

**UNDERSTANDING SCHOOL BASED MENTAL  
HEALTH & MEDICAID WEBINAR SERIES:  
5 PART SERIES**

PRESENTER: MATT BUCKMAN, PH D

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 Illinois.

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.

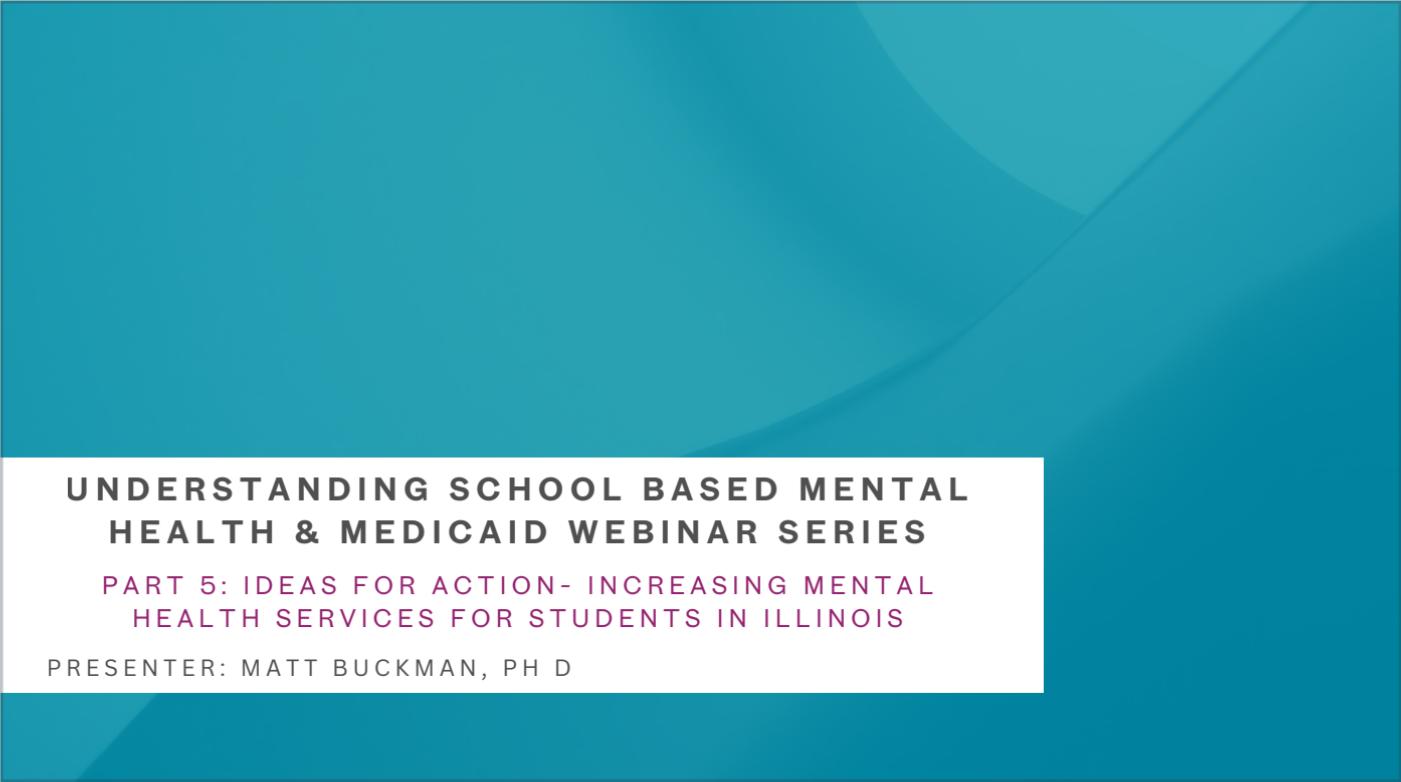
My name is Matt Buckman. I am a licensed clinical psychologist, dually credentialed as a school psychologist, and the Executive Director of the Stress and Trauma Treatment Center. I will be guiding you through today's content and the broader five-part series.

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.



**UNDERSTANDING SCHOOL BASED MENTAL  
HEALTH & MEDICAID WEBINAR SERIES**

**PART 5: IDEAS FOR ACTION- INCREASING MENTAL  
HEALTH SERVICES FOR STUDENTS IN ILLINOIS**

PRESENTER: MATT BUCKMAN, PH D

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.

# AGENDA

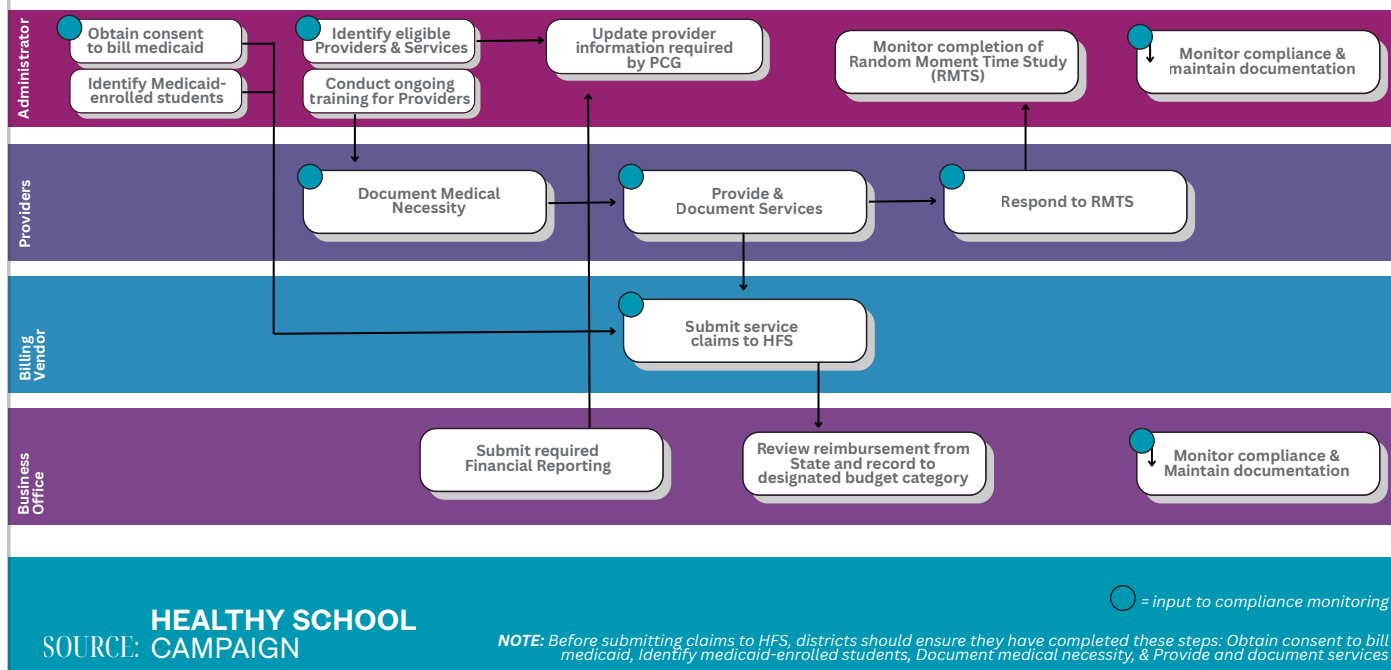
## IDEAS FOR ACTION- INCREASING MENTAL HEALTH SERVICES FOR STUDENTS IN ILLINOIS

- Medicaid Outreach
- Staff Pooling and Cost Reporting
- Service Provision
- Community Partnership Ideas
- Resources

### Today's Agenda:

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

# IL School Medicaid Reimbursement Process



## 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.

# What can you do?



## **Obtain Consent on All Students**

Obtain consent at first enrollment in the district.

Consent is good for the lifetime of the student

SOURCE:  **HFS**  
Illinois Department of  
Healthcare and Family Services

## 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

Read your "Notice" or "Consent" form to make sure you understand the rights and responsibilities of the school district and your child. After completing the form, please return it to the school district.

