

1 AN ACT concerning health.

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

4 Section 5. The School Code is amended by changing and
5 renumbering Section 2-3.196, as added by Public Act 103-546,
6 as follows:

7 (105 ILCS 5/2-3.203)

8 Sec. 2-3.203 ~~2-3.196~~. Mental health screenings.

9 (a) On or before December 15, 2023, the State Board of
10 Education, in consultation with the Children's Behavioral
11 Health Transformation Officer, Children's Behavioral Health
12 Transformation Team, and the Office of the Governor, shall
13 file a report with the Governor and the General Assembly that
14 includes recommendations for implementation of mental health
15 screenings in schools for students enrolled in kindergarten
16 through grade 12. This report must include a landscape scan of
17 current district-wide screenings, recommendations for
18 screening tools, training for staff, and linkage and referral
19 for identified students.

20 (b) On or before October 1, 2024, the State Board of
21 Education, in consultation with the Children's Behavioral
22 Health Transformation Team, the Office of the Governor, and
23 relevant stakeholders as needed shall release a strategy that

1 includes a tool for measuring capacity and readiness to
2 implement universal mental health screening of students. The
3 strategy shall build upon existing efforts to understand
4 district needs for resources, technology, training, and
5 infrastructure supports. The strategy shall include a
6 framework for supporting districts in a phased approach to
7 implement universal mental health screenings. The State Board
8 of Education shall issue a report to the Governor and the
9 General Assembly on school district readiness and plan for
10 phased approach to universal mental health screening of
11 students on or before April 1, 2025.

12 (Source: P.A. 103-546, eff. 8-11-23; revised 9-25-23.)

13 (105 ILCS 155/Act rep.)

14 Section 10. The Wellness Checks in Schools Program Act is
15 repealed.

16 Section 15. The Illinois Public Aid Code is amended by
17 changing Section 5-30.1 as follows:

18 (305 ILCS 5/5-30.1)

19 Sec. 5-30.1. Managed care protections.

20 (a) As used in this Section:

21 "Managed care organization" or "MCO" means any entity
22 which contracts with the Department to provide services where
23 payment for medical services is made on a capitated basis.

1 "Emergency services" include:

2 (1) emergency services, as defined by Section 10 of
3 the Managed Care Reform and Patient Rights Act;

4 (2) emergency medical screening examinations, as
5 defined by Section 10 of the Managed Care Reform and
6 Patient Rights Act;

7 (3) post-stabilization medical services, as defined by
8 Section 10 of the Managed Care Reform and Patient Rights
9 Act; and

10 (4) emergency medical conditions, as defined by
11 Section 10 of the Managed Care Reform and Patient Rights
12 Act.

13 (b) As provided by Section 5-16.12, managed care
14 organizations are subject to the provisions of the Managed
15 Care Reform and Patient Rights Act.

16 (c) An MCO shall pay any provider of emergency services
17 that does not have in effect a contract with the contracted
18 Medicaid MCO. The default rate of reimbursement shall be the
19 rate paid under Illinois Medicaid fee-for-service program
20 methodology, including all policy adjusters, including but not
21 limited to Medicaid High Volume Adjustments, Medicaid
22 Percentage Adjustments, Outpatient High Volume Adjustments,
23 and all outlier add-on adjustments to the extent such
24 adjustments are incorporated in the development of the
25 applicable MCO capitated rates.

26 (d) An MCO shall pay for all post-stabilization services

1 as a covered service in any of the following situations:

2 (1) the MCO authorized such services;

3 (2) such services were administered to maintain the
4 enrollee's stabilized condition within one hour after a
5 request to the MCO for authorization of further
6 post-stabilization services;

7 (3) the MCO did not respond to a request to authorize
8 such services within one hour;

9 (4) the MCO could not be contacted; or

10 (5) the MCO and the treating provider, if the treating
11 provider is a non-affiliated provider, could not reach an
12 agreement concerning the enrollee's care and an affiliated
13 provider was unavailable for a consultation, in which case
14 the MCO must pay for such services rendered by the
15 treating non-affiliated provider until an affiliated
16 provider was reached and either concurred with the
17 treating non-affiliated provider's plan of care or assumed
18 responsibility for the enrollee's care. Such payment shall
19 be made at the default rate of reimbursement paid under
20 Illinois Medicaid fee-for-service program methodology,
21 including all policy adjusters, including but not limited
22 to Medicaid High Volume Adjustments, Medicaid Percentage
23 Adjustments, Outpatient High Volume Adjustments and all
24 outlier add-on adjustments to the extent that such
25 adjustments are incorporated in the development of the
26 applicable MCO capitated rates.

