AN ACT concerning government.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the 9-8-8 Suicide and Crisis Lifeline Workgroup Act.

Section 5. Findings. The General Assembly finds that:

(1) In the summer of 2022, 31% of Illinois adults experienced symptoms of anxiety or depression more than half of the days of each week, which is an increase of 20% since 2019.

(2) Suicide is the third leading cause of death in Illinois for young adults who are 15 to 34 years of age, and it is the 11th leading cause of death for all Illinoisans. In 2021, 1,488 Illinois lives were lost to suicide, and an estimated 376,000 adults had thoughts of suicide.

(3) Historically, people in Illinois and nationwide have had few and fragmented options to call upon during a mental health crisis and have relied upon 9-1-1 and various privately funded crisis lines for help.

(4) In July 2022, Illinois joined the nation in launching the 9-8-8 Suicide and Crisis Lifeline, a universal 3-digit dialing code for a national suicide prevention and mental health hotline, meant to offer 24-hour-a-day, 7-day-a-week

access to trained counselors who can help people experiencing mental health-related distress.

(5) Congress delegated to the states significant decision-making responsibility for structuring and funding the states' 9-8-8 call center networks.

(6) States had limited data on which to base their initial decisions because the Substance Abuse and Mental Health Services Administration's projections of future increases in call volumes varied widely, and there was no national best-practice model for the number and organization of 9-8-8 call centers.

(7) The Substance Abuse and Mental Health Services Administration described the 2022 launch of 9-8-8 as being just the first step toward reimagining our country's mental health crisis system and stipulated that long-term transformation will rely on the willingness of states and territories to build and invest strategically in every level of the continuum of mental health crisis care over the next several years.

(8) In 2023, the General Assembly and other State leaders can assess the first year of operations of the 9-8-8 call center system, identify legislative solutions to any funding and programmatic gaps that are emerging, and set the course for Illinois to eventually lead the country in providing quality and accessible 9-8-8 care and in connecting individuals with the mental health resources necessary to

sustain long-term recovery.

(9) The launch of the 9-8-8 Suicide and Crisis Lifeline has created a once-in-a-generation opportunity to improve mental health crisis care in Illinois.

(10) Illinois' success or failure in building a high-quality call center network in the initial years will be an important factor in determining whether 9-8-8 is perceived as a trusted resource in the State.

(11) Illinois' success or failure in building a high-quality 9-8-8 call center network will disproportionately affect Black, Brown, and other marginalized residents who are most likely to rely on crisis services to access mental health care and are most likely to be criminalized or harmed by the existing crisis response system.

Section 10. Suicide and Crisis Lifeline Workgroup.

(a) The Department of Human Services, Division of Mental Health, shall convene a workgroup that includes:

(1) bicameral, bipartisan members of the General Assembly;

(2) at least one representative from the Department of Human Services, Division of Substance Use Prevention and Recovery; the Department of Public Health; the Department of Healthcare and Family Services; and the Department of Insurance;

(3) the State's Chief Behavioral Health Officer;

(4) the Director of the Children's Behavioral Health Transformation Initiative;

(5) service providers from the regional and statewide 9-8-8 call centers;

(6) representatives of organizations that represent people with mental health conditions or substance use disorders;

(7) representatives of organizations that operate an Illinois social services helpline or crisis line other than 9-8-8, including veterans' crisis services;

(8) more than one individual with personal or family lived experience of a mental health condition or substance use disorder;

(9) experts in research and operational evaluation; and

(10) and any other person or persons as determined by the Department of Human Services, Division of Mental Health.

(b) On or before December 31, 2023, the Department of Human Services, Division of Mental Health, shall submit a report to the General Assembly regarding the Workgroup's findings under Section 15 related to the 9-8-8 call system.

Section 15. Responsibilities; action plan.

(a) The Workgroup has the following responsibilities:

(1) to review existing information about the first

year of 9-8-8 call center operations in Illinois, including, but not limited to, state-level and county-level use data, progress around the federal measures of success determined by the Substance Abuse and Mental Health Services Administration, and research conducted by any State-contracted partners around cost projections, best-practice standards, and geographic needs;

(2) to review other states' models and emerging best practices around structuring 9-8-8 call center networks, with an emphasis on promoting high-quality phone interventions, coordination with other crisis lines and crisis services, and connection to community-based support for those in need;

(3) to review governmental infrastructures created in other states to promote sustainability and quality in 9-8-8 call centers and crisis system operations;

(4) to review changes and new initiatives that have been advanced by the Substance Abuse and Mental Health Services Administration and Vibrant Emotional Health since Vibrant transitioned to 9-8-8 in July 2022, such as new training curricula for call takers and new technology platforms;

(5) to consider input from call center personnel, providers, and advocates about strengths, weaknesses, and service gaps in Illinois; and

(6) to develop an action plan with recommendations to the General Assembly that include the following:

(A) a future structure for a network of 9-8-8 call centers in Illinois that will best promote equity, quality, and connection to care;

(B) metrics that Illinois should use to measure the success of our statewide system in promoting equity, quality, and connection to care and a system to measure those metrics, considering the metrics imposed by the Substance Abuse and Mental Health Services Administration as only a starting point for measurement of success in Illinois;

(C) recommendations to further fund and strengthen the rest of Illinois' behavioral health services and crisis assistance programs based on lessons learned from 9-8-8 use; and

(D) recommendations on a long-term governmental infrastructure to provide advice and recommendations necessary to sustainably implement and monitor the progress of the 9-8-8 Suicide and Crisis Lifeline in Illinois and to make recommendations for the statewide improvement of behavioral health crisis response and suicide prevention services in the State.

