School Health and Related Services (SHARS)

Informal Review Information Session
Presented by HHSC Rate Analysis
Agenda

1. Housekeeping Items
2. Cost Report Reconciliation Process
3. Settlement Notices
4. Step 8
5. Informal Review Requests/Process
6. Summary/Questions
Housekeeping Items

- Webinar audio options
  - Phone Audio
    - Must use the telephone number, access code and audio pin found on the right hand side of screen
  - Computer Audio
    - Must have a microphone enabled computer to speak during webinar

- For all technical difficulties contact Webinar Support at 1-800-263-6317

- Training duration

- Breaks

- No credit awarded for attending session
Housekeeping Items

• GoToMeeting Chat Function
• GoToMeeting Raise Hand Feature
• Email questions to ra_shars@hhsc.state.tx.us or call the SHARS Help Line at (512) 730-7400
Cost Report Reconciliation Process

- Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as School Health and Related Services (SHARS). SHARS allows local school districts, including public charter schools, to obtain Medicaid reimbursement for certain health-related services prescribed by a health professional and documented in a student's Individualized Education Program (IEP).

- Centers for Medicare & Medicaid Services (CMS) requires annual cost reporting, cost reconciliation, and cost settlement processes for all Medicaid SHARS services delivered by school districts.

- The primary purpose of the cost report is to document the provider’s costs for delivering SHARS services to reconcile the provider’s interim payments received for SHARS services with its actual total Medicaid allowable costs.
Cost Report Reconciliation Process

• The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SHARS cost report.

• If a provider has not complied with all cost report requirements, HHSC will recoup all federal funds issued as interim payments for services delivered during the reporting period.

• The total Medicaid-allowable costs are compared to the provider’s interim payments for SHARS delivered during the reporting period, which results in a cost reconciliation.
Settlement Notices

• On December 2, 2019, settlement notices will be issued to all districts that submitted a 2018 SHARS Cost Report and complied with all cost reporting requirements.

• Settlement notices are issued via email by Fairbanks LLC (info@fairbanks.com).

• Settlement notices are issued to inform districts that all HHSC reviews have been completed, any adjustments made are now available for review, and that a settlement amount has been calculated and is being proposed to the district.
Settlement Notices

Settlement notices include:

- Instructions
- Deadlines
- Resources/contact information
Step 8

Step 8 of the SHARS Cost Report is activated once settlement notices are issued. As stated in the settlement notice, districts must log into STAIRS within 30 days of the date of the notice to “Agree” or “Disagree” with the proposed settlement.

Step 8 consists of 3 parts:
  1. Settlement Notice
  2. Adjustment Report
  3. Agree/Disagree Entry

Once the district’s response has been entered, it will receive a confirmation notice that includes instructions for how to proceed. The instructions will vary depending on the district’s response.
Step 8

• After the reconciliation period has expired, HHSC will process the payout or recoupment calculated for districts that Agree with their proposed settlement.

• Cost reports that are “Disagreed” to are withheld from payment until an informal review determination has been issued.

• If no response is received from a district within the allotted time frame, the cost reporting system will agree with the settlement amount by default.
Informal Review Requests/Process

• An ISD or the Superintendent, CFO, Business Officer, or other ISD Official with legal authority who disagrees with the adjustments made during the cost reconciliation process has the right to request an informal review of the adjustments.

• If a district does not submit an informal review request, no action will be taken as a result of its “Disagree” response.

• A “Disagree” response reflects a disagreement with the contained data. It is not an opportunity to submit additional claims material.

• The Informal Review period for the 2017 – 2018 Cost Report will begin on December 2, 2019.
Informal Reviews vs. Cost Report Corrections

- Cost Report Corrections Request Instructions
  - Cost report corrections may be made up to 60 days after the original due date of the cost report.

