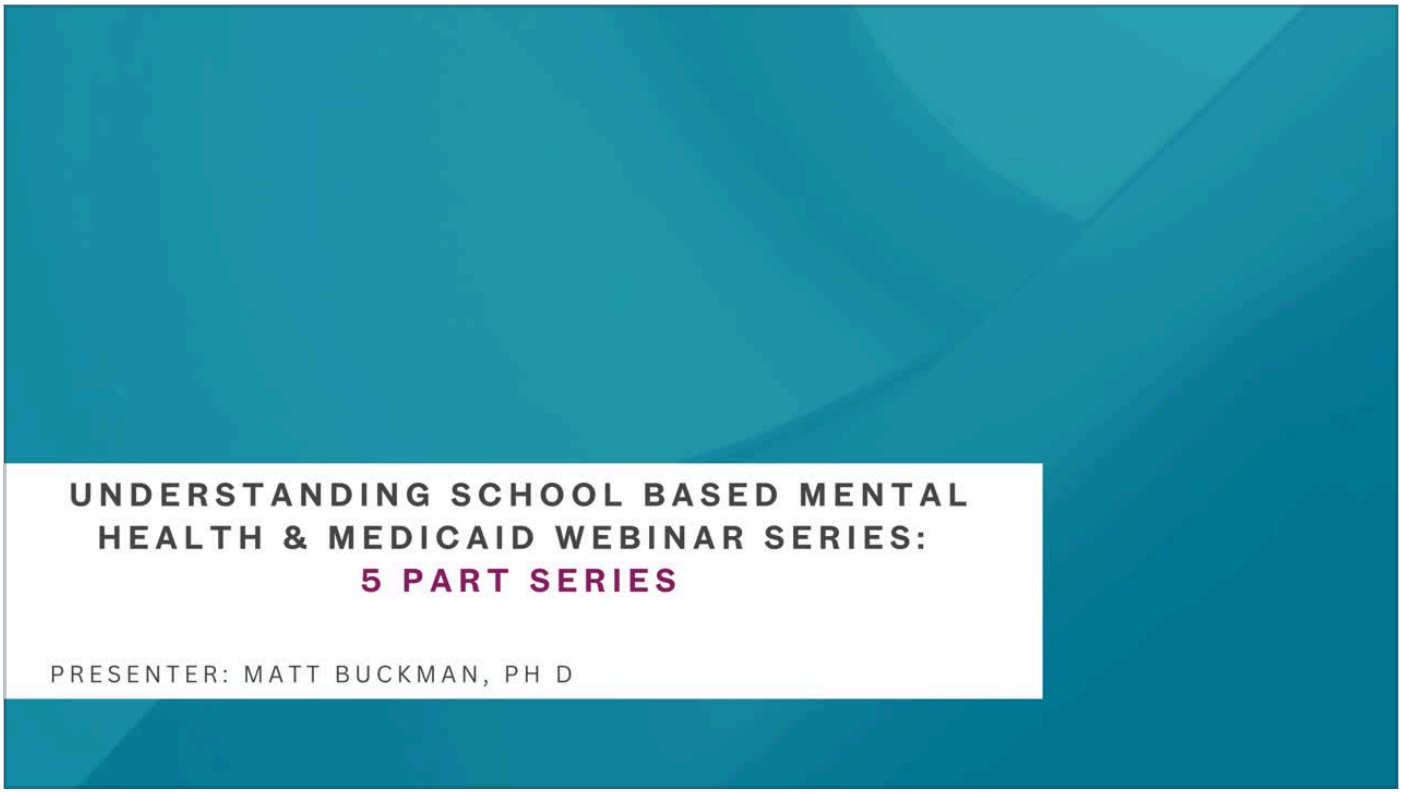


Welcome to the Understanding School-Based Mental Health and Medicaid webinar series. This five-part series is designed to build a shared foundation for understanding how Medicaid supports mental health services in both school-based and community-based settings across the state of Illin ois.

The vision of this series is to support the provision of mental health services to students within school settings—reaching all youth, especially those who are most vulnerable and may not otherwise be able to access services.

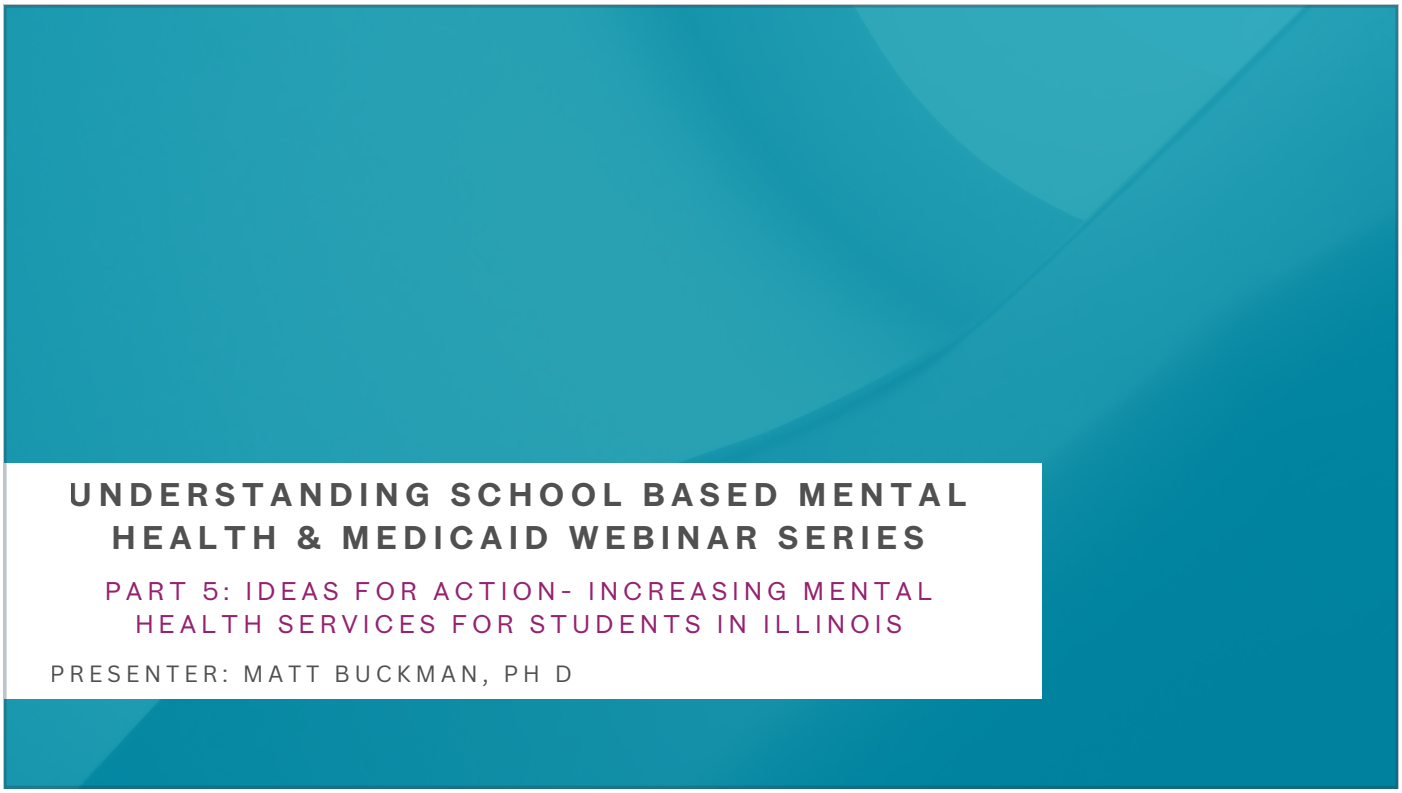
My name is Matt Buckman. I am a licensed clinical psychologist, dually credentialed as a school psychologist, and the Executive Director of the Stress and Trauma Treatment Center. I will be guiding you through today's content and the broader five-part series.

This webinar was developed with support from the U.S. Department of Education's School-Based Mental Health Services Grant, awarded to West 40 Intermediate Service Center #2 in partnership with the Stress and Trauma Treatment Center.

This material is provided for educational purposes as a broad overview and does not replace official guidance from HHS, CMS, or the Illinois Department of Healthcare and Family Services (HFS). Regulations and compliance requirements may change, and participants should always consult authoritative sources.

This five-part series progresses from foundational Medicaid concepts to increasingly specific

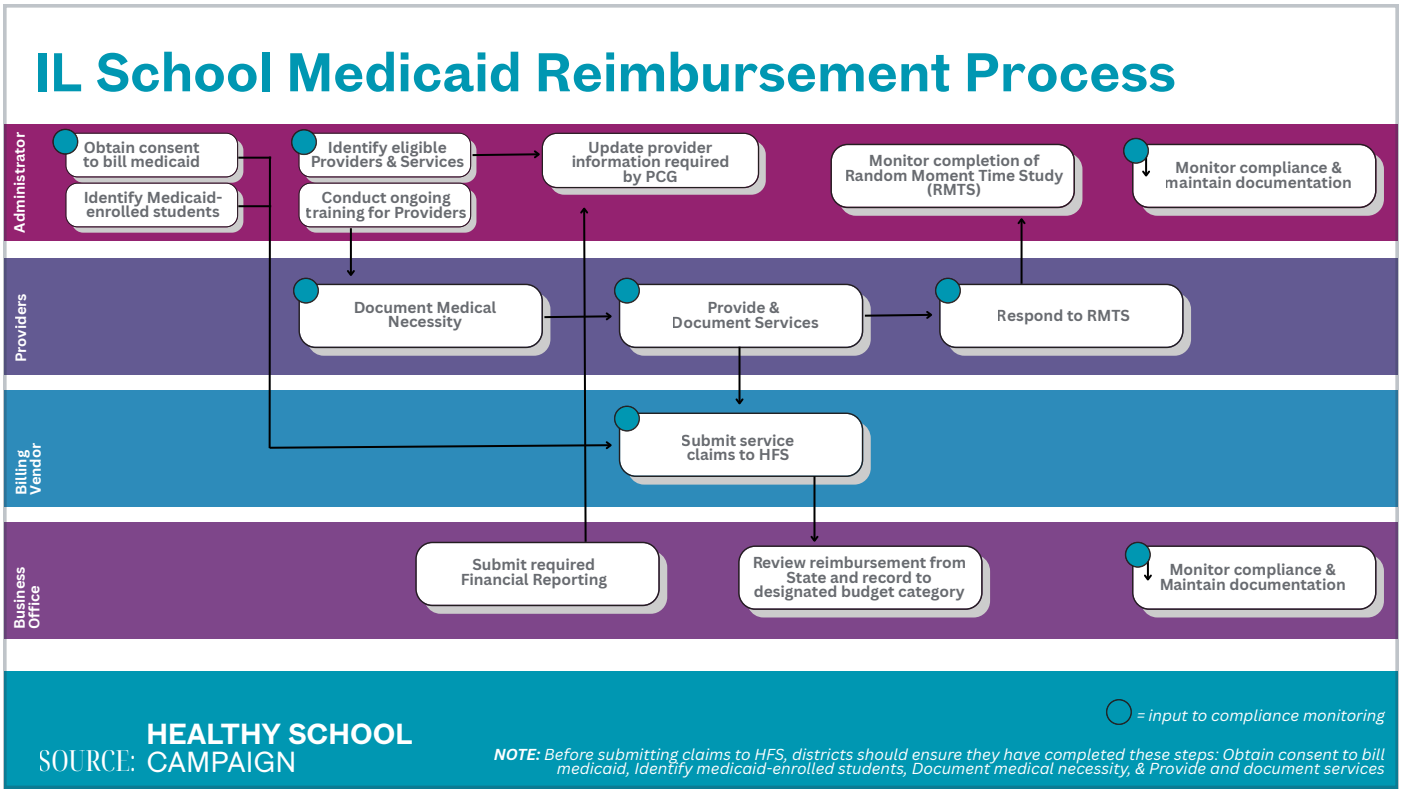
applications. A strong understanding of Medicaid allows districts to more effectively navigate school-based reimbursement systems, community mental health services, and specialized care coordination and Pathways programs.



Part Five focuses on Ideas for Action—concrete strategies districts can use to leverage Medicaid funding to increase access to mental health services for students in Illinois.

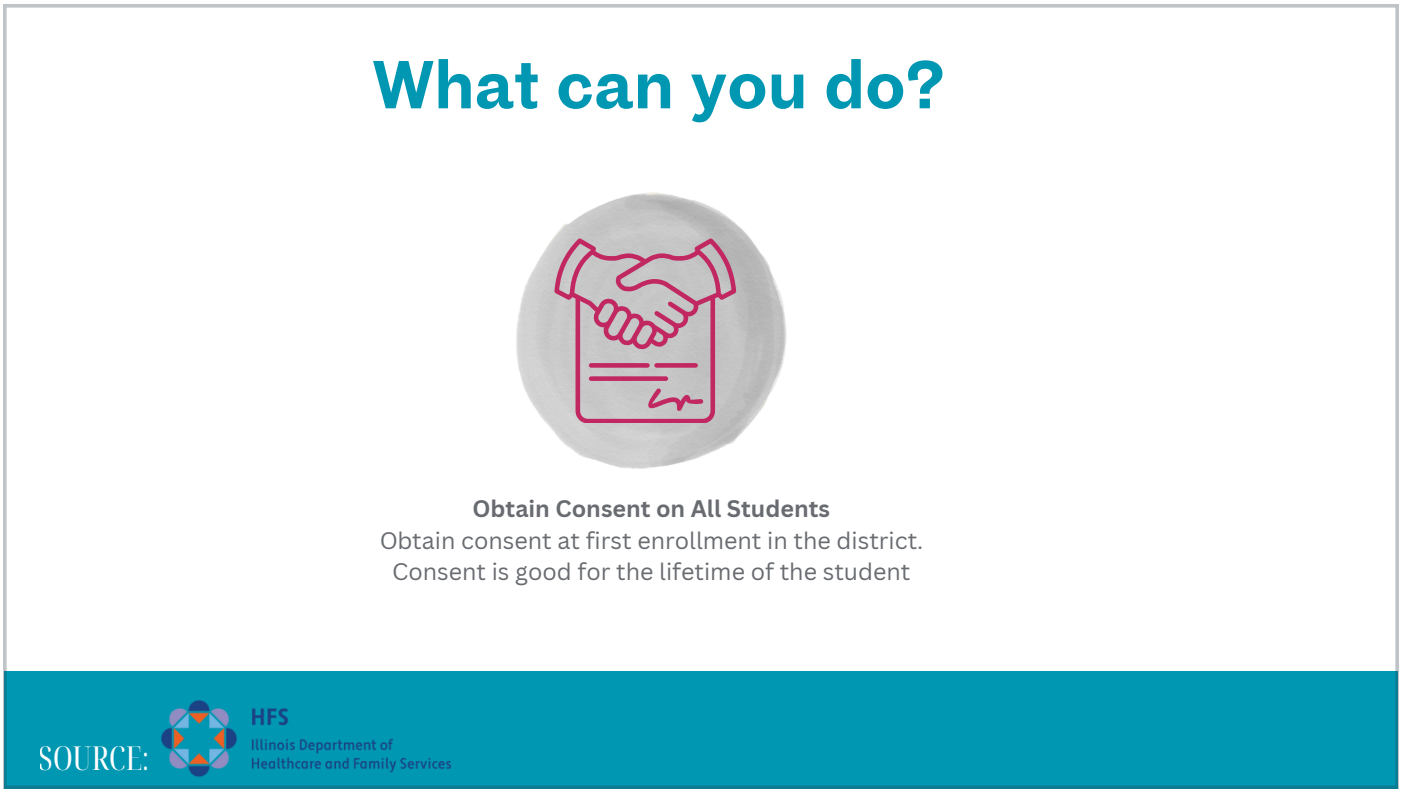
Today's Agenda:

-Medicaid outreach and enrollment support
-Staff pooling and cost reporting strategies
-Service provision models
-Community partnership opportunities
-Resources



Reimbursement Process Overview:

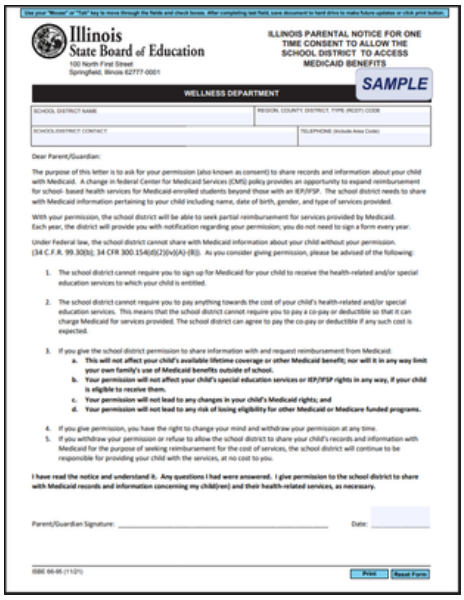
Using the Healthy Schools Campaign mapping framework, this section reviews the Medicaid reimbursement process from start to finish and highlights district-level strategies to expand mental health services and maximize Medicaid reimbursement.



Obtaining Consent:

Districts are encouraged to obtain parental consent for all students early in the enrollment process. One consent remains valid for the duration of a student's enrollment, making early collection an effective long-term strategy. For students transferring into the district, consent should be obtained at the onset of enrollment or services.

ISBE
Parental Notice



Illinois State Board of Education
100 North First Street
Springfield, Illinois 62777-0001

ILLINOIS PARENTAL NOTICE FOR ONE TIME CONSENT TO ALLOW THE SCHOOL DISTRICT TO ACCESS MEDICAID BENEFITS

SAMPLE

WELLNESS DEPARTMENT

SCHOOL DISTRICT NAME | REGION, COUNTY DISTRICT, TYPE (RCDT) CODE

SCHOOL DISTRICT CONTACT | TELEPHONE (Include Area Code)

Dear Parent/Guardian:

The purpose of this letter is to ask for your permission (also known as consent) to share records and information about your child with Medicaid. A change in federal Center for Medicaid Services (CMS) policy provides an opportunity to expand reimbursement for school- based health services for Medicaid-enrolled students beyond those with an IEP/IFSP. The school district needs to share with Medicaid information pertaining to your child including name, date of birth, gender, and type of services provided.

With your permission, the school district will be able to seek partial reimbursement for services provided by Medicaid. Each year, the district will provide you with notification regarding your permission; you do not need to sign a form every year.

