Memorandum of Understanding
Between CountyCare Health Plan and the
Cook County Health and Hospitals System

Whereas the County, through the Cook County Health and Hospitals System ("CCHHS"), entered into a contract with the State of Illinois to operate a County Managed Care Community Network ("County MCCN") which it calls CountyCare; and

Whereas, the CountyCare is obligated to furnish to its members the covered services set forth in the contract; and

Whereas, CountyCare provides its members the covered services through a network of providers; and

Whereas, those providers enter into provider agreements with CountyCare; and

Whereas, one of the CountyCare providers is the CCHHS itself through its facilities, services and healthcare personnel; and

Whereas, as a provider, CCHHS is obligated to comply with many, but not all, of the terms and conditions contained in the CountyCare provider agreements; and

Whereas, in order to memorialize those CountyCare provider requirements applicable to the CCHHS as a CountyCare provider;

Now therefore, this Memorandum of Understanding ("MOU") is entered into between the CCHHS and CountyCare.

I. CCHHS Obligations:

Attached hereto are the following Exhibits:

1. Delegated Credentialing
2. Facility
3. Physician
4. Provider Incentives
5. Access Fees

CCHHS shall comply with the requirements set forth in each of the Exhibits when rendering covered services to a CountyCare member.

II. Delegated Credentialing

CountyCare delegates to CCHHS the credentialing of CCHHS providers pursuant to the terms set forth it the Delegation Terms attached hereto as Exhibit 1.

III. Services Provided

CCHHS shall provide those services and comply with the terms set forth in Exhibit 2, Facility Provider Terms and Exhibit 3, Physician Provider Terms.

IV. Payment for Services

CCHHS will be reimbursed for its approved claims for covered services as set forth in Exhibits 2 and 3 which may be changed from time to time. The initial and each rate change shall be incorporated herein and made a part hereof. Additional fees may be reimbursed for provider access to CCHHS facilities as outlined in Exhibit 5. CountyCare shall not be obligated to issue actual cash payment to CCHHS for its approved claims for covered services, care management, or provider incentives, however such transfer of funds must be reflected in CCHHS financial statements.

V. Provider Incentive Payments

CountyCare may make provider incentive payments as set forth in Exhibit 4 to CCHHS in recognition of innovative initiatives to improve member services. Such incentive payments shall be in addition to those it is otherwise entitled to receive for providing covered services to CountyCare members. The initiatives for which such payments are made shall be evidence-based practices that demonstrate cost savings for Medicaid beneficiaries. The details of such initiatives and the amount of such bonus or incentive payments shall be negotiated between CCHHS and CountyCare and shall be memorialized in written documents which shall be incorporated herein and made a part hereof.

VI. Compliance Monitoring and Auditing Functions.

CountyCare shall oversee CCHHS' performance of activities under this MOU. Oversight activity may include, but is not limited to, a review of periodic written reports provided by CCHHS, meetings with appropriate CCHHS representatives and desk reviews and/or on-site audits and assessments of CCHHS. CCHHS shall fully cooperate, participate and comply with CountyCare during such monitoring, auditing and oversight activities. All audits or assessments will be performed in a manner consistent with the requirements of all Applicable Laws and the MCCN Contract. Where requested, CCHHS shall promptly provide CountyCare with relevant and material results of its own auditing activities in the form mutually agreed by the Parties.

1) CCHHS shall not employ, subcontract with, or affiliate itself with or otherwise accept any Excluded Person into its network.

2) CCHHS shall screen all current and prospective providers, employees, and contractors and assure their Providers are screened and Subcontractors, prior to engaging their services under this Part III by: (i) requiring them to disclose whether they are Excluded Persons; and (ii) reviewing the OIG's list of sanctioned Persons (available at http://www.arnet.gov/epls) and the HHS/OIG List of Excluded Individuals/Entities (available at http://www.dhhs.gov/oig). CCHHS shall, on a monthly basis, screen all of its then-current employees, contractors, Provider Networks and Subcontractors and assure Providers are monthly screened. CCHHS shall maintain records of its

screening activities conducted during the duration of this Contract and shall provide CountyCare with such screening records upon request.

3) CCHHS shall notify CountyCare and terminate its relations with any Excluded Person or cause an Provider Network to immediately terminate its relationship with a Provider upon learning that such Person meets the definition of an Excluded Person and notify the OIG of the termination.

VI. Term

This MOU shall be effective as of July 1, 2014 when signed and shall remain in effect until terminated with 30 day notice by either party.

John Jay Shannon, M.D.
Chief Executive Officer
Cook County Health and Hospitals System

Acknowledged for CCHHS

Mary Sajdak
Senior Director of Integrated Care

Acknowledged for CountyCare Health Plan

Steven Glass, Executive Director
Executive Director of Managed Care

EXHIBIT 1

DELEGATED CREDENTIALING AGREEMENT

Delegated credentialing shall be consistent with policies of COUNTYCARE as approved by the credentialing oversight committee of COUNTYCARE.

EXHIBIT 2
FACILITY PROVIDER TERMS

COUNTYCARE POLICIES AND PROCEDURES

The CountyCare Provider Manual ("Provider Manual") shall provide operational details about CountyCare, including, but not limited to, enrollment, continuity of care, coordination of care, referral, appeals and hearing rights, compliance, credentialing, claims review and payment policies and procedures.

Participating Facility shall comply with the CountyCare Provider Manual and otherwise maintain its facility services consistent with the goals of CountyCare as set forth in this Agreement and the CountyCare Provider Manual, as communicated in writing to Participating Facility.

