

AN ACT concerning public aid.

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

Section 1. References to Act; intent; purposes. This Act may be referred to as the Children and Young Adult Mental Health Crisis Act. It is intended to fill in significant gaps in Illinois' mental health treatment system for children and young adults given that this is the age group that most mental health conditions begin to manifest.

Section 5. Findings. The General Assembly finds as follows:

(1) Over 850,000 children and young adults under age 25 in Illinois will experience a mental health condition. Barely one-third will get treatment even though treatment can lead to recovery and wellness.

(2) Every year hundreds of Illinois children with treatable serious mental health conditions are forced to remain in psychiatric hospitals far beyond medical necessity because subsequent treatment options are not available.

(3) There are many gaps in Illinois' publicly funded mental health system, and private insurance does not cover proven treatment approaches covered by the public sector.

(4) Children and young adults must have access to the level of mental health treatment they need at the first signs of a

problem to prevent worsening of the condition and the use of substances for purposes of self-medication.

(5) Illinois' mental health system for children and young adults must align with system of care principles, which were developed by The Georgetown University Center for Child and Human Development and are the nationally recognized best practices for developing a strong treatment system.

(6) This Act contains many of the crucial elements that Illinois requires for building an appropriate service delivery system and for coverage of a comprehensive array of services through private insurance.

Section 10. The State Employees Group Insurance Act of 1971 is amended by changing Section 6.11 as follows:

(5 ILCS 375/6.11)

(Text of Section before amendment by P.A. 100-1170)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, ~~and~~ 356z.26, ~~and~~

356z.29, 356z.32, and 356z.33 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised 1-8-19.)

(Text of Section after amendment by P.A. 100-1170)

Sec. 6.11. Required health benefits; Illinois Insurance Code requirements. The program of health benefits shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t of the Illinois Insurance Code. The program of health benefits shall provide the coverage required under Sections 356g, 356g.5, 356g.5-1, 356m, 356u, 356w, 356x, 356z.2, 356z.4, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.22, 356z.25, 356z.26, 356z.29,

~~and~~ 356z.32, and 356z.33 of the Illinois Insurance Code. The program of health benefits must comply with Sections 155.22a, 155.37, 355b, 356z.19, 370c, and 370c.1 of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section with respect to Sections 370c and 370c.1 of the Illinois Insurance Code; all other requirements of this Section shall be enforced by the Department of Central Management Services.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; 100-1170, eff. 6-1-19.)

Section 15. The Counties Code is amended by changing Section 5-1069.3 as follows:

(55 ILCS 5/5-1069.3)

Sec. 5-1069.3. Required health benefits. If a county, including a home rule county, is a self-insurer for purposes of providing health insurance coverage for its employees, the

coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, ~~and 356z.26, and 356z.29,~~ 356z.32, and 356z.33 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section. The requirement that health benefits be covered as provided in this Section is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule county to which this Section applies must comply with every provision of this Section.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised 10-3-18.)

Section 20. The Illinois Municipal Code is amended by changing Section 10-4-2.3 as follows:

(65 ILCS 5/10-4-2.3)

Sec. 10-4-2.3. Required health benefits. If a municipality, including a home rule municipality, is a self-insurer for purposes of providing health insurance coverage for its employees, the coverage shall include coverage for the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, ~~and 356z.26, and 356z.29,~~ 356z.32, and 356z.33 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, 356z.19, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section. The requirement that health benefits be covered as provided in this is an exclusive power and function of the State and is a denial and limitation under Article VII, Section 6, subsection (h) of the Illinois Constitution. A home rule municipality to which this Section applies must comply with every provision of this Section.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance

with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-480, eff. 9-9-15; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised 10-4-18.)

Section 25. The School Code is amended by changing Section 10-22.3f as follows:

(105 ILCS 5/10-22.3f)

Sec. 10-22.3f. Required health benefits. Insurance protection and benefits for employees shall provide the post-mastectomy care benefits required to be covered by a policy of accident and health insurance under Section 356t and the coverage required under Sections 356g, 356g.5, 356g.5-1, 356u, 356w, 356x, 356z.6, 356z.8, 356z.9, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.22, 356z.25, ~~and~~ 356z.26, ~~and~~ 356z.29, 356z.32, and 356z.33 of the Illinois Insurance Code. Insurance policies shall comply with Section 356z.19 of the Illinois Insurance Code. The coverage shall comply with Sections 155.22a, 355b, and 370c of the Illinois Insurance Code. The Department of Insurance shall enforce the requirements of this Section.

Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1024, eff. 1-1-19; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised 10-4-18.)

Section 30. The Illinois Insurance Code is amended by adding Section 356z.33 as follows:

(215 ILCS 5/356z.33 new)

Sec. 356z.33. Coverage of treatment models for early treatment of serious mental illnesses.

