AN ACT concerning State government.

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

Article 1.

Section 5. The Freedom of Information Act is amended by changing Section 7 as follows:

(5 ILCS 140/7)

(Text of Section before amendment by P.A. 104-300)

Sec. 7. Exemptions.

(1) When a request is made to inspect or copy a public record that contains information that is exempt from disclosure under this Section, but also contains information that is not exempt from disclosure, the public body may elect to redact the information that is exempt. The public body shall make the remaining information available for inspection and copying. Subject to this requirement, the following shall be exempt from inspection and copying:

(a) Information specifically prohibited from disclosure by federal or State law or rules and regulations implementing federal or State law.

(b) Private information, unless disclosure is required by another provision of this Act, a State or federal law,

or a court order.

(b-5) Files, documents, and other data or databases maintained by one or more law enforcement agencies and specifically designed to provide information to one or more law enforcement agencies regarding the physical or mental status of one or more individual subjects.

(c) Personal information contained within public records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, unless the disclosure is consented to in writing by the individual subjects of the information. "Unwarranted invasion of personal privacy" means the disclosure of information that is highly personal or objectionable to a reasonable person and in which the subject's right to privacy outweighs any legitimate public interest in obtaining the information. The disclosure of information that bears on the public duties of public employees and officials shall not be considered an invasion of personal privacy.

(d) Records in the possession of any public body created in the course of administrative enforcement proceedings, and any law enforcement or correctional agency for law enforcement purposes, but only to the extent that disclosure would:

(i) interfere with pending or actually and reasonably contemplated law enforcement proceedings

conducted by any law enforcement or correctional agency that is the recipient of the request;

(ii) interfere with active administrative enforcement proceedings conducted by the public body that is the recipient of the request;

(iii) create a substantial likelihood that a person will be deprived of a fair trial or an impartial hearing;

(iv) unavoidably disclose the identity of a confidential source, confidential information furnished only by the confidential source, or persons who file complaints with or provide information to administrative, investigative, law enforcement, or penal agencies; except that the identities of witnesses to traffic crashes, traffic crash reports, and rescue reports shall be provided by agencies of local government, except when disclosure would interfere with an active criminal investigation conducted by the agency that is the recipient of the request;

(v) disclose unique or specialized investigative techniques other than those generally used and known or disclose internal documents of correctional agencies related to detection, observation, or investigation of incidents of crime or misconduct, and disclosure would result in demonstrable harm to the

agency or public body that is the recipient of the request;

(vi) endanger the life or physical safety of law enforcement personnel or any other person; or

(vii) obstruct an ongoing criminal investigation by the agency that is the recipient of the request.

(d-5) A law enforcement record created for law enforcement purposes and contained in a shared electronic record management system if the law enforcement agency or criminal justice agency that is the recipient of the request did not create the record, did not participate in or have a role in any of the events which are the subject of the record, and only has access to the record through the shared electronic record management system. As used in this subsection (d-5), "criminal justice agency" means the Illinois Criminal Justice Information Authority or the Illinois Sentencing Policy Advisory Council.

(d-6) Records contained in the Officer Professional Conduct Database under Section 9.2 of the Illinois Police Training Act, except to the extent authorized under that Section. This includes the documents supplied to the Illinois Law Enforcement Training Standards Board from the Illinois State Police and Illinois State Police Merit Board.

(d-7) Information gathered or records created from the use of automatic license plate readers in connection with

Section 2-130 of the Illinois Vehicle Code.

(e) Records that relate to or affect the security of correctional institutions and detention facilities.

(e-5) Records requested by persons committed to the Department of Corrections, Department of Human Services Division of Mental Health, or a county jail if those materials are available in the library of the correctional institution or facility or jail where the inmate is confined.

(e-6) Records requested by persons committed to the Department of Corrections, Department of Human Services Division of Mental Health, or a county jail if those materials include records from staff members' personnel files, staff rosters, or other staffing assignment information.

(e-7) Records requested by persons committed to the Department of Corrections or Department of Human Services Division of Mental Health if those materials are available through an administrative request to the Department of Corrections or Department of Human Services Division of Mental Health.

(e-8) Records requested by a person committed to the Department of Corrections, Department of Human Services Division of Mental Health, or a county jail, the disclosure of which would result in the risk of harm to any person or the risk of an escape from a jail or correctional

institution or facility.

(e-9) Records requested by a person in a county jail or committed to the Department of Corrections or Department of Human Services Division of Mental Health, containing personal information pertaining to the person's victim or the victim's family, including, but not limited to, a victim's home address, home telephone number, work or school address, work telephone number, social security number, or any other identifying information, except as may be relevant to a requester's current or potential case or claim.

(e-10) Law enforcement records of other persons requested by a person committed to the Department of Corrections, Department of Human Services Division of Mental Health, or a county jail, including, but not limited to, arrest and booking records, mug shots, and crime scene photographs, except as these records may be relevant to the requester's current or potential case or claim.

(f) Preliminary drafts, notes, recommendations, memoranda, and other records in which opinions are expressed, or policies or actions are formulated, except that a specific record or relevant portion of a record shall not be exempt when the record is publicly cited and identified by the head of the public body. The exemption provided in this paragraph (f) extends to all those

records of officers and agencies of the General Assembly that pertain to the preparation of legislative documents.

(g) Trade secrets and commercial or financial information obtained from a person or business where the trade secrets or commercial or financial information are furnished under a claim that they are proprietary, privileged, or confidential, and that disclosure of the trade secrets or commercial or financial information would cause competitive harm to the person or business, and only insofar as the claim directly applies to the records requested.

The information included under this exemption includes all trade secrets and commercial or financial information obtained by a public body, including a public pension fund, from a private equity fund or a privately held company within the investment portfolio of a private equity fund as a result of either investing or evaluating a potential investment of public funds in a private equity fund. The exemption contained in this item does not apply to the aggregate financial performance information of a private equity fund, nor to the identity of the fund's managers or general partners. The exemption contained in this item does not apply to the identity of a privately held company within the investment portfolio of a private equity fund, unless the disclosure of the identity of a privately held company may cause competitive harm.

Nothing contained in this paragraph (g) shall be construed to prevent a person or business from consenting to disclosure.

(h) Proposals and bids for any contract, grant, or agreement, including information which if it were disclosed would frustrate procurement or give an advantage to any person proposing to enter into a contractor agreement with the body, until an award or final selection is made. Information prepared by or for the body in preparation of a bid solicitation shall be exempt until an award or final selection is made.

(i) Valuable formulae, computer geographic systems, designs, drawings, and research data obtained or produced by any public body when disclosure could reasonably be expected to produce private gain or public loss. The exemption for "computer geographic systems" provided in this paragraph (i) does not extend to requests made by news media as defined in Section 2 of this Act when the requested information is not otherwise exempt and the only purpose of the request is to access and disseminate information regarding the health, safety, welfare, or legal rights of the general public.

(j) The following information pertaining to educational matters:

(i) test questions, scoring keys, and other examination data used to administer an academic

examination;

(ii) information received by a primary or secondary school, college, or university under its procedures for the evaluation of faculty members by their academic peers;

(iii) information concerning a school or university's adjudication of student disciplinary cases, but only to the extent that disclosure would unavoidably reveal the identity of the student; and

(iv) course materials or research materials used by faculty members.

(k) Architects' plans, engineers' technical submissions, and other construction related technical documents for projects not constructed or developed in whole or in part with public funds and the same for projects constructed or developed with public funds, including, but not limited to, power generating and distribution stations and other transmission and distribution facilities, water treatment facilities, airport facilities, sport stadiums, convention centers, and all government owned, operated, or occupied buildings, but only to the extent that disclosure would compromise security.

(l) Minutes of meetings of public bodies closed to the public as provided in the Open Meetings Act until the public body makes the minutes available to the public

under Section 2.06 of the Open Meetings Act.

(m) Communications between a public body and an attorney or auditor representing the public body that would not be subject to discovery in litigation, and materials prepared or compiled by or for a public body in anticipation of a criminal, civil, or administrative proceeding upon the request of an attorney advising the public body, and materials prepared or compiled with respect to internal audits of public bodies.

(n) Records relating to a public body's adjudication of employee grievances or disciplinary cases; however, this exemption shall not extend to the final outcome of cases in which discipline is imposed.

(o) Administrative or technical information associated with automated data processing operations, including, but not limited to, software, operating protocols, computer program abstracts, file layouts, source listings, object modules, load modules, user guides, documentation pertaining to all logical and physical design of computerized systems, employee manuals, and any other information that, if disclosed, would jeopardize the security of the system or its data or the security of materials exempt under this Section.

(p) Records relating to collective negotiating matters between public bodies and their employees or representatives, except that any final contract or

agreement shall be subject to inspection and copying.

(q) Test questions, scoring keys, and other examination data used to determine the qualifications of an applicant for a license or employment.

(r) The records, documents, and information relating to real estate purchase negotiations until those negotiations have been completed or otherwise terminated. With regard to a parcel involved in a pending or actually and reasonably contemplated eminent domain proceeding under the Eminent Domain Act, records, documents, and information relating to that parcel shall be exempt except as may be allowed under discovery rules adopted by the Illinois Supreme Court. The records, documents, and information relating to a real estate sale shall be exempt until a sale is consummated.

(s) Any and all proprietary information and records related to the operation of an intergovernmental risk management association or self-insurance pool or jointly self-administered health and accident cooperative or pool. Insurance or self-insurance (including any intergovernmental risk management association or self-insurance pool) claims, loss or risk management information, records, data, advice, or communications.

(t) Information contained in or related to examination, operating, or condition reports prepared by, on behalf of, or for the use of a public body responsible

for the regulation or supervision of financial institutions, insurance companies, or pharmacy benefit managers, unless disclosure is otherwise required by State law.

(u) Information that would disclose or might lead to the disclosure of secret or confidential information, codes, algorithms, programs, or private keys intended to be used to create electronic signatures under the Uniform Electronic Transactions Act.

(v) Vulnerability assessments, security measures, and response policies or plans that are designed to identify, prevent, or respond to potential attacks upon a community's population or systems, facilities, or installations, but only to the extent that disclosure could reasonably be expected to expose the vulnerability or jeopardize the effectiveness of the measures, policies, or plans, or the safety of the personnel who implement them or the public. Information exempt under this item may include such things as details pertaining to the mobilization or deployment of personnel or equipment, to the operation of communication systems or protocols, to cybersecurity vulnerabilities, or to tactical operations.

(w) (Blank).

(x) Maps and other records regarding the location or security of generation, transmission, distribution, storage, gathering, treatment, or switching facilities

owned by a utility, by a power generator, or by the Illinois Power Agency.

(y) Information contained in or related to proposals, bids, or negotiations related to electric power procurement under Section 1-75 of the Illinois Power Agency Act and Section 16-111.5 of the Public Utilities Act that is determined to be confidential and proprietary by the Illinois Power Agency or by the Illinois Commerce Commission.

(z) Information about students exempted from disclosure under Section 10-20.38 or 34-18.29 of the School Code, and information about undergraduate students enrolled at an institution of higher education exempted from disclosure under Section 25 of the Illinois Credit Card Marketing Act of 2009.

(aa) Information the disclosure of which is exempted under the Viatical Settlements Act of 2009.

(bb) Records and information provided to a mortality review team and records maintained by a mortality review team appointed under the Department of Juvenile Justice Mortality Review Team Act.

(cc) Information regarding interments, entombments, or inurnments of human remains that are submitted to the Cemetery Oversight Database under the Cemetery Care Act or the Cemetery Oversight Act, whichever is applicable.

(dd) Correspondence and records (i) that may not be

disclosed under Section 11-9 of the Illinois Public Aid Code or (ii) that pertain to appeals under Section 11-8 of the Illinois Public Aid Code.

(ee) The names, addresses, or other personal information of persons who are minors and are also participants and registrants in programs of park districts, forest preserve districts, conservation districts, recreation agencies, and special recreation associations.

(ff) The names, addresses, or other personal information of participants and registrants in programs of park districts, forest preserve districts, conservation districts, recreation agencies, and special recreation associations where such programs are targeted primarily to minors.

(gg) Confidential information described in Section 1-100 of the Illinois Independent Tax Tribunal Act of 2012.

(hh) The report submitted to the State Board of Education by the School Security and Standards Task Force under item (8) of subsection (d) of Section 2-3.160 of the School Code and any information contained in that report.

(ii) Records requested by persons committed to or detained by the Department of Human Services under the Sexually Violent Persons Commitment Act or committed to the Department of Corrections under the Sexually Dangerous

Persons Act if those materials: (i) are available in the library of the facility where the individual is confined; (ii) include records from staff members' personnel files, staff rosters, or other staffing assignment information; or (iii) are available through an administrative request to the Department of Human Services or the Department of Corrections.

(jj) Confidential information described in Section 5-535 of the Civil Administrative Code of Illinois.

(kk) The public body's credit card numbers, debit card numbers, bank account numbers, Federal Employer Identification Number, security code numbers, passwords, and similar account information, the disclosure of which could result in identity theft or impression or defrauding of a governmental entity or a person.

(ll) Records concerning the work of the threat assessment team of a school district, including, but not limited to, any threat assessment procedure under the School Safety Drill Act and any information contained in the procedure.

(mm) Information prohibited from being disclosed under subsections (a) and (b) of Section 15 of the Student Confidential Reporting Act.

(nn) Proprietary information submitted to the Environmental Protection Agency under the Drug Take-Back Act.

(oo) Records described in subsection (f) of Section 3-5-1 of the Unified Code of Corrections.

(pp) Any and all information regarding burials, interments, or entombments of human remains as required to be reported to the Department of Natural Resources pursuant either to the Archaeological and Paleontological Resources Protection Act or the Human Remains Protection Act.

(qq) Reports described in subsection (e) of Section 16-15 of the Abortion Care Clinical Training Program Act.

(rr) Information obtained by a certified local health department under the Access to Public Health Data Act.

(ss) For a request directed to a public body that is also a HIPAA-covered entity, all information that is protected health information, including demographic information, that may be contained within or extracted from any record held by the public body in compliance with State and federal medical privacy laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act and its regulations, 45 CFR Parts 160 and 164. As used in this paragraph, "HIPAA-covered entity" has the meaning given to the term "covered entity" in 45 CFR 160.103 and "protected health information" has the meaning given to that term in 45 CFR 160.103.

(tt) Proposals or bids submitted by engineering

consultants in response to requests for proposal or other competitive bidding requests by the Department of Transportation or the Illinois Toll Highway Authority.

(uu) Documents that, pursuant to the State of Illinois' 1987 Agreement with the U.S. Nuclear Regulatory Commission and the corresponding requirement to maintain compatibility with the National Materials Program, have been determined to be security sensitive. These documents include information classified as safeguards, safeguards-modified, and sensitive unclassified nonsafeguards information, as identified in U.S. Nuclear Regulatory Commission regulatory information summaries, security advisories, and other applicable communications or regulations related to the control and distribution of security sensitive information.

(1.5) Any information exempt from disclosure under the Judicial Privacy Act shall be redacted from public records prior to disclosure under this Act.

(1.6) Any information exempt from disclosure under the Public Official Safety and Privacy Act shall be redacted from public records prior to disclosure under this Act.

(1.7) Any information exempt from disclosure under paragraph (3.5) of Section 9-15 of the Election Code shall be redacted from public records prior to disclosure under this Act.

(2) A public record that is not in the possession of a

public body but is in the possession of a party with whom the agency has contracted to perform a governmental function on behalf of the public body, and that directly relates to the governmental function and is not otherwise exempt under this Act, shall be considered a public record of the public body, for purposes of this Act.

(3) This Section does not authorize withholding of information or limit the availability of records to the public, except as stated in this Section or otherwise provided in this Act.

(Source: P.A. 103-154, eff. 6-30-23; 103-423, eff. 1-1-24; 103-446, eff. 8-4-23; 103-462, eff. 8-4-23; 103-540, eff. 1-1-24; 103-554, eff. 1-1-24; 103-605, eff. 7-1-24; 103-865, eff. 1-1-25; 104-438, eff. 1-1-26; 104-443, eff. 1-1-26; revised 1-7-26.)

(Text of Section after amendment by P.A. 104-300)

Sec. 7. Exemptions.

(1) When a request is made to inspect or copy a public record that contains information that is exempt from disclosure under this Section, but also contains information that is not exempt from disclosure, the public body may elect to redact the information that is exempt. The public body shall make the remaining information available for inspection and copying. Subject to this requirement, the following shall be exempt from inspection and copying:

(a) Records created or compiled by a State public defender agency or commission subject to the State Public Defender Act that contain: individual client identity; individual case file information; individual investigation records and other records that are otherwise subject to attorney-client privilege; records that would not be discoverable in litigation; records under Section 2.15; training materials; records related to attorney consultation and representation strategy; or any of the above concerning clients of county public defenders or other defender agencies and firms. This exclusion does not apply to deidentified, aggregated, administrative records, such as general case processing and workload information.

(a-5) Information specifically prohibited from disclosure by federal or State law or rules and regulations implementing federal or State law.

(b) Private information, unless disclosure is required by another provision of this Act, a State or federal law, or a court order.

(b-5) Files, documents, and other data or databases maintained by one or more law enforcement agencies and specifically designed to provide information to one or more law enforcement agencies regarding the physical or mental status of one or more individual subjects.

(c) Personal information contained within public records, the disclosure of which would constitute a

clearly unwarranted invasion of personal privacy, unless the disclosure is consented to in writing by the individual subjects of the information. "Unwarranted invasion of personal privacy" means the disclosure of information that is highly personal or objectionable to a reasonable person and in which the subject's right to privacy outweighs any legitimate public interest in obtaining the information. The disclosure of information that bears on the public duties of public employees and officials shall not be considered an invasion of personal privacy.

(d) Records in the possession of any public body created in the course of administrative enforcement proceedings, and any law enforcement or correctional agency for law enforcement purposes, but only to the extent that disclosure would:

(i) interfere with pending or actually and reasonably contemplated law enforcement proceedings conducted by any law enforcement or correctional agency that is the recipient of the request;

(ii) interfere with active administrative enforcement proceedings conducted by the public body that is the recipient of the request;

(iii) create a substantial likelihood that a person will be deprived of a fair trial or an impartial hearing;

(iv) unavoidably disclose the identity of a confidential source, confidential information furnished only by the confidential source, or persons who file complaints with or provide information to administrative, investigative, law enforcement, or penal agencies; except that the identities of witnesses to traffic crashes, traffic crash reports, and rescue reports shall be provided by agencies of local government, except when disclosure would interfere with an active criminal investigation conducted by the agency that is the recipient of the request;

(v) disclose unique or specialized investigative techniques other than those generally used and known or disclose internal documents of correctional agencies related to detection, observation, or investigation of incidents of crime or misconduct, and disclosure would result in demonstrable harm to the agency or public body that is the recipient of the request;

(vi) endanger the life or physical safety of law enforcement personnel or any other person; or

(vii) obstruct an ongoing criminal investigation by the agency that is the recipient of the request.

(d-5) A law enforcement record created for law enforcement purposes and contained in a shared electronic

record management system if the law enforcement agency or criminal justice agency that is the recipient of the request did not create the record, did not participate in or have a role in any of the events which are the subject of the record, and only has access to the record through the shared electronic record management system. As used in this subsection (d-5), "criminal justice agency" means the Illinois Criminal Justice Information Authority or the Illinois Sentencing Policy Advisory Council.

(d-6) Records contained in the Officer Professional Conduct Database under Section 9.2 of the Illinois Police Training Act, except to the extent authorized under that Section. This includes the documents supplied to the Illinois Law Enforcement Training Standards Board from the Illinois State Police and Illinois State Police Merit Board.

(d-7) Information gathered or records created from the use of automatic license plate readers in connection with Section 2-130 of the Illinois Vehicle Code.

(e) Records that relate to or affect the security of correctional institutions and detention facilities.

(e-5) Records requested by persons committed to the Department of Corrections, Department of Human Services ~~Division of Mental Health~~, or a county jail if those materials are available in the library of the correctional institution or facility or jail where the inmate is

confined.

(e-6) Records requested by persons committed to the Department of Corrections, Department of Human Services ~~Division of Mental Health~~, or a county jail if those materials include records from staff members' personnel files, staff rosters, or other staffing assignment information.

(e-7) Records requested by persons committed to the Department of Corrections or Department of Human Services ~~Division of Mental Health~~ if those materials are available through an administrative request to the Department of Corrections or Department of Human Services ~~Division of Mental Health~~.

(e-8) Records requested by a person committed to the Department of Corrections, Department of Human Services ~~Division of Mental Health~~, or a county jail, the disclosure of which would result in the risk of harm to any person or the risk of an escape from a jail or correctional institution or facility.

(e-9) Records requested by a person in a county jail or committed to the Department of Corrections or Department of Human Services ~~Division of Mental Health~~, containing personal information pertaining to the person's victim or the victim's family, including, but not limited to, a victim's home address, home telephone number, work or school address, work telephone number, social security

number, or any other identifying information, except as may be relevant to a requester's current or potential case or claim.

(e-10) Law enforcement records of other persons requested by a person committed to the Department of Corrections, Department of Human Services ~~Division of Mental Health~~, or a county jail, including, but not limited to, arrest and booking records, mug shots, and crime scene photographs, except as these records may be relevant to the requester's current or potential case or claim.

(f) Preliminary drafts, notes, recommendations, memoranda, and other records in which opinions are expressed, or policies or actions are formulated, except that a specific record or relevant portion of a record shall not be exempt when the record is publicly cited and identified by the head of the public body. The exemption provided in this paragraph (f) extends to all those records of officers and agencies of the General Assembly that pertain to the preparation of legislative documents.

(g) Trade secrets and commercial or financial information obtained from a person or business where the trade secrets or commercial or financial information are furnished under a claim that they are proprietary, privileged, or confidential, and that disclosure of the trade secrets or commercial or financial information would

cause competitive harm to the person or business, and only insofar as the claim directly applies to the records requested.

The information included under this exemption includes all trade secrets and commercial or financial information obtained by a public body, including a public pension fund, from a private equity fund or a privately held company within the investment portfolio of a private equity fund as a result of either investing or evaluating a potential investment of public funds in a private equity fund. The exemption contained in this item does not apply to the aggregate financial performance information of a private equity fund, nor to the identity of the fund's managers or general partners. The exemption contained in this item does not apply to the identity of a privately held company within the investment portfolio of a private equity fund, unless the disclosure of the identity of a privately held company may cause competitive harm.

Nothing contained in this paragraph (g) shall be construed to prevent a person or business from consenting to disclosure.

(h) Proposals and bids for any contract, grant, or agreement, including information which if it were disclosed would frustrate procurement or give an advantage to any person proposing to enter into a contractor agreement with the body, until an award or final selection

is made. Information prepared by or for the body in preparation of a bid solicitation shall be exempt until an award or final selection is made.

(i) Valuable formulae, computer geographic systems, designs, drawings, and research data obtained or produced by any public body when disclosure could reasonably be expected to produce private gain or public loss. The exemption for "computer geographic systems" provided in this paragraph (i) does not extend to requests made by news media as defined in Section 2 of this Act when the requested information is not otherwise exempt and the only purpose of the request is to access and disseminate information regarding the health, safety, welfare, or legal rights of the general public.

(j) The following information pertaining to educational matters:

(i) test questions, scoring keys, and other examination data used to administer an academic examination;

(ii) information received by a primary or secondary school, college, or university under its procedures for the evaluation of faculty members by their academic peers;

(iii) information concerning a school or university's adjudication of student disciplinary cases, but only to the extent that disclosure would

unavoidably reveal the identity of the student; and

(iv) course materials or research materials used by faculty members.

(k) Architects' plans, engineers' technical submissions, and other construction related technical documents for projects not constructed or developed in whole or in part with public funds and the same for projects constructed or developed with public funds, including, but not limited to, power generating and distribution stations and other transmission and distribution facilities, water treatment facilities, airport facilities, sport stadiums, convention centers, and all government owned, operated, or occupied buildings, but only to the extent that disclosure would compromise security.

(l) Minutes of meetings of public bodies closed to the public as provided in the Open Meetings Act until the public body makes the minutes available to the public under Section 2.06 of the Open Meetings Act.

(m) Communications between a public body and an attorney or auditor representing the public body that would not be subject to discovery in litigation, and materials prepared or compiled by or for a public body in anticipation of a criminal, civil, or administrative proceeding upon the request of an attorney advising the public body, and materials prepared or compiled with

respect to internal audits of public bodies.

(n) Records relating to a public body's adjudication of employee grievances or disciplinary cases; however, this exemption shall not extend to the final outcome of cases in which discipline is imposed.

(o) Administrative or technical information associated with automated data processing operations, including, but not limited to, software, operating protocols, computer program abstracts, file layouts, source listings, object modules, load modules, user guides, documentation pertaining to all logical and physical design of computerized systems, employee manuals, and any other information that, if disclosed, would jeopardize the security of the system or its data or the security of materials exempt under this Section.

(p) Records relating to collective negotiating matters between public bodies and their employees or representatives, except that any final contract or agreement shall be subject to inspection and copying.

(q) Test questions, scoring keys, and other examination data used to determine the qualifications of an applicant for a license or employment.

(r) The records, documents, and information relating to real estate purchase negotiations until those negotiations have been completed or otherwise terminated. With regard to a parcel involved in a pending or actually

and reasonably contemplated eminent domain proceeding under the Eminent Domain Act, records, documents, and information relating to that parcel shall be exempt except as may be allowed under discovery rules adopted by the Illinois Supreme Court. The records, documents, and information relating to a real estate sale shall be exempt until a sale is consummated.

(s) Any and all proprietary information and records related to the operation of an intergovernmental risk management association or self-insurance pool or jointly self-administered health and accident cooperative or pool. Insurance or self-insurance (including any intergovernmental risk management association or self-insurance pool) claims, loss or risk management information, records, data, advice, or communications.

(t) Information contained in or related to examination, operating, or condition reports prepared by, on behalf of, or for the use of a public body responsible for the regulation or supervision of financial institutions, insurance companies, or pharmacy benefit managers, unless disclosure is otherwise required by State law.

(u) Information that would disclose or might lead to the disclosure of secret or confidential information, codes, algorithms, programs, or private keys intended to be used to create electronic signatures under the Uniform

Electronic Transactions Act.

(v) Vulnerability assessments, security measures, and response policies or plans that are designed to identify, prevent, or respond to potential attacks upon a community's population or systems, facilities, or installations, but only to the extent that disclosure could reasonably be expected to expose the vulnerability or jeopardize the effectiveness of the measures, policies, or plans, or the safety of the personnel who implement them or the public. Information exempt under this item may include such things as details pertaining to the mobilization or deployment of personnel or equipment, to the operation of communication systems or protocols, to cybersecurity vulnerabilities, or to tactical operations.

(w) (Blank).

(x) Maps and other records regarding the location or security of generation, transmission, distribution, storage, gathering, treatment, or switching facilities owned by a utility, by a power generator, or by the Illinois Power Agency.

(y) Information contained in or related to proposals, bids, or negotiations related to electric power procurement under Section 1-75 of the Illinois Power Agency Act and Section 16-111.5 of the Public Utilities Act that is determined to be confidential and proprietary by the Illinois Power Agency or by the Illinois Commerce

Commission.

(z) Information about students exempted from disclosure under Section 10-20.38 or 34-18.29 of the School Code, and information about undergraduate students enrolled at an institution of higher education exempted from disclosure under Section 25 of the Illinois Credit Card Marketing Act of 2009.

(aa) Information the disclosure of which is exempted under the Viatical Settlements Act of 2009.

(bb) Records and information provided to a mortality review team and records maintained by a mortality review team appointed under the Department of Juvenile Justice Mortality Review Team Act.

(cc) Information regarding interments, entombments, or inurnments of human remains that are submitted to the Cemetery Oversight Database under the Cemetery Care Act or the Cemetery Oversight Act, whichever is applicable.

(dd) Correspondence and records (i) that may not be disclosed under Section 11-9 of the Illinois Public Aid Code or (ii) that pertain to appeals under Section 11-8 of the Illinois Public Aid Code.

(ee) The names, addresses, or other personal information of persons who are minors and are also participants and registrants in programs of park districts, forest preserve districts, conservation districts, recreation agencies, and special recreation

associations.

(ff) The names, addresses, or other personal information of participants and registrants in programs of park districts, forest preserve districts, conservation districts, recreation agencies, and special recreation associations where such programs are targeted primarily to minors.

(gg) Confidential information described in Section 1-100 of the Illinois Independent Tax Tribunal Act of 2012.

(hh) The report submitted to the State Board of Education by the School Security and Standards Task Force under item (8) of subsection (d) of Section 2-3.160 of the School Code and any information contained in that report.

(ii) Records requested by persons committed to or detained by the Department of Human Services under the Sexually Violent Persons Commitment Act or committed to the Department of Corrections under the Sexually Dangerous Persons Act if those materials: (i) are available in the library of the facility where the individual is confined; (ii) include records from staff members' personnel files, staff rosters, or other staffing assignment information; or (iii) are available through an administrative request to the Department of Human Services or the Department of Corrections.

(jj) Confidential information described in Section

5-535 of the Civil Administrative Code of Illinois.

(kk) The public body's credit card numbers, debit card numbers, bank account numbers, Federal Employer Identification Number, security code numbers, passwords, and similar account information, the disclosure of which could result in identity theft or impression or defrauding of a governmental entity or a person.

(ll) Records concerning the work of the threat assessment team of a school district, including, but not limited to, any threat assessment procedure under the School Safety Drill Act and any information contained in the procedure.

(mm) Information prohibited from being disclosed under subsections (a) and (b) of Section 15 of the Student Confidential Reporting Act.

(nn) Proprietary information submitted to the Environmental Protection Agency under the Drug Take-Back Act.

(oo) Records described in subsection (f) of Section 3-5-1 of the Unified Code of Corrections.

(pp) Any and all information regarding burials, interments, or entombments of human remains as required to be reported to the Department of Natural Resources pursuant either to the Archaeological and Paleontological Resources Protection Act or the Human Remains Protection Act.

(qq) Reports described in subsection (e) of Section 16-15 of the Abortion Care Clinical Training Program Act.

(rr) Information obtained by a certified local health department under the Access to Public Health Data Act.

(ss) For a request directed to a public body that is also a HIPAA-covered entity, all information that is protected health information, including demographic information, that may be contained within or extracted from any record held by the public body in compliance with State and federal medical privacy laws and regulations, including, but not limited to, the Health Insurance Portability and Accountability Act and its regulations, 45 CFR Parts 160 and 164. As used in this paragraph, "HIPAA-covered entity" has the meaning given to the term "covered entity" in 45 CFR 160.103 and "protected health information" has the meaning given to that term in 45 CFR 160.103.

(tt) Proposals or bids submitted by engineering consultants in response to requests for proposal or other competitive bidding requests by the Department of Transportation or the Illinois Toll Highway Authority.

(uu) Documents that, pursuant to the State of Illinois' 1987 Agreement with the U.S. Nuclear Regulatory Commission and the corresponding requirement to maintain compatibility with the National Materials Program, have been determined to be security sensitive. These documents

include information classified as safeguards, safeguards-modified, and sensitive unclassified nonsafeguards information, as identified in U.S. Nuclear Regulatory Commission regulatory information summaries, security advisories, and other applicable communications or regulations related to the control and distribution of security sensitive information.

(1.5) Any information exempt from disclosure under the Judicial Privacy Act shall be redacted from public records prior to disclosure under this Act.

(1.6) Any information exempt from disclosure under the Public Official Safety and Privacy Act shall be redacted from public records prior to disclosure under this Act.

(1.7) Any information exempt from disclosure under paragraph (3.5) of Section 9-15 of the Election Code shall be redacted from public records prior to disclosure under this Act.

(2) A public record that is not in the possession of a public body but is in the possession of a party with whom the agency has contracted to perform a governmental function on behalf of the public body, and that directly relates to the governmental function and is not otherwise exempt under this Act, shall be considered a public record of the public body, for purposes of this Act.

(3) This Section does not authorize withholding of information or limit the availability of records to the

public, except as stated in this Section or otherwise provided in this Act.

(Source: P.A. 103-154, eff. 6-30-23; 103-423, eff. 1-1-24; 103-446, eff. 8-4-23; 103-462, eff. 8-4-23; 103-540, eff. 1-1-24; 103-554, eff. 1-1-24; 103-605, eff. 7-1-24; 103-865, eff. 1-1-25; 104-300, eff. 1-1-27; 104-438, eff. 1-1-26; 104-443, eff. 1-1-26; revised 1-7-26.)

