HEALTH PLAN OF SAN MATEO

MEDI-CAL
HOSPITAL AGREEMENT

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HOSPITAL AGREEMENT

This Agreement is made this First day of _____, 200_, by and between the San Mateo Health Commission, d.b.a. Health Plan of San Mateo, hereinafter referred to as "PLAN", and San Mateo County d.b.a. San Mateo Medical Center, a hospital, hereinafter referred to as "HOSPITAL."

RECITALS

WHEREAS, the PLAN is an independent public agency authorized to negotiate and to enter into hospital agreements with institutional health care providers for the purpose of arranging for the provision of "Medi-Cal Benefits", as that term is defined and more particularly set forth in this Agreement, (hereinafter referred to as "Benefits" or "Covered Services"), to "Medi-Cal Members", as that term is defined and more particularly set forth in this Agreement and in the PLAN's Medi-Cal Services Contract with the State of California; and

WHEREAS, the HOSPITAL, a general acute care facility licensed in accordance with the requirements of the California Health Facilities Licensure Act (Health and Safety Code, Sections 1250 et seq.) and the regulations promulgated pursuant thereto, is currently certified under Title XVIII of the Federal Social Security Act, and is equipped, staffed, and prepared to provide Medi-Cal Benefits to Medi-Cal Members; and

WHEREAS, the parties hereto desire to enter into this Agreement to provide a statement of their respective rights and responsibilities in connection with the provision of Medi-Cal Benefits to San Mateo County Medi-Cal Members by the HOSPITAL during the term hereof;

NOW THEREFORE, in consideration of the mutual promises and covenants hereinafter contained the parties agree as follows:

ARTICLE I
DEFINITIONS

General Meaning of Words and Terms - The words and terms used in this Agreement, and any and all attachments, are intended to have their usual meanings unless a particular or more limited meaning is associated with their usage in Sections 14000 et seq. of the Welfare and Institutions

Code or the Knox-Keene Health Care Services Plan Act of 1975, as amended (the "Act") Sections 1340 et seq. of the Health and Safety Code, and/or Title 22 and Title 28 of the California Code of Regulations pertaining to the rendition of health care, or unless specifically defined in this Article I or otherwise in this Agreement.

A. **"Acute Medical/Surgical Day"** shall mean a day approved in an acute care inpatient facility which provides a medical-surgical, intensive, or other inpatient care not specifically designated as ICU Heart Day, Obstetrical Common Day, Nursery Common Day, ICU Burn Day, Neonatal Critical Care Day, Pediatric Critical Care Day, Obstetrical Critical Care Day, or Administrative Day.

B. **"Administrative Day"** shall mean any day of care in an acute care facility for which acute inpatient care is not required, and whose care has been approved by the PLAN as such.

C. **"Attending Physician"** shall mean (a) any Physician who is acting in the provision of Emergency Services or in an acute care setting to meet the medical needs of the Member or (b) any Physician who is, through delegation from the Member's Primary Care Physician, actively engaged in the treatment or evaluation of a Member's condition.

D. **"Claim"** shall mean a claim for compensation for services to PLAN Members filed by the HOSPITAL in accordance with Medi-Cal policy and procedures as defined in Title 22, State Fiscal Intermediary Provider Manual and bulletins, and as specifically modified by the PLAN issued Provider Manual and bulletins.

E. **"Contracting Hospital"** shall mean a Hospital which has executed an Agreement with the PLAN to provide services to PLAN Members as specified in the Hospital Services Agreement.

F. **"Contracting Physician"** shall mean a person who holds a degree of Doctor of Medicine or Osteopathy, who is licensed to practice medicine in the State of California, and who has contracted with the PLAN to provide medical services to Medi-Cal Beneficiaries.

G. "**Contracting Provider**" shall mean a health professional or institution licensed and certified to provide Covered Services to Medi-Cal Members and who has executed an Agreement with the PLAN.

H. "**Contracting Primary Care Physician" or "PCP**" shall mean a physician or physicians who have executed an Agreement with PLAN to provide the services of a Primary Care Physician as specified in PLAN's Primary Care Physician Contract.

I. "**Emergency Medical Condition**" shall mean those HOSPITAL services required to relieve a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

a) placing the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

b) serious impairment of bodily functions, or

c) serious dysfunction of any bodily organ or part.

Emergency services and care include psychiatric screening, examination, evaluation, and treatment by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges.

J. **"Emergency Services"** shall mean those HOSPITAL services provided to a Member for an Emergency Medical Condition.

K. "**Evidence of Coverage**" shall mean the document issued by the PLAN to Members that describes Covered Services and Non-Covered Services in the PLAN.

L. "**Excluded Services**" shall mean those health care services which are excluded as non-covered services in Exhibit 3 and in PLAN's Evidence of Coverage and for which the Member is financially responsible. These services may also be called "Non-Covered Services".

M. **"Health Plan of San Mateo"** (HPSM) shall mean the health plan governed by the San Mateo Health Commission.

N. "**ICU Burn Day**" shall mean a day of that care provided on an inpatient basis to persons whose primary diagnosis is extensive burn, and whose care has been approved by the PLAN as such.

O. "**ICU Heart Day**" shall mean a day approved in an acute care inpatient facility for patients undergoing open-heart surgery or other cardiovascular procedures such as percutaneous transluminal coronary angioplasty so approved by the PLAN.

P. "**Identification Card**" shall mean that card which is issued by the PLAN to each covered Member and that bears the name and symbol of the PLAN and contains: Member's name, Member's identification number, Member's Primary Care Physician and other identifying data. The Identification Card is not proof of Member eligibility.

Q. "**Inpatient Services**" includes, but is not limited to, the following services when ordered by a Member's Physician or other qualified health provider and rendered in accordance with Section 51327 of Title 22 of the California Administrative Code to a Member, subject, however, to such exclusions, limitations, exceptions, and conditions as are otherwise set forth in any provision of this Agreement or an Exhibit thereto:

(1) Bed and Board;

(2) Medical, nursing, surgical, pharmaceuticals, dietary services, medical social services, biologicals, supplies, appliances and equipment provided on an inpatient basis, with the exception of those services and items which the Hospital is not equipped or staffed to provide as specified in Exhibit 1, Excluded Services and Items, to this Agreement (Exhibit 1 is attached hereto and hereby incorporated by reference).