(a) For purposes of early treatment of a serious mental illness in a child or young adult under age 26, a group or individual policy of accident and health insurance, or managed care plan, that is amended, delivered, issued, or renewed after December 31, 2020 shall provide coverage of the following bundled, evidence-based treatment:

(1) Coordinated specialty care for first episode psychosis treatment, covering the elements of the treatment model included in the most recent national research trials conducted by the National Institute of

Mental Health in the Recovery After an Initial Schizophrenia Episode (RAISE) trials for psychosis resulting from a serious mental illness, but excluding the components of the treatment model related to education and employment support.

(2) Assertive community treatment (ACT) and community support team (CST) treatment. The elements of ACT and CST to be covered shall include those covered under Article V of the Illinois Public Aid Code, through 89 Ill. Adm. Code 140.453(d)(4).

(b) Adherence to the clinical models. For purposes of ensuring adherence to the coordinated specialty care for first episode psychosis treatment model, only providers contracted with the Department of Human Services' Division of Mental Health to be FIRST.IL providers to deliver coordinated specialty care for first episode psychosis treatment shall be permitted to provide such treatment in accordance with this Section and such providers must adhere to the fidelity of the treatment model. For purposes of ensuring fidelity to ACT and CST, only providers certified to provide ACT and CST by the Department of Human Services' Division of Mental Health and approved to provide ACT and CST by the Department of Healthcare and Family Services, or its designee, in accordance with 89 Ill. Adm. Code 140, shall be permitted to provide such services under this Section and such providers shall be required to adhere to the fidelity of the models.

(c) Development of medical necessity criteria for coverage. Within 6 months after the effective date of this amendatory Act of the 101st General Assembly, the Department of Insurance shall lead and convene a workgroup that includes the Department of Human Services' Division of Mental Health, the Department of Healthcare and Family Services, providers of the treatment models listed in this Section, and insurers operating in Illinois to develop medical necessity criteria for such treatment models for purposes of coverage under this Section. The workgroup shall use the medical necessity criteria the State and other states use as guidance for establishing medical necessity for insurance coverage. The Department of Insurance shall adopt a rule that defines medical necessity for each of the 3 treatment models listed in this Section by no later than June 30, 2020 based on the workgroup's recommendations.

(d) For purposes of credentialing the mental health professionals and other medical professionals that are part of a coordinated specialty care for first episode psychosis treatment team, an ACT team, or a CST team, the credentialing of the psychiatrist or the licensed clinical leader of the treatment team shall qualify all members of the treatment team to be credentialed with the insurer.

(e) Payment for the services performed under the treatment models listed in this Section shall be based on a bundled treatment model or payment, rather than payment for each separate service delivered by a treatment team member. By no

later than 6 months after the effective date of this amendatory Act of the 101st General Assembly, the Department of Insurance shall convene a workgroup of Illinois insurance companies and Illinois mental health treatment providers that deliver the bundled treatment approaches listed in this Section to determine a coding solution that allows for these bundled treatment models to be coded and paid for as a bundle of services, similar to intensive outpatient treatment where multiple services are covered under one billing code or a bundled set of billing codes. The coding solution shall ensure that services delivered using coordinated specialty care for first episode psychosis treatment, ACT, or CST are provided and billed as a bundled service, rather than for each individual service provided by a treatment team member, which would deconstruct the evidence-based practice. The coding solution shall be reached prior to coverage, which shall begin for plans amended, delivered, issued, or renewed after December 31, 2020, to ensure coverage of the treatment team approaches as intended by this Section.

(f) If, at any time, the Secretary of the United States Department of Health and Human Services, or its successor agency, adopts rules or regulations to be published in the Federal Register or publishes a comment in the Federal Register or issues an opinion, guidance, or other action that would require the State, under any provision of the Patient Protection and Affordable Care Act (P.L. 111-148), including,

but not limited to, 42 U.S.C. 18031(d)(3)(b), or any successor provision, to defray the cost of any coverage for serious mental illnesses or serious emotional disturbances outlined in this Section, then the requirement that a group or individual policy of accident and health insurance or managed care plan cover the bundled treatment approaches listed in this Section is inoperative other than any such coverage authorized under Section 1902 of the Social Security Act, 42 U.S.C. 1396a, and the State shall not assume any obligation for the cost of the coverage.

(g) After 5 years following full implementation of this Section, if requested by an insurer, the Department of Insurance shall contract with an independent third party with expertise in analyzing health insurance premiums and costs to perform an independent analysis of the impact coverage of the team-based treatment models listed in this Section has had on insurance premiums in Illinois. If premiums increased by more than 1% annually solely due to coverage of these treatment models, coverage of these models shall no longer be required.

(h) The Department of Insurance shall adopt any rules necessary to implement the provisions of this Section by no later than June 30, 2020.

Section 35. The Health Maintenance Organization Act is amended by changing Section 5-3 as follows:

(215 ILCS 125/5-3) (from Ch. 111 1/2, par. 1411.2)

Sec. 5-3. Insurance Code provisions.

