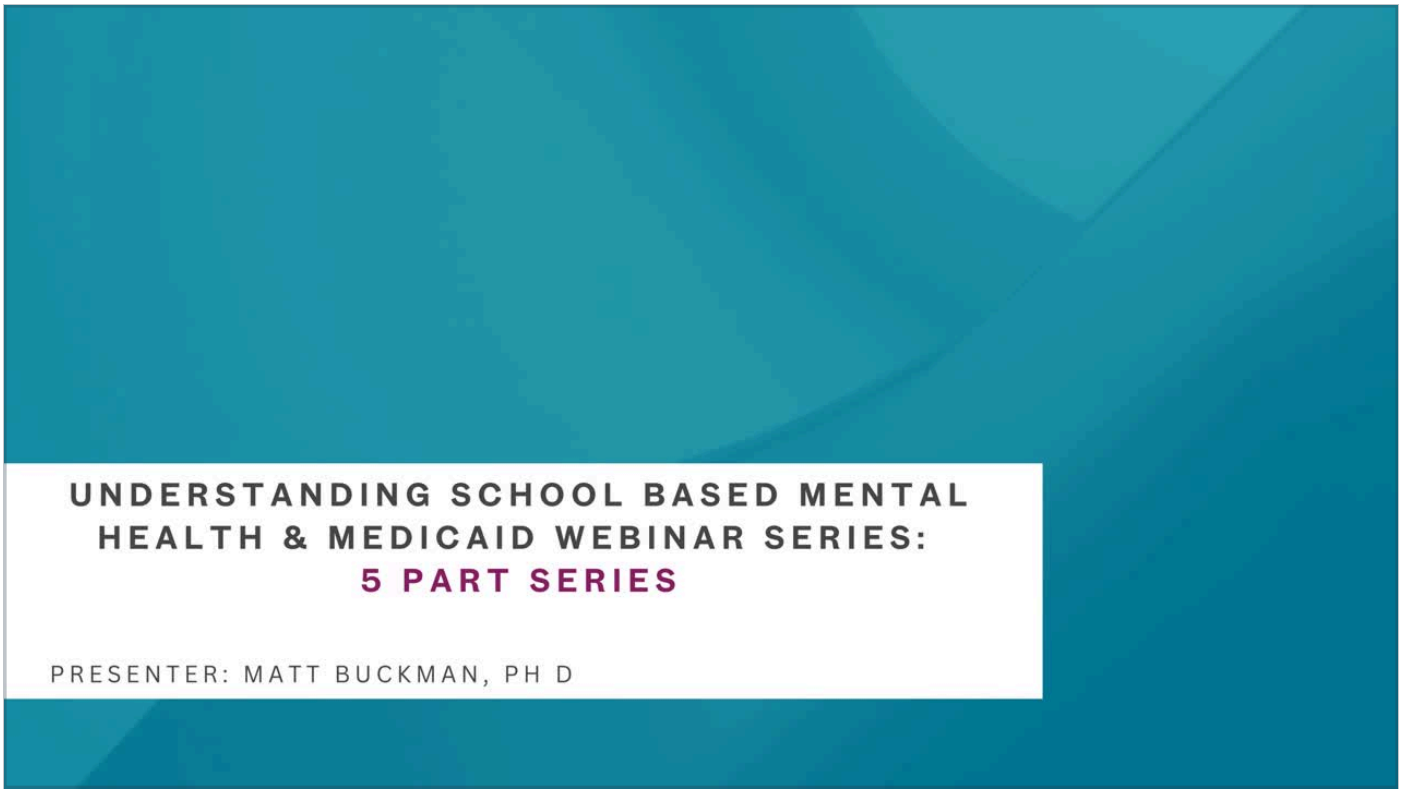


Introduction
Welcome to the Understanding School-Based Mental Health and Medicaid webinar series. This five-part series is designed to build a shared foundation for understanding how Medicaid supports mental health services in both school-based and community-based settings across the state of Illin ois.

The vision of this series is to support the provision of mental health services to students within school settings—particularly 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 Five-Part Series

This series progresses from foundational Medicaid concepts to increasingly specific applications:

-Foundations of Medicaid

-School-Based Mental Health and Medicaid Reimbursement in Illinois

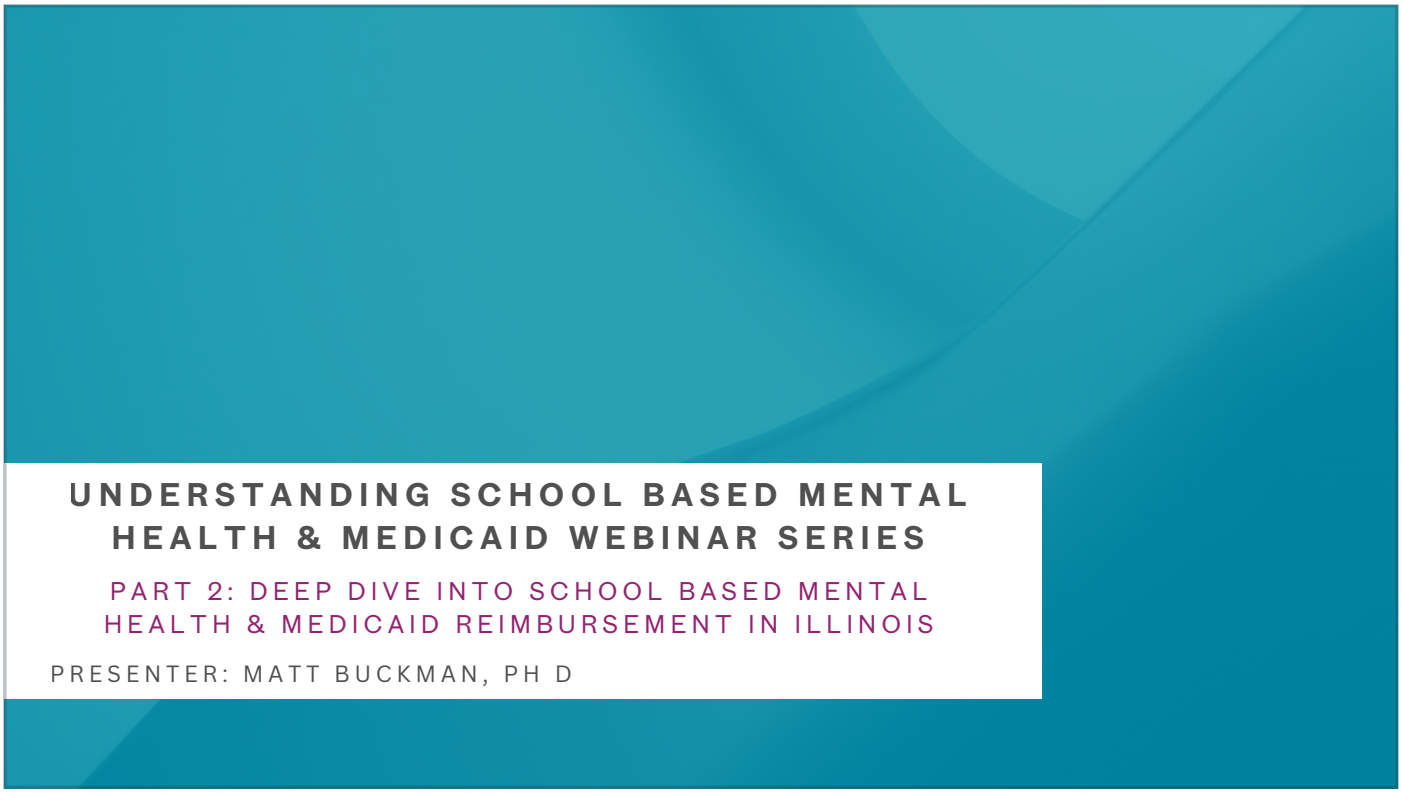
-Community-Based Mental Health Services

-Care Coordination Service Organizations and Pathways

-Ideas for Action and Strategies to Increase Access to Services

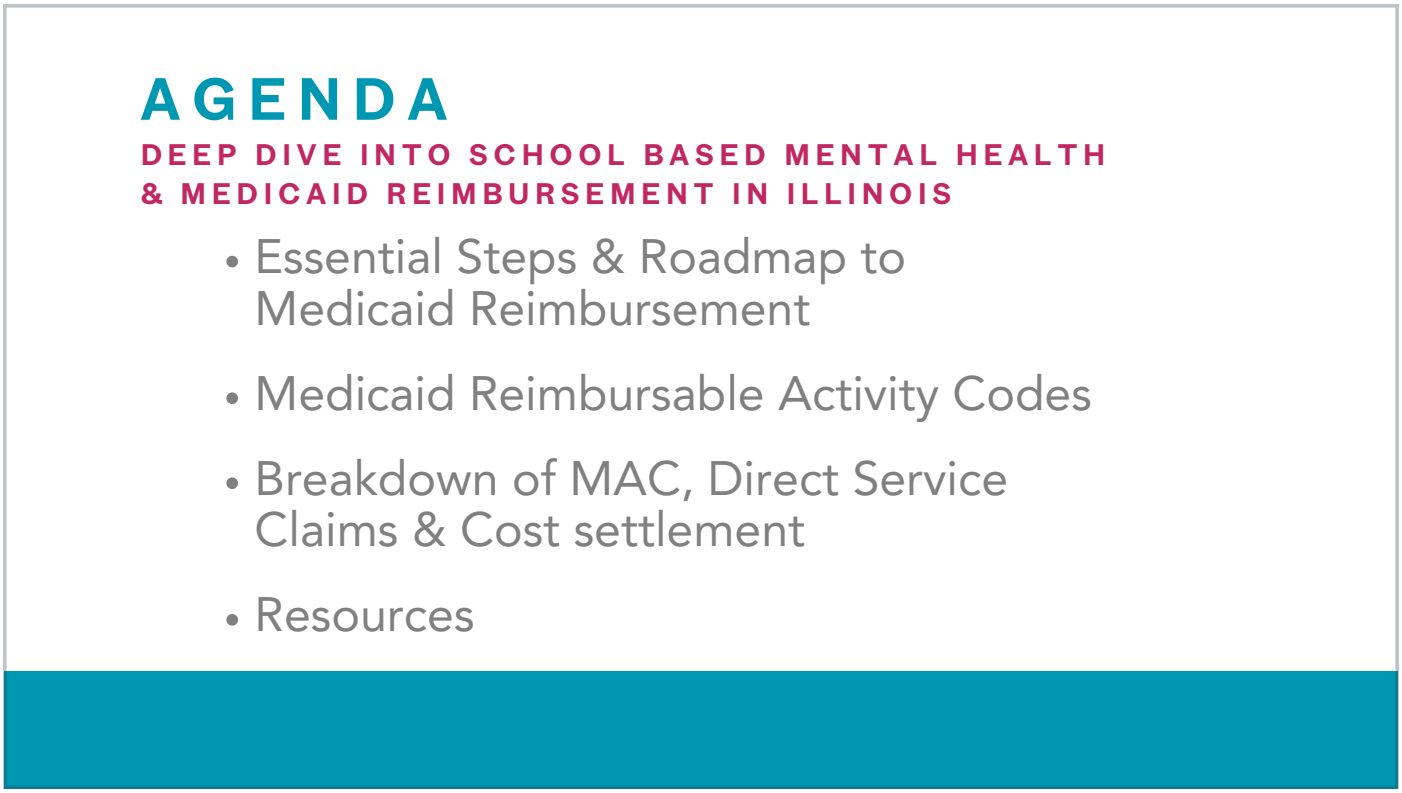
The final session will focus on concrete strategies to leverage funding to expand mental health services for students.

This series progresses from foundational Medicaid concepts to increasingly specific applications, culminating in actionable strategies to expand access to mental health services for students.



Part Two: School-Based Mental Health and Medicaid Reimbursement

In this session, we take a deep dive into Medicaid reimbursement for school-based mental health services in Illinois.



Today's Agenda

-Essential steps and a roadmap to Medicaid reimbursement using the Healthy Schools Campaign MESH Project

-Medicaid-reimbursable activity codes (Allowable and unallowable reimbursements)

-Medicaid Administrative Claiming (MAC), Direct service claims, & The cost settlement model

-Resources for continued learning

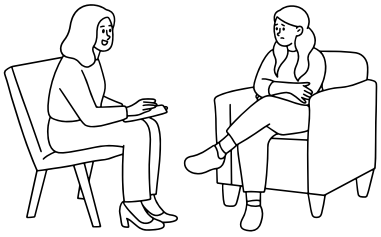
Medicaid Reimbursement for Schools

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

Medicaid Reimbursement for Schools

Medicaid reimbursement is available for a wide range of school-based service providers serving Medicaid-enrolled students.