(3) Diagnostic and therapeutic services required by the Member, which shall exclude Physicians' services, except as noted in Exhibit 1. The HOSPITAL shall not be responsible for assuring that the Member will be able to obtain Physician services.

(4) Administrative Services required in providing inpatient services hereunder.

R. "**Interpreter**" shall mean a person fluent in English and in the necessary second language, who has been assessed and is qualified as someone who can accurately speak, read, and readily interpret the necessary second language, or a person who can accurately sign and read sign language.

S. **"Limited English Proficient Member (LEP)"** shall mean Members who are limited-English-speaking or non-English-speaking including those who speak a language other than a threshold language, as defined herein.

T. **"Long-Term Care Services"** shall mean any sub- acute level inpatient services, including but not limited to the following: Skilled Nursing Facilities Services, Intermediate Care Facilities Services, Extended Care Services, and Sub-Acute Level Services excluding the PLAN approved administrative days.

U. **"May"** is used to indicate a permissive or discretionary term or function.

V. **"Medi-Cal Benefits"** shall mean those Inpatient, Outpatient, and Emergency Services for which Medi-Cal Members are eligible pursuant to Welfare and Institutions Code, Sections 14000 et seq. and regulations promulgated thereto, and all other services designated by the PLAN. Also may be referred to as "Covered Service".

W. **"Medical Director"** shall mean the PLAN's Medical Director.

X. **"Medi-Cal Rates"** shall mean the schedule of Medi-Cal maximum allowances and rates of payment for physician and non-physician hospital services in effect for California's Medi-Cal Program at the time the services were rendered.

Y. **"Medical Interpreter"** shall mean a person fluent in English and in the necessary second language, who is qualified due to having been trained to provide language services at medical points of contact with language proficiency related to clinical settings.

Z. **"Member"** shall mean any person certified as eligible for the Medi-Cal Program, pursuant to Welfare and Institutions Code, Sections 14016 and 14018, whose Member I.D. number contains San Mateo County Code Number "41", as the first two numbers and whose Aid Code is included for capitation payment in the PLAN's contract with the State of California.

AA. **"Neonatal Critical Care Day"** shall mean a day of care provided on an inpatient basis to a child whose neonatal care requires the provision of specialized services not currently

available at all Contract Hospitals and whose need for such care has been determined by the PLAN's Medical Director pursuant to criteria in Exhibit 1A (Exhibit 1A is attached hereto and hereby incorporated by reference).

BB. **"Non-Medical Interpreter"** shall mean a person fluent in English and the necessary second language, who is qualified due to having been trained to provide language services at non-medical points of contact with language proficiency related to the specific setting or circumstance.

CC. **"Nursery Common Day"** shall mean a day of that care provided on an inpatient basis to newborns when the mother is also an inpatient in the HOSPITAL.

DD. **"Obstetrical Common Day"** shall mean a day approved in an acute care inpatient facility for Members delivering a baby when the newborn child (children) is an inpatient at the HOSPITAL.

EE. **"Obstetrical Critical Care Day"** shall mean a day of care provided on an inpatient basis to Members whose obstetrical care requires the provision of services pursuant to Exhibit 1B (Exhibit 1B is attached hereto and hereby incorporated by reference).

FF. **"Outpatient Services"** shall mean all HOSPITAL Covered Services other than Inpatient Services and Emergency Services provided to a Medi-Cal Beneficiary.

GG. **"Pediatric Critical Care Day"** shall mean a day of care provided on an inpatient basis to a child whose pediatric care requires the provision of specialized services not currently available at all Contract Hospitals and whose need for such care has been determined by the PLAN's Medical Director pursuant to criteria in Exhibit 1A.

HH. **"Physician"** shall mean an individual licensed to practice medicine or osteopathy in accordance with applicable California law.

II. **"Referral/Authorization"** shall mean the process by which Contracting Physicians or Providers direct a Member to seek or obtain Covered Services from a health professional, hospital or any other Provider of Covered Services in accordance with the PLAN's referral and authorization procedures.

JJ. **"Referral Physician"** shall mean a Contracting Physician who is professionally qualified to practice his/her designated specialty and to whom the Primary Care Physician may refer any Member for consultation or treatment.

KK. **"Referral Services"** shall mean any services which are not Primary Care Services and which are provided by Physicians on referral from the Primary Care Physician or by the Primary Care Physician.

LL. **"San Mateo County"** shall also be referred to as "County".

MM. **"Shall"** is used to introduce an obligation of either the PLAN or the HOSPITAL, and is mandatory.

NN. **"Special Member"** shall mean a member of the PLAN who has not selected or is not assigned to a Contracting Primary Care Physician and who is designated a Special Member by the PLAN.

OO. **"State"** shall mean the State Department of Health Care Services, Department of Managed Health Care, and the United States Department of Health and Human Services.

PP. **"Suspension"** shall mean the PLAN's action to temporarily and immediately suspend all rights and responsibilities of the HOSPITAL while the termination process takes place as set forth in Article X of this Agreement.

QQ. **"Threshold Language"** shall mean primary languages spoken by Limited English Proficiency (LEP) population groups meeting a numeric threshold of 3,000 eligible Members residing in a county. Additionally, languages spoken by a population of eligible LEP Members residing in a county, who meet the concentration standard of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes, are also considered threshold languages for a county. Threshold languages in each county are designated by the California Department of Health Care Services.

RR. **"Utilization Management (UM)"** shall mean those review processes and procedures which are designed to determine whether services are Covered Services or medically necessary and which all Contracting Providers must follow.

ARTICLE II
HOSPITAL PERFORMANCE PROVISIONS

A. Services Provided by the HOSPITAL. The HOSPITAL shall provide Medi-Cal Benefits to Members and all other services designated by the PLAN, subject to the availability of appropriate HOSPITAL facilities and HOSPITAL services.

B. Services Neither Covered Nor Compensated. The HOSPITAL shall not be obligated to provide Members with, and the PLAN shall not be obligated to compensate the HOSPITAL for, the following services pursuant to this Agreement (services not covered under the PLAN's contract with the State):

(1) Services rendered under the California Children Services Program which are not reimbursable under the State's Medi-Cal Program.

(2) Dental Services, as defined in Title 22, California Code of Regulations, Section 51059, except, hospital services provided by a dentist or an oral surgeon for medically indicated dental procedures when they are a Covered Service authorized by the PLAN.