**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, DISTRICT 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 law (the Affordable Care Act) provides an opportunity to expand reimbursement for school-based health services for Medicaid-enrolled students beyond those with an IEP/504. 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 benefits; 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/504 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: \_\_\_\_\_

0000 00-00 (1/12/17)

SOURCE:  **ILLINOIS  
STATE BOARD OF  
EDUCATION**

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

# What can you do?



**Outreach to help families enroll students in Medicaid**  
conduct regular education, awareness, and eligibility  
reviews for students to enroll in Medicaid

SOURCE:



**HFS**  
Illinois Department of  
Healthcare and Family Services

## Medicaid Outreach and Enrollment Support:

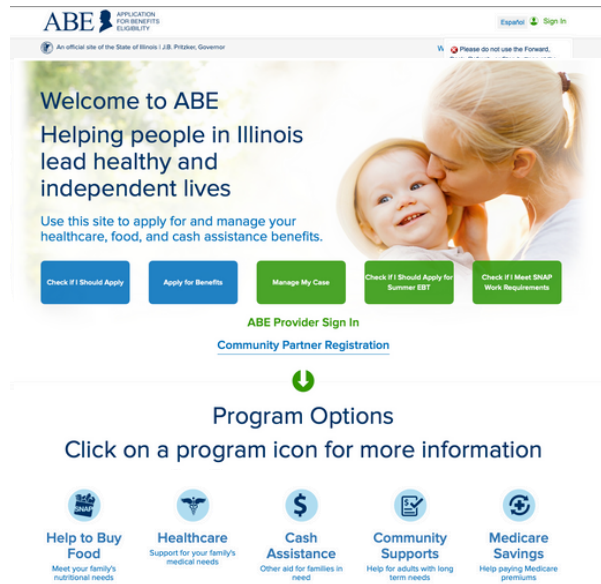
Districts can provide outreach to help families enroll in Medicaid, increasing access to primary care, mental health services, and other supports while reducing the financial burden on families.

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/>

**IDHS** Illinois Department of Human Services  
Ill. Pittsbur. Governor • Duane M. Quisenberry, Secretary

Search

Customers Providers About News Contact

IDHS > Customers > Services by Division > Family & Community Services > Cash, SNAP & Medical Assistance > ABE Customer Support >

ABE Application Guide

Apply for Coverage

Start

✓ People

Liquid Resources

Other Resources

Job Income

Other Income

Housing Bills

Other Bills

Finish

Submit

**Note:** If this is your first time applying for benefits or you are a returning user that hasn't set up an [iLogin](#) account to access ABE or connect your ABE profile, visit [Creating an iLogin & ABE User Account](#) to get started.

This guide is to assist you in completing an application in ABE. The links on the right of this page follow the path shown on the left within ABE. If you need help when filling out your application, use these links for assistance.

**Note:** The *Apply for benefits without an Account* process currently does not support Safari. Supported browsers include Google Chrome, Microsoft Edge and Mozilla Firefox.

If you are an ABE User and have additional questions or encounter a problem, use the [ABE User Assistance](#) form, or reach out to the ABE Customer Call Center at (800) 843-6154.

Links

[About ABE](#)

[Creating an iLogin & ABE User Account](#)

[Navigating](#)

[Start](#)

[People](#)

[Verifying Identity](#)

[Liquid Resources](#)

[Job Income](#)

[Other Income](#)

[Housing Bills](#)

[Other Bills](#)

[Finish](#)

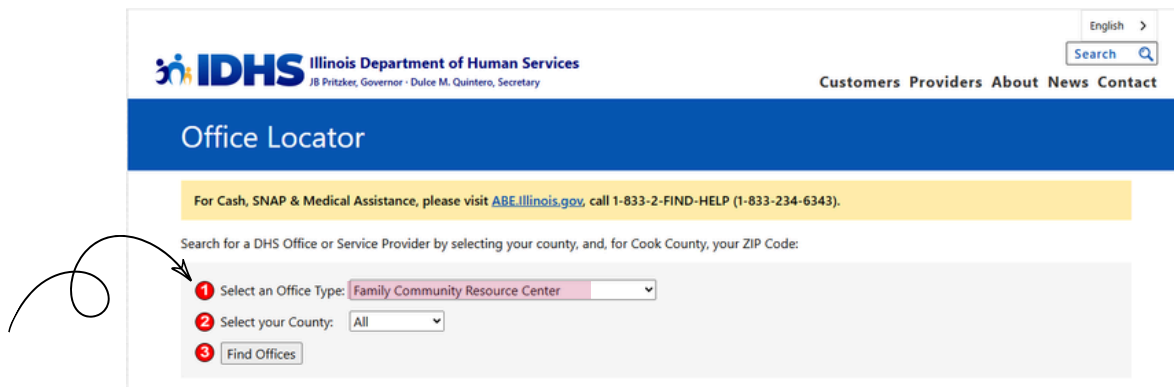
[Submit](#)

[Uploading Documents](#)

**IDHS**  
Illinois Department of Human Services  
Ill. Pittsbur. Governor • Duane M. Quisenberry, Secretary

SOURCE:  **IDHS**

# IDHS Office Locator



The screenshot shows the IDHS Office Locator webpage. At the top, the IDHS logo and name are displayed, along with the names of the Governor and Secretary. A search bar is in the top right corner. Below the header, a blue banner reads "Office Locator". A yellow box contains text about cash, SNAP, and medical assistance. Below that, instructions for searching by county and ZIP code are provided. A hand-drawn arrow points to the first step of the search process: "1 Select an Office Type: Family Community Resource Center".

English >  
Search

**IDHS** Illinois Department of Human Services  
JB Pritzker, Governor · Dulce M. Quintero, Secretary

Customers Providers About News Contact

**Office Locator**

For Cash, SNAP & Medical Assistance, please visit [ABE.Illinois.gov](http://ABE.Illinois.gov), call 1-833-2-FIND-HELP (1-833-234-6343).

Search for a DHS Office or Service Provider by selecting your county, and, for Cook County, your ZIP Code:

1 Select an Office Type: Family Community Resource Center

2 Select your County: All

3 Find Offices

SOURCE: 

## 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:



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

The screenshot displays the HFS website's Medicaid Client Renewals page. The header includes the Illinois state logo, the HFS logo, the director's name (Elizabeth M. Whitehorn), a language selector (English), and a search bar. The main navigation bar lists various services like Home, My Healthcare, Medical Providers, Child Support Services, HFS OIG, Community, Info Center, and About Us. The breadcrumb trail shows the path: HFS > Medical Clients > Report Medicaid Change... The left sidebar contains links to Medicaid Client Renewals, Report Medicaid Change of Address, Understanding the Renewal Process, Three-Part Webinar Series: Training for the End of..., Ready to Renew Messaging Toolkit, Ready to Renew Frequently Asked Questions, Unwinding Operational Plan - Coming Soon, Are You Covered Toolkit, and Medicaid Redetermination Data Report. The main content area is titled 'Illinois Medicaid Renewals Information Center' and 'For Medicaid Customers'. It states: 'There are two ways to change your Medicaid address:'. The first way is to 'Click Manage My Case at [abe.illinois.gov](http://abe.illinois.gov) to:', followed by a list of steps: 'Verify your address (under "Contact Us")', 'Find your renewal due date (under "Benefit Details")', and 'Complete your renewal when you are due'. A button labeled 'Manage my case at [abe.illinois.gov](http://abe.illinois.gov)' is provided. The second way is 'Or another way for Medicaid Customers to update their address with us:', followed by a button labeled 'Medicaid Address Change Form' and a button labeled 'Are you covered?'.

ILLINOIS gov

AGENCIES SERVICES

Elizabeth M. Whitehorn, Director English Search

Home My Healthcare Medical Providers Child Support Services HFS OIG Community Info Center About Us

HFS > Medical Clients > Report Medicaid Change...

Medicaid Client Renewals

Report Medicaid Change of Address

Understanding the Renewal Process

Three-Part Webinar Series: Training for the End of...

