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Report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

June 2005

MAIL ORDER PHARMACIES

DOD's Use of VA's Mail Pharmacy Could Produce Savings and Other Benefits

GAO-05-555

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Highlights

Highlights of GAO-05-555, a report to the Chairman, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

There has been long-standing congressional interest in whether the Department of Defense (DOD) could use the Department of Veterans Affairs (VA) Consolidated Mail Outpatient Pharmacy (CMOP) system as a cost-effective alternative to beneficiaries picking up outpatient refill prescriptions at DOD military treatment facilities (MTF). To evaluate this possibility, DOD and VA conducted a pilot program in fiscal year 2003 in which a VA CMOP provided outpatient pharmaceutical refill services to DOD beneficiaries served through three MTFs. GAO was asked to estimate cost savings that could be achieved if DOD used VA's CMOP instead of MTF pharmacies for outpatient refill prescriptions, and what other benefits were achieved at the three pilot sites.

To estimate potential cost savings and determine what other benefits were achieved, GAO reviewed pilot and pharmacy program documentation and interviewed DOD and VA officials responsible for purchasing and dispensing drugs. GAO also compared drug and administrative costs of dispensing outpatient refills through the fiscal year 2003 pilot program with the costs of dispensing the refills at the three DOD MTFs that participated in the pilot.

www.gao.gov/cgi-bin/getrpt?GAO-05-555.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cynthia A. Bascetta at (202) 512-7101.

What GAO Found

DOD could achieve savings if it used VA's CMOP to dispense its outpatient refill prescriptions by taking advantage of VA's generally lower drug prices. Based on the drugs dispensed through the pilot, GAO estimated that the three MTFs that participated in the CMOP pilot program in fiscal year 2003 could have saved about $1.39 per prescription in drug costs, or a total of about $1.5 million, if the MTFs moved all their refill prescriptions to the CMOP. However, while DOD saved money on drug costs at the pilot MTFs, these savings were offset because DOD paid administrative costs for refill operations twice—first to pay VA for the administrative costs charged by the CMOP and second to maintain outpatient pharmacy refill operations at the MTFs. Consequently, achieving savings would require closing MTF outpatient pharmacy refill operations to offset CMOP administrative expenses.

In addition to demonstrating that financial savings are possible, the pilot produced nonmonetary benefits. MTF officials reported benefits such as reduced automobile traffic congestion and shorter pharmacy waiting times because many civilian beneficiaries at the pilot sites no longer came to MTFs to pick up refill prescriptions. Further, DOD beneficiaries who participated in the pilot program reported satisfaction with the CMOP's accurate and timely distribution of pharmaceuticals.

There are other potential cost implications for DOD if it decides to close MTF outpatient refill pharmacies and move the workload to the VA CMOP. Because DOD beneficiaries are allowed to choose among various options for obtaining drugs, they would be able to obtain their drugs from retail pharmacies and DOD's mail order pharmacy instead of the CMOP. These options, however, are more costly for DOD than having beneficiaries obtain their drugs from the CMOP. Consequently, if DOD closes the outpatient refill pharmacies at the pilot sites with the expectation that beneficiaries would use the CMOP and they did not, DOD's costs could increase. Any cost increases will challenge DOD to find more efficient ways to manage its pharmacy benefits program, such as by encouraging beneficiaries to choose the most cost-effective options for where they obtain their drugs.

We provided a draft of this report to VA and DOD for comment. VA said that it concurred with the draft report and DOD said that it was technically accurate but neither explicitly concurred nor nonconcurred.

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Abbreviations

CMOP	Consolidated Mail Outpatient Pharmacy
DOD	Department of Defense
FSS	federal supply schedule
MHS	military health system
MTF	military treatment facility
PDTS	pharmacy data transaction service
POS	point of service
TMA	TRICARE Management Activity
VA	Department of Veterans Affairs

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Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

June 22, 2005

The Honorable Michael Bilirakis
Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

In fiscal year 2004, the Department of Defense (DOD) dispensed over 100 million prescriptions to about 6 million health care beneficiaries.[1] These beneficiaries picked up their drugs at military treatment facilities (MTF) or at retail pharmacies, or had them delivered through DOD's mail order program. About 19 million of the prescriptions were refill prescriptions that were dispensed at MTF outpatient pharmacies. These drugs cost DOD about $840 million. During that year, active duty military personnel and their dependents[2] accounted for 14 percent of MTF 30-day outpatient refill prescriptions; 85 percent were for civilians, mainly retired military personnel and their dependents.[3]

While DOD dispenses most prescriptions at MTFs, the Department of Veterans Affairs (VA) uses a different approach to dispense prescriptions for its beneficiaries. It dispenses most of its prescriptions through a system of seven Consolidated Mail Outpatient Pharmacies (CMOP) that mail prescriptions to VA beneficiaries. There has been long-standing congressional interest in whether VA's CMOP could be a cost effective alternative for DOD beneficiaries instead of picking up outpatient refill

[1]In fiscal year 2004, DOD served about 9 million health care beneficiaries, of which about 6 million received prescriptions.

[2]This figure includes service academy students, active duty beneficiaries who are transitioning from active duty as part of the Transitional Assistance Management Program, and foreign military members.

[3]About 84 percent of DOD MTFs' 30-day outpatient pharmacy refills were for retired military personnel (now civilians) and their dependents, and 1 percent was for other civilians, such as non-active duty Medal of Honor recipients, or their dependents. DOD reported that the remaining 1 percent of recipients was unknown.

prescriptions at MTFs.[4] Due, in part, to this congressional interest, DOD and VA conducted a pilot program during fiscal year 2003 to determine the feasibility of using one CMOP to provide outpatient pharmacy refill services free of charge to DOD beneficiaries who received prescriptions at three participating MTFs. You asked us to report on the results of the pilot program, specifically, what estimated cost savings could be achieved if DOD used VA's CMOP instead of MTF pharmacies for outpatient refill prescriptions, and what other benefits were achieved at the three pilot sites.

To estimate potential cost savings and determine what other benefits were achieved, we reviewed pilot and pharmacy program documentation and interviewed DOD and VA officials responsible for purchasing and dispensing drugs, including officials from the VA CMOP located in Leavenworth, Kansas, and each of the three DOD MTFs involved in the pilot—Darnall Army Community Hospital, Fort Hood, Texas (Fort Hood); the 377th Medical Group, Kirtland Air Force Base, New Mexico (Kirtland); and the Naval Medical Center San Diego, San Diego, California (San Diego). (See app. I for more information on our scope and methodology.) To assess the costs of the pilot, we considered two types of costs at each location—the costs of the drugs themselves and the administrative costs of dispensing them. For drug costs, we compared the costs of the drugs at the CMOP with the costs at the three MTFs. To make this comparison, we identified 90 of the drugs with the highest total costs out of the 1,397 drugs dispensed by the CMOP through the pilot. The 90 drugs that we included in our comparison accounted for 65 percent of total drug costs for the pilot program ($15.6 million), while the remaining drugs dispensed during the pilot accounted for 35 percent of total drug costs. To compare VA's costs with DOD's costs for the 90 drugs, we obtained the prices that the CMOP and MTFs paid for the drugs in June 2004 (see app. II) and applied these prices to the quantity of each drug dispensed during the pilot. To estimate costs for the remaining drugs dispensed during the pilot, we collected information on general differences in DOD and VA pricing that applies to all drugs. We combined estimated savings from the 90 drugs in

[4]For example, on May 25, 2000, the Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, conducted a hearing on joint procurement of drugs by DOD and VA. In his closing statement, the subcommittee chairman directed DOD and VA to explore the possibility of DOD using VA's CMOP. See also, GAO, *DOD and VA Health Care: Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars*, GAO/T-HEHS-00-121 (Washington, D.C.: May 25, 2000) and GAO, *DOD and VA Pharmacy: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs*, GAO-01-588 (Washington, D.C.: May 25, 2001).

our analysis and the remaining drugs to determine an estimate of drug cost savings during the pilot. During the pilot program, beneficiaries chose to have the CMOP fill a combined 47 percent of the prescription refills that usually would have been handled at the three pilot MTFs. To estimate the potential for savings if all prescription refills from the pilot MTFs were dispensed by the CMOP, we multiplied the savings per prescription estimated from the drugs dispensed through the pilot by the total number of refill prescriptions from the three pilot MTFs in fiscal year 2003—including those dispensed through the CMOP and those dispensed at the MTFs. For administrative costs, we collected information on the costs of personnel, equipment, supplies, and other aspects of dispensing outpatient refill prescriptions at the MTFs and compared them to the administrative cost of dispensing prescriptions through the CMOP. (See app. III.) We also compared the costs and services of the CMOP program with DOD's mail order program, the TRICARE Mail Order Pharmacy. (See app. IV.) To assess the reliability of DOD and VA data, we interviewed agency officials and tested the data for errors. We determined that the data were sufficiently reliable for our purposes. We conducted our work from April 2004 through May 2005 in accordance with generally accepted government auditing standards.