(3) Short-Doyle/Medi-Cal Mental Health Services.

(4) Long-Term Care Institutional Services including the use of swing beds.

C. Availability of Services.

(1) The HOSPITAL shall not differentiate or discriminate in the treatment of Medi-Cal Members, nor shall the Hospital discriminate on the basis of sex, race, creed, color, ancestry, religious creed, national origin, marital status, sexual orientation, physical disability including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental or developmental disability, age, medical condition or mental status, except as limited by the scope of services HOSPITAL is qualified to provide. HOSPITAL shall render health services to Members in the same manner, with the same dignity and respect, in

accordance with the same standards and within the same time availability as offered HOSPITAL's other patients, except as limited by existing Medi-Cal restrictions.

(2) Throughout the term of this Agreement and subject to the conditions within the Agreement, the HOSPITAL shall use its best efforts to maintain its current facilities, equipment and patient service personnel (as well as allied health personnel), as the HOSPITAL, in its reasonable discretion, may employ, to meet the HOSPITAL's obligation to provide Medi-Cal Benefits hereunder.

(3) The HOSPITAL shall not be obligated hereunder to provide Members with those inpatient, outpatient or emergency services that are not maintained by the HOSPITAL due to religious reasons as of the effective date of this Agreement and throughout the term of this Agreement.

(4) The HOSPITAL shall retain the right, within its sole discretion, to alter, enlarge, reconstruct, modify, or shut down all or any part of its facilities, provided, however, that written notice of any action described herein, which would materially affect the services available to Members hereunder, shall be given to the PLAN at least sixty (60) days prior to implementation of such change, and the PLAN shall have the right to terminate this Agreement upon providing the HOSPITAL with thirty (30) days prior written notice given at any time within the foregoing sixty (60) day notice period.

D. Standards of Care. The HOSPITAL shall, in rendering services to Medi-Cal Members, provide hospital care in accordance with recognized HOSPITAL and professional standards and applicable State licensing laws and regulations.

E. Emergency Services. Both parties recognize that the provision of Emergency Services, both in the HOSPITAL's Emergency Department and for inpatients who require immediate treatment for conditions, requires the professional care of a Physician who is immediately available on or near the HOSPITAL premises. The HOSPITAL has arranged for the provision of such services to all patients of the HOSPITAL requiring

such services, and shall arrange for such services to be provided to PLAN Members on the same basis as they are provided to all other patients of the HOSPITAL.

F. The PLAN Not to Interfere with the HOSPITAL. The PLAN and the HOSPITAL agree that the PLAN is responsible for paying for medical care, and that HOSPITAL is responsible for providing service to PLAN Members. However, except in emergencies, the HOSPITAL shall not be entitled to reimbursement for any services provided to a Member unless the HOSPITAL has obtained the necessary authorization from the PLAN in accordance with the PLAN's procedures. The Member's Attending Physician shall determine the need for acute care in accordance with national, professionally recognized standards of medical practice, and Member's Attending Physician shall decide the course of treatment which is medically necessary. Nothing in this Agreement is intended to create (nor shall it be construed to create) any right in the PLAN or Contracting Physicians (except in their capacity as members of the HOSPITAL's medical staff) to intervene with the method(s) by which the HOSPITAL or Attending Physicians render services hereunder. The PLAN shall have no authority to override the medical judgment of a Member's Attending Physician.

G. Licensure and Certification.

(1) The HOSPITAL hereby represents and warrants that it is currently, and for the duration of this Agreement shall remain, licensed as a general acute care hospital in accordance with Sections 1250 et seq. of the Health and Safety Code and the licensing regulations contained in Titles 22 and 17 of the California Code of Regulations.

(2) The HOSPITAL hereby represents and warrants that it is currently and for the duration of this Agreement shall remain, certified under Title XVIII of the Federal Social Security Act.

H. Utilization Controls. With the sole exception of emergency services as set forth in the following paragraph, the PLAN shall not be obligated to pay the HOSPITAL for any services provided to a Member unless the HOSPITAL adheres to all Utilization Management requirements and obtains prior authorization for services in accordance with Medi-Cal policy and procedures as defined in Title 22, State Fiscal Intermediary Provider Manual and Bulletins, and as specifically modified by the PLAN issued Provider Manual and Bulletins.

I. Notification of Emergency Services. The HOSPITAL shall provide Emergency Services to each Medi-Cal Member who presents at the HOSPITAL's Emergency Room and who, within the judgment of the Attending Physician, requires such Emergency Services. The HOSPITAL (its employee or Attending Physician) shall contact a Member's Contracting Primary Care Physician or the PLAN subsequent to providing said Emergency Services to a Member regarding said Member's condition, in accordance with the PLAN's protocols, procedures and provider manuals and bulletins.

ARTICLE III
PLAN PERFORMANCE PROVISIONS

A. Payment Obligation. The PLAN shall pay the HOSPITAL those amounts set forth and in the manner and at the times as specified in Exhibit 2, Reimbursement Addendum to this Agreement for Medi-Cal Benefits provided to Members hereunder.

B. Eligibility Verification. The PLAN shall reimburse the HOSPITAL for Covered Services properly authorized for any person certified as eligible for the Medi-Cal Program pursuant to Welfare and Institutions Code, Sections 14016 et seq. and where Member ID number contains San Mateo County Code Number "41" as the first two numbers and the Aid Code is included for the capitation payment in the PLAN's contract with the State of California. Eligible Members shall include individuals whose eligibility is not determined until after the rendition of Covered Services to individual by the HOSPITAL.

C. List of Contracting Physicians. The PLAN shall provide the HOSPITAL with a continually updated list of all Contracting Physicians.

ARTICLE IV
REIMBURSEMENT FOR SERVICES

A. The HOSPITAL Services. The PLAN shall pay to the HOSPITAL, and the HOSPITAL shall accept from the PLAN in full and final satisfaction of the PLAN's reimbursement obligation for Medi-Cal Benefits provided to Members by the HOSPITAL hereunder

those amounts set forth and in the manner and at the times as specified in Exhibit 2 to this Agreement.

