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VA HEALTH CARE

Opportunities to Significantly Reduce Outpatient Pharmacy Costs

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The Honorable Tim Hutchinson
Chairman, Subcommittee on
Hospitals and Health Care
Committee on Veterans' Affairs
House of Representatives

Dear Mr. Chairman:

In recent years, officials of the Department of Veterans Affairs (VA) have testified that resources are not sufficient to serve all veterans seeking care and that they expect such shortages to worsen in future years. For fiscal year 1996, VA sought an appropriation of about $17 billion to provide expected inpatient hospital care to 930,000 patients, nursing home care to 35,000 patients, and domiciliary care to 18,700 patients. In addition, VA outpatient clinics were expected to handle 25.3 million visits.

Others have expressed concerns about the operating costs of VA pharmacies. Specifically, some have questioned whether VA pharmacies' provision of over-the-counter (OTC) products represents the most prudent and economical use of VA's available resources. In fiscal year 1995, VA's pharmacies filled prescriptions more than 65 million times, at a cost of almost $1 billion. VA physicians wrote over 34 million prescriptions for veterans for pharmaceuticals, including OTC products,[1] to be used on an outpatient basis and usually provided at low or no cost to the veterans. VA allows its physicians to prescribe OTC products primarily because VA physicians and others are concerned that veterans who need such products may lack the resources to purchase them and, as a result, not use them.

We evaluated VA's provision of medications, medical supplies, and dietary supplements that are available to the general public as OTC products in private sector outlets nationwide. More specifically, we addressed (1) what OTC products VA pharmacies dispense; (2) how VA's provision of OTC products compares with that of non-VA health care providers; (3) how much VA spends on OTC products and how much VA recovers through

[1]As a way to control veterans' access to OTC products in VA pharmacies, VA requires prescriptions for them. VA physicians may write prescriptions that are nonrefillable or that extend for as long as 12 months with several refills.

veterans' copayments; and (4) what opportunities exist to reduce federal expenditures.[2]

To develop this information, we reviewed nationwide OTC product utilization data VA maintained for 165 pharmacies[3] and obtained information from several headquarters offices, including the Pharmacy Service and the Medical Care Cost Recovery Office. We also obtained information on VA facilities' provision of outpatient OTC products to veterans from 150 VA pharmacies and officials in VA's 22 networks.[4] (See app. I for the questionnaire we sent to all VA pharmacies and their responses.)

To compare VA's provision of OTC products with that of other health providers and insurers, we contacted the Department of Defense, the Health Care Financing Administration, the Federal Employees Health Benefits Program, and the Group Health Cooperative of Puget Sound. At VA's pharmacy in Baltimore, we observed dispensing and copayment collection practices; reviewed a wide range of records and documents; and discussed VA's provision of OTC products with 20 physicians, pharmacists, and administrators.

Our work was performed between October 1995 and July 1996 in accordance with generally accepted government auditing standards.

Results in Brief

Our work has shown that all VA pharmacies provide medications and medical supplies to veterans that are available over the counter through other local outlets. The most frequently dispensed OTC products include (1) medications, such as aspirin, acetaminophen, and insulin; (2) dietary supplements, including Sustacal and Ensure; and (3) medical supplies, such as alcohol prep pads, lancets, and glucose test strips.

Each VA pharmacy offers a different assortment of products. Individual pharmacies generally handled fewer than 480 OTC products, but the number of OTC products ranged from 160 to 940. Some pharmacies restrict which veterans may receive OTC products or in what quantity they may receive them. As a result, veterans' access to OTC products through VA pharmacies varies considerably across the country.

[2]On June 11, 1996, we provided information on our work at a hearing held by your Subcommittee (see GAO/T-HEHS-96-162).

[3]VA's pharmacies frequently distribute OTC products through two or more locations.

[4]VA has 22 service networks, each consisting of between 5 and 12 facilities.

Unlike VA, other public and private health care plans cover few, if any, OTC products for their beneficiaries. When covered, OTC products are generally made available on a uniform basis to all beneficiaries. These plans' coverage of OTC products is more restrictive than all but a few of VA's facilities.

VA pharmacies dispensed OTC products more than 15 million times in fiscal year 1995 at an estimated cost of $165 million, including handling costs of $48 million. VA recovered an estimated $7 million through veterans' copayments, or about 4 percent of its total OTC costs. Individually, veterans' costs varied, depending on the type of product and the veterans' eligibility status. Although many veterans shared a modest portion of the costs and some paid the full cost, most veterans paid nothing.

Our work suggests several ways that VA could reduce the resources devoted to dispensing OTC products or enhance the revenues from copayments. First, VA could more narrowly define when to provide OTC products. Second, VA could more efficiently dispense OTC products and collect copayments. Third, VA facilities could further reduce the number of OTC products available to veterans on an outpatient basis. Finally, the Congress could expand copayment requirements.

Background

Under current law, marketed medical products are classified into two groups: one group has about 65,000 products that are safe for consumers to use only as prescribed by a physician; the other group has over 300,000 products that, according to U.S. Food and Drug Administration standards, are safe for use on the basis of a manufacturer's labeling instructions alone. Prescription products are available only in licensed pharmacies; whereas, other products are available over the counter at a wide variety of outlets. OTC products are generally for conditions for which users can recognize their own symptoms and levels of relief.

VA Pharmacies Provide an Assortment of OTC Products

VA physicians prescribed OTC products for veterans more than 7 million times in fiscal year 1995, accounting for about one-fifth of all VA prescriptions. VA pharmacies filled these OTC prescriptions over 15 million times, about one-fourth of all prescriptions filled.

VA physicians prescribed more than 2,000 different OTC products. VA pharmacies classify these products into three groups: medications (such as antacids), medical supplies (such as insulin syringes), and dietary

supplements (such as Ensure). Medications account for about 73 percent of the 15 million OTC prescriptions filled; medical supplies for 26 percent; and dietary supplements for less than 1 percent.

VA Facilities Limit Physicians' Prescription of OTC Products

VA's network and facility directors have considerable freedom in developing operating policies, procedures, and practices for VA physicians and pharmacies. Some facility directors have taken different actions to limit the number of OTC products available through the pharmacies and the quantity of products veterans can receive. Little uniformity in the application of limits is evident, however.

In general, each facility has a pharmacy and therapeutics committee that decides which OTC products to provide based on product safety, efficacy, and cost-effectiveness. These products are listed on a formulary and VA physicians are generally to prescribe only these products.

Of the 2,000 different OTC products dispensed systemwide, individual pharmacies generally handled fewer than 480, with the number of OTC products ranging from 160 to 940. (See app. II for a list of VA facilities and the number of OTC products dispensed.) Medical supplies account for the majority of products, with pharmacies generally dispensing fewer than 10 types of dietary supplements. Moreover, three facilities' formularies excluded dietary supplements.

The volume of OTC products dispensed also varied among facilities. Overall, OTC products accounted for about 25 percent of all prescriptions filled systemwide. But OTC products represented between 7 and 47 percent of all prescriptions dispensed at individual facilities. (See app. III for a list of facilities with the percentage of pharmacy workload represented by OTC products.)

Of note, 100 products accounted for about 70 percent of the 15 million times that OTC products were dispensed. VA pharmacies dispensed analgesics such as aspirin and acetaminophen almost 3 million times in fiscal year 1995. The most frequently dispensed OTC products included (1) the medications aspirin, acetaminophen, and insulin; (2) the dietary supplements Sustacal and Ensure; and (3) the supplies alcohol prep pads, lancets, and glucose test strips. (See app. IV for a list of commonly dispensed OTC products.)

