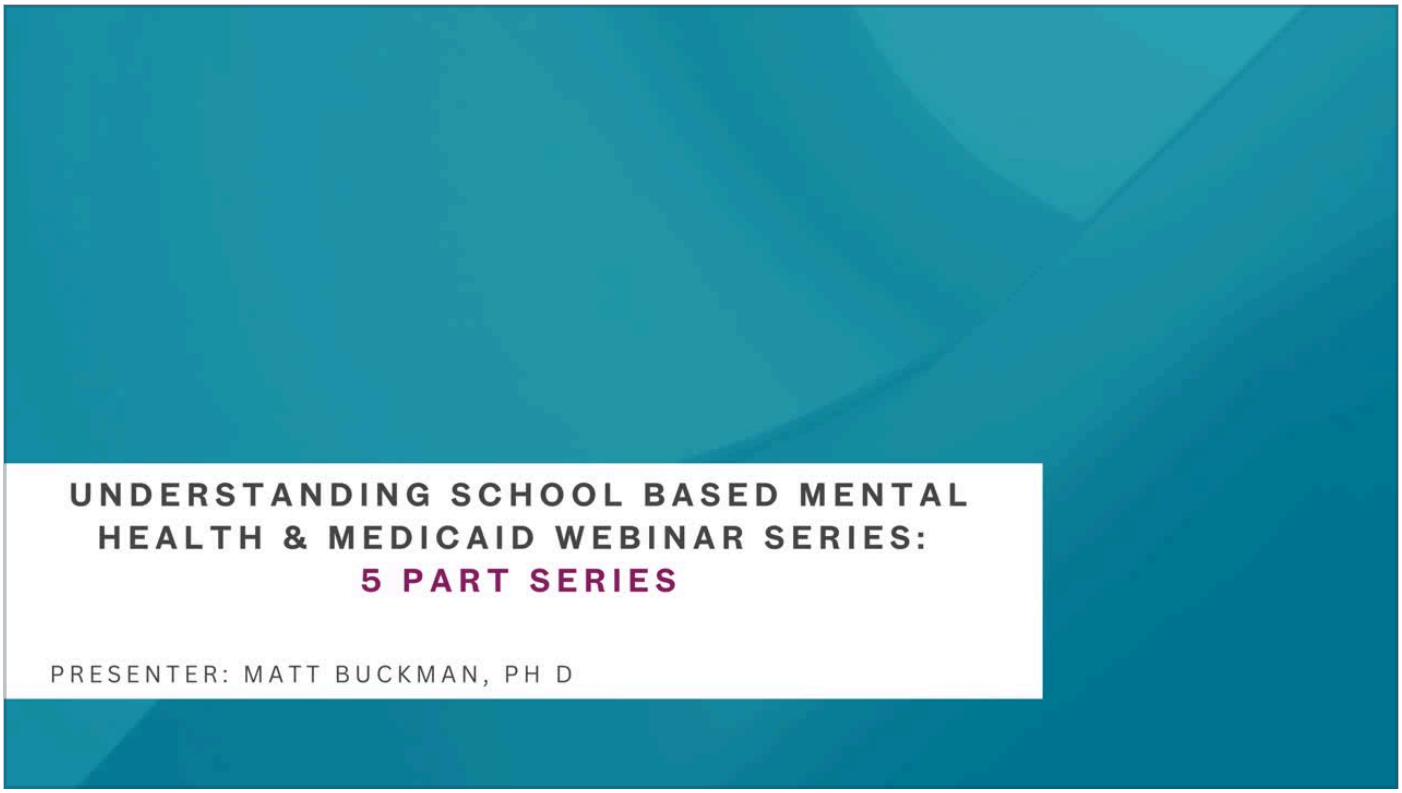


Introduction:

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—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.

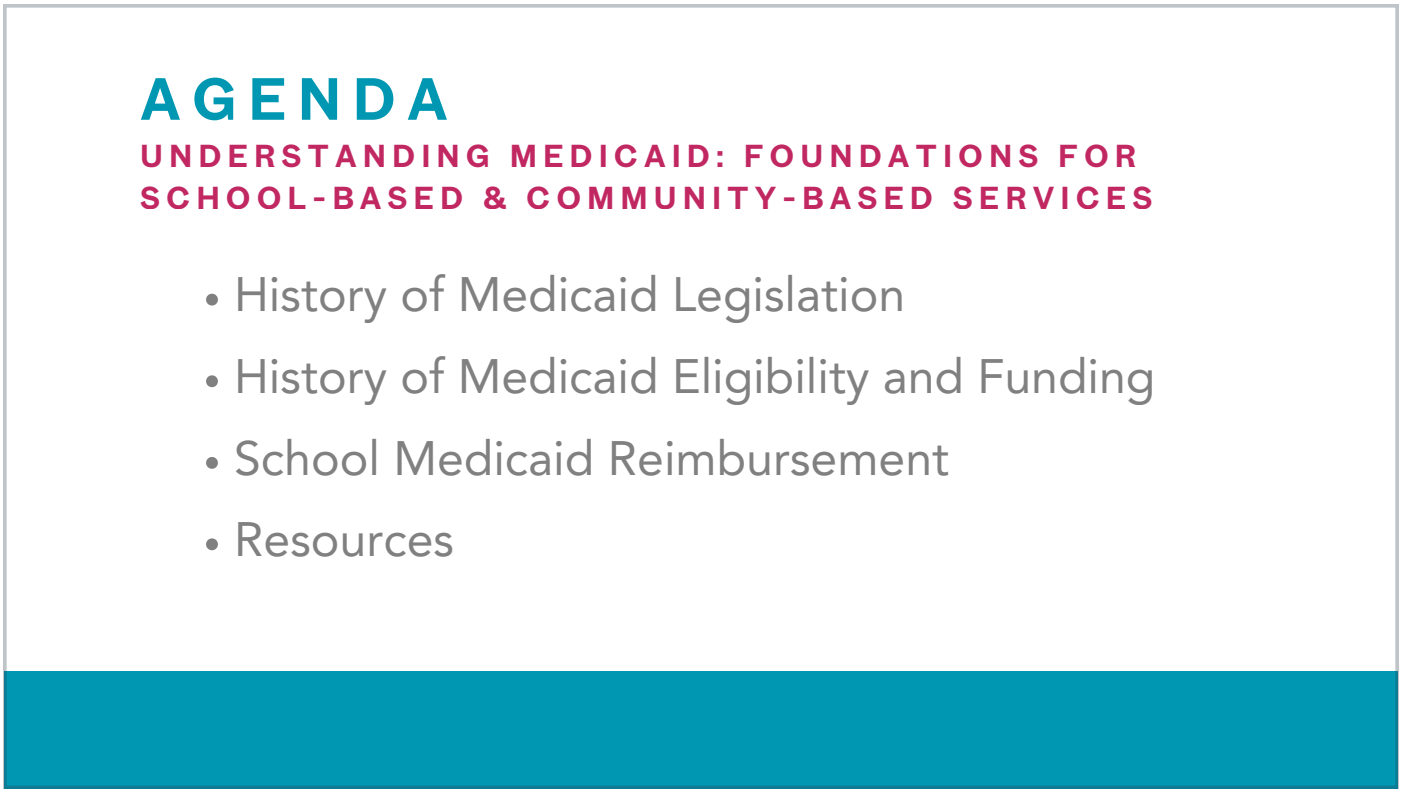
This webinar was developed with support from the U.S. Department of Education's School-Based Mental Health Services Grant, awarded to West 40 Intermediate Service Center #2 in partnership with the Stress and Trauma Treatment Center.

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.

Overview of the Webinar Series:

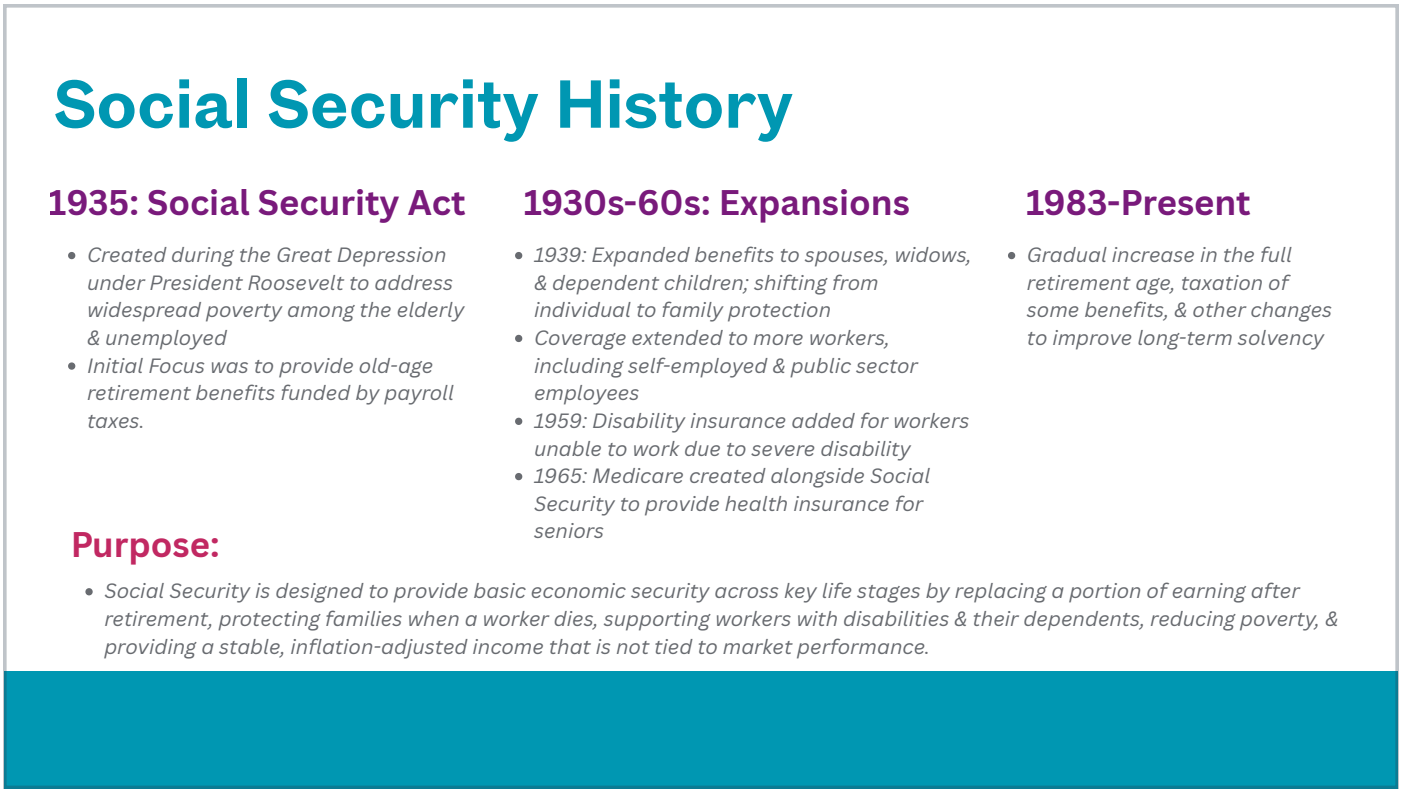
This five-part series progresses from foundational Medicaid concepts to increasingly specific applications. Beginning with a core understanding of Medicaid allows us to explore school-based reimbursement systems, community mental health services, specialized care coordination programs, and actionable strategies to expand access to mental health services for students.

Part one: Understanding Medicaid and the Foundation of Medicaid Reimbursement for School-based and Community- based services.



Agenda:

-History of Medicaid legislation
-History of Medicaid Eligibility & Funding
-school Medicaid reimbursement and funding models
-Resources



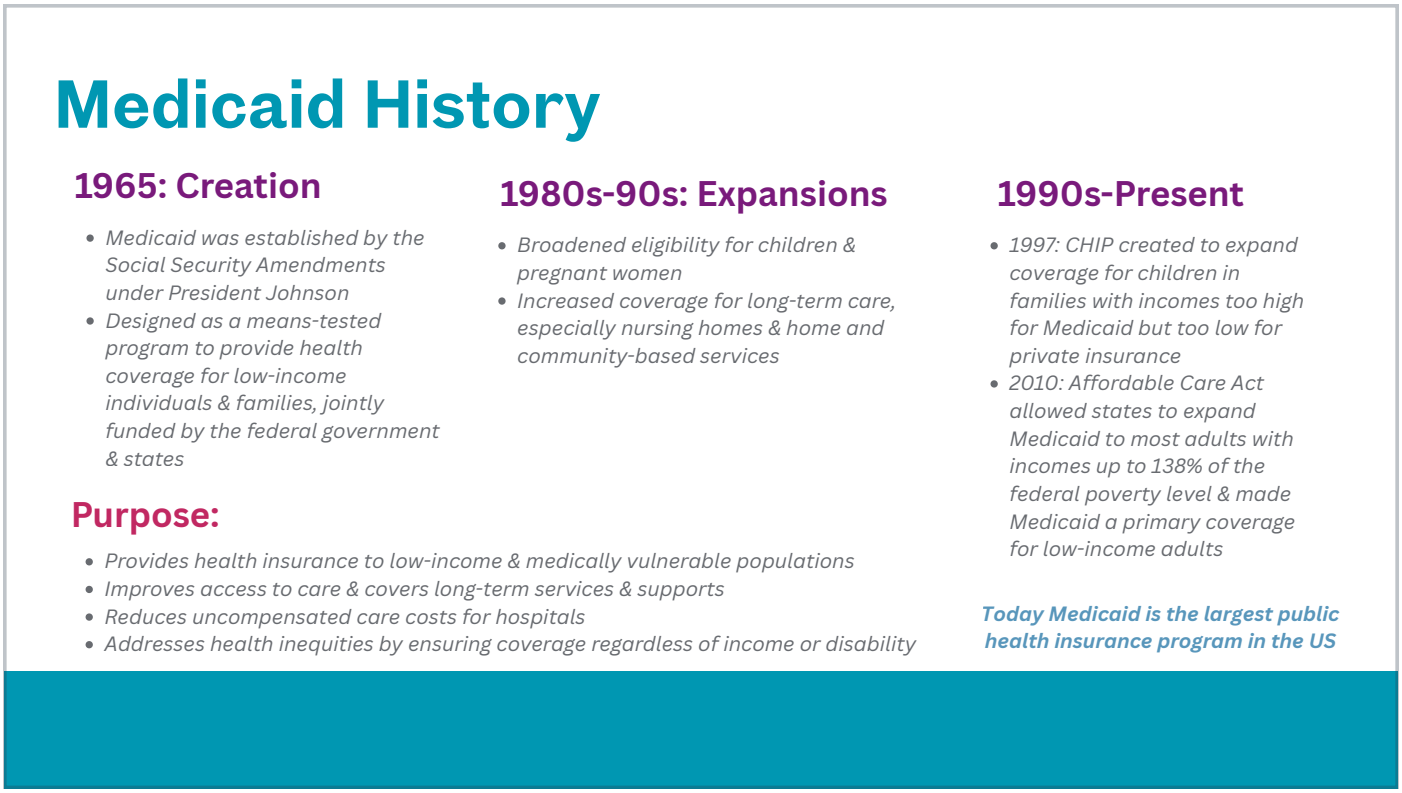
History of Medicaid Legislation:

Medicaid originated from the Social Security Act of 1935, developed during the Great Depression under President Franklin D. Roosevelt. The goal of this legislation was to provide economic security and reduce poverty, particularly for vulnerable populations such as individuals with disabilities, older adults, and families who had lost wage earners.

