



# School Health and Related Services (SHARS)

2015 Cost Report Training

# WELCOME!!! Before we get started...

## Housekeeping...

- Training duration
- Breaks
- Must be present and attentive throughout the entire training presentation in order to obtain credit.
- Full screen mode
- To listen to the presentation you have two options:
  - Dial in using your telephone.
    - Must use the telephone number, access code, and audio pin found on the right side of your screen
  - Listen through your computer.
    - Must have speakers to listen and a microphone enabled computer to ask questions throughout the training.
- If you experience technical difficulties, please contact Webinar Support at 1-800-263-6317.

## For Questions...

- Email questions to: [ra\\_shars@hhsc.state.tx.us](mailto:ra_shars@hhsc.state.tx.us)
- Call the SHARS Help Line:  
(512) 730-7400
- SHARS FAQs
- Texas Medicaid Providers Procedure Manual (Children's Services Handbook Section 3).  
([http://www.tmhp.com/Pages/Medicaid/Medicaid\\_Publications\\_Provider\\_manual.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx))

# Training Agenda

- SHARS Program Overview
- Billing
- RMTS & MAC Overviews
- SHARS Cost Report (Steps 1 – 10)
- STAIRS Demonstration
- Additional SHARS Information
  - Appeal Process
  - Cost Report Correction Procedures
  - STAIRS Edits
  - Oversight
  - Documentation Requirements
  - SHARS Financial Contacts

Resources & Contacts

# SHARS Program Overview

Medicaid services provided by school districts in Texas to Medicaid-eligible students are known as School Health and Related Services (SHARS). The oversight of SHARS is a cooperative effort between the Texas Education Agency (TEA) and the Health and Human Services Commission (HHSC). 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).



# SHARS Program Overview

School districts/shared services arrangements (SSAs) receive federal Medicaid money for SHARS services provided to students who meet all three of the following requirements. These students must:

- be Medicaid eligible,
- meet eligibility requirements for Special Education described in the Individuals with Disabilities Education Act (IDEA), and
- have Individual Educational Plans (IEPs) that details how the prescribed services will be delivered.

The individuals with Disabilities Education Act (IDEA) is a United States federal law that governs how states and public agencies provide special education, and related services to children with disabilities. It addresses the educational needs of children with disabilities in cases that involve 14 specified categories of disability.



# SHARS Program Overview

To be eligible to receive and retain federal reimbursement for Texas Medicaid reimbursement, as a provider of medical services for SHARS an ISD must:

- Be enrolled and approved as an active provider with the Texas Medicaid & Healthcare Partnership (TMHP)\*;
- Ensure that SHARS services are provided by approved/qualified providers as indicated in the Texas Medicaid Provider Procedures Manual (TMPPM);
- Bill for allowable Medicaid services, in the SHARS program, as they are delivered;
- Abide by HHSC rules and regulations and meet TEA standards for the delivery of SHARS;
- Meet all eligibility requirements and participate in the Random Moment Time Study (RMTS);
- Submit an annual SHARS Cost Report; and
- Comply with all state and federal audits.

\*As a result of a new federal regulation, all Texas Medicaid providers must periodically revalidate their enrollment in the new program. To comply with this mandate, **any Texas Medicaid provider, including SHARS providers, enrolled before January 1, 2013 must be fully enrolled by March 24, 2016.**

# SHARS Program Overview

Services covered by SHARS include:

- Audiology & Hearing, including evaluations and therapy sessions;
- Counseling Services;
- Nursing Services, including routine medication administration services;
- Occupational Therapy, including evaluations and therapy sessions;
- Personal Care Services;
- Physical Therapy, including evaluations and therapy sessions;
- Physician Services;
- Psychological Services, including evaluations and therapy sessions;
- Speech & Language Services, including evaluations and therapy sessions;
- Specialized Transportation.

# Billing



- SHARS providers are required to submit claims as services are delivered to Medicaid clients. Districts are required to bill for these services through the TMHP claim system.
- The TMHP claim system provides for prompt eligibility verification, identifies duplicate claim filings, creates a complete audit trail from service to claim, and documents payment data necessary for the Surveillance and Utilization Review Subsystem (SURS).
- Failure to bill for services in accordance with the Texas Medicaid Provider Procedures Manual (TMPPM) and the Texas Administrative Code (TAC) may impact a school district's Medicaid funding.

# Billing

- Refer to (TMPPM) Volume 1: Section 3 - TMHP Electronic Data Interchange (EDI) for information on electronic claims submissions.
- Refer to (TMPPM) Volume 1: Section 6 - Claims Filing for general information on claims filing protocol. Claims must be submitted within 365 days from the date of service, or no later than 95 days after the end of the Federal Fiscal Year (i.e., January 3), whichever comes first.
- Payment denial codes are applied to Texas Provider Identifiers (TPIs) that have had no claim activity for a period of 24 months or more. Once a payment denial code has been applied to a TPI, it will be considered inactive and will not be able to be used to submit claims. To have the payment denial code removed from a TPI, providers must submit a completed application for the state health-care program in which they wish to enroll and the application must be approved by TMHP. The information on the application must match the information currently on the provider's file for the payment denial code to be removed.

# Billing – Parental Consent

The Texas Education Agency and the Individuals with Disabilities Education Act (IDEA) requires parental consent and written notification before accessing a child's or parent's public benefits or insurance. All schools participating in SHARS must be in compliance with 34 CFR § 300.154 and 34 CFR § 300.300.

## TEA SHARS Website:

[http://tea.texas.gov/Curriculum and Instructional Programs/Special Education/Programs and Services/School Health and Related Services/](http://tea.texas.gov/Curriculum_and_Instructional_Programs/Special_Education/Programs_and_Services/School_Health_and_Related_Services/)



# Billing-Parental Consent

It is the district's responsibility to maintain the documentation verifying parental notice was provided and consent has been obtained. If the district is selected for a desk review/audit, it may be asked to produce documentation showing that all parental notice/consent requirements were followed.



# Billing – Appeal Process

## **(TMPPM) Children’s Services Handbook, Volume 2: Section 3.5.1.1 Appealing Denied SHARS Claims**

SHARS providers that appeal claims denied for exceeding benefit limitations must submit documentation of medical necessity with the appeal.

Documentation submitted with an appeal must include the pages from the IEP and ARD documents that show the authorization of the services, including the specified frequency and duration and the details of the need for additional time or the reasons for exceeding the benefit limitations. Each page of the documentation must list the client’s name and Medicaid number.

## **(TMPPM) Volume 1: Section 6.1.4.4 Appeal Time Limits**

All appeals of denied claims and requests for adjustments on paid claims must be received by TMHP within 120 days from the date of disposition, the date of the Remittance and Status (R&S) Report on which that claim appears. If the 120-day appeal deadline falls on a weekend or holiday, the deadline will be extended to the next business day.