Some Facilities Restrict OTC Products to Certain Veterans

Facilities have sometimes restricted physicians' prescriptions of OTC products to veterans with certain conditions or within certain eligibility categories. For example, 115 facilities restricted dietary supplements to veterans who required tube feeding or received approval for the supplements from dieticians. For medical supplies, one facility provided certain supplies only to patients who received them when hospitalized, and another provided diapers only to veterans with service-connected conditions. One facility provided OTC medications only to veterans with service-connected disabilities.

Some Facilities Restrict Quantities of OTC Products

Facilities have sometimes restricted the quantities of OTC products that pharmacies may dispense. Twenty-eight facilities had restrictions that included limits on the quantity of OTC products dispensed within specified time periods or on the number of times a prescription could be refilled. For example, one facility restricted cough syrup prescriptions to an 8-ounce bottle with one refill. It had similar quantity restrictions for 15 other OTC medications. Another facility had a no-refill policy for certain medical supplies, such as diapers, underpads, and bandages.

Other Health Care Plans Provide Few, If Any, OTC Products

Unlike VA, other public and private health care plans cover few, of any, OTC products for their beneficiaries. The Department of Defense, for instance, operates a health care system for military beneficiaries, including active duty members, retired members, and dependents, that provides a more restricted number of OTC products than most VA facilities. In 1992, Defense eliminated all OTC products except insulin from its formularies to control costs. Subsequently, however, Defense reinstated a few OTC products in its formularies because physicians had begun substituting more expensive prescription medications. All beneficiaries are eligible for covered OTC products without a copayment.

The Health Care Financing Administration directs the Medicare and Medicaid programs that pay nonfederal health care providers for medical care for people who are elderly, disabled, or poor. Unlike VA, Medicare does not cover outpatient OTC medications for its beneficiaries. Like VA, Medicaid, at the option of the states, can cover OTC products for its low-income beneficiaries. The availability of OTC products varies by state, ranging from very few to a substantial array of products.

The Federal Employees Health Benefits Program offers a range of health insurance plans to federal employees and their dependents. The program

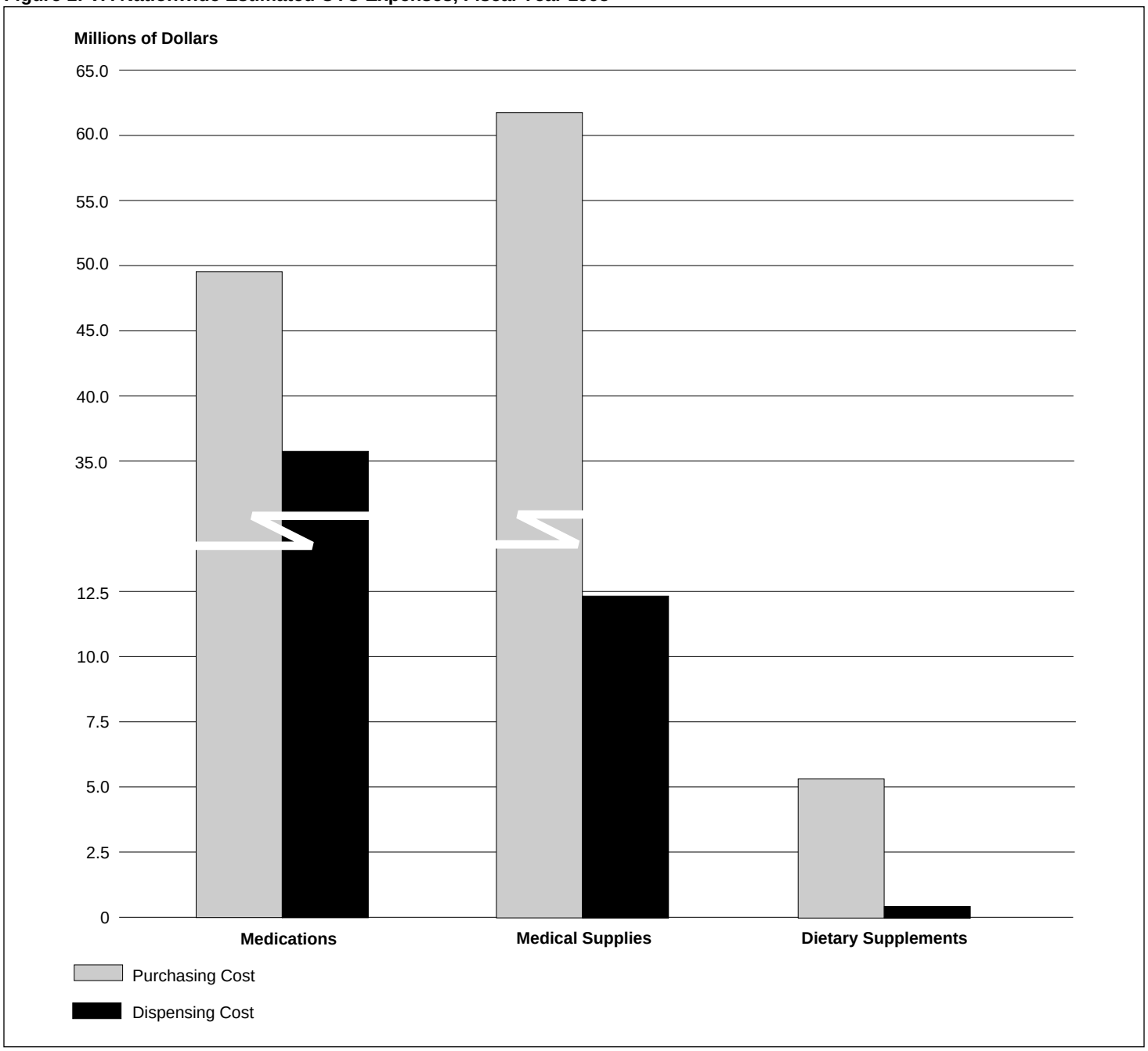
requires plans to meet certain minimum standards, which include coverage for prescription medications but not for OTC products, except for insulin and related supplies. Blue Cross and Blue Shield and Kaiser Permanente, two of the larger plans involved, cover no OTC products other than insulin and related supplies. Both plans require beneficiaries to help cover the cost of prescriptions. Kaiser charges $7 for each prescription provided by its pharmacies. Blue Cross and Blue Shield requires beneficiaries to pay a $50 deductible and 15 to 20 percent of the cost of individual prescriptions obtained at retail pharmacies, depending on whether the beneficiaries have high- or standard-option plans.

Finally, most private health insurers generally do not cover OTC products, with a few exceptions such as insulin and insulin syringes. For example, the Group Health Cooperative of Puget Sound, in Seattle, provides insulin with a $5 copayment but no other OTC products. Before 1995, the Cooperative provided an OTC drug benefit but dropped it because no other similar health plan provided this benefit.

Federal Resources Finance Most of VA's OTC Costs

Nationwide, VA pharmacies spent an estimated $117 million to purchase OTC products and $48 million to dispense them to veterans in fiscal year 1995. Of the total $165 million spent, about $85 million was for medications, with purchasing costs representing about two-thirds of that amount. About $74 million was spent for medical supplies and $6 million for dietary supplements, with purchasing costs accounting for most of these costs, as shown in figure 1.