Under Federal law, the school district cannot share with Medicaid information about your child without your permission. (34 C.F.R. 99.30(b); 34 CFR 300.154(d)(2)(iv)(A)-(B)). As you consider giving permission, please be advised of the following:

1. The school district cannot require you to sign up for Medicaid for your child to receive the health-related and/or special education services to which your child is entitled.
2. The school district cannot require you to pay anything towards the cost of your child's health-related and/or special education services. This means that the school district cannot require you to pay a co-pay or deductible so that it can charge Medicaid for services provided. The school district can agree to pay the co-pay or deductible if any such cost is expected.
3. If you give the school district permission to share information with and request reimbursement from Medicaid:
   a. **This will not affect your child's available lifetime coverage or other Medicaid benefit; nor will it in any way limit your own family's use of Medicaid benefits outside of school.**
   b. **Your permission will not affect your child's special education services or IEP/IFSP rights in any way, if your child is eligible to receive them.**
   c. **Your permission will not lead to any changes in your child's Medicaid rights; and**
   d. **Your permission will not lead to any risk of losing eligibility for other Medicaid or Medicare funded programs.**
4. If you give permission, you have the right to change your mind and withdraw your permission at any time.
5. If you withdraw your permission or refuse to allow the school district to share your child's records and information with Medicaid for the purpose of seeking reimbursement for the cost of services, the school district will continue to be responsible for providing your child with the services, at no cost to you.

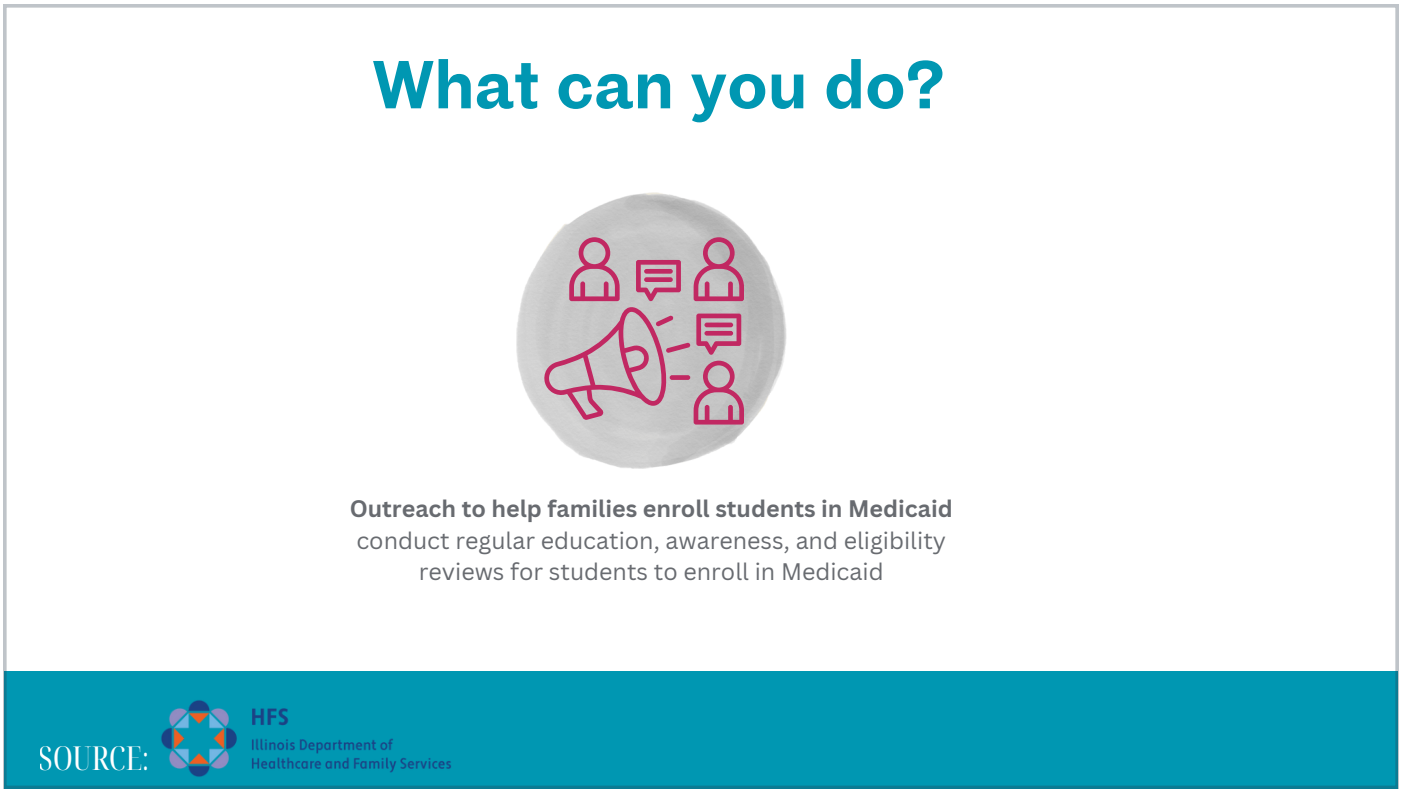
I have read the notice and understand it. Any questions I had were answered. I give permission to the school district to share with Medicaid records and information concerning my child(ren) and their health-related services, as necessary.

Parent/Guardian Signature: _____ Date: _____

ISBE 66-85 (11/21) Print Reset Form

SOURCE: ILLINOIS STATE BOARD OF EDUCATION

ISBE provides a sample parental notice, though districts may use their own forms.



Medicaid Outreach and Enrollment Support:

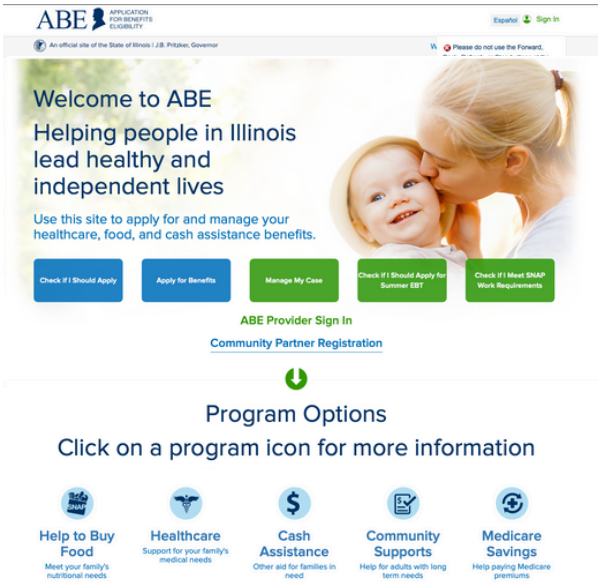
Districts can provide outreach to help families enroll in Medicaid, increasing access to primary care, mental health services, and other supports while reducing the financial burden on families.

Outreach activities may include:

-Education on Medicaid eligibility
-Assistance completing applications
-Support with redetermination and renewal

These activities are Medicaid-reimbursable and provide significant benefits to families.

ABE - Application for Benefits Eligibility



SOURCE:

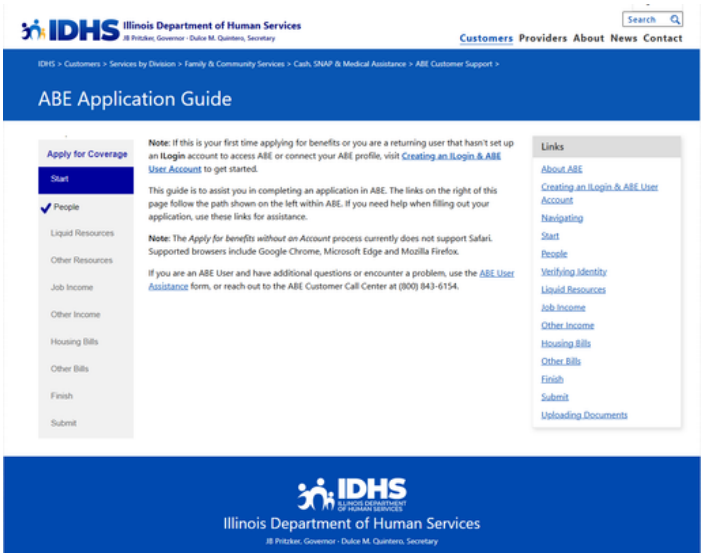
ABE (Application for Benefits Eligibility)

Illinois' ABE website allows families to:

-Check potential eligibility without entering identifying information
-Apply for benefits online if eligible

Districts can support families in using this tool, helping eligible students gain or maintain coverage.

https://www.dhs.state.il.us/



SOURCE: IDHS

IDHS Office Locator

SOURCE: IDHS

Medicaid Redetermination and Coverage Continuity:

Medicaid eligibility must be renewed annually. Families who do not receive or respond to redetermination notices—often due to address changes—may lose coverage unintentionally.

Federal Poverty Guidelines Charts

Annual:

Household/ Family Size	2025 Federal Poverty Level for the 48 Contiguous States (Annual Income)						
	100%	133%	138%	150%	200%	300%	400%
1	$15,650	$20,815	$21,597	$23,475	$31,300	$46,950	$62,600
2	$21,150	$28,130	$29,187	$31,725	$42,300	$63,450	$84,600
3	$26,650	$35,445	$36,777	$39,975	$53,300	$79,950	$106,600
4	$32,150	$42,760	$44,367	$48,225	$64,300	$96,450	$128,600
5	$37,650	$50,075	$51,957	$56,475	$75,300	$112,950	$150,600
6	$43,150	$57,390	$59,547	$64,725	$86,300	$129,450	$172,600
7	$48,650	$64,705	$67,137	$72,975	$97,300	$145,950	$194,600
8	$54,150	$72,020	$74,727	$81,225	$108,300	$162,450	$216,600
Each person over 8, add	$5,500	$7,315	$7,590	$8,250	$11,000	$16,500	$22,000

Monthly:

Household/ Family Size	2025 Federal Poverty Level for the 48 Contiguous States (Monthly Income)						
	100%	133%	138%	150%	200%	300%	400%
1	$1,304.17	$1,734.54	$1,799.75	$1,956.25	$2,608.33	$3,912.50	$5,216.67
2	$1,762.50	$2,344.13	$2,432.25	$2,643.75	$3,525.00	$5,287.50	$7,050.00
3	$2,220.83	$2,953.71	$3,064.75	$3,331.25	$4,441.67	$6,662.50	$8,883.33
4	$2,679.17	$3,563.29	$3,697.25	$4,018.75	$5,358.33	$8,037.50	$10,716.67
5	$3,137.50	$4,172.88	$4,329.75	$4,706.25	$6,275.00	$9,412.50	$12,550.00
6	$3,595.83	$4,782.46	$4,962.25	$5,393.75	$7,191.67	$10,787.50	$14,383.33
7	$4,054.17	$5,392.04	$5,594.75	$6,081.25	$8,108.33	$12,162.50	$16,216.67
8	$4,512.50	$6,001.63	$6,227.25	$6,768.75	$9,025.00	$13,537.50	$18,050.00
Each person over 8, add	$458	$610	$633	$688	$917	$1,375	$1,833

SOURCE: American Council On Aging

Chart includes multiple percentages in the Federal Poverty Level, as there are several programs, including Medicaid, that use a percentage of the FPL as the income criteria for program participation.

What can you do?

Outreach to help families update their change of mailing address
At knowledge of change of address,
support families to update their mailing address.
Renewal requests will be mailed to families.
If no response occurs, Medicaid coverage will be terminated

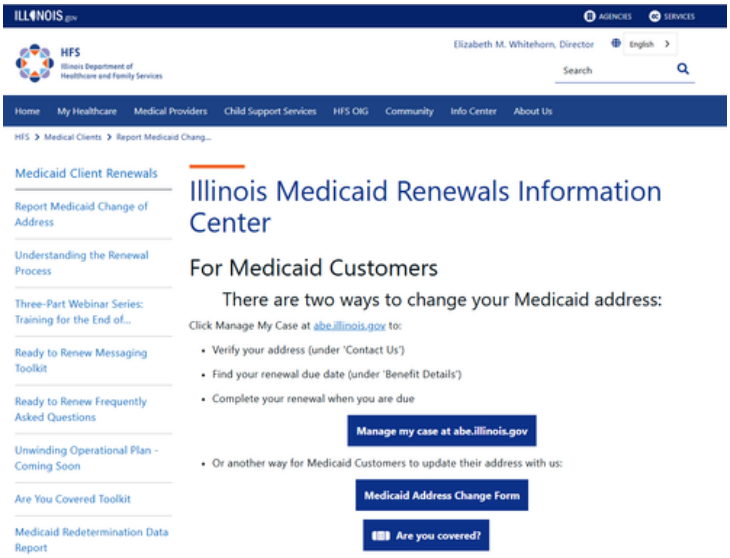
SOURCE: HFS Illinois Department of Healthcare and Family Services

Support families by:

-Encouraging timely address updates with HFS
-Assisting with renewal submissions
-Helping families reapply if coverage lapses

If coverage is reinstated, Medicaid may retroactively cover claims up to 60 days, reducing gaps in reimbursement and care.

HFS Website: Address Change



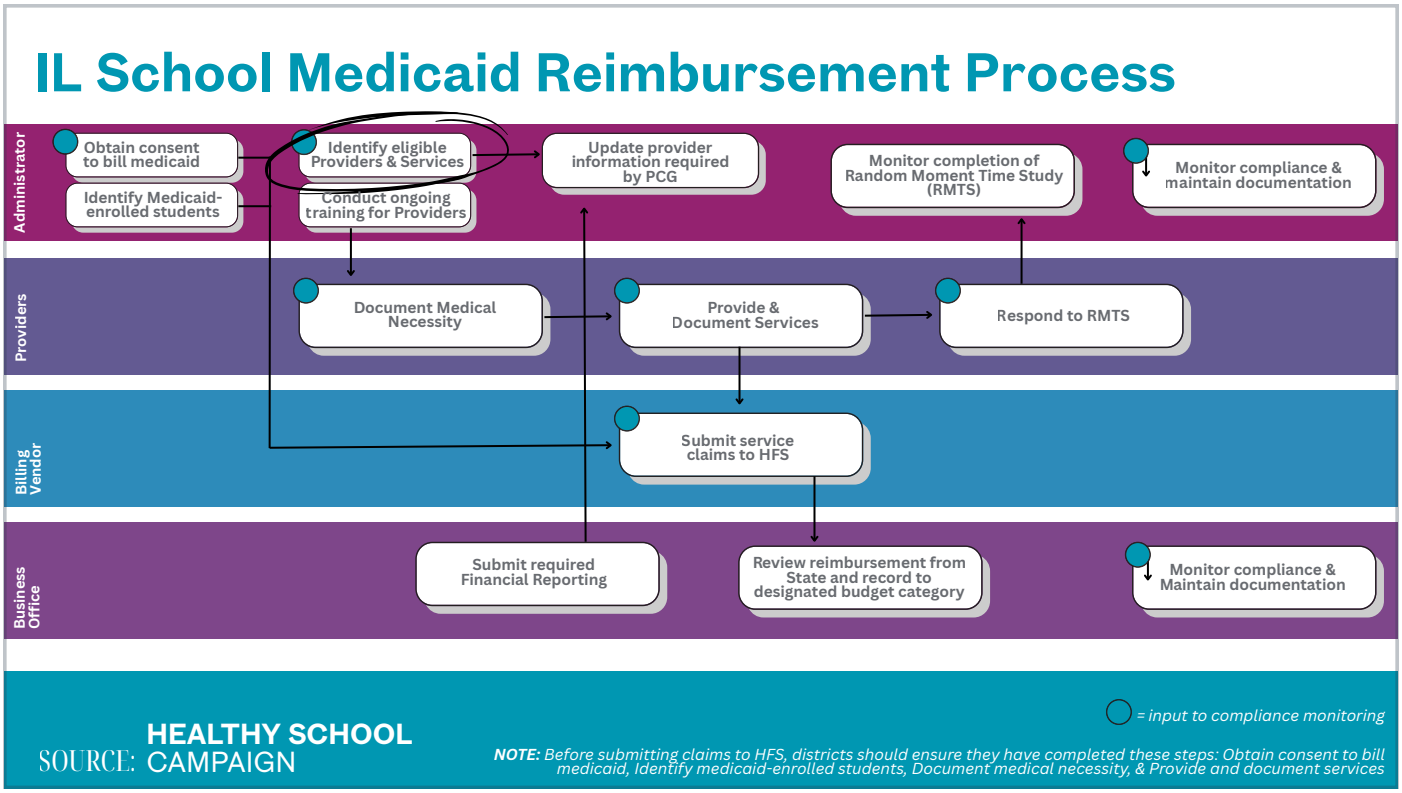
SOURCE: HFS Illinois Department of Healthcare and Family Services

What can you do?

Help families that lose coverage that are still eligible
Families can renew their coverage if they missed
the renew or redetermination deadline.

Medicaid can cover claims up to 60 days prior to the renewal application.

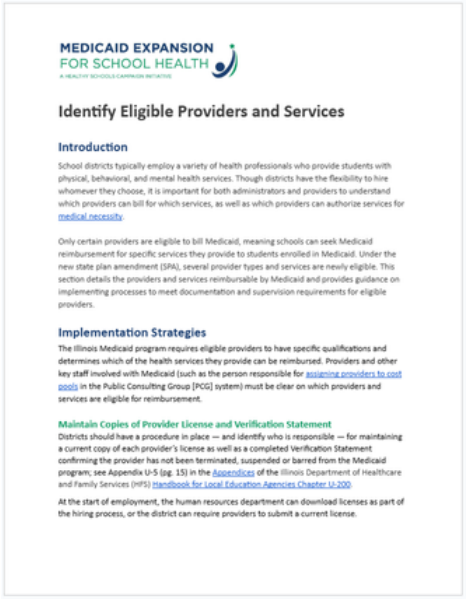
SOURCE: HFS Illinois Department of Healthcare and Family Services



Identifying Eligible Providers and Staff Pooling:

Correctly identifying eligible providers is critical for maximizing reimbursement through staff pooling and cost reporting.

Identify Eligible Providers and Services



MEDICAID EXPANSION FOR SCHOOL HEALTH

A HEALTHY SCHOOLS CAMPAIGN INITIATIVE

Identify Eligible Providers and Services

Introduction

School districts typically employ a variety of health professionals who provide students with physical, behavioral, and mental health services. Though districts have the flexibility to hire whomever they choose, it is important for both administrators and providers to understand which providers can bill for which services, as well as which providers can authorize services for medical necessity.

Only certain providers are eligible to bill Medicaid, meaning schools can seek Medicaid reimbursement for specific services they provide to students enrolled in Medicaid. Under the new state plan amendment (SPA), several provider types and services are newly eligible. This section details the providers and services reimbursable by Medicaid and provides guidance on implementing processes to meet documentation and supervision requirements for eligible providers.