B. Medi-Cal Member Billing. The HOSPITAL shall not submit claims to demand, or otherwise collect reimbursement from a Medi-Cal Member, or from other persons on behalf of the Member, for any service included in the Medi-Cal Program's Scope of Benefits in addition to a claim submitted to the PLAN for that service, except to:

(1) Collect payments due under a contractual or legal entitlement pursuant to Section 14000 (b) of the Welfare and Institutions Code;

(2) Collect co-payment pursuant to Welfare and Institutions Code Section 14134.

C. Member Hold Harmless. The HOSPITAL agrees to hold harmless the Member in the event the PLAN cannot or will not pay for services rendered or materials provided by the HOSPITAL pursuant to the terms of this Agreement.

ARTICLE V
CONTRACTING PHYSICIANS

A. Relationship of the HOSPITAL and Contracting Physicians. It is expressly understood and agreed that no Contracting Physician or other Physician shall be entitled to admit, or treat, or prescribe for Members in the HOSPITAL if the Physician is not a member in good standing of the HOSPITAL's Medical Staff with appropriate clinical privileges to admit and treat Medi-Cal Members in the HOSPITAL. Medical Staff membership and clinical privileges may be granted to Contracting Physicians by the HOSPITAL's Governing Board, acting in conjunction with its Medical Staff, in accordance with the standards, procedures, and other provisions of the HOSPITAL's Medical Staff Bylaws and the Rules and Regulations relating thereto which have been adopted by the HOSPITAL's Medical Staff with the approval of said Board.

The HOSPITAL shall henceforth notify the PLAN when it revokes or modifies privileges of any Physician who is also contracted with the PLAN. Written notification shall be submitted to the PLAN at the time of occurrence or at least on a quarterly basis.

ARTICLE VI
PAYMENT PROCEDURES

A. Coordination of Benefits. The HOSPITAL shall use its reasonable efforts to collect monies due and owing, for health care services provided to a Member, from the Federal Medicare Program, Kaiser Permanente, Ross-Loos, the TRICARE/CHAMPUS Program and Health Maintenance Organizations and other private health insurance plans when the HOSPITAL has knowledge that a Patient is a Member of one of the foregoing programs or plans. In the event the HOSPITAL collects monies from one of the foregoing entities listed in this Article VI A, the HOSPITAL shall notify the PLAN and the PLAN's obligation hereunder shall be reduced by the amount actually collected by the HOSPITAL. No adjustment shall be made for any amounts which the HOSPITAL is unable to collect.

B. Billing Procedures. Completed claims submitted by the HOSPITAL to the PLAN shall be paid by the PLAN in accordance with existing Medi-Cal policies as evidenced in Title 22, State Fiscal Intermediary Provider Manual and Bulletins, and as modified by the PLAN issued Provider Manual and Bulletins.

C. Day of Services. A day of service shall be billed and paid for each Member who occupies an inpatient bed at 12:01 a.m. in the facilities of either the HOSPITAL or an appropriately licensed HOSPITAL subcontractor. However, a day of service may be billed if the Member is admitted and discharged during the same day provided that such admission and discharge are not within twenty-four (24) hours of a prior discharge. Payment for said day shall be the lesser of billed charges or the amounts set forth in Exhibit 2 to this Agreement. Separate patient days of service shall be billed and paid for mother and newborn child (children) when both mother and newborn child (children) are inpatients of the HOSPITAL. Such days shall be billed as Obstetrical Common Day for mother and Nursery Common Day for newborn child (children) unless otherwise approved by the PLAN. There shall be no separate billing hereunder for those Outpatient and Emergency Services provided to a Medi-Cal Member during the same calendar day as the admission of the Member to the HOSPITAL when the foregoing services are directly related to the condition(s) for which the Member is admitted to the HOSPITAL, except as permitted in Exhibit 2.

D. Member Notification. The HOSPITAL shall comply with existing State and Federal law and regulations promulgated thereto pertaining to the issuance of explanations of benefits for Members.

E. Discharge Planning. The HOSPITAL shall continue to be responsible for discharge planning and the HOSPITAL shall prepare a written discharge summary within thirty (30) days of Member's discharge and shall make said summary available to the PLAN upon receiving a prior written request from the PLAN. Said discharge summary shall contain that information ordinarily prepared by the HOSPITAL and provided to patients and third-party payors at the time a bill for service is submitted.

ARTICLE VII
INSURANCE

A. PLAN Insurance. The PLAN, at its sole cost and expense, shall procure and maintain a professional liability policy in the amount of $1,000,000.00 to insure the PLAN and its agents, and employees, acting within the scope of their duties, against any claims for personal injury or death occasioned directly or indirectly by the PLAN or by its agents, or employees in connection with the performance of the PLAN's responsibilities under this Agreement.

B. HOSPITAL Insurance. The HOSPITAL and its subcontractors providing patient care services at their sole cost and expense, shall procure and maintain policies or self-insurance programs of comprehensive general liability, professional liability in excess of $10,000,000.00, and other insurance as shall be necessary to insure the HOSPITAL and its agents, employees, and subcontractors acting within the scope of their duties, against any claims for personal injury or death occasioned directly or indirectly by the HOSPITAL or by its agents, or employees in connection with the performance of the HOSPITAL's responsibilities under this Agreement.

C. HOSPITAL Indemnification. The HOSPITAL agrees to indemnify, defend and hold harmless the PLAN, its agents, officers and employees from and against any and all liability, expense, including defense costs and legal fees, and claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury, or property damage arising from or connected with the HOSPITAL's operations or its

services hereunder. This provision is not intended to nor shall it be construed to require the HOSPITAL to indemnify the PLAN for any PLAN liability independent of that of the HOSPITAL, nor to cause the HOSPITAL to be subject to any liability to any third party (either directly, or as an indemnitor of the PLAN or its agents, officers, and employees) in any case where the HOSPITAL liability would not otherwise exist. Rather, the purpose of this provision is to assure that the PLAN and its agents, officers, and employees, will be provided with indemnification for and a defense to any vicarious or other indirect liability or claim against the PLAN or such agents, officers, or employees resulting from the actions or other omissions of the HOSPITAL in connection with the HOSPITAL's operations or its services under this Agreement.

