Coordination of Therapy Services Provided by School Districts and Other Medicaid Providers

As Required by

2018-19 General Appropriations Act, Senate Bill, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 42)

Health and Human Services Commission

December 2018
The Coordination of Therapy Services Provided by School Districts and Other Medicaid Providers report is submitted pursuant to Rider 42 of the 2018-19 General Appropriations Act, Senate Bill (S.B. 1) 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission).

The Health and Human Services Commission (HHSC) is required to submit a report identifying barriers and making recommendations to improve coordination of services with a comparison of data for therapy services delivered by school districts through the School Health and Related Services (SHARS) program and by other Medicaid providers.

The SHARS program in fiscal year 2015 totaled $1.08 billion dollars all funds (AF) in Medicaid allowable costs; participating school districts were reimbursed $208 million AF through the interim claiming process and $420 million in federal funds through the cost settlement process ($450 million non-federal share satisfied by the school districts through the Certified Public Expenditure process). HHSC analyzed billing data from SHARS interim reimbursement claims in fiscal year 2017 and compared to therapy services outside of the school setting through either Medicaid Fee-for-Service (FFS) or Managed Care Organizations (MCOs). HHSC prepared recommendations that should improve claims data collection, in detail and timeliness, which may then be leveraged to improve coordination of therapy services delivered by school districts through the SHARS program and by other Medicaid providers in Texas.

Although HHSC suggests strategies to improve the coordination of services between participating SHARS school districts and other Medicaid providers, HHSC is uncertain whether improved service coordination would result from modification of billing practices or affect client outcomes. In addition, HHSC faces challenges in accessing data with sufficient detail to fully accomplish the goal of Rider 42.

The report concludes with recommendations for the formation of a workgroup, as well as other suggestions related to the administration of SHARS. These suggestions, if implemented, are intended to remove some of the barriers to collecting the SHARS data that is necessary to meet the goal of Rider 42. HHSC plans to form the above workgroup as an initial step, while continuing to assess the other recommendations for service coordination.
1. Background

The 2018-19 General Appropriations Act, S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, Rider 42) directed HHSC to submit a report identifying barriers and making recommendations to improve coordination of services with a comparison of data for therapy services delivered by public independent school districts through the SHARS program and by other Medicaid providers.

Medicaid

Children with Medicaid coverage are eligible to receive a wide range of services including physical, occupational, and speech therapy.

Most Medicaid services are delivered through managed care. The traditional Medicaid payment system, or FFS, pays health care providers a fee for each unit of service they provide. In managed care, an MCO is paid a capitated rate for each enrolled member. Through managed care, clients receive health care services through an MCOs contracted network of doctors, hospitals, and other health care providers responsible for managing and delivering quality, cost-effective care.

Although most Medicaid health care services are delivered through managed care, some, such as the SHARS program, remain in FFS. This means that while Medicaid MCOs are not responsible for paying or reimbursing non-capitated services like SHARS, they are responsible for educating members about the availability of these services, providing appropriate referrals for members to obtain or access these services, and for educating providers about where to submit claims for these services.¹

Medicaid Therapy Goals

Texas Medicaid provides medically necessary physical, occupational, and speech therapies to treat, correct and ameliorate illnesses and conditions for clients aged 20 and younger under the Early Periodic Screening, Diagnostic, and Treatment

(EPSDT) regulation, Section 1905(r) of the Social Security Act, known in Texas as Texas Health Steps\(^2\).

Therapies provided in the public-school setting are governed by the Federal Individuals with Disabilities Education Act (IDEA) expressly to support access to a free and appropriate public education for children with disabilities regardless of Medicaid eligibility. School-based therapies may be eligible for reimbursement under the SHARS program when they meet the criteria referenced on the following page.