Ready to Renew Messaging Toolkit

Ready to Renew Frequently Asked Questions

Unwinding Operational Plan - Coming Soon

Are You Covered Toolkit

Medicaid Redetermination Data Report

## Illinois Medicaid Renewals Information Center

### For Medicaid Customers

There are two ways to change your Medicaid address:

Click Manage My Case at [abe.illinois.gov](http://abe.illinois.gov) to:

- Verify your address (under "Contact Us")
- Find your renewal due date (under "Benefit Details")
- Complete your renewal when you are due

[Manage my case at \[abe.illinois.gov\]\(http://abe.illinois.gov\)](#)

Or another way for Medicaid Customers to update their address with us:

[Medicaid Address Change Form](#)

[Are you covered?](#)

SOURCE:  **HFS**  
Illinois Department of  
Healthcare and Family Services

# What can you do?

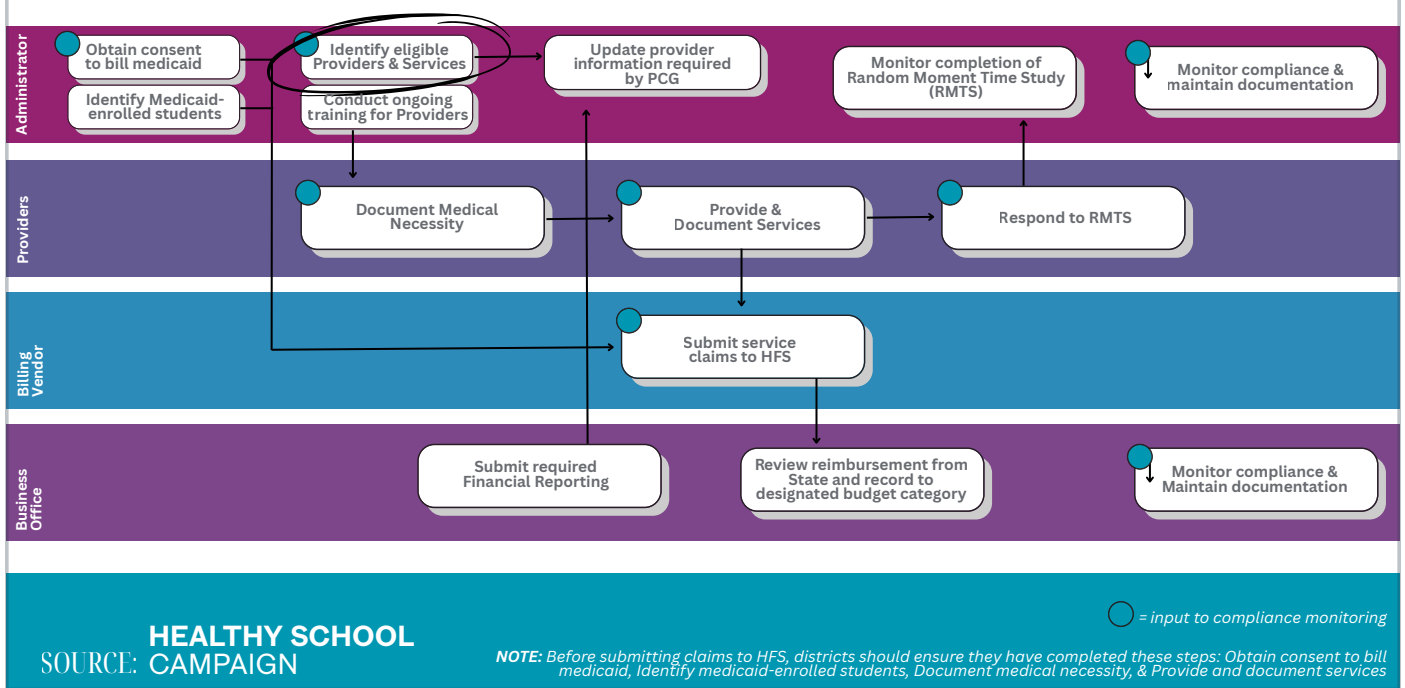


## **Help families that lose coverage that are still eligible**

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.

# IL School Medicaid Reimbursement Process



## 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 [assessing providers to meet goals](#)) 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 (IDHS) [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**

# Assign Providers to the Correct Cost Pool:

## **Cost Pool 1 - Direct Service Personnel:**

- The provider must have a Medicaid-eligible license
- The provider must deliver at least some services that are eligible to be billed to Medicaid

## **Cost Pool 2 - Other Personnel:**

- The staff member/contractor must not be paid with funds that are used to calculate the district's indirect cost percentage
- The staff member/contractor must conduct some Medicaid-reimbursable administrative activities such as:
  - Arranging specialized transportation
  - Assisting students and families with Medicaid enrollment
  - Arranging for translation services for Medicaid services

## **Cost Pool 3 - Other Direct Service Personnel:**

- School Health Aides



## 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?

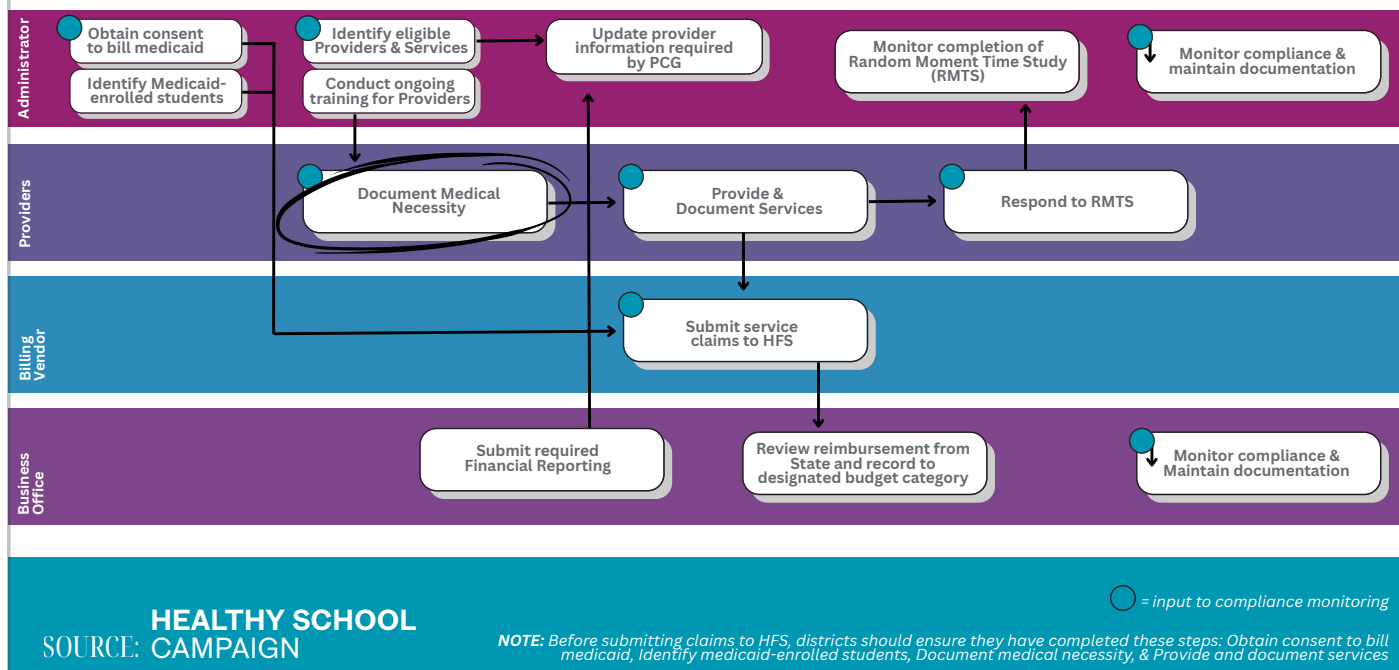


## **Utilize federal funding for non-direct service providers if possible**

The cost of those funded by federal dollars will be excluded from the reimbursable costs.

SOURCE:  **HFS**  
Illinois Department of  
Healthcare and Family Services

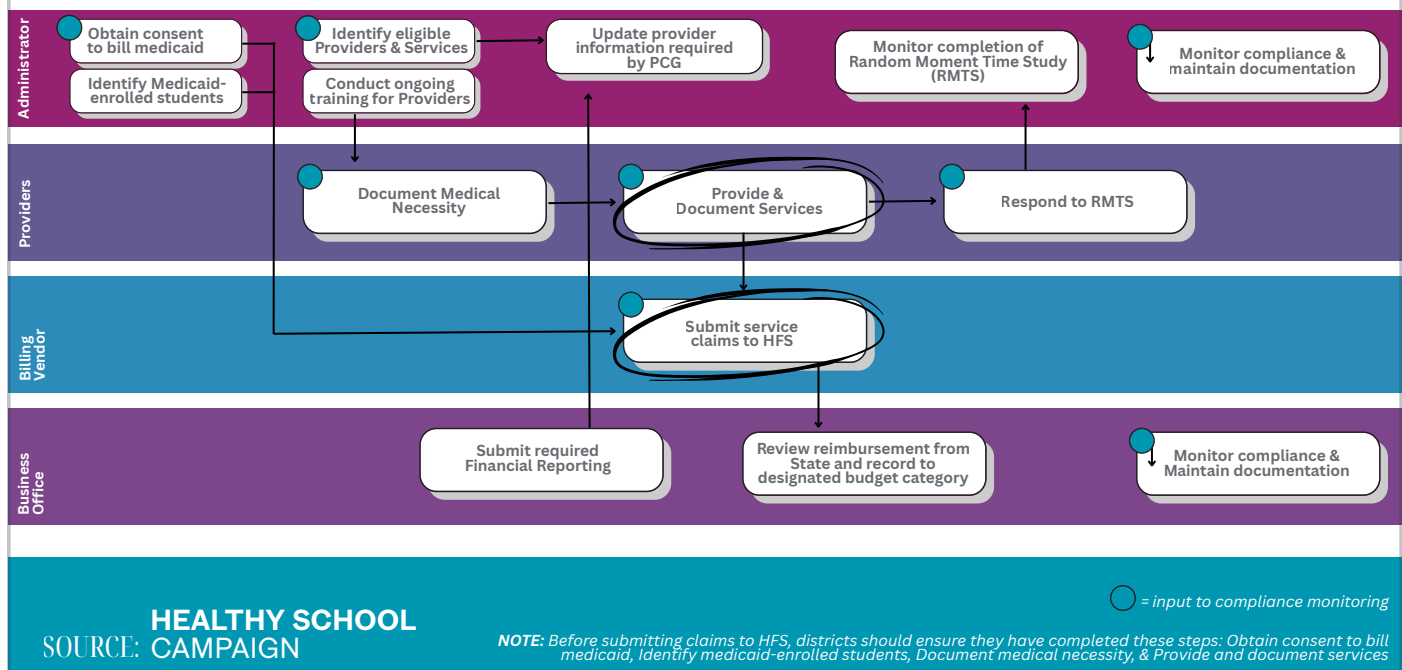
# IL School Medicaid Reimbursement Process



