RELAY

TEXAS SHARS · SESSION FOR CFOs & BUSINESS MANAGERS

The SHARS Cost Report: What's Actually at Stake

WHAT WE'LL COVER

Where Your Cost Report Number Actually Comes Comes From

1. What one district's cost report swing looked like —and what closed the gap
2. How the annual cost report actually works —and why "submitted" and "paid" are different numbers on it
3. The three places revenue actually gets left behind
4. Denied claims —where they actually come from, and how to catch them faster
5. How this compares to state and regional benchmarks —and questions worth asking about your own program

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What This Looks Like Inside One District's Program

Details specific to the district have been removed. The numbers are real, drawn from one Texas district's program over a single school year.

16% → 23%

IEP ratio, one year to the next

436 → 536

students with at least one paid claim

$1.0M owed → ~$900K back

cost report swing, one year apart

The consultant working the account traced the swing to exactly the three levers this session covers: missing parental consent, missing prescriptions and referrals, and inconsistent documentation. Fixing those three things —not finding new students or new services —is what moved 100 additional students onto a paid claim and turned the cost report around. That's what the rest of this session unpacks.

Anonymized from an actual client account, shared for illustration. Figures should be confirmed before use in any external-facing version of this material.

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Interim Payments Are a Down Payment. The Cost Report Is the Bill.

Every claim paid throughout the year gets reconciled once, annually, against actual allowable cost —and that reconciliation is what your district is actually accountable for.

During the Year — Interim Claims

- Paid at a set interim rate, claim by claim, throughout the federal fiscal year
- Reporting period runs October 1 through September 30
- Interim payments are provisional, not final
- RMTS participation required every quarter to stay eligible to bill at all

Every dollar paid here is provisional until reconciled

Once a Year — The Cost Report

- Filing is mandatory for every provider that received interim payments
- Due on or before April 1 of the following year
- Reconciles actual allowable cost against every interim dollar already paid
- Certified and notarized by your business officer —this is a personal signature on district numbers

Failure to file recoups every interim dollar for the period

Source: TMPPM Vol. 2, SHARS Handbook, Section 2.7.2.2–2.7.2.5 (May 2026 edition)—cost reporting, filing deadlines, and recoupment rules

THE CORE DISTINCTION

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Submitting a Claim Isn’t the Same as Getting Paid

1

paid claim required per student, per service type, per cost report period—to count toward your IEP ratio

A submitted claim that gets denied doesn’t count. A claim that never gets submitted doesn’t count either.

Most districts track their reimbursement total. Far fewer can say, in real time, what their paid claim rate is by service type—OT, PT, speech, audiology, nursing, and counseling all behave differently.

WHAT ONE MISSING PIECE COSTS

The Three-Layer Revenue Hit

One missing prescription or consent form doesn't just cost one claim. It cascades.

1

Lost Interim Revenue

Services can't be billed to TMHP without a valid prescription or consent on file. Every session delivered stays unbillable until the gap is resolved—and if it goes unresolved, the whole service period may be lost.

2

Missing Paid Claim / Weaker IEP IEP Ratio

No paid claim means the student doesn't count toward the IEP ratio on the cost report. That ratio drives the cost report reimbursement rate, so a weaker ratio means a smaller settlement.

3

Lost Transportation Billing

Transportation trip reimbursement requires a paid claim from another SHARS-eligible service on the same day. No paid claim there means no transportation billing for that day—multiplied across every date affected.

THE THREE PLACES REVENUE GETS LEFT BEHIND

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Where the Gap Actually Lives

Parental Consent

If consent isn't on file before services start, those claims can't be submitted at all. Expired or missing consent is one of the most common reasons earned reimbursement goes unclaimed.

Prescriptions & Referrals

OT, PT, speech, and audiology services need a prescription or referral on file. When it's missing, expired, or from the wrong provider type, claims get held — often invisibly, until someone looks.

Documentation

Session notes have to meet TMHP standards to generate a paid claim. Incomplete notes, missing credentials, or group billing where individual documentation is required all turn valid services into denials.

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Where Denials Actually Come From

Most prescription- and referral-driven denials trace back to one of five things:

1. Prescribing or referring provider isn't enrolled with TMHP
2. NPI is missing from the claim, the student record, or both
3. The prescription or referral on file doesn't match the service code billed
4. PT or OT services billed beyond the frequency the prescription authorizes
5. Prescription or referral wasn't signed and dated within the last 3 years

5 days

A good rule of thumb: review denial codes within 5 days of each remittance. A denial code tells you exactly what to fix. A denial that sits unread even a couple of weeks tells you nothing—and the pattern behind it keeps repeating, straight through to the cost report.

SUPPORT, BUILT AROUND YOUR PROGRAM

Where Relay's Team Fits In

This is oversight infrastructure, not just task relief.

- ✓ **A dedicated client success manager** —reviews claims before they go out —a second set of eyes on consent and documentation, and a defensible trail if the cost report is ever questioned.
- ✓ **Consent and prescription status visible by student** —in real time, with reminders that keep going until a parent responds.
- ✓ **Denial codes surfaced as they come in** —so fixable claims get corrected and resubmitted instead of sitting in a queue.
- ✓ **Ongoing provider training and accountability support** —including at transitions like staff turnover or a move to a new billing model.

It's the same kind of support behind the district example earlier in this session.

BRINGING IT TOGETHER

What Healthy Cost Report Programs Have in Common

- **Prescriptions on file before services begin** —Not chased after the fact —the clock starts when the service starts.
- **Consent collected at the student level, tracked by system** —Gathered at initial testing or transfer, not managed in a spreadsheet where gaps hide.
- **Service logs documented within the 7-day window** —Consistently —late documentation is the second most common denial trigger.
- **Cost report prep starts in Q3, not at year-end** —IEP ratios, RMTS, and the provider list get reconciled while there's still time to fix something —not reconstructed against an April 1 deadline.
- **Denial codes monitored and acted on** —Fixable claims get identified and resubmitted —a denial sitting in a queue is revenue sitting on a table.

A DISCUSSION PROMPT

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Questions Worth Asking About Your Own Program

1. If your cost report were due today, do you know what you'd be signing your name to?
2. Can you see, in real time, how many students have at least one paid claim this cost report period?
3. What percentage of submitted claims are being denied —and do you know why?
4. What's the dollar range between what you've submitted and what's actually been paid this cost report period?
5. How does this period's reimbursement compare to the same period last year?
6. If a board member asked today, could you say with confidence whether this year's settlement is trending up or down?

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THE TAKEAWAY

Paid is the metric that matters. Consent, prescriptions, and documentation decide what your cost report says.

Thank you —happy to open this up for questions and discussion. If you'd like a closer look at your own numbers, ask us about Relay's SHARS assessment.