1 (e) The following requirements apply to MCOs in
2 determining payment for all emergency services:

3 (1) MCOs shall not impose any requirements for prior
4 approval of emergency services.

5 (2) The MCO shall cover emergency services provided to
6 enrollees who are temporarily away from their residence
7 and outside the contracting area to the extent that the
8 enrollees would be entitled to the emergency services if
9 they still were within the contracting area.

10 (3) The MCO shall have no obligation to cover medical
11 services provided on an emergency basis that are not
12 covered services under the contract.

13 (4) The MCO shall not condition coverage for emergency
14 services on the treating provider notifying the MCO of the
15 enrollee's screening and treatment within 10 days after
16 presentation for emergency services.

17 (5) The determination of the attending emergency
18 physician, or the provider actually treating the enrollee,
19 of whether an enrollee is sufficiently stabilized for
20 discharge or transfer to another facility, shall be
21 binding on the MCO. The MCO shall cover emergency services
22 for all enrollees whether the emergency services are
23 provided by an affiliated or non-affiliated provider.

24 (6) The MCO's financial responsibility for
25 post-stabilization care services it has not pre-approved
26 ends when:

1 (A) a plan physician with privileges at the
2 treating hospital assumes responsibility for the
3 enrollee's care;

4 (B) a plan physician assumes responsibility for
5 the enrollee's care through transfer;

6 (C) a contracting entity representative and the
7 treating physician reach an agreement concerning the
8 enrollee's care; or

9 (D) the enrollee is discharged.

10 (f) Network adequacy and transparency.

11 (1) The Department shall:

12 (A) ensure that an adequate provider network is in
13 place, taking into consideration health professional
14 shortage areas and medically underserved areas;

15 (B) publicly release an explanation of its process
16 for analyzing network adequacy;

17 (C) periodically ensure that an MCO continues to
18 have an adequate network in place;

19 (D) require MCOs, including Medicaid Managed Care
20 Entities as defined in Section 5-30.2, to meet
21 provider directory requirements under Section 5-30.3;

22 (E) require MCOs to ensure that any
23 Medicaid-certified provider under contract with an MCO
24 and previously submitted on a roster on the date of
25 service is paid for any medically necessary,
26 Medicaid-covered, and authorized service rendered to

1 any of the MCO's enrollees, regardless of inclusion on
2 the MCO's published and publicly available directory
3 of available providers; and

4 (F) require MCOs, including Medicaid Managed Care
5 Entities as defined in Section 5-30.2, to meet each of
6 the requirements under subsection (d-5) of Section 10
7 of the Network Adequacy and Transparency Act; with
8 necessary exceptions to the MCO's network to ensure
9 that admission and treatment with a provider or at a
10 treatment facility in accordance with the network
11 adequacy standards in paragraph (3) of subsection
12 (d-5) of Section 10 of the Network Adequacy and
13 Transparency Act is limited to providers or facilities
14 that are Medicaid certified.

15 (2) Each MCO shall confirm its receipt of information
16 submitted specific to physician or dentist additions or
17 physician or dentist deletions from the MCO's provider
18 network within 3 days after receiving all required
19 information from contracted physicians or dentists, and
20 electronic physician and dental directories must be
21 updated consistent with current rules as published by the
22 Centers for Medicare and Medicaid Services or its
23 successor agency.

24 (g) Timely payment of claims.

25 (1) The MCO shall pay a claim within 30 days of
26 receiving a claim that contains all the essential

1 information needed to adjudicate the claim.