The action plan shall be approved by a majority of Workgroup members.

(b) Nothing in the action plan filed under this Section

shall be construed to supersede the recommendations of the Statewide Advisory Committee or Regional Advisory Committees created by the Community Emergency Services and Support Act.

Section 20. Repeal. This Act is repealed on January 1, 2025.

Section 85. The Community Emergency Services and Support Act is amended by changing Sections 5, 15, 20, 25, 30, 35, 40, 45, 50, and 65 and by adding Section 70 as follows:

(50 ILCS 754/5)

Sec. 5. Findings. The General Assembly recognizes that the Illinois Department of Human Services Division of Mental Health is preparing to provide mobile mental and behavioral health services to all Illinoisans as part of the federally mandated adoption of the 9-8-8 phone number. The General Assembly also recognizes that many cities and some states have successfully established mobile emergency mental and behavioral health services as part of their emergency response system to support people who need such support and do not present a threat of physical violence to the mobile mental health relief providers ~~responders~~. In light of that experience, the General Assembly finds that in order to promote and protect the health, safety, and welfare of the public, it is necessary and in the public interest to provide

emergency response, with or without medical transportation, to individuals requiring mental health or behavioral health services in a manner that is substantially equivalent to the response already provided to individuals who require emergency physical health care.

(Source: P.A. 102-580, eff. 1-1-22.)

(50 ILCS 754/15)

Sec. 15. Definitions. As used in this Act:

"Division of Mental Health" means the Division of Mental Health of the Department of Human Services.

"Emergency" means an emergent circumstance caused by a health condition, regardless of whether it is perceived as physical, mental, or behavioral in nature, for which an individual may require prompt care, support, or assessment at the individual's location.

"Mental or behavioral health" means any health condition involving changes in thinking, emotion, or behavior, and that the medical community treats as distinct from physical health care.

"Mobile mental health relief provider" means a person engaging with a member of the public to provide the mobile mental and behavioral service established in conjunction with the Division of Mental Health establishing the 9-8-8 emergency number. "Mobile mental health relief provider" does not include a Paramedic (EMT-P) or EMT, as those terms are defined

in the Emergency Medical Services (EMS) Systems Act, unless that responding agency has agreed to provide a specialized response in accordance with the Division of Mental Health's services offered through its 9-8-8 number and has met all the requirements to offer that service through that system.

"Physical health" means a health condition that the medical community treats as distinct from mental or behavioral health care.

"PSAP" means a Public Safety Answering Point tele-communicator.

"Community services" and "community-based mental or behavioral health services" may include both public and private settings.

"Treatment relationship" means an active association with a mental or behavioral care provider able to respond in an appropriate amount of time to requests for care.

~~"Responder" is any person engaging with a member of the public to provide the mobile mental and behavioral service established in conjunction with the Division of Mental Health establishing the 9-8-8 emergency number. A responder is not an EMS Paramedic or EMT as defined in the Emergency Medical Services (EMS) Systems Act unless that responding agency has agreed to provide a specialized response in accordance with the Division of Mental Health's services offered through its 9-8-8 number and has met all the requirements to offer that service through that system.~~

(Source: P.A. 102-580, eff. 1-1-22.)

(50 ILCS 754/20)

Sec. 20. Coordination with Division of Mental Health. Each 9-1-1 PSAP and provider of emergency services dispatched through a 9-1-1 system must coordinate with the mobile mental and behavioral health services established by the Division of Mental Health so that the following State goals and State prohibitions are met whenever a person interacts with one of these entities for the purpose of seeking emergency mental and behavioral health care or when one of these entities recognizes the appropriateness of providing mobile mental or behavioral health care to an individual with whom they have engaged. The Division of Mental Health is also directed to provide guidance regarding whether and how these entities should coordinate with mobile mental and behavioral health services when responding to individuals who appear to be in a mental or behavioral health emergency while engaged in conduct alleged to constitute a non-violent misdemeanor.

(Source: P.A. 102-580, eff. 1-1-22.)

(50 ILCS 754/25)

Sec. 25. State goals.

(a) 9-1-1 PSAPs, emergency services dispatched through 9-1-1 PSAPs, and the mobile mental and behavioral health service established by the Division of Mental Health must

coordinate their services so that the State goals listed in this Section are achieved. Appropriate mobile response service for mental and behavioral health emergencies shall be available regardless of whether the initial contact was with 9-8-8, 9-1-1 or directly with an emergency service dispatched through 9-1-1. Appropriate mobile response services must:

(1) whenever possible, ensure that individuals experiencing mental or behavioral health crises are diverted from hospitalization or incarceration ~~whenever possible,~~ and are instead linked with available appropriate community services;

(2) include the option of on-site care if that type of care is appropriate and does not override the care decisions of the individual receiving care. Providing care in the community, through methods like mobile crisis units, is encouraged. If effective care is provided on site, and if it is consistent with the care decisions of the individual receiving the care, further transportation to other medical providers is not required by this Act;

(3) recommend appropriate referrals for available community services if the individual receiving on-site care is not already in a treatment relationship with a service provider or is unsatisfied with their current service providers. The referrals shall take into consideration waiting lists and copayments, which may present barriers to access; and

(4) subject to the care decisions of the individual receiving care, provide transportation for any individual experiencing a mental or behavioral health emergency. Transportation shall be to the most integrated and least restrictive setting appropriate in the community, such as to the individual's home or chosen location, community crisis respite centers, clinic settings, behavioral health centers, or the offices of particular medical care providers with existing treatment relationships to the individual seeking care.