Figure 1: VA Nationwide Estimated OTC Expenses, Fiscal Year 1995



Purchasing and dispensing costs differ among the product categories for two reasons. First, VA physicians generally provide more prescriptions with refills for medications than for supplies, thereby causing pharmacies to handle medications more often. Second, ingredient costs of medications are generally significantly lower than those of medical supplies.

VA recovered an estimated $7 million of total OTC costs (about 4 percent) through veterans' copayments.[5] By law, unless they meet statutory exemption criteria, veterans are to pay $2 for each 30-day supply of OTC medications and dietary supplements that VA provides. Veterans' copayments are not required for any OTC products used to treat service-connected conditions. Also, veterans are exempt from the copayment requirement if they have low incomes.

Our analysis of veterans' copayments and pharmacy costs at VA's Baltimore facility showed that copayments offset 7 percent of costs for OTC products, as shown in table 1.

Table 1: Comparison of Federal and Veteran Shares of OTC Expenses at VA's Baltimore Facility, Fiscal Year 1995

Figures are in percent

	Medications	Dietary supplements	Medical supplies	Total
Federal funds	88	99	100	93
Veteran copayments	12	1	0	7

Federal funds financed most of Baltimore's OTC product costs. Copayments collected covered a relatively small portion of these costs for several reasons. First, the $2 copayment collected for a 30-day supply represented only a portion of the ingredient, dispensing, and collection costs of most OTC medications and dietary supplements. Second, copayments were not required for medical supplies. Third, most veterans receiving medications and dietary supplements were exempted, and some nonexempt veterans did not make the copayments they owed.

For individual OTC products, veterans' medication copayments covered from 4 percent to more than 100 percent of VA's costs, depending on the type of product and the quantities dispensed. For example, a veteran's medication copayment of $6 for a 90-day supply of a relatively expensive product, such as the dietary supplement Ensure, may cover about 4 percent of VA's costs. In contrast, a veteran's copayment of $6 for a

[5]These copayments are referred to as "medication copayments" but apply to both medications and dietary supplements. No copayment is required for medical supplies.

90-day supply of an inexpensive medication, such as aspirin, may cover more than VA's total cost.

Opportunities to Reduce Federal Expenditures

A variety of actions could help reduce the level of federal resources devoted to the provision of OTC products. VA pharmacies could dispense considerably fewer OTC products. Also, savings could be achieved through more efficient OTC dispensing and copayment collection processes. Finally, the Congress could expand the copayment requirements to generate additional revenues.

Dispensing Fewer OTC Products Could Cut VA's Cost

VA dispenses OTC products to veterans in several situations. In general, VA provides OTC products to treat veterans for service-connected disabilities. For the treatment of nonservice-connected conditions, VA provides OTC products for hospital-related as well as non-hospital-related situations. VA could save money by limiting the situations under which it dispenses OTC products.

We identified many hospital-related situations in which VA provided OTC products. For example, veterans received phosphate enemas, magnesium citrate, and prep kits for barium enemas in preparation for colonoscopies and other diagnostic tests. Following hospital stays, veterans received ostomy supplies after some surgeries, wound-care supplies, aspirin for heart surgery or angioplasties, and decongestants after sinus surgery.

We also identified situations in which VA physicians determined that a veteran would be likely to be hospitalized if OTC products were not used. These included diabetic veterans using insulin to control their blood sugar, veterans suffering renal failure using sodium bicarbonate tablets to balance their electrolytes, and veterans who have suffered heart attacks or strokes using aspirin to prevent secondary occurrences.

We identified, however, some non-hospital-related situations in which VA provided OTC products. These included antacids for heartburn, preparations for dry skin, acetaminophen for arthritis pain, and cough medications for common colds. Given that VA pharmacies filled prescriptions for such products over 2 million times last year, VA facilities have an opportunity to reduce costs significantly.

Increased Efficiency Could Reduce VA's Costs

VA pharmacies could more efficiently dispense OTC products by reducing the number of times staff handle these items or by restricting mail service. VA facilities could also reduce costs by collecting medication copayments at the time of dispensing.

Reducing OTC Product Handling Costs

VA pharmacies could significantly reduce their OTC product dispensing costs of $48 million by providing more economical quantities of medications and supplies. Dispensing larger quantities would reduce the number of times that VA pharmacists fill prescriptions for OTC products, saving about $3 for each time a product would have otherwise been dispensed.

As previously discussed, VA physicians generally prescribe OTC products to treat acute or chronic conditions or to prevent future illness. While prescriptions for acute conditions are generally for periods of 30 days or less, OTC products used for chronic or preventive situations are generally prescribed for longer periods. For example, in fiscal year 1995, about 1,800 veterans received aspirin at the Baltimore pharmacy in quantities sufficient for at least 6 months.

VA allows pharmacies to dispense most OTC products in quantities sufficient for a 90-day supply. Not all pharmacies dispense OTC products in such economical quantities, however; 15 reported that they dispense OTC products in 30-day or 60-day supplies.

Limiting pharmacies to dispensing no more than a 90-day supply is uneconomical for certain high-volume OTC products used to treat chronic conditions or to prevent illness. Dispensing larger quantities in those instances seems to provide opportunities to reduce costs. For example, we estimate that VA's Baltimore pharmacy could have saved over $8,000 if it had dispensed 180-day supplies of aspirin to certain veterans in fiscal year 1995. Assuming a prescribed usage of 1 aspirin tablet a day, supplying 180 tablets rather than 90 would be more consistent with the quantities veterans could purchase from local outlets, which generally stock packages containing between 100 and 500 tablets.

Reducing OTC Mailing Costs

VA pharmacies could also reduce dispensing costs by using mail service for only certain situations (such as for veterans who are housebound or must travel long distances to reach VA facilities) or requiring veterans to pay shipping charges. Last year, VA pharmacies spent about $7.5 million mailing OTC products to veterans.

VA pharmacies generally encourage veterans to use mail service when refilling most prescriptions for OTC products. Almost all pharmacies mail OTC products, relying on mail service for almost 60 percent of the 15 million times that OTC products were dispensed last year. Some pharmacies have already transferred most of their OTC prescription refills to VA's new regional mail service pharmacies, and others will do so when additional regional pharmacies become operational.

While mailing costs vary, they can be particularly costly for liquid items or items that are dispensed in large packages or for long periods. For example, one facility reported that mailing a prescription of liquid antacid cost $2.88 and mailing a case of adult diapers cost $17.49. Mailing costs for a year's supply of diapers could exceed $200. Some VA facilities cited high mailing costs as one of the principal reasons for eliminating OTC products from their formularies.

Several facilities have attempted to reduce costs by prohibiting the mailing of certain OTC products, such as cases of liquid dietary supplements and diapers. In addition, some facilities reported switching from liquid products to powders to reduce the weight—and associated mailing costs—for particular OTC products.