Implementation Strategies

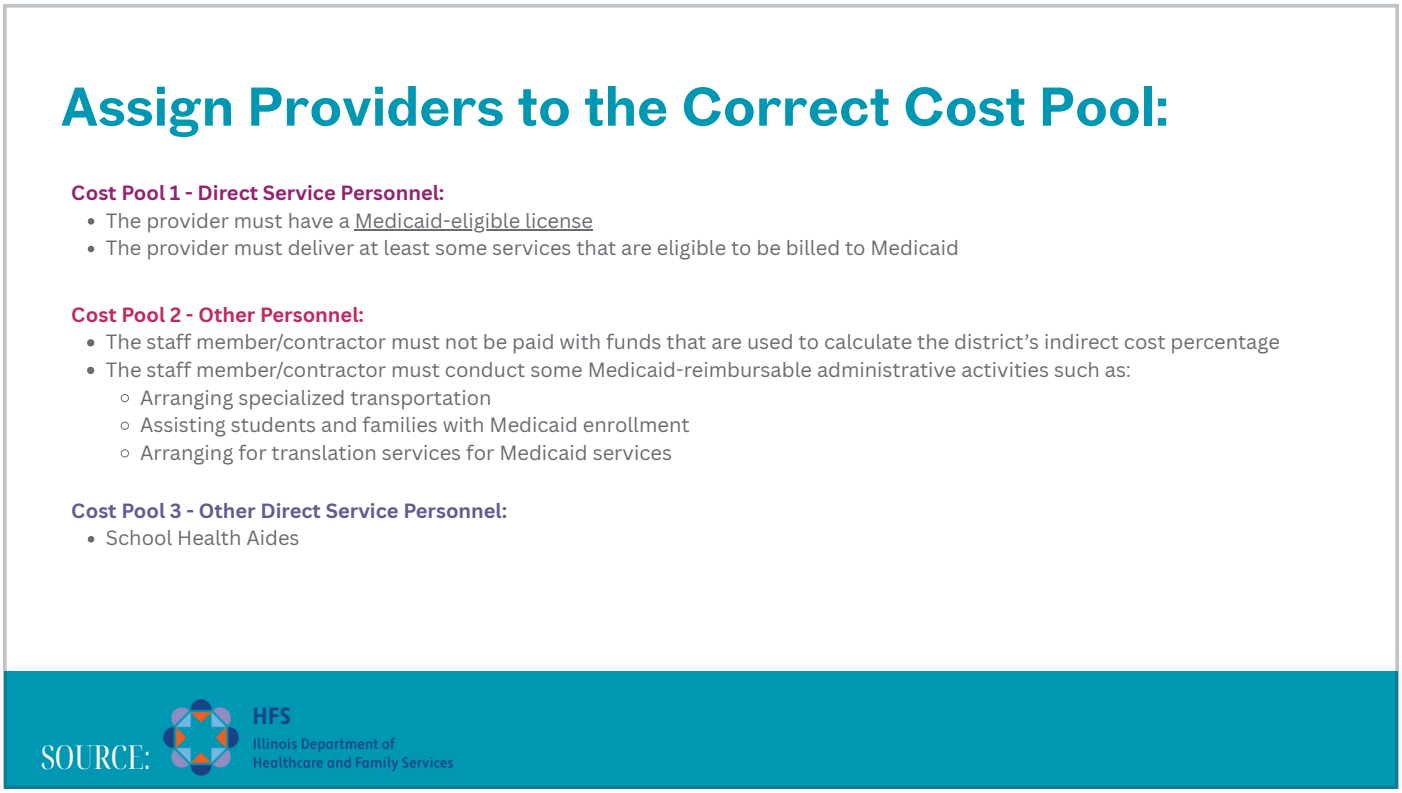
The Illinois Medicaid program requires eligible providers to have specific qualifications and determines which of the health services they provide can be reimbursed. Providers and other key staff involved with Medicaid (such as the person responsible for assigning providers to cost pools in the Public Consulting Group [PCG] system) must be clear on which providers and services are eligible for reimbursement.

Maintain Copies of Provider License and Verification Statement

Districts should have a procedure in place — and identify who is responsible — for maintaining a current copy of each provider's license as well as a completed Verification Statement confirming the provider has not been terminated, suspended or barred from the Medicaid program; see Appendix U-5 (pg. 15) in the Appendices of the Illinois Department of Healthcare and Family Services (HFS) Handbook for Local Education Agencies Chapter U-200.

At the start of employment, the human resources department can download licenses as part of the hiring process, or the district can require providers to submit a current license.

SOURCE: HEALTHY SCHOOL CAMPAIGN



Key points:

-Direct service providers should be included in Cost Pool 1

-ISBE-certified counselors and other licensed mental health professionals are eligible under the State Plan Amendment

-Educational vs. medical social worker classification depends on services provided, not licensure differences

-Providers may participate in both direct service reimbursement and Medicaid administrative claiming

Staff funded entirely by federal dollars (e.g., IDEA) may require different placement strategies to maximize reimbursement.

Free Care Rule Expansion

The 504 Plan, an individualized plan of care, or where medical necessity has been otherwise established.

Newly Eligible Providers:

- ISBE Certified Counselors
- Licensed Clinical Professional Counselor
- Licensed Marriage & Family Therapist
- Orientation & Mobility Specialist
- Licensed Clinical Psychologist
- Registered Behavior Technician

What can you do?

Put all direct service staff and Medicaid administrative staff in the staff pools
Any staff member that provides direct services to youth
with Medicaid should be in the direct service provider pool.

Any staff submitting for interim claims must be in the staff pool

SOURCE: HFS Illinois Department of Healthcare and Family Services

PCG Staff Pool List

Cost Pool 1

Direct Service Personnel:

- Audiologist
- ISBE Licensed Counselors
- Hearing & Vision Technicians
- Licensed Clinical Professional Counselors (LCPCs)
- Licensed Practical Nurses (LPN)
- Licensed Marriage & Family Therapists
- Medical Social Worker
- Occupational Therapist
- Occupational Therapy Assistant (COTA)
- Orientation & Mobility Specialist
- Physical Therapist
- Physical Therapist Assistant (CPTA)
- Registered Nurse (RN)
- School Psychologist
- Psychologist Interns
- Registered Behavior Technician (RBT) / Board Verified Behavior Analyst (BCBA)
- Speech Language Pathologist
- Speech Assistant / Speech Aide

Cost Pool 2

Administrative Services Service Providers Only:

- Educational Social Workers
- School Counselor
- Administrators
- Interpreters & School Bilingual Assistants
- Case Managers / Service Coordinators
- Clerical Support Staff
- Other Administrative Personnel

Cost Pool 3

Other Direct Service Personnel:

- School Health Aides

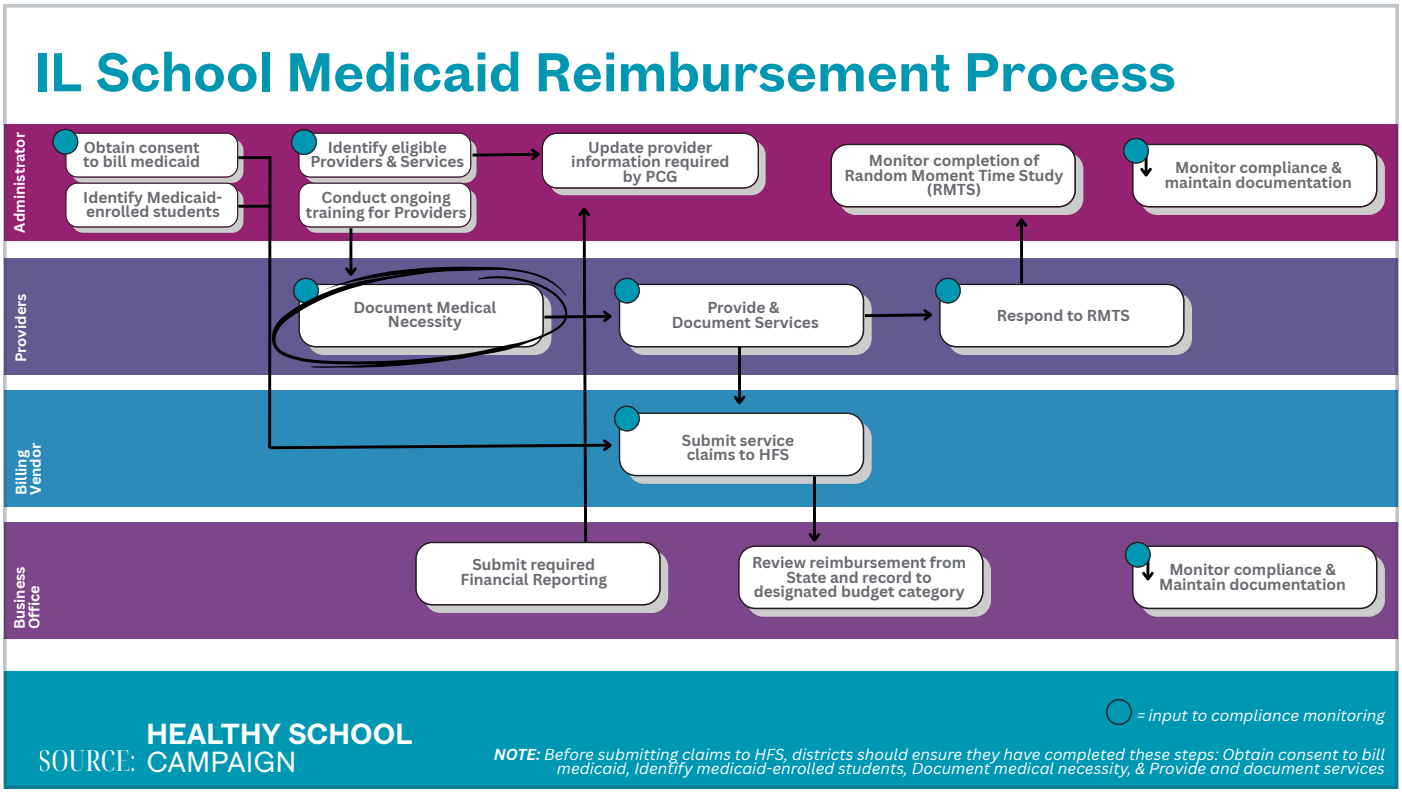
Excludes Staff Members who are 100% paid with Federal Funds from the PCG Staff Pool List.

SOURCE: School Medicaid Consulting LLC

What can you do?

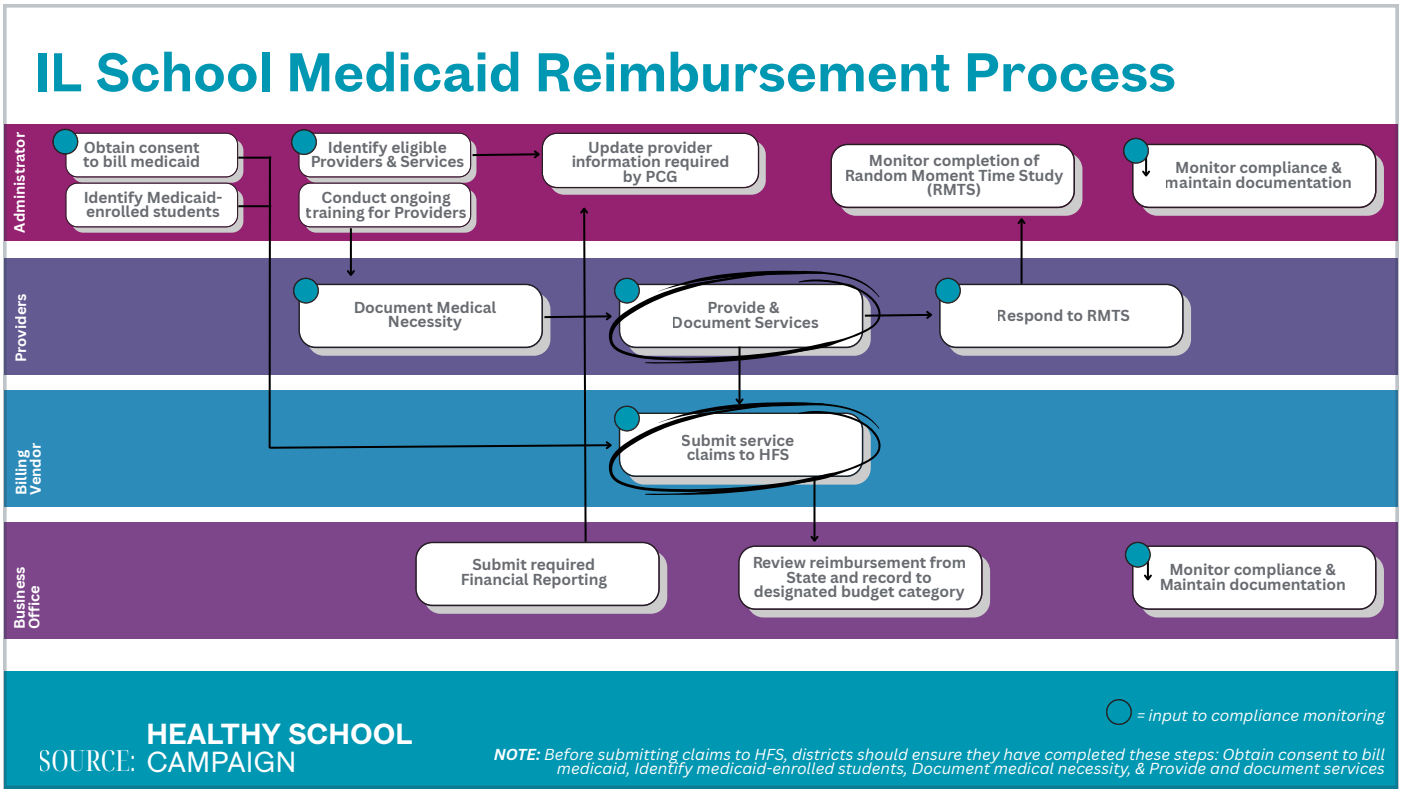
Utilize federal funding for non-direct service providers if possible
The cost of those funded by federal dollars will
be excluded from the reimbursable costs.

SOURCE: HFS Illinois Department of Healthcare and Family Services



Documenting Medical Necessity and Cost Reporting:

Medical necessity documentation must be maintained in student records but is not submitted with claims. Accurate and timely financial cost reports, however, are essential for reimbursement.

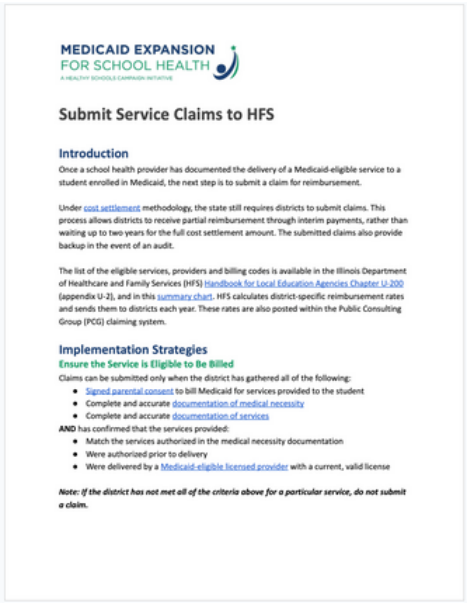


Cost reports determine:

-Interim payment rates
-Final cost settlement amounts (typically received 1.5–2 years later)

Including all eligible staff, salaries, benefits, and indirect costs ensures districts receive full reimbursement for allowable services.

Submit Service Claims to HFS



MEDICAID EXPANSION FOR SCHOOL HEALTH

A HEALTHY SCHOOLS CAMPAIGN INITIATIVE

Submit Service Claims to HFS

Introduction

Once a school health provider has documented the delivery of a Medicaid-eligible service to a student enrolled in Medicaid, the next step is to submit a claim for reimbursement.

Under cost settlement methodology, the state still requires districts to submit claims. This process allows districts to receive partial reimbursement through interim payments, rather than waiting up to two years for the full cost settlement amount. The submitted claims also provide backup in the event of an audit.

The list of the eligible services, providers and billing codes is available in the Illinois Department of Healthcare and Family Services (HFS) Handbook for Local Education Agencies Chapter U-200 (appendix U-2), and in this summary chart. HFS calculates district-specific reimbursement rates and sends them to districts each year. These rates are also posted within the Public Consulting Group (PCG) claiming system.

Implementation Strategies

Ensure the Service is Eligible to Be Billed

Claims can be submitted only when the district has gathered all of the following:

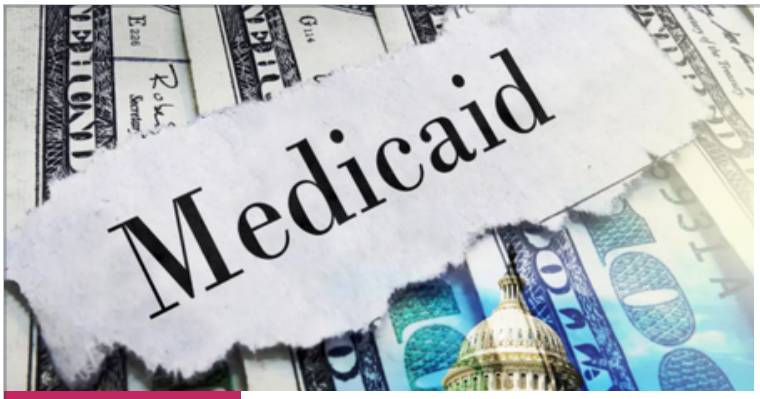
- Signed parental consent to bill Medicaid for services provided to the student
- Complete and accurate documentation of medical necessity
- Complete and accurate documentation of services

AND has confirmed that the services provided:

- Match the services authorized in the medical necessity documentation
- Were authorized prior to delivery
- Were delivered by a Medicaid-eligible licensed provider with a current, valid license

Note: if the district has not met all of the criteria above for a particular service, do not submit a claim.

SOURCE: HEALTHY SCHOOL CAMPAIGN



Medicaid Fee-for-Service

Fee-for-Service: Qualified Providers

Direct Service Personnel:

- Audiologist
- ISBE Licensed Counselors
- Hearing & Vision Technicians
- Licensed Clinical Professional Counselors (LCPCs)
- Licensed Practical Nurses (LPN)
- Licensed Marriage & Family Therapists
- Medical Social Worker
- Occupational Therapist
- Occupational Therapy Assistant (COTA)
- Orientation & Mobility Specialist
- Physical Therapist
- Physical Therapist Assistant (CPTA)
- Registered Nurse (RN)
- School Psychologist
- Psychologist Interns
- Registered Behavior Technician (RBT) / Board Verified Behavior Analyst (BCBA)
- Speech Language Pathologist
- Speech Assistant / Speech Aide

Cost Pool 1

Other Direct Service Personnel:

- School Health Aides

Cost Pool 3

Fee-for-Service payments are received throughout the school year.