(b) Prioritize requests for emergency assistance. 9-1-1 PSAPs, emergency services dispatched through 9-1-1 PSAPs, and the mobile mental and behavioral health service established by the Division of Mental Health must provide guidance for prioritizing calls for assistance and maximum response time in relation to the type of emergency reported.

(c) Provide appropriate response times. From the time of first notification, 9-1-1 PSAPs, emergency services dispatched through 9-1-1 PSAPs, and the mobile mental and behavioral health service established by the Division of Mental Health must provide the response within response time appropriate to the care requirements of the individual with an emergency.

(d) Require appropriate mobile mental health relief provider ~~responder~~ training. Mobile mental health relief providers ~~Responders~~ must have adequate training to address the needs of individuals experiencing a mental or behavioral

health emergency. Adequate training at least includes:

(1) training in de-escalation techniques;

(2) knowledge of local community services and supports; and

(3) training in respectful interaction with people experiencing mental or behavioral health crises, including the concepts of stigma and respectful language.

(e) Require minimum team staffing. The Division of Mental Health, in consultation with the Regional Advisory Committees created in Section 40, shall determine the appropriate credentials for the mental health providers responding to calls, including to what extent the mobile mental health relief providers ~~responders~~ must have certain credentials and licensing, and to what extent the mobile mental health relief providers ~~responders~~ can be peer support professionals.

(f) Require training from individuals with lived experience. Training shall be provided by individuals with lived experience to the extent available.

(g) Adopt guidelines directing referral to restrictive care settings. Mobile mental health relief providers ~~Responders~~ must have guidelines to follow when considering whether to refer an individual to more restrictive forms of care, like emergency room or hospital settings.

(h) Specify regional best practices. Mobile mental health relief providers ~~Responders~~ providing these services must do so consistently with best practices, which include respecting

the care choices of the individuals receiving assistance. Regional best practices may be broken down into sub-regions, as appropriate to reflect local resources and conditions. With the agreement of the impacted EMS Regions, providers of emergency response to physical emergencies may participate in another EMS Region for mental and behavioral response, if that participation shall provide a better service to individuals experiencing a mental or behavioral health emergency.

(i) Adopt system for directing care in advance of an emergency. The Division of Mental Health shall select and publicly identify a system that allows individuals who voluntarily chose to do so to provide confidential advanced care directions to individuals providing services under this Act. No system for providing advanced care direction may be implemented unless the Division of Mental Health approves it as confidential, available to individuals at all economic levels, and non-stigmatizing. The Division of Mental Health may defer this requirement for providing a system for advanced care direction if it determines that no existing systems can currently meet these requirements.

(j) Train dispatching staff. The personnel staffing 9-1-1, 3-1-1, or other emergency response intake systems must be provided with adequate training to assess whether coordinating with 9-8-8 is appropriate.

(k) Establish protocol for emergency responder coordination. The Division of Mental Health shall establish a

protocol for mobile mental health relief providers ~~responders~~, law enforcement, and fire and ambulance services to request assistance from each other, and train these groups on the protocol.

(l) Integrate law enforcement. The Division of Mental Health shall provide for law enforcement to request mobile mental health relief provider ~~responder~~ assistance whenever law enforcement engages an individual appropriate for services under this Act. If law enforcement would typically request EMS assistance when it encounters an individual with a physical health emergency, law enforcement shall similarly dispatch mental or behavioral health personnel or medical transportation when it encounters an individual in a mental or behavioral health emergency.

(Source: P.A. 102-580, eff. 1-1-22.)

(50 ILCS 754/30)

Sec. 30. State prohibitions. 9-1-1 PSAPs, emergency services dispatched through 9-1-1 PSAPs, and the mobile mental and behavioral health service established by the Division of Mental Health must coordinate their services so that, based on the information provided to them, the following State prohibitions are avoided:

(a) Law enforcement responsibility for providing mental and behavioral health care. In any area where mobile mental health relief providers ~~responders~~ are available for dispatch,

law enforcement shall not be dispatched to respond to an individual requiring mental or behavioral health care unless that individual is (i) involved in a suspected violation of the criminal laws of this State, or (ii) presents a threat of physical injury to self or others. Mobile mental health relief providers ~~Responders~~ are not considered available for dispatch under this Section if 9-8-8 reports that it cannot dispatch appropriate service within the maximum response times established by each Regional Advisory Committee under Section 45.

(1) Standing on its own or in combination with each other, the fact that an individual is experiencing a mental or behavioral health emergency, or has a mental health, behavioral health, or other diagnosis, is not sufficient to justify an assessment that the individual is a threat of physical injury to self or others, or requires a law enforcement response to a request for emergency response or medical transportation.

