



Sen. Sara Feigenholtz

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LRB103 03199 RLC 72352 a

1 AMENDMENT TO SENATE BILL 726

2 AMENDMENT NO. _____. Amend Senate Bill 726 by replacing
3 everything after the enacting clause with the following:

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

1 current district-wide screenings, recommendations for
2 screening tools, training for staff, and linkage and referral
3 for identified students.

4 (b) On or before October 1, 2024, the State Board of
5 Education, in consultation with the Children's Behavioral
6 Health Transformation Team, the Office of the Governor, and
7 relevant stakeholders as needed shall release a strategy that
8 includes a tool for measuring capacity and readiness to
9 implement universal mental health screening of students. The
10 strategy shall build upon existing efforts to understand
11 district needs for resources, technology, training, and
12 infrastructure supports. The strategy shall include a
13 framework for supporting districts in a phased approach to
14 implement universal mental health screenings. The State Board
15 of Education shall issue a report to the Governor and the
16 General Assembly on school district readiness and plan for
17 phased approach to universal mental health screening of
18 students on or before April 1, 2025.

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

20 (105 ILCS 155/Act rep.)

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22 repealed.

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

1 (305 ILCS 5/5-30.1)

2 Sec. 5-30.1. Managed care protections.

3 (a) As used in this Section:

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

7 "Emergency services" include:

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

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

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

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

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

22 (c) An MCO shall pay any provider of emergency services
23 that does not have in effect a contract with the contracted
24 Medicaid MCO. The default rate of reimbursement shall be the
25 rate paid under Illinois Medicaid fee-for-service program

1 methodology, including all policy adjusters, including but not
2 limited to Medicaid High Volume Adjustments, Medicaid
3 Percentage Adjustments, Outpatient High Volume Adjustments,
4 and all outlier add-on adjustments to the extent such
5 adjustments are incorporated in the development of the
6 applicable MCO capitated rates.

7 (d) An MCO shall pay for all post-stabilization services
8 as a covered service in any of the following situations:

9 (1) the MCO authorized such services;

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

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

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

17 (5) the MCO and the treating provider, if the treating
18 provider is a non-affiliated provider, could not reach an
19 agreement concerning the enrollee's care and an affiliated
20 provider was unavailable for a consultation, in which case
21 the MCO must pay for such services rendered by the
22 treating non-affiliated provider until an affiliated
23 provider was reached and either concurred with the
24 treating non-affiliated provider's plan of care or assumed
25 responsibility for the enrollee's care. Such payment shall
26 be made at the default rate of reimbursement paid under

1 Illinois Medicaid fee-for-service program methodology,
2 including all policy adjusters, including but not limited
3 to Medicaid High Volume Adjustments, Medicaid Percentage
4 Adjustments, Outpatient High Volume Adjustments and all
5 outlier add-on adjustments to the extent that such
6 adjustments are incorporated in the development of the
7 applicable MCO capitated rates.

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

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

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

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

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

24 (5) The determination of the attending emergency
25 physician, or the provider actually treating the enrollee,
26 of whether an enrollee is sufficiently stabilized for

1 discharge or transfer to another facility, shall be
2 binding on the MCO. The MCO shall cover emergency services
3 for all enrollees whether the emergency services are
4 provided by an affiliated or non-affiliated provider.

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

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

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

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

16 (D) the enrollee is discharged.

17 (f) Network adequacy and transparency.

18 (1) The Department shall:

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

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

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

26 (D) require MCOs, including Medicaid Managed Care

1 Entities as defined in Section 5-30.2, to meet
2 provider directory requirements under Section 5-30.3;

3 (E) require MCOs to ensure that any
4 Medicaid-certified provider under contract with an MCO
5 and previously submitted on a roster on the date of
6 service is paid for any medically necessary,
7 Medicaid-covered, and authorized service rendered to
8 any of the MCO's enrollees, regardless of inclusion on
9 the MCO's published and publicly available directory
10 of available providers; and

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

22 (2) Each MCO shall confirm its receipt of information
23 submitted specific to physician or dentist additions or
24 physician or dentist deletions from the MCO's provider
25 network within 3 days after receiving all required
26 information from contracted physicians or dentists, and

1 electronic physician and dental directories must be
2 updated consistent with current rules as published by the
3 Centers for Medicare and Medicaid Services or its
4 successor agency.