2 (2) The MCO shall notify the billing party of its
3 inability to adjudicate a claim within 30 days of
4 receiving that claim.

5 (3) The MCO shall pay a penalty that is at least equal
6 to the timely payment interest penalty imposed under
7 Section 368a of the Illinois Insurance Code for any claims
8 not timely paid.

9 (A) When an MCO is required to pay a timely payment
10 interest penalty to a provider, the MCO must calculate
11 and pay the timely payment interest penalty that is
12 due to the provider within 30 days after the payment of
13 the claim. In no event shall a provider be required to
14 request or apply for payment of any owed timely
15 payment interest penalties.

16 (B) Such payments shall be reported separately
17 from the claim payment for services rendered to the
18 MCO's enrollee and clearly identified as interest
19 payments.

20 (4) (A) The Department shall require MCOs to expedite
21 payments to providers identified on the Department's
22 expedited provider list, determined in accordance with 89
23 Ill. Adm. Code 140.71(b), on a schedule at least as
24 frequently as the providers are paid under the
25 Department's fee-for-service expedited provider schedule.

26 (B) Compliance with the expedited provider requirement

1 may be satisfied by an MCO through the use of a Periodic
2 Interim Payment (PIP) program that has been mutually
3 agreed to and documented between the MCO and the provider,
4 if the PIP program ensures that any expedited provider
5 receives regular and periodic payments based on prior
6 period payment experience from that MCO. Total payments
7 under the PIP program may be reconciled against future PIP
8 payments on a schedule mutually agreed to between the MCO
9 and the provider.

10 (C) The Department shall share at least monthly its
11 expedited provider list and the frequency with which it
12 pays providers on the expedited list.

13 (g-5) Recognizing that the rapid transformation of the
14 Illinois Medicaid program may have unintended operational
15 challenges for both payers and providers:

16 (1) in no instance shall a medically necessary covered
17 service rendered in good faith, based upon eligibility
18 information documented by the provider, be denied coverage
19 or diminished in payment amount if the eligibility or
20 coverage information available at the time the service was
21 rendered is later found to be inaccurate in the assignment
22 of coverage responsibility between MCOs or the
23 fee-for-service system, except for instances when an
24 individual is deemed to have not been eligible for
25 coverage under the Illinois Medicaid program; and

26 (2) the Department shall, by December 31, 2016, adopt

1 rules establishing policies that shall be included in the
2 Medicaid managed care policy and procedures manual
3 addressing payment resolutions in situations in which a
4 provider renders services based upon information obtained
5 after verifying a patient's eligibility and coverage plan
6 through either the Department's current enrollment system
7 or a system operated by the coverage plan identified by
8 the patient presenting for services:

9 (A) such medically necessary covered services
10 shall be considered rendered in good faith;

11 (B) such policies and procedures shall be
12 developed in consultation with industry
13 representatives of the Medicaid managed care health
14 plans and representatives of provider associations
15 representing the majority of providers within the
16 identified provider industry; and

17 (C) such rules shall be published for a review and
18 comment period of no less than 30 days on the
19 Department's website with final rules remaining
20 available on the Department's website.

21 The rules on payment resolutions shall include, but
22 not be limited to:

23 (A) the extension of the timely filing period;

24 (B) retroactive prior authorizations; and

25 (C) guaranteed minimum payment rate of no less
26 than the current, as of the date of service,

1 fee-for-service rate, plus all applicable add-ons,
2 when the resulting service relationship is out of
3 network.

4 The rules shall be applicable for both MCO coverage
5 and fee-for-service coverage.

6 If the fee-for-service system is ultimately determined to
7 have been responsible for coverage on the date of service, the
8 Department shall provide for an extended period for claims
9 submission outside the standard timely filing requirements.

10 (g-6) MCO Performance Metrics Report.

11 (1) The Department shall publish, on at least a
12 quarterly basis, each MCO's operational performance,
13 including, but not limited to, the following categories of
14 metrics:

15 (A) claims payment, including timeliness and
16 accuracy;

17 (B) prior authorizations;

18 (C) grievance and appeals;

19 (D) utilization statistics;

20 (E) provider disputes;

21 (F) provider credentialing; and

22 (G) member and provider customer service.