Results in Brief

DOD could achieve savings if it used VA's CMOP to dispense its outpatient pharmacy refill prescriptions by taking advantage of VA's generally lower drug prices. VA's prices for the 90 drugs in our cost comparison were generally lower than DOD's prices for the same drugs, based on June 2004 prices for the drugs dispensed during the pilot in fiscal year 2003. Using the estimated differences in price for the 1,397 drugs dispensed through the pilot, we estimate that the three pilot MTFs saved approximately $646,000, or about $1.39 per prescription, in fiscal year 2003. If these MTFs had fully utilized the pilot for all their outpatient refill prescriptions dispensed during fiscal year 2003—including those dispensed through the CMOP and those dispensed at the MTFs—savings could have been higher, potentially totaling $1.5 million if the MTFs achieved the same savings per prescription ($1.39) as estimated for the pilot. Additional drug cost savings would also be possible if the CMOP was made aware of and was able to use lower prices that DOD has negotiated for some drugs. However, while DOD saved money on drug costs at the pilot MTFs, these savings were offset because DOD paid administrative costs for refill operations twice—first to pay VA for the administrative costs charged by the CMOP and second to maintain outpatient pharmacy refill operations at the MTFs. Consequently, to realize savings from the cost of drugs, DOD would have to close its MTF outpatient pharmacy refill operations, as most of the

MTFs' dispensing costs are for personnel and equipment. In addition to demonstrating the potential for financial savings, the pilot produced nonmonetary benefits. For example, DOD beneficiaries who participated in the pilot program reported satisfaction with the CMOP's accurate and timely distribution of drugs. MTF officials reported benefits such as reduced automobile traffic congestion and shorter pharmacy waiting times because many civilian beneficiaries at the pilot sites no longer came to MTFs to pick up refill prescriptions. In addition, according to DOD officials, using the CMOP could allow military personnel to focus primarily on DOD's core mission to provide services for active duty beneficiaries and their families at the MTFs, consistent with DOD's goal to support military readiness.

We provided a draft of this report to DOD and VA for comment. VA said that it concurred with the draft report, and DOD said that it was technically accurate but neither explicitly concurred nor nonconcurred. DOD also included technical comments that we incorporated where appropriate. In addition, DOD raised some concerns with the information presented in the draft report such as the amount of refunds DOD expects to receive from drug manufacturers. We believe the information in our report supports the presentation of our findings.

Background

DOD's beneficiaries have four options for obtaining prescription drugs. They can pick them up directly from MTFs, network retail pharmacies, or nonnetwork retail pharmacies. They can also receive them in the mail through DOD's TRICARE Mail Order Pharmacy. DOD operates 536 pharmacies at 121 of its MTFs. Each MTF may have multiple pharmacies. For example, San Diego maintains satellite pharmacies at several locations in addition to its main pharmacy, which has a separate section that dispenses outpatient refill prescriptions. Fort Hood and Kirtland each maintain a separate pharmacy to dispense outpatient refill prescriptions, and Fort Hood maintains several satellite pharmacies at health care clinics. In addition to pharmacies at its MTFs, DOD contracts with Express Scripts, Inc., a private pharmacy benefits management company, to operate DOD's retail pharmacy program and its TRICARE Mail Order Pharmacy. For the retail system, Express Scripts has a network of over 54,000 retail pharmacies where DOD beneficiaries can pick up prescriptions; beneficiaries can also utilize nonnetwork pharmacies, that is, any retail pharmacy not in Express Scripts' network. For the TRICARE Mail Order Pharmacy, beneficiaries submit their prescriptions to Express Scripts, which dispenses and mails the drugs directly to the beneficiary. Civilian beneficiaries pay copayments for drugs obtained through the mail

or at retail pharmacies, but do not pay at MTFs. (See table 1.) Active duty service members do not pay copayments.

Table 1: Copayments for DOD Civilian Beneficiaries

Delivery option	Copayment	Supply
Military treatment facility	None	Up to 90 days
Retail network pharmacy	$3 generic; $9 brand	Up to 30 days
Retail nonnetwork pharmacy	Greater of $9 or 20 percent of total cost	Up to 30 days
TRICARE Mail Order Pharmacy	$3 generic; $9 brand	Up to 90 days

Source: DOD.

Note: Active duty service members do not pay copayments. For retail pharmacies and the TRICARE Mail Order Pharmacy, DOD has established a new copayment of $22 per prescription for drugs designated "non-formulary." For nonnetwork retail pharmacies, the copayment is the greater of $22 or 20 percent of total cost. As of April 27, 2005, DOD had designated three non-formulary drugs that are subject to the copayment. According to DOD officials, drugs that are designated "non-formulary" are not available at MTFs.

For most drugs, all four options are available to DOD beneficiaries regardless of where they obtain health care services. For example, a beneficiary can obtain a prescription from a private or military physician and then choose to have the prescription filled at an MTF, a network or nonnetwork retail pharmacy, or the TRICARE Mail Order Pharmacy. However, DOD's cost differs considerably depending on the delivery option the beneficiary chooses. (See table 2.)

Table 2: DOD Outpatient Prescription Drug Costs, Fiscal Year 2004

Delivery option	Cost to DOD	Number of 30-day prescriptions	Average DOD cost per 30-day prescription
MTF pharmacies	$1,703,728,991[a]	78,572,443	$21.68
Network and nonnetwork retail pharmacies	$2,430,383,288[b]	39,879,525	$60.94
TRICARE Mail Order Pharmacy	$546,040,968[b]	16,890,727	$32.33

Source: DOD.

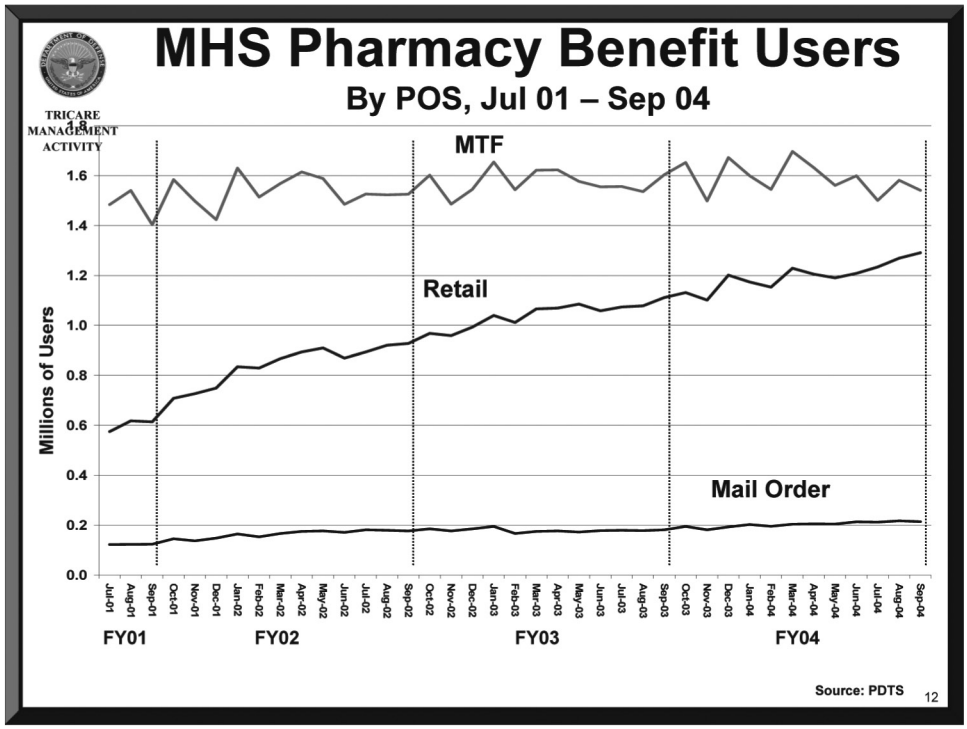
[a]Includes only drug costs because beneficiaries at MTFs are not subject to copayments and because DOD generally does not separate administrative costs related to dispensing prescriptions from other administrative costs at its MTFs.

[b]DOD's drug costs after adjusting for administrative fees and beneficiary copayments.

DOD's average cost per 30-day prescription varies among the delivery options for a number of reasons, including differences in the price of drugs dispensed in each system, copayments, and administrative costs of dispensing the drugs. For example, DOD does not receive federal discounts when beneficiaries obtain drugs through retail pharmacies, so DOD's costs for purchases at retail pharmacies are generally higher than at MTFs or through the TRICARE Mail Order Pharmacy.[5] The administrative cost of dispensing drugs is not included in the MTF costs, but according to DOD officials, MTFs remain the least expensive of the three systems. However, an increasing number of DOD beneficiaries have chosen in recent years to use retail pharmacies (see fig. 1), which is DOD's most expensive delivery option.

[5]DOD has begun the process of seeking refunds from manufacturers who supply drugs to DOD beneficiaries through retail network pharmacies. In March 2005, the Coalition for Common Sense in Government Procurement, which includes drug manufacturers, filed a petition with the United States Court of Appeals for the Federal Circuit, seeking the court's review of an October 2004 letter from the VA directing that refunds be made to DOD.

Figure 1: Number of Outpatient Pharmacy Benefit Users, July 2001 through September 2004



Source: DOD.

Note: This figure shows which of the three points of service (POS) for drugs in the military health system (MHS)—MTF, Retail, and DOD's TRICARE Mail Order Pharmacy—that beneficiaries chose to use from fiscal years 2001 through 2004. The MHS has three missions: (1) maintaining the health of active-duty service personnel; (2) medically supporting military operations; and (3) providing care to the dependents of active duty personnel, retirees and their families, as well as to survivors and their dependents. The information in the figure was compiled by DOD from its pharmacy data transaction service (PDTS).

