DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENT

1) **Heading of the Part:** Health Maintenance Organizations Code

2) **Code Citation:** 77 Ill. Adm. Code 240

3) **Section Number:** 240.60  
   **Adopted Action:** Amendment

4) **Statutory Authority:** Health Maintenance Organization Act [215 ILCS 125]

5) **Effective Date of Rulemaking:** June 2, 2010

6) **Does this rulemaking contain an automatic repeal date?** No

7) **Does this rulemaking contain incorporations by reference?** No

8) A copy of the adopted amendment, including any material incorporated by reference, is on file in the Department's principal office and is available for public inspection.

9) **Notice of Proposal Published in Illinois Register:** January 15, 2010; 34 Ill. Reg. 746

10) **Has JCAR issued a Statement of Objection to this rulemaking?** No

11) **Differences between proposal and final version:** The following changes were made in response to comments received during the first notice or public comment period:

    In Section 240.60(c)(1)(B), "random" was removed and "HMO policy" was changed to "HMO medical record review program".

    In addition, various typographical, grammatical and form changes were made in response to JCAR comments.

12) **Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR?** Yes

13) **Will this rulemaking replace any emergency rulemaking currently in effect?** No

14) **Are there any amendments pending on this Part?** No
15) **Summary and Purpose of the Rulemaking:** The Minimum Health Care Standards for Health Maintenance Organizations (77 Ill. Adm. Code 240) establishes minimum standards for HMOs, including the minimum standards for reviewing, every two years, of participating physicians' medical records.

In this rulemaking, Section 240.60 (HMO Self-Evaluation Structure) is being amended to drop the requirement for a medical records review every two years. The two-year requirement presents a burden on physicians, especially those who are members of multiple managed care plans. Additionally, it is in conflict with the accreditation requirements of the Managed Care Reform and Patient Rights Act [215 ILCS 134].

16) **Information and questions regarding this adopted amendment shall be directed to:**

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The full text of the Adopted Amendment begins on the next page:
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TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER b: HOSPITAL AND AMBULATORY CARE FACILITIES

PART 240
MINIMUM HEALTH CARE STANDARDS FOR
HEALTH MAINTENANCE ORGANIZATIONS CODE

SUBPART A: GENERAL PROVISIONS

Section
240.10 Authority, Scope and Purpose
240.20 Definitions

SUBPART B: APPLICATION FOR HMO CERTIFICATE OF AUTHORITY

Section
240.30 Submission of Application for HMO Certificate of Authority
240.40 Personnel, Organization and Provider Requirements
240.50 Provision of Care Requirements
240.60 HMO Self-Evaluation Structure

SUBPART C: HMO OPERATING REQUIREMENTS

Section
240.80 General Operating Requirements
240.90 HMO Provider Site Medical Record Requirements
240.100 Required Information and Reports
240.110 Department Interventions
240.120 Fees

AUTHORITY: Implementing and authorized by the Health Maintenance Organization Act [215 ILCS 125].

SUBPART B: APPLICATION FOR HMO CERTIFICATE OF AUTHORITY

Section 240.60 HMO Self-Evaluation Structure

a) The application for an HMO Certificate of Authority shall contain a description of the actions that will be taken by the HMO to:

1) Monitor, on an ongoing basis, the quality, availability and accessibility of care delivered under the auspices of the HMO, and

2) Implement change, where necessary, based on problem identification, analysis and identification of corrective action.

b) The application for an HMO Certificate of Authority shall contain a description of the quality assessment program adopted by the HMO, which shall meet the following requirements:

1) The quality assessment program shall address both the medical and administrative aspects of the provision and delivery of health care services, such as availability, accessibility and continuity of care.

2) The HMO shall have a written quality assessment plan that:

   A) Establishes goals, timeframes and objectives for the quality assessment program;

   B) Outlines the organizational structure that will be utilized in implementing the quality assessment monitoring activities and the recommendations that result from the quality assessment monitoring activities; and

   C) Describes the methodology and criteria that will be used to evaluate the health care services provided under the auspices of the HMO.

3) Quality assessment monitoring activities shall include the following:

   A) Problems or concerns relative to the care rendered to enrollees
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shall be identified. Enrollees' accessibility to health care providers, appropriateness of utilization, and concerns identified by the HMO's medical or administrative staff and enrollees shall be considered.