OBLIGATIONS OF PARTICIPATING FACILITY

Admission Notifications and/or Pre-Authorizations. As further detailed in the Provider Manual, Participating Facility agrees: (i) in the event of an emergency to notify CountyCare of a Covered Person's admission to Participating Facility within twenty-four (24) hours of such admission.

Provision of Covered Services. Participating Facility shall provide Covered Services to Covered Persons and, where medically appropriate, shall provide referral services (e.g., as part of intake or discharge planning as applicable), with such services and referrals being provided in accordance with applicable laws, regulations, guidance, and the Provider Manual, to the extent that such services are customarily provided by Participating Facility and Participating Facility has the then current capacity to provide such services.

Participating Facility shall provide Covered Services to a Covered Person in the same manner in which Participating Facility provides those services to all other individuals receiving services from Participating Facility. Participating Facility shall not differentiate or discriminate in the treatment of or in the quality of services delivered to a Covered Person on the basis of race, color, national

origin, religion, ancestry, marital status, sex, sexual orientation, source of payment or any other basis prohibited by federal or State law or County ordinance.

In providing Covered Services to Covered Persons under this Agreement, Participating Facility agrees that its staff shall: (i) use diligent efforts and professional skills and judgment, as applicable; and (ii) perform professional and supervisory services and render care to Covered Persons in accordance with and in a manner consistent with customary and recognized community standards and performance, as applicable.

Participating Facility Obligations under Medicaid Programs. Participating Facility agrees and understands that Covered Services shall be provided in accordance with all applicable contracts between the DHFS and CountyCare for Medicaid Covered Services (each, as applicable, a "State Contract"), the Provider Manual, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. To this end, Participating Facility shall at all times during the term of the Agreement comply with the Medicaid Product Requirements relating to the Medicaid Programs in which CountyCare participates. To the extent Participating Facility is unclear about Participating Facility's duties and obligations, Participating Facility shall request clarification from CountyCare.

Participating Facility Hours and Access. To the extent Participating Facility is a twenty-four (24) hours a day, seven (7) days a week, three-hundred sixty-five days a year facility, Participating Facility shall be accessible to Covered Persons at all times during which Participating Facility has capacity.

Referrals. To the extent medically appropriate based on the individual Covered Person's care needs, as part of intake or discharge planning as applicable, Participating Facility agrees to refer patients within the CountyCare Network (taking into consideration Covered Person's freedom of choice in selecting a health care provider). As further addressed in the Provider Manual, Participating Facility may refer Covered Persons to providers that are not within the CountyCare network: (i) for services associated with an emergency medical condition; and (ii) as otherwise prior authorized including in situations where there are no CountyCare Network providers willing and able to treat the Covered Person on a timely basis so as to satisfy the access requirements, and where out-of-network services are necessary to ensure continuity of care for ongoing treatment.

Referral Acceptance and New Patients. Participating Facility agrees to accept new Covered Persons for whom Participating Facility's services are medically appropriate under the terms of this Agreement as long as Participating Facility has capacity. Participating Facility agrees to accept transfers of Covered Persons from other CountyCare Network participants, consistent with medical appropriateness.

Provision of Credentialing Information. Participating Facility shall provide to CountyCare documentation demonstrating that Participating Facility and each Facility Provider has satisfied the credentialing requirements under the Illinois Health Connect Program, as applicable, and shall update CountyCare of any changes thereto in a timely manner.

Performance Reviews. Participating Facility shall be subject to and shall actively participate in performance monitoring and formal reviews according to a periodic schedule established by the State or its designee, consistent with industry standards or the State's laws and regulations governing CountyCare.

Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Participating Facility shall abide by the formulary or preferred drug list set forth in the Illinois Medicaid State Plan if dispensing medications for Covered Persons.

PAYMENT FOR HEALTH CARE SERVICES & FINANCIAL REQUIREMENTS

The Parties agree that the following terms shall govern the payment for health care services that are received pursuant to this Agreement.

Pay for Performance. In addition to the reimbursement, Participating Facility may be eligible for performance-based bonus payments as will be further described in the CountyCare Provider Manual.

Non-Covered Services. For any services that are not Covered Services (the "Non-Covered Services") provided to any Covered Person, Participating Facility may bill such Covered Person directly for such Non-Covered Services, provided that prior to providing such Non-Covered Services Participating Facility shall advise such Covered Person of non-coverage and shall obtain such Covered Person's written acknowledgment and acceptance of individual financial responsibility; provided, however, that where it is not practicable to obtain such patient acknowledgment in writing, Participating Facility shall obtain, at a minimum, a verbal patient acknowledgment to be followed up in writing when appropriate.

Financial Incentives. Nothing in this Agreement shall, or shall be construed to, create any financial incentives for Participating Facility to withhold medically necessary services.