VA CMOP

As part of its pharmacy system, VA operates a mail pharmacy program, the CMOP, which uses automated equipment to dispense and mail prescriptions to beneficiaries. VA operates seven CMOP facilities, which dispensed about 88 million prescriptions in fiscal year 2004. In that year, CMOP facilities dispensed 76 percent of all VA prescriptions, including over 95 percent of refill prescriptions. Most of the remaining prescriptions were dispensed through pharmacies at VA's hospitals and clinics. VA beneficiaries generally do not have the option to obtain prescriptions at retail pharmacies.

DOD and VA Drug Procurement Practices

DOD and VA have a number of drug procurement options available to them that can result in differences in drug prices. For example, DOD and VA have access to discounted drug prices through the federal supply schedule (FSS). The FSS is maintained by VA's National Acquisition Center and is available to all federal purchasers. All FSS prices, regardless of which federal agency purchases the drug, include a fee of 0.5 percent of the price to fund the National Acquisition Center's activities. DOD and VA also have access to federal ceiling prices, which are mandated by law to be 24 percent lower than nonfederal average manufacturer prices.[6] For some drugs, DOD and VA negotiate, through national contracts or other agreements, prices that are even lower than FSS or federal ceiling prices. Generally, DOD and VA negotiate these contracts and agreements jointly, in which case they both pay the same price for the drug. However, when VA or DOD negotiates contracts and agreements separately, the two agencies may pay different prices for the same drug. In a few cases, individual VA medical centers or DOD MTFs have obtained lower prices through local purchase agreements with manufacturers than they could have through the national contracts, FSS, or federal ceiling prices. Differences in DOD and VA prices can also occur when the departments order the same drug in different package sizes or from different manufacturers.

Two other factors account for the departments paying different prices for the same drugs. First, both DOD and VA use prime vendors, which are drug distributors, to purchase drugs from manufacturers and deliver them to DOD or VA facilities. As of June 2004, VA used one prime vendor, while DOD used five prime vendors, each one servicing different geographic areas. Both departments receive discounts from their prime vendors that further reduce the prices that DOD and VA pay for drugs. For DOD, the

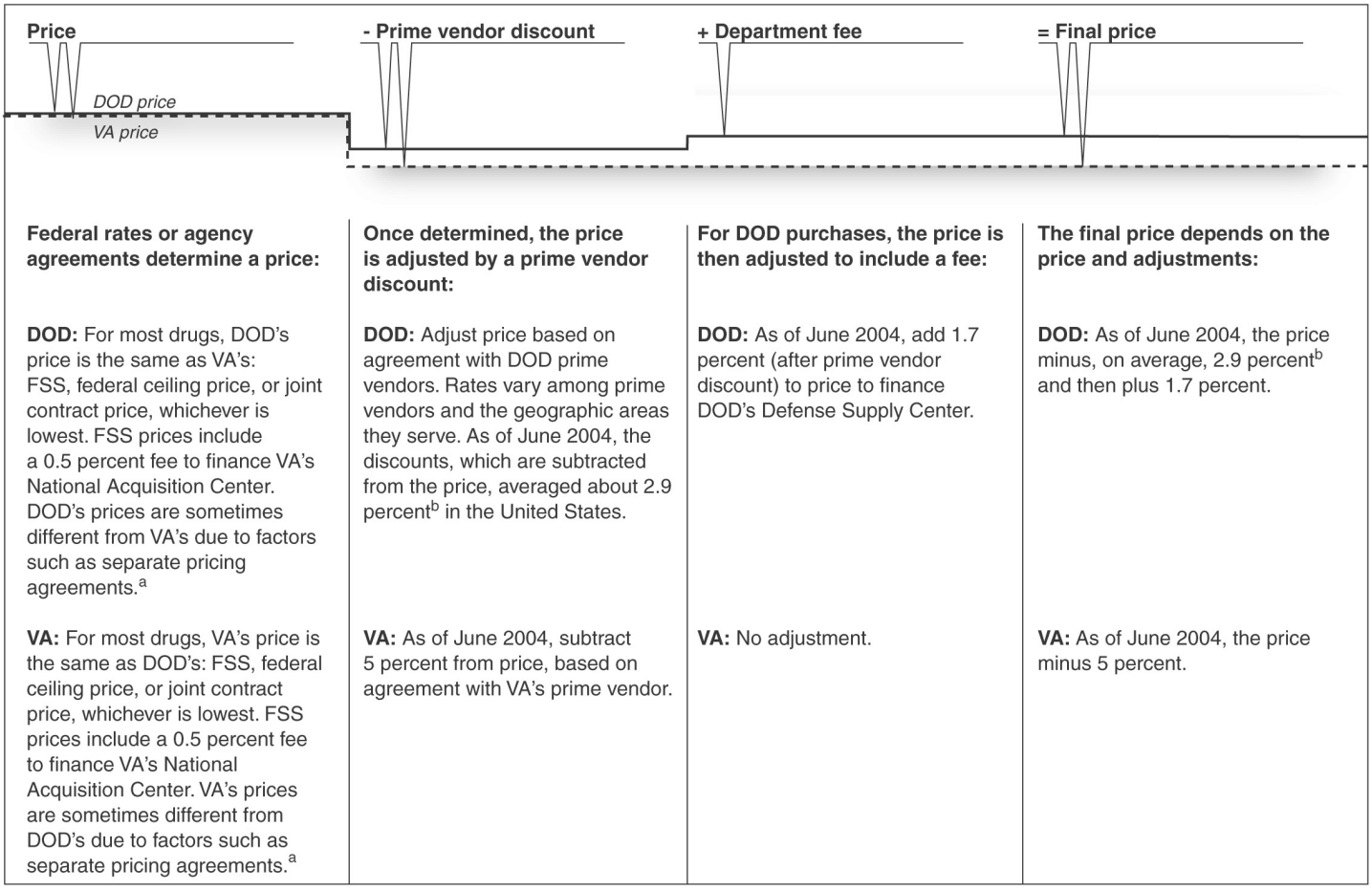
[6] *See* 38 U.S.C. § 8126(a)(2) (2000). In addition to DOD and VA, the Public Health Service and the Coast Guard have access to federal ceiling prices. The nonfederal average manufacturer price, used to set the federal ceiling price, is the weighted average price of a single form and dosage unit paid by wholesalers to a manufacturer, taking into account cash discounts or similar price reductions. Federal ceiling prices, in general, do not apply to generic drugs.

discounts vary among prime vendors and the areas they serve.[7] As of June 2004, VA's prime vendor discount was 5 percent, while DOD's discounts averaged about 2.9 percent within the United States. Discounts from the prime vendors serving the three pilot MTFs averaged about 3 percent. Second, the price of drugs purchased directly by DOD facilities or the TRICARE Mail Order Pharmacy included a 1.7 percent fee to fund the Defense Supply Center's activities.[8] Figure 2 shows the various components of DOD and VA drug prices.

[7]Both departments have negotiated these discounts, known as negative distribution fees, with their prime vendors. The prime vendors can offer DOD and VA these discounts because the vendors generate profits in the following three ways: First, prime vendors generally can earn interest on funds from the time they receive payment to when they pay manufacturers. Second, combining purchases for their government and commercial customers, prime vendors use leverage to negotiate discounts from drug manufacturers. Third, according to a DOD official, prime vendors sometimes purchase large quantities of drugs in advance of manufacturer price increases, a practice that manufacturers are beginning to limit.

[8]The Defense Supply Center Philadelphia, part of the Defense Logistics Agency, supplies and manages drugs, medical supplies, food, clothing, and textiles for DOD.

Figure 2: Components of Final DOD and VA Drug Prices as of June 2004



Federal rates or agency agreements determine a price:	Once determined, the price is adjusted by a prime vendor discount:	For DOD purchases, the price is then adjusted to include a fee:	The final price depends on the price and adjustments:
DOD: For most drugs, DOD's price is the same as VA's: FSS, federal ceiling price, or joint contract price, whichever is lowest. FSS prices include a 0.5 percent fee to finance VA's National Acquisition Center. DOD's prices are sometimes different from VA's due to factors such as separate pricing agreements.[a]	**DOD:** Adjust price based on agreement with DOD prime vendors. Rates vary among prime vendors and the geographic areas they serve. As of June 2004, the discounts, which are subtracted from the price, averaged about 2.9 percent[b] in the United States.	**DOD:** As of June 2004, add 1.7 percent (after prime vendor discount) to price to finance DOD's Defense Supply Center.	**DOD:** As of June 2004, the price minus, on average, 2.9 percent[b] and then plus 1.7 percent.
VA: For most drugs, VA's price is the same as DOD's: FSS, federal ceiling price, or joint contract price, whichever is lowest. FSS prices include a 0.5 percent fee to finance VA's National Acquisition Center. VA's prices are sometimes different from DOD's due to factors such as separate pricing agreements.[a]	**VA:** As of June 2004, subtract 5 percent from price, based on agreement with VA's prime vendor.	**VA:** No adjustment.	**VA:** As of June 2004, the price minus 5 percent.

Source: GAO.

[a]Differences in price also occur when the departments order the same drug in different package sizes or from different manufacturers, or when individual facilities use local purchase agreements.

[b]Discounts from the prime vendors serving the three pilot MTFs averaged about 3 percent.