Section 10. The Youth Homelessness Prevention Subcommittee Act is amended by changing Sections 5 and 15 as follows:

(15 ILCS 60/5)

Sec. 5. Legislative findings. The General Assembly finds that 1 in 10 young people ages 18-25 experience a form of homelessness over a 12-month period. Also 1 in 30 youths ages 13-17 experience a form of homelessness over a 12-month period. Homelessness disproportionately impacts African-American youth and mirrors the racial disparities in school suspensions, incarceration rates, and foster care placement. Youth who have interacted with State systems of care, such as the Department of Children and Family Services, the Department of Juvenile Justice, the Department of Human Services ~~Services' Division of Mental Health~~, and the Department of Corrections, and youth who have been hospitalized for mental health problems are disproportionately overrepresented in the population of people experiencing

homelessness. The U.S. Department of Education classifies youth living "doubled up" as homeless. "Doubled up" is a term that refers to a situation where individuals are unable to maintain their own housing situation and are forced to stay with a series of friends or extended family members. The individual has no right or authority over the housing. The "homes" of such individuals are often unstable, not permanent, and can be as dangerous as living on the streets. As a result, doubled up housing situations are potentially detrimental to the health and well-being of these homeless youth. A study conducted by the U.S. Bureau of Justice Statistics found that 12% of prisoners were homeless at the time of their arrest. Similarly, a national survey of jail inmates concluded that more than 15% of the jail population had been homeless at some point in the preceding year, a rate 8 to 11 times the national average. Illinois needs a cohesive strategy across our child welfare, mental health, corrections, and human services agencies that is designed to reduce the rates of homelessness among youth and to lessen the likelihood of youth experiencing chronic homelessness into adulthood.

(Source: P.A. 101-98, eff. 1-1-20.)

(15 ILCS 60/15)

Sec. 15. Duties. The Youth Homelessness Prevention Subcommittee shall:

(1) Review the discharge planning, service plans, and

discharge procedures for youth leaving the custody or guardianship of the Department of Children and Family Services, the Department of Juvenile Justice, the Department of Human Services ~~Services' Division of Mental Health~~, and the Department of Corrections to determine whether such discharge planning and procedures ensure housing stability for youth leaving State systems of care.

(2) Collect data on the housing stability of youth for one year after they are released from the custody or guardianship of the Department of Children and Family Services, the Department of Juvenile Justice, the Department of Human Services ~~Services' Division of Mental Health~~, or the Department of Corrections.

(3) Based on data collected under paragraph (2) regarding youth experiencing homelessness after leaving State systems of care, create a plan to improve discharge policies and procedures to ensure housing stability for youth leaving State systems of care.

(4) Provide recommendations on community plans for sustainable housing; create education and employment plans for homeless youth; and create strategic collaborations between the Department of Children and Family Services, the Department of Juvenile Justice, the Department of Human Services ~~Services' Division of Mental Health~~, and the Department of Corrections with respect to youth leaving State systems of care.

(Source: P.A. 101-98, eff. 1-1-20.)

Section 15. The Substance Use Disorder Act is amended by changing Sections 1-10, 50-10, and 55-30 as follows:

(20 ILCS 301/1-10)

Sec. 1-10. Definitions. As used in this Act, unless the context clearly indicates otherwise, the following words and terms have the following meanings:

"Case management" means a coordinated approach to the delivery of health and medical treatment, substance use disorder treatment, mental health treatment, and social services, linking patients with appropriate services to address specific needs and achieve stated goals. In general, case management assists patients with other disorders and conditions that require multiple services over extended periods of time and who face difficulty in gaining access to those services.

"Crime of violence" means any of the following crimes: murder, voluntary manslaughter, criminal sexual assault, aggravated criminal sexual assault, predatory criminal sexual assault of a child, armed robbery, robbery, arson, kidnapping, aggravated battery, aggravated arson, or any other felony that involves the use or threat of physical force or violence against another individual.

"Department" means the Department of Human Services.

"DUI" means driving under the influence of alcohol or other drugs.

"Designated program" means a category of service authorized by an intervention license issued by the Department for delivery of all services as described in Article 40 in this Act.

"Early intervention" means services, authorized by a treatment license, that are sub-clinical and pre-diagnostic and that are designed to screen, identify, and address risk factors that may be related to problems associated with substance use disorders and to assist individuals in recognizing harmful consequences. Early intervention services facilitate emotional and social stability and involves referrals for treatment, as needed.

"Facility" means the building or premises are used for the provision of licensable services, including support services, as set forth by rule.

"Gambling disorder" means persistent and recurring maladaptive gambling behavior that disrupts personal, family, or vocational pursuits.

"Holds itself out" means any activity that would lead one to reasonably conclude that the individual or entity provides or intends to provide licensable substance-related disorder intervention or treatment services. Such activities include, but are not limited to, advertisements, notices, statements, or contractual arrangements with managed care organizations,

private health insurance, or employee assistance programs to provide services that require a license as specified in Article 15.

"Informed consent" means legally valid written consent, given by a client, patient, or legal guardian, that authorizes intervention or treatment services from a licensed organization and that documents agreement to participate in those services and knowledge of the consequences of withdrawal from such services. Informed consent also acknowledges the client's or patient's right to a conflict-free choice of services from any licensed organization and the potential risks and benefits of selected services.

"Intoxicated person" means a person whose mental or physical functioning is substantially impaired as a result of the current effects of alcohol or other drugs within the body.

"Medication assisted treatment" means the prescription of medications that are approved by the U.S. Food and Drug Administration and the Center for Substance Abuse Treatment to assist with treatment for a substance use disorder and to support recovery for individuals receiving services in a facility licensed by the Department. Medication assisted treatment includes opioid treatment services as authorized by a Department license.

"Off-site services" means licensable services are conducted at a location separate from the licensed location of the provider, and services are operated by an entity licensed

under this Act and approved in advance by the Department.

"Person" means any individual, firm, group, association, partnership, corporation, trust, government or governmental subdivision or agency.

"Prevention" means an interactive process of individuals, families, schools, religious organizations, communities and regional, state and national organizations whose goals are to reduce the prevalence of substance use disorders, prevent the use of illegal drugs and the abuse of legal drugs by persons of all ages, prevent the use of alcohol by minors, build the capacities of individuals and systems, and promote healthy environments, lifestyles, and behaviors.

"Recovery" means a process of change through which individuals improve their health and wellness, live a self-directed life, and reach their full potential.

"Recovery support" means services designed to support individual recovery from a substance use disorder that may be delivered pre-treatment, during treatment, or post treatment. These services may be delivered in a wide variety of settings for the purpose of supporting the individual in meeting his or her recovery support goals.

"Secretary" means the Secretary of the Department of Human Services or the Secretary's ~~his or her~~ designee.

"Substance use disorder" means a spectrum of persistent and recurring problematic behavior that encompasses 10 separate classes of drugs: alcohol; caffeine; cannabis;

hallucinogens; inhalants; opioids; sedatives, hypnotics and anxiolytics; stimulants; and tobacco; and other unknown substances leading to clinically significant impairment or distress.

"Treatment" means the broad range of emergency, outpatient, and residential care (including assessment, diagnosis, case management, treatment, and recovery support planning) may be extended to individuals with substance use disorders or to the families of those persons.

"Withdrawal management" means services designed to manage intoxication or withdrawal episodes (previously referred to as detoxification), interrupt the momentum of habitual, compulsive substance use and begin the initial engagement in medically necessary substance use disorder treatment. Withdrawal management allows patients to safely withdraw from substances in a controlled medically-structured environment.
(Source: P.A. 100-759, eff. 1-1-19.)

(20 ILCS 301/50-10)

Sec. 50-10. ~~Alcoholism and~~ Substance Use Disorder ~~Abuse~~ Fund. Monies received from the federal government, except monies received under the Block Grant for the prevention ~~Prevention~~ and treatment ~~Treatment~~ of substance use disorder ~~Alcoholism and Substance Abuse~~, and other gifts or grants made by any person or other organization or State entity to the fund shall be deposited into the Substance Use Disorder ~~Alcoholism~~

~~and Substance Abuse~~ Fund which is hereby created as a special fund in the State treasury. Monies in this fund shall be appropriated to the Department and expended for the purposes and activities specified by the person, organization or federal agency making the gift or grant.

(Source: P.A. 100-759, eff. 1-1-19.)

(20 ILCS 301/55-30)

Sec. 55-30. Rate increase.

(a) The Department shall by rule develop the increased rate methodology and annualize the increased rate beginning with State fiscal year 2018 contracts to licensed providers of community-based substance use disorder intervention or treatment, based on the additional amounts appropriated for the purpose of providing a rate increase to licensed providers. The Department shall adopt rules, including emergency rules under subsection (y) of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section.

(b) (Blank).

(c) Beginning on July 1, 2022, the Department ~~Division of Substance Use Prevention and Recovery~~ shall increase reimbursement rates for all community-based substance use disorder treatment and intervention services by 47%, including, but not limited to, all of the following:

(1) Admission and Discharge Assessment.

(2) Level 1 (Individual).

(3) Level 1 (Group).

(4) Level 2 (Individual).

(5) Level 2 (Group).

(6) Case Management.

(7) Psychiatric Evaluation.

(8) Medication Assisted Recovery.

(9) Community Intervention.

(10) Early Intervention (Individual).

(11) Early Intervention (Group).

Beginning in State Fiscal Year 2023, and every State fiscal year thereafter, reimbursement rates for those community-based substance use disorder treatment and intervention services shall be adjusted upward by an amount equal to the Consumer Price Index-U from the previous year, not to exceed 2% in any State fiscal year. If there is a decrease in the Consumer Price Index-U, rates shall remain unchanged for that State fiscal year. The Department shall adopt rules, including emergency rules in accordance with the Illinois Administrative Procedure Act, to implement the provisions of this Section.

As used in this Section, "Consumer Price Index-U" means the index published by the Bureau of Labor Statistics of the United States Department of Labor that measures the average change in prices of goods and services purchased by all urban consumers, United States city average, all items, 1982-84 =

100.

(d) Beginning on January 1, 2024, subject to federal approval, the Department ~~Division of Substance Use Prevention and Recovery~~ shall increase reimbursement rates for all ASAM level 3 residential/inpatient substance use disorder treatment and intervention services by 30%, including, but not limited to, the following services:

(1) ASAM level 3.5 Clinically Managed High-Intensity Residential Services for adults;

(2) ASAM level 3.5 Clinically Managed Medium-Intensity Residential Services for adolescents;

(3) ASAM level 3.2 Clinically Managed Residential Withdrawal Management;

(4) ASAM level 3.7 Medically Monitored Intensive Inpatient Services for adults and Medically Monitored High-Intensity Inpatient Services for adolescents; and

(5) ASAM level 3.1 Clinically Managed Low-Intensity Residential Services for adults and adolescents.

(e) Beginning in State fiscal year 2025, and every State fiscal year thereafter, reimbursement rates for licensed or certified substance use disorder treatment providers of ASAM Level 3 residential/inpatient services for persons with substance use disorders shall be adjusted upward by an amount equal to the Consumer Price Index-U from the previous year, not to exceed 2% in any State fiscal year. If there is a decrease in the Consumer Price Index-U, rates shall remain

unchanged for that State fiscal year. The Department shall adopt rules, including emergency rules, in accordance with the Illinois Administrative Procedure Act, to implement the provisions of this Section.

(Source: P.A. 102-699, eff. 4-19-22; 103-102, eff. 6-16-23; 103-588, eff. 6-5-24.)

Section 20. The Department of Human Services Act is amended by changing Sections 1-40 and 10-66 as follows:

(20 ILCS 1305/1-40)

Sec. 1-40. Substance use disorders; mental health; provider payments. For authorized Medicaid services to enrolled individuals, the Department's ~~Division of Substance Use Prevention and Recovery and Division of Mental Health~~ providers shall receive payment in accordance with the Illinois Public Aid Code for such authorized services, with payment occurring no later than in the next fiscal year.

(Source: P.A. 100-759, eff. 1-1-19.)

(20 ILCS 1305/10-66)

Sec. 10-66. Rate reductions. Rates for medical services purchased by ~~the Divisions of Substance Use Prevention and Recovery, Community Health and Prevention, Developmental Disabilities, Mental Health, or Rehabilitation Services within~~ the Department of Human Services shall not be reduced below

the rates calculated on April 1, 2011 unless the Department of Human Services promulgates rules and rules are implemented authorizing rate reductions.

(Source: P.A. 99-78, eff. 7-20-15; 100-759, eff. 1-1-19.)

Section 25. The Mental Health and Developmental Disabilities Administrative Act is amended by changing Sections 14, 18.4, and 75 as follows:

(20 ILCS 1705/14) (from Ch. 91 1/2, par. 100-14)

Sec. 14. Chester Mental Health Center. To maintain and operate a facility for the care, custody, and treatment of persons with mental illness or habilitation of persons with developmental disabilities hereinafter designated, to be known as the Chester Mental Health Center.

Within the Chester Mental Health Center there shall be confined the following classes of persons, whose history, in the opinion of the Department, discloses dangerous or violent tendencies and who, upon examination under the direction of the Department, have been found a fit subject for confinement in that facility:

(a) Any male person who is charged with the commission of a crime but has been acquitted by reason of insanity as provided in Section 5-2-4 of the Unified Code of Corrections.

(b) Any male person who is charged with the commission

of a crime but has been found unfit under Article 104 of the Code of Criminal Procedure of 1963.

(c) Any male person with mental illness or developmental disabilities or person in need of mental treatment now confined under the supervision of the Department or hereafter admitted to any facility thereof or committed thereto by any court of competent jurisdiction.

If and when it shall appear to the facility director of the Chester Mental Health Center that it is necessary to confine persons in order to maintain security or provide for the protection and safety of recipients and staff, the Chester Mental Health Center may confine all persons on a unit to their rooms. This period of confinement shall not exceed 10 hours in a 24 hour period, including the recipient's scheduled hours of sleep, unless approved by the Secretary of the Department. During the period of confinement, the persons confined shall be observed at least every 15 minutes. A record shall be kept of the observations. This confinement shall not be considered seclusion as defined in the Mental Health and Developmental Disabilities Code.

The facility director of the Chester Mental Health Center may authorize the temporary use of handcuffs on a recipient for a period not to exceed 10 minutes when necessary in the course of transport of the recipient within the facility to maintain custody or security. Use of handcuffs is subject to

the provisions of Section 2-108 of the Mental Health and Developmental Disabilities Code. The facility shall keep a monthly record listing each instance in which handcuffs are used, circumstances indicating the need for use of handcuffs, and time of application of handcuffs and time of release therefrom. The facility director shall allow the Illinois Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of the Protection and Advocacy for Persons with Developmental Disabilities Act, and the Department to examine and copy such record upon request.

The facility director of the Chester Mental Health Center may authorize the temporary use of transport devices on a civil recipient when necessary in the course of transport of the civil recipient outside the facility to maintain custody or security. The decision whether to use any transport devices shall be reviewed and approved on an individualized basis by a physician, an advanced practice registered nurse, or a physician assistant based upon a determination of the civil recipient's: (1) history of violence, (2) history of violence during transports, (3) history of escapes and escape attempts, (4) history of trauma, (5) history of incidents of restraint or seclusion and use of involuntary medication, (6) current functioning level and medical status, and (7) prior experience during similar transports, and the length, duration, and purpose of the transport. The least restrictive transport device consistent with the individual's need shall be used.

Staff transporting the individual shall be trained in the use of the transport devices, recognizing and responding to a person in distress, and shall observe and monitor the individual while being transported. The facility shall keep a monthly record listing all transports, including those transports for which use of transport devices was not sought, those for which use of transport devices was sought but denied, and each instance in which transport devices are used, circumstances indicating the need for use of transport devices, time of application of transport devices, time of release from those devices, and any adverse events. The facility director shall allow the Illinois Guardianship and Advocacy Commission, the agency designated by the Governor under Section 1 of the Protection and Advocacy for Persons with Developmental Disabilities Act, and the Department to examine and copy the record upon request. This use of transport devices shall not be considered restraint as defined in the Mental Health and Developmental Disabilities Code. For the purpose of this Section "transport device" means ankle cuffs, handcuffs, waist chains or wrist-waist devices designed to restrict an individual's range of motion while being transported. These devices must be approved by the Department ~~Division of Mental Health~~, used in accordance with the manufacturer's instructions, and used only by qualified staff members who have completed all training required to be eligible to transport patients and all other required training

relating to the safe use and application of transport devices, including recognizing and responding to signs of distress in an individual whose movement is being restricted by a transport device.

If and when it shall appear to the satisfaction of the Department that any person confined in the Chester Mental Health Center is not or has ceased to be such a source of danger to the public as to require his subjection to the regimen of the center, the Department is hereby authorized to transfer such person to any State facility for treatment of persons with mental illness or habilitation of persons with developmental disabilities, as the nature of the individual case may require.

Subject to the provisions of this Section, the Department, except where otherwise provided by law, shall, with respect to the management, conduct and control of the Chester Mental Health Center and the discipline, custody and treatment of the persons confined therein, have and exercise the same rights and powers as are vested by law in the Department with respect to any and all of the State facilities for treatment of persons with mental illness or habilitation of persons with developmental disabilities, and the recipients thereof, and shall be subject to the same duties as are imposed by law upon the Department with respect to such facilities and the recipients thereof.

The Department may elect to place persons who have been

ordered by the court to be detained under the Sexually Violent Persons Commitment Act in a distinct portion of the Chester Mental Health Center. The persons so placed shall be separated and shall not comingle with the recipients of the Chester Mental Health Center. The portion of Chester Mental Health Center that is used for the persons detained under the Sexually Violent Persons Commitment Act shall not be a part of the mental health facility for the enforcement and implementation of the Mental Health and Developmental Disabilities Code nor shall their care and treatment be subject to the provisions of the Mental Health and Developmental Disabilities Code. The changes added to this Section by this amendatory Act of the 98th General Assembly are inoperative on and after June 30, 2015.

(Source: P.A. 99-143, eff. 7-27-15; 99-581, eff. 1-1-17; 100-513, eff. 1-1-18.)

(20 ILCS 1705/18.4)

Sec. 18.4. Community Mental Health Medicaid Trust Fund; reimbursement.

(a) The Community Mental Health Medicaid Trust Fund is hereby created in the State Treasury.

(b) Amounts paid to the State during each State fiscal year by the federal government under Title XIX or Title XXI of the Social Security Act for services delivered by community mental health providers, and any interest earned thereon,

shall be deposited 100% into the Community Mental Health Medicaid Trust Fund. Not more than $4,500,000 of the Community Mental Health Medicaid Trust Fund may be used by the Department of Human Services' Division of Behavioral Health and Recovery ~~Mental Health~~ for oversight and administration of community mental health services, and of that amount no more than $1,000,000 may be used for the support of community mental health service initiatives. The remainder shall be used for the purchase of community mental health services.

(b-5) Whenever a State mental health facility operated by the Department is closed and the real estate on which the facility is located is sold by the State, the net proceeds of the sale of the real estate shall be deposited into the Community Mental Health Medicaid Trust Fund and used for the purposes enumerated in subsections (c) and (c-1) of Section 4.6 of the Community Services Act.

(c) The Department shall reimburse community mental health providers for services provided to eligible individuals. Moneys in the Trust Fund may be used for that purpose.

(c-5) The Community Mental Health Medicaid Trust Fund is not subject to administrative charge-backs.

(c-10) The Department of Human Services shall annually report to the Governor and the General Assembly, by September 1, on both the total revenue deposited into the Trust Fund and the total expenditures made from the Trust Fund for the previous fiscal year. This report shall include detailed

descriptions of both revenues and expenditures regarding the Trust Fund from the previous fiscal year. This report shall be presented by the Secretary of Human Services to the appropriate Appropriations Committee in the House of Representatives, as determined by the Speaker of the House, and in the Senate, as determined by the President of the Senate. This report shall be made available to the public and shall be published on the Department of Human Services' website in an appropriate location, a minimum of one week prior to presentation of the report to the General Assembly.

(d) As used in this Section:

"Trust Fund" means the Community Mental Health Medicaid Trust Fund.

"Community mental health provider" means a community agency that is funded by the Department to provide a service.

"Service" means a mental health service provided pursuant to the provisions of administrative rules adopted by the Department and funded by or claimed through the Department of Human Services ~~Services' Division of Mental Health~~.

(Source: P.A. 103-616, eff. 7-1-24.)

(20 ILCS 1705/75)

Sec. 75. Rate increase. Within 30 days after July 6, 2017 (the effective date of Public Act 100-23), the Department ~~Division of Mental Health~~ shall by rule develop the increased rate methodology and annualize the increased rate beginning

with State fiscal year 2018 contracts to certified community mental health centers, based on the additional amounts appropriated for the purpose of providing a rate increase to certified community mental health centers, with the annualization to be maintained in State fiscal year 2019. The Department shall adopt rules, including emergency rules under subsections (y) and (bb) of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section.

(Source: P.A. 100-23, eff. 7-6-17; 100-587, eff. 6-4-18.)

Section 30. The Blind Vendors Act is amended by changing Sections 5 and 30 as follows:

(20 ILCS 2421/5)

Sec. 5. Definitions. As used in this Act:

"Blind licensee" means a blind person licensed by the Department to operate a vending facility on State, federal, or other property.

"Blind person" means a person whose central visual acuity does not exceed 20/200 in the better eye with correcting lenses or whose visual acuity, if better than 20/200, is accompanied by a limit to the field of vision in the better eye to such a degree that its widest diameter subtends an angle of no greater than 20 degrees. In determining whether an individual is blind, there shall be an examination by a

physician skilled in diseases of the eye, or by an optometrist, whichever the individual shall select.

"Building" means only the portion of a structure owned or leased by the State or any State agency.

"Cafeteria" means a food dispensing facility capable of providing a broad variety of prepared foods and beverages (including hot meals) primarily through the use of a line where the customer serves himself or herself from displayed selections. A cafeteria may be fully automatic or some limited waiter or waitress service may be available and provided within a cafeteria and table or booth seating facilities are always provided.

"Committee" means the Illinois Committee of Blind Vendors, an independent representative body for blind vendors established by the federal Randolph-Sheppard Act.

"Department" means the Department of Human Services.

"Director" means the Bureau Director of the Bureau for the Blind in the Department of Human Services.

"Federal property" means any structure, land, or other real property owned, leased, or occupied by any department, agency or instrumentality of the United States (including the Department of Defense and the U.S. Postal Service), or any other instrumentality wholly owned by the United States, or by any department or agency of the District of Columbia or any territory or possession of the United States.

"License" means a written instrument issued by the

Department to a blind person, authorizing such person to operate a vending facility on State, federal, or other property.

"Net proceeds" means the amount remaining from the sale of articles or services of vending facilities, and any vending machine or other income accruing to blind vendors after deducting the cost of such sale and other expenses (excluding any set-aside charges required to be paid by the blind vendors).

"Normal working hours" means an 8-hour work period between the approximate hours of 8:00 a.m. to 6:00 p.m., Monday through Friday.

"Other property" means property that is not State or federal property and on which vending facilities are established or operated by the use of any funds derived in whole or in part, directly or indirectly, from the operation of vending facilities on any State or federal property.

"Priority" means the right of a blind person licensed by the Department of Human Services, Division of Rehabilitation Services, to operate a vending facility on any and all State property in the State of Illinois, in the same manner and to the same extent as the priority is provided to blind licensees on federal property under the Randolph-Sheppard Act, 20 U.S.C. 107, and federal regulations, 34 C.F.R. 395.30.

"Secretary" means the Secretary of Human Services.

"Set-aside funds" means funds that accrue to the

Department from an assessment against the net income of each vending facility in the State's vending facility program and any income from vending machines on State or federal property that accrues to the Department.

"State agency" means any department, board, commission, or agency created by the Constitution or Public Act, whether in the executive, legislative, or judicial branch.

"State property" means all property owned, leased, or rented by any State agency. For purposes of this Act, "State property" does not include property owned or controlled by a unit of local government, a public school district, or a public university, college, or community college.

"Vending facility" means automatic vending machines, snack bars, cart service, counters, rest areas, and such other appropriate auxiliary equipment that may be operated by blind vendors and that is necessary for the sale of newspapers, periodicals, confections, tobacco products, foods, beverages, and notions dispensed automatically or manually and prepared on or off the premises in accordance with all applicable health laws, and including the vending and payment of any lottery tickets or shares authorized by State law and conducted by a State agency within the State. "Vending facility" does not include cafeterias, restaurants, the Department of Corrections' non-vending machine commissaries, the Department of Juvenile Justice's non-vending machine commissaries, or commissaries and employment programs of the

Department of Human Services ~~Division of Mental Health or Division of Developmental Disabilities~~ that are operated by residents or State employees.

"Vending machine", for the purpose of assigning vending machine income under this Act, means a coin, currency, or debit card operated machine that dispenses articles or services, except that those machines operated by the United States Postal Service for the sale of postage stamps or other postal products and services, machines providing services of a recreational nature, and telephones shall not be considered to be vending machines.

"Vending machine income" means the commissions or fees paid to the State from vending machine operations on State property where the machines are operated, serviced, or maintained by, or with the approval of, a State agency by a commercial or not-for-profit vending concern that operates, services, and maintains vending machines.

"Vendor" means a blind licensee who is operating a vending facility on State, federal, or other property.

(Source: P.A. 96-644, eff. 1-1-10.)

(20 ILCS 2421/30)

Sec. 30. Vending machine income and compliance.

(a) Except as provided in subsections (b), (c), (d), (e), and (i) of this Section, after July 1, 2010, all vending machine income, as defined by this Act, from vending machines

on State property shall accrue to (1) the blind vendor operating the vending facilities on the property or (2) in the event there is no blind vendor operating a facility on the property, the Blind Vendors Trust Fund for use exclusively as set forth in subsection (a) of Section 25 of this Act.

(b) Notwithstanding the provisions of subsection (a) of this Section, all State university cafeterias and vending machines are exempt from this Act.

(c) Notwithstanding the provisions of subsection (a) of this Section, all vending facilities at the Governor Samuel H. Shapiro Developmental Center in Kankakee are exempt from this Act.

(d) Notwithstanding the provisions of subsection (a) of this Section, in the event there is no blind vendor operating a vending facility on the State property, all vending machine income, as defined in this Act, from vending machines on the State property of the Department of Corrections and the Department of Juvenile Justice shall accrue to the State agency and be allocated in accordance with the commissary provisions in the Unified Code of Corrections.

(e) Notwithstanding the provisions of subsection (a) of this Section, in the event a blind vendor is operating a vending facility on the State property of the Department of Corrections or the Department of Juvenile Justice, a commission shall be paid to the State agency equal to 10% of the net proceeds from vending machines servicing State

employees and 25% of the net proceeds from vending machines servicing visitors on the State property.

(f) The Secretary, directly or by delegation of authority, shall ensure compliance with this Section and Section 15 of this Act with respect to buildings, installations, facilities, roadside rest stops, and any other State property, and shall be responsible for the collection of, and accounting for, all vending machine income on this property. The Secretary shall enforce these provisions through litigation, arbitration, or any other legal means available to the State, and each State agency in control of this property shall be subject to the enforcement. State agencies or departments failing to comply with an order of the Department may be held in contempt in any court of general jurisdiction.

(g) Any limitation on the placement or operation of a vending machine by a State agency based on a determination that such placement or operation would adversely affect the interests of the State must be explained in writing to the Secretary. The Secretary shall promptly determine whether the limitation is justified. If the Secretary determines that the limitation is not justified, the State agency seeking the limitation shall immediately remove the limitation.

(h) The amount of vending machine income accruing from vending machines on State property that may be used for the functions of the Committee shall be determined annually by a two-thirds vote of the Committee, except that no more than 25%

of the annual vending machine income may be used by the Committee for this purpose, based upon the income accruing to the Blind Vendors Trust Fund in the preceding year. The Committee may establish its budget and expend funds through contract or otherwise without the approval of the Department.

(i) Notwithstanding the provisions of subsection (a) of this Section, with respect to vending machines located on any facility or property controlled or operated by the Department of Human Services ~~Division of Mental Health or the Division of Developmental Disabilities within the Department of Human Services~~:

(1) Any written contract in place as of the effective date of this Act between the Division and the Business Enterprise Program for the Blind shall be maintained and fully adhered to including any moneys paid to the individual facilities.

(2) With respect to existing vending machines with no written contract or agreement in place as of the effective date of this Act between the Division and a private vendor, bottler, or vending machine supplier, the Business Enterprise Program for the Blind has the right to provide the vending services as provided in this Act, provided that the blind vendor must provide 10% of gross sales from those machines to the individual facilities.

(Source: P.A. 99-78, eff. 7-20-15.)

Section 35. The State Finance Act is amended by changing Section 5.13 as follows:

(30 ILCS 105/5.13) (from Ch. 127, par. 141.13)

Sec. 5.13. The ~~Alcoholism and~~ Substance Use Disorder ~~Abuse~~ Fund.

(Source: P.A. 83-969.)

Section 40. The Community Behavioral Health Center Infrastructure Act is amended by changing Section 5 as follows:

(30 ILCS 732/5)

Sec. 5. Definitions. In this Act:

"Behavioral health center site" means a physical site where a community behavioral health center shall provide behavioral healthcare services linked to a particular Department-contracted community behavioral healthcare provider, from which this provider delivers a Department-funded service and has the following characteristics:

(i) The site must be owned, leased, or otherwise controlled by a Department-funded provider.

(ii) A Department-funded provider may have multiple service sites.

(iii) A Department-funded provider may provide both

Medicaid and non-Medicaid services for which they are certified or approved at a certified site.

"Board" means the Capital Development Board.

"Community behavioral healthcare provider" includes, but is not limited to, Department-contracted prevention, intervention, or treatment care providers of services and supports for persons with mental health services, alcohol and substance abuse services, rehabilitation services, and early intervention services provided by a vendor.

For the purposes of this definition, "vendor" includes, but is not limited to, community providers, including community-based organizations that are licensed or certified to provide prevention, intervention, or treatment services and support for persons with mental illness or substance abuse problems in this State, that comply with applicable federal, State, and local rules and statutes, including, but not limited to, the following:

(A) Federal requirements:

(1) Block Grants for Community Mental Health Services, Subpart I & III, Part B, Title XIX, P.H.S. Act/45 CFR Part 96.

(2) Medicaid (42 U.S.C. 1396 (1996)).

(3) 42 CFR 440 (Services: General Provision) and 456 (Utilization Control) (1996).

(4) Health Insurance Portability and Accountability Act (HIPAA) as specified in 45 CFR

160.310.

(5) The Substance Abuse Prevention Block Grant Regulations (45 CFR Part 96).

(6) Program Fraud Civil Remedies Act of 1986 (45 CFR Part 79).

(7) Federal regulations regarding Opioid Maintenance Therapy (21 CFR 29) (21 CFR 1301-1307 (D.E.A.)).

(8) Federal regulations regarding Diagnostic, Screening, Prevention, and Rehabilitation Services (Medicaid) (42 CFR 440.130).

(9) Charitable Choice: Providers that qualify as religious organizations under 42 CFR 54.2(b), who comply with the Charitable Choice Regulations as set forth in 42 CFR 54.1 et seq. with regard to funds provided directly to pay for substance abuse prevention and treatment services.

(B) State requirements:

(1) 59 Ill. Adm. Code 50, Office of Inspector General Investigations of Alleged Abuse or Neglect in State-Operated Facilities and Community Agencies.

(2) (Blank).

(3) 59 Ill. Adm. Code 103, Grants.

(4) 59 Ill. Adm. Code 115, Standards and Licensure Requirements for Community-Integrated Living Arrangements.

(5) 59 Ill. Adm. Code 117, Family Assistance and Home-Based Support Programs for Persons with Mental Disabilities.

(6) 59 Ill. Adm. Code 125, Recipient Discharge/Linkage/Aftercare.

(7) (Blank). ~~59 Ill. Adm. Code 131, Children's Mental Health Screening, Assessment and Supportive Services Program.~~

(8) 59 Ill. Adm. Code 132, ~~Medicaid~~ Community Mental Health Services Program.

(9) (Blank).

(10) 89 Ill. Adm. Code 140, Medical Payment.

(11) (Blank). ~~89 Ill. Adm. Code 140.642, Screening Assessment for Nursing Facility and Alternative Residential Settings and Services.~~

(12) 89 Ill. Adm. Code 507, Audit Requirements of Illinois Department of Human Services.