5 (g) Timely payment of claims.

6 (1) The MCO shall pay a claim within 30 days of
7 receiving a claim that contains all the essential
8 information needed to adjudicate the claim.

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

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

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

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

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

7 (B) Compliance with the expedited provider requirement
8 may be satisfied by an MCO through the use of a Periodic
9 Interim Payment (PIP) program that has been mutually
10 agreed to and documented between the MCO and the provider,
11 if the PIP program ensures that any expedited provider
12 receives regular and periodic payments based on prior
13 period payment experience from that MCO. Total payments
14 under the PIP program may be reconciled against future PIP
15 payments on a schedule mutually agreed to between the MCO
16 and the provider.

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

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

23 (1) in no instance shall a medically necessary covered
24 service rendered in good faith, based upon eligibility
25 information documented by the provider, be denied coverage
26 or diminished in payment amount if the eligibility or

1 coverage information available at the time the service was
2 rendered is later found to be inaccurate in the assignment
3 of coverage responsibility between MCOs or the
4 fee-for-service system, except for instances when an
5 individual is deemed to have not been eligible for
6 coverage under the Illinois Medicaid program; and

7 (2) the Department shall, by December 31, 2016, adopt
8 rules establishing policies that shall be included in the
9 Medicaid managed care policy and procedures manual
10 addressing payment resolutions in situations in which a
11 provider renders services based upon information obtained
12 after verifying a patient's eligibility and coverage plan
13 through either the Department's current enrollment system
14 or a system operated by the coverage plan identified by
15 the patient presenting for services:

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

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

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

1 available on the Department's website.

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

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

5 (B) retroactive prior authorizations; and

6 (C) guaranteed minimum payment rate of no less
7 than the current, as of the date of service,
8 fee-for-service rate, plus all applicable add-ons,
9 when the resulting service relationship is out of
10 network.

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

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

17 (g-6) MCO Performance Metrics Report.

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

22 (A) claims payment, including timeliness and
23 accuracy;

24 (B) prior authorizations;

25 (C) grievance and appeals;

26 (D) utilization statistics;

- 1 (E) provider disputes;
2 (F) provider credentialing; and
3 (G) member and provider customer service.

4 (2) The Department shall ensure that the metrics
5 report is accessible to providers online by January 1,
6 2017.

7 (3) The metrics shall be developed in consultation
8 with industry representatives of the Medicaid managed care
9 health plans and representatives of associations
10 representing the majority of providers within the
11 identified industry.

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

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

26 (g-8) Dispute resolution process. The Department shall

1 maintain a provider complaint portal through which a provider
2 can submit to the Department unresolved disputes with an MCO.
3 An unresolved dispute means an MCO's decision that denies in
4 whole or in part a claim for reimbursement to a provider for
5 health care services rendered by the provider to an enrollee
6 of the MCO with which the provider disagrees. Disputes shall
7 not be submitted to the portal until the provider has availed
8 itself of the MCO's internal dispute resolution process.
9 Disputes that are submitted to the MCO internal dispute
10 resolution process may be submitted to the Department of
11 Healthcare and Family Services' complaint portal no sooner
12 than 30 days after submitting to the MCO's internal process
13 and not later than 30 days after the unsatisfactory resolution
14 of the internal MCO process or 60 days after submitting the
15 dispute to the MCO internal process. Multiple claim disputes
16 involving the same MCO may be submitted in one complaint,
17 regardless of whether the claims are for different enrollees,
18 when the specific reason for non-payment of the claims
19 involves a common question of fact or policy. Within 10
20 business days of receipt of a complaint, the Department shall
21 present such disputes to the appropriate MCO, which shall then
22 have 30 days to issue its written proposal to resolve the
23 dispute. The Department may grant one 30-day extension of this
24 time frame to one of the parties to resolve the dispute. If the
25 dispute remains unresolved at the end of this time frame or the
26 provider is not satisfied with the MCO's written proposal to

1 resolve the dispute, the provider may, within 30 days, request
2 the Department to review the dispute and make a final
3 determination. Within 30 days of the request for Department
4 review of the dispute, both the provider and the MCO shall
5 present all relevant information to the Department for
6 resolution and make individuals with knowledge of the issues
7 available to the Department for further inquiry if needed.
8 Within 30 days of receiving the relevant information on the
9 dispute, or the lapse of the period for submitting such
10 information, the Department shall issue a written decision on
11 the dispute based on contractual terms between the provider
12 and the MCO, contractual terms between the MCO and the
13 Department of Healthcare and Family Services and applicable
14 Medicaid policy. The decision of the Department shall be
15 final. By January 1, 2020, the Department shall establish by
16 rule further details of this dispute resolution process.
17 Disputes between MCOs and providers presented to the
18 Department for resolution are not contested cases, as defined
19 in Section 1-30 of the Illinois Administrative Procedure Act,
20 conferring any right to an administrative hearing.