Pilot Program for DOD Use of VA's CMOP

During fiscal year 2003, DOD and VA conducted a pilot program to assess the feasibility of dispensing outpatient refill prescriptions for DOD beneficiaries using a VA CMOP. Under the program, the CMOP in Leavenworth, Kansas, dispensed prescriptions for three DOD MTFs—Fort Hood, Kirtland, and San Diego. Using automated phone systems for ordering prescription refills—already in place at the three pilot MTFs—beneficiaries chose whether to have each prescription refilled at the CMOP or at the MTF. Once a beneficiary chose the option to have the

CMOP dispense a refill, the prescription was electronically transmitted from the MTF to the CMOP. The CMOP then purchased drugs—or used drugs already in inventory—to dispense each prescription. The CMOP mailed each refill prescription directly to the beneficiary. After sending the refill prescription, the CMOP sent a report of its activity back to the MTF, which maintained responsibility for patient care.

During the pilot program, the VA CMOP distributed only prescription refills—no original prescriptions and no controlled substances—to DOD beneficiaries, although the CMOP routinely dispenses them for VA beneficiaries. The TRICARE Management Activity (TMA)[9] paid both drug and administrative costs of the pilot program to VA during fiscal year 2003. DOD beneficiaries did not pay a copayment or any other charge for the drugs they received from the CMOP, the same as if they had obtained the drugs at an MTF.

As of April 2005, two of the three MTFs, San Diego and Kirtland, continued to have prescriptions filled through the VA CMOP. Fort Hood ended its CMOP participation at the end of fiscal year 2003 when TMA informed the three MTFs that it would not fund administrative or drug costs for CMOP-dispensed drugs in fiscal year 2004. TMA later decided to pay administrative costs, so, for fiscal year 2004, San Diego and Kirtland paid only drug costs.

In fiscal year 2003, during the pilot program, beneficiaries chose to have the VA CMOP fill a combined 47 percent of the prescription refills that usually would have been handled at the three pilot site MTFs. In fiscal year 2004 at San Diego and Kirtland, the two sites that continued CMOP participation, beneficiaries chose to have the CMOP fill a combined 65 percent of the outpatient pharmacy refill prescriptions. The remaining outpatient refill prescriptions were dispensed by MTF pharmacies.

[9]The TRICARE Management Activity manages DOD's health care system.

DOD Could Realize Financial Savings and Nonmonetary Benefits by Using VA's CMOP

DOD could achieve savings by taking advantage of VA's generally lower drug prices if it used the VA CMOP to dispense its outpatient pharmacy refill prescriptions. Estimated savings from the 90 drugs included in our price comparison plus estimated savings from the other drugs dispensed in the pilot during fiscal year 2003 total $646,000, or about $1.39 per prescription. Additional savings would also be possible if the CMOP were made aware of and used lower prices that DOD has negotiated for some drugs. However, achieving savings would require closing MTF outpatient pharmacy refill operations to offset CMOP administrative expenses. In addition to demonstrating that financial savings are possible, the pilot produced nonmonetary benefits such as providing high-quality service as indicated by measurements of beneficiary satisfaction and rates of accurate and timely distribution of drugs, reducing automobile traffic congestion and pharmacy wait times, and freeing DOD resources for its core mission of supporting military readiness.

DOD Can Save on Drug Costs by Using the CMOP

Our analysis showed that June 2004 VA CMOP drug prices were generally lower than prices at the DOD MTFs. Based on the differences in drug prices that existed in June 2004, we estimate that for these 90 drugs the three pilot sites produced savings during fiscal year 2003 for DOD of about $437,000, or about 4 percent. For these drugs, the estimated savings averaged $2.74 per prescription. We estimated these savings by comparing the June 2004 prices that the CMOP and DOD paid for 90 of the drugs with the highest total costs that were dispensed at Fort Hood, Kirtland, and San Diego by the CMOP during the fiscal year 2003 pilot program. (See app. I for the methodology we used to select these drugs.)

These drugs comprised 65 percent of total drug costs in the pilot. We did not obtain individual prices for the drugs that comprised the remaining 35 percent of pilot drug expenditures. Therefore, we do not know what, if any, specific differences exist in DOD's and VA's prices for these drugs. However, general differences in DOD and VA drug purchasing apply to all the drugs. As of June 2004, VA received a 5 percent price discount from its prime vendor, and the three pilot MTFs received price discounts averaging 3 percent from their prime vendors. In addition, DOD's Defense Supply Center charged a fee of 1.7 percent for MTF drug purchases. These differences amount to VA's drug prices being about 3.7 percent lower than DOD's. Applying a 3.7 percent reduction to the remaining 35 percent of drug expenditures yields overall estimated savings of about $209,000, which amounts to $0.69 per prescription for the drugs in the pilot that were not included in our analysis.

We estimate that the combined savings from the 90 drugs and the other drugs dispensed through the pilot in fiscal year 2003 total $646,000, making VA's total drug costs during the pilot approximately 3.9 percent less than DOD costs, or approximately $1.39 less per prescription. If the three MTFs had been able to achieve the same savings per prescription and had fully utilized the pilot for all their outpatient refill prescriptions in fiscal year 2003—including those dispensed through the CMOP and those dispensed at the MTFs—drug cost savings during fiscal year 2003 could have been about $1.5 million.

DOD could have realized even greater savings if the VA CMOP were made aware of and used DOD's lower negotiated price for some drugs. About 15 percent of the prices for the 90 drugs in our price comparison were more expensive for DOD MTFs when purchased through the VA than if they had been acquired through DOD purchase agreements. For example, MTFs involved in the pilot paid an average of $0.64 in June 2004 for each 30 mg capsule of lansoprazole, a drug that stops production of stomach acid and is prescribed for conditions such as gastroesophageal reflux disease, based on an agreement with the drug's manufacturer. When ordering through the CMOP, however, the pilot sites paid a higher price for lansoprazole—$1.77 per capsule in June 2004—which was based on the FSS price. DOD could obtain the lower prices it has negotiated, according to CMOP officials, if the MTFs ordered these drugs through their prime vendors at DOD prices and had them delivered to the CMOP for distribution to DOD patients. Another way to achieve lower drug prices, they said, would be for MTFs to obtain rebates from drug manufacturers for the difference between the CMOP price and the lower DOD price. For example, San Diego began to use this process in fiscal year 2004. Officials at the MTF expect to receive rebates from drug manufacturers of over $300,000 for drugs purchased during the first quarter of fiscal year 2005. Based on our comparison of June 2004 drug prices for the 90 drugs in our analysis, we estimate that if DOD's lower prices had applied to the 15 percent of those drugs with lower prices at the MTFs than at the CMOP—either by MTFs having the drugs delivered to the CMOP through their prime vendors or obtaining rebates from drug manufacturers—DOD would have saved an additional $500,000 in drug costs during fiscal year 2003.

Cost Savings Depend on Closing MTF Outpatient Refill Operations

Since DOD beneficiaries chose to use the VA CMOP for 47 percent of their outpatient refill prescriptions in fiscal year 2003, the MTFs' refill workload was not eliminated. For example, the three MTFs dispensed about 79,000 refill prescriptions in September 2002, the month before the pilot began,

and dispensed about 37,000 prescriptions in September 2003, during the pilot. The outpatient refill workload that remained at the MTFs required that the MTF outpatient pharmacy refill operations remain open and maintain personnel and equipment to dispense refills. Because most of the MTFs' costs of dispensing refills are for personnel and equipment, according to officials at the three MTFs, the decreased workload did not lead to a proportional decrease in costs.

For dispensing drugs through the VA CMOP during the pilot, DOD agreed to pay the CMOP's average administrative cost, which includes the cost to mail prescriptions to beneficiaries. Because of a change in the way the CMOP computed administrative costs in fiscal year 2003, DOD paid VA $2.36 prior to July 2003 and $2.27 from July 2003 to the end of the fiscal year, on average per prescription to cover these costs.[10] These costs include VA's average administrative costs to fill each prescription of $1.34 prior to July 2003 and $1.24 from July 2003 to the end of the fiscal year, plus mailing costs of $1.02 and $1.03, respectively. We estimate that DOD's administrative costs at the three MTFs were about $2.31 per refill prescription—roughly equal to the administrative costs of obtaining refill prescriptions through the CMOP and mailing them to beneficiaries.[11] Consequently, closing MTF outpatient pharmacy refill operations would offset CMOP administrative expenses and yield drug cost savings for DOD from its use of the CMOP.[12] (See app. III for a calculation of DOD's and VA's administrative cost.)

Use of CMOP Provided Nonmonetary Benefits to DOD

The pilot also produced nonmonetary benefits. Based on VA's measurements of beneficiary satisfaction and rates of prescription accuracy and timeliness, the VA CMOP provided high-quality service to

[10]Before July 2003, the costs of individual CMOP facilities were funded separately. In the case of the DOD pilot, the MTFs paid based on the costs of only the Leavenworth CMOP. Beginning in July 2003, the CMOP changed the way it allocated costs by charging a blended rate based on the costs of all seven CMOP facilities.

[11]Since we could not obtain comparable cost information for fiscal year 2003 from each of the pilot sites, we used different time periods to estimate annual administrative costs for each of the three pilot MTFs. We used San Diego cost information from fiscal year 2002, Kirtland cost information from fiscal year 2003, and Fort Hood cost information from calendar year 2004.

[12]If MTFs close their outpatient refill operations, MTFs could continue to dispense outpatient refill prescriptions at their main pharmacies or at other pharmacies at the facilities.

DOD beneficiaries. However, because the pilot MTFs and the CMOP used different methods for measuring accuracy and because DOD did not conduct satisfaction and timeliness surveys for the three pilot MTFs, we could not make a meaningful comparison between the two dispensing options.

