CARE ADVANTAGE
Medical Services Agreement
Between
San Mateo Health Commission
And
Referral Provider

This Medical Services Agreement ("Agreement") is entered into this _____ day of _____, 2005, by and between San Mateo County Mental Health Services, a provider duly licensed to practice in the State of California (hereinafter referred to as "Referral Provider"), and the San Mateo Health Commission, a public corporation (hereinafter referred to as "Commission" or "PLAN"). The parties agree as follows:

This Referral Provider Medical Services Agreement in its entirety is comprised of the following:

Referral Provider Medical Services Agreement and	
Attachment A --	Terms and Conditions
Attachment B --	Care Advantage Program Evidence of Coverage

Referral Provider
Executed by:

_____
Signature

Richard S. Gordon
President, Board of Supervisors
(Print Name)

_____
Address

_____
Date

Commission
Executed by:

_____
Authorized signature for San Mateo Health Commission

701 Gateway Blvd, Suite 400
South San Francisco, CA 94080

_____
Address

_____
Date

ATTACHMENT A

TERMS AND CONDITIONS

Recitals:

A. The PLAN has entered into or will enter into and maintain contracts with Center for Medicare and Medicaid Services (CMS) pursuant to which individuals who subscribe and are enrolled under the HPSM Care Advantage Program will receive, through the PLAN, health services hereinafter defined as "Covered Services".

B. The PLAN shall arrange such Covered Services under the Case Management of the Primary Care Physician chosen by or assigned to Members.

C. The Referral Provider shall participate in providing Covered Services to Members and shall receive payment from the PLAN for the rendering of those Covered Services.

NOW, THEREFORE, it is agreed that the above Recitals are true and correct and as follows:

SECTION I

DEFINITIONS

1.1 "Case Management" shall mean 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.

1.2 "Commission" shall mean the San Mateo Health Commission.

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

1.4 "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.

1.5 "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.

1.6 "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 a Plan or PLAN to provide Covered Services to Members.

1.7 "Copayment and Deductible" mean those charges for Covered Services which shall be collected directly by Referral Provider from Member in accordance with the Member's Evidence of Coverage.

1.8 "Covered Services" mean those health care services, equipment and supplies which a Member is entitled to receive under the Care Advantage program and which are set forth in the Care Advantage Evidence of Coverage (Attachment B).

1.9 "CRVS" means the 1974 California Relative Value Studies published by the California Medical Association.

1.10 "Emergency" 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; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

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

1.12 "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.

1.13 "Member" means a person who is enrolled in a Plan who is entitled to receive Covered Services.

1.14 "Non-Covered Services" mean those health care services, equipment and supplies which a Member is not entitled to receive pursuant to a Plan's Evidence of Coverage.

1.15 "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.

1.16 "Primary Care Services" mean those Covered Services set forth in Exhibit "A," which is attached to this Agreement and incorporated by reference into it, and any other Covered Services so designated by PLAN.

1.17 "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").

1.18 "Referral" means the process by which a Primary Care Physician directs a Member to a Contracted Provider.

1.19 "Referral Provider" means a Contracted Provider 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.

SECTION II
SERVICES TO BE PERFORMED BY THE REFERRAL PROVIDER

2.1 Services. Referral Provider agrees to provide Covered Services in his/her specialty to Members of HPSM Care Advantage. Provider acknowledges that Members are the patients of PLAN for purposes of this Agreement.

Referral Provider shall only provide non-Emergency Covered Services to a Member after initially receiving prior written authorization to treat the Member from the Member's PCP and the PLAN. After the initial authorization to treat the Member is received from the Member's PCP and the PLAN, the Referral Provider must receive additional authorization from the Member's PCP and the PLAN to render additional Covered Services, except in an Emergency. Failure of the Referral Provider to obtain prior authorization may result, at PLAN's option, in PLAN's non-payment for those Covered Services provided to the Member. In the event Covered Services are provided to an ineligible Member based on erroneous or delayed information, PLAN shall not be financially responsible to Referral Provider for those Covered Services even if the services were authorized by the PLAN.

2.2 Treatment Plan. Except in an Emergency, Referral Provider agrees to submit a written report to the Member's PCP and PLAN outlining the plan of treatment proposed by the Referral Provider, including any proposed hospitalization or surgery, prior to any treatment proposed by Referral Provider. The Referral Provider, the Member's PCP, and the PLAN shall agree on the plan of treatment proposed by the Referral Provider prior to the Referral Provider treating a Member, except in an Emergency. If the Referral Provider, Member's PCP, and PLAN do not agree on the proposed plan of treatment, the disagreement shall be appealed to the PLAN Grievance Coordinator.