**Refer to: Subsection 6.1.2, “Claims Filing Instructions” in this section.**



# Billing – Remittance & Status (R&S) Reports

- TMHP provides weekly R&S Reports to give providers detailed information about the status of claims submitted to TMHP.
- The R&S Report also identifies accounts receivables established as a result of inappropriate payment. These receivables are recouped from claim submissions.
- If no claim activity or outstanding account receivables exist during the cycle week, a provider will not receive an R&S Report.
- The R&S reflects claim payments processed during the period stated on the report regardless of the SHARS dates of service.
- **Providers are responsible for reconciling their records to the R&S report to determine payments and denials received.**

# Billing – Certification of Funds

- The purpose of the Certification of Funds (COF) statement is to verify that the school district incurred costs on the dates of service that were funded from state or local funds in an amount equal to, or greater than, the combined total of its interim rates times the paid units of service.
- TMHP Provider Enrollment mails the quarterly COF statement to SHARS providers after the end of each quarter of the federal fiscal year (October 1 through September 30). SHARS providers are required to certify the amount reimbursed during the previous federal fiscal quarter.
- While the payments were received the previous federal fiscal quarter, the actual dates of service could have been many months prior. Therefore, the certification of public expenditures is for the dates of service and not the dates of payment.

# Billing – Certification of Funds

- The Certification of Funds statement must be:
  - Signed by the business officer or other financial representative who is responsible for signing other documents that are subject to audit.
  - Notarized
  - Returned to TMHP within 25 calendar days of the date printed on the letter.

Failure to meet the COF requirement may result in recoupment of funds or the placement of a vendor hold on a provider's payments until the signed Certification of Funds statement is received by TMHP. Providers should call the TMHP Contact Center at 1-800-925-9126 if they do not receive their COF statement within a week of the end of the federal fiscal quarter.



# RANDOM MOMENT TIME STUDY (RMTS) OVERVIEW



Presented by HHSC Time Study

# MEDICAID ADMINISTRATIVE CLAIMING (MAC) FINANCIAL OVERVIEW FOR ISDS

Presented by HHSC MAC Team

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## Medicaid Administrative Claiming Financial OVERVIEW

Independent School Districts



Federal Fiscal Year 2016

# SHARS Cost Report

- 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.
- In accordance with Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443, each SHARS provider must complete an annual cost report for all SHARS services delivered during the previous federal fiscal year covering October 1 through September 30.
- Each SHARS provider who is a member of a cooperative or shared services arrangement must submit a separate SHARS cost report and have a district-specific RMTS Participant List (PL).
- All annual SHARS cost reports that are filed are subject to audit and/or desk review by HHSC or its designee.
- Failure to file a complete and acceptable cost report by the cost report due date in accordance with all instructions and rules will result in recoupment of all interim payments received during the cost report year.

# SHARS Cost Report

## Important Dates

- Federal Fiscal Year (SHARS Cost Report Period)
  - **October 1 – September 30**
  
- Cost Report Due Date (Strictly Enforced)
  - **April 1**
  
- Cost Report Corrections Due Date (Strictly Enforced)
  - **June 1** (60 days after initial submittal of cost report)
  
- Cost Report Training (Mandatory)
  - **January, February, and March**
  
- Cost Report Settlement
  - **August 31**



# SHARS Cost Report

- All SHARS cost reports are built, maintained, and submitted through the State of Texas Automated Information Reporting System (STAIRS).
- STAIRS is a web-based system provided at no charge by the HHSC Rate Analysis Department and its contractor, Fairbanks, LLC.



<https://mac.fairbanksllc.com/login/>

# SHARS Cost Report

## Standards For An Acceptable Cost Report:

Each submitted cost report must:

- be completed in accordance with the cost report instructions and reimbursement methodology rules;
- be completed for the correct cost-reporting period;
- be completed using the accrual, modified accrual or cash basis method of accounting for governmental entities;
- reconcile to the district's trial balance and general ledger accounts;
- report dollar amounts properly rounded to the nearest dollar and report statistical information to two decimal places;
- calculate all percentages used in calculations to at least two decimal places;
- have complete edit explanations with sufficient detail to explain all variances;
- be submitted in the SHARS web-based cost report system; and
- have signed, notarized, original certification pages uploaded and submitted in STAIRS on or before the posted due date.

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## 2015 SHARS Cost Report Training

# SHARS Provider Data (Step 1)

Consists of the following:

- District Identification
- SHARS Provider Identification
- Financial Contact
- Report Preparer Identification
- Location of Accounting Records that Support This Report
- Cooperative Information

# General & Statistical Information (Step 2)

Costs are allocated using statistics that have been approved by CMS to facilitate the identification of costs associated with Medicaid. There are 5 key allocations methods used in the SHARS Cost Report.

1. Direct Services Time Study Percentage – Reports the amount of time related to all medical services and Medicaid administrative claiming. (Derived from data obtained from the RMTS.)
2. Direct Medical Services IEP Ratio –  $(\text{Total number of Medicaid students with IEPs requiring medical services}) / (\text{Total number of students with IEPs requiring medical services})$
3. Specialized Transportation Services IEP Ratio –  $(\text{Total number of Medicaid students requiring specialized transportation services}) / (\text{Total number of students requiring specialized transportation services})$
4. Specially-Adapted Vehicles Ratio – Used to allocate transportation costs that cannot be direct costed to specialized transportation services, e.g., fuel, insurance, and/or mechanic costs.  $(\text{Total number of specially adapted vehicles}) / (\text{Total number of vehicles})$
5. One-Way Trip Ratio –  $(\text{Total one-way trips for Medicaid students with IEPs requiring specialized transportation services}) / (\text{Total one-way trips for all students with IEPs requiring specialized transportation services})$

# General & Statistical Information (Step 2): One-Way Trip Ratio

Reimbursement for covered transportation services is calculated on a student one-way trip\* basis, as long as the student receives at least one direct medical service on the same day.

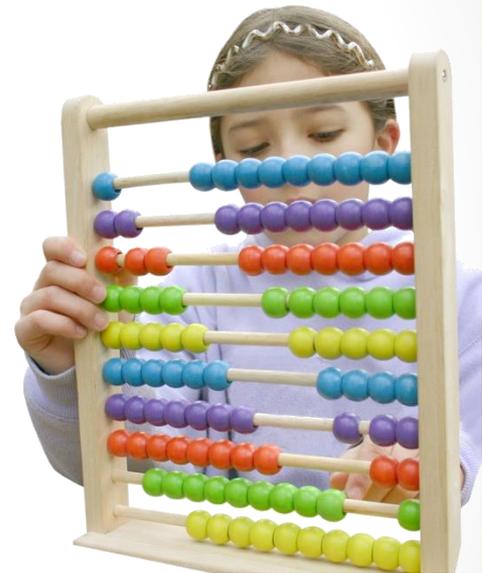
**\*Important: If the student receives a billable SHARS service that is documented in his/her IEP (including personal care services on the bus) and is transported on a specially adapted vehicle, the following one-way trips may be claimed:**

- From the student's residence to school
- From the school to the student's residence
- From the student's residence to a provider's office that is contracted with the district
- From a provider's office that is contracted with the district to the student's residence
- From the school to a provider's office that is contracted with the district
- From a provider's office that is contracted with the district to the student's school
- From the school to another campus to receive a billable SHARS service
- From the campus where the student received a billable SHARS service back to the student's school

For more information on SHARS Transportation see: [Texas Medicaid Provider Procedure Manual](#) – Children's Services Handbook, Vol. 2, Section 3.3.10 Transportation Services in a School Setting

