2017 Special Education Solutions Members’ Conference
Building on the Best

Ready, Set, Prep.

Dr. Karlyn Keller, Special Education Solutions
The SHARS Audit

A step by step approach that lead to our success

MICHELLE GOEBEL, DIRECTOR OF SPECIAL EDUCATION, VICTORIA ISD
DR. KARLYN KELLER, LEAD ACCOUNT EXECUTIVE, TASB SPECIAL EDUCATION SOLUTIONS

Types of Audits

- Office of Inspector General (OIG)
- Texas Medicaid Healthcare Partnership (TMHP) & Health and Human Services Commission (HHSC)
  - School Health and Related Services (SHARS) & Medicaid Administrative Claiming (MAC)
    - Cost Report
    - Interim Billing
- Texas Education Agency (TEA)
  - SHARS Department & Performance Based Monitoring (PBM)
- Others???
Stakeholders in Audits

It takes a lot of manpower to pull everything together.

The Ten P’s of Audit Preparation

- Prepare
- Precise
- Plan
- Predict
- Past
- Partner
- Polished
- Perform
- Patient
- Protest
Prepare

• Be **prepared** for the audit ahead of time.
• Have guidelines for how your SHARS program works. Create timelines for all staff.
• Checks and balances will assist with compliance.
• Train all staff for compliance.
• Regularly self evaluate your documentation.

Precise

• Review the audit expectations to ensure you meet the **precise** requirements. Leave nothing out!
• Read the notification thoroughly to be sure you understand the perimeters of the audit.
• Read the audit letter carefully and provide everything that it asks for.
• Communicate the specifics of the audit both to leadership and to all stakeholders.
Plan

• **Have a plan and follow it.**
  • Create a plan of action to collect all the documents required as part of the audit.
  • Assign the overall coordinator to pulling everything together.
  • Assign each item from the list to a responsible person and include a due date.
  • Make sure to allow adequate time for review and correction of schedules if necessary.
  • Pay attention to the deadlines. If a deadline is approaching and the records are not going to be ready, contact the auditor and request an extension before it is due. Do this by telephone and follow up with a letter (not an email). Send the letter before the deadline.

Predict

• **Predict the auditor’s questions.**
  • As you collect the documentation and review your data, think about who will be reviewing your information.
  • Remember they probably aren’t educators. They have experience with medical insurance. You may need to explain what you are sending.
  • Draw the auditors attention to what they are looking for.
  • The temptation is to think that because the records make sense to you, they will make sense to the auditor.
  • The biggest mistake that someone who is the subject of an audit can make is to hastily copy only a portion of the available records and send them off for review.
Past

• **Learn from the past.**
• Take stock of any prior year audit adjustments, internal recommendations, or struggles encountered during prior audits
• Have you been involved in an audit before, what was the outcome?
• What has been successful in past audits? What has been a problem in the past?
• Is there someone you have access to that has gone through an audit in the past?

Partner

• **Build partnerships across the district to assist in gathering everything.**
• Communicate that it is all hands on deck and expect support from the team. This takes a team.
• Ask your billing support if available. Remember you are not alone.
• Call the agency that will be auditing your district if you have questions. They want to help you to ensure they get all the documents they need.
• Any telephone communication with the auditor should be followed up with a letter confirming the telephone conference.
Polished

• **Take the time to ensure everything looks polished.**
• Plan for a professional submission.
• Have a table of contents. Use dividers. Have a uniform submission.
• Send a cover letter with the requested documents and records explaining what is included and how it is organized as well as who to contact if the auditors have any questions.
• It is so important to compile a thorough set of records that are presented in a clearly labeled and organized fashion that provide justification for every service or item billed.
• Setting the expectation that your submission will be complete and compliant.