(2) If, based on its assessment of the threat to public safety, law enforcement would not accompany medical transportation responding to a physical health emergency, unless requested by mobile mental health relief providers ~~responders~~, law enforcement may not accompany emergency response or medical transportation personnel responding to a mental or behavioral health emergency that presents an equivalent level of threat to self or public safety.

(3) Without regard to an assessment of threat to self or threat to public safety, law enforcement may station personnel so that they can rapidly respond to requests for assistance from mobile mental health relief providers ~~responders~~ if law enforcement does not interfere with the provision of emergency response or transportation services. To the extent practical, not interfering with services includes remaining sufficiently distant from or out of sight of the individual receiving care so that law enforcement presence is unlikely to escalate the emergency.

(b) Mobile mental health relief provider ~~Responder~~ involvement in involuntary commitment. In order to maintain the appropriate care relationship, mobile mental health relief providers ~~responders~~ shall not in any way assist in the involuntary commitment of an individual beyond (i) reporting to their dispatching entity or to law enforcement that they believe the situation requires assistance the mobile mental health relief providers ~~responders~~ are not permitted to provide under this Section; (ii) providing witness statements; and (iii) fulfilling reporting requirements the mobile mental health relief providers ~~responders~~ may have under their professional ethical obligations or laws of this state. This prohibition shall not interfere with any mobile mental health relief provider's ~~responder's~~ ability to provide physical or mental health care.

(c) Use of law enforcement for transportation. In any area where mobile mental health relief providers ~~responders~~ are available for dispatch, unless requested by mobile mental health relief providers ~~responders~~, law enforcement shall not be used to provide transportation to access mental or behavioral health care, or travel between mental or behavioral health care providers, except where no alternative is available.

(d) Reduction of educational institution obligations. The services coordinated under this Act may not be used to replace any service an educational institution is required to provide to a student. It shall not substitute for appropriate special education and related services that schools are required to provide by any law.

(e) Subsections (a), (c), and (d) are operative beginning on the date the 3 conditions in Section 65 are met or July 1, 2024, whichever is earlier. Subsection (b) is operative beginning on July 1, 2024.

(Source: P.A. 102-580, eff. 1-1-22.)

(50 ILCS 754/35)

Sec. 35. Non-violent misdemeanors. The Division of Mental Health's Guidance for 9-1-1 PSAPs and emergency services dispatched through 9-1-1 PSAPs for coordinating the response to individuals who appear to be in a mental or behavioral health emergency while engaging in conduct alleged to

constitute a non-violent misdemeanor shall promote the following:

(a) Prioritization of Health Care. To the greatest extent practicable, community-based mental or behavioral health services should be provided before addressing law enforcement objectives.

(b) Diversion from Further Criminal Justice Involvement. To the greatest extent practicable, individuals should be referred to health care services with the potential to reduce the likelihood of further law enforcement engagement <u>and referral to a pre-arrest or pre-booking case management unit should be prioritized in any areas served by pre-arrest or pre-booking case management</u>.

(Source: P.A. 102-580, eff. 1-1-22.)

(50 ILCS 754/40)

Sec. 40. Statewide Advisory Committee.

(a) The Division of Mental Health shall establish a Statewide Advisory Committee to review and make recommendations for aspects of coordinating 9-1-1 and the 9-8-8 mobile mental health response system most appropriately addressed on a State level.

(b) Issues to be addressed by the Statewide Advisory Committee include, but are not limited to, addressing changes necessary in 9-1-1 call taking protocols and scripts used in

9-1-1 PSAPs where those protocols and scripts are based on or otherwise dependent on national providers for their operation.

(c) The Statewide Advisory Committee shall recommend a system for gathering data related to the coordination of the 9-1-1 and 9-8-8 systems for purposes of allowing the parties to make ongoing improvements in that system. As practical, the system shall attempt to determine issues including, but not limited to:

(1) the volume of calls coordinated between 9-1-1 and 9-8-8;

(2) the volume of referrals from other first responders to 9-8-8;

(3) the volume and type of calls deemed appropriate for referral to 9-8-8 but could not be served by 9-8-8 because of capacity restrictions or other reasons;

(4) the appropriate information to improve coordination between 9-1-1 and 9-8-8; and

(5) the appropriate information to improve the 9-8-8 system, if the information is most appropriately gathered at the 9-1-1 PSAPs.

(d) The Statewide Advisory Committee shall consist of:

(1) the Statewide 9-1-1 Administrator, ex officio;

(2) one representative designated by the Illinois Chapter of National Emergency Number Association (NENA);

(3) one representative designated by the Illinois Chapter of Association of Public Safety Communications

Officials (APCO);

(4) one representative of the Division of Mental Health;

(5) one representative of the Illinois Department of Public Health;

(6) one representative of a statewide organization of EMS responders;

(7) one representative of a statewide organization of fire chiefs;

(8) two representatives of statewide organizations of law enforcement;

(9) two representatives of mental health, behavioral health, or substance abuse providers; and

(10) four representatives of advocacy organizations either led by or consisting primarily of individuals with intellectual or developmental disabilities, individuals with behavioral disabilities, or individuals with lived experience.

