



HEALTH SERVICES AGENCY  
ADMINISTRATION

# COUNTY OF SANTA CRUZ

## HEALTH SERVICES AGENCY

P.O. BOX 962, 1080 EMELINE AVENUE  
SANTA CRUZ, CA 95061  
(408) 454-4066 FAX: (408) 454-4770  
TDD: (408) 454-4123

June 6, 2000

AGENDA: June 20, 2000

### BOARD OF SUPERVISORS

Santa Cruz County  
701 Ocean Street  
Santa Cruz, CA 95060

RE: APPROVE CONTRACT AMENDMENT FOR AIDS DRUG PROGRAM

Dear Board Members:

The Health Services Agency participates in the State's AIDS Drug Assistance Program (ADAP), which provides medications to qualifying individuals infected with HIV. This program is administered on behalf of the State by Professional Management Development Corporation (PMDC), a private pharmacy benefits contractor. Under an existing agreement, the County is reimbursed by PMDC for ADAP medications dispensed through HSA's pharmacies. The attached amendment revises the reimbursement formula, resulting in a higher level of reimbursement. There are no other changes in this agreement; these revenues are already included in the budget.

It is therefore RECOMMENDED that your Board:

1. Approve the attached amendment to the AIDS Drug Assistance Program (ADAP) and authorize the HSA Administrator to sign the amendment.

Sincerely,

Rama Khalsa, Ph.D., HSA Administrator

RECOMMENDED:

Susan A. Mauriello  
County Administrative Officer  
cc: County Administrative Office  
Auditor-Controller  
County Counsel  
HSA Administration  
HSA Clinic Administration

COUNTY OF SANTA CRUZ  
REQUEST FOR APPROVAL OF AGREEMENT

0138

TO: Board of Supervisors  
County Administrative Officer  
County Counsel  
Auditor-Controller

FROM: **HEALTH SERVICES AGENCY** (Dept.)  
Ran Klum (Signature) 6/6/00 (Date)

The Board of Supervisors is hereby requested to approve the attached agreement and authorize the execution of the same.

1. Said agreement is between the COUNTY OF SANTA CRUZ (Health Services Agency) (Agency)  
PROFESSIONAL MANAGEMENT DEVELOPMENT CORPORATION  
and, 1485 Baysgore Blvd., #54, San Francisco, CA 94124 (Name & Address)

2. The agreement will provide reimbursement for pharmacy services provided by the Health Services Agency's pharmacies as part of the AIDS Drug Assistance Program (ADAP).

**to provide for the above reimbursement.**

3. The agreement is needed, \_\_\_\_\_

4. Period of the agreement is from October 1, 1997 to June 30, 2000 (continuous)

5. Anticipated cost is \$ n/a - revenue agreement (Fixed amount; Monthly rate; Not to exceed)

6. Remarks: Amendment revising reimbursement formula.

7. Appropriations are budgeted in n/a - revenue agreement 361210 (Index#) 1674 (Subject)

NOTE: IF APPROPRIATIONS ARE INSUFFICIENT, ATTACH COMPLETED FORM AUD-74

Appropriations are available and have been encumbered. Contract No. R-663 Date 6/13/00  
one not will be  
N/A  
GARY A. KNUTSON, Auditor - Controller  
BY Ronald J. Silver Deputy.

Proposal reviewed and approved. It is recommended that the Board of Supervisors approve the agreement and authorize the HSA Administrator to execute the same on behalf of the County of Santa Cruz  
Health Services Agency (Agency).  
County Administrative Officer

Remarks: LG (Analyst) By Eh Sch Date 6/13/00

Agreement approved as to form. Date \_\_\_\_\_

- Distribution:  
Bd. of Supv. - White  
Auditor-Controller - Blue  
Counsel -   
Co. Admin. Officer - Canary  
Auditor-Controller - Pink  
Originating Dept. - Goldenrod

\*To Orig. Dept. if rejected.