## 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.

# IL School Medicaid Reimbursement Process



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



## 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

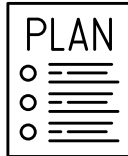
### Other Direct Service Personnel:

- School Health Aides

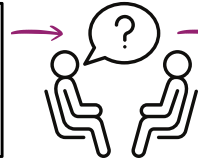
Cost Pool 3

**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.



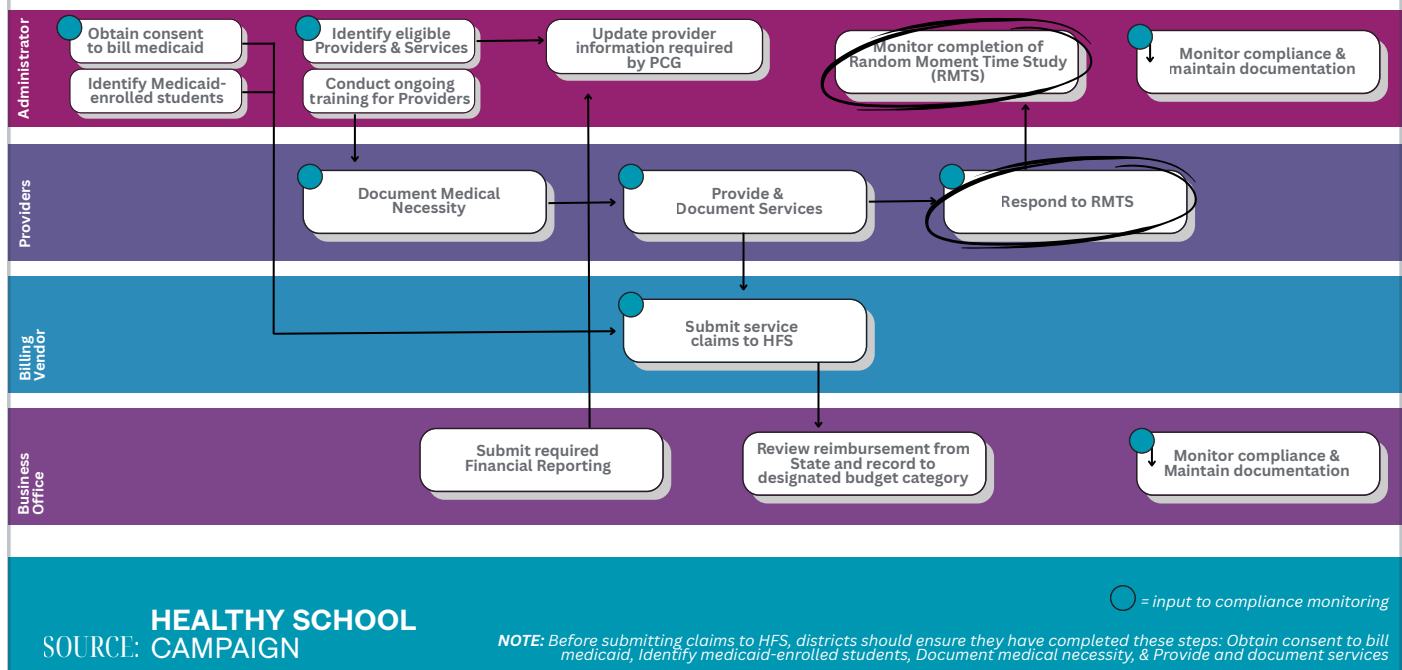
Document services within 6 months from date of session in the Medicaid Vendor program.

SOURCE:



School Medicaid Consulting LLC

# IL School Medicaid Reimbursement Process



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



## 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.

## Time Study Codes for RMTs:

CODE	CODE TEXT	ACTIVITY	DIRECT SERVICE	MAC INDICATOR					
	Prov Svcs	Provision of Services							
1A	Outreach	Non-	U	U					
1B	Outreach	Medicaid	U	TM/50%					
2A	Enrollment	Facilitation	U	U					
2B	Enrollment	Facilitation	U	TM/50%					
3	Education	School	U	U					
4A	Direct Non	Direct	U	U					
4B	Direct Medical	Direct Medical Services - Covered as IDEA/IEP Services, Not Covered on a Medical Plan of Care	PM	U					
4C	Direct Medical	Direct	PM	U					
5A	Transportation	Transportation	U	U					
5B	Transportation	Medicaid	U	PM/50%					
6A	Translation	Non-	U	U					
6B	Translation	Medicaid	U	PM/75%					
7A	Planning		U	U					
7B	Planning	Medical	U	PM/50%					
8A	Training	Non-	U	U					
8B	Training	Medical/	U	PM/50%					
9A	Referral	Referral,	U	U					
9B	Referral	Referral,	U	PM/50%					
10	General	General	P	P					
11	Unlabeled	Not	U	U					

## Provider Example

- Salary = \$75,000
- Indirect Rate = 15%
- Fringe = \$23,750



### 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.

# What can you do?



## **Participate & Create Training**

Training for staff to adjust their scope of work to focus on Medicaid reimbursable activities

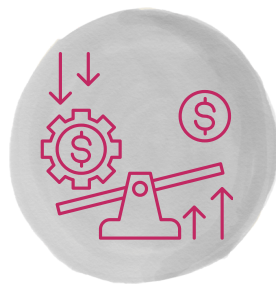
SOURCE:  **HFS**  
Illinois Department of  
Healthcare and Family Services

## 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.

# What can you do?



## **Maximize Activities as Reimbursable Activities**

Focus meetings, trainings, and planning on the needs of students with Medicaid, Medicaid approved service providers, or Medicaid approved services.

SOURCE:



**HFS**  
Illinois Department of  
Healthcare and Family Services

## 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.

# What can you do?



## **Educate or Translate Job Activities to Medicaid Reimbursement Language**

Educate staff the reimbursable Medicaid activity name for the day to day activities conducted within the school.

SOURCE:



**HFS**  
Illinois Department of  
Healthcare and Family Services

## 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:

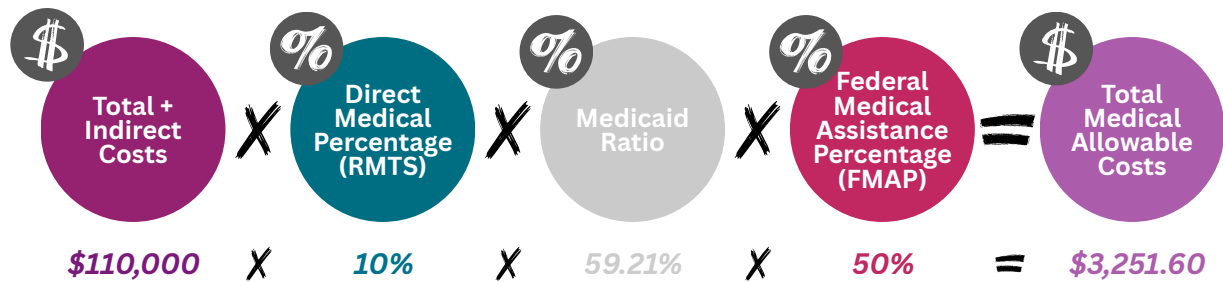
Accurate RMTS responses

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.