D. PLAN Indemnification. The PLAN agrees to indemnify, defend and hold harmless the HOSPITAL, its agents, officers and employees from and against any and all liability, expense, including defense costs and legal fees, and claims for damages of any nature whatsoever, including, but not limited to, bodily injury, death, personal injury, or property damage arising from or connected with the PLAN's operations or its services hereunder. This provision is not intended to nor shall it be construed to require the PLAN to indemnify the HOSPITAL for any HOSPITAL liability independent of that of the PLAN, nor to cause the PLAN to be subject to any liability to any third party (either directly, or as an indemnitor of the HOSPITAL or its agents, officers, and employees) in any case where the PLAN liability would not otherwise exist. Rather, the purpose of this provision is to assure that the HOSPITAL and its agents, officers, and employees, will be provided with indemnification for and a defense to any vicarious or other indirect liability or claim against the HOSPITAL or such agents, officers, or employees resulting from the actions or other omission of the PLAN in connection with the PLAN's operations or its services (including utilization review services) under this Agreement.

ARTICLE VIII
RECORDS, AUDITS, AND REPORTS

A. Inspection Rights

(1) The HOSPITAL shall make all of its books and records, pertaining to the goods and services furnished under the terms of this Agreement, available for inspection, examination or copying:

(a) By the PLAN, or any entity designated by the PLAN (e.g. for HEDIS data collection), the State Department of Health Care Services, the State Department of Managed Health Care, and the United States Department of Health and Human Services, and all applicable state and federal agencies, and self regulatory agencies.

(b) Upon reasonable notice and at all reasonable times at the HOSPITAL or at such other mutually agreeable location in California .

(c) In a form maintained in accordance with the general standards applicable to such book or record keeping.

(d) For a term of at least five (5) years from the close of the State's fiscal year in which this Agreement was in effect. The requirement to maintain records shall remain in effect even upon the termination of this Agreement.

(2) These audits or reviews may evaluate the following pertinent to Medi-Cal Members:

(a) Level and quality of care, and the necessity and appropriateness of the services provided.

(b) Internal procedures for assuring efficiency, economy, and quality of care.

(c) Grievances relating to medical care and their disposition.

(d) Financial records when determined necessary by the PLAN to assure accountability for public funds.

(3) The parties agree that the purpose of the audits and reviews authorized by this Paragraph VIII A is solely to assess the HOSPITAL and the HOSPITAL's subcontract's compliance with the terms and conditions of this Agreement.

(4) HOSPITAL does not waive the provisions of Evidence Code 1157 with regard to Medical Staff records.

B. Records to be Kept; Audits or Review; Availability; Period of Retention.

(1) The HOSPITAL shall maintain books, records, documents, and other evidence, using accounting procedures and practices sufficient to reflect properly all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement in accordance with generally accepted accounting principles.

(2) The HOSPITAL shall maintain the above information in accordance with Medicare principles of reimbursement, and shall be consistent with the requirements of the California Health Facilities Commission. In cases where any of the above requirements are in conflict, the HOSPITAL's compliance with any one of such requirements is sufficient.

(3) The HOSPITAL shall maintain medical records required by Sections 70747-70751 of Title 22 of the California Code of Regulation, and other records related to a Member's eligibility for services, the service rendered, the Member to whom the service was rendered, the date of the service, the medical necessity of the service and the quality of the service provided. Records shall be maintained in accordance with Section 51476 of Title 22 of the California Administrative Code. The foregoing constitutes "records" for the purposes of this Paragraph.

C. HOSPITAL's Subcontracts. The HOSPITAL shall maintain and make available to the PLAN, the U.S. Department of Health and Human Services, Department of Managed Health Care, and the State Department of Health Care Services, upon written request, copies of all subcontracts for the performance of any of the HOSPITAL's obligations under this Agreement. The HOSPITAL shall further assure that all subcontracts entered into from the effective date of this Agreement shall require that the subcontractor:

(1) Make all applicable books and records available at all reasonable times for inspection, examination, or copying by the PLAN, the Department of Managed Health Care, the above named State agencies, all applicable state and federal agencies, and self regulatory agencies.

(2) Retain such books and records for a term of five (5) years from the close of the State's fiscal year in which the subcontract became effective.

D. Confidentiality of Member Information. Notwithstanding any other provision of this Agreement, names of Members receiving public social services hereunder are confidential and are to be protected from unauthorized disclosure in accordance with Title 42, Code of Federal Regulations, Section 431.300 et seq. and Section 14100.2 of the Welfare and Institutions Code and regulations adopted hereunder. For the purpose of this Agreement, all information, records, payment information, data and data elements collected and maintained for the operation of the Agreement and pertaining to Members

shall be protected by the HOSPITAL from unauthorized disclosure as required by Medi-Cal and any applicable law.

E. Third-Party Liability. The HOSPITAL shall report to the PLAN, when the HOSPITAL discovers that Medi-Cal Benefits rendered either directly by the HOSPITAL or through the instrumentality of a HOSPITAL subcontractor are covered, in whole or in part, by workers' compensation, tort liability, or casualty insurance. Nothing contained herein shall be construed to reduce or modify the PLAN's obligation to reimburse the HOSPITAL for Medi-Cal Benefits rendered to a Member.

ARTICLE IX
PATIENT RIGHTS

A. Patient Rights. The HOSPITAL or any subcontractor performing the obligations of the HOSPITAL pursuant to the terms of this Agreement shall adopt and post in a conspicuous place a written policy on patient's rights in accordance with Section 70707 of Title 22 of the California Code of Regulations.

B. Linguistic Services and Cultural Sensitivity

1. Interpreter Services for Limited English Proficient (LEP) Members

The HOSPITAL shall ensure equal access to health care services for all Limited English Proficient (LEP) members through the utilization of qualified interpreter services at medical (advice, face-to-face or telephone encounters), and non-medical (appointment services, reception) points of contact.

a) Qualified interpreter services shall be furnished during encounters with providers (physicians, physician extenders, registered nurses, or other personnel) who provide medical or health care advice to Members, when identified by a Provider or requested by a Member.

i. Qualified interpreter services may be obtained through the HPSM 24 hour telephone language line service, on-site trained interpreters, bilingual or multilingual providers. NOTE: The use

of ad hoc interpreters (e.g. family members, friends) is not to be recommended per state and federal regulations, and is only to be used if a Member insists on this after provider explanation that ad hoc interpreters have been demonstrated in clinical studies to lead to lower quality of care due to errors in translation.

ii. The PLAN contracts with Language Line Services, a telephonic interpreter service (formerly known as AT & T Language Line) to assist Providers in complying with this Section. Providers are encouraged to use this service with HPSM Members if there is no staff availability of language assistance to the Member.

b) The HOSPITAL must document the patient's preferred language, the request/type of interpreter services provided or refusal of language interpreter services by a Limited English Proficient (LEP) Member in the medical record.

c) HOSPITAL should utilize bilingual staff and/or the PLAN's interpreter services to ensure that Limited English Proficient members receive timely interpretation services at no charge and at all points of contact. This ensures that members are not subjected to unreasonable delays in receiving services.