Social Security History

Purpose:

- ***Social Security is designed to provide basic economic security across key life stages by replacing a portion of earning after retirement, protecting families when a worker dies, supporting workers with disabilities & their dependents, reducing poverty, & providing a stable, inflation-adjusted income that is not tied to market performance.***

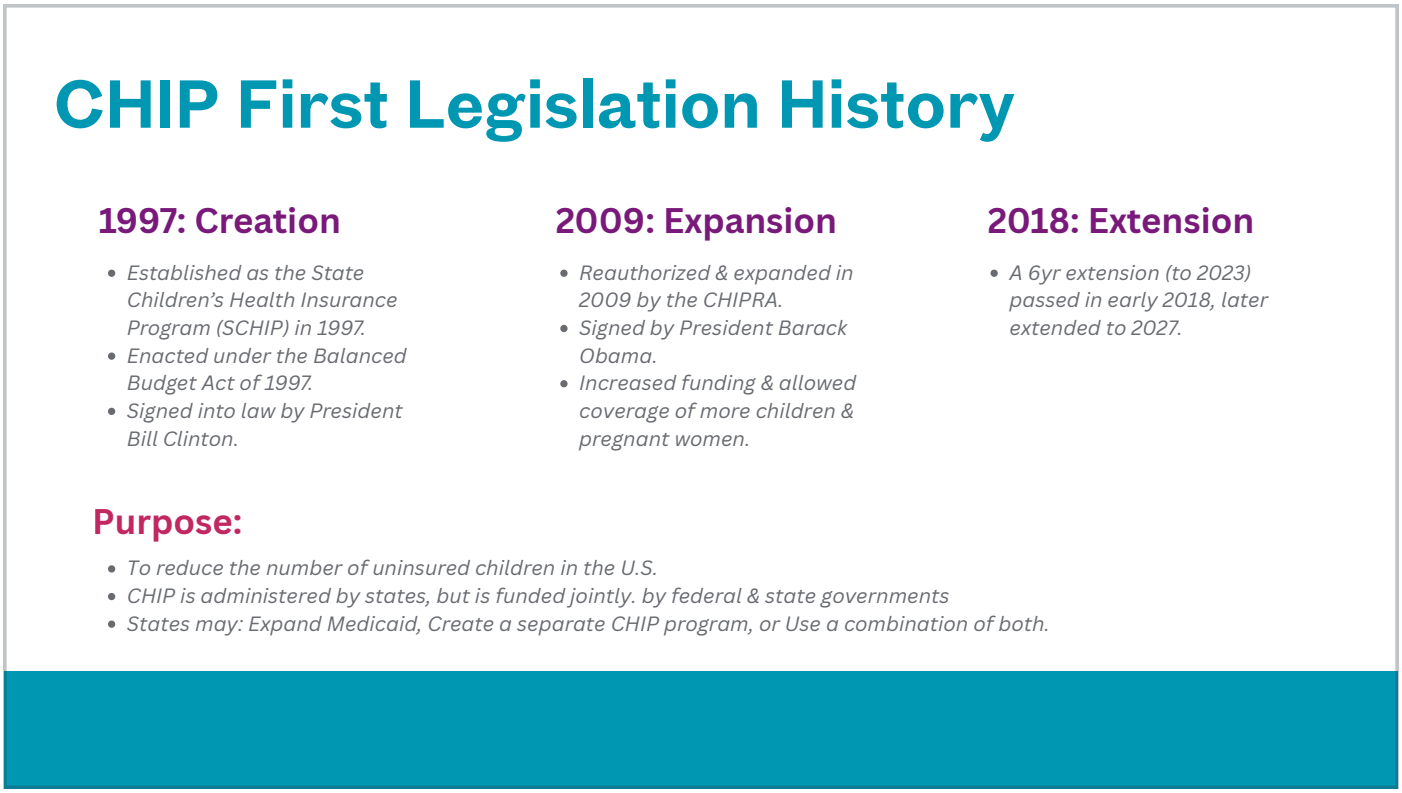


In 1965, this legislation was expanded to create Medicare and Medicaid. Medicaid was designed to serve individuals with low income, those below the federal poverty level, and medically vulnerable populations. Its purpose was to ensure access to services and reduce inequities in health care coverage.

Medicaid History

Purpose:

- ***Provides health insurance to low-income & medically vulnerable populations***
- ***Improves access to care & covers long-term services & supports***
- ***Reduces uncompensated care costs for hospitals***
- ***Addresses health inequities by ensuring coverage regardless of income or disability***



CHIP and Expanded Eligibility:

In 1997, Congress passed the Children's Health Insurance Program (CHIP), allowing states to expand health coverage for children. While still state-administered, CHIP provided federal funding support and enhanced matching rates, known as the Federal Medical Assistance Percentage (FMAP).

The goal of CHIP was to reduce the number of uninsured children nationwide. Illinois adopted CHIP and expanded eligibility, significantly increasing coverage for children.

CHIP First Legislation History

1997: Creation

- Established as the State Children's Health Insurance Program (SCHIP) in 1997
- Balanced Budget Act of 1997

2009: Expansion

- Reauthorized & expanded in 2009 by the CHIPRA
- Signed by President Barack Obama
- Increased funding & allowed

2018: Extension

- A 6yr extension (to 2023) passed in early 2018, later extended to 2027

Purpose:

- ***To reduce the number of uninsured children in the U.S.***
- ***CHIP is administered by states, but is funded jointly by the federal & state government***
- ***States may: Expand Medicaid, Create a separate CHIP program, or Use a combination of both.***

Purpose:

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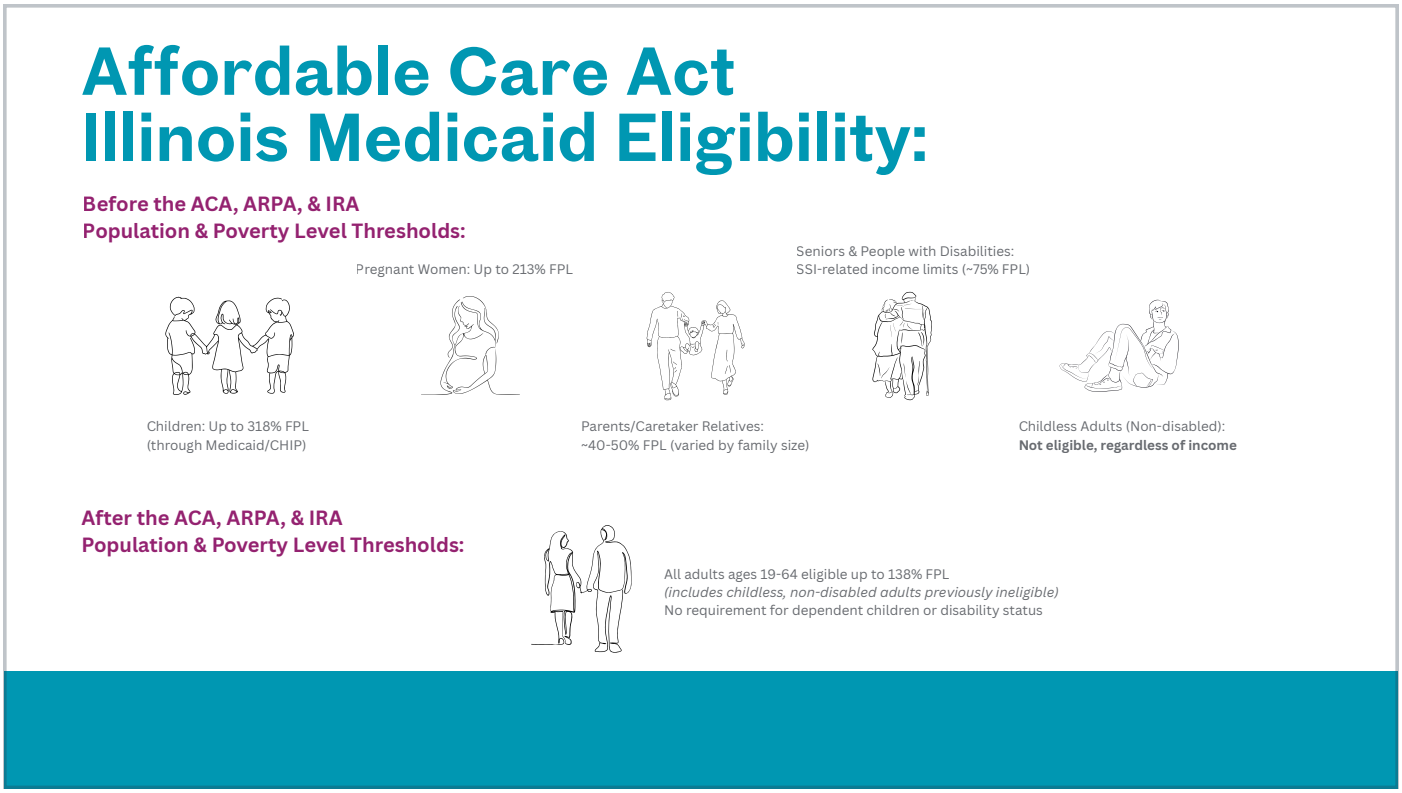


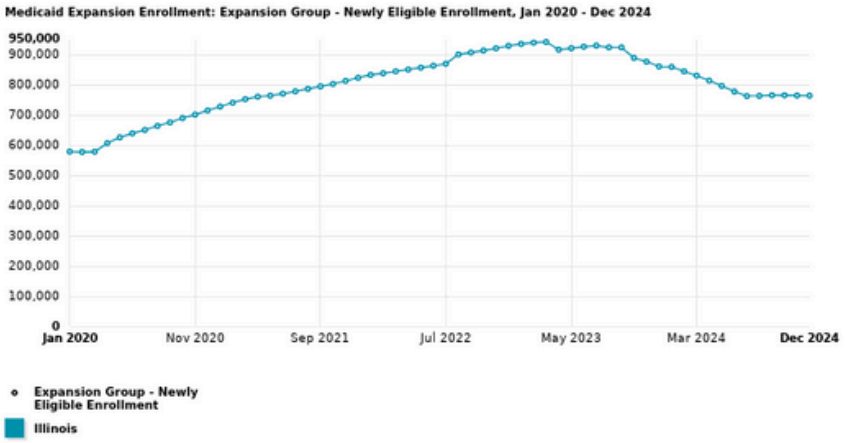
Affordable Care Act and Medicaid Expansion

The Affordable Care Act (ACA) further expanded Medicaid eligibility and reimbursement. It extended coverage to additional vulnerable populations, particularly adults aged 19–64 without dependent children who were previously ineligible.

Current eligibility:

-Children up to 318% of the federal poverty level
-Pregnant women up to 213%
-Caregivers up to 40–50%

Medicaid Adult Expansion Enrollment

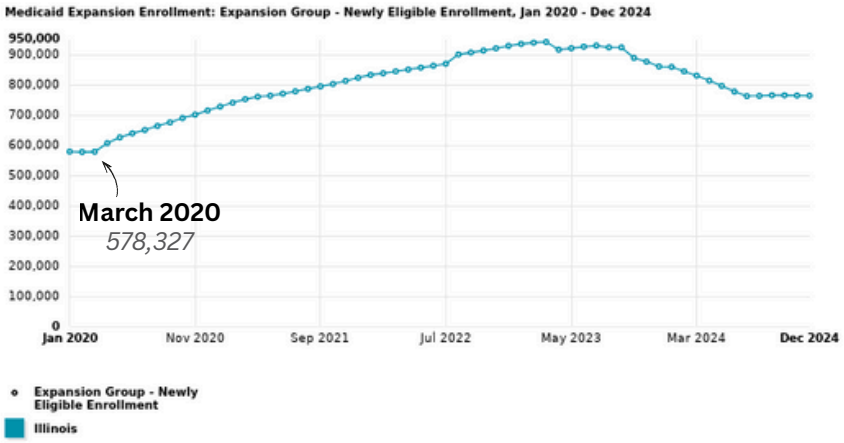


SOURCE: KFF The independent source for health policy research, polling, and news.