2.3 Covering Provider. If Referral Provider is unable from time to time to provide Covered Services when needed, Referral Provider may secure the services of a qualified covering physician who shall render the Covered Services required of Referral Provider; provided, however, that the covering physician must be a physician approved by PLAN to provide Covered Services to Members and must comply with the representations set forth in Section 3.2 of this Agreement. Referral Provider shall be solely responsible for securing the services of the covering physician. Referral Provider shall ensure that the covering physician: (1) looks solely to PLAN for payment of Covered Services; (2) will accept PLAN's peer review procedures; (3) will not directly bill Members for Covered Services under any circumstances; (4) will comply with PLAN's utilization review/quality assurance program; and (5) will comply with the terms of this Agreement.

2.4 Performance. Subject to the provisions of Section XI hereinafter, Referral Provider as an independent contractor will determine the method and means of performing Covered Services under this Agreement, in a manner consistent with professionally recognized standards of health care.

2.5 Assistants. Referral Provider shall, at Referral Provider's sole cost and expense, employ such assistants and employees as Referral Provider deems necessary to perform Covered Services for Members in Referral Provider's office. PLAN may not control, direct or supervise Referral Provider's assistants and employees in the performance of those Covered Services. Referral Provider warrants that all such assistants and employees shall be properly licensed, certified and/or registered, and shall comply with all applicable federal, state and municipal laws.

2.6 Hospital Admission Authorization. Referral Provider shall admit Members only to a Contracted Hospital unless an appropriate service is unavailable or in an Emergency. Referral Provider may not admit a Member to any hospital on a non-Emergency basis without first receiving the prior written authorization of PLAN's Medical Director or his/her designee.

2.7 Referral Procedures. Referral Provider shall comply with those Referral procedures designed, developed and adopted by PLAN. Failure of Referral Provider to follow such Referral procedures may result in non-payment of Referral Provider for Covered Services. In addition, Referral Provider shall be financially responsible for all claims for services which were incurred as a result of Referral Provider's non-compliance with PLAN's Referral procedures.

SECTION III
REPRESENTATIONS

3.1 Representations by PLAN. PLAN hereby warrants and represents that it is a public corporation in good standing with the State of California. PLAN also warrants and represents that it oversees and is accountable to the Center for Medicare and Medicaid Services (CMS) for functions and responsibilities as described in 42 CFR 422 as applicable to the Care Advantage program.

At the time the PLAN is notified that an individual is enrolled in the HPSM Care Advantage Program, the PLAN will request each individual to select a PCP from among all of those PCPs contracting with the PLAN, if the individual has not already done so. ThePCP shall be the Physician through whom the Member will seek all medical services, except Emergency Services. If no selection is made, the PLAN shall assign Members to aPCP, although the member will be able to request a change in PCP from the assigned PCP should the member so choose.

The PLAN shall notify the PCP each month of those members who are entitled to receive Covered Services from the PCP and for whom the PCP is responsible for managing health care services. If an individual is not listed, the PCP may contact the PLAN's Member Services department for eligibility and PCP assignment verification.

3.2 Representations by Referral Provider. Referral Provider hereby warrants and represents that Referral Provider is a physician or California professional corporation duly licensed to practice medicine in the State of California and in good standing with the Medical Board of California or the California Board of Osteopathic Examiners. Referral Provider warrants and represents that Referral Provider is currently, and for the duration of this Agreement shall remain, a member in good standing of the medical staff of a PlanContracted Hospital or has been specifically exempted from this requirement by the PLAN. Referral Provider warrants and represents that Referral Provider will make every effort to comply with PLAN's drug formularies. Referral Provider also warrants that he/she is a Medicare provider in good standing with the Medicare program.

Referral Provider hereby warrants and represents that he/she is responsible for standing in the relationship of the Referral Provider to Members over indefinite time periods, during which Members may present a wide variety of health problems requiring diagnosis and the selection and the management of appropriate care, including, as necessary, admission to institutional care.

The Referral Provider has indicated the type of practice in which he or she engages and hereby represents that he/she is professionally qualified to practice his/her designated specialty and that PCPs may refer any member for consultation and treatment.