Streamlining Copayment Collections

A third way to reduce federal costs is to streamline copayment collections for OTC products. VA primarily bills veterans for copayments, unlike other providers that generally require copayments to be made at the time that the products are dispensed. VA facilities incur administrative costs to prepare and mail bills for copayments related to OTC products, costs that are significant in relation to total collections. A VA-sponsored study estimated that VA facilities spend about 38 cents for every $1 collected to prepare medication copayment bills, mail them, and resolve questions.[6]

VA facilities generally send an initial bill and three follow-up bills to veterans who are delinquent in paying. For OTC products dispensed to veterans in fiscal year 1995, VA's Baltimore pharmacy collected about 75 percent of the value of the copayments billed. The other 25 percent remained unpaid 5 months past the end of the fiscal year. The veterans who had not paid for these products had not applied for waivers and, as a result, VA officials view them as able to pay. If the Baltimore facility's costs approximate the rate of 38 cents of every $1 collected, it incurred an estimated $26,000 to collect $67,000 for OTC products. The 25 percent of

[6]Birch & Davis Associates Inc., Medical Care Cost Recovery Cost of Collections Study (final report) (Washington, D.C.: VA, Medical Care Cost Recovery Program Office, Nov. 21, 1995).

the medication copayments that were billed but went unpaid would have required additional costs to resolve. Because of the relatively small outstanding balances for most veterans, VA officials told us that they are reluctant to continue contacting nonpayers or to pursue legal or other actions to collect these debts.

VA has the option of not providing OTC products if a veteran refuses to make a medication copayment at the time the product is dispensed. VA officials, however, told us that it is not their policy to withhold OTC products from nonpayers for this reason.

Collecting the copayment at the time a product is dispensed could eliminate most administrative costs and increase revenues. Veterans requesting prescription refills by mail could enclose their copayments with their requests.

VA Facilities Could Increase Restrictions on OTC Products

VA facilities could adopt less generous policies for OTC products that would be more consistent with other health plans' policies. This could be achieved by adopting such cost-containment measures as limiting the OTC products available or limiting quantities dispensed.

As previously discussed, each VA facility offers a different assortment of OTC products. For example, the most generous OTC product assortment contains about 285 medications, 514 medical supplies, and 14 dietary supplements. In contrast, the least generous assortment includes about 124 medications, 114 medical supplies, and 4 dietary supplements.

Over the last 3 years, 45 pharmacies have reduced the number of OTC products provided to veterans. The most commonly removed OTC products are medications such as soaps, skin lotions, and laxatives; dietary supplements such as Ensure, multiple vitamins, and mineral supplements; and medical supplies such as ostomy products and glucose test strips.

As part of VA's ongoing reorganization, each of the 22 network directors has developed a list of OTC products dispensed by facilities operating in the network. In general, each network's formulary more closely approximates the more generous OTC product assortments available in each network rather than the less generous assortments. Some network directors plan to review their formularies to identify products that could be removed.

Recently, 58 facilities told us that they are considering removing some OTC products from their formularies. Most are examining fewer than 10 products, although the number of products under review ranges from 1 to 205. Products most commonly mentioned include dietary supplements, antacids, diapers, aspirin, and acetaminophen. Ninety facilities are not contemplating changes at this time.

Interestingly, wide disagreement exists within VA about providing OTC products on an outpatient basis. For example, 23 facilities suggested that all OTC products should be eliminated. In contrast, 57 suggested that all OTC products should remain available. The other 70 facilities provided no opinion regarding whether OTC products should be kept or eliminated.

Many facilities pointed out that eliminating all OTC products could result in greater VA health care costs. This is because some OTC products are relatively cheap compared with prescription products that might be used or because they help prevent significant health problems that could be expensive for VA facilities to ultimately treat.

Facilities reported that were they to remove certain OTC products from their formularies, greater costs to VA would result. Of those 21 products reported, the most frequently mentioned were aspirin, acetaminophen, antacids, and insulin. These facilities also reported that 14 of the 21 products had prescription substitutes, among them, aspirin, acetaminophen, and antacids (insulin has no prescription substitute).

While 45 facilities removed OTC products during the last 3 years, only 6 of them said that they reinstated some products on their formularies. One facility stated that although it is commonly believed that limiting OTC medications would result in a higher use of more expensive prescription medications, it had not found this to be true.

As OTC products are removed from formularies, veterans will have to obtain the products elsewhere. Some VA facilities reported that they are using VA's Canteen Service to provide OTC products that have been eliminated from their formularies. The Canteen Service operates stores in almost every VA facility to sell a variety of items, including some OTC products. For example, the Baltimore pharmacy has asked the Canteen Service store to stock about 13 OTC products that were recently eliminated from its formulary. The Baltimore pharmacy has already shifted most dietary supplements to the store.

VA Canteen Service stores do not use federal funds to operate and generally provide items at a discount, in large part because they do not have the expense of advertising. By allowing these stores to sell OTC products, VA may reduce both dispensing and ingredient costs for its pharmacies. At the same time, VA's Canteen Service stores can provide many veterans with a convenient and possibly less costly option for obtaining these products than other local outlets.

Expanding Veteran Copayment Requirements Would Enhance Revenues

The Congress could reduce the federal share of VA pharmacies' costs for filling OTC prescriptions by expanding copayment requirements. This could be achieved through (1) tightening exemption criteria, (2) requiring copayments for medical supplies, or (3) raising the copayment amount.

An example using VA's Baltimore facility shows the different degree of impact these changes would have. There, as previously discussed, veterans' copayments cover only 7 percent of the pharmacy's OTC costs. If the copayment were to remain at $2 for each 30-day supply, changes that expand the number of veterans required to make copayments could increase the veterans' share of costs up to 31 percent and thereby reduce the pharmacy's share from 93 to 69 percent. In contrast, a copayment of about $9 would be needed to achieve a comparable sharing rate if existing exemptions were maintained.

Restricting OTC Copayment Exemptions

Some veterans are required to make copayments, while others are not. When the Congress established medication copayments in 1990, veterans with service-connected disabilities rated at 50 percent or higher were exempted for any condition as were other veterans who receive medications for service-connected conditions. In 1992, the Congress exempted veterans from the copayment requirement for nonservice-connected conditions if their income was below a specified threshold.

Veterans with service-connected conditions received about one-third of the 116,000 prescriptions filled at the Baltimore pharmacy. Of these, half had disability ratings of 50 percent or higher. Veterans without service-connected conditions received the remaining two-thirds, and about half of these veterans were exempt from making copayments because their incomes were below the statutory threshold. VA officials told us that while some low-income veterans may have difficulties making copayments, most had not seemed to have such a problem before the 1992 enactment of the low-income exemption.

The Baltimore pharmacy could have recovered an additional 7 percent of its costs if all veterans without service-connected conditions were required to make copayments for OTC products and an additional 11 percent if veterans were required to make copayments for OTC products provided for service-connected and nonservice-connected conditions.

Using a lower income level in determining which veterans are exempt from making copayments would also reduce the federal cost of providing OTC products. We found that VA facilities were inappropriately using an income level set at VA's aid-and-attendance pension rate rather than at the regular pension rate.[7] After we informed VA's General Counsel of the practice, it issued a May 1996 opinion that the law requires VA facilities to use the regular pension rate as the income level. Using this lower income level should allow facilities to collect copayments from veterans who would not otherwise have been charged. (See app. V for VA's General Counsel's memorandum on the pension rate.)

Requiring OTC Copayments for Medical Supplies

Requiring copayments for medical supplies would enhance revenues. When the Congress established a copayment requirement for medications in 1990, it did not include a copayment requirement for medical supplies. VA officials told us that they know of no reason why medical supplies should be treated differently from other product categories in terms of copayments.

Nationwide, VA pharmacies dispensed medical supplies about 4 million times to veterans in fiscal year 1995, including about 36,000 times at the Baltimore pharmacy. Baltimore provided most supplies for 30 days or less, generally preceding or following a VA hospital stay. Many kinds of supplies, however, were provided for longer term conditions such as diabetic and ostomy supplies or diapers for those suffering from incontinence.