To make a correction to a cost report:
- Scan and send a written district-initiated correction request to ra_shars@hhsc.state.tx.us
- Correction requests must be on district letterhead, dated and signed by the Financial Contact.
- Correction requests must be notarized.
- Requests should include:
  - District Name
  - District NPI and TPI
  - Year of the cost report in need of correction
  - Brief description of the issue/correction
  - Length of time needed to complete the revisions
Informal Reviews: TAC Rules

TAC Rule §355.110

- HHSC Rate Analysis must receive a written request for an informal review by hand delivery, United States (U.S.) mail, or special mail delivery no later than 30 calendar days from the date on the written notification of the adjustments.
  - If the 30th calendar day is a weekend day, national holiday, or state holiday, then the first business day following the 30th calendar day is the final day the receipt of the written request will be accepted.
  - HHSC Rate Analysis will extend this deadline if it receives a written request for the extension by hand delivery, U.S. mail, or special mail delivery no later than 30 calendar days from the date of the written notice of adjustments.
  - A request for an informal review or extension that is not received by the stated deadline will not be accepted.
- The request must include a concise statement of the specific actions or determinations being disputed, the ISD’s recommended resolution, & any supporting documentation deemed relevant. It is the responsibility of the interested party to render all pertinent information at the time of its request for an informal review. A request for an informal review that does not meet these requirements will not be accepted.
- The written request for the informal review or extension must be signed by an individual legally responsible for the conduct of the interested party. Informal review requests signed and/or submitted by a district’s vendor/third party contractor will not be accepted.
- Failure to follow these instructions will result in the denial of the district’s informal review request. If a district’s request is denied, HHSC will proceed with the settlement as if the district had “Agreed.”
Informal Review Requests/Process

• Upon receipt of a district’s informal review request, HHSC will review the documents submitted and will determine the appropriate course of action.

• Additional information may be requested by HHSC staff.
  • The additional information must be submitted no later than 14 calendar days from the date the district receives the request for additional information.
    • If the 14th calendar day is a weekend day, national holiday, or state holiday, then the first business day following the 14th calendar day is the final day the receipt of the additional information will be accepted.
    • Information received after 14 calendar days may not be used in the informal review written decision unless the interested party receives written approval of the lead staff member to submit the information after 14 calendar days.
    • A request for an extension to the 14-calendar-day due date must be received by HHSC Rate Analysis prior to the 14th calendar day.
Informal Review Requests/Process

• HHSC remains in constant contact with districts while conducting informal reviews.

• Within 30 calendar days of the date a written request for informal review that complies with all requirements is received, or the date additional information is due or received, whichever is later, HHSC will issue the agency’s written decision by certified mail.
  • If the 30th calendar day is a weekend day, national holiday, or state holiday, then the first business day following the 30th calendar day is the final day by which the written decision must be sent.
Certification & Claimed Expenditures

- To complete the Informal Review process, districts must sign and submit new Cost Report Certification Claimed Expenditures forms.
- Districts that disagree with the results of the Informal Review can request a formal appeal.
- Submission of the new Certification and Claimed Expenditures forms does not waive the district’s right to request a formal appeal.

The new forms are required in order for HHSC to initiate the settlement payment/recoupment process.

- If a formal appeal is requested, granted, and a decision is made in favor of the district, any supplemental payment due to the district will be issued separately.
Formal Appeals

Formal Appeal Process

If a district does not agree with the informal review decision made by the HHSC Rate Analysis Department, the district has an option to appeal through the HHSC appeal process. Formal appeals are conducted in accordance with the provisions of Chapter 357, Subchapter I of the Texas Administrative Code (related to Hearings under the Administrative Procedure Act). Written requests for a formal appeal from the interested party must be received within 15 calendar days after the interested party receives the written decision. Requests must be sent directly to:

HHSC Appeals Division
Mail Code W-613
P.O. Box 149030
Austin, TX 78714-9030

This written request for a formal appeal must state the basis of the appeal of the adverse action and include a legible copy of the written decision from the informal review. The formal appeal is limited to issues that were considered in the informal review process. See TAC Rule §355.110 for additional appeal details and information.
Common Informal Review Request Items

1. Direct Medical Services Individualized Education Program (IEP) Ratio
2. Specialized Transportation Services One-Way Trip Ratio
3. Direct Medical Services Payroll, Benefits, and Taxes
4. Transportation Payroll, Benefits, and Taxes
5. Direct Medical Services Other Cost Summary Data (Appendix A)
   • Personal Care Services (PCS)
Common Informal Review Request Items

Direct Medical Services IEP Ratio

The IEP Ratio is used in the calculation of Medicaid-allowable costs for direct medical services.