3.3 Compliance with Care Advantage Laws and Regulations. Referral Provider 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 Plans, and that PLAN may be held accountable by CMS if Referral Provider violates the provisions of such law or regulations or PLAN policies in the performance of this Agreement. In furtherance of the foregoing, Referral Provider shall comply with applicable Medicare laws, regulations, and CMS instructions.

Referral Provider shall comply with the reporting requirements in 42 CFR §422.516 and the requirements in 42 CFR §422.257 for submitting encounter data to CMS. Referral Provider also agrees to furnish medical records that may be required to obtain any additional information or corroborate the encounter data.

Referral Provider understands and agrees that PLAN is responsible for the monitoring and oversight of all duties of Referral Provider under this Agreement, and that PLAN has the authority and responsibility to: (i) implement, maintain and enforce PLAN's policies governing Referral Provider's duties under this Agreement and/or governing PLAN's oversight role; (ii) conduct audits, inspections and/or investigations in order to oversee Referral Provider's performance of duties described in this Agreement; (iii) require Referral Provider 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 Referral Provider fails to meet PLAN standards in the performance of that duty. Referral Provider 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/or PLAN policies governing the duties of Referral Provider or the oversight of those duties.

COMPENSATION

4.1 Compensation Formula. PLAN shall pay Referral Provider on a fee-for-service basis an amount equal to ninety percent (90%) of the current Medicare Fee Schedule/RBRVS for Covered Services provided to eligible Members.

4.2 Timing of Payment of Compensation. PLAN shall pay Referral Provider on a biweekly basis based on claims received for Covered Services. Claims must be received by PLAN within six (6) months from the date of service or such claims may be denied by the PLAN in its sole and absolute discretion. PLAN shall ensure that 100% of claims for payment submitted byReferral Provider for which no further written documentation or substantiation is required are processed and paid or denied within 45 working days after receipt.

4.3 Billing for Services. Referral Provider shall look only to PLAN for payment of Covered Services and shall bill PLAN within six (6) months from the date of service. Referral Provider shall bill PLAN with complete and accurate data and any necessary supporting documentation and/or remarks. In billing PLAN, Referral Provider shall submit complete and accurate encounter data as required by CMS to allow PLAN to report collective data to CMS as required. Referral Provider shall also make available for review medical records for the validation of encounter data as per Section VII.

4.4 Patient Billing. Referral Provider shall look only to PLAN for payment of Covered Services and shall at no time seek compensation from Members for Covered Services, except for Copayments and Deductibles. Such payment by PLAN will be considered payment in full. In addition, the Referral Provider 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.

No surcharge to any Member shall be permitted. A surcharge for purposes of this Agreement shall be any additional fee not permitted by a Plan. Referral Provider acknowledges that should a Plan receive notice of any surcharge and if Referral Provider fails to reimburse Member within fifteen (15) calendar days of notice to do so by the Plan,PLAN shall have the right to remit payment to the Member and offset the remittance against any amount owed by PLAN to Referral Provider and/or terminate this Agreement immediately.

4.5 Overpayments. In the event the PLAN determines that it has overpaid a claim,the PLAN shall notify the Referral Provider 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 Referral Provider does not contest the PLAN's notice of overpayment, the Referral Provider shall have 30 working days from the receipt of the notice to reimburse the PLAN the amount of the overpayment. If the Referral Provider contests the PLAN's notice of overpayment, the Referral Provider shall have 30 working days from the receipt of the notice to send written notice to the PLAN stating the basis upon which the Referral Provider 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 Referral Provider 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 Referral Provider's current or future claim submissions. In the event that an overpayment of a claim or claims is offset against a Referral Provider's current or future claim or claims, the PLAN shall provide the Referral Provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific claim or claims.

4.6 Patient Responsibility. Referral Provider shall use his/her best efforts to bill and collect from Members all Copayments and Deductibles permitted by Plans. Referral Provider shall be permitted to bill a Member his/her usual charges for those non-Covered Services provided to a Member. Referral Provider shall use his/her best efforts to obtain an acknowledgment of financial responsibility from a Member prior to providing Non-Covered Services to the Member. PLAN shall not be financially responsible to Referral Provider for any amounts owed to Referral Provider by a Member.

SECTION V
COORDINATION OF BENEFITS

5.1 Definition. Coordination of Benefits ("COB") refers to the determination of which of two or more Plans are primarily and secondarily responsible for the Covered Services provided to a Member. Such coordination is intended to preclude the Member from receiving an aggregate of more than one hundred percent (100%) of charges from all Plans. When primary and secondary benefits are coordinated, determination of liability will be in accordance with the usual procedures employed by the California Department of Managed Health Care and applicable state regulations.