23 (2) The Department shall ensure that the metrics
24 report is accessible to providers online by January 1,
25 2017.

26 (3) The metrics shall be developed in consultation

1 with industry representatives of the Medicaid managed care
2 health plans and representatives of associations
3 representing the majority of providers within the
4 identified industry.

5 (4) Metrics shall be defined and incorporated into the
6 applicable Managed Care Policy Manual issued by the
7 Department.

8 (g-7) MCO claims processing and performance analysis. In
9 order to monitor MCO payments to hospital providers, pursuant
10 to Public Act 100-580, the Department shall post an analysis
11 of MCO claims processing and payment performance on its
12 website every 6 months. Such analysis shall include a review
13 and evaluation of a representative sample of hospital claims
14 that are rejected and denied for clean and unclean claims and
15 the top 5 reasons for such actions and timeliness of claims
16 adjudication, which identifies the percentage of claims
17 adjudicated within 30, 60, 90, and over 90 days, and the dollar
18 amounts associated with those claims.

19 (g-8) Dispute resolution process. The Department shall
20 maintain a provider complaint portal through which a provider
21 can submit to the Department unresolved disputes with an MCO.
22 An unresolved dispute means an MCO's decision that denies in
23 whole or in part a claim for reimbursement to a provider for
24 health care services rendered by the provider to an enrollee
25 of the MCO with which the provider disagrees. Disputes shall
26 not be submitted to the portal until the provider has availed

1 itself of the MCO's internal dispute resolution process.
2 Disputes that are submitted to the MCO internal dispute
3 resolution process may be submitted to the Department of
4 Healthcare and Family Services' complaint portal no sooner
5 than 30 days after submitting to the MCO's internal process
6 and not later than 30 days after the unsatisfactory resolution
7 of the internal MCO process or 60 days after submitting the
8 dispute to the MCO internal process. Multiple claim disputes
9 involving the same MCO may be submitted in one complaint,
10 regardless of whether the claims are for different enrollees,
11 when the specific reason for non-payment of the claims
12 involves a common question of fact or policy. Within 10
13 business days of receipt of a complaint, the Department shall
14 present such disputes to the appropriate MCO, which shall then
15 have 30 days to issue its written proposal to resolve the
16 dispute. The Department may grant one 30-day extension of this
17 time frame to one of the parties to resolve the dispute. If the
18 dispute remains unresolved at the end of this time frame or the
19 provider is not satisfied with the MCO's written proposal to
20 resolve the dispute, the provider may, within 30 days, request
21 the Department to review the dispute and make a final
22 determination. Within 30 days of the request for Department
23 review of the dispute, both the provider and the MCO shall
24 present all relevant information to the Department for
25 resolution and make individuals with knowledge of the issues
26 available to the Department for further inquiry if needed.

1 Within 30 days of receiving the relevant information on the
2 dispute, or the lapse of the period for submitting such
3 information, the Department shall issue a written decision on
4 the dispute based on contractual terms between the provider
5 and the MCO, contractual terms between the MCO and the
6 Department of Healthcare and Family Services and applicable
7 Medicaid policy. The decision of the Department shall be
8 final. By January 1, 2020, the Department shall establish by
9 rule further details of this dispute resolution process.
10 Disputes between MCOs and providers presented to the
11 Department for resolution are not contested cases, as defined
12 in Section 1-30 of the Illinois Administrative Procedure Act,
13 conferring any right to an administrative hearing.

14 (g-9)(1) The Department shall publish annually on its
15 website a report on the calculation of each managed care
16 organization's medical loss ratio showing the following:

17 (A) Premium revenue, with appropriate adjustments.

18 (B) Benefit expense, setting forth the aggregate
19 amount spent for the following:

20 (i) Direct paid claims.

21 (ii) Subcapitation payments.

22 (iii) Other claim payments.

23 (iv) Direct reserves.

24 (v) Gross recoveries.