\(^2\) https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
The SHARS program in Texas allows independent school districts (ISDs) and public charter schools, to obtain federal Medicaid reimbursement for their costs of providing certain medically necessary services related to special education for participating Medicaid-eligible students under IDEA. IDEA requires that every child with a disability have available to them a free and appropriate public education (FAPE) that includes special education and related services, at no assumed cost to the parents. Related services include transportation, speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, therapeutic recreation, early identification and assessment of disabilities in children, counseling services, rehabilitation counseling, orientation and mobility services, medical services for diagnostic or evaluation purposes, school health services and school nurse services, social work services in schools, and parent counseling and training. By enrolling as a Medicaid provider, school districts participating in the SHARS program that have qualified personnel who are under contract with or employed by the school (and with consent of the child's parent) can bill Medicaid to receive reimbursement for medically necessary services documented in a child's Individualized Education Program (IEP).

Management of the SHARS program is a cooperative effort between the Texas Education Agency (TEA) and HHSC. A Memorandum of Understanding (MOU) between TEA and HHSC, in place since 2005, outlines the roles and responsibilities of each agency.

As the state Medicaid agency, HHSC has responsibility for the SHARS program cost reconciliation process and establishing the reimbursement rates, as well as for ensuring that services are delivered in a manner consistent with the Medicaid state

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3 Students must meet the following criteria for schools to receive Medicaid reimbursement: the student is 20 years or younger, has Medicaid, meets eligibility requirements for special education per IDEA, and has an IEP documenting the needed services.

4 See http://idea.ed.gov/explore/view/p/,root,regs,300,A,300 percent252E34 for more detail on IDEA.

5 See 25 TAC §354.1342 for Conditions for Participation in SHARS.
plan and the Texas Medicaid Provider Procedures Manual (TMPPM)\(^6\). HHSC also is responsible for developing and updating policy guidance related to the delivery of SHARS services.

TEA is responsible for communications and contacts with the school districts, including programmatic communications and the maintenance of a website containing HHSC-approved content. The MOU also states that TEA has the primary responsibility for program compliance monitoring.

**SHARS Services**

Treatment reimbursed by the SHARS program includes:

- Audiology services
- Counseling
- Nursing services
- Occupational therapy (OT)
- Personal care services (PCS)
- Physical therapy (PT)
- Physician services
- Psychological services, including assessments
- Speech therapy (ST)
- Transportation in a school setting\(^7\)

Each school district has Admission, Review, and Dismissal (ARD) committees\(^8\) that determine what services are both medically necessary and reasonable to ensure that a child with a disability receives the special education and related services


\(^7\) See 25 TAC §354.1341 for SHARS Benefits and Limitations.

\(^8\) The ARD committee must include (minimally) the following: the parents of the child with a disability; not less than one regular education teacher of the child who must, to the extent practicable, be a teacher who is responsible for implementing a portion of the child’s individualized education program (IEP) if the child is, or may be, participating in the regular education environment; not less than one special education teacher of the child, or where appropriate, not less than one special education provider of the child; a representative of the local educational agency (LEA); at the discretion of the parent or the LEA, other discretionary members or individuals who have knowledge or special expertise regarding the child, including related services personnel as appropriate; an individual who can interpret the instructional implications of evaluation results, who may be the regular education teacher, special education teacher or provider, an LEA representative, or a discretionary member on the ARD committee; the child with a disability, when appropriate; and the special education teacher or special education provider that participates in the ARD committee meeting must be appropriately certified or licensed. Reference: 19 TAC Sec. 89.1050.
available under the IDEA, and develops an IEP to fit the child’s needs. If a child is also eligible for Medicaid, school districts that participate in the SHARS program must obtain parental consent to seek reimbursement from Medicaid for any services in the IEP that are also SHARS services.

SHARS services are authorized in the Medicaid state plan as EPSDT services provided at schools. Under EPSDT, there are no set limitations or caps on Medicaid services to clients 20 years of age or younger, as long as the services are medically necessary. Therefore, the Medicaid services the child receives at school pursuant to an IEP as SHARS services do not affect the type or amount of Medicaid services the child receives outside of school.