5.2 COB Obligations of Referral Provider. Referral Provider agrees to perform COB with PLAN and to bill and collect from Plans and other financially responsible entities the charges they are responsible for paying when they are the primary payor. Referral Provider shall report all collections received in accordance with this Section 5.2 to PLAN.

SECTION VI
OBLIGATIONS OF REFERRAL PROVIDER

6.1 Nonexclusivity. PLAN and Referral Provider agree that:

(a) Referral Provider may continue to provide health care services to Referral Provider's own patients.

(b) In rendering health care services to Referral Provider's own patients, Referral Provider shall neither represent nor imply in any way that such health care services are being rendered by or on behalf of PLAN.

(c) Referral Provider shall be responsible for providing his/her own professional liability insurance coverage for any health care services he/she renders to any patients.

(d) Any health care services rendered by Referral Provider to his/her own patients shall not be billed by or through PLAN.

6.2 Hours. Referral Provider agrees to be available to provide or arrange Covered Services to Members twenty-four (24) hours per day, seven (7) days per week.

6.3 Personnel, Equipment and Supplies. Referral Provider shall supply all necessary office personnel, equipment and supplies required to perform Covered Services under this Agreement.

6.4 Workers Compensation Insurance. Referral Provider agrees to provide at Referral Provider's sole cost and expense workers compensation insurance for Referral Provider's employees throughout the entire term of this Agreement in accordancewith the laws of the State of California.

6.5 Malpractice Insurance. Referral Provider shall provide at Referral Provider's sole cost and expense throughout the entire term of this Agreement a policy of professional liability insurance with a licensed insurance company admitted to do business in the State of California in a minimum amount of One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the annual aggregate to cover any loss, liability or damage committed byReferral Provider or Referral Provider's agents, servants or employees. Referral Provider shall maintain

continuity of this coverage by assuring an appropriate retroactive effective date of coverage, should the forgoing policy terminate.

6.6 Comprehensive Insurance. Referral Provider shall provide at Referral Provider's sole cost and expense throughout the entire term of this Agreement a policy or policies of insurance covering Referral Provider's principal place of business against any loss, liability or damage arising out of the alleged condition of the premises or the furniture, fixtures, appliances or equipment located therein, together with standard liability protection against any loss, liability or damage as a result of Referral Provider's or Referral Provider's agents', servants' or employees' operation of a motor vehicle for business purposes, both in a minimum amount of One Hundred Thousand Dollars ($100,000) per claim and Three Hundred Thousand Dollars ($300,000) in the annual aggregate.

6.7 Notice and Proof of Insurance. Referral Provider shall provide PLAN with a minimum of thirty (30) days prior written notice in the event any of the policies set forth in thisSection VI are canceled, changed or amended. Referral Provider shall from time to time upon the request of PLAN furnish to PLAN written evidence that the policies of insurance required under Sections 6.4, 6.5 and 6.6 are in full force and effect.

6.8 Performance. Referral Provider shall devote the time and attention necessary to competently and effectively perform his/her obligations under this Agreement.

6.9 Compliance with Law and Ethical Standards. Referral Provider shall at all times during the term of this Agreement comply with all applicable federal, state and municipal laws (including applicable Medicare laws and regulations), all applicable rules and regulations of the Medical Board of California or the California Board of Osteopathic Examiners and the ethical standards of the American and California Medical Associations. If at any timeduring the term of this Agreement, Referral Provider shall have Referral Provider's license to practice medicine in the State of California suspended, conditioned orrevoked, this Agreement shall terminate immediately and become null and void without regard to whether or not such suspension, condition or revocation has been finally adjudicated. Referral Provider agrees that Care Advantage Members' health services are being paid for with federal funds and, therefore, payments for such services are subject to laws applicable to individuals or entities receiving federal funds.

6.10 Hospital Privileges. During the entire term of this Agreement,Referral Provider and any covering physician for Referral Provider shall be and remain a member in good standing of the medical staff of a Contracted Hospital unless this requirement is waived by PLAN. Loss of such medical staff membership or loss, impairment, suspension or reduction of privileges at aContracted Hospital shall, at the option of PLAN, immediately terminate this Agreement, whereupon it shall

become null and void without regard to whether or not such loss of membership or loss, impairment, suspension or reduction of privileges has been finally adjudicated.