Following ACA implementation:

Medicaid coverage for adults increased substantially, peaking at approximately 941,000 newly covered individuals in Illinois by March 2023.

Medicaid Adult Expansion Enrollment



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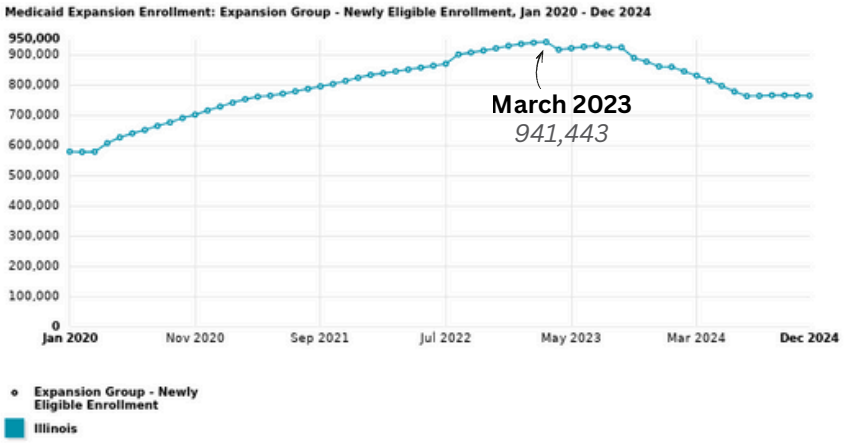

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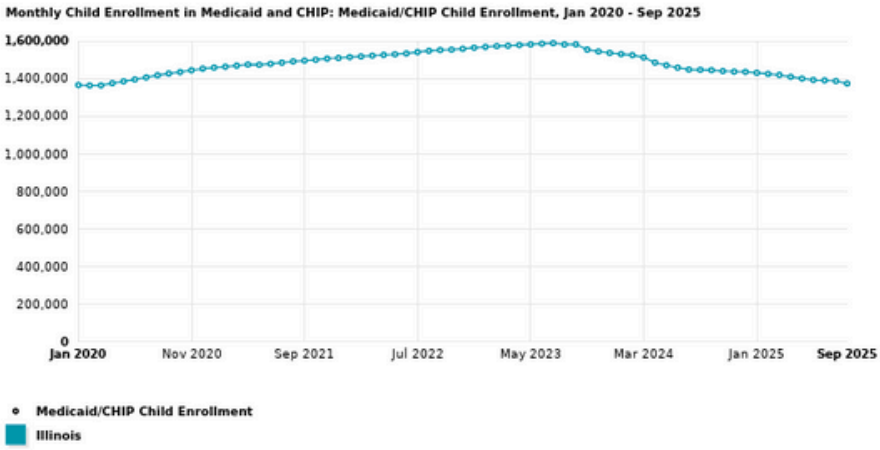
Monthly Child Enrollment - Medicaid & CHIP

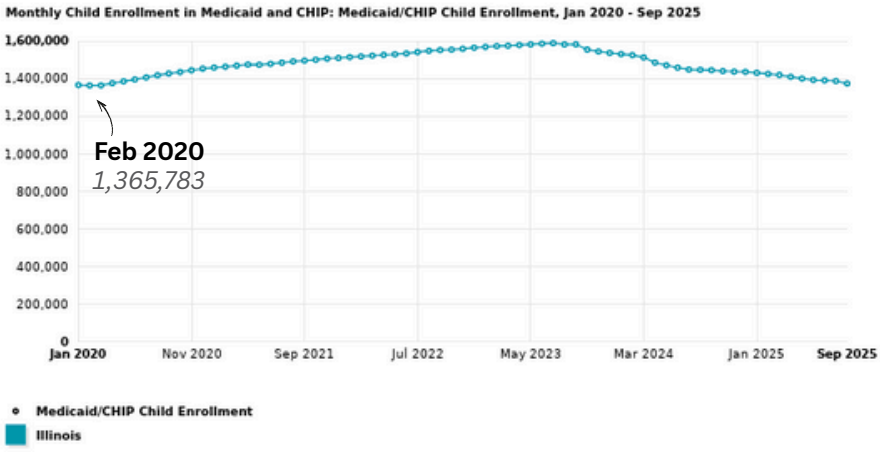


SOURCE: KFF The independent source for health policy research, polling, and news.

Children's Medicaid coverage remained relatively stable, increasing from approximately 1.3–1.4 million in 2020 to nearly 1.6 million in subsequent years.

Illinois had already expanded children's coverage prior to the ACA, which limited the magnitude of change for pediatric populations.

Monthly Child Enrollment - Medicaid & CHIP



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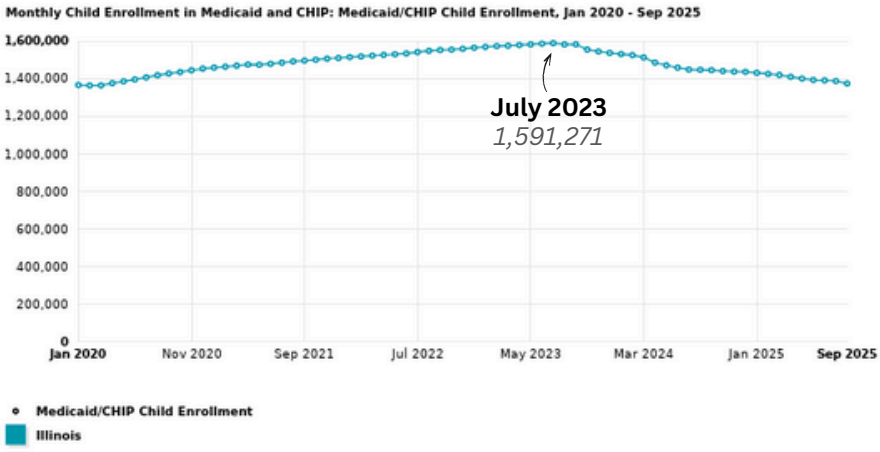
Monthly Child Enrollment - Medicaid & CHIP



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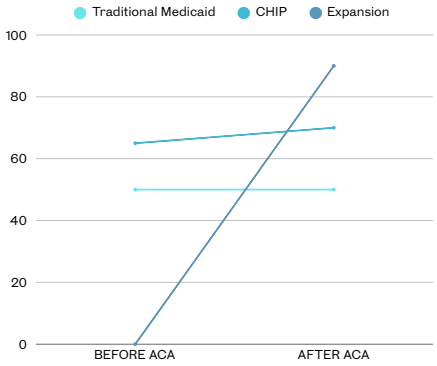
Federal Medicaid Match Rate in Illinois

Before the ACA:
Federal Medical Assistance Percentages (FMAP)

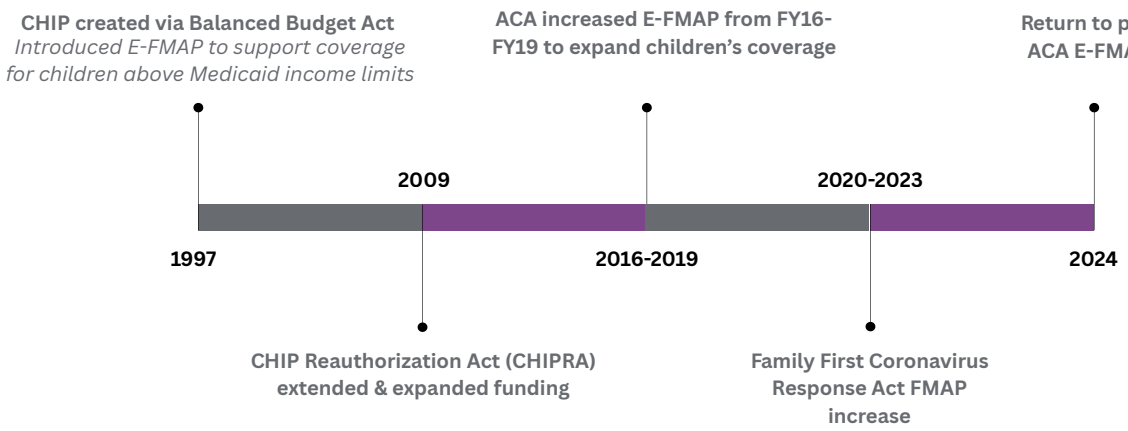
- Traditional Medicaid (children, pregnant women, low-income parents, disabled, elderly): ~50% federal match
- CHIP (Children's Health Insurance Program): ~65% federal match
- No federal match for non-disabled childless adults (not covered)

After the ACA:
Post-ACA Match Rates

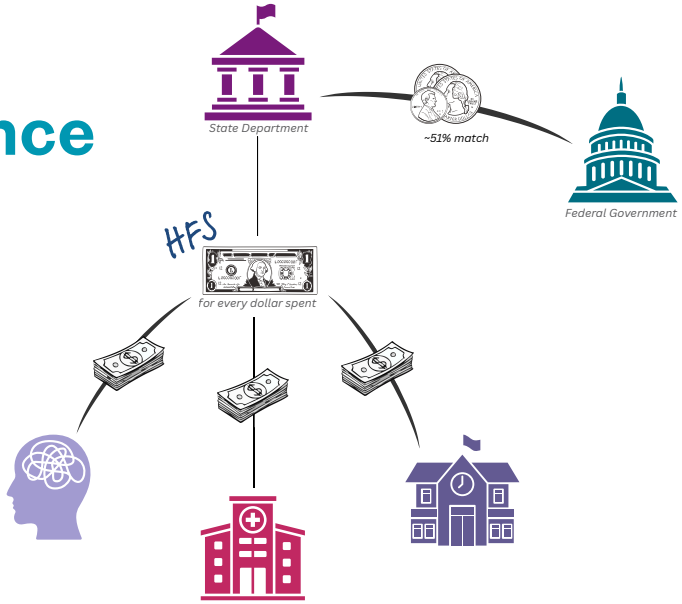
- Traditional Medicaid Populations: Remain at ~50% federal match
- CHIP: Maintains enhanced match (~65-70%)
- Expansion Population (newly eligible adults): 90% federal match (as of 2024)



History of Enhanced FMAP for Children



Match: Federal Medical Assistance Percentage (FMAP)



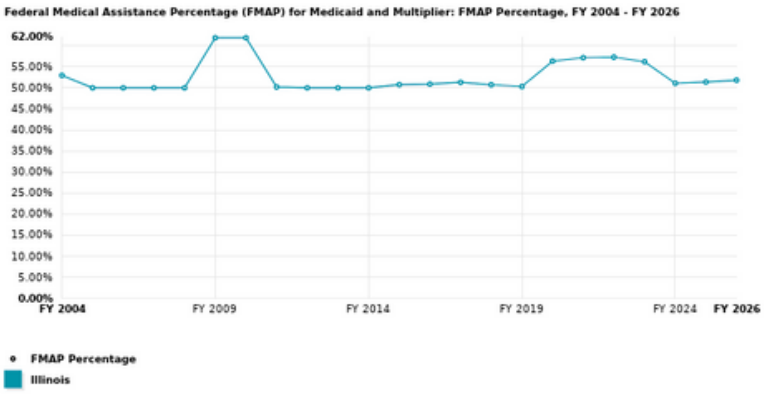
Medicaid Funding and FMAP:

Medicaid is jointly funded by federal and state governments. States administer Medicaid, while the federal government provides matching funds through FMAP.

Illinois' standard FMAP is approximately 51%

The statutory minimum FMAP is 50%

Federal Medical Assistance Percentage (FMAP) for Medicaid

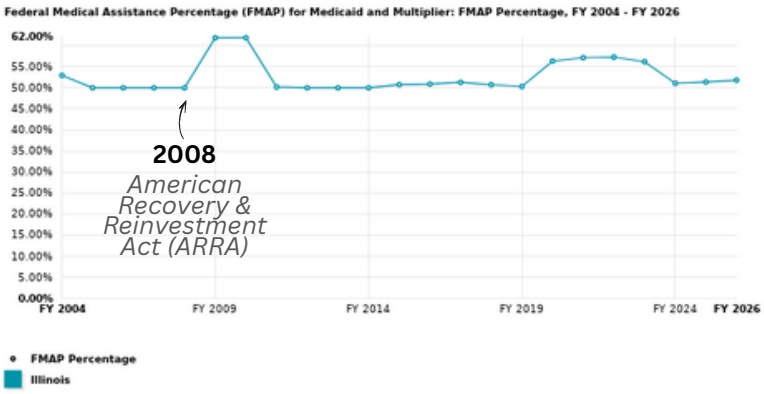


SOURCE: KFF The independent source for health policy research, polling, and news.

Enhanced FMAP rates apply to certain populations and programs, including CHIP and ACA-expanded adults

During economic downturns and emergencies—such as the American Recovery and Reinvestment Act (2008) and COVID-19—FMAP rates temporarily increased.