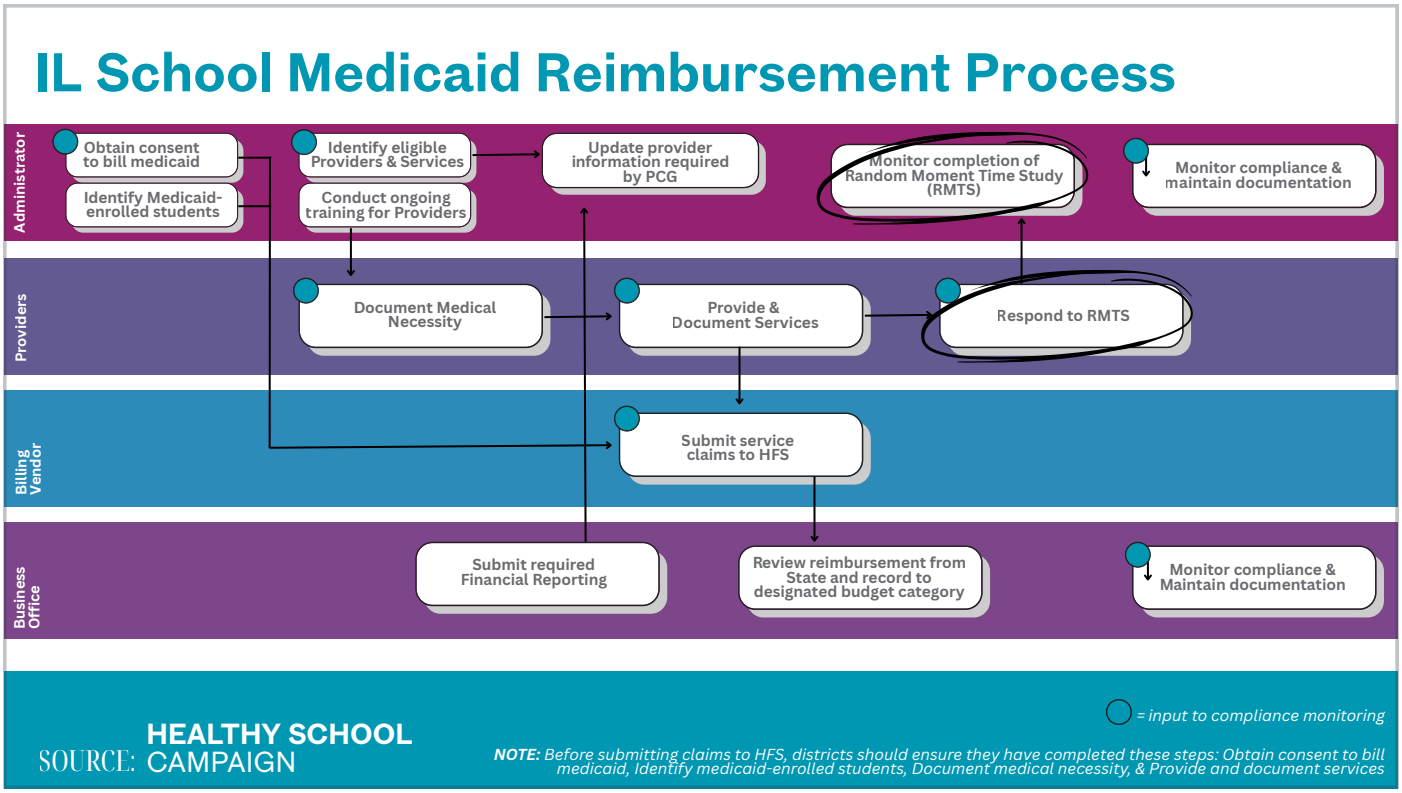
Rates are still based on 2020 rates. These will be low if there is not a long history of provision of services for interim payments but the cost settlement will flush this out.

Student has a Plan that outlines services.
IEP
504
Health Care Plan

Provide direct therapy services to students - Therapy MUST match Plan minutes.

Document services within 6 months from date of session in the Medicaid Vendor program.

SOURCE: School Medicaid Consulting LLC



Random Moment Time Study (RMTS):

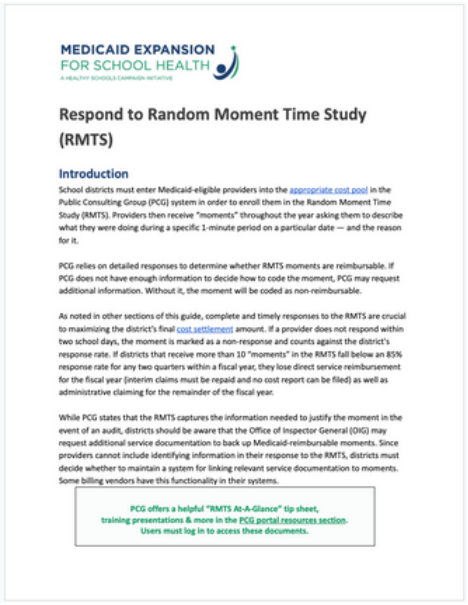
Participation in the RMTS is essential for Medicaid administrative claiming. All staff in cost pools may receive RMTS moments and must respond accurately and on time.

Districts can maximize reimbursement by:

-Training staff on reimbursable activities
-Aligning meetings and planning with Medicaid-allowable activities
-Encouraging “top-of-license” work for licensed providers

Failure to meet RMTS participation thresholds can result in lost reimbursement.

Respond to RMTS



MEDICAID EXPANSION FOR SCHOOL HEALTH

A HEALTHY SCHOOLS CAMPAIGN INITIATIVE

Respond to Random Moment Time Study (RMTS)

Introduction

School districts must enter Medicaid-eligible providers into the appropriate cost pool in the Public Consulting Group (PCG) system in order to enroll them in the Random Moment Time Study (RMTS). Providers then receive "moments" throughout the year asking them to describe what they were doing during a specific 1-minute period on a particular date — and the reason for it.

PCG relies on detailed responses to determine whether RMTS moments are reimbursable. If PCG does not have enough information to decide how to code the moment, PCG may request additional information. Without it, the moment will be coded as non-reimbursable.

As noted in other sections of this guide, complete and timely responses to the RMTS are crucial to maximizing the district's final cost settlement amount. If a provider does not respond within two school days, the moment is marked as a non-response and counts against the district's response rate. If districts that receive more than 10 "moments" in the RMTS fall below an 85% response rate for any two quarters within a fiscal year, they lose direct service reimbursement for the fiscal year (interim claims must be repaid and no cost report can be filed) as well as administrative claiming for the remainder of the fiscal year.

While PCG states that the RMTS captures the information needed to justify the moment in the event of an audit, districts should be aware that the Office of Inspector General (OIG) may request additional service documentation to back up Medicaid-reimbursable moments. Since providers cannot include identifying information in their response to the RMTS, districts must decide whether to maintain a system for linking relevant service documentation to moments. Some billing vendors have this functionality in their systems.

PCG offers a helpful "RMTS At-A-Glance" tip sheet, training presentations & more in the PCG portal resources section. Users must log in to access these documents.

SOURCE: HEALTHY SCHOOL CAMPAIGN

Time Study Code Indicators:

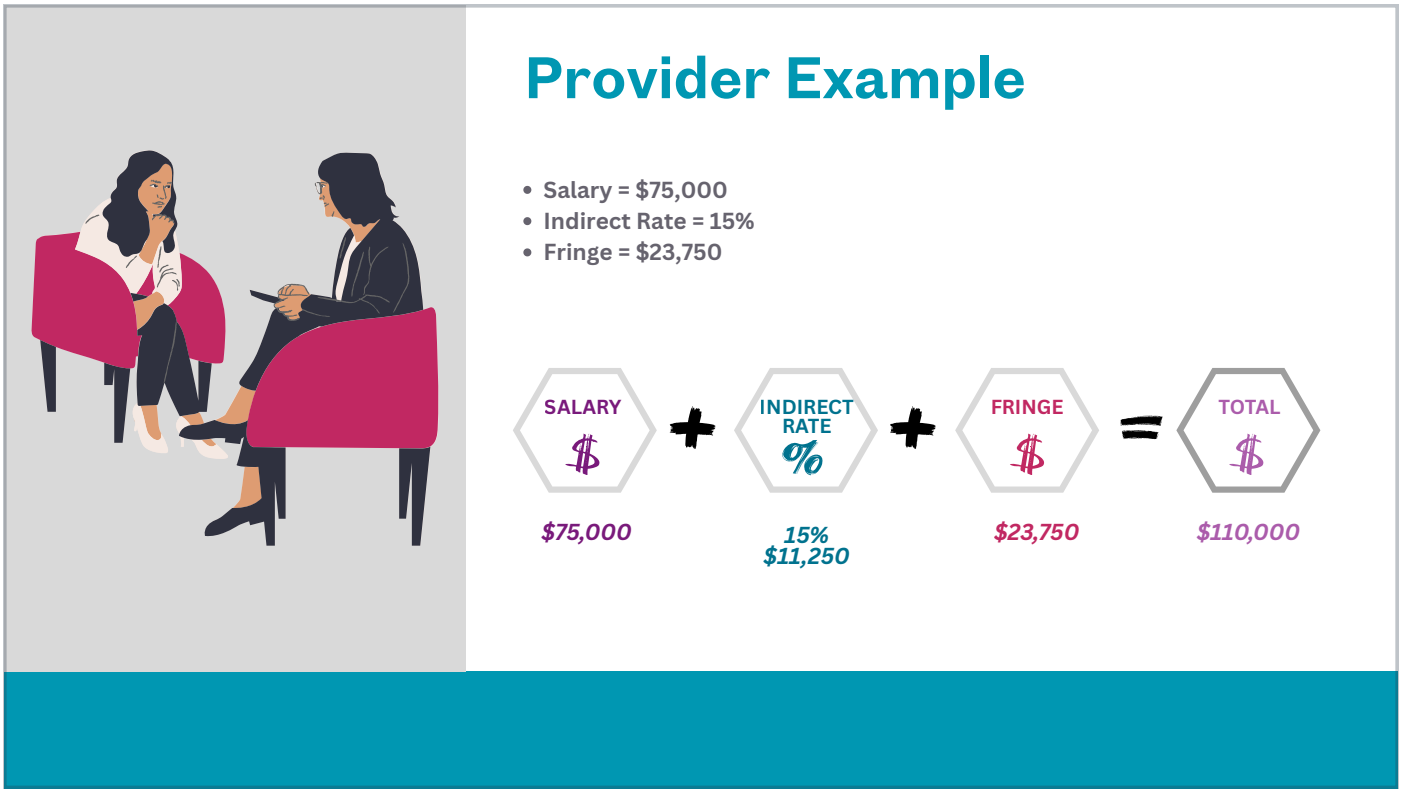
CODE	DESCRIPTION
U	Unallowable - refers to an activity that is unallowable under the SBHS Program. This is regardless of whether or not the population served includes Medicaid enrolled individuals.
TM	Total Medicaid - refers to an activity that is 100% allowable under the SBHS Program
PM	Proportional Medicaid - refers to an activity, which is allowable as Medicaid administration under the SBHS Program, but for which the allowable share of
R	Reallocated - refers to those general administrative activities which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under General Administration.

SOURCE: HFS Illinois Department of Healthcare and Family Services

Time Study Codes for RMTS:

CODE	CODE TEXT	ACTIVITY	DIRECT SERVICE	MAC INDICATOR
	Prov Svcs	Provision of Services		
1A	Outrea	Non-	U	U
1B	Outrea	Medicai	U	TM/50%
2A	Enrollm	Facilitati	U	U
2B	Enrollm	Facilitati	U	TM/50%
3	Educat	School	U	U
4A	DirNon	Direct	U	U
4B	DirMed	Direct Medical Services - Covered as IDEA?IEP Services, Not Covered on a Medical Plan of Care	PM	U
4C	DirMed	Direct	PM (MED)	U
5A	Transp	Transpo	U	U
5B	Transp	Medicaid	U	PM/50%
6A	Transla	Non-	U	U
6B	Transla	Medicaid	U	PM/75%
7A	Planning		U	U
7B	Plannir	Medical	U	PM/50%
8A	Trainin	Non-	U	U
8B	Trainin	Medical/	U	PM/50%
9A	Referra	Referral,	U	U
9B	Referra	Referral,	U	PM/50%
10	GA	General	R	R
11	Unalloy	Not	U	U

SOURCE: HFS Illinois Department of Healthcare and Family Services



Provider Examples and Reimbursement Comparisons:

Using a sample provider with an annual cost of $110,000, this section illustrates how reimbursement is generated through:

-Medicaid administrative claiming
-Outreach activities
-IEP-based direct services
-Free care (general education Medicaid-enrolled students)

IEP services typically generate higher reimbursement due to higher Medicaid enrollment ratios and direct medical percentages. Free care reimbursement is lower but still contributes meaningful revenue when scaled across multiple providers.

Training and “Top-of-License” Work:

Districts can increase Medicaid reimbursement by investing in training and adjusting staff scope of work toward Medicaid-reimbursable activities. Training focused on Medicaid and allowable services qualifies as a Medicaid administrative claiming activity.

A key strategy is ensuring providers work at the top of their license. Licensed social workers, psychologists, and counselors should focus on activities that require their specialized clinical expertise rather than tasks that could be completed by administrative or support staff. This approach increases the proportion of Medicaid-reimbursable activities and improves overall reimbursement.

Maximizing Medicaid Administrative Claiming (MAC):

Districts should examine how meetings, trainings, planning processes, leadership sessions, and team meetings are structured. When these activities focus on Medicaid-approved services, providers, and populations, they qualify for Medicaid administrative claiming.

Because many Medicaid-enrolled students are higher risk, districts often focus meetings and trainings on this population. While the strategies discussed typically benefit all students, framing and documenting these activities as serving the Medicaid population ensures they are properly captured during Random Moment Time Studies (RMTS).

Educating staff in cost pools to recognize and accurately report these activities is critical. When RMTS moments occur during meetings or trainings, staff should understand how to identify those activities as Medicaid-reimbursable when appropriate.

Translating Job Activities into Medicaid Language:

Another important strategy is translating existing job duties into Medicaid-reimbursable language. While the work itself may not change, staff must understand how their activities align with Medicaid activity codes.

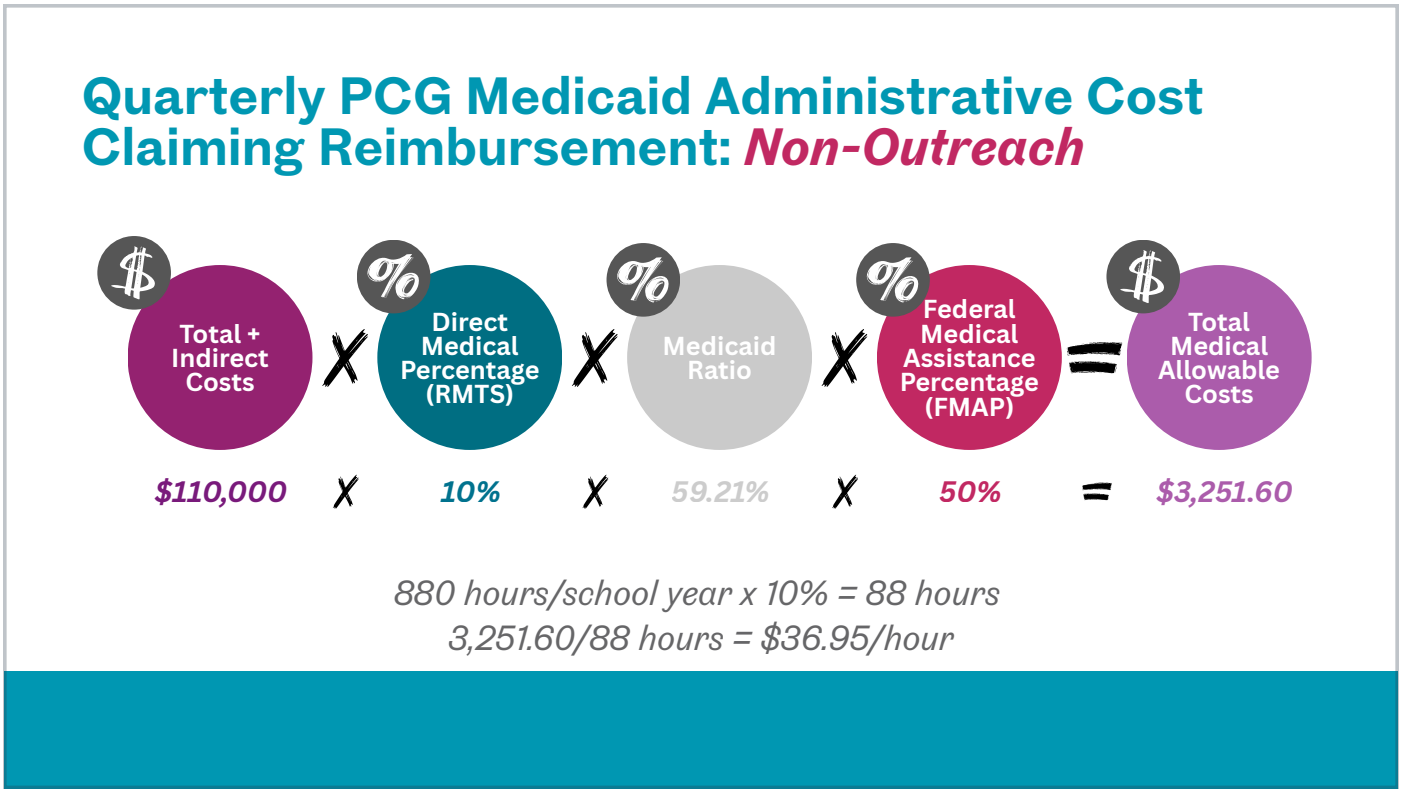
This alignment supports:

Accurate RMTS responses

Fee-for-service and interim billing

Consistent documentation of Medicaid-reimbursable services

Using the correct terminology ensures that staff accurately report allowable activities and that districts capture the maximum reimbursement available.



Medicaid Administrative Claiming Rate Example (non-outreach):

Using the $110,000 provider example, consider quarterly PCG Medicaid administrative claiming for non-outreach activities.

Assuming:

-880 work hours per school year
-10% of time spent on Medicaid administrative activities (88 hours)

This equates to an estimated reimbursement of approximately $36.95 per hour. While this is not a fee-for-service model and should not be interpreted as an actual hourly billing rate, it provides a useful comparison point.

Examples of Allowable Medicaid and CHIP Administrative Activities

Medicaid & CHIP Outreach:

- Informing Medicaid- and CHIP-eligible and potentially Medicaid- or CHIP- eligible students and families about the benefits and availability of services covered by Medicaid and CHIP, including services that may be covered under the EPSDT benefit.
- Developing and/or compiling materials to inform individuals about the Medicaid and CHIP programs, including EPSDT, and how and where to apply for and obtain those benefits. As appropriate, outreach materials should have prior approval of the State Medicaid/CHIP agency.
- Distributing literature about the benefits, eligibility requirements, and availability of the Medicaid and CHIP programs, including EPSDT.

SOURCE: Medicaid.gov Keeping America Healthy

Outreach Activities and Higher Reimbursement:

Medicaid outreach activities generate the highest reimbursement rate because they are not reduced by Medicaid enrollment ratios.

