MEDI-CAL
MEDICAL SERVICES AGREEMENT
BETWEEN
SAN MATEO HEALTH COMMISSION
AND
COUNTY OF SAN MATEO

This Medical Services Agreement ("Agreement") is entered into this ___ day of _________, 2__, by and between_____________________________, the County of San Mateo (the "County"), San Mateo Medical Center (SMMC), which employs or contracts for physicians duly licensed to practice in the State of California and certified to provide services under the California Medi-Cal Program (each such physician hereinafter referred to as "Primary Care Physician" or "PCP"), and the San Mateo Health Commission, a public corporation (hereinafter referred to as "Commission" or "PLAN"). The parties agree as follows:

In addition to this Primary Care Physician Medical Services Agreement, the following are attached hereto and incorporated by reference herein:

Primary Care Physician Medical Services Agreement
Attachment A Terms and Conditions
Attachment B Case Management Protocol
Attachment C Full Capitation Rates for Case Managed Members
Attachment D Primary Care Services
Attachment E Extended Office Hours Verification
Attachment F Primary Care Physician Automatic Assignment Supplemental Payment

The County agrees that each PCP employed by or contracted for by the County shall participate as a Primary Care Physician and shall serve a maximum of ________ (not to exceed 1500 per Physician) Members subject to the attached Terms and Conditions and other Attachments.

The County agrees that each PCP employed by or contracted for by the County is to be placed onto a list of Primary Care Physicians from which Medi-Cal Members may choose or to whom Members may be assigned by the Health Plan.

County of San Mateo	**Commission**
Executed by:	Executed by:
______________________	______________________
Signature	Authorized signature for San Mateo Health Commission
______________________	
Print Name	
______________________	______________________
Address	Address
______________________	______________________
Date	Date

MEDI-CAL
PRIMARY CARE PHYSICIAN
MEDICAL SERVICES AGREEMENT

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ATTACHMENT A
TERMS AND CONDITIONS

Recitals:

A. The PLAN has entered into or will enter into and maintain contracts with the State of California under which San Mateo County Medi-Cal Members will receive, through the PLAN, all medical services hereinafter defined as "Covered Services."

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

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

D. Both parties desire to demonstrate that effective and economical health care can be provided through a locally administered program.

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

SEE SECTIONS 1 - 11

SECTION 1
DEFINITIONS

As used in this Agreement, the following terms (listed alphabetically) shall have the meaning set forth herein below, except where, from the context, it is clear that another meaning is intended.

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

1.2 **"Capitation"** shall mean the average budgeted expenditures per Member per month for the provision of a defined scope of services.

1.3 **"Case Managed Members"** shall mean those Members who select or are assigned to a Primary Care Physician and are identified on the Primary Care Physician's Case Management list. The Primary Care Physician is responsible for delivering or arranging for delivery of all health services required by these Members under the conditions set forth in the Primary Care Physician Medical Services Agreement.

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

1.5 **"Commission"** shall mean the San Mateo Health Commission.

1.6 **"Co-payment"** shall mean the fee prescribed by State statute and paid by most Members for certain Covered Services.

1.7 **"Covered Services"** shall mean those services set forth in Section 4 of this Agreement. Covered Services do not include services excluded in Section 5.1 and are subject to the limitation of Sections 5.2, 5.3 and 5.4.

1.8 **"Emergency Services"** shall mean those healthcare services required to relieve acute symptoms of sufficient severity, including severe pain, such that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

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

ii) serious impairment to bodily functions, or

iii) serious dysfunction of any bodily organ or part.

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

1.9 **"Excluded Services"** shall mean those services for which the PLAN is not responsible and for which it does not receive a capitation payment. Excluded services include:

Dental, long term institutional care (home and community-based waivered), mental health (except

for outpatient pharmaceuticals and laboratory services prescribed by a non-psychiatrist provider), Child Health and Disability Prevention, Multipurpose Senior, and Adult Day Health Services.

1.10 **"Fiscal Year of San Mateo Health Commission"** shall mean January 1 through December 31 of each year.

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

1.12 **"Hospital"** shall mean any licensed acute general care hospital.

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

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

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

1.16 **"Limited Service Hospital"** shall mean any hospital which is under contract to the PLAN, but not as a Primary Hospital.

1.17 **"Limited Services"** shall mean services rendered by a chiropractor, acupuncturist, podiatrist, or faith healer as covered under the Medi-Cal Program.

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

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

1.20 **"Medi-Cal Provider Manual"** shall mean the Medi-Cal Provider Manuals of the Department of Health Services, issued by the Department's Fiscal Intermediary.

1.21 **"Medi-Cal Rates"** shall mean the schedule of Medi-Cal maximum allowances and rates of payment for Physician and non-Physician services in effect for the Medi-Cal Program at the time the services were rendered.

1.22 **"Member"** shall mean any person who is enrolled in the PLAN.

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

1.24 **"Other Services"** shall mean Limited Services and other covered services.

1.25 **"Participating Hospital"** shall mean a Hospital which has entered into an agreement with the PLAN to provide Covered Services to Members. The terms Participating and Contracting may be used interchangeably.

1.26 **"Participating Physician"** shall mean a Physician who has entered into an Agreement with the PLAN to provide Covered Services to Members, or a Physician employed by or contracted for by the County while the County is a party to an Agreement with the PLAN to provide services to Members. The terms Participating and Contracting may be used interchangeably.

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

1.28 **"Physician Advisory Group"** shall mean the committee of Physicians practicing in San Mateo County who serve on the advisory group appointed by the Commission to provide input on the Plan's quality program.

1.29 **"Physician Patient Load Limitation"** shall mean that maximum number of Members for whom the Primary Care Physician has contracted to serve, and the limit accepted by the PLAN beyond which the PLAN agrees that additional Members shall not be permitted to select or be assigned to that Primary Care Physician. Such limit may be changed by mutual agreement of the parties.

