CareAdvantage

HOSPITAL SERVICE AGREEMENT

BETWEEN

SAN MATEO HEALTH COMMISSION, d.b.a. HEALTH PLAN OF SAN MATEO

AND

COUNTY OF SAN MATEO, SAN MATEO MEDICAL CENTER

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AND

COUNTY OF SAN MATEO, SAN MATEO MEDICAL CENTER

THIS AGREEMENT is made and entered into as of the ____ day of _____ 2009, by and between San Mateo Health Commission, d.b.a. Health Plan of San Mateo, an independent public agency established by the San Mateo County Board of Supervisors pursuant to WIC section 14087.51, hereinafter referred to as "PLAN" and **COUNTY OF SAN MATEO, SAN MATEO MEDICAL CENTER**, a HOSPITAL, licensed under the laws of the State of California, hereinafter referred to as "Hospital".

RECITALS

A. PLAN is licensed as a Health Care Service Plan under the Knox-Keene Health Care Service Plan Act of 1975 as amended ("Knox-Keene Act").

B. PLAN intends to operate a Medicare Advantage Plan ("CareAdvantage") pursuant to the Balanced Budget Act of 1997 ("BBA") and to offer a prepaid health benefits plan to individuals covered under the Federal Medicare program.

C. Hospital desires to provide certain Covered Services to Members under the terms and conditions set forth herein.

D. PLAN desires to enter into an agreement with Hospital obligating Hospital to provide certain Covered Services for Members of PLAN.

E. PLAN and Hospital mutually desire to preserve and enhance patient dignity.

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein stated, it is agreed by and between the parties hereto as follows:

I. DEFINITIONS

1.1 **"CMS"** means the Centers for Medicare and Medicaid Services, which is the agency of the federal government responsible for administration of the Medicare program including PLAN's CareAdvantage Program.

1.2 **"Case Management"** means the coordination and follow up by the Primary Care Physician, of all services deemed necessary to provide the Member with a plan of medically necessary and appropriate health care.

1.3 **"Commission"** means the San Mateo Health Commission.

1.4 **"Contracted Hospital"** means a licensed hospital which has entered into an agreement with the PLAN to provide Covered Services to Members.

1.5 **"Contracted Medical Group"** means a medical group or independent practice association which has entered into an agreement with the PLAN to provide Covered Services to Members.

1.6 **"Contracted Physician"** means a physician who is duly licensed to practice medicine or osteopathy under California law and who has contracted with the PLAN or is employed or contracts with a Contracted Medical Group to provide Covered Services to Members.

1.7 **"Contracted Provider"** means a Contracted Physician, Contracted Hospital, Contracted Medical Group or other licensed health facility or health professional which has entered into an agreement with PLAN to provide Covered Services to Members.

1.8 **"Copayment and Deductible"** means cost sharing charges for Covered Services.

1.9 **"Covered Services"** means those health care services, equipment and supplies, inclusive of Medicare Services and Medi-Cal Wraparound Services, which a member is entitled to receive under the PLAN's CareAdvantage Program as described in the Evidence of Coverage. They include, but are not limited to, services provided during the entire inpatient hospitalization stay as well as outpatient, ancillary and emergency services provided within a span of seventy-two (72) hours on an inpatient admission.

1.10 **"Downstream Entity"** means any party that enters into an acceptable written arrangement below the level of the arrangement between a Plan and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of health and/or administrative services.

1.11 **"Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; or (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.12 **"Emergency Services"** means those medical and hospital services required that are (i) furnished by a physician qualified to furnish emergency services; and/or (ii) needed to evaluate or stabilize an Emergency Medical Condition.

1.13 **"Evidence of Coverage"** means the document issued by the PLAN to a Member that sets forth the PLAN's Covered Services.

1.14 **"First Tier Entity"** means any party that enters into a written arrangement with Plan to provide administrative services or health care services for a Medicare eligible individual.

1.15 **"Group Physician"** means a Physician who is employed by or under contract to provide services for a Physician Group.

1.16 **"Hospital Services"** means those institutional and other services which Hospital will provide, either directly or by arrangement, to Members. Hospital will only be responsible for the provision of services available at Hospital.

1.17 **"Medi-Cal Wraparound Services"** means those Medi-Cal services that PLAN provides to eligible Medi-Cal beneficiaries who are enrolled in PLAN under PLAN's Medi-Cal contract with the California Department of Health Care Services and that are provided secondary to services, including Medicare Services, covered by other payers or programs that have primary payment responsibility.

1.18 **"Medically Necessary"** means health care services which a Member requires as determined by a Contracted Provider and PLAN in accordance with accepted medical practices and standards prevailing at the time of treatment and in conformity with the professional standards adopted by PLAN.

1.19 **"Medicare Services"** means those health care services that are covered under the Original Medicare program in accordance with Medicare coverage guidelines and offered through HPSM CareAdvantage, as well as supplemental Medicare benefits offered through HSPM CareAdvantage in accordance with the Centers for Medicare and Medicaid Services approval of PLAN's annual Medicare Advantage-Prescription Drug Plan bid.

1.20 **"Member"** means a Medicare beneficiary who is enrolled in the PLAN's CareAdvantage plan who is entitled to receive Covered Services.

1.21 **"Non-Covered Services"** means those health care services, equipment and supplies which a Member is not entitled to receive pursuant to the CareAdvantage Evidence of Coverage.

1.22 **"Non-Participating Provider"** means an institutional, professional or other provider of health care services who has not entered into an agreement with PLAN, either directly or through another organization, to provide Covered Services to Members.

1.23 **"Other Services Provider"** means a Contracted Provider who is professionally qualified to practice his/her designated specialty, whose agreement with PLAN includes responsibility for providing Covered Services in his/her designated specialty, but whose professional qualifications do not require approval by the Medical Board of California or the California Board of Osteopathic Examiners.

1.24 **"Participating Provider"** means an institutional, professional or other provider of health care services who has entered into an agreement, either with PLAN, Physician Group or through an agreement with another organization, to provide Covered Services to Members.

1.25 **"Physician"** means a person with an unrestricted license to practice medicine or osteopathy by the State of California.

1.26 **"Physician Group"** means a partnership, association, corporation or other legal entity which is under contract with PLAN to deliver or arrange for the delivery of health services and which has entered into written service agreements with health professionals, a majority of which are licensed to practice medicine or osteopathy, and which meets the requirements set forth in Section 110.102(a) of Title 42 of the Code of Federal Regulations.

1.27 **"Plan Physician"** means a Physician who is under contract with PLAN, either directly or through a contract with a Physician Group or other organization, to provide professional Covered Services to Members. Plan Physician shall also mean a Physician or other health professional who acts on behalf of, at the request of, or under the supervision of a licensed Physician who is a Plan Physician.

1.28 **"Primary Care Physician (PCP)"** means a Contracted Physician selected by a Member to render first contact medical care and to provide Primary Care Services. PCPs may include internists, pediatricians, family practitioners, obstetricians/gynecologists and general practitioners.