Administrative Requirements. CountyCare to provide assistance to Participating Facility, as applicable, in its active and good faith adherence to evidence-based clinical performance measures, quality benchmarks, practice guidelines and protocols, utilization control mechanisms, including, but not limited to, quality performance measures established by CMS to assess the quality of care furnished by Medicaid Managed Care Organizations (collectively "Performance Measures"), and case and disease management programs, if applicable, and updates thereto, and other goals established and modified from time to time for CountyCare. CountyCare will provide Participating Facility with educational opportunities and tools regarding CountyCare, including real time access to CountyCare's information system, which shall include providing Participating Facility the ability to monitor the Performance Measures applicable to it, to the extent the information system is set up for such monitoring. CCHHS shall also facilitate and actively participate in a timely manner in: (i) data collection and monitoring efforts for the purpose of monitoring the performance of Participating Facility in relation to the Performance Measures; (ii)

CountyCare oversight and operational functions; (iii) development and implementation of Performance Measures; (iv) reporting by Participating Facility concerning all patient and medical care data being provided by Participating Facility, to and through the CountyCare Network; (v) promoting satisfactory performance of those CountyCare Network participants who provide health care services for Covered Persons pursuant to recommendations regarding such Participating Facility's practice patterns in accordance with the CountyCare Provider Manual; and (vi) monitor and assess the performance of Participating Facility to ensure ongoing adherence to CountyCare goals.

COMPLIANCE WITH MEDICAID PROGRAM INTEGRITY LAWS & REGULATIONS

CCHHS and Participating Facility shall maintain compliance with the following, as may be amended or supplemented from time to time:

a) Any relevant Medicaid statutes, regulations, and guidance, including those pertaining to a Medicaid Managed Care Organization such as Sections 1902, 1903 and 1932 of the Social Security Act ("Act"), except as expressly waived by the Secretary of HHS ("Secretary") and communicated in writing to Participating Facility;

b) Federal and State criminal law;

c) Statutes, regulations, and guidance regarding violations of the Physician Self-Referral Statute (Section 1877 of the Act, 42 C.F.R. §411.350 through §411.389) the Anti-kickback Statute (Section 1128B(b) of the Act, 42 C.F.R. § 1001.952), and the Civil Monetary Penalty Law (Section 1128A of the Act, 42 C.F.R. § 1003.102); and

d) The False Claims Act, Medicare and Medicaid billings and claims submissions rules, any applicable State fraud and abuse laws, and all other relevant statutes, regulations, and written directives of HHS governing the functioning of programs under titles XVIII and XIX of the Act.

MEDICAID PRODUCT REQUIREMENTS

Compliance with State Contract. Participating Facility agrees that it, and its respective subcontractors are bound to the terms and conditions of the applicable State Contract that are appropriate to the services or activities performed, and that such requirements include, but are not limited to, the record keeping and audit provisions of the applicable State Contract, such that DHFS or Authorized Persons shall have the same rights to audit and inspect Participating Facility, and its subcontractors as they have to audit and inspect CountyCare.

Grievances and Appeals. Participating Facility acknowledges and agrees that the Provider Manual includes information about CountyCare's grievance and appeal processes. If necessary upon

notification from DHFS of any substantive change to such processes, CountyCare shall amend the Provider Manual as soon as practicable and such amendment shall be deemed effective immediately upon notice to Participating Facility.

Compliance with Law. CountyCare, Participating Facility, and their respective employees and agents shall comply with all applicable federal, State, and local laws, rules, ordinances, regulations, orders, federal circulars and all license and permit requirements, and all amendments thereto, in the performance of the applicable State Contract and the Agreement, including, without limitation, the Managed Care Reform and Patient Rights Act (215 ILCS 134/1 et seq.), the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by the State Department of Financial and Professional Regulation, the State Department of Public Health, or the State Department of Central Management Services and any successor agency.

Fraud and Abuse. Participating Facility and Facility Providers shall abide by and cooperate with CountyCare's Fraud and Abuse program, which shall be consistent with State and federal law.

Disclosure of Significant Business Transactions. In order to allow CountyCare to comply with applicable regulatory requirements, Participating Facility agrees to furnish, upon request and within thirty-five (35) calendar days of the date of the request, full and complete information about the ownership of any: (i) subcontractor; and (ii) wholly owned supplier, with whom Participating Facility has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the five (5) year period (or lesser period) ending on the date of the request.

Marketing Activities. Participating Facility shall not conduct marketing activities unless expressly approved in writing and only after all training and credentialing required under the applicable State Contract; provided, however, that no marketing activities will be conducted in emergency room waiting areas or in treatment areas at any provider office or facility. Participating Facility's marketing personnel shall not have access to a Covered Person's medical record regardless of whether such marketing activity is conducted at a provider's office or facility or another location.

Medical Records. Participating Facility shall maintain a permanent medical record for every Covered Person and shall make such record available to other providers. Participating Facility agrees to send a copy of the medical record to any new provider to which the Covered Person transfers. Participating Facility shall only release copies of records to authorized individuals. Medical records will include Participating Facility identification and Covered Person identification, and all entries will be legible and dated, and the following where applicable will be included: patient identification, personal health, social history and family history, with updates as needed, risk assessment, obstetrical history (if any) and/or profile, hospital admissions and discharges, relevant history of current illness or injury (if any) and physical findings, diagnostic and therapeutic orders, clinical observations, including results of treatment, reports of procedure, tests and results, diagnostic impressions, patient disposition and pertinent instructions to patient for follow-up care, immunization record, allergy history, periodic exam record, weight and height information and as appropriate growth chart, referral information (if any), health education and

anticipatory guidance provided, and family planning and/or counseling. In addition, Participating Facility shall comply with all rules concerning the maintenance of written policies and procedures with respect to advance directives as promulgated by CMS.

STATE MANDATED REQUIREMENTS

State Quality Assurance Programs. Participating Facility shall provide, arrange for, or participate in the quality assurance programs mandated by law, unless the IDPH certifies that such programs will be fully implemented without any participation of action from Participating Facility.