(e) The members of the Statewide Advisory Committee, other than the Statewide 9-1-1 Administrator, shall be appointed by the Secretary of Human Services.

(f) The Statewide Advisory Committee shall continue to meet until this Act has been fully implemented, as determined by the Division of Mental Health, and mobile mental health relief providers are available in all parts of Illinois. The Division of Mental Health may reconvene the Statewide Advisory

Committee at its discretion after full implementation of this Act.

(Source: P.A. 102-580, eff. 1-1-22.)

(50 ILCS 754/45)

Sec. 45. Regional Advisory Committees.

(a) The Division of Mental Health shall establish Regional Advisory Committees in each EMS Region to advise on regional issues related to emergency response systems for mental and behavioral health. The Secretary of Human Services shall appoint the members of the Regional Advisory Committees. Each Regional Advisory Committee shall consist of:

(1) representatives of the 9-1-1 PSAPs in the region;

(2) representatives of the EMS Medical Directors Committee, as constituted under the Emergency Medical Services (EMS) Systems Act, or other similar committee serving the medical needs of the jurisdiction;

(3) representatives of law enforcement officials with jurisdiction in the Emergency Medical Services (EMS) Regions;

(4) representatives of both the EMS providers and the unions representing EMS or emergency mental and behavioral health responders, or both; and

(5) advocates from the mental health, behavioral health, intellectual disability, and developmental disability communities.

If no person is willing or available to fill a member's seat for one of the required areas of representation on a Regional Advisory Committee under paragraphs (1) through (5), the Secretary of Human Services shall adopt procedures to ensure that a missing area of representation is filled once a person becomes willing and available to fill that seat.

(b) The majority of advocates on the Regional Advisory ~~Emergency Response Equity~~ Committee must either be individuals with a lived experience of a condition commonly regarded as a mental health or behavioral health disability, developmental disability, or intellectual disability~~,~~ or be from organizations primarily composed of such individuals. The members of the Committee shall also reflect the racial demographics of the jurisdiction served. To achieve the requirements of this subsection, the Division of Mental Health must establish a clear plan and regular course of action to engage, recruit, and sustain areas of established participation. The plan and actions taken must be shared with the general public.

(c) Subject to the oversight of the Department of Human Services Division of Mental Health, the EMS Medical Directors Committee is responsible for convening the meetings of the committee. Impacted units of local government may also have representatives on the committee subject to approval by the Division of Mental Health, if this participation is structured in such a way that it does not give undue weight to any of the

groups represented.

(Source: P.A. 102-580, eff. 1-1-22.)

(50 ILCS 754/50)

Sec. 50. Regional Advisory Committee responsibilities. Each Regional Advisory Committee is responsible for designing the local protocol to allow its region's 9-1-1 call center and emergency responders to coordinate their activities with 9-8-8 as required by this Act and monitoring current operation to advise on ongoing adjustments to the local protocol. Included in this responsibility, each Regional Advisory Committee must:

(1) negotiate the appropriate amendment of each 9-1-1 PSAP emergency dispatch protocols, in consultation with each 9-1-1 PSAP in the EMS Region and consistent with national certification requirements;

(2) set maximum response times for 9-8-8 to provide service when an in-person response is required, based on type of mental or behavioral health emergency, which, if exceeded, constitute grounds for sending other emergency responders through the 9-1-1 system;

(3) report, geographically by police district if practical, the data collected through the direction provided by the Statewide Advisory Committee in aggregated, non-individualized monthly reports. These reports shall be available to the Regional Advisory Committee members, the Department of Human Service

Division of Mental Health, the Administrator of the 9-1-1 Authority, and to the public upon request; ~~and~~

(4) convene, after the initial regional policies are established, at least every 2 years to consider amendment of the regional policies, if any, and also convene whenever a member of the Committee requests that the Committee consider an amendment; and~~.~~

(5) identify regional resources and supports for use by the mobile mental health relief providers as they respond to the requests for services.

(Source: P.A. 102-580, eff. 1-1-22.)

(50 ILCS 754/65)

Sec. 65. PSAP and emergency service dispatched through a 9-1-1 PSAP; coordination of activities with mobile and behavioral health services. Each 9-1-1 PSAP and emergency service dispatched through a 9-1-1 PSAP must begin coordinating its activities with the mobile mental and behavioral health services established by the Division of Mental Health once all 3 of the following conditions are met, but not later than July 1, 2024 ~~2023~~:

(1) the Statewide Committee has negotiated useful protocol and 9-1-1 operator script adjustments with the contracted services providing these tools to 9-1-1 PSAPs operating in Illinois;

(2) the appropriate Regional Advisory Committee has

completed design of the specific 9-1-1 PSAP's process for coordinating activities with the mobile mental and behavioral health service; and

(3) the mobile mental and behavioral health service is available in their jurisdiction.

(Source: P.A. 102-580, eff. 1-1-22; 102-1109, eff. 12-21-22.)

(50 ILCS 754/70 new)

Sec. 70. Report. On or before July 1, 2023 and on a quarterly basis thereafter, the Division of Mental Health shall submit a report to the General Assembly on its progress in implementing this Act, which shall include, but not be limited to, a strategic assessment that evaluates the success toward current strategy, identification of future targets for implementation that help estimate the potential for success and provides a basis for assessing future performance, and key benchmarks to provide a comparison to set in context and help stakeholders understand their positions.