## Quarterly PCG Medicaid Administrative Cost Claiming Reimbursement: *Non-Outreach*



$$880 \text{ hours/school year} \times 10\% = 88 \text{ hours}$$

$$3,251.60 / 88 \text{ hours} = \$36.95/\text{hour}$$

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

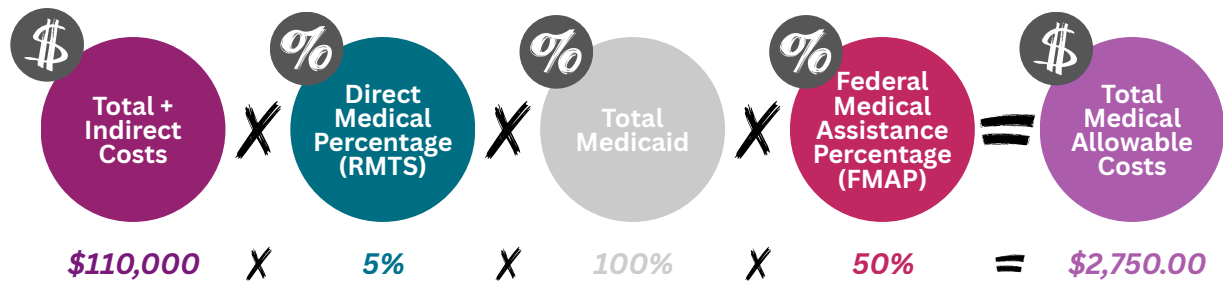
## *Facilitating Medicaid and CHIP Eligibility Determinations:*

- 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*



$$880 \text{ hours/school year} \times 5\% = 44 \text{ hours}$$

$$\$2,750 / 44 \text{ hours} = \$62.50/\text{hour}$$

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			5B	Transp	Medicaid	U	PM/50%
					6A	Transla	Non-	U	U
1A	Outrea	Non-	U	U	6B	Transla	Medicaid	U	PM/75%
1B	Outrea	Medicaid	U	TM/50%	7A	Planning		U	U
2A	Enrollm	Facilitati	U	U	7B	Plannir	Medical	U	PM/50%
2B	Enrollm	Facilitati	U	TM/50%	8A	Trainin	Non-	U	U
3	Educate	School	U	U	8B	Trainin	Medical/	U	PM/50%
4A	DirNon	Direct	U	U	9A	Referra	Referral,	U	U
4B	DirMed	Direct Medical Services - Covered as IDEA/IEP Services, Not Covered on a Medical Plan of Care	PM	U	9B	Referra	Referral,	U	PM/50%
4C	DirMed	Direct	PM	U	10	GA	General	P	P
5A	Transp	Transpo	U	U	11	Unallo	Not	U	U

SOURCE:  HFS  
Illinois Department of  
Healthcare and Family Services

# Activity Codes

## Code 4B: DIRECT MEDICAL SERVICES – COVERED AS IDEA/ IEP SERVICES

*All IDEA and/or IEP direct client care services when the student is present:*

- Providing health/mental health services as covered in the student's IEP.
- Conducting medical/health assessments/evaluations and diagnostic testing and preparing related reports as covered in the student's IEP
- Psychological services, including evaluations\*
- Counseling services, including therapy services\*
- Social Work services and evaluation, 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 IEP
- 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. Such paperwork could include the preparation of progress notes, translation of session notes, or completion of billing activities
- 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 IEP*

## 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 been 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:*

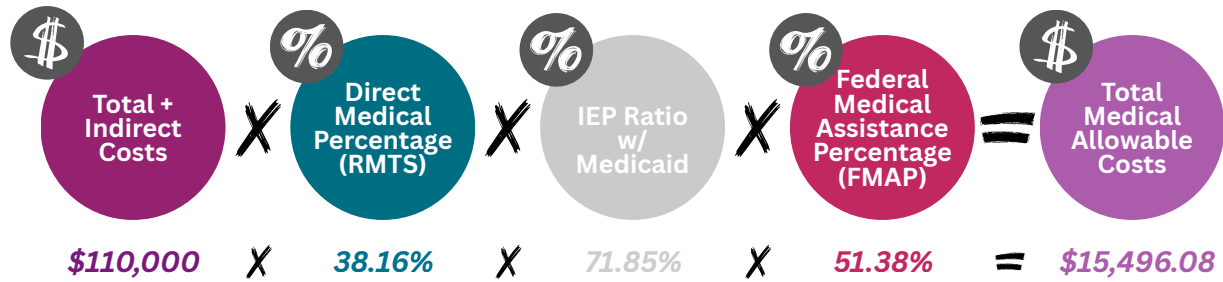
- Updating the medical/health-related service goals and objectives of the medical plan of care
- Travel to the direct service/therapy
- Paperwork associated with the delivery of the direct care service, as long as the student/client is not present.
- Interpretation of the evaluation results and/or preparation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

SOURCE: **Medicaid.gov**  
Keeping America Healthy

*\*only if included in the student's medical plan*  
*\*\*only if medical necessity has been determined*

## IEP Cost Settlement Formula - Single Provider

### *Single Provider Example*



$$880 \text{ hours/school year} \times 38.16\% = 335.81 \text{ hours}$$

$$15,496.08 / 335.81 \text{ hours} = \$46.15/\text{hour}$$

#### 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:

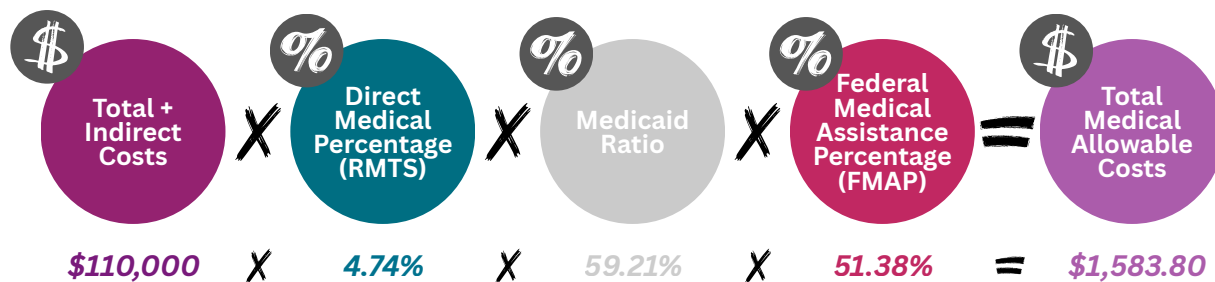
- Statewide direct medical percentage: 38.16%
- Medicaid enrollment ratio for students with IEPs: typically much higher than the general population
- FMAP is applied to determine final reimbursement

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 Formula

### Single Provider Example



$$880 \text{ school hours/school year} \times 4.74\% = 41.71 \text{ hours}$$

$$1,583.80 / 41.71 \text{ hours} = \$37.97/\text{hour}$$

#### Free Care Cost Settlement Example:

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

In this example:

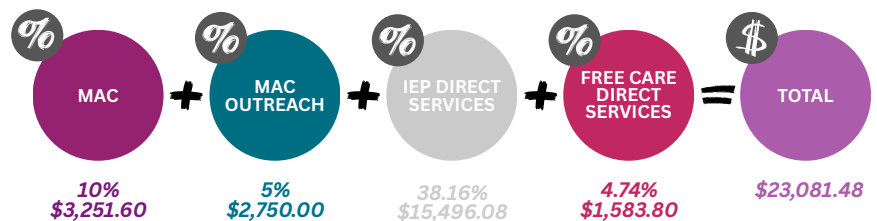
- Statewide direct medical percentage: 4.74%
- Medicaid enrollment ratio: lower than the IEP ratio
- FMAP remains the same

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

- MAC = 10% FTE
- MAC Outreach = 5% FTE
- IEP Direct Service = 38.16% FTE
- Free Care Direct Service = 4.74% FTE



## 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 reimbursement.

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

**Quarterly  
Salary &  
Benefit Data  
Rolls Up to  
Annual Cost  
Report**

## COST SETTLEMENT CALCULATION

EXAMPLE 1: \$100,000 - \$20,000 = \$80,000

EXAMPLE 2: \$100,000 - \$60,000 = \$40,000

EXAMPLE 3: \$100,000 - \$120,000 = -\$20,000  
Get \$ during school year Get \$ 2 years later



**FY22 Allowable Costs**  
Based on expenses entered into the PCG system throughout the school year



**FY22 Interim Payments**  
Based on actual Fee-for-Service payments received during the school year



**FY22 Cost Settlement**  
Receive a lump sum payment or recoupment notice once the school year financials are processed

SOURCE:



**School Medicaid Consulting LLC**

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.

# What can you do?



## **Focus on providing services to students with IEPs**

District employed school based mental health professionals provide services within the IEP.