Regarding the VA CMOP's performance for fiscal year 2003, 97 percent of DOD beneficiaries surveyed by VA rated their overall satisfaction with the services it provided as excellent or very good. This rate is even higher than the 91 percent of surveyed VA patients who rated the CMOP's performance as excellent or very good in that year. In addition, for fiscal year 2003, the CMOP reported that more than 99.9 percent of its prescriptions were accurately dispensed, meaning that beneficiaries received the correct medications in the correct amounts, with no damage or labeling problems. Finally, the CMOP was able to deliver drugs to DOD beneficiaries on average in 3.5 days from the time the prescription was requested to the time it was received by the patient. To put VA's delivery time in some perspective, a company that has one of the country's largest private mail order pharmacy operations estimates that its customers typically receive their mail order refill prescriptions in 3 to 5 days.

Another benefit, reported by DOD officials, was that use of the VA CMOP helped reduce the number of civilians coming to military installations. Because most prescriptions dispensed at MTFs were for civilian retirees and their dependents (see table 3), using the CMOP to dispense some of the prescriptions helped reduce facility overcrowding. For example, San Diego and Fort Hood officials reported less crowding and shorter waiting times at their MTF pharmacies during the pilot, and San Diego officials reported less automobile traffic congestion and fewer parking shortages. In addition, a Fort Hood official reported that after the CMOP pilot was terminated, lines at the main pharmacy got very long and beneficiaries had to wait 2 or more hours to have prescriptions dispensed. Moreover, these officials told us that using the CMOP could fill a critical need during times of heightened security because civilian beneficiaries might have difficulty getting onto military installations to pick up their prescriptions at MTF pharmacies.

Table 3: MTF Outpatient Refills, Fiscal Year 2003

Beneficiary type	Number of 30-day prescriptions	Percentage of total prescriptions	Drug cost[a]	Percentage of total drug cost
Active duty and their dependents[b]	4,302,836	12	$124,063,735	17
Retirees and their dependents[c]	29,155,884	84	558,064,896	78
Other civilians and their dependents	396,951	1	8,270,558	1
Unknown	780,108	2	22,575,907	3
Totals	**34,635,780**	**100**	**$712,975,097**	**100**

Source: DOD.

Note: Columns may not add to totals due to rounding.

[a]These figures include only drug costs; administrative costs of dispensing drugs are not included.

[b]This category includes service academy students, active duty beneficiaries who are transitioning from active duty as part of the Transitional Assistance Management Program, and foreign military members.

[c]Retirees and dependents are considered civilians.

According to DOD officials, using the VA CMOP could allow DOD pharmacy staff to focus on DOD's core mission of supporting military readiness by serving the pharmacy needs of active duty members and their dependents. They said that the pilot, to the extent that it moved civilian workload away from MTFs, was consistent with DOD's emphasis on having military personnel support military readiness. If a greater percentage of MTFs' workload was moved to the CMOP, then MTFs could have additional flexibility to focus on military readiness needs. In addition, DOD officials told us that transferring the outpatient refill pharmacy workload to the CMOP could help in other ways, such as allowing the department more flexibility to redeploy pharmacy staff to clinical services.

Concluding Observations

The pilot demonstrated that DOD could achieve cost savings at very high levels of beneficiary satisfaction by delivering drugs to beneficiaries using the CMOP rather than MTF outpatient refill operations. Additional cost savings could be realized if the CMOP were made aware of and used lower prices that DOD had negotiated for some drugs. However, DOD savings are dependent on closing the refill portion of its MTF pharmacy operations to avoid paying MTF administrative costs for refills in addition to administrative costs charged by the VA CMOP. While DOD's use of the CMOP is a significant opportunity for DOD to achieve savings and expand its sharing of resources with VA, there are other cost implications that could become important if MTF refill operations were closed with the expectation that beneficiaries would use the CMOP. Specifically, rather than obtaining drugs from the CMOP, beneficiaries might choose instead

to obtain their drugs from a more costly option for DOD, such as retail pharmacies. Any cost increases will challenge DOD to find more efficient ways to manage its pharmacy benefits program, such as by encouraging beneficiaries to choose the most cost-effective options for where they obtain their drugs.

Agency Comments and Our Evaluation

We received written comments from DOD and VA on a draft of this report. VA concurred with our draft report. VA stated that our report would benefit from a discussion of market pressures that control the cost of generic drugs. However, these pressures were reflected in our work that focused on the lowest prices VA and DOD could secure, which included purchasing generic drugs. VA's written comments are reprinted in appendix V.

DOD made an overall comment that our report was technically accurate. It made additional comments that we address below.

One comment concerned our characterization of refunds from drug manufacturers. During our audit work DOD pharmacy officials told us that they expect that manufacturer refunds will cover only a small portion of the difference in cost between retail and MTF prices, and we included this information in our draft report. However, in its letter providing the agency's comments, DOD commented that this statement is inaccurate and misleading, so we removed it from the report.

DOD also commented that the 1.7 percent fee charged on DOD drug purchases should be considered in the context that it supports DOD's readiness mission. Specifically, DOD stated that reducing the amount of drugs upon which the fee is paid would cost DOD "somewhere else" to support the mission. We disagree, and based on our findings, we believe that more money would be available for DOD's use by using VA's CMOP. For example, drugs purchased during the pilot by VA's CMOP were about 3.9 percent less than if they had been purchased by the MTFs.

In addition, DOD stated that it is not correct that DOD would always realize a savings on the acquisition cost of a drug by using the VA CMOP. We noted in the draft report that we found VA's prices to be generally, but not always, lower than DOD's. We noted that in some cases drugs were more expensive for DOD MTFs when purchased through the VA than if they had been acquired through DOD purchase agreements, and that additional cost savings could be realized if the CMOP used these lower prices that DOD had negotiated for some drugs.

DOD stated that it is unlikely that it could move all refill prescriptions to the CMOP, and asserted that GAO recommended closing all MTF refill services and providing them only to active duty members. However, our report makes no such recommendation. Although cost savings through the CMOP are dependent on closing MTF outpatient pharmacy refill operations, we noted in the draft report that MTFs could continue to dispense outpatient refill prescriptions at MTF main pharmacies. As noted in the draft report, in fiscal year 2003, during the pilot program, 47 percent of the prescription refills that usually would be handled at the three pilot MTFs were dispensed at the CMOP. In fiscal year 2004 at San Diego and Kirtland, the two sites that continued CMOP participation, program participation increased as the CMOP filled 65 percent of the outpatient pharmacy refill prescriptions. Determining whether to encourage beneficiaries to use the most cost-effective dispensing method, which would assure that savings are achieved while continuing to provide high-quality pharmacy service to beneficiaries, is part of DOD's responsibility to manage its pharmacy program in a fiscally sound manner.

DOD agreed that the pilot produced other benefits, such as reducing facility traffic congestion, but further stated that our reference to "civilian beneficiaries" could be misinterpreted to include beneficiaries not currently covered, and should be defined as "retiree beneficiaries." We believe that our use of the term "civilian beneficiaries" is appropriate because, as DOD's data show, 85 percent of MTF 30-day outpatient refill prescriptions in both fiscal years 2003 and 2004 were for retirees and their dependents, and other civilians and their dependents.

DOD also commented that patient choice as a DOD pharmacy benefit is a lawful entitlement. According to DOD, it cannot mandate DOD beneficiaries to utilize one option over another, and such a restriction would require legislative action. We note, however, that DOD has taken action to influence beneficiary behavior to choose one option over another option, for example, by increasing copayment amounts to help it manage the pharmacy benefit and control costs. DOD's pharmacy benefit regulations state that "the higher cost-share paid for prescriptions dispensed by a non-network retail pharmacy is established to encourage the use of the most economical venue to the government."[13] This type of action demonstrates fiscal responsibility on DOD's part while it strives to provide cost-effective pharmacy services to its beneficiaries.

[13]32 C.F.R. § 199.21(i) (2004).

Finally, DOD stated that we assumed that current options are more costly for DOD than having beneficiaries obtain their drugs from the CMOP, and that this was a subjective conclusion. We based our conclusion on our finding that the CMOP's drug costs during the pilot were approximately 3.9 percent lower than the costs for the same drugs at the three pilot MTFs. In addition, we found that the administrative costs for dispensing refill prescriptions were about the same at the MTFs and at the CMOP. And, as noted in the draft report, the CMOP's drug costs and administrative costs were lower than the drug and administrative costs for DOD's TRICARE Mail Order Pharmacy.

DOD also included technical comments that we incorporated where appropriate. DOD's written comments are reprinted in appendix VI.

As we agreed with your office, unless you publicly announce the contents of this report earlier, we plan no further distribution of it until 30 days from the date of this letter. We will then send copies to the Secretaries of Veterans Affairs and Defense, and relevant congressional committees. We will also make copies available upon request. In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me on (202) 512-7101 or Michael T. Blair, Jr. on (404) 679-1944. William Simerl and Richard Wade made key contributions to this report.

Sincerely yours,

Cynthia Bascetta

Cynthia A. Bascetta
Director, Health Care

Appendix I: Scope and Methodology

To address our objective, we compiled information on the operations of the Department of Defense (DOD) and the Department of Veterans Affairs (VA) Consolidated Mail Outpatient Pharmacy (CMOP) pilot program, and we compared the costs of purchasing and dispensing drugs at the CMOP that dispensed drugs for the pilot with the costs at the pilot military treatment facilities (MTF).