1.30 **"PLAN"** shall mean the programs governed by the San Mateo Health Commission which serve San Mateo County Medi-Cal Members also called Health Plan of San Mateo.

1.31 **"Primary Care Physician"** or **"PCP"** shall mean a Participating Physician or Physicians duly licensed in California and certified by the Medi-Cal Program and who has executed an Agreement with the PLAN to provide the services of a Primary Care Physician, or a Physician employed by or contracted for by the County while the County is a party to an Agreement with the PLAN to provide services to Members.

1.32 **"Primary Care Physician Account"** shall mean a specific account set up in the name of the County of San Mateo by the PLAN to which the agreed upon capitation amount shall be credited and against which claims for Members of that Primary Care Physician shall be debited.

1.33 **"Primary Care Services"** shall mean those services defined in Attachment D and provided to Members by a Primary Care Physician.

1.34 **"Participating Hospital"** shall mean any hospital which has entered into a general services contract with the PLAN, and with which Primary Care Physicians are affiliated by virtue of their contract.

1.35 **"Provider"** shall mean any health professional or institution certified to render services to Members and who has entered into a Medical Services Agreement with the PLAN.

1.36 **"Quality Program "** shall mean those processes, procedures and projects established by the PLAN and designed to optimize the quality of care received by members as well as to improve the overall health status of members.

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

1.38 **"Referral Authorization Form" (RAFs)** shall mean forms generated by the Primary Care Physician identifying needs based on Member's clinical status. RAFs are used by the Primary Care Physician to authorize referral to a Referral Provider.

1.39 **"Referral Provider"** shall mean any qualified Physician, duly licensed in California and certified by the Medi-Cal Program and who has executed an Agreement with the PLAN, to whom the Primary Care Physician may refer any Member for consultation or treatment.

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

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

1.42 **"Surcharge"** shall mean an additional fee which is charged to a Member for a Covered Service which is not authorized by the State or contained in the Evidence of Coverage.

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

1.44 **"Treatment Authorization Form" (TARs)** shall mean forms generated by Providers to request a service/treatment that requires prior authorization by the PLAN.

1.45 **"Utilization Management (UM)"** shall mean those review processes and procedures which are designed to determine whether services are Covered Services or medically necessary and which all Participating Physicians agree to follow.

SECTION 2
QUALIFICATIONS

2.1 Primary Care Physicians

Any physician duly licensed in the State of California may elect to serve Members hereunder as a Primary Care Physician if that Physician meets the qualifications that may be set by the PLAN and:

2.1.1 Is certified and in good standing to provide services under the Medi-Cal Program including those requirements contained in Article 3, Chapter 3, Subdivision 1, Division 3, of Title 22 of the California Administrative Code; and

2.1.2 Is a General Practitioner, Family Practitioner, Pediatrician, Internist, or OB/GYN appropriately credentialed by HPSM; and

2.1.3 If providing obstetric services to Medi-Cal members, agrees to follow the latest American College of Obstetrics and Gynecology (ACOG) standards and guidelines; and

2.1.4 Is responsible for standing in the relationship of the Primary Care Physician 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 and referral to specialists and the coordination of these and other types of care through diverse resources; and

2.1.5 Is responsible for organizing a pattern of supportive medical resources, so that Members may be appropriately served by medical advice and supervision seven (7) days each week and twenty-four (24) hours per day. This includes the physician arranging for: 1) appropriate cross-coverage when not available during regular business hours (e.g. for vacation, illness, etc) and 2) a coverage plan for Members if the physician is not available/cannot be contacted for urgent issues on evenings and weekends.

2.1.6 Maintains medical staff privileges at one or more of the PLAN's Participating Hospitals.

2.2 Scope of Service

The Primary Care Physician has indicated the type of practice in which he or she engages and the maximum number of Members for whom he or she has agreed to provide services hereunder. The Primary Care Physician may later change the number of Members upon mutual agreement of the Primary Care Physician and the PLAN.

At a minimum, any Primary Care Physician's scope of services is to include general health care services for the population the physician agrees to serve consistent with his/her specialty training and certification, including health care screening/annual health visits, recommended preventive health care services, management of routine clinical conditions and availability (via office hours, office cross-coverage, on-call coverage or comparable) for urgent care services during at least forty (40) business hours per week. It should be noted that referring a patient to the emergency room for urgent (non-emergency) care during expected office availability does not constitute suitable coverage.

2.3 Minimum Number of Members

The Primary Care Physician agrees that he/she is willing to serve and shall serve a minimum of 125 Members. This policy may be excepted upon recommendation of the PLAN. (A maximum number of Members may be specified on the first page of the Medical Services Agreement. If no maximum is specified, the maximum will be 1,500 Members per Physician).

SECTION 3
PHYSICIAN/PATIENT RELATIONSHIP

3.1 Member Designation

At the time of determining Medi-Cal eligibility, the PLAN will request each member to select from among all of those Primary Care Physicians contracting with the PLAN the Primary Care Physician through whom that Member will seek all medical services. If no selection is made, the PLAN shall assign the Member to a Primary Care Physician.

3.2 Listing

The PLAN will enter the name of each Physician signing a Primary Care Physician Medical Services Agreement onto a list of Primary Care Physicians from which Members may choose. Such a list shall contain the following information concerning the Primary Care Physician in order to allow for an appropriate Primary Care Physician selection procedure:

- Name
- Address(es)
- Telephone Number(s)
- Clinic or medical group affiliation, if any
- Language Capabilities
- Member age and sex limitations, if any
- Hospital Affiliation
- Medical Specialty

3.3 Change of Primary Care Physician

Members may change their choice of Primary Care Physician in accordance with procedures established by the PLAN. The Primary Care Physician may also request the PLAN assist the Member to make another choice if Primary Care Physician does not believe that a satisfactory physician/patient relationship can be developed or continued with that Member. In such a circumstance, the Primary Care Physician agrees to provide a written request to the PLAN for the change explaining the reason for the request and agrees to follow the patient until a new PCP is assigned. The PLAN will track the Member and the Primary Care Physician generated change requests for quality purposes. Primary Care Physicians may not request changes due to a Member's medical condition requiring increased care.

