# 340B Pharmacy Program

**OPS.510**

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| Approved By: | Chief Operating Officer | Effective Date: | 10/27/2014 |
| Distribution: | | Revision Date(s): | |
| | | Last Revised: | 10/27/2014 |
| | | Retired Date: | N/A |

## PURPOSE:

As a participant in the 340B Drug Pricing Program created by Section 340B of the Public Health Service Act of 1992, ODCHC has instituted a contract pharmacy model, that assures the availability of low priced medications for our patients, while using the additional savings to expand services and assure access for our patient population.

## POLICY:

1. ODCHC will meet with all 340B eligibility requirements:
    a. ODCHC is deemed a Federally Qualified Health Center
    b. ODCHC receives HRSA Funds
    c. ODCHC is listed as a covered entity on the Office of Pharmacy Affairs (OPA) website and maintains complete and accurate listings of all sites and contract pharmacies.
2. ODCHC will comply with all requirements and restrictions of the 340B Public Service Act and any accompanying regulations or guidelines including, but not limited to the prohibitions against duplicate discounts/rebates under Medi-Cal diverting medication to another non-340B entity.
3. ODCHC will maintain auditable records of the 340B program in both paper and electronic form.
4. ODCHC will perform yearly financial audits.
5. ODCHC will perform monthly compliance audits of the 340B program insuring that all prescriptions filled under this program meet the criteria for an eligible transaction including:
    a. Provider is either an employee, has a contractual or other relationship with ODCHC.
    b. Patient is an active patient with current medical record in the electronic medical record system.
    c. The pharmacy is a contracted pharmacy and listed on the OPA website.
    d. ODCHC will not bill Medi-Cal fee for service for any medications, but will refer the patient to a contract pharmacy for all prescription needs.

## PROTOCOL:

ODCHC follows all procedures outlined in the 340B Program Manual located in the Pharmacy Coordinators office or on the S-drive.

### Responsible Staff

CEO

- Acts as the principal officer in charge for the compliance and administration of the program.
- Responsible for attesting to the compliance of the program through the yearly recertification process.

COO

- Accountable agent for 340B compliance. Ensures current policy statements and procedures are in place to maintain program compliance.
- Maintains knowledge of the policy changes that impact the 340B program which includes, but not limited to, HRSA/OPA rules and Medi-Cal changes.
- Assure compliance with 340B program requirements of qualified patients, drugs, providers, vendors, payers and locations

CFO

- Agent of CEO responsible to administer the 340B program to fully implement and optimize savings.
- Oversees the Senior Financial Analyst in reconciling all statement from 340b vendors and suppliers.

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- Establishes accounts with appropriate vendors.
- Reconciles and reports on all savings generated by the 340B program.
- Oversees yearly financial audits.

**Pharmacy Coordinator**

- Day to day manager of the program
- Responsible for maintenance and testing of tracking software
- Responsible for documentation of policy and procedures
- Maintain system databases to reflect changes in the drug formulary or product specifications
- Manage purchasing, receiving and inventory with Pharmacy Benefits Management Company.
- Assure appropriate safeguards and system integrity
- Review and refine 340B cost savings report detailing purchasing, and replacement practices, as well as dispensing patterns
- Monitor ordering processes, integrating most current pricing from wholesaler, analyze invoices, shipping and inventory processes.
- Conduct monthly internal audits of all contracted pharmacies.
- Reports unusual or unanticipated findings to CEO, COO and CFO.

**Approved:**

Cheyenne Spetzler
Chief Operations Officer