1.29 **"Provider Manual"** means the document, as amended from time to time, which is prepared by the PLAN and given to Hospital. The Provider Manual will describe PLAN's policies and procedures as they affect Providers.

1.30 **"RBRVS (Resource-Based Relative Value Scale)"** means the current year's physician compensation schedules published by the United States Centers for Medicare and Medicaid Services ("CMS"), which are used by CMS to reimburse those physicians Contracted in the Federal Medicare Program ("Medicare").

1.31 **"Referral"** means the process by which a Contracted Physician directs a Member to a Non-Contracted Provider.

1.32 **"Referral Provider"** means a Contracted Physician who is professionally qualified to practice his/her designated specialty and whose agreement with PLAN includes responsibility for providing Covered Services in his/her designated specialty.

1.33 **"Service Area"** means the geographic area that is within a thirty (30) air mile radius of Hospital.

1.34 **"Urgent Care"** means Covered Services required to prevent deterioration of a Member's health that results from an unforeseen illness or injury.

1.35 **"Utilization Management Plan"** means the programs and processes established and carried out by PLAN, Hospital and Plan Physicians, and approved by PLAN, to evaluate, authorize and monitor the utilization of Covered Services provided to Members.

II. HOSPITAL OBLIGATIONS

2.1 **Accessibility of Care.** Hospital agrees that Covered Services provided by it will be made available and accessible to Members promptly and in a manner which ensures continuity of care.

2.2 **Participation Requirements.** Hospital understands that PLAN is prohibited by CMS and the California Department of Health Care Services from contracting with a provider who itself, its employees, managers, or subcontractors are excluded from participating in the Medicare or Medi-Cal programs. Hospital warrants that it shall review the Office of the Inspector General, General Services Administration, and Medi-Cal exclusions, debarment, licensure or sanctions lists at the time of entering into this Agreement and annually thereafter to ensure that neither itself, nor any employee, manager, or subcontractor responsible for administering or delivering benefits under any federal or state health care program is listed. If Hospital, any employee, manager, or subcontractor is on an exclusion list, that person or entity will immediately be removed from any work related directly or indirectly to all federal or state health care programs. In the event Hospital fails to comply with the above, PLAN reserves the right to require Hospital to pay immediately to PLAN the amount of any sanctions that may be imposed on PLAN by CMS or Medi-Cal for violation of this prohibition.

2.3 **Collection of Copayments from Members.** Hospital shall look only to PLAN for payment of Covered Services and shall at no time seek compensation from Members for Covered Services. Such payment by PLAN shall be considered payment in full. Hospital shall

not hold Members responsible for any Medicare or Medi-Cal cost sharing in accordance with the agreement that payment from PLAN for Covered Services shall be considered payment in full. In addition, the Hospital shall not invoice or balance bill a Member for the difference between the provider's billed charges and the reimbursement paid by the PLAN for Covered Services.

2.4 **Compliance.** Hospital shall comply and have any Downstream Entity comply with Federal and State laws and regulations. Hospital shall include in its contracts with any Downstream Entity all provisions required by Federal and State laws, including the BBA and related regulations. Hospital shall ensure that all contracts with any Downstream Entity comply with all applicable CareAdvantage regulations as described in this Agreement and as outlined in the Provider Manual, as a condition for Hospital's continued participation in the PLAN's CareAdvantage plan.

Hospital understands that payments made by PLAN are, in whole or in part, derived from Federal funds, and therefore Hospital and any Downstream Entity are subject to certain laws that are applicable to individuals and entities receiving Federal funds. Hospital agrees to comply with all applicable Federal laws, regulations, reporting requirements, CMS instructions, and with the PLAN's contractual obligations to CMS, including, but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Federal criminal law, the False Claims Act (31 U.S.C. §3729 et.seq.) and the Anti-Kickback statute (section 1128B(b) of the Act), HIPAA administrative simplification rules at 45 CFR Part 160, 162, and 164. Hospital agrees to include the requirements of this section in its contracts with any Downstream Entity, and to require any Downstream Entity to comply accordingly.

2.5 **Member Grievances and Appeals.** PLAN retains responsibility for grievance and appeal resolution and does not delegate it to Hospital. Hospital agrees to cooperate with PLAN in resolving Member grievances and appeals related to Hospital. PLAN will bring to the Hospital's attention all Member complaints involving Hospital and Hospital will, in accordance with its regular procedure, investigate such complaints and use its best efforts to resolve them in a fair and equitable manner. Hospital agrees to notify PLAN promptly of any action taken or proposed with respect to the resolution of such complaints and the avoidance of similar complaints in the future.

2.6 **PLAN Liaison.** Hospital agrees to designate an individual(s) who will assume the day-to-day responsibilities with regard to Hospital's obligations hereunder and to serve as liaison with PLAN. Such individual will also be responsible for responding promptly to a Member's grievance and appeal by following PLAN's grievance and/or appeals procedures.

2.7 **Hospital Services.** Hospital agrees to provide or arrange for the provision of Hospital Services to Members of PLAN.

2.8 **Identification of Hospital.** Hospital agrees that PLAN may list its name, address, telephone number and a description of its facilities and services in PLAN's roster of participating hospitals that is given to Members and prospective Members, and may use Hospital's name for advertising/marketing purposes. The use of Hospital's trademarks or logos by PLAN without Hospital's prior written approval is prohibited.

2.9 **Non-Discrimination.** Hospital agrees: (1) not to differentiate or discriminate in his/her provision of Covered Services to Members because of race, color, national origin, ancestry, religion, sex, health status, marital status, sexual orientation, age, or other protected classes according to federal and state law; and (2) to render Covered Services to Members in the same manner, in accordance with the same standards and within the same time availability

as offered to non-Members consistent with existing medical/ethical/legal requirements for providing continuity of care to any patient.

2.10 **Private Contract.** Hospital understands that PLAN is prohibited by CMS from including in its provider network any provider that has entered into a private contract with a Medicare beneficiary (excludes fee-for-service Medicare beneficiary for the provision of Covered Services). In such an event, PLAN reserves the right to exclude any such provider from its provider network. In addition, PLAN shall have the right to reduce Hospital's reimbursement by the amount of any reimbursement that was paid either directly or indirectly to such provider(s). This provision shall remain in effect for a period of two (2) years from the time that all direct contracts between provider and Member were completed or terminated.

2.11 **Quality Improvement Programs.** PLAN retains responsibility for quality improvement. Hospital agrees to comply with PLAN's quality improvement program. PLAN's quality improvement program shall be developed in consultation with its Participating Providers to ensure that practice guidelines of quality improvement and quality management pursuant to CMS regulations and instructions are met.

Hospital and its Downstream Entities shall fully cooperate with and participate in PLAN's quality improvement program and procedures as described in the Provider Manual. Hospital shall immediately notify PLAN of those Members and cases which fall within the catastrophic and targeted case management guidelines set forth in the Provider Manual and shall cooperate with PLAN's case management program for catastrophic and targeted cases. Hospital and Participating Providers shall comply with PLAN's Medical Policy. Hospital shall comply with and accept as final, the decisions of the PLAN's quality improvement program, or pending resolution of any dispute through the dispute resolution process, the decisions made through that process.