6.11 Continuing Education. During the entire term of this Agreement, Referral Provider shall maintain his/her professional competence and skills as well as CME units in accordance with community standards and as required by federal, state and municipal laws.

6.12 Compliance with PLAN's Policies, Rules and Regulations. Referral Provider agrees to be bound by PLAN's policies, rules and regulations. Referral Provider recognizes that such documents may be amended from time to time. Referral Provider agrees to cooperate with any administrative procedures which may be adopted by PLAN.

6.13 Professional Roster. Referral Provider agrees that PLAN may use Referral Provider's name, address, phone number, office hours, age and sex limitations (if any), hospital affiliation(s), language capabilities, type of practice, and willingness to accept new patients in their rosters of providers.

6.14 Compliance with Laws. Referral Provider agrees to cooperate with PLAN so that PLAN may meet any requirements imposed on PLAN by state, municipal and federal laws. Referral Provider agrees to maintain such records and provide such information to PLAN, and applicable state and federal regulatory agencies for compliance as required. Such obligations shall not be terminated upon termination of this Agreement. Referral Provider agrees to permit PLAN, and PLAN's authorized representative(s) at all reasonable times to have access upon request to books, records and other documents relating to Covered Services rendered by Referral Provider to Members, the cost thereof and the amounts of any payments received from Members or others on Members' behalf. Referral Provider agrees to retain such books, records and documents for the greater of six (6) years or such time period as may be required by applicable law or regulation from the termination of this Agreement. Referral Provider further agrees to permit access to and inspection by PLAN, the California Department of Managed Health Care, the California Department of Health Services, the United States Department of Health and Human Services, the Center for Medicare and Medicaid Services, and the Comptroller General of the United States at all reasonable times of all facilities, books, records and documents maintained or utilized by Referral Provider in the performance of Covered Services to Members pursuant to this Agreement.

6.15 Nondiscrimination. Referral Provider 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.

6.16 Cooperation with Plans. Referral Provider understands that PLAN has certain obligations including the credentialing of Referral Provider, and that PLAN will have the right to oversee and review the quality of care and services provided to Members by Referral Provider. Referral Provider agrees to be accountable to cooperate and comply with PLAN whenever PLAN and/or its Medical Director impose such obligations on Referral Provider. Obligations may include, but may not be limited to: on-site review, member transfer from or to referring facilities, cooperation with Health Employer Data Information Sets ("HEDIS") measurements and other internal and external quality review and improvement programs.

6.17 Confidentiality/Non-Disclosure/Non-Waiver of Privileges. Referral Provider recognizes that he/she may have a fiduciary duty to PLAN and will be privy to confidential information owned and/or disclosed by PLAN. Therefore, Referral Provider agrees that:

(a) he/she will not at any time, use or disclose, directly or indirectly, to any entity any confidential information owned by PLAN unless the use or disclosure is authorized in writing by PLAN or the use or disclosure is mandated by law;

(b) at the request of PLAN, he/she will return to PLAN any and all confidential information owned by PLAN and in the possession of Referral Provider; and

(c) for purposes of this Agreement, the term "confidential information" shall mean information such as programs, business plans, financial records, marketing plans, strategies and other information which constitutes proprietary or trade secret information of PLAN and shall specifically exclude the name, address or phone number of any patient whom Referral Provider has rendered medical care to.

6.18 Completion of PLAN's Application. Prior to executing this Agreement, Referral Provider must complete in full PLAN's Physician Application Forms including supporting documentation.

6.19 Cooperation with Participation Requirements. Referral Provider understands that PLAN is prohibited by the Centers for Medicare and Medicaid Services ("CMS") from contracting with a provider who itself, its employees or subcontractors are excluded from participating in Medicare or Medicaid for the provision of any of the following: healthcare services, utilization review services, medical social work services and administrative services. Referral Provider further understands that PLAN is prohibited by CMS from including as a Contracted Provider, any provider

that has entered into a private contract with a Medicare beneficiary for the provision of Covered Services. In such an event, PLAN reserves the right to terminate this Agreement immediately and require Referral Provider to reimburse PLAN immediately for any direct or indirect payments to Referral Provider and the amount of any sanctions imposed on PLAN by CMS for violation of this prohibition.