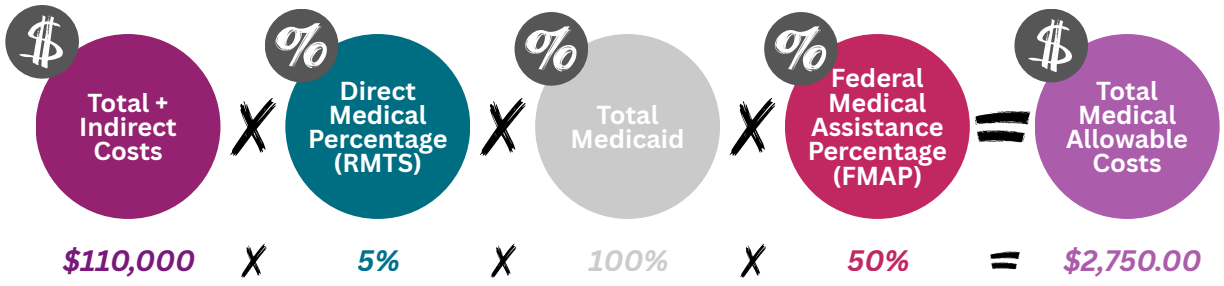
Examples of Allowable Medicaid and CHIP Administrative Activities

Facilitating Medicaid and CHIP Eligibility Determinations:

- Verifying an individual's current Medicaid or CHIP eligibility status for purposes of the Medicaid and CHIP eligibility process.
- Explaining Medicaid and CHIP eligibility rules and the Medicaid and CHIP eligibility processes to prospective applicants.
- Assisting individuals or families with completing a Medicaid and CHIP eligibility application.
- Gathering information related to the application and eligibility determination for an individual, including resource information and TPL information, as preparation for submitting a formal Medicaid and CHIP application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid or CHIP eligibility determination.
- Referring an individual or family to the local assistance office or online to complete an application for Medicaid or CHIP benefits (Note: assisting with applying for Marketplace or other commercial coverage is not an allowable expense).
- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid and CHIP application.

SOURCE: Medicaid.gov Keeping America Healthy

Quarterly PCG Medicaid Administrative Cost Claiming Reimbursement: *Medicaid Outreach*



880 hours/school year x 5% = 44 hours
$2,750/44 hours = $62.50/hour

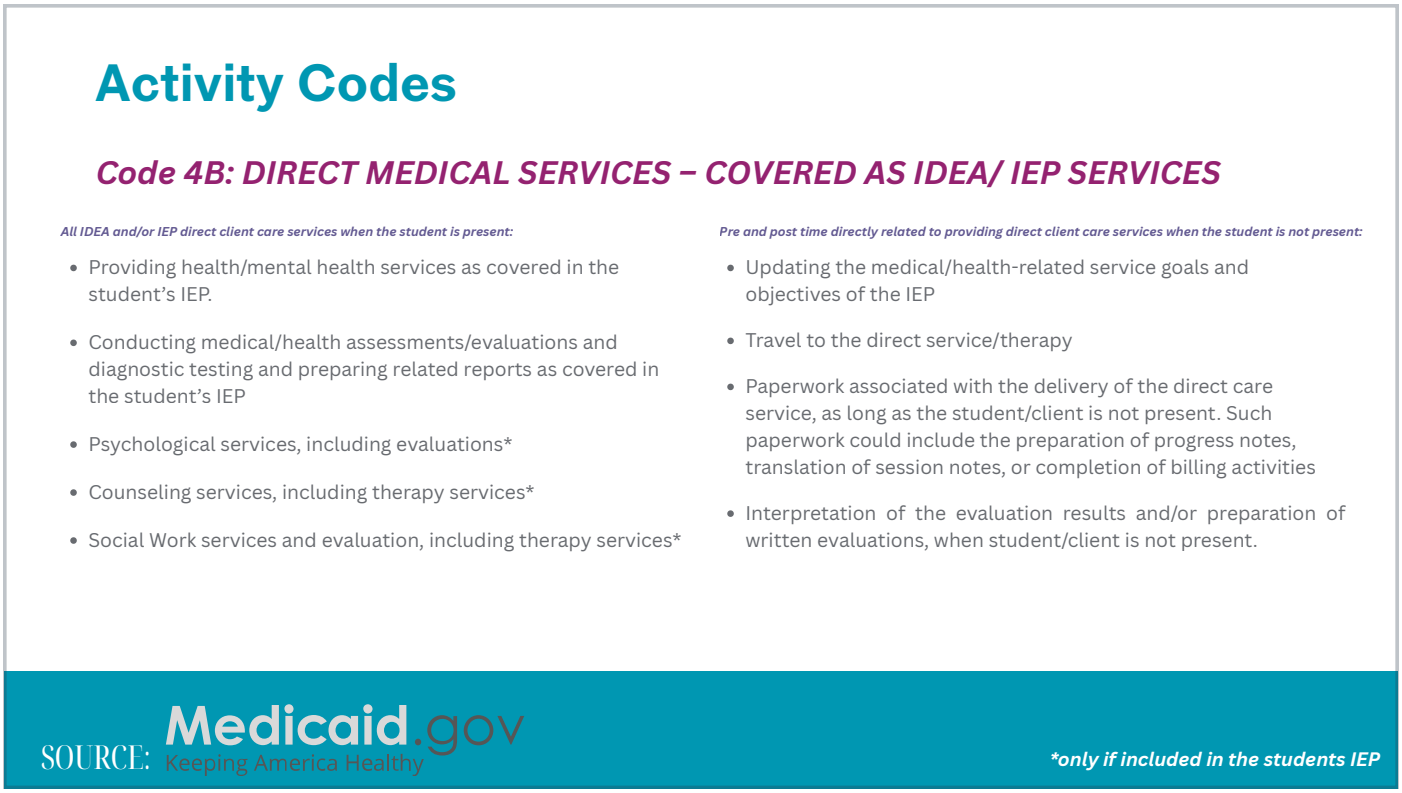
If a provider spends approximately 5% of their time on outreach activities—such as helping families understand eligibility or complete enrollment—this translates to approximately $62.50 per hour in reimbursement. This reflects the 100% Medicaid rate.

Outreach percentages may vary by district. While an individual provider does not receive this rate independently, the district's aggregate direct medical percentage determines reimbursement, reinforcing the importance of district-wide participation.

Time Study Codes for RMTS:

CODE	CODE TEXT	ACTIVITY	DIRECT SERVICE	MAC INDICATOR
	Prov Svcs	Provision of Services		
1A	Outrea	Non-	U	U
1B	Outrea	Medicai	U	TM/50%
2A	Enrollm	Facilitati	U	U
2B	Enrollm	Facilitati	U	TM/50%
3	Educat	School	U	U
4A	DirNon	Direct	U	U
4B	DirMed	Direct Medical Services - Covered as IDEA?IEP Services, Not Covered on a Medical Plan of Care	PM	U
4C	DirMed	Direct	PM	U
5A	Transp	Transpo	U	U
5B	Transp	Medicaid	U	PM/50%
6A	Transla	Non-	U	U
6B	Transla	Medicaid	U	PM/75%
7A	Planning		U	U
7B	Plannir	Medical	U	PM/50%
8A	Trainin	Non-	U	U
8B	Trainin	Medical/	U	PM/50%
9A	Referra	Referral,	U	U
9B	Referra	Referral,	U	PM/50%
10	GA	General	R	R
11	Unalloy	Not	U	U

SOURCE: HFS Illinois Department of Healthcare and Family Services



Direct Services and Plan of Care Requirements

Direct service providers continue to use proportional Medicaid codes. Services must align with:

-An IEP
-A plan of care
-A medical 504 plan or similar medical plan

Providers may deliver services to:

-Students with IEPs (IEP cost settlement)
-Students without IEPs through free care

These service types differ significantly in reimbursement.

Activity Codes

Code 4C: Direct Medical Services – Covered on a Medical Plan of Care, Not Covered as IDEA/ IEP service

All medical services with the student present including:

- Providing health/mental health services as covered in the student's medical plan other than an IEP/IFSP
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student's medical plan other than an IEP/IFSP or as part of the development of an IEP/IFSP
- Covered services for which medical necessity has bee determined.

The services outlined in the Medicaid State Plan:

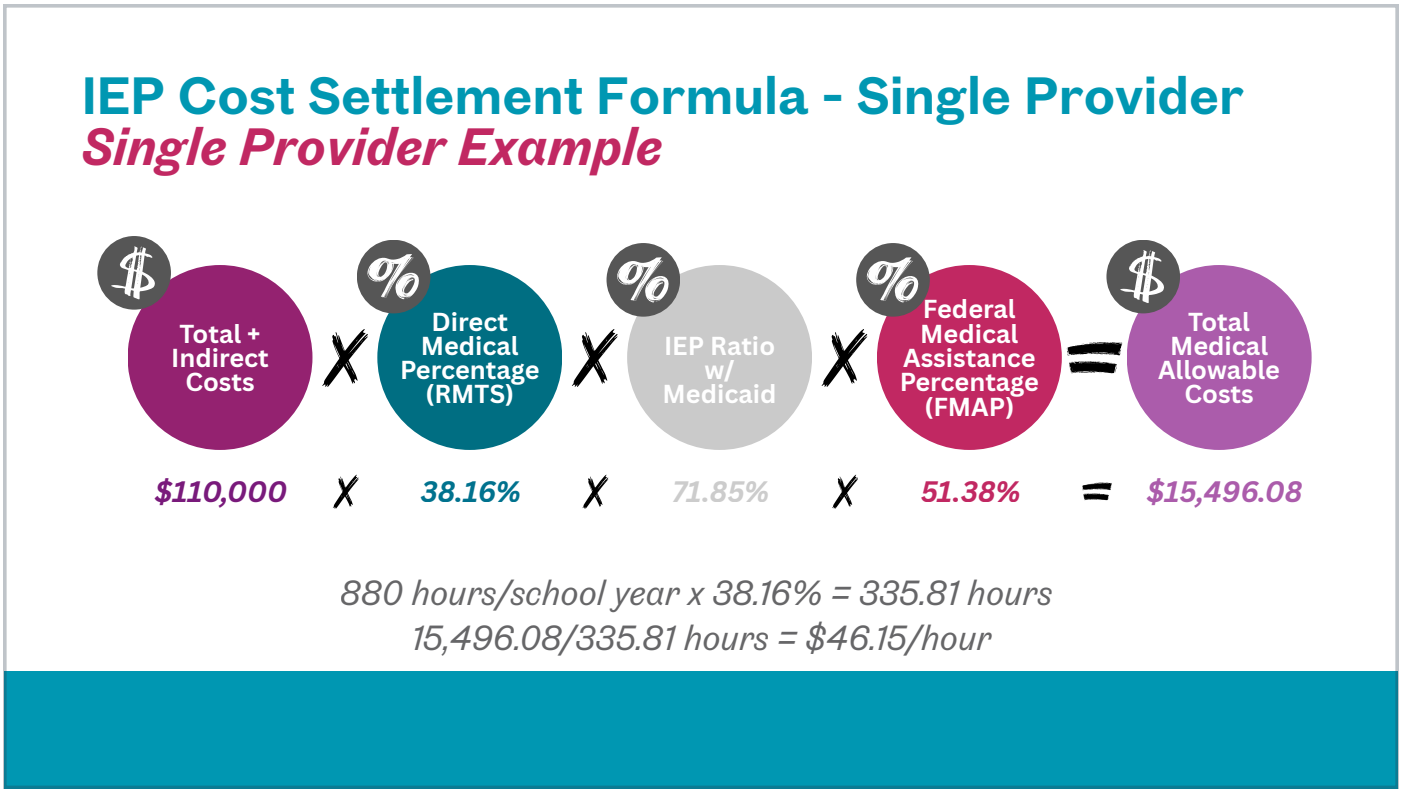
- Social Work services and evaluation, including therapy services*
- Psychological services, including evaluations*
- Counseling services, including therapy services*

Pre and post time directly related to providing direct client care services when the student is not present:

- Updating the medical/health-related service goals and objectives of the medical plan of care
- Travel to the direct service/therapy
- Paperwork associated with the delivery of the direct care service, as long as the student/client is not present.
- Interpretation of the evaluation results and/or preparation of written evaluations, when student/client is not present.

SOURCE: Medicaid.gov Keeping America Healthy

***only if included in the students medical plan**
****only if medical necessity has been determined**



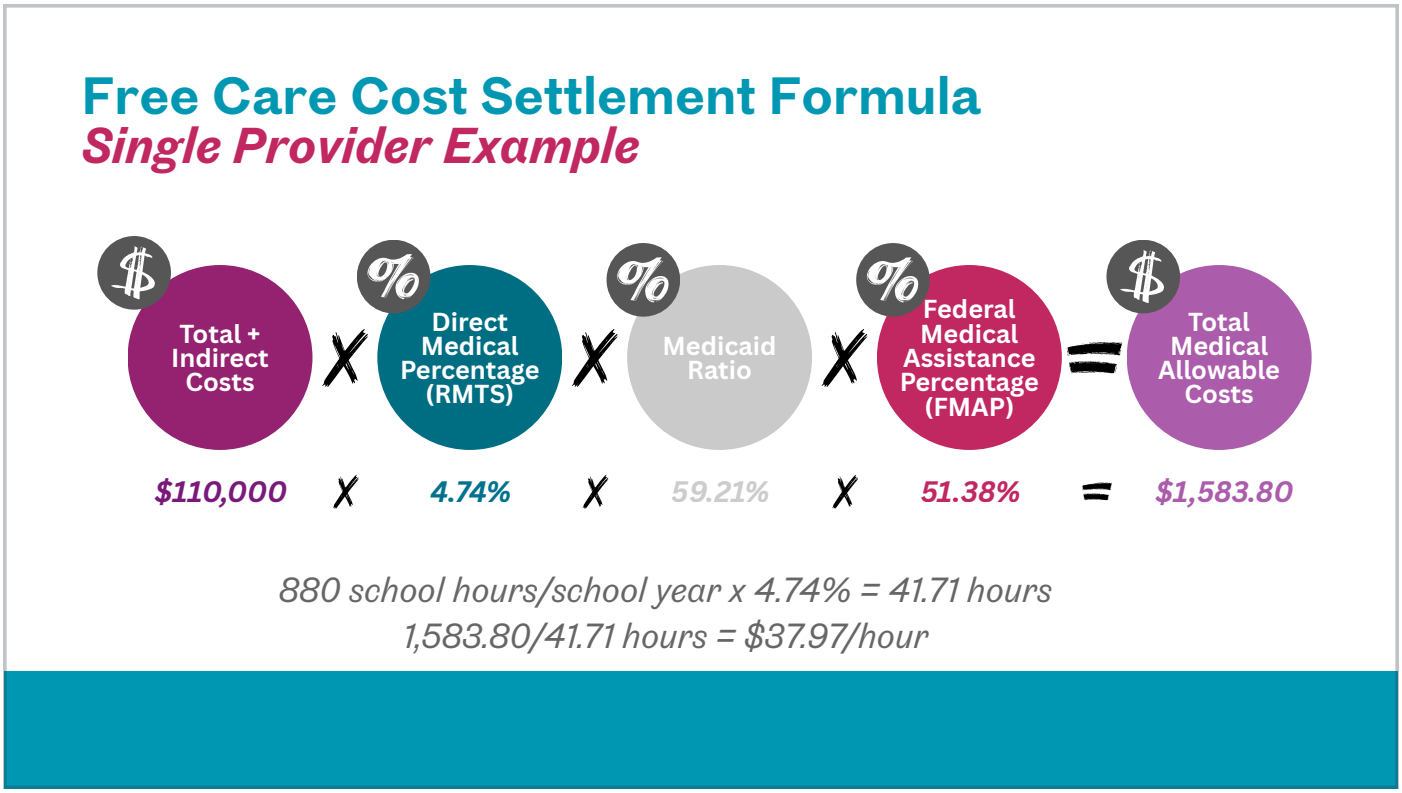
IEP Cost Settlement Example:

For IEP services, the direct medical percentage is a statewide average, not a district- or provider-specific figure. In this example:

-Statewide direct medical percentage: 38.16%
-Medicaid enrollment ratio for students with IEPs: typically much higher than the general population
-FMAP is applied to determine final reimbursement

Using these figures, a $110,000 provider generates approximately $15,496 in IEP-related Medicaid reimbursement. When multiplied across 10 providers, the reimbursement increases substantially.

For reference, this equates to an estimated $46.15 per hour, based on 880 hours per year. Again, this is illustrative rather than a true billing rate.



Free Care Cost Settlement Example:

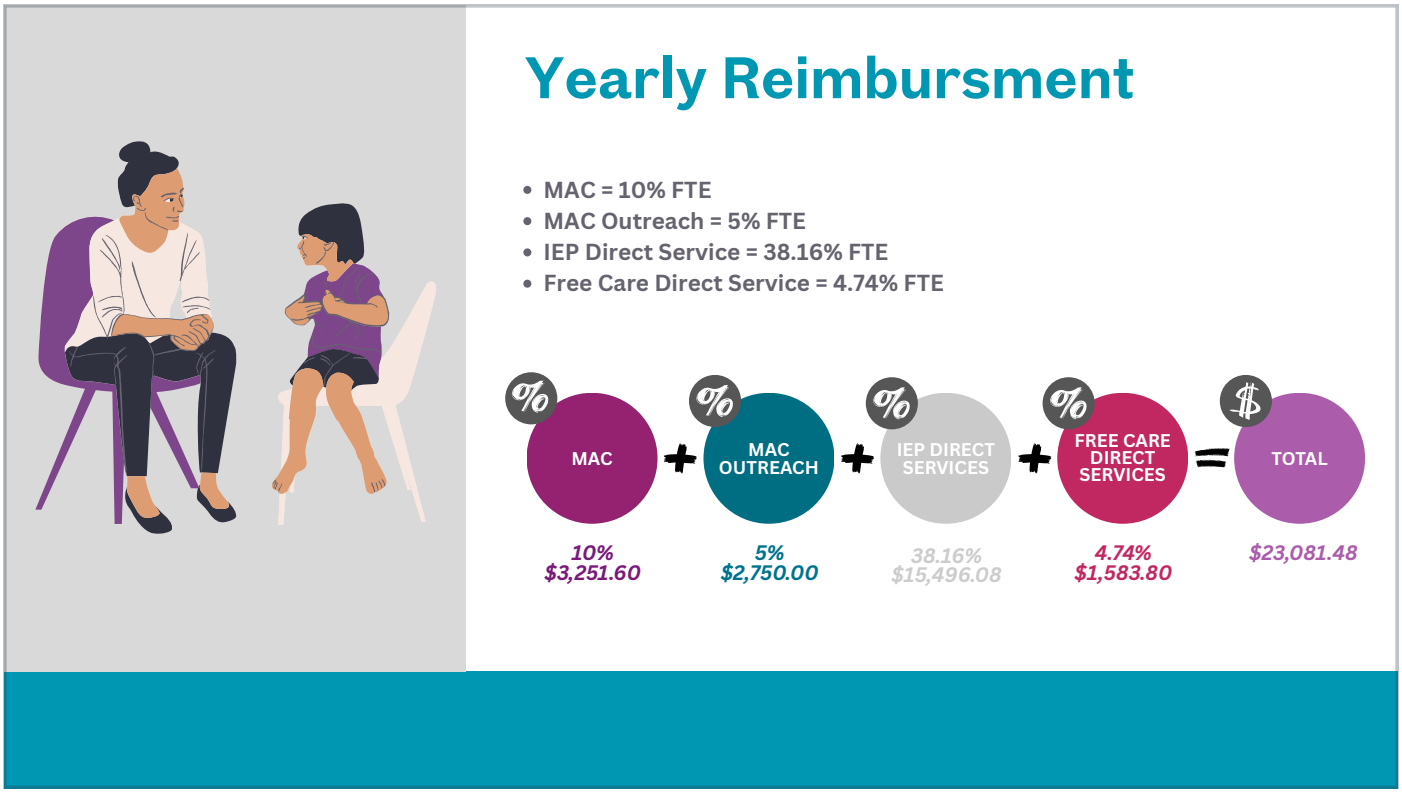
Free care reimbursement is more limited due to a significantly lower direct medical percentage.