Federal Medical Assistance Percentage (FMAP):

Administrative activities: 50%

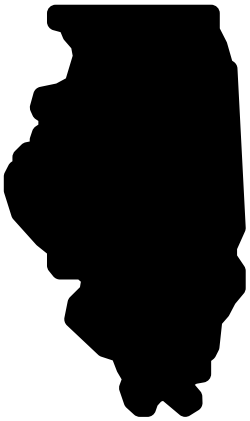
Direct services: State-specific FMAP (Illinois)

A significant change resulting from the State Plan Amendment is that services no longer need to be tied to an IEP or IFSP due to the expansion of the free care rule.

Another major shift is the move from a rate-based reimbursement model to a cost settlement model, which has significantly increased reimbursement statewide.

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

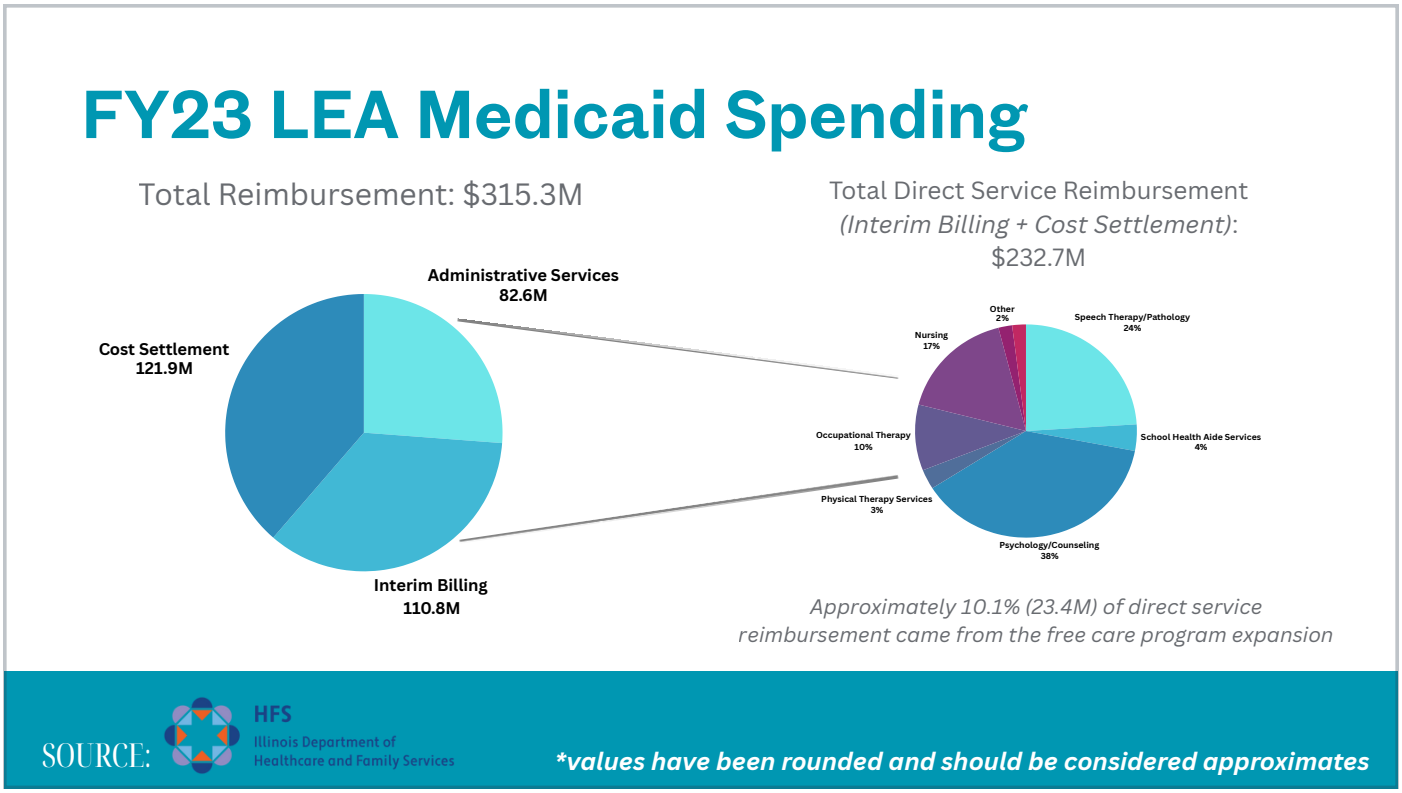
Early Successes

Even before widespread understanding of the new system:

Year 1: $18 million increase statewide

Year 2: $23 million increase statewide

Future increases are expected as districts strengthen their practices.



LEA Medicaid Spending Breakdown (FY23)

Total reimbursement: $315 million

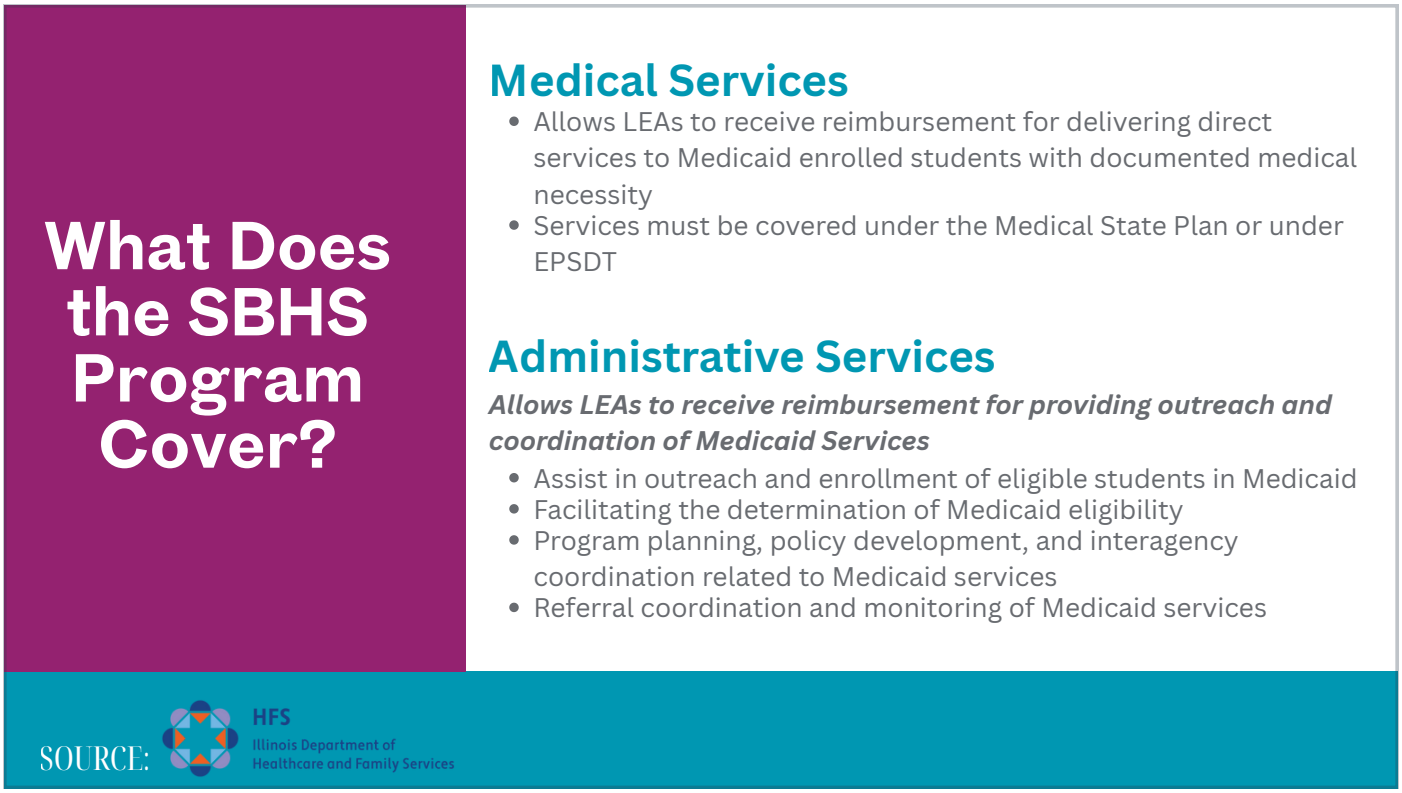
Medicaid Administrative Claiming (MAC): $82.6 million

Interim direct service billing: $110 million

Cost settlement: $121–122 million

Due to the cost settlement process, reimbursements typically occur 1.5–2 years after services are delivered.

School-based mental health services—psychology, social work, and counseling—represent the largest share of direct service reimbursement.



School-Based Health Services (SBHS) Program

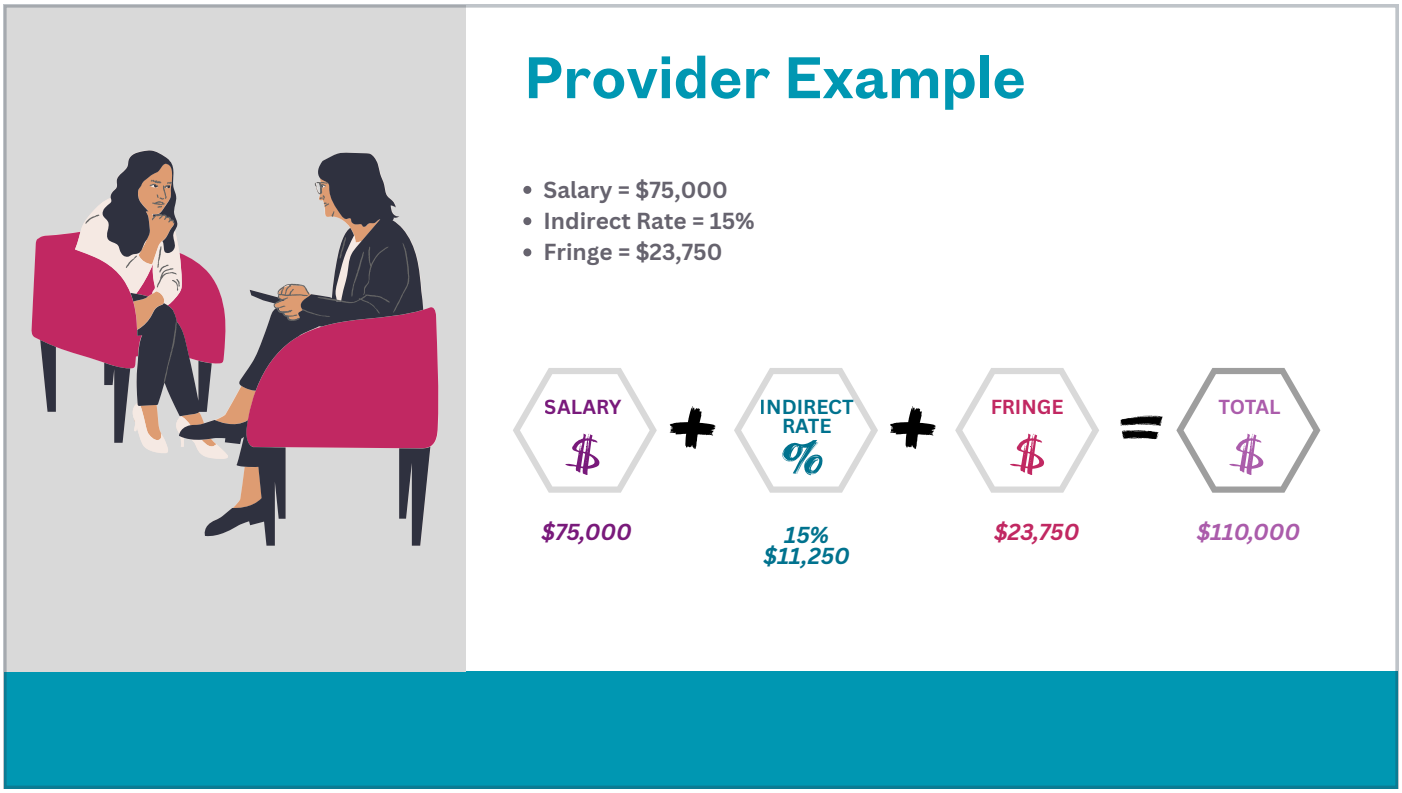
School-based health services now cover:

Any Medicaid-eligible medical service with documented medical necessity and a plan of care

Services do not require an educational diagnosis or special education eligibility