2. Additional Linguistic Services for Threshold Language Members

Threshold languages in each county are designated by the State Department of Health Care Services. These are primary languages spoken by the LEP population groups meeting a specific numeric threshold or concentration standard. The threshold language for San Mateo County is published annually.

In addition to interpreter services for LEP members as stated in section B1., the HOSPITAL shall provide the following services for Members whose language proficiency is in a threshold language.

a) Translated signage;

b) Translated written materials; and

c) Referrals to culturally and linguistically appropriate community service programs.

d) Information on how to file a grievance and the ability to file a grievance in a non-English language.

The HOSPITAL may request assistance from the PLAN in meeting these requirements.

3. Hospital shall comply with all of the following requirements related to the provision of linguistic and culturally sensitive services in accordance with this Agreement and PLAN Policies.

Hospital shall address the special health care needs of all Members. Hospital shall ensure equal access and participation in federally funded programs to Members with Limited English Proficiency (LEP) or hearing, speech or vision impairment through the provision of bilingual services. Hospital shall in policies, administration, and services practice the values of: (a) honoring the Member's beliefs, traditions and customs; (b) recognizing individual differences within a culture; (c) creating an open, supportive and responsive organization in which differences are valued, respected and managed; (d) through cultural diversity training, fostering in staff and Contracting Providers attitudes and interpersonal communication styles which respect Member's cultural backgrounds and are sensitive to their special needs; and (e) referring Members to linguistically and culturally sensitive programs.

ARTICLE X
TERM, TERMINATION, AND EFFECT OF TERMINATION

A. Term. The term of this Agreement shall commence on 1/1/07 and shall terminate on 12/31/09

This Agreement will automatically renew for successive twelve (12) month periods on the same terms and conditions (including subsequent amendments) unless terminated pursuant to the terms of this Agreement.

B. Termination Without Cause. The HOSPITAL or the PLAN may terminate this Agreement without cause upon providing the other party with ninety (90) days prior written notice.

C. Termination for Material Breach. Either party shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to the other party if the party to whom such notice is given is in material default under this Agreement. The party claiming the right to terminate hereunder shall set forth in the notice of intended termination required hereby the effective date of such termination and the facts underlying its claim that the other party is in breach of this Agreement. If the HOSPITAL or the PLAN remedies such alleged breach within twenty (20) days of the receipt of such notice, the Agreement shall remain in effect for the remaining term and such termination notice shall no longer be in effect. Notwithstanding the other provisions of this paragraph, the PLAN may immediately suspend this Agreement pending completion of applicable termination procedures, if the PLAN makes a reasonable determination, supported by written findings, that the health and welfare of Members is jeopardized by continuation of the Agreement.

D. Termination Based upon Unforeseen Events. In the event there are (1) changes effected in the PLAN's contract with the State of California, or (2) changes effected in the Medi-Cal Program, or changes in Federal laws governing the Medi-Cal Program, or (3) changes in the Federal Medicare Program and/or substantial changes under other public or private health and/or hospital care insurance programs or policies which will have a material detrimental financial effect on the operations of the HOSPITAL or the PLAN, the HOSPITAL or the PLAN may terminate this Agreement upon providing the other party with thirty (30) days prior written notice. In any case where such notice is provided, both parties shall negotiate in good faith during such thirty (30) day period in an effort to develop a revised Agreement, which, to the extent reasonably practicable, under the circumstance, will adequately protect the interests of both parties in light of the governmental program or private insurance policy changes which constituted the basis for the exercise of this termination provision.

E. Termination for Insufficient Provider Participation. If, for any reason, the PLAN is unable to enter into or maintain service contracts with sufficient numbers of Primary Care Physician and Providers on the Medical Staff of Contracting Hospitals to assure adequate Member access to needed Physician Services, the PLAN may terminate this Agreement upon thirty (30) days written notice to the HOSPITAL.

F. Termination by U.S. Department of Health and Human Services or the State Department of Health Care Services. If the qualification of the HOSPITAL under the Federal Social Security Act is terminated or ceases for any reason or if the PLAN's Medi-Cal Services Contract with the State of California is terminated or ceases for any reason, the PLAN shall give the HOSPITAL immediate written notice of the foregoing termination(s) and this Agreement shall terminate in accordance with the terms under D of this Article.

G. Effect of Termination. As of the date of termination pursuant to any provision of this Agreement, this Agreement shall be of no further force or effect whatsoever, and each of the parties hereto shall be relieved and discharged herefrom, except that the PLAN shall remain liable for payment for all Medi-Cal Benefits rendered to PLAN's Medi-Cal Members up to the date of termination and for any Medi-Cal Benefits rendered hereunder after such date until such time as appropriate transfer (or other medically acceptable disposition) of Medi-Cal Members receiving inpatient services as of the date of termination is achieved.

H. Termination for Interruption. The PLAN may terminate Agreement upon ten (10) days written notice pursuant to Article XI.

I. Amendments to Avoid Termination. If the provisions of Article X D of this Agreement are invoked, the party who invokes them shall make all reasonable efforts, if so requested by the other party, to negotiate amendments to this Agreement which will bring the terms of the Agreement in compliance with such statute, regulation, or judicial decision.

ARTICLE XI
INTERRUPTIONS

Cause Beyond Control of the HOSPITAL. In the event the operations of the HOSPITAL's facilities, or any substantial portion thereof, are interrupted by war, fire, insurrection, riots, the elements, earthquakes, acts of God, or without limiting the foregoing, any other cause beyond the control of the HOSPITAL, the HOSPITAL shall be relieved of its obligations with respect to the provisions of this Agreement (or such portions hereof which the HOSPITAL is thereby rendered incapable of performing) for the duration of such interruptions. Nothing contained herein shall be construed to limit or reduce the PLAN's obligation to pay the HOSPITAL for Medi-Cal Benefits rendered to Members prior to or subsequent to an event described herein. Should a substantial part of the services which the HOSPITAL has agreed to provide hereunder be interrupted for a period in excess of thirty (30) days, the PLAN shall have the right to terminate this Agreement upon providing ten (10) days prior written notice to the HOSPITAL.