SOURCE:



**HFS**

Illinois Department of  
Healthcare and Family Services

## 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)*

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

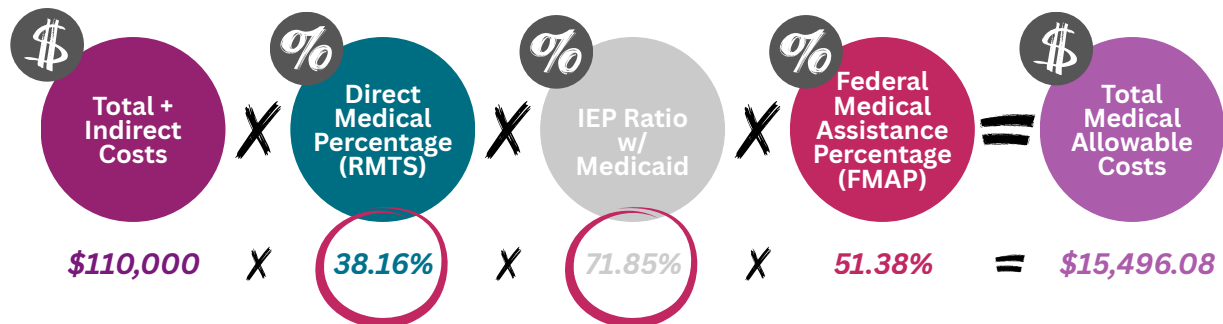
# Free Care & Medicaid Administrative Claiming

*Medicaid Enrollment Rate (MER)*

$$\text{Proportional Medicaid} = \frac{\text{\# Medicaid Enrolled Students}}{\text{\# Total Students}}$$

## IEP Cost Settlement Formula

### Single Provider Example



$$\begin{aligned}
 880 \text{ hours/school year} \times 38.16\% &= 335.81 \text{ hours} \\
 15,496.08 / 335.81 \text{ hours} &= \$46.15/\text{hour}
 \end{aligned}$$

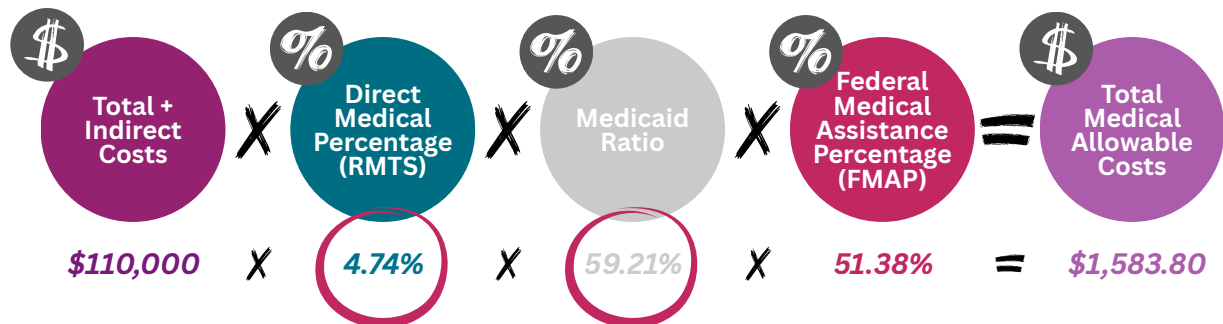
## Provider Reimbursement Comparison

Using an example IEP cost settlement formula:

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

## Free Care Cost Settlement Formula

### Single Provider Example



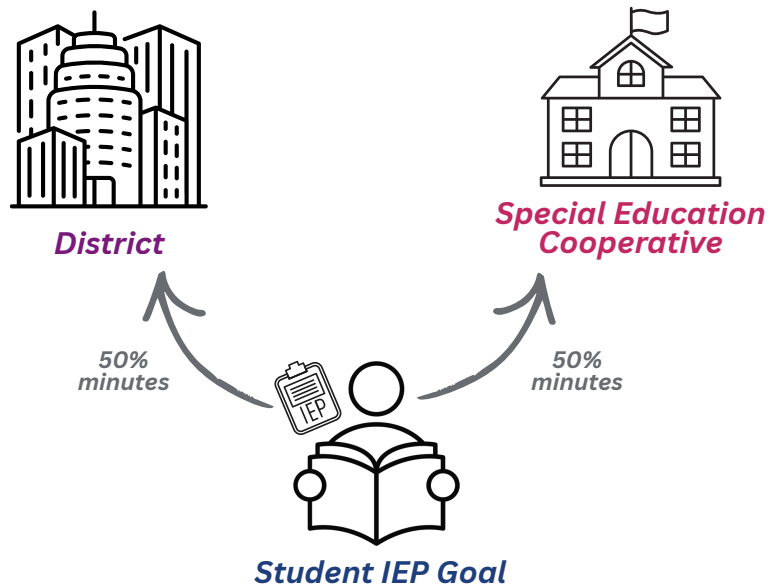
$$\begin{aligned}
 & 880 \text{ school hours/school year} \times 4.74\% = 41.71 \text{ hours} \\
 & 1,583.80 / 41.71 \text{ hours} = \$37.97/\text{hour}
 \end{aligned}$$

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.

## Student IEP:



### IEP Service Delivery Models:

There are multiple ways districts can structure IEP service delivery:

#### -Special Education Cooperative as Provider:

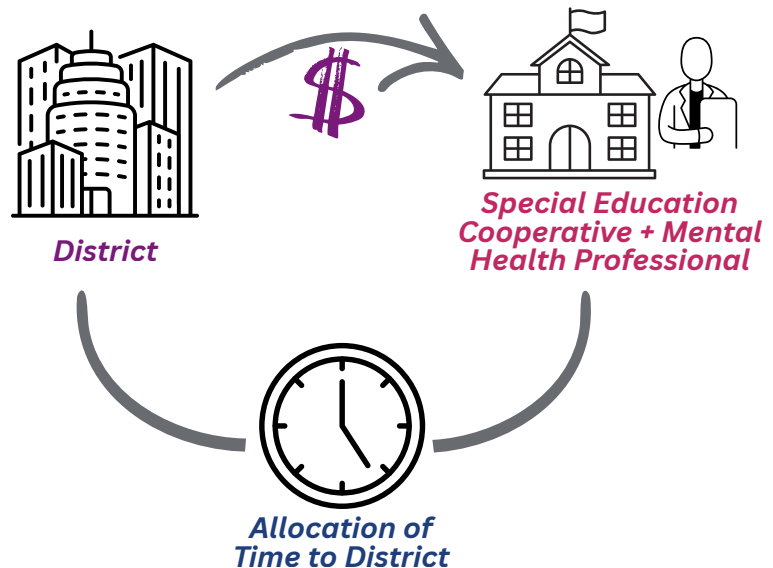
The cooperative may serve as the primary provider as districts expand mental health services.

#### -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:



### 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:

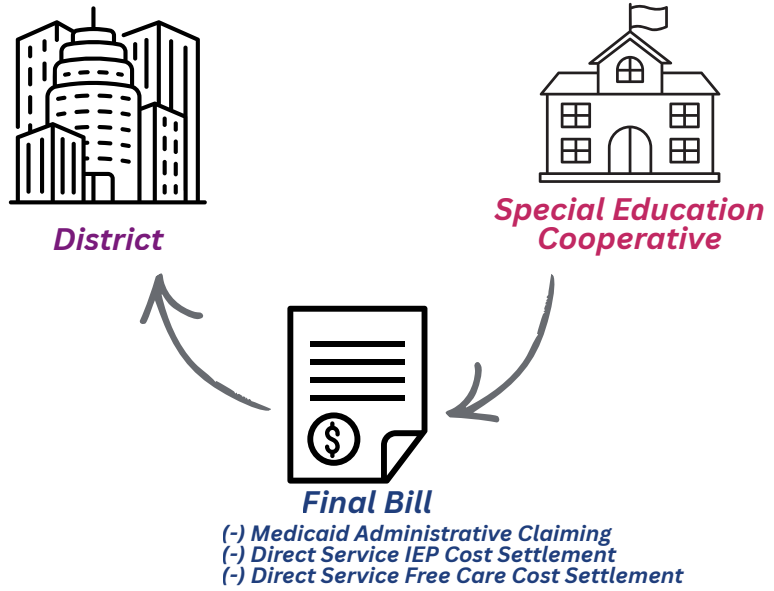
- Shared administrative costs across districts
- Defined time allocations for specific district needs

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



# 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



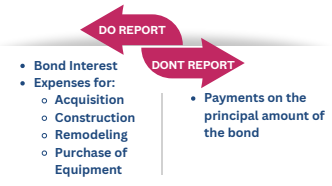
## HELPFUL TIPS & RESOURCES:

- 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:



## Reporting Interest:



## Reporting Rental Costs:



## Reporting LEA-wide Expenditures:



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.