**SHARS Reimbursement Methodology**

To participate in the SHARS program, school districts must enroll in Texas Medicaid as a SHARS provider, and must employ or contract with individuals or entities that meet certification and licensing requirements in accordance with the Texas Medicaid state plan to provide program services. Once enrolled as a SHARS Medicaid provider, Centers for Medicare and Medicaid Services (CMS) requires these providers to participate in the Random Moment Time Study (RMTS) to be eligible to claim and receive reimbursement for SHARS services.

The RMTS is used to determine the percent of total time the sampled group spent on each activity to document activities relating to reimbursable federal programs. Applying the applicable percentage to costs incurred for delivering services determines the portion of those costs that may be claimed for federal reimbursement. When reporting expenses in the SHARS cost report, ISDs report their costs in total. The time study percentage as well as four other CMS approved allocation ratios (Direct Medical Services IEP Ratio, Specialized Transportation Services IEP Ratio, Specially Adapted Vehicles Ratio, and One-Way Trip Ratio) are applied to the ISD’s total costs to calculate the ISD’s total Medicaid allowable costs. Aside from the time study percentage, all allocation ratios used for the SHARS program are calculated using data reported in each district’s cost report. The Medicaid allowable cost for the district is used as the base for all settlement calculations.

Reimbursement for SHARS is provided through an interim claiming process, and by way of cost reconciliation and settlement of the annual SHARS cost report that participating ISDs must submit. The interim claiming process exists to allow SHARS participating ISDs a more timely option to receive reimbursement and ensure adequate cash flow to offset the financial burden of providing these services. Interim claims are submitted to the Medicaid claims administrator, TMHP, for
reimbursement. Claims are paid at the lesser of the billed charge or the interim rate set by the HHSC Rate Analysis Department (Rate Analysis) for the specific procedure code billed. The interim rates are statewide rates and are rebased on a biennial basis or as deemed necessary by HHSC. The rates are rebased using actual cost data submitted by ISDs in the most recently settled cost report. The current SHARS interim rates can be viewed at https://rad.hhs.texas.gov/acute-care/school-health-and-related-services-shars. ISDs are required to bill for services delivered as active providers in the SHARS program. Participating districts that do not bill for services through TMHP are not permitted to submit a cost report for cost settlement purposes.

Cost reconciliation and settlement of annual SHARS cost reports is conducted after all audit reviews are completed. The ISD’s total costs for both direct medical and transportation services as reported in the cost report are adjusted using the federally mandated allocation methodologies referenced above, including the percentages determined by the RMTS.

If an ISD’s interim payments exceed 99 percent\(^9\) of the ISD’s federal portion of the total certified Medicaid allowable costs, the ISD must repay the overpayment or HHSC will offset the ISD’s future claims payments until the amount has been recovered in full. If 99 percent of the ISD’s federal portion of the total certified Medicaid allowable costs exceeds the ISD’s interim Medicaid payments, HHSC will pay the difference to the ISD in accordance with the final actual certification agreement.

\(^9\) Beginning in fiscal year 2019, HHSC retains one percent of the federal share of the total certified Medicaid allowable cost as an administrative fee to be used for Health and Human Services administrative activities, including HHSC compliance monitoring, technical assistance, and to establish and maintain an audit reserve fund. See 23 TAC §355.8443(f)(1-3) for Reimbursement for Methodology for School Health and Related Services (SHARS)
3. Service/Billing Data Analysis

Many Medicaid students receive Medicaid covered services both in and outside of the school setting. However, there is not a regular reporting or analytics process to identify these children, compare the services received, and report this information to the managed care organizations. With this data limitation in mind, the HHSC Center for Analytics and Decision Support (CADS) used FFS claims billed through the interim process to identify Medicaid clients who received SHARS therapy services in fiscal year 2017, and then compared that data to the Medicaid Managed Care encounters for those same clients. The resulting information in the tables on page 11 and 12 of this report, shows how many of these clients also received non-SHARS Medicaid therapy services during the same time period.