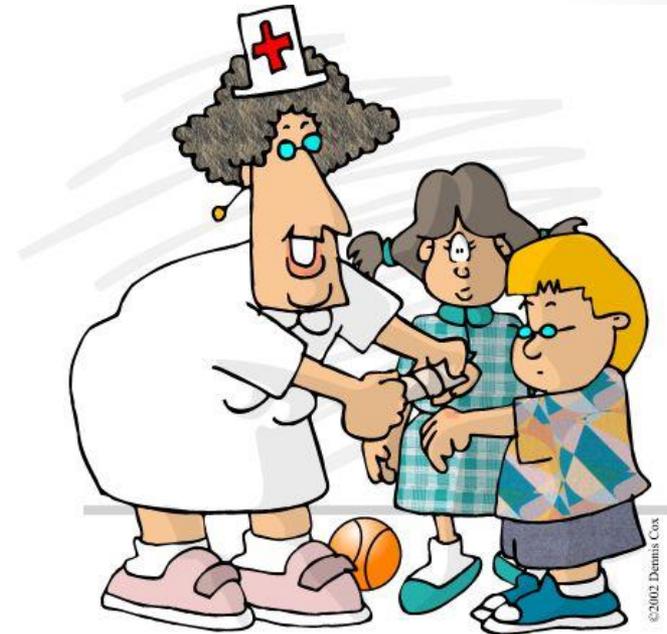
# General & Statistical Information (Step 2)

- All five allocation ratios/methods are listed in the General & Statistical Information section of the SHARS Cost Report.
- Each district's General Provider Information, Unrestricted Indirect Cost Rate, and Direct Medical Services Percentage Derived From Approved Time Study (Direct Services Time Study Percentage) are provided by HHSC.
- The Direct Medical Services IEP Ratio, Specialized Transportation Services IEP Ratio, Specially-Adapted Vehicles Ratio, and One-Way Trip Ratio are calculated within the cost report using data entered by the preparer.



# Direct Medical Services Data (Step 3)

- The purpose of the SHARS Cost Report is to:
  - capture Medicaid-allowable costs for the CMS-approved personnel delivering direct medical services and
  - capture Medicaid-allowable costs associated with specialized transportation services, in accordance with the CMS-approved Texas Medicaid State Plan.
- See Slide 7 for a list of the allowable SHARS services.
- Direct Medical Services Data can be entered in detail (Step 3a) or in summary (Step 3b). The detail provider data entered in Step 3a will be auto-summarized by the cost reporting system into Step 3b.



# Direct Medical Services Data (Step 3)

## **(Direct Medical Services) Employee Information:**

- In Step 3a, the data for Provider Category, External ID, Name, Employment Type, Title, and Quarters Reported on Participant List is pre-populated based on information reported on the district's participant lists throughout the cost report period.
- All Employee Information, excluding the quarters reported on the district's participant list, can be edited in Step 3a.
- Employee Information is summarized and reduced to Provider Category, Number of Employees (headcount), and Number of Contactors (headcount) in Step 3b.

## **Direct Medical Services Payroll, Benefits, and Taxes:**

- **Hours\*** - Total hours paid to an employee/contractor for direct medical services provided to the district's Medicaid and/or non-Medicaid clients during the quarters the employee/contractor was included on the district's participant list. *Hours includes overtime, travel time, documentation time, training time, staff meeting time, paid vacation time, and paid sick leave time relating to the Gross Salary/Contractor Payments reported for the employee/contractor. Employee hours and Contractor Hours are reported separately in Step 3b.*
- **Gross Salary/Contractor Payments\*** – Salary/payments paid to an employee or contractor (before taxes or any deductions) for the hours he/she provided direct medical services to the district's Medicaid and/or non-Medicaid clients during the quarters the employee/contractor was included on the district's participant list. *Gross Salary/Contractor Payments includes overtime pay, cash bonuses, and any cash incentives paid from which payroll taxes are (or should be) deducted. Gross Salaries and Contractor Payments are reported separately in Step 3b.*



\*If an employee or contracted staff member only provides supervisory services and does not deliver any direct medical services to clients, that individual's paid hours & costs should NOT be reported on the cost report.

# Direct Medical Services Data (Step 3)



## Direct Medical Services Payroll Benefits and Taxes

- **Gross Salary / Contractor Payment (continued)**
  - Report 100% of the salary payments for ALL eligible participants on the participant (PL) list for the quarters the positions were included on the district's PL.
  - Costs reported are “position-specific” not “person-specific”.
  - Example: Position #85 had the following employee changes from January - March:
    - Employee A works Jan 1 thru Jan 19, earns \$800
    - Substitute A works Jan 20 thru Feb 28, earns \$1,200
    - Employee B works March 1 thru March 31, earns \$1,500
    - The Total SHARS Reportable Expenditure for Position #85 is \$800 + \$1,200 + \$1,500 = \$3,500

# Direct Medical Services Data (Step 3)

## **Direct Medical Services Payroll, Benefits, and Taxes:**

- **Employer-Paid Retirement** – Direct costed, employer-paid retirement contributions made by the district for a direct medical services employee during the quarters the employee was listed on the district’s participant list.
- **Employer-Paid FICA** – Direct costed, employer-paid Federal Insurance Contributions Act (FICA) contributions made by the district for a direct medical services employee during the quarters the employee was listed on the district’s participant list.
- **Employer-Paid Medicare** – Direct costed, employer-paid Medicare contributions paid for a direct medical services employee during the quarters the employee was listed on the district’s participant list.
- **State Unemployment (Payroll Taxes or Reimbursing Employer Costs)** – The direct costed, employer-paid Texas Unemployment Compensation Act (TUCA) contributions paid for a direct medical services employee during the quarters the employee was listed on the district’s participant list. *Reimbursing employers that pay into an unemployment account in lieu of taxes should report the actual amount of unemployment compensation paid for any direct medical services staff members.*
- **Federal Unemployment** – The direct costed, employer-paid Federal Unemployment Taxes Act (FUTA) contributions paid for a direct medical services employee during the quarters the employee was listed on the district’s participant list.
- **Worker’s Compensation Costs (including Self-Insurance Costs)** - Costs for direct medical services staff must be reported with amounts accrued for premiums, modifiers, and surcharges, and net of any refunds and discounts actually received or settlements paid during the quarters the employee was listed on the district’s participant list. *Costs related to self-insurance are allowable on a claims-paid basis and are to be reported on a cash basis. Contributions to self-insurance funds that do not represent payments based on current liabilities are unallowable costs.*

# Direct Medical Services Data (Step 3)

## **Direct Medical Services Payroll, Benefits, and Taxes:**

- **Other Benefit** – Any direct costed, employer-paid benefits paid on behalf of a direct medical services employee during the quarters the employee was included on the district's participant list other than dental, disability, health, or life insurance premiums or employer-paid child day care.
- **Child Day Care** – Employer-paid child day care costs for the children of a direct medical services employee paid as employee benefits during the quarters the employee was included on the district's participant list.
- **Dental Insurance** – The direct costed, employer-paid dental insurance premiums for a direct medical services employee during the quarters the employee was included on the district's participant list.
- **Disability Insurance** – The direct costed, employer-paid disability insurance premiums for a direct medical services employee during the quarters the employee was included on the district's participant list.
- **Health Insurance** – The direct costed, employer-paid health insurance premiums for a direct medical services employee during the quarters the employee was included on the district's participant list.
- **Life Insurance** – The direct costed, employer-paid life insurance premiums for a direct medical services employee during the quarters the employee was included on the district's participant list.