(13) 89 Ill. Adm. Code 509, Fiscal/Administrative Recordkeeping and Requirements.

(14) 89 Ill. Adm. Code 511, Grants and Grant Funds Recovery.

(15) (Blank). ~~77 Ill. Adm. Code Parts 2030, 2060, and 2090.~~

(16) Title 77 Illinois Administrative Code:

(a) Part 630: Maternal and Child Health Services Code.

(b) Part 635: Family Planning Services Code.

(c) Part 672: WIC Vendor Management Code.

(d) Part 2030: Award and Monitoring of Funds.

(d-1) Part 2060: Substance Use Disorder Treatment and Intervention Services.

(d-2) Part 2090: Subacute Alcoholism and Substance Abuse Treatment Services.

(e) Part 2200: School Based/Linked Health Centers.

(17) Title 89 Illinois Administrative Code:

(a) Section 130.200: Domestic Violence Shelter and Service Programs.

(b) Part 310: Delivery of Youth Services Funded by the Department of Human Services.

(c) Part 313: Community Services.

(d) Part 334: Administration and Funding of Community-Based Services to Youth.

(e) Part 500: Early Intervention Program.

(f) Part 501: Partner Abuse Intervention.

(18) State statutes:

(a) The Mental Health and Developmental Disabilities Code.

(b) The Community Services Act.

(c) The Mental Health and Developmental Disabilities Confidentiality Act.

(d) The Substance Use Disorder Act.

(e) The Early Intervention Services System Act.

(f) The Children and Family Services Act.

(g) The Illinois Commission on Volunteerism and Community Services Act.

(h) The Department of Human Services Act.

(i) The Domestic Violence Shelters Act.

(j) The Illinois Youthbuild Act.

(k) The Civil Administrative Code of Illinois.

(l) The Illinois Grant Funds Recovery Act.

(m) The Child Care Act of 1969.

(n) The Solicitation for Charity Act.

(o) Sections 9-1, 12-4.5 through 12-4.7, and 12-13 of the Illinois Public Aid Code.

(p) The Abused and Neglected Child Reporting Act.

(q) The Charitable Trust Act.

(C) The Provider shall be in compliance with all applicable requirements for services and service reporting as specified by the Department. ~~in the following Department manuals or handbooks:~~

~~(1) DHS/DMH Provider Manual.~~

~~(2) DHS Mental Health CSA Program Manual.~~

~~(3) DHS/DMH PAS/MH Manual.~~

~~(4) Community Forensic Services Handbook.~~

~~(5) Community Mental Health Service Definitions~~

~~and Reimbursement Guide.~~

~~(6) DHS/DMH Collaborative Provider Manual.~~

~~(7) Handbook for Providers of Screening Assessment and Support Services, Chapter CMH-200 Policy and Procedures For Screening, Assessment and Support Services.~~

~~(8) DHS Division of Substance Use Prevention and Recovery:~~

~~(a) Contractual Policy Manual.~~

~~(b) Medicaid Handbook.~~

~~(c) DARTS Manual.~~

~~(9) Division of Substance Use Prevention and Recovery Best Practice Program Guidelines for Specific Populations.~~

~~(10) Division of Substance Use Prevention and Recovery Contract Program Manual.~~

"Community behavioral healthcare services" means any of the following:

(i) Behavioral health services, including, but not limited to, prevention, intervention, or treatment care services and support for eligible persons provided by a vendor of the Department.

(ii) Referrals to providers of medical services and other health-related services, including substance abuse and mental health services.

(iii) Patient case management services, including

counseling, referral, and follow-up services, and other services designed to assist community behavioral health center patients in establishing eligibility for and gaining access to federal, State, and local programs that provide or financially support the provision of medical, social, educational, or other related services.

(iv) Services that enable individuals to use the services of the behavioral health center including outreach and transportation services and, if a substantial number of the individuals in the population are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of those individuals.

(v) Education of patients and the general population served by the community behavioral health center regarding the availability and proper use of behavioral health services.

(vi) Additional behavioral healthcare services consisting of services that are appropriate to meet the health needs of the population served by the behavioral health center involved and that may include housing assistance.

"Department" means the Department of Human Services.

"Uninsured population" means persons who do not own private healthcare insurance, are not part of a group insurance plan, and are not eligible for any State or federal

government-sponsored healthcare program.

(Source: P.A. 103-154, eff. 6-30-23.)

Section 45. The Community Partnership for Deflection and Substance Use Disorder Treatment Act is amended by changing Section 25 as follows:

(50 ILCS 71/25) (was 5 ILCS 820/25)

Sec. 25. Reporting and evaluation.

(a) The Illinois Criminal Justice Information Authority, in conjunction with an association representing police chiefs and the Department of Human Services' Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery, shall within 6 months of the effective date of this Act:

(1) develop a set of minimum data to be collected from each deflection program and reported annually, beginning one year after the effective date of this Act, by the Illinois Criminal Justice Information Authority, including, but not limited to, demographic information on program participants, number of law enforcement encounters that result in a treatment referral, and time from law enforcement encounter to treatment engagement; and

(2) develop a performance measurement system, including key performance indicators for deflection programs including, but not limited to, rate of treatment engagement at 30 days from the point of initial contact.

Each program that receives funding for services under Section 35 of this Act shall include the performance measurement system in its local plan and report data quarterly to the Illinois Criminal Justice Information Authority for the purpose of evaluation of deflection programs in aggregate.

(b) The Illinois Criminal Justice Information Authority shall make statistical data collected under subsection (a) of this Section available to the Department of Human Services, Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery for inclusion in planning efforts for services to persons with criminal justice or law enforcement involvement.
(Source: P.A. 100-1025, eff. 1-1-19.)

Section 50. The Drug School Act is amended by changing Sections 10, 15, and 40 as follows:

(55 ILCS 130/10)

Sec. 10. Definition. As used in this Act, "drug school" means a drug intervention and education program established and administered by the State's Attorney's Office of a particular county as an alternative to traditional prosecution. A drug school shall include, but not be limited to, the following core components:

(1) No less than 10 and no more than 20 hours of drug education delivered by an organization licensed, certified

or otherwise authorized by the Illinois Department of Human Services~~, Division of Substance Use Prevention and Recovery~~ to provide treatment, intervention, education or other such services. This education is to be delivered at least once per week at a class of no less than one hour and no greater than 4 hours, and with a class size no larger than 40 individuals.

(2) Curriculum designed to present the harmful effects of drug use on the individual, family and community, including the relationship between drug use and criminal behavior, as well as instruction regarding the application procedure for the sealing and expungement of records of arrest and any other record of the proceedings of the case for which the individual was mandated to attend the drug school.

(3) Education regarding the practical consequences of conviction and continued justice involvement. Such consequences of drug use will include the negative physiological, psychological, societal, familial, and legal areas. Additionally, the practical limitations imposed by a drug conviction on one's vocational, educational, financial, and residential options will be addressed.

(4) A process for monitoring and reporting attendance such that the State's Attorney in the county where the drug school is being operated is informed of class

attendance no more than 48 hours after each class.

(5) A process for capturing data on drug school participants, including but not limited to total individuals served, demographics of those individuals, rates of attendance, and frequency of future justice involvement for drug school participants and other data as may be required by the Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery.

(Source: P.A. 100-759, eff. 1-1-19.)

(55 ILCS 130/15)

Sec. 15. Authorization.

(a) Each State's Attorney may establish a drug school operated under the terms of this Act. The purpose of the drug school shall be to provide an alternative to prosecution by identifying drug-involved individuals for the purpose of intervening with their drug use before their criminal involvement becomes severe. The State's Attorney shall identify criteria to be used in determining eligibility for the drug school. Only those participants who successfully complete the requirements of the drug school, as certified by the State's Attorney, are eligible to apply for the sealing and expungement of records of arrest and any other record of the proceedings of the case for which the individual was mandated to attend the drug school.

(b) A State's Attorney seeking to establish a drug school

may apply to the Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery of the Illinois Department of Human Services for funding to establish and operate a drug school within his or her respective county. Nothing in this subsection shall prevent State's Attorneys from establishing drug schools within their counties without funding from the Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery.

(c) Nothing in this Act shall prevent 2 or more State's Attorneys from applying jointly for funding as provided in subsection (b) for the purpose of establishing a drug school that serves multiple counties.

(d) Drug schools established through funding from the Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery shall operate according to the guidelines established thereby and the provisions of this Act.

(Source: P.A. 100-759, eff. 1-1-19.)

(55 ILCS 130/40)

Sec. 40. Appropriations to the Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery.

(a) Moneys shall be appropriated to the Department of Human Services' Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery to enable the Division (i) to contract with Cook County, and (ii) counties other than Cook County to reimburse for services delivered in those counties under the

county Drug School program.

(b) The Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery shall establish rules and procedures for reimbursements paid to the Cook County Treasurer which are not subject to county appropriation and are not intended to supplant monies currently expended by Cook County to operate its drug school program. Cook County is required to maintain its efforts with regard to its drug school program.

(c) Expenditure of moneys under this Section is subject to audit by the Auditor General.

(d) In addition to reporting required by the Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery, State's Attorneys receiving monies under this Section shall each report separately to the General Assembly by January 1, 2008 and each and every following January 1 for as long as the services are in existence, detailing the need for continued services and contain any suggestions for changes to this Act.
(Source: P.A. 100-759, eff. 1-1-19.)

Section 60. The Behavioral Health Workforce Education Center of Illinois Act is amended by changing Section 65-25 as follows:

(110 ILCS 185/65-25)

Sec. 65-25. Selection process.

(a) No later than 90 days after the effective date of this

Act, the Board of Higher Education shall select a public institution of higher education, with input and assistance from the ~~Division of Mental Health of the~~ Department of Human Services, to administer the Behavioral Health Workforce Education Center of Illinois.

(b) The selection process shall articulate the principles of the Behavioral Health Workforce Education Center of Illinois, not inconsistent with this Act.

(c) The Board of Higher Education, with input and assistance from the ~~Division of Mental Health of the~~ Department of Human Services, shall make its selection of a public institution of higher education based on its ability and willingness to execute the following tasks:

(1) Convening academic institutions providing behavioral health education to:

(A) develop curricula to train future behavioral health professionals in evidence-based practices that meet the most urgent needs of Illinois' residents;

(B) build capacity to provide clinical training and supervision; and

(C) facilitate telehealth services to every region of the State.

(2) Functioning as a clearinghouse for research, education, and training efforts to identify and disseminate evidence-based practices across the State.

(3) Leveraging financial support from grants and

social impact loan funds.

(4) Providing infrastructure to organize regional behavioral health education and outreach. As budgets allow, this shall include conference and training space, research and faculty staff time, telehealth, and distance learning equipment.

(5) Working with regional hubs that assess and serve the workforce needs of specific, well-defined regions and specialize in specific research and training areas, such as telehealth or mental health-criminal justice partnerships, for which the regional hub can serve as a statewide leader.

(d) The Board of Higher Education may adopt such rules as may be necessary to implement and administer this Section.

(Source: P.A. 102-4, eff. 4-27-21.)

Section 65. The Specialized Mental Health Rehabilitation Act of 2013 is amended by changing Sections 2-103, 4-103, 4-105, and 4-106 as follows:

(210 ILCS 49/2-103)

Sec. 2-103. Staff training. Training for all new employees specific to the various levels of care offered by a facility shall be provided to employees during their orientation period and annually thereafter. Training shall be independent of the Department and overseen by the Illinois

Department of Human Services ~~Division of Mental Health~~ to determine the content of all facility employee training and to provide training for all trainers of facility employees. Training of employees shall be consistent with nationally recognized national accreditation standards as defined later in this Act. Training of existing staff of a recovery and rehabilitation support center shall be conducted in accordance with, and on the schedule provided in, the staff training plan approved by the Illinois Department of Human Services ~~Division of Mental Health~~. Training of existing staff for any other level of care licensed under this Act, including triage, crisis stabilization, and transitional living shall be completed at a facility prior to the implementation of that level of care. Training shall be required for all existing staff at a facility prior to the implementation of any new services authorized under this Act.

(Source: P.A. 100-365, eff. 8-25-17.)

(210 ILCS 49/4-103)

Sec. 4-103. Provisional licensure emergency rules. The Department, in consultation with the ~~Division of Mental Health of the~~ Department of Human Services and the Department of Healthcare and Family Services, is granted the authority under this Act to establish provisional licensure and licensing procedures by emergency rule. The Department shall file emergency rules concerning provisional licensure under this

Act within 120 days after the effective date of this Act. Rules governing the provisional license and licensing process shall contain rules for the different levels of care offered by the facilities authorized under this Act and shall address each type of care hereafter enumerated:

(1) triage centers;

(2) crisis stabilization;

(3) recovery and rehabilitation supports;

(4) transitional living units; or

(5) other intensive treatment and stabilization programs designed and developed in collaboration with the Department.

(Source: P.A. 98-104, eff. 7-22-13; 99-712, eff. 8-5-16.)

(210 ILCS 49/4-105)

Sec. 4-105. Provisional licensure duration. A provisional license shall be valid upon fulfilling the requirements established by the Department by emergency rule. The license shall remain valid as long as a facility remains in compliance with the licensure provisions established in rule. Provisional licenses issued upon initial licensure as a specialized mental health rehabilitation facility shall expire at the end of a 3-year period, which commences on the date the provisional license is issued. Issuance of a provisional license for any reason other than initial licensure (including, but not limited to, change of ownership, location, number of beds, or

services) shall not extend the maximum 3-year period, at the end of which a facility must be licensed pursuant to Section 4-201. An extension for 120 days may be granted if requested and approved by the Department. Notwithstanding any other provision of this Act or the Specialized Mental Health Rehabilitation Facilities Code, 77 Ill. Adm. Code 380, to the contrary, if a facility has received notice from the Department that its application for provisional licensure to provide recovery and rehabilitation services has been accepted as complete and the facility has attested in writing to the Department that it will comply with the staff training plan approved by the Illinois Department of Human Services ~~Division of Mental Health~~, then a provisional license for recovery and rehabilitation services shall be issued to the facility within 60 days after the Department determines that the facility is in compliance with the requirements of the Life Safety Code in accordance with Section 4-104.5 of this Act.

(Source: P.A. 103-1, eff. 4-27-23; 103-154, eff. 6-30-23.)

(210 ILCS 49/4-106)

Sec. 4-106. Provisional licensure outcomes. The Department of Healthcare and Family Services, in conjunction with the ~~Division of Mental Health of the~~ Department of Human Services and the Department of Public Health, shall establish a methodology by which financial and clinical data are reported and monitored from each program that is implemented

in a facility after the effective date of this Act. The Department of Healthcare and Family Services shall work in concert with a managed care entity, a care coordination entity, or an accountable care entity to gather the data necessary to report and monitor the progress of the services offered under this Act.

(Source: P.A. 98-104, eff. 7-22-13.)

Section 70. The Illinois Insurance Code is amended by changing Sections 356z.22, 356z.31, and 356z.36 as follows:

(215 ILCS 5/356z.22)

Sec. 356z.22. Coverage for telehealth services.

(a) For purposes of this Section:

"Asynchronous store and forward system" has the meaning given to that term in Section 5 of the Telehealth Act.

"Distant site" has the meaning given to that term in Section 5 of the Telehealth Act.

"E-visits" has the meaning given to that term in Section 5 of the Telehealth Act.

"Facility" means any hospital facility licensed under the Hospital Licensing Act or the University of Illinois Hospital Act, a federally qualified health center, a community mental health center, a behavioral health clinic, a substance use disorder treatment program licensed by the Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery of the

Department of Human Services, or other building, place, or institution that is owned or operated by a person that is licensed or otherwise authorized to deliver health care services.

"Health care professional" has the meaning given to that term in Section 5 of the Telehealth Act.

"Interactive telecommunications system" has the meaning given to that term in Section 5 of the Telehealth Act. As used in this Section, "interactive telecommunications system" does not include virtual check-ins.

"Originating site" has the meaning given to that term in Section 5 of the Telehealth Act.

"Telehealth services" has the meaning given to that term in Section 5 of the Telehealth Act. As used in this Section, "telehealth services" do not include asynchronous store and forward systems, remote patient monitoring technologies, e-visits, or virtual check-ins.

"Virtual check-in" has the meaning given to that term in Section 5 of the Telehealth Act.

(b) An individual or group policy of accident or health insurance that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall cover telehealth services, e-visits, and virtual check-ins rendered by a health care professional when clinically appropriate and medically necessary to insureds, enrollees, and members in the same manner as any

other benefits covered under the policy. An individual or group policy of accident or health insurance may provide reimbursement to a facility that serves as the originating site at the time a telehealth service is rendered.

(c) To ensure telehealth service, e-visit, and virtual check-in access is equitable for all patients in receipt of health care services under this Section and health care professionals and facilities are able to deliver medically necessary services that can be appropriately delivered via telehealth within the scope of their licensure or certification, coverage required under this Section shall comply with all of the following:

(1) An individual or group policy of accident or health insurance shall not:

(A) require that in-person contact occur between a health care professional and a patient before the provision of a telehealth service;

(B) require patients, health care professionals, or facilities to prove or document a hardship or access barrier to an in-person consultation for coverage and reimbursement of telehealth services, e-visits, or virtual check-ins;

(C) require the use of telehealth services, e-visits, or virtual check-ins when the health care professional has determined that it is not appropriate;

(D) require the use of telehealth services when a patient chooses an in-person consultation;

(E) require a health care professional to be physically present in the same room as the patient at the originating site, unless deemed medically necessary by the health care professional providing the telehealth service;

(F) create geographic or facility restrictions or requirements for telehealth services, e-visits, or virtual check-ins;

(G) require health care professionals or facilities to offer or provide telehealth services, e-visits, or virtual check-ins;

(H) require patients to use telehealth services, e-visits, or virtual check-ins, or require patients to use a separate panel of health care professionals or facilities to receive telehealth service, e-visit, or virtual check-in coverage and reimbursement; or

(I) impose upon telehealth services, e-visits, or virtual check-ins utilization review requirements that are unnecessary, duplicative, or unwarranted or impose any treatment limitations, prior authorization, documentation, or recordkeeping requirements that are more stringent than the requirements applicable to the same health care service when rendered in-person, except procedure code modifiers may be required to

document telehealth.

(2) Deductibles, copayments, coinsurance, or any other cost-sharing applicable to services provided through telehealth shall not exceed the deductibles, copayments, coinsurance, or any other cost-sharing required by the individual or group policy of accident or health insurance for the same services provided through in-person consultation.

(3) An individual or group policy of accident or health insurance shall notify health care professionals and facilities of any instructions necessary to facilitate billing for telehealth services, e-visits, and virtual check-ins.

(d) For purposes of reimbursement, an individual or group policy of accident or health insurance that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall reimburse an in-network health care professional or facility, including a health care professional or facility in a tiered network, for telehealth services provided through an interactive telecommunications system on the same basis, in the same manner, and at the same reimbursement rate that would apply to the services if the services had been delivered via an in-person encounter by an in-network or tiered network health care professional or facility. This subsection applies only to those services provided by telehealth that may otherwise be

billed as an in-person service. This subsection is inoperative on and after January 1, 2028, except that this subsection is operative after that date with respect to mental health and substance use disorder telehealth services.

(e) The Department and the Department of Public Health shall commission a report to the General Assembly administered by an established medical college in this State wherein supervised clinical training takes place at an affiliated institution that uses telehealth services, subject to appropriation. The report shall study the telehealth coverage and reimbursement policies established in subsections (b) and (d) of this Section, to determine if the policies improve access to care, reduce health disparities, promote health equity, have an impact on utilization and cost-avoidance, including direct or indirect cost savings to the patient, and to provide any recommendations for telehealth access expansion in the future. An individual or group policy of accident or health insurance shall provide data necessary to carry out the requirements of this subsection upon request of the Department. The Department and the Department of Public Health shall submit the report by December 31, 2026. The established medical college may utilize subject matter expertise to complete any necessary actuarial analysis.

(f) Nothing in this Section is intended to limit the ability of an individual or group policy of accident or health insurance and a health care professional or facility to

voluntarily negotiate alternate reimbursement rates for telehealth services. Such voluntary negotiations shall take into consideration the ongoing investment necessary to ensure these telehealth platforms may be continuously maintained, seamlessly updated, and integrated with a patient's electronic medical records.

(g) An individual or group policy of accident or health insurance that is amended, delivered, issued, or renewed on or after the effective date of this amendatory Act of the 102nd General Assembly shall provide coverage for telehealth services for licensed dietitian nutritionists and certified diabetes educators who counsel diabetes patients in the diabetes patients' homes to remove the hurdle of transportation for diabetes patients to receive treatment, in accordance with the Dietitian Nutritionist Practice Act.

(h) Any policy, contract, or certificate of health insurance coverage that does not distinguish between in-network and out-of-network health care professionals and facilities shall be subject to this Section as though all health care professionals and facilities were in-network.

(i) Health care professionals and facilities shall determine the appropriateness of specific sites, technology platforms, and technology vendors for a telehealth service, as long as delivered services adhere to all federal and State privacy, security, and confidentiality laws, rules, or regulations, including, but not limited to, the Health

Insurance Portability and Accountability Act of 1996 and the Mental Health and Developmental Disabilities Confidentiality Act.

(j) Nothing in this Section shall be deemed as precluding a health insurer from providing benefits for other telehealth services, including, but not limited to, services not required for coverage provided through an asynchronous store and forward system, remote patient monitoring services, other monitoring services, or oral communications otherwise covered under the policy.

(k) There shall be no restrictions on originating site requirements for telehealth coverage or reimbursement to the distant site under this Section other than requiring the telehealth services to be medically necessary and clinically appropriate.

(l) The Department may adopt rules, including emergency rules subject to the provisions of Section 5-45 of the Illinois Administrative Procedure Act, to implement the provisions of this Section.

(Source: P.A. 102-104, eff. 7-22-21.)

(215 ILCS 5/356z.31)

Sec. 356z.31. Recovery housing for persons with substance use disorders.

(a) Definitions. As used in this Section:

"Substance use disorder" and "case management" have the

meanings ascribed to those terms in Section 1-10 of the Substance Use Disorder Act.

"Hospital" means a facility licensed by the Department of Public Health under the Hospital Licensing Act.

"Federally qualified health center" means a facility as defined in Section 1905(l)(2)(B) of the federal Social Security Act.

"Recovery housing" means a residential extended care treatment facility or a recovery home as defined and licensed in 77 Illinois Administrative Code, Part 2060, by the Illinois Department of Human Services, Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery.

(b) A group or individual policy of accident and health insurance or managed care plan amended, delivered, issued, or renewed on or after January 1, 2019 (the effective date of Public Act 100-1065) may provide coverage for residential extended care services and supports for persons recovery housing for persons with substance use disorders who are at risk of a relapse following discharge from a health care clinic, federally qualified health center, hospital withdrawal management program or any other licensed withdrawal management program, or hospital emergency department so long as all of the following conditions are met:

(1) A health care clinic, federally qualified health center, hospital withdrawal management program or any other licensed withdrawal management program, or hospital

emergency department has conducted an individualized assessment, using criteria established by the American Society of Addiction Medicine, of the person's condition prior to discharge and has identified the person as being at risk of a relapse and in need of supportive services, including employment and training and case management, to maintain long-term recovery. A determination of whether a person is in need of supportive services shall also be based on whether the person has a history of poverty, job insecurity, and lack of a safe and sober living environment.

(2) The recovery housing is administered by a community-based agency that is licensed by or under contract with the Department of Human Services, Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery.

(3) The recovery housing is administered by a community-based agency as described in paragraph (2) upon the referral of a health care clinic, federally qualified health center, hospital withdrawal management program or any other licensed withdrawal management program, or hospital emergency department.

(c) Based on the individualized needs assessment, any coverage provided in accordance with this Section may include, but not be limited to, the following:

(1) Substance use disorder treatment services that are

in accordance with licensure standards promulgated by the Department of Human Services, Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery.

(2) Transitional housing services, including food or meal plans.

(3) Individualized case management and referral services, including case management and social services for the families of persons who are seeking treatment for a substance use disorder.

(4) Job training or placement services.

(d) The insurer may rate each community-based agency that is licensed by or under contract with the Department of Human Services, Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery to provide recovery housing based on an evaluation of each agency's ability to:

(1) reduce health care costs;

(2) reduce recidivism rates for persons suffering from a substance use disorder;

(3) improve outcomes;

(4) track persons with substance use disorders; and

(5) improve the quality of life of persons with substance use disorders through the utilization of sustainable recovery, education, employment, and housing services.

The insurer may publish the results of the ratings on its official website and shall, on an annual basis, update the

posted results.

(e) The Department of Insurance may adopt any rules necessary to implement the provisions of this Section in accordance with 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. 100-1065, eff. 1-1-19; 101-81, eff. 7-12-19.)

(215 ILCS 5/356z.36)

Sec. 356z.36. 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 ~~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 ~~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 January 1, 2020 (the effective date of Public Act 101-461), the Department of Insurance shall lead and convene a workgroup that includes the Department of

Human Services ~~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 January 1, 2020 (the effective date of Public Act 101-461), 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.

(Source: P.A. 101-461, eff. 1-1-20; 102-558, eff. 8-20-21.)

Section 75. The Pharmacy Practice Act is amended by changing Section 39.5 as follows:

(225 ILCS 85/39.5)

(Section scheduled to be repealed on January 1, 2028)

Sec. 39.5. Emergency kits.

(a) As used in this Section:

"Emergency kit" means a kit containing drugs that may be required to meet the immediate therapeutic needs of a patient and that are not available from any other source in sufficient time to prevent the risk of harm to a patient by delay resulting from obtaining the drugs from another source. An automated dispensing and storage system may be used as an emergency kit.

"Licensed facility" means an entity licensed under the Nursing Home Care Act, the Hospital Licensing Act, or the University of Illinois Hospital Act or a facility licensed under the Illinois Department of Human Services, ~~Division of Substance Use Prevention and Recovery,~~ for the prevention, intervention, treatment, and recovery support of substance use disorders or certified by the Illinois Department of Human Services~~, Division of Mental Health~~ for the treatment of mental health.

"Offsite institutional pharmacy" means: (1) a pharmacy that is not located in facilities it serves and whose primary purpose is to provide services to patients or residents of facilities licensed under the Nursing Home Care Act, the Hospital Licensing Act, or the University of Illinois Hospital Act; and (2) a pharmacy that is not located in the facilities it serves and the facilities it serves are licensed under the Illinois Department of Human Services~~, Division of Substance~~

~~Use Prevention and Recovery,~~ for the prevention, intervention, treatment, and recovery support of substance use disorders or certified under the Illinois Department of Human Services for the treatment of mental illnesses ~~health~~.

(b) An offsite institutional pharmacy may supply emergency kits to a licensed facility.

(Source: P.A. 101-649, eff. 7-7-20.)

Section 80. The Telehealth Act is amended by changing Section 5 as follows:

(225 ILCS 150/5)

Sec. 5. Definitions. As used in this Act:

"Asynchronous store and forward system" means the transmission of a patient's medical information through an electronic communications system at an originating site to a health care professional or facility at a distant site that does not require real-time or synchronous interaction between the health care professional and the patient.

"Distant site" means the location at which the health care professional rendering the telehealth service is located.

"Established patient" means a patient with a relationship with a health care professional in which there has been an exchange of an individual's protected health information for the purpose of providing patient care, treatment, or services.

"E-visit" means a patient-initiated non-face-to-face

communication through an online patient portal between an established patient and a health care professional.

"Facility" includes a facility that is owned or operated by a hospital under the Hospital Licensing Act or University of Illinois Hospital Act, a facility under the Nursing Home Care Act, a rural health clinic, a federally qualified health center, a local health department, a community mental health center, a behavioral health clinic as defined in 89 Ill. Adm. Code 140.453, an encounter rate clinic, a skilled nursing facility, a substance use treatment program licensed by the ~~Division of Substance Use Prevention and Recovery of the~~ Department of Human Services, a school-based health center as defined in 77 Ill. Adm. Code 641.10, a physician's office, a podiatrist's office, a supportive living program provider, a hospice provider, home health agency, or home nursing agency under the Home Health, Home Services, and Home Nursing Agency Licensing Act, a facility under the ID/DD Community Care Act, community-integrated living arrangements as defined in the Community-Integrated Living Arrangements Licensure and Certification Act, and a provider who receives reimbursement for a patient's room and board.

"Health care professional" includes, but is not limited to, physicians, physician assistants, optometrists, advanced practice registered nurses, clinical psychologists licensed in Illinois, prescribing psychologists licensed in Illinois, dentists, occupational therapists, pharmacists, physical

therapists, clinical social workers, speech-language pathologists, audiologists, hearing instrument dispensers, licensed certified substance use disorder treatment providers and clinicians, and mental health professionals and clinicians authorized by Illinois law to provide mental health services, and qualified providers listed under paragraph (8) of subsection (e) of Section 3 of the Early Intervention Services System Act, dietitian nutritionists licensed in Illinois, and health care professionals associated with a facility.

"Interactive telecommunications system" means an audio and video system, an audio-only telephone system (landline or cellular), or any other telecommunications system permitting 2-way, synchronous interactive communication between a patient at an originating site and a health care professional or facility at a distant site. "Interactive telecommunications system" does not include a facsimile machine, electronic mail messaging, or text messaging.

"Originating site" means the location at which the patient is located at the time telehealth services are provided to the patient via telehealth.

"Remote patient monitoring" means the use of connected digital technologies or mobile medical devices to collect medical and other health data from a patient at one location and electronically transmit that data to a health care professional or facility at a different location for collection and interpretation.

"Telehealth services" means the evaluation, diagnosis, or interpretation of electronically transmitted patient-specific data between a remote location and a licensed health care professional that generates interaction or treatment recommendations. "Telehealth services" includes telemedicine and the delivery of health care services, including mental health treatment and substance use disorder treatment and services to a patient, regardless of patient location, provided by way of an interactive telecommunications system, asynchronous store and forward system, remote patient monitoring technologies, e-visits, or virtual check-ins.

"Virtual check-in" means a brief patient-initiated communication using a technology-based service, excluding facsimile, between an established patient and a health care professional. "Virtual check-in" does not include communications from a related office visit provided within the previous 7 days, nor communications that lead to an office visit or procedure within the next 24 hours or soonest available appointment.

(Source: P.A. 101-81, eff. 7-12-19; 101-84, eff. 7-19-19; 102-104, eff. 7-22-21.)

Section 85. The Illinois Public Aid Code is amended by changing Sections 5-5.05f, 5-5.12, 5-5.12f, 5-5.23, 5-5.25, 5-44, 5-45, 5-47, and 5-50 as follows:

(305 ILCS 5/5-5.05f)

Sec. 5-5.05f. Medicaid coverage for peer recovery support services. On or before January 1, 2023, the Department shall seek approval from the federal Centers for Medicare and Medicaid Services to cover peer recovery support services under the medical assistance program when rendered by certified peer support specialists for the purposes of supporting the recovery of individuals receiving substance use disorder treatment. As used in this Section, "certified peer support specialist" means an individual who:

(1) is a self-identified current or former recipient of substance use disorder services who has the ability to support other individuals diagnosed with a substance use disorder;

(2) is affiliated with a substance use prevention and recovery provider agency that is licensed by the Department of Human Services ~~Services' Division of Substance Use Prevention and Recovery~~; and

(A) is certified in accordance with applicable State law to provide peer recovery support services in substance use disorder settings; or

(B) is certified as qualified to furnish peer support services under a certification process consistent with the National Practice Guidelines for Peer Supporters and inclusive of the core competencies identified by the Substance Abuse and Mental Health

Services Administration in the Core Competencies for Peer Workers in Behavioral Health Services.

(Source: P.A. 102-1037, eff. 6-2-22.)

(305 ILCS 5/5-5.12) (from Ch. 23, par. 5-5.12)

Sec. 5-5.12. Pharmacy payments.

(a) Every request submitted by a pharmacy for reimbursement under this Article for prescription drugs provided to a recipient of aid under this Article shall include the name of the prescriber or an acceptable identification number as established by the Department.

(b) Pharmacies providing prescription drugs under this Article shall be reimbursed at a rate which shall include a professional dispensing fee as determined by the Illinois Department, plus the current acquisition cost of the prescription drug dispensed. The Illinois Department shall update its information on the acquisition costs of all prescription drugs no less frequently than every 30 days. However, the Illinois Department may set the rate of reimbursement for the acquisition cost, by rule, at a percentage of the current average wholesale acquisition cost.