2.12 **Provider Terminations.** In the event a provider intending to become a Participating Provider is denied a contract with Hospital, or a Participating Provider is suspended or terminated for cause, Hospital shall provide the provider with written notice of the reason for the action as required by Federal law, including any standards and profiling data Hospital used to evaluate the provider, the number and mix of similar health care providers that Hospital needs (if applicable), and notice of the provider's right to appeal the action, including notice of the process and timing to request a hearing. In the event Hospital terminates a contract with a Participating Provider for deficiencies in the quality of care provided, Hospital shall give notice of the action to the appropriate licensing and disciplinary bodies.

2.13 **Prohibited Interference With Enrollment Relationships.** Hospital agrees that it will not: (a) violate any laws and regulations governing the solicitation of PLAN members; (b) encourage or seek to have an Member disenroll from PLAN and/or enroll in (i) a health maintenance organization, including one in which Hospital has an ownership interest, (ii) another managed care plan, (iii) a case management arrangement, or (iv) any other similar arrangement, including any other arrangement in which Hospital has a direct or indirect ownership interest (collectively referred to as "Alternative Care Plan"); and/or (c) interfere with the enrollment of PLAN Members. Any such activity would constitute a material breach of this contract. The provisions of this Section shall apply to all Hospital employees and subsidiaries of Hospital, including any such arrangements established after the Effective Date of this Agreement. Nothing in this Section shall prohibit Hospital from providing information to the public as to its affiliation with an Alternative Care Plan, so long as such activities do not include any of the prohibited activities set forth above. Both parties agree that if a dispute arises as to whether there has been a breach of this Section it shall be resolved in accordance with the dispute resolution section of this Agreement, set forth in Article XIII.

2.14 **Communications Regarding PLAN.** Hospital agrees that in connection with all actions taken on behalf of Members and in all communications with Members in connection with this Agreement, Hospital shall avoid actions and communications that could or shall undermine the confidence of the Member, a potential Member or the public in PLAN or in the quality of care which PLAN provides. The obligations set forth in this Section shall survive termination of this Agreement.

2.15 **Standards of Care.** Hospital will provide all Hospital Services in accordance with professionally recognized standards of care and which takes into consideration the Members' input into treatment decisions

2.16 **State and Federal Site Visits.** Hospital agrees to permit the California Department of Managed Health Care ("DMHC"), CMS and the U.S. Department of Health and Human Services ("HHS") to conduct on-site evaluations of Hospital periodically in accordance with the current state and federal laws and regulations and to comply with the agency's recommendations, if any. Hospital shall give CMS, DMHC, HHS, the U.S. General Accounting Office ("GAO"), the Comptroller General, any Peer Review Organization ("PRO"), Quality Improvement Organization ("QIO"), or accrediting organizations, their designees, and other representatives of regulatory or accrediting organizations the right to audit, evaluate, inspect books, contracts, medical records, patient care documentation, other records of contractors, subcontractors or related entities for a minimum of ten (10) years from the final date of the contract period or the date of completion of the last audit, whichever is later unless further extended for the reasons specified in Title 42, Code of Federal Regulations ("42 CFR"), §422.504(e)(4).

2.17 **Transfers.** Hospital agrees to assist in facilitating the transfer of Members to Hospital if determined medically acceptable by attending physicians and the PLAN Medical Director.

2.18 **Utilization Management Coordinator.** Hospital agrees to designate an individual(s) to assume the day-to-day responsibilities with regard to the Hospital's obligation to prospectively and concurrently review services to Members and to support the Utilization Management Plan as it relates to the services provided to Members assigned to Hospital.

2.19 **Hospital-Based Physician Services.** Hospital shall make best efforts to facilitate that its entire staff of Hospital-based Physicians become Plan Physicians, under contract with PLAN. Except for Emergency Services, Hospital shall not utilize a non-Plan Physician for Hospital-based Physician services for PLAN Members, including, but not limited to emergency medicine, anesthesiology, radiology and pathology services, without the express approval of PLAN's Medical Director or his/her designee. In the event a Member needs Hospital-based Physician services and a Plan Physician is not available, Hospital shall contact PLAN's Utilization Management Program to obtain authorization for such services by a non-Plan Physician. Hospital shall make best efforts to ensure that its Hospital-based Physicians comply with the terms and conditions of this Agreement, including participation in PLAN's Utilization Management Program and Quality Management Program.

2.20 **Skilled Nursing Facility and Other Sub-acute Services.** In the event that Hospital contracts with PLAN to provide skilled nursing facility ("SNF") or any other type of sub-acute institutional service to Members, the applicability of which level of care shall be determined by the PLAN's Medical Director or his/her designee and the Hospital's case manager, then Hospital's obligation to provide such service(s) shall be binding whether or not Hospital is currently licensed or maintains such licenses to bill Medicare for such services, or has otherwise separately licensed or maintains such separate licenses for the SNF or other contracted for sub-acute institutional services from its acute care beds.

2.21 **Linguistic and Cultural Sensitivity.** Hospital shall comply with all the following requirements related to the provision of linguistic and culturally sensitive services in accordance to this Contract and PLAN Policies.

2.21.1 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 Participating 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.

2.22 **Provision of Interpreters.** Hospital shall contact PLAN to ensure that Members are provided with linguistic interpreter services and interpreter services for Members who are deaf and hard of hearing as necessary to ensure effective communication regarding treatment, diagnosis, and medical history or health education pursuant to the requirements in this Contract, and PLAN Policies.

Upon a Member request for interpreter services in a specific situation where care is needed, Hospital shall make all reasonable efforts to provide services in the Member's preferred language using bilingual providers, bilingual clinical staff, or Hospital interpreter services. Members should not be subject to unreasonable delays in receiving appropriate interpreter services, when the need for such services is identified by the Hospital or requested by the Member. Hospital is required to notify Members of the availability of alternative interpreter services and to document the request, need or refusal of an interpreter in the medical record. Hospital should not encourage the use of family members or friends as interpreters. However, if Members continue to request the use of friends or family members as interpreters, such requests should be honored. Hospital shall also document in the Member's medical record, the Member's primary language, if other than English, and provide to the Member information materials in English and Spanish when appropriate. Hospital is also required to provide any signage in English and Spanish, and other languages that pertain to the patient population, and to inform a Member of his/her right to file a grievance in the Member's primary language.

2.23 **Fraud, Waste, and Abuse Reporting.** Hospital shall report to PLAN all cases of suspected fraud, waste, and/or abuse, as defined in 42 CFR §455.2, and 42 CFR §423.504(b)(4)(vi)(H), relating to the rendering of Covered Services by Hospital, Contracted Providers, Members, or Hospital employees and subcontractors, within ten (10) working days of the date when Hospital first becomes aware of or is on notice of such activity.

2.24 **Health Insurance Portability and Accountability Act (HIPAA) Compliance.** Hospital shall comply with all HIPAA statutory and regulatory requirements (HIPAA requirements), whether existing now or in the future within a reasonable time prior to the effective date of such requirements, but not later than the time permitted by the applicable HIPAA requirement.