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

24 (A) Premium revenue, with appropriate adjustments.

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

- 1 (i) Direct paid claims.
2 (ii) Subcapitation payments.
3 (iii) Other claim payments.
4 (iv) Direct reserves.
5 (v) Gross recoveries.
6 (vi) Expenses for activities that improve health
7 care quality as allowed by the Department.

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

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

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

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

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

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

4 (3) By October 1, 2019, the Department shall require all
5 MCOs to update their provider directory with information for
6 new practitioners of existing contracted providers within 30
7 days of receipt of a complete and accurate standardized roster
8 template in the format approved by the Department provided
9 that the provider is effective in the Department's provider
10 enrollment subsystem within the IMPACT system. Such provider
11 directory shall be readily accessible for purposes of
12 selecting an approved health care provider and comply with all
13 other federal and State requirements.

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

26 (g-12) Notwithstanding any other provision of law, if the

1 Department or an MCO requires submission of a claim for
2 payment in a non-electronic format, a provider shall always be
3 afforded a period of no less than 90 business days, as a
4 correction period, following any notification of rejection by
5 either the Department or the MCO to correct errors or
6 omissions in the original submission.

7 Under no circumstances, either by an MCO or under the
8 State's fee-for-service system, shall a provider be denied
9 payment for failure to comply with any timely submission
10 requirements under this Code or under any existing contract,
11 unless the non-electronic format claim submission occurs after
12 the initial 180 days following the latest date of service on
13 the claim, or after the 90 business days correction period
14 following notification to the provider of rejection or denial
15 of payment.

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

24 (h-5) Leading indicator data sharing. By January 1, 2024,
25 the Department shall obtain input from the Department of Human
26 Services, the Department of Juvenile Justice, the Department

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

1 respond to lead indicators with services and interventions
2 that are designed to help stabilize the child.

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

7 (j) Health care information released to managed care
8 organizations. A health care provider shall release to a
9 Medicaid managed care organization, upon request, and subject
10 to the Health Insurance Portability and Accountability Act of
11 1996 and any other law applicable to the release of health
12 information, the health care information of the MCO's
13 enrollee, if the enrollee has completed and signed a general
14 release form that grants to the health care provider
15 permission to release the recipient's health care information
16 to the recipient's insurance carrier.

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

22 (l) The requirements of this Section added by Public Act
23 102-4 shall apply to services provided on or after the first
24 day of the month that begins 60 days after April 27, 2021 (the
25 effective date of Public Act 102-4).

26 (Source: P.A. 102-4, eff. 4-27-21; 102-43, eff. 7-6-21;

1 102-144, eff. 1-1-22; 102-454, eff. 8-20-21; 102-813, eff.
2 5-13-22; 103-546, eff. 8-11-23.)

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

5 (405 ILCS 49/5)

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

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

22 (1) Increasing public awareness on issues connected to
23 children's mental health and wellness to decrease stigma,
24 promote acceptance, and strengthen the ability of

1 children, families, and communities to access supports.

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

6 (3) Funding and resources for children's mental health
7 prevention, early identification, and treatment across
8 child-serving State agencies.

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

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

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

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

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

25 (b) The Partnership shall have the responsibility of
26 developing and updating the Children's Mental Health Plan and

1 advising the relevant State agencies on implementation of the
2 Plan. The Children's Mental Health Partnership shall be
3 comprised of the following members:

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

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

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

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

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

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

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

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

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

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

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

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

26 (13) One member of the General Assembly appointed by

1 the Minority Leader of the Senate.