Perform

• **Perform a self-review to evaluate your submission.**
• Before finalizing everything and sending it in, have someone look over your everything.
• Use a checklist approach to ensure you have addressed everything.
• Determine any discrepancies, admit them, address them and create a plan of action to ensure they don’t occur in the future.
• Make a copy of everything you send exactly as it is sent. This way there are no valid questions later on as to whether a particular document was forwarded to the auditors.
Patient

- Be **patient**. Sometimes it take a while for a response to your audit.
- Send the response package using some form of package tracking or delivery confirmation to arrive before the deadline.
- Celebrate the success of pulling everything together and getting it out the door.
- While you may have only been given a few weeks, remember that the agency is auditing across the state.
- This may mean you have some time to wait for a response.

Protest

- Don’t be afraid to **protest** if you feel like the audit missed something.
- If the results returned aren’t what you hoped for, don’t fret. You have the right to appeal.
- Think about an appeal. What is the potential upside? Downside?
- Think about the long game. Is it worth staff time?
- We are all human, even your auditor. Maybe you just need to explain.
The Ten P’s of Audit Preparation

SHARS Audit Supports

Audit Preparation Recommendations for the School Health and Related Services (SHARS) Medicaid Billing Program

By TASB Special Education Solutions
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**TASB Special Education Solutions**

**Texas Level Bill Overview**

**Medicaid & Special Education Related Bills Filed (149 Bills)**

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**Bold items relate to Medicaid**
March 7 2017

The Honorable Greg Walden                           The Honorable Frank Pallone
Chairman                                                                          Ranking Member
House Energy and Commerce Committee              House Energy and Commerce Committee
U.S. House of Representatives                             U.S. House of Representatives
Washington, D.C. 20515                                              Washington, D.C. 20515

Re: Vote on The American Health Care Act

Dear Chairman Walden and Ranking Member Pallone:

The undersigned member organizations of the Save Medicaid in the Schools Coalition are concerned that the Medicaid refinancing proposal the committee is considering this week jeopardizes healthcare for the nation’s most vulnerable children: students with disabilities and students in poverty. Specifically, a per capita cap system will undermine states’ ability to provide America’s neediest children access to vital healthcare that ensures they have adequate educational opportunities and can contribute to society. Medicaid is a cost-effective and efficient funder of essential health care services for children. In fact, while children comprise almost half of Medicaid beneficiaries, less than one in five dollars spent by Medicaid is consumed by children. Accordingly, a per capita cap, even one that is based on different groups of beneficiaries, will disproportionately harm children’s access to care, including services received at school. Considering these unintended consequences, we urge a ‘no’ vote on The American Health Care Act.

Schools Provide Critical Health Care for Students

A school’s primary responsibility is to provide students with a high-quality education. However, children cannot learn to their fullest potential with unmet health needs. As such, school district personnel regularly provide critical health services to ensure that all children are ready to learn and able to thrive alongside their peers. Schools deliver services effectively and efficiently since school is where children spend their days. Increasing access to health care services through Medicaid improves health care and educational outcomes for students. Providing health and wellness services for students in poverty and services that benefit students with disabilities ultimately enables more children to become employable and attend higher-education.

Since 1988, Medicaid has permitted payment to schools for certain medically necessary services provided to children under the Individuals with Disabilities Education Act (IDEA) through an individualized education program (IEP) or individualized family service program (IFSP). Schools are thus eligible to be reimbursed for direct medical services to Medicaid-eligible students with an IEP or IFSP. In addition, districts can receive Medicaid reimbursements for providing Early Periodic Screening Diagnostic and Treatment Benefits (EPSDT), which provide Medicaid-eligible children under age 21 with a broad array of diagnosis and treatment services. The goal of EPSDT is to assure that health problems are diagnosed and treated as early as possible before the problems become complex and treatment is more expensive.

School districts use their Medicaid reimbursement funds in a variety of ways to help support the learning and development of the children they serve. In a 2017 survey of school districts, district officials reported that two-thirds of Medicaid dollars are used to support the work of health professionals and other specialized instructional support personnel (e.g., speech-language pathologists, audiologists, occupational therapists, school psychologists, school social workers, and school nurses) who provide comprehensive health and mental health services to students. Districts also use these funds to expand the availability of a wide range of health and mental health services available to students in poverty, who are more likely to lack consistent access to healthcare professionals. Further, some districts depend on Medicaid reimbursement to purchase and update...
specialized equipment (e.g., walkers, wheelchairs, exercise equipment, special playground equipment, and equipment to assist with hearing and seeing) as well as assistive technology for students with disabilities to help them learn alongside their peers.

