**Section 240.50 Provision of Care Requirements**

The application for an HMO Certificate of Authority shall contain the following information about the provision of health care services by the HMO:

a) A copy of the evidence of coverage that will be issued to enrollees.

b) A description of the HMO's referral system that will be used when an enrollee is in need of a health care service covered by the HMO plan, but not available through the participating plan physicians. The referral mechanism shall require that the provider make any appointments, hospitalization, surgical procedures and any other health services available to enrollees within a medically appropriate timeframe. This policy shall not be construed so as to relieve an enrollee of any financial obligation incurred when that enrollee fails or refuses to utilize the HMO referral system.

c) A description of the medical record system of the HMO or HMO providers. The HMO and its providers shall meet the following medical record system requirements:

1) Clinical records shall be maintained on each enrollee who receives health care services through the HMO. The medical records system shall be organized to facilitate retrieval and compilation of medical records information necessary to provide continuity of care among various member and nonmember providers who are directly involved in the care of the enrollee.

2) There shall be a policy regarding the retention and retirement of enrollees' medical records.

3) There shall be a policy regarding confidentiality, security and release of enrollees' medical records.

d) Sample copies of all types of contracts entered into with providers. Copies of portions of actual contracts that pertain to the scope of services to be provided by the HMO shall be made available for review by the Department.

1) The HMO's contracts shall contain the following:

A) Descriptions of the arrangements for the provision of each of the types of services included in the evidence of coverage,

B) Descriptions of how the providers will ensure that the HMO's enrollees will receive health care services at all times, and

C) The provider's responsibilities within the HMO self-evaluation structure and activities described in Section 240.60 of this Part.

2) Services which are to be provided by participating plan primary care physicians shall be covered by a written contract with the HMO.

3) The HMO is not required to execute contracts for emergency and highly specialized services, such as pediatric cardiology, when the HMO provides the Department with documentation describing the mechanism for the provision of such services and the utilization review of such services. Emergency treatment shall include responses to emergency health problems as defined in the Department of Insurance Health Maintenance Organization rules located at 50 Ill. Adm. Code 6101.130 (d).

4) If providers will be serving both HMO patients and fee-for-service clients, there shall be a statement in each HMO provider contract assuring no discrimination in the provision of health care services toward patients due to payment source.

e) A description of the HMO's program of health education which shall relate to preventive health care and be oriented toward reducing health risks. This program can be provided by the HMO, or the HMO can choose to utilize health education programs currently being offered by entities other than the HMO.

f) A plan for the implementation of an enrollee education program which shall relate to the use of the HMO system. Such a program shall describe the sources and types of care accessible and available within the HMO. The HMO shall include information on procedures for the coverage of emergency services both inside and out of the plan service area and within the terms of the enrollee certificate. When the scope of health care services available through the HMO changes, the enrollee education program shall be modified to communicate the changes in services available to enrollees.

g) A description of how the HMO proposes to ensure the continued provision of health care services to enrollees in the event of the insolvency or unexpected closures of provider sites. Specific information shall be provided regarding hospitals and primary care provider sites.