B) Problems or concerns identified by the quality assessment activities shall be evaluated in accordance with the written plan's methodology and criteria to determine whether problems or concerns do indeed exist, and what the causes of the problems or concerns are.

C) An action plan shall be developed and implemented to correct the problems or concerns that have been verified. The action plan shall include an educational component related to the area dealt with in the action plan for providers included in the action plan.

D) Follow-up measures shall be implemented to evaluate the effectiveness of the action plan.

E) The HMO shall have an ongoing process for monitoring the continued effectiveness of action plans in preventing problems from reoccurring, and in preventing problems from developing.

4) There shall be physician participation in the quality assessment program, and all medical decisions shall be made by the medical director or the HMO's peer review body.

5) Reports of quality assessment activities shall be made to the governing board of the HMO, at a minimum, on a quarterly basis.

A) Records and minutes shall be kept on meetings that pertain to quality assessment activities.

B) Copies of reports of quality assessment activities shall be forwarded to the administrators of the HMO.

C) The HMO shall make records and reports of quality assessment activities available for review by the Department, and the HMO
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shall submit the records to the Department upon request. In accordance with Sections 8-2101 and 8-2102 of the Code of Civil Procedure [735 ILCS 5] [Ill. Rev. Stat. 1987, ch. 110, pars. 8-2101 and 8-2102], these records and reports shall be used solely for the purpose of evaluating and improving the quality of care rendered to enrollees through the HMO, and shall therefore not be admissible as evidence, nor discoverable in any action of any kind in any court or before any tribunal, board, agency or person. (Section 8-2102 of the Code of Civil Procedure)

c) The application for an HMO Certificate of Authority shall contain a description of the medical record review program adopted by the HMO, which shall meet the following requirements:

1) There shall be a written medical record review program shall that
   A) Establishes minimum chart standards which shall be consistent with the medical record standards contained in this Part (see Section 240.90),
   B) Provides for a review and evaluation of the medical record documentation of each primary care physician at least once every two years,
   C) Includes a program of correction and education that will be implemented when deficiencies relative to chart documentation are found. Such a program shall include a means for the follow-up and correction of deficiencies.

2) Reports of medical record review activities shall be made at a minimum, on a quarterly basis.
   A) Records and minutes shall be kept on meetings that pertain to medical record review activities.
   B) Copies of reports of medical record review activities shall be forwarded to the administrators of the HMO.
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C) The HMO shall make records and reports of medical record review activities available for review by the Department, and the HMO shall submit the records to the Department upon request. In accordance with Sections 8-2101 and 8-2102 of the Code of Civil Procedure (Ill. Rev. Stat. 1987, ch. 110, pars. 8-2101 and 8-2102), these records and reports shall be used solely for the purpose of evaluating and improving the quality of care rendered to enrollees through the HMO, and shall therefore not be admissible as evidence, nor discoverable in any action of any kind in any court or before any tribunal, board, agency or person. (Section 8-2102 of the Code of Civil Procedure)

3) The HMO shall provide an outline of the organizational structure that will be used in implementing the medical record review activities and the recommendations that result from the medical record review activities.

d) The application for an HMO Certificate of Authority shall contain a description of the utilization review program adopted by the HMO, which shall meet the following requirements:

1) The utilization review program shall include procedures for the compilation of statistics that relate to health services information.

2) The utilization review program shall review and evaluate health related statistical information, such as hospital admissions, ambulatory encounters, and the level of care utilized.

3) The HMO shall provide an outline of the organizational structure that will be used in implementing the utilization review program activities and the recommendations that result from the utilization review activities.

4) Reports of utilization review activities shall be made to the governing board of the HMO at a minimum, on a quarterly basis.

A) Records and minutes shall be kept on meetings that pertain to utilization review activities.
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B) Copies of reports of utilization review activities shall be forwarded to the administrators of the HMO.

C) The HMO shall make records and reports of utilization review activities available for review by the Department, and the HMO shall submit the records to the Department upon request. In accordance with Sections 8-2101 and 8-2102 of the Code of Civil Procedure (Ill. Rev. Stat. 1987, ch. 110, pars. 8-2101 and 8-2102), these records and reports shall be used solely for the purpose of evaluating and improving the quality of care rendered to enrollees through the HMO, and shall therefore not be admissible as evidence, nor discoverable in any action of any kind in any court or before any tribunal, board, agency or person. (Section 8-2102 of the Code of Civil Procedure)

(Source: Amended at 34 Ill. Reg. 8104, effective June 2, 2010)