Hospital shall comply with HIPAA requirements as currently established in PLAN Policies and Provider Manual. Hospital shall also take actions and develop capabilities as required to support PLAN compliance with HIPAA requirements, including acceptance and generation of applicable electronic files in HIPAA compliant standards formats.

III. PLAN OBLIGATIONS

3.1 **PLAN Services.** PLAN agrees to provide certain consumer and administrative services, including but not limited to processing Member application, maintaining eligibility records and a system of verifying eligibility and processing enrollments and disenrollments through communication with CMS, responding to Member complaints and grievances, informing Members of PLAN policies, providing Members with membership cards and informational material and informing Members of Participating Providers.

3.2 **Orientation.** PLAN agrees to provide orientation and training for Hospital in the application of the policies and procedures of PLAN.

3.3 **Listing of PLAN.** PLAN agrees that Hospital may list its name, address, telephone number and a description of the PLAN along with other plans that use Hospital in Hospital's promotional materials and advertisements. The use of PLAN's trademarks, logos, or other intellectual property by Hospital is prohibited without PLAN's prior written approval.

IV. UTILIZATION MANAGEMENT PROGRAM

4.1 **Procedures for Emergencies.** In case of Emergency Services or Urgent Care services for which prior authorization has not been received by Hospital, Hospital agrees to contact PLAN by telephone to obtain authorization at the time, or within twenty four (24) hours, of any admission. Hospital shall make best efforts to encourage Members that present themselves to the Emergency Department to contact PLAN for temporary authorization. Hospital further agrees that if services are provided in its emergency room which are neither Emergency Services nor Urgent Care services, as determined by PLAN, PLAN shall not pay Hospital for such services. Hospital agrees that PLAN's Utilization Management staff shall have access to timely information and documentation in order to enable PLAN to review emergency admissions in order to certify the number of inpatient days authorized under the Utilization Management Program. Hospital agrees that, irrespective of the requirements for authorization of services set forth herein, it will not withhold or delay emergency treatment to Members whose condition, in the judgment of the physician in attendance is a Medical Necessity requiring immediate diagnosis or treatment to prevent death, disability or significant functional impairment. Emergency Services provided within twenty-four (24) hours of inpatient admission will be included in the inpatient per diems, DRG and/or case rates.

4.2 **Acceptance of Pre-Admission Testing.** PLAN at its option may elect to arrange for pre-admission diagnostic testing for any elective admissions to the Hospital. Hospital shall accept the results of diagnostic tests performed in accordance with PLAN's arrangements provided that: (i) diagnostic test results are provided to the Hospital at the time of Member's admission; (ii) test results are reported in a format mutually acceptable to PLAN and Hospital; (iii) for diagnostic laboratory tests performed, test results shall be acceptable only if the facility that performed the tests is certified under the federal Clinical Laboratory Improvement Act; (iv) the diagnostic tests to be utilized shall be performed within the time frames established by the rules and regulations of Hospital's Medical Staff, which rules shall not unduly impede use of pre-admission tests; and (v) that additional testing is not medically necessary. Hospital shall not require duplicate tests or procedures to be performed or charged to PLAN after the Member is admitted, unless ordered by a Specialist or Primary Care Physician.

4.3 **Discharge Planning.** Hospital agrees to give timely notice to PLAN's Utilization Management Department for each Member admitted to the Hospital. At minimum, timely notice shall require Hospital to telephone the PLAN Utilization Management Department to discuss a Member's health status at least twenty-four (24) hours in advance of discharge.

4.4 **Tertiary and Non-Primary Hospital Referrals.** Scheduled admissions or referrals to tertiary or general acute hospitals, other than Primary Hospital, must be authorized by PLAN. Failure to receive prior authorization by PLAN can result in financial penalties to the Hospital equal to the cost of the differential between approved facilities and the facility of admission.

4.5 **Hospital Cooperation with Concurrent Review.** Hospital will cooperate with Physician Group and PLAN and Plan Physicians in conducting concurrent and retrospective review of the services provided to Members. Such cooperation will include periodic review of Member's medical records by Hospital utilization management staff and the communication of such information to Plan Physicians, Physician Group and PLAN personnel involved in the Utilization Management Plan.

4.6 **Resolving Utilization Management Disputes.** Disputes regarding Covered Services, Medical Necessity, utilization management, admissions, length of stay or selection of facilities will be resolved by PLAN subject to dispute resolution procedures described in Article XIII.

4.7 **On-Site Review of Inpatient Records.** Hospital shall permit PLAN utilization management staff and other qualified representatives of PLAN to conduct on-site review of the medical records of Members. PLAN staff shall notify Hospital's utilization management department prior to conducting such on-site reviews and shall wear appropriate identification.

4.8 **Quality Management.** Hospital will cooperate with PLAN in the establishment of peer review and quality management programs to evaluate the services provided to and outcomes experienced by Members.

4.9 **Medical Decision-Making.** It is not the intention of PLAN to use the preauthorization and approval provisions set forth herein as a device by which it may practice medicine. Rather, the authorization and approval procedures are used to make benefit and coverage determinations so that the Member and Contracting Providers know, before a course of treatment is initiated, that such course of treatment is covered in full, in part or not at all. If a course of treatment is not covered, e.g., not approved, such determination is not intended to suggest that the course of treatment is medically inappropriate. PLAN will notify the attending Plan Physician (Referral Provider) and, if applicable the Primary Care Physician, of a denial of coverage; however, Plan Physicians and/or Hospital may choose to provide such course of treatment, so long as prior written notice is given to the Member that the course of treatment is not covered by PLAN. Hospital may bill a Member for non-Covered Services, but may not bill a Member for Covered Services which are not Medically Necessary.

V. PROVIDER MANUAL

5.1 **Policies and Procedures.** PLAN will provide Hospital with a Provider Manual that contains those PLAN policies and procedures necessary for the proper operation of the Hospital as it relates to Members and which describes all benefits plans, including Copayments, limitations and exclusions offered by the PLAN to subscriber groups. Hospital agrees to comply and will have any Downstream Entity agree to comply with PLAN standards and policies outlined the Provider Manual.

5.2 **Precedence.** The Provider Manual and all revisions thereto shall be consistent with the laws and regulations governing the Medicare program, the regulations established by CMS, the Knox-Keene Act and the provisions of this Agreement. In the event of any conflict or inconsistency between the Provider Manual, the Agreement, and/or any of the cited State or Federal laws and regulations, the provision which governs shall be determined by applying the

following order of precedence: federal laws and regulations, state laws and regulations, the Agreement, and, then, the Provider Manual.

VI. COMPENSATION

6.1 **Hospital Compensation.** Compensation to Hospital for Hospital Services will be the payments set forth in Attachment A. Such payments shall be payment in full for Hospital Services. Copayments and collections from other third party payers resulting from Coordination of Benefits shall be deducted from the compensation due Hospital by PLAN pursuant to Attachment A.