Patient Record Confidentiality. Each Party shall protect the confidentiality of all patient information (including but not limited to medical records, electronic data, radiology films, laboratory slides, and billing information), and shall comply with all written policies regarding the release of Covered Person's patient information. Each Party shall also comply with all applicable State and federal laws and regulations protecting the confidentiality of patient records, including the Health Insurance Portability and Accountability Act of 1996, corresponding Standards for Privacy of Individually Identifiable Health Information regulations, and the Security Standards for Protection of Electronic Protected Health Information, the Health Information Technology and Economic and Clinical Health Act, and the interim final rule on the Notification in the Case of Breach of Unsecured Protected Health Information each as amended from time to time (collectively, "HIPAA").

As part of its activities, Participating Facility agree and understand that Participating Facility will engage in utilization review activities and quality assessment and improvement activities. Participating Facility and the other providers or suppliers participating in the CountyCare Network acknowledge that their participation in the CountyCare Network includes participation in an Organized Health Care Arrangement ("OHCA"), as defined in the HIPAA regulations, 45 C.F.R. § 160.103.

Attachment A

Participating Facility Reimbursement Methodology

Inpatient and Outpatient Services. For inpatient and outpatient Covered Services rendered to a Covered Person during a single admission, and billed under the Participating Facility's tax identification number ("TIN"), CCHHS shall pay Participating Facility 100% of charges from July 1, 2014 to November 30th, 2015, and 75% of charges from December 1, 2015 – November 30th 2016. For reference and information only, the rates identified below in table 1 are CCHHS Medicaid Fee Schedule for this period:

Table 1

Facility	Inpatient	Outpatient
J H Stroger hospital of Cook County	$ 3,375.00	$ 1,955.53
Provident Medical Center	$ 5,735.00	$ 1,755.20

Inpatient Outlier. Outlier claims shall be reimbursed based upon the State reimbursement methodology.

Participating Facility pursuant to this Attachment A shall at all times be subject to the terms and conditions set forth in this Exhibit 2 and the Provider Manual.

Additional Provisions:

1. Application of Seventy-Two (72) House Rule. If applicable, payments made to Participating Facility for inpatient services shall include all costs relating to a Covered Person's pre-admission diagnostic testing and procedures, including, but not limited to, laboratory services, pathology services, radiology services, and medical/surgical supplies, occurring within seventy-two (72) hours of an admission.

2. Payment for Professional Services. Payment for those professional Covered Services, including but not limited to services provided by hospital-based physicians, certified nurse anesthetists or other professionals, that are billed on a claim form under Participating Facility's TIN and provider identification number in connection with inpatient Covered Services is included in any payment for such inpatient Covered Services pursuant to this Exhibit 2. Payment for those professional Covered Services that are billed on a CMS 1500 or its successor form under Participating Facility's TIN and provider identification number in connection with outpatient Covered Services shall be determined pursuant to the Medicaid physician services fee schedule.

3. Coordination for Transplant Services. Participating Facility agrees to coordinate transplant Covered Services and reimbursement for such Covered Services with HMO's designated transplant vendor.

4. Multiple Dates of Service on Single Claim Form. Participating Facility is required to identify each date of service on the Claim Form when submitting claims for multiple dates of service.

5. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

6. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

7. Payment under this Attachment. All payments under this Attachment are subject to the terms and conditions set forth in this Agreement and the Provider Manual.

Definitions:

Allowable Charges means those Participating Facility-billed charges for services that qualify as Covered Services.

EXHIBIT 3

SPECIALIST/PRIMARY CARE PHYSICIAN PROVIDER TERMS

COUNTYCARE POLICIES AND PROCEDURES

The CountyCare Provider Manual ("Provider Manual") shall provide operational details about CountyCare including, but not limited to, enrollment, continuity of care, coordination of care, referral, appeals and hearing rights, compliance, credentialing, claims review and payment policies and procedures.

Participating Physician shall comply with the CountyCare Provider Manual and otherwise maintain a practice consistent with the goals of CountyCare as set forth in this Agreement and the CountyCare Provider Manual, as communicated in writing to Participating Physician.

OBLIGATIONS OF PARTICIPATING PHYSICAN

Promotion of Performance Improvement and PCMH Model Guidelines. As applicable, to actively promote the elements of the Performance Improvement and Patient Centered Medical Home Guidelines as described in the Provider Manual.

Provision of Medically Necessary Services. Participating Physician shall provide Covered Services to Covered Persons and, where medically appropriate, shall provide referral services, with such services and referrals being provided in accordance with applicable laws, regulations, guidance, and the Provider Manual in accordance with applicable laws, regulations and guidance to the extent that such services are customarily provided by Participating Physician and Participating Physician has the then current capacity to provide such services.

Participating Physician shall provide Covered Services to a Covered Person in the same manner in which Participating Physician provides those services to all other individuals receiving services from Participating Physician. Participating Physician shall not differentiate or discriminate in the treatment of or in the quality of services delivered to a Covered Person on the basis of race, color, national origin, religion, ancestry, marital status, sex, sexual orientation, source of payment or any other basis prohibited by federal or State law or County ordinance.

In providing Covered Services to Covered Persons under this Agreement, Participating Physician agrees that it shall: (i) use diligent efforts and professional skills and judgment; and (ii) perform professional and supervisory services and render care to Covered Persons in accordance with and in a manner consistent with customary and recognized community standards and performance.