To compile information on the pilot program and on related aspects of DOD's and VA's pharmacy programs, we conducted site visits, reviewed program documentation, and interviewed DOD and VA officials responsible for purchasing and dispensing drugs. We interviewed or collected documentation from

- officials at the VA CMOP involved in the pilot located in Leavenworth, Kansas, including the national CMOP director;
- officials at each of the three DOD MTFs involved in the pilot—Darnall Army Community Hospital, Fort Hood, Texas (Fort Hood); the 377th Medical Group, Kirtland Air Force Base, New Mexico (Kirtland); and the Naval Medical Center San Diego, San Diego, California (San Diego);
- DOD pharmacy officials, including the director of DOD pharmacy programs and pharmacy officials for the Air Force, Army, and Navy;
- officials at DOD's Pharmacoeconomic Center; and
- officials at VA's National Acquisition Center and DOD's Defense Supply Center, responsible for procurement of drugs.

To compare the drug costs at the VA CMOP and the participating MTFs, we selected 90 of the drugs with the highest total expenditures dispensed through the pilot during fiscal year 2003. These 90 drugs, due to high volume, high unit cost, or both, comprised about 65 percent of total drug costs for the pilot. To select drugs for our analysis, we first identified the 100 drugs with the highest total expenditures dispensed through the pilot in fiscal year 2003. We then obtained available price information for June 2004 purchases of these drugs at the CMOP in Leavenworth, Kansas and the three MTFs that participated in the pilot. We used June 2004 prices for each drug because DOD and VA officials told us that June 2004 data were the most reliable data available. According to the officials, because drugs can have many different prices throughout the year, obtaining DOD prices that can be accurately compared to the full range of prices that VA paid for drugs throughout fiscal year 2003 was not feasible.

We evaluated the quality of the drug pricing data by checking for missing and inconsistent values and interviewing agency officials, including those from VA's CMOP, VA's National Acquisition Center, DOD's

Pharmacoeconomic Center, and DOD's Defense Supply Center. Based on these interviews and on documentation obtained from the officials, we considered differences between DOD and VA drug prices caused by separate pricing agreements, differences in prime vendor discounts, differences in fees to fund drug procurement, differences in drug package sizes, and, for some drugs, differences in manufacturers.

We eliminated drugs from our analysis in cases where differences in the prices for them at the various locations could not be explained by these factors, in cases where DOD officials believed the drug pricing to be erroneous, or in cases where June 2004 drug pricing was unavailable. After eliminating these drugs, 90 of our original 100 drugs remained. We also adjusted for differences in DOD and VA unit measurements to ensure that the unit prices were comparable to each other.

We estimated VA CMOP drug costs during fiscal year 2003 for each of the 90 drugs by multiplying the CMOP's June 2004 unit price by the number of units dispensed by the CMOP for each MTF during fiscal year 2003. Using the same method for costs at the three MTFs—multiplying MTF June 2004 unit prices by the number of units dispensed by the CMOP for each MTF during fiscal year 2003—we estimated the amount that the three DOD MTFs would have spent on the same drugs. The difference between VA's and DOD's total estimated costs for the 90 drugs during fiscal year 2003 is our estimate of savings for these drugs during the pilot. In cases where no units of a drug were ordered through the pilot by an MTF during fiscal year 2003, the price of that drug at that location was not included in our comparison.

We did not obtain individual prices for the drugs that comprise the remaining 35 percent of pilot drug expenditures. Therefore, we do not know what, if any, differences exist in the VA's and DOD's prices for these drugs. For these drugs, we estimated differences in drug prices as of June 2004 based on differences in prime vendor discounts and the fee charged by DOD's Defense Supply Center, which are general differences in DOD and VA drug pricing that apply to all drugs.

To compare the administrative costs of dispensing refill prescriptions at the CMOP with the costs at MTFs participating in the pilot, we collected cost information from program officials and evaluated it to ensure that it was comparable to the costs from the other sites. Although DOD generally does not separate information on MTF administrative costs, we were able to obtain this information for refill prescriptions at the three MTFs. Our cost comparison included the costs of personnel, equipment, supplies,

space, utilities, and other aspects of refill operations. Although precise cost information was not always available, we reviewed the information and interviewed officials at each site to determine that it was sufficiently reliable for the purposes of our cost comparison.

Because moving refill workload to the CMOP without decreasing fixed costs could inflate the average MTF administrative cost per prescription, we used the best available information to estimate the per prescription administrative costs for dispensing refill prescriptions at the three DOD MTFs as if the CMOP pilot did not exist. For Fort Hood, we obtained information on administrative costs for calendar year 2004 after officials had discontinued use of the CMOP and reorganized the outpatient refill pharmacy to separate it from the main pharmacy in January 2004. For Kirtland, we obtained cost information for fiscal year 2003. Although the pilot was operating during this time, Kirtland officials indicated that they had not changed any fixed costs, such as personnel or equipment, due to the pilot. To estimate the number of refill prescriptions that the Kirtland pharmacy would have filled if the CMOP pilot had not been operating, we added the number of outpatient refill prescriptions filled through the CMOP for Kirtland beneficiaries to the number of outpatient refill prescriptions dispensed at the Kirtland pharmacy. Because the operating costs for Kirtland were incurred while the number of MTF prescriptions was lower due to the CMOP operation, we had to adjust the variable costs to correspond with the higher number of prescriptions that the MTF would have dispensed without the CMOP. Therefore, we used the total number of outpatient refill prescriptions that the Kirtland pharmacy would have filled if the CMOP pilot had not been operating to estimate variable costs, such as bottles, labels, and other supplies. We also used this total number of prescriptions when determining the overall average cost of dispensing refill prescriptions at the MTFs. San Diego has been participating in the CMOP program since the start of fiscal year 2003, and has made changes to its pharmacy operations, such as changes to staffing, due to CMOP use. To estimate the cost of refill prescriptions without influence from the CMOP pilot, San Diego officials provided us with information on costs and the number of refill prescriptions from fiscal year 2002, before the pilot began operation. Appendix III contains the information we obtained from the pilot sites and VA to estimate MTF and CMOP administrative costs.

To compare the VA CMOP with DOD's TRICARE Mail Order Pharmacy, we interviewed or obtained documentation from officials at VA's CMOP; VA's National Acquisition Center; DOD's Defense Supply Center; DOD's Pharmacoeconomic Center; and the TRICARE Mail Order Pharmacy contractor, Express Scripts, Inc. To compare drug costs between the

CMOP and the TRICARE Mail Order Pharmacy, we selected the 100 drugs with the highest total costs dispensed during the first year of the TRICARE Mail Order Pharmacy program (March 2003-February 2004). Next, we obtained June 2004 prices for these drugs for the CMOP and the TRICARE Mail Order Pharmacy. We used June 2004 prices for each drug to ensure comparability since drug prices can vary significantly over time, and because DOD and VA officials told us that June 2004 data were the most reliable data available. We eliminated 11 drugs from our comparison because prices were unavailable or due to inconsistencies in the data that we could not explain. We compared prices for each of the remaining 89 drugs, adjusting for differences in VA's and DOD's drug data, such as unit measurement differences. To estimate annual cost differences for the drugs in our comparison, we multiplied the June 2004 DOD and VA unit prices by the number of units ordered for each drug during the first year of the TRICARE Mail Order Pharmacy program, from March 2003 to February 2004.

We conducted our work from April 2004 through May 2005 in accordance with generally accepted government auditing standards.

Appendix II: Average Drug Prices Included in Cost Comparison, June 2004

	June 2004 price per unit			
Drug	VA Leavenworth CMOP	Darnall Army Community Hospital, Ft. Hood	377th Medical Group, Kirtland Air Force Base	Naval Medical Center San Diego
accu-chek comfort curve-h test strip	$0.32	$0.33		
albuterol 90mcg/ipratropium 18mcg 200 dose inhaler	$23.91	$24.18	$24.35	$24.36
alendronate 10mg	$0.78			$0.80
alendronate 35mg	$5.50	$5.60	$5.65	$6.84
alendronate 70mg	$5.48	$5.63	$5.64	$6.19
amlodipine besylate 10mg	$1.23	$0.88	$0.88	$0.88
amlodipine besylate 2.5mg	$0.80		$0.83	$0.83
amlodipine besylate 5mg	$0.78	$0.80	$0.81	$0.81
anastrozole 1mg	$4.21	$4.35		$4.38
atorvastatin calcium 10mg	$1.28	$1.33		$1.34
atorvastatin calcium 20mg	$1.92	$1.99		$2.00
atorvastatin calcium 40mg	$2.07	$2.13		$2.15
atorvastatin calcium 80mg	$2.06	$2.13		$2.14
brimonidine tartrate 0.15% solution	$4.01	$4.10	$4.13	$4.18
bupropion (wellbutrin SR) 150mg	$0.98	$1.01	$1.02	$1.02
carvedilol 25mg	$0.97	$1.00		$1.01
celecoxib 100mg	$0.91		$0.85	$0.94
celecoxib 200mg	$1.53	$1.59	$1.40	$1.60
cetirizine HCL 10mg	$0.92	$0.95	$0.95	$0.95
citalopram hydrobromide 20mg	$1.18	$1.22	$1.22	$1.23
citalopram hydrobromide 40mg	$1.17	$1.22	$1.22	$1.23
clopidogrel bisulfate 75mg	$2.19	$2.27	$2.26	$2.29
diltiazem (tiazac) 240mg	$1.03		$0.98	
divalproex 250mg (delayed release)	$0.49	$0.51	$0.54	$0.52
donepezil hydrochloride 10mg	$2.20			$2.28
donepezil hydrochloride 5mg	$2.20	$2.27		$2.28
efavirenz 600mg	$8.00			$8.32
epoetin alfa 10,000 units/ml	$51.97			$76.00
estrogens, conjugated 0.625mg	$0.42	$0.43	$0.44	$0.44
etanercept 25mg/vial	$85.53	$88.28		$88.94
fexofenadine 60mg/pseudoephedrine 120mg	$0.78		$0.81	$0.81
fexofenadine hydrochloride 180mg	$1.35	$0.83	$0.84	$0.84