6.2 **Payment of Claims.** Hospital agrees to submit claims to PLAN in such format as PLAN may require (but at minimum the CMS form UB-92 or CMS approved form) within six (6) months after the services are rendered. For inpatient admissions, Hospital must make available discharge summary or additional medical information if required by PLAN's Utilization Management Program in order to approve claims. Hospital agrees to refrain from duplicate billing any claims submitted to PLAN, unless expressly approved by PLAN in order to process coordination of benefit claims. PLAN shall make prompt payment to Hospital within thirty (30) calendar days of PLAN's receipt of a clean and uncontested claim from Hospital, or, within sixty (60) calendar days following PLAN's receipt thereof, PLAN will contest or deny Hospital's claim.

6.3 **Retroactive Denials Of Payment.** When PLAN is notified of retroactive disenrollments of Members or when PLAN obtains information or data that contradicts its reliance on an authorization for Covered Services, PLAN may retroactively deny Covered Services furnished to Members and shall send immediate written notice of such denial to Hospital. Hospital shall recognize PLAN's immediate right to recovery for retroactively disenrolled Members who were disenrolled no earlier than sixty (60) calendar days prior to the date of service at the Hospital and shall repay contested paid claims within thirty (30) calendar days of notice from PLAN. For Covered Services that are retroactively denied due to determinations by PLAN that all or part of a Hospital stay was not of Medically Necessity, Hospital shall either repay the contested claim or respond with additional documentation within thirty (30) calendar days of notice from PLAN.

6.4 **Payment for Non-Covered Services.** Hospital may seek payment from Members for Non-Covered Services at usual and customary charges. The determination of whether a service or supply is a Covered Service rests with PLAN, subject to the Evidence of Coverage and the regulations and appeals procedure established by CMS.

6.5 **Overpayments**. In the event the PLAN determines that it has overpaid a claim, the PLAN shall notify the Hospital in writing through a separate notice clearly identifying the claim, the name of the patient, the date of service, and a clear explanation of the basis upon which the PLAN believes the amount paid on the claim was in excess of the amount due.

If the Hospital does not contest the PLAN's notice of overpayment, the Hospital shall have 30 working days from the receipt of the notice to reimburse the PLAN the amount of the overpayment. If the Hospital contests the PLAN's notice of overpayment, the Hospital shall have 30 working days from the receipt of the notice to send written notice to the PLAN stating the basis upon which the Hospital believes that the claim was not overpaid. The PLAN will receive and process the contested notice of overpayment of a claim as a provider dispute under the PLAN's provider dispute processes.

If the Hospital does not contest the overpayment and does not reimburse the PLAN according to the above timelines, then the PLAN may offset the uncontested overpayment against payments made to the Hospital's current or future claim submissions. In

the event that an overpayment of a claim or claims is offset against a Hospital's current or future claim or claims, the PLAN shall provide the Hospital a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific claim or claims.

VII. COORDINATION OF BENEFITS/THIRD PARTY LIABILITY

7.1 **Definition.** Coordination of Benefits ("COB") refers to the determination of order of financial responsibility which applies when two or more health benefit plans provide coverage of services for an individual. Such coordination is intended to preclude the Hospital from receiving an aggregate of more than one hundred percent (100%) of usual and customary charges from all coverage. When the primary and secondary benefits are coordinated, determination of liability will be in accordance with the usual procedures of the Centers for Medicare and Medicaid Services, and applicable federal Medicare Secondary Payer requirements, the model regulation created by the National Association of Insurance Commissioners (NAIC) and applicable state regulations.

7.2 **COB Obligations of Hospital**. Hospital agrees to cooperate with PLAN for proper determination of COB and to bill and collect from other payers and third parties such charges for which the other party is responsible. Such collections will be deducted from any amount payable by PLAN to Hospital pursuant to this Agreement. In any case where a Member admitted to Hospital has primary coverage from any third party payor, and Hospital has reason to know of a primary payor other than PLAN, Hospital shall bill the third party payor and notify PLAN of the existence of any primary payor source at the time that Hospital submits a claim to PLAN.

7.3 **COB Obligations of PLAN.** PLAN will cooperate in providing COB information to Hospital by collecting appropriate data from the Member at the point of enrollment and supplying such data to Hospital.

7.4 **Assignment of Third Party Liability Payments.** If the Hospital collects any third party liability payments for services provided to a Member and has previously received payments for such services from PLAN, PLAN shall be entitled to receive all such third party liability payments up to the amount of any payments made to Hospital by PLAN on behalf of such Member, and Hospital shall promptly remit the same to PLAN. Hospital may bill Member if Member receives reimbursement from a third party that is primarily responsible for payment under Medicare regulations.

VIII. WARRANTIES/COMPLIANCE WITH PLAN AND CMS RULES AND REGULATIONS

8.1 **Hospital Certification, Accreditation and License Requirements.** Hospital warrants that it is licensed as a general acute care hospital pursuant to the California Health and Safety Code Section 1250 et seq., certified as a hospital provider under Title XVIII (Medicare) of the Social Security Act, and is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Hospital further agrees that it will maintain said licensure, certification and accreditation during the term of this Agreement.

8.2 **Violation of Governing Provisions.** Hospital is subject to the rules and regulations of PLAN as set forth in this Agreement as well as all applicable state and federal laws, rules and regulations. If Hospital violates any provision of rules and regulations of PLAN as specified in this Agreement, or such state or federal laws, rules and regulations, all contractual rights under this Agreement may be terminated at the election of PLAN.

8.3 **Compliance with CareAdvantage Laws and Regulations.** Hospital understands that PLAN oversees and is accountable to CMS for any functions or responsibilities

that are described in the laws or regulations applicable to Medicare Advantage plans, and that PLAN may be held accountable by CMS if Hospital and/or its Downstream Entities violate the provisions of such law or regulations or PLAN policies in the performance of this Agreement. In furtherance of the foregoing, Hospital shall comply with and ensure any of its related entities providing services under this Agreement also comply with applicable Medicare laws, regulations, and reporting requirements, and CMS instructions, and will cooperate, assist, and provide information, as requested.

8.3.1 Hospital shall comply with the reporting requirements in 42 CFR §422.516 and the requirements in 42 CFR §422.310 for submitting data to CMS. Hospital also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

8.3.2 Hospital understands and agrees that PLAN is responsible for the monitoring and oversight of all duties, including deemable and non-deemable activities of Hospital under this Agreement, and that PLAN has the authority and responsibility to: (i) implement, maintain and enforce PLAN's policies governing Hospital's duties under this Agreement and/or governing PLAN's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Hospital's performance of duties described in this Agreement; (iii) require Hospital to take corrective action if PLAN or an applicable federal or state regulator determines that corrective action is needed with regard to any duty under this Agreement; and/or (iv) revoke the delegation of any duty, if Hospital fails to meet PLAN standards in the performance of that duty. Hospital shall cooperate with PLAN in its oversight efforts and shall take corrective action as PLAN determines necessary to comply with the laws, accreditation agency standards, and PLAN policies governing the duties of Hospital or the oversight of those duties.

