**Section 140.12 Participation Requirements for Medical Providers**

The provider shall agree to:

a) Verify eligibility of recipients prior to providing each service;

b) Allow recipients the choice of accepting or rejecting medical or surgical care or treatment;

c) Provide supplies and services in full compliance with all applicable provisions of State and federal laws and regulations pertaining to nondiscrimination and equal employment opportunity including but not limited to:

1) Full compliance with Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color or national origin;

2) Full compliance with Section 504 of the Rehabilitation Act of 1973 and 45 CFR 84, which prohibit discrimination on the basis of handicap; and

3) Without discrimination on the basis of religious belief, political affiliation, sex, age or disability;

d) Comply with the requirements of applicable federal and State laws and not engage in practices prohibited by such laws;

e) Provide, and upon demand present documentation of, education of employees, contractors and agents regarding the federal False Claims Act (31 USC 3729‑3733) that complies with all requirements of 42 USC 1396a(a)(68). Providers subject to this requirement include a governmental agency, organization, unit, corporation, partnership, or other business arrangement (including any Medicaid managed care organization, irrespective of the form of business structure or arrangement by which it exists), whether for-profit or no‑for‑profit, that receives or makes payments totaling at least $5 million annually;

f) Hold confidential, and use for authorized program purposes only, all Medical Assistance information regarding recipients;

g) Furnish to the Department, in the form and manner requested by it, any information it requests regarding payments for providing goods or services, or in connection with the rendering of goods or services or supplies to recipients by the provider, his agent, employer or employee;

h) Make charges for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges and in the same quality and mode of delivery as are provided to the general public;

i) Accept as payment in full the amounts established by the Department.

1) If a provider accepts an individual eligible for medical assistance from the Department as a Medicaid recipient, such provider shall not bill, demand or otherwise seek reimbursement from that individual or from a financially responsible relative or representative of the individual for any service for which reimbursement would have been available from the Department if the provider had timely and properly billed the Department. For purposes of this subsection, "accepts" shall be deemed to include:

A) an affirmative representation to an individual that payment for services will be sought from the Department;

B) an individual presents the provider with his or her medical card and the provider does not indicate that other payment arrangements will be necessary; or

C) billing the Department for the covered medical service provided an eligible individual.

2) If an eligible individual is entitled to medical assistance with respect to a service for which a third party is liable for payment, the provider furnishing the service may not seek to collect from the individual payment for that service if the total liability of the third party for that service is at least equal to the amount payable for that service by the Department.

j) Accept assignment of Medicare benefits for public aid recipients eligible for Medicare, when payment for services to such persons is sought from the Department;

k) Complete an MCH (Maternal and Child Health) Primary Care Provider Agreement in order to participate in the Maternal and Child Health Program (see Section 140.924(a)(1)(D)); and

l) In the case of long term care providers, assume liability for repayment to the Department of any overpayment made to a facility regardless of whether the overpayment was incurred by a current owner or operator or by a previous owner or operator. Liability of current and previous providers to the Department shall be joint and several. Recoveries by the Department under this Section may be made pursuant to Sections 140.15 and 140.25. A current or previous owner or lessee may request from the Department a list of all known outstanding liabilities due the Department by the facility and of any known pending Department actions against a facility that may result in further liability. For purposes of this Section, "overpayment" shall include, but not be limited to:

1) Amounts established by final administrative decisions pursuant to 89 Ill. Adm. Code 104;

2) Overpayments resulting from advance C-13 payments made pursuant to Section 140.71;

3) Liabilities resulting from nonpayment or delinquent payment of assessments pursuant to Sections 140.82, 140.84 and 140.94; and

4) Amounts identified during past, pending or future audits that pertain to audit periods prior to a change in ownership and are conducted pursuant to Sections 140.30 and 140.590. Liability of current owners or operators for amounts identified during such audits shall be as follows:

A) For past audits (audits completed before changes in ownership), liability shall be the amount established by final administrative decision.

B) For pending audits (audits initiated, but not completed prior to the change in ownership), liability shall be limited to the lesser of the amounts established by final administrative decision or two months of service revenue. Two months of service revenue is defined as the most recent two months of Medicaid patient days multiplied by the total Medicaid rate in effect on the date the new owner or operator is enrolled in the Program as a provider by the Department. The Medicaid rate in effect on the date of enrollment shall be used even if that rate is subsequently changed.

C) For future audits (audits initiated after the change in ownership but pertaining to an audit period prior to a change in ownership), liability shall be limited as described in subsection (l)(4)(B) of this Section.

m) A provider that is eligible to participate in the 340B federal Drug Pricing Program under section 340B of the federal Public Health Service Act (47 USC 201 et seq.), shall enroll in that program. No entity participating in the federal Drug Pricing Program under section 340B of the federal Public Health Services Act may exclude Medicaid from their participation in that program. A provider enrolled in the 340B federal Drug Pricing Program must charge the Department no more than its actual acquisition cost for the drug product, plus the Department established dispensing fee. This requirement is effective October 1, 2012 for 340B providers who own and/or operate a pharmacy that bills the Department for drugs, unless the 340B provider is a Hemophilia Treatment Center (HTC); July 1, 2013 for providers who are eligible to participate in the 340B program as HTCs; and January 1, 2013 for all other 340B-eligible providers who bill the Department for drugs. Contract pharmacies are exempt from the requirements of this subsection (m).

(Source: Amended at 38 Ill. Reg. 18462, effective August 19, 2014)