**Total Medicaid IEP Students**
- Report the unduplicated count of Medicaid-eligible students with IEPs requiring one or more direct medical services covered under the Medicaid SHARS program during the cost-reporting period.

**Total IEP Students**
- Report the unduplicated count of all students (Medicaid and non-Medicaid) with IEPs requiring one or more direct medical services covered under the Medicaid SHARS program during the cost-reporting period.

<table>
<thead>
<tr>
<th>Direct Medical Services Individual Education Program (IEP) Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>00.00.10 Total # of Medicaid students with IEPs requiring direct medical services</td>
</tr>
<tr>
<td>00.00.11 Total # of students with IEPs requiring direct medical services</td>
</tr>
<tr>
<td>00.00.12 IEP ratio (Item 00.00.10 divided by Item 00.00.11)</td>
</tr>
</tbody>
</table>
Common Review Requests Items

Direct Medical Services IEP Ratio Cont’d.

- The IEP ratio compares Medicaid to Non-Medicaid IEP students with one or more direct medical SHARS services.
- If a student was Medicaid eligible during the cost reporting period and had an IEP for one or more direct medical services covered under the SHARS program, he or she should be included in the numerator as well as the denominator of the IEP Ratio.
- If a student was not Medicaid eligible during the cost reporting period, but did have an IEP for one or more direct medical services during the cost reporting period, he or she should only be included in the denominator.
Common Review Requests Items

Direct Medical Services IEP Ratio Cont’d

IEP Ratio Supporting Documentation

• Provide a Medicaid eligibility list which includes:
  • A Medicaid eligibility column
    For students who are Medicaid, please provide their Medicaid number. For those who aren’t, please leave blank.
• Provide the method the district used to calculate the IEP ratio.
• Ensure LD-only students are not included in the ratio.
Common Review Requests Items

Specialized Transportation Services One-Way Trip Ratio

• Transportation services are available to Medicaid-eligible recipients under the age of 21 years, who are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services and for whom the services are medically necessary.

Total number of one-way trips for Medicaid students with IEPs requiring specialized transportation services

• Report the total number of specialized transportation one-way trips during the cost-reporting period. Medicaid reimburses one-way trips on days when another direct medical service was delivered to that student, pursuant to an IEP.

Total number of one-way trips for students with IEPs requiring specialized transportation

• Report the total number of specialized transportation one-way trips during the cost-reporting period for all students (Medicaid and non-Medicaid) whose IEP’s require specialized transportation services.
Common Review Requests Items

Specialized Transportation Services One-Way Trip Ratio Cont’d.

• The ratio of one-way specialized transportation trips provided on a day when medical services pursuant to an IEP were provided divided by the total number of one-way specialized transportation trips.

• One-way trip ratio = (total one-way trips for Medicaid students with IEPs requiring specialized transportation services)/(total one-way trips for all students with IEPs requiring specialized transportation services.

<table>
<thead>
<tr>
<th>Specialized Transportation Services One-Way Trip Ratio</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>00.00.13 Total number of one-way trips for Medicaid students with IEPs requiring specialized transportation services</td>
<td>71,026</td>
</tr>
<tr>
<td>00.00.14 Total number of one-way trips for students with IEPs requiring specialized transportation</td>
<td>150,409</td>
</tr>
<tr>
<td>00.00.15 One-Way Trip Ratio (Item 00.00.13 divided by Item 00.00.14)</td>
<td>47.22%</td>
</tr>
</tbody>
</table>
Common Review Requests Items

Specialized Transportation for One-Way Trip Ratio Cont’d.