3.4 Limitation of Members

The PLAN will not permit Members to select any Primary Care Physician who is serving the maximum number of Members specified in this Agreement. Primary Care Physician may request that only current patients be included in his/her patient load and PLAN will comply with that request.

3.5 Primary Care Physician as Case Manager

The Member's Primary Care Physician shall be the principal source of a Member's primary medical contact and advice. The Primary Care Physician shall be responsible for the management of all of a Member's medical care, except where specifically excepted herein, for the Member until such time as the PLAN changes the Member's Primary Care Physician at the request of the Member or the Primary Care Physician. The Primary Care Physician agrees to abide by the Case Management Protocols which are included as Attachment B to this Agreement and are incorporated herein by this reference.

3.6 Referral

The Member's Primary Care Physician shall have the right to refer the Member to any Referral Provider. Referrals to contracting Providers outside the County or non-contracting certified Medi-Cal Providers may be made only after authorization for such has been obtained from the PLAN's Medical Director or designee.

3.7 Referral for Capitated Services

Primary Care Physicians are expected to provide any capitated services that a Member assigned to their panel may need. The PLAN periodically monitors the frequency of Primary Care Physician referral for capitated services. The PLAN recognizes that, on occasion, it may be in the Member's best interest for the Primary Care Physician to refer the patient for some of these services (e.g. male physician and teen or older woman needing pap test), in order for the Member to consent to the service. However, referrals for many types of capitated services should not occur frequently, and Primary Care Physicians should always be looking for ways to maximize the capitated services they can provide to their assigned Members (e.g. in the example above, a contract with a part-time female nurse practitioner might be arranged). This is because, often referral services, especially those for preventive care, are less likely to actually occur if the services are not provided by the Primary Care Physician.

3.8 Physician Responsibility

The Member's Primary Care Physician, and any Attending Physician or Referral Provider to whom the Primary Care Physician has delegated the authority to proceed with treatment or the use of resources, shall be responsible for monitoring all medical advice and services performed or prescribed through them for the Member. The Primary Care Physician is responsible for coordinating the care of the Member among multiple providers.

3.9 Unsatisfactory Relationships Between Members and Primary Care Physicians

The physician/patient relationship is a personal relationship and circumstances may arise under which relations between a particular Member and a particular Primary Care Physician may become unsatisfactory. In such cases, the Primary Care Physician and the PLAN shall use their best efforts to provide the Member with the opportunity to be served by a Primary Care Physician with whom a satisfactory physician/patient relationship may be developed. If, however, the PLAN is unable to make such arrangements, the Primary Care Physician shall continue to serve the Member according to the Primary Care Physician's best professional judgment until the PLAN is able to change the Member's Primary Care Physician, for a period not to exceed three (3) months.

SECTION 4
SERVICES TO BE COVERED

4.1 Management of Care

It shall be the responsibility of the Primary Care Physician to determine what care is necessary and appropriate and to prescribe any Covered Services (either directly or through referral) and to manage the care provided and authorized for Members in accord with professionally recognized standards of care and with proper attention to the need for containment of costs. Except as otherwise provided herein, it shall be the responsibility of the Primary Care Physician to provide or authorize a mix of any Covered Services for each Member which seems at that time to be necessary for the control and prevention of disease, illness, or disability. The Primary Care Physician shall abide by the Case Management Protocol, incorporated into the Agreement as Attachment B. In addition, there are specific items or services that require PLAN prior authorization (e.g. durable medical equipment, certain medications, specific procedures, etc.). The Primary Care Physician, or the Referral Physician to whom the Primary Care Physician sends a Member, shall work together to ensure that appropriate prior authorization is obtained from the PLAN where necessary, to assist the Member in getting necessary care as expeditiously as possible.

4.2 Consultation with Medical Director

The Primary Care Physician or any other Provider may at any time seek consultation with the PLAN's Medical Director on any matter concerning the treatment of the Member.

4.3 Covered Services

For each Member who has chosen or has been assigned to a Primary Care Physician, that Primary Care Physician shall provide or authorize the provision of all services covered under the Medi-Cal Program when they are necessary and appropriate for the care of that Member. Covered Services include but are not limited to:

4.3.1 Timely access (within twenty-four (24) hours for Urgent Care, and fourteen (14) days for Routine Care and thirty (30) days for an Annual History and Physical) to the Primary Care Physician or Attending Physician for medical advice when requested by the Member or some person legitimately acting on the Member's behalf.

4.3.2 Consultation and treatment services by the Referral Physicians including referrals for a second professional opinion as these may become necessary for 1) the prevention of anticipated illness, or 2) for treatment called for due to exposure to illness, or 3) for detection, treatment, or diagnosis of illness or injury or the health effects of illness or injury, or 4) for care of mother and unborn or newborn child during and following pregnancy, 5) if the Member questions the reasonableness or necessity of recommended surgical procedures, 6) if the Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment , including but not limited to, a serious chronic condition, 7) if the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating Provider is unable to diagnose the condition, and the Member requests and additional diagnosis, 8) if the treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second

opinion regarding the diagnosis or continuance of the treatment, 9) if the Member has attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care.