Administrative services related to Medicaid populations

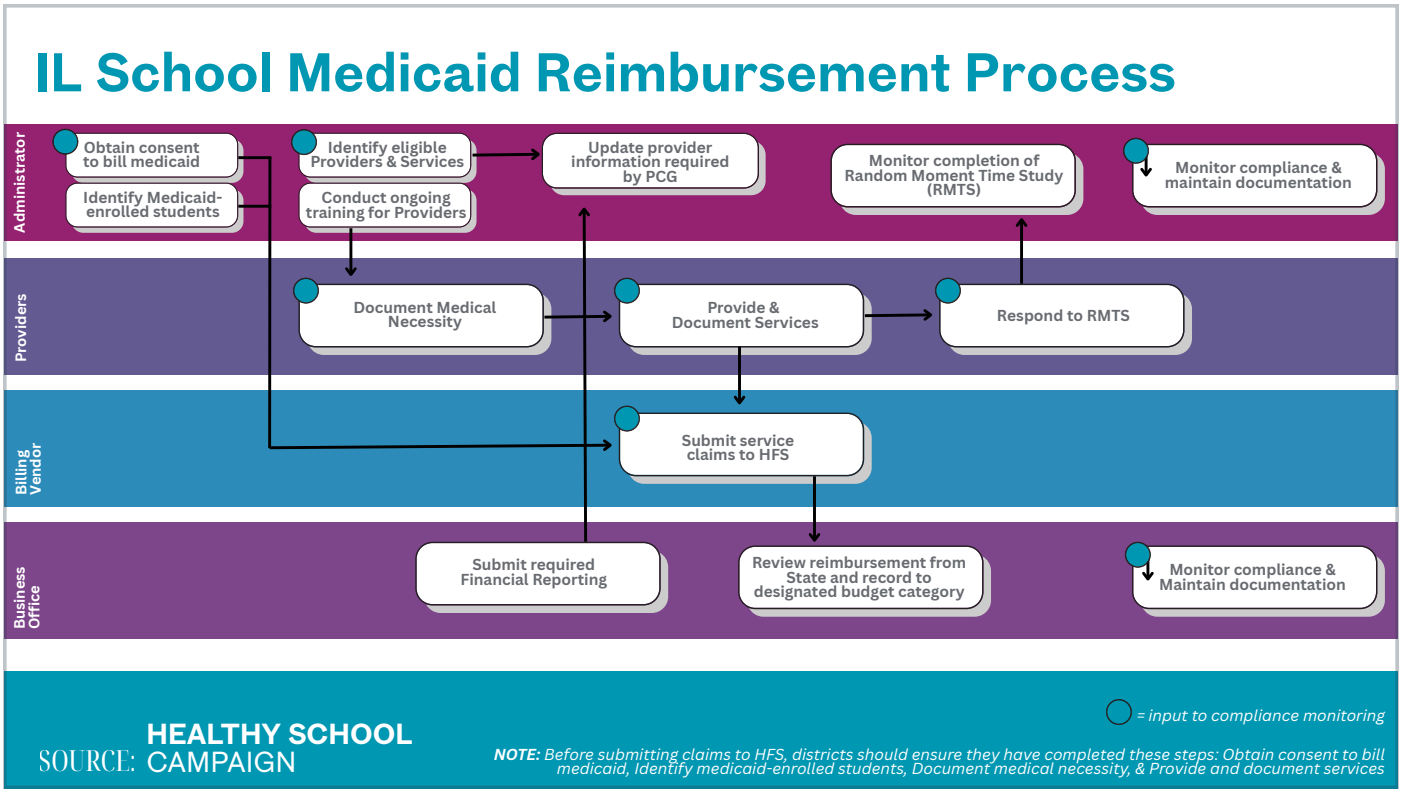
Outreach and eligibility determination activities are particularly valuable due to their higher reimbursement rates.



Provider Cost Example

Sample Provider Annual Costs:
Salary: $75,000
Fringe benefits: $23,750
Indirect rate (15%): Included
Total cost: $110,000

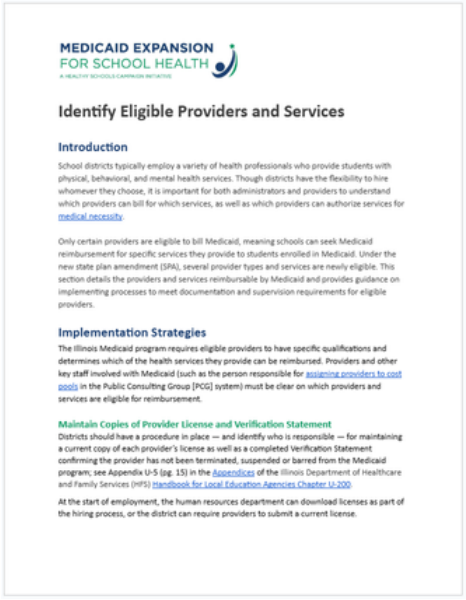
Accurate quarterly cost reporting is essential. Without it, districts risk losing reimbursement entirely.



Medicaid Reimbursement Roadmap

Using the Healthy Schools Campaign roadmap, districts can identify areas for growth and maximize reimbursement.

Identify Eligible Providers and Services



MEDICAID EXPANSION FOR SCHOOL HEALTH

A HEALTHY SCHOOLS CAMPAIGN INITIATIVE

Identify Eligible Providers and Services

Introduction

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

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

Implementation Strategies

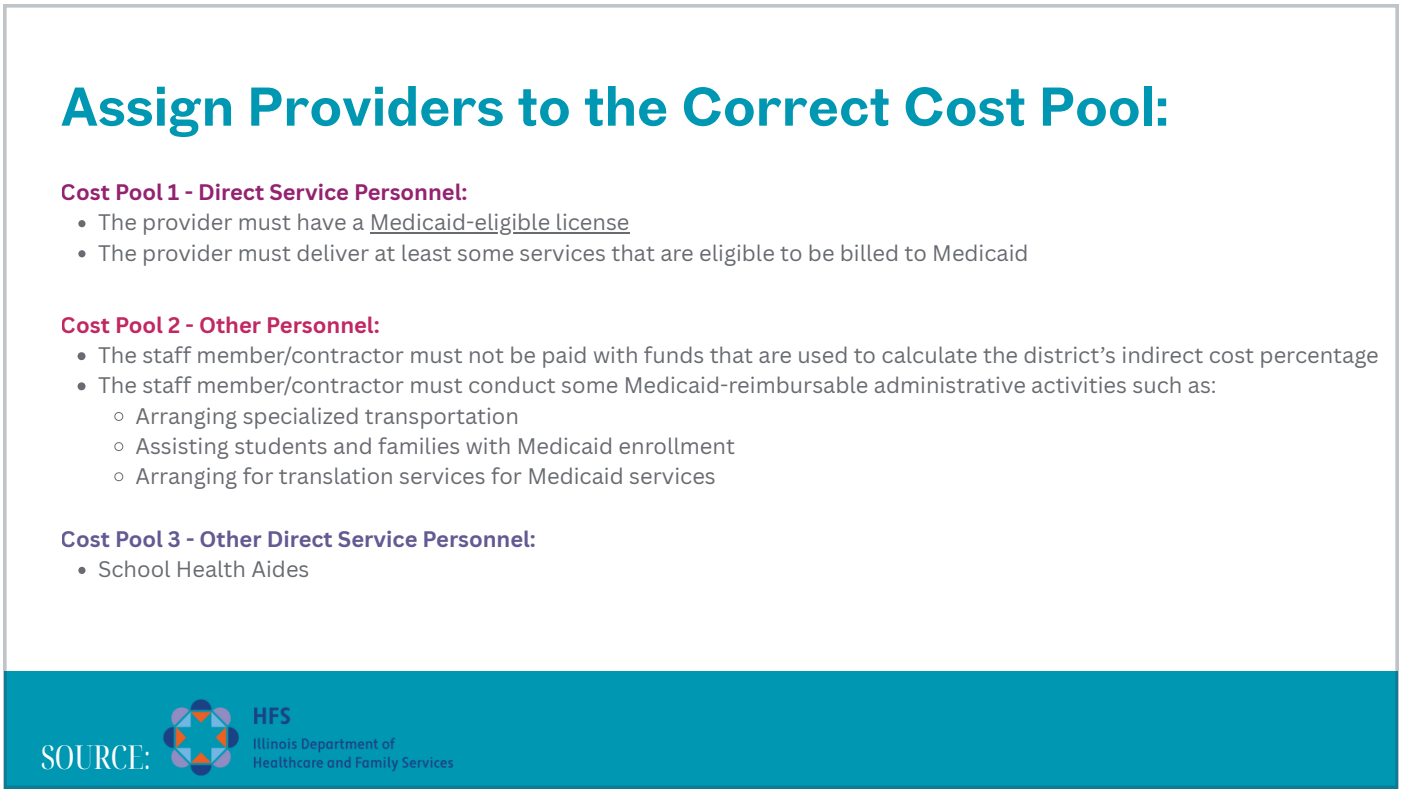
The Illinois Medicaid program requires eligible providers to have specific qualifications and determines which of the health services they provide can be reimbursed. Providers and other key staff involved with Medicaid (such as the person responsible for assigning providers to cost pools in the Public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

Maintain Copies of Provider License and Verification Statement

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

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

SOURCE: HEALTHY SCHOOL CAMPAIGN



Assigning Cost Pools

Cost Pool 1: Direct service personnel (licensed, Medicaid-eligible providers serving students)

Cost Pool 2: Administrative personnel (e.g., administrators, paraprofessionals, case managers)

Correct placement in cost pools is critical for reimbursement eligibility.

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

Free Care Rule Expansion:

Services may now be billed under individualized plans of care, medical recommendations, or community-based provider guidance—not only IEPs or 504 plans.

Medical necessity must be documented, though a full diagnostic assessment is not always required.

Newly Eligible Providers:

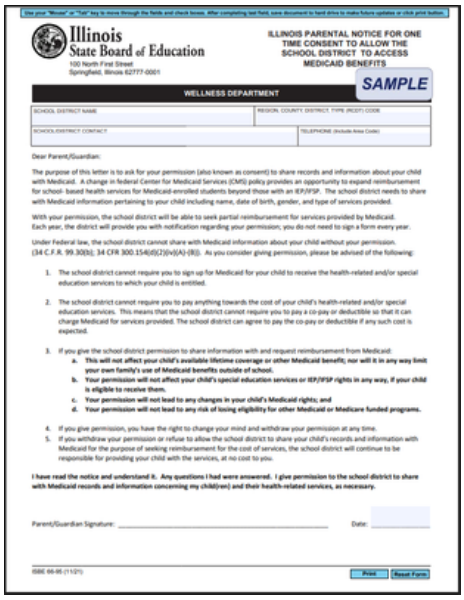
-Expanded provider eligibility includes:
-ISBE-certified counselors
-Licensed Clinical Professional Counselors
-Licensed Marriage and Family Therapists
-Licensed Clinical Psychologists
-Registered Behavior Technician
-Orientation and mobility specialists

PCG Staff Pool Management

Staff pool assignments must be reviewed and updated quarterly through Public Consulting Group (PCG). Incorrect staff pool placement can eliminate eligibility for interim billing and cost settlement reimbursement.

ONE-TIME

Parental Consent to bill & share information with Medicaid



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

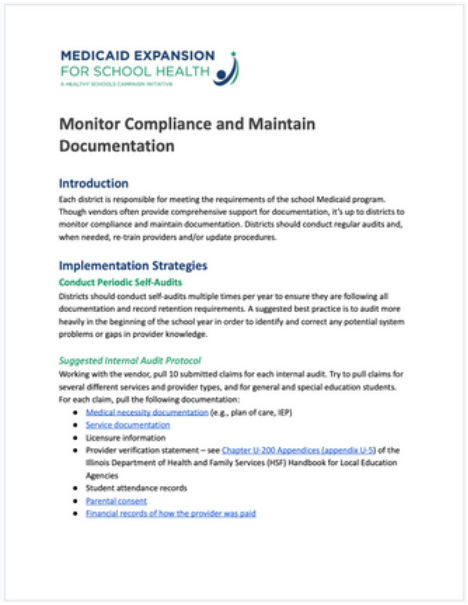
WELLNESS DEPARTMENT

SOURCE: ILLINOIS STATE BOARD OF EDUCATION

Districts must obtain parental consent to bill Medicaid and share information.

-Consent is lifetime, not annual
-Can be obtained during enrollment
-May be revoked at any time

Monitor Compliance & Maintain Documentation



MEDICAID EXPANSION FOR SCHOOL HEALTH

Monitor Compliance and Maintain Documentation

Introduction

Each district is responsible for meeting the requirements of the school Medicaid program. Though vendors often provide comprehensive support for documentation, it's up to districts to monitor compliance and maintain documentation. Districts should conduct regular audits and, when needed, re-train providers and/or update procedures.