In this example:

-Statewide direct medical percentage: 4.74%
-Medicaid enrollment ratio: lower than the IEP ratio
-FMAP remains the same

This results in approximately $1,583 in reimbursement per provider annually. Across 10 providers, free care generates approximately $15,000 in reimbursement.

This equates to an estimated $37.97 per hour, though reimbursement is constrained by the statewide direct medical percentage and is not unlimited.



Yearly Reimbursement Overview:

Let's look at an example of a provider with an annual cost of $110,000 and how Medicaid reimbursement comes together across different claiming mechanisms.

-Medicaid Administrative Claiming (MAC):
Approximately 10% of the provider's time, generating $3,251.

-MAC Outreach:
About 5% of time, generating $2,750. Expanding outreach across staff pools can significantly increase reimbursement due to its relatively high return.

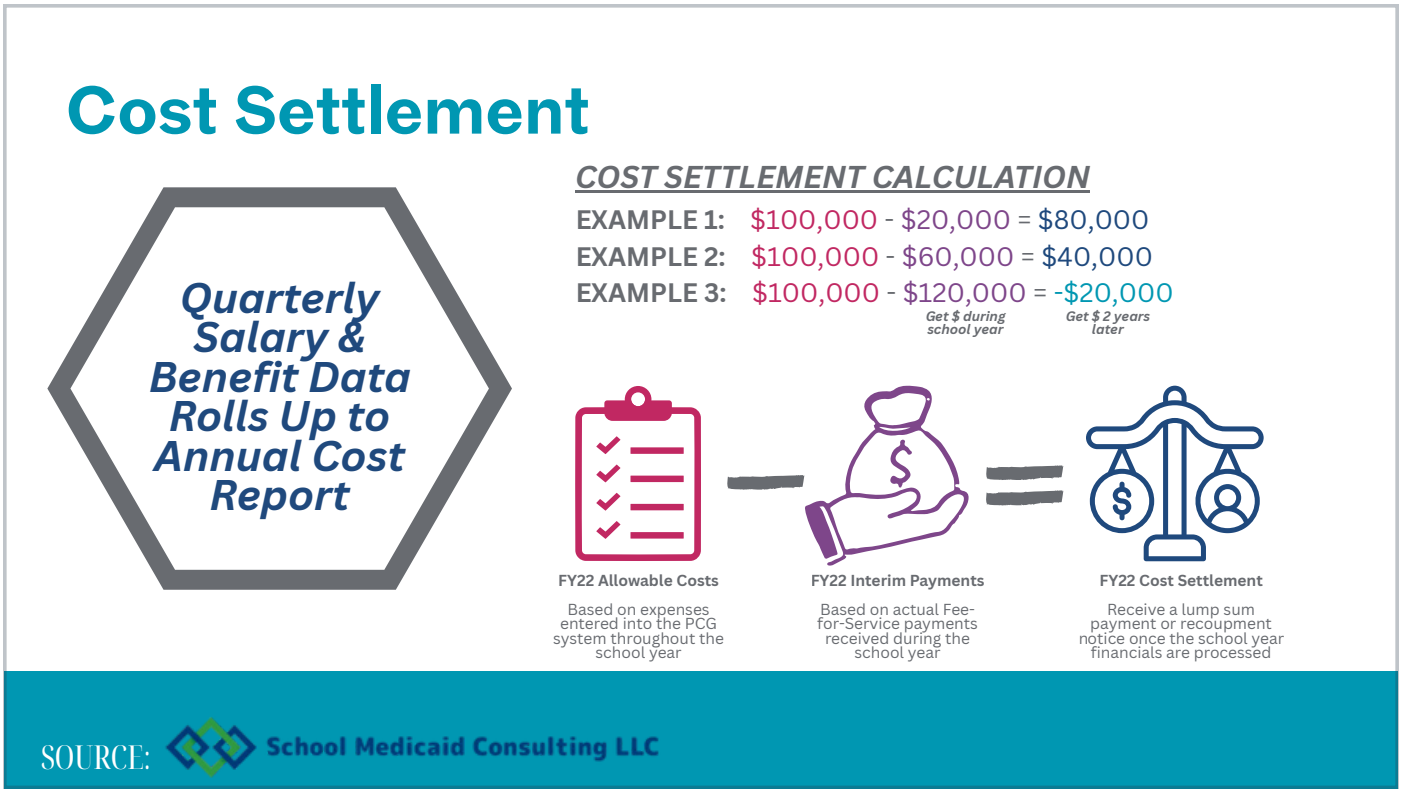
-IEP Direct Services:
Approximately 38% of time, generating $15,496.

-Free Care (General Education Students with a Plan of Care on Medicaid):
Generates approximately $1,583.

In total, a provider costing $110,000 can generate approximately $23,081 in Medicaid reimbursem ent.

Some of this reimbursement comes through interim or quarterly administrative claims processed by PCG and the Comptroller's Office. Additional funds may come through interim fee-for-service

claims submitted by vendors. A significant portion of reimbursement is ultimately received one and a half to two years later through the cost settlement process, when final reconciliation occurs.



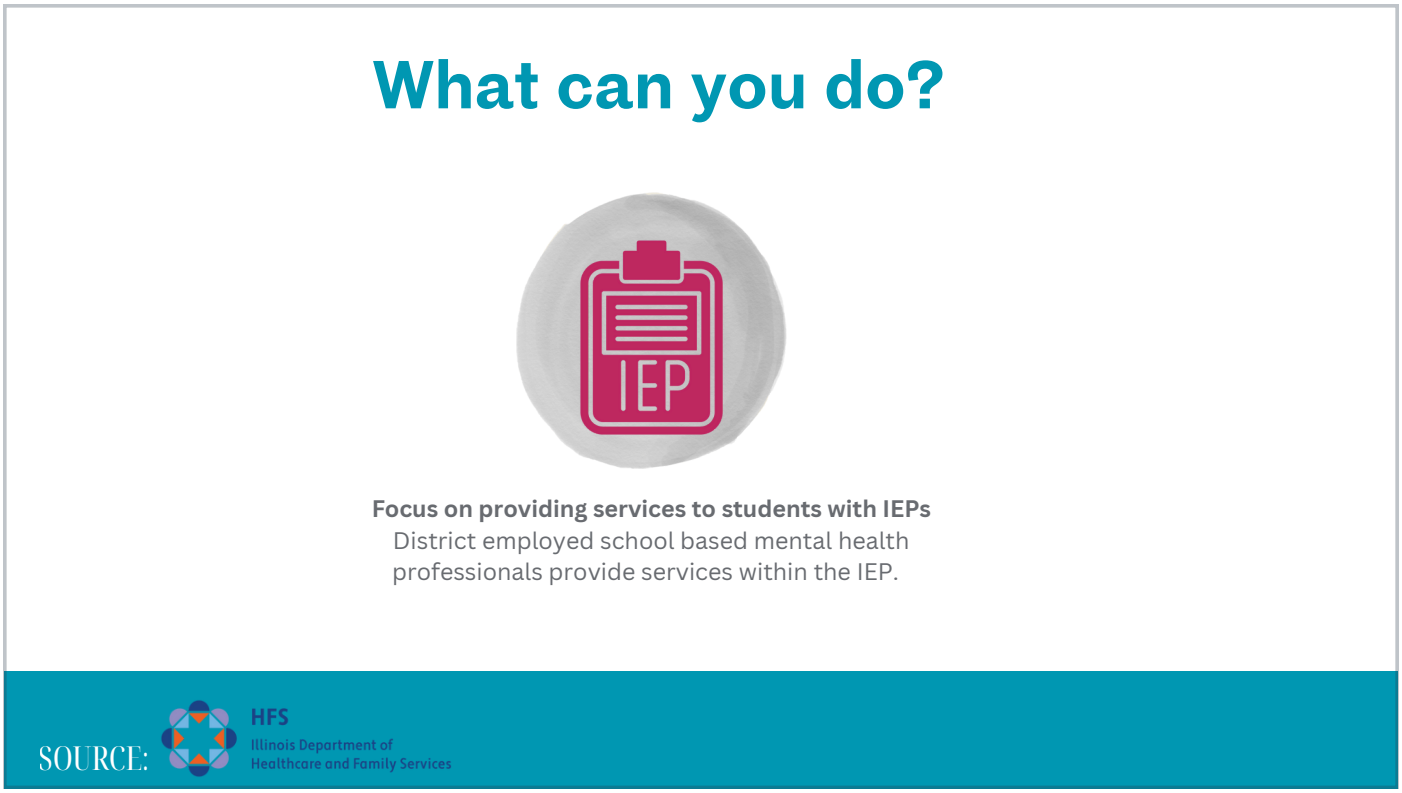
Cost Settlement Model Reminder:

Under the cost settlement model:

-Total allowable costs are calculated
-Interim payments are subtracted
-Remaining funds are paid during settlement

Even if fee-for-service claims are missed, districts may still receive reimbursement through cost settlement. However, missing RMTS participation or cost reports can jeopardize reimbursement entirely.

Participation in the Random Moment Time Study (RMTS) is critical. If the district fails to meet the 85% participation threshold, cost settlement will not occur for administrative claiming. While missed fee-for-service claims may reconcile later, lack of interim payments can create cash flow challenges, even when reimbursement is expected in the future.



Increasing Reimbursement Through IEP Services:

One effective strategy to increase Medicaid reimbursement is focusing on services provided to students with IEPs.

District-employed school-based mental health professionals may provide services under IEPs, which typically yield higher Medicaid reimbursement than free care or administrative claiming.

This is because:
-The Medicaid enrollment rate among students with IEPs is higher than in the general student population.
-Proportional Medicaid calculations for IEP services consistently result in higher reimbursement percentages.

Free care and administrative claiming rely on overall student Medicaid enrollment, which is typically lower.

Direct Services

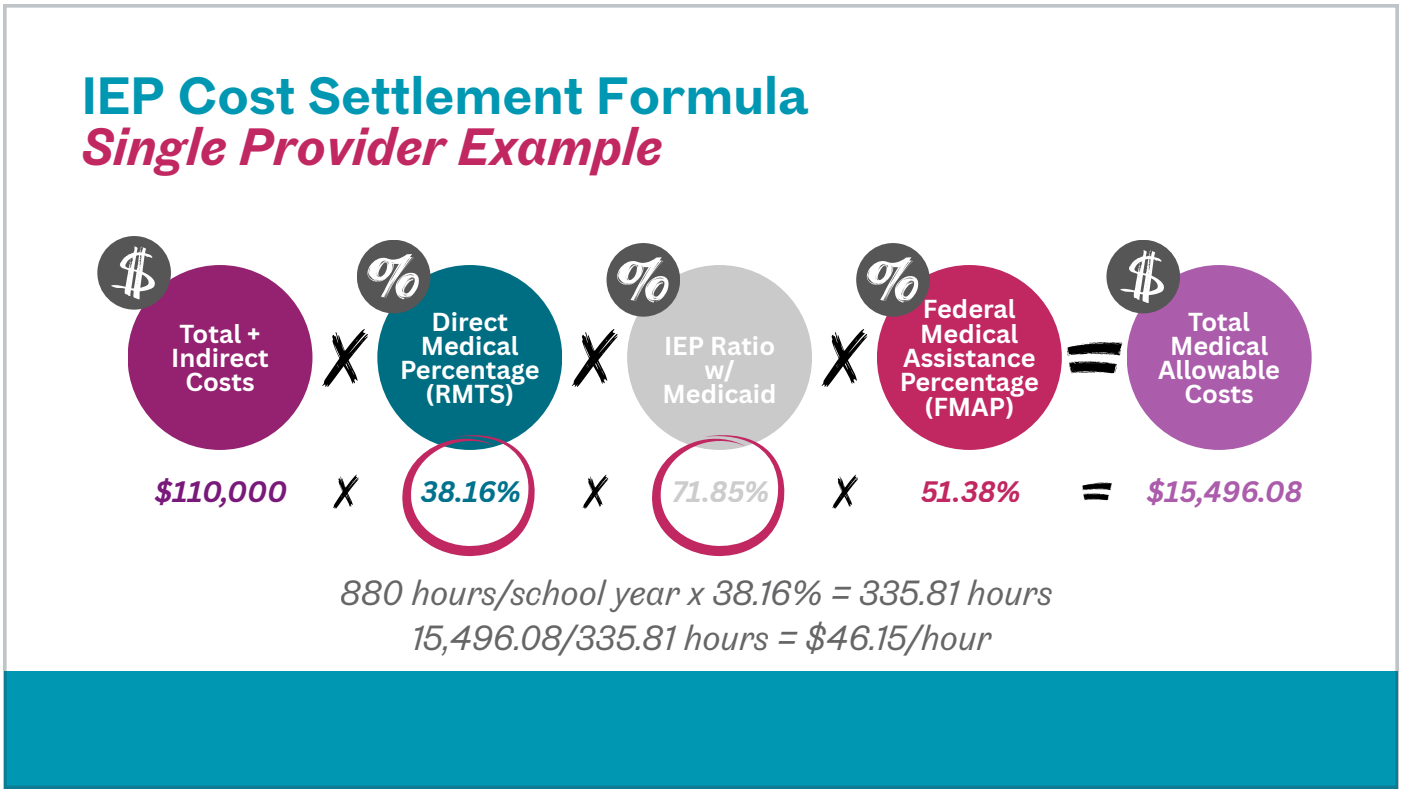
IEP Enrollment Rate (IEP)

$$\textit{Proportional Medicaid} = \frac{\textit{\# Medicaid Enrolled Special Education Students}}{\textit{\# Total Special Education Students}}$$

Free Care & Medicaid Administrative Claiming

Medicaid Enrollment Rate (MER)

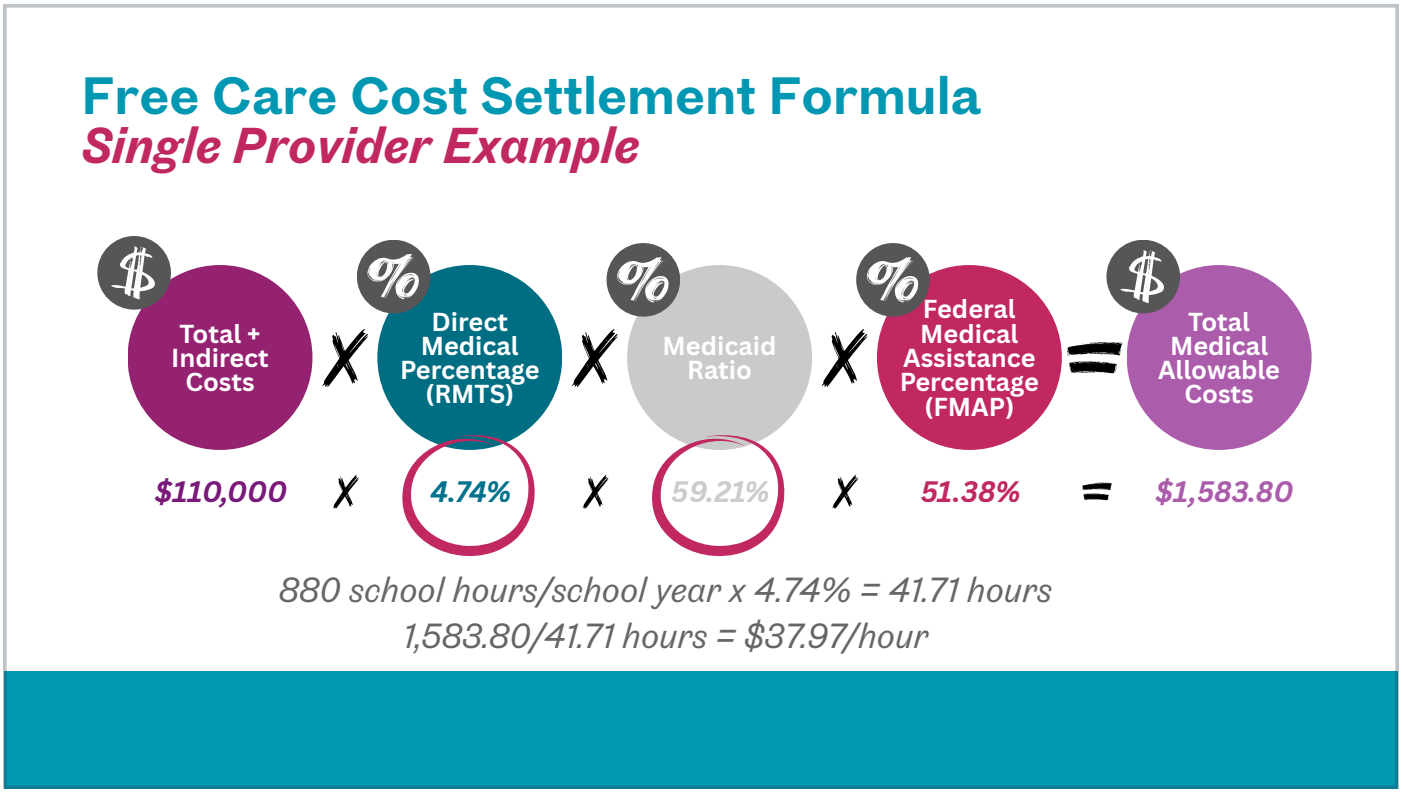
Proportional Medicaid = ***# Medicaid Enrolled Students*** / ***# Total Students***



Provider Reimbursement Comparison

Using an example IEP cost settlement formula:

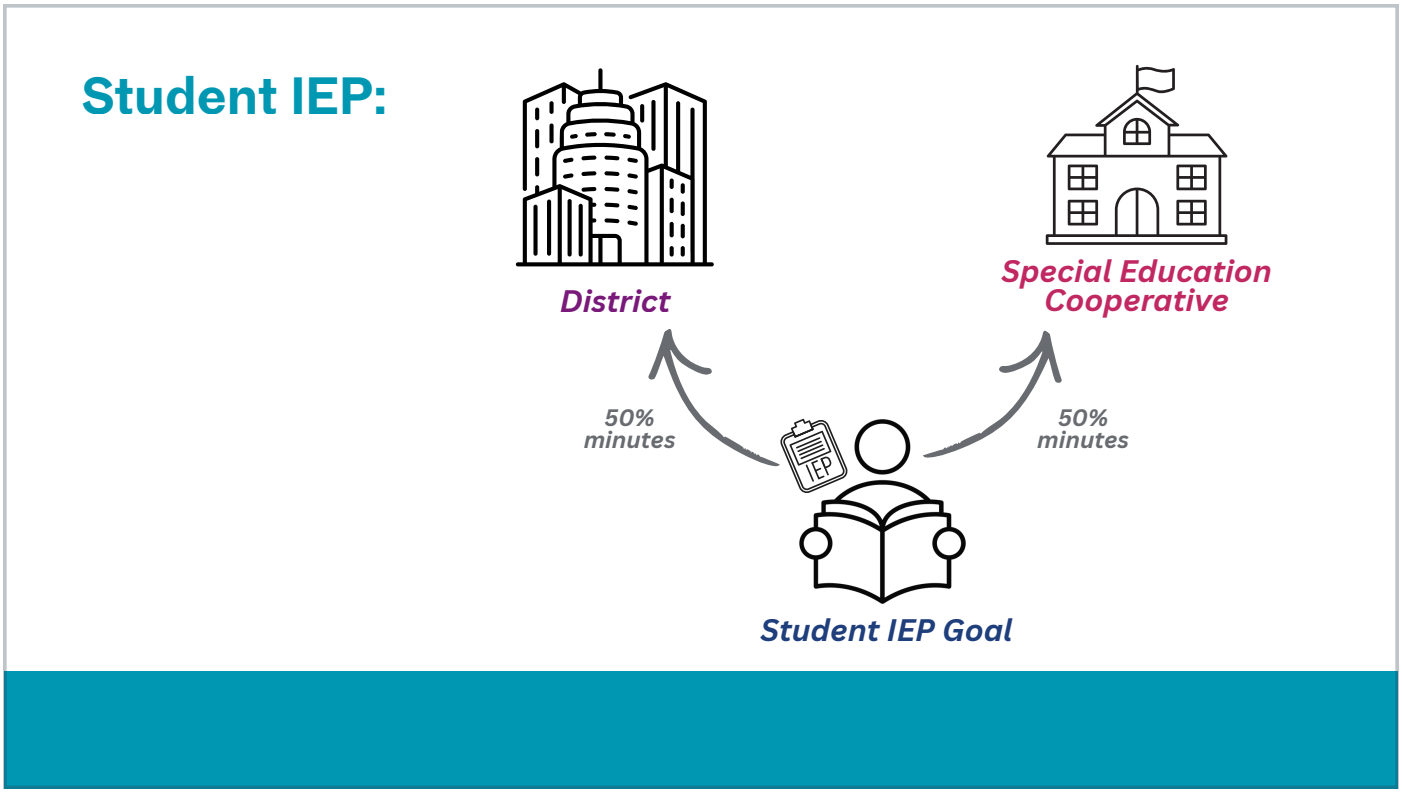
-Direct medical percentage: approximately 38.16%
-IEP Medicaid ratio: approximately 71.85%



In contrast, for free care:

-Direct medical percentage: approximately 5%
-Medicaid ratio: approximately 59%

By ensuring that all eligible direct service providers deliver services to students with IEPs when appropriate, districts can significantly increase Medicaid reimbursement through the cost settlement process.



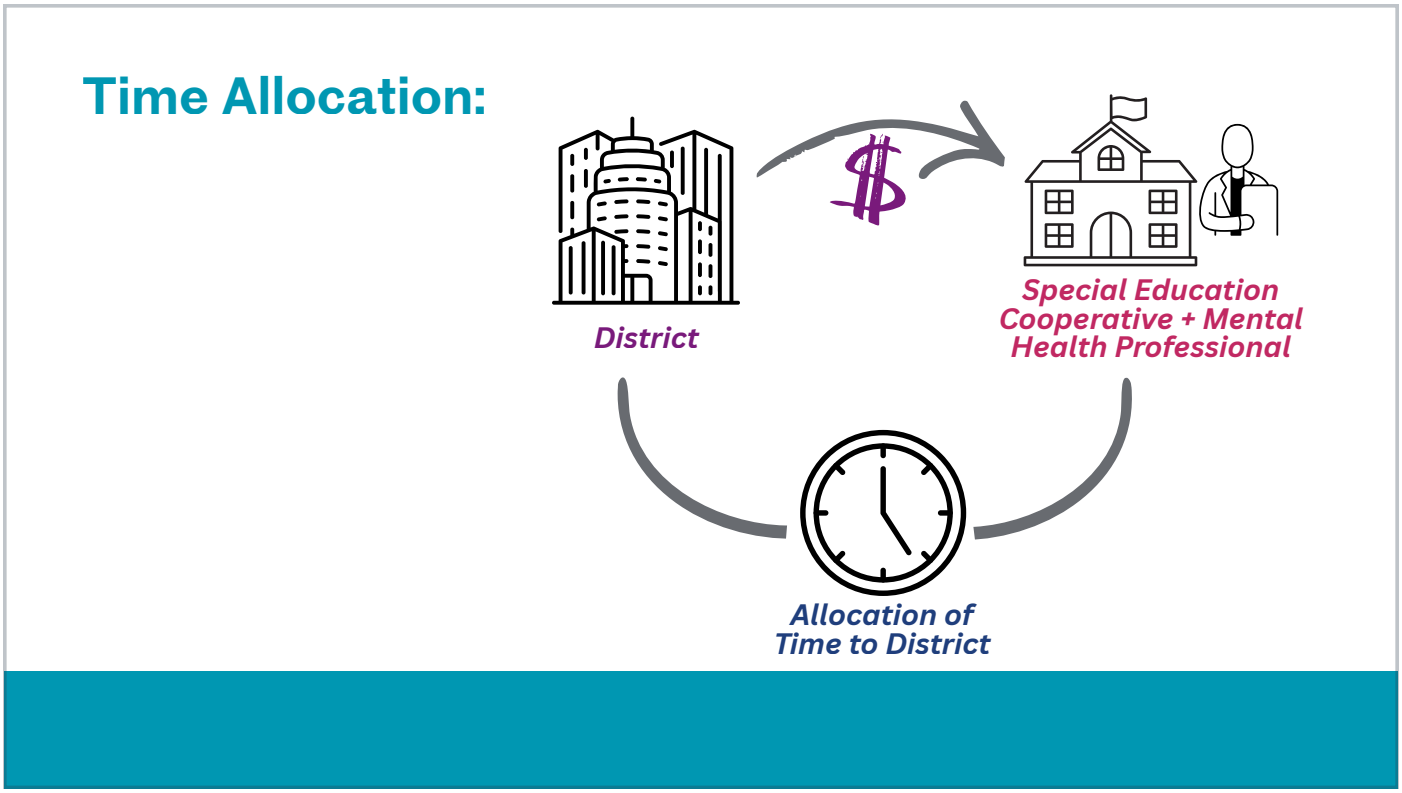
IEP Service Delivery Models:

There are multiple ways districts can structure IEP service delivery:

-Special Education Cooperative as Provider:
The cooperative may serve as the primary provider as districts expand mental health services.

-Shared Service Delivery:
IEP service minutes can be split between the district and the cooperative, based on collaboration and agreement. There are no regulatory limitations on this arrangement beyond mutual consent.

These models allow districts to increase Medicaid reimbursement even when they are not the sole provider of special education services.



Time Allocation and Funding Flow:

Districts may pass grant or supplemental funding to special education cooperatives to support expanded mental health roles. In return, cooperatives allocate additional staff time to the district.

This arrangement often includes:

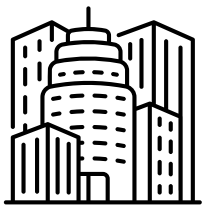
-Shared administrative costs across districts
-Defined time allocations for specific district needs

Trade-offs include:

-Cooperatives may receive higher interim reimbursement rates due to longer participation in school health services.
-Final cost settlement amounts are equivalent across entities, regardless of interim rates.

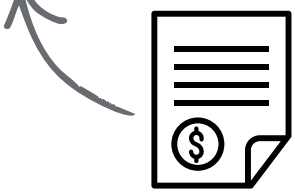
Medicaid reimbursement generated through administrative claiming, IEP services, and free care can ultimately reduce the district's net costs through settlement reconciliation between districts and cooperatives.

Bill Utilization



District

Special Education Cooperative



Final Bill

(-) Medicaid Administrative Claiming
(-) Direct Service IEP Cost Settlement
(-) Direct Service Free Care Cost Settlement

What can you do?

Finance Office Complete and Certify Quarterly Cost Reports
Cost reports must be completed quarterly.
Missing cost reports will result in returning interim payments or not receiving cost settlement funding for those quarters.

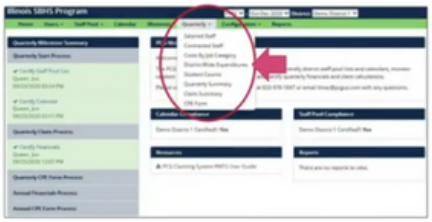
SOURCE: HFS Illinois Department of Healthcare and Family Services

Importance of Accurate Cost Reporting:

Finance offices play a critical role in ensuring reimbursement by:

-Completing and certifying quarterly cost reports
-Including all eligible staff in cost pools
-Applying the negotiated indirect rate
-Capturing all allowable expenses

Quarterly Financials



HELPFUL TIPS & RESOURCES:

- Quarterly costs are reported on a cash-basis or based on date of payment.
- Costs can only be reported for participants on the SPL for the reporting quarter.
- Be sure the appropriate quarter is selected in the 'Quarter' dropdown menu when working with the quarterly costs.
- Report 100% of costs (including federal funds) in the salaries / benefits / contractor costs sections and ONLY the federal portion in the appropriate Compensation Federal Revenue section. The Claiming System will automatically subtract the federal portion from the gross salaries and benefits.

Reporting Insurance Costs:

DO REPORT

- Liability
- Vehicle
- Transportation Insurance
- If not reported in benefits:
  - Workers Comp
  - Unemployment

DONT REPORT

- Property / Building
- Health
- Life
- Dental

Reporting Interest:

DO REPORT

- Bond Interest
- Expenses for:
  - Acquisition
  - Construction
  - Remodeling
  - Purchase of Equipment

DONT REPORT

- Payments on the principal amount of the bond

Reporting Rental Costs:

DO REPORT

- Bus Leases
- Building Facility Rentals
- Non-Data Processing Equipment

DONT REPORT

- Daily Operating Expenses
- Purchased Services
- Computers
- Repairs/Maintenance

Reporting LEA-wide Expenditures:

DO REPORT

- Salaries & Benefits
- All Cost - not just SPL participants
- FT, PT, & Contracted Staff regardless of Title

DONT REPORT

- Back out Federal Funding Dollars

SOURCE: School Medicaid Consulting LLC

Accurate and complete cost reporting results in higher total allowable costs, which directly increases Medicaid reimbursement through cost settlement.

Missing cost reports may require districts to return interim payments or may disqualify them from receiving settlement funding for those quarters.

Leveraging Expertise and Community Partnerships

Districts may benefit from consultants, vendors, and internal expertise to better understand and manage Medicaid reimbursement systems. Leaders beyond finance staff—including administrators and program leaders—should have access to systems such as PCG to better understand what variables can and cannot be controlled.

What can you do?

Enlist a Community Partner
to hire staff until they are
certified or indefinitely

SOURCE: HFS Illinois Department of Healthcare and Family Services

When districts lack internal capacity, community partners can help expand services by:

-Hiring staff on behalf of the district
-Providing certified professionals
-Accepting referrals and participating in care coordination
-Supporting system-level collaboration

Through intentional partnerships, districts and community providers can fill service gaps and strengthen systems of care for students and families.

When districts lack internal capacity, community partners can help expand services by:

-Hiring staff on behalf of the district
-Providing certified professionals
-Accepting referrals and participating in care coordination
-Supporting system-level collaboration

Through intentional partnerships, districts and community providers can fill service gaps and strengthen systems of care for students and families.

Community Partnerships

When districts lack internal capacity, community partners can help expand services. Effective partnerships include:

-Clear communication channels
-Memoranda of understanding defining roles and expectations
-Shared prioritization of student mental health needs

Community providers may deliver services on-site, increasing access for students and reducing barriers to care.

2025 FQHC Rates

AgencyName	2025 MEDICAL RATES	2025 DENTA RATES	2025 BEHAVIORAL HEALTH RATES
219 Health Network Inc.	$194.80		[illegible]
Access Community Health Network	$194.96	$160.95	$82.02
AHS Family Health Center	$194.80	$146.13	$75.78
Alivio Medical Center	$194.18	$146.13	$56.39
American Indian Health Service of Chicago	$175.91		$78.78
Aunt Martha's Health & Wellness	$188.58	$146.13	$75.78
Beloit Area Community Health CenterCommunity Health Systems	$182.87	$149.89	$85.36
Beloved Community Family Wellness Center	$194.80	$146.13	$75.78
Cass County Health Department	$187.38	$149.89	$85.36
Central Counties Health Centers, Inc.	$193.52	$149.89	$85.36
Chestnut Health Systems	$187.38	$149.89	$85.36
Chicago Family Health Center	$197.43	$153.02	$75.78
Christian Community Health Center	$197.66	$146.13	$75.78
Christopher Greater Area Rural Health Planning Corporation	$167.14	$144.41	$85.36
Community Health & Emergency Svcs	$173.96	$153.02	$83.25
Community Health Care, Inc.	$201.14	$144.05	$85.36
Community Health Centers SE IA	$187.38	$149.89	$85.36
Community Health Partnership of IL	$194.80	$146.13	$75.78

SOURCE: HFS Illinois Department of Healthcare and Family Services

Community Provider Rates and Models:

Approximate reimbursement benchmarks include:

FQHCs: ~$84 per encounter

2025 FQHC Rates

~ $84.00 / hr

SOURCE: HFS Illinois Department of Healthcare and Family Services

2025 RHC Rates

Name	Address 1	Address 2	City	ST	Zip	CY 2025 Medical Rates	CY 2025 Behavioral Health Rates
GOOD SAMARITAN FAMILY HEALTH C	1027 WASHINGTON AVE STE B		VINCENNES	IN	475912240	$104.58	$79.87
TRINITY HEALTH AND WELLNESS LL	850 BRYANT ST		LOUISVILLE	IL	628581000	$104.58	
CARLE EUREKA FAMILY MEDICINE -	105 S MAJOR ST		EUREKA	IL	615301246	$104.58	
CARLE EUREKA FAMILY MEDICINE -	385 S ORANGE ST		EL PASO	IL	617381613	$104.58	
CARLE EUREKA FAMILY MEDICINE -	415 W FRONT ST		ROANOKE	IL	615617817	$104.58	$79.87
RED BUD HEALTH CLINIC	325 SPRING ST FL 2		RED BUD	IL	622781105	$104.58	
AMERICAN FAMILY MEDICAL CENTER	1254 OGDEN AVE		DOWNERS GROVE	IL	605152740	$104.58	$79.87
CROSSROADS FAMILY MEDICINE OF	1209 W ROBINSON ST		WAYNE CITY	IL	628959672	$104.58	
CROSSROADS INTERNAL MEDICINE	4101 N WATER TOWER PL		MOUNT VERNON	IL	628646296	$104.58	
UNION COUNTY HOSPITAL CLINIC	517 N MAIN ST RM 22		ANNA	IL	629061668	$104.58	

SOURCE: HFS Illinois Department of Healthcare and Family Services

Community Provider Rates and Models

Approximate reimbursement benchmarks include:

RHCs: ~$80 per encounter

2025 RHC Rates

~ $79.87 / hr

SOURCE: HFS Illinois Department of Healthcare and Family Services

2025 SBHC Fee Schedule

Procedure Code	NOTE	DESCRIPTION	*EFF DATE	UNIT PRICE	MAX QTY	STATE MAX
90832		PSYCHOTHERAPY				46.98
90833		PSYCHOTHERAPY, 30 MNS WITH PT. &/OR FAMILY W EVAL AND MANAGEMENT SERVICES				44.06
90834		PSYCHOTHERAPY, 45 MINS WITH PT. &/OR FAMILY MEMBERS		62.03	2	124.06
90836		PSYCHOTHERAPY, 45 MINS WITH PT. &/OR FAMILY W EVAL AND MANAGEMENT SERVICES				55.67
94760		NONINV EAR/PULSE OXIM SINGLE	04/01/24			2.54
95115		IMMUNOTHERAPY NO PROVISIONS, SINGLE INJECTION	04/01/24			6.59
95117		IMMUNOTHERAPY ALLERG NOT MULTI	07/01/02			8.30
96110		DEVELOP. SCREENING,W INTERP & REPORT, PER STANDARDIZED INSTRUMENT	01/01/06	16.07	2	32.15
96112		DEVELOP. TESTING; ADMINISTRATION W/ INTERP & REPORT; FIRST HOUR	04/01/24			83.91
96113		DEVELOP. TESTING; ADMINISTRATION W/ INTERP & REPORT; EACH ADDITIONAL 30 MINS	01/01/19	38.42	6	230.52
96127		BRIEF EMOTIONAL/BEHAVIORAL ASSESSMENT W SCORING AND DOCUMENTATION	01/01/17	14.60	2	29.20
96160		PT FOCUSED HEALTH RISK ASSESSMENT INTRUMENT W/ SCORING & DOCUMENTATION	01/01/17			14.60
99173		SCREENING TEST VISUAL ACUITY QUANT, BILATERAL	01/01/06			7.45
99202	CC	OFFICE/OTHER OUTPT VISIT, NEW PT, EXPANDED PROBLEM FOCUSED	04/01/24			32.21
99203	CC	OFFICE/OTHER OUTPT VISIT, NEW PT, DETAILED/LOW COMPLEXITY	04/01/24			55.95
99204	CC	OFFICE/OTHER OUTPT VISIT, NEW PT, COMPREHENSIVE/MOD COMPLEXITY	04/01/24			90.81
99205	CC	OFFICE/OTHER OUTPT VISIT, NEW PT, COMPREHENSIVE/HIGH COMPLEX	04/01/24			123.49
99211	CC	OFFICE/OTHER OUTPT VISIT, ESTABLISHED PT, MINIMAL, MD SUPERVISION	04/01/24			8.44
99212	CC	E/M OFFICE/OTHER OUTPT VISIT, ESTABLISHED PT, PROBLEM FOCUSED	10/01/23			24.25
99213	CC	OFFICE/OTHER OUTPT VISIT, ESTABLISHED PT, EXPANDED FOCUS	04/01/24			44.67

This Fee Schedule is applicable to services rendered by a Physician, Advance Practice Nurse (APN), or Physician Assistant. Psychiatric services are subject to policy limitations, and certification requirements for physicians and APNs, as outlined in the Chapter 200 Practitioner Handbook

Community Provider Rates and Models

Approximate reimbursement benchmarks include:

School-Based Health Centers: ~$91 per hour (CPT 90837)

2025 SBHC Fee Schedule

This Fee Schedule is applicable to services rendered by a Physician, Advance Practice Nurse (APN), or Physician Assistant. Psychiatric services are subject to policy limitations, and certification requirements for physicians and APNs, as outlined in the Chapter 200 Practitioner Handbook

What can you do?