We estimate that the Baltimore facility could have recovered an additional 6 percent of its OTC product costs in fiscal year 1995 if veterans had been required to make copayments for medical supplies used to treat nonservice-connected conditions.

Raising the OTC Copayment Amount

If the exemptions and collection rates remain unchanged, facilities would need to charge a higher copayment to recover a larger share of their OTC product costs. For example, at the Baltimore facility, recoveries could be raised from 7 percent to 32 percent if the legislatively established copayment amount were $9 for a 30-day supply. If some changes are made

[7]VA pension rates are income levels established by law and vary by the number of dependents.

to the exemptions, however, this target share could be achieved with a smaller increase in the copayment rate, as shown in table 2.

Table 2: Estimated Recoveries as a Percentage of the Baltimore Facility's OTC Costs for Different Exemption Options and Copayments

	Medication copayment				
Options	**$2**	**$3**	**$5**	**$7**	**$9**
Existing exemptions	7%	11%	18%	25%	32%
Veterans with nonservice-connected conditions (before 1992)	14	22	36	51	65
Veterans with nonservice-connected conditions (includes medical supplies)	20	30	50	70	90
All veterans (includes medical supplies and veterans with service-connected conditions)	31	47	78	109	140

Note: Data are for fiscal year 1995; the Baltimore facility's estimated OTC costs that year were $1.1 million.

Conclusions

Most VA facilities provide more generous OTC product benefits than other health care plans. In addition, VA facilities provide other features, such as free OTC product mail service, that are not commonly available from other plans. As a result, VA facilities devote significant resources to the provision of OTC products that other plans have elected not to spend.

VA should be commended for instructing network directors to consolidate formularies. This action, which is currently in progress, has not yet achieved an adequate level of consistency or cost-containment systemwide because the networks' current formularies approximate the more generous coverage of OTC products at some VA facilities. Moreover, some networks are permitting facilities to provide less generous coverage of OTC products than these networks' formularies allow. This is likely to perpetuate the uneven availability of OTC products.

Given the disagreement among networks and facilities over the provision of OTC products, additional guidance may be needed to ensure that veterans have a consistent level of access to OTC products systemwide. In light of concerns about potential resource shortages at some facilities, tailoring the availability of OTC products for nonservice-connected conditions to be more in line with that at less generous facilities would

seem desirable. This would essentially limit OTC products to those most directly related to VA hospitalizations.

VA facilities could also reduce their costs if they restructured OTC product dispensing and copayment collection processes. In general, most facilities dispense OTC product refills too frequently, mail products too often, and allow veterans to delay copayments too frequently. Although some facilities have adopted measures to operate more efficiently, all facilities could benefit by doing so.

VA facilities should be able to collect copayments for OTC products from more veterans if they use the appropriate income threshold to determine which veterans owe copayments. In May 1996, VA's General Counsel concluded that the income threshold, as prescribed by law, should be the regular pension rate for most cases, not the higher aid-and-attendance rate. VA facilities had been using the higher aid-and-attendance rate.

Expanding veterans' share of the costs would also help reduce federal resource needs. This could be achieved by expanding copayment requirements to include medical supplies, reducing the income threshold for veterans with nonservice-connected conditions, or increasing the amount of copayment required. In addition to enhancing revenues, such changes could also act as important incentives for veterans to obtain only the OTC products from VA facilities that they expect to use.

Finally, some VA facilities have had success using the Canteen Service stores to stock and sell OTC products that the facilities had removed from their formularies. This seems to be a reasonable alternative for providing OTC products to veterans at costs below those of other local outlets.

Matters for Consideration by the Congress

The Congress could reduce federal expenditures for OTC products provided to veterans by amending 38 U.S.C. 1722A to

- increase the medication copayment amount;
- expand the coverage of the medication copayment to include medical supplies; or
- lower the income threshold VA uses to determine which veterans owe medication copayments.

Recommendations to the Secretary

We recommend that the Secretary of Veterans Affairs require the Under Secretary of Health to

- limit OTC products for nonservice-connected conditions to those most directly related to VA hospitalizations or those considered most essential to prevent hospitalization;
- standardize the availability of OTC products to give veterans more consistent levels of access to them systemwide;
- reduce VA's dispensing costs for OTC products by (1) providing, when appropriate, more economical quantities (more than a 90-day supply) of medications and supplies and (2) limiting mail service to certain situations;
- require veterans to make copayments at the time OTC products are dispensed; and
- direct facilities to apply the statutory income threshold to determine which veterans owe medication copayments.

Agency Comments and Our Evaluation

In commenting on a draft of our report, VA's Under Secretary for Health agreed to standardize the availability of OTC products nationwide and estimated this will be done by May 1997. VA also agreed to use the statutory income threshold (the regular pension rate) instead of the aid-and-attendance rate to determine which veterans should be exempt from medication copayments. VA estimated that most veterans who were previously exempt from the medication copayment because of their income levels will now be required to make payments. However, VA expressed disagreement with our other recommendations.

Our recommendations were intended to identify ways that VA could conserve OTC pharmaceutical resources so that they could be redirected to provide more essential health care services for veterans. VA faces serious budget challenges today and in the future. These challenges are forcing management to make choices about how to best use limited resources to maintain the present level of health care services for veterans. Nationwide, VA's managers are faced with taking every reasonable action to ensure that they are providing high-quality medical care in a cost-effective manner. Our recommendations, for the most part, were based on actions certain VA pharmacies have already taken.

Limiting OTC Products

VA did not concur with our recommendation to limit OTC products for nonservice-connected conditions to those most directly related to VA

hospitalizations or those considered most essential to prevent hospitalization. VA stated that its policy to provide patients with medications, medical supplies, and dietary supplements is based on the clinical determination that these items are medically necessary. VA pointed out that continuity of care is a cornerstone of primary care practice with emphasis on preventive care and asserted that implementation of this recommendation would probably lead to fragmented care. VA stated that fragmentation of care can lead to an overall increase in health care costs. Restriction of OTC products could also lead to a shift in prescribing patterns. To ensure that the patient will actually get the needed medication, physicians may order more expensive prescription items if OTC versions are not provided by VA pharmacies, a practice that would lead to increased overall expenditures.

Our recommendation was designed to bring VA's provision of OTC products into closer alignment with the practices of the vast majority of health care plans in this country. Generally, private health care plans provide primary care but exclude OTC products as a benefit for their participants—that is, they expect enrollees to obtain OTC products from other sources at their own expense. Furthermore, what we are recommending is that VA do on a systemwide basis what several of its own facilities have done. VA's local facilities generally factor in drug substitution and potential health effects when making their decisions about which drugs to provide. Some of them have already made the tough choices about which OTC drugs were essential to provide, and they did not report encountering, to any great extent, the types of potential problems that VA expressed concern about in its comments. Limiting VA pharmacies' provision of certain OTC items presumes that veterans will obtain the items from other local outlets if they share their physicians' assessment of the products' medical necessity.

Dispensing More Economical Quantities

VA agreed that OTC products should be provided in more economical quantities to reduce VA's dispensing costs but only in those instances deemed clinically appropriate. VA stated that the current medication renewal process often serves as a good opportunity for the patient to have personal contact with the health care provider and to be reevaluated for medication compliance. VA also stated that quantity limitation must be based on quality of care considerations and the individual veteran's ability to comply with his or her medication regimen. Also, consideration must be given to the stability of the drug in question.