Implementation Strategies

Conduct Periodic Self-Audits

Districts should conduct self-audits multiple times per year to ensure they are following all documentation and record retention requirements. A suggested best practice is to audit more heavily in the beginning of the school year in order to identify and correct any potential system problems or gaps in provider knowledge.

Suggested Internal Audit Protocol

Working with the vendor, pull 10 submitted claims for each internal audit. Try to pull claims for several different services and provider types, and for general and special education students. For each claim, pull the following documentation:

- Medical necessity documentation (e.g., plan of care, IEP)
- Service documentation
- Licensure information
- Provider verification statement – see Chapter U-200 Appendices (appendix U-5) of the Illinois Department of Health and Family Services (HSF) Handbook for Local Education Agencies
- Student attendance records
- Parental consent
- Financial records of how the provider was paid

SOURCE: HEALTHY SCHOOL CAMPAIGN

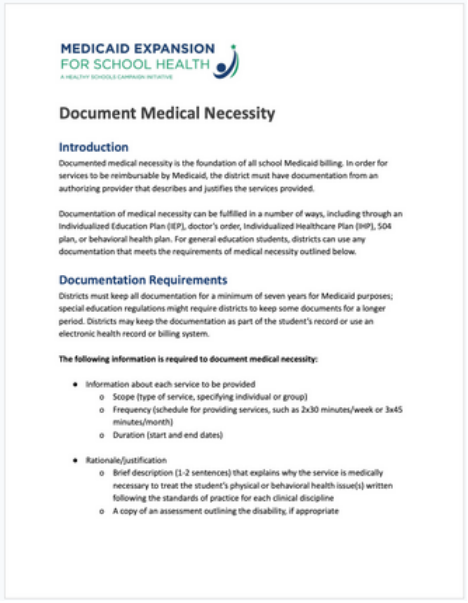
Documentation and Medical Necessity

Districts must maintain documentation demonstrating:

Parental consent, A plan of care, Medical necessity, Services delivered match the plan...

Providers qualified under Medicaid are authorized to determine medical necessity within their scope of practice.

Document Medical Necessity



MEDICAID EXPANSION FOR SCHOOL HEALTH

A HEALTHY SCHOOLS CAMPAIGN INITIATIVE

Document Medical Necessity

Introduction

Documented medical necessity is the foundation of all school Medicaid billing. In order for services to be reimbursable by Medicaid, the district must have documentation from an authorizing provider that describes and justifies the services provided.

Documentation of medical necessity can be fulfilled in a number of ways, including through an Individualized Education Plan (IEP), doctor's order, Individualized Healthcare Plan (IHP), 504 plan, or behavioral health plan. For general education students, districts can use any documentation that meets the requirements of medical necessity outlined below.

Documentation Requirements

Districts must keep all documentation for a minimum of seven years for Medicaid purposes; special education regulations might require districts to keep some documents for a longer period. Districts may keep the documentation as part of the student's record or use an electronic health record or billing system.

The following information is required to document medical necessity:

- Information about each service to be provided
  - Scope (type of service, specifying individual or group)
  - Frequency (schedule for providing services, such as 2x30 minutes/week or 3x45 minutes/month)
  - Duration (start and end dates)
- Rationale/justification
  - Brief description (1-2 sentences) that explains why the service is medically necessary to treat the student's physical or behavioral health issue(s) written following the standards of practice for each clinical discipline
  - A copy of an assessment outlining the disability, if appropriate

SOURCE: HEALTHY SCHOOL CAMPAIGN

Documentation Requirements in the Context of SBS

In general, providers must maintain documentation that covered Medicaid services have been provided to beneficiaries to support the provider's claim for Medicaid payment. 120 However, many school-based settings are not traditional health care providers with a sophisticated billing infrastructure in place. A number of OIG audits have noted that States' methodologies did not capture information that would allow the States to support cost allocations. 121 To prevent these types of findings, be sure to state clear and consistent billing requirements in State provider billing manuals. While this section details the current documentation requirements to support the claiming of FFP, there is a need for collaboration among State Medicaid agencies, SEAs, and LEAs to determine documentation and retention policies that are suitable to satisfy applicable legal requirements and withstand audits without unnecessarily impeding service delivery. For example, there may be overlap between medical service documentation and educational documentation that could be consolidated or reconciled into a more efficient documentation process that meets medical (including billing) and educational purposes.

REQUIRED DOCUMENTATION	REQUIRED BY CMS	REQUIRED BY IDEA
Date of Service	✓	✗
Name od Recipient	✓	✓
Medicaid Identification Number (of student)	✓	✗
Provider Agency & Person Providing the Service	✓	✓
Nature, Extent, or Units of Service	✓	✓
Place of Service	✓	✓
Eligibility for IDEA Services	✗	✓

SOURCE: Medicaid.gov Keeping America Healthy

✗ = No specific program requirement

Here's a quick list of what
the center for Medicaid and Medicare services will require as far as documentation of services that are there.

These are very similar to what IDEA has always required for us. Difference is we need to be able to track the Medicaid identification number in the state of Illinois. That's the REN registered identification number and that REN that a student has that number will stay with that student their entire life.

Internal Program Review Checklist:

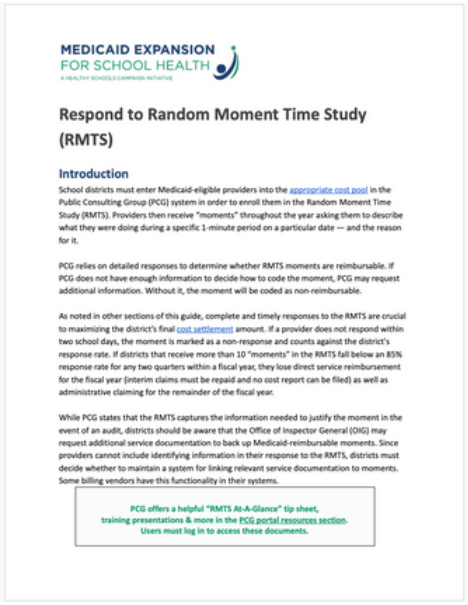
Review Item	Y/N	Notes	Corrective Action Needed? (Y/N)
Documenting Medical Necessity			
Can you locate the medical necessity documentation?			
Is the documentation signed by a provider authorized to order the service(s)?			
Is the medical necessity documentation/plan of care dated?			
Does the medical necessity documentation/plan of care clearly indicate the type, scope, frequency and duration of the services to be provided?			
Service Documentation			
Can you locate the service documentation?			
Does the service billed match the service ordered by the medical necessity documentation/plan of care?			
Was the service provided after the plan was authorized?			
Was the service provided by a practitioner licensed to deliver that service?			
Did the provider sign and date the documentation?			
If the provider required supervision, did the supervisor sign off on the service documentation?			
Does the service documentation have each of the required elements?			

Review Item	Y/N	Notes	Corrective Action Needed? (Y/N)
Licensure			
Does the district have a valid copy of the provider's license on file?			
Was the license valid the day the service was provided?			
Does the district have a completed copy of the Verification Statement located in Chapter U-200 Appendices (appendix U-5) in the provider's file?			
If the provider required supervision, does the district have all the above for the individual who provided that supervision?			
Attendance Records			
Are you able to locate the student's attendance records?			
Does the student's attendance record indicate that the student was in school at the time of the service?			
Parental Consent			
Are you able to locate the student's signed parental consent form?			
Was the parental consent form dated before the district billed for the service?			
Parental Consent			
Are you able to locate the employee records pertaining to payroll, timesheets, contracts, and benefits including insurance and retirement?			
Do the records demonstrate that the provider was paid at least partially with state/local funds?			

SOURCE: HEALTHY SCHOOL CAMPAIGN

The healthy schools campaign has several types of internal program review checklist and ways to be able to self audit and just make sure we have our own compliance down for the quality of our documentation and that services are happening for the right students.

Respond to RMTS



MEDICAID EXPANSION FOR SCHOOL HEALTH

A HEALTHY SCHOOLS CAMPAIGN INITIATIVE

Respond to Random Moment Time Study (RMTS)

Introduction

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

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

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

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

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

SOURCE: HEALTHY SCHOOL CAMPAIGN

Random Moment Time Study (RMTS)

-RMTS is a critical component of Medicaid reimbursement.

-Staff have two days to respond

-Districts must maintain at least an 85% response rate

-Low response rates can jeopardize funding

RMTS Sampling Periods:

Effective on 7/1/2023: The sampling period is defined as follows for the SBHS Program:

- Sample Period 1 = mid-August – December 31*
- Sample Period 2 = January 1 – March 31
- Sample Period 3 = April 1 – June 30
- Sample Period 4 = July 1 – mid-August** *(the summer sample period)*

**the time study period will begin with the first regular school day when any participating district returns from the summer break and will continue until the end of December*

***no time study will be generated. The sample period will run from the day after the last regular school day until the day before the first regular school day for any participating district.*

SOURCE: HFS Illinois Department of Healthcare and Family Services

The sampling periods are designed to be in accordance with the May 2003 Medicaid School-Based Administrative Claiming Guide

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 costs must be determined by the application of the proportional Medicaid share (using the Medicaid Enrollment Rate (MER) and the IEP ratio). The proportional Medicaid share will be determined for each district. • For the Direct Service (cost settlement process), the Medicaid share is defined as the ratio of Medicaid enrolled special education students with billable medical service on an IEP/IFSP to the total special education students with billable medical service on an IEP/IFSP, i.e. the IEP ratio. • For Free Care (cost settlement process) and MAC, the Medicaid share is determined as the ratio of Medicaid enrolled students to total students, i.e. the MER
R	Reallocated - refers to those general administrative activities which must be reallocated across the other activity codes on a pro rata basis. These reallocated activities are reported under General Administration.

SOURCE: HFS Illinois Department of Healthcare and Family Services

Time Study Codes Overview

Total Medicaid (TM): Outreach and eligibility determination (100% Medicaid, 50% FMAP)

Proportional Medicaid: Based on district Medicaid enrollment ratio

Unallowable activities: Educational-only or non-Medicaid services

Time Study Codes for RMTS:

CODE	CODE TEXT	ACTIVITY	DIRECT SERVICE INDICATOR	MAC INDICATOR
	Prov Svcs	**Provision of Services**		
1A	Outreach	Non-Medicaid Outreach	U	U
1B	Outreach	Medicaid Outreach	U	TM/50%
2A	Enrollment	Facilitating Non-Medicaid Eligibility Determination	U	U
2B	Enrollment	Facilitating Medicaid Eligibility Determination	U	TM/50%
3	Educational Services	School Related and Educational Services	U	U
4A	DirNonIEP	Direct Medical Services - Not Covered as IDEA/IEP Services, Not Covered on a Medical Plan of Care	U	U
4B	DirMedIEP	Direct Medical Services - Covered as IDEA?IEP Services, Not Covered on a Medical Plan of Care	PM (IEP Ratio)	U
4C	DirMedFreeCare	Direct Medical Services - Covered on a Medical Plan of Care, Not Covered as a IDEA/IEP Service	PM (MER)	U
5A	Transportation	Transportation Non-Medicaid	U	U
5B	Transportation	Medicaid Transportation	U	PM/50%
6A	Translation	Non-Medicaid Translation Services	U	U
6B	Translation	Medicaid Translation	U	PM/75%
7A	Planning		U	U
7B	Planning	Medical Program Planning, Policy Development, & Interagency Coordination	U	PM/50%
8A	Training	Non-Medical/medicaid Related Training	U	U
8B	Training	Medical/medicaid Related Training	U	PM/50%
9A	Referral	Referral, Coordination, & Monitoring of Non-Medicaid Services	U	U
9B	Referral	Referral, Coordination, & Monitoring of Medicaid Services	U	PM/50%
10	GA	General Administration	R	R
11	Unallowable	Not Paid/Not Worked	U	U