(a) Health Maintenance Organizations shall be subject to the provisions of Sections 133, 134, 136, 137, 139, 140, 141.1, 141.2, 141.3, 143, 143c, 147, 148, 149, 151, 152, 153, 154, 154.5, 154.6, 154.7, 154.8, 155.04, 155.22a, 355.2, 355.3, 355b, 356g.5-1, 356m, 356v, 356w, 356x, 356y, 356z.2, 356z.4, 356z.5, 356z.6, 356z.8, 356z.9, 356z.10, 356z.11, 356z.12, 356z.13, 356z.14, 356z.15, 356z.17, 356z.18, 356z.19, 356z.21, 356z.22, 356z.25, 356z.26, 356z.29, 356z.30, 356z.32, 356z.33, 364, 364.01, 367.2, 367.2-5, 367i, 368a, 368b, 368c, 368d, 368e, 370c, 370c.1, 401, 401.1, 402, 403, 403A, 408, 408.2, 409, 412, 444, and 444.1, paragraph (c) of subsection (2) of Section 367, and Articles IIA, VIII 1/2, XII, XII 1/2, XIII, XIII 1/2, XXV, and XXVI of the Illinois Insurance Code.

(b) For purposes of the Illinois Insurance Code, except for Sections 444 and 444.1 and Articles XIII and XIII 1/2, Health Maintenance Organizations in the following categories are deemed to be "domestic companies":

(1) a corporation authorized under the Dental Service Plan Act or the Voluntary Health Services Plans Act;

(2) a corporation organized under the laws of this State; or

(3) a corporation organized under the laws of another state, 30% or more of the enrollees of which are residents of this State, except a corporation subject to

substantially the same requirements in its state of organization as is a "domestic company" under Article VIII 1/2 of the Illinois Insurance Code.

(c) In considering the merger, consolidation, or other acquisition of control of a Health Maintenance Organization pursuant to Article VIII 1/2 of the Illinois Insurance Code,

(1) the Director shall give primary consideration to the continuation of benefits to enrollees and the financial conditions of the acquired Health Maintenance Organization after the merger, consolidation, or other acquisition of control takes effect;

(2) (i) the criteria specified in subsection (1) (b) of Section 131.8 of the Illinois Insurance Code shall not apply and (ii) the Director, in making his determination with respect to the merger, consolidation, or other acquisition of control, need not take into account the effect on competition of the merger, consolidation, or other acquisition of control;

(3) the Director shall have the power to require the following information:

(A) certification by an independent actuary of the adequacy of the reserves of the Health Maintenance Organization sought to be acquired;

(B) pro forma financial statements reflecting the combined balance sheets of the acquiring company and the Health Maintenance Organization sought to be

acquired as of the end of the preceding year and as of a date 90 days prior to the acquisition, as well as pro forma financial statements reflecting projected combined operation for a period of 2 years;

(C) a pro forma business plan detailing an acquiring party's plans with respect to the operation of the Health Maintenance Organization sought to be acquired for a period of not less than 3 years; and

(D) such other information as the Director shall require.

(d) The provisions of Article VIII 1/2 of the Illinois Insurance Code and this Section 5-3 shall apply to the sale by any health maintenance organization of greater than 10% of its enrollee population (including without limitation the health maintenance organization's right, title, and interest in and to its health care certificates).

(e) In considering any management contract or service agreement subject to Section 141.1 of the Illinois Insurance Code, the Director (i) shall, in addition to the criteria specified in Section 141.2 of the Illinois Insurance Code, take into account the effect of the management contract or service agreement on the continuation of benefits to enrollees and the financial condition of the health maintenance organization to be managed or serviced, and (ii) need not take into account the effect of the management contract or service agreement on competition.

(f) Except for small employer groups as defined in the Small Employer Rating, Renewability and Portability Health Insurance Act and except for medicare supplement policies as defined in Section 363 of the Illinois Insurance Code, a Health Maintenance Organization may by contract agree with a group or other enrollment unit to effect refunds or charge additional premiums under the following terms and conditions:

(i) the amount of, and other terms and conditions with respect to, the refund or additional premium are set forth in the group or enrollment unit contract agreed in advance of the period for which a refund is to be paid or additional premium is to be charged (which period shall not be less than one year); and

(ii) the amount of the refund or additional premium shall not exceed 20% of the Health Maintenance Organization's profitable or unprofitable experience with respect to the group or other enrollment unit for the period (and, for purposes of a refund or additional premium, the profitable or unprofitable experience shall be calculated taking into account a pro rata share of the Health Maintenance Organization's administrative and marketing expenses, but shall not include any refund to be made or additional premium to be paid pursuant to this subsection (f)). The Health Maintenance Organization and the group or enrollment unit may agree that the profitable or unprofitable experience may be calculated taking into

account the refund period and the immediately preceding 2 plan years.

The Health Maintenance Organization shall include a statement in the evidence of coverage issued to each enrollee describing the possibility of a refund or additional premium, and upon request of any group or enrollment unit, provide to the group or enrollment unit a description of the method used to calculate (1) the Health Maintenance Organization's profitable experience with respect to the group or enrollment unit and the resulting refund to the group or enrollment unit or (2) the Health Maintenance Organization's unprofitable experience with respect to the group or enrollment unit and the resulting additional premium to be paid by the group or enrollment unit.