4.3.3 Admission to Hospital, Skilled Nursing Facility, Intermediate Care Facility, or other institutional care setting.

4.3.4 Audiology, physical therapy, occupational therapy, speech therapy, family planning services, adult day health care, and/or other therapeutic and diagnostic measures prescribed by the Primary Care Physician or Attending Physician which are held to be necessary and appropriate for the prevention, diagnosis, the management or treatment of diagnosed health impairment, or rehabilitation of the Member and are Medi-Cal/HPSM benefits.

4.3.5 Ambulance Services as the result of a "911" emergency response system request for assistance if either of the following conditions apply:

1) The request was made for an emergency medical condition and ambulance transport services were requested.

2) A Member reasonably believed that the medical condition was an emergency medical condition and reasonably believed that the condition required ambulance transport services.

4.3.6 Other necessary durable medical equipment rental, medical supplies, and medical transportation.

All services and goods required or provided hereunder shall be of quality consistent with established clinical standards of care.

4.4 Payment to Other Provider

Subject to the exclusions listed in Section 5.1, and the limitations and provisions of Sections 5.2, 5.3, and 5.4, the PLAN will pay Providers for Covered Services authorized by the Primary Care Physician which are not services covered by the monthly capitation payment to Primary Care Physician as specified in Attachment C to the Agreement.

4.5 Direct Access

When a Member contacts the Primary Care Physician and requests medical advice, diagnosis, treatment, or relief, the Primary Care Physician shall make suitable arrangements for personal contact with the Member, or for services by appropriate personnel in accordance with customary medical practice and with law, and shall provide for the Member, or order for the Member on his or her behalf, all Covered Services which are consistent with the Member's presenting conditions and medical needs, and with the objectives of the Program, as made explicit in the Recitals to this Attachment. These arrangements shall be made in a timely fashion suitable to meet the medical needs of the Member's condition/request.

4.6 Physician Authority

Nothing expressed or implied herein shall require the Primary Care Physician to provide to the Member, or order on behalf of the Member, Covered Services which, in the professional opinion of the Primary Care Physician, are not medically necessary. It should be noted that when a Primary Care Physician determines that a Member-requested service is NOT medically necessary, then the Physician shall inform the Member of his/her PLAN appeal rights if the Member does not agree with the PCP's decision.

4.7 Place of Service

All services are to be provided at a place which the Primary Care Physician, Referral Physician or Attending Physician determines is appropriate for the proper rendition thereof, within the constraints of the State Medi-Cal Program regulations. In accordance with Medi-Cal regulations, please keep in mind, that whatever the lowest cost service or item that is medically necessary to meet a member's needs, is the item that should be ordered. This allows HPSM to use resources efficiently to the benefit of all members.

4.8 Imposition of Controls if Necessary

The Primary Care Physician recognizes the possibility that the PLAN may be required to take action requiring consultation with the PLAN's Medical Director or with other Physicians prior to authorization of services or supplies or to terminate this Agreement. In the interest of Program integrity or the welfare of Members, the PLAN may introduce utilization controls as may be necessary at any time and without advance notice to the Primary Care Physician. In the event of such change, the change may take effect immediately upon receipt by the Primary Care Physician of notice from the PLAN's Medical Director. However, the Primary Care Physician shall be entitled to appeal such action to the Physician Review Committee, and, if still dissatisfied, then to the Commission.

4.9 Discrimination Prohibited

The Primary Care Physician shall not differentiate or discriminate in the treatment of Medi-Cal Members, nor shall he/she discriminate on the basis of sex, race, creed, color, ancestry, religious creed, national origin, marital status, sexual orientation, physical disability including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), mental or developmental disability, age, medical condition or mental status, except as limited by the scope of services he or she is qualified to provide. The Primary Care Physician shall render health services to Members in the same manner, with the same dignity and respect, in accordance with the same standards and within the same time availability as offered his or her other patients, except as limited by existing Medi-Cal restrictions.

4.10 Hospital Privileges

The Primary Care Physician shall secure and maintain staff privileges with at least one (1) Participating Hospital contracting with the PLAN.

4.11 Compliance with PLAN and Commission Activities and Decisions

The Primary Care Physician shall cooperate and participate with the PLAN in Quality Assessment and Improvement and Utilization Review programs, Grievance procedures and all PLAN efforts undertaken as necessary for the PLAN to comply with federal and state regulatory and contractual requirements. The Primary Care Physician shall also comply with all final determinations rendered by PLAN and Commission decisions.

4.12 Linguistic Services

4.12.1 Interpreter Services for Limited English Proficient (LEP) Members

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

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

X Qualified Interpreter services may be obtained through the HPSM (24) hour telephone language line service, on-site trained interpreters, bilingual or multilingual Providers. NOTE: The use of ad hoc interpreters (e.g. family members, friends) is not to be recommended per state and federal regulations, and is only to be used if a Member insists on this after provider explanation that ad hoc interpreters have been demonstrated in clinical studies to lead to lower quality of care due to errors in translation.

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

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

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

4.12.2 Additional Linguistic Services for Threshold Language Members

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

In addition to interpreter services for LEP Members, as stated in Section 4.12.1, the Primary Care Physician shall provide the following services for Members whose language proficiency is in a threshold language.

a. Translated signage;
b. Translated written materials; and
c. Referrals to culturally and linguistically appropriate community service programs.
d. Information on how to file a grievance and the ability to file a grievance in a non-English language.

The Primary Care Physician may request assistance from the Plan in meeting these requirements.

4.13 Enrollment in Vaccines For Children (VFC) Program

4.13.1 Any Primary Care Physician who provides primary care services for children under age 19 is expected to enroll as a Vaccines for Children (VFC) provider and meet all the requirements of this program.

4.13.2 The vaccine for any immunization provided as part of routine primary care as well as for boosters due to a change in medical condition, to any child enrolled as an HPSM Medi-Cal member, are to be obtained from the VFC program, and thus not separately reimbursed by HPSM.

4.13.3 These vaccines are to be provided by the Primary Care Physician in his/her office, so the Member should not need to be referred to Public Health Clinics.