Our recommendation was intended to reduce the dispensing costs associated with OTC products and touches on prescription refills rather than prescription renewals. For chronic conditions, VA prescriptions are usually written for 6- or 12-month periods with refills. Renewing the prescriptions once or twice a year does provide opportunities for veterans to see VA health care practitioners, but refilling those prescriptions every 90 days in the interim does not. VA pharmacy officials told us that routine refills are generally handled by mail with no interaction between physicians and veterans.

Analgesics, such as aspirin and acetaminophen, which VA dispensed almost 3 million times in fiscal year 1995, provide an example of how refill quantities influence costs. VA could save about $3 in dispensing costs each time it provided one 180-day supply instead of two 90-day supplies. When sold in local outlets, aspirin is commonly packaged in quantities of 100 to 500 tablets, making it possible for veterans and others to readily buy more than 180-day supplies without raising concerns about medical safety or product stability. OTC products are safe when the manufacturers' labeling directions are followed and, as in the case of aspirin, are stable enough to be stored in users' homes for 6 months or longer without adverse consequences.

Limiting Mail Service

VA did not concur with our recommendation to reduce VA's dispensing costs for OTC products by limiting mail service to certain situations. VA stated that implementing this recommendation would undermine the important health care goals of patient satisfaction and customer service. Also, VA stated that mail service helps to reduce daily crowding and congestion in ambulatory care and parking areas of VA treatment facilities.

When resources are limited, choices about whether to fund certain OTC products have to be made by local VA pharmacies. Some VA pharmacies reported to us that they continued to provide certain OTC products, such as cases of liquid dietary supplements or diapers, but did not mail them. Veterans needing such OTC products have to pick them up at the pharmacy (exceptions are made when warranted). Again, we are only recommending that VA do, on a systemwide basis, what several of its facilities have done independently.

Collecting Copayments When Products Are Dispensed

VA did not concur with our recommendation to require veterans to make copayments at the time OTC products are dispensed. VA stated that to the fullest extent possible, veterans are encouraged to make copayments at

the time OTC products are dispensed. An estimated 35 percent of prescription copayments are collected at the time of dispensing. Because approximately 50 percent of all outpatient prescriptions are mailed, VA stated, it is obvious that copayment collection rates at the time of dispensing are already high. Collection decisions must be made on an individual basis, according to VA, which stated that a veteran will not be denied a medically necessary product if for some reason copayment cannot be made at the time the product is dispensed.

During our examination of the copayment process at the VA facility we visited, however, we found that veterans were not presented a copayment bill or required to make payments at the time OTC products were dispensed at the pharmacy. Instead, the facility primarily mailed copayment bills to veterans, incurring additional administrative costs. Because VA's records showed only total copayment collections, copayments received by mail or collected by the cashier could not be differentiated.

Our work showed that about 25 percent of OTC copayments billed were uncollected. VA incurs additional administrative costs to pursue these uncollected copayments. Collecting the copayments for OTC products at the time of dispensing would eliminate the administrative costs to bill and rebill delinquent payers. Veterans could help conserve VA's limited resources by making copayments when they pick up the OTC products at the pharmacy or by including their copayments when ordering refills by mail. Given current copayment rates of $2 for a 30-day quantity, our recommendation would not seem to be overly burdensome on veterans. The full text of VA's comments is in appendix VI.

We are sending copies to appropriate congressional committees; the Secretary of Veterans Affairs; the Director, Office of Management and Budget; and other interested parties. We will also make copies available to others upon request.

Please call me on (202) 512-7101 if you or your staff have any questions concerning this report. Contributors to this report are listed in appendix VII.

Sincerely yours,

David P. Baine
Director, Veterans' Affairs and
Military Health Care Issues

Contents

Abbreviations

OTC	over-the-counter
VA	Department of Veterans Affairs

GAO Questionnaire Results

United States General Accounting Office

GAO

1996

Questionnaire on VA's Dispensing of Over-the-Counter Drugs and Supplies

This survey contains questions concerning over the counter (OTC) drugs, medical supplies and dietary supplements that are dispensed by VA pharmacies. All VA pharmacies are being asked to answer these questions.

The purpose of our study is to examine the benefits and costs of OTC drugs, supplies and supplements VA provides to veterans. This work is being done at the request of the Chairman of the House Subcommittee on Hospitals and Health Care, Committee on Veterans' Affairs.

Questions concerning this survey or our work in this area should be directed to Walter Gembacz in our Washington, DC, headquarters office at 202-512-6982.

Complete and Return to GAO by March 8, 1996

Notes concerning responses to this questionnaire:

Note 1: This questionnaire was answered by 150 VA pharmacies. In our June 1996 testimony concerning VA's dispensing of OTCs (GAO/T-HEHS-96-162), we reported data on 149 pharmacies. Since that testimony, we incorporated questionnaire data from an additional pharmacy. This new data did not significantly affect the questionnaire results.

Note 2: The number who responded to each question and the number eligible to respond to each question is expressed as two numbers separated by a slash (e.g., N=149/150).

Note 3: Percents may not add to 100 because of rounding or because some pharmacies failed to provide a response.

INSTRUCTIONS:

Unless otherwise directed, please answer each question. When answering our questions, please:

INCLUDE:

- Include only drugs, medical supplies and dietary supplements that were dispensed by your pharmacy (Include items dispensed directly from your pharmacy as well as a CMOP).
- Include only items for ***outpatients.***

EXCLUDE:

- Exclude over the counter drugs, medical supplies or dietary supplements that were purchased by veterans outside your pharmacy.
- Exclude over the counter drugs, medical supplies or dietary supplements for medical center inpatients, VA nursing home care units, or patients in other facilities under a VA or VAMC contract.

DEFINITIONS:

OTCs	"OTCs" is the encompassing, general term for the 3 categories of Over The Counter items described below.
Over the counter	We include three different categories of **items that civilians can purchase without a prescription**, but for purposes of this study, are dispensed by VA pharmacies: (1) OTC **drugs** (for example, aspirin, insulin), (2) OTC **medical supplies** (for example, gauze pads, bandaides, ostomy supplies), and (3) OTC **dietary supplements** (for example, "Ensure Plus").
Prescription	The original order for an item issued by a VA physician.
Fill	Each packaging and dispensing of a single item. The initial fill and its subsequent re-fills are each counted as a separate "fill". (For example, a prescription for 100 aspirin tablets of 325 mg each with 3 refills represents 4 fills: the initial plus 3 refills.)

Questions? If you need additional information or assistance, please call Walter Gembacz between 8am and 3pm, Eastern time at 202-512-6982.