ISDs participating in the SHARS program are not required to submit every service provided through the interim claiming process to TMHP. To be eligible to submit a SHARS cost report and receive a cost settlement, ISDs must bill TMHP for interim reimbursement. ISDs must bill for each cost category for which the ISD will seek reimbursement through the annual cost report. If one claim is billed for a cost category, the district can claim its total costs for that category for reimbursement through the settlement process. As a result, a large proportion of SHARS services are not submitted for interim reimbursement, but instead are submitted in the annual cost report. While the data queried is significant, it only represents approximately one-third of the actual services provided in the school setting that can be reimbursed through the SHARS program.

The data provided below is representative of approximately one-third of the actual SHARS data compared to all associated therapy claims for the same clients. This context is important to note prior to drawing definitive conclusions from this data.

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10 See 23 TAC §354.1342(8) for Conditions for Participation
Key points from analysis of SHARS interim claims data

- Overall, out of the 103,184 Medicaid clients who received a therapy service in school through SHARS, 26 percent also received a therapy service through Medicaid Managed Care.

- The SHARS program operates on the federal fiscal year, but the data in this report consists of data from state fiscal year 2017;

- The fiscal year 2017 data was queried as it is the most recent, final billing data available.

- **Speech Therapy**: The most frequently used SHARS service was speech therapy. Of the 97,498 clients who received this service in school, 25 percent received a therapy outside of school as well. The therapy service received was typically ST services (22 percent), but some also received OT services (13 percent) and/or PT services (7 percent).

- **Occupational Therapy**: 14,356 clients received OT in school. Approximately 45 percent also received a therapy service outside of school (35 percent ST, 32 percent OT, and 23 percent PT).

- **Physical Therapy**: 7,010 clients received PT in school. Approximately 64 percent of these clients also received a therapy service outside of school (51 percent PT, 44 percent OT, and 41 percent ST).

- The amounts paid for all therapy services delivered outside of the school setting, in aggregate, are significantly higher than amounts paid for services claimed in the school setting by SHARS providers through the interim process; despite this result, a complete comparison cannot be made at this time as the SHARS paid amounts through the cost settlement process are not included in this data.

The tables below provide information regarding therapy service utilization among SHARS clients and the associated SHARS and non-SHARS services those same clients received. The data is broken down by factors such as Type of Therapy, Average Cost Per Client and Average Number of Services Per Client. As mentioned on the previous page, the data in the following tables was generated by first identifying SHARS therapy services that were billed through the FFS interim rate process then comparing to therapy services those same clients received outside of the school setting.
Key points to note in data presentation tables

- Tables reflect all SHARS therapy services compared to therapy services those same clients received outside of the school setting. The majority of SHARS services are paid through the cost settlement process and the cost reports provide summary level information that does not contain the level of detail necessary to be used for comparison to the interim claims data.

- The Number of Services represents the sum of the number of distinct procedure codes billed for a client during each visit for a particular type of therapy (PT/OT/ST).

- The Total Paid Amount for SHARS services does not include services reimbursed through the cost settlement process.

- Data cannot be summed across therapy category (PT, OT, ST) because some clients received more than one type of therapy.

The data provided below shows that Medicaid clients receive therapy services in both SHARS and outside of the school setting. It shows that the cost of SHARS therapy appears to be lower but as noted above, the SHARS data in the tables below reflects only portion of the total SHARS therapy claims.
## Comparison of Utilization of Therapy Services Provided to SHARS Clients Through the Interim Claiming Process to Therapy Utilization for the Same SHARS Clients in Other Settings, Fiscal Year 2017