4.14 Enrollment as a Child Health and Disability Prevention Program (CHDP) Provider or Equivalent

4.14.1 Any Primary Care Physician who provides primary care services for children under age 19 is expected to enroll as a Child Health and Disability Prevention Program (CHDP) provider or be the equivalent thereof. This means that, at a minimum, all clinical requirements for this program are to be met.

4.14.2 The PLAN recognizes that some Primary Care Providers may choose not to become CHDP providers due to paperwork requirements. However, all the clinical aspects of the program (e.g. equipment used, testing performed, and so forth) are expected to be met by these "equivalency" providers so that Members receive comparable care.

SECTION 5
EXCLUSIONS FROM AND LIMITATIONS ON COVERED SERVICES

5.1 Exclusions

In addition to those services not covered under the California Medi-Cal Program as specified in Division 3, Subdivision 1, Chapter 3, Article 4, Title 22, California Administrative Code, the PLAN shall not make payment for the following services if they are provided to Members:

5.1.1 Dental Services

5.1.2 Services which in the judgment of the Primary Care Physicians (for services requiring referral) and/or the PLAN's Medical Director (for services requiring prior authorization), are not medically necessary or appropriate for the control and prevention of health related illness, disease, or disability.

5.1.3 Services reimbursed by the Child Health and Disability Prevention Program (CHDP), any skilled nursing or intermediate care facilities (but not services provided in such facilities by Physicians or other Providers), long term in-home waivered services, Multi-Senior Services, Adult Day Health Services, mental health services (except for outpatient pharmaceuticals and laboratory services prescribed by a non-psychiatrist Provider or mental health services specifically related to a medical, not psychiatric diagnosis.

5.1.4 Other services as may be determined by the PLAN, and as noticed to the participating Primary Care Physicians.

5.2 Medi-Cal Restrictions

5.21 Services provided shall be subject to the Plan's most current Medi-Cal agreement with the State of California.

5.2.2 Services provided shall be subject to the limitations and procedures listed in the Medi-Cal Provider Manual unless the Primary Care Physician is notified of modification to that policy. However, prior authorization shall be provided only through the Primary Care Physician, his/her on-call designee or the PLAN's Medical Director.

5.2.3 The Medi-Cal Provider Manual specifies certain restrictions and limitations with respect to abortion and sterilization. These services under the PLAN shall be subject to the limitations specified therein.

5.3 Formulary

Prescriptions payable by the PLAN shall be subject to the restrictions on the State's Medi-Cal Formulary except where Formulary changes are authorized by the PLAN in accord with its contract with the State of California. Primary Care Physicians are expected to use formulary medications when clinically appropriate.

5.4 Exceptions to Case Management Control

5.4.1 Obstetrical and Family Planning Services may be obtained on direct patient self-referral to certain qualified contracting Providers in accord with Federal requirements at 42 CFR 441.20, and the Knox-Keene Health Care Service Plan Act of 1975, Section 1367.695. No prior authorization is required.

5.4.2 Primary Care Physician authorization is not required for Members designated as Special Members.

5.4.3 Primary Care Services for Members eligible for California Children's Services (CCS) are expected to be coordinated by the Member's Primary Care Physician who is serving as the Member's medical home. Any CCS eligible services must be authorized by CCS

SECTION 6
PAYMENTS AND INCENTIVES

6.1 Payment for Services Provided by Primary Care Physicians

6.1.1 Guaranteed Payment

The PLAN shall pay to the County a monthly sum called the "Guaranteed Payment" for each Member served by a PCP employed by or contracted for by the County per month. This sum shall be 100% percent of the portion of the Full Capitation rate allocated to the Primary Care Services and adjusted by eligibility category, and shall be paid to the County each month within ten (10) days of receipt of the PLAN's monthly payment from the State. This payment is payment in full for all services defined as Primary Care Services provided in that month, provided by the Primary Care Physician and listed in Attachment D.

6.1.2 Fee-For-Service Payments (FFS)

The PLAN shall pay the County the prevailing Medi-Cal schedule of payments or the PLAN payment rate, whichever is higher, for all properly documented Medi-Cal Covered Services provided to:

- Case Managed Members affiliated with a Primary Care Physician employed by or contracted for by the County when the service is not listed in Primary Care Services (Attachment D); and
- All other Members when the service is medically necessary

6.2 Reporting of Capitated Services

The Primary Care Physician shall complete an encounter form to be specified by the PLAN for all capitated services rendered to Members,

6.3 Provider Incentives

NOTE: Each of these incentives stands alone, and can be billed separately from any other incentive listed.

6.3.1 As an incentive for reporting capitated services, the PLAN shall reimburse the County three dollars ($3.00) for each paper encounter form and five dollars ($5.00) for each electronic encounter form that is submitted and that has been completed with the services rendered for that date of service.

6.3.2 Primary Care Physicians with extended hours as defined in Attachment E and who have completed this attachment and been approved shall be paid an amount equal to ten percent (10%) of the monthly capitation payment made to PCP pursuant to this Agreement as listed in the "Extended Office Hours PCP Cap" column of the Attachment C.

6.3.3 Primary Care Physicians accepting Automatic Assignment and completing Attachment F shall be paid an amount equal to twenty percent (20%) of the monthly capitation payment made to PCP pursuant to this Agreement as listed in the "Automatic Assignment PCP Cap" column of Attachment C.

6.3.4 For every new Member seen within 120 days of enrollment, the PLAN shall reimburse the County an incentive of ninety dollars ($90) when the Member is seen in a timely fashion and the Staying Healthy Assessment Tool for that Member's age group is completed.

6.3.5 For every adolescent (ages 13-18 years old) Member seen annually, the PLAN shall reimburse the County an incentive of ninety dollars ($90) each year when the Member is seen and the Staying Healthy Assessment Tool for that Member's age group is completed.