# What can you do?



Talk with Vendor



Get Consultation/Training

SOURCE:  **HFS**  
Illinois Department of  
Healthcare and Family Services

## 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.

# What can you do?



## **Make Referrals**

for youth that need it & participate  
in coordination of services



## **Improve Coordination & Reduce Redundancy of Work**

Influence community agency  
to do their part

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.

# Community Partnership

- Establish communication mechanisms (*e.g. team meetings, email communications, conference calls*) to ensure ongoing & effective communication between school leadership/staff & community partners
- Use memorandums of understanding or other agreements to detail the terms of the partnership (*e.g. by whom, what, when, where, & how will services/supports be provided*)
- Support a full continuum of care within a multi-tiered system of support by school & community partners working together & maximizing their respective knowledge & resources
- Use data sharing agreements to allow for accessing & sharing data to inform needed services & supports & the impact of partnership activities

SOURCE:  Southern Illinois  
Education Alliance

## 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 DENTAL RATES	2025 BEHAVIORAL HEALTH RATES
219 Health Network Inc.	\$194.80		\$75.78
Access Community Health Network	\$194.96	\$160.95	\$82.02
AHS Family Health Center	\$194.80	\$146.13	\$75.78
Alvio 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

Agency/Phone	2025 MEDICAL RATES	2025 DENTAL RATES	2025 BEHAVIORAL HEALTH RATES
1st Health Network Inc.	\$194.80		\$75.75
Acacia Community Health Network	\$194.80	\$180.00	\$82.00
Adelphi Family Health Center	\$194.80	\$180.00	\$75.75
Adelle Medical Center	\$194.18	\$180.00	\$75.75
American Indian Health Service of Chicago	\$175.80		\$75.75
Aunt Martha's Health & Wellness	\$188.00	\$180.00	\$75.75
Bethel Area Community Health Center	\$182.80	\$180.00	\$80.00
Bethel Community Family Wellness Center	\$194.80	\$180.00	\$75.75
Care County Health Department	\$187.00	\$180.00	\$80.00
Central Counties Health Centers, Inc.	\$180.00	\$180.00	\$80.00
Central Health Systems	\$187.00	\$180.00	\$80.00
Chicago Family Health Center	\$187.80	\$180.00	\$75.75
Christian Community Health Center	\$187.80	\$180.00	\$75.75
Chrysalis Greater Area Rural Health Planning Corporation	\$187.00	\$180.00	\$80.00
Community Health & Emergency Inc.	\$175.80	\$180.00	\$80.00
Community Health Care, Inc.	\$188.00	\$180.00	\$80.00
Community Health Centers, Inc.	\$187.00	\$180.00	\$80.00
Community Health Partners of IL	\$194.80	\$180.00	\$75.75

**~ \$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	628999672	\$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**

**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 MINS 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 INSTRUMENT 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

Procedure Code	Units	Description	Unit Price	Unit Price	Unit Price	Unit Price
90.01		Initial Assessment				45.00
90.02		Psychiatric Assessment				45.00
90.03		Psychiatric Assessment				45.00
90.04		Psychiatric Assessment				45.00
90.05		Psychiatric Assessment				45.00
90.06		Psychiatric Assessment				45.00
90.07		Psychiatric Assessment				45.00
90.08		Psychiatric Assessment				45.00
90.09		Psychiatric Assessment				45.00
90.10		Psychiatric Assessment				45.00
90.11		Psychiatric Assessment				45.00
90.12		Psychiatric Assessment				45.00
90.13		Psychiatric Assessment				45.00
90.14		Psychiatric Assessment				45.00
90.15		Psychiatric Assessment				45.00
90.16		Psychiatric Assessment				45.00
90.17		Psychiatric Assessment				45.00
90.18		Psychiatric Assessment				45.00
90.19		Psychiatric Assessment				45.00
90.20		Psychiatric Assessment				45.00
90.21		Psychiatric Assessment				45.00
90.22		Psychiatric Assessment				45.00
90.23		Psychiatric Assessment				45.00
90.24		Psychiatric Assessment				45.00
90.25		Psychiatric Assessment				45.00
90.26		Psychiatric Assessment				45.00
90.27		Psychiatric Assessment				45.00
90.28		Psychiatric Assessment				45.00
90.29		Psychiatric Assessment				45.00
90.30		Psychiatric Assessment				45.00
90.31		Psychiatric Assessment				45.00
90.32		Psychiatric Assessment				45.00
90.33		Psychiatric Assessment				45.00
90.34		Psychiatric Assessment				45.00
90.35		Psychiatric Assessment				45.00
90.36		Psychiatric Assessment				45.00
90.37		Psychiatric Assessment				45.00
90.38		Psychiatric Assessment				45.00
90.39		Psychiatric Assessment				45.00
90.40		Psychiatric Assessment				45.00
90.41		Psychiatric Assessment				45.00
90.42		Psychiatric Assessment				45.00
90.43		Psychiatric Assessment				45.00
90.44		Psychiatric Assessment				45.00
90.45		Psychiatric Assessment				45.00
90.46		Psychiatric Assessment				45.00
90.47		Psychiatric Assessment				45.00
90.48		Psychiatric Assessment				45.00
90.49		Psychiatric Assessment				45.00
90.50		Psychiatric Assessment				45.00
90.51		Psychiatric Assessment				45.00
90.52		Psychiatric Assessment				45.00
90.53		Psychiatric Assessment				45.00
90.54		Psychiatric Assessment				45.00
90.55		Psychiatric Assessment				45.00
90.56		Psychiatric Assessment				45.00
90.57		Psychiatric Assessment				45.00
90.58		Psychiatric Assessment				45.00
90.59		Psychiatric Assessment				45.00
90.60		Psychiatric Assessment				45.00
90.61		Psychiatric Assessment				45.00
90.62		Psychiatric Assessment				45.00
90.63		Psychiatric Assessment				45.00
90.64		Psychiatric Assessment				45.00
90.65		Psychiatric Assessment				45.00
90.66		Psychiatric Assessment				45.00
90.67		Psychiatric Assessment				45.00
90.68		Psychiatric Assessment				45.00
90.69		Psychiatric Assessment				45.00
90.70		Psychiatric Assessment				45.00
90.71		Psychiatric Assessment				45.00
90.72		Psychiatric Assessment				45.00
90.73		Psychiatric Assessment				45.00
90.74		Psychiatric Assessment				45.00
90.75		Psychiatric Assessment				45.00
90.76		Psychiatric Assessment				45.00
90.77		Psychiatric Assessment				45.00
90.78		Psychiatric Assessment				45.00
90.79		Psychiatric Assessment				45.00
90.80		Psychiatric Assessment				45.00
90.81		Psychiatric Assessment				45.00
90.82		Psychiatric Assessment				45.00
90.83		Psychiatric Assessment				45.00
90.84		Psychiatric Assessment				45.00
90.85		Psychiatric Assessment				45.00
90.86		Psychiatric Assessment				45.00
90.87		Psychiatric Assessment				45.00
90.88		Psychiatric Assessment				45.00
90.89		Psychiatric Assessment				45.00
90.90		Psychiatric Assessment				45.00
90.91		Psychiatric Assessment				45.00
90.92		Psychiatric Assessment				45.00
90.93		Psychiatric Assessment				45.00
90.94		Psychiatric Assessment				45.00
90.95		Psychiatric Assessment				45.00
90.96		Psychiatric Assessment				45.00
90.97		Psychiatric Assessment				45.00
90.98		Psychiatric Assessment				45.00
90.99		Psychiatric Assessment				45.00
91.00		Psychiatric Assessment				45.00

~ \$91.58 / hr

*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 employ this person as a provider.

The district can also employee this person as a paraprofessional.

