**Section 4521.50 Contracts, Administrative Arrangements and Material Modifications**

a) Agreements or Contracts

1) All sample agreements or contracts, with variable language bracketed, under which any person is delegated management duties or control of the HMO or that transfer a substantial part of any major function of the HMO, including, but not limited to, all reinsurance treaties, all agreements with providers and all administrative service contracts must be submitted to the Department of Insurance and the HMO must file with the Department any contract amendments, renewals, addendums thereto, or any change from those originally submitted and any material modification to the application submitted pursuant to Section 1-2 of the Act [215 ILCS 125/1-2] including, but not limited to, extension of service area.

2) The Illinois Department of Public Health shall also receive for review copies of all sample agreements with providers, as well as any amendments, addendums or any change from those agreements originally submitted.

3) On a quarterly basis, each HMO must submit a list identifying any MCO with which the HMO has a current contract. The list must contain the name, address and telephone number of the MCO, as well as the name of its Administrator, and must identify the bond or letter of credit issuer as required by subsection (d)(2), along with the expiration date and principal dollar amount for the instrument. The quarterly report shall be due at the Department within 10 days following the end of each quarter.

4) All types of written health care provider agreements must contain provisions under which the provider shall provide, arrange for, or participate in the quality assurance programs mandated by the Act [215 ILCS 125/2-8(b)], unless the Illinois Department of Public Health certifies that those programs will be fully implemented without any participation or action from the contracting provider.

5) All provider agreements shall provide for at least 60 days notice by the provider for termination with cause, as defined in the provider agreement, and at least 90 days notice by the provider for termination without cause. The HMO must inform the Department immediately of any known or intended termination, with or without cause, of an MCO.

6) Subscribers must receive notice from the HMO at least 60 days in advance of any termination that would curtail or eliminate services to subscribers. However, in the event that the HMO receives notice of less than 60 days from any provider for termination of any contract that would curtail or eliminate services to subscribers, the HMO must provide immediate notice to the subscribers. The Notice shall include instructions regarding referrals which have been issued and appointments which may be pending.

7) The contractual agreement between the provider and the HMO must contain evidence that the provider has professional liability insurance and that such insurance coverage is effective as of the effective date of such contract. Furthermore, the contract must set forth that the Provider will give at least 15 days advance notice of cancellation of such insurance. In those instances in which the HMO will provide physician services directly through employed physicians and not through contractual arrangement with a provider, the HMO shall provide evidence to the Department that each individual physician has professional liability insurance or that the HMO has coverage on behalf of the employed physicians.

b) The Director must disapprove any provider agreement if, at any time, he or she finds:

1) that the charges to the HMO are based on factors unrelated to the value of providing services to the HMO;

2) that the contract will significantly impact or threaten the financial viability of the HMO;

3) that the provider agreement would transfer substantial control of the HMO or any powers vested in the board of directors, by statute, articles of incorporation or bylaws, or substantially all of the basic functions of the HMO management;

4) that the provider agreement contains provisions contrary to the Illinois Insurance Code;

5) that the provider is or has been affiliated directly or indirectly, through ownership, control, management, reinsurance transactions or other insurance, or business relations with any person or persons known to have been involved in the improper manipulation of assets, accounts or reinsurance; or

6) that the provider agreement does not contain the provisions required by subsections (d) and (e) of this Section.

c) If the Director disapproves of any provider agreement, notice of that action shall be given to the HMO, listing the reasons for the disapproval in writing. The Director shall grant any party to the provider agreement a hearing upon request according to Article XXIV [215 ILCS 5/Art. XXIV] of the Illinois Insurance Code.

d) This subsection shall apply to all HMO agreements with MCOs authorized to furnish health care services, when the fees for furnishing, arranging or providing the health care services are capitated.

1) All capitated MCO agreements shall contain a provision that states that the MCO will submit, to the HMO, copies of its quarterly financial statements, which shall include the MCO's balance sheet and statements of income and cash flow within 45 days after the end of each fiscal period. In addition, the HMOs shall require the MCO to submit within 90 days after the end of the MCO's fiscal year copies of its audited annual financial statements prepared in accordance with generally accepted accounting principles if available. The Department, at its discretion, may require the HMO to submit for inspection by the Department statements the HMO has received from the MCO. This information shall be deemed confidential by the Department.

2) All MCO capitated agreements shall contain provisions requiring the disclosure of language whereby the MCO agrees to fully cooperate with, and disclose all relevant information requested by, the HMO's actuaries for the preparation of their opinion in accordance with the Actuarial Standards Board Actuarial Standards of Practice No. 16.

3) All MCO capitated agreements shall contain provisions under which the HMO acknowledges that, in the event of the MCO's insolvency, the HMO is secondarily liable as the ultimate risk bearer for unpaid health care services rendered to its enrollees.

e) Beginning January 1, 2007, all capitated provider agreements between the HMO and its capitated providers shall contain the following hold-harmless clause. To the extent that any provider contract renewed or extended after December 31, 2007 fails to incorporate the hold-harmless clause, the clause shall be deemed incorporated into those contracts by operation of law as of the date of the renewal of execution.

"The provider agrees that in no event, including but not limited to nonpayment by the HMO of amounts due the provider under this contract, insolvency of the HMO or any breach of this contract by the HMO, shall the provider or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the enrollee, persons acting on the enrollee's behalf (other than the HMO), the employer or group contract holder for services provided pursuant to this contract; except for the payment of applicable co‑payments or deductibles for services covered by the organization or fees for services not covered by the HMO. The requirements of this clause shall survive any termination of this contract for services rendered prior to such termination, regardless of the cause of such termination. The HMO's enrollees, the persons acting on the enrollee's behalf (other than the HMO), and the employer or group contract holder shall be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between the provider and the enrollee, persons acting on the enrollee's behalf (other than the HMO) and the employer or group contract holder."

f) The procedure to be followed by HMOs for extension of operations into additional counties in Illinois shall be as follows:

1) Upon receipt of certification by the Illinois Department of Public Health, the HMO shall submit a letter to the Director amending its service area. This letter will indicate that all subscription certificates, rates, provider agreements, and any other applicable documents to be used to service the extended area are those previously filed or, if not, new or revised documents will be submitted to the Department for review.

2) Each such notification for extension of operations shall be accompanied by a list of the counties in which the HMO is authorized to operate prior to any requested extension of service area.

(Source: Amended at 37 Ill. Reg. 14032, effective August 26, 2013)