Drug	June 2004 price per unit			
	VA Leavenworth CMOP	Darnall Army Community Hospital, Ft. Hood	377th Medical Group, Kirtland Air Force Base	Naval Medical Center San Diego
fexofenadine hydrochloride 60mg	$0.77	$0.80	$0.79	$0.79
fluconazole 200mg	$7.40			$7.69
fluticasone propionate 110mcg 120 dose inhaler	$41.83	$43.18	$43.48	$43.50
fluticasone propionate 220mcg 120 dose inhaler	$61.62	$63.59	$64.04	$64.07
fosinopril sodium 10mg	$0.36		$0.49	$0.48
fosinopril sodium 20mg	$0.31		$0.45	$0.30
fosinopril sodium 40mg	$0.30		$0.49	$0.47
gabapentin 300mg	$0.74	$0.76	$0.77	$0.77
gabapentin 600mg	$1.48	$1.53	$1.54	$1.49
insulin lispro 100 units/ml	$30.37	$31.34		$31.58
insulin glargine 100 units/ml	$24.74	$25.54	$25.72	$25.73
interferon beta-1a 30mcg/vial	$166.19	$171.53		
ipratropium bromide 18mcg 200 dose inhaler	$16.63	$16.83	$16.94	$16.95
irbesartan 150mg	$0.50	$0.51	$0.52	$0.78
irbesartan 300mg	$0.50	$0.51	$0.52	$0.61
lamivudine 150mg	$2.99	$3.09		$3.11
lamivudine 150mg/zidovudine 300mg	$6.44	$6.65		$6.70
lansoprazole 30mg	$1.77	$0.64	$0.64	$0.64
latanoprost 0.005% solution	$11.59	$7.09	$7.13	$10.07
lisinopril 20mg	$0.10	$0.26	$0.57	$0.10
meloxicam 15mg	$0.94	$0.97	$0.97	$0.97
mesalamine 400mg	$0.53	$0.54	$0.55	$0.55
mometasone furoate 50mcg 120 dose nasal inhaler/ spray	$23.55	$35.67	$35.92	$35.93
montelukast sodium 10mg	$1.63	$1.68	$1.69	$1.69
montelukast sodium 5mg	$1.62	$1.68	$1.68	$1.70
mycophenolate mofetil 250mg	$1.53	$1.60		$1.60
nifedipine 30mg	$0.33	$0.34	$0.35	$0.35
omeprazole 20mg	$0.39	$2.39		$2.41
ortho tri-cyclen 28 pack	$11.62	$11.99		
ortho-cyclen 28 pack	$11.26	$11.63		
paroxetine hydrochloride 20mg	$0.80	$1.33	$0.82	$0.83
paroxetine hydrochloride 40mg	$0.88		$0.89	$1.04
precision xtra (glucose) test strip	$0.31		$0.32	$0.32

	June 2004 price per unit			
Drug	VA Leavenworth CMOP	Darnall Army Community Hospital, Ft. Hood	377th Medical Group, Kirtland Air Force Base	Naval Medical Center San Diego
prempro 0.625mg/2.5mg, 28 pack	$18.24	$11.85	$11.93	$11.76
rabeprazole 20mg	$0.62	$0.64	$0.65	$0.65
raloxifene hydrochloride 60mg	$1.44	$1.49	$1.50	
risperidone 1mg	$1.72	$1.74	$1.72	$1.75
rofecoxib 25mg	$1.30	$1.37	$1.24	$1.45
rosiglitazone maleate 8mg	$2.77	$2.12	$2.14	$2.14
salmeterol 21mcg 120 dose inhaler	$42.35	$43.71	$44.02	$44.04
sertraline hydrochloride 100mg	$1.19	$1.41	$1.42	$1.42
sertraline hydrochloride 50mg	$1.15	$1.41	$1.42	$1.42
sildenafil citrate 100mg	$4.64	$5.54	$5.58	$5.59
sildenafil citrate 50mg	$4.51	$5.47		$5.51
simvastatin 10mg	$0.25	$0.26	$0.26	$0.26
simvastatin 20mg	$0.43	$0.44	$0.44	$0.44
simvastatin 40mg	$0.64	$0.66	$0.67	$0.67
simvastatin 80mg	$0.87	$0.89	$0.90	$0.90
sumatriptan succinate 6mg/0.5ml statdose	$65.59		$68.17	$68.21
sumatriptan succinate 50mg	$9.73	$4.44	$4.47	
tacrolimus 1mg	$1.79	$1.85		$1.86
tamoxifen citrate 10mg	$0.19	$0.68	$0.19	$0.19
tamsulosin hydrochloride 0.4mg	$1.08	$1.03	$1.04	$1.04
tenofovir disoproxil fumarate 300mg	$7.84	$8.09		$8.15
topiramate 100mg	$1.93	$1.99		$2.01
triamcinolone 100mcg 240 dose inhaler	$36.79	$37.97	$38.24	$38.26
ursodiol 300mg	$1.30	$1.24		$1.25
venlafaxine hydrochloride 75mg	$1.42	$1.47	$1.48	$1.48

Source: GAO analysis of DOD and VA data.

Note: These prices are the average final prices paid by the Leavenworth CMOP and three MTFs during June 2004, including prime vendor discounts and fees for DOD's Defense Supply Center and VA's National Acquisition Center. In some cases, drug prices do not appear in this table because we eliminated them from our analysis for a number of reasons. For example, the MTF did not dispense the drug through the fiscal year 2003 pilot, or DOD officials believed the drug price was erroneous.

Appendix III: Components of Administrative Costs

Table 4: Estimated Annual Administrative Cost for MTF Outpatient Refill Operations

Naval Medical Center San Diego (estimates for fiscal year 2002)	Estimated annual cost
Pharmacists and technicians	$928,661
Equipment lease	$192,000
Supplies (including containers and labels)	$81,623
Other	
Courier contract	$17,132
Utilities	$57,016
Housekeeping	$18,329
Communications	$30,429
Information services	$23,507
377th Medical Group, Kirtland Air Force Base (estimates for fiscal year 2003)	
Pharmacist and technicians	$275,308
Equipment	$25,922
Supplies (including containers and labels)	$1,671
Other	
Utilities	$1,747
Custodial maintenance	$2,192
Fire and police	$312
Darnall Army Community Hospital, Fort Hood (estimates for calendar year 2004)	
Pharmacy technicians	$588,482
Equipment	$75,028
Supplies (including containers and labels)	$33,671
Other	
Utilities	$12,000
Administrative support	$24,500
Total estimated annual cost of operations to dispense 1,036,549 refill prescriptions	$2,389,530
Average administrative cost to fill each prescription	**$2.31**

Source: GAO analysis of DOD data.

Note: See appendix I for how we obtained these estimates.

Table 5: Average Administrative Cost Per Prescription for VA CMOP, Fiscal Years 2003 and 2004

	Average cost per prescription		
	October 2002-June 2003	July 2003-September 2003	Fiscal year 2004
Category	**Leavenworth CMOP**	**CMOP System**	**CMOP System**
Personnel	$0.78	$0.72	$0.71
General operation	$0.44	$0.41	$0.42
Inventory upgrades	$0.12	$0.11	$0.06
Information technology upgrades			$0.10
National initiatives			$0.01
Average administrative cost to fill each prescription	**$1.34**	**$1.24**	**$1.31**
Mail	$1.02	$1.03	$1.04
Total cost to deliver each prescription	**$2.36**	**$2.27**	**$2.35**

Source: VA.

Note: These costs are the average costs charged to DOD in fiscal years 2003 and 2004. Before July 2003, the VA charged DOD based on costs at the Leavenworth CMOP. Beginning in July 2003, the VA charged based on the average costs of all seven CMOP facilities. Costs of individual categories may not add to totals due to rounding.