Before answering any questions, please provide the following information:

. . . . . .
VA facility name and location

. . . . . .
Name of person completing this questionnaire

. . . . . .
Telephone number (with area code)

1. What was the total number of fills (legend + OTC items) your pharmacy dispensed during fiscal year 1995? *(Enter number.)* ***(N=150/150)***

   Mean . . . . . **420,893 fills**
   Median . . . . . **386,979 fills**
   Range . . . . . **55,784 - 1,290,298 fills**

2. Did your pharmacy dispense any over the counter (OTC) drugs, medical supplies or dietary supplements during fiscal year 1995? *(Check yes or no for each category.)*

	Yes	No
1. OTC Drugs . . . . . ***(N=150/150)***	**99%**	**1%**
2. OTC Medical supplies . . . . . ***(N=150/150)***	**100%**	**0%**
3. OTC Dietary supplements . . . . ***(N=150/150)***	**98%**	**2%**

3. Are there any restrictions or limits on a veteran's ability to receive OTC drugs, medical supplies or dietary supplements from your pharmacy? (Hypothetical example, certain drugs that may only be dispensed to service connected veterans) *(Check yes or no for each category.)*

	Yes	No
1. OTC Drugs . . . . . ***(N=150/150)***	**32%**	**68%**
2. OTC Medical supplies . . . . . ***(N=149/150)***	**29%**	**71%**
3. OTC Dietary supplements . . . ***(N=146/150)***	**77%**	**21%**

4. Approximately what percent of your pharmacy's FY95 OTC fills were dispensed by a CMOP (Consolidated Mail Outpatient Pharmacy), mailed by your pharmacy, dispensed from the pharmacy window or by some other method or location? *(Enter percent, estimates are acceptable. If none, enter 0.)* ***(N=150/150)***

1. Mailed by CMOP*	**11%**
2. Mailed by pharmacy	**46%**
3. Dispensed from pharmacy window . . .	**41%**
4. Dispensed other method or location . .	**<1%**
Total, all OTC fills	100 %

   **Note: Only 44 of the 150 facilities reported using a CMOP. For these facilities, 38 % of their fills, on average, were dispensed through the CMOP.*

5. In about what proportion does your pharmacy repackage OTC drugs from their original container into containers with smaller quantities? *(Check one.)* ***(N=149/150)***

1.	**15%**	80 to 100%
2.	**7%**	60 to less than 80%
3.	**13%**	40 to less than 60%
4.	**17%**	20 to less than 40%
5.	**42%**	Less than 20%, but not zero

6.	**6%**	Do not repackage

6. Except for when there is no longer a medical need, does your facility limit either how long or how many times a veteran may receive OTC drugs, medical supplies, or dietary supplements from your pharmacy? (Hypothetical example: a veteran may receive aspirin for 1 year but is expected to make retail purchase after 1 year.) *(Check yes or no for each of the 3 OTC categories.)*

	Yes	No
1. OTC Drugs	9%	91%
(N=150/150)		
2. OTC Medical supplies	7%	93%
(N=150/150)		
3. OTC Dietary supplements ...	19%	79%
(N=147/150)		

7. While a physician determines how long a patient's OTC prescription will be in force (for example, 1 year), what is the maximum day supply your pharmacy dispenses per fill? *(Check one.)* ***(N=149/150)***

1. 9% 30 days per fill
2. 1% 60 days per fill
3. 88% 90 days per fill
4. 1% 120 days per fill
5. 0% 365 days per fill
6. 0% Other *(Specify:)* . . _____ days per fill

8. Were any OTC drugs, medical supplies or dietary supplements removed from your pharmacy's formulary during fiscal years 1993, '94 or '95? *(Check one.)* ***(N=150/150)***

1. 70% No----->*Go to question 12.*
2. 30% Yes---->*List*

9. What criteria were used to determine which OTC drugs, medical supplies or dietary supplements would be eliminated from your formulary? *(Check all that apply.)* ***(N=45/45)***

1. 36% Pharmacy workload
2. 20% Storage/space constraints
3. 44% Lack of physician demand for item
4. 53% Ability to substitute another, but cheaper or more effective OTC item
5. 47% Cost of item to VA
6. 11% Medication co-payment exceeds veteran's cost
7. 38% Cost of mailing item
8. 49% Changes in treatment practices
9. 22% Item's availability in locality
10. 18% Other *(Specify):*

10. Of the criteria you selected in the preceding question, including any you may have written, which criteria were given greater weight to items eliminated from your formulary? *(Enter up to 3 criteria using the number of the box checked in the preceding question.)* ***(N=44/45)***

1. 44% (4.) Ability to substitute another, but cheaper or more effective OTC item
2. 42% (5.) Cost of item to VA
3. 38% (3.) Lack of physician demand for item

11. Were any of the OTC drugs, medical supplies or dietary supplements that were eliminated from your pharmacy's formulary during fiscal years 1993, '94, or '95 reinstated onto your formulary? *(Check one.)* ***(N=45/45)***

1. 87% No
2. 13% Yes-->*List items.*

12. Is there any thought being given to eliminating any OTC drugs, medical supplies or dietary supplements from your pharmacy's formulary? *(Check one.)* ***(N=149/150)***

1. 61% No
2. 39% Yes-->*List items being considered for elimination.*

13. Consider the costs and medical benefits of the OTC drugs, medical supplies and dietary supplements currently on your pharmacy's formulary. If the number of OTC items had to be limited, which OTC items, if any, would you want to retain because their loss from your formulary would result in greater costs to VA? Provide the information requested under each item you list. *(The item's cost per a specific unit, the benefits the OTC provides, availability of a legend substitute, and the highest and lowest cost for available legend substitutes.)* ***(N=142/150)***

38% I would suggest keeping all OTC items from the formulary.----->*Go to question 14, next page.*
15% I would suggest eliminating all OTC items from the formulary.----->*Go to question 14, next page.*
10% I don't know.----->*Go to question 14, next page.*

31% of the pharmacies provided the following information for up to 4 OTC items:

OTC item: . . . . . .
Cost: $_____.____ per _____ (unit)
Benefit: . . . . . .
. . . . . .
Is there a legend substitute for this OTC on your formulary?

☐ No
☐ Yes-----> Highest legend substitute cost: $_____.____ per _____ (unit)
Lowest legend substitute cost: $_____.____ per _____ (unit)

14. Has your pharmacy arranged with a canteen, store, or use some other mechanism to provide certain OTC drugs, medical supplies or dietary supplements to veterans instead of providing them through the pharmacy? *(Check one.)* ***(N=150/150)***

1. **83%** No
2. **17%** Yes-->*Describe arrangement:*

15. What actions, if any, has your pharmacy taken since FY93 to reduce costs associated with dispensing and handling OTC items? ***(N=150/150)***

1. **41%** No actions taken

We've taken the following actions: ***(100 pharmacies provided comments)***

16. (OPTIONAL) If you would like to provide your views on the advantages and disadvantages of prescribing OTC drugs, supplies and supplements or any other comments concerning VA's policies, procedures or practices for providing OTC drugs, supplies and supplements, please write them in the space below. ***(91 pharmacies provided comments)***

VA Facilities by the Total Number of Unique OTC Products Dispensed, Fiscal Year 1995

VA facility location	Medications	Dietary supplements	Medical supplies	Total OTC products
Livermore, CA	80	1	82	163
Fort Howard, MD	110	4	84	198
Canandaigua, NY	112	2	88	202
Coatesville, PA	135	6	77	218
Montrose, NY	161	2	70	233
Bath, NY	142	4	87	233
Beckley, WV	110	6	123	239
Knoxville, IA	154	10	85	249
Tuskegee, AL	115	5	129	249
Big Spring, TX	112	2	137	251
Newington, CT	68	3	180	251
Marion, IN	137	2	117	256
Fort Lyon, CO	140	5	120	265
Sheridan, WY	137	3	129	269
Clarksburg, WV	119	1	154	274
Perry Point, MD	141	4	135	280
Tomah, WI	138	3	140	281
Dublin, GA	131	2	148	281
Poplar Bluff, MO	134	3	165	302
Pittsburgh (HD), PA	169	7	135	311
Los Angeles OPC, CA	173	1	139	313
Cheyenne, WY	177	6	132	315
Alexandria, LA	129	4	184	317
Saginaw, MI	116	6	197	319
Bronx, NY	159	3	161	323
Miles City, MT	151	5	167	323
Grand Island, NE	154	4	166	324
White City, OR	150	3	175	328
Hot Springs, SD	149	5	177	331
Fort Meade, SD	138	4	190	332
Marion, IL	134	5	195	334
Bonham, TX	194	2	143	339
Butler, PA	148	3	194	345
Montgomery, AL	169	0	177	346
Chillicothe, OH	129	5	212	346
Danville, IL	143	4	199	346
Altoona, PA	125	11	212	348