# Direct Medical Services Data (Step 3)

## Federal Funding Reduction:

**Federal Funding Amount (including ARRA funds)** – The federal grants, matching funds, and/or ARRA/Stimulus funds received by the district for a direct medical services employee/contractor during the quarters the employee/contractor was included on the district’s participant list. *The Federal Funding Reduction column is used to subtract the federal funds applied to the costs that were included in the Payroll Taxes & Benefits columns to arrive at the net cost for the employee/contractor.*

NOTE: MAC funds are considered “reimbursement” funds and are not required to be backed out.



# Direct Medical Services Data (Step 3)

Steps 3c and 3d of the cost report are used to document direct costed supplies, materials and certain allowable expenses related to all services.

- Do not report supplies or materials that support administrative services.
- If costs were not reported for a cost category in Step 3a or 3b of a district's cost report, the district will not be allowed to report costs for that cost category in Steps 3c or 3d.



# Direct Medical Services Data (Step 3)

## **3c. Direct Medical Services Other Costs Summary Data (Includes Appendix A less than \$5,000)**

- **Direct Medical Travel** - Travel costs incurred by district employees to provide direct medical services to a recipient. Allowable staff travel expenditures include mileage reimbursements, fuel allowances/reimbursements, cab or bus fare, hotel and other travel reimbursements paid to staff.
- **Required Continuing Education** - Allowable expenditures include training and continuing education seminars, travel and other staff costs to maintain professional licensure and/or certification. *Education and/or training costs are not allowable for staff pursuing licensure or certification as a new profession.*
- **Appendix A Other Direct Medical (less than \$5,000)** - Appendix A is an all inclusive list of Medicaid-allowable costs for direct medical services. The list provided in Appendix A includes the only CMS approved materials and supplies. Any request for additional items not included will require CMS approval. The total cost of Appendix A items reported is allowable if the materials and supplies are only dedicated to the provision of direct medical services. For example, computer software, hardware, including computers and word processors, and assistive technology software total cost is allowable only if the items are utilized for specialized services, such as for clinical evaluations and instructional software.
- **Other Reductions** - Other funding by which costs are reduced would include recovery of costs. For example, if an insurance claim were filed and the insurance company made a payment to the provider, the payment would be considered a recovery of costs and should be reported as a reduction to costs.

# Direct Medical Services Data (Step 3)

Each cost entered in Step 3c will require four key components.

1. Cost Category (Drop-down menu varies by cost item)
2. Amount
3. Federal Funding Amount
4. Type (Drop-down menu varies by cost item)



# Direct Medical Services Data (Step 3)

## **3d. Appendix A – Depreciation of Direct Medical Services Materials & Supplies (\$5,000 or over)**

Appendix A items costing \$5,000 and over should be documented for depreciation in Step 3d. Depreciation is the periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset.

Allowable depreciation expense for direct medical services includes only pure straight-line depreciation. Any single item purchased during the cost-reporting period costing less than \$5,000 must be expensed and reported accordingly in Step 3c. *Refer to the Cost Reporting Instructions manual (pages 33-35) for more information on depreciation of assets.*

# Transportation Data (Step 4)

Transportation services in a school setting may be reimbursed when they are provided on a specially adapted vehicle and if the following criteria are met:

- Provided to or from a Medicaid-covered service on the day for which the claim is made
- A child requires transportation in a specially-adapted vehicle to serve the needs of the disabled
- A child resides in an area that does not have school bus transportation, such as those in close proximity to a school
- The Medicaid services covered by SHARS are included in the student's IEP
- The special transportation service is included in the student's IEP

# Transportation Data (Step 4)



A specially adapted vehicle is one that has been physically modified (e.g. addition of wheelchair lift, addition of harnesses/protective restraint devices, addition of child protective seating or addition of air conditioning).

# Transportation Data (Step 4)

## Transportation Services (Only Specialized Trans)

- Reflects transportation employees/contractors whose transportation duties are to service and/or drive a specially adapted vehicle.
- Reduced by the One-Way Trip Ratio.
  - 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)

## Transportation Services (Not Only Specialized Trans)

- Reflects transportation employees/contractors whose servicing and/or driving duties float between specially adapted vehicles and regular transportation vehicles.
- Reduced by the Specially-Adapted Vehicles Ratio & the One-Way Trip Ratio.
  - Specially-Adapted Vehicles Ratio = (Total number of specially adapted vehicles)/(Total number of vehicles)
  - 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)

# Transportation Data (Step 4)

## (Transportation) Employee Information:

- Employee Information consists of Provider Category, External ID, Name, and Employment Type.
  - Provider Category – Employees and contractors should be designated as “Only Specialized Trans” or “Not Only Specialized Trans.” If a transportation employee or contractor’s costs cannot be direct costed to only specialized transportation or the individual’s duties included driving and/or servicing both specially adapted vehicles and regular transportation vehicles the employee should be designated as “not only specialized trans.” See *Cost Report Manual (page 11)* for more information.
  - Employment Type – Full Time, Part Time, or Contract
- Most Employee Information data can be added and/or edited from Step 4a or 4b.
- Employee Information reported in Step 4a is summarized and reduced to Provider Category, Number of Employees (headcount), and Number of Contractors (headcount) in Step 4b.

## (Transportation) Payroll, Taxes, and Benefits:

- **Hours** - Total hours paid to the transportation staff member (district employee or contractor) during the cost report period. Transportation staff includes bus drivers, mechanics and mechanic assistants. *Hours includes overtime, travel time, documentation time, training time, staff meeting time, paid vacation time, and paid sick leave time relating to the Gross Salary/Contractor Payments reported for the staff member. **Employee Hours** and **Contractor Hours** are reported separately in Step 4b.*



# Transportation Data (Step 4)

## **(Transportation) Payroll, Taxes, and Benefits:**

- **Gross Salary/Contractor Payments** – Salary/payments paid to an employee or contractor (before taxes or any deductions) for the hours he/she provided transportation services as a bus driver, mechanic or mechanic assistant. *Gross Salary/Contractor Payments includes overtime pay, cash bonuses, and any cash incentives paid from which payroll taxes are (or should be) deducted. **Gross Salaries** and **Contractor Payments** are reported separately in Step 4b.*
- **Employer-Paid Retirement** – Direct costed, employer-paid retirement contributions made by the district for a transportation employee during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district.
- **Employer-Paid FICA** – Direct costed, employer-paid FICA contributions made by the district for a transportation employee during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district.
- **Employer-Paid Medicare** – Direct costed, employer-paid Medicare contributions paid for a transportation employee during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district.