6.3.6 For every Member on a Primary Care Provider's Case Management List with persistent asthma (on at least one controller medication), the PLAN shall reimburse the County an incentive of twenty-five dollars ($25) for the first asthma Action Plan for a Member that is completed and updated each calendar year, for which the physician certifies that the plan has been explained to the Member/parent, a copy has been given to the Member/parent and a copy is submitted to the Plan.

6.3.7 OB referrals in first trimester: For every positive pregnancy test carried out by the PCP, where an obstetrics referral is requested by the Member, and made to an OB provider and an appointment scheduled there by the Primary Care Provider's office for the Member during the Member's first trimester, with all of the above documented by the Primary Care Provider to the PLAN, the PLAN shall reimburse the County an incentive of fifty dollars ($50).

6.3.8 OB appointments in the first trimester: For every pregnant Member for whom an OB provider accepts and sees the patient in the first trimester, and documents this to the PLAN, the OB provider shall be reimbursed an incentive of one hundred dollars ($100).

6.3.9 Diabetes Care: For every member diagnosed with diabetes, the County shall be reimbursed thirty dollars ($30) per member per calendar year for completion, or arranging for the completion of each of the following services—Hemoglobin A1c (HbA1c); Low density Lipoprotein cholesterol (LDL-C); Retinal eye exam (referral visit to an eye care professional); Nephropathy screening (acceptable tests include 24 hour urine for microalbumin, timed urine for microalbumin, spot urine for microalbumin, urine for microalbumin/creatinine ratio, 24 hour urine for total protein, random urine for protein/creatinine ratio or urinalysis positive for albumin or protein) or referral visit to a nephrologist. Thus, if all four are arranged/occur in the calendar year, the County shall be reimbursed one hundred and twenty dollars ($120). In addition, for every adult member whose HbA1c is below 7% during the calendar year, the County will be reimbursed sixty-five dollars ($65), and for every member whose LDL-C is below 100 during the calendar year, the County shall be reimbursed sixty-five dollars ($65). For pediatric members, the HbA1c rates to be met to earn the incentive reimbursement are as follows (per American Diabetes Association guidelines): ages < 6: ≤ 8.5%; ages 6-12: ≤ 8%; ages 13-19: ≤ 7.5%. Documentation sources shall include claims data, lab data and provider chart documentation.

6.3.10 Obesity Screening: For every Member on a Primary Care Provider's Case Management List for whom the PCP measures and graphs the member's Body Mass Index (BMI), the PLAN shall reimburse the County an incentive of twenty-five dollars ($25) for the first BMI graph for a Member that is completed and updated each calendar year, for which the physician certifies that the BMI graph has been discussed with the Member/parent, a copy has been given to the Member/parent and a copy is submitted to the Plan.

6.3.11 Immunization Registry: Every Primary Care Provider who cares for pediatric (less than 19 years of age) patients and joins the San Mateo County Immunization Program's Immunization Registry shall be reimbursed five hundred dollars ($500) for enrollment and start up (entering current patients into the registry). The Primary Care Provider who then continues to be part of the San Mateo County Immunization Registry shall be reimbursed one dollar ($1.00) per member per month for each HPSM Medi-Cal member the Primary Care Provider continues to include and actively updates in the Registry.

6.4 The obligations set forth in this Section shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Members, and the provisions of this Section shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between the Primary Care Physician and the Member or any persons acting on their behalf.

6.5 Member Liability

Other than copayments, the County shall look only to the PLAN for compensation for Covered Services and shall at no time seek compensation from Members for Covered Services, including but not limited to, nonpayment by the PLAN, the PLAN's insolvency, dissolution, bankruptcy or breach of the Agreement. The County shall not bill, charge, surcharge, collect a deposit, or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any other recourse against any Member for any debts owed by PLAN under this Agreement for Covered Services payable by the PLAN. The County shall report to the PLAN in writing all surcharges and co-payments paid by Members to any Primary Care Physician. If the PLAN receives notice of any surcharges upon any Member, it shall be empowered to take appropriate action. This provision shall not prohibit billing and collecting from Members for services which are not Covered Services. The Provider shall supply to the Member prior to treatment of a non-covered service, a written notice informing them of their financial responsibility for said services.

The obligations set forth in this Section shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Members, and the provisions of this Section shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between the Primary Care Physician and the Member or any persons acting on their behalf.

6.6 Member Hold Harmless

The County agrees to hold harmless the Member in the event the PLAN cannot or will not pay for services performed by the Primary Care Physician pursuant to the terms of the Agreement.

SECTION 7
TERM, TERMINATION, AND AMENDMENT

7.1 Effective Date

This Agreement shall become effective on January 1, 2008 or on the date specified on the Primary Care Physician Medical Services Agreement, whichever is later.

7.2 Term

This Agreement shall be for a term of one (1) year from the date it becomes effective and shall be automatically renewed for subsequent terms of one (1) year each. This Agreement may be terminated or amended as hereinafter provided.

7.3 Termination

This Agreement may be terminated by either party as follows:

7.3.1 If terminated by the County, termination shall require sixty (60) days advance written notice of intent to terminate, transmitted by the Primary Care Physician to the PLAN by Certified U.S. Mail, Return Receipt Requested, addressed to the office of the PLAN, as provided in Section 11.4.1. A copy of the written notice shall also be mailed as first-class registered mail to State Department of Health Care Services, Capitated Health Systems Division, 714/744 "P" Street, Sacramento, CA 95814.

7.3.2 The County may terminate this Agreement upon thirty (30) days written notice in the following circumstance: If in response to a contract amendment instituted according to the provision of Section 7.7, the County notifies the PLAN in writing of termination within sixty (60) days of notice said amendment.