Commonly requested One-Way Trip Ratio supporting documentation:

Provide actual trip logs with the following elements:

1. Bus driver signature on each log, dated in the appropriate month/year
2. Route name/number
3. District name
4. Logs must be from the cost report period (October 1, 2017 – September 30, 2018), anything outside of these dates cannot be included in one-way trip ratio
5. Provide documentation or confirm that another direct medical service was provided the same day as each trip (needs to be available in the event of an audit)
6. Provide a Medicaid eligibility list which includes:
   • A Medicaid column for students who are Medicaid eligible, for students that are not Medicaid eligible, please leave blank
   • Provide a column that indicates whether or not the student required specialized transportation
Common Review Requests Items

Direct Medical Services Payroll, Benefits, and Taxes Costs

Providers are required to maintain the requested employee information, payroll, benefits, and federal funding reduction information for each individual employee and contracted staff member delivering SHARS-covered services during the reporting period. Report the requested information by type of service provided (i.e., audiology & hearing services).
Per TAC Rule §354.1342(8), a district must bill for each cost category for which it intends to seek reimbursement through the annual cost report. All associated costs will also be disallowed if the cost category is not billed for at least once.
Common Review Requests Items

Direct Medical Services Payroll, Benefits, and Taxes Costs Cont’d.

Direct Medical Services Payroll, Benefits, and Taxes Costs Supporting Documentation

RECORDKEEPING: Providers must maintain records that are accurate and sufficiently detailed to substantiate the legal, financial, and statistical information reported on the cost report.

- These records include, but are not limited to:
  - Accounting ledgers, journals, invoices, purchase orders, vouchers, timecards, payrolls, mileage logs, flight logs, loan documents, insurance policies, asset records, inventory records, organizational charts, time studies, functional job descriptions, verification of credentials work papers used in the preparation of the cost report, trial balances, and cost allocation spreadsheets.

HHSC requires that the provider maintain cost report work papers for a minimum period of seven years or until audited whichever is longer following the end of each cost-reporting period.
Common Review Requests Items

Direct Medical Services Other Cost Summary Data

Direct Medical Travel and Required Continuing Education

- Direct medical services Required Continuing Education is allowable for professional staff for licensure and/or certification required to perform direct medical services.

- Allowable expenditures include training and continuing education seminars, travel and other staff costs to maintain professional licensure and/or certification. Other allowable staff travel expenditures include mileage reimbursements, gasoline/oil allowances/reimbursements, cab fare, bus fare, hotel, air fare and other travel reimbursements paid to staff.

- Please note that Personal Care Services (PCS) as a profession has no licensure requirements, therefore no Required Continuing Education costs for PCS are allowable.

Appendix A

- Appendix A is an all-inclusive list of Medicaid-allowable costs for direct medical services. The list provided in Appendix A includes the only approved materials and supplies. Any request for additional items not included will require CMS approval.

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Direct Medical Travel</th>
<th>Required Continuing Education</th>
<th>Appendix A Other Direct Medical (less than $5,000)</th>
<th>Other Reductions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Services</td>
<td>Enter Detail</td>
<td>0</td>
<td>0</td>
<td>$273</td>
</tr>
<tr>
<td>Occupational Therapy (OT)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$7,968</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$3,229</td>
</tr>
<tr>
<td>Physical Therapy (PT)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$806</td>
</tr>
<tr>
<td>Speech and Language Services (SLP)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$4,190</td>
</tr>
</tbody>
</table>
Common Review Requests Items

Direct Medical Services Other Cost Summary Data

Exclusions to Direct Medical Services Costs

• Personal Care Services (PCS) providers cannot claim Continuing Education and direct medical travel costs associated with travel for Continuing Education (hotel, airfare, etc.), as there are no licensure requirements associated with PCS.
• Settlement notices will be issued on December 2, 2019
• Districts must complete Step 8 within 30 days of the date indicated on the settlement notice
• Informal review requests must be submitted timely and complete or they will be denied.

Questions?
Thank you

HHSC Rate Analysis
SHARS Help Line: (512) 730-7400
SHARS Mailbox: ra_shars@hhsc.state.tx.us