Appendix IV: Services and Costs of VA's CMOP and DOD's TRICARE Mail Order Pharmacy

	VA CMOP	DOD TRICARE Mail Order Pharmacy
Operated by	VA	Express Scripts, Inc.
Services provided	Under VA's system, the CMOP shares responsibility for pharmacy services with VA medical centers. The CMOP dispenses and mails prescriptions. VA medical centers provide other services, such as verifying patients' eligibility, providing customer service, or contacting providers and patients when necessary.	Under DOD's system, the TRICARE Mail Order Pharmacy handles the entire prescription-filling process, separate from pharmacies in DOD's military treatment facilities. In addition to dispensing and mailing prescriptions, the TRICARE Mail Order Pharmacy conducts activities such as verifying patients' eligibility in DOD's computer system, providing customer service, contacting providers or patients for additional information when necessary, and converting paper prescriptions to electronic format.
Number of prescriptions	77,876,597 (fiscal year 2003) 87,968,560 (fiscal year 2004)	5,472,583 (March 2003 through February 2004)
Average administrative cost per prescription	$2.24 per prescription (fiscal year 2003) $2.35 per prescription (fiscal year 2004)	$10.66 which included $10.20 per prescription and an average of $0.46 per prescription for customer service incentives (March 2003 through February 2004).
Estimated annual drug cost for 89 high-expenditure drugs, based on June 2004 prices and the quantities dispensed in the first year of TRICARE Mail Order Pharmacy operation[a]	$239 million	$265 million
Estimated drug cost per prescription for same 89 drugs based on estimated annual cost[a]	$107	$118
Copayment	For VA patients, $7 for up to 30 day supply. DOD beneficiaries did not pay a copayment or any other charge for the drugs they received from the CMOP, the same as if they had obtained the drugs at an MTF. VA does not charge copayments for medications to treat service-connected conditions, nor does it assign copayments to veterans with service-connected conditions rated 50 percent disabling or greater.	$3 generic; $9 brand for up to 90 day supply. Active duty service members do not pay copayments. DOD has established a new copayment of $22 per prescription for drugs designated "non-formulary." As of April 27, 2005, DOD had designated three non-formulary drugs that are subject to the copayment.
Customer satisfaction	VA's fiscal year 2003 customer satisfaction surveys indicated that 92 percent of all beneficiaries who responded rated the CMOP's services as excellent or very good. In the same surveys, 97 percent of DOD beneficiaries who responded rated the CMOP's services as excellent or very good.	DOD conducted four surveys of TRICARE Mail Order Pharmacy beneficiaries for the period of March 2003 through February 2004. TRICARE Mail Order Pharmacy program satisfaction rates for beneficiaries who responded ranged from 87 percent in the first of the surveys to 97 percent in the most recent of the four surveys.

	VA CMOP	DOD TRICARE Mail Order Pharmacy
Accuracy rate	VA reports that the CMOP accuracy rate exceeded 99.9 percent for fiscal year 2003.	Express Scripts reports that the TRICARE Mail Order Pharmacy accuracy rate exceeded 99.9 percent for the period from March 2003 through February 2004.

Source: GAO analysis of DOD and VA data.

[a]To estimate drug prices for the two programs, we selected the 100 drugs with the highest total costs dispensed during the first year of the TRICARE Mail Order Pharmacy (March 2003-February 2004). Next, we obtained June 2004 prices for these drugs for the CMOP and the TRICARE Mail Order Pharmacy. We eliminated 11 drugs from our comparison because prices were unavailable or due to inconsistencies in the data that we could not explain. For each of the remaining 89 drugs, we adjusted for differences in DOD's and VA's drug data, such as unit measurement differences. To estimate annual costs for the drugs in our comparison, we multiplied the June 2004 DOD and VA unit prices by the number of units ordered for each drug during the first year of the TRICARE Mail Order Pharmacy, from March 2003 to February 2004. For more information on our scope and methodology, see app. I. CMOP and TRICARE Mail Order Pharmacy drug prices can differ for a number of reasons, including separate contracts or other agreements with manufacturers, different prime vendor discounts negotiated by DOD and VA, and different DOD and VA fees for procuring drugs.

Appendix V: Comments from the Department of Veterans Affairs

THE DEPUTY SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 20, 2005

Ms. Cynthia A. Bascetta
Director, Health Care
U. S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Ms. Bascetta:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***MAIL ORDER PHARMACIES: DOD's Use of VA's Mail Pharmacy Could Produce Savings and Other Benefits,*** (GAO-05-555). VA concurs with GAO's report and provides additional comments in the enclosure.

VA appreciates the opportunity to comment on your draft report.

Sincerely yours,

Gordon H. Mansfield

Enclosure

Enclosure

DEPARTMENT OF VETERANS AFFAIRS (VA)
COMMENTS TO
GOVERNMENT ACCOUNTABILITY OFFICE (GAO) DRAFT REPORT,
MAIL ORDER PHARMACIES: DOD's Use of VA's Mail Pharmacy Could Produce Savings and Other Benefits
(GAO-05-555)

Comments:

The Department of Veterans Affairs (VA) concurs with the Government Accountability Office's (GAO) report and appreciates the efforts of GAO's staff in examining all aspects of the pilot program, including prescription processing costs, dispensing quality, and patient satisfaction.

It is important to note that of the 90 drug prices that GAO analyzed during this review, there were a few cases where significant differences existed on prices between what VA and the Department of Defense (DoD) each paid for specific drugs during June 2004. These differences do not reflect a failure by either department to purchase drugs wisely, but rather they reflect rational choices made by each department to use slightly different drugs within a therapeutic category.

VA also notes that the market pressure that controls the cost of generic drugs is a significant factor not discussed by GAO in the draft report. Although a large portion of VA's costs are directed to the purchase of single source pharmaceuticals, the report would benefit from a discussion of these market pressures.

The Department is proud of the prescription fulfillment services at VA's Consolidated Mail Outpatient Pharmacy (CMOPs) are providing to VA and DoD beneficiaries. VA remains focused on continually improving the ecomomic and technical quality of the CMOP program and for assuring prescription fulfillment services continue to provide high quality and cost effective service long into the future.

Appendix VI: Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

MAY 25 2006

Ms. Cynthia A. Bascetta
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Ms. Bascetta:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) draft report GAO-05-555, "MAIL ORDER PHARMACIES: DOD's Use of VA's Mail Pharmacy Could Produce Savings and Other Benefits," dated May 4 (GAO Code 290368).

DoD has received and reviewed the draft report and has found it to be technically accurate. Although the draft report has no recommendations, DoD would like to comment on the following points.

On page five, table one, the cost shares in the different venues are listed, however, they do not include the cost share for non-formulary drugs in the retail non-network pharmacies and should be added. Also, on the same page, footnote five says we have "....begun the process of obtaining rebates from manufactures who supply drugs for the retail pharmacy program...." but the term "rebate" should be changed to "refund" and the statement should be clarified to state it is for network retail pharmacies only. Furthermore, the footnote states, "....However, officials expect that these rebates will cover only a small portion of the difference in cost between retail and MTF prices...." This statement is inaccurate and misleading in that the purpose of these refunds from manufacturers is to reduce the difference between current prices charged in the TRICARE retail network and the federal price for these same drugs to which DoD is entitled.

On page eight and 11, the GAO discusses the difference in the Department of Veterans Affairs (VA) and DoD prime vendor discounts and the 1.7 percent fee charged to the DoD by Defense Logistics Agency (DLA). It is important to point out that this fee supports the DoD readiness mission which is accomplished by DLA. Reducing the amount of drugs upon which DoD pays this fee may reduce this cost, but would cost DoD somewhere else to support the mission and therefore should be considered in context.

The GAO stated that DoD could achieve savings if it used VA's Consolidated Mail Outpatient Pharmacy (CMOP) by taking advantage of VA's "....generally lower

drug prices...." Please note that the DoD and the VA share the same pricing authority and utilize it similarly. Therefore, it is not correct that DoD would always realize a savings on the acquisition cost of the drug by using the VA CMOP. Additionally, the GAO stated that the three military treatment facilities (MTFs) participating in the CMOP pilot program in Fiscal Year 2003 could have saved about $1.5 million if the MTFs moved all their refill prescriptions to the CMOP. Please note it is unlikely "all" refills could ever be moved to the CMOP, or any other venue. In fact, the VA does not enjoy a 100 percent success rate in moving "all" VA refills from their facilities to their CMOP.

The GAO stated that DoD paid administrative costs twice for refill operations in that they paid the VA for the administrative costs to operate the CMOP and a second time to maintain out-patient pharmacy refill operations at the MTF. While this may be true, it must be noted, as stated above, that DoD cannot expect to move "all" refill prescriptions to the CMOP and must therefore maintain some refill capability at the DoD MTF. Therefore, the GAO assertion that achieving savings would require "....closing MTF outpatient pharmacy refill operations to offset CMOP administrative expenses...." must be cautiously evaluated. The GAO recommendation for closing all MTF refill services and providing them only to active duty members may be flawed since some portion of this staff and equipment needs to be maintained to support initial prescriptions, whether or not they allow for a refill.

The GAO appropriately noted that, in addition to demonstrating that financial savings are possible, "....the pilot produced non-monetary benefits...." We agree that these are benefits associated with reduced traffic congestion on the base and shorter waiting times overall, but they may be difficult to accurately value. Please note that the reference to "civilian beneficiaries" should not be misinterpreted to include beneficiaries not currently covered but should be more clearly identified as "retiree beneficiaries."

As a final comment, DoD agrees with GAO in recognizing the other potential cost implications of attempting to close MTF outpatient refill pharmacies. GAO commented that DoD allows its beneficiaries to choose among various options. Please note that this patient choice as a DoD pharmacy benefit and it's basic structure are lawful entitlements. DoD cannot mandate DoD beneficiaries to utilize one option over another. Such a restriction would require legislative action. The GAO assumption that current options are more costly for DoD than having beneficiaries obtain their drugs from the CMOP is a subjective conclusion. In fact, all overhead costs, patient cost shares, and discounted acquisition costs must be carefully computed to arrive at an actual cost to both the patient and to the government. We must take an overall look at the costs for the government and the Congressionally-established pharmacy benefit as we make such far-reaching decisions that will impact millions of beneficiaries.

In closing, DoD would like to thank the GAO for its in-depth look at this issue and possibility of DoD's use of VA's mail pharmacy producing savings and other benefits.

My points of contact on this action are Colonel James Young at (703) 681-0064 and Mr. Gunther Zimmerman (Audit Liaison) at (703) 681-3492.

Sincerely,

William Winkenwerder, Jr., MD

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