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th># of Clients</th>
<th>Avg. Cost Per Client</th>
<th># of Services</th>
<th>Avg. # of Services Per Client</th>
<th>Total Paid Amount</th>
<th>Type of Therapy</th>
<th># of Clients</th>
<th>% of SHARS Clients with Non-SHARS Services</th>
<th>Avg. Cost Per Client</th>
<th># of Services</th>
<th>Avg. # of Services Per Client</th>
<th>Total Paid Amount</th>
</tr>
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<tbody>
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<td>PT</td>
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<td>75,022</td>
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<td>518,063</td>
<td>40.6</td>
<td>$58,081,665</td>
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<td>PT</td>
<td>6,646</td>
<td>6.8%</td>
<td>$3,992</td>
<td>261,721</td>
<td>39.4</td>
<td>$26,529,868</td>
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<td>ST</td>
<td>21,696</td>
<td>22.3%</td>
<td>$4,564</td>
<td>953,042</td>
<td>43.9</td>
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<td>4,307</td>
<td>3.2</td>
<td>$233,683</td>
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<tr>
<td>ST Summary</td>
<td>24,599</td>
<td>25.2%</td>
<td></td>
<td></td>
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<td>OT</td>
<td>12,745</td>
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<td>$4,557</td>
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<tr>
<td>ST Summary</td>
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<td>25.2%</td>
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## Comparison of Utilization of Therapy Services Provided to SHARS Clients Through the Interim Claiming Process to Therapy Utilization for the Same SHARS Clients in Other Settings, Fiscal Year 2017 (Continued)

<table>
<thead>
<tr>
<th>Type of Therapy</th>
<th># of Clients</th>
<th>Avg. Cost Per Client</th>
<th># of Services Per Client</th>
<th>Avg. # of Services</th>
<th>Total Paid Amount</th>
<th>% of SHARS Clients with Non-SHARS Services</th>
<th>Avg. Cost Per Client</th>
<th># of Services</th>
<th>Avg. # of Services Per Client</th>
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<tr>
<td>OT</td>
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</table>

Total for ALL 103,184 $115.8 2,111,541 9.4 $11,948,005

Total for ALL 27,306 26% $438 1,959,513 71.8 $206,925,792

### Notes:

Data includes Medicaid clients under 21 years old who are receiving therapies through School Health and Related Service (SHARS) and the services these clients received outside of SHARS in fiscal year 2017.

Clients who received SHARS therapy services are defined by the indicator H_BLING_SHARS_IND = “Y”.

Data cannot be summed across therapy category (PT, OT, ST) because some clients have received more than one type of therapy.

Amount paid for SHARS services may be incomplete due to the program drawing funds from sources other than state Medicaid. CHIP and NorthStar clients are excluded.

Data Source: TMHP claims and encounter universes (Enc_Best Picture and AHQP Claims)

Prepared by: MCDA, Center for Analytics and Decision Support, HHSC, October 2018
4. Challenges

The Family Educational Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.

FERPA gives parents the right to inspect and review, seek amendment, and consent to the disclosure of information from the student’s education records. Generally, under FERPA, a parent or eligible student (parental rights transfer to the student when the student turns 18 years of age or is attending an institution of postsecondary education) must provide signed and dated written consent before an educational agency or institution can disclose personally identifiable information from a student’s education records. For FERPA, consent has to be specific as to what is being shared, to whom it is shared, and the purpose of disclosure. Prior SHARS consents would not meet this criteria.

School districts must notify parents and eligible students annually of their rights under FERPA. Accordingly, a request to share information with outside therapists or agencies, would be renewed annually or when a student moves to a different district. Depending on the district’s practices, the consent may need to be renewed when a child changes campuses within the same district.

Schools must maintain a record of each request for access to, and each disclosure of personally identifying information from, the education records of each student. The school must maintain this record with the education records of the student as long as the education records are maintained.

According to FERPA, a parent or eligible student with "standing," i.e., having suffered an alleged violation of his or her rights under FERPA, has the right to file a complaint. The Family Policy Compliance Office (FPCO) of the U.S. Department of Education may investigate timely complaints that contain specific allegations of fact giving reasonable cause to believe that a school has violated FERPA.

If it is determined that a school has violated FERPA, the FPCO may initiate a more comprehensive administrative investigation. If a determination is made that a school violated FERPA, the school and the complainant are so advised, and the school is informed of the steps it must take to come into compliance with the law.
MCOs, therapy providers, and primary care physicians may request client records in order to coordinate client services. However, clients and families cannot be compelled to provide FERPA-protected information. Furthermore, approval of Medicaid therapy services provided by an MCO may not be made contingent upon review of FERPA-protected educational records.