In no event shall the Illinois Health Maintenance Organization Guaranty Association be liable to pay any contractual obligation of an insolvent organization to pay any refund authorized under this Section.

(g) Rulemaking authority to implement Public Act 95-1045, if any, is conditioned on the rules being adopted in accordance with all provisions of the Illinois Administrative Procedure Act and all rules and procedures of the Joint Committee on Administrative Rules; any purported rule not so adopted, for whatever reason, is unauthorized.

(Source: P.A. 99-761, eff. 1-1-18; 100-24, eff. 7-18-17; 100-138, eff. 8-18-17; 100-863, eff. 8-14-18; 100-1026, eff.

8-22-18; 100-1057, eff. 1-1-19; 100-1102, eff. 1-1-19; revised 10-4-18.)

Section 40. The Illinois Public Aid Code is amended by changing Section 5-5.23 and by adding Sections 5-36, 5-37, and 5-38 as follows:

(305 ILCS 5/5-5.23)

Sec. 5-5.23. Children's mental health services.

(a) The Department of Healthcare and Family Services, by rule, shall require the screening and assessment of a child prior to any Medicaid-funded admission to an inpatient hospital for psychiatric services to be funded by Medicaid. The screening and assessment shall include a determination of the appropriateness and availability of out-patient support services for necessary treatment. The Department, by rule, shall establish methods and standards of payment for the screening, assessment, and necessary alternative support services.

(b) The Department of Healthcare and Family Services, to the extent allowable under federal law, shall secure federal financial participation for Individual Care Grant expenditures made by the Department of Healthcare and Family Services for the Medicaid optional service authorized under Section 1905(h) of the federal Social Security Act, pursuant to the provisions of Section 7.1 of the Mental Health and Developmental

Disabilities Administrative Act. The Department of Healthcare and Family Services may exercise the authority under this Section as is necessary to administer Individual Care Grants as authorized under Section 7.1 of the Mental Health and Developmental Disabilities Administrative Act.

(c) The Department of Healthcare and Family Services shall work collaboratively with the Department of Children and Family Services and the Division of Mental Health of the Department of Human Services to implement subsections (a) and (b).

(d) On and after July 1, 2012, the Department shall reduce any rate of reimbursement for services or other payments or alter any methodologies authorized by this Code to reduce any rate of reimbursement for services or other payments in accordance with Section 5-5e.

(e) All rights, powers, duties, and responsibilities currently exercised by the Department of Human Services related to the Individual Care Grant program are transferred to the Department of Healthcare and Family Services with the transfer and transition of the Individual Care Grant program to the Department of Healthcare and Family Services to be completed and implemented within 6 months after the effective date of this amendatory Act of the 99th General Assembly. For the purposes of the Successor Agency Act, the Department of Healthcare and Family Services is declared to be the successor agency of the Department of Human Services, but only with respect to the functions of the Department of Human Services

that are transferred to the Department of Healthcare and Family Services under this amendatory Act of the 99th General Assembly.

(1) Each act done by the Department of Healthcare and Family Services in exercise of the transferred powers, duties, rights, and responsibilities shall have the same legal effect as if done by the Department of Human Services or its offices.

(2) Any rules of the Department of Human Services that relate to the functions and programs transferred by this amendatory Act of the 99th General Assembly that are in full force on the effective date of this amendatory Act of the 99th General Assembly shall become the rules of the Department of Healthcare and Family Services. All rules transferred under this amendatory Act of the 99th General Assembly are hereby amended such that the term "Department" shall be defined as the Department of Healthcare and Family Services and all references to the "Secretary" shall be changed to the "Director of Healthcare and Family Services or his or her designee". As soon as practicable hereafter, the Department of Healthcare and Family Services shall revise and clarify the rules to reflect the transfer of rights, powers, duties, and responsibilities affected by this amendatory Act of the 99th General Assembly, using the procedures for recodification of rules available under the Illinois Administrative Procedure Act, except that

existing title, part, and section numbering for the affected rules may be retained. The Department of Healthcare and Family Services, consistent with its authority to do so as granted by this amendatory Act of the 99th General Assembly, shall propose and adopt any other rules under the Illinois Administrative Procedure Act as necessary to administer the Individual Care Grant program. These rules may include, but are not limited to, the application process and eligibility requirements for recipients.

(3) All unexpended appropriations and balances and other funds available for use in connection with any functions of the Individual Care Grant program shall be transferred for the use of the Department of Healthcare and Family Services to operate the Individual Care Grant program. Unexpended balances shall be expended only for the purpose for which the appropriation was originally made. The Department of Healthcare and Family Services shall exercise all rights, powers, duties, and responsibilities for operation of the Individual Care Grant program.

(4) Existing personnel and positions of the Department of Human Services pertaining to the administration of the Individual Care Grant program shall be transferred to the Department of Healthcare and Family Services with the transfer and transition of the Individual Care Grant program to the Department of Healthcare and Family

Services. The status and rights of Department of Human Services employees engaged in the performance of the functions of the Individual Care Grant program shall not be affected by this amendatory Act of the 99th General Assembly. The rights of the employees, the State of Illinois, and its agencies under the Personnel Code and applicable collective bargaining agreements or under any pension, retirement, or annuity plan shall not be affected by this amendatory Act of the 99th General Assembly. All transferred employees who are members of collective bargaining units shall retain their seniority, continuous service, salary, and accrued benefits.