(c) (Blank).

(d) The Department shall review utilization of narcotic medications in the medical assistance program and impose utilization controls that protect against abuse.

(e) When making determinations as to which drugs shall be

on a prior approval list, the Department shall include as part of the analysis for this determination, the degree to which a drug may affect individuals in different ways based on factors including the gender of the person taking the medication.

(f) The Department shall cooperate with the Department of Public Health and the Department of Human Services ~~Division of Mental Health~~ in identifying psychotropic medications that, when given in a particular form, manner, duration, or frequency (including "as needed") in a dosage, or in conjunction with other psychotropic medications to a nursing home resident or to a resident of a facility licensed under the ID/DD Community Care Act or the MC/DD Act, may constitute a chemical restraint or an "unnecessary drug" as defined by the Nursing Home Care Act or Titles XVIII and XIX of the Social Security Act and the implementing rules and regulations. The Department shall require prior approval for any such medication prescribed for a nursing home resident or to a resident of a facility licensed under the ID/DD Community Care Act or the MC/DD Act, that appears to be a chemical restraint or an unnecessary drug. The Department shall consult with the Department of Human Services ~~Division of Mental Health~~ in developing a protocol and criteria for deciding whether to grant such prior approval.

(g) The Department may by rule provide for reimbursement of the dispensing of a 90-day supply of a generic or brand name, non-narcotic maintenance medication in circumstances

where it is cost effective.

(g-5) On and after July 1, 2012, the Department may require the dispensing of drugs to nursing home residents be in a 7-day supply or other amount less than a 31-day supply. The Department shall pay only one dispensing fee per 31-day supply.

(h) Effective July 1, 2011, the Department shall discontinue coverage of select over-the-counter drugs, including analgesics and cough and cold and allergy medications.

(h-5) On and after July 1, 2012, the Department shall impose utilization controls, including, but not limited to, prior approval on specialty drugs, oncolytic drugs, drugs for the treatment of HIV or AIDS, immunosuppressant drugs, and biological products in order to maximize savings on these drugs. The Department may adjust payment methodologies for non-pharmacy billed drugs in order to incentivize the selection of lower-cost drugs. For drugs for the treatment of AIDS, the Department shall take into consideration the potential for non-adherence by certain populations, and shall develop protocols with organizations or providers primarily serving those with HIV/AIDS, as long as such measures intend to maintain cost neutrality with other utilization management controls such as prior approval. For hemophilia, the Department shall develop a program of utilization review and control which may include, in the discretion of the

Department, prior approvals. The Department may impose special standards on providers that dispense blood factors which shall include, in the discretion of the Department, staff training and education; patient outreach and education; case management; in-home patient assessments; assay management; maintenance of stock; emergency dispensing timeframes; data collection and reporting; dispensing of supplies related to blood factor infusions; cold chain management and packaging practices; care coordination; product recalls; and emergency clinical consultation. The Department may require patients to receive a comprehensive examination annually at an appropriate provider in order to be eligible to continue to receive blood factor.

(i) 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.

(j) On and after July 1, 2012, the Department shall impose limitations on prescription drugs such that the Department shall not provide reimbursement for more than 4 prescriptions, including 3 brand name prescriptions, for distinct drugs in a 30-day period, unless prior approval is received for all prescriptions in excess of the 4-prescription limit. Drugs in the following therapeutic classes shall not be subject to prior approval as a result of the 4-prescription limit:

immunosuppressant drugs, oncolytic drugs, anti-retroviral drugs, and, on or after July 1, 2014, antipsychotic drugs. On or after July 1, 2014, the Department may exempt children with complex medical needs enrolled in a care coordination entity contracted with the Department to solely coordinate care for such children, if the Department determines that the entity has a comprehensive drug reconciliation program.

(k) No medication therapy management program implemented by the Department shall be contrary to the provisions of the Pharmacy Practice Act.

(l) Any provider enrolled with the Department that bills the Department for outpatient drugs and is eligible to enroll in the federal Drug Pricing Program under Section 340B of the federal Public Health Service Act shall enroll in that program. No entity participating in the federal Drug Pricing Program under Section 340B of the federal Public Health Service Act may exclude fee-for-service Medicaid from their participation in that program, however, entities defined in Section 1905(l)(2)(B) of the Social Security Act are excluded from this requirement. This subsection does not apply to outpatient drugs billed to Medicaid managed care organizations.

(Source: P.A. 102-558, eff. 8-20-21; 102-778, eff. 7-1-22.)

(305 ILCS 5/5-5.12f)

Sec. 5-5.12f. Prescription drugs for mental illness; no

utilization or prior approval mandates.

(a) Notwithstanding any other provision of this Code to the contrary, except as otherwise provided in subsection (b), for the purpose of removing barriers to the timely treatment of serious mental illnesses, prior authorization mandates and utilization management controls shall not be imposed under the fee-for-service and managed care medical assistance programs on any FDA-approved prescription drug that is recognized by a generally accepted standard medical reference as effective in the treatment of conditions specified in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association if a preferred or non-preferred drug is prescribed to an adult patient to treat serious mental illness and one of the following applies:

(1) the patient has changed providers, including, but not limited to, a change from an inpatient to an outpatient provider, and is stable on the drug that has been previously prescribed, and received prior authorization, if required;

(2) the patient has changed Medical assistance program or managed care plan coverage and is stable on the drug that has been previously prescribed and received prior authorization under the previous source of coverage; or

(3) subject to federal law on maximum dosage limits and safety edits adopted by the Department's Drug and

Therapeutics Board, including those safety edits and limits needed to comply with federal requirements contained in 42 CFR 456.703, the patient has previously been prescribed and obtained prior authorization for the drug and the prescription modifies the dosage, dosage frequency, or both, of the drug as part of the same treatment for which the drug was previously prescribed.

(b) The following safety edits shall be permitted for prescription drugs covered under this Section:

(1) clinically appropriate drug utilization review (DUR) edits, including, but not limited to, drug-to-drug, drug-age, and drug-dose;

(2) generic drug substitution if a generic drug is available for the prescribed medication in the same dosage and formulation; and

(3) any utilization management control that is necessary for the Department to comply with any current consent decrees or federal waivers.

(c) As used in this Section, "serious mental illness" means any one or more of the following diagnoses and International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) codes listed by the Department of Human Services' Division of Behavioral Health and Recovery ~~Services' Division of Mental Health~~, as amended, on its official website:

(1) Delusional Disorder (F22)

(2) Brief Psychotic Disorder (F23)

(3) Schizophreniform Disorder (F20.81)

(4) Schizophrenia (F20.9)

(5) Schizoaffective Disorder (F25.x)

(6) Catatonia Associated with Another Mental Disorder (Catatonia Specifier) (F06.1)

(7) Other Specified Schizophrenia Spectrum and Other Psychotic Disorder (F28)

(8) Unspecified Schizophrenia Spectrum and Other Psychotic Disorder (F29)

(9) Bipolar I Disorder (F31.xx)

(10) Bipolar II Disorder (F31.81)

(11) Cyclothymic Disorder (F34.0)

(12) Unspecified Bipolar and Related Disorder (F31.9)

(13) Disruptive Mood Dysregulation Disorder (F34.8)

(14) Major Depressive Disorder Single episode (F32.xx)

(15) Major Depressive Disorder, Recurrent episode (F33.xx)

(16) Obsessive-Compulsive Disorder (F42)

(17) Posttraumatic Stress Disorder (F43.10)

(18) Anorexia Nervosa (F50.0x)

(19) Bulimia Nervosa (F50.2)

(20) Postpartum Depression (F53.0)

(21) Puerperal Psychosis (F53.1)

(22) Factitious Disorder Imposed on Another (F68.A)

(d) Notwithstanding any other provision of law, nothing in

this Section shall not be construed to conflict with Section 1927(a)(1) and (b)(1)(A) of the federal Social Security Act and any implementing regulations and agreements.

(e) The Department shall publish a report semi-annually on its website on compliance with the conditions of this Section by the fee-for-service program and managed care organizations beginning with dates of service on and after July 1, 2025. These reports shall be due 12 months after the end of the period to be reported. These reports shall include:

(1) The number of clinically denied prescriptions summarized by each of the allowed categories specified in subsection (b). This paragraph shall include the number of prior authorization denials.

(2) The number of clinically denied prescriptions as summarized by each of the nonallowed categories specified in subsection (a), categorized by denial reason.

(3) The number of prior authorizations of prescriptions contrary to the prohibition described in subsection (a).

(4) The number of complaints filed concerning denials for prescriptions, which meet the conditions specified in subsection (a).

(5) The number of approved and paid prescriptions described in subsection (a) and the potential net cost to the State.

(6) The number of persons enrolled in the medical

assistance program using emergency room services based on categories specified in subsection (c) as the primary diagnosis for the emergency room visit.

(7) The number of persons admitted into a hospital and the number of hospital readmissions, based on categories specified in subsection (c) as the primary diagnosis for the hospital admission or readmission.

As used in this Section, "net cost" means the difference in total ingredient cost due to changes in product mix plus total loss in aggregate rebate revenue based on product mix realized in Fiscal Year 2025. Nothing in this Section shall require the Department to disclose information that is exempt from disclosure under paragraph (g) of subsection (1) of Section 7 of the Freedom of Information Act.

For purposes of this Section, a hospital readmission occurs when a patient is discharged from a hospital and then admitted into the same or another hospital within 30 days of discharge for the same primary diagnosis.

(Source: P.A. 103-593, eff. 6-7-24; 104-9, eff. 6-16-25.)

(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).

(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, a statewide association representing physicians, 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) (Blank)

(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 attempt to contact the youth and the youth's parents, guardian, or caregiver about the BEACON portal and shall assist

with entering the youth's information into the BEACON portal to begin the process of connecting the youth and family to available resources.

(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. Nothing in this Section shall prohibit discussion of medical treatment options or a referral to legal counsel.

(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 ~~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 ~~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.

(l) 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. 104-32, eff. 1-1-26.)

(305 ILCS 5/5-5.25)

Sec. 5-5.25. Access to behavioral health, medical, and epilepsy treatment services.

(a) The General Assembly finds that providing access to behavioral health, medical, and epilepsy treatment services in a timely manner will improve the quality of life for persons suffering from illness and will contain health care costs by avoiding the need for more costly inpatient hospitalization.

(b) The Department of Healthcare and Family Services shall reimburse psychiatrists, federally qualified health centers as defined in Section 1905(l)(2)(B) of the federal Social Security Act, clinical psychologists, clinical social workers, advanced practice registered nurses certified in psychiatric and mental health nursing, and mental health professionals and clinicians authorized by Illinois law to provide behavioral health services to recipients via telehealth. The Department shall reimburse epilepsy specialists, as defined by the

Department by rule, who are authorized by Illinois law to provide epilepsy treatment services to persons with epilepsy or related disorders via telehealth. The Department, by rule, shall establish: (i) criteria for such services to be reimbursed, including appropriate facilities and equipment to be used at both sites and requirements for a physician or other licensed health care professional to be present at the site where the patient is located; however, the Department shall not require that a physician or other licensed health care professional be physically present in the same room as the patient for the entire time during which the patient is receiving telehealth services; (ii) a method to reimburse providers for mental health services provided by telehealth; and (iii) a method to reimburse providers for epilepsy treatment services provided by telehealth.

(c) The Department shall reimburse any Medicaid certified eligible facility or provider organization that acts as the location of the patient at the time a telehealth service is rendered, including substance abuse centers licensed by the Department of Human Services ~~Services' Division of Alcoholism and Substance Abuse~~.

(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.

(Source: P.A. 101-81, eff. 7-12-19; 102-207, eff. 7-30-21.)

(305 ILCS 5/5-44)

Sec. 5-44. Screening, Brief Intervention, and Referral to Treatment. As used in this Section, "SBIRT" means a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons who are at risk of developing substance use disorders or have substance use disorders including, but not limited to, an addiction to alcohol, opioids, tobacco, or cannabis. SBIRT services include all of the following:

(1) Screening to quickly assess the severity of substance use and to identify the appropriate level of treatment.

(2) Brief intervention focused on increasing insight and awareness regarding substance use and motivation toward behavioral change.

(3) Referral to treatment provided to those identified as needing more extensive treatment with access to specialty care.

SBIRT services may include, but are not limited to, the following settings and programs: primary care centers, hospital emergency rooms, hospital in-patient units, trauma centers, community behavioral health programs, and other community settings that provide opportunities for early intervention with at-risk substance users before more severe

consequences occur.

The Department of Healthcare and Family Services shall develop and seek federal approval of a SBIRT benefit for which qualified providers shall be reimbursed under the medical assistance program.

In conjunction with the Department of Human Services ~~Services' Division of Substance Use Prevention and Recovery~~, the Department of Healthcare and Family Services may develop a methodology and reimbursement rate for SBIRT services provided by qualified providers in approved settings.

For opioid specific SBIRT services provided in a hospital emergency department, the Department of Healthcare and Family Services shall develop a bundled reimbursement methodology and rate for a package of opioid treatment services, which include initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services when necessary. This package of opioid related services shall be billed on a separate claim and shall be reimbursed outside of the Enhanced Ambulatory Patient Grouping system.

(Source: P.A. 102-598, eff. 1-1-22; 102-813, eff. 5-13-22.)

(305 ILCS 5/5-45)

Sec. 5-45. Reimbursement rates; substance use disorder treatment providers and facilities. Beginning on July 1, 2022,

the Department of Human Services ~~Services' Division of Substance Use Prevention and Recovery~~ in conjunction with the Department of Healthcare and Family Services, shall provide for an increase in reimbursement rates by way of an increase to existing rates of 47% for all community-based substance use disorder treatment services, including, but not limited to, all of the following:

(1) Admission and Discharge Assessment.

(2) Level 1 (Individual).

(3) Level 1 (Group).

(4) Level 2 (Individual).

(5) Level 2 (Group).

(6) Psychiatric/Diagnostic.

(7) Medication Monitoring (Individual).

(8) Methadone as an Adjunct to Treatment.

No existing or future reimbursement rates or add-ons shall be reduced or changed to address the rate increase proposed under this Section. The Department of Healthcare and Family Services shall immediately, no later than 3 months following April 19, 2022 (the effective date of Public Act 102-699), submit any necessary application to the federal Centers for Medicare and Medicaid Services for a waiver or State Plan amendment to implement the requirements of this Section. Beginning in State fiscal year 2023, and every State fiscal year thereafter, reimbursement rates for those community-based substance use disorder treatment services shall be adjusted

upward by an amount equal to the Consumer Price Index-U from the previous year, not to exceed 2% in any State fiscal year. If there is a decrease in the Consumer Price Index-U, rates shall remain unchanged for that State fiscal year. The Department of Human Services shall adopt rules, including emergency rules under Section 5-45.1 of the Illinois Administrative Procedure Act, to implement the provisions of this Section.

As used in this Section, "consumer price index-u" means the index published by the Bureau of Labor Statistics of the United States Department of Labor that measures the average change in prices of goods and services purchased by all urban consumers, United States city average, all items, 1982-84 = 100.

(Source: P.A. 102-699, eff. 4-19-22; 103-154, eff. 6-30-23.)

(305 ILCS 5/5-47)

Sec. 5-47. Medicaid reimbursement rates; substance use disorder treatment providers and facilities.

(a) Beginning on January 1, 2024, subject to federal approval, the Department of Healthcare and Family Services, in conjunction with the Department of Human Services ~~Services' Division of Substance Use Prevention and Recovery~~, shall provide a 30% increase in reimbursement rates for all Medicaid-covered ASAM Level 3 residential/inpatient substance use disorder treatment services.

No existing or future reimbursement rates or add-ons shall be reduced or changed to address this proposed rate increase. No later than 3 months after June 16, 2023 (the effective date of Public Act 103-102), the Department of Healthcare and Family Services shall submit any necessary application to the federal Centers for Medicare and Medicaid Services to implement the requirements of this Section.

(a-5) Beginning in State fiscal year 2025, and every State fiscal year thereafter, reimbursement rates for licensed or certified substance use disorder treatment providers of ASAM Level 3 residential/inpatient services for persons with substance use disorders shall be adjusted upward by an amount equal to the Consumer Price Index-U from the previous year, not to exceed 2% in any State fiscal year. If there is a decrease in the Consumer Price Index-U, rates shall remain unchanged for that State fiscal year. The Department shall adopt rules, including emergency rules, in accordance with the Illinois Administrative Procedure Act, to implement the provisions of this Section.

As used in this Section, "Consumer Price Index-U" means the index published by the Bureau of Labor Statistics of the United States Department of Labor that measures the average change in prices of goods and services purchased by all urban consumers, United States city average, all items, 1982-84 = 100.

(b) Parity in community-based behavioral health rates;

implementation plan for cost reporting. For the purpose of understanding behavioral health services cost structures and their impact on the Medical Assistance Program, the Department of Healthcare and Family Services shall engage stakeholders to develop a plan for the regular collection of cost reporting for all entity-based substance use disorder providers. Data shall be used to inform on the effectiveness and efficiency of Illinois Medicaid rates. The Department and stakeholders shall develop a plan by April 1, 2024. The Department shall engage stakeholders on implementation of the plan. The plan, at minimum, shall consider all of the following:

(1) Alignment with certified community behavioral health clinic requirements, standards, policies, and procedures.

(2) Inclusion of prospective costs to measure what is needed to increase services and capacity.

(3) Consideration of differences in collection and policies based on the size of providers.

(4) Consideration of additional administrative time and costs.

(5) Goals, purposes, and usage of data collected from cost reports.

(6) Inclusion of qualitative data in addition to quantitative data.

(7) Technical assistance for providers for completing cost reports including initial training by the Department

for providers.

(8) Implementation of a timeline which allows an initial grace period for providers to adjust internal procedures and data collection.

Details from collected cost reports shall be made publicly available on the Department's website and costs shall be used to ensure the effectiveness and efficiency of Illinois Medicaid rates.

(c) Reporting; access to substance use disorder treatment services and recovery supports. By no later than April 1, 2024, the Department of Healthcare and Family Services, with input from the Department of Human Services ~~Services' Division of Substance Use Prevention and Recovery~~, shall submit a report to the General Assembly regarding access to treatment services and recovery supports for persons diagnosed with a substance use disorder. The report shall include, but is not limited to, the following information:

(1) The number of providers enrolled in the Illinois Medical Assistance Program certified to provide substance use disorder treatment services, aggregated by ASAM level of care, and recovery supports.

(2) The number of Medicaid customers in Illinois with a diagnosed substance use disorder receiving substance use disorder treatment, aggregated by provider type and ASAM level of care.

(3) A comparison of Illinois' substance use disorder

licensure and certification requirements with those of comparable state Medicaid programs.

(4) Recommendations for and an analysis of the impact of aligning reimbursement rates for outpatient substance use disorder treatment services with reimbursement rates for community-based mental health treatment services.

(5) Recommendations for expanding substance use disorder treatment to other qualified provider entities and licensed professionals of the healing arts. The recommendations shall include an analysis of the opportunities to maximize the flexibilities permitted by the federal Centers for Medicare and Medicaid Services for expanding access to the number and types of qualified substance use disorder providers.

(Source: P.A. 103-102, eff. 6-16-23; 103-588, eff. 6-5-24; 103-605, eff. 7-1-24.)

(305 ILCS 5/5-50)

Sec. 5-50. Coverage for mental health and substance use disorder telehealth services.

(a) As used in this Section:

"Behavioral health care professional" has the meaning given to "health care professional" in Section 5 of the Telehealth Act, but only with respect to professionals ~~licensed or certified by the Division of Mental Health or Division of Substance Use Prevention and Recovery of the~~

~~Department of Human Services~~ engaged in the delivery of mental health or substance use disorder treatment or services at a provider licensed or certified by the Department of Human Services.

"Behavioral health facility" means a community mental health center, a behavioral health clinic, a substance use disorder treatment program, or a facility or provider licensed or certified by the ~~Division of Mental Health or Division of Substance Use Prevention and Recovery of the~~ Department of Human Services.

"Behavioral telehealth services" has the meaning given to the term "telehealth services" in Section 5 of the Telehealth Act, but limited solely to mental health and substance use disorder treatment or services to a patient, regardless of patient location.

"Distant site" has the meaning given to that term in Section 5 of the Telehealth Act.

"Originating site" has the meaning given to that term in Section 5 of the Telehealth Act.

(b) The Department and any managed care plans under contract with the Department for the medical assistance program shall provide for coverage of mental health and substance use disorder treatment or services delivered as behavioral telehealth services as specified in this Section. The Department and any managed care plans under contract with the Department for the medical assistance program may also

provide reimbursement to a behavioral health facility that serves as the originating site at the time a behavioral telehealth service is rendered.

(c) To ensure behavioral telehealth services are equitably provided, coverage required under this Section shall comply with all of the following:

(1) The Department and any managed care plans under contract with the Department for the medical assistance program shall not:

(A) require that in-person contact occur between a behavioral health care professional and a patient before the provision of a behavioral telehealth service;

(B) require patients, behavioral health care professionals, or behavioral health facilities to prove or document a hardship or access barrier to an in-person consultation for coverage and reimbursement of behavioral telehealth services;

(C) require the use of behavioral telehealth services when the behavioral health care professional has determined that it is not appropriate;

(D) require the use of behavioral telehealth services when a patient chooses an in-person consultation;

(E) require a behavioral health care professional to be physically present in the same room as the

patient at the originating site, unless deemed medically necessary by the behavioral health care professional providing the behavioral telehealth service;

(F) create geographic or facility restrictions or requirements for behavioral telehealth services;

(G) require behavioral health care professionals or behavioral health facilities to offer or provide behavioral telehealth services;

(H) require patients to use behavioral telehealth services or require patients to use a separate panel of behavioral health care professionals or behavioral health facilities to receive behavioral telehealth services; or

(I) impose upon behavioral telehealth services utilization review requirements that are unnecessary, duplicative, or unwarranted or impose any treatment limitations, prior authorization, documentation, or recordkeeping requirements that are more stringent than the requirements applicable to the same behavioral health care service when rendered in-person, except that procedure code modifiers may be required to document behavioral telehealth.

(2) Any cost sharing applicable to services provided through behavioral telehealth shall not exceed the cost sharing required by the medical assistance program for the

same services provided through in-person consultation.

(3) The Department and any managed care plans under contract with the Department for the medical assistance program shall notify behavioral health care professionals and behavioral health facilities of any instructions necessary to facilitate billing for behavioral telehealth services.

(d) For purposes of reimbursement, the Department and any managed care plans under contract with the Department for the medical assistance program shall reimburse a behavioral health care professional or behavioral health facility for behavioral telehealth services on the same basis, in the same manner, and at the same reimbursement rate that would apply to the services if the services had been delivered via an in-person encounter by a behavioral health care professional or behavioral health facility. This subsection applies only to those services provided by behavioral telehealth that may otherwise be billed as an in-person service.

(e) Behavioral health care professionals and behavioral health facilities shall determine the appropriateness of specific sites, technology platforms, and technology vendors for a behavioral telehealth service, as long as delivered services adhere to all federal and State privacy, security, and confidentiality laws, rules, or regulations, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, 42 CFR Part 2, and the Mental

Health and Developmental Disabilities Confidentiality Act.

(f) Nothing in this Section shall be deemed as precluding the Department and any managed care plans under contract with the Department for the medical assistance program from providing benefits for other telehealth services.

(g) There shall be no restrictions on originating site requirements for behavioral telehealth coverage or reimbursement to the distant site under this Section other than requiring the behavioral telehealth services to be medically necessary and clinically appropriate.

(h) Nothing in this Section shall be deemed as precluding the Department and any managed care plans under contract with the Department for the medical assistance program from establishing limits on the use of telehealth for a particular behavioral health service when the limits are consistent with generally accepted standards of mental, emotional, nervous, or substance use disorder or condition care.

(i) The Department may adopt rules to implement the provisions of this Section.

(Source: P.A. 103-243, eff. 1-1-24; 103-605, eff. 7-1-24.)

Section 90. The Early Mental Health and Addictions Treatment Act is amended by changing Sections 5 and 10 as follows:

(305 ILCS 65/5)

Sec. 5. Medicaid Pilot Program; early treatment for youth and young adults.

(a) The General Assembly finds as follows:

(1) Most mental health conditions begin in adolescence and young adulthood, yet it can take an average of 10 years before the right diagnosis and treatment are received.

(2) Over 850,000 Illinois youth under age 25 will experience a mental health condition.

(3) Early treatment of significant mental health conditions can enable wellness and recovery and prevent a life of disability or early death from suicide.

(4) Early treatment leads to higher rates of school completion and employment.

(5) Illinois' mental health system is aimed at adults with advanced mental illnesses who have become disabled, rather than focusing on youth in the early stages of a mental health condition to prevent progression.

(6) Many states are implementing programs and services for the early treatment of significant mental health conditions in youth.

(7) The cost of early community-based treatment is a fraction of the cost of a life of multiple hospitalizations, disability, criminal justice involvement, and homelessness, the common trajectory for someone with a serious mental health condition.

(8) Early treatment for adolescents and young adults

with mental health conditions will save lives and State dollars.

(b) As the sole Medicaid State agency, the Department of Healthcare and Family Services, in partnership with the Department of Human Services ~~Services' Division of Mental Health~~ and with meaningful input from stakeholders, shall develop a pilot program under which a qualifying adolescent or young adult, as defined in subsection (d), may receive community-based mental health treatment from a youth-focused community support team for early treatment, as provided in subsection (e), that is specifically tailored to the needs of youth and young adults in the early stages of a serious emotional disturbance or serious mental illness for purposes of stabilizing the youth's condition and symptoms and preventing the worsening of the illness and debilitating or disabling symptoms. The pilot program shall be implemented across a broad spectrum of geographic regions across the State.

(c) Federal waiver or State Plan amendment; implementation timeline.

(1) Federal approval. The Department of Healthcare and Family Services shall submit any necessary application to the federal Centers for Medicare and Medicaid Services for a waiver or State Plan amendment to implement the pilot program described in this Section no later than September 30, 2019. If the Department determines the pilot program

can be implemented without federal approval, the Department shall implement the program no later than December 31, 2019. The Department shall not draft any rules in contravention of this timetable for pilot program development and implementation. This pilot program shall be implemented only to the extent that federal financial participation is available.

(2) Implementation. After federal approval is secured, if federal approval is required, the Department of Healthcare and Family Services shall implement the pilot program within 6 months after the date of federal approval.

(d) Qualifying adolescent or young adult. As used in this Section, "qualifying adolescent or young adult" means a person age 16 through 26 who is enrolled in the Medical Assistance Program under Article V of the Illinois Public Aid Code and has a diagnosis of a serious emotional disturbance as interpreted by the federal Substance Abuse and Mental Health Services Administration or a serious mental illness listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. Because the purpose of the pilot program is treatment in the early stages of a significant mental health condition or emotional disturbance for purposes of preventing progression of the illness, debilitating symptoms and disability, a qualifying adolescent or young adult shall not be required to demonstrate disability due to the mental health

condition, show a reduction in functioning as a result of the condition, or have a reality impairment (psychosis) to be eligible for services through the pilot program. A qualifying adolescent or young adult who is determined to be eligible for pilot program services before the age of 21 shall continue to be eligible for such services without interruption through age 26 as long as he or she remains enrolled in the Medical Assistance Program.

(e) Community-based treatment model. The pilot program shall create youth-focused community support teams for early treatment. The community-based treatment model shall be a multidisciplinary, team-based model specifically tailored for adolescents and young adults and their needs for wellness, symptom management, and recovery. The model shall take into consideration area workforce, community uniqueness, and cultural diversity. All services shall be evidence-based or evidence-informed as applicable, and the services shall be flexibly provided in-office, in-home, and in-community with an emphasis on in-home and in-community services. The model shall allow for and include each of the following:

(1) Community-based, outreach treatment, and wrap-around services that begin in the early stages of a serious mental illness or serious emotional disturbance (functional impairment shall not be required for service eligibility under the pilot program).

(2) Youth specific engagement strategies to encourage

participation and retention in services.

(3) Same-age or similar-age peer services to foster resiliency.

(4) Family psycho-education and family involvement.

(5) Expertise or knowledge in school and university systems, special education and work, volunteer and social life for youth.

(6) Evidence-informed and young person-specific psychotherapies.

(7) Care coordination for primary care.

(8) Medication management.

(9) Case management for problem solving to address practicable problems, including criminal justice involvement and housing challenges; and assisting the young person or family in organizing all treatment and goals.

(10) Supported education and employment to keep the young person engaged in school and work to attain self-sufficiency.

(11) Trauma-informed expertise for youth.

(12) Substance use treatment expertise.

(f) Pay-for-performance payment model. The Department of Healthcare and Family Services, with meaningful input from stakeholders, shall develop a pay-for-performance payment model aimed at achieving high-quality mental health and overall health and quality of life outcomes for the youth,

rather than a fee-for-service payment model. The payment model shall allow for service flexibility to achieve such outcomes, shall cover actual provider costs of delivering the pilot program services to enable sustainability, and shall include all provider costs associated with the data collection for purposes of the analytics and outcomes reporting required under subsection (h). The Department shall ensure that the payment model works as intended by this Section within managed care.

(g) Rulemaking. The Department of Healthcare and Family Services, in partnership with the Department of Human Services ~~Services' Division of Mental Health~~ and with meaningful input from stakeholders, shall develop rules for purposes of implementation of the pilot program contemplated in this Section within 6 months of federal approval of the pilot program. If the Department determines federal approval is not required for implementation, the Department shall develop rules with meaningful stakeholder input no later than December 31, 2019.

(h) Pilot program analytics and outcomes reports. The Department of Healthcare and Family Services shall engage a third party partner with expertise in program evaluation, analysis, and research at the end of 5 years of implementation to review the outcomes of the pilot program in stabilizing youth with significant mental health conditions early on in their condition to prevent debilitating symptoms and

disability and enable youth to reach their full potential. For purposes of evaluating the outcomes of the pilot program, the Department shall require providers of the pilot program services to track the following annual data:

(1) days of inpatient hospital stays of service recipients;

(2) periods of homelessness of service recipients and periods of housing stability;

(3) periods of criminal justice involvement of service recipients;

(4) avoidance of disability and the need for Supplemental Security Income;

(5) rates of high school, college, or vocational school engagement and graduation for service recipients;

(6) rates of employment annually of service recipients;

(7) average length of stay in pilot program services;

(8) symptom management over time; and

(9) youth satisfaction with their quality of life, pre-pilot and post-pilot program services.

(i) The Department of Healthcare and Family Services shall deliver a final report to the General Assembly on the outcomes of the pilot program within one year after 4 years of full implementation, and after 7 years of full implementation, compared to typical treatment available to other youth with significant mental health conditions, as well as the cost

savings associated with the pilot program taking into account all public systems used when an individual with a significant mental health condition does not have access to the right treatment and supports in the early stages of his or her illness.

The reports to the General Assembly shall be filed with the Clerk of the House of Representatives and the Secretary of the Senate in electronic form only, in the manner that the Clerk and the Secretary shall direct.

Post-pilot program discharge outcomes shall be collected for all service recipients who exit the pilot program for up to 3 years after exit. This includes youth who exit the program with planned or unplanned discharges. The post-exit data collected shall include the annual data listed in paragraphs (1) through (9) of subsection (h). Data collection shall be done in a manner that does not violate individual privacy laws. Outcomes for enrollees in the pilot and post-exit outcomes shall be included in the final report to the General Assembly under this subsection (i) within one year of 4 full years of implementation, and in an additional report within one year of 7 full years of implementation in order to provide more information about post-exit outcomes on a greater number of youth who enroll in pilot program services in the final years of the pilot program.

(Source: P.A. 100-1016, eff. 8-21-18.)

(305 ILCS 65/10)

Sec. 10. Medicaid pilot program for opioid and other drug addictions.

(a) Legislative findings. The General Assembly finds as follows:

(1) Illinois continues to face a serious and ongoing opioid epidemic.

(2) Opioid-related overdose deaths rose 76% between 2013 and 2016.

(3) Opioid and other drug addictions are life-long diseases that require a disease management approach and not just episodic treatment.

(4) There is an urgent need to create a treatment approach that proactively engages and encourages individuals with opioid and other drug addictions into treatment to help prevent chronic use and a worsening addiction and to significantly curb the rate of overdose deaths.