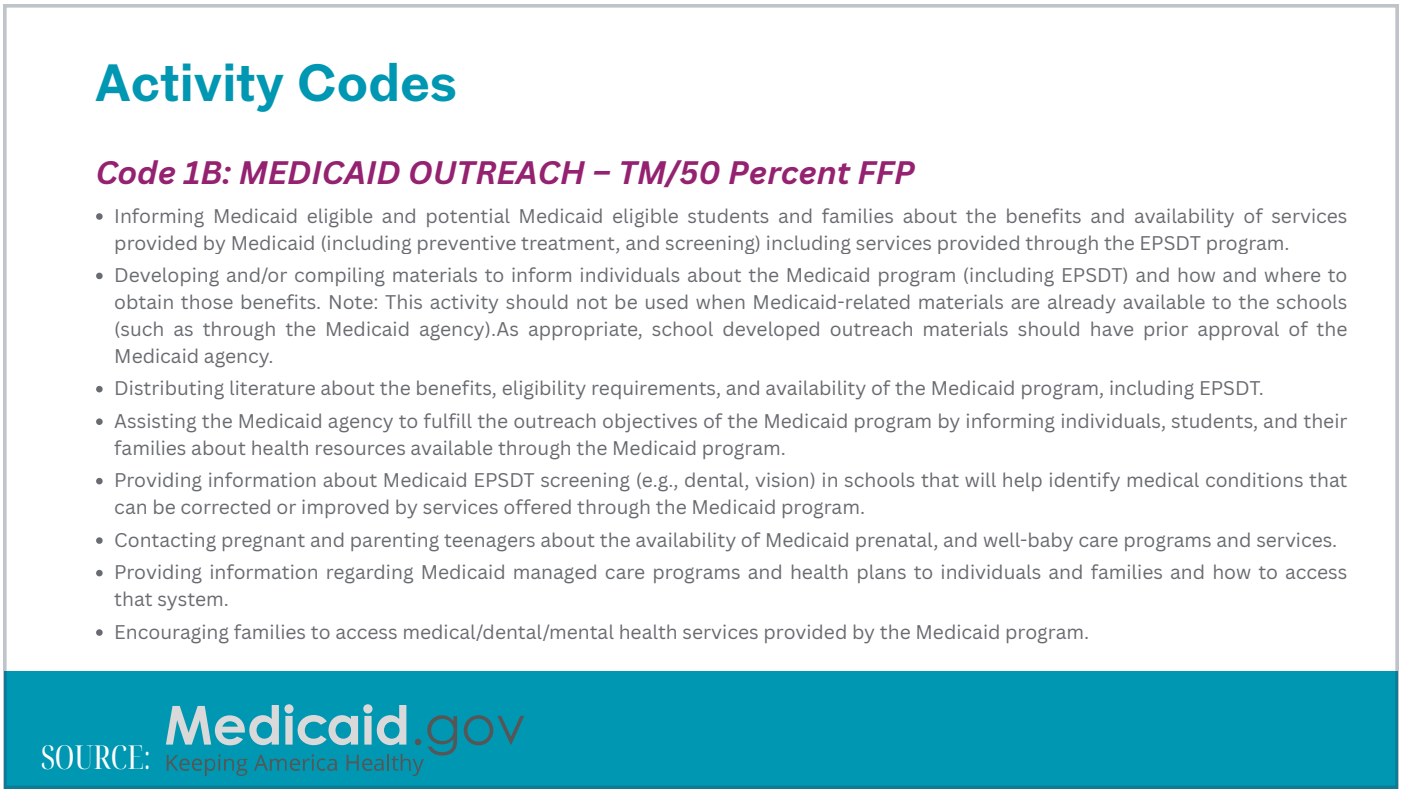
SOURCE: HFS Illinois Department of Healthcare and Family Services

Activity Codes

Code 1A: NON-MEDICAID OUTREACH - U

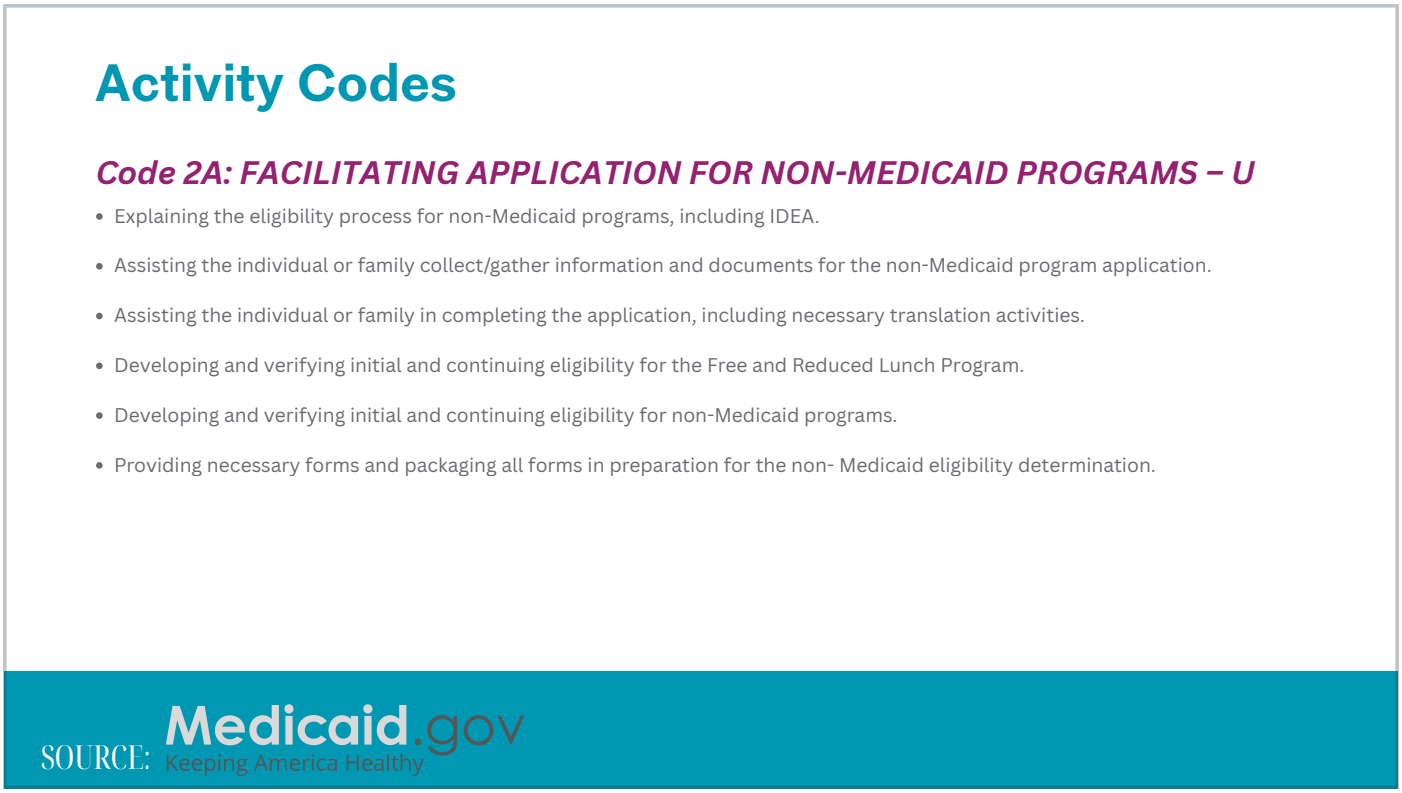
- Informing families about wellness programs and how to access these programs.
- Scheduling and promoting activities that educate individuals about the benefits of healthy life-styles and practices.
- Conducting general health education programs or campaigns that address life-style changes in the general population (e.g., dental prevention, anti-smoking, alcohol reduction, etc.).
- Conducting outreach campaigns that encourage persons to access social, educational, legal, or other services not covered by Medicaid.
- Assisting in early identification of students with special education medical/dental/mental health needs through various child find activities.
- Outreach activities in support of programs that are 100 percent funded by State general revenue.
- Developing outreach materials such as brochures or handbooks for these programs.
- Distributing outreach materials regarding the benefits and availability of these programs.

SOURCE: Medicaid.gov Keeping America Healthy



If I'm trying to help students determine whether or not they're eligible for Medicaid or I'm giving educational information to families to newly pregnant parents if I'm distributing literature around the benefits of Medicaid and eligibility requirements perhaps the federal poverty levels and what % of the federal poverty level with that amount is any of that type of education those educational activities that is all reimbursable by Medicaid for those moments and what's happening there.

Also, if I have a student that we put out educational materials, we put out information and there's some
screening or activity that then I can help them apply for Medicaid in facilitating their application for Medicaid. That would be a covered service as I'm helping them become eligible for that. I may be collecting or helping them collect different information or documentation that's required to become Medicaid eligible. Any of those supports that I'm providing, those are reimbursable by Medicaid.



Facilitating application to anything that is a non-Medicaid program, including anything that is idea that's non-Medicaid reimbursable. Those that that activity is a non-reimbursable or unallowable activity. so we won't be able to see Medicaid reimbursement for those activities.

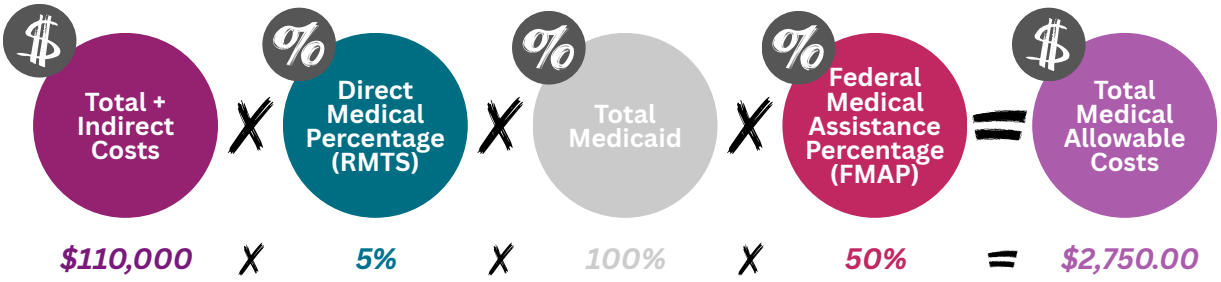
Activity Codes

Code 2B: FACILITATING MEDICAID ELIGIBILITY DETERMINATION – TM/50 Percent FFP

- Verifying an individual's current Medicaid eligibility status for purposes of the Medicaid eligibility process.
- Explaining Medicaid eligibility rules and the Medicaid eligibility process to prospective applicants.
- Assisting individuals or families to complete a Medicaid eligibility application.
- Gathering information related to the application and eligibility determination for an individual, including resource information and TPL information, as a prelude to submitting a formal Medicaid application.
- Providing necessary forms and packaging all forms in preparation for the Medicaid eligibility determination.
- Referring an individual or family to the local Assistance Office to make application for Medicaid benefits.
- Assisting the individual or family in collecting/gathering required information and documents for the Medicaid application.
- Participating as a Medicaid eligibility outreach outstation, but does not include determining eligibility.

SOURCE: Medicaid.gov Keeping America Healthy

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



Medicaid Outreach:

For a provider with $110,000 in annual costs:

5% time spent on Medicaid outreach

Reimbursement: $2,750 per year

Across 10 providers, this equals $27,500 annually.

Free Care & Medicaid Administrative Claiming

Medicaid Enrollment Rate (MER)

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

Activity Codes

Code 3: SCHOOL-RELATED AND EDUCATIONAL ACTIVITIES – U

- Providing classroom instruction (including lesson planning).
- Testing, correcting papers.
- Developing, coordinating, and monitoring the IEP for a student, which includes ensuring annual reviews of the IEP are conducted, parental sign-offs are obtained, and the actual IEP meetings with the parents.
- Compiling attendance reports.
- Performing activities that are specific to instructional, curriculum, and student- focused areas.
- Reviewing the education record for students who are new to the school district.
- Providing general supervision of students (e.g., playground, lunchroom).
- Monitoring student academic achievement.
- Providing academic instruction (e.g., math concepts) to a special education student.
- Conducting external relations related to school educational issues/matters.
- Compiling report cards.
- Carrying out discipline.
- Performing clerical activities specific to instructional or curriculum areas.
- Activities related to the educational aspects of meeting immunization requirements for school attendance.
- Compiling, preparing, and reviewing reports on textbooks or attendance.
- Enrolling new students or obtaining registration information.
- Conferring with students or parents about discipline, academic matters, or other school-related issues.
- Evaluating curriculum and instructional services, policies, and procedures.
- Participating in or presenting training related to curriculum or instruction (e.g., language arts workshop, computer instruction).
- Translating an academic test for a student.

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 4A: DIRECT MEDICAL SERVICES - NOT COVERED AS IDEA/ IEP SERVICES, Not Covered by Medicaid

- Administering first aid
- Screening services conducted by non-qualified providers
- Mental health services conducted by non-qualified providers
- Nursing services conducted by non-qualified providers.
- Providing a medically necessary service to someone who is not a student (e.g. staff member)

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 5A: TRANSPORTATION FOR NON-MEDICAID SERVICES – U

- Scheduling or arranging transportation to social, vocational, and/or educational programs and activities

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 5B: TRANSPORTATION-RELATED ACTIVITIES IN SUPPORT OF MEDICAID-COVERED SERVICES – PM/50 Percent FFP

- Scheduling or arranging transportation that meets the Medicaid definition of "specialized transportation" to and/or from school for students with specialized medical needs."
- Scheduling or arranging transportation to Medicaid-covered services.