6.20 Unsatisfactory Relationships Between Member and Referral Provider. The physician/patient relationship is a personal relationship and circumstances may arise under which relations between a particular Member and a particular Referral Provider may become unsatisfactory. In such cases, the Referral Provider and the PLAN shall use their efforts to provide the Member with the opportunity to be served by a Referral Provider with whom a satisfactory physician/patient relationship may be developed. If, however, the PLAN is unable to make such arrangements, the Referral Provider shall continue to serve the Member according to the Referral Provider's best professional judgment until the PLAN is able to change the Member's Referral Provider, a period not to exceed three (3) months. Whenever a member identifies another Referral Provider within the network and desires to change Referral Providers, the Plan will assist in the transition to ensure continuity of care.

6.21 Continuity of Care. Upon termination of this Agreement for any reason, the Referral Provider shall ensure an orderly transition of care for Case Managed Members, including but not limited to the transfer of Member's medical records. The costs to the Physician of photocopying such records will be reimbursed by the PLAN at a cost not to exceed $.05 per page.

SECTION VII
MEDICAL RECORDS

Referral Provider and its employees shall maintain for each Member receiving Covered Services under this Agreement a single standard confidential medical record in such form, containing such accurate, descriptive and timely information and preserved for such time period(s) as required by federal, state and municipal laws but not less than six (6) years. Referral Provider will ensure that unauthorized individuals are unable to gain access to or alter physical or electronic patient records. Original medical records will be released only in accordance with federal or state laws, court order or subpoenas. Information from, or copies of records may be released only to authorized individuals and may not be intentionally shared, sold or used for any purpose other than to provide necessary healthcare services to Members. To the extent required or permitted by law or regulation, Referral

Provider shall permit PLAN, and appropriate regulatory agencies to inspect and make copies of Referral Provider's records relating to Members pursuant to this Agreement and upon request shall provide timely copies of such records at no charge to PLAN or Members. The negligent disposal or destruction of medical records is prohibited.

SECTION VIII
TERM

This Agreement will become effective on the latter of the date first written above, or on the date which the PLAN first assumes responsibility for members under the HPSM Care Advantage Program, and will continue for a period of twelve (12) months thereafter. This Agreement will automatically renew for successive twelve (12) month periods on the same terms and conditions (including subsequent amendments) unless terminated pursuant to this Agreement.

SECTION IX
TERMINATION

9.1 Termination with Notice. This Agreement may be terminated by Referral Provider without cause by giving ninety (90) days prior written notice to PLAN. Referral Provider may terminate this agreement upon less than ninety (90) days notice if it is in response to an Agreement amendment proposed by the PLAN. This Agreement may be terminated by PLAN without cause by giving ninety (90) days prior written notice to Referral Provider.

9.2 Responsibility for Members at Termination. Referral Provider shall continue to provide Covered Services to any Member who is receiving Covered Services from Referral Provider on the effective termination date of this Agreement until the Covered Services being rendered to the Member by Referral Provider are completed, consistent with existing medical/ethical/legal requirements for providing continuity of care to a patient, unless PLAN or a Plan makes reasonable and medically appropriate provisions for the assumption of such Covered Services by another Contracted Provider. PLAN shall compensate Referral Provider for those Covered Services provided to a Member pursuant to this Section 9.2 (prior to and following the effective termination date of this Agreement) in accordance with Section IV.

9.3 Notification of Members at Termination. The PLAN will notify all Members if their Referral Provider is terminated or terminates so that the Member may choose a new Referral

Provider as soon as practicable. Members will be notified at least 60 days in advance of the effective date of termination, unless circumstances (i.e. Physician death) prevent this.

If the Agreement has been signed by a group, and not a sole practitioner, the PLAN will notify members as above in the case of the group termination. Should an individual provider within a group terminate his/her relationship with the group, the group will have the responsibility to notify Members that the provider(s) has terminated and is no longer available to serve the Member. Members will be notified at least 60 days in advance of the effective date of termination, unless circumstances (i.e. Physician death) prevent this.

Upon termination of this Agreement, the Referral Provider shall cooperate with the PLAN to arrange for prompt assumption of Covered Services by another Referral Provider. The PLAN shall compensate the Referral Provider for those Covered Services provided to a Member until a new Referral Provider is selected or assigned with the payment rates developed by the PLAN.

9.4 Immediate Termination. PLAN shall have the right to terminate this Agreement immediately upon written notice to Referral Provider upon the occurrence of any of the following events:

(a) Referral Provider's license to practice medicine in the State of California is suspended, restricted or revoked;

(b) Referral Provider's medical staff privileges at a Contracted Hospital or any other general acute care hospital are denied, revoked, relinquished, suspended or reduced, other than temporary suspensions (i.e., for fewer than five (5) days) for incomplete medical records;

(c) Referral Provider's professional liability insurance coverage or any other insurance required under this Agreement is reduced, cancelled, non-renewed or is no longer in effect;

(d) Referral Provider's death or incapacity.

