COUNTY OF SANTA CRUZ

HEALTH SERVICES AGENCY
ADMINISTRATION

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.)

Ron Klein (Signature) 6/6/00 (Date)

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

1. Said agreement is between the COUNTY OF SANTA CRUZ (Health Services Agency) (Agency)
and,, PROFESSIONAL MANAGEMENT DEVELOPMENT CORPORATION
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).

3. The agreement is needed, to provide for the above reimbursement.

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 (Subobject)

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

Appropriations ~~are~~ / ~~are not~~ N/A available and ~~have been~~ / ~~will be~~ encumbered. Contract No. R-663 Date 6/13/00

GARY A. KNUTSON, Auditor - Controller

By Ronald J. Silva Deputy.

Proposol 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).

Remarks:

(Analyst)

County Administrative Officer

By Ed Shelton Dote 6/13/00

Agreemtnt approved as to form. Date _____

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

*To Orig. Dept. if rejected.

AUD - 25 (6/95)

32

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 _____ 19 ____

County Administrative Officer

By _____ Deputy Clerk

Professional Management Development Corporation

PMDC

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 Al.**

Provider Pharmacy:	PMDC:
_____	_____
Signature	Signature
_____	SYLESTER FLOWERS
Printed Name	Printed Name
_____	Program Director, CEO
Title	Title
_____	5-15-00
Date	Date:

SLnet/data/stae99-2000/rxcont/sec14mod

SIGNATURE PAGE

PMDC

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 I 110
San Francisco, CA 94109
888-313-7632

Signature: _____ Date: 5-16-00
Sylester Flowers, FACA

Title: Program Director/Chief Executive Officer

Provider: NABP: _____

_____

_____

_____

_____

Signature: _____ Date: _____

Printed Name: _____ Title: _____

Telephone No.: ( ) _____ x _____ Fax No.: ( ) _____

Email Address: _____

Professional Management Development Corporation

PMDC

Section

PROVIDER SERVICES: 888-311-7632
FAX : 800-848-4241

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: ☐

CONTACT NAME: _____

TITLE: _____

Please check services provided below

☐ **Free Rx Delivery** 0 **Delivery - Fee Required** ☐ **Free Mail Order** 0 **Mail Order – Fee Required**

Compounding Specialty % of **Rx** Activity

Home Infusion ____ % of Rx Activity

HIV Specialty ____ **% of** Rx Activity

List any other specialty : _____

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 _____ N o _____

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

PMDC

Pharmacy Provider Agreement

ATTACHMENT A-l

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 [IO points]		
Inset initial		Point value	Insert initial		Point value
	Client access to prescription service not less than 140 hours per week (not including on-call)	2		Client access to prescription service GREATER than 40 hours per week (not including on-call)	3
	New provider or ADHERENCE' at or below program average rating	0		ADHERENCE rating greater than the program average rating	4
	Delivery or mail service provided with or without a fee	1		Delivery or mail service provided with or without a fee	1
	Client REFILL NOTICES generated, mailed, e-mailed, paged or telephoned routinely when due	4		Client REFILL NOTICES generated, mailed, e-mailed, paged or telephoned routinely when due	4
	Emergency on-call service available 7 days per week	1		Emergency on-call service available 7 days per week	1
	Compounding specialty service provided	1		Compounding specialty service provided	1
	Home infusion preparation	2		Home infusion preparation	2
	Dose packs (bubble packs) prepared without a fee to client	2		Dose packs (bubble packs) prepared without a fee to client	2
	Maximum Total	13		Maximum Total	18
YOUR TOTAL			YOUR TOTAL		

BASIC SERVICE REIMBURSEMENT SCHEDULE (NETWORK CODE 1008)	ENHANCED SERVICE REIMBURSEMENT SCHEDULE (NETWORK CODE 2008)
a. *BRAND products for each of your pharmacies in this category will be reimbursed at AWP – 28.25% + $3.00 fee, or	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	b. **Multiple source GENERIC products (including BRAND dispensed as GENERIC) will be reimbursed at AWP – 30.00% + $2.50 fee

FROVIDER NABP: _____

F ROVIDER NAME: _____

S IGNATURE: _____

PRINTED NAME: _____

"ITLE: _____

DATE: _____

ADAP Program Administration

5-15-00

Date

Sylester Flowers
Program Director, Chief Executive Officer

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