AN ACT concerning public aid.

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

Section 5. The Illinois Public Aid Code is amended by changing Sections 8A-2.5, 8A-13, and 8A-15 as follows:

(305 ILCS 5/8A-2.5)

Sec. 8A-2.5. Unauthorized use of medical assistance.

(a) Any person who knowingly uses, acquires, possesses, or transfers a medical card in any manner not authorized by law or by rules and regulations of the Illinois Department, or who knowingly alters a medical card, or who knowingly uses, acquires, possesses, or transfers an altered medical card, is guilty of a violation of this Article and shall be punished as provided in Section 8A-6.

(b) Any person who knowingly obtains unauthorized medical benefits <u>or causes to be obtained unauthorized medical benefits</u> with or without use of a medical card is guilty of a violation of this Article and shall be punished as provided in Section 8A-6.

<u>(b-5) Any vendor that knowingly assists a person in committing a violation under subsection (a) or (b) of this Section is guilty of a violation of this Article and shall be punished as provided in Section 8A-6.</u>

(b-6) Any person (including a vendor, organization, agency, or other entity) that, in any matter related to the medical assistance program, knowingly or willfully falsifies, conceals, or omits by any trick, scheme, artifice, or device a material fact, or makes any false, fictitious, or fraudulent statement or representation, or makes or uses any false writing or document, knowing the same to contain any false, fictitious, or fraudulent statement or entry in connection with the provision of health care or related services, is guilty of a violation of this Article and shall be punished as provided in Section 8A-6.

(c) The Department may seek to recover any and all State and federal monies for which it has improperly and erroneously paid benefits as a result of a fraudulent action and any civil penalties authorized in this Section. Pursuant to Section 11-14.5 of this Code, the Department may determine the monetary value of benefits improperly and erroneously received. The Department may recover the monies paid for such benefits and interest on that amount at the rate of 5% per annum for the period from which payment was made to the date upon which repayment is made to the State. Prior to the recovery of any amount paid for benefits allegedly obtained by fraudulent means, the recipient or payee of such benefits shall be afforded an opportunity for a hearing after reasonable notice. The notice shall be served personally or by certified or registered mail or as otherwise provided by law upon the

parties or their agents appointed to receive service of process and shall include the following:

(1) A statement of the time, place and nature of the hearing.

(2) A statement of the legal authority and jurisdiction under which the hearing is to be held.

(3) A reference to the particular Sections of the substantive and procedural statutes and rules involved.

(4) Except where a more detailed statement is otherwise provided for by law, a short and plain statement of the matters asserted, the consequences of a failure to respond, and the official file or other reference number.

(5) A statement of the monetary value of the benefits fraudulently received by the person accused.

(6) A statement that, in addition to any other penalties provided by law, a civil penalty in an amount not to exceed $2,000 may be imposed for each fraudulent claim for benefits or payments.

(7) A statement providing that the determination of the monetary value may be contested by petitioning the Department for an administrative hearing within 30 days from the date of mailing the notice.

(8) The names and mailing addresses of the administrative law judge, all parties, and all other persons to whom the agency gives notice of the hearing unless otherwise confidential by law.

An opportunity shall be afforded all parties to be represented by legal counsel and to respond and present evidence and argument.

Unless precluded by law, disposition may be made of any contested case by stipulation, agreed settlement, consent order, or default.

Any final order, decision, or other determination made, issued or executed by the Director under the provisions of this Article whereby any person is aggrieved shall be subject to review in accordance with the provisions of the Administrative Review Law, and the rules adopted pursuant thereto, which shall apply to and govern all proceedings for the judicial review of final administrative decisions of the Director.

Upon entry of a final administrative decision for repayment of any benefits obtained by fraudulent means, or for any civil penalties assessed, a lien shall attach to all property and assets of such person, firm, corporation, association, agency, institution, <u>vendor,</u> or other legal entity until the judgment is satisfied.

Within 18 months of the effective date of this amendatory Act of the 96th General Assembly, the Department of Healthcare and Family Services will report to the General Assembly on the number of fraud cases identified and pursued, and the fines assessed and collected. The report will also include the Department's analysis as to the use of private sector resources to bring action, investigate, and collect monies owed.

(d) In subsections (a),(b),(b-5) and (b-6), "knowledge" has the meaning ascribed to that term in Section 4-5 of the Criminal Code of 2012. For any administrative action brought under subsection (c) pursuant to a violation of this Section, the Department shall define "knowing" by rule.

(Source: P.A. 96-1501, eff. 1-25-11; 97-23, eff. 1-1-12.)

(305 ILCS 5/8A-13)

Sec. 8A-13. Managed health care fraud.

(a) As used in this Section, "health plan" means any of the following:

(1) Any health care reimbursement plan sponsored wholly or partially by the State.

(2) Any private insurance carrier, health care cooperative or alliance, health maintenance organization, insurer, organization, entity, association, affiliation, or person that contracts to provide or provides goods or services that are reimbursed by or are a required benefit of a health benefits program funded wholly or partially by the State.

(3) Anyone who provides or contracts to provide goods and services to an entity described in paragraph (1) or (2) of this subsection.

For purposes of item (2) in subsection (b), "representation" and "statement" include, but are not limited to, reports, claims, certifications, acknowledgments and

ratifications of financial information, enrollment claims, demographic statistics, encounter data, health services available or rendered, and the qualifications of person rendering health care and ancillary services.

(b) Any person, firm, corporation, association, agency, institution, or other legal entity that, with the intent to obtain benefits or payments under this Code to which the person or entity is not entitled or in a greater amount than that to which the person or entity is entitled, knowingly or willfully: ~~executes or conspires to execute a scheme or artifice~~

(1) executes or conspires to execute a scheme or artifice to defraud any State or federally funded or mandated health plan in connection with the delivery of or payment for health care benefits, items, or services; ~~, or~~

(2) executes or conspires to execute a scheme or artifice to obtain by means of false or fraudulent pretense, representation, statement, or promise money or anything of value in connection with the delivery of or payment for health care benefits, items, or services that are in whole or in part paid for, reimbursed, or subsidized by, or are a required benefit of, a State or federally funded or mandated health plan;

(3) falsifies, conceals, or covers up by any trick, scheme, or device a material fact in connection with the delivery of or payment for health care benefits, items, or services that are in whole or in part paid for or

reimbursed by a State or federal health plan;

(4) makes any materially false, fictitious, or fraudulent statements or representations, or makes or uses any materially false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of or payment for health care benefits, items, or services that are in whole or in part paid for or reimbursed by a State or federal health plan; or

(5) makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry in connection with the delivery of or payment for health care benefits, items, or services that are in whole or in part paid for or reimbursed by a State or federal health plan;

is guilty of a violation of this Article and shall be punished as provided in Section 8A-6.

(Source: P.A. 90-538, eff. 12-1-97.)

(305 ILCS 5/8A-15)

Sec. 8A-15. False statements relating to health care delivery. Any person, firm, corporation, association, agency, institution, or other legal entity that, in any matter related to a State or federally funded or mandated health plan, knowingly and wilfully falsifies, conceals, or omits by any trick, scheme, artifice, or device a material fact, or makes

any false, fictitious, or fraudulent statement or representation, or makes or uses any false writing or document, knowing the same to contain any false, fictitious, or fraudulent statement or entry in connection with the provision of health care or related services, is guilty of a Class 4 felony ~~A misdemeanor~~.

(Source: P.A. 90-538, eff. 12-1-97.)

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