(5) All books, records, papers, documents, property (real and personal), contracts, and pending business pertaining to the powers, duties, rights, and responsibilities related to the functions of the Individual Care Grant program, including, but not limited to, material in electronic or magnetic format and necessary computer hardware and software, shall be delivered to the Department of Healthcare and Family Services; provided, however, that the delivery of this information shall not violate any applicable confidentiality constraints.

(6) Whenever reports or notices are now required to be made or given or papers or documents furnished or served by any person to or upon the Department of Human Services in connection with any of the functions transferred by this

amendatory Act of the 99th General Assembly, the same shall be made, given, furnished, or served in the same manner to or upon the Department of Healthcare and Family Services.

(7) This amendatory Act of the 99th General Assembly shall not affect any act done, ratified, or canceled or any right occurring or established or any action or proceeding had or commenced in an administrative, civil, or criminal cause regarding the Department of Human Services before the effective date of this amendatory Act of the 99th General Assembly; and those actions or proceedings may be defended, prosecuted, and continued by the Department of Human Services.

(f) (Blank). ~~The Individual Care Grant program shall be inoperative during the calendar year in which implementation begins of any remedies in response to litigation against the Department of Healthcare and Family Services related to children's behavioral health and the general status of children's behavioral health in this State. Individual Care Grant recipients in the program the year it becomes inoperative shall continue to remain in the program until it is clinically appropriate for them to step down in level of care.~~

(g) Family Support Program. The Department of Healthcare and Family Services shall restructure the Family Support Program, formerly known as the Individual Care Grant program, to enable early treatment of youth, emerging adults, and transition-age adults with a serious mental illness or serious

emotional disturbance.

(1) As used in this subsection and in subsections (h) through (s):

(A) "Youth" means a person under the age of 18.

(B) "Emerging adult" means a person who is 18 through 20 years of age.

(C) "Transition-age adult" means a person who is 21 through 25 years of age.

(2) The Department shall amend 89 Ill. Adm. Code 139 in accordance with this Section and consistent with the timelines outlined in this Section.

(3) Implementation of any amended requirements shall be completed within 8 months of the adoption of any amendment to 89 Ill. Adm. Code 139 that is consistent with the provisions of this Section.

(4) To align the Family Support Program with the Medicaid system of care, the services available to a youth, emerging adult, or transition-age adult through the Family Support Program shall include all Medicaid community-based mental health treatment services and all Family Support Program services included under 89 Ill. Adm. Code 139. No person receiving services through the Family Support Program or the Specialized Family Support Program shall become a Medicaid enrollee unless Medicaid eligibility criteria are met and the person is enrolled in Medicaid. No part of this Section creates an entitlement to services

through the Family Support Program, the Specialized Family Support Program, or the Medicaid program.

(5) The Family Support Program shall align with the following system of care principles:

(A) Treatment and support services shall be based on the results of an integrated behavioral health assessment and treatment plan using an instrument approved by the Department of Healthcare and Family Services.

(B) Strong interagency collaboration between all State agencies the parent or legal guardian is involved with for services, including the Department of Healthcare and Family Services, the Department of Human Services, the Department of Children and Family Services, the Department of Juvenile Justice, and the Illinois State Board of Education.

(C) Individualized, strengths-based practices and trauma-informed treatment approaches.

(D) For a youth, full participation of the parent or legal guardian at all levels of treatment through a process that is family-centered and youth-focused. The process shall include consideration of the services and supports the parent, legal guardian, or caregiver requires for family stabilization, and shall connect such person or persons to services based on available insurance coverage.

(h) Eligibility for the Family Support Program. Eligibility criteria established under 89 Ill. Adm. Code 139 for the Family Support Program shall include the following:

(1) Individuals applying to the program must be under the age of 26.

(2) Requirements for parental or legal guardian involvement are applicable to youth and to emerging adults or transition-age adults who have a guardian appointed under Article XIa of the Probate Act.

(3) Youth, emerging adults, and transition-age adults are eligible for services under the Family Support Program upon their third inpatient admission to a hospital or similar treatment facility for the primary purpose of psychiatric treatment within the most recent 12 months and are hospitalized for the purpose of psychiatric treatment.

(4) School participation for emerging adults applying for services under the Family Support Program may be waived by request of the individual at the sole discretion of the Department of Healthcare and Family Services.

(5) School participation is not applicable to transition-age adults.

(i) Notification of Family Support Program and Specialized Family Support Program services.