(b) With the goal of early initial engagement of individuals who have an opioid or other drug addiction in addiction treatment and for keeping individuals engaged in treatment following detoxification, a residential treatment stay, or hospitalization to prevent chronic recurrent drug use, the Department of Healthcare and Family Services, in partnership with the Department of Human Services ~~Services' Division of Substance Use Prevention and Recovery~~ and with

meaningful input from stakeholders, shall develop an Assertive Engagement and Community-Based Clinical Treatment Pilot Program for early treatment of an opioid or other drug addiction. The pilot program shall be implemented across a broad spectrum of geographic regions across the State.

(c) Assertive engagement and community-based clinical treatment services. All services included in the pilot program established under this Section shall be evidence-based or evidence-informed as applicable and the services shall be flexibly provided in-office, in-home, and in-community with an emphasis on in-home and in-community services. The model shall take into consideration area workforce, community uniqueness, and cultural diversity. The model shall, at a minimum, allow for and include each of the following:

(1) Assertive community outreach, engagement, and continuing care strategies to encourage participation and retention in addiction treatment services for both initial engagement into addiction treatment services, and for post-hospitalization, post-detoxification, and post-residential treatment.

(2) Case management for purposes of linking individuals to treatment, ongoing monitoring, problem solving, and assisting individuals in organizing their treatment and goals. Case management shall be covered for individuals not yet engaged in treatment for purposes of reaching such individuals early on in their addiction and

for individuals in treatment.

(3) Clinical treatment that is delivered in an individual's natural environment, including in-home or in-community treatment, to better equip the individual with coping mechanisms that may trigger re-use.

(4) Coverage of provider transportation costs in delivering in-home and in-community services in both rural and urban settings. For rural communities, the model shall take into account the wider geographic areas providers are required to travel for in-home and in-community pilot services for purposes of reimbursement.

(5) Recovery support services.

(6) For individuals who receive services through the pilot program but disengage for a short duration (a period of no longer than 9 months), allow seamless treatment re-engagement in the pilot program.

(7) Supported education and employment.

(8) Working with the individual's family, school, and other community support systems.

(9) Service flexibility to enable recovery and positive health outcomes.

(d) Federal waiver or State Plan amendment; implementation timeline. The Department shall follow the timeline for application for federal approval and implementation outlined in subsection (c) of Section 5. The pilot program contemplated in this Section shall be implemented only to the extent that

federal financial participation is available.

(e) Pay-for-performance payment model. The Department of Healthcare and Family Services, in partnership with the Department of Human Services ~~Services' Division of Substance Use Prevention and Recovery~~ and with meaningful input from stakeholders, shall develop a pay-for-performance payment model aimed at achieving high-quality treatment and overall health and quality of life outcomes, rather than a fee-for-service payment model. The payment model shall allow for service flexibility to achieve such outcomes, shall cover actual provider costs of delivering the pilot program services to enable sustainability, and shall include all provider costs associated with the data collection for purposes of the analytics and outcomes reporting required in subsection (g). The Department shall ensure that the payment model works as intended by this Section within managed care.

(f) Rulemaking. The Department of Healthcare and Family Services, in partnership with the Department of Human Services ~~Services' Division of Substance Use Prevention and Recovery~~ and with meaningful input from stakeholders, shall develop rules for purposes of implementation of the pilot program within 6 months after federal approval of the pilot program. If the Department determines federal approval is not required for implementation, the Department shall develop rules with meaningful stakeholder input no later than December 31, 2019.

(g) Pilot program analytics and outcomes reports. The

Department of Healthcare and Family Services shall engage a third party partner with expertise in program evaluation, analysis, and research at the end of 5 years of implementation to review the outcomes of the pilot program in treating addiction and preventing periods of symptom exacerbation and recurrence. For purposes of evaluating the outcomes of the pilot program, the Department shall require providers of the pilot program services to track all of the following annual data:

(1) Length of engagement and retention in pilot program services.

(2) Recurrence of drug use.

(3) Symptom management (the ability or inability to control drug use).

(4) Days of hospitalizations related to substance use or residential treatment stays.

(5) Periods of homelessness and periods of housing stability.

(6) Periods of criminal justice involvement.

(7) Educational and employment attainment during following pilot program services.

(8) Enrollee satisfaction with his or her quality of life and level of social connectedness, pre-pilot and post-pilot services.

(h) The Department of Healthcare and Family Services shall deliver a final report to the General Assembly on the outcomes

of the pilot program within one year after 4 years of full implementation, and after 7 years of full implementation, compared to typical treatment available to other youth with significant mental health conditions, as well as the cost savings associated with the pilot program taking into account all public systems used when an individual with a significant mental health condition does not have access to the right treatment and supports in the early stages of his or her illness.

The reports to the General Assembly shall be filed with the Clerk of the House of Representatives and the Secretary of the Senate in electronic form only, in the manner that the Clerk and the Secretary shall direct.

Post-pilot program discharge outcomes shall be collected for all service recipients who exit the pilot program for up to 3 years after exit. This includes youth who exit the program with planned or unplanned discharges. The post-exit data collected shall include the annual data listed in paragraphs (1) through (8) of subsection (g). Data collection shall be done in a manner that does not violate individual privacy laws. Outcomes for enrollees in the pilot and post-exit outcomes shall be included in the final report to the General Assembly under this subsection (h) within one year of 4 full years of implementation, and in an additional report within one year of 7 full years of implementation in order to provide more information about post-exit outcomes on a greater number

of youth who enroll in pilot program services in the final years of the pilot program.

(Source: P.A. 100-1016, eff. 8-21-18; 101-81, eff. 7-12-19.)

Section 95. The Adult Protective Services Act is amended by changing Sections 5.1 and 15 as follows:

(320 ILCS 20/5.1)

Sec. 5.1. Procedure for self-neglect.

(a) A provider agency, upon receiving a report of self-neglect, shall conduct no less than 2 unannounced face-to-face visits at the residence of the eligible adult to administer, upon consent, the eligibility screening. The eligibility screening is intended to quickly determine if the eligible adult is posing a substantial threat to themselves or others. A full assessment phase shall not be completed for self-neglect cases, and with individual consent, verified self-neglect cases shall immediately enter the casework phase to begin service referrals to mitigate risk unless self-neglect occurs concurrently with another reported abuse type (abuse, neglect, or exploitation), a full assessment shall occur.

(b) The eligibility screening shall include, but is not limited to:

(1) an interview with the eligible adult;

(2) with eligible adult consent, interviews or

consultations regarding the allegations with immediate family members, and other individuals who may have knowledge of the eligible adult's circumstances; and

(3) an inquiry of active service providers engaged with the eligible adult who are providing services that are mitigating the risk identified on the intake. These services providers may be, but are not limited to:

(i) Managed care organizations.

(ii) Case coordination units.

(iii) The Department of Human Services' Division of Rehabilitation Services.

(iv) The Department of Human Services' Division of Developmental Disabilities.

(v) The Department of Human Services' Division of Behavioral ~~Mental~~ Health and Recovery.

(c) During the visit, a provider agency shall obtain the consent of the eligible adult before initiating the eligibility screening. If the eligible adult cannot consent and no surrogate decision maker is established, and where the provider agency is acting in the best interest of an eligible adult who is unable to seek assistance for themselves, the provider agency shall conduct the eligibility screening as described in subsection (b).

(d) When the eligibility screening indicates that the individual is experiencing self-neglect, the provider agency shall within 10 business days and with client consent, develop

an initial case plan.

(e) In developing a case plan, the provider agency shall consult with any other appropriate provider of services to ensure no duplications of services. Such providers shall be immune from civil or criminal liability on account of such acts except for intentional, willful, or wanton misconduct.

(f) The case plan shall be client directed and include recommended services which are appropriate to the needs and wishes of the individual, and which involve the least restriction of the individual's activities commensurate with the individual's needs.

(g) Only those services to which consent is provided in accordance with Section 9 of this Act shall be provided, contingent upon the availability of such services.

(Source: P.A. 103-626, eff. 1-1-25.)

(320 ILCS 20/15)

Sec. 15. Fatality review teams.

(a) State policy.

(1) Both the State and the community maintain a commitment to preventing the abuse, abandonment, neglect, and financial exploitation of at-risk adults. This includes a charge to bring perpetrators of crimes against at-risk adults to justice and prevent untimely deaths in the community.

(2) When an at-risk adult dies, the response to the

death by the community, law enforcement, and the State must include an accurate and complete determination of the cause of death, and the development and implementation of measures to prevent future deaths from similar causes.

(3) Multidisciplinary and multi-agency reviews of deaths can assist the State and counties in developing a greater understanding of the incidence and causes of premature deaths and the methods for preventing those deaths, improving methods for investigating deaths, and identifying gaps in services to at-risk adults.

(4) Access to information regarding the deceased person and his or her family by multidisciplinary and multi-agency fatality review teams is necessary in order to fulfill their purposes and duties.

(a-5) Definitions. As used in this Section:

"Advisory Council" means the Illinois Fatality Review Team Advisory Council.

"Review Team" means a regional interagency fatality review team.

(b) The Director, in consultation with the Advisory Council, law enforcement, and other professionals who work in the fields of investigating, treating, or preventing abuse, abandonment, or neglect of at-risk adults, shall appoint members to a minimum of one review team in each of the Department's planning and service areas. If a review team in an established planning and service area may be better served

combining with adjacent planning and service areas for greater access to cases or expansion of expertise, then the Department maintains the right to combine review teams. Each member of a review team shall be appointed for a 2-year term and shall be eligible for reappointment upon the expiration of the term. A review team's purpose in conducting review of at-risk adult deaths is: (i) to assist local agencies in identifying and reviewing suspicious deaths of adult victims of alleged, suspected, or substantiated abuse, abandonment, or neglect in domestic living situations; (ii) to facilitate communications between officials responsible for autopsies and inquests and persons involved in reporting or investigating alleged or suspected cases of abuse, abandonment, neglect, or financial exploitation of at-risk adults and persons involved in providing services to at-risk adults; (iii) to evaluate means by which the death might have been prevented; and (iv) to report its findings to the appropriate agencies and the Advisory Council and make recommendations that may help to reduce the number of at-risk adult deaths caused by abuse, abandonment, and neglect and that may help to improve the investigations of deaths of at-risk adults and increase prosecutions, if appropriate.

(b-5) Each such team shall be composed of representatives of entities and individuals including, but not limited to:

(1) the Department on Aging or the delegated regional administrative agency as appointed by the Department;

(2) coroners or medical examiners (or both);

(3) State's Attorneys;

(4) local police departments;

(5) forensic units;

(6) local health departments;

(7) a social service or health care agency that provides services to persons with mental illness, in a program whose accreditation to provide such services is recognized by the ~~Division of Mental Health within the~~ Department of Human Services;

(8) a social service or health care agency that provides services to persons with developmental disabilities, in a program whose accreditation to provide such services is recognized by the Division of Developmental Disabilities within the Department of Human Services;

(9) a local hospital, trauma center, or provider of emergency medicine;

(10) providers of services for eligible adults in domestic living situations; and

(11) a physician, psychiatrist, or other health care provider knowledgeable about abuse, abandonment, and neglect of at-risk adults.

(c) A review team shall review cases of deaths of at-risk adults occurring in its planning and service area (i) involving blunt force trauma or an undetermined manner or

suspicious cause of death; (ii) if requested by the deceased's attending physician or an emergency room physician; (iii) upon referral by a health care provider; (iv) upon referral by a coroner or medical examiner; (v) constituting an open or closed case from an adult protective services agency, law enforcement agency, State's Attorney's office, or the Department of Human Services' Office of the Inspector General that involves alleged or suspected abuse, abandonment, neglect, or financial exploitation; or (vi) upon referral by a law enforcement agency or State's Attorney's office. If such a death occurs in a planning and service area where a review team has not yet been established, the Director shall request that the Advisory Council or another review team review that death. A team may also review deaths of at-risk adults if the alleged abuse, abandonment, or neglect occurred while the person was residing in a domestic living situation.

A review team shall meet not less than 2 times a year to discuss cases for its possible review. Each review team, with the advice and consent of the Department, shall establish criteria to be used in discussing cases of alleged, suspected, or substantiated abuse, abandonment, or neglect for review and shall conduct its activities in accordance with any applicable policies and procedures established by the Department.

(c-5) The Illinois Fatality Review Team Advisory Council, consisting of one member from each review team in Illinois, shall be the coordinating and oversight body for review teams

and activities in Illinois. The Director may appoint to the Advisory Council any ex-officio members deemed necessary. Persons with expertise needed by the Advisory Council may be invited to meetings. The Advisory Council must select from its members a chairperson and a vice-chairperson, each to serve a 2-year term. The chairperson or vice-chairperson may be selected to serve additional, subsequent terms. The Advisory Council must meet at least 2 times during each calendar year.

The Department may provide or arrange for the staff support necessary for the Advisory Council to carry out its duties. The Director, in cooperation and consultation with the Advisory Council, shall appoint, reappoint, and remove review team members.

The Advisory Council has, but is not limited to, the following duties:

(1) To serve as the voice of review teams in Illinois.

(2) To oversee the review teams in order to ensure that the review teams' work is coordinated and in compliance with State statutes and the operating protocol.

(3) To ensure that the data, results, findings, and recommendations of the review teams are adequately used in a timely manner to make any necessary changes to the policies, procedures, and State statutes in order to protect at-risk adults.

(4) To collaborate with the Department in order to develop any legislation needed to prevent unnecessary

deaths of at-risk adults.

(5) To ensure that the review teams' review processes are standardized in order to convey data, findings, and recommendations in a usable format.

(6) To serve as a link with review teams throughout the country and to participate in national review team activities.

(7) To provide the review teams with the most current information and practices concerning at-risk adult death review and related topics.

(8) To perform any other functions necessary to enhance the capability of the review teams to reduce and prevent at-risk adult fatalities.

The Advisory Council may prepare an annual report, in consultation with the Department, using aggregate data gathered by review teams and using the review teams' recommendations to develop education, prevention, prosecution, or other strategies designed to improve the coordination of services for at-risk adults and their families.

In any instance where a review team does not operate in accordance with established protocol, the Director, in consultation and cooperation with the Advisory Council, must take any necessary actions to bring the review team into compliance with the protocol.

(d) Any document or oral or written communication shared within or produced by the review team relating to a case

discussed or reviewed by the review team is confidential and is not admissible as evidence in any civil or criminal proceeding, except for use by a State's Attorney's office in prosecuting a criminal case against a caregiver. Those records and information are, however, subject to discovery or subpoena, and are admissible as evidence, to the extent they are otherwise available to the public.

Any document or oral or written communication provided to a review team by an individual or entity, and created by that individual or entity solely for the use of the review team, is confidential, is not subject to disclosure to or discoverable by another party, and is not admissible as evidence in any civil or criminal proceeding, except for use by a State's Attorney's office in prosecuting a criminal case against a caregiver. Those records and information are, however, subject to discovery or subpoena, and are admissible as evidence, to the extent they are otherwise available to the public.

Each entity or individual represented on the fatality review team may share with other members of the team information in the entity's or individual's possession concerning the decedent who is the subject of the review or concerning any person who was in contact with the decedent, as well as any other information deemed by the entity or individual to be pertinent to the review. Any such information shared by an entity or individual with other members of the review team is confidential. The intent of this paragraph is

to permit the disclosure to members of the review team of any information deemed confidential or privileged or prohibited from disclosure by any other provision of law. Release of confidential communication between domestic violence advocates and a domestic violence victim shall follow subsection (d) of Section 227 of the Illinois Domestic Violence Act of 1986 which allows for the waiver of privilege afforded to guardians, executors, or administrators of the estate of the domestic violence victim. This provision relating to the release of confidential communication between domestic violence advocates and a domestic violence victim shall exclude adult protective service providers.

A coroner's or medical examiner's office may share with the review team medical records that have been made available to the coroner's or medical examiner's office in connection with that office's investigation of a death.

Members of a review team and the Advisory Council are not subject to examination, in any civil or criminal proceeding, concerning information presented to members of the review team or the Advisory Council or opinions formed by members of the review team or the Advisory Council based on that information. A person may, however, be examined concerning information provided to a review team or the Advisory Council.

(d-5) Meetings of the review teams and the Advisory Council are exempt from the Open Meetings Act. Records and information provided to a review team and the Advisory

Council, and records maintained by a team or the Advisory Council, are exempt from release under the Freedom of Information Act.

(e) A review team's recommendation in relation to a case discussed or reviewed by the review team, including, but not limited to, a recommendation concerning an investigation or prosecution, may be disclosed by the review team upon the completion of its review and at the discretion of a majority of its members who reviewed the case.

(e-5) The State shall indemnify and hold harmless members of a review team and the Advisory Council for all their acts, omissions, decisions, or other conduct arising out of the scope of their service on the review team or Advisory Council, except those involving willful or wanton misconduct. The method of providing indemnification shall be as provided in the State Employee Indemnification Act.

(f) The Department, in consultation with coroners, medical examiners, and law enforcement agencies, shall use aggregate data gathered by and recommendations from the Advisory Council and the review teams to create an annual report and may use those data and recommendations to develop education, prevention, prosecution, or other strategies designed to improve the coordination of services for at-risk adults and their families. The Department or other State or county agency, in consultation with coroners, medical examiners, and law enforcement agencies, also may use aggregate data gathered

by the review teams to create a database of at-risk individuals.

(g) The Department shall adopt such rules and regulations as it deems necessary to implement this Section.

(Source: P.A. 102-244, eff. 1-1-22; 103-626, eff. 1-1-25.)

Section 100. The Department of Early Childhood Act is amended by changing Section 10-30 as follows:

(325 ILCS 3/10-30)

Sec. 10-30. Illinois Interagency Council on Early Intervention.

(a) There is established the Illinois Interagency Council on Early Intervention. The Council shall be composed of at least 20 but not more than 30 members. The members of the Council and the designated chairperson of the Council shall be appointed by the Governor. The Council member representing the lead agency may not serve as chairperson of the Council. On and after July 1, 2026, the Council shall be composed of the following members:

(1) The Secretary of Early Childhood (or the Secretary's designee) and 2 additional representatives of the Department of Early Childhood designated by the Secretary, plus the Directors (or their designees) of the following State agencies involved in the provision of or payment for early intervention services to eligible infants and toddlers and their families:

(A) Department of Insurance; and

(B) Department of Healthcare and Family Services.

(2) Other members as follows:

(A) At least 20% of the members of the Council shall be parents, including minority parents, of infants or toddlers with disabilities or children with disabilities aged 12 or younger, with knowledge of, or experience with, programs for infants and toddlers with disabilities. At least one such member shall be a parent of an infant or toddler with a disability or a child with a disability aged 6 or younger;

(B) At least 20% of the members of the Council shall be public or private providers of early intervention services;

(C) One member shall be a representative of the General Assembly;

(D) One member shall be involved in the preparation of professional personnel to serve infants and toddlers similar to those eligible for services under this Act;

(E) Two members shall be from advocacy organizations with expertise in improving health, development, and educational outcomes for infants and toddlers with disabilities;

(F) One member shall be a Child and Family Connections manager from a rural district;

(G) One member shall be a Child and Family Connections

manager from an urban district;

(H) One member shall be the co-chair of the Illinois Early Learning Council (or their designee); and

(I) Members representing the following agencies or entities: the Department of Human Services; the State Board of Education; the Department of Public Health; the Department of Children and Family Services; the University of Illinois Division of Specialized Care for Children; the Illinois Council on Developmental Disabilities; Head Start or Early Head Start; and the Department of Human Services' Division of Behavioral ~~Mental~~ Health and Recovery. A member may represent one or more of the listed agencies or entities.

The Council shall meet at least quarterly and in such places as it deems necessary. The Council shall be a continuation of the Council that was created under Section 4 of the Early Intervention Services System Act and that is repealed on July 1, 2026 by Section 20.1 of the Early Intervention Services System Act. Members serving on June 30, 2026 who have served more than 2 consecutive terms shall continue to serve on the Council on and after July 1, 2026. Once appointed, members shall continue to serve until their successors are appointed. Successors appointed under paragraph (2) shall serve 3-year terms. No member shall be appointed to serve more than 2 consecutive terms.

Council members shall serve without compensation but shall

be reimbursed for reasonable costs incurred in the performance of their duties, including costs related to child care, and parents may be paid a stipend in accordance with applicable requirements.

The Council shall prepare and approve a budget using funds appropriated for the purpose to hire staff, and obtain the services of such professional, technical, and clerical personnel as may be necessary to carry out its functions under this Act. This funding support and staff shall be directed by the lead agency.

(b) The Council shall:

(1) advise and assist the lead agency in the performance of its responsibilities including but not limited to the identification of sources of fiscal and other support services for early intervention programs, and the promotion of interagency agreements which assign financial responsibility to the appropriate agencies;

(2) advise and assist the lead agency in the preparation of applications and amendments to applications;

(3) review and advise on relevant rules and standards proposed by the related State agencies;

(4) advise and assist the lead agency in the development, implementation and evaluation of the comprehensive early intervention services system;

(4.5) coordinate and collaborate with State

interagency early learning initiatives, as appropriate; and

(5) prepare and submit an annual report to the Governor and to the General Assembly on the status of early intervention programs for eligible infants and toddlers and their families in Illinois. The annual report shall include (i) the estimated number of eligible infants and toddlers in this State, (ii) the number of eligible infants and toddlers who have received services under this Act and the cost of providing those services, and (iii) the estimated cost of providing services under this Act to all eligible infants and toddlers in this State. The report shall be posted by the lead agency on the early intervention website as required under paragraph (f) of Section 10-35 of this Act.

No member of the Council shall cast a vote on or participate substantially in any matter which would provide a direct financial benefit to that member or otherwise give the appearance of a conflict of interest under State law. All provisions and reporting requirements of the Illinois Governmental Ethics Act shall apply to Council members.

(Source: P.A. 103-594, eff. 6-25-24.)

Section 105. The Early Intervention Services System Act is amended by changing Section 4 as follows:

(325 ILCS 20/4) (from Ch. 23, par. 4154)

(Section scheduled to be repealed on July 1, 2026)

Sec. 4. Illinois Interagency Council on Early Intervention.

(a) There is established the Illinois Interagency Council on Early Intervention. The Council shall be composed of at least 20 but not more than 30 members. The members of the Council and the designated chairperson of the Council shall be appointed by the Governor. The Council member representing the lead agency may not serve as chairperson of the Council. The Council shall be composed of the following members:

(1) The Secretary of Human Services (or his or her designee) and 2 additional representatives of the Department of Human Services designated by the Secretary, plus the Directors (or their designees) of the following State agencies involved in the provision of or payment for early intervention services to eligible infants and toddlers and their families:

(A) Department of Insurance; and

(B) Department of Healthcare and Family Services.

(2) Other members as follows:

(A) At least 20% of the members of the Council shall be parents, including minority parents, of infants or toddlers with disabilities or children with disabilities aged 12 or younger, with knowledge of, or experience with, programs for infants and toddlers

with disabilities. At least one such member shall be a parent of an infant or toddler with a disability or a child with a disability aged 6 or younger;

(B) At least 20% of the members of the Council shall be public or private providers of early intervention services;

(C) One member shall be a representative of the General Assembly;

(D) One member shall be involved in the preparation of professional personnel to serve infants and toddlers similar to those eligible for services under this Act;

(E) Two members shall be from advocacy organizations with expertise in improving health, development, and educational outcomes for infants and toddlers with disabilities;

(F) One member shall be a Child and Family Connections manager from a rural district;

(G) One member shall be a Child and Family Connections manager from an urban district;

(H) One member shall be the co-chair of the Illinois Early Learning Council (or his or her designee); and

(I) Members representing the following agencies or entities: the State Board of Education; the Department of Public Health; the Department of Children and

Family Services; the University of Illinois Division of Specialized Care for Children; the Illinois Council on Developmental Disabilities; Head Start or Early Head Start; and the Department of Human Services ~~Services' Division of Mental Health~~. A member may represent one or more of the listed agencies or entities.

The Council shall meet at least quarterly and in such places as it deems necessary. Terms of the initial members appointed under paragraph (2) shall be determined by lot at the first Council meeting as follows: of the persons appointed under subparagraphs (A) and (B), one-third shall serve one year terms, one-third shall serve 2 year terms, and one-third shall serve 3 year terms; and of the persons appointed under subparagraphs (C) and (D), one shall serve a 2 year term and one shall serve a 3 year term. Thereafter, successors appointed under paragraph (2) shall serve 3 year terms. Once appointed, members shall continue to serve until their successors are appointed. No member shall be appointed to serve more than 2 consecutive terms.

Council members shall serve without compensation but shall be reimbursed for reasonable costs incurred in the performance of their duties, including costs related to child care, and parents may be paid a stipend in accordance with applicable requirements.

The Council shall prepare and approve a budget using funds

appropriated for the purpose to hire staff, and obtain the services of such professional, technical, and clerical personnel as may be necessary to carry out its functions under this Act. This funding support and staff shall be directed by the lead agency.

(b) The Council shall:

(1) advise and assist the lead agency in the performance of its responsibilities including but not limited to the identification of sources of fiscal and other support services for early intervention programs, and the promotion of interagency agreements which assign financial responsibility to the appropriate agencies;

(2) advise and assist the lead agency in the preparation of applications and amendments to applications;

(3) review and advise on relevant regulations and standards proposed by the related State agencies;

(4) advise and assist the lead agency in the development, implementation and evaluation of the comprehensive early intervention services system;

(4.5) coordinate and collaborate with State interagency early learning initiatives, as appropriate; and

(5) prepare and submit an annual report to the Governor and to the General Assembly on the status of early intervention programs for eligible infants and

toddlers and their families in Illinois. The annual report shall include (i) the estimated number of eligible infants and toddlers in this State, (ii) the number of eligible infants and toddlers who have received services under this Act and the cost of providing those services, and (iii) the estimated cost of providing services under this Act to all eligible infants and toddlers in this State. The report shall be posted by the lead agency on the early intervention website as required under paragraph (f) of Section 5 of this Act.

No member of the Council shall cast a vote on or participate substantially in any matter which would provide a direct financial benefit to that member or otherwise give the appearance of a conflict of interest under State law. All provisions and reporting requirements of the Illinois Governmental Ethics Act shall apply to Council members.

(Source: P.A. 97-902, eff. 8-6-12; 98-41, eff. 6-28-13.)

Section 110. The Mental Health and Developmental Disabilities Code is amended by changing Section 6-104.3 as follows:

(405 ILCS 5/6-104.3)

Sec. 6-104.3. Comparable programs for the services contained in the Specialized Mental Health Rehabilitation Act of 2013. The ~~Division of Mental Health of the~~ Department of

Human Services shall oversee the creation of comparable programs for the services contained in the Specialized Mental Health Rehabilitation Act of 2013 for community-based providers to provide the following services:

(1) triage center;

(2) crisis stabilization; and

(3) transitional living.

These comparable programs shall operate under the regulations that may currently exist for such programs, or, if no such regulations are in existence, regulations shall be created. The comparable programs shall be provided through a managed care entity, a coordinated care entity, or an accountable care entity. The Department shall work in concert with any managed care entity, care coordination entity, or accountable care entity to gather the data necessary to report and monitor the progress of the services offered under this Section. The services to be provided under this Section shall be subject to a specific appropriation of the General Assembly for the specific purposes of this Section.

The Department shall adopt any emergency rules necessary to implement this Section.

(Source: P.A. 98-104, eff. 7-22-13.)

Section 115. The Community Services Act is amended by changing Section 4.6 as follows:

(405 ILCS 30/4.6)

Sec. 4.6. Closure and sale of State mental health or developmental disabilities facility.

(a) Whenever a State mental health facility operated by the Department of Human Services is closed and the real estate on which the facility is located is sold by the State, then, to the extent that net proceeds are realized from the sale of that real estate, those net proceeds must be used for mental health services or to support mental health services. To that end, those net proceeds shall be deposited into the Community Mental Health Medicaid Trust Fund. The net proceeds from the sale of a State mental health facility may be spent over a number of fiscal years and are not required to be spent in the same fiscal year in which they are deposited.

(b) Whenever a State developmental disabilities facility operated by the Department of Human Services is closed and the real estate on which the facility is located is sold by the State, then, to the extent that net proceeds are realized from the sale of that real estate, those net proceeds must be directed toward providing other services and supports for persons with developmental disabilities needs. To that end, those net proceeds shall be deposited into the Community Developmental Disability Services Medicaid Trust Fund. The net proceeds from the sale of a State developmental disabilities facility may be spent over a number of fiscal years and are not required to be spent in the same fiscal year in which they are

deposited.

(c) The sale of a State mental health or developmental disabilities facility shall be done in accordance with applicable State laws and, if a State mental health or developmental disabilities facility to be sold has been financed or refinanced with tax-exempt bonds, applicable federal laws. In determining whether any net proceeds are realized from a sale of real estate described in subsection (a) or (b), ~~the Division of Developmental Disabilities and the Division of Mental Health of~~ the Department of Human Services shall ~~each~~ first determine the money, if any, that shall be made available for infrastructure not to exceed 25% of the proceeds of the sale of the real estate to ensure that life, safety, and care concerns are addressed so as to provide for persons with developmental disabilities or mental illness at the remaining respective State-operated facilities. That amount shall be excluded from the calculation of net proceeds by the Division of Developmental Disabilities or the Division of Mental Health, or both, of the Department of Human Services. Amounts determined by the Department for infrastructure to be necessary to ensure that life, safety, and care concerns are addressed shall be deposited, respectively, into the Community Mental Health Medicaid Trust Fund or the Community Developmental Disability Services Medicaid Trust Fund.

(c-1) To the extent that a State mental health facility

which has been closed served a geographical area, at minimum, 40% of the resulting net proceeds of its sale shall be made exclusively in the facility's geographical area. If any other State-operated mental health facility which served a specific geographic area was closed within one year before or after the closure of the facility whose sale has resulted in net proceeds under this Section, 20% of the proceeds shall be used to provide services in the geographic area of this facility. The remainder of the net proceeds may be spent anywhere in the State. All net proceeds may be used for the following mental health services and supports, to include, but not limited to:

(1) Permanent Supportive housing.

(2) Technology that enables behavioral health providers to participate in health information exchanges.

(3) Assertive Community Treatment and Community Support Team.

(4) Transitional living apartments.

(5) Crisis residential services targeted at diverting persons with mental illnesses from emergency departments (including peer run crisis services).

(6) Psychiatric services.

(7) Community mental health services targeted at diverting persons with mental illness from the criminal justice system.

(8) Individual Placement and Support and other services to support employment.

(9) Alcohol and substance abuse treatment.

(d) The purposes for which the net proceeds from a sale of real estate as provided in subsection (b) of this Section may be used include, but are not limited to, the following:

(1) Providing individuals with developmental disabilities community-based Medicaid services and supports such as residential habilitation, day programs, supported employment, home-based supports, therapies, adaptive equipment, and home modifications.

(2) Assisting individuals with developmental disabilities through case management, service coordination, and assessments.

(3) Strengthening the service delivery system through crisis intervention services.

(4) Enhancing the service delivery system through infrastructure improvements, including technology improvements.

(e) Whenever any net proceeds are realized from a sale of real estate as provided in this Section, the Department of Human Services shall share and discuss its plan or plans for using those net proceeds with advocates, advocacy organizations, and advisory groups whose mission includes advocacy for persons with developmental disabilities or persons with mental illness.

(f) Consistent with the provisions of Sections 4.4 and 4.5 of this Act, whenever a State mental health facility operated

by the Department of Human Services is closed, the Department of Human Services, at the direction of the Governor, shall transfer funds from the closed facility to the appropriate line item providing appropriation authority for the new venue of care to facilitate the transition of services to the new venue of care, provided that the new venue of care is a Department of Human Services funded provider or facility.

(g) As used in this Section, the term "mental health facility" has the meaning ascribed to that term in the Mental Health and Developmental Disabilities Code.

(Source: P.A. 98-403, eff. 1-1-14; 98-815, eff. 8-1-14.)

Section 120. The Children's Mental Health Act is amended by changing Section 10 as follows:

(405 ILCS 49/10)

Sec. 10. Illinois Department of Human Services ~~Office of Mental Health services~~. The ~~Office of Mental Health within the~~ Department of Human Services shall allow grant and purchase-of-service moneys to be used for services for children from birth through age 18.

(Source: P.A. 93-495, eff. 8-8-03.)

Section 125. The Developmental Disability and Mental Disability Services Act is amended by changing Section 7-1 as follows:

(405 ILCS 80/7-1)

Sec. 7-1. Community-based pilot program.