Because SHARS services are delivered in FFS, and because parents’ written FERPA consent must be obtained (but cannot be required), MCOs may not be aware that their members are receiving school based services, making service coordination a challenge.

Furthermore, medical records on therapies are protected by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). SHARS records for services delivered in the school setting are considered both educational and medical records and so must be maintained and protected as such. The HIPAA privacy rule protects all individually identifiable health information that is held or transmitted by a covered entity or a business associate. This information can be held in any form, including digital, paper or oral and includes:

- a patient's name, address, birth date and Social Security number;
- an individual's physical or mental health condition;
- any care provided to an individual; or
- information concerning the payment for the care provided to the individual that identifies the patient, or information for which there is a reasonable basis to believe could be used to identify the patient.

To comply with HIPAA regulations, medical providers would need to obtain parental consent before coordinating with SHARS providers. Additionally, if MCOs were able to secure parental consent to coordinate services, coordination between school based and non-school based therapy providers could be time intensive to schedule and participate in phone conversations or meetings and is not currently reimbursable by Medicaid.
5. Recommendations

As requested by Rider 42, this report includes recommendations to improve coordination of services and to revise current policies to allow for the collection of the data needed to accurately compare therapy services provided inside and outside of the school setting. Of the following recommendations proposed by HHSC, one or multiple recommendations may be pursued either concurrently or at different points.

- Establish a SHARS workgroup
- Require ISDs to bill as services are provided
- Reduce the claims filing deadline for SHARS participating ISDs
- Modification of data elements in SHARS cost reports
- Update TMPPM to encourage coordination between providers

1 – Establish a SHARS workgroup

HHSC recommends establishing a workgroup comprised of SHARS participating ISDs, MCOs, HHSC, TEA, and other stakeholders (if applicable) to evaluate current practices, identify additional barriers and/or restraints, and develop policy and/or program modifications to improve coordination of therapy services between ISDs, MCOs and other non-school Medicaid therapy providers.

To be effective, this work group requires participation from local education agency representatives, TEA staff, HHSC staff, ISDs, MCO representatives, SHARS third party vendors/consultants, and therapy providers. Participation from groups that would implement or oversee any policy changes by either state agency would provide valuable insight to move forward. By understanding the challenges for other participating entities, HHSC and TEA would be equipped to better anticipate barriers or issues that may arise from any proposed policy/legislation.

The workgroup could begin by focusing on the identification of any existing service coordination efforts between ISDs and non-school therapy providers in Texas. Providers or districts identified as engaging in coordination efforts could then be studied to identify best practices. If new approaches or methods are discovered that can be applied on a large scale to some or all SHARS participating ISDs, the State will develop and propose new policy to improve and support the goals of Rider 42.
2 – Require ISDs to bill as services are provided

HHSC recommends implementation of a policy to require SHARS participating ISDs to bill as services are provided rather than waiting for the cost settlement process. This would be a means to increase the SHARS billing data available for review at a detail level.

SHARS is a settle-to-cost program that allows for interim claiming from participating ISDs. The cost reconciliation process can take 24 months to complete due to the claim filing period, claims appeal process, and audit/desk reviews of all cost reports submitted by SHARS participating ISDs. Per 1 TAC 354.1342(8), districts need only bill for each cost category for which they will seek reimbursement through the annual cost report. While HHSC recommends districts bill for services as they are delivered, there is no percentage or total volume of services that an ISD must submit for interim reimbursement to be eligible for settlement through the cost report reconciliation process. Some SHARS ISDs submit claims actively throughout the year, while others bill the minimum required (1 claim per cost category annually). The interim claims data in the Medicaid claims processing system is detailed and identifies specific services received by student in the school setting. This is useful information but not an ideal comparator because it includes only a small sample of the services provided in the school setting.