Section 90. The Illinois Insurance Code is amended by changing Section 370c.1 as follows:

(215 ILCS 5/370c.1)

Sec. 370c.1. Mental, emotional, nervous, or substance use disorder or condition parity.

(a) On and after July 23, 2021 (the effective date of

Public Act 102-135), every insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions shall ensure prior to policy issuance that:

(1) the financial requirements applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant financial requirements applied to substantially all hospital and medical benefits covered by the policy and that there are no separate cost-sharing requirements that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits; and

(2) the treatment limitations applicable to such mental, emotional, nervous, or substance use disorder or condition benefits are no more restrictive than the predominant treatment limitations applied to substantially all hospital and medical benefits covered by the policy and that there are no separate treatment limitations that are applicable only with respect to mental, emotional, nervous, or substance use disorder or condition benefits.

(b) The following provisions shall apply concerning

aggregate lifetime limits:

(1) In the case of a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace amended, delivered, issued, or renewed in this State on or after September 9, 2015 (the effective date of Public Act 99-480) that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions the following provisions shall apply:

(A) if the policy does not include an aggregate lifetime limit on substantially all hospital and medical benefits, then the policy may not impose any aggregate lifetime limit on mental, emotional, nervous, or substance use disorder or condition benefits; or

(B) if the policy includes an aggregate lifetime limit on substantially all hospital and medical benefits (in this subsection referred to as the "applicable lifetime limit"), then the policy shall either:

(i) apply the applicable lifetime limit both to the hospital and medical benefits to which it otherwise would apply and to mental, emotional, nervous, or substance use disorder or condition benefits and not distinguish in the application of

the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

(ii) not include any aggregate lifetime limit on mental, emotional, nervous, or substance use disorder or condition benefits that is less than the applicable lifetime limit.

(2) In the case of a policy that is not described in paragraph (1) of subsection (b) of this Section and that includes no or different aggregate lifetime limits on different categories of hospital and medical benefits, the Director shall establish rules under which subparagraph (B) of paragraph (1) of subsection (b) of this Section is applied to such policy with respect to mental, emotional, nervous, or substance use disorder or condition benefits by substituting for the applicable lifetime limit an average aggregate lifetime limit that is computed taking into account the weighted average of the aggregate lifetime limits applicable to such categories.

(c) The following provisions shall apply concerning annual limits:

(1) In the case of a group or individual policy of accident and health insurance or a qualified health plan offered through the Health Insurance Marketplace amended, delivered, issued, or renewed in this State on or after September 9, 2015 (the effective date of Public Act

99-480) that provides coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions the following provisions shall apply:

(A) if the policy does not include an annual limit on substantially all hospital and medical benefits, then the policy may not impose any annual limits on mental, emotional, nervous, or substance use disorder or condition benefits; or

(B) if the policy includes an annual limit on substantially all hospital and medical benefits (in this subsection referred to as the "applicable annual limit"), then the policy shall either:

(i) apply the applicable annual limit both to the hospital and medical benefits to which it otherwise would apply and to mental, emotional, nervous, or substance use disorder or condition benefits and not distinguish in the application of the limit between the hospital and medical benefits and mental, emotional, nervous, or substance use disorder or condition benefits; or

(ii) not include any annual limit on mental, emotional, nervous, or substance use disorder or condition benefits that is less than the applicable annual limit.

(2) In the case of a policy that is not described in

paragraph (1) of subsection (c) of this Section and that includes no or different annual limits on different categories of hospital and medical benefits, the Director shall establish rules under which subparagraph (B) of paragraph (1) of subsection (c) of this Section is applied to such policy with respect to mental, emotional, nervous, or substance use disorder or condition benefits by substituting for the applicable annual limit an average annual limit that is computed taking into account the weighted average of the annual limits applicable to such categories.

(d) With respect to mental, emotional, nervous, or substance use disorders or conditions, an insurer shall use policies and procedures for the election and placement of mental, emotional, nervous, or substance use disorder or condition treatment drugs on their formulary that are no less favorable to the insured as those policies and procedures the insurer uses for the selection and placement of drugs for medical or surgical conditions and shall follow the expedited coverage determination requirements for substance abuse treatment drugs set forth in Section 45.2 of the Managed Care Reform and Patient Rights Act.

(e) This Section shall be interpreted in a manner consistent with all applicable federal parity regulations including, but not limited to, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of

2008, final regulations issued under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and final regulations applying the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 to Medicaid managed care organizations, the Children's Health Insurance Program, and alternative benefit plans.

(f) The provisions of subsections (b) and (c) of this Section shall not be interpreted to allow the use of lifetime or annual limits otherwise prohibited by State or federal law.

(g) As used in this Section:

"Financial requirement" includes deductibles, copayments, coinsurance, and out-of-pocket maximums, but does not include an aggregate lifetime limit or an annual limit subject to subsections (b) and (c).

"Mental, emotional, nervous, or substance use disorder or condition" means a condition or disorder that involves a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the current edition of the International Classification of Disease or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

"Treatment limitation" includes limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. "Treatment limitation"

includes both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of treatment. A permanent exclusion of all benefits for a particular condition or disorder shall not be considered a treatment limitation. "Nonquantitative treatment" means those limitations as described under federal regulations (26 CFR 54.9812-1). "Nonquantitative treatment limitations" include, but are not limited to, those limitations described under federal regulations 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR 146.136.