# 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		Units	NB Service Add On	State Max	
		1	2			On-Site	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	S2		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

\*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

SOURCE:



HFS

Illinois Department of  
Healthcare and Family Services

## 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

Service Name	Proc Code	Modifiers		Units	MR Service Add On	State Max	
		1	2			Per Unit	Per Session
Assessment and Treatment Planning							
Integrated Assessment and Treatment Planning (IATP)	90999	400		1.00 hr	--	\$139.36	\$139.36
Integrated Assessment and Treatment Planning (IATP)	90999	401		1.00 hr	--	\$139.36	\$139.36
IATP Review and Update	90999	400	2P	1.00 hr	--	\$139.36	\$139.36
IATP Review and Update	90999	401	2P	1.00 hr	--	\$139.36	\$139.36
IATP Clinical Assessment Tool under IATP direction	90999	512		1.00 hr	--	\$139.36	\$139.36
IATP Clinical Assessment Tool performed by an IATP	90999	513		1.00 hr	--	\$139.36	\$139.36
IATP Psychological Assessment	90999	400		1.00 hr	--	\$139.36	\$139.36
IATP Psychological Assessment	90999	401		1.00 hr	--	\$139.36	\$139.36
IATP IATP Assessment	90999	400		1.00 hr	--	\$139.36	\$139.36
Pathways to Success Program Services	90999	400		1.00 hr	--	\$139.36	\$139.36
~ \$139.36 / hr							
IATP Child and Family Team (CFT) session	90999	400		1.00 hr	--	\$139.36	\$139.36
IATP Child and Family Team (CFT) session	90999	401		1.00 hr	--	\$139.36	\$139.36
Case Services							
Case Intervention	90999	400		1.00 hr	--	\$139.36	\$139.36
Therapy/Counseling Services							
Therapy/Counseling, Individual	90999	400		1.00 hr	--	\$139.36	\$139.36
Therapy/Counseling, Individual	90999	401		1.00 hr	--	\$139.36	\$139.36
Therapy/Counseling, Brief Intervention	90999	512	15	1.00 hr	--	\$139.36	\$139.36
Therapy/Counseling, Group	90999	400	400	1.00 hr	--	\$139.36	\$139.36
Therapy/Counseling, Group	90999	401	400	1.00 hr	--	\$139.36	\$139.36
Therapy/Counseling, Family	90999	400	400	1.00 hr	--	\$139.36	\$139.36
Therapy/Counseling, Family	90999	401	400	1.00 hr	--	\$139.36	\$139.36

~ \$139.36 / hr

\*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.

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SOURCE:



HFS

Illinois Department of  
Healthcare and Family Services

# Group A, B, C Services:

billable by BHC, CMHC, IPs

Service Name	Proc Code	Modifiers		Units	NB Service Add On	State	Max
		1	2			On-Site	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	S2		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

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## Group A, B, C Services:

billable by BHC, CMHC, IPs

Service Name	Proc Code	Modifiers		Units	Rate (Per Hour)		
		1	2		Per Hour	Per Hour	Per Hour
Assessment and Treatment Planning							
Integrated Assessment and Treatment Planning (IATP)	90980	400		1.00	12.64	12.64	12.64
Integrated Assessment and Treatment Planning (IATP)	90980	401		1.00	12.64	12.64	12.64
IATP Review and Update	90980	400	2P	1.00	12.64	12.64	12.64
IATP Review and Update	90980	401	2P	1.00	12.64	12.64	12.64
IATP Clinical Assessment Tool under IATP direction	90980	512		1.00	12.64	12.64	12.64
IATP Clinical Assessment Tool performed by an IATP	90980	513		1.00	12.64	12.64	12.64
IATP Psychological Assessment	90980	400		1.00	12.64	12.64	12.64
IATP Psychological Assessment	90980	401		1.00	12.64	12.64	12.64
IATP IATP Assessment	90980	400		1.00	12.64	12.64	12.64
Pathways to Success Program Services							
IATP Clinical and Family Team (IATP)	90980	400		1.00	12.64	12.64	12.64
IATP Clinical and Family Team (IATP)	90980	401		1.00	12.64	12.64	12.64
Case Services							
Case Intervention	90980	400		1.00	12.64	12.64	12.64
Therapeutic Counseling Services							
Therapeutic Counseling, Individual	90980	400		1.00	12.64	12.64	12.64
Therapeutic Counseling, Individual	90980	401		1.00	12.64	12.64	12.64
Therapeutic Counseling, Brief Intervention	90980	512	15	1.00	12.64	12.64	12.64
Therapeutic Counseling, Group	90980	400	400	1.00	12.64	12.64	12.64
Therapeutic Counseling, Group	90980	401	400	1.00	12.64	12.64	12.64
Therapeutic Counseling, Family	90980	400	400	1.00	12.64	12.64	12.64
Therapeutic Counseling, Family	90980	401	400	1.00	12.64	12.64	12.64

~ +\$12.64 / hr

\*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.

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SOURCE:

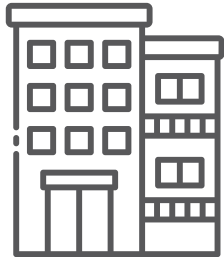


HFS

Illinois Department of  
Healthcare and Family Services



**VS.**



## School-based Providers:

- Medicaid payor of first resort

## Community-based Providers:

- Medicaid payor of last resort
- Commercial insurance must pay portion first
- Medicaid is secondary and can cover out of pocket costs

SOURCE:

### School-Based vs. Community-Based Billing:

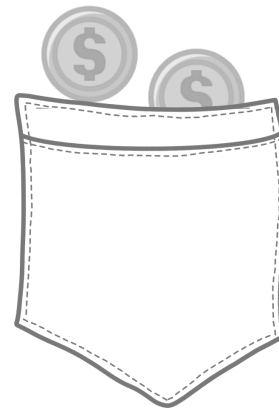
Medicaid functions differently across settings:

- 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



University Bursar

SOURCE: 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

University Bursar

SOURCE: 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 <i>after</i> deductible is met
Deductible impact	Usually doesn't count	Applies after deductible is met
Cost predictability	Easy to predict	Varies by service cost

University Bursar

SOURCE: STUDENT MONEY MANAGEMENT CENTER

## Ideas to Engage a Community Partner

- A small contract that phases out over six months for onboarding costs prior to Medicaid sustainability.
- Make referrals and create a culture of collaboration and prioritization of access to services.
- Provide dedicated space, access to wifi, access to copy machine/printer, access card to the building, and included in staff emails and text communication systems.
- Be flexible that the service model has different requirements and looks different than a traditional IEP service model.
- Use data sharing agreements for the provider to get access to the student database and to share information about participation in services.
- Similar to IEP services, providers must provide services directly connected to mental health diagnosis and listed in the treatment or service plan.

SOURCE:  Southern Illinois  
Education Alliance

### 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

# MTTS Support & Services:

## Mental Health Staff Mental Health Services

### Tier 3/Tertiary Interventions

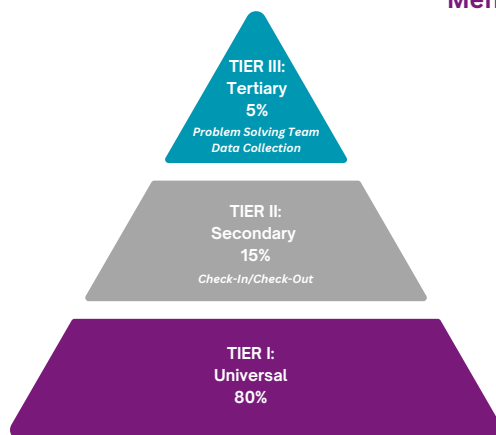
- FBA & Teacher Consultation
- Individual MAP Counseling (>45m/wk)
- Parent Beh Mgmt Training

### Tier 2/Secondary Interventions

- Coordinated Care with PCP, Caseworker, etc
- Infrequent 1:1 Services (>15m/wk)
- Homework, Organization & Planning Skills Group
- Anger Coping Group
- Social Skills Group
- Coping CATS Depression Group
- Anxiety Group
- Cogn Beh Interv Trauma in the Schools Group

### Tier 1/Universal Interventions

- ALGEE Approach
- Stigma Reduction & Awareness on Mental Health Diagnosis & Treatment Options
- SEL Lessons (Data Driven Selection)
- PBIS
- Predictable & Consistent Rules & Consequences
- Rewards & Praise System
- Predictable, Low-Moderate Stress Opportunities
- Promote Developmental Assets



## School Staff Mental Health Supports

### Tier 3/Tertiary Interventions

- Beh Interv Plan
- 1:1 Intensive SEL Instruction (>45m/wk)

### Tier 2/Secondary Interventions

- Supplemental SEL Lesson - small group, class, or grade
- Creative Change to Improve Functioning
- Infrequent 1:1 Supports (<15m/wk)

### Tier 1/Universal Interventions

- ALGEE Approach
- Stigma Reduction & Awareness on Mental Health Diagnosis & Treatment Options
- SEL Lessons (Data Driven Selection)
- PBIS
- Predictable & Consistent Rules & Consequences
- Rewards & Praise System
- Predictable, Low-Moderate Stress Opportunities
- Promote Developmental Assets

SOURCE:



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**



**University Bursar  
STUDENT MONEY MANAGEMENT CENTER**



**Medicaid.gov**  
Keeping America Healthy



## FOR MORE INFORMATION

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**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.