Federal Medical Assistance Percentage (FMAP) for Medicaid



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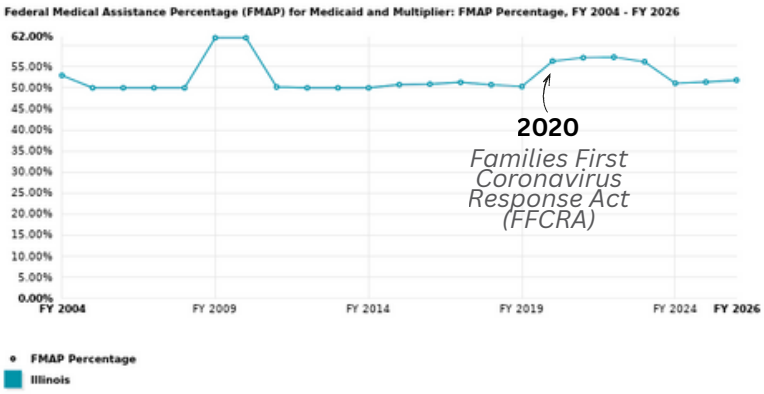
Federal Medical Assistance Percentage (FMAP) for Medicaid



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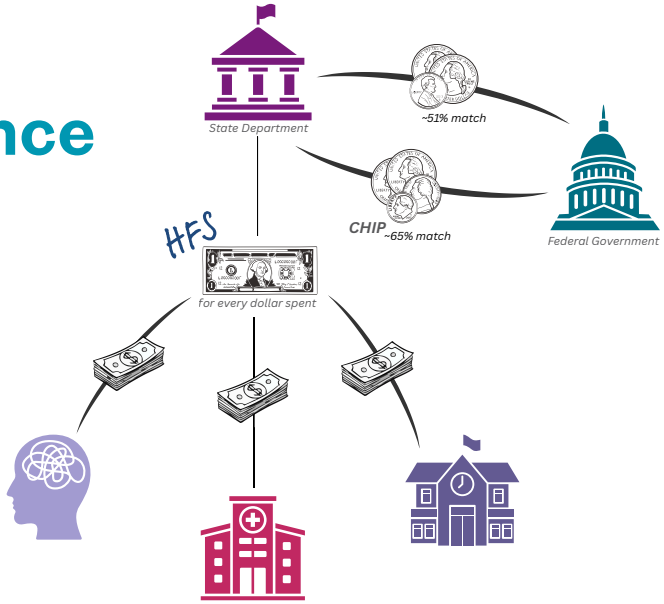
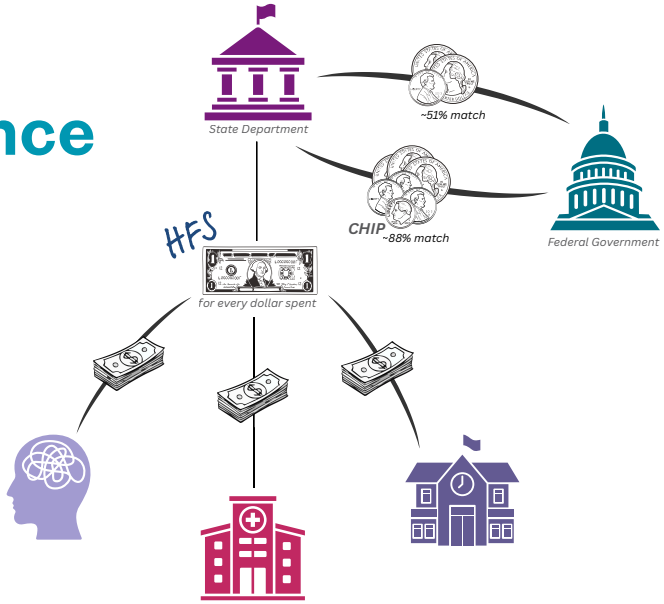
Match: Federal Medical Assistance Percentage (FMAP)

Pre ACA

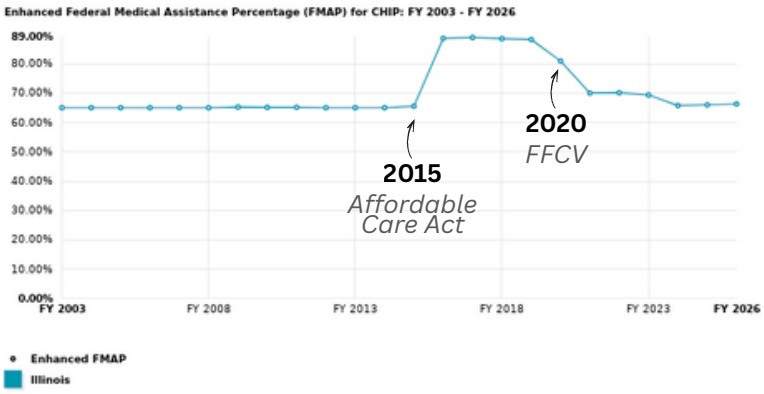


Match: Federal Medical Assistance Percentage (FMAP)

Post ACA



Enhanced Federal Medical Assistance Percentage (FMAP) for CHIP



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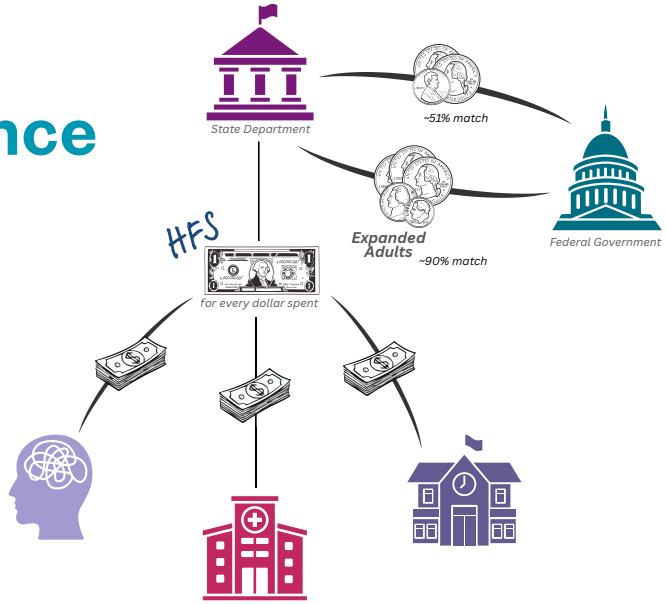
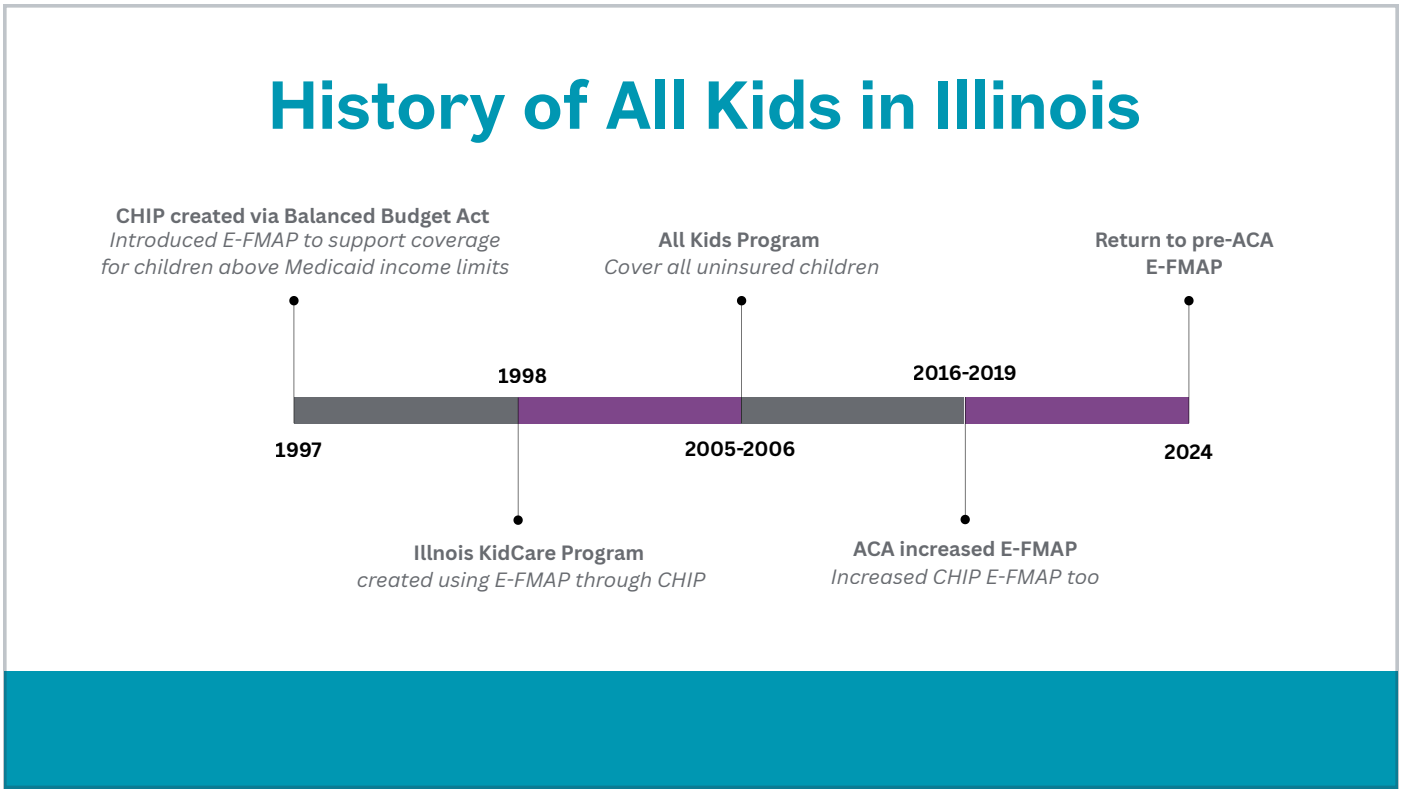
Match: Federal Medical Assistance Percentage (FMAP)



For ACA-expanded adults, the federal government currently matches 90% of eligible Medicaid expenditures.



Extended Medicaid Coverage in Illinois

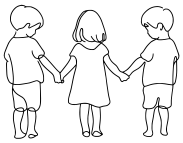
Illinois has a long history of expanding Medicaid eligibility for children:

1998: KidCare created under CHIP

2005–2006: All Kids expanded to cover all uninsured children

AllKids/FamilyCare Eligibility

Pregnant Women: Up to 213% FPL



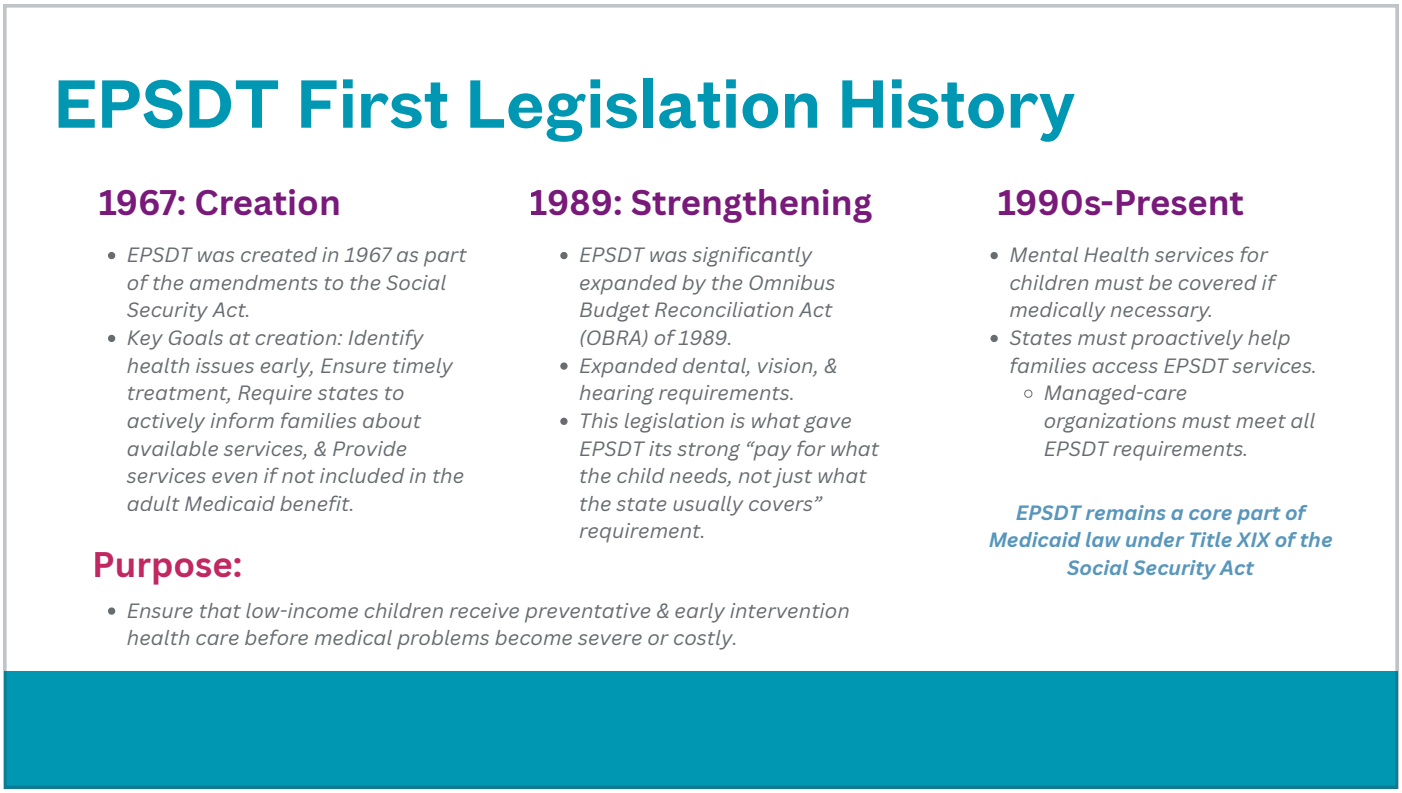
Children: Up to 318% FPL
(through Medicaid/CHIP)

Parents/Caretaker Relatives:
~40-50% FPL (varied by family size)

Current eligibility:

-Children up to 318% of the federal poverty level
-Pregnant women up to 213%
-Caregivers up to 40–50%

These eligibility levels remain in place today



EPSDT and Preventive Care:

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services were established in 1967 to ensure low-income children receive preventive and early intervention care. EPSDT emphasizes addressing health and mental health needs early to prevent more severe and costly conditions later.

This framework aligns closely with modern school-based mental health approaches focused on early identification and prevention.