(h) The Department of Insurance shall implement the following education initiatives:

(1) By January 1, 2016, the Department shall develop a plan for a Consumer Education Campaign on parity. The Consumer Education Campaign shall focus its efforts throughout the State and include trainings in the northern, southern, and central regions of the State, as defined by the Department, as well as each of the 5 managed care regions of the State as identified by the Department of Healthcare and Family Services. Under this Consumer Education Campaign, the Department shall: (1) by January 1, 2017, provide at least one live training in each region on parity for consumers and providers and one webinar training to be posted on the Department website and (2)

establish a consumer hotline to assist consumers in navigating the parity process by March 1, 2017. By January 1, 2018 the Department shall issue a report to the General Assembly on the success of the Consumer Education Campaign, which shall indicate whether additional training is necessary or would be recommended.

(2) The Department, in coordination with the Department of Human Services and the Department of Healthcare and Family Services, shall convene a working group of health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups for the purpose of discussing issues related to the treatment and coverage of mental, emotional, nervous, or substance use disorders or conditions and compliance with parity obligations under State and federal law. Compliance shall be measured, tracked, and shared during the meetings of the working group. The working group shall meet once before January 1, 2016 and shall meet semiannually thereafter. The Department shall issue an annual report to the General Assembly that includes a list of the health care insurance carriers, mental health advocacy groups, substance abuse patient advocacy groups, and mental health physician groups that participated in the working group meetings, details on the issues and topics covered, and any legislative recommendations developed by the working

group.

(3) Not later than January 1 of each year, the Department, in conjunction with the Department of Healthcare and Family Services, shall issue a joint report to the General Assembly and provide an educational presentation to the General Assembly. The report and presentation shall:

(A) Cover the methodology the Departments use to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), and any federal regulations or guidance relating to the compliance and oversight of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and 42 U.S.C. 18031(j).

(B) Cover the methodology the Departments use to check for compliance with this Section and Sections 356z.23 and 370c of this Code.

(C) Identify market conduct examinations or, in the case of the Department of Healthcare and Family Services, audits conducted or completed during the preceding 12-month period regarding compliance with parity in mental, emotional, nervous, and substance use disorder or condition benefits under State and federal laws and summarize the results of such market conduct examinations and audits. This shall include:

(i) the number of market conduct examinations and audits initiated and completed;

(ii) the benefit classifications examined by each market conduct examination and audit;

(iii) the subject matter of each market conduct examination and audit, including quantitative and nonquantitative treatment limitations; and

(iv) a summary of the basis for the final decision rendered in each market conduct examination and audit.

Individually identifiable information shall be excluded from the reports consistent with federal privacy protections.

(D) Detail any educational or corrective actions the Departments have taken to ensure compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. 18031(j), this Section, and Sections 356z.23 and 370c of this Code.

(E) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the Departments find appropriate, posting the report on the Departments' websites.

(i) The Parity Advancement Fund is created as a special

fund in the State treasury. Moneys from fines and penalties collected from insurers for violations of this Section shall be deposited into the Fund. Moneys deposited into the Fund for appropriation by the General Assembly to the Department shall be used for the purpose of providing financial support of the Consumer Education Campaign, parity compliance advocacy, and other initiatives that support parity implementation and enforcement on behalf of consumers.

(j) (Blank). ~~The Department of Insurance and the Department of Healthcare and Family Services shall convene and provide technical support to a workgroup of 11 members that shall be comprised of 3 mental health parity experts recommended by an organization advocating on behalf of mental health parity appointed by the President of the Senate; 3 behavioral health providers recommended by an organization that represents behavioral health providers appointed by the Speaker of the House of Representatives; 2 representing Medicaid managed care organizations recommended by an organization that represents Medicaid managed care plans appointed by the Minority Leader of the House of Representatives; 2 representing commercial insurers recommended by an organization that represents insurers appointed by the Minority Leader of the Senate; and a representative of an organization that represents Medicaid managed care plans appointed by the Governor.~~

~~The workgroup shall provide recommendations to the General~~

~~Assembly on health plan data reporting requirements that separately break out data on mental, emotional, nervous, or substance use disorder or condition benefits and data on other medical benefits, including physical health and related health services no later than December 31, 2019. The recommendations to the General Assembly shall be filed with the Clerk of the House of Representatives and the Secretary of the Senate in electronic form only, in the manner that the Clerk and the Secretary shall direct. This workgroup shall take into account federal requirements and recommendations on mental health parity reporting for the Medicaid program. This workgroup shall also develop the format and provide any needed definitions for reporting requirements in subsection (k). The research and evaluation of the working group shall include, but not be limited to:~~

~~(1) claims denials due to benefit limits, if applicable;~~

~~(2) administrative denials for no prior authorization;~~

~~(3) denials due to not meeting medical necessity;~~

~~(4) denials that went to external review and whether they were upheld or overturned for medical necessity;~~

~~(5) out-of-network claims;~~

~~(6) emergency care claims;~~

~~(7) network directory providers in the outpatient benefits classification who filed no claims in the last 6 months, if applicable;~~