Participating Physician Obligations under Medicaid Programs. Participating Physician agrees and understands that Covered Services shall be provided in accordance with all applicable

contracts between the DHFS and CountyCare for Medicaid Covered Services (each, as applicable, a "State Contract"), the Provider Manual, any applicable State handbooks or policy and procedure guides, and all applicable State and federal laws and regulations. To this end, Participating Physician shall at all times during the term of the Agreement comply with the Medicaid Product Requirements relating to the Medicaid Programs in which CCHHS participates. To the extent Participating Physician is unclear about Participating Physician's duties and obligations, Participating Physician shall request clarification from CountyCare.

Referrals. To the extent medically appropriate based on the individual Covered Person's care needs, Participating Physician agrees to refer patients within the CountyCare Network (taking into consideration Covered Person's freedom of choice in selecting a health care provider within the CountyCare Network), which includes Covered Services required for a Covered Person that are not available from the Participating Physician. As further addressed in the Provider Manual, Participating Physician may refer Covered Persons to providers that are not within the CountyCare network: (i) for services associated with an emergency medical condition; and (ii) as otherwise prior authorized, including in situations where there are no CountyCare Network providers willing and able to treat the Covered Person on a timely basis so as to satisfy the access requirements, and where out-of-network services are necessary to ensure continuity of care for ongoing treatment.

Referral Acceptance. Participating Physician agrees to accept referrals of Covered Persons from other CountyCare Network providers, consistent with medical appropriateness and the capacity of Participating Physician as determined by Participating Physician in its sole discretion.

Compliance with Performance Improvement and Patient Centered Medical Home Guidelines. Participating Physician agrees to comply with any Performance Improvement and Patient Centered Medical Home Guidelines applicable to Participating Physician as delineated in the CountyCare Provider Manual.

Performance Reviews. Participating Physician shall be subject to and shall actively participate in performance monitoring and formal reviews conducted by CountyCare according to a periodic schedule established by the State or its designee, consistent with industry standards or the State's laws and regulations governing CountyCare.

Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Participating Physician shall abide by the formulary or preferred drug list set forth in the Illinois Medicaid State Plan when prescribing medications for Covered Persons.

Administrative Requirements. To provide assistance to Participating Physician in Participating Physician's active and good faith adherence to evidence-based clinical performance measures, quality benchmarks, practice guidelines and protocols, utilization control mechanisms, including, but not limited to, quality performance measures established by CMS to assess the quality of care furnished by Medicaid Managed Care Organizations (collectively "Performance Measures"), and case and disease management programs, if applicable, and updates thereto, and other goals established and modified from time to time by CountyCare. CountyCare will provide

Participating Physician with educational opportunities and tools regarding CountyCare, including real time access to the CountyCare's information system, which shall include providing Participating Physician the ability to monitor the Performance Measures applicable to it, to the extent the information system is set up for such monitoring. CountyCare shall also facilitate and actively participate in a timely manner in: (i) data collection and monitoring efforts for the purpose of monitoring the performance of Participating Physician in relation to the Performance Measures; (ii) CountyCare oversight and operational functions; (iii) development and implementation of Performance Measures; (iv) reporting by Participating Physician concerning all patient and medical care data being provided by Participating Physician, to and through the CountyCare Network; (v) promoting satisfactory performance of those CountyCare Network participants who provide health care services for Covered Persons pursuant to recommendations regarding such Participating Physician's practice patterns in accordance with the CountyCare Provider Manual; and (vi) monitor and assess the performance of Participating Physician to ensure ongoing adherence to CountyCare goals.

PAYMENT FOR HEALTH CARE SERVICES & FINANCIAL REQUIREMENTS

The Parties agree that the following terms shall govern the payment for health care services that are received pursuant to this Agreement.

Pay for Performance. In addition to the reimbursement provided, Participating Physician may be eligible for performance-based bonus payments from CountyCare and will be further described in the CountyCare Provider Manual.

Non-Covered Services. For any services that are not Covered Services (the "Non-Covered Services") provided to any Covered Person, Participating Physician may bill such Covered Person directly for such Non-Covered Services, provided that prior to providing such Non-Covered Services Participating Physician shall advise such Covered Person of non-coverage and shall obtain such Covered Person's written acknowledgment and acceptance of individual financial responsibility; provided, however, that where it is not practicable to obtain such patient acknowledgment in writing, Participating Physician shall obtain, at a minimum, a verbal patient acknowledgment to be followed up in writing when appropriate.

Financial Incentives. Nothing in this Agreement shall, or shall be construed to, create any financial incentives for Participating Physician to withhold medically necessary services.

COMPLIANCE WITH MEDICAID PROGRAM INTEGRITY LAWS & REGULATIONS

Participating Physician shall maintain compliance with the following, as may be amended or supplemented from time to time:

e) Any relevant Medicaid statutes, regulations, and guidance, including those pertaining to a Medicaid Managed Care Organization such as Sections 1902, 1903

and 1932 of the Social Security Act ("Act"), except as expressly waived by the Secretary of HHS ("Secretary") and communicated in writing;

f) Federal and State criminal law;

g) Statutes, regulations, and guidance regarding violations of the Physician Self-Referral Statute (Section 1877 of the Act, 42 C.F.R. §411.350 through §411.389) the Anti-kickback Statute (Section 1128B(b) of the Act, 42 C.F.R. § 1001.952), and the Civil Monetary Penalty Law (Section 1128A of the Act, 42 C.F.R. § 1003.102); and

h) The False Claims Act, Medicare and Medicaid billings and claims submissions rules, any applicable State fraud and abuse laws, and all other relevant statutes, regulations, and written directives of HHS governing the functioning of programs under titles XVIII and XIX of the Act.