State of California )  
County of Santa Cruz ) ss  
I \_\_\_\_\_ ex-officio Clerk of the Board of Supervisors of the County of Santa Cruz,  
State of California, do hereby certify that the foregoing request for approval of agreement was approved by  
said Board of Supervisors as recommended by the County Administrative Officer by an order duly entered  
in the minutes of said Board on \_\_\_\_\_ County Administrative Officer  
\_\_\_\_\_ 19 \_\_\_\_\_ BY \_\_\_\_\_ Deputy Clerk



# Professional Management Development Corporation

## PHARMACY PROVIDER CONTRACT MODIFICATION

### Section XIV Modifications, 14.1

This letter is a notice of modification of the existing contract between Professional Management Development Corporation (hereupon referred to as PMDC) and your agency, company, pharmacy or jurisdiction starting no sooner than July 1, 2000 or any date after July 1, 2000 that is acceptable to PMDC (or at the discretion of PMDC.)

The following modifications are to be implemented:

Page 13 of the existing contract will be formatted as a new signature page updated and identified as page 13A (enclosed).

Compensation (Attachment A) will be formatted as a new version and identified as **Attachment A1**.

Provider Pharmacy:

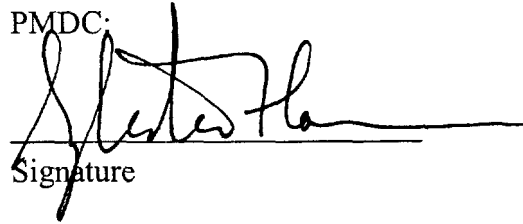
\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

PMDC:

  
\_\_\_\_\_  
Signature

SYLESTER FLOWERS  
\_\_\_\_\_  
Printed Name

Program Director, CEO  
\_\_\_\_\_  
Title

5-15-00  
\_\_\_\_\_  
Date



# SIGNATURE PAGE

PMDC PROVIDER SERVICES : (888) 311 - 7632  
FAX : (800) 848 - 4241

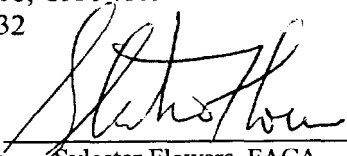
California ADAP

0140

**IN WITNESS WHEREOF**, the parties have caused this Agreement to be executed by their respective officers, duly authorized to do so, effective as of the dates stated below.

## PROFESSIONAL MANAGEMENT DEVELOPMENT CORPORATION

Corporate Office  
1255 Post St., Suite 1110  
San Francisco, CA 94109  
888-313-7632

Signature:   
Sylester Flowers, FACA

Date: 5-18-08

Title: Program Director/Chief Executive Officer

Provider: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

NABP: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Telephone No.: ( ) \_\_\_\_\_ x \_\_\_\_\_

Fax No.: ( ) \_\_\_\_\_

Email Address: \_\_\_\_\_



**Professional Management Development Corporation**

PROVIDER SERVICES: 888-311-7632

FAX : 800-848-4241

PMDC

# Section

## PROVIDER QUESTIONNAIRE DATA SHEET

0141

15.4, Exhibit A, of the Contract gives you the option to provide a list of pharmacies within your organization, either in this printed format or an electronic file. Please follow the format listed to supply information to us that is shared with the PROGRAM SPONSORS. Only service information, such as hours of operation, delivery etc. will be supplied to clients. \*\* Please photocopy if additional sheets are needed.

NABP # \_\_\_\_\_ FED. TAX ID # \_\_\_\_\_ CA LISC.# \_\_\_\_\_

PHARMACY NAME : \_\_\_\_\_

ADDRESS : \_\_\_\_\_

CITY: \_\_\_\_\_ STATE : \_\_\_\_\_ ZIP: \_\_\_\_\_

COUNTY: \_\_\_\_\_ PHONE ( ) - - e - n - - - -

FAX ( ) \_\_\_\_\_ - \_\_\_\_\_

PHARMACY HOURS OF OPERATION:	
Monday – Friday :	_____
Saturday:	_____
Sunday:	_____
Holidays:	_____
Total Hours per week:	<input type="text"/>

CONTACT NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

Please check services provided below

Free Rx Delivery  Delivery - Fee Required  Free Mail Order  Mail Order – Fee Required

Compounding Specialty \_\_\_\_\_ % of Rx Activity List any other specialty : \_\_\_\_\_