(e) Referral Provider's license to prescribe or administer controlled substances is modified, restricted, suspended or revoked;

(f) any sanctions are imposed against Referral Provider under the Medicare or Medi-Cal programs;

(g) any other professional disciplinary action or criminal action of any kind against Referral Provider is initiated, in progress or completed during the term of this Agreement;

(h) PLAN makes a reasonable and good faith determination that such termination is necessary in order to protect the health or welfare of Members;

(i) Referral Provider charges Members for Covered Services in excess of allowed Copayments and Deductibles;

(j) Referral Provider's repeated violations of PLAN's policies and procedures or other requirements of this Agreement. The Commission shall determine whether Referral Provider has repeatedly violated PLAN's policies and procedures or other requirements of this Agreement; and/or

(k) any other reason enumerated in this Agreement as grounds for immediate termination.

In the event that Referral Provider is a professional corporation or partnership and one of the events listed in Section 9.4(a)-(j) occurs with respect to a shareholder/partner/employee of Referral Provider, this Agreement may be continued, at the sole option of PLAN, provided that Referral Provider prohibits the affected shareholder/partner/employee from providing services under this Agreement and adheres to any other conditions that may be imposed by PLAN. This Agreement may also be terminated immediately by PLAN if Referral Provider is no longer a professional corporation or partnership (as applicable) in good standing under the laws of the State of California or if there is a change in the majority stock ownership or control of Referral Provider.

9.5 Termination for Breach. Either party may terminate this Agreement for cause if the other party materially breaches this Agreement by giving ninety (90) days written notice to the other party. The remedy of such breach to the satisfaction of the non-breaching party within thirty (30) days of the receipt of such notice will revive the Agreement for the remaining term, subject to any other rights of termination contained in this Agreement. The party claiming the right to terminate shall set forth in the notice of termination the facts underlying its claim that the other party has breached this Agreement.

9.6 Automatic Termination. This agreement shall terminate automatically upon the termination of the PLAN's contract with the Centers for Medicare and Medicaid Services. The

PLAN shall notify Referral Provider as soon as is practical upon receiving or sending such notice of termination

9.7 Referral Provider Rights Upon Termination. Issues raised about a provider's performance shall be considered initially by HPSM's Medical Director, who shall have the broad discretion to determine how to proceed as delegated by the Commission. His/her options shall include but not be limited to maintaining a record of the matter without further investigation or action; referring the matter to HPSM's Peer Review Committee or Quality Management Council for investigation and the preparation of a report to the Executive Director and/or the Commission.

Effective immediately upon notice to the provider, pending reconsideration and action by the PRC or QMC, the Chair of the PRC, or the Medical Director or Executive Director may summarily reduce or suspend the provider's privilege to provide patient care services, in instances where there may be immediate danger to the health of any individual. The Committees may perpetuate the reduction or suspension pending action by the Commission.

In the event that HPSM decides to deny, reduce, suspend, or terminate a provider for a medical disciplinary cause or reason, the provider shall be entitled to a hearing at with representatives from HPSM's Peer Review Committee.

SECTION X
AMENDMENT

This Agreement may be amended by PLAN unilaterally upon written notice to Referral Provider to comply with any requirement of any applicable state, municipal orfederal law. All other amendments must be in writing and signed by PLAN and Referral Provider.

SECTION XI
UTILIZATION REVIEW, QUALITY ASSURANCE AND GRIEVANCE PROCEDURES

11.1 Utilization Review and Quality Assurance Procedures. A utilization review program shall be established to review the Medical Necessity of Covered Services furnished by Referral Provider to Members on an inpatient and outpatient basis. The program will be established by PLAN and will include pre-admission, concurrent and retrospective review. A quality assurance

program shall be established to ensure quality care and service. The program may include audits, reviews and surveys performed from time to time upon the request ofPLAN. The utilization review and quality assurance programs will complement any programs required by CMS. Referral Provider shall comply with and, subject to Referral Provider's rights of appeal, shall be bound by such utilization review and quality assurance programs. Referral Provider agrees that the decisions of PLAN's utilization review may be used to deny Referral Provider's payment for those health care services provided to a Member which are determined not to be Medically Necessary.

