsequently be certified as public expenditures eligible for Medicaid federal financial participation, in accordance with the provisions of this agreement.
12. Designate an employee to act as liaison with BHSF for issues concerning this Agreement.
13. **Charter School Only.** Agrees to annually submit its most current valid charter agreement as part of its annual cost report.
14. **Type 1 or Type 3 Charter School approved under RS 17:3995(G)(2) Only.** Agrees to inform the Louisiana Department of Health if at any time the approval to act as its own local education agency is revoked.

**III. FISCAL PROVISION** - Payment provisions under this Agreement shall be made in the following manner:

- A. Upon Local School Board/Charter School's compliance with its responsibilities pursuant to Section II of this Agreement in a satisfactory manner and after BHSF has received federal financial participation for expenditures claimed, BHSF agrees to reimburse to Local School Board/Charter School an equal amount equal to no less than 85 percent of the federal share of certified costs (as demonstrated by audit of actual cost incurred in Local School Board/Charter School cost centers and appropriation accounts that are paid by non-federal funds).
- B. In addition, BHSF agrees to reimburse for IDEA School-Based Health Services provided by Local School Board/Charter School only if Local School Board/Charter School certifies that sufficient state/local funds are available to support the total cost for IDEA School-Based Health Services claimed as Medicaid expenditures. This Agreement is also subject to any additional restrictions, limitations or conditions required by federal or state government which may affect the provisions, term or funding of this Agreement in any manner.
- C. Each year Local School Board/Charter School agrees to provide BHSF with a certification of the estimate of non-federal public (local and/or state) funds to be expended for Medicaid IDEA School-Based Direct Health Services at the beginning of each state fiscal year, and a certification at the end of the fiscal year of the actual amount of non-federal public funds, (local and/or State General Revenue funds) used to reimburse for IDEA School-Based Direct Services for clients in an amount equal to the total Medicaid claimed expenditures for IDEA School-Based Direct Health Services. Said certification will be made on a form provided to the Local School Board/Charter School by BHSF. If payments made during the fiscal year under the term of this agreement exceed the costs as reported on the cost report, the DHH will recoup those amounts determined to be overpayments to the Local School Board/Charter School. If a fiscal year's cost report is not submitted by the date specified by DHH, then DHH may initiate recovery of all payments to the Local School Board/Charter School made under this agreement and may suspend further payments until the

required cost report is received and the provider is in compliance with this agreement. DHH may allow repayment plans for Local School Board/Charter School if necessary.

- D. This Agreement will terminate at the end of any State or Federal fiscal year in the event funds are not appropriated by the Louisiana Legislature or the U.S. Congress for the next succeeding State or Federal fiscal year. If funds are appropriated for a portion of the fiscal year, this agreement will terminate at the end of the term for which funds are appropriated.
- E. BHSF's obligation to transfer these funds under this Agreement is contingent upon the availability of Federal Financial Participation for these services.
- F. Since State Fiscal Years (July - June) and Federal Fiscal Years (October - September) do not run concurrently, Federal financial Participation will be determined by weighed rates based on the state fiscal year (one quarter of the prior Federal Fiscal Year's FMAP plus three quarters of the current Federal Fiscal Year's FMAP based on federal fiscal years).
- G. Any audit exception, deferral or denial taken by CMS against payments covered under this Agreement will be the responsibility of Local School Board/Charter School, unless said exception, deferral, or denial is the direct result of instructions given in writing by BHSF.

**IV. AMENDMENT**

This Agreement may be amended at any time by mutual written content of the parties of this Agreement. Either party may also terminate this Agreement without cause by delivery of written notice of termination to the other party at least thirty (30) days prior to the effective date of termination. Revised 10/2014

**V. TERM OF CONTRACT**

This Agreement is effective, \_\_\_\_\_ and shall continue indefinitely.  
This Agreement is executed by the undersigned in their capacities as stated below.

\_\_\_\_\_ Parish School Board/Charter School

\_\_\_\_\_  
Superintendent

\_\_\_\_\_  
Medicaid Director or Designee

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Date Signed



## Individual Clinician Form

Provider Name: \_\_\_\_\_

List all clinical individuals providing health services to children with disabilities, as identified on the PE-50 EPSDT Provider Supplement Agreement C form.

Attach a copy of the current license for each practitioner listed below.

| Clinician Name | Clinician Specialty | Clinician License Number |
|----------------|---------------------|--------------------------|
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |
|                |                     |                          |

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Authorized Representative

Date of Signature

Print Name of Authorized Representative \_\_\_\_\_