School districts would stand to lose much of their funding for Medicaid under the Committee’s proposal. Schools currently receive roughly $4 billion in Medicaid reimbursements each year. Yet under this proposal, states would no longer have to consider schools to be eligible Medicaid providers, which would mean that districts would have the same obligation to provide services for students with disabilities under IDEA, but no Medicaid dollars to provide medically-necessary services. Schools would be unable to provide EPSDT to students, which would mean screenings and treatment that take place in school settings would have to be moved to physician offices, where some families may not visit regularly, or to hospital emergency rooms where costs are much higher.

In addition, basic health screenings for vision, hearing, and mental health problems for students would no longer be possible, making these problems more difficult to address and more expensive to treat. Moving health screenings out of schools also reduces access to early identification and treatment, which also leads to more costly treatment down the road. Efforts by schools to enroll eligible students in Medicaid would also decline.

The Consequences of Medicaid Per Capita Caps Will Potentially Be Devastating for Children

Significant reductions to Medicaid spending could have devastating effects on our nation’s children, especially those with disabilities. Due to the underfunding of IDEA, districts rely on Medicaid reimbursements to ensure students with disabilities have access to the supports and services they need to access a Free and Appropriate Public Education. Potential consequences of this critical loss of funds include:

- **Fewer health services**: Providing comprehensive physical and mental health services in schools improves accessibility for many children and youth, particularly in high needs and hard to serve areas such as rural and urban communities. In a 2017 survey of school district leaders, half indicated they have recently taken steps to increase Medicaid enrollment in their districts. Reduced funding for Medicaid would result in decreased access to critical healthcare for many children and youth.

- **Cuts to general education**: Cuts in Medicaid funding would require districts to divert funds from other educational programs to provide the services as mandated under IDEA. These funding reductions could result in an elimination of program cuts of equivalent cost in "non-mandated" areas of regular education.

- **Higher taxes**: Many districts rely on Medicaid reimbursement to cover personnel costs for their special education programs. A loss in Medicaid reimbursement could lead to deficits in districts that require increases in property taxes or new levies to cover the costs of the special education programs.

- **Job loss**: Districts use Medicaid reimbursement to support the salaries and benefits of the staff performing eligible services. Sixty-eight percent of districts use Medicaid funding to pay for direct salaries for health professionals who provide services for students. Cuts to Medicaid funding would impact districts’ ability to maintain employment for school nurses, physical and occupational therapists, speech-language pathologists, school social workers, school psychologists, and many other critical school personnel who ensure students with disabilities and those with a variety of educational needs are able to learn.

- **Fewer critical supplies**: Districts use Medicaid reimbursement for critical supplies such as wheelchairs, therapeutic bicycles, hydraulic changing tables, walkers, weighted vests, lifts, and student-specific items that are necessary for each child to access curriculum as closely as possible to their non-disabled peers. Replacing this equipment would be difficult if not impossible without Medicaid reimbursement.
• **Fewer mental health supports**: Seven out of ten students receiving mental health services receive these services at school. Cuts to Medicaid would further marginalize these critical services and leave students without access to care.

• **Noncompliance with IDEA**: Given the failure to commit federal resources to fully fund IDEA, Medicaid reimbursement serves as a critical funding stream to help school provide the specialized instructional supports that students with disabilities need to be educated with their peers.

We urge you to carefully consider the important benefits that Medicaid, as it is currently structured, provides to our nation’s most vulnerable children. Schools are often the hub of the community, and converting Medicaid to per capita caps threatens to significantly reduce access to comprehensive health and mental and behavioral health care for children with disabilities and those living in poverty. We look forward to working with you to prevent unnecessary changes to this highly effective and beneficial program.