8.3.3 If Hospital gives Confidential Information including Protected Health Information, as defined in 45 CFR §164.501, received from PLAN, or created or received by Hospital on behalf of PLAN, to any of its Downstream Entities, including agents or subcontractors, Hospital shall require the Downstream Entity to agree to the same restrictions and conditions that apply to Hospital under this Agreement. Hospital shall be fully liable to PLAN for any acts, failures or omissions of the Downstream Entity in providing the services as if they were Hospital's own acts, failures or omissions, to the extent permitted by law. Hospital further expressly warrants that its agents will be specifically advised of, and will comply in all respects with the terms of this Agreement.

IX. MEDICAL AND ADMINISTRATIVE RECORDS

9.1 **Medical Records.** Hospital will maintain for Members a single standard hospital medical record, containing such accurate, descriptive and timely information and preserved for such time period(s) as required by the rules and regulations of the California Department of Health Services, the Federal Medicare Program, and the Joint Commission on Accreditation of Health Care Organizations. Unless otherwise specifically agreed by Hospital, it is the understanding and agreement of the parties that the records described herein are deemed to meet all record keeping requirements imposed on Hospital pursuant to the Knox-Keene Act.

9.2 **Right to Inspection.** It is understood that the medical records referred to in Section 9.1 above will be and remain the property of Hospital and will not be removed or transferred from Hospital except in accordance with applicable laws and general Hospital policies. PLAN or its designated representatives will have the right, in accordance with Section 9.3 below, to inspect, review, and make copies of such records at PLAN's expense upon request to facilitate PLAN's obligation to conduct quality management, utilization monitoring, and peer review activities. The amount paid by PLAN to Hospital for the copying of such

records shall not be more than would have been paid by the federal Medicare program or the Medicare contracted Quality Improvement Organization (QIO) for obtaining copies of such records.

9.3 **Confidentiality.** Hospital and PLAN agree to maintain the confidentiality of information contained in the medical records of Members in accordance with the "Confidentiality of Medical Information Act", Cal. Civ. Code § 56 et seq., with 42 CFR § 422.118, and HIPAA. Medical records may be disseminated to authorized Plan Physicians or PLAN representatives, to Hospital's morbidity, mortality, tissue, utilization management, judicial review, other quality of care and administrative review committees, to PLAN itself, or to a PLAN peer review, quality management or utilization management committees or subcommittees identified by PLAN.

9.4 **Release of Records.** Notwithstanding the provisions of Section 9.3 above, Hospital will be authorized to release Member's medical records to official governmental agencies or for purposes of civil discovery, subject to applicable law and Hospital's policies and procedures.

9.5 **PLAN and Governmental Agency Access to Records.** Hospital will cooperate and assist with PLAN and agencies of the state and federal governments and their designees in maintaining and providing medical, financial, administrative and other records of Members as shall be requested by PLAN or such agencies. PLAN and such agencies will have access at reasonable times upon demand to the books, records and papers of Hospital relating to services provided to Members, the quality, appropriateness, timeliness, cost thereof, and any payments received by Hospital for Covered Services provided to Members.

9.6 **Availability of Records Upon Termination.** The obligations contained in this article will continue despite the termination of this Agreement, whether by rescission or otherwise. In the event of termination of this Agreement, Hospital will provide PLAN, Member, Plan Physicians, and any duly designated third party with reasonable access to medical records of Members maintained by Hospital, for a period of ten (10) years after the termination of this Agreement, and at any time thereafter that such access is required in connection with an Member's medical care. PLAN will be entitled to obtain copies of Member's medical records if it either makes arrangements to have such copies prepared on Hospital premises, or agrees to reimburse the Hospital for the reasonable cost of preparing such copies. The amount paid by PLAN to Hospital for the copying of such records shall not be more than would have been paid by the federal Medicare program or the Medicare contracted Quality Improvement Organization (QIO) for obtaining copies of such records. The provisions of this paragraph will not operate to waive or limit any restriction on release or disclosure of patient records established in any other provision of this Agreement or as otherwise required by law.

9.7 **Member Access to Records.** Hospital shall ensure that Members have access to their medical records in accordance with the requirements of State and Federal law.

X. INSURANCE AND INDEMNIFICATION

10.1 **Hospital Liability Insurance.** Hospital shall maintain, by purchase of a policy or through self-insurance, throughout the term of this Agreement, malpractice and general liability insurance in the minimum amounts of one million dollars ($1,000,000) per occurrence coverage for Hospital, its agents and employees. In the event Hospital procures a "claims made" policy as distinguished from an occurrence policy, Hospital shall procure and maintain prior to termination of such insurance, continuing "tail" coverage for a period of not less than seven (7) years following such termination. Hospital shall immediately notify PLAN of any material changes in insurance coverage or self-insurance arrangements and shall provide a certificate of insurance coverage to PLAN upon PLAN's request.

10.2 **PLAN Liability Insurance.** PLAN, at its sole cost and expense, will procure and maintain policies of general liability and other insurance necessary, or programs of self-insurance, to insure PLAN and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the use of any property and facilities or equipment provided by PLAN, and the activities performed by PLAN in connection with this Agreement. A copy of such insurance policies will be provided to Hospital upon its request.

10.3 **Mutual Indemnification.** Hospital and PLAN agree to indemnify each other and hold the other harmless against any and all loss, damage, liability, and expense, including court costs, with respect to this Agreement directly resulting from or arising out of the dishonest, fraudulent, negligent or criminal acts of the respective party, their respective officers, directors, shareholders, employees, contractors, agents and/or representatives, acting alone or in collusion with others.

10.4 **Notification of Claims.** PLAN and Hospital agree to promptly notify the other party hereto of any claims or demands which arise and for which indemnification hereunder is sought.

10.5 **Termination.** The terms of Sections 10.3 and 10.4 shall survive the termination of this Agreement.

XI. COOPERATION

11.1 **Non-Interference by Hospital.** Hospital agrees that it will not, during the term of this Agreement, advise or counsel any Member to disenroll from PLAN and will not solicit such Member to become enrolled with any other health maintenance organization, preferred provider organization or any other similar hospitalization, medical payment plan or insurance program.

11.2 **Cooperation.** PLAN and Hospital agree that, to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Members at the most reasonable cost, consistent with quality standards of hospital and physician care.

11.3 **Cooperation Regarding Utilization Management and Quality Management.** Hospital agrees to cooperate in the implementation of an effective on-site Utilization Management Plan consisting of prospective, concurrent and post-discharge review of Hospital's services. In this regard, Hospital will cooperate with Physician Group, PLAN and Plan Physicians in the development and operation of utilization management and quality management programs.

11.4 **Signs.** Hospital agrees that PLAN may post notices, mutually acceptable as to size, content and form in a prominent place in patient receiving areas, including the emergency room, instructing Members as to proper procedures and limitations on coverage.

XII. TERM AND TERMINATION

12.1 **Term of Agreement.** This Agreement will become effective on January 1, 2009 and will remain in effect up to and including December 31, 2009. 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.

12.2 **Termination.** This Agreement may be terminated without cause by either party by written notice given at least sixty (60) calendar days in advance of such termination. Said

termination shall become effective the first (1st) day of the month following the expiration of the sixty (60) calendar day notice. The obligation of Hospital to provide Covered Services following the effective date of termination will be as set forth in this Article.