EPSDT First Legislation History

1967: Creation

- *EPSDT was created in 1967 as part of the amendments to the Social Security Act.*
- *Key goals of creation: identify health problems early, ensure timely treatment, require states to actively inform families about available services, and cover necessary services even if not included in the adult Medicaid benefit.*

1989: Strengthening

- *EPSDT was significantly expanded by the Omnibus Budget Reconciliation Act (OBRA) of 1989.*
- *Expanded dental, vision, & hearing requirements.*
- *Introduced the "whatever the child needs, not just what the state usually covers" requirement.*

1990s-Present

- *Mental health services for children must be covered if medically necessary.*
- *States must proactively help families access EPSDT services.*
  - *Managed care*
- *meet all EPSDT requirements.*

EPSDT remains a core part of Medicaid law under Title XIX of the Social Security Act

Purpose:

- *Ensure that low income children receive preventative & early intervention health care before medical problems become severe or costly.*

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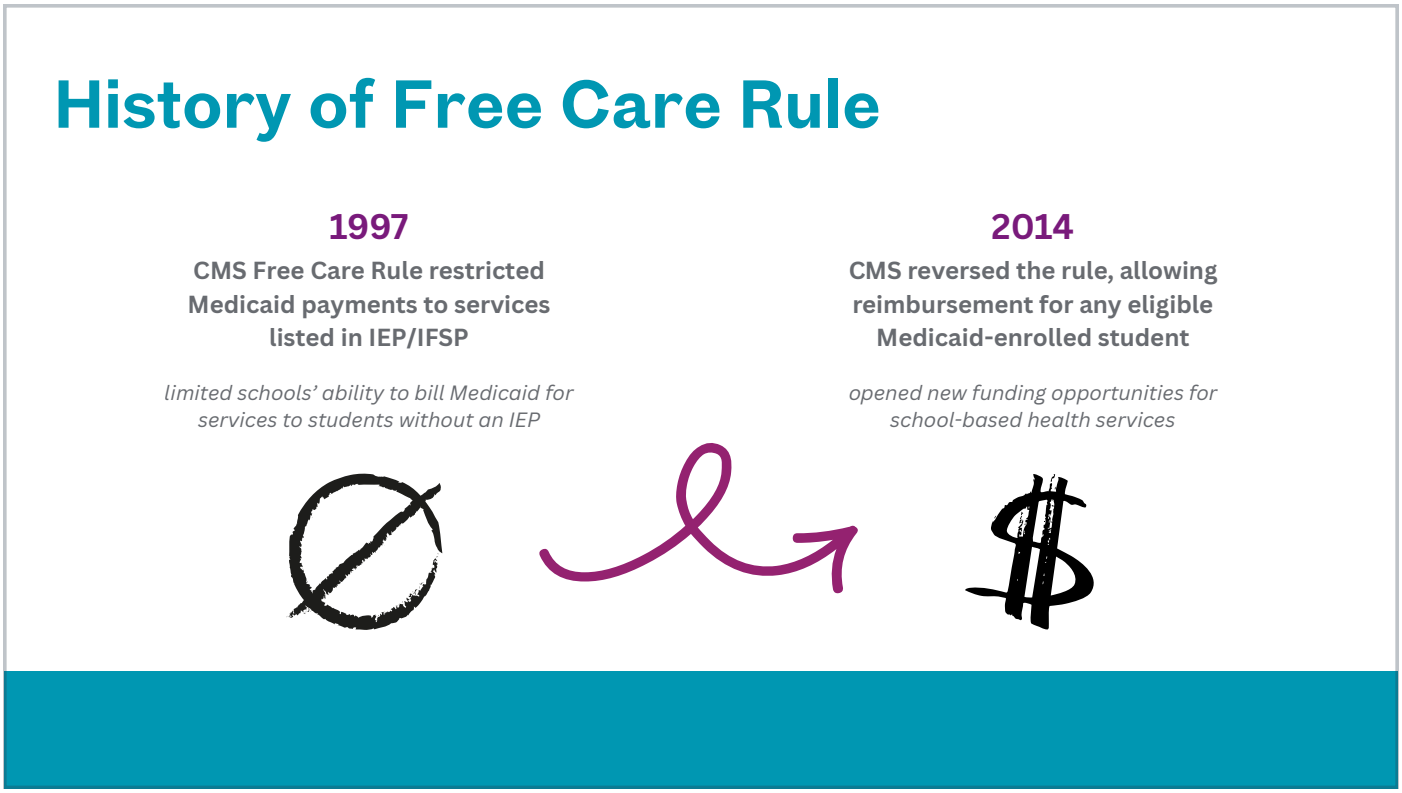


Free Care Rule and State Plan Amendment

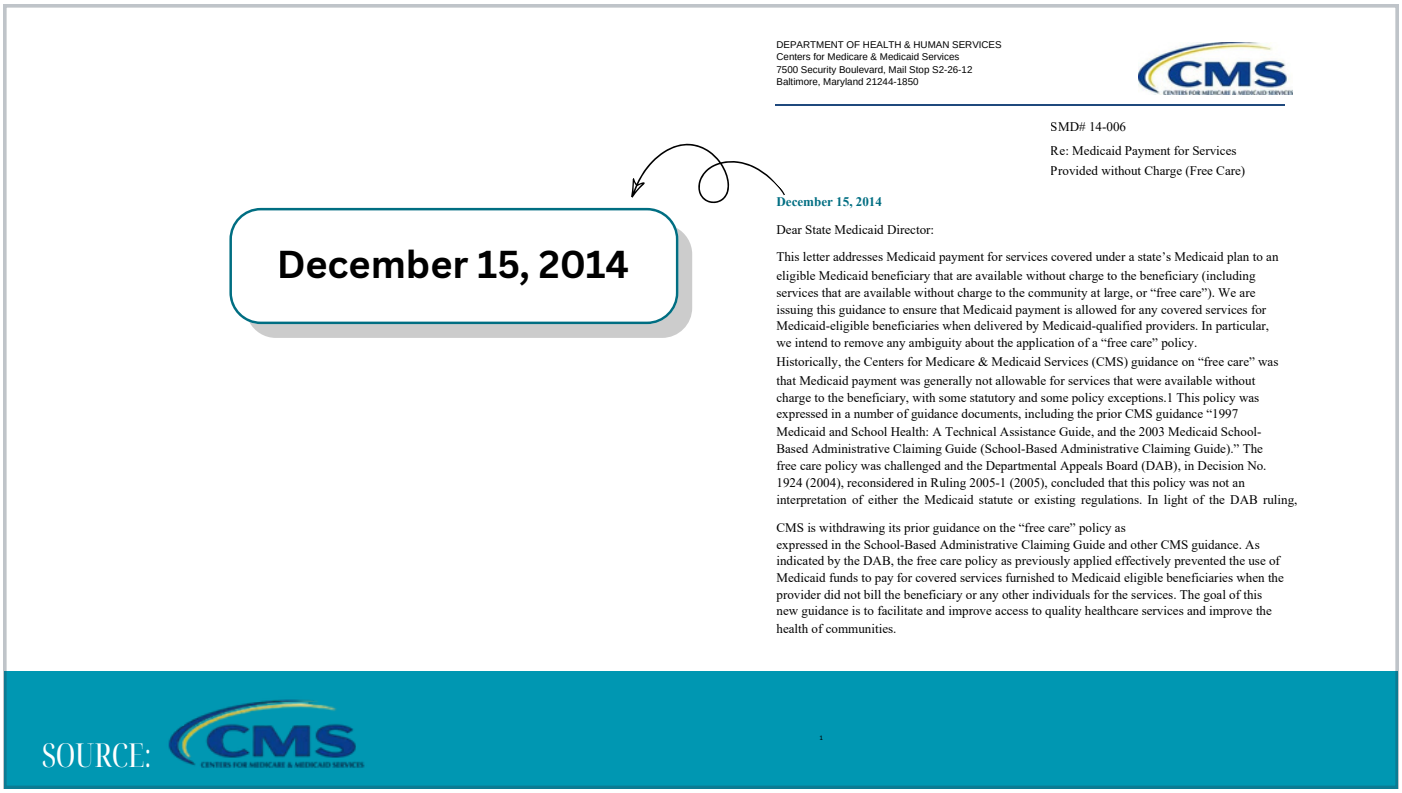
In 1997, CMS guidance restricted Medicaid reimbursement in schools to students with IEPs or IFSPs. This became known as the Free Care Rule.

In 2014, CMS formally withdrew this guidance, acknowledging that it limited access to covered services for Medicaid-eligible students.

Illinois revised its Medicaid State Plan through a State Plan Amendment (SPA) effective July 1, 2021, expanding eligibility for reimbursement to include services provided to all Medicaid-enrolled students—not just those with IEPs.

This change:

-Expanded eligible provider types
-Allowed reimbursement for services to the general student population
-Shifted reimbursement methodology

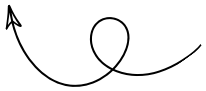


In 2014, a letter was written by CMS that clarified that they were withdrawing this guidance on the free care policy as expressed in their their guidance and their ruling and regulations.

At that point they indicated that the free care policy as it was applied actually prevented the use of Medicaid funds to pay for covered services furnished to Medicaid eligible beneficiaries. What was part of this was if we were providing free services to someone else that wasn't a Medicaid client, we couldn't provide services to an individual with Medicaid client that had Medicaid and get reimbursement for that. So since services in general education often times are provided to everyone that was where the free care rule came into play.

Ultimately they said the goal of this guidance is to facilitate and improve access to quality health care services and improve the health of communities, so seeing as that was a hindrance to the provision of services to youth and students with Medicaid specifically that has now been lifted which allows us to look at our state plan...

CMS is withdrawing its prior guidance on the "free care" policy as expressed in the School-Based Administrative Claiming Guide and other CMS guidance.



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

SMD# 14-006

Re: Medicaid Payment for Services Provided without Charge (Free Care)

December 15, 2014

Dear State Medicaid Director:

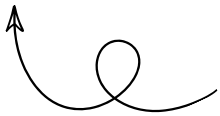
This letter addresses Medicaid payment for services covered under a state's Medicaid plan to an eligible Medicaid beneficiary that are available without charge to the beneficiary (including services that are available without charge to the community at large, or "free care"). We are issuing this guidance to ensure that Medicaid payment is allowed for any covered services for Medicaid-eligible beneficiaries when delivered by Medicaid-qualified providers. In particular, we intend to remove any ambiguity about the application of a "free care" policy.

Historically, the Centers for Medicare & Medicaid Services (CMS) guidance on "free care" was that Medicaid payment was generally not allowable for services that were available without charge to the beneficiary, with some statutory and some policy exceptions.1 This policy was expressed in a number of guidance documents, including the prior CMS guidance "1997 Medicaid and School Health: A Technical Assistance Guide, and the 2003 Medicaid School-Based Administrative Claiming Guide (School-Based Administrative Claiming Guide)." The free care policy was challenged and the Departmental Appeals Board (DAB), in Decision No. 1924 (2004), reconsidered in Ruling 2005-1 (2005), concluded that this policy was not an interpretation of either the Medicaid statute or existing regulations. In light of the DAB ruling,

CMS is withdrawing its prior guidance on the "free care" policy as expressed in the School-Based Administrative Claiming Guide and other CMS guidance. As indicated by the DAB, the free care policy as previously applied effectively prevented the use of Medicaid funds to pay for covered services furnished to Medicaid eligible beneficiaries when the provider did not bill the beneficiary or any other individuals for the services. The goal of this new guidance is to facilitate and improve access to quality healthcare services and improve the health of communities.

SOURCE:

As indicated by the DAB, the free care policy as previously applied effectively prevented the use of Medicaid funds to pay for covered services furnished to Medicaid eligible beneficiaries.



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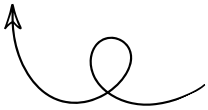