The SHARS conditions for participation listed in §354.1342 could be expanded to require that a minimum volume or all services be claimed through the interim claiming process. If this approach was taken and all services were required a claim to be submitted, HHSC would have data available to provide the detailed therapy data requested in Rider 42(a). It is assumed that requiring districts to submit a claim for every service throughout the year would be an administrative burden on some participating SHARS ISDs that could be problematic because many school districts do not have dedicated staff to support this level of claim administration and billing. A lesser amount or percentage could be required, for example 50 percent, and still yield statistically significant, measurable results that could be extrapolated to provide an estimate of the types of therapy services provided in the school setting. HHSC could also use a tiered approach and consider ISD size or volume of claims when deciding what percentage of services districts would be required to do interim claiming for. This would help to lessen the administrative burden on smaller school districts who may have even less staff and associated resources for billing. The data collected would allow HHSC to evaluate coordination of care by comparing the therapy services received in the school based setting to therapy services delivered by other Medicaid providers.
3 – Reduce the claims filing deadline for SHARS participating ISDs

HHSC recommends examining the claims filing deadline for SHARS participating ISDs to allow for more timely data collection.

Interim claims for SHARS services 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, whichever comes first. Claims for SHARS must be submitted to TMHP in an approved electronic claims format or on a CMS-1500 claim form. As a result, the SHARS interim claim data available through TMHP is not inclusive of all interim services and cannot be analyzed until at least 365 days after a service is provided. The filing deadline for most other Medicaid providers is 95 days after the date of service.

Reducing the SHARS filing deadline to mirror other Medicaid providers could be problematic. Some SHARS ISDs are not as sophisticated with billing as other Medicaid providers and they may not have available staff to submit claims more frequently. Some SHARS ISDs may find it difficult to meet a reduced filing deadline. In addition, school district schedules should be considered to identify any anticipated issues, such as being out of office for the summer months, that would prevent participating SHARS ISD from claiming within a reduced filing timeframe if the deadline were to be reduced.

4 – Modification of data elements in SHARS cost reports

HHSC recommends modifying the existing SHARS cost reports to collect additional detail that could then be leveraged to further analyze therapy services provided in the school and outside of the school setting.

The SHARS cost report could possibly be modified to require ISDs to report more specific information regarding the therapy services received by students to include the type of therapy discipline (ST, OT, or PT) received, the child receiving the service and the therapy provider. Certain elements of the information requested in Rider 42 is already captured in the annual SHARS cost report. However, the information is summary level data that cannot be directly associated to the services any one Medicaid client received during the reporting period. Rate Analysis allows SHARS ISDs to submit cost report data in detail or by summary level. Summary level data is totaled by cost category and reported in aggregate for all positions and expenditures that fall under each cost category. The option to report in summary
has led to an increase in district participation, as it was viewed as an administrative burden for some larger districts to enter information on a detail level for each position claimed in each cost report.

Currently, neither HHSC nor TEA has a reporting mechanism that captures all of the requested information in a single, reliable source. If the cost report was expanded to require SHARS ISDs to report detailed information along with their cost data, HHSC would be required to implement changes to the existing cost report as it currently is not built to support this level of reporting. The state’s web based cost reporting application, the State of Texas Automated Information Reporting System (STAIRS) may require adjustments to the platform to receive the detailed information. There are newer platforms of STAIRS available that may be able to accommodate this modification. To move the SHARS cost report to another platform, if required, would take extensive research, coding, and testing. In addition, a modification to the STAIRS contractor’s agreement may be necessary. The potential cost of this modification cannot be estimated at this time and requires more time to determine specific steps and associated costs. If detailed information was collected on the SHARS cost reports, the result would include more accurate data that could be used to demonstrate the actual services provided in schools and compared to services delivered by other Medicaid providers for the same Medicaid clients. Prior to implementing or authorizing a change of this type, HHSC would ensure this change in level of detail would not violate FERPA regulations.

5 – Update TMPPM to encourage coordination between providers.

HHSC recommends updating the TMPPM to encourage coordination between therapy providers.