12.3 **PLAN's Right to Terminate Agreement.** Nothing herein will be construed as limiting the right of PLAN to terminate this Agreement immediately upon the occurrence of any of the following events and delivery of written notice:

(a) The suspension or revocation of any license, certification or accreditation required by Hospital to perform its obligations under this Agreement;

(b) The imposition of sanctions or disciplinary action against Hospital or against Hospital officers and directors in their capacities with the Hospital by a state or federal licensing agency;

(c) The violation of Sections 2.13 or 2.14 of this Agreement;

(d) The cancellation, termination or reduction of Hospital's malpractice or general liability insurance coverage;

(e) A determination by PLAN, based on reasonable evidence, that the health and well-being of Members is jeopardized as a result of continuation of this Agreement; or

(f) Hospital commits fraud.

12.4 **Hospital's Right to Terminate Agreement.** Nothing herein will be construed as limiting the right of Hospital to terminate this Agreement immediately upon the occurrence of any of the following events and delivery of written notice:

(a) PLAN commits fraud; or

(b) The State of California or the United States Government revokes any certification or license of PLAN necessary for the performance of this Agreement.

12.5 **Hospital Obligations Following Termination.** In the event of termination of this Agreement, Hospital shall continue to provide Hospital Services to hospitalized Members in accordance with generally accepted medical standards and practices until the earlier of:

(a) Member's discharge from Hospital; or

(b) Alternate coverage is arranged for Members by PLAN or subscriber group.

Payment for any continued Hospital Services as described in this Section shall be at the rates set forth in Attachment A to this Agreement.

12.6 **Hospital Relationship with Member Following Termination of Agreement.** In the event of termination of this Agreement, with or without cause, Hospital agrees that it shall not, under any circumstances, including failure of PLAN to pay amount owed Hospital, seek payment from Members for Covered Services rendered prior to the termination of this Agreement This section does not preclude Hospital from pursuing legal action against PLAN to collect payments owed to Hospital by PLAN.

12.7 **Bankruptcy.** PLAN or Hospital may terminate this Agreement with thirty (30) calendar day written notice to the other party in the event a petition is filed in a court of competent jurisdiction to declare either party bankrupt or for reorganization under the bankruptcy laws of the United States or any similar statute of a state of the United States, or if a trustee in bankruptcy or a receiver is appointed for such party, and such petition, trustee, or receiver, as the case may be, is not dismissed within one hundred and twenty (120) calendar days thereof.

12.8 **Breach of Contract.** Either party will have the right to terminate this Agreement if the other party is in material breach of this Agreement and such breach remains uncured within thirty (30) calendar days following the breaching party's receipt of written notice from the non-breaching party. The remedy of such breach within twenty (20) calendar days of the receipt of such notice will revive the Agreement in effect for the remaining term, subject to any other rights of termination contained in this, or any other provision of this Agreement.

The party claiming the right to terminate hereunder will set forth in the required notice of intended termination the facts underlying its claim that the other party is in breach of this Agreement.

Each party will retain the right to seek redress through dispute resolution in accordance with Article XIII.

12.9 **Interruption by Disasters.** In the event the operations of Hospital's facilities or any substantial portion thereof, are interrupted by war, fire, and other elements, insurrection, labor disputes, riots, earthquakes, acts of God, or, without limiting the foregoing, any other cause beyond the control of Hospital, the provisions of this Agreement (or such portions hereof as Hospital is thereby rendered incapable of performing) may be suspended for the duration of such interruption. Such suspension shall be determined by mutual agreement of the parties and shall include an identification of the necessary adjustments to any provision of this Agreement.

Should a substantial part of the services which Hospital has agreed to provide hereunder be interrupted pursuant to such event for a period in excess of thirty (30) calendar days, PLAN or Hospital will have the right to terminate this Agreement upon ten (10) calendar days prior written notice to the other party.

12.10 **Continuation of Benefits.** Hospital and its Participating Providers agree that, in the event of PLAN's insolvency or cessation of operations, benefits to Members will continue until the discharge of Member from an inpatient facility, or through the eligibility period.

XIII. DISPUTE RESOLUTION

13.1 **Dispute Resolution.** Controversies between Hospital, Physician Group and PLAN shall be resolved, to the extent possible, by informal meetings or discussions between appropriate representatives of the parties.

13.2. **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 Grievance and Appeals mechanisms.

13.3 **PLAN Grievance and Appeals Procedure Responsibility**. The PLAN's Executive Director has primary responsibility for maintenance, review, formulation of policy

changes, and procedural improvements of the Grievance and Appeals review system. The Executive Director shall be assisted by other PLAN staff as requested.

13.4. **Resolution of Member and Provider-Initiated Grievances or Appeals.** 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 CMS guidelines and regulations. PLAN retains responsibility for grievance and appeals resolution and does not delegate it to Hospital. Hospital agrees to cooperate with PLAN in resolving Member grievances and/or appeals related to the Hospital and Downstream Entities. PLAN will bring to the Hospital's attention all Member complaints involving Hospital and Downstream Entities. Hospital and Downstream Entities will, in accordance with PLAN approved procedures, investigate such complaints and use their best efforts to resolve them in a fair and equitable manner that is acceptable to PLAN. Hospital agrees to notify PLAN promptly of any action taken or proposed with respect to the resolution of such complaints and the avoidance of similar complaints 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 and the resolution of any and all disputes with Members.

XIV. GENERAL PROVISIONS

14.1 **Compliance with State and Federal Laws.** This Agreement is intended to be in compliance with all state and federal laws. Should this Agreement be out of compliance with any existing or newly enacted or adopted laws or regulations, the parties shall meet immediately to develop alternative provisions to comply with the laws. Such alternative provisions shall be incorporated into this Agreement by addendum. Hospital shall comply with all applicable state and federal laws, licensing requirements and professional standards and shall provide CareAdvantage benefits in accordance with generally accepted medical and surgical practices and standards in the applicable professional community at the time of treatment. In addition, Hospital and Downstream Entities shall comply with the professional and technical standards adopted by the PLAN's Quality and Utilization Management Program set forth in the Provider Manual.

14.2 **Waiver.** The waiver by either party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach thereof.

14.3 **Governing Law.** This Agreement will be governed in all respects by the laws of the State of California.

14.4 **Assignment.** This Agreement shall not be assigned, delegated or transferred by Hospital without the prior written consent of PLAN. PLAN may assign this Agreement and its rights, interests and benefits hereunder to any entity which has at least majority control of PLAN or to any entity whose financial solvency has been approved by Hospital, which approval shall not be unreasonably withheld. If required, any assignment or delegation of this Agreement shall be void unless prior written approval is obtained from the appropriate state or federal agencies.