25 (vi) Expenses for activities that improve health
26 care quality as allowed by the Department.

1 (2) The medical loss ratio shall be calculated consistent
2 with federal law and regulation following a claims runout
3 period determined by the Department.

4 (g-10)(1) "Liability effective date" means the date on
5 which an MCO becomes responsible for payment for medically
6 necessary and covered services rendered by a provider to one
7 of its enrollees in accordance with the contract terms between
8 the MCO and the provider. The liability effective date shall
9 be the later of:

10 (A) The execution date of a network participation
11 contract agreement.

12 (B) The date the provider or its representative
13 submits to the MCO the complete and accurate standardized
14 roster form for the provider in the format approved by the
15 Department.

16 (C) The provider effective date contained within the
17 Department's provider enrollment subsystem within the
18 Illinois Medicaid Program Advanced Cloud Technology
19 (IMPACT) System.

20 (2) The standardized roster form may be submitted to the
21 MCO at the same time that the provider submits an enrollment
22 application to the Department through IMPACT.

23 (3) By October 1, 2019, the Department shall require all
24 MCOs to update their provider directory with information for
25 new practitioners of existing contracted providers within 30
26 days of receipt of a complete and accurate standardized roster

1 template in the format approved by the Department provided
2 that the provider is effective in the Department's provider
3 enrollment subsystem within the IMPACT system. Such provider
4 directory shall be readily accessible for purposes of
5 selecting an approved health care provider and comply with all
6 other federal and State requirements.

7 (g-11) The Department shall work with relevant
8 stakeholders on the development of operational guidelines to
9 enhance and improve operational performance of Illinois'
10 Medicaid managed care program, including, but not limited to,
11 improving provider billing practices, reducing claim
12 rejections and inappropriate payment denials, and
13 standardizing processes, procedures, definitions, and response
14 timelines, with the goal of reducing provider and MCO
15 administrative burdens and conflict. The Department shall
16 include a report on the progress of these program improvements
17 and other topics in its Fiscal Year 2020 annual report to the
18 General Assembly.

19 (g-12) Notwithstanding any other provision of law, if the
20 Department or an MCO requires submission of a claim for
21 payment in a non-electronic format, a provider shall always be
22 afforded a period of no less than 90 business days, as a
23 correction period, following any notification of rejection by
24 either the Department or the MCO to correct errors or
25 omissions in the original submission.

26 Under no circumstances, either by an MCO or under the

1 State's fee-for-service system, shall a provider be denied
2 payment for failure to comply with any timely submission
3 requirements under this Code or under any existing contract,
4 unless the non-electronic format claim submission occurs after
5 the initial 180 days following the latest date of service on
6 the claim, or after the 90 business days correction period
7 following notification to the provider of rejection or denial
8 of payment.

9 (h) The Department shall not expand mandatory MCO
10 enrollment into new counties beyond those counties already
11 designated by the Department as of June 1, 2014 for the
12 individuals whose eligibility for medical assistance is not
13 the seniors or people with disabilities population until the
14 Department provides an opportunity for accountable care
15 entities and MCOs to participate in such newly designated
16 counties.

17 (h-5) Leading indicator data sharing. By January 1, 2024,
18 the Department shall obtain input from the Department of Human
19 Services, the Department of Juvenile Justice, the Department
20 of Children and Family Services, the State Board of Education,
21 managed care organizations, providers, and clinical experts to
22 identify and analyze key indicators and data elements that can
23 be used in an analysis of lead indicators from assessments and
24 data sets available to the Department that can be shared with
25 managed care organizations and similar care coordination
26 entities contracted with the Department as leading indicators