(a) Subject to appropriation, the Department of Human Services ~~Services' Division of Mental Health~~ shall make available funding for the development and implementation of a comprehensive and coordinated continuum of community-based pilot programs for persons with or at risk for a mental health diagnosis that is sensitive to the needs of local communities.

The funding shall allow for the development of one or more pilot programs that will support the development of local social media campaigns that focus on the prevention or promotion of mental wellness and provide linkages to mental health services, especially for those individuals who are uninsured or underinsured.

For a provider to be considered for the pilot program, the provider must demonstrate the ability to:

(1) implement the pilot program in an area that shows a high need or underutilization of mental health services;

(2) offer a comprehensive strengths-based array of mental health services;

(3) collaborate with other systems and government entities that exist in a community;

(4) provide education and resources to the public on mental health issues, including suicide prevention and wellness;

(5) develop a local social media campaign that focuses on the prevention or promotion of mental wellness;

(6) ensure that the social media campaign is culturally relevant, developmentally appropriate, trauma informed, and covers information across an individual's lifespan;

(7) provide linkages to other appropriate services in the community;

(8) provide a presence staffed by mental health professionals in natural community settings, which includes any setting where an individual who has not been diagnosed with a mental illness typically spends time; and

(9) explore partnership opportunities with institutions of higher learning in the areas of social work or mental health.

(b) The Department of Human Services is authorized to adopt and implement any administrative rules necessary to carry out the pilot program.

(Source: P.A. 101-61, eff. 1-1-20.)

Section 130. The Housing is Recovery Pilot Program Act is amended by changing Sections 3, 5, 15, 20, 25, 30, 40, 45, 50, 55, 60, 70, and 75 as follows:

(405 ILCS 125/3)

Sec. 3. Definitions. As used in this Act:

"Department" means the Illinois Department of Human Services.

"Individual at high risk of unnecessary institutionalization" means a person who has a serious mental illness who is homeless (or will be homeless upon hospital discharge or correctional facility release) and who has had:

(1) three or more psychiatric inpatient hospital admissions within the most recent 12-month period;

(2) three or more stays in a State or county correctional facility in the State of Illinois within the most recent 12-month period; or

(3) a disability determination due to a serious mental illness and has been incarcerated in a State or county correctional facility in Illinois for the most recent 12 consecutive months.

"Individual at high risk of overdose" means a person with a substance use disorder who is homeless (or will be homeless upon hospital discharge or correctional facility release) who has had:

(A) three or more hospital inpatient or inpatient detoxification admissions for a substance use disorder within the most recent 12-month period;

(B) three or more stays in a State or county correctional facility in the State of Illinois within the most recent 12-month period; or

(C) one or more drug overdoses in the last 12 months.

"Engagement services" means home-based or community-based visits that assist the individual with maintaining his or her housing, and providing other wrap-around support, including linkage to mental health or substance use recovery support services. Such engagement services shall align with Medicaid-covered tenancy support services, and Medicaid community-based mental health and substance use treatment services, including case management, to ensure alignment with any existing or future Illinois Medicaid benefits, waivers or State plan amendments that include these services, and to maximize any potential federal Medicaid matching dollars that may be available to support engagement services.

"Homeless" means the definition used by the U.S. Department of Health and Human Services, Health Resources and Services Administration in Section 330(h)(5)(A) of the Public Health Services Act (42 U.S.C. 254(b)). Under Section 330(h)(5)(A), a homeless individual is an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations, and an individual who is a resident in transitional housing. This includes individuals who are doubled up with other households.

"Serious mental illness" means meeting both the diagnostic and functioning criteria consistent with the definition of Serious Mental Illness as defined by ~~in the most current~~

~~edition of~~ the Illinois Department of Human Services/Division of Behavioral ~~Mental~~ Health and Recovery ~~Community Mental Health Provider Manual~~.

"Substance use disorder" as defined in Section 1-10 of the Substance Use Disorder Act.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/5)

Sec. 5. Establishment of program. Subject to appropriation, the Housing is Recovery pilot program shall be established and administered by the Department ~~of Human Services, Division of Mental Health~~. The purpose of the program is to prevent a person with a serious mental illness who is at high risk of unnecessary institutionalization, or a person with a substance use disorder who is at high risk of overdose, due to homelessness, a lack of access to recovery support services, and repeating cycles of hospitalizations or justice system involvement from being institutionalized or dying. This will be accomplished by enabling affordable housing through the use of a bridge rental subsidy combined with access to recovery support services or treatment. The triple aim of Housing is Recovery is:

(1) preventing institutionalization and overdose deaths;

(2) improving health outcomes and access to recovery support services; and

(3) reducing State costs.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/15)

Sec. 15. Housing is Recovery bridge rental subsidy. A bridge rental subsidy received by an individual (the "subsidy holder") pursuant to this Act shall mirror the subsidies issued by the Department ~~of Human Services, Division of Mental Health~~ through the Moving On Program. The rental subsidy shall be for scattered-site rental units owned by a landlord or for rental units secured through a master lease. The rental subsidy shall assist the subsidy holder with monthly rental payments for rent that does not exceed the Fair Market Rent published annually for that year by the U.S. Department of Housing and Urban Development. The Department ~~of Human Services, Division of Mental Health,~~ shall have the discretion to allow a subsidy to apply to rent up to 120% of the Fair Market Rent if this is justified by the lack of available affordable housing in the local housing market. Community Mental Health Centers certified pursuant to 59 Ill. Adm. Code 132 or supported housing service providers participating in this pilot program shall be responsible for assisting the subsidy holder with maintaining his or her housing that is supported by the bridge rental subsidy and either providing or coordinating engagement services with a mental health or substance use treatment provider.

(1) The subsidy holder shall be responsible for contributing 30% of his or her income toward the cost of rent (zero income does not preclude participation).

(2) The subsidy holder must agree to sign a lease with a landlord or a sublease agreement with the Community Mental Health Center or the housing services provider that has a master lease for the rental unit and agree to engagement services initiated by the supported housing provider, the Community Mental Health Center or contracted mental health or substance use treatment provider at least 2 times a month, with at least one of those visits being a home visit. The engagement services shall be permitted in a home-based or community-based setting, and do not require a clinic visit.

(3) A goal of this program is to encourage the subsidy holder to engage in mental health and substance use recovery support services or treatment when the individual is ready. However, this is a Housing First model that does not require abstinence from substance or alcohol use and does not require mental health or substance use treatment.

(4) If a subsidy holder does not have an income due to a psychiatric disability, he or she shall be offered the opportunity for assistance with filing a "SOAR application" (Supplemental Security Income (SSI)/Social Security Disability Income (SSDI), Outreach, Access and Recovery application) by the Community Mental Health

Center participating in the Housing is Recovery program that is providing his or her mental health support or treatment within 6 months of the initiation of mental health services. If the subsidy holder is only receiving housing support services, the housing services provider must partner with a Community Mental Health Center to do SOAR applications for individuals who elect to apply for a psychiatric disability. A subsidy holder is not required to apply for a disability determination.

(5) The subsidy holder, if he or she is eligible, must apply for rental assistance or housing through the appropriate Public Housing Authority within 6 months of receiving a Housing is Recovery bridge rental subsidy or agree to apply when it is permissible to do so, and also be placed on the Illinois Housing Development Authority's Statewide Referral Network.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/20)

Sec. 20. Identification and referral of eligible individuals prior to hospital discharge or correctional facility release for purposes of rapid housing post discharge/release and illness stability. The pilot program is intended to enable affordable housing to avoid institutionalization or overdose death by providing for connection to housing through a variety of settings, including

in hospitals, county jails, prisons, homeless shelters and inpatient detoxification facilities and the referral process established must take this into account. Within 2 months of the effective date of this Act, the Department ~~of Human Services, Division of Mental Health~~, in partnership with the Department of Healthcare and Family Services ~~and the Department of Human Services, Division of Substance Use Prevention and Recovery (SUPR)~~, the Department of Corrections, and with meaningful stakeholder input through a working group of Community Mental Health Centers, homeless service providers, substance use treatment providers, hospitals with inpatient psychiatric units or detoxification units, representatives from county jails, persons with lived experience, and family support organizations, shall develop a process for identifying and referring eligible individuals for the Housing is Recovery program prior to hospital discharge or correctional system release, or other appropriate place for referral, including homeless shelters. The process developed shall aim to enable rapid access to housing post-discharge/release to avoid unnecessary institutionalization or a return to homelessness or unstable housing. The working group shall meet at least monthly prior to development of an administrative rule or policy established to carry out the intent of this Act. The Department ~~of Human Services, Division of Mental Health,~~ shall explore ways to collaborate with the U.S. Department of Housing and Urban

Development's Coordinated Entry System and other ways for electronic referral. The Department ~~of Human Services, Division of Mental Health,~~ and the Department of Healthcare and Family Services shall collaborate to ensure that the referral process aligns with any existing or future Medicaid waivers or State plan amendments for tenancy support services. (Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/25)

Sec. 25. Participating Community Mental Health Centers and housing service provider responsibilities for locating and transitioning the individual into housing, assisting in retaining housing, and the provision of engagement and recovery support services. The Department ~~of Human Services, Division of Mental Health,~~ shall select interested Community Mental Health Centers that are certified pursuant to 59 Ill. Adm. Code 132 and interested housing service providers for participation in the Housing is Recovery program.

(1) For purposes of incentivizing continuity of care, the same participating Community Mental Health Center may be responsible for providing both the housing support and the mental health or substance use engagement, recovery support services and treatment to a subsidy holder. If a housing support services provider does not also provide the mental health or substance use treatment services the individual engages in, there must be strong coordination

of care between the housing services provider and the treatment provider.

(2) The provider must demonstrate that the rental units secured through this program pass minimum quality inspection standards.

(3) Community Mental Health Centers providing housing support through this program shall be responsible for any SOAR applications for a subsidy holder that has a psychiatric disability who does not have SSI or SSDI if the subsidy holder chooses to apply for disability. A housing services provider delivering the housing support services through this program must contract with a Community Mental Health Center to provide assistance with SOAR applications to subsidy holders electing to apply for SSI or SSDI within 6 months of the subsidy holder receiving the subsidy.

(4) Service providers shall be permitted to engage in master leasing to secure apartments for those who are hard to house due to criminal backgrounds, history of substance use and stigma.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/30)

Sec. 30. Securing rental housing units for purposes of immediate temporary housing following hospital discharge or release from a correctional facility while a long-term rental

unit is secured. Up to 20% of the available annual appropriation for the Housing is Recovery program shall be available to Community Mental Health Centers or the housing services provider for purposes of securing critical time intervention rental units to house an eligible individual immediately following discharge from a hospitalization or release from a correctional facility because locating an apartment unit for a longer-term one-year lease and the related move-in can take up to 3 months. Such temporary units may be used for immediate temporary housing, not to exceed 90 days for purposes of preventing the individual from reentering homelessness or unstable housing, or avoiding unnecessary institutionalization. The Department ~~of Human Services, Division of Mental Health,~~ shall allow providers to certify that such rental units meet minimum housing quality standards and ensure a process by which community providers are able to secure vacant rental units for the purpose of immediate short-term housing post-hospital discharge or correctional system release while a longer term housing rental unit is secured.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/40)

Sec. 40. Subsidy administration. The bridge rental subsidy administration (such as payment of rent to the landlord and other administration expenses) and quality inspection of the

rental units may be done by community-based organizations with experience and expertise in housing subsidy administration and by Community Mental Health Centers that the Department ~~of Human Services, Division of Mental Health,~~ determines have the administrative infrastructure for subsidy administration. Such organizations shall manage and administer all aspects of the subsidy (such as payment of rent, quality inspections) on behalf of the subsidy holder.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/45)

Sec. 45. Landlord education and stigma reduction plan and materials. The Department ~~of Human Services, Division of Mental Health,~~ with meaningful input from stakeholders, shall develop a plan for educating prospective landlords that may lease to individuals receiving a bridge rental subsidy through the Housing is Recovery program. This educational plan shall include written materials that indicate that individuals with psychiatric disabilities and substance use disorders often have criminal justice involvement due to their previously untreated mental health or substance use condition and periods of homelessness. Implementation of this plan shall be rolled out in conjunction with the implementation of the Housing is Recovery program.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/50)

Sec. 50. State agency coordination. The Department ~~of Human Services, Division of Mental Health,~~ shall ~~partner with SUPR to~~ ensure coordination of the services required pursuant to this Act and all substance use recovery support services and treatment for which the Department ~~SUPR~~ has oversight. The Department ~~of Human Services, Division of Mental Health,~~ shall also work with the Department of Healthcare and Family Services to maximize all recovery support services and treatment that are or can be covered by Medicaid.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/55)

Sec. 55. Provider and State agency education on the pilot program. The Department ~~of Human Services, Division of Mental Health~~ shall put together written materials on the Housing is Recovery program and eligibility criteria for purposes of educating participating providers, county jails, the Department of Corrections, hospitals and other relevant stakeholders on the program. The Department ~~of Human Services, Division of Mental Health,~~ shall engage in an ongoing education effort to ensure that all stakeholders are aware of the program and how to screen for eligibility and referral.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/60)

Sec. 60. Reimbursement for subsidy administration, housing support and engagement services and other program costs. The Department ~~of Human Services, Division of Mental Health~~ shall develop a reimbursement approach for community providers doing subsidy administration that covers all costs of subsidy administration, quality inspection and other services. The Department ~~of Human Services, Division of Mental Health~~ shall also develop a reimbursement approach that covers all costs incurred by Community Mental Health Centers and housing services providers for identifying and securing rental units for subsidy holders, including all travel related to finding and locating an apartment and move-in of the subsidy holder, quality inspections for temporary housing units, completing and submitting SOAR applications, the costs associated with obtaining necessary documents associated with obtaining a lease for the subsidy holder (such as obtaining a State ID); for engagement services not covered by Medicaid; and for any other reasonable and necessary costs associated with the program outlined in this Act. Reimbursement shall also include all costs associated with collecting and tracking data for purposes of program evaluation and improvement. At the discretion of the Department ~~of Human Services, Division of Mental Health~~, up to 5% of the annual appropriation may be applied to growing mental health or substance use treatment or recovery support capacity if a participating provider in the Housing is Recovery program demonstrates an inability to take

eligible individuals due to such capacity limitations.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/70)

Sec. 70. Developing public-private partnerships to expand affordable housing options for those with serious mental illnesses. The Department ~~of Human Services, Division of Mental Health~~ shall work with the Department of Healthcare and Family Services, Medicaid managed care organizations and hospitals across the State to develop public-private partnerships to incentivize private funding from hospitals and managed care organizations to match State dollars invested in the Housing is Recovery program for purposes of preventing repeated preventable hospitalizations, overdose deaths and unnecessary institutionalization.

(Source: P.A. 102-66, eff. 7-9-21.)

(405 ILCS 125/75)

Sec. 75. Data collection and program evaluation.

(a) For purposes of evaluating the effectiveness of the Housing is Recovery program and for making improvements to the program, the Department ~~of Human Services, Division of Mental Health~~ shall contract with an independent outside research organization with expertise in housing services for individuals with serious mental illnesses and substance use disorders to evaluate the program's effectiveness on enabling

housing stability, reducing hospitalizations and justice system involvement, encouraging engagement in mental health and substance use treatment, fostering employment engagement, and reducing institutionalization and overdose deaths. Such evaluation shall commence after 4 years of implementation of the program and shall be submitted to the General Assembly by the end of the fifth year of implementation. For purposes of assisting with this evaluation, the working group established pursuant to Section 20 shall also make recommendations to the Department ~~of Human Services, Division of Mental Health,~~ regarding what data must be tracked by providers and the Department ~~of Human Services, Division of Mental Health,~~ to evaluate the program and to make future changes to the program to ensure its effectiveness in meeting the triple aim stated in Section 5.

(b) Beginning after the first 12 months of implementation and on an annual basis, the Department ~~of Human Services, Division of Mental Health,~~ shall track and make public the following information: (1) the number of individuals receiving subsidies in reporting period (12-month average); (2) participant demographics including age, race, gender identity, and primary language; (3) the average duration of time individuals are enrolled in the program (by months); (4) the number of individuals removed from the program and reasons for removal; (5) the number of grievances filed by participants and a summary of grievance type; and (6) program referral

sources. Reports shall be generated on an annual basis and publicly posted on the Department of Human Services website.
(Source: P.A. 102-66, eff. 7-9-21.)

Section 135. The Ensuring a More Qualified, Competent, and Diverse Community Behavioral Health Workforce Act is amended by changing Sections 1-10, 1-20, 1-30, and 1-35 as follows:

(405 ILCS 145/1-10)

Sec. 1-10. Grant awards. To develop and enhance professional development opportunities and diversity in the behavioral health field, and increase access to quality care, the Department of Human Services~~, Division of Mental Health,~~ shall award grants or contracts to community mental health centers or behavioral health clinics licensed or certified by the Department of Human Services or the Department of Healthcare and Family Services to establish or enhance training and supervision of interns and behavioral health providers-in-training pursuing licensure as a licensed clinical social worker, licensed clinical professional counselor, and licensed marriage and family therapist.
(Source: P.A. 102-1053, eff. 6-10-22.)

(405 ILCS 145/1-20)

Sec. 1-20. Priority. In awarding grants and contracts under this Act, the Department of Human Services~~, Division of~~

~~Mental Health,~~ shall give priority to eligible entities in underserved urban areas and rural areas of the State.
(Source: P.A. 102-1053, eff. 6-10-22.)

(405 ILCS 145/1-30)

Sec. 1-30. Application submission. An entity seeking a grant or contract under this Act shall submit an application at such time, in such manner, and accompanied by such information as the Department of Human Services~~, Division of Mental Health,~~ may require. Requirements by the Department of Human Services~~, Division of Mental Health~~ shall be done in a way that ensures minimum additional administrative work.
(Source: P.A. 102-1053, eff. 6-10-22.)

(405 ILCS 145/1-35)

Sec. 1-35. Reporting. Reporting requirements for the grant agreement shall be set forth by the Department of Human Services~~, Division of Mental Health~~.
(Source: P.A. 102-1053, eff. 6-10-22.)

Section 140. The Workforce Direct Care Expansion Act is amended by changing Sections 10 and 15 as follows:

(405 ILCS 162/10)

Sec. 10. The Behavioral Health Administrative Burden Task Force.

(a) The Behavioral Health Administrative Burden Task Force is established within the Office of the Chief Behavioral Health Officer, in partnership with the Department of Human Services ~~Division of Mental Health and Division of Substance Use Prevention and Recovery~~, the Department of Healthcare and Family Services, the Department of Children and Family Services, and the Department of Public Health.

(b) The Task Force shall review policies and regulations affecting the behavioral health industry to identify inefficiencies, duplicate or unnecessary requirements, unduly burdensome restrictions, and other administrative barriers that prevent behavioral health professionals from providing services.

(c) The Task Force shall analyze the impact of administrative burdens on the delivery of quality care and access to behavioral health services by:

(1) collecting data on the administrative tasks, paperwork, and reporting requirements currently imposed on behavioral health professionals in Illinois;

(2) engaging with behavioral health professionals, including providers of all relevant license and certification types, to gather input on specific administrative challenges they face;

(3) seeking input from clients and service recipients to understand the impact of administrative requirements on their care; and

(4) conducting a comparative analysis of documentation requirements with other geographic jurisdictions.

(d) The Task Force shall collaborate with relevant State agencies to identify areas where administrative processes can be standardized and harmonized by:

(1) researching best practices and successful administrative burden reduction models from other states or jurisdictions;

(2) unifying administrative requirements, such as screening, assessment, treatment planning, and personnel requirements, including background checks, where possible among state bodies; and

(3) identifying and seeking to replicate reform efforts that have been successful in other jurisdictions.

(e) The Task Force shall identify innovative technologies and tools that can help automate and streamline administrative tasks and explore the potential for interagency data sharing and integration to reduce redundant reporting by:

(1) researching best practices around shared data platforms to improve the delivery of behavioral health services and ensure that such platforms do not result in a duplication of data entry, including coverage of any relevant software costs to avoid duplication;

(2) facilitating the secure exchange of client information, treatment plans, and service coordination among health care providers, behavioral health facilities,

State-level regulatory bodies, and other relevant entities;

(3) reducing administrative burdens and duplicative data entry for service providers;

(4) ensuring compliance with federal and state privacy regulations, including the Health Insurance Portability and Accountability Act, 42 CFR Part 2, and other relevant laws and regulations; and

(5) improving access to timely client care, with an emphasis on clients receiving services under the Medical Assistance Program.

(f) The Task Force shall eliminate documentation redundancy and coordinate the sharing of information among State agencies by:

(1) standardizing forms at the State-level to simplify access, reduce administrative burden, ensure consistency, and unify requirements across all behavioral health provider types where possible;

(2) identifying areas where standardized language would be allowable so that staff can focus on individualizing relevant components of documentation;

(3) reducing and standardizing, when possible, the information required for assessments and treatment plan goals and consolidate documentation required in these areas for mental health and substance use clients;

(4) evaluating, reducing, and streamlining information

collected for the registration process, including the process for uploading information and resolving errors;

(5) reducing the number of data fields that must be repeated across forms; and

(6) streamlining State-level reporting requirements for federal and State grants and remove unnecessary reporting requirements for provider grants funded with state or federal dollars where possible.

(g) The Task Force shall develop recommendations for legislative or regulatory changes that can reduce administrative burdens while maintaining client safety and quality of care by:

(1) advocating for parity across settings and regulatory entities, including among community, private practice, and State-operated settings;

(2) identifying opportunities for reporting efficiencies or technology solutions to share data across reports;

(3) evaluating and considering opportunities to simplify funding and seek legislative reform to align requirements across funding streams and regulatory entities; and

(4) recommending procedures for more flexibility with deadlines where justified.

(h) The Task Force shall participate in statewide efforts to integrate mental health and substance use disorder

administrative functions.

(Source: P.A. 103-690, eff. 7-19-24.)

(405 ILCS 162/15)

Sec. 15. Membership. The Task Force shall be chaired by Illinois' Chief Behavioral Health Officer or the Officer's designee. The chair of the Task Force may designate an entity or entities to provide administrative support to the Task Force. Except as otherwise provided in this Section, members of the Task Force shall be appointed by the chair. The Task Force shall consist of at least 15 members, including, but not limited to, the following:

(1) community mental health and substance use providers representing geographical regions across the State;

(2) representatives of statewide associations that represent behavioral health providers;

(3) representatives of advocacy organizations either led by or consisting primarily of individuals with lived experience;

(4) 2 representatives ~~a representative~~ from the Division of Behavioral Health and Recovery ~~Mental Health~~ in the Department of Human Services;

(5) (blank); ~~a representative from the Division of Substance Use Prevention and Recovery in the Department of Human Services;~~

(6) a representative from the Department of Children and Family Services;

(7) a representative from the Department of Public Health;

(8) one member of the House of Representatives, appointed by the Speaker of the House of Representatives;

(9) one member of the House of Representatives, appointed by the Minority Leader of the House of Representatives;

(10) one member of the Senate, appointed by the President of the Senate; and

(11) one member of the Senate, appointed by the Minority Leader of the Senate.

(Source: P.A. 103-690, eff. 7-19-24; 103-1075, eff. 3-21-25.)

Section 145. The Overdose Prevention and Harm Reduction Act is amended by changing Section 10 as follows:

(410 ILCS 710/10)

Sec. 10. Dispensing of drug adulterant testing supplies. A pharmacist, physician, advanced practice registered nurse, or physician assistant, or the pharmacist's, physician's, advanced practice registered nurse's, or physician assistant's designee, or a trained overdose responder for an organization enrolled in the Drug Overdose Prevention Program administered by the Department of Human Services, Division of Behavioral

Health ~~Substance Use Prevention~~ and Recovery may dispense drug adulterant testing supplies to any person. Any drug adulterant testing supplies to be dispensed under this Section must be stored at a licensed pharmacy, hospital, clinic, or other health care facility, at the medical office of a physician, advanced practice registered nurse, or physician assistant, or at the premises of the organization enrolled in the Drug Overdose Prevention Program. Drug adulterant testing supplies shall also be stored so that they are accessible only by pharmacists, physicians, advanced practice registered nurses, or physician assistants employed at the pharmacy, hospital, clinic, or other health care facility or medical office, the designees of the pharmacist, physician, advanced practice registered nurse, or physician assistant, and trained overdose responders for those organizations enrolled in the Drug Overdose Prevention Program administered by the Department of Human Services, Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery. Drug adulterant testing supplies dispensed at a retail store containing a pharmacy under this Section may be dispensed only from the pharmacy department of the retail store. No quantity of drug adulterant testing supplies greater than necessary to conduct 5 assays of substances suspected of containing adulterants shall be dispensed in any single transaction.

(Source: P.A. 102-1039, eff. 6-2-22; 103-115, eff. 1-1-24.)

Section 150. The DUI Prevention and Education Commission Act is amended by changing Section 5 as follows:

(625 ILCS 70/5)

Sec. 5. The DUI Prevention and Education Commission.

(a) The DUI Prevention and Education Commission is created, consisting of the following members:

(1) one member from the Office of the Secretary of State, appointed by the Secretary of State;

(2) one member representing law enforcement, appointed by the Department of State Police;

(3) one member from the Division of Behavioral Health ~~Substance Use Prevention~~ and Recovery of the Department of Human Services, appointed by the Secretary of the Department of Human Services;

(4) one member from the Bureau of Safety Programs and Engineering of the Department of Transportation, appointed by the Secretary of the Department of Transportation; and

(5) the Director of the Office of the State's Attorneys Appellate Prosecutor, or his or her designee.

(b) The members of the Commission shall be appointed within 60 days after the effective date of this Act.

(c) The members of the Commission shall receive no compensation for serving as members of the Commission.

(d) The Department of Transportation shall provide administrative support to the Commission.

(Source: P.A. 101-196, eff. 1-1-20.)

Section 155. The Illinois Controlled Substances Act is amended by changing Sections 102, 220, and 316 as follows:

(720 ILCS 570/102) (from Ch. 56 1/2, par. 1102)

Sec. 102. Definitions. As used in this Act, unless the context otherwise requires:

(a) "Person with a substance use disorder" means any person who has a substance use disorder diagnosis defined as a spectrum of persistent and recurring problematic behavior that encompasses 10 separate classes of drugs: alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives, hypnotics and anxiolytics; stimulants; and tobacco; and other unknown substances leading to clinically significant impairment or distress.

(b) "Administer" means the direct application of a controlled substance, whether by injection, inhalation, ingestion, or any other means, to the body of a patient, research subject, or animal (as defined by the Humane Euthanasia in Animal Shelters Act) by:

(1) a practitioner (or, in his or her presence, by his or her authorized agent),

(2) the patient or research subject pursuant to an order, or

(3) a euthanasia technician as defined by the Humane

Euthanasia in Animal Shelters Act.

(c) "Agent" means an authorized person who acts on behalf of or at the direction of a manufacturer, distributor, dispenser, prescriber, or practitioner. It does not include a common or contract carrier, public warehouseman or employee of the carrier or warehouseman.

(c-1) "Anabolic Steroids" means any drug or hormonal substance, chemically and pharmacologically related to testosterone (other than estrogens, progestins, corticosteroids, and dehydroepiandrosterone), and includes:

(i) 3[beta],17-dihydroxy-5a-androstane,

(ii) 3[alpha],17[beta]-dihydroxy-5a-androstane,

(iii) 5[alpha]-androstan-3,17-dione,

(iv) 1-androstenediol (3[beta], 17[beta]-dihydroxy-5[alpha]-androst-1-ene),

(v) 1-androstenediol (3[alpha], 17[beta]-dihydroxy-5[alpha]-androst-1-ene),

(vi) 4-androstenediol (3[beta],17[beta]-dihydroxy-androst-4-ene),

(vii) 5-androstenediol (3[beta],17[beta]-dihydroxy-androst-5-ene),

(viii) 1-androstenedione ([5alpha]-androst-1-en-3,17-dione),

(ix) 4-androstenedione (androst-4-en-3,17-dione),

(x) 5-androstenedione

(androst-5-en-3,17-dione),

(xi) bolasterone (7[alpha],17a-dimethyl-17[beta]-hydroxyandrost-4-en-3-one),

(xii) boldenone (17[beta]-hydroxyandrost-1,4,-diene-3-one),

(xiii) boldione (androsta-1,4-diene-3,17-dione),

(xiv) calusterone (7[beta],17[alpha]-dimethyl-17[beta]-hydroxyandrost-4-en-3-one),

(xv) clostebol (4-chloro-17[beta]-hydroxyandrost-4-en-3-one),

(xvi) dehydrochloromethyltestosterone (4-chloro-17[beta]-hydroxy-17[alpha]-methyl-androst-1,4-dien-3-one),

(xvii) desoxymethyltestosterone (17[alpha]-methyl-5[alpha]-androst-2-en-17[beta]-ol)(a.k.a., madol),

(xviii) [delta]1-dihydrotestosterone (a.k.a. '1-testosterone') (17[beta]-hydroxy-5[alpha]-androst-1-en-3-one),

(xix) 4-dihydrotestosterone (17[beta]-hydroxy-androstan-3-one),

(xx) drostanolone (17[beta]-hydroxy-2[alpha]-methyl-5[alpha]-androstan-3-one),

(xxi) ethylestrenol (17[alpha]-ethyl-17[beta]-hydroxyestr-4-ene),

(xxii) fluoxymesterone (9-fluoro-17[alpha]-methyl-1[beta],17[beta]-dihydroxyandrost-4-en-3-one),

(xxiii) formebolone (2-formyl-17[alpha]-methyl-11[alpha], 17[beta]-dihydroxyandrost-1,4-dien-3-one),

(xxiv) furazabol (17[alpha]-methyl-17[beta]-hydroxyandrostano[2,3-c]-furazan),

(xxv) 13[beta]-ethyl-17[beta]-hydroxygon-4-en-3-one,

(xxvi) 4-hydroxytestosterone (4,17[beta]-dihydroxy-androst-4-en-3-one),

(xxvii) 4-hydroxy-19-nortestosterone (4,17[beta]-dihydroxy-estr-4-en-3-one),

(xxviii) mestanolone (17[alpha]-methyl-17[beta]-hydroxy-5-androstan-3-one),

(xxix) mesterolone (1amethyl-17[beta]-hydroxy-[5a]-androstan-3-one),

(xxx) methandienone (17[alpha]-methyl-17[beta]-hydroxyandrost-1,4-dien-3-one),

(xxxi) methandriol (17[alpha]-methyl-3[beta],17[beta]-dihydroxyandrost-5-ene),

(xxxii) methenolone (1-methyl-17[beta]-hydroxy-5[alpha]-androst-1-en-3-one),

(xxxiii) 17[alpha]-methyl-3[beta], 17[beta]-dihydroxy-5a-androstane,

(xxxiv) 17[alpha]-methyl-3[alpha],17[beta]-dihydroxy -5a-androstane,

(xxxv) 17[alpha]-methyl-3[beta],17[beta]-

dihydroxyandrost-4-ene),

(xxxvi) 17[alpha]-methyl-4-hydroxynandrolone (17[alpha]-methyl-4-hydroxy-17[beta]-hydroxyestr-4-en-3-one),

(xxxvii) methyldienolone (17[alpha]-methyl-17[beta]-hydroxyestra-4,9(10)-dien-3-one),

(xxxviii) methyltrienolone (17[alpha]-methyl-17[beta]-hydroxyestra-4,9-11-trien-3-one),

(xxxix) methyltestosterone (17[alpha]-methyl-17[beta]-hydroxyandrost-4-en-3-one),

(xl) mibolerone (7[alpha],17a-dimethyl-17[beta]-hydroxyestr-4-en-3-one),

(xli) 17[alpha]-methyl-[delta]1-dihydrotestosterone (17b[beta]-hydroxy-17[alpha]-methyl-5[alpha]-androst-1-en-3-one)(a.k.a. '17-[alpha]-methyl-1-testosterone'),

(xlii) nandrolone (17[beta]-hydroxyestr-4-en-3-one),

(xliii) 19-nor-4-androstenediol (3[beta], 17[beta]-dihydroxyestr-4-ene),

(xliv) 19-nor-4-androstenediol (3[alpha], 17[beta]-dihydroxyestr-4-ene),

(xlv) 19-nor-5-androstenediol (3[beta], 17[beta]-dihydroxyestr-5-ene),

(xlvi) 19-nor-5-androstenediol (3[alpha], 17[beta]-dihydroxyestr-5-ene),

(xlvii) 19-nor-4,9(10)-androstadienedione (estra-4,9(10)-diene-3,17-dione),

(xlviii) 19-nor-4-androstenedione (estr-4-en-3,17-dione),

(xlix) 19-nor-5-androstenedione (estr-5-en-3,17-dione),

(l) norbolethone (13[beta], 17a-diethyl-17[beta]-hydroxygon-4-en-3-one),

(li) norclostebol (4-chloro-17[beta]-hydroxyestr-4-en-3-one),

(lii) norethandrolone (17[alpha]-ethyl-17[beta]-hydroxyestr-4-en-3-one),

(liii) normethandrolone (17[alpha]-methyl-17[beta]-hydroxyestr-4-en-3-one),

(liv) oxandrolone (17[alpha]-methyl-17[beta]-hydroxy-2-oxa-5[alpha]-androstan-3-one),

(lv) oxymesterone (17[alpha]-methyl-4,17[beta]-dihydroxyandrost-4-en-3-one),

(lvi) oxymetholone (17[alpha]-methyl-2-hydroxymethylene-17[beta]-hydroxy-(5[alpha]-androstan-3-one),

(lvii) stanozolol (17[alpha]-methyl-17[beta]-hydroxy-(5[alpha]-androst-2-eno[3,2-c]-pyrazole),

(lviii) stenbolone (17[beta]-hydroxy-2-methyl-(5[alpha]-androst-1-en-3-one),

(lix) testolactone (13-hydroxy-3-oxo-13,17-secoandrosta-1,4-dien-17-oic acid lactone),

(lx) testosterone (17[beta]-hydroxyandrost-

4-en-3-one),

(lxi) tetrahydrogestrinone (13[beta], 17[alpha]-diethyl-17[beta]-hydroxygon-4,9,11-trien-3-one),

(lxii) trenbolone (17[beta]-hydroxyestr-4,9,11-trien-3-one).