7.3.3 If termination is initiated by the PLAN, the date of such termination shall be set by consideration for the welfare of Members and necessary allowance for notification of Members, and the County shall be notified as hereinafter provided. The PLAN may terminate this Agreement at any time and for any reason upon thirty (30) days written notice.

7.3.4 Conditions for Termination by the PLAN

7.3.4.1 The PLAN shall terminate this Agreement effective immediately in the following situations: change in licensure status resulting in restricted licensure or loss; loss by the Primary Care Physician of Medi-Cal Provider certification.

7.3.4.2 The PLAN may terminate this Agreement effective immediately in the following situations: charges to Members by the County other than authorized co-payments; the County's failure to comply with the PLAN's utilization control procedures; the County's failure to abide by PLAN or Commission decisions; failure to maintain adequate levels of insurance as specified in Section 9; failure to meet the PLAN's credentialing criteria; failure to comply with Corrective Action Plan requirements; failure to provide adequate level of service to Members as

demonstrated by inadequate hours of operation, failure to provide minimum scope of services in care delivery, or repeated (two or more) grievances filed by Members that are not adequately addressed in spite of PLAN offers of assistance.

7.3.5 This Agreement shall terminate automatically on the date of the termination of the PLAN's contract with the State of California. The PLAN shall notify the County as soon as is practical upon receiving or sending such notice of termination.

7.4 Member Notification

The PLAN will immediately notify all Members if their Primary Care Physician is terminated or terminates so that the Member may choose a new Primary Care Physician as soon as practicable.

7.5 Practice Closure

In the event of the withdrawal of the County from practice, this Agreement shall terminate immediately.

7.6 Assignment

This Agreement is a personal service agreement and shall not be transferred or assigned to any other person or entity.

7.7 Amendment

7.7.1 Amendment by Mutual Agreement

This Agreement may be amended at any time upon written agreement of both parties subject to Section 11.8.

7.7.2 Amendment by the PLAN

This Agreement may be amended by the PLAN upon thirty (30) days written notice to the County. If the County does not give written notice of termination within thirty (30) days, as authorized by Section 7.3.2, the Primary Care Physician agrees that any such amendment by the PLAN shall be a part of the Agreement. However, the provisions of Section 7.7.2 may not be invoked to amend any portion of Section 7 of this Agreement or to reduce the rates presented in the Full Capitation Rates for Case Managed Members (Attachment C of this Agreement.)

7.7.3 Knox-Keene Amendments

The terms of this Agreement shall be subject to the requirements of the Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), as amended, and the regulations promulgated thereunder (the "Regulations"), to the extent applicable hereto, and any provision required to be in this Agreement by either the Act or Regulations shall bind the PLAN and the Primary Care Physician as appropriate, whether or not provided herein. If the Director of Department of Managed Health Care or his/her successor requires further amendments to this Agreement, the PLAN shall notify the County in writing of such amendments. The County will have thirty (30) days from the date of the PLAN's notice to reject the proposed amendments

by written notice of rejection to the PLAN. If the PLAN does not receive such written notice of rejection within the thirty (30) day period, the amendments shall be deemed accepted by and binding upon the County. Amendments for this purpose shall include, but not be limited to, material changes to the PLAN's Utilization Management, Quality Assessment and Improvement and Grievance programs and procedures and to the health care services covered by this Agreement. Without limiting the foregoing, the validity and enforceability of this Agreement, as well as the rights and the duties of the parties herein shall be governed by California law.

7.8 Continuity of Care

Upon termination of this Agreement for any reason, the Primary Care Physician shall ensure an orderly transition of care for Case Managed Members, including but not limited to the transfer of Member 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 8
MEDICAL RECORDS, ACCOUNTS, REPORTING AND RECOVERIES

8.1 Medical Record

The County shall maintain for each Member who has received Covered Services, a legible medical record, kept in detail consistent with appropriate medical and professional practice, which permits effective internal professional review and external medical audit process and which facilitates an adequate system for follow-up treatment. The County shall maintain such records for at least five (5) years from the close of the State's fiscal year in which this Agreement was in effect.

8.2 Inspection Rights

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

8.2.1 By the PLAN or any entity designated by the PLAN (e.g. for HEDIS data collection), the State Department of Health Care Services, Department of Managed Health Care and the United States Department of Health and Human Services and all applicable State and Federal agencies and Self Regulatory agencies.

8.2.2 At all reasonable times at the Primary Care Physician's place of business or at such other mutually-agreeable location in California.

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

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

8.3 Member Eligibility

The PLAN shall notify the County each month of those Members who are entitled to receive Covered Services from the County and for whom the Full Capitation is credited to the County's Account.

8.4 Confidentiality of Member Information

For the purpose of this Agreement, all information, records, payment information, data and data elements collected and maintained for the operation of the Agreement and pertaining to Members shall be protected by the Primary Care Physician and his/her staff from unauthorized disclosure as required by Medi-Cal and any applicable law.

8.5 Subcontracts

The County shall maintain and make available to the PLAN, the U. S. Department of Health and Human Services, Department of Managed Health Care, State Department of Health Services, and all applicable State and Federal agencies and Self Regulatory agencies upon request all subcontracts and shall ensure that all subcontracts are in writing and require that the subcontractor:

- o Make all books and records pertaining to the goods and services furnished under the terms of the Agreement available at all reasonable times for inspection, examination, or copying by the State Department of Health Services, the Department of Managed Health Care, the U. S. Department of Health and Human Services, the PLAN and all applicable State and Federal agencies and Self Regulatory agencies; and
- o Retain such books and records for a term of at least five (5) years from the close of the State Department of Health Services' fiscal year in which the subcontract is in effect.