1 for elevated behavioral health crisis risk for children,
2 including data sets such as the Illinois Medicaid
3 Comprehensive Assessment of Needs and Strengths (IM-CANS),
4 calls made to the State's Crisis and Referral Entry Services
5 (CARES) hotline, health services information from Health and
6 Human Services Innovators, or other data sets that may include
7 key indicators. The workgroup shall complete its
8 recommendations for leading indicator data elements on or
9 before September 1, 2024. To the extent permitted by State and
10 federal law, the identified leading indicators shall be shared
11 with managed care organizations and similar care coordination
12 entities contracted with the Department on or before December
13 1, 2024 ~~within 6 months of identification~~ for the purpose of
14 improving care coordination with the early detection of
15 elevated risk. Leading indicators shall be reassessed annually
16 with stakeholder input. The Department shall implement
17 guidance to managed care organizations and similar care
18 coordination entities contracted with the Department, so that
19 the managed care organizations and care coordination entities
20 respond to lead indicators with services and interventions
21 that are designed to help stabilize the child.

22 (i) The requirements of this Section apply to contracts
23 with accountable care entities and MCOs entered into, amended,
24 or renewed after June 16, 2014 (the effective date of Public
25 Act 98-651).

26 (j) Health care information released to managed care

1 organizations. A health care provider shall release to a
2 Medicaid managed care organization, upon request, and subject
3 to the Health Insurance Portability and Accountability Act of
4 1996 and any other law applicable to the release of health
5 information, the health care information of the MCO's
6 enrollee, if the enrollee has completed and signed a general
7 release form that grants to the health care provider
8 permission to release the recipient's health care information
9 to the recipient's insurance carrier.

10 (k) The Department of Healthcare and Family Services,
11 managed care organizations, a statewide organization
12 representing hospitals, and a statewide organization
13 representing safety-net hospitals shall explore ways to
14 support billing departments in safety-net hospitals.

15 (l) The requirements of this Section added by Public Act
16 102-4 shall apply to services provided on or after the first
17 day of the month that begins 60 days after April 27, 2021 (the
18 effective date of Public Act 102-4).

19 (Source: P.A. 102-4, eff. 4-27-21; 102-43, eff. 7-6-21;
20 102-144, eff. 1-1-22; 102-454, eff. 8-20-21; 102-813, eff.
21 5-13-22; 103-546, eff. 8-11-23.)

22 Section 20. The Children's Mental Health Act is amended by
23 changing Section 5 as follows:

24 (405 ILCS 49/5)

1 Sec. 5. Children's Mental Health Partnership; Children's
2 Mental Health Plan.

3 (a) The Children's Mental Health Partnership (hereafter
4 referred to as "the Partnership") created under Public Act
5 93-495 and continued under Public Act 102-899 shall advise
6 State agencies and the Children's Behavioral Health
7 Transformation Initiative on designing and implementing
8 short-term and long-term strategies to provide comprehensive
9 and coordinated services for children from birth to age 25 and
10 their families with the goal of addressing children's mental
11 health needs across a full continuum of care, including social
12 determinants of health, prevention, early identification, and
13 treatment. The recommended strategies shall build upon the
14 recommendations in the Children's Mental Health Plan of 2022
15 and may include, but are not limited to, recommendations
16 regarding the following:

17 (1) Increasing public awareness on issues connected to
18 children's mental health and wellness to decrease stigma,
19 promote acceptance, and strengthen the ability of
20 children, families, and communities to access supports.

21 (2) Coordination of programs, services, and policies
22 across child-serving State agencies to best monitor and
23 assess spending, as well as foster innovation of adaptive
24 or new practices.

25 (3) Funding and resources for children's mental health
26 prevention, early identification, and treatment across

1 child-serving State agencies.

2 (4) Facilitation of research on best practices and
3 model programs and dissemination of this information to
4 State policymakers, practitioners, and the general public.

5 (5) Monitoring programs, services, and policies
6 addressing children's mental health and wellness.

7 (6) Growing, retaining, diversifying, and supporting
8 the child-serving workforce, with special emphasis on
9 professional development around child and family mental
10 health and wellness services.

11 (7) Supporting the design, implementation, and
12 evaluation of a quality-driven children's mental health
13 system of care across all child services that prevents
14 mental health concerns and mitigates trauma.

15 (8) Improving the system to more effectively meet the
16 emergency and residential placement needs for all children
17 with severe mental and behavioral challenges.