14.5 **Notices.** Any notice required to be given pursuant to the terms and provisions hereof, unless otherwise indicated herein shall be in writing and shall be delivered or sent postage paid by certified, registered or express mail, courier services (Airborne, Federal Express, UPS, etc.), or other means which can provide written proof of delivery, and shall be deemed given two (2) days after the date of mailing unless written proof indicates differently, and is to be addressed as follows:

To PLAN: Health Plan of San Mateo
701 Gateway Blvd, Suite 400
South San Francisco, CA 94080
Attn: Provider Services

To Hospital: San Mateo Medical Center
222 – 39th Avenue
San Mateo, CA 94403
ATTN: Chief Executive Officer

14.6 **Independent Parties.** None of the provisions of this Agreement are intended to create nor will be deemed or construed to create any relationship between the parties hereto other than that of independent contractors, solely for the purposes of effecting the provisions of the Agreement. Neither of the parties hereto, nor any of their respective officers, directors, or employees, shall act as nor be construed to be the agent, the employee or the representative of the other.

14.7 **Integration of Entire Agreement.** This Agreement contains all of the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations of or between the parties, either oral or written, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement are null and void and of no further force or effect. All Attachments to this Agreement are considered part of this Agreement and are hereby incorporated herein.

14.8 **Invalidity or Unenforceability.** The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other term or provision.

14.9 **Headings.** The captions contained herein are for convenience of reference purposes only and shall have no force or effect.

14.10 **Amendment.** PLAN may amend this Agreement immediately upon written notice to Hospital in the event such amendment is required in order to maintain compliance with applicable state or federal laws. Other amendments to the Agreement shall be effective only upon mutual, written agreement of the parties.

14.11 **Member Hold Harmless.** Hospital agrees that neither Hospital or any of its Downstream Entities in any circumstances, including but not limited to nonpayment by the PLAN or intermediary, insolvency of PLAN, or breach of this Agreement, shall bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or a person (other than the PLAN or intermediary) acting on behalf of the Member for services provided pursuant to this Agreement. This Agreement does not prohibit the Hospital from collecting copayments as specifically provided in the Evidence of Coverage, or fees for non-covered services delivered on a fee-for-service basis to Members. This Agreement does not prohibit Hospital (except for a health care professional who is employed full-time on staff of Hospital and has agreed to provide services exclusively to that Hospital's Members and others) and a Member from agreeing to continue services solely at the expense of the Member, subject to Hospital, prior to rendering such service, specifically informing the Member that the PLAN may not cover or continue to cover a specific service or services. Except as provided herein, this Agreement does not prohibit the PLAN from pursuing any available legal remedy. Hospital further agrees that this provision shall survive the

termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the PLAN's Members.

14.12 **Free Exchange of Information.** No provision of this Agreement shall be construed to prohibit, nor shall any provision in any contract between Hospital and its employees or subcontractors prohibit, the free, open and unrestricted exchange of any and all information of any kind between health care providers and Members regarding the nature of the Member's medical condition, the health care treatment options and alternatives available and their relative risks and benefits, whether or not covered or excluded under the Member's PLAN, and the Member's right to appeal any adverse decision made by Hospital or PLAN regarding coverage of treatment which has been recommended or rendered. Moreover, Hospital and PLAN agree not to penalize nor sanction any health care provider in any way for advising or engaging in such free, open and unrestricted communication with a Member nor for advocating for a particular service on a Member's behalf.

14.13 **Confidential And Proprietary Information.** Hospital agrees to maintain confidential (the "Confidential Information"): (a) protected health information, including eligibility lists and any other information containing the names, addresses or telephone numbers, and/or social security numbers of PLAN Members; (b) PLAN's administrative service manuals and all forms related thereto; (c) the financial arrangements between PLAN and any Participating Provider; and (d) any other information compiled or created by PLAN which is proprietary to PLAN and which PLAN identifies as proprietary to Hospital in writing. Hospital shall not disclose or use the Confidential Information for its own benefit or gain either during the term of this Agreement or after the date of termination of this Agreement. Hospital may use the Confidential Information to the extent necessary to perform its duties under this Agreement or upon express prior written permission of PLAN. Upon the effective date of termination of this Agreement, Hospital shall promptly return to PLAN the Confidential Information in its possession, upon PLAN's notice. PLAN shall maintain the confidentiality of the rates and special terms of this Agreement that are unique to the Hospital. The obligations contained in this Section shall survive the termination of this Agreement.

14.14 **Confidentiality Of This Agreement.** Each party agrees to maintain the terms of this Agreement confidential. Disclosure of the terms of the Agreement shall not be made without the prior written approval of the other party, which approval may be withheld in either party's sole and absolute discretion.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement.

SAN MATEO HEALTH COMMISSION, d.b.a. HEALTH PLAN OF SAN MATEO

By: _____

Name: Maya Altman

Title: Executive Director

Date: _____

COUNTY OF SAN MATEO, SAN MATEO MEDICAL CENTER

By: _____

Name: _____

Title: _____

Date: _____

Tax ID #: _____

NPI #'s: _____

_____

_____

_____

ATTACHMENT A

PAYMENT FOR HOSPITAL SERVICES

SAN MATEO MEDICAL CENTER

Inpatient Services

Inpatient services will be paid based on Diagnostic Related Group (DRG) payments. The DRG payment is defined as the hospital-specific DRG final calculated rate as defined in the Medicare A Online DRG/PPS System which includes pass-through reimbursement, outlier payments, indirect teaching reimbursement, and/or disproportionate share hospital reimbursement. Reimbursement will be at 100% of the DRG payment rate. This total payment is comprised of 1) payment for Medicare Service at 100% of the DRG payment rate adjudicated for benefits and 2) payment from PLAN's Medi-Cal funds for Medi-Cal covered cost-sharing. This rate will be considered payment in full from PLAN to Hospital.

Outpatient Services

Outpatient services will be paid based on Ambulatory Payment Classification (APC) payments. The APC payment is defined as the hospital-specific APC final calculated rate as defined in the Medicare Outpatient Prospective Payment System. Reimbursement will be at 90% of the APC rate. This total payment is comprised of 1) payment for Medicare Services priced at one hundred percent of the Medicare Fee Schedule adjudicated for benefits – that is, 80% of the Medicare Fee Schedule, and 2) payment from PLAN's Medi-Cal funds for Medi-Cal Wraparound Services and Medi-Cal covered cost-sharing priced at ten percent (10%) of the Medicare APC Schedule. This rate will be considered payment in full from PLAN to Hospital.

Skilled Nursing Services

Skilled Nursing (SNF) services will be paid an all inclusive per diem rate of **$425.00** per day for a maximum of 100 days of stay.

In Addition, the health services listed and described in the Medicare Benefit Policy Manual, Chapter 6, "Hospital Services Covered Under Part B," §10, are covered when furnished by the SNF either directly or under arrangements to: inpatients who have exhausted their 100 days of stay or the 3-day prior stay requirement has not been met. These services will be billed to the PLAN per instructions in the Medicare Claims Processing Manual.

Inpatient Mental Health Services

Inpatient Mental Health Services will be reimbursed at an all inclusive per diem rate of **$1,084.24** per day. This rate will be considered payment in full from PLAN to FACILITY, and the Member will not be responsible for any deductible, copay, or coinsurance amounts.

Payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during the PLAN member's lifetime.

Professional services will be billed directly to San Mateo County Mental Health Services.