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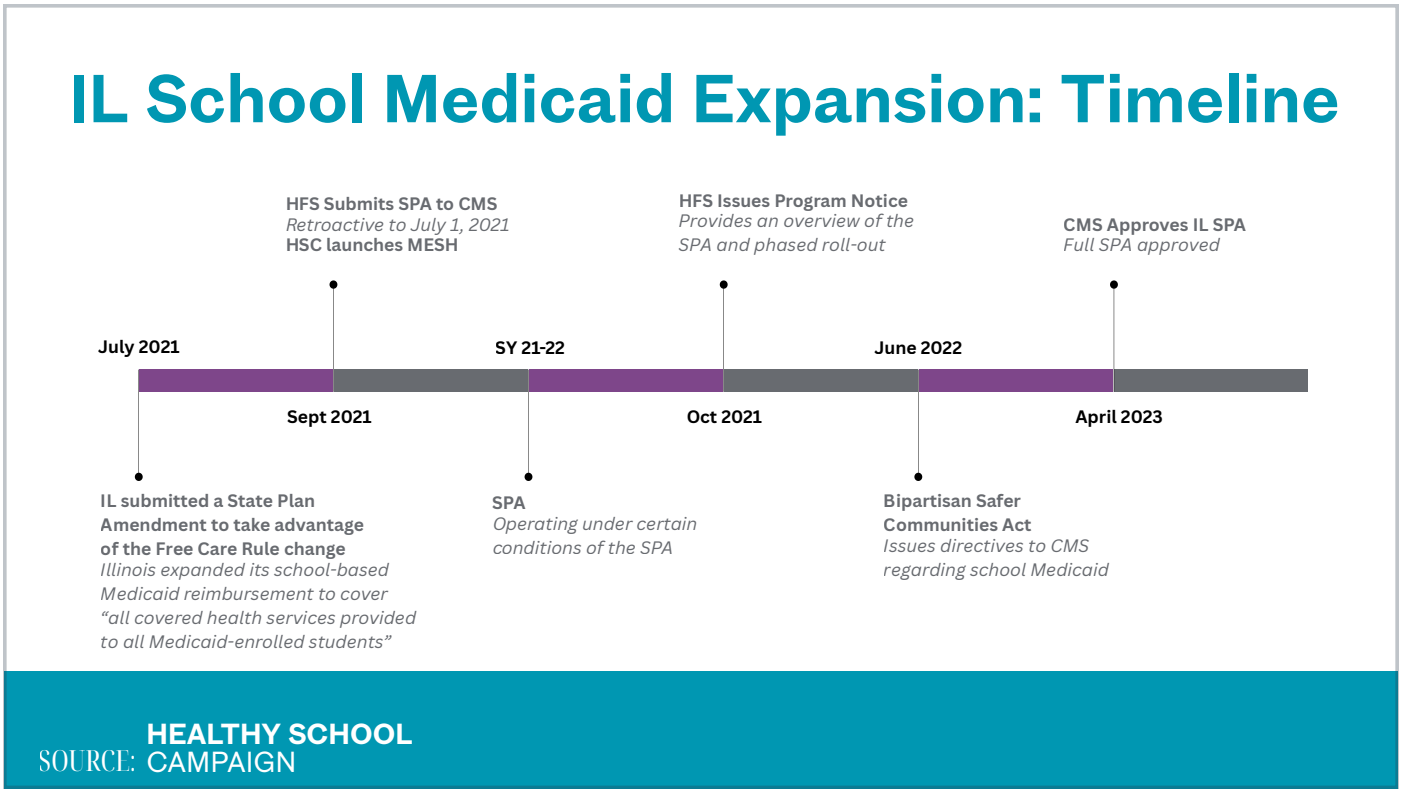
Historically, the Centers for Medicare & Medicaid Services (CMS) guidance on "free care" was that Medicaid payment was generally not allowable for services that were available without charge to the beneficiary, with some statutory and some policy exceptions.1 This policy was expressed in a number of guidance documents, including the prior CMS guidance "1997 Medicaid and School Health: A Technical Assistance Guide, and the 2003 Medicaid School-Based Administrative Claiming Guide (School-Based Administrative Claiming Guide)." The free care policy was challenged and the Departmental Appeals Board (DAB), in Decision No. 1924 (2004), reconsidered in Ruling 2005-1 (2005), concluded that this policy was not an interpretation of either the Medicaid statute or existing regulations. In light of the DAB ruling, CMS is withdrawing its prior guidance on the "free care" policy as expressed in the School-Based Administrative Claiming Guide and other CMS guidance. As indicated by the DAB, the free care policy as previously applied effectively prevented the use of Medicaid funds to pay for covered services furnished to Medicaid eligible beneficiaries when the provider did not bill the beneficiary or any other individuals for the services. **The goal of this new guidance is to facilitate and improve access to quality healthcare services and improve the health of communities.**

SOURCE:



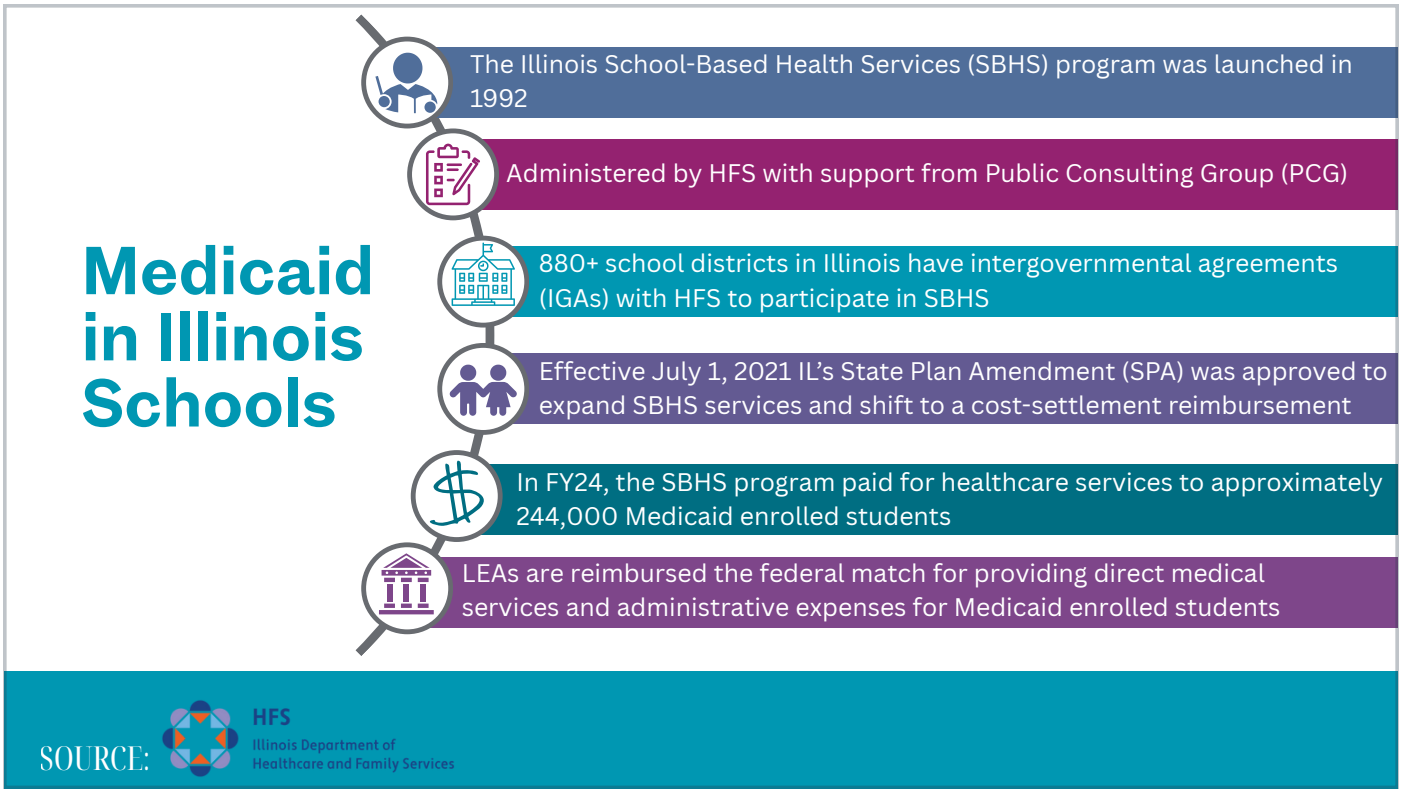
and the state of Illinois did so and decided to revise our state plan through a state plan Amendment, or SPA, back in July of 2021.

Now, that plan was under review and back and forth with revision a few times before it was finally approved; but after that approval, it went back to July 2021 as the effective date for promising opportunities such as changing the way the methodology is, who's eligible for services and are eligible to provide those services, and how we're able to provide services to the entire student population, not just those who may have an IEP or IFSP.

Medicaid school-based services, also known as Medicaid SPS, are any physical and/or mental and behavioral health services provided to Medicaid enrolled children in school settings or by school-based providers that are reimbursable by Medicaid. These services often include early and periodic screening, diagnostic, and treatment EPSDT services.

EPSDT services are a type of Medicaid benefit that provides comprehensive and preventive health care services for Medicaid enrolled children under the age of 21. EPSDT services are key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, specialty, and rehabilitative services. Schools across the United States currently support access and delivery to physical and or mental and behavioral health services in a variety of ways. Some examples include school nursing, school counseling and mental health services, occupational and physical therapy, speech language pathology, sometimes called speech therapy, school-based health centers, which offer a full range of health services, dental services, vision and hearing screenings, audiological services, substance use prevention screening and treatment services, and clinics offering vaccinations such as the flu vaccination. Schools can provide these services directly using their own employed providers and in partnership with other organizations such as private healthcare providers, federally qualified community health centers, school-based health centers, public health systems, and hospitals. Why schools? Approximately 56 million children are enrolled in K through2 schools in the United States. Students spend an average of 6 hours a day in school, making it an incredible opportunity to deliver physical and or mental and behavioral health services to those in need. This helps keep children in schools, especially those that may have

limited access to health care. This also enables students with disabilities who need services in order to learn at school, to receive them. School settings offer a way to improve health equity by reaching students with low household incomes. Delivering these health services to students in schools also reduces absenteeism, especially chronic absenteeism. Reduces or eliminates the time and cost associated with transportation and scheduling health visits. Reduces future health services needs by providing timely preventive care, and reduces stigma related to receiving services and support. Services at schools complement and do not replace services that students receive through their health care homes, usually pediatricians offices or other community providers. Simply put, children who access physical and/or mental and behavioral health services in schools are less likely to be absent and more likely to graduate, be healthy, and earn higher wages as adults. Why is Medicaid important in providing school-based services? Medicaid plays a critical role in providing health services to children in schools. Approximately half of all children in the United States or 38 million are enrolled in Medicaid or the Children's Health Insurance Program, CHIP. Approximately 3 million of these children currently receive health services funded by Medicaid at school and many more children may benefit from these services. With Medicaid coverage, schools can receive reimbursement for health services they already provide to students. Schools can seek reimbursement for delivering covered Medicaid and CHIP services and associated administrative and outreach activities. Medicaid SPS can be combined with other approaches to delivering physical and/or mental and behavioral health services in schools to ensure that the needs of all children are being met. Medicaid services provided to Medicaid enrolled students in schools helps to reach more children, which may in turn reduce absenteeism, bring in additional providers to meet student needs, redirect dollars that would have gone to pay for services for Medicaid enrolled students back to schools, and lessen the need to use general or special education dollars on health services and increase what is available for teachers. Medicaid SPS particularly matters to schools that serve children with disabilities, which is all schools. Under the Individuals with Disabilities in Education Act, IDA, children with disabilities are guaranteed access to a free and appropriate public education, FAPE, including all services outlined in a child's individualized education program, IEP. Many students with disabilities require physical and/or mental and behavioral health services to make it possible for them to learn. Medicaid reimbursement for those services reduces special education costs and supports limited education budgets overall...



Illinois school-based health services were first launched in 1992.

HFS is the lead Medicaid agency, and their lead vendor for the statewide administration of school Medicaid reimbursement services is PCG, Public Consulting Group.

Then each district will likely have their own vendor for interim claims as well. There's only a handful of those that facilitate most of the interim claims and other process that are oftentimes a really good resource for technical assistance and guidance on how to enhance Medicaid reimbursement activities within your district.

In 2021 the state plan amendment was administered, but it was in revision and review for several years... but the state plan amendment still goes back to July 1st, 2021. And so it goes back to the original submission date, with some changes that did end up happening within the state, but vastly the majority of districts have not or or had not implemented significant changes for the state plan amendment and for free care rule; but now definitely has the opportunity and we are hoping to see our entire state rise together to increase the amount of federal medical assistance percentage or match that comes to districts for the Medicaid reimbursable services, especially through free care that was not possible before.

Then in FY24 school-based health services addressed the needs of 244,000 Medicaid enrolled students.

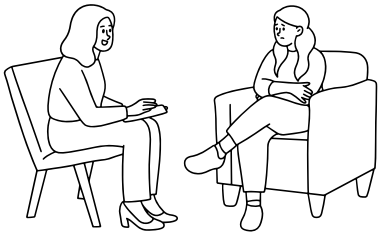
Medicaid Reimbursement for Schools

Eligible services include:

- Nursing, OT, PT, Speech/Language, Social Work, Audiology, Psychology

Reimbursement based on:

- Direct service costs to Medicaid-enrolled students
- Administrative costs of Medicaid service delivery



Federal match rate varies by service type (typically ~50%)

Services no longer needs to be tied to IEP/IFSP under Free Care Rule revision

School Medicaid Reimbursement in Illinois:

Illinois launched school-based Medicaid services in 1992. HFS serves as the state's lead Medicaid agency, with Public Consulting Group (PCG) managing statewide school Medicaid administration.

The 2021 State Plan Amendment expanded free care and reimbursement opportunities. By FY24, school-based health services reached approximately 244,000 Medicaid-enrolled students.

School-based mental health services—including counseling, psychology, and social work—represent the largest share of Medicaid-reimbursed services.

SPA Expansion

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

Newly Eligible Providers:

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

Now, we're seeing licensed clinical psychologists, licensed marriage and family therapists, licensed clinical professional counselors, and even registered behavior technicians that could be providing behavioral health or mental health services and supports to our students.