18 (b) The Partnership shall have the responsibility of
19 developing and updating the Children's Mental Health Plan and
20 advising the relevant State agencies on implementation of the
21 Plan. The Children's Mental Health Partnership shall be
22 comprised of the following members:

23 (1) The Governor or his or her designee.

24 (2) The Attorney General or his or her designee.

25 (3) The Secretary of the Department of Human Services
26 or his or her designee.

1 (4) The State Superintendent of Education or his or
2 her designee.

3 (5) The Director of the Department of Children and
4 Family Services or his or her designee.

5 (6) The Director of the Department of Healthcare and
6 Family Services or his or her designee.

7 (7) The Director of the Department of Public Health or
8 his or her designee.

9 (8) The Director of the Department of Juvenile Justice
10 or his or her designee.

11 (9) The Executive Director of the Governor's Office of
12 Early Childhood Development or his or her designee.

13 (10) The Director of the Criminal Justice Information
14 Authority or his or her designee.

15 (11) One member of the General Assembly appointed by
16 the Speaker of the House.

17 (12) One member of the General Assembly appointed by
18 the President of the Senate.

19 (13) One member of the General Assembly appointed by
20 the Minority Leader of the Senate.

21 (14) One member of the General Assembly appointed by
22 the Minority Leader of the House.

23 (15) Up to 25 representatives from the public
24 reflecting a diversity of age, gender identity, race,
25 ethnicity, socioeconomic status, and geographic location,
26 to be appointed by the Governor. Those public members

1 appointed under this paragraph must include, but are not
2 limited to:

3 (A) a family member or individual with lived
4 experience in the children's mental health system;

5 (B) a child advocate;

6 (C) a community mental health expert,
7 practitioner, or provider;

8 (D) a representative of a statewide association
9 representing a majority of hospitals in the State;

10 (E) an early childhood expert or practitioner;

11 (F) a representative from the K-12 school system;

12 (G) a representative from the healthcare sector;

13 (H) a substance use prevention expert or
14 practitioner, or a representative of a statewide
15 association representing community-based mental health
16 substance use disorder treatment providers in the
17 State;

18 (I) a violence prevention expert or practitioner;

19 (J) a representative from the juvenile justice
20 system;

21 (K) a school social worker; and

22 (L) a representative of a statewide organization
23 representing pediatricians.

24 (16) Two co-chairs appointed by the Governor, one
25 being a representative from the public and one being the
26 Director of Public Health ~~a representative from the State.~~

1 The members appointed by the Governor shall be appointed
2 for 4 years with one opportunity for reappointment, except as
3 otherwise provided for in this subsection. Members who were
4 appointed by the Governor and are serving on January 1, 2023
5 (the effective date of Public Act 102-899) shall maintain
6 their appointment until the term of their appointment has
7 expired. For new appointments made pursuant to Public Act
8 102-899, members shall be appointed for one-year, 2-year, or
9 4-year terms, as determined by the Governor, with no more than
10 9 of the Governor's new or existing appointees serving the
11 same term. Those new appointments serving a one-year or 2-year
12 term may be appointed to 2 additional 4-year terms. If a
13 vacancy occurs in the Partnership membership, the vacancy
14 shall be filled in the same manner as the original appointment
15 for the remainder of the term.

16 The Partnership shall be convened no later than January
17 31, 2023 to discuss the changes in Public Act 102-899.

18 The members of the Partnership shall serve without
19 compensation but may be entitled to reimbursement for all
20 necessary expenses incurred in the performance of their
21 official duties as members of the Partnership from funds
22 appropriated for that purpose.

23 The Partnership may convene and appoint special committees
24 or study groups to operate under the direction of the
25 Partnership. Persons appointed to such special committees or
26 study groups shall only receive reimbursement for reasonable

1 expenses.