# Transportation Data (Step 4)

## **(Transportation) Payroll, Taxes, and Benefits:**

- **State Unemployment (Payroll Taxes or Reimbursing Employer Costs)** – The direct costed, employer-paid Texas Unemployment Compensation Act (TUCA) contributions paid for a transportation employee during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district. *Reimbursing employers that pay into an unemployment account in lieu of taxes should report the actual amount of unemployment compensation paid for the transportation staff member.*
- **Federal Unemployment** – The direct costed, employer-paid Federal Unemployment Taxes Act (FUTA) contributions paid for a transportation employee during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district.
- **Worker's Compensation Costs (including Self-Insurance Costs)** - Costs for transportation staff must be reported with amounts accrued for premiums, modifiers, and surcharges, and net of any refunds and discounts actually received or settlements paid during the federal fiscal year the employee served as a bus driver, mechanic, or mechanic assistant for the district. *Costs related to self-insurance are allowable on a claims-paid basis and are to be reported on a cash basis. Contributions to self-insurance funds that do not represent payments based on current liabilities are unallowable costs.*



# Transportation Data (Step 4)

## (Transportation) Payroll, Taxes, and Benefits:

- **Other Benefit** – Any direct costed, employer-paid benefits paid on behalf of a transportation services employee other than dental, disability, health, or life insurance premiums or employer-paid child day care during the federal fiscal year the employee served as a bus driver, mechanic or mechanic assistant for the district.
- **Child Day Care** – Employer-paid child day care costs for the children of a transportation services employee paid as employee benefits during the federal fiscal year the employee served as a bus driver, mechanic or mechanic assistant for the district.
- **Dental Insurance** – The direct costed, employer-paid dental insurance premiums for a transportation services employee during the federal fiscal year the employee served as a bus driver, mechanic or mechanic assistant for the district.
- **Disability Insurance** – The direct costed, employer-paid disability insurance premiums for a transportation services employee during the federal fiscal year the employee served as a bus driver, mechanic or mechanic assistant for the district.
- **Health Insurance** – The direct costed, employer-paid health insurance premiums for a transportation services employee during the federal fiscal year the employee served as a bus driver, mechanic or mechanic assistant for the district.
- **Life Insurance** – The direct costed, employer-paid life insurance premiums for a transportation services employee during the federal fiscal year the employee served as a bus driver, mechanic or mechanic assistant for the district.

# Transportation Data (Step 4)

## Federal Funding Reduction:

**Federal Funding Amount (including ARRA funds)** – The federal grants, matching funds, and/or ARRA/Stimulus funds received by the district for a transportation employee/contractor during the federal fiscal year in which the individual served as a bus driver, mechanic, or mechanic assistant for the district. *The Federal Funding Reduction column is used to subtract the federal funds applied to the costs that were included in the Payroll, Taxes & Benefits columns to arrive at the net cost for the employee.*

NOTE: MAC funds are considered “reimbursement” funds and are not required to be backed out.

# Transportation Data (Step 4)

## 4c. Transportation Other Costs Summary Data

In addition to payroll expenses, SHARS allows school districts to report other costs incurred by the district's staff/contractors to provide specialized transportation services. The other costs that can be reported in Step 4c should be reported as either Transportation Services (only Specialized Trans) or Transportation Services (not only Specialized Trans). The costs allowable in this section include:

- **Required Continuing Education** – Allowable expenditures include training and continuing education seminars, travel, and other staff costs to maintain professional licensure and/or certification. *Education and/or training costs are not allowable for staff pursuing licensure or certification as a new profession.*
- **Private Payments to Parents/Guardians** – Payments made to parents for specialized transportation one-way trips. *See Cost Report Manual for more information on Private Payments to Parents/Guardians.*
- **Other Reductions** – Includes federal funding for any of the costs reported for specialized transportation services. Specialized transportation services costs are not reduced by MAC funding. An example of federal funding to be reported as a reduction to costs is funding through the Individuals with Disabilities Education Act (IDEA).

# Transportation Data (Step 4)

## **4d. Worksheet C – Other Transportation Costs**

Like Step 4c, Step 4d allows cost report preparers to enter other transportation costs. Section 4d allowable costs are those expenses that resulted from the district's use of transportation equipment/services. Like Step 4c costs, the allowable costs a district can claim in Section 4d should be submitted under the appropriate Cost Category (Transportation Services – only Specialized Trans or Transportation Services – not only Specialized Trans) to ensure that data is properly calculated by the annual cost report system. The Step 4d allowable Cost Types include:

**Contract-Transportation Equipment** - Report costs of contracted specialized transportation equipment.

**Contract-Transportation Services** - Report costs of contracted specialized transportation services.

**Fuel and Oil** - Report gasoline, diesel, other fuel and oil costs for specialized transportation vehicles.

**Insurance** - Report the cost for insurance premiums for specialized transportation vehicles. Costs should be reported with amounts accrued for premiums, modifiers, and surcharges and net of any refunds and discounts actually received or settlements paid during the same cost reporting period.

**Lease/Rental** - Report the lease/rental costs of specialized transportation equipment as indicated. If a vehicle lease includes both specialized transportation equipment and non-specialized transportation equipment, allocate the costs based on the number of leased specialized transportation equipment items divided by the total number of leased transportation equipment items and report the amount as "Transportation Services (only Specialized Trans)" or report the total cost as "Transportation Services (not only Specialized Trans)."

# Transportation Data (Step 4)

## 4d. Worksheet C – Other Transportation Costs

**Maintenance and Repairs** – Report repairs and maintenance, including non-depreciable tune-ups, oil changes, cleaning, licenses, inspections, and replacement parts due to normal wear and tear for specialized transportation vehicles. Report maintenance supplies related to specialized transportation vehicles. *Major vehicles repairs costing \$5,000 or more must be depreciated and reported as “Depreciation-Transportation Equipment.”*

**Major Purchases Under \$5,000** – Report non-depreciable equipment purchases required to maintain and repair specialized transportation equipment as purchases under \$5,000.

**Other** – Direct costed supplies and materials related to specialized transportation equipment and/or services other than those specifically identified in this section.

# Transportation Data (Step 4)

## Contract Transportation Services/ Equipment

Many districts use contractors to provide transportation services for their students. This cost can be claimed in the SHARS cost report in Step 4d. The method in determining the allowable cost to report can vary based on the terms of each individual district's negotiated contract. To determine if the cost is allowable and what percentage of the cost is allowable, the district must evaluate the contract to determine what cost contributes to Specialized Transportation. If the contract has a direct cost impact, determine the allocation that will justify the appropriate amount specific to Specialized Transportation. The district must be able to provide supporting documentation to justify the allocation. Consider the following when evaluating and reporting cost:

- If a district owns the vehicles the contractor used to provide transportation services, the district should identify the owned vehicles under the Specially-Adapted Vehicle Ratio in Section 2 (Lines 00.00.16 & 00.00.17) of the cost report. The cost report preparer can then either allocate the total contract transportation services/equipment cost into "only specialized trans" and "not only specialized trans," or simply report the total expense as "not only specialized trans."
- If a district does not own the vehicles used to provide transportation services, it should report its contractors Specially-Adapted Vehicle Ratio in Section 2 (Lines 00.00.16 & 00.00.17) of the cost report. The ratio should only include the contractor's vehicles used to provide services to the district. The cost report preparer can then either allocate the total contract transportation services/equipment cost into "only specialized trans" and "not only specialized trans," or simply report the total expense as "not only specialized trans."