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

4 (15) Up to 25 representatives from the public
5 reflecting a diversity of age, gender identity, race,
6 ethnicity, socioeconomic status, and geographic location,
7 to be appointed by the Governor. Those public members
8 appointed under this paragraph must include, but are not
9 limited to:

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

12 (B) a child advocate;

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

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

17 (E) an early childhood expert or practitioner;

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

19 (G) a representative from the healthcare sector;

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

25 (I) a violence prevention expert or practitioner;

26 (J) a representative from the juvenile justice

1 system;

2 (K) a school social worker; and

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

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

8 The members appointed by the Governor shall be appointed
9 for 4 years with one opportunity for reappointment, except as
10 otherwise provided for in this subsection. Members who were
11 appointed by the Governor and are serving on January 1, 2023
12 (the effective date of Public Act 102-899) shall maintain
13 their appointment until the term of their appointment has
14 expired. For new appointments made pursuant to Public Act
15 102-899, members shall be appointed for one-year, 2-year, or
16 4-year terms, as determined by the Governor, with no more than
17 9 of the Governor's new or existing appointees serving the
18 same term. Those new appointments serving a one-year or 2-year
19 term may be appointed to 2 additional 4-year terms. If a
20 vacancy occurs in the Partnership membership, the vacancy
21 shall be filled in the same manner as the original appointment
22 for the remainder of the term.

23 The Partnership shall be convened no later than January
24 31, 2023 to discuss the changes in Public Act 102-899.

25 The members of the Partnership shall serve without
26 compensation but may be entitled to reimbursement for all

1 necessary expenses incurred in the performance of their
2 official duties as members of the Partnership from funds
3 appropriated for that purpose.

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

9 (b-5) The Partnership shall include an adjunct council
10 comprised of no more than 6 youth aged 14 to 25 and 4
11 representatives of 4 different community-based organizations
12 that focus on youth mental health. Of the community-based
13 organizations that focus on youth mental health, one of the
14 community-based organizations shall be led by an
15 LGBTQ-identified person, one of the community-based
16 organizations shall be led by a person of color, and one of the
17 community-based organizations shall be led by a woman. Of the
18 representatives appointed to the council from the
19 community-based organizations, at least one representative
20 shall be LGBTQ-identified, at least one representative shall
21 be a person of color, and at least one representative shall be
22 a woman. The council members shall be appointed by the Chair of
23 the Partnership and shall reflect the racial, gender identity,
24 sexual orientation, ability, socioeconomic, ethnic, and
25 geographic diversity of the State, including rural, suburban,
26 and urban appointees. The council shall make recommendations

1 to the Partnership regarding youth mental health, including,
2 but not limited to, identifying barriers to youth feeling
3 supported by and empowered by the system of mental health and
4 treatment providers, barriers perceived by youth in accessing
5 mental health services, gaps in the mental health system,
6 available resources in schools, including youth's perceptions
7 and experiences with outreach personnel, agency websites, and
8 informational materials, methods to destigmatize mental health
9 services, and how to improve State policy concerning student
10 mental health. The mental health system may include services
11 for substance use disorders and addiction. The council shall
12 meet at least 4 times annually.

13 (c) (Blank).

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

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

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

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

25 (4) Using funding from federal, State, or
26 philanthropic partners, to fund pilot programs or research

1 activities to resource innovative practices by
2 organizational partners that will address children's
3 mental health. However, the Partnership may not provide
4 direct services.

5 (4.1) The Partnership shall work with community
6 networks and the Children's Behavioral Health
7 Transformation Initiative team to implement a community
8 needs assessment, that will raise awareness of gaps in
9 existing community-based services for youth.

10 (5) Submitting an annual report, on or before December
11 30 of each year, to the Governor and the General Assembly
12 on the progress of the Plan, any recommendations regarding
13 State policies, laws, or rules necessary to fulfill the
14 purposes of the Act, and any additional recommendations
15 regarding mental or behavioral health that the Partnership
16 deems necessary.

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

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

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

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

7 (f) On or before January 1, 2027, the Partnership shall
8 submit recommendations to the Governor and General Assembly
9 that includes recommended updates to the Act to reflect the
10 current mental health landscape in this State.

11 (Source: P.A. 102-16, eff. 6-17-21; 102-116, eff. 7-23-21;
12 102-899, eff. 1-1-23; 102-1034, eff. 1-1-23; 103-154, eff.
13 6-30-23.)

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

16 (405 ILCS 165/6 new)

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

23 Section 99. Effective date. This Act takes effect upon

1 becoming law.".