~~(8) the impact of existing and pertinent limitations and restrictions related to approved services, licensed providers, reimbursement levels, and reimbursement methodologies within the Division of Mental Health, the Division of Substance Use Prevention and Recovery programs, the Department of Healthcare and Family Services, and, to the extent possible, federal regulations and law; and~~

~~(9) when reporting and publishing should begin.~~

~~Representatives from the Department of Healthcare and Family Services, representatives from the Division of Mental Health, and representatives from the Division of Substance Use Prevention and Recovery shall provide technical advice to the workgroup.~~

(k) An insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions shall submit an annual report, the format and definitions for which will be determined ~~developed~~ by ~~the workgroup in subsection (j), to~~ the Department and ~~, or, with respect to medical assistance,~~ the Department of Healthcare and Family Services and posted on their respective websites, starting on September 1, 2023 and annually thereafter, ~~or before July 1, 2020~~ that contains the

following information separately for inpatient in-network benefits, inpatient out-of-network benefits, outpatient in-network benefits, outpatient out-of-network benefits, emergency care benefits, and prescription drug benefits in the case of accident and health insurance or qualified health plans, or inpatient, outpatient, emergency care, and prescription drug benefits in the case of medical assistance:

(1) A summary of the plan's pharmacy management processes for mental, emotional, nervous, or substance use disorder or condition benefits compared to those for other medical benefits.

(2) A summary of the internal processes of review for experimental benefits and unproven technology for mental, emotional, nervous, or substance use disorder or condition benefits and those for other medical benefits.

(3) A summary of how the plan's policies and procedures for utilization management for mental, emotional, nervous, or substance use disorder or condition benefits compare to those for other medical benefits.

(4) A description of the process used to develop or select the medical necessity criteria for mental, emotional, nervous, or substance use disorder or condition benefits and the process used to develop or select the medical necessity criteria for medical and surgical benefits.

(5) Identification of all nonquantitative treatment

limitations that are applied to both mental, emotional, nervous, or substance use disorder or condition benefits and medical and surgical benefits within each classification of benefits.

(6) The results of an analysis that demonstrates that for the medical necessity criteria described in subparagraph (A) and for each nonquantitative treatment limitation identified in subparagraph (B), as written and in operation, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to mental, emotional, nervous, or substance use disorder or condition benefits within each classification of benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the medical necessity criteria and each nonquantitative treatment limitation to medical and surgical benefits within the corresponding classification of benefits; at a minimum, the results of the analysis shall:

(A) identify the factors used to determine that a nonquantitative treatment limitation applies to a benefit, including factors that were considered but rejected;

(B) identify and define the specific evidentiary standards used to define the factors and any other

evidence relied upon in designing each nonquantitative treatment limitation;

(C) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to design each nonquantitative treatment limitation, as written, for mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and are applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation, as written, for medical and surgical benefits;

(D) provide the comparative analyses, including the results of the analyses, performed to determine that the processes and strategies used to apply each nonquantitative treatment limitation, in operation, for mental, emotional, nervous, or substance use disorder or condition benefits are comparable to, and applied no more stringently than, the processes or strategies used to apply each nonquantitative treatment limitation, in operation, for medical and surgical benefits; and

(E) disclose the specific findings and conclusions reached by the insurer that the results of the analyses described in subparagraphs (C) and (D) indicate that the insurer is in compliance with this

Section and the Mental Health Parity and Addiction Equity Act of 2008 and its implementing regulations, which includes 42 CFR Parts 438, 440, and 457 and 45 CFR 146.136 and any other related federal regulations found in the Code of Federal Regulations.

(7) Any other information necessary to clarify data provided in accordance with this Section requested by the Director, including information that may be proprietary or have commercial value, under the requirements of Section 30 of the Viatical Settlements Act of 2009.

(l) An insurer that amends, delivers, issues, or renews a group or individual policy of accident and health insurance or a qualified health plan offered through the health insurance marketplace in this State providing coverage for hospital or medical treatment and for the treatment of mental, emotional, nervous, or substance use disorders or conditions on or after January 1, 2019 (the effective date of Public Act 100-1024) shall, in advance of the plan year, make available to the Department or, with respect to medical assistance, the Department of Healthcare and Family Services and to all plan participants and beneficiaries the information required in subparagraphs (C) through (E) of paragraph (6) of subsection (k). For plan participants and medical assistance beneficiaries, the information required in subparagraphs (C) through (E) of paragraph (6) of subsection (k) shall be made available on a publicly-available website whose web address is

prominently displayed in plan and managed care organization informational and marketing materials.

(m) In conjunction with its compliance examination program conducted in accordance with the Illinois State Auditing Act, the Auditor General shall undertake a review of compliance by the Department and the Department of Healthcare and Family Services with Section 370c and this Section. Any findings resulting from the review conducted under this Section shall be included in the applicable State agency's compliance examination report. Each compliance examination report shall be issued in accordance with Section 3-14 of the Illinois State Auditing Act. A copy of each report shall also be delivered to the head of the applicable State agency and posted on the Auditor General's website.

(Source: P.A. 102-135, eff. 7-23-21; 102-579, eff. 8-25-21; 102-813, eff. 5-13-22.)

Section 99. Effective date. This Act takes effect upon becoming law.