MEDICAID PRODUCT REQUIREMENTS

Compliance with State Contract. Participating Physician agrees that it, and its respective subcontractors are bound to the terms and conditions of the applicable State Contract that are appropriate to the services or activities performed, and that such requirements include, but are not limited to, the record keeping and audit provisions of the applicable State Contract, such that DHFS or Authorized Persons shall have the same rights to audit and inspect Participating Physician, and its subcontractors as they have to audit.

Grievances and Appeals. Participating Physician acknowledges and agrees that the Provider Manual includes information about grievance and appeal processes. If necessary upon notification from DHFS of any substantive change to such processes, CountyCare shall amend the Provider Manual as soon as practicable and such amendment shall be deemed effective immediately upon notice to Participating Physician.

Compliance with Law. Participating Physician, and their respective employees and agents shall comply with all applicable federal, State, and local laws, rules, ordinances, regulations, orders, federal circulars and all license and permit requirements, and all amendments thereto, in the performance of the applicable State Contract and the Agreement, including, without limitation, the Managed Care Reform and Patient Rights Act (215 ILCS 134/1 et seq.), the federal Balanced Budget Act of 1997 (Public Law 105-33), and regulations promulgated by the State Department of Financial and Professional Regulation, the State Department of Public Health, or the State Department of Central Management Services and any successor agency.

Fraud and Abuse. Participating Physician shall abide by and cooperate with CountyCare's Fraud and Abuse program, which shall be consistent with State and federal law.

Disclosure of Significant Business Transactions. In order to allow to comply with applicable regulatory requirements, Participating Physician agrees to furnish, upon request and within thirty-five (35) calendar days of the date of the request, full and complete information about the ownership of any: (i) subcontractor; and (ii) wholly owned supplier, with whom Participating Physician has had business transactions totaling more than twenty-five thousand dollars ($25,000) during the five (5) year period (or lesser period) ending on the date of the request.

Marketing Activities. Participating Physician shall not conduct marketing activities unless expressly approved in writing and only after all training and credentialing required under the applicable State Contract; provided, however, that no marketing activities will be conducted in emergency room waiting areas or in treatment areas at any provider office or facility. Participating Physician's marketing personnel shall not have access to a Covered Person's medical record regardless of whether such marketing activity is conducted at a provider's office or facility or another location.

Medical Records. Participating Physician shall maintain a permanent medical record for every Covered Person and shall make such record available to other providers. Participating Physician agrees to send a copy of the medical record to any new provider to which the Covered Person transfers. Participating Physician shall only release copies of records to authorized individuals. Medical records will include Participating Physician identification and Covered Person identification, and all entries will be legible and dated, and the following where applicable will be included: patient identification, personal health, social history and family history, with updates as needed, risk assessment, obstetrical history (if any) and/or profile, hospital admissions and discharges, relevant history of current illness or injury (if any) and physical findings, diagnostic and therapeutic orders, clinical observations, including results of treatment, reports of procedure, tests and results, diagnostic impressions, patient disposition and pertinent instructions to patient for follow-up care, immunization record, allergy history, periodic exam record, weight and height information and as appropriate growth chart, referral information (if any), health education and anticipatory guidance provided, and family planning and/or counseling. In addition, Participating Physician shall comply with all rules concerning the maintenance of written policies and procedures with respect to advance directives as promulgated by CMS.

STATE MANDATED REQUIREMENTS

State Quality Assurance Programs. Participating Physician shall provide, arrange for, or participate in the quality assurance programs mandated by law, unless the Illinois Department of Public Health certifies that such programs will be fully implemented without any participation of action from Participating Physician.

Patient Record Confidentiality. Each Party shall protect the confidentiality of all patient information (including but not limited to medical records, electronic data, radiology films, laboratory slides, and billing information), and shall comply with all written policies regarding the release of Covered Person's patient information. Each Party shall also comply with all applicable State and federal laws and regulations protecting the confidentiality of patient records, including the Health Insurance Portability and Accountability Act of 1996, corresponding Standards for Privacy of Individually Identifiable Health Information regulations, and the Security Standards for Protection of Electronic Protected Health Information, the Health Information Technology and Economic and Clinical Health Act, and the interim final rule on the Notification in the Case of Breach of Unsecured Protected Health Information each as amended from time to time (collectively, "HIPAA").

As part of its activities, Participating Physician agree and understand that CountyCare will engage in utilization review activities and quality assessment and improvement activities.

Force and Effect. The Parties acknowledge and agree that this Agreement shall be of no force and effect unless and until a duly authorized representative of each Party has signed this signature page where indicated.

Attachment A

Participating Physician Reimbursement Methodology

For Covered Services rendered to a Covered Person, and billed under the Participating Physician's tax identification number ("TIN"), CCHHS shall pay Participating Physician 100% of charges from July 1, 2014 to November 30th, 2015, and 75% of charges from December 1, 2015 – November 30th 2016. CCHHS' obligation to pay Participating Physician pursuant to this Attachment shall at all times be subject to the terms and conditions set forth in this Exhibit 3 and the Provider Manual.

Additional Provisions:

1. Multiple Dates of Service on Single Claim Form. Participating Physician is required to identify each date of service on the Claim Form when submitting claims for multiple dates of service.

2. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

3. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

4. Payment under this Attachment. All payments under this Attachment are subject to the terms and conditions set forth in this Agreement and the Provider Manual.

Definitions:

Allowable Charges means those Participating Physician-billed charges for services that qualify as Covered Services.