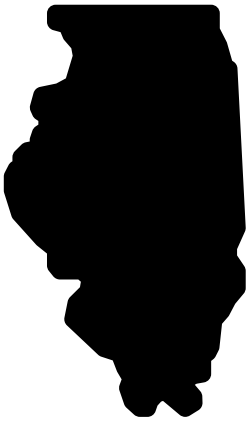
Key Updates in SPA

- Expanded reimbursement eligibility from IEP/IFSP eligible students to any Medicaid-enrolled students for any allowable service deemed medically necessary
- Moved from rate settlement to cost settlement reimbursement methodology
- Implemented Random Moment Time Study (RMTS) changes

SOURCE: HEALTHY SCHOOL CAMPAIGN

Financial Impact of School Medicaid

- **Year 1** - $18M in expansion reimbursement, and $200M in total reimbursement
- **Year 2** - $23M in expansion reimbursement, and $233M in total reimbursement



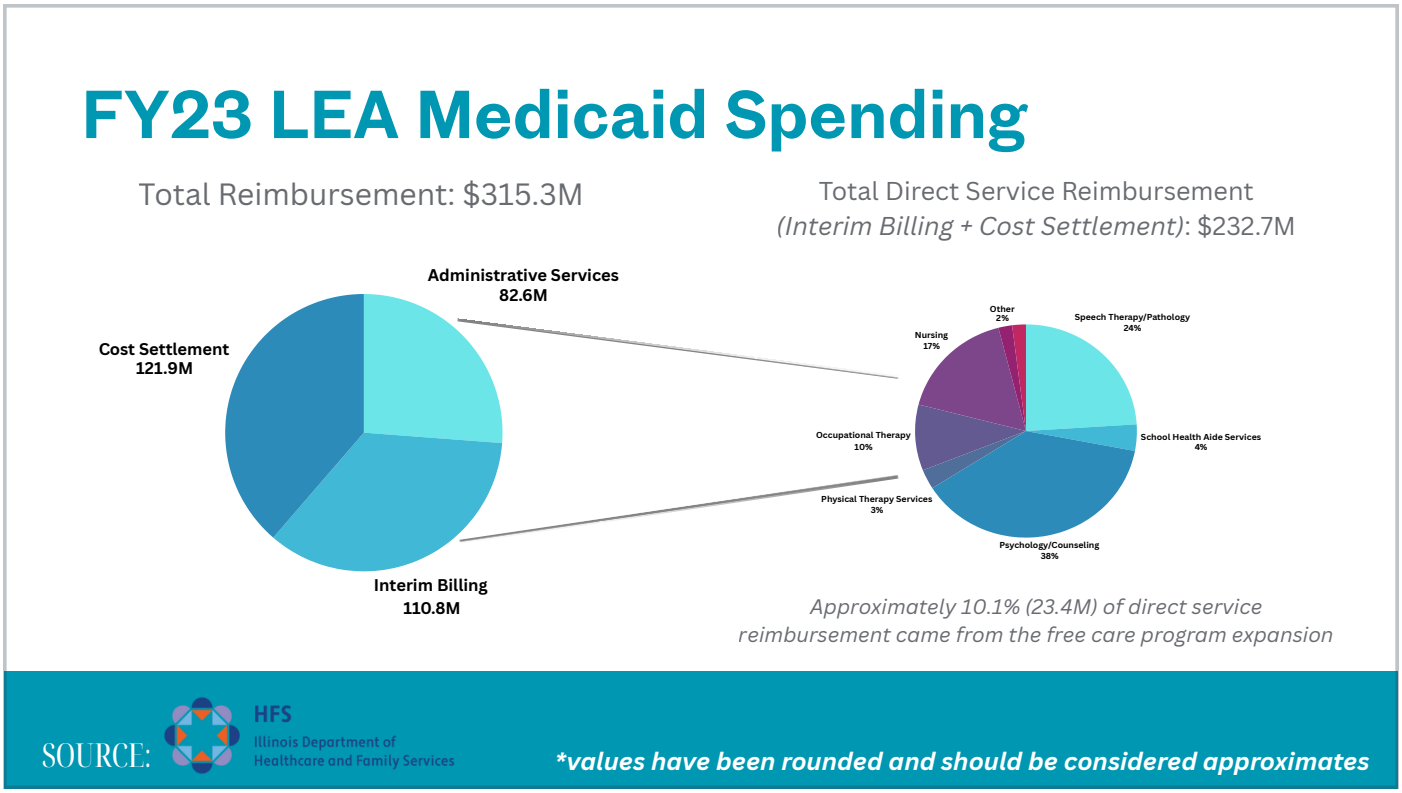
SOURCE: HEALTHY SCHOOL CAMPAIGN

Cost Settlement Model:

Illinois transitioned from a rate-based reimbursement system to a cost settlement model.

Under this model Districts receive interim payments throughout the year, Total allowable costs are reconciled later, and Final reimbursement may occur 1–2 years after services are delivered.

This model ensures districts are reimbursed for the full cost of allowable services, not just interim rates.

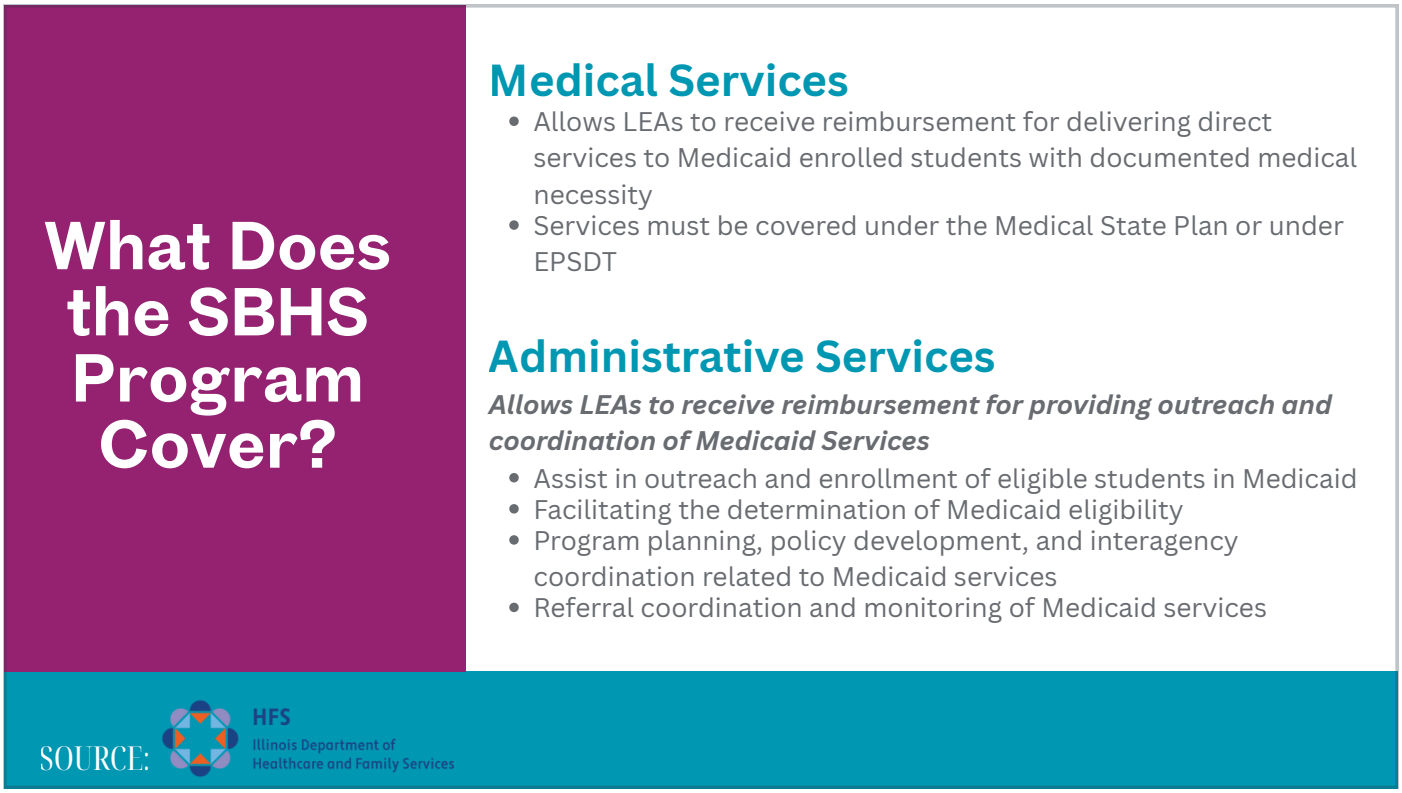


When we're looking at FY23, this will show you the the total for direct services was 232 million in funding for that year and about 82/83 additional million in administrative services or cost.

The number one is going to be outreach type of activities trying to help eligible students obtain Medicaid, enroll in Medicaid, and get the services that they need.

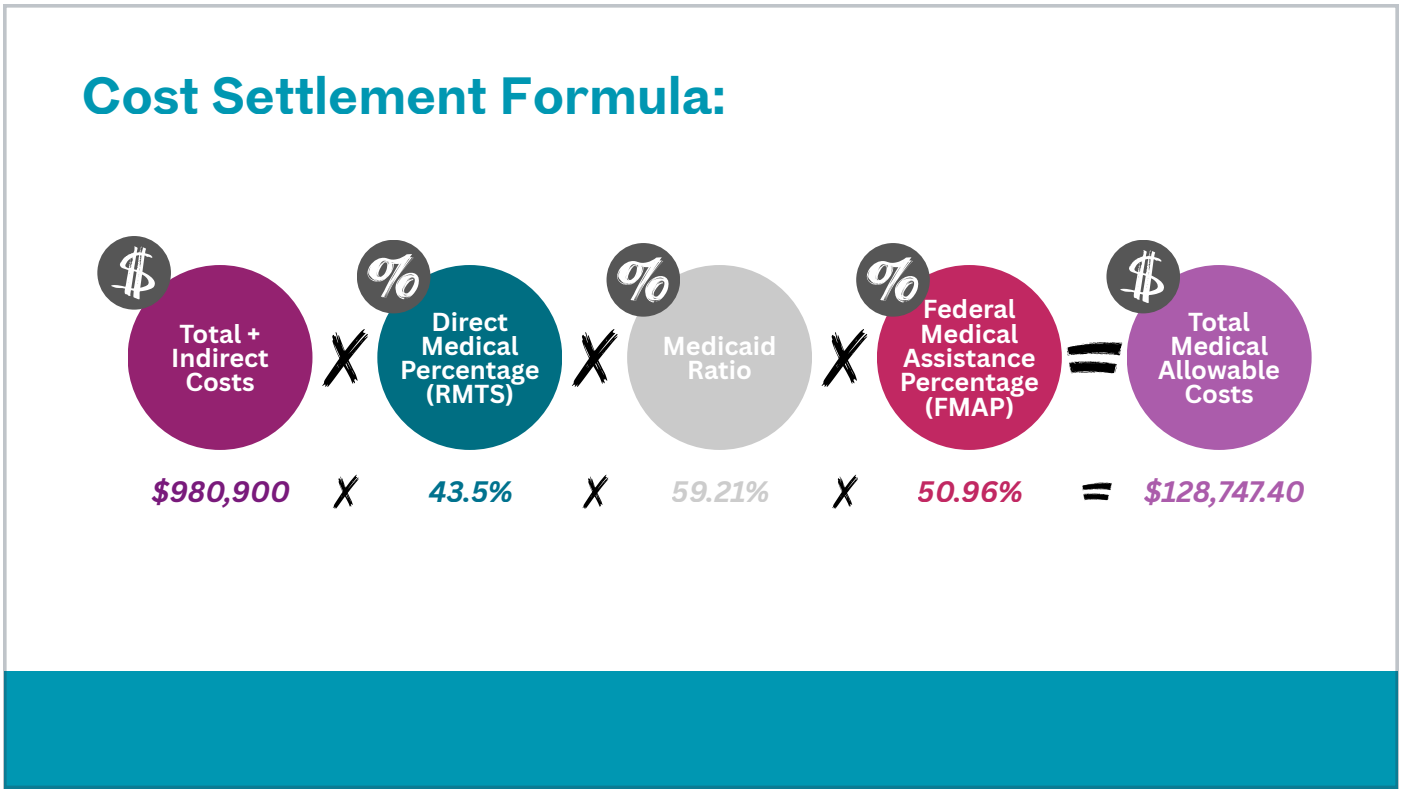
Another point that I'll make is that if you look at that pie chart when you look at psychological counseling, social work, school-based mental health services is the largest percentage of service activities that contribute to the Medicaid reimbursement that goes to districts.

Oftentimes special education cooperatives, if that's a model that you're used to in your district, oftentimes they're the entity that are receiving a lot of this reimbursement. We may not always be submitting or involved in a reimbursement system for district staff that are not part of the special education cooperative. Whereas now a social worker, a counselor, psychologist that is employed by the district, even when there's a special education cooperative in your region, that those individuals can now start to use the free care rule and reimbursement can happen for those individuals.



In addition to what is happening for special education cooperatives or the students that are being served through the IEP system, I mentioned this already about medical services being reimbursable and and those services still have to fall under the Medicaid or medical state plan and/or EPSDT. So there are some variations there, but there's guidance and regulation on services that are going to be reimbursable and services that are not going to be reimbursable.

And so I'll talk a little more about this in the next part of this series.



The cost settlement formula, or here's a generic formula - it has more complexity to it.