(1) Within 12 months after the effective date of this amendatory Act of the 101st General Assembly, the Department of Healthcare and Family Services, with

meaningful stakeholder input through a working group of psychiatric hospitals, Family Support Program providers, family support organizations, the Community and Residential Services Authority, a statewide association representing a majority of hospitals, and foster care alumni advocates, shall establish a clear process by which a youth's or emerging adult's parents, guardian, or caregiver, or the emerging adult or transition-age adult, is identified, notified, and educated about the Family Support Program and the Specialized Family Support Program upon a first psychiatric inpatient hospital admission, and any following psychiatric inpatient admissions. Notification and education may take place through a Family Support Program coordinator, a mobile crisis response provider, a Comprehensive Community Based Youth Services provider, the Community and Residential Services Authority, or any other designated provider or coordinator identified by the Department of Healthcare and Family Services. In developing this process, the Department of Healthcare and Family Services and the working group shall take into account the unique needs of emerging adults and transition-age adults without parental involvement who are eligible for services under the Family Support Program. The Department of Healthcare and Family Services and the working group shall ensure the appropriate provider or coordinator is required to assist individuals and their

parents, guardians, or caregivers, as applicable, in the completion of the application or referral process for the Family Support Program or the Specialized Family Support Program.

(2) Upon a youth's, emerging adult's or transition-age adult's second psychiatric inpatient hospital admission, the hospital must ensure that the youth's parents, guardian, or caregiver, or the emerging adult or transition-age adult, have been notified of the Family Support Program and the Specialized Family Support Program prior to hospital discharge.

(3) Psychiatric lockout as last resort.

(A) Prior to referring any youth to the Department of Children and Family Services for the filing of a petition in accordance with subparagraph (c) of paragraph (1) of Section 2-4 of the Juvenile Court Act of 1987 alleging that the youth is dependent because the youth was left in a psychiatric hospital beyond medical necessity, the hospital shall educate the youth and the youth's parents, guardian, or caregiver about the Family Support Program and the Specialized Family Support Program and shall assist with connections to the designated Family Support Program coordinator in the service area. Once this process has begun, any such youth shall be considered a youth for whom an application for the Family Support Program is

pending with the Department of Healthcare and Family Services or an active application for the Family Support Program was being reviewed by the Department for the purposes of subparagraph (b) of paragraph (1) of Section 2-4 of the Juvenile Court Act of 1987.

(B) No state agency or hospital shall coach a parent or guardian of a youth in a psychiatric hospital inpatient unit to lock out or otherwise relinquish custody of a youth to the Department of Children and Family Services for the sole purpose of obtaining necessary mental health treatment for the youth. In the absence of abuse or neglect, a psychiatric lockout or custody relinquishment to the Department of Children and Family Services shall only be considered as the option of last resort.

(4) Development of new Family Support Program services.

(A) Development of specialized therapeutic residential treatment for youth and emerging adults with high-acuity mental health conditions. Through a working group led by the Department of Healthcare and Family Services that includes the Department of Children and Family Services and residential treatment providers for youth and emerging adults, the Department of Healthcare and Family Services, within 12 months after the effective date of this amendatory

Act of the 101st General Assembly, shall develop a plan for the development of specialized therapeutic residential treatment beds similar to a qualified residential treatment program, as defined in the federal Family First Prevention Services Act, for youth in the Family Support Program with high-acuity mental health needs. The Department of Healthcare and Family Services and the Department of Children and Family Services shall work together to maximize federal funding through Medicaid and Title IV-E of the Social Security Act in the development and implementation of this plan.

(B) Using the Department of Children and Family Services' beyond medical necessity data over the last 5 years and any other relevant, available data, the Department of Healthcare and Family Services shall assess the estimated number of these specialized high-acuity residential treatment beds that are needed in each region of the State based on the number of youth remaining in psychiatric hospitals beyond medical necessity and the number of youth placed out-of-state who need this level of care. The Department of Healthcare and Family Services shall report the results of this assessment to the General Assembly by no later than December 31, 2020.

(C) Development of an age-appropriate therapeutic

residential treatment model for emerging adults and transition-age adults. Within 30 months after the effective date of this amendatory Act of the 101st General Assembly, the Department of Healthcare and Family Services, in partnership with the Department of Human Services' Division of Mental Health and with significant and meaningful stakeholder input through a working group of providers and other stakeholders, shall develop a supportive housing model for emerging adults and transition-age adults receiving services through the Family Support Program who need residential treatment and support to enable recovery. Such a model shall be age-appropriate and shall allow the residential component of the model to be in a community-based setting combined with intensive community-based mental health services.

(j) Workgroup to develop a plan for improving access to substance use treatment. The Department of Healthcare and Family Services and the Department of Human Services' Division of Substance Use Prevention and Recovery shall co-lead a working group that includes Family Support Program providers, family support organizations, and other stakeholders over a 12-month period beginning in the first quarter of calendar year 2020 to develop a plan for increasing access to substance use treatment services for youth, emerging adults, and transition-age adults who are eligible for Family Support

Program services.

(k) Appropriation. Implementation of this Section shall be limited by the State's annual appropriation to the Family Support Program. Spending within the Family Support Program appropriation shall be further limited for the new Family Support Program services to be developed accordingly:

(1) Targeted use of specialized therapeutic residential treatment for youth and emerging adults with high-acuity mental health conditions through appropriation limitation. No more than 12% of all annual Family Support Program funds shall be spent on this level of care in any given state fiscal year.