If neither of the scenarios above describes the district's contract of transportation services/equipment arrangement please contact the SHARS rate analyst for assistance.

# Transportation Data (Step 4)

All Step 4d costs should be recorded under the appropriate cost category and should include:

- Gross Costs
- Federal Funding Amount
- Other Reductions – Other funding by which costs are reduced would include recovery of costs. For example, if an insurance claim were filed and the insurance company made a payment to the provider, the payment would be considered the recovery of costs and should be reported under “Other Reductions.”

Federal Funding Amounts and Other Reductions are auto-summed within Section 4d to arrive at the Total Reductions amount. All Step 4d cost components are auto-summed and used in the annual cost report’s total SHARS calculations in Step 5.



# Transportation Data (Step 4)

## **4e. Depreciation – Transportation Services (Specially Adapted Vehicles Only)**

Depreciation is the periodic reduction of the value of an asset over its useful life or the recovery of the asset's cost over the useful life of the asset. Allowable depreciation expense for specialized transportation services includes only pure straight-line depreciation and is limited to specially adapted vehicles. No accelerated or additional first-year depreciation is allowed. In Step 4e:

- Each depreciable item must be reported individually. Items should not be combined under generic descriptions such as “various” or “equipment.”
- Detail data is required for each item reported. The data is used to auto-calculate the item's depreciation.
- Years of Useful Life is pre-programmed for each type of depreciable asset that can be reported.
- The annual cost report will auto-update a depreciable item's “Prior Period Accumulated Depreciation” each year until the item has reached the end of its useful life.
- Current depreciation for depreciable items is calculated within the annual cost report in this section and is then transferred to the cost report's Transportation Services table as “Other Costs” for cost category “Transportation Services (only Specialized Trans).” The amount is then used to calculate the district's Medicaid allowable (transportation) costs.

Any single (transportation) item purchased during the cost-reporting period costing less than \$5,000 must be expensed and reported accordingly in Step 4d.

# Online Claim Verification & Submission (Step 5)

- In Step 5, all the cost entries submitted by a preparer are summarized and totaled by cost category and then presented to the preparer for review.
- A SHARS Financial Contact must review the district's data to verify that all costs listed are accurate.
- Once the data has been approved, the contact must then submit the cost report to HHSC.



# Online Claim Verification & Submission (Step 5)

## Proposed Reimbursement:

This section is being displayed as a courtesy only. All amounts in this section are subject to change during the desk review process. Final Settlement numbers will be provided during the SHARS Reconciliation and Settlement process. The formal settlement notice will be when this information is available.

Proposed Reconciliation	
Reduce by interim payments made by TMHP during cost report period to date (NOT FINAL)	\$(912,804)
Total Proposed Reconciliation	\$(912,804)
Medicaid Allowable Amount Costs	\$6,524,345
FMAP Rate	69.03
Federal Portion of Medicaid Costs	\$4,503,755
Proposed Reconciliation (see details above)	\$(919,619)
Proposed Settlement Amount (NOT FINAL)	\$3,584,136

I verify that these numbers are accurate. By clicking "Verify" your data will be transmitted to HHSC and you will no longer be able to make any further modifications without contacting Fairbanks.

# Print Cost Report Certification & Claimed Expenditures Form (Step 6)

- Once the cost report has been submitted, districts must print and upload a Cost Report Certification form and a Claimed Expenditures form.
- Both forms must contain original signatures & original notary stamps/seals.
  - If the forms are not completed properly, the cost report will not be processed until the provider makes the necessary corrections.



# Print Cost Report Certification & Claimed Expenditures Form (Step 6)

## Cost Report Certification Form

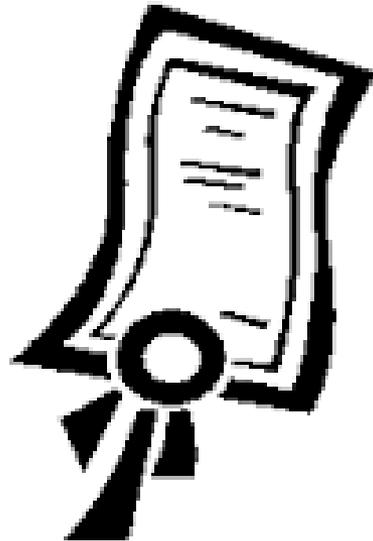
- Used to formally acknowledge that the cost report is true, correct and complete, and was prepared in accordance to all rules and regulations.
- Must be completed & signed by an individual legally responsible for the conduct of the provider such as the authorized agent and/or school representative.
- The responsible party's signature must be notarized.

## Claimed Expenditures Form

- Certifies that expenditures are allocable and allowable to the State Medicaid program under Title XIX of the Social Security Act and in accordance with all procedures, instructions and guidance issued by the single state agency and in effect during the cost report year.
- District/Government Provider Name, Total Computable amount, and reporting period dates are auto-populated.
- Must be completed & signed by an individual legally responsible for the conduct of the provider such as the authorized agent and/or school representative.
- The responsible party's signature must be notarized.
- The responsible party should read the seven certification statements carefully before signing the form before a notary.

# Attach Cost Report Certification & Claimed Expenditures Form (Step 7)

- Prior to the 2011 cost report year, providers were required to mail their certification forms to HHSC.
- STAIRS now requires users to upload these forms directly to the system. *Districts may be asked to submit an original copy if the notary seal is not visible on the uploaded copy.*
- Maintain originals with the district's records.



# Adjustments/Reconciliation/Settlement Report (Step 8)

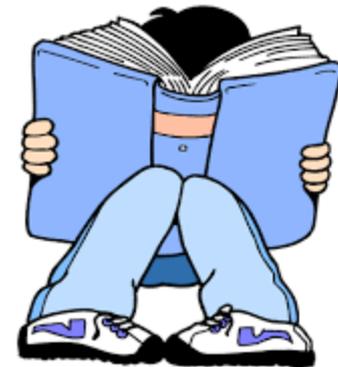
- The cost reconciliation process must be completed within 24 months of the end of the reporting period covered by the annual SHARS cost report.
- The total Medicaid-allowable costs are compared to the provider's interim payments for SHARS delivered during the reporting period, which results in a cost reconciliation.
- If a provider has not complied with all cost report requirements or a provider's interim payments exceed the actual certified Medicaid-allowable costs of the provider for SHARS to Medicaid clients, HHSC will recoup the federal share of the overpayment.
- If the actual certified Medicaid-allowable costs of a provider for SHARS exceed the provider's interim payments, HHSC will pay the federal share of the difference to the provider in accordance with the final, actual certification agreement.

# Adjustments/Reconciliation/Settlement Report (Step 8)

- HHSC issues a notice of settlement that denotes the amount due to or from the provider. Notices are issued by August 31<sup>st</sup> each year.
- The district must log into STAIRS within 30 days of the date of the notice to “Agree” or “Disagree” with the proposed settlement.
- HHSC will process the payout or recoupment listed for districts that Agree. If no response is received from a district within the allotted time frame, STAIRS will agree with the settlement by default.
  - Once a district agrees with its settlement, if it is owed money, it will receive the settlement payment within **60 days after HHSC submits the action request to TMHP.**
- 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.