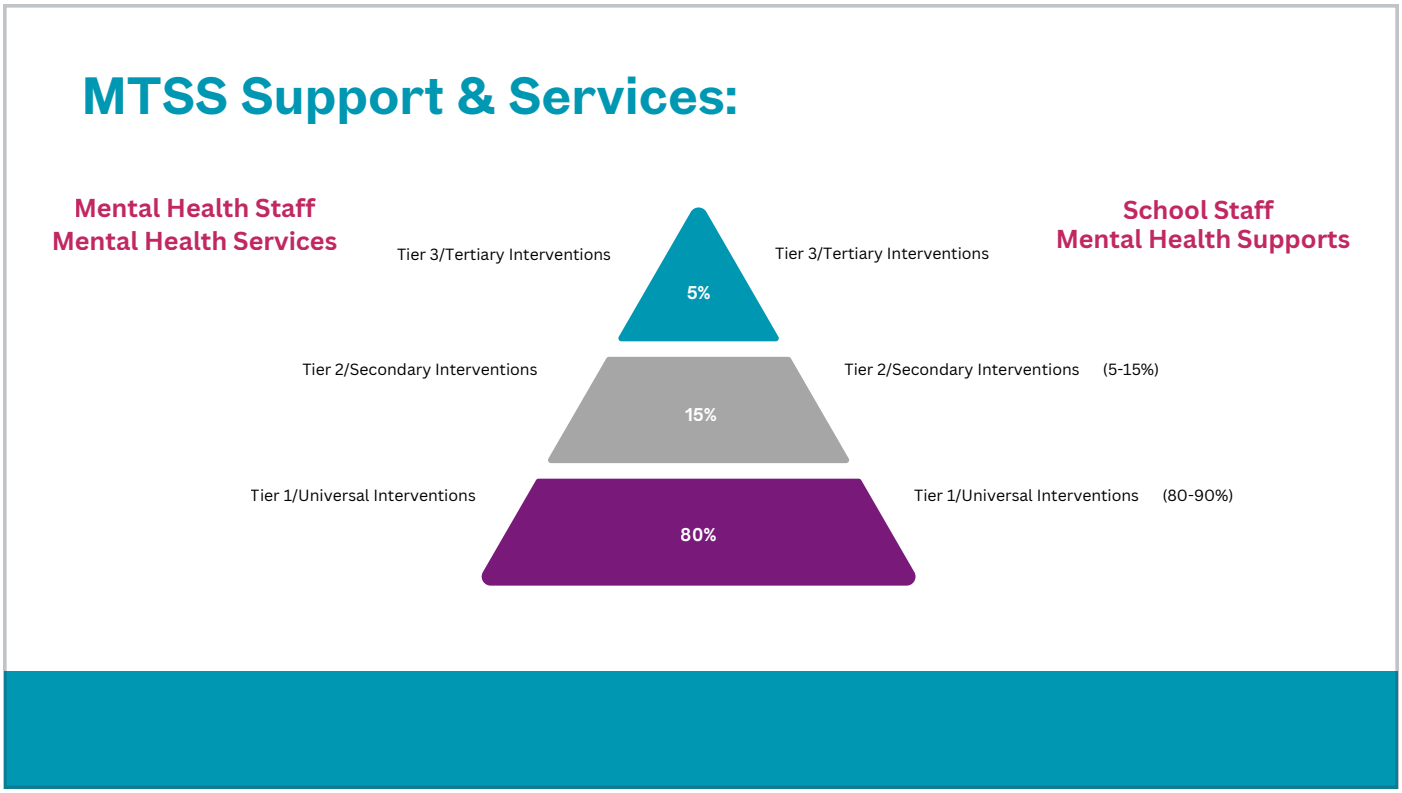
If you look at the total cost both indirect cost and direct cost and if you have a negotiated indirect cost rate then that can go into this. If you don't, you may be doing the minimums. That multiplies by the medical percentage, the percentage of the time through the random moment time study that individuals are providing reimbursable services or approved services.

I could be working with a student with Medicaid, but if I'm doing an unapproved service or I'm doing a service that doesn't require my licensure for mental health services as an example, then that would not count here, but if I'm doing a service that does require my license credential training and a service that is on a plan of care that I've determined medical necessity for and the student has Medicaid that will show up here, and so multiply that from our random moment time study and by the medical ratio or Medicaid ratio, that's the ratio of the total number of students that have Medicaid divided by the total number of students overall, and that will give us the Medicaid ratio provided and then multiplied by the federal medical assistance percentage or match rate (the FMAP rate) just going to be our standard FMAP rate not the enhanced rate that is around 51% and during COVID that was a little bit higher at around 56/57% - that was a temporary enhancement across the entire nation. But around 51% would give me my total medical allowable cost or the total amount that I could get reimbursed for.

So, if it's $128,000, if I received interim payments of $100,000 throughout the year, then that would be at the end of the yea, my cost settlement would have me getting reimbursed for $28,747.40.

Now, on the flip side, unlikely but possible, if I had received interim payments of $150,000 and my total cost was $128,747,000 based on how I used my cost pools and what information I put in there and how my district did the random moment time study. If that was the case, then in the next year, I would not get the first $32,000. I would owe that for the next year because I received more interim payments than I actually settled on at the end of the year. But again, that's less likely to be happening but is possible in that system.

So, why does all of this matter? We know that mental health needs and the struggles of youth and the stress that youth are under and the effects that that has on both physical and emotional and behavioral health that this continues to grow and we need more and more supports and more professional supports and students especially students in underserved communities and from more vulnerable families, they're not necessarily going to be able to get access to the mental health services that they need, which then ends up creating bigger problems and it turns into more of a crisis type of cycle or a danger to themselves or others and we're finding these unmet mental health needs are going to grow into bigger issues.



Student mental health needs continue to rise, particularly in underserved communities. Schools play a critical role in addressing these needs through multi-tiered systems of support (MTSS), including:

Universal supports (Tier 1)

Targeted interventions (Tier 2)

Intensive, individualized services (Tier 3)

Access to sustainable Medicaid funding is essential to expand and maintain school-based mental health staffing, including counselors, social workers, and psychologists.

2025 Support Personnel to Student Ratios

Social Workers
420:1
4,396.2

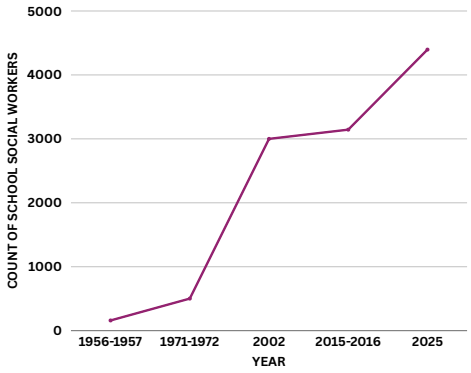
Counselors
491:1
3,767.5

Psychologists
871:1
2,121.8

SOURCE: ILLINOIS STATE BOARD OF EDUCATION

We're seeing the ratios for social workers, counselors, & psychologists across the state are improving, meaning there are more providers than there ever have been in each one of those, but we know it's still not enough.

School Social Work in Illinois Increases

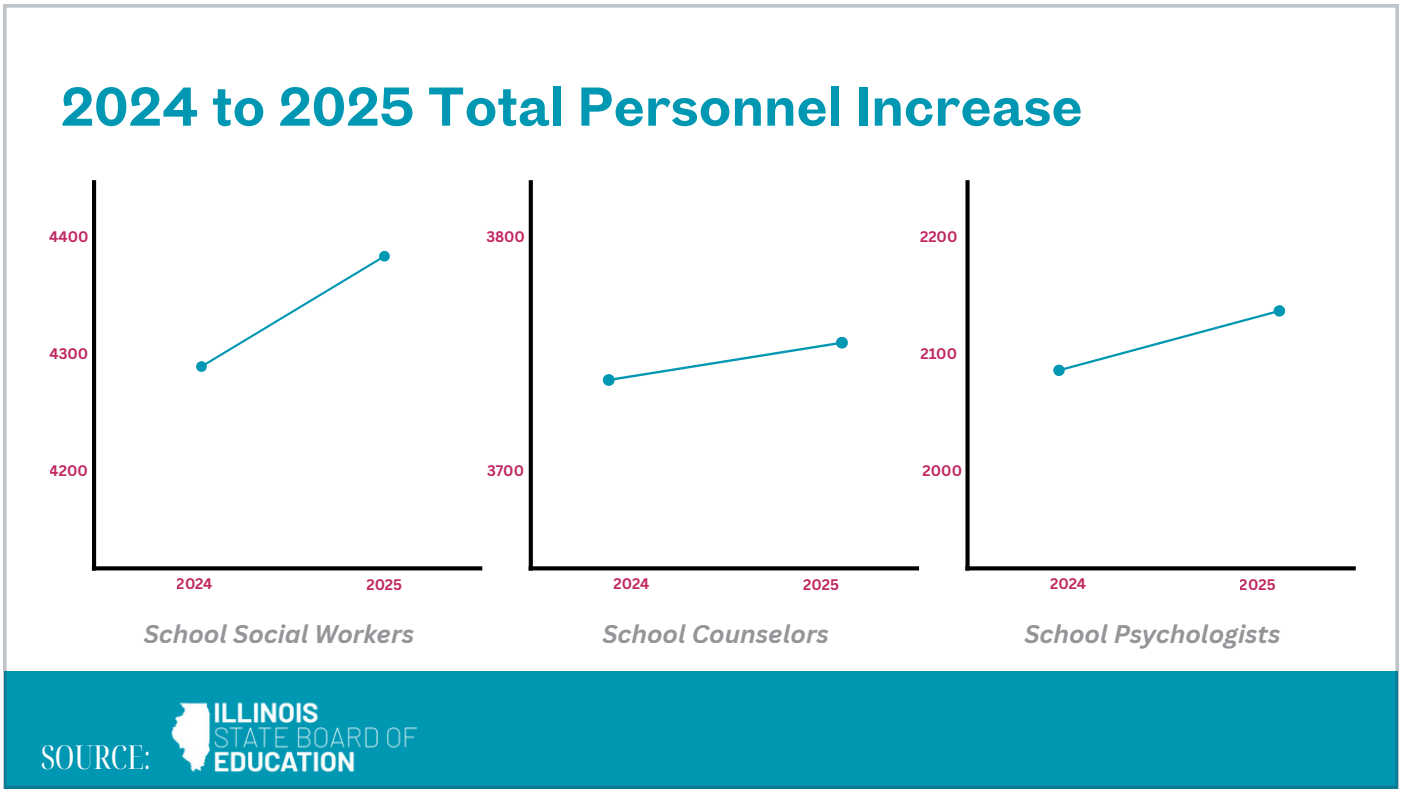


NOTE: The actual number of school social workers in Illinois may be higher; numbers are potentially unknown due to inconsistent regulations within charter/private schools as well as differing position titles.

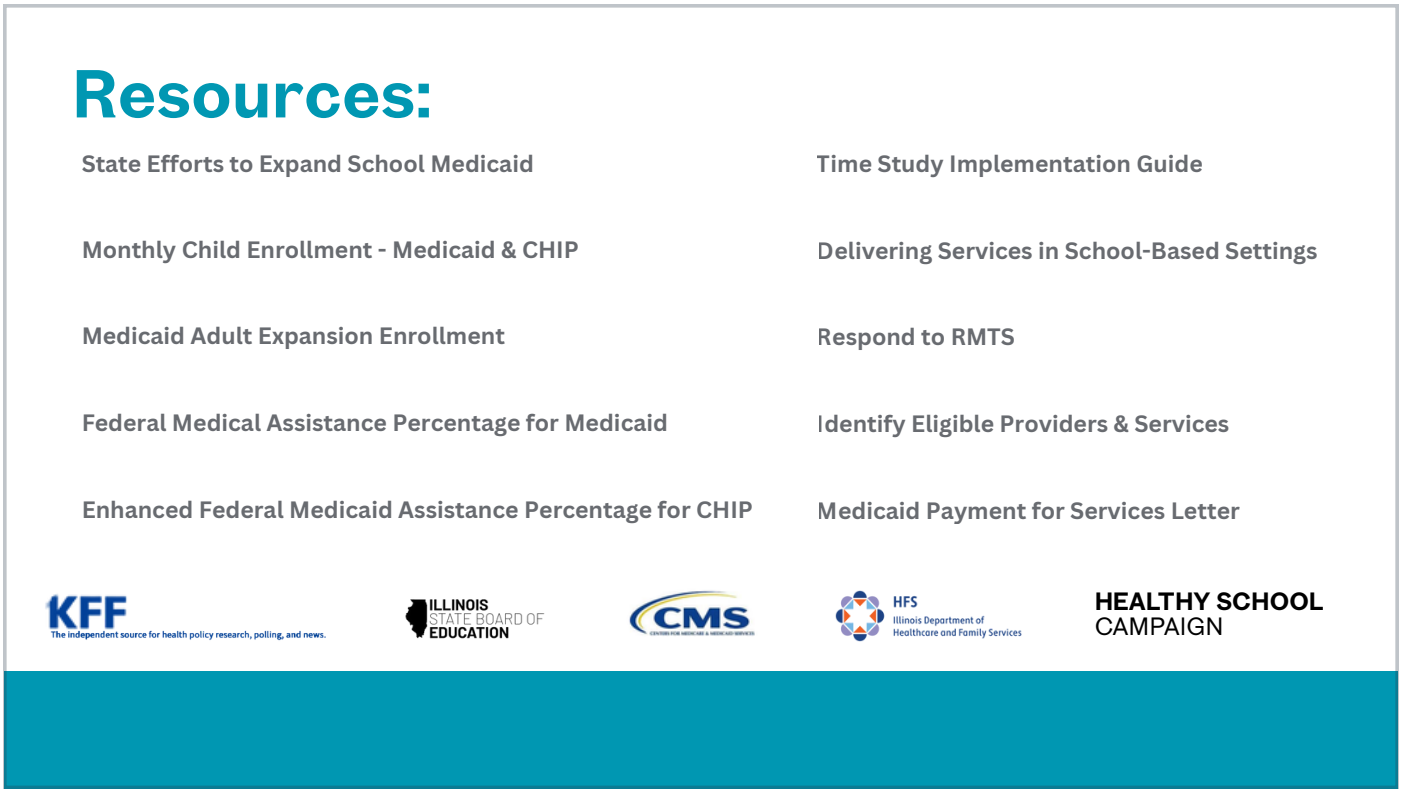
SOURCE: ILLINOIS STATE BOARD OF EDUCATION

We're at half the amount of providers than what we need based on best practice ratios, and we see this in our students and in our families. The needs keep rising while we are stretched thin to be able to provide those services.

So as we expand, we're going to need dollars to be able to expand, support, and sustain these positions.



We are seeing again the numbers are growing in all the fields there from school social workers, school counselors, & school psychologists with the largest number in school social workers providing services across the state of Illinois. But we need to keep growing and keep expanding and we need dollars that are sustainable to be able to do that, that are not soft grant dollars. Those are important too, but we need sustainable long-term dollars to be able to allow for this expansion and to support the mental health services that our students need across the state of Illinois.



Resources

Additional resources and links are available in the webinar materials. These resources provide deeper guidance on Medicaid, school-based services, and reimbursement strategies.

FOR MORE INFORMATION

E-mail dmattbuckman@stressandtrauma.org

Website www.west40.org

Watch Webinar Series Part 2:
Deep Dive into School Based Mental Health & Medicaid Reimbursement in Illinois

Thank you for participating in Part One of this webinar series. Please stay tuned for Part Two, which will provide a deeper dive into school-based mental health services and Medicaid reimbursement at the district level.