This recommendation can be accomplished in the short term and can be accomplished by adding language to the SHARS section (Chapter 3) of the Children’s Services Handbook in the TMPPM, encouraging (but not requiring) coordination between providers, with parental consent. This would vary in efficacy as it is not a requirement but may result in increased coordination.
Medically necessary physical, occupational, and speech therapies are provided to Medicaid clients in Texas through managed care and through FFS Medicaid with non-SHARS providers. SHARS ISDs also deliver medically necessary therapies, but only those specified in students’ IEPs as necessary for educational access. Rider 42 required HHSC to study ways to coordinate services between SHARS and other Medicaid providers, including identifying any barriers, and report applicable data with recommendations on how to improve coordination of services and data comparison. There are challenges to accessing data to use in coordination of care as explained in this report. Neither HHSC nor TEA currently maintain the detailed level data needed to accomplish the goal of Rider 42. While the information currently available is useful, it is not fully representative of the therapy services being provided in the school setting.

HHSC and TEA have been increasing coordination efforts to provide more oversight of the SHARS program and to provide additional guidance to SHARS ISDs. The state agencies began traveling together to school districts in April 2018 and are evaluating opportunities to further enhance coordination. HHSC plans to form the workgroup, which will require participation from TEA, representative ISDs and others as recommended above as a first step while continuing to evaluate the other options for improving service coordination and obtaining reliable data.
## List of Acronyms

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<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>ARD</td>
<td>Admission, Review, and Dismissal</td>
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<tr>
<td>CADS</td>
<td>Center for Analytics and Decision Support</td>
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<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>DFPS</td>
<td>Department of Family and Protective Services</td>
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<tr>
<td>EPSDT</td>
<td>Early Periodic Screening, Diagnostic and Treatment</td>
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<tr>
<td>FERPA</td>
<td>Family Educational Rights and Privacy Act</td>
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<td>FFS</td>
<td>Fee-for-Service</td>
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<td>HHSC</td>
<td>Texas Health and Human Services Commission</td>
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<td>HHSC RAD</td>
<td>HHSC Rate Analysis Department</td>
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<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act</td>
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<td>IDEA</td>
<td>Individuals with Disabilities Education Act</td>
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<td>IEP</td>
<td>Individualized Education Program</td>
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<td>LEA</td>
<td>Local Educational Agency</td>
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<td>MCO</td>
<td>Managed Care Organization</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<td>OT</td>
<td>Occupational Therapy</td>
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<td>PCS</td>
<td>Personal Care Services</td>
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<td>PT</td>
<td>Physical Therapy</td>
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<td>RMTS</td>
<td>Random Moment Time Study</td>
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<td>SHARS</td>
<td>School Health and Related Services</td>
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<td>ST</td>
<td>Speech Therapy</td>
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<tr>
<td>STAIRS</td>
<td>State of Texas Automated Information Reporting System</td>
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<td>STAR</td>
<td>State of Texas Access Reform</td>
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<td>TEA</td>
<td>Texas Education Agency</td>
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<td>TMHP</td>
<td>Texas Medicaid and Healthcare Partnership</td>
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<td>TMPPM</td>
<td>Texas Medicaid Provider Procedures Manual</td>
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Appendix A. Text of Rider 42


42. Coordination of Services. Out of funds appropriated above, the Health and Human Services Commission (HHSC) shall study ways to improve coordination of therapy services that are billable to Medicaid provided by school districts that are also provided by other Medicaid providers. HHSC shall identify barriers to data collection and, in coordination with the Texas Education Agency (TEA) and participating school districts, evaluate the feasibility of participating school districts reporting to HHSC data to allow HHSC to determine:

a. Data on the number of children identified, types of therapy services received, and cost of therapy services by fiscal year and provider type; and

b. Recommendations to improve coordination of services for children who receive therapy services from both school districts and other Medicaid providers.

HHSC shall submit a report identifying barriers to coordination and making recommendations to improve coordination of services and comparison of data to the LBB and Governor no later than December 1, 2018. (Conference Committee Report Rider 166)