EXHIBIT 4

PROVIDER INCENTIVE PAYMENTS

A) **Care Coordination and Management Services**. In recognition of care management activities provided to CountyCare members empaneled at CCHHS ACHN medical home sites, the following reimbursement will be provided:

Date	Unit Measure	Per Member Per Month Reimbursement
July 2014 – November 2015	Per ACHN Empaneled Member	$6 PMPM

EXHIBIT 5 – PROVIDENT HOSPITAL ACCESS FEE

RECITALS

WHEREAS, PROVIDER is comprised of System affiliates including: the John H. Stroger, Jr. Hospital of Cook County ("Stroger Hospital"); Provident Hospital of Cook County ("Provident"); the Ambulatory and Community Health Network of Cook County ("ACHN"), including the Ruth M. Rothstein CORE Health Center ("CORE"); Cermak Health Services of Cook County ("Cermak"); and the Cook County Department of Public Health ("CCDPH"); and

WHEREAS, PROVIDER operates Provident Hospital, an integrated provider of health care services that addresses community health care needs by offering physician services, comprehensive diagnostic imaging services, acute care services, same day surgery, cardiac diagnostics, laboratory services, rehabilitative services including physical therapy, occupational therapy, and speech pathology, and promoting health and wellness through health fairs, support groups and educational programs (collectively "Provident Services"); and

WHEREAS, from time to time, HEALTH PLAN may receive a Medicaid managed care capitation rate that includes a Cook County Access component from the State of Illinois; and

WHEREAS, HEALTH PLAN desires to pay any such Medicaid managed care capitation rate component (collectively "Provident Access Payments") to PROVIDER to ensure that HEALTH PLAN and its enrollees have access to Provident Services and PROVIDER desires to receive such payments and provide such access.

NOW, THEREFORE, in consideration of the mutual promises, covenants, terms and conditions hereinafter set forth, the sufficiency and adequacy of which is hereby acknowledged, HEALTH PLAN and PROVIDER hereby agree as follows:

I. RECITALS

The foregoing recitals are hereby incorporated into and made a part of this Attachment.

II. AMENDMENT TO AGREEMENT

The Attachment to the Agreement is hereby amended by adding the following language:

A. Provident Access Payments

a. ***Payment***

Should Region 4 Medicaid Managed Care Capitation Rates from the State of Illinois include Access Payments, before or after the execution of this amendment, HEALTH PLAN shall pay to PROVIDER the amount of such Provident Access Payments, in accordance with subparagraph (c.) below entitled "Form and Timing of Payments". Provident Access Payments paid to PROVIDER shall not replace or supplant any other amounts paid or payable to PROVIDER by HEALTH PLAN unless otherwise agreed to by the parties. If no amount is included from the State of Illinois in Region 4 Medicaid

Managed Care Capitation Rates, parties may mutually agree to an access payment amount.

Time Period	Rate	Type
July 1st, 2014 – November 30th 2015	$10	Per Member Per Month (PMPM)
December 1st, 2015 – November 30th 2016	TBD	Per Member Per Month (PMPM)

b. ***Conditions for Receiving Provident Access Payments***

As a condition for receiving Provident Access Payments, PROVIDER and Provident shall:

i. Remain a participating provider in the HEALTH PLAN and not issue a notice of termination of the Agreement;

ii. Maintain its current emergency room licensure status and not close its emergency room;

iii. Maintain its current inpatient surgery suites and not close these facilities;

iv. Maintain its current outpatient services and not close these facilities; and

v. Maintain physician services available to Medicaid beneficiaries.

c. ***Form and Timing of Payments***

HEALTH PLAN agrees to pay the Provident Access Payments to PROVIDER using the same mechanism through which compensation and payments are normally paid to PROVIDER (e.g., electronic transfer).

d. ***Use of Funds***

i. PROVIDER shall use the Provident Access Payments for the following purposes and shall treat the Provident Access Payments in the following manner:

a) The Provident Access Payments shall represent compensation for Medicaid services rendered to HEALTH PLAN members by PROVIDER during the State of Illinois fiscal year to which the Provident Access Payments apply.

b) The Provident Access Payments received will be used by PROVIDER to maintain Provident Services.

e. HEALTH PLAN's Oversight Responsibilities

i. HEALTH PLAN's oversight responsibilities regarding PROVIDER's use of the Provident Access Payments shall be limited as described in this paragraph.

ii. After the end of each State fiscal year in which Provident Access Payments are transferred to PROVIDER, when so requested by HEALTH PLAN, PROVIDER shall provide HEALTH PLAN with written confirmation of the provision of Provident Services, within 20 business days of HEALTH PLAN's request.

f. Cooperation Among Parties

Should disputes or disagreements arise regarding the ultimate computation or appropriateness of any aspect of the Provident Access Payments, PROVIDER and HEALTH PLAN agree to work together in all respects to support and preserve the Provident Access Payments to the full extent possible on behalf of the health care safety net in Cook County.

g. Reconciliation

i. Within one hundred twenty (120) calendar days after the end of each of HEALTH PLAN's fiscal years in which Provident Access Payments were made to PROVIDER, HEALTH PLAN shall, when so requested by PROVIDER, perform a reconciliation of the Provident Access Payments transmitted to PROVIDER during the preceding fiscal year to ensure that the supporting amount of Provident Access Payments were received by HEALTH PLAN from the State of Illinois. PROVIDER understands that further reconciliation may be necessary based on retroactive activity by the State, which may retroactively increase or decrease the Provident Access Payment.

ii. PROVIDER agrees to return to HEALTH PLAN any overpayment of Provident Access Payments made in error to PROVIDER within ninety (90) business days after receipt from HEALTH PLAN of a written notice of the overpayment error, unless PROVIDER submits a written objection to HEALTH PLAN. Any such objection shall be resolved in accordance with the dispute resolution processes set forth in Section 8 of the Agreement.

iii. HEALTH PLAN agrees to transmit to PROVIDER any underpayment of Provident Access Payments within thirty (30) business days of HEALTH PLAN's identification of such underpayment.