# Adjustments/Reconciliation/Settlement Report (Step 8)

- Informal review requests must be sent by certified mail and received by HHSC by the due date listed on the settlement notice.
- 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.
- Failure to follow these instructions will result in the denial of the request. If a district's request is denied, HHSC will proceed with the settlement as if the district had "Agreed."



# HHSC Informal Review (Step 9)

- Upon receipt of a district's informal review request, HHSC will review the documents submitted and will determine the appropriate course of action.
- The agency will contact the district with its determination.



# Informal Review Notarized Certification Forms (Step 10)

- Once HHSC completes its informal review, the district will be required to submit new Cost Report Certification and Claimed Expenditures forms.
- See slides 53-55 for more information on the Cost Report Certification and Claimed Expenditures forms.



# 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

# Cost Report Corrections

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](mailto:ra_shars@hhsc.state.tx.us).
- Correction requests must be on district letterhead 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

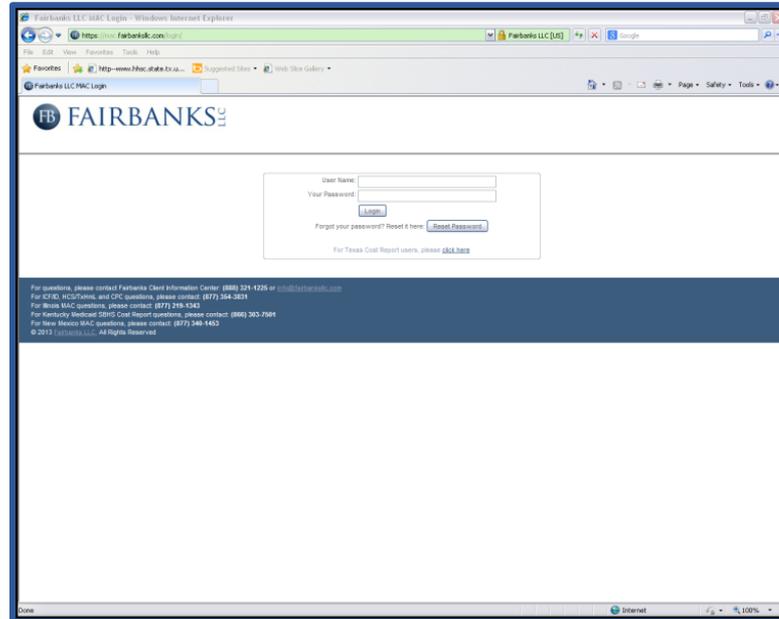


Please note, cost reports that are made available for corrections will require new signed and notarized certification forms. Official signature and notary dates must be no earlier than the electronic cost report re-submission date.

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# STAIRS Demonstration



Presented by Fairbanks LLC

# STAIRS System Edits

- STAIRS is designed to perform various edit checks on the data entered by cost report preparers.
- Explanation of variances is required.
- When prompted, provide a clear and concise explanation as to why a cost increased, decreased, etc.
- System edits find possible errors and allow ISDs to correct the current financial report before certifying their data.

# SHARS Oversight

The Texas Education Agency (TEA) and Health and Human Services Commission (HHSC) jointly provide oversight to the SHARS program. As part of the joint effort to manage and evaluate the SHARS program, both agencies conduct desk reviews/audits to verify program compliance. These audits/reviews consist of the following:

- HHSC Office of Inspector General (OIG), Research, Analysis and Detection (OIG RAD) unit reviews of SHARS provider billing activity utilizing the department's Surveillance and Utilization Review System (SURS) application.
- TEA desk reviews/audits of IEP documentation.
- HHSC Rate Analysis Department (RAD) desk reviews on SHARS cost reports.
- HHSC RAD Cost Report Review Unit (CRRU) audit.
- **All SHARS Cost Reports will be audited by HHSC RAD's CRRU**

# SHARS Oversight: SURS Desk Review

- ❑ Section 456.23 of Title 42, Code of Federal Regulations states that agencies are required to have a post-payment review process that allows State personnel to develop and review: (1) recipient utilization profiles, (2) provider service profiles, (3) exception criteria; and (4) identifies exceptions so that the agency can correct mis-utilization practices of recipients and providers.
- ❑ In Texas, the OIG RAD unit is responsible for identifying inappropriate payments in the state's Medicaid programs. When conducting retrospective reviews of SHARS provider records, the OIG RAD unit applies policy in effect at the time of the service to determine appropriateness of payment. The billing provider is notified via a certified letter of the outcome of the review.

# SHARS Oversight: SURS Desk Review

- The OIG RAD unit utilizes a variety of tools to conduct post-payment review activities including the CMS approved Surveillance Utilization Review System application (SURS Profiler +).
- OIG RAD works in conjunction with TMHP clinical specialists to evaluate a sample of the provider's documentation to verify all Texas Medicaid Provider Procedure Manual (TMPPM) requirements have been met, including:
  - Billing Requirements,
  - Provider qualifications, and
  - Supporting information such as medical necessity, completeness of records, physician prescription for certain services, required IEP documentation, etc...
- Providers are recouped for any paid services that are determined to be non-compliant with all program requirements.

# SHARS Oversight: SURS Desk Review

- If an ISD disagrees with the results of a SURS desk review an appeal can be requested.
- The following appeal instructions are included in the certified letter sent to the provider and can be found in Volume 1, Section 7.1.5, “Paper Appeals” of the TMPPM. Details specific to the retrospective utilization review process have been added below in **bold**.
  1. Copy the R&S page where the claim is paid or denied.
  2. Circle one claim per R&S page.
  3. A copy of other official notification from TMHP (**the SURS findings letter and spreadsheet attachment**) may also be submitted.
  4. Identify the reason for the appeal.
  5. If the claim was incorrect, indicate what was incorrect and submit a corrected paper claim.
  6. **It is not necessary to resubmit medical record documentation or submit additional documentation for the dates of services already submitted. All documentation reviewed was accompanied by the required affidavit attesting that duplicates of the complete original record were submitted or that no record for the dates of service was found. Previously submitted records will remain in the custody of TMHP during the appeal filing period and will be made available to any future reviewer.**

# SHARS Oversight: SURS Desk Review

For proper adjudication of appeals associated with SURS desk review actions send the applicable correspondence to the following address:

Texas Medicaid & Healthcare Partnership SURS  
Provider Review Assistant – Sheila Chadwick

MC A11 SURS

12357 – B Riata Trace Parkway, Suite 100

Austin, TX 78727-6524



# Common SHARS Desk Review/Audit Findings

- Documentation does not support services rendered.
- Documentation does not include billable time.
- Documentation does not include session notes, start and stop times, total minutes, activity performed, student observation, or related IEP objective.
- Amount of time billed does not match amount of time documented.
- Student was absent on the date of service billed.
- Medical records requested were not submitted.
- Documentation does not support costs reported on cost report (IEP ratio, one-way trip ratio, time study, etc.).

# SHARS Documentation

The following documents should be maintained by SHARS districts as they may be requested for review during the compliance review process:

- Eligibility/assessment records
- IEP/ARD documents
- Prescriptions, evaluations, and/or referral information for related services, as appropriate
- Provider qualifications, including licensure/certification records
- Session notes/service logs
- PCS documentation
- Delegated nursing services documentation
- Specialized transportation documentation (daily trip/maintenance logs)
- Attendance records
- Time study participant list
- Parental notice/consent records
- Written agreements/contracts
- Supervision logs
- Claims submittal and payment histories
- Cost report documentation (invoices, salary information, time study documentation, etc.)