(2) Targeted use of residential treatment model established for emerging adults and transition-age adults through appropriation limitation. No more than one-quarter of all annual Family Support Program funds shall be spent on this level of care in any given state fiscal year.

(1) Exhausting third party insurance coverage first.

(A) A parent, legal guardian, emerging adult, or transition-age adult with private insurance coverage shall work with the Department of Healthcare and Family Services, or its designee, to identify insurance coverage for any and all benefits covered by their plan. If insurance cost-sharing by any method for treatment is cost-prohibitive for the parent, legal guardian, emerging adult, or transition-age adult, Family Support Program

funds may be applied as a payer of last resort toward insurance cost-sharing for purposes of using private insurance coverage to the fullest extent for the recommended treatment. If the Department, or its agent, has a concern relating to the parent's, legal guardian's, emerging adult's, or transition-age adult's insurer's compliance with Illinois or federal insurance requirements relating to the coverage of mental health or substance use disorders, it shall refer all relevant information to the applicable regulatory authority.

(B) The Department of Healthcare and Family Services shall use Medicaid funds first for an individual who has Medicaid coverage if the treatment or service recommended using an integrated behavioral health assessment and treatment plan (using the instrument approved by the Department of Healthcare and Family Services) is covered by Medicaid.

(C) If private or public insurance coverage does not cover the needed treatment or service, Family Support Program funds shall be used to cover the services offered through the Family Support Program.

(m) Service authorization. A youth, emerging adult, or transition-age adult enrolled in the Family Support Program or the Specialized Family Support Program shall be eligible to receive a mental health treatment service covered by the applicable program if the medical necessity criteria

established by the Department of Healthcare and Family Services are met.

(n) Streamlined application. The Department of Healthcare and Family Services shall revise the Family Support Program applications and the application process to reflect the changes made to this Section by this amendatory Act of the 101st General Assembly within 8 months after the adoption of any amendments to 89 Ill. Adm. Code 139.

(o) Study of reimbursement policies during planned and unplanned absences of youth and emerging adults in Family Support Program residential treatment settings. The Department of Healthcare and Family Services shall undertake a study of those standards of the Department of Children and Family Services and other states for reimbursement of residential treatment during planned and unplanned absences to determine if reimbursing residential providers for such unplanned absences positively impacts the availability of residential treatment for youth and emerging adults. The Department of Healthcare and Family Services shall begin the study on July 1, 2019 and shall report its findings and the results of the study to the General Assembly, along with any recommendations for or against adopting a similar policy, by December 31, 2020.

(p) Public awareness and educational campaign for all relevant providers. The Department of Healthcare and Family Services shall engage in a public awareness campaign to educate hospitals with psychiatric units, crisis response providers

such as Screening, Assessment and Support Services providers and Comprehensive Community Based Youth Services agencies, schools, and other community institutions and providers across Illinois on the changes made by this amendatory Act of the 101st General Assembly to the Family Support Program. The Department of Healthcare and Family Services shall produce written materials geared for the appropriate target audience, develop webinars, and conduct outreach visits over a 12-month period beginning after implementation of the changes made to this Section by this amendatory Act of the 101st General Assembly.

(q) Maximizing federal matching funds for the Family Support Program and the Specialized Family Support Program. The Department of Healthcare and Family Services, as the sole Medicaid State agency, shall seek approval from the federal Centers for Medicare and Medicaid Services within 12 months after the effective date of this amendatory Act of the 101st General Assembly to draw additional federal Medicaid matching funds for individuals served under the Family Support Program or the Specialized Family Support Program who are not covered by the Department's medical assistance programs. The Department of Children and Family Services, as the State agency responsible for administering federal funds pursuant to Title IV-E of the Social Security Act, shall submit a State Plan to the federal government within 12 months after the effective date of this amendatory Act of the 101st General Assembly to

maximize the use of federal Title IV-E prevention funds through the federal Family First Prevention Services Act, to provide mental health and substance use disorder treatment services and supports, including, but not limited to, the provision of short-term crisis and transition beds post-hospitalization for youth who are at imminent risk of entering Illinois' youth welfare system solely due to the inability to access mental health or substance use treatment services.

(r) Outcomes and data reported annually to the General Assembly. Beginning in 2021, the Department of Healthcare and Family Services shall submit an annual report to the General Assembly that includes the following information with respect to the time period covered by the report:

(1) The number and ages of youth, emerging adults, and transition-age adults who requested services under the Family Support Program and the Specialized Family Support Program and the services received.

(2) The number and ages of youth, emerging adults, and transition-age adults who requested services under the Specialized Family Support Program who were eligible for services based on the number of hospitalizations.

(3) The number and ages of youth, emerging adults, and transition-age adults who applied for Family Support Program or Specialized Family Support Program services but did not receive any services.

(s) Rulemaking authority. Unless a timeline is otherwise

specified in a subsection, if amendments to 89 Ill. Adm. Code 139 are needed for implementation of this Section, such amendments shall be filed by the Department of Healthcare and Family Services within one year after the effective date of this amendatory Act of the 101st General Assembly.