8.6 Other Insurance Coverage

8.6.1 Health Insurance Other Than Medicare

The County shall inform the PLAN of all potential third party insurance recoveries. The County agrees to notify the PLAN that health insurance or another health program other than Medicare may cover any Covered Services provided by the County whenever the County discovers this potential coverage. The requirements concerning notification and recoveries in the current Medi-Cal Provider Manual shall apply. The County also shall cooperate with and assist the PLAN in obtaining such recoveries.

8.6.2 Medicare Recoveries Care Advantage

The County's capitation rate for Members covered by Medicare requires that the County shall recover directly from Medicare for Medicare services rendered without going through the PLAN. Such Medicare recoveries belong to the County, but shall be reported to the PLAN on the encounter form.

8.7 Member's Potential Tort, Casualty, or Worker's Compensation Awards

The County shall notify the PLAN that a potential tort, casualty insurance, or Worker's Compensation award may reimburse the Physician for any covered services provided by the Primary Care Physician whenever the Physician discovers such potential awards.

SECTION 9
INSURANCE AND INDEMNIFICATION

9.1 Liability Insurance

Each Primary Care Physician covered by this Agreement shall carry at its sole expense liability insurance of at least ONE MILLION DOLLARS ($1,000,000) per person per occurrence, insuring against professional errors and omissions (malpractice) in providing medical services under the terms of this Agreement and for the protection of the interests and property of the Primary Care Physician, its members and employees, and the PLAN Members.

9.2 Other Insurance Coverage

The Primary Care Physician shall carry at its sole expense at least THREE HUNDRED THOUSAND DOLLARS ($300,000) per person per occurrence of the following insurance for the protection of the interest and property of the Primary Care Physician, its members and employees, the PLAN Members, the PLAN and third parties; namely, personal injury on or about the premises of the Primary Care Physician, general liability, employer's liability and Workers' Compensation to the extent said Workers' Compensation is required by law.

9.3 Certificates of Insurance

The Primary Care Physician at its sole expense, if any, shall provide to the PLAN certificates of insurance or verifications of required coverage, and shall notify the PLAN of any notice of cancellation for any and all coverage required by this Agreement, and for subsequent renewals of all required coverage.

9.4 Automatic Notice of Termination

The Primary Care Physician shall arrange with the insurance carrier to have automatic notification of insurance coverage termination given to the PLAN.

SECTION 10
GRIEVANCES AND APPEALS

10.1 Grievances and Appeals

It is understood that the County may have Grievances which may arise as a health care provider under contract with the PLAN. These Grievances shall be resolved through the mechanisms set out in Sections 10.2. The County and the PLAN shall be bound by the decisions of the PLAN Grievance and Appeal mechanisms. Primary Care Physician agrees to participate when requested by the Plan in the resolution of grievances and appeals, including the provision of timely evaluation of and response to the concerns raised by Members.

10.2 PLAN Member/Provider Initiated Grievance Procedure

10.2.1 Responsibility

The PLAN's Executive Director has primary responsibility for maintenance, review, formulation of policy changes, and procedural improvements of the Grievance review system. The Executive Director shall be assisted by the Director of Planning and Evaluation, the Director of Health and Provider Services and the Medical Director or their designees.

10.2.2 Resolution of Member and Provider-Initiated Grievances

The County agrees that all disputes or disagreements between the Primary Care Physician and the PLAN or the Member, shall be resolved in accordance with such Grievance resolution process as the PLAN may establish, and amend from time to time. To the extent permitted by law, in accordance with applicable provisions of the Knox-Keene Health Service Plan Act of 1975, as amended, and the regulations promulgated hereunder by the Department of Managed Health Care, the Primary Care Physician shall permit the PLAN to inspect and make copies of any and all records pertaining to any such dispute or disagreement, and shall provide copies of such records to the PLAN upon request.

The Primary Care Physician shall display in a prominent place at their place of service, notice informing Members how to contact the PLAN and file a complaint.

The Primary Care Physician may submit grievances and disputes to PLAN at the address provided in Section 11.4.1, or by calling PLAN's Grievance Coordinator at 1-650-616-2164.

SECTION 11
GENERAL PROVISIONS

11.1 In the event any part of this Agreement is found to be unlawful or Legislation modifies the entitlement of Members or other provision hereunder, the Agreement shall automatically and without prior notice, be modified to reflect that which is lawful and all other provisions shall remain in full force and effect.

11.2 Within constraints of applicable State and Federal statutes, the PLAN shall inform Members regarding the Primary Care Physician's willingness to undertake service to them.

11.3 The waiver by the PLAN of any one or more defaults, if any, on the part of the Primary Care Physician hereunder, shall not be construed to operate as a waiver by the PLAN of any other or future default in the same obligation or any other obligation in this Agreement.

11.4 Any notice or other communications required or which may be given relative to this Agreement 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, 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:

11.4.1 If served on the PLAN, it should be addressed to --

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

11.4.2 If served on the Primary Care Physician, it shall be addressed to the Primary Care Physician at the address which appears on the Primary Care Physician Medical Services Agreement or PLAN's records.

Either party shall have the right to change the place to which notice is to be sent by giving forty-eight (48) hours written notice to the other of any change of address.

11.5 It is agreed by these parties that neither this Agreement in its entirety, nor any portion thereof, may be modified, altered or changed in any manner, except as provided in Sections 7.7.1 and 7.7.2.

11.6 None of the provisions of this Agreement is intended to create nor shall be deemed or construed to create any relationship between the parties hereto other than that of independent entities contracting with each other hereunder solely for the purpose of effecting the provisions of this Agreement. Neither of the parties hereto, nor any of their respective employees, shall be construed to be the agent, the employee or the representative of the other.

11.7 Throughout this Agreement the singular shall include the plural, and the plural the singular; the masculine shall include the neuter and feminine, and the neuter the masculine and feminine.

11.8 This Agreement and any Amendment to it shall become effective only after approval by the State Department of Health Care Services of the form of the Agreement or amendment.