**Section 240.80 General Operating Requirements**

a) The HMO operations shall be consistent with the information provided to the Department in the application.

b) The HMO shall appoint a medical director prior to commencing operations. The medical director's credentials shall be submitted to the Department.

c) The HMO shall develop and implement a process which will enable the HMO to maintain current information regarding each provider site under contract with the HMO, including the following:

1) Attestation of the presence of valid certifications, registrations and licenses as required for physicians, nurses, and other ancillary and paramedic personnel who render care to enrollees at the provider site.

2) The hours the provider site is open,

3) The hours each physician is routinely available at the provider site,

4) The extent to which twenty-four (24) hour a day, seven (7) day a week coverage is provided through the provider site,

5) The number of HMO enrollees the provider site serves as well as the total number of patients served by the provider site.

d) The HMO shall maintain a log that summarizes enrollee grievances and evidences HMO response to those grievances.

e) The HMO's participating physicians, other than those whose scope of practice is limited to radiology, anesthesiology, pathology, or emergency medical services, shall have one of the following:

1) admitting or staff privileges in at least one hospital within the plan service area, or

2) documentation of an arrangement with a physician or physician group who has admitting or staff privileges within the plan service area to provide access to required hospital services. This documentation shall be maintained by the HMO.

f) Within six (6) months of commencement of operation, the HMO shall establish operational medical records, quality assessment and utilization review programs as described in Section 240.60 of this Part.

g) The HMO shall inform the Department of the procedure to be used in responding to an enrollee's need for an urgent appointment at a provider site.

h) The HMO shall not cancel an enrollee's membership unless the HMO can present documentation verifying that:

1) fraud or material misrepresentation in enrollment or in the use of services or facilities;

2) material violation of the terms of the contract or evidence of coverage;

3) termination of the group or individual contract under which the enrollee was covered, pursuant to the terms of the contract;

4) failure of the enrollee and the primary care physician to establish a satisfactory patient-physician relationship if it is shown that:

i) the HMO has, in good faith, provided the enrollee with the opportunity to select an alternative primary care physician; or

ii) the enrollee has repeatedly refused to follow the plan of treatment ordered by the physician.

i) In order to exercise the provisions of subsection (h) (4) of this Section, the HMO must notify the enrollee in writing at least 31 days in advance that the HMO considers the physician-patient relationship to be unsatisfactory and has outlined specific changes required to avoid termination.

j) For purposes of subsection (h) of this Section, "material" means a fact or situation which is not merely technical in nature and results or could result in a substantive change in the situation. In addition, the definitions afforded this term by the courts of the State of Illinois shall apply when appropriate to the situation.

k) For purposes of subsection (h) of this Section, "good faith" means honesty of purpose, freedom from intention to defraud and being faithful to one's duty or obligation. In addition, the definitions afforded this term by the courts of the State of Illinois shall apply when appropriate to the situation.