Home Infusion \_\_\_\_\_ % of Rx Activity \_\_\_\_\_

HIV Specialty \_\_\_\_\_ % of Rx Activity \_\_\_\_\_

Please identify your Primary Wholesaler (s) : \_\_\_\_\_

Are you a contract pharmacy that receives, stores, dispenses and maintains an inventory of drugs purchased under provisions of Section 340 B of the PHS Act. Yes \_\_\_\_\_ No \_\_\_\_\_

**Complete the Public Health Program Declaration below if you checked "yes".**

**PUBLIC HEALTH PROGRAM DECLARATION:**

( Identify the entity you contract with. )

Entity Name : \_\_\_\_\_

Contact Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number : ( ) - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Z i p : \_\_\_\_\_

I certify that reasonable safeguards are in place to assure compliance with the provisions of Section 340B of the PHS Act that prohibits drug diversion, resale or transfer.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_



# Professional Management Development Corporation

## Pharmacy Provider Agreement

### ATTACHMENT A-1

Implementation Date July 1, 2000

0142

Compensation:

PMDC will review and adjust reimbursement schedules following a 30-day evaluation of points accrued from ratings and scope of services listed below, conducted in June of each year.

Your reimbursement (dispensing fees plus ingredient costs) will be the lowest of your usual and customary charge to the general public; or calculated at the appropriate Basic or Enhanced Service Reimbursement Schedule below.

Minimum points required for Basic Reimbursement Schedule [3 points]		Minimum points required for Enhanced Reimbursement Schedule [10 points]	
Inset initial	Point value	Inset initial	Point value
<input type="checkbox"/> Client access to prescription service not less than 40 hours per week (not including on-call)	2	<input type="checkbox"/> Client access to prescription service GREATER than 40 hours per week (not including on-call)	3
<input type="checkbox"/> New provider or ADHERENCE at or below program average rating	0	<input type="checkbox"/> ADHERENCE rating greater than the program average rating	4
<input type="checkbox"/> Delivery or mail service provided with or without a fee	1	<input type="checkbox"/> Delivery or mail service provided with or without a fee	1
<input type="checkbox"/> Client REFILL NOTICES generated, mailed, e-mailed, paged or telephoned routinely when due	4	<input type="checkbox"/> Client REFILL NOTICES generated, mailed, e-mailed, paged or telephoned routinely when due	4
<input type="checkbox"/> Emergency on-call service available 7 days per week	1	<input type="checkbox"/> Emergency on-call service available 7 days per week	1
<input type="checkbox"/> Compounding specialty service provided	1	<input type="checkbox"/> Compounding specialty service provided	1
<input type="checkbox"/> Home infusion preparation	2	<input type="checkbox"/> Home infusion preparation	2
<input type="checkbox"/> Dose packs (bubble packs) prepared without a fee to client	2	<input type="checkbox"/> Dose packs (bubble packs) prepared without a fee to client	2
Maximum Total <b>13</b>		Maximum Total <b>18</b>	
YOUR TOTAL <input type="text"/>		YOUR TOTAL <input type="text"/>	
<b>BASIC SERVICE REIMBURSEMENT SCHEDULE (NETWORK CODE 1008)</b> a. *BRAND products for each of your pharmacies in this category will be reimbursed at AWP - 28.25% + \$3.00 fee, or b. **Multiple source GENERIC products (including BRAND dispensed as GENERIC) will be reimbursed at AWP - 30.00% + \$2.50 fee		<b>ENHANCED SERVICE REIMBURSEMENT SCHEDULE (NETWORK CODE 2008)</b> a. *BRAND products for each of your pharmacies in this category will be reimbursed at AWP - 28.00% + \$3.00 fee, or b. **Multiple source GENERIC products (including BRAND dispensed as GENERIC) will be reimbursed at AWP - 30.00% + \$2.50 fee	

PROVIDER NABP: \_\_\_\_\_

PROVIDER NAME: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

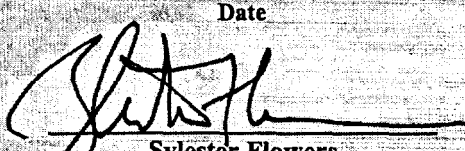
PRINTED NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_

**ADAP Program Administration**

5-15-00  
Date

  
**Sylvester Flowers**  
Program Director, Chief Executive Officer

- Redbook Product Category Codes: 01, 04, 05, 07, 10
- \*\* Redbook Product Category Codes: 02, OS, 09