B. TERM

This Attachment shall be effective upon execution by the parties.

C. OTHER PROVISIONS OF UNDERLYING AGREEMENT

All other terms and provisions of said Agreement shall remain in full force and effect so that all rights, duties, obligations, and liabilities of the parties hereto otherwise remain unchanged; provided, however, if there is any conflict between the terms of this Attachment and the underlying Agreement, then the terms of this Attachment shall govern.

FIRST AMENDMENT
TO THE
COOK COUNTY HEALTH AND HOSPITALS SYSTEM
COUNTYCARE MEMORANDUM OF UNDERSTANDING

This **First Amendment ("Amendment")** to the **Cook County Health and Hospitals System CountyCare Memorandum of Understanding** is entered into between the County of Cook ("County"), through its **Cook County Health and Hospitals System ("CCHHS")**, and **Cook County Health and Hospitals System (Participating Provider")**, (CCHHS and Participating Provider referred to herein individually as a "Party" or, collectively, as the "Parties").

RECITALS

WHEREAS, on July 1, 2014, the Parties entered into an agreement entitled the "Memorandum of Understanding between CountyCare Health Plan and Cook County Health and Hospitals System" (referred to herein as the "Memorandum of Understanding"); and this amendment effective on December 1, 2017 AB

WHEREAS, the Parties desire to amend the Memorandum of Understanding as set forth in this Amendment;

NOW THEREFORE, in consideration of the forgoing recitals, as well as the mutual agreements herein set forth, the adequacy and sufficiency of which is hereby acknowledged, CCHHS and Participating Provider hereby agree as follows:

1. **RECITALS**
   - **1.1.** The foregoing recitals are hereby incorporated into and made a part of this Amendment.

2. **AMENDMENT**
   - **2.1.** The Memorandum of Understanding is hereby amended in the following respects:
     - **2.1.1.** Attachment A, entitled "Participating Facility Reimbursement Methodology" shall be deleted in its entirety and replaced by the following amended Attachment A:

Attachment A

Participating Facility Reimbursement Methodology

Inpatient and Outpatient Services. For inpatient and outpatient Covered Services rendered to a Covered Person during a single admission, and billed under the Participating Facility's tax identification number ("TIN"), CCHHS shall pay Participating Facility twenty-six percent (26%) of billed charges for all services, exclusive of Pharmacy services. Pharmacy services shall be reimbursed at seventy-percent (70%) of adjudicated claim cost. CCHHS' obligation to pay Participating Facility pursuant to this Exhibit shall at all times be subject to the terms and conditions set forth in the Agreement, this Exhibit and the Provider Manual.

Inpatient Outlier. Outlier claims shall be reimbursed based upon the State reimbursement methodology.

Additional Provisions:

1. Application of Seventy-Two (72) House Rule. If applicable, payments made to Participating Facility for inpatient services shall include all costs relating to a Covered Person's pre-admission diagnostic testing and procedures, including, but not limited to, laboratory services, pathology services, radiology services, and medical/surgical supplies, occurring within seventy-two (72) hours of an admission.

2. Payment for Professional Services. Payment for those professional Covered Services, including but not limited to services provided by hospital-based physicians, certified nurse anesthetists or other professionals, that are billed on a claim form under Participating Facility's TIN and provider identification number in connection with inpatient Covered Services is included in any payment for such inpatient Covered Services pursuant to this Exhibit. Payment for those professional Covered Services that are billed on a CMS 1500 or its successor form under Participating Facility's TIN and provider identification number in connection with outpatient Covered Services shall be determined pursuant to the Medicaid physician services fee schedule.

3. Coordination for Transplant Services. Participating Facility agrees to coordinate transplant Covered Services and reimbursement for such Covered Services with HMO's designated transplant vendor.

4. Multiple Dates of Service on Single Claim Form. Participating Facility is required to identify each date of service on the Claim Form when submitting claims for multiple dates of service.

5. Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-9, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such code updates; or (ii) the effective date of such code updates, as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any code updates.

6. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; or (ii) the effective date of such fee schedule updates, as determined by such governmental agency. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

7. Payment under this Exhibit. All payments under this Exhibit are subject to the terms and conditions set forth in the Agreement and the Provider Manual.

Definitions:

Allowable Charges means those Participating Facility-billed charges for services that qualify as Covered Services.

OTHER TERMS AND CONDITIONS OF THE AGREEMENT

All other terms, conditions and provisions of the Memorandum of Understanding shall remain in full force and effect.

IN WITNESS WHEREOF, the Parties agree to the above terms and have caused this Amendment to be signed by their duly authorized representatives:

FOR PARTICIPATING ~~PROVIDER~~ PLAN: _____

Signature: _____ Date: 2/14/18

Name: James E. Kim

Title: Exec. Dir., Managed Care

FOR COOK COUNTY HEALTH AND HOSPITALS SYSTEM:

Deputy CEO of Finance & Strategy Date: 2-6-18

for John T. Shannon, M.D.
Chief Executive Officer
Cook County Health and Hospitals System