SHARS records need to be retained for at least seven years because they are both Medicaid and educational records.

# SHARS Documentation

For SHARS purposes, the ARD/IEPs/Supplement forms should include the following:

- Type (name) of service
- Time, frequency and duration of service
- Medical necessity
- Medical condition related to service
- Rationale/reason for service
- Goals/objectives for service (e.g., OT, PT) and/or description of service with detailed activities (e.g. PCS, nursing services)
- Parental notice and consent records
- Medicaid number on each page of ARD

# SHARS Documentation

Services requiring session notes are:

- Audiology
- Counseling Services
- Occupational Therapy
- Physical Therapy
- Psychological Services
- Speech Therapy



# SHARS Documentation

Session notes must include:

- Student's Medicaid number on each page
- Reference to medical necessity; IEP objective
- Date of service
- Time session begins/ends
- Total billable minutes
- Number of units
- Specifics of the service provided (individual or in a group setting)
- Notation as to activity performed
- Student observation
- Signature/initials



# Shared Services Arrangement (SSA)/ Cooperative (Co-op)

- Providers who are members of a cooperative or shared services arrangement must each submit a separate SHARS cost report.
  - Each ISD must have a district specific RMTS participant list (PL) that includes “contracted staff” employed by the fiscal agent and district employees for which costs will be claimed.
  - Failure to maintain a complete district specific PL limits the allowable costs that a district is able to claim on the cost report.
- Allocation methodologies used to distribute shared costs to member districts of a SSA/Co-Op must be documented and presented to HHSC upon request.
- Allocation methodologies should appropriately reflect the level of direct service costs associated with the students enrolled in each district.

# Shared Services Arrangement (SSA)/ Cooperative (Co-Op)

The fiscal agent of a SSA or Co-Op can only report costs for the students “enrolled” in the district serving as the fiscal agent. **All “shared” costs must be allocated to each of the member districts.**

Determination of “enrolled” per the TEA...

“While it is true that multiple districts may be involved in the provision of special education and related services to a student with disabilities, only one district can report Public Education Information Management System (PEIMS) data on a student, so it is our position that the SHARS-related billing should be through the district that is reporting the PEIMS data.”

# SHARS Financial Contact Responsibilities

- Oversight, monitoring and coordination with the RMTS Coordinator to ensure the quarterly participant list data is accurate and appropriate for inclusion of cost on the cost report.
- Must verify that financial data submitted is true and accurate, and that appropriate documentation is maintained to support the time study (i.e., participant training) and cost report.
- Ensure all supporting documentation appropriately identifies the certified funds used for claiming is maintained.
- Ensure the district cooperates with state and federal audits.



# SHARS Financial Contact Responsibilities

- Review the findings made by OIG/HHSC/TEA;
- Evaluate the client files currently assigned to the district's provider(s);
- Determine if the documentation is appropriate for all Medicaid services delivered by the district's provider(s); and
- Determine if cost is allowable on the cost report.

# Wrap Up

- Training session participants not listed in STAIRS as a SHARS financial contact will not receive credit for completing SHARS Cost Report training.
  - Any primary contact at the district can add new SHARS contacts in STAIRS.
- There are no certificates for training.
  - Emails will be sent thanking those who attend a training session; however, this does not necessarily mean that training credit will be awarded to all session participants.
- Training credits can be viewed in STAIRS.
  - Users MUST filter appropriately to view their training credits.
  - Contacts are encouraged to print training credit screens for their records.
- Please allow a maximum of 7 days (from the day of training) processing time for training credit information to be updated and uploaded to STAIRS.
- Once full access is indicated, contacts will be able to build and submit their district's 2015 SHARS Cost Report.

# HHSC – SHARS Website

<http://www.hhsc.state.tx.us/rad/acute-care/shars/index.shtml>

The HHSC-SHARS website contains:

- General & Related Information
- Contacts
- Enrollment & Participation
- Frequently Asked Questions
- Guides/Manuals
- Methodology/Rules
- Notices
- Payment Rate Information
- Cost Reporting Information
- Time Study
- Training



# Additional Resources...

- CMS Medicaid School-Based Administrative Claiming Guide
- 2 Code of Federal Regulations (CFR) 225
- Office of Management & Budget (OMB) Circular A-87
- Title 45 Code of Federal Regulation (CFR) Part 74 and 95
- Title 42 CFR 430.1 and 42 CFR 431.15
- Title 19 of the Social Security Act, section 1903(a)(7)
- Title 1 of the Texas Administrative Code, Part 15, Chapter 354, SubChapter A, Division 25, Rules 1341-1342
  - [http://texreg.sos.state.tx.us/public/readtac\\$ext.ViewTAC?tac\\_view=5&ti=1&pt=15&ch=354&sch=A&div=25&rl=Y](http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=1&pt=15&ch=354&sch=A&div=25&rl=Y)
- Title 1 of the Texas Administrative Code, Part 15, Chapter 355, SubChapter J, Division 23, Rule 8443
  - [http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p\\_dir=&p\\_rloc=&p\\_tl oc=&p\\_ploc=&pg=1&p\\_tac=&ti=1&pt=15&ch=355&rl=8443](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tl oc=&p_ploc=&pg=1&p_tac=&ti=1&pt=15&ch=355&rl=8443)
- General information regarding Texas Medicaid Program
  - <http://www.hhsc.state.tx.us/medicaid/>

# Reference Materials

Texas Education Agency website:

[http://tea.texas.gov/Curriculum and Instructional Programs/Special Education/Programs and Services/School Health and Related Services/](http://tea.texas.gov/Curriculum_and_Instructional_Programs/Special_Education/Programs_and_Services/School_Health_and_Related_Services/)

Texas Medicaid & Healthcare Partnership

[http://www.tmhp.com/Pages/Medicaid/Medicaid\\_home.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_home.aspx)

Texas Medicaid Provider Procedures Manual

[http://www.tmhp.com/Pages/Medicaid/Medicaid Publications Provider manual.aspx](http://www.tmhp.com/Pages/Medicaid/Medicaid_Publications_Provider_manual.aspx)

# Contacts

## **SHARS Cost Reports & SHARS Interim Rates:**

Phone: (512) 730-7400

Email: [ra\\_shars@hhsc.state.tx.us](mailto:ra_shars@hhsc.state.tx.us)

## **SHARS Program/Policy/Certification of Funds/Billing/Payment Questions:**

Phone: (512) 462-6278

Email: [HHSC\\_Oversight@hhsc.state.tx.us](mailto:HHSC_Oversight@hhsc.state.tx.us)



## **SHARS Cost Report System Questions:**

Fairbanks Hotline: (888) 321-1225

Email: [info@fairbanksllc.com](mailto:info@fairbanksllc.com)

## **TEA – Division of Federal Fiscal Compliance & Reporting:**

Phone: (512) 463-9127

Email: [compliance@tea.state.tx.us](mailto:compliance@tea.state.tx.us)