ARTICLE XII
GENERAL PROVISIONS

A. Applicability of State and Federal Laws and Regulations. This Agreement shall be governed and construed in accordance with the laws of the State of California and of the United States. Any provision of this Agreement which is in conflict with, or does not conform to applicable State or Federal statutes or regulations promulgated pursuant thereto shall be amended to conform to the requirements of such statutes or regulations.

B. Severability. In the event any provision of this Agreement is rendered invalid or unenforceable by Act of Congress, by statute of the State of California, by any regulation duly promulgated by the United States or the State of California in accordance with law or is declared null and void by any court of competent jurisdiction, the remainder of the provisions hereof shall remain in full force and effect.

C. Limitation of Severability. In the event the removal of a provision rendered invalid or unenforceable or declared null and void has the effect of materially altering the obligations of either party in such manner as to cause serious financial hardship to such

party, the party so affected shall have the right to terminate this Agreement upon providing thirty (30) days prior written notice to the other party.

ARTICLE XIII
GRIEVANCES AND APPEALS

A. Grievance and Appeals. It is understood that the Hospital may have Grievances and Appeals which may arise as a health care Provider under contract with the PLAN. These Grievances and Appeals shall be resolved through the mechanisms set out in this section. Hospital and the PLAN shall be bound by the decisions of the PLAN's Grievances and Appeals mechanisms.

B. Disputes. It is understood that the Hospital may have disputes which may arise as a health care Provider under contract with the PLAN. These disputes shall be resolved through the mechanisms set out in this section. Hospital and the PLAN shall be bound by the decisions of the PLAN's Grievances and Appeals mechanisms.

C. PLAN Grievances and Appeals and Dispute Resolution Procedure Responsibility. The PLAN's Executive Director has primary responsibility for maintenance, review, formulation of policy changes, and procedural improvements of the Grievances and Appeals and dispute resolution review system. The Executive Director shall be assisted by other PLAN staff as requested.

D. Resolution of Member and Provider Initiated Grievances or Appeals at PLAN Level. The Hospital agrees that all disputes or disagreements between the Hospital and the PLAN or the Member shall be resolved in accordance with the Provider Manual, PLAN policies and State guidelines and regulations. Hospital agrees to cooperate with PLAN in resolving Member grievances and/or appeals related to the Hospital. PLAN will bring to the Hospital's attention all Member complaints involving Hospital. Hospital will, in accordance with PLAN approved procedures, investigate such complaints and use their best efforts to resolve them in a fair and equitable manner. Hospital shall immediately make available to PLAN, any and all records, notes, and documents or other information regarding Hospital's dispute resolution mechanism and the resolution of any and all disputes with Members. If a Member files a complaint at the Hospital Level, Hospital agrees to send to the PLAN's Grievances and Appeals Coordinator, a quarterly report, containing the Member's name, PLAN ID Number, date of complaint or grievance, type of complaint or grievance, category, and the resolution.

E. Dispute Resolution. The Hospital agrees that all disputes between the Hospital and the PLAN shall be resolved in accordance with the Provider Manual, PLAN policies and State guidelines and regulations. PLAN retains responsibility for dispute resolution and does not delegate it to Hospital. PLAN agrees to cooperate with Hospital in resolving disputes. PLAN will investigate such disputes and use their best efforts to resolve them

in a fair and equitable manner that is acceptable to PLAN and Hospital. Hospital agrees to notify PLAN promptly of any action taken or proposed with respect to the resolution of such disputes and the avoidance of similar disputes in the future. Hospital shall immediately make available to PLAN, any and all records, notes, and documents or other information regarding Hospital's dispute resolution mechanism.

ARTICLE XIV
MISCELLANEOUS

A. Time of the Essence. Time shall be of the essence of each and every term, obligation, and condition of this Agreement.

B. Entire Agreement. This Agreement (together with all Exhibits hereto) contains the entire Agreement between the parties relating to the rights herein granted and the obligations herein assumed. It is the express intention of the HOSPITAL and the PLAN that any and all prior or contemporaneous agreements, promises, negotiations or representations, either oral or written, relating to the subject matter and period governed by this Agreement which are not expressly set forth herein shall be of no further force, effect or legal consequence after the effective date hereunder.

C. Amendments. This Agreement and any Exhibits hereto may be amended only by an instrument in writing, duly executed by both parties hereto in accordance with applicable provisions of the Knox-Keene Health Service Plan Act of 1975, as amended, and the regulations promulgated hereunder by the Department of Managed Health Care.

D. Waivers. No obligation under this Agreement or an Exhibit hereto may be waived by any party hereto except by an instrument in writing, duly executed by the party waiving such obligations. All manners shall specify the provisions being waived, and no waiver of any provision of this Agreement extends or implies the extension of the waiver to any other provisions of this Agreement unless so specified in writing.

E. State Approval. This Agreement and any amendment hereto shall become effective only upon review and approval by the State Department of Health Care Services.

F. Independent Contractors. The PLAN and The HOSPITAL hereby acknowledge that they are independent contractors and neither is an officer, agent or employee of the other for any purpose.

G. Counterparts. This Agreement may be executed in counterparts, each of which shall be considered to be an original; however, all such counterparts shall constitute but one and the same Agreement.

H. Headings. The headings or titles of articles and sections contained in this Agreement are intended solely for the purpose of facilitating reference, are not a part of the Agreement and shall not affect in any way the meaning or interpretation of this Agreement.

I. Inurement. This Agreement shall be binding upon all assignees, heirs and successors-in-interest of either party.

J. Assignment. Neither the PLAN nor the HOSPITAL shall assign this Agreement without the written consent of the other party.

ARTICLE XV
NOTICES

A. Any notice required to be given pursuant to the terms and provisions hereof, unless otherwise indicated herein, shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or courier service (Airborne, Federal Express, UPS, etc.) or other means which can provide written proof of delivery, to the PLAN at:

Health Plan of San Mateo
701 Gateway Blvd., Suite 400
South San Francisco, CA 94080
Attn: Executive Director

and

HOSPITAL at:

San Mateo Medical Center
222 W. 39th Avenue
San Mateo, CA 94403
Attn: Raul Gorospe

IN WITNESS WHEREOF, the parties hereto, by their duly authorized representatives, have affixed their hands.