Collaborate with Community Partner to hire known effective providers

If we know of effective interns/providers-in-training, paraprofessionals, or staff members that are effective at providing mental health services because of their personality, lived experience, etc, than a community partner may be able to employee this person as a provider.

The district can also employee this person as a paraprofessional.

SOURCE: HFS Illinois Department of Healthcare and Family Services

Key Medicaid-Recognized Staff Types

LPHA
- Licensed Practitioner of the Healing Arts - psychologist, LCSW, LCPC, LMFT, RN/APRN with MH scope

QMHP
- Qualified Mental Health Professional

MHP
- Mental Health Professional

RSA
- Rehabilitative Services Associate

Prescribers
- MD/DO/APRN/PA for medication services

Psychologists
- Required for certain assessments

Peer Support Workers
- CRSS/CFPP may provide select services *(CST, ACT, etc.)*

School Setting Note:
IPs, CMHC/BHC clinicians, and contracted prescribers can all deliver Medicaid-covered behavioral health services inside school buildings, as long as IMPACT enrollment and documentation requirements are met.

Group A, B, C Services:

billable by BHC, CMHC, IPs

Service Name	Proc Code	Modifiers 1	Modifiers 2	Units	NB Service Add On	State Max On-Site	State Max Off-Site
Assessment and Treatment Planning							
Integrated Assessment and Treatment Planning (IATP)	H2000	HN		1/4 hr	-	$33.32	$36.26
Integrated Assessment and Treatment Planning (IATP)	H2000	HO		1/4 hr	-	$34.84	$38.00
IATP: Review and Update	H2000	HN	SF	1/4 hr	-	$33.32	$36.26
IATP: Review and Update	H2000	HO	SF	1/4 hr	-	$34.84	$38.00
IATP: Clinical Assessment Tool under LPHA direction	H2000	52		1/4 hr	-	$33.32	$36.26
IATP: Clinical Assessment Tool performed by an LPHA	H2000	TF		1/4 hr	-	$34.84	$38.00
IATP: Psychological Assessment	H2000	AH		1/4 hr	-	$34.84	$38.00
IATP: Psychological Assessment	H2000	HP		1/4 hr	-	$41.54	$45.80
IATP: LOCUS Assessment	H2000	HN	HE	1/4 hr	-	$33.32	$36.26
Pathways to Success Program Services**							
IATP: Child and Family Team <= 90 mins	G9007			Event	-	$75.00	$75.00
IATP: Child and Family Team >90 mins	G9007	TG		Event	-	$150.00	$150.00
Crisis Services							
Crisis Intervention	H2011	HN		1/4 hr	-	$47.98	$53.27
Therapy/Counseling Services							
Therapy/Counseling - Individual	H0004	HN		1/4 hr	-	$27.32	$30.26
Therapy/Counseling - Individual	H0004	HO		1/4 hr	-	$34.84	$38.00
Therapy/Counseling - Brief Intervention	H0004	TF	TL	1/4 hr	-	$31.81	$35.60
Therapy/Counseling - Group	H0004	HN	HQ	1/4 hr	-	$7.58	$8.31
Therapy/Counseling - Group	H0004	HO	HQ	1/4 hr	-	$9.62	$10.67
Therapy/Counseling - Family	H0004	HN	HR	1/4 hr	-	$30.32	$33.26
Therapy/Counseling - Family	H0004	HO	HR	1/4 hr	-	$37.84	$41.00

SOURCE: HFS Illinois Department of Healthcare and Family Services

**CST, VP-CST, and ACT services must be billed with an additional modifier indicating the highest level of practitioner level delivering the unit(s) of service from the acceptable list of modifiers. See the Handbook for Providers of Community-Based Behavioral Services for more information.*
***Pathways to Success Program services are only reimbursable when delivered to customers enrolled in the Pathways to Success program and when the services are authorized on an IATP maintained by the customer's CCSO (pathways.illinois.gov).*
****Claims must be submitted directly to HFS for reimbursement.*
+CCSO service delivery and billing guidance can be found in the Handbook for Care Coordination and Support Organizations

Community Provider Rates and Models

Approximate reimbursement benchmarks include:

Community Mental Health Clinics: ~$139 per hour for master's-level providers

Off-site or community-based services may qualify for higher reimbursement rates, providing incentives for partnerships.

Group A, B, C Services:

billable by BHC, CMHC, IPs

SOURCE: HFS Illinois Department of Healthcare and Family Services

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		1	2			On-Site	Off-Site
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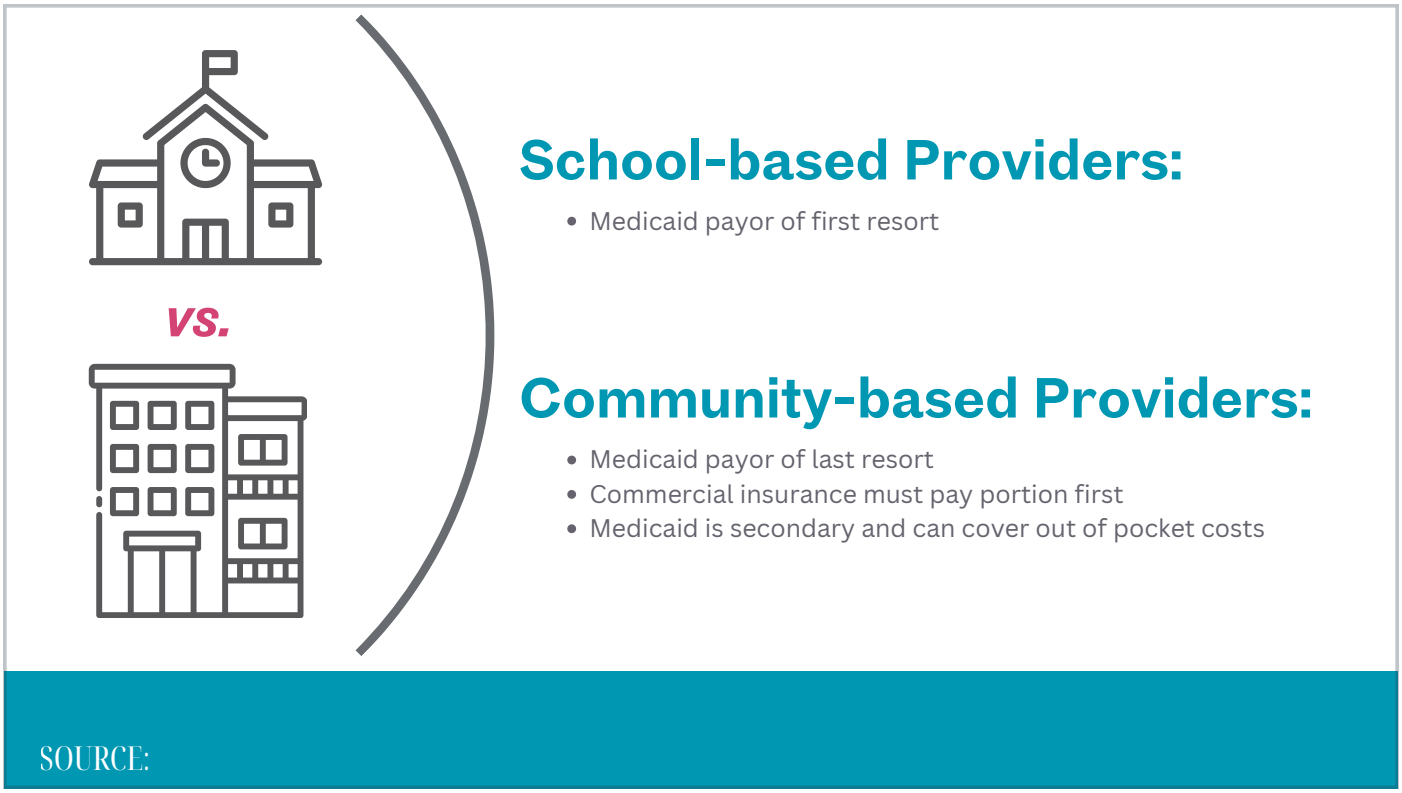


School-Based vs. Community-Based Billing:

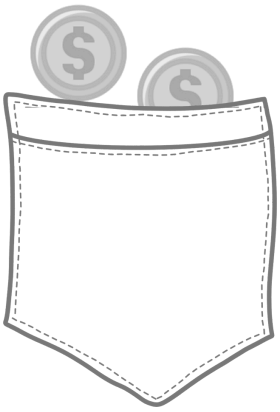
Medicaid functions differently across settings:

-In schools, Medicaid is often the payer of first resort
-In community settings, Medicaid is the payer of last resort

When students have commercial insurance, claims must be submitted to the primary insurer first. Medicaid may then cover co-pays, deductibles, and co-insurance as a secondary payer, reducing out-of-pocket costs for families.

Out of Pocket Costs:

- Deductibles
- Copayments (copays)
- Coinsurance



SOURCE: University Bursar STUDENT MONEY MANAGEMENT CENTER

What applies to your Out of Pocket Maximum:

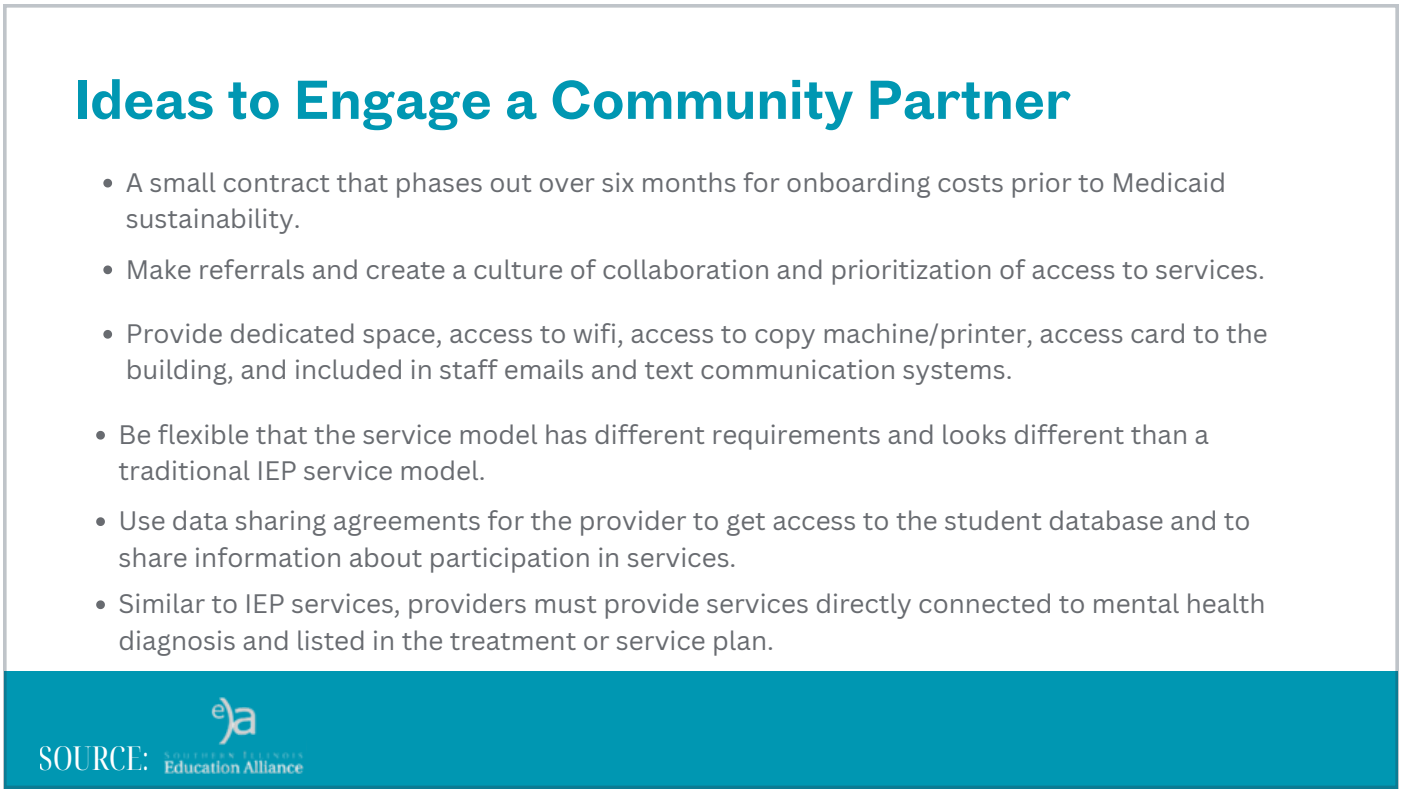
What Counts:	Does Not Count:
Deductibles	Monthly premiums
Coinsurance (after deductible)	Out-of-network services
Eligible copayments (depending on your plan)	Non-covered services, amounts above plan limits

SOURCE: University Bursar STUDENT MONEY MANAGEMENT CENTER

Copay vs Coinsurance:

Features	Copay	Coinsurance
Payment amount	Fixed (e.g., $26/visit)	Percentage (e.g., 20%)
Payment timing	Each visit or Rx fill	Paid *after* deductible is met
Deductible impact	Usually doesn't count	Applies after deductible is met
Cost predictability	Easy to predict	Varies by service cost

SOURCE: University Bursar STUDENT MONEY MANAGEMENT CENTER



Engaging and Sustaining Community Partnerships:

Effective engagement strategies include:

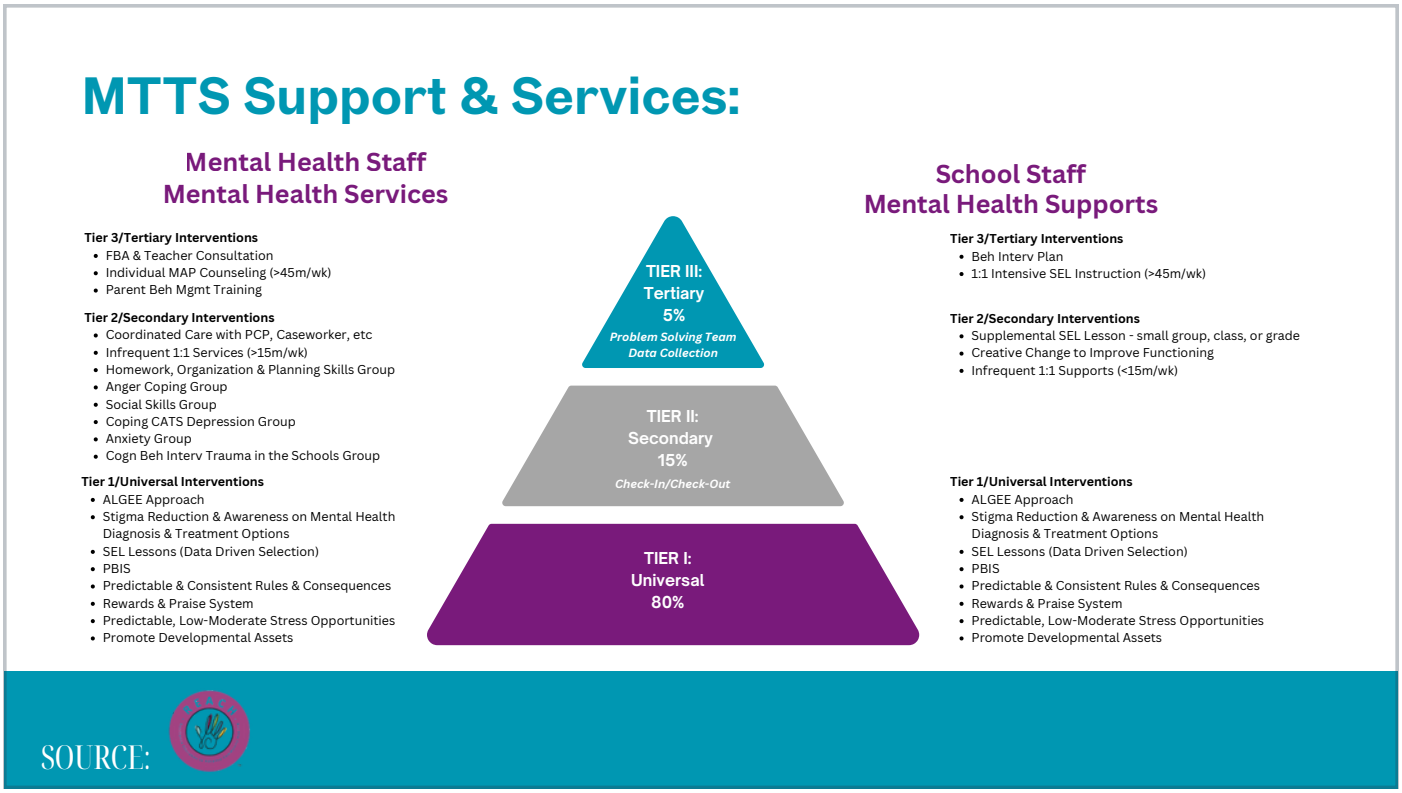
-Phased onboarding contracts
-Dedicated space and resources for providers
-Flexible scheduling aligned with provider work hours
-Data-sharing agreements and coordinated consent processes

Sustainability depends on providers delivering sufficient Medicaid-reimbursable services—typically four to five hours per day—to support staffing costs.

Ideas to Engage a Community Partner

- Remember that community partners do not have the same work hours or school year.
  - May need access to students during afterschool or summer times.
  - May need continued access to their office to do telehealth services afterschool
  - May take off campus lunch hour
- Sustainability is based on reimbursement of fee for service hours that are documented in the providers Electronic Health Record.
  - Staff may have 24-72 hours to complete service notes.
  - Staff need 4-5 full hours providing 1:1 or group services,
- Providers must make families aware and charge families co-pays, deductibles, and co-insurances unless families have Medicaid as a secondary payor source.
  - Can be considered Medicare/Medicaid Fraud if this does not happen
  - Sometimes grants or contracts can cover the out of pocket costs to families
  - Some districts will only have outside providers serve Medicaid clients.

SOURCE: Southern Illinois Education Alliance



Whether districts expand internal services or partner with community organizations, the shared goal is improving student mental health and well-being.

Resources:

HEALTHY SCHOOL CAMPAIGN

HFS Illinois Department of Healthcare and Family Services

University Bursar STUDENT MONEY MANAGEMENT CENTER

ABE APPLICATION FOR BENEFITS ELIGIBILITY

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

School Medicaid Consulting LLC

ILLINOIS STATE BOARD OF EDUCATION

IDHS

Medicaid.gov Keeping America Healthy

REACH

eja Southern Illinois Education Alliance

American Council On Aging

FOR MORE INFORMATION

E-mail dmattbuckman@stressandtrauma.org

Website www.west40.org

That concludes this 5 part series on Understanding School Based Mental Health & Medicaid.

This series has highlighted strategies to:

-Increase access to care
-Maximize Medicaid reimbursement
-Build sustainable systems of support

By leveraging allowable Medicaid funding and effective partnerships, districts can better meet the needs of students and families and contribute to a healthier Illinois.