AN ACT concerning health.

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

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

(105 ILCS 5/2-3.203)

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

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

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

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

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

(105 ILCS 155/Act rep.)

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 The Wellness Checks in Schools Program Act is repealed.

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

(305 ILCS 5/5-30.1)

Sec. 5-30.1. Managed care protections.

(a) As used in this Section:

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

"Emergency services" include:

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

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

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

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

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

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

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

as a covered service in any of the following situations:

(1) the MCO authorized such services;

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

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

(4) the MCO could not be contacted; or

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

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

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

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

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

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

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

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

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

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

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

(D) the enrollee is discharged.

(f) Network adequacy and transparency.

(1) The Department shall:

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

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

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

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

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

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

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

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

(g) Timely payment of claims.

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

information needed to adjudicate the claim.

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

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

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

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

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

(B) Compliance with the expedited provider requirement

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

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

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

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

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

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

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

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

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

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

(A) the extension of the timely filing period;

(B) retroactive prior authorizations; and

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

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

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

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

(g-6) MCO Performance Metrics Report.

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

(A) claims payment, including timeliness and accuracy;

(B) prior authorizations;

(C) grievance and appeals;

(D) utilization statistics;

(E) provider disputes;

(F) provider credentialing; and

(G) member and provider customer service.

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

(3) The metrics shall be developed in consultation

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

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

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

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

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

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

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

(A) Premium revenue, with appropriate adjustments.

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

(i) Direct paid claims.

(ii) Subcapitation payments.

(iii) Other claim payments.

(iv) Direct reserves.

(v) Gross recoveries.

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

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

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

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

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

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

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

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

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

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

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

Under no circumstances, either by an MCO or under the

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

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

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

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

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

(j) Health care information released to managed care

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

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

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

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

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

(405 ILCS 49/5)

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

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

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

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

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

child-serving State agencies.

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

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

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

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

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

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

(1) The Governor or his or her designee.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) a child advocate;

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

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

(E) an early childhood expert or practitioner;

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

(G) a representative from the healthcare sector;

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

(I) a violence prevention expert or practitioner;

(J) a representative from the juvenile justice system;

(K) a school social worker; and

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

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

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

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

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

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

expenses.

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

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

(c) (Blank).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(405 ILCS 165/6 new)

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

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