If you have questions about the letter or wish to meet to discuss this issue further, please do not hesitate to reach out to the coalition co-chairs via email: John Hill (john.hill@medicaidforeducation.org), Sasha Pudelski (spudelski@aasa.org), and Kelly Vaillancourt Strobach (kvaillancourt@naspweb.org).

Sincerely,

AASA, The School Superintendents Association
Acclify
American Civil Liberties Union
American Dance Therapy Association
American Federation of School Administrators (AFSA)
American Federation of Teachers
American Music Therapy Association
American Psychological Association
Association of Educational Service Agencies
Association of School Business Officials International
Children's Hospital Colorado
Coalition for Community Schools
Colorado Children's Immunization Coalition
Colorado School Medicaid Consortium
Council for Exceptional Children
Council of Administrators of Special Education
Council of Parent Attorneys and Advocates
Division for Early Childhood of the Council for Exceptional Children (DEC)
Easterseals
First Focus Campaign for Children
Healthy Schools Campaign
Institute for Educational Leadership
Judge David L. Bazelon Center for Mental Health Law
LEAnet, a national coalition of local education agencies
Learning Disabilities Association of America
Michigan Association of Intermediate School Administrators
Michigan Association of School Administrators
National Association of School Nurses
National Association of School Psychologists
National Association of Social Workers
National Association of State Directors of Special Education (NASDSE)
Turning Medicaid into a block grant is not a new or innovative idea—it is just another way to cut Medicaid. Block granting Medicaid would ultimately mean cuts in services to people who need health care the most. It would also put states completely on the hook for unanticipated health care costs—instead of sharing the risk of higher Medicaid spending with the federal government.

**Medicaid Block Grants Put States and Medicaid Enrollees at Risk**

A “block grant” is a fixed amount of money that the federal government gives to a state for a specific purpose. If Medicaid was turned into a block grant, the federal government would set its Medicaid spending amount in advance. That amount would presumably be based on some estimate of state Medicaid costs, but most block grant proposals start with significant reductions in federal Medicaid support.

Once the amount is set by the federal government, it will not change, even if a state’s actual program costs are greater than the allotted amount. If a state’s costs exceed the amount of the block grant, it will have to use its own funds to make up the difference or, more likely, cut services for low-income residents, including children, seniors, and people with disabilities.

**Medicaid Block Grants Don’t Give States More Flexibility**

States already have a lot of flexibility in their Medicaid programs. They have flexibility in

» the services covered

» the way health care providers are paid for those services

» how services are delivered, such as whether managed care is used and how managed care contracts are structured

» eligibility levels

Each state can design a program that fits its particular health care system and that best meets the needs of its residents.

If a block grant proposal includes reductions in federal Medicaid spending, as most do, states will start out with less federal funding than they have now. States will have to either make up
that lost funding or cut insurance benefits or program eligibility. At the end of the day, the only real “flexibility” a Medicaid block grant would give states is the flexibility to decide how to make up Medicaid funding shortfalls: which services to cut, which hospital or doctor payments to cut, which taxes to raise, or which non-health care programs to cut.

**Medicaid Block Grants Would Make It Harder for States to Serve Their Residents**

The federal government has been a reliable partner for state Medicaid programs since Medicaid was created in 1965. The federal match rate for the traditional Medicaid program is always at least half of all Medicaid costs, and for the Medicaid expansion population, it is much higher. This structure insulates states from unexpected cost increases and ensures coverage for low-income residents.

The current federal Medicaid funding structure also helps states provide better health insurance to their residents than they could do on their own. States can do more to help kids get a healthy start in life, provide long-term and home care to seniors and people with disabilities, and provide health care to pregnant women and low-income working families. Turning the program into a block grant would put states—and their residents—at risk.

**Turning Medicaid into a block grant would put states and Medicaid enrollees at financial risk, and it would make it harder for states to serve their residents’ health care needs. There is no reason for politicians to change a federal funding structure that has worked well for more than 50 years.**

**Endnotes**

1 All states must cover several specific groups of people, including low-income children, pregnant women, and certain seniors and people with disabilities. But states have significant flexibility in the coverage they provide to other adults and in the eligibility levels they set for the remaining seniors and people with disabilities.