Any person who is otherwise lawfully in possession of an anabolic steroid, or who otherwise lawfully manufactures, distributes, dispenses, delivers, or possesses with intent to deliver an anabolic steroid, which anabolic steroid is expressly intended for and lawfully allowed to be administered through implants to livestock or other nonhuman species, and which is approved by the Secretary of Health and Human Services for such administration, and which the person intends to administer or have administered through such implants, shall not be considered to be in unauthorized possession or to unlawfully manufacture, distribute, dispense, deliver, or possess with intent to deliver such anabolic steroid for purposes of this Act.

(d) "Administration" means the Drug Enforcement Administration, United States Department of Justice, or its successor agency.

(d-5) "Clinical Director, Prescription Monitoring Program" means a Department of Human Services administrative employee licensed to either prescribe or dispense controlled substances who shall run the clinical aspects of the Department of Human

Services Prescription Monitoring Program and its Prescription Information Library.

(d-10) "Compounding" means the preparation and mixing of components, excluding flavorings, (1) as the result of a prescriber's prescription drug order or initiative based on the prescriber-patient-pharmacist relationship in the course of professional practice or (2) for the purpose of, or incident to, research, teaching, or chemical analysis and not for sale or dispensing. "Compounding" includes the preparation of drugs or devices in anticipation of receiving prescription drug orders based on routine, regularly observed dispensing patterns. Commercially available products may be compounded for dispensing to individual patients only if both of the following conditions are met: (i) the commercial product is not reasonably available from normal distribution channels in a timely manner to meet the patient's needs and (ii) the prescribing practitioner has requested that the drug be compounded.

(e) "Control" means to add a drug or other substance, or immediate precursor, to a Schedule whether by transfer from another Schedule or otherwise.

(f) "Controlled Substance" means (i) a drug, substance, immediate precursor, or synthetic drug in the Schedules of Article II of this Act or (ii) a drug or other substance, or immediate precursor, designated as a controlled substance by the Department through administrative rule. The term does not

include distilled spirits, wine, malt beverages, or tobacco, as those terms are defined or used in the Liquor Control Act of 1934 and the Tobacco Products Tax Act of 1995.

(f-5) "Controlled substance analog" means a substance:

(1) the chemical structure of which is substantially similar to the chemical structure of a controlled substance in Schedule I or II;

(2) which has a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II; or

(3) with respect to a particular person, which such person represents or intends to have a stimulant, depressant, or hallucinogenic effect on the central nervous system that is substantially similar to or greater than the stimulant, depressant, or hallucinogenic effect on the central nervous system of a controlled substance in Schedule I or II.

(g) "Counterfeit substance" means a controlled substance, which, or the container or labeling of which, without authorization bears the trademark, trade name, or other identifying mark, imprint, number or device, or any likeness thereof, of a manufacturer, distributor, or dispenser other than the person who in fact manufactured, distributed, or

dispensed the substance.

(h) "Deliver" or "delivery" means the actual, constructive or attempted transfer of possession of a controlled substance, with or without consideration, whether or not there is an agency relationship. "Deliver" or "delivery" does not include the donation of drugs to the extent permitted under the Illinois Drug Reuse Opportunity Program Act.

(i) "Department" means the Illinois Department of Human Services (as successor to the Department of Alcoholism and Substance Abuse) or its successor agency.

(j) (Blank).

(k) "Department of Corrections" means the Department of Corrections of the State of Illinois or its successor agency.

(l) "Department of Financial and Professional Regulation" means the Department of Financial and Professional Regulation of the State of Illinois or its successor agency.

(m) "Depressant" means any drug that (i) causes an overall depression of central nervous system functions, (ii) causes impaired consciousness and awareness, and (iii) can be habit-forming or lead to a substance misuse or substance use disorder, including, but not limited to, alcohol, cannabis and its active principles and their analogs, benzodiazepines and their analogs, barbiturates and their analogs, opioids (natural and synthetic) and their analogs, and chloral hydrate and similar sedative hypnotics.

(n) (Blank).

(o) "Director" means the Director of the Illinois State Police or his or her designated agents.

(p) "Dispense" means to deliver a controlled substance to an ultimate user or research subject by or pursuant to the lawful order of a prescriber, including the prescribing, administering, packaging, labeling, or compounding necessary to prepare the substance for that delivery.

(q) "Dispenser" means a practitioner who dispenses.

(r) "Distribute" means to deliver, other than by administering or dispensing, a controlled substance.

(s) "Distributor" means a person who distributes.

(t) "Drug" means (1) substances recognized as drugs in the official United States Pharmacopoeia, Official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them; (2) substances intended for use in diagnosis, cure, mitigation, treatment, or prevention of disease in man or animals; (3) substances (other than food) intended to affect the structure of any function of the body of man or animals and (4) substances intended for use as a component of any article specified in clause (1), (2), or (3) of this subsection. It does not include devices or their components, parts, or accessories.

(t-3) "Electronic health record" or "EHR" means an electronic record of health-related information on an individual that is created, gathered, managed, and consulted by authorized health care clinicians and staff.

(t-3.5) "Electronic health record system" or "EHR system" means any computer-based system or combination of federally certified Health IT Modules (defined at 42 CFR 170.102 or its successor) used as a repository for electronic health records and accessed or updated by a prescriber or authorized surrogate in the ordinary course of his or her medical practice. For purposes of connecting to the Prescription Information Library maintained by the Division of Behavioral Health and Recovery ~~Bureau of Pharmacy and Clinical Support Systems~~ or its successor, an EHR system may connect to the Prescription Information Library directly or through all or part of a computer program or system that is a federally certified Health IT Module maintained by a third party and used by the EHR system to secure access to the database.

(t-4) "Emergency medical services personnel" has the meaning ascribed to it in the Emergency Medical Services (EMS) Systems Act.

(t-5) "Euthanasia agency" means an entity certified by the Department of Financial and Professional Regulation for the purpose of animal euthanasia that holds an animal control facility license or animal shelter license under the Animal Welfare Act. A euthanasia agency is authorized to purchase, store, possess, and utilize Schedule II nonnarcotic and Schedule III nonnarcotic drugs for the sole purpose of animal euthanasia.

(t-10) "Euthanasia drugs" means Schedule II or Schedule

III substances (nonnarcotic controlled substances) that are used by a euthanasia agency for the purpose of animal euthanasia.

(u) "Good faith" means the prescribing or dispensing of a controlled substance by a practitioner in the regular course of professional treatment to or for any person who is under his or her treatment for a pathology or condition other than that individual's physical or psychological dependence upon a controlled substance, except as provided herein: and application of the term to a pharmacist shall mean the dispensing of a controlled substance pursuant to the prescriber's order which in the professional judgment of the pharmacist is lawful. The pharmacist shall be guided by accepted professional standards, including, but not limited to, the following, in making the judgment:

(1) lack of consistency of prescriber-patient relationship,

(2) frequency of prescriptions for same drug by one prescriber for large numbers of patients,

(3) quantities beyond those normally prescribed,

(4) unusual dosages (recognizing that there may be clinical circumstances where more or less than the usual dose may be used legitimately),

(5) unusual geographic distances between patient, pharmacist and prescriber,

(6) consistent prescribing of habit-forming drugs.

(u-0.5) "Hallucinogen" means a drug that causes markedly altered sensory perception leading to hallucinations of any type.

(u-1) "Home infusion services" means services provided by a pharmacy in compounding solutions for direct administration to a patient in a private residence, long-term care facility, or hospice setting by means of parenteral, intravenous, intramuscular, subcutaneous, or intraspinal infusion.

(u-5) "Illinois State Police" means the Illinois State Police or its successor agency.

(v) "Immediate precursor" means a substance:

(1) which the Department has found to be and by rule designated as being a principal compound used, or produced primarily for use, in the manufacture of a controlled substance;

(2) which is an immediate chemical intermediary used or likely to be used in the manufacture of such controlled substance; and

(3) the control of which is necessary to prevent, curtail or limit the manufacture of such controlled substance.

(w) "Instructional activities" means the acts of teaching, educating or instructing by practitioners using controlled substances within educational facilities approved by the State Board of Education or its successor agency.

(x) "Local authorities" means a duly organized State,

County or Municipal peace unit or police force.

(y) "Look-alike substance" means a substance, other than a controlled substance which (1) by overall dosage unit appearance, including shape, color, size, markings or lack thereof, taste, consistency, or any other identifying physical characteristic of the substance, would lead a reasonable person to believe that the substance is a controlled substance, or (2) is expressly or impliedly represented to be a controlled substance or is distributed under circumstances which would lead a reasonable person to believe that the substance is a controlled substance. For the purpose of determining whether the representations made or the circumstances of the distribution would lead a reasonable person to believe the substance to be a controlled substance under this clause (2) of subsection (y), the court or other authority may consider the following factors in addition to any other factor that may be relevant:

(a) statements made by the owner or person in control of the substance concerning its nature, use or effect;

(b) statements made to the buyer or recipient that the substance may be resold for profit;

(c) whether the substance is packaged in a manner normally used for the illegal distribution of controlled substances;

(d) whether the distribution or attempted distribution included an exchange of or demand for money or other

property as consideration, and whether the amount of the consideration was substantially greater than the reasonable retail market value of the substance.

Clause (1) of this subsection (y) shall not apply to a noncontrolled substance in its finished dosage form that was initially introduced into commerce prior to the initial introduction into commerce of a controlled substance in its finished dosage form which it may substantially resemble.

Nothing in this subsection (y) prohibits the dispensing or distributing of noncontrolled substances by persons authorized to dispense and distribute controlled substances under this Act, provided that such action would be deemed to be carried out in good faith under subsection (u) if the substances involved were controlled substances.

Nothing in this subsection (y) or in this Act prohibits the manufacture, preparation, propagation, compounding, processing, packaging, advertising or distribution of a drug or drugs by any person registered pursuant to Section 510 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360).

(y-1) "Mail-order pharmacy" means a pharmacy that is located in a state of the United States that delivers, dispenses or distributes, through the United States Postal Service or other common carrier, to Illinois residents, any substance which requires a prescription.

(z) "Manufacture" means the production, preparation, propagation, compounding, conversion or processing of a

controlled substance other than methamphetamine, either directly or indirectly, by extraction from substances of natural origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis, and includes any packaging or repackaging of the substance or labeling of its container, except that this term does not include:

(1) by an ultimate user, the preparation or compounding of a controlled substance for his or her own use;

(2) by a practitioner, or his or her authorized agent under his or her supervision, the preparation, compounding, packaging, or labeling of a controlled substance:

(a) as an incident to his or her administering or dispensing of a controlled substance in the course of his or her professional practice; or

(b) as an incident to lawful research, teaching or chemical analysis and not for sale; or

(3) the packaging, repackaging, or labeling of drugs only to the extent permitted under the Illinois Drug Reuse Opportunity Program Act.

(z-1) (Blank).

(z-5) "Medication shopping" means the conduct prohibited under subsection (a) of Section 314.5 of this Act.

(z-10) "Mid-level practitioner" means (i) a physician

assistant who has been delegated authority to prescribe through a written delegation of authority by a physician licensed to practice medicine in all of its branches, in accordance with Section 7.5 of the Physician Assistant Practice Act of 1987, (ii) an advanced practice registered nurse who has been delegated authority to prescribe through a written delegation of authority by a physician licensed to practice medicine in all of its branches or by a podiatric physician, in accordance with Section 65-40 of the Nurse Practice Act, (iii) an advanced practice registered nurse certified as a nurse practitioner, nurse midwife, or clinical nurse specialist who has been granted authority to prescribe by a hospital affiliate in accordance with Section 65-45 of the Nurse Practice Act, (iv) an animal euthanasia agency, or (v) a prescribing psychologist.

(aa) "Narcotic drug" means any of the following, whether produced directly or indirectly by extraction from substances of vegetable origin, or independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis:

(1) opium, opiates, derivatives of opium and opiates, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation; however the term "narcotic drug" does not include the isoquinoline

alkaloids of opium;

(2) (blank);

(3) opium poppy and poppy straw;

(4) coca leaves, except coca leaves and extracts of coca leaves from which substantially all of the cocaine and ecgonine, and their isomers, derivatives and salts, have been removed;

(5) cocaine, its salts, optical and geometric isomers, and salts of isomers;

(6) ecgonine, its derivatives, their salts, isomers, and salts of isomers;

(7) any compound, mixture, or preparation which contains any quantity of any of the substances referred to in subparagraphs (1) through (6).

(bb) "Nurse" means a registered nurse licensed under the Nurse Practice Act.

(cc) (Blank).

(dd) "Opiate" means a drug derived from or related to opium.

(ee) "Opium poppy" means the plant of the species Papaver somniferum L., except its seeds.

(ee-5) "Oral dosage" means a tablet, capsule, elixir, or solution or other liquid form of medication intended for administration by mouth, but the term does not include a form of medication intended for buccal, sublingual, or transmucosal administration.

(ff) "Parole and Pardon Board" means the Parole and Pardon Board of the State of Illinois or its successor agency.

(gg) "Person" means any individual, corporation, mail-order pharmacy, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other entity.

(hh) "Pharmacist" means any person who holds a license or certificate of registration as a registered pharmacist, a local registered pharmacist or a registered assistant pharmacist under the Pharmacy Practice Act.

(ii) "Pharmacy" means any store, ship or other place in which pharmacy is authorized to be practiced under the Pharmacy Practice Act.

(ii-5) "Pharmacy shopping" means the conduct prohibited under subsection (b) of Section 314.5 of this Act.

(ii-10) "Physician" (except when the context otherwise requires) means a person licensed to practice medicine in all of its branches.

(jj) "Poppy straw" means all parts, except the seeds, of the opium poppy, after mowing.

(kk) "Practitioner" means a physician licensed to practice medicine in all its branches, dentist, optometrist, podiatric physician, veterinarian, scientific investigator, pharmacist, physician assistant, advanced practice registered nurse, licensed practical nurse, registered nurse, emergency medical services personnel, hospital, laboratory, or pharmacy, or

other person licensed, registered, or otherwise lawfully permitted by the United States or this State to distribute, dispense, conduct research with respect to, administer or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research.

(ll) "Pre-printed prescription" means a written prescription upon which the designated drug has been indicated prior to the time of issuance; the term does not mean a written prescription that is individually generated by machine or computer in the prescriber's office.

(mm) "Prescriber" means a physician licensed to practice medicine in all its branches, dentist, optometrist, prescribing psychologist licensed under Section 4.2 of the Clinical Psychologist Licensing Act with prescriptive authority delegated under Section 4.3 of the Clinical Psychologist Licensing Act, podiatric physician, or veterinarian who issues a prescription, a physician assistant who issues a prescription for a controlled substance in accordance with Section 303.05, a written delegation, and a written collaborative agreement required under Section 7.5 of the Physician Assistant Practice Act of 1987, an advanced practice registered nurse with prescriptive authority delegated under Section 65-40 of the Nurse Practice Act and in accordance with Section 303.05, a written delegation, and a written collaborative agreement under Section 65-35 of the Nurse Practice Act, an advanced practice registered nurse

certified as a nurse practitioner, nurse midwife, or clinical nurse specialist who has been granted authority to prescribe by a hospital affiliate in accordance with Section 65-45 of the Nurse Practice Act and in accordance with Section 303.05, or an advanced practice registered nurse certified as a nurse practitioner, nurse midwife, or clinical nurse specialist who has full practice authority pursuant to Section 65-43 of the Nurse Practice Act.

(nn) "Prescription" means a written, facsimile, or oral order, or an electronic order that complies with applicable federal requirements, of a physician licensed to practice medicine in all its branches, dentist, podiatric physician or veterinarian for any controlled substance, of an optometrist in accordance with Section 15.1 of the Illinois Optometric Practice Act of 1987, of a prescribing psychologist licensed under Section 4.2 of the Clinical Psychologist Licensing Act with prescriptive authority delegated under Section 4.3 of the Clinical Psychologist Licensing Act, of a physician assistant for a controlled substance in accordance with Section 303.05, a written delegation, and a written collaborative agreement required under Section 7.5 of the Physician Assistant Practice Act of 1987, of an advanced practice registered nurse with prescriptive authority delegated under Section 65-40 of the Nurse Practice Act who issues a prescription for a controlled substance in accordance with Section 303.05, a written delegation, and a written collaborative agreement under

Section 65-35 of the Nurse Practice Act, of an advanced practice registered nurse certified as a nurse practitioner, nurse midwife, or clinical nurse specialist who has been granted authority to prescribe by a hospital affiliate in accordance with Section 65-45 of the Nurse Practice Act and in accordance with Section 303.05 when required by law, or of an advanced practice registered nurse certified as a nurse practitioner, nurse midwife, or clinical nurse specialist who has full practice authority pursuant to Section 65-43 of the Nurse Practice Act.

(nn-5) "Prescription Information Library" (PIL) means an electronic library that contains reported controlled substance data.

(nn-10) "Prescription Monitoring Program" (PMP) means the entity that collects, tracks, and stores reported data on controlled substances and select drugs pursuant to Section 316.

(oo) "Production" or "produce" means manufacture, planting, cultivating, growing, or harvesting of a controlled substance other than methamphetamine.

(pp) "Registrant" means every person who is required to register under Section 302 of this Act.

(qq) "Registry number" means the number assigned to each person authorized to handle controlled substances under the laws of the United States and of this State.

(qq-5) "Secretary" means, as the context requires, either

the Secretary of the Department or the Secretary of the Department of Financial and Professional Regulation, and the Secretary's designated agents.

(rr) "State" includes the State of Illinois and any state, district, commonwealth, territory, insular possession thereof, and any area subject to the legal authority of the United States of America.

(rr-5) "Stimulant" means any drug that (i) causes an overall excitation of central nervous system functions, (ii) causes impaired consciousness and awareness, and (iii) can be habit-forming or lead to a substance use disorder, including, but not limited to, amphetamines and their analogs, methylphenidate and its analogs, cocaine, and phencyclidine and its analogs.

(rr-10) "Synthetic drug" includes, but is not limited to, any synthetic cannabinoids or piperazines or any synthetic cathinones as provided for in Schedule I.

(ss) "Ultimate user" means a person who lawfully possesses a controlled substance for his or her own use or for the use of a member of his or her household or for administering to an animal owned by him or her or by a member of his or her household.

(Source: P.A. 102-389, eff. 1-1-22; 102-538, eff. 8-20-21; 102-813, eff. 5-13-22; 103-881, eff. 1-1-25.)

(720 ILCS 570/220)

Sec. 220. Electronic health record systems. The Division of Behavioral Health and Recovery ~~Bureau of Pharmacy and Clinical Support Systems~~ shall establish a form to allow EHR systems to certify the identity of a third party that will provide access to the Prescription Information Library for the EHR system using all or part of a computer program or system that is a federally certified Health IT Module for the EHR system. Before the Health IT Module is permitted to connect to the Prescription Information Library, it must enter into a business associate agreement with the EHR system that requires the Health IT Module to agree to adhere to all requirements imposed on the EHR system by the laws of this State, including data privacy and security obligations that the Bureau otherwise imposes on EHR systems.

(Source: P.A. 101-666, eff. 1-1-22.)

(720 ILCS 570/316)

Sec. 316. Prescription Monitoring Program.

(a) The Department must provide for a Prescription Monitoring Program for Schedule II, III, IV, and V controlled substances that includes the following components and requirements:

(1) The dispenser must transmit to the central repository, in a form and manner specified by the Department, the following information:

(A) The recipient's name and address.

(B) The recipient's date of birth and gender.

(C) The national drug code number of the controlled substance dispensed.

(D) (Blank).

(E) The quantity of the controlled substance dispensed and days supply.

(F) The dispenser's United States Drug Enforcement Administration registration number.

(G) The prescriber's United States Drug Enforcement Administration registration number.

(H) The dates the controlled substance prescription is filled.

(I) The payment type used to purchase the controlled substance (i.e. Medicaid, cash, third party insurance).

(J) The patient location code (i.e. home, nursing home, outpatient, etc.) for the controlled substances other than those filled at a retail pharmacy.

(K) Any additional information that may be required by the department by administrative rule, including but not limited to information required for compliance with the criteria for electronic reporting of the American Society for Automation and Pharmacy or its successor.

(2) The information required to be transmitted under this Section must be transmitted not later than the end of

the business day on which a controlled substance is dispensed, or at such other time as may be required by the Department by administrative rule.

(3) A dispenser must transmit electronically, as provided by Department rule, the information required to be transmitted under this Section.

(3.5) The requirements of paragraphs (1), (2), and (3) of this subsection also apply to opioid treatment programs that are licensed or certified by the Department of Human Services ~~Services' Division of Substance Use Prevention and Recovery~~ and are authorized by the federal Drug Enforcement Administration to prescribe Schedule II, III, IV, or V controlled substances for the treatment of opioid use disorders. Opioid treatment programs shall attempt to obtain written patient consent, shall document attempts to obtain the written consent, and shall not transmit information without patient consent. Documentation obtained under this paragraph shall not be utilized for law enforcement purposes, as proscribed under 42 CFR 2, as amended by 42 U.S.C. 290dd-2. Treatment of a patient shall not be conditioned upon his or her written consent.

(4) The Department may impose a civil fine of up to $100 per day for willful failure to report controlled substance dispensing to the Prescription Monitoring Program. The fine shall be calculated on no more than the number of days from the time the report was required to be

made until the time the problem was resolved, and shall be payable to the Prescription Monitoring Program.

(a-5) Notwithstanding subsection (a), a licensed veterinarian is exempt from the reporting requirements of this Section. If a person who is presenting an animal for treatment is suspected of fraudulently obtaining any controlled substance or prescription for a controlled substance, the licensed veterinarian shall report that information to the local law enforcement agency.

(b) The Department, by rule, may include in the Prescription Monitoring Program certain other select drugs that are not included in Schedule II, III, IV, or V. The Prescription Monitoring Program does not apply to controlled substance prescriptions as exempted under Section 313.

(c) The collection of data on select drugs and scheduled substances by the Prescription Monitoring Program may be used as a tool for addressing oversight requirements of long-term care institutions as set forth by Public Act 96-1372. Long-term care pharmacies shall transmit patient medication profiles to the Prescription Monitoring Program monthly or more frequently as established by administrative rule.

(d) The Department of Human Services shall appoint a full-time Clinical Director of the Prescription Monitoring Program.

(e) (Blank).

(f) It is the responsibility of any new, ceased, or

unconnected healthcare facility and its selected Electronic Health Records System or Pharmacy Management System to make contact with and ensure integration with the Prescription Monitoring Program. As soon as practicable after the effective date of this amendatory Act of the 103rd General Assembly, the Department shall adopt rules requiring Electronic Health Records Systems and Pharmacy Management Systems to interface, by January 1, 2024, with the Prescription Monitoring Program to ensure that providers have access to specific patient records during the treatment of their patients. The Department shall identify actions to be taken if a prescriber's Electronic Health Records System and Pharmacy Management Systems does not effectively interface with the Prescription Monitoring Program once the Prescription Monitoring Program is aware of the non-integrated connection.

(g) The Department, in consultation with the Prescription Monitoring Program Advisory Committee, shall adopt rules allowing licensed prescribers or pharmacists who have registered to access the Prescription Monitoring Program to authorize a licensed or non-licensed designee employed in that licensed prescriber's office or a licensed designee in a licensed pharmacist's pharmacy who has received training in the federal Health Insurance Portability and Accountability Act and 42 CFR 2 to consult the Prescription Monitoring Program on their behalf. The rules shall include reasonable parameters concerning a practitioner's authority to authorize

a designee, and the eligibility of a person to be selected as a designee. In this subsection (g), "pharmacist" shall include a clinical pharmacist employed by and designated by a Medicaid Managed Care Organization providing services under Article V of the Illinois Public Aid Code under a contract with the Department of Healthcare and Family Services for the sole purpose of clinical review of services provided to persons covered by the entity under the contract to determine compliance with subsections (a) and (b) of Section 314.5 of this Act. A managed care entity pharmacist shall notify prescribers of review activities.

(Source: P.A. 102-527, eff. 8-20-21; 102-813, eff. 5-13-22; 103-477, eff. 8-4-23.)

Section 160. The County Jail Act is amended by changing Section 14 as follows:

(730 ILCS 125/14) (from Ch. 75, par. 114)

Sec. 14. At any time, in the opinion of the Warden, the lives or health of the committed persons are endangered or the security of the penal institution is threatened, to such a degree as to render their removal necessary, the Warden may cause an individual committed person or a group of committed persons to be removed to some suitable place within the county, or to the jail of some convenient county, where they may be confined until they can be safely returned to the place

whence they were removed. No committed person charged with a felony shall be removed by the warden to a Mental Health or Developmental Disabilities facility as defined in the Mental Health and Developmental Disabilities Code, except as specifically authorized by Article 104 or 115 of the Code of Criminal Procedure of 1963, or the Mental Health and Developmental Disabilities Code. Any place to which the committed persons are so removed shall, during their imprisonment there, be deemed, as to such committed persons, a prison of the county in which they were originally confined; but, they shall be under the care, government and direction of the Warden of the jail of the county in which they are confined. When any criminal detainee is transferred to the custody of the Department of Human Services, the warden shall supply the Department of Human Services with all of the legally available information as described in 20 Ill. Adm. Code 701.60(f). When a criminal detainee is delivered to the custody of the Department, the following information must be included with the items delivered:

(1) the sentence imposed;

(2) any findings of great bodily harm made by the court;

(3) any statement by the court on the basis for imposing the sentence;

(4) any presentence reports;

(5) any sex offender evaluations;

(6) any substance abuse treatment eligibility screening and assessment of the criminal detainee by an agent designated by the State to provide assessments for Illinois courts;

(7) the number of days, if any, which the criminal detainee has been in custody and for which he or she is entitled to credit against the sentence. Certification of jail credit time shall include any time served in the custody of the Illinois Department of Human Services ~~Division of Mental Health or Division of Developmental Disabilities~~, time served in another state or federal jurisdiction, and any time served while on probation or periodic imprisonment;

(8) State's Attorney's statement of facts, including the facts and circumstances of the offenses for which the criminal detainee was committed, any other factual information accessible to the State's Attorney prior to the commitment to the Department relative to the criminal detainee's habits, associates, disposition, and reputation or other information that may aid the Department during the custody of the criminal detainee. If the statement is unavailable at the time of delivery, the statement must be transmitted within 10 days after receipt by the clerk of the court;

(9) any medical or mental health records or summaries;

(10) any victim impact statements;

(11) name of municipalities where the arrest of the criminal detainee and the commission of the offense occurred, if the municipality has a population of more than 25,000 persons;

(12) all additional matters that the court directs the clerk to transmit;

(13) a record of the criminal detainee's time and his or her behavior and conduct while in the custody of the county. Any action on the part of the criminal detainee that might affect his or her security status with the Department, including, but not limited to, an escape attempt, participation in a riot, or a suicide attempt should be included in the record; and

(14) the mittimus or sentence (judgment) order that provides the following information:

(A) the criminal case number, names and citations of the offenses, judge's name, date of sentence, and, if applicable, whether the sentences are to be served concurrently or consecutively;

(B) the number of days spent in custody; and

(C) if applicable, the calculation of pre-trial program sentence credit awarded by the court to the criminal detainee, including, at a minimum, identification of the type of pre-trial program the criminal detainee participated in and the number of eligible days the court finds the criminal detainee

spent in the pre-trial program multiplied by the calculation factor of 0.5 for the total court-awarded credit.

(Source: P.A. 103-745, eff. 1-1-25.)

Section 165. The Drug Court Treatment Act is amended by changing Sections 10, 25, and 30 as follows:

(730 ILCS 166/10)

Sec. 10. Definitions. As used in this Act:

"Certification" means the process by which a problem-solving court obtains approval from the Supreme Court to operate in accordance with the Problem-Solving Court Standards.

"Clinical treatment plan" means an evidence-based, comprehensive, and individualized plan that: (i) is developed by a qualified professional in accordance with the Department of Human Services ~~substance use prevention and recovery~~ rules under 77 Ill. Adm. Code 2060 or an equivalent standard in any state where treatment may take place; and (ii) defines the scope of treatment services to be delivered by a court treatment provider.

"Combination drug court program" means a type of problem-solving court that allows an individual to enter a problem-solving court before a plea, conviction, or disposition while also permitting an individual who has

admitted guilt, or been found guilty, to enter a problem-solving court as a part of the individual's sentence or disposition.

"Community behavioral health center" means a physical site where behavioral healthcare services are provided in accordance with the Community Behavioral Health Center Infrastructure Act.

"Community mental health center" means an entity:

(1) licensed by the Department of Public Health as a community mental health center in accordance with the conditions of participation for community mental health centers established by the Centers for Medicare and Medicaid Services; and

(2) that provides outpatient services, including specialized outpatient services, for individuals who are chronically mental ill.

"Co-occurring mental health and substance use disorders court program" means a program that includes an individual with co-occurring mental illness and substance use disorder diagnoses and professionals with training and experience in treating individuals with diagnoses of substance use disorder and mental illness.

"Drug court", "drug court program", "court", or "program" means a specially designated court, court calendar, or docket facilitating intensive therapeutic treatment to monitor and assist participants with substance use disorders in making

positive lifestyle changes and reducing the rate of recidivism. Drug court programs are nonadversarial in nature and bring together substance use disorder professionals, local social programs, and monitoring in accordance with the nationally recommended 10 key components of drug courts and the Problem-Solving Court Standards. Common features of a drug court program include, but are not limited to, a designated judge and staff; specialized intake and screening procedures; coordinated treatment procedures administered by a trained, multidisciplinary professional team; close evaluation of participants, including continued assessments and modification of the court requirements and use of sanctions, incentives, and therapeutic adjustments to address behavior; frequent judicial interaction with participants; less formal court process and procedures; voluntary participation; and a low treatment staff-to-client ratio.

"Drug court professional" means a member of the drug court team, including but not limited to a judge, prosecutor, defense attorney, probation officer, coordinator, or treatment provider.

"Peer recovery coach" means a mentor assigned to a defendant during participation in a drug treatment court program who has been trained by the court, a service provider used by the court for substance use disorder or mental health treatment, a local service provider with an established peer recovery coach or mentor program not otherwise used by the

court for treatment, or a Certified Recovery Support Specialist certified by the Illinois Certification Board. "Peer recovery coach" includes individuals with lived experiences of the issues the problem-solving court seeks to address, including, but not limited to, substance use disorder, mental illness, and co-occurring disorders or involvement with the criminal justice system. "Peer recovery coach" includes individuals required to guide and mentor the participant to successfully complete assigned requirements and to facilitate participants' independence for continued success once the supports of the court are no longer available to them.