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 6A: NON-MEDICAID TRANSLATION - U

- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand social, educational, and vocational services.
- Arranging for or providing translation services (oral or signing services) that assist the individual to access and understand State education or State-mandated health screenings (e.g., vision, hearing, scoliosis) and general health education outreach campaigns intended for the student population.
- Developing translation materials that assist individuals to access and understand social, educational, and vocational services.

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 6B: TRANSLATION RELATED TO MEDICAID SERVICES – PM/75 percent FFP or the CHIP rate subject to the administrative claiming 10 percent cap

- Arranging for or providing translation services (oral and signing) that assist the individual to access and understand necessary care or treatment covered by Medicaid.
- Developing translation materials that assist individuals to access and understand necessary care or treatment covered by Medicaid.

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 7A: PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO NON-MEDICAL SERVICES - U

- Identifying gaps or duplication of non-medical services (e.g., social, vocational educational and State mandated general health care programs) to school age students and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of non-medical school programs.
- Monitoring the non-medical delivery systems in schools.
- Developing procedures for tracking families' requests for assistance with non-medical services and the providers of such services.
- Evaluating the need for non-medical services in relation to specific populations or geographic areas.
- Analyzing non-medical data related to a specific program, population, or geographic area.
- Working with other agencies providing non-medical services to improve the coordination and delivery of services and to improve collaboration around the early identification of non-medical problems.
- Defining the relationship of each agency's non-medical services to one another.
- Developing advisory or work groups of professionals to provide consultation and advice regarding the delivery of non-medical services and State-mandated health screenings to the school populations.
- Developing non-medical referral sources.
- Coordinating with interagency committees to identify, promote and develop non-medical services in the school system.

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 7B: PROGRAM PLANNING, POLICY DEVELOPMENT, AND INTERAGENCY COORDINATION RELATED TO MEDICAL SERVICES – PM/50 percent FFP

- Identifying gaps or duplication of medical/dental/mental services to school age students and developing strategies to improve the delivery and coordination of these services.
- Developing strategies to assess or increase the capacity of school medical/dental/mental health programs.
- Monitoring the medical/dental/mental health delivery systems in schools.
- Developing procedures for tracking families' requests for assistance with medical/dental/mental services and providers, including Medicaid.
- Evaluating the need for medical/dental/mental services in relation to specific populations or geographic areas.
- Analyzing Medicaid data related to a specific program, population, or geographic area.
- Working with other agencies and/or providers that provide medical/dental/mental services to improve the coordination and delivery of services, to expand access to specific populations of Medicaid eligible beneficiaries, and to increase provider participation and improve provider relations.
- Working with other agencies and/or providers to improve collaboration around the early identification of medical/dental/mental problems.
- Developing strategies to assess or increase the cost effectiveness of school medical/dental/mental health programs.
- Working with the Medicaid agency to identify, recruit and promote the enrollment of potential Medicaid providers.
- Coordinating with interagency committees to identify, promote and develop EPSDT services in the school system.

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 8A: NON-MEDICAL/NON-MEDICAID RELATED TRAINING - U

- Participating in or coordinating training that improves the delivery of services for programs other than Medicaid.
- Participating in or coordinating training that enhances IDEA child find programs.

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 8B: MEDICAL/MEDICAID RELATED TRAINING – PM/50 Percent FFP

- Participating in or coordinating training that improves the delivery of medical/Medicaid related services.
- Participating in or coordinating training that enhances early identification, intervention, screening, and referral of students with special health needs to such services (e.g., Medicaid EPSDT services). (This is distinguished from IDEA child find programs.)
- Participating in training on administrative requirements related to medical/Medicaid services.

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 9A: REFERRAL, COORDINATION, AND MONITORING OF NON-MEDICAID SERVICES - U

- Making referrals for and coordinating access to social and educational services such as child care, employment, job training, and housing.
- Making referrals for, coordinating, and/or monitoring the delivery of SEA mandated student health screens (e.g., vision, hearing, scoliosis).
- Making referrals for, coordinating, and monitoring the delivery of scholastic, vocational, and other non-health related examinations.
- Gathering any information that may be required in advance of these non-Medicaid related referrals.
- Participating in a meeting/discussion to coordinate or review a student's need for scholastic, vocational, and non-health related services not covered by Medicaid.
- Monitoring and evaluating the non-medical components of the individualized plan as appropriate.

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 9B: REFERRAL, COORDINATION, AND MONITORING OF MEDICAID SERVICES – PM/50 Percent FFP

- Identifying and referring adolescents who may be in need of Medicaid family planning services.
- Making referrals for and/or coordinating medical or physical examinations and necessary medical/dental/mental health evaluations.
- Making referrals for and/or scheduling EPSDT screens, interperiodic screens, and appropriate immunization, but NOT to include the State-mandated health services.
- Referring students for necessary medical health, including mental health or substance use disorder services, covered by Medicaid.
- Arranging for any Medicaid-covered medical/dental/mental health diagnostic or treatment services that may be required as the result of a specifically identified medical/dental/mental health condition.
- Gathering any information that may be required in advance of medical/dental/mental health referrals.
- Participating in a meeting/discussion to coordinate or review a student's needs for health- related services covered by Medicaid.
- Providing follow-up contact to ensure that a student has received the prescribed medical/dental/mental health services covered by Medicaid.
- Coordinating the delivery of community based medical/dental/mental health services for a student with special/severe health care needs.
- Coordinating the completion of the prescribed services, termination of services, and the referral of the student to other Medicaid service providers as may be required to provide continuity of care.
- Monitoring and evaluating the Medicaid service components of the IEP as appropriate.

SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 10: GENERAL ADMINISTRATION - R

- Taking lunch, breaks, leave, or other paid time not at work.
- Establishing goals and objectives of health-related programs as part of the school's annual or multi-year plan.
- Reviewing school or district procedures and rules that are not related to the delivery of health care services.
- Attending or facilitating school or unit staff meetings or training that is not related to the delivery of health care services, or board meetings.
- Performing administrative or clerical activities related to general building or district functions or operations.
- Providing general supervision of staff, including supervision of student teachers or classroom volunteers, and evaluation of employee performance.
- Reviewing technical literature and research articles.
- Other general administrative activities of a similar nature as listed above that cannot be specifically identified under other activity codes.

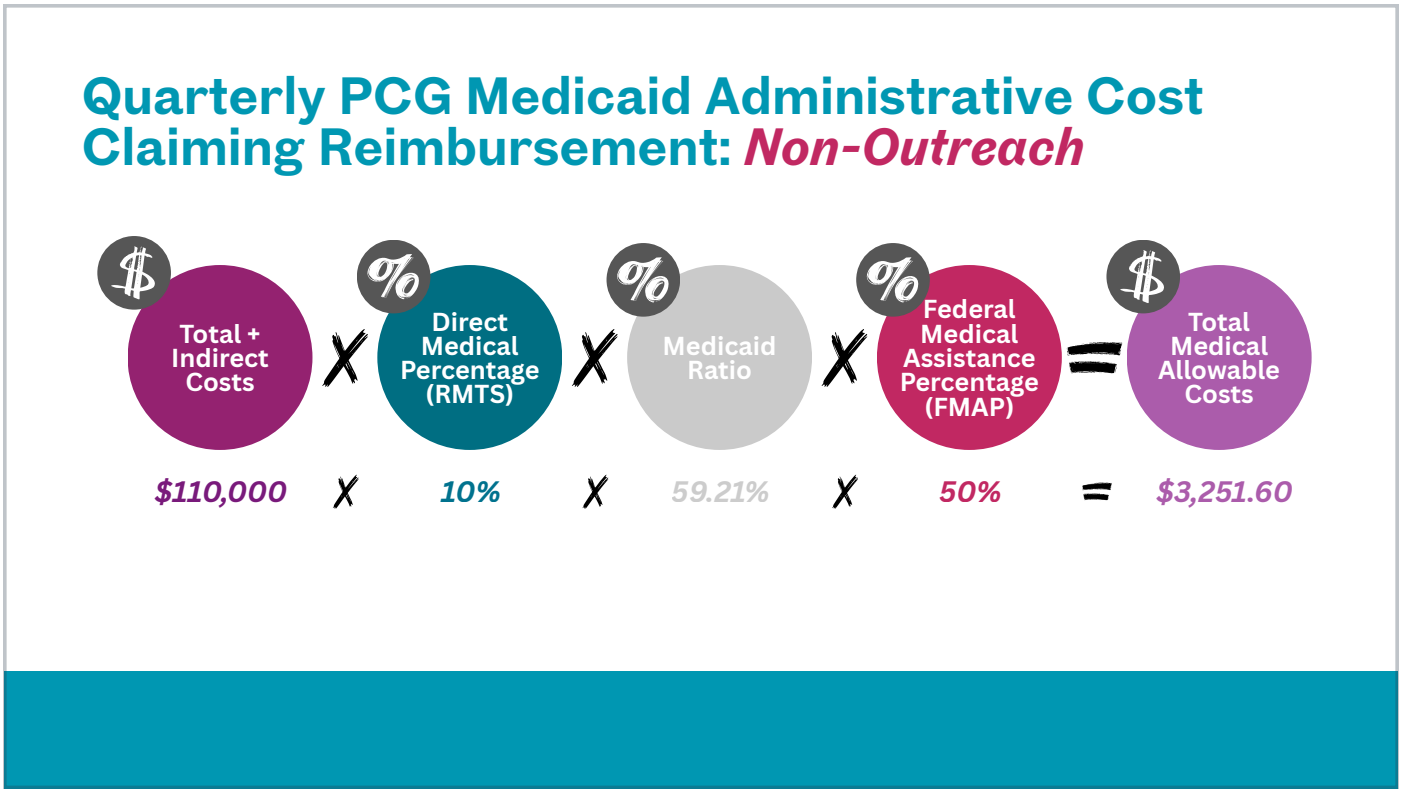
SOURCE: Medicaid.gov Keeping America Healthy

Activity Codes

Code 11: UNALLOW – UNPAID TIME OFF

- Use if the participant indicates that the moment occurred at a time when he or she was not scheduled to work, including unpaid days off.

SOURCE: Medicaid.gov Keeping America Healthy



Non-Outreach Administrative Example:

Using a Medicaid enrollment ratio of 59.21%:

10% allowable administrative activity

Annual reimbursement: $3,251.60 per provider

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
- Audiologist services including evaluation and therapy services*
- PT services and evaluations*
- OT services and evaluations*
- Speech Language Therapy and evaluations*
- Psychological services, including evaluations*
- Counseling services, including therapy services*
- Providing personal aide services*
- Nursing services and evaluations*
- Physician services and evaluation, including therapy services*
- Social Work services and evaluation, including therapy services*
- Any other services defined as covered by the states SBS program and included on the student's IEP.