(Source: P.A. 99-479, eff. 9-10-15.)

(305 ILCS 5/5-36 new)

Sec. 5-36. Education on mental health and substance use treatment services for children and young adults. The Department of Healthcare and Family Services shall develop a layman's guide to the mental health and substance use treatment services available in Illinois through the Medical Assistance Program and through the Family Support Program, or other publicly funded programs, similar to what Massachusetts developed, to help families understand what services are available to them when they have a child in need of treatment or support. The guide shall be in easy-to-understand language, be prominently available on the Department of Healthcare and Family Services' website, and be part of a statewide communications campaign to ensure families are aware of Family Support Program services. It shall briefly explain the service and whether it is covered by the Medical Assistance Program, the Family Support Program, or any other public funding source. Within one year after the effective date of this amendatory Act of the 101st General Assembly, the Department of Healthcare and

Family Services shall complete this guide, have it available on its website, and launch the communications campaign.

(305 ILCS 5/5-37 new)

Sec. 5-37. Billing mechanism for preventive mental health services delivered to children.

(a) The General Assembly finds:

(1) It is common for children to have mental health needs but to not have a full-blown diagnosis of a mental illness. Examples include, but are not limited to, children who have mild or emerging symptoms of a mental health condition (such as meeting some but not all the criteria for a diagnosis, including, but not limited to, symptoms of depression, attentional deficits, anxiety or prodromal symptoms of bipolar disorder or schizophrenia); cutting or engaging in other forms of self-harm; or experiencing violence or trauma).

(2) The federal requirement that Medicaid-covered children have access to Early and Periodic Screening, Diagnostic and Treatment services includes ensuring that Medicaid-covered children who have a mental health need but do not have a mental health diagnosis have access to treatment.

(3) The Department of Healthcare and Family Services' existing policy acknowledges this federal requirement by allowing for Medicaid billing for mental health services

for children who have a need for services but who do not have a mental health diagnosis in Section 207.3.3 of the Community-Based Behavioral Services Provider Handbook. However, the current policy of the Department of Healthcare and Family Services requires clinicians to specify a diagnosis code and make a notation in the child's medical record that the service is preventive. This effectively requires the clinician to associate a diagnosis with the child and is a major barrier for services because many clinicians rightly are unwilling to document a mental health diagnosis in the medical record when a diagnosis is not medically appropriate.

(b) Consistent with the existing policy of the Department of Healthcare and Family Services and the federal Early and Periodic Screening, Diagnostic and Treatment requirement, within 3 months after the effective date of this amendatory Act of the 101st General Assembly, the Department of Healthcare and Family Services shall convene a working group that includes children's mental health providers to receive input on recommendations to develop a medically appropriate and practical solution that enables mental health providers and professionals to deliver and receive reimbursement for medically necessary mental health services provided to a Medicaid-eligible child under age 21 that has a mental health need but does not have a mental health diagnosis in order to prevent the development of a serious mental health condition.

The working group shall ensure that the recommended solution works in practice and does not deter clinicians from delivering prevention and early treatment to children with mental health needs but who do not have a diagnosed mental illness. The Department of Healthcare and Family Services shall meet with this working group at least 4 times prior to finalizing the solution to enable and allow for mental health services for a child without a mental health diagnosis for purposes of prevention and early treatment when recommended by a licensed practitioner of the healing arts. If the Department of Healthcare and Family Services determines that an Illinois Title XIX State Plan amendment is necessary to implement this Section, the State Plan amendment shall be filed with the federal Centers for Medicare and Medicaid Services by no later than 12 months after the effective date of this amendatory Act of the 101st General Assembly. If rulemaking is required to implement this Section, the rule shall be filed by the Department of Healthcare and Family Services with the Joint Committee on Administrative Rules by no later than 12 months after the effective date of this amendatory Act of the 101st General Assembly, or if federal approval is required, within 6 months after federal approval. If federal approval is required but not granted, this Section shall become inoperative.

(305 ILCS 5/5-38 new)

Sec. 5-38. Alignment of children's mental health treatment

systems. The Governor's Office shall establish, convene, and lead a working group that includes the Director of Healthcare and Family Services, the Secretary of Human Services, the Director of Public Health, the Director of Children and Family Services, the Director of Juvenile Justice, the State Superintendent of Education, and the appropriate agency staff who will be responsible for implementation or oversight of reforms to children's behavioral health services. The working group shall meet at least quarterly to foster interagency collaboration and work toward the goal of aligning services and programs to begin to create a coordinated children's behavioral health system consistent with system of care principles that spans across State agencies, rather than separate siloed systems with different requirements, rates, and administrative processes and standards.

Section 95. No acceleration or delay. Where this Act makes changes in a statute that is represented in this Act by text that is not yet or no longer in effect (for example, a Section represented by multiple versions), the use of that text does not accelerate or delay the taking effect of (i) the changes made by this Act or (ii) provisions derived from any other Public Act.

Section 99. Effective date. This Act takes effect January 1, 2020.