SAN MATEO HEALTH COMMISSION

Dated: 2/6/08 By: _____

Title: Chairperson, San Mateo Health Commission

HOSPITAL

Name Sang-ick Chang, M.D.

Dated: _____ By: _____

Title: Chief Executive Officer

COUNTY OF SAN MATEO

By: _____

Adrienne J. Tissier, President
Board of Supervisors, San Mateo County

Date: _____

ATTEST:

By: _____
Clerk of Said Board

LIST OF EXHIBITS

1. EXCLUDED SERVICES AND ITEMS

1A. CRITICAL CARE CRITERIA - NEONATOLOGY and PEDIATRICS

1B. CRITICAL CARE CRITERIA - OBSTETRICAL

2. REIMBURSEMENT ADDENDUM

EXHIBIT 1

EXCLUDED SERVICES AND ITEMS

EXHIBIT 1A

CRITICAL CARE CRITERIA FOR NEONATOLOGY AND PEDIATRICS

A provider of service will be eligible for reimbursement at the critical care rate for each day of service for which the medical record demonstrate that (for any amount of time) any one of the following criteria has been met:

1. Mechanical ventilation outside the operating room, CAP (for non-chronic use only), or other modes of positive pressure ventilation, supplemental F_1O_2 of greater than or equal to 40% [1] or ECMO (extra corporeal membrane oxygenation).
2. Requires nitric oxide or prostaglandin administration (e.g. for pulmonary immaturity or pulmonary hypertension, congenital heart disease, or respiratory therapy.
3. Chest tube.
4. Invasive monitoring (e.g. arterial lines – umbilical or peripheral 1, CVP or umbilical venous lines [1]) associated with appropriate critical conditions (such as exchange transfusions [1]), including intravenous lines for administration of pharmacological agents to support the cardiovascular system[1]
5. Intracranial pressure monitoring (for Pediatric Intensive Care only), neurological monitoring in the setting of ongoing seizures or for apnea.
6. Central or peripheral hyperalimentation [1]
7. Pre-mature infants< 27 weeks gestation or extremely low birth weight $\leq$1000 grams recently weaned from assisted ventilation (within 5 days).
8. Day of surgery and 24 hours post-operative major surgical procedure.
9. Medical instability requiring the need for continuous measurement and interpretation of hemodynamic data for at least one of the following conditions: shock, cardiac failure CNS or ventilator status.

Additional Critical Care Criteria would be demonstrated by the documentation of continuous or hourly monitoring of blood pressure, and at least TWO CRITERIA (any combination) from the following categories.

- Pharmacological treatment for apnea and/or bradycardic episodes [1]
- Peripheral intravenous line for administration of intravenous fluids, blood or blood products, or medications other than those agents used in support of the cardiovascular system [1]
- Surgical or interventional radiology procedures for 24 hours per and post-procedure
- Dialysis or Renal replacement therapy used for dialysis or hemofiltration in the pediatric intensive care (PICU) setting
- Tube feedings [1]

[1] CCS defined and revised NICU criteria proposed and under review, 01/28/02

EXHIBIT 1B

CRITICAL CARE CRITERIA FOR OBSTETRICS

Required provision of one or more of the following services to obstetrical inpatients:

1. Any person whose days of care have been approved by the PLAN as "obstetrical critical care"
2. Multiple Gestation (with delivery or complications subject to PLAN review)
3. Severe Pre-eclampsia, HELLP syndrome, or eclampsia with seizure
4. Maternal hemorrhage requiring transfusion, operative intervention and/or vascoactive drug therapy, or embolization
5. Disseminated intravascular coagulopathy and/or transfusion of blood or blood products
6. Respiratory failure requiring assisted ventilation
7. Invasive hemodynamic monitoring such as central venous or arterial lines
8. Other maternal trauma or maternal medical condition requiring transfer from Labor and Delivery to the adult ICU (examples: Renal disease, Maternal heart disease or maternal seizures)

a. Maternal/Fetal reasons:
    a. Pre-term labor/rupture of membranes prior to 34 weeks
    b. Extreme pre-term (24 to 29 weeks)
    c. Known fetal anomalies (craniofacial, cardiac, GI)
    d. Invasive fetal procedures (other than amniocentesis); and fetal procedure assessing the fetal body cavity or circulatory system
    e. Operative procedures on the fetal – placental unit

EXHIBIT 2

REIMBURSEMENT ADDENDUM

A. Hospital Inpatient Service Reimbursement

(1) The PLAN shall pay the HOSPITAL, as a non-full scope hospital, the all-inclusive rates per day for admissions as follows:

Service Type	Jan.1 – Jun. 30, 2007	Effective July 1, 2007
Med/Surg	$ 1,302.00	$ 1,432.00
NICU(UB Rev code 172)	$ 1,302.00	$ 1,950.00
NICU(UB Rev codes, 173,174	$ 1,900.00	$ 2,090.00
PICU(All 200 series UB Rev cds)	$ 1,900.00	$ 2,090.00
OB Vag	$ 1,650.00	$ 1,750.00
OB C-Section	$ 1,650.00	$ 1,950.00
OB Critical Care	$ 1,900.00	$ 2,090.00
ICU Heart/Burn	$ 1,900.00	$ 2,090.00
Rehab	$ 1,302.00	$ 1,432.00
Admin/Observation	$ 231.30	$ 310.00

B. HOSPITAL Outpatient Services Reimbursement

(1) The PLAN shall pay the HOSPITAL for those outpatient hospital services, excluding physician services, provided to Medi-Cal Members, and for which approved claims have been submitted by the HOSPITAL at 123 % of the prevailing state Medi-Cal outpatient service reimbursement rates for services rendered or the PLAN's payment rate, whichever is higher.

The PLAN shall pay the Hospital for professional services, provided to Medi-Cal Members, and for which approved claims have been submitted by the HOSPITAL at 123 % of the prevailing state Medi-Cal reimbursement rate for services rendered or the PLAN's payment rate, whichever is higher.

(2) The all-inclusive per diem rates, as described above, are to be the only payments made by the PLAN to the HOSPITAL for inpatient services provided to Medi-Cal Members except where otherwise provided hereunder.