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

- Pre and post activities associated with physical therapy services.
- Pre and post activities associated with speech language pathology services.
- 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

Activity Codes

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

All medical services with the student present including:

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

The services outlined in the Medicaid State Plan:

- Audiologist services including evaluation and therapy services *
- PT services and evaluations*
- OT services and evaluations*
- Speech Language Therapy services and evaluations*
- Counseling services, including therapy services*
- Nursing services, evaluations, and administering / monitoring medication**
- Physician services and evaluation, including therapy services*, Social Work services and evaluation, including therapy services*
- Any other services defined as covered by the states SBS program and included on the student's medical plan

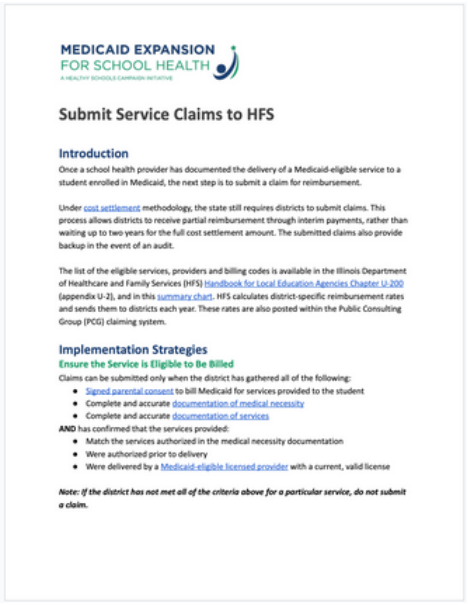
Pre and post time directly related to providing direct client care services when the student is not present:

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

SOURCE: Medicaid.gov Keeping America Healthy

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

Submit Service Claims to HFS



MEDICAID EXPANSION FOR SCHOOL HEALTH

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

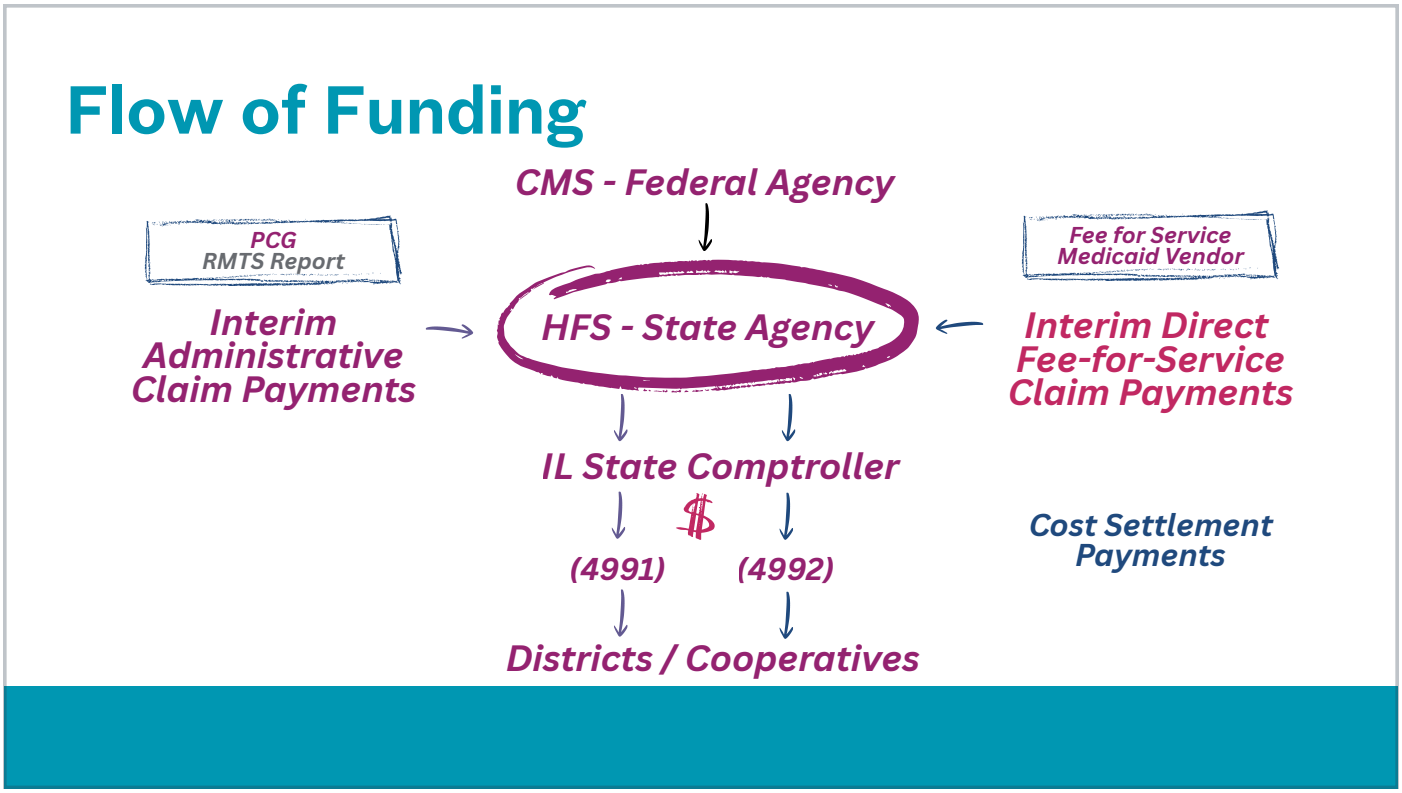
AND has confirmed that the services provided:

- 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

Submitting claims to HFS is a multiple part process and comes through both PCG and through your fee for service interim claims that are submitted through the Medicaid administrative claims which go to PCG.



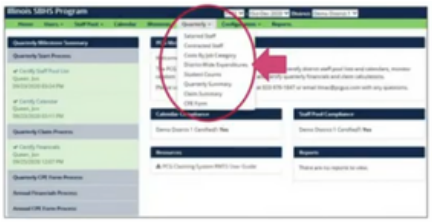
Flow of Funding:

-Medicaid Administrative Claims (via PCG)

-Fee-for-Service Interim Claims (via vendor)

-Cost Settlement (final reconciliation after 1.5–2 years)

Quarterly Financials



HELPFUL TIPS & RESOURCES:

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

Reporting Insurance Costs:

DO REPORT

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

DONT REPORT

- Property / Building
- Health
- Life
- Dental

Reporting Interest:

DO REPORT

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

DONT REPORT

- Payments on the principal amount of the bond

Reporting Rental Costs:

DO REPORT

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

DONT REPORT

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

Reporting LEA-wide Expenditures:

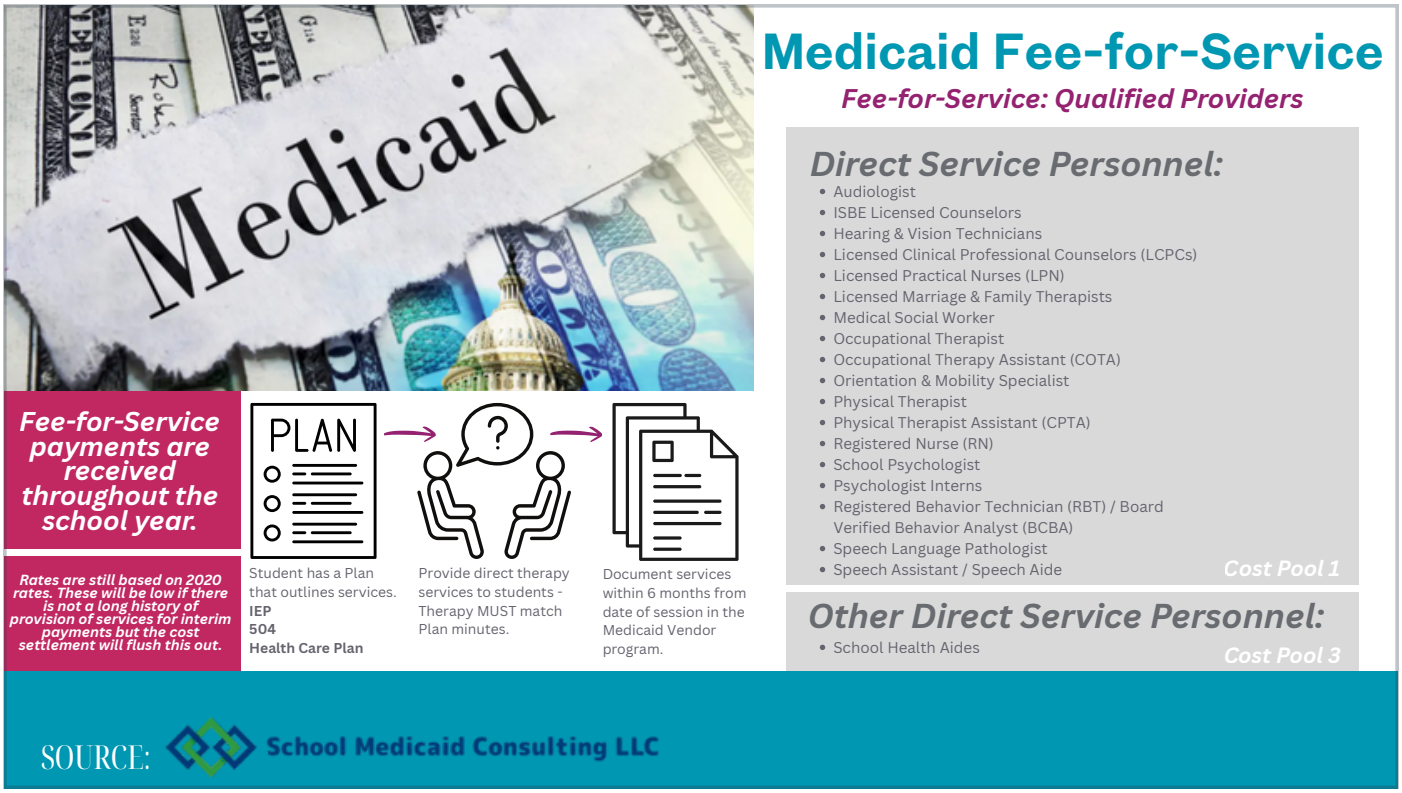
DO REPORT

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

DONT REPORT

- Back out Federal Funding Dollars

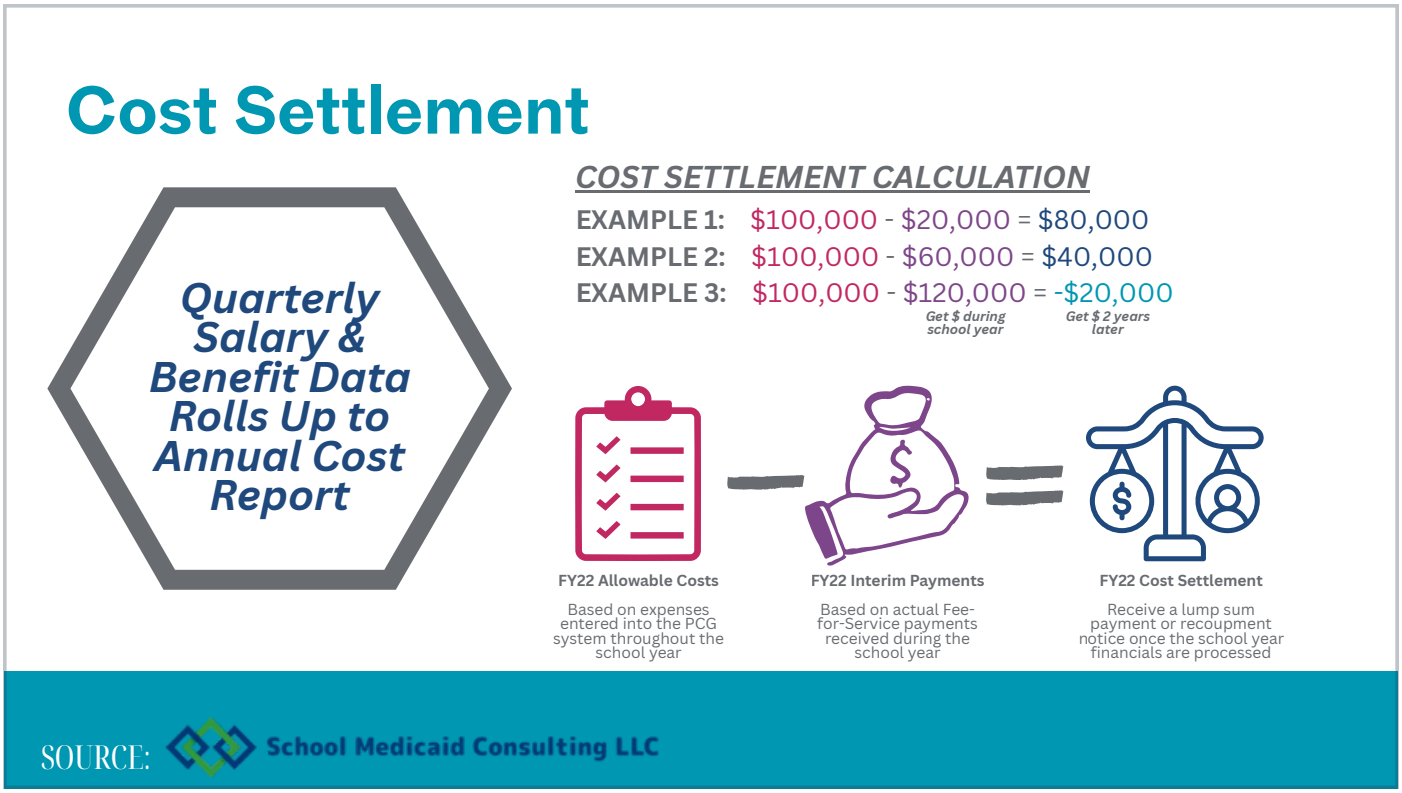
SOURCE: School Medicaid Consulting LLC



And our fee for service system, whether it's an IEP, a plan, some other new health care plan that you're implementing for your general education or free care students, you will have that plan. You'll provide the direct service that must match that plan as far as the services that were listed and the number of minutes or amount of time for the provision of those services. And then service activities would be documented within six months of the date of service. Six months is the maximum amount, the goal is oftentimes to get it in quicker; especially if you want to be able to get those interim payments quicker. That can be a process or a strategy to be able to increase or reduce down your wait time for reimbursement.