2 (b-5) The Partnership shall include an adjunct council
3 comprised of no more than 6 youth aged 14 to 25 and 4
4 representatives of 4 different community-based organizations
5 that focus on youth mental health. Of the community-based
6 organizations that focus on youth mental health, one of the
7 community-based organizations shall be led by an
8 LGBTQ-identified person, one of the community-based
9 organizations shall be led by a person of color, and one of the
10 community-based organizations shall be led by a woman. Of the
11 representatives appointed to the council from the
12 community-based organizations, at least one representative
13 shall be LGBTQ-identified, at least one representative shall
14 be a person of color, and at least one representative shall be
15 a woman. The council members shall be appointed by the Chair of
16 the Partnership and shall reflect the racial, gender identity,
17 sexual orientation, ability, socioeconomic, ethnic, and
18 geographic diversity of the State, including rural, suburban,
19 and urban appointees. The council shall make recommendations
20 to the Partnership regarding youth mental health, including,
21 but not limited to, identifying barriers to youth feeling
22 supported by and empowered by the system of mental health and
23 treatment providers, barriers perceived by youth in accessing
24 mental health services, gaps in the mental health system,
25 available resources in schools, including youth's perceptions
26 and experiences with outreach personnel, agency websites, and

1 informational materials, methods to destigmatize mental health
2 services, and how to improve State policy concerning student
3 mental health. The mental health system may include services
4 for substance use disorders and addiction. The council shall
5 meet at least 4 times annually.

6 (c) (Blank).

7 (d) The Illinois Children's Mental Health Partnership has
8 the following powers and duties:

9 (1) Conducting research assessments to determine the
10 needs and gaps of programs, services, and policies that
11 touch children's mental health.

12 (2) Developing policy statements for interagency
13 cooperation to cover all aspects of mental health
14 delivery, including social determinants of health,
15 prevention, early identification, and treatment.

16 (3) Recommending policies and providing information on
17 effective programs for delivery of mental health services.

18 (4) Using funding from federal, State, or
19 philanthropic partners, to fund pilot programs or research
20 activities to resource innovative practices by
21 organizational partners that will address children's
22 mental health. However, the Partnership may not provide
23 direct services.

24 (4.1) The Partnership shall work with community
25 networks and the Children's Behavioral Health
26 Transformation Initiative team to implement a community

1 needs assessment, that will raise awareness of gaps in
2 existing community-based services for youth.

3 (5) Submitting an annual report, on or before December
4 30 of each year, to the Governor and the General Assembly
5 on the progress of the Plan, any recommendations regarding
6 State policies, laws, or rules necessary to fulfill the
7 purposes of the Act, and any additional recommendations
8 regarding mental or behavioral health that the Partnership
9 deems necessary.

10 (6) (Blank). ~~Employing an Executive Director and~~
11 ~~setting the compensation of the Executive Director and~~
12 ~~other such employees and technical assistance as it deems~~
13 ~~necessary to carry out its duties under this Section.~~

14 The Partnership may designate a fiscal and administrative
15 agent that can accept funds to carry out its duties as outlined
16 in this Section.

17 The Department of Public Health ~~Healthcare and Family~~
18 ~~Services~~ shall provide technical and administrative support
19 for the Partnership.

20 (e) The Partnership may accept monetary gifts or grants
21 from the federal government or any agency thereof, from any
22 charitable foundation or professional association, or from any
23 reputable source for implementation of any program necessary
24 or desirable to carry out the powers and duties as defined
25 under this Section.

26 (f) On or before January 1, 2027, the Partnership shall

1 submit recommendations to the Governor and General Assembly
2 that includes recommended updates to the Act to reflect the
3 current mental health landscape in this State.

4 (Source: P.A. 102-16, eff. 6-17-21; 102-116, eff. 7-23-21;
5 102-899, eff. 1-1-23; 102-1034, eff. 1-1-23; 103-154, eff.
6 6-30-23.)

7 Section 25. The Interagency Children's Behavioral Health
8 Services Act is amended by adding Section 6 as follows:

9 (405 ILCS 165/6 new)

10 Sec. 6. Personal support workers. The Children's
11 Behavioral Health Transformation Team in collaboration with
12 the Department of Human Services shall develop a program to
13 provide one-on-one in-home respite behavioral health aids to
14 youth requiring intensive supervision due to behavioral health
15 needs.

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