11.2 Grievance Procedures. Grievance procedures shall be established by PLAN and Plans for the processing of Member complaints in compliance with requirements of the Medicare program. Referral Provider shall comply with and, subject to Referral Provider's rights of appeal, shall be bound by such grievance procedures.

11.3 Fifteen Business Days Review. This Agreement contains provisions that require the Referral Provider to comply with quality improvement, case management, and utilization management programs. By signing this Agreement, theReferral Provider indicates that he/she has been given 15 business days in which to consider this Agreement. If he/she executes this Agreement within these 15 business days, he/she does so of his/her own free will.

SECTION XII
GENERAL PROVISIONS

12.1 Notices. Any notice required or permitted to be given under this Agreement by either party to the other shall be in writing and shall be delivered or sent postage prepaid by certified, registered, or express mail, courier services (Airborne, Federal Express, UPS, etc.), or other means which can provide written proof of delivery,. Notices shall be addressed to the parties at the addresses appearing in the introductory paragraph on the first page of this Agreement, but either party may change its address by written notice given in accordance with this Section 12.1. Notices delivered personally will be deemed delivered when received and mailed notices will be deemed delivered three (3) days after mailing unless written proof indicates differently.

12.2 Entire Agreement of the Parties. This Agreement supersedes any and all agreements, either written or oral, between the parties with respect to the subject matter contained in this Agreement. Each party acknowledges that no representations, inducements or promises, oral or written, have been made by either party which are not embodied in this Agreement.

12.3 Severability. If any provision of this Agreement is held by a court of competent jurisdiction or applicable state, municipal or federal law to be invalid, void or unenforceable, the remaining provisions will nevertheless continue in full force and effect.

12.4 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of California.

12.5 Assignment. This Agreement shall be binding upon and shallinure to the benefit of the parties to it and their respective heirs, legal representatives, successors and assigns. Notwithstanding the foregoing, Referral Provider may not assign any of its rights or delegate any of its duties under this Agreement without the prior written consent of PLAN

12.6 Independent Contractor. Under this Agreement, Referral Provider is and shall be construed to be an independent contractor practicing Referral Provider's profession, and shall not be deemed to be an agent, servant or employee of PLAN

12.7 Confidentiality. The provisions of this Agreement are confidential and shall not be disclosed except as necessary to the performance of this Agreement and as required by law.

12.8 Waiver. The waiver of any provision or the breach of any provision of this Agreement must be set forth specifically in writing and signed by the waiving party. Any such waiver shall not operate or be deemed to be a waiver of any prior or future provision or breach of such provision.

12.9 No Third Party Beneficiaries. No Members or other third parties are intended by Referral Provider and PLAN to be third party beneficiaries of this Agreement, and no action to enforce the terms of this Agreement may be brought by any party except PLAN and Referral Provider.

12.10 Third Party Liability. Third Party Liability shall be defined as the existence of another party, his/her insurance and/or representative, who has potential financial responsibility due to accidental injury of a Member by such person(s). The PLAN Agreement with Referral Provider provides that PLAN will make primary payment in such cases (except Worker's Compensation) and seek subsequent reimbursement from such responsible parties.

12.11 CMS Approval. This Agreement shall become effective only after approval by the Center for Medicare and Medicaid Services.

12.12 Headings. The subject headings of this Agreement are included for the purpose of convenience only and shall not affect the construction or interpretation of any of its provisions.

COUNTY OF SAN MATEO

HEALTH DEPARTMENT ADMINISTRATION

MEMORANDUM

DATE: April 14, 2005

TO: Steve Rossi, Risk Management/Insurance Division

FROM: John Klyver, Mental Health Services/PONY #MLH 322

CONTRACTOR: Health Plan of San Mateo – Medicare Advantage

DO THEY TRAVEL: No

PERCENT OF TRAVEL TIME:

NUMBER OF EMPLOYEES: 80

DUTIES (SPECIFIC): See attached

COVERAGE:

Comprehensive General Liability:	$ 1,000,000
Motor Vehicle Liability:	$ ~~———~~ 0
Professional Liability:	$ 1,000,000
Worker's Compensation:	$ Yes

APPROVE ✓ WAIVE_____ MODIFY_____

REMARKS/COMMENTS:

Reviewed and re-approved.
Steve M. Rossi
4/15/05

SIGNATURE
Steve M. Rossi
Risk Manager 4/18/05
363-4247