You can do that using all of the direct service providers that are listed over on the right hand side. This includes our existing providers prior to the SPA and includes our new providers with a SPA. Now something to note about the rates that you're going to get through your fee for service vendor provider; these rates are estimates based on the cost reporting system that you used back in 2020. So these rates are based on 2020. So, if you're a district that primarily all Medicaid reimbursable services were happening through a special education cooperative, as an example, you may not have very high or maybe non-existent rates from 2020. And that means your interim reimbursement or payments will be lower. However, your overall reimbursement will not be lower. It's just your interim payments will be lower because these rates are based on 2020 and you maybe have not set higher rates, and at some point the rates may reset but if you are disappointed in some of the interim payments that wouldn't be surprising if you weren't doing a lot of Medicaid reimbursable activities or if you weren't submitting cost reports or if you weren't working in PCG in 2020. If that was the case, those rates are going to be really low. Just expect that.

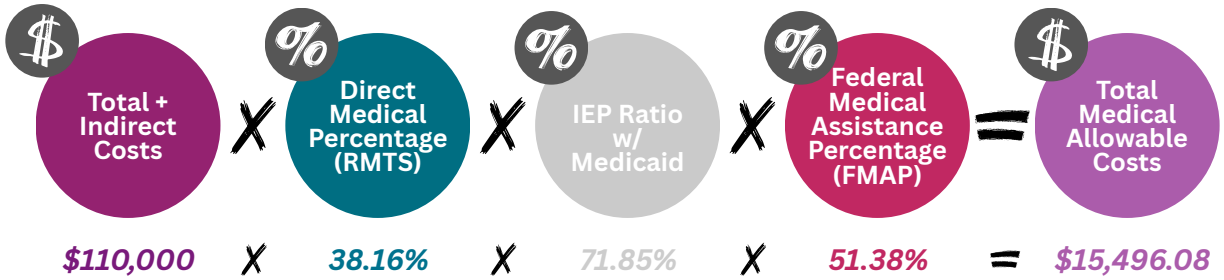
But the cost settlement will still get you that Medicaid reimbursement amount, and you're going to maybe be seeing more in cost settlement than what you can get in your interim claims along the way



Cost Settlement Model:

The cost settlement model accounts for Total allowable costs and Interim payments already received. This model is the primary driver of increased Medicaid reimbursement statewide.

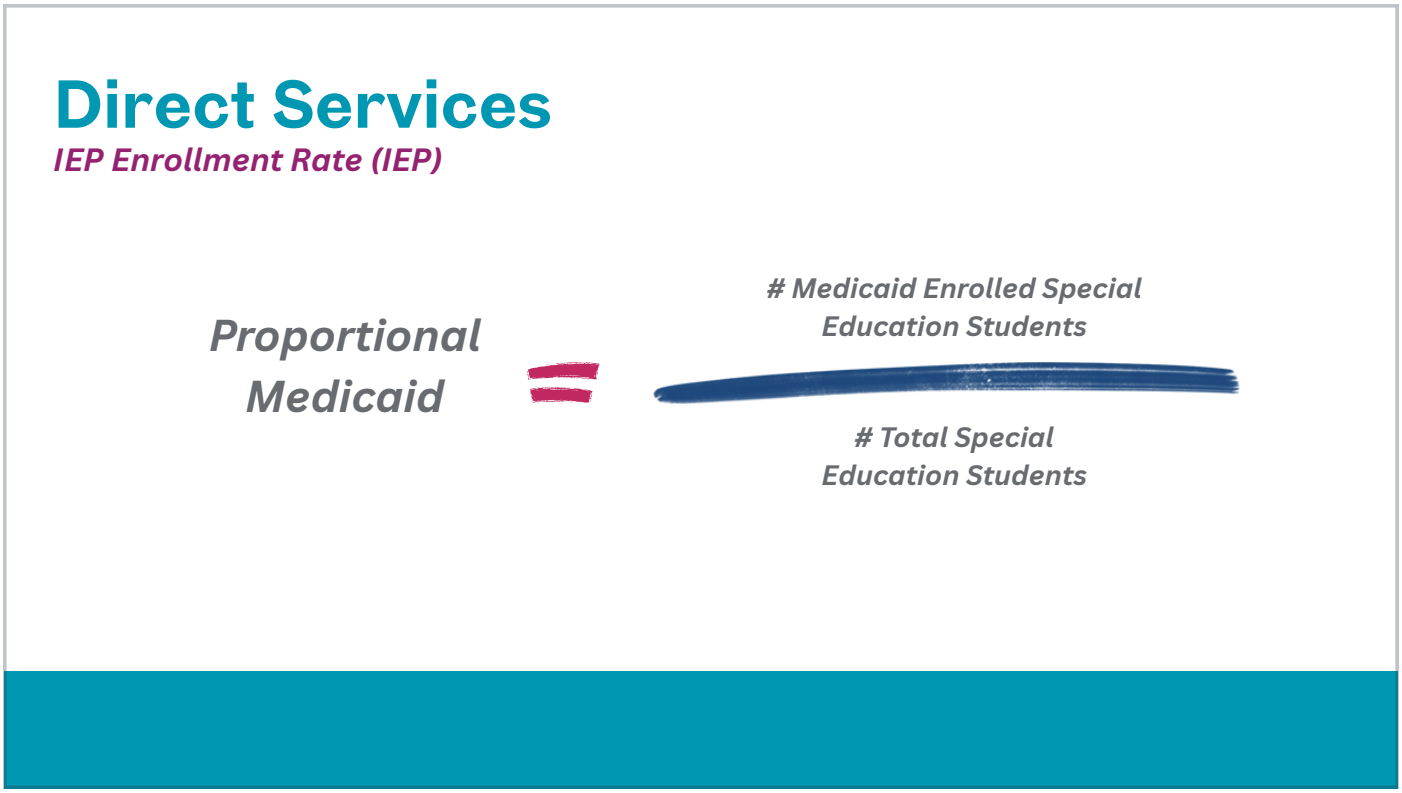
IEP Cost Settlement Formula - Single Provider



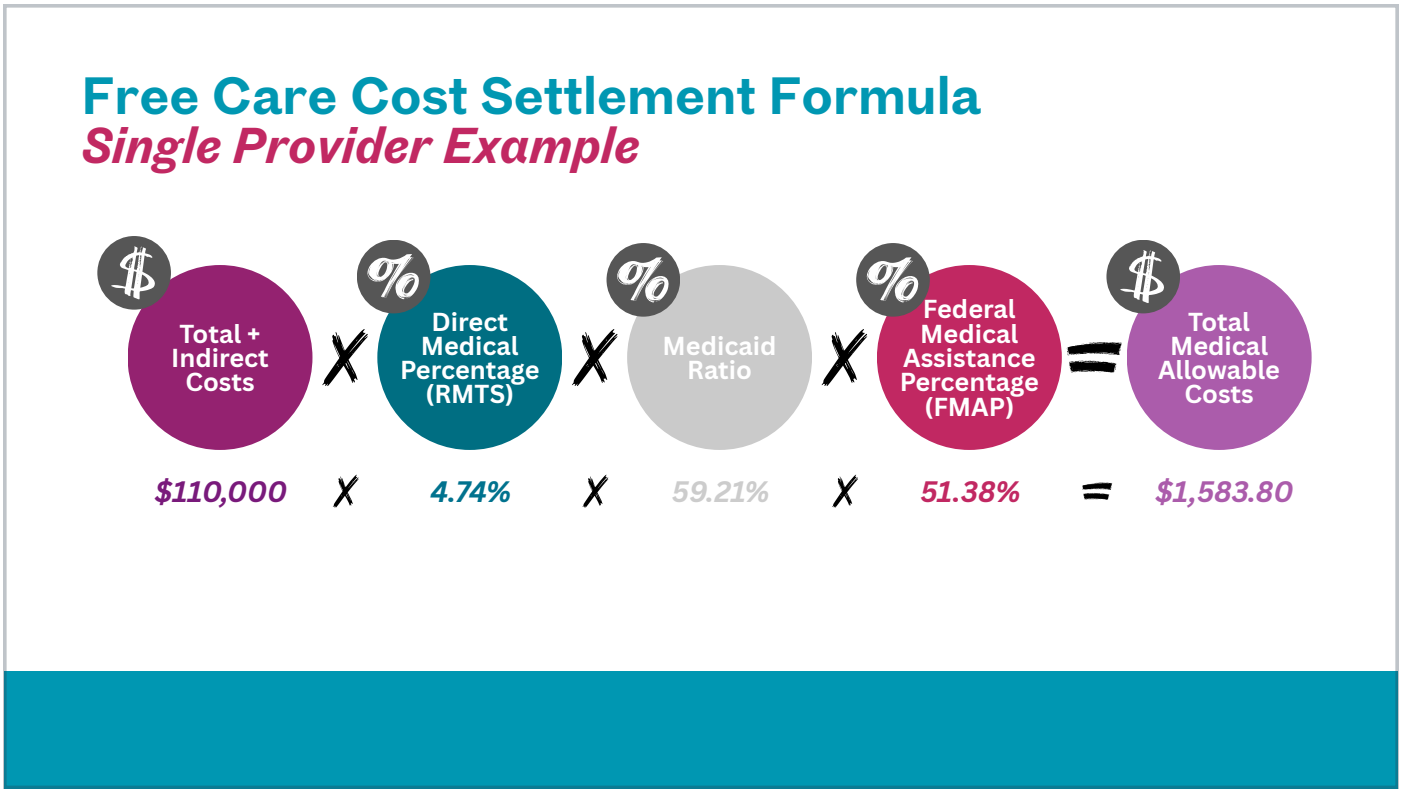
IEP Example:

IEP Services: Approximately $15,500 per provider annually

Across multiple providers, these amounts scale significantly.



So again, for the IEP enrollment rate, the proportional Medicaid are the number of Medicaid enrolled special education students with or special education students with Medicaid divided by the total number of special education students. That proportional Medicaid is often times much higher.



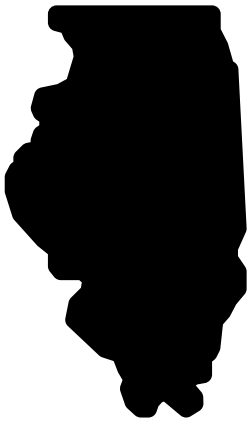
Free Care Cost Example:

Free Care Services: Approximately $1,600 per provider annually

Across multiple providers, these amounts scale significantly.

Moving to a Cost Settlement Reimbursement System Created Most of this Increase

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



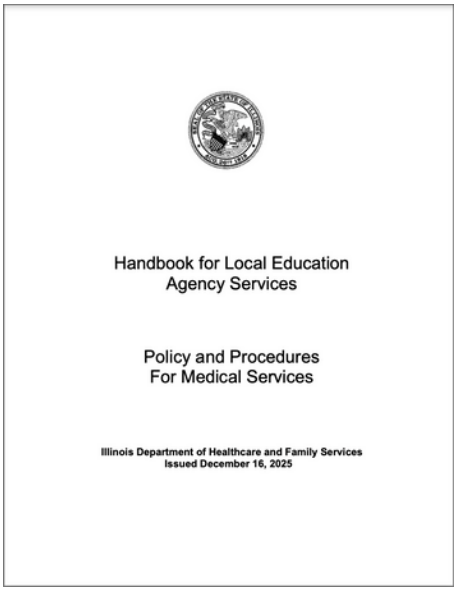
SOURCE: HEALTHY SCHOOL CAMPAIGN

Key Takeaway: Cost Settlement Is Critical

The largest gains in Medicaid funding come from Accurate staff pooling, Complete cost reporting,& Timely certification of reports.

Interim payments support cash flow, but cost settlement delivers the majority of reimbursement.

Local Education Agencies Handbook


Handbook for Local Education Agency Services

Policy and Procedures For Medical Services

Illinois Department of Healthcare and Family Services
Issued December 16, 2025

SOURCE: HFS Illinois Department of Healthcare and Family Services

Resources:

- Identify Eligible Providers & Services
- Illinois Parental Notice
- Monitor Compliance & Maintain Documentation
- Document Medical Necessity
- Respond to RMTS
- Time Study Implementation Guide
- Submit Service Claims to HFS
- Local Education Agencies Handbook
- State Efforts to Expand School Medicaid

ILLINOIS STATE BOARD OF EDUCATION | School Medicaid Consulting LLC | HFS Illinois Department of Healthcare and Family Services | Medicaid.gov Keeping America Healthy | HEALTHY SCHOOL CAMPAIGN

FOR MORE INFORMATION

E-mail dmattbuckman@stressandtrauma.org

Website www.west40.org

Watch Webinar Series Part 3:
Overview of Community-Based Mental Health Services in Illinois

Part three of this series will focus on community-based mental health services in Illinois and how partnerships can expand access to care.