"Post-adjudicatory drug court program" means a program that allows an individual who has admitted guilt or has been found guilty, with the defendant's consent, and the approval of the court, to enter a drug court program as part of the defendant's sentence or disposition.

"Pre-adjudicatory drug court program" means a program that allows the defendant, with the defendant's consent and the approval of the court, to enter the drug court program before plea, conviction, or disposition and requires successful completion of the drug court program as part of the agreement.

"Problem-Solving Court Standards" means the statewide standards adopted by the Supreme Court that set forth the minimum requirements for the planning, establishment, certification, operation, and evaluation of all problem-solving courts in this State.

"Validated clinical assessment" means a validated assessment tool administered by a qualified clinician to determine the treatment needs of participants. "Validated clinical assessment" includes assessment tools required by public or private insurance.

(Source: P.A. 102-1041, eff. 6-2-22.)

(730 ILCS 166/25)

Sec. 25. Procedure.

(a) A screening and clinical needs assessment and risk assessment of the defendant shall be performed as required by the court's policies and procedures prior to the defendant's admission into a drug court. The clinical needs assessment shall be conducted in accordance with the Department of Human Services ~~substance use prevention and recovery~~ rules under 77 Ill. Adm. Code 2060. The assessment shall include, but is not limited to, assessments of substance use and mental and behavioral health needs. The assessment shall be administered by individuals approved under the Department of Human Services ~~substance use prevention and recovery~~ rules for professional staff under 77 Ill. Adm. Code 2060 and used to inform any clinical treatment plans. Clinical treatment plans shall be developed in accordance with the Problem-Solving Court Standards and in part upon the known availability of treatment resources.

Any risk assessment shall be performed using an assessment

tool approved by the Administrative Office of the Illinois Courts and as required by the court's policies and procedures.

An assessment need not be ordered if the court finds a valid assessment related to the present charge pending against the defendant has been completed within the previous 60 days.

(b) The judge shall inform the defendant that if the defendant fails to meet the conditions of the drug court program, eligibility to participate in the program may be revoked and the defendant may be sentenced or the prosecution continued as provided in the Unified Code of Corrections for the crime charged.

(c) The defendant shall execute a written agreement as to his or her participation in the program and shall agree to all of the terms and conditions of the program, including but not limited to the possibility of sanctions or incarceration for failing to abide or comply with the terms of the program.

(d) In addition to any conditions authorized under the Pretrial Services Act and Section 5-6-3 of the Unified Code of Corrections, the court may order the participant to complete mental health counseling or substance use disorder treatment in an outpatient or residential treatment program and may order the participant to comply with physicians' recommendations regarding medications and all follow-up treatment for any mental health diagnosis made by the provider. Substance use disorder treatment programs must be licensed by the Department of Human Services in accordance

with the Department of Human Services ~~substance use prevention and recovery~~ rules, or an equivalent standard in any other state where the treatment may take place, and use evidence-based treatment. When referring participants to mental health treatment programs, the court shall prioritize providers certified as community mental health or behavioral health centers if possible. The court shall consider the least restrictive treatment option when ordering mental health or substance use disorder treatment for participants and the results of clinical and risk assessments in accordance with the Problem-Solving Court Standards.

(e) The drug court program shall include a regimen of graduated requirements, including fines, fees, costs, restitution, individual and group therapy, substance analysis testing, close monitoring by the court, restitution, educational or vocational counseling as appropriate, and other requirements necessary to fulfill the drug court program. Program phases, therapeutic adjustments, incentives, and sanctions, including the use of jail sanctions, shall be administered in accordance with evidence-based practices and the Problem-Solving Court Standards. A participant's failure to pay program fines or fees shall not prevent the participant from advancing phases or successfully completing the program. If the participant needs treatment for an opioid use disorder or dependence, the court may not prohibit the participant from receiving medication-assisted treatment under the care of a

physician licensed in this State to practice medicine in all of its branches. Drug court participants may not be required to refrain from using medication-assisted treatment as a term or condition of successful completion of the drug court program.

(f) Recognizing that individuals struggling with mental health, substance use, and related co-occurring disorders have often experienced trauma, drug court programs may include specialized service programs specifically designed to address trauma. These specialized services may be offered to individuals admitted to the drug court program. Judicial circuits establishing these specialized programs shall partner with advocates, survivors, and service providers in the development of the programs. Trauma-informed services and programming shall be operated in accordance with evidence-based best practices as outlined by the Substance Abuse and Mental Health Service Administration's National Center for Trauma-Informed Care.

(g) The court may establish a mentorship program that provides access and support to program participants by peer recovery coaches. Courts shall be responsible to administer the mentorship program with the support of mentors and local mental health and substance use disorder treatment organizations.

(Source: P.A. 102-1041, eff. 6-2-22.)

(730 ILCS 166/30)

Sec. 30. Mental health and substance use disorder treatment.

(a) The drug court program shall maintain a network of substance use disorder treatment programs representing a continuum of graduated substance use disorder treatment options commensurate with the needs of the participant.

(b) Any substance use disorder treatment program to which participants are referred must hold a valid license from the Department of Human Services ~~Division of Substance Use Prevention and Recovery~~, use evidence-based treatment, and deliver all services in accordance with 77 Ill. Adm. Code 2060, including services available through the United States Department of Veterans Affairs, the Illinois Department of Veterans Affairs, or Veterans Assistance Commission, or an equivalent standard in any other state where treatment may take place.

(c) The drug court program may, at its discretion, employ additional services or interventions, as it deems necessary on a case by case basis.

(d) The drug court program may maintain or collaborate with a network of mental health treatment programs representing a continuum of treatment options commensurate with the needs of the participant and available resources, including programs with the State and community-based programs supported and sanctioned by the State. Partnerships with

providers certified as mental health or behavioral health centers shall be prioritized when possible.

(Source: P.A. 104-234, eff. 8-15-25.)

Section 170. The Veterans and Servicemembers Court Treatment Act is amended by changing Sections 10, 25, and 30 as follows:

(730 ILCS 167/10)

Sec. 10. Definitions. In this Act:

"Certification" means the process by which a problem-solving court obtains approval from the Supreme Court to operate in accordance with the Problem-Solving Court Standards.

"Clinical treatment plan" means an evidence-based, comprehensive, and individualized plan that: (i) is developed by a qualified professional in accordance with the Department of Human Services ~~substance use prevention and recovery~~ rules under 77 Ill. Adm. Code 2060 or an equivalent standard in any state where treatment may take place; and (ii) defines the scope of treatment services to be delivered by a court treatment provider.

"Combination Veterans and Servicemembers court program" means a type of problem-solving court that allows an individual to enter a problem-solving court before a plea, conviction, or disposition while also permitting an individual

who has admitted guilt, or been found guilty, to enter a problem-solving court as a part of the individual's sentence or disposition.

"Community behavioral health center" means a physical site where behavioral healthcare services are provided in accordance with the Community Behavioral Health Center Infrastructure Act.

"Community mental health center" means an entity:

(1) licensed by the Department of Public Health as a community mental health center in accordance with the conditions of participation for community mental health centers established by the Centers for Medicare and Medicaid Services; and

(2) that provides outpatient services, including specialized outpatient services, for individuals who are chronically mental ill.

"Co-occurring mental health and substance use disorders court program" means a program that includes an individual with co-occurring mental illness and substance use disorder diagnoses and professionals with training and experience in treating individuals with diagnoses of substance use disorder and mental illness.

"Court" means veterans and servicemembers court.

"IDVA" means the Illinois Department of Veterans Affairs.

"Peer recovery coach" means a veteran mentor as defined nationally by Justice for Vets and assigned to a veteran or

servicemember during participation in a veteran treatment court program who has been approved by the court, and trained according to curriculum recommended by Justice for Vets, a service provider used by the court for substance use disorder or mental health treatment, a local service provider with an established peer recovery coach or mentor program not otherwise used by the court for treatment, or a Certified Recovery Support Specialist certified by the Illinois Certification Board. "Peer recovery coach" includes individuals with lived experiences of the issues the problem-solving court seeks to address, including, but not limited to, substance use disorder, mental illness, and co-occurring disorders or involvement with the criminal justice system. "Peer recovery coach" includes individuals required to guide and mentor the participant to successfully complete assigned requirements and to facilitate participants' independence for continued success once the supports of the court are no longer available to them.

"Post-adjudicatory veterans and servicemembers court program" means a program that allows a defendant who has admitted guilt or has been found guilty and agrees, with the defendant's consent, and the approval of the court, to enter a veterans and servicemembers court program as part of the defendant's sentence or disposition.

"Pre-adjudicatory veterans and servicemembers court program" means a program that allows the defendant, with the

defendant's consent and the approval of the court, to enter the Veterans and Servicemembers Court program before plea, conviction, or disposition and requires successful completion of the Veterans and Servicemembers Court programs as part of the agreement.

"Problem-Solving Court Standards" means the statewide standards adopted by the Supreme Court that set forth the minimum requirements for the planning, establishment, certification, operation, and evaluation of all problem-solving courts in this State.

"Servicemember" means a person who is currently serving in the Army, Air Force, Marines, Navy, or Coast Guard on active duty, reserve status or in the National Guard.

"VA" means the United States Department of Veterans Affairs.

"VAC" means a veterans assistance commission.

"Validated clinical assessment" means a validated assessment tool administered by a qualified clinician to determine the treatment needs of participants. "Validated clinical assessment" includes assessment tools required by public or private insurance.

"Veteran" means a person who previously served as an active servicemember.

"Veterans and servicemembers court professional" means a member of the veterans and servicemembers court team, including, but not limited to, a judge, prosecutor, defense

attorney, probation officer, coordinator, treatment provider.

"Veterans and servicemembers court", "veterans and servicemembers court program", "court", or "program" means a specially designated court, court calendar, or docket facilitating intensive therapeutic treatment to monitor and assist veteran or servicemember participants with substance use disorder, mental illness, co-occurring disorders, or other assessed treatment needs of eligible veteran and servicemember participants and in making positive lifestyle changes and reducing the rate of recidivism. Veterans and servicemembers court programs are nonadversarial in nature and bring together substance use disorder professionals, mental health professionals, VA professionals, local social programs, and intensive judicial monitoring in accordance with the nationally recommended 10 key components of veterans treatment courts and the Problem-Solving Court Standards. Common features of a veterans and servicemembers court program include, but are not limited to, a designated judge and staff; specialized intake and screening procedures; coordinated treatment procedures administered by a trained, multidisciplinary professional team; close evaluation of participants, including continued assessments and modification of the court requirements and use of sanctions, incentives, and therapeutic adjustments to address behavior; frequent judicial interaction with participants; less formal court process and procedures; voluntary participation; and a low

treatment staff-to-client ratio.

(Source: P.A. 104-234, eff. 8-15-25.)

(730 ILCS 167/25)

Sec. 25. Procedure.

(a) A screening and clinical needs assessment and risk assessment of the defendant shall be performed as required by the court's policies and procedures prior to the defendant's admission into a veteran and servicemembers court. The assessment shall be conducted through the VA, VAC, and/or the IDVA to provide information on the defendant's veteran or servicemember status.

Any risk assessment shall be performed using an assessment tool approved by the Administrative Office of the Illinois Courts and as required by the court's policies and procedures.

(b) A mental health and substance use disorder screening and assessment of the defendant shall be performed by the VA, VAC, or by the IDVA, or as otherwise outlined and as required by the court's policies and procedures. The assessment shall include, but is not limited to, assessments of substance use and mental and behavioral health needs. The clinical needs assessment shall be administered by a qualified professional of the VA, VAC, or IDVA, or individuals who meet the Department of Human Services ~~substance use prevention and recovery~~ rules for professional staff under 77 Ill. Adm. Code 2060, or an equivalent standard in any other state where treatment may

take place, and used to inform any clinical treatment plans. Clinical treatment plans shall be developed, in accordance with the Problem-Solving Court Standards and be based, in part, upon the known availability of treatment resources available to the veterans and servicemembers court. An assessment need not be ordered if the court finds a valid screening or assessment related to the present charge pending against the defendant has been completed within the previous 60 days.

(c) The judge shall inform the defendant that if the defendant fails to meet the conditions of the veterans and servicemembers court program, eligibility to participate in the program may be revoked and the defendant may be sentenced or the prosecution continued as provided in the Unified Code of Corrections for the crime charged.

(d) The defendant shall execute a written agreement with the court as to the defendant's participation in the program and shall agree to all of the terms and conditions of the program, including but not limited to the possibility of sanctions or incarceration for failing to abide or comply with the terms of the program.

(e) In addition to any conditions authorized under the Pretrial Services Act and Section 5-6-3 of the Unified Code of Corrections, the court may order the participant to complete mental health counseling or substance use disorder treatment in an outpatient or residential treatment program and may

order the participant to comply with physicians' recommendations regarding medications and all follow-up treatment for any mental health diagnosis made by the provider. Substance use disorder treatment programs must be licensed by the Department of Human Services in accordance with the Department of Human Services ~~substance use prevention and recovery~~ rules, or an equivalent standard in any other state where the treatment may take place, and use evidence-based treatment. When referring participants to mental health treatment programs, the court shall prioritize providers certified as community mental health or behavioral health centers if possible. The court shall consider the least restrictive treatment option when ordering mental health or substance use disorder treatment for participants and the results of clinical and risk assessments in accordance with the Problem-Solving Court Standards.

(e-5) The veterans and servicemembers court shall include a regimen of graduated requirements, including individual and group therapy, substance analysis testing, close monitoring by the court, supervision of progress, restitution, educational or vocational counseling as appropriate, and other requirements necessary to fulfill the veterans and servicemembers court program. Program phases, therapeutic adjustments, incentives, and sanctions, including the use of jail sanctions, shall be administered in accordance with evidence-based practices and the Problem-Solving Court

Standards. If the participant needs treatment for an opioid use disorder or dependence, the court may not prohibit the participant from receiving medication-assisted treatment under the care of a physician licensed in this State to practice medicine in all of its branches. Veterans and servicemembers court participants may not be required to refrain from using medication-assisted treatment as a term or condition of successful completion of the veteran and servicemembers court program.

(e-10) Recognizing that individuals struggling with mental health, substance use, and related co-occurring disorders have often experienced trauma, veterans and servicemembers court programs may include specialized service programs specifically designed to address trauma. These specialized services may be offered to individuals admitted to the veterans and servicemembers court program. Judicial circuits establishing these specialized programs shall partner with advocates, survivors, and service providers in the development of the programs. Trauma-informed services and programming shall be operated in accordance with evidence-based best practices as outlined by the Substance Abuse and Mental Health Service Administration's National Center for Trauma-Informed Care (SAMHSA).

(f) The Court may establish a mentorship program that provides access and support to program participants by peer recovery coaches. Courts shall be responsible to administer

the mentorship program with the support of volunteer veterans and local veteran service organizations, including a VAC. Peer recovery coaches shall be trained and certified by the Court prior to being assigned to participants in the program.

(Source: P.A. 102-1041, eff. 6-2-22.)

(730 ILCS 167/30)

Sec. 30. Mental health and substance use disorder treatment.

(a) The veterans and servicemembers court program may maintain a network of substance use disorder treatment programs representing a continuum of graduated substance use disorder treatment options commensurate with the needs of participants; these shall include programs with the VA, IDVA, a VAC, the State, and community-based programs supported and sanctioned by either or both.

(b) Any substance use disorder treatment program to which participants are referred must hold a valid license from the Department of Human Services ~~Division of Substance Use Prevention and Recovery~~, use evidence-based treatment, and deliver all services in accordance with 77 Ill. Adm. code 2060, including services available through the VA, IDVA or VAC, or an equivalent standard in any other state where treatment may take place.

(c) The veterans and servicemembers court program may, in its discretion, employ additional services or interventions,

as it deems necessary on a case by case basis.

(d) The veterans and servicemembers court program may maintain or collaborate with a network of mental health treatment programs and, if it is a co-occurring mental health and substance use disorders court program, a network of substance use disorder treatment programs representing a continuum of treatment options commensurate with the needs of the participant and available resources including programs with the VA, the IDVA, a VAC, and the State of Illinois. When not using mental health treatment or services available through the VA, IDVA, or VAC, partnerships with providers certified as community mental health or behavioral health centers shall be prioritized, as possible.

(Source: P.A. 102-1041, eff. 6-2-22.)

Section 175. The Mental Health Court Treatment Act is amended by changing Sections 10, 25, and 30 as follows:

(730 ILCS 168/10)

Sec. 10. Definitions. As used in this Act:

"Certification" means the process by which a problem-solving court obtains approval from the Supreme Court to operate in accordance with the Problem-Solving Court Standards.

"Clinical treatment plan" means an evidence-based, comprehensive, and individualized plan that: (i) is developed

by a qualified professional in accordance with Department of Human Services ~~substance use prevention and recovery~~ rules under 77 Ill. Adm. Code 2060 or an equivalent standard in any state where treatment may take place; and (ii) defines the scope of treatment services to be delivered by a court treatment provider.

"Combination mental health court program" means a type of problem-solving court that allows an individual to enter a problem-solving court before a plea, conviction, or disposition while also permitting an individual who has admitted guilt, or been found guilty, to enter a problem-solving court as a part of the individual's sentence or disposition.

"Community behavioral health center" means a physical site where behavioral healthcare services are provided in accordance with the Community Behavioral Health Center Infrastructure Act.

"Community mental health center" means an entity:

(1) licensed by the Department of Public Health as a community mental health center in accordance with the conditions of participation for community mental health centers established by the Centers for Medicare and Medicaid Services; and

(2) that provides outpatient services, including specialized outpatient services, for individuals who are chronically mental ill.

"Co-occurring mental health and substance use disorders court program" means a program that includes an individual with co-occurring mental illness and substance use disorder diagnoses and professionals with training and experience in treating individuals with diagnoses of substance use disorder and mental illness.

"Mental health court", "mental health court program", "court", or "program" means a specially designated court, court calendar, or docket facilitating intensive therapeutic treatment to monitor and assist participants with mental illness in making positive lifestyle changes and reducing the rate of recidivism. Mental health court programs are nonadversarial in nature and bring together mental health professionals and local social programs in accordance with the Bureau of Justice Assistance and Council of State Governments Justice Center's Essential Elements of a Mental Health Court and the Problem-Solving Court Standards. Common features of a mental health court program include, but are not limited to, a designated judge and staff; specialized intake and screening procedures; coordinated treatment procedures administered by a trained, multidisciplinary professional team; close evaluation of participants, including continued assessments and modification of the court requirements and use of sanctions, incentives, and therapeutic adjustments to address behavior; frequent judicial interaction with participants; less formal court process and procedures; voluntary participation; and a

low treatment staff-to-client ratio.

"Mental health court professional" means a member of the mental health court team, including but not limited to a judge, prosecutor, defense attorney, probation officer, coordinator, or treatment provider.

"Peer recovery coach" means a mentor assigned to a defendant during participation in a mental health treatment court program who has been trained by the court, a service provider used by the court for substance use disorder or mental health treatment, a local service provider with an established peer recovery coach or mentor program not otherwise used by the court for treatment, or a Certified Recovery Support Specialist certified by the Illinois Certification Board. "Peer recovery coach" includes individuals with lived experiences of the issues the problem-solving court seeks to address, including, but not limited to, substance use disorder, mental illness, and co-occurring disorders or involvement with the criminal justice system. "Peer recovery coach" includes individuals required to guide and mentor the participant to successfully complete assigned requirements and to facilitate participants' independence for continued success once the supports of the court are no longer available to them.

"Post-adjudicatory mental health court program" means a program that allows an individual who has admitted guilt or has been found guilty, with the defendant's consent, and the

approval of the court, to enter a mental health court program as part of the defendant's sentence or disposition.

"Pre-adjudicatory mental health court program" means a program that allows the defendant, with the defendant's consent and the approval of the court, to enter the mental health court program before plea, conviction, or disposition and requires successful completion of the mental health court program as part of the agreement.

"Problem-Solving Court Standards" means the statewide standards adopted by the Supreme Court that set forth the minimum requirements for the planning, establishment, certification, operation, and evaluation of all problem-solving courts in this State.

"Validated clinical assessment" means a validated assessment tool administered by a qualified clinician to determine the treatment needs of participants. "Validated clinical assessment" includes assessment tools required by public or private insurance.

(Source: P.A. 102-1041, eff. 6-2-22.)

(730 ILCS 168/25)

Sec. 25. Procedure.

(a) An eligibility screening and an assessment of the defendant shall be performed as required by the court's policies and procedures. The assessment shall include a validated clinical assessment. The clinical assessment shall

include, but is not limited to, assessments of substance use and mental and behavioral health needs. The clinical assessment shall be administered by a qualified professional and used to inform any clinical treatment plans. Clinical treatment plans shall be developed, in part, upon the known availability of treatment resources available. Assessments for substance use disorder shall be conducted in accordance with the Department of Human Services ~~substance use prevention and recovery~~ rules contained in 77 Ill. Adm. Code 2060 or an equivalent standard in any other state where treatment may take place, and conducted by individuals who meet the Department of Human Services ~~substance use prevention and recovery~~ rules for professional staff also contained within that Code, or an equivalent standard in any other state where treatment may take place. The assessments shall be used to inform any clinical treatment plans. Clinical treatment plans shall be developed in accordance with Problem-Solving Court Standards and, in part, upon the known availability of treatment resources. An assessment need not be ordered if the court finds a valid assessment related to the present charge pending against the defendant has been completed within the previous 60 days.

(b) The judge shall inform the defendant that if the defendant fails to meet the conditions of the mental health court program, eligibility to participate in the program may be revoked and the defendant may be sentenced or the

prosecution continued as provided in the Unified Code of Corrections for the crime charged.

(c) The defendant shall execute a written agreement as to his or her participation in the program and shall agree to all of the terms and conditions of the program, including but not limited to the possibility of sanctions or incarceration for failing to abide or comply with the terms of the program.

(d) In addition to any conditions authorized under the Pretrial Services Act and Section 5-6-3 of the Unified Code of Corrections, the court may order the participant to complete mental health counseling or substance use disorder treatment in an outpatient or residential treatment program and may order the participant to comply with physicians' recommendations regarding medications and all follow-up treatment for any mental health diagnosis made by the provider. Substance use disorder treatment programs must be licensed by the Department of Human Services in accordance with the Department of Human Services ~~substance use prevention and recovery~~ rules, or an equivalent standard in any other state where the treatment may take place, and use evidence-based treatment. When referring participants to mental health treatment programs, the court shall prioritize providers certified as community mental health or behavioral health centers if possible. The court shall consider the least restrictive treatment option when ordering mental health or substance use disorder treatment for participants and the

results of clinical and risk assessments in accordance with the Problem-Solving Court Standards.

(e) The mental health court program shall include a regimen of graduated requirements, including fines, fees, costs, restitution, individual and group therapy, medication, substance analysis testing, close monitoring by the court, supervision of progress, restitution, educational or vocational counseling as appropriate, and other requirements necessary to fulfill the mental health court program. Program phases, therapeutic adjustments, incentives, and sanctions, including the use of jail sanctions, shall be administered in accordance with evidence-based practices and the Problem-Solving Court Standards. A participant's failure to pay program fines or fees shall not prevent the participant from advancing phases or successfully completing the program. If the participant needs treatment for an opioid use disorder or dependence, the court may not prohibit the participant from receiving medication-assisted treatment under the care of a physician licensed in this State to practice medicine in all of its branches. Mental health court participants may not be required to refrain from using medication-assisted treatment as a term or condition of successful completion of the mental health court program.

(f) The mental health court program may maintain or collaborate with a network of mental health treatment programs and, if it is a co-occurring mental health and substance use

disorders court program, a network of substance use disorder treatment programs representing a continuum of treatment options commensurate with the needs of the participant and available resources, including programs of this State.

(g) Recognizing that individuals struggling with mental health, addiction, and related co-occurring disorders have often experienced trauma, mental health court programs may include specialized service programs specifically designed to address trauma. These specialized services may be offered to individuals admitted to the mental health court program. Judicial circuits establishing these specialized programs shall partner with advocates, survivors, and service providers in the development of the programs. Trauma-informed services and programming shall be operated in accordance with evidence-based best practices as outlined by the Substance Abuse and Mental Health Service Administration's National Center for Trauma-Informed Care.

(h) The court may establish a mentorship program that provides access and support to program participants by peer recovery coaches. Courts shall be responsible to administer the mentorship program with the support of mentors and local mental health and substance use disorder treatment organizations.

(Source: P.A. 102-1041, eff. 6-2-22.)

(730 ILCS 168/30)

Sec. 30. Mental health and substance use disorder treatment.

(a) The mental health court program may maintain or collaborate with a network of mental health treatment programs and, if it is a co-occurring mental health and substance use disorders court program, a network of substance use disorder treatment programs representing a continuum of treatment options commensurate with the needs of participants and available resources.

(b) Any substance use disorder treatment program to which participants are referred must hold a valid license from the Department of Human Services ~~Division of Substance Use Prevention and Recovery~~, use evidence-based treatment, and deliver all services in accordance with 77 Ill. Adm. Code 2060, including services available through the United States Department of Veterans Affairs, the Illinois Department of Veterans Affairs, or the Veterans Assistance Commission, or an equivalent standard in any other state where treatment may take place.

(c) The mental health court program may, at its discretion, employ additional services or interventions, as it deems necessary on a case by case basis.

(Source: P.A. 102-1041, eff. 6-2-22.)

Section 180. The Consumer Fraud and Deceptive Business Practices Act is amended by changing Section 2VVV as follows:

(815 ILCS 505/2VVV)

Sec. 2VVV. Deceptive marketing, advertising, and sale of mental health disorder and substance use disorder treatment.

(a) As used in this Section:

"Facility" has the meaning ascribed to that term in Section 1-10 of the Substance Use Disorder Act when used in reference to a facility that provides substance use disorder treatment. "Facility" has the same meaning as "mental health facility" under Section 1-114 of the Mental Health and Developmental Disabilities Code when used in reference to a facility that provides mental health disorder treatment.

"Hospital affiliate" has the meaning ascribed to that term in Section 10.8 of the Hospital Licensing Act.

"Mental health disorder" has the same meaning as "mental illness" under Section 1-129 of the Mental Health and Developmental Disabilities Code.

"Program" means a licensable or fundable activity or service, or a coordinated range of such activities or services, established or licensed by the Department of Human Services.

"Substance use disorder" has the same meaning as "substance abuse" under Section 1-10 of the Substance Use Disorder Act.

"Treatment" has the meaning ascribed to that term in Section 1-10 of the Substance Use Disorder Act when used in

reference to treatment for a substance use disorder. "Treatment" has the meaning ascribed to that term in Section 1-128 of the Mental Health and Developmental Disabilities Code when used in reference to treatment for a mental health disorder.

(b) It is an unlawful practice for any person to engage in misleading or false advertising or promotion that misrepresents the need to seek mental health disorder or substance use disorder treatment outside of the State of Illinois.

(c) Any marketing, advertising, promotional, or sales materials directed to Illinois residents concerning mental health disorder or substance use disorder treatment must:

(1) prominently display or announce the full physical address of the treatment program or facility;

(2) display whether the treatment program or facility is licensed in the State of Illinois;

(3) display whether the treatment program or facility has locations in Illinois;

(4) display whether the services provided by the treatment program or facility are covered by an insurance policy issued to an Illinois resident;

(5) display whether the treatment program or facility is an in-network or out-of-network provider;

(6) include a link to the Internet website for the Department of Human Services ~~Services' Division of Mental~~

~~Health and Division of Substance Use Prevention and Recovery~~, or any successor State agency that provides information regarding licensed providers of services; and

(7) disclose that mental health disorder and substance use disorder treatment may be available at a reduced cost or for free for Illinois residents within the State of Illinois.

(d) It is an unlawful practice for any person to solicit, offer, or enter into an arrangement under which a patient seeking mental health disorder or substance use disorder treatment is referred to a mental health disorder or substance use disorder treatment program or facility in exchange for a fee, a percentage of the treatment program's or facility's revenues that are related to the patient, or any other remuneration that takes into account the volume or value of the referrals to the treatment program or facility. Such practice shall also be considered a violation of the prohibition against fee splitting in Section 22.2 of the Medical Practice Act of 1987 and a violation of the Health Care Worker Self-Referral Act. It is not a violation of this Section for programs or facilities to enter into personal services agreements or management services agreements with third parties that do not take into account the volume or value of referrals. It is not a violation of this Section for programs or facilities to provide discounts for treatment services to clients as long as the discount is based on

financial necessity in accordance with the program's or facility's charity care plan, regardless of referral source or reason. Compensation paid by programs or facilities to their employees and independent contractors related to identifying, locating, and securing referrals to that program or facility is not a violation of this Section if the amount of compensation provided to the employee or independent contractor does not vary based upon the volume or value of such referrals. This Section does not apply to health insurance companies, health maintenance organizations, managed care plans, or organizations, including hospitals and hospital affiliates licensed in Illinois.

(Source: P.A. 101-81, eff. 7-12-19; 102-550, eff. 8-20-21.)

(110 ILCS 165/Act rep.)

Section 185. The Behavioral Health Workforce Education Center Task Force Act is repealed.

(305 ILCS 5/5-1.5 rep.)

Section 190. The Illinois Public Aid Code is amended by repealing Section 5-1.5.

(405 ILCS 90/35 rep.)

Section 195. The Health Care Workplace Violence Prevention Act is amended by repealing Section 35.

(405 ILCS 115/Act rep.)

Section 200. The Advisory Council on Early Identification and Treatment of Mental Health Conditions Act is repealed.

(405 ILCS 140/10 rep.)

(405 ILCS 140/15 rep.)

Section 205. The Mental Health Inpatient Facility Access Act is amended by repealing Sections 10 and 15.

(405 ILCS 160/Act rep.)

Section 210. The Strengthening and Transforming Behavioral Health Crisis Care in Illinois Act is repealed.

Article 5.

Section 5-5. The Department of Human Services Act is amended by changing and renumbering Section 1-90, as added by Public Act 104-159, as follows:

(20 ILCS 1305/1-91)

Sec. 1-91 ~~1-90~~. Statewide plan; victims of human trafficking.

(a) In this Section, "human trafficking" means a violation or attempted violation of Section 10-9 of the Criminal Code of 2012. Human trafficking includes trafficking of children and adults for both labor and sex services.

(b) The Department of Human Services shall:

(1) on or before December 31, 2025, develop and submit a strategic plan to the Governor and General Assembly to establish a statewide system of identification and response to survivors of human trafficking and recommended levels of funding for phase-in of comprehensive victim-centered, trauma-informed statewide services for victims of human trafficking, including adults, youth and children, and to sex and labor trafficking victims regardless of immigration or legal status. The plan shall be developed in consultation with survivors, human trafficking service providers, and State agencies including the Department of Human Services, Department of Children and Family Services, Illinois State Police, and Department of Labor. The Department of Human Services shall also solicit input from a broad range of partners with relevant expertise in the areas of: housing and shelter; youth crisis response; adult and pediatric healthcare; substance use disorders, behavioral and mental health; legal and immigration services; disability; domestic violence and sexual assault advocacy; law enforcement; justice system including the Office of the State's Attorneys Appellate Prosecutor, prosecutors and public defenders, county detention centers, probation court services, and the Administrative Office of the Illinois Courts; State agencies, including the Department

of Juvenile Justice, Department of Public Health, Department of Corrections, and Illinois Criminal Justice Information Authority; and federally funded and regional multi-disciplinary human trafficking task forces; ~~.~~

(2) within one calendar year of the release of federal standards ~~on or before July 1, 2026~~, develop service standards for organizations providing victim services to survivors of human trafficking based upon victim-centered, trauma-informed best practices in consultation with survivors and experts in the field and consistent with standards developed by the United States Department of Justice, Office of Victims of Crime;

(3) within one calendar year of the release of federal standards ~~on or before October 1, 2026~~, develop standardized training curriculum for individuals who provide advocacy, counseling, mental health, substance use disorder, homelessness, immigration, legal, and case-management services for survivors of human trafficking with input from survivors and experts in the field;

(4) provide consultation to State professional associations in the development of trainings for healthcare professionals, including those in training, and attorneys who are likely to provide services to survivors of human trafficking; and

(5) provide consultation to State agencies, including,

but not limited to, the Department of Children and Family Services, the Department of Juvenile Justice, and the Department of Corrections, to assist with development of training and screening tools.

(Source: P.A. 104-159 (See Section 99 of P.A. 104-159); revised 10-7-25.)

Article 910.

Section 910-995. 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.

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