(continued)

VA facility location	Medications	Dietary supplements	Medical supplies	Total OTC products
Memphis, TN	166	8	176	350
Lyons, NJ	181	4	166	351
Fayetteville, NC	138	3	214	355
Northport, NY	181	5	170	356
Prescott, AZ	144	0	214	358
Tuscaloosa, AL	187	11	160	358
Anchorage, AK	137	9	213	359
Castle Point, NY	147	5	207	359
American Lake and Seattle, WA	150	6	205	361
Fort Wayne, IN	132	7	224	363
Asheville, NC	162	20	184	366
Salt Lake City, UT	157	6	204	367
Wilmington, DE	161	11	195	367
Biloxi, MS	151	6	212	369
Grand Junction, CO	183	9	179	371
Ann Arbor, MI	125	5	242	372
Kerrville, TX	206	3	165	374
Northampton, MA	187	15	175	377
Iron Mountain, MI	203	4	172	379
San Juan, PR	152	11	217	380
Chicago (Lakeside), IL	163	6	213	382
Walla Walla, WA	157	9	218	384
North Chicago (Downey), IL	163	9	214	386
Batavia, NY	182	3	209	394
Manchester, NH	198	5	193	396
Erie, PA	165	16	215	396
El Paso OPC, TX	208	4	193	405
Hampton, VA	164	0	243	407
Fayetteville, AR	145	10	252	407
Bedford, MA	241	6	166	413
Durham, NC	157	8	250	415
Lake City, FL	180	9	227	416
Fargo, ND	169	9	239	417
Shreveport, LA	164	10	244	418
St. Cloud, MN	181	8	232	421
Hines, IL	158	12	262	432

(continued)

VA facility location	Medications	Dietary supplements	Medical supplies	Total OTC products
Fort Harrison, MT	142	4	287	433
Providence, RI	145	7	286	438
Fresno, CA	178	9	257	444
Brockton/West Roxbury, MA	182	9	257	448
Huntington, WV	167	6	283	456
Honolulu, HI	189	15	256	460
Battle Creek, MI	171	17	273	461
Murfreesboro, TN	164	11	286	461
West Palm Beach, FL	177	5	283	465
New York, NY	254	7	204	465
San Francisco, CA	181	9	280	470
Pittsburgh (UD), PA	162	12	298	472
Topeka, KS	213	9	253	475
Denver, CO	150	11	314	475
Mountain Home, TN	181	9	287	477
Chicago (Westside), IL	205	7	266	478
Columbus OPC, OH	104	1	379	484
Roseburg, OR	171	1	315	487
Jackson, MS	221	10	256	487
Sepulveda, CA	197	4	289	490
Columbia, SC	197	9	285	491
Las Vegas OPC, NV	162	5	326	493
Baltimore, MD	241	12	243	496
West Haven, CT	179	11	307	497
Little Rock, AR	195	3	302	500
Syracuse, NY	163	11	326	500
Cincinnati, OH	182	5	317	504
New Orleans, LA	179	9	316	504
Buffalo, NY	166	10	332	508
Leavenworth, KS	216	7	288	511
Augusta, GA	234	11	266	511
Richmond, VA	192	13	316	521
Phoenix, AZ	245	6	271	522
Sioux Falls, SD	236	3	283	522
Dayton, OH	177	11	336	524
Loma Linda, CA	188	8	331	527
Birmingham, AL	229	14	285	528

(continued)

VA facility location	Medications	Dietary supplements	Medical supplies	Total OTC products
Reno, NV	232	4	292	528
Martinez, CA	193	19	319	531
Brooklyn, NY	302	12	222	536
Amarillo, TX	283	2	260	545
Madison, WI	141	19	394	554
Philadelphia, PA	230	9	315	554
White River Junction, VT	172	11	380	563
Spokane, WA	265	11	289	565
Tampa, FL	197	10	364	571
San Diego, CA	178	6	391	575
Oklahoma City, OK	242	3	333	578
Martinsburg, WV	286	11	281	578
Omaha, NE	224	3	352	579
Lexington, KY	210	14	357	581
Albuquerque, NM	246	7	339	592
East Orange, NJ	204	12	381	597
San Antonio, TX	354	17	227	598
Boise, ID	306	14	286	606
Boston, MA	268	15	331	614
Gainesville, FL	187	16	412	615
Louisville, KY	235	11	372	618
Lincoln, NE	258	8	355	621
Houston, TX	246	12	364	622
Wichita, KS	218	9	399	626
Iowa City, IA	234	12	384	630
Tucson, AZ	241	27	366	634
Central Texas Health Care System, TX	307	16	311	634
Dallas, TX	225	18	392	635
Charleston, SC	212	14	421	647
Atlanta, GA	252	10	386	648
Washington, DC	245	5	402	652
Muskogee, OK	272	12	370	654
Cleveland, OH	234	9	417	660
Miami, FL	238	19	422	679
West Los Angeles (Wadsworth), CA	296	11	393	700
Wilkes-Barre, PA	314	12	381	707

(continued)

VA facility location	Medications	Dietary supplements	Medical supplies	Total OTC products
Allen Park, MI	218	6	484	708
Togus, ME	280	9	421	710
Columbia, MO	249	11	454	714
Kansas City, MO	276	8	433	717
Long Beach, CA	312	16	405	733
Salem, VA	343	11	387	741
Des Moines, IA	299	9	435	743
Portland, OR	210	8	567	785
Nashville, TN	284	22	494	800
Minneapolis, MN	277	12	518	807
Milwaukee, WI	192	11	612	815
Lebanon, PA	395	21	405	821
Salisbury, NC	392	22	407	821
Puget Sound Health Care System, WA	242	9	570	821
Bay Pines, FL	229	7	604	840
Palo Alto, CA	241	14	615	870
Indianapolis, IN	267	34	624	925
St. Louis, MO	347	13	580	940
Albany, NY	297	15	631	943

Note: OPC = outpatient clinic; HD = facility on Highland Drive, Pittsburgh; UD = facility on University Drive, Pittsburgh.

Percentage of Pharmacy Workload Attributable to OTC Products, Fiscal Year 1995

VA facility location	Percentage of pharmacy workload for OTC products
West Haven, CT	7
Alexandria, LA	8
Kerrville, TX	8
Asheville, NC	9
Fresno, CA	12
Madison, WI	13
San Diego, CA	14
Roseburg, OR	14
Saginaw, MI	14
Shreveport, LA	15
West Palm Beach, FL	15
Atlanta, GA	15
Pittsburgh (HD), PA	16
Fargo, ND	17
Hampton, VA	17
Temple, TX	17
Miles City, MT	17
Providence, RI	18
Sheridan, WY	18
Salem, VA	18
Poplar Bluff, MO	18
Allen Park, MI	18
Loma Linda, CA	18
Minneapolis, MN	18
Denver, CO	18
New Orleans, LA	18
Buffalo, NY	18
Tuscaloosa, AL	18
Northport, NY	19
Ann Arbor, MI	19
Fort Harrison, MT	19
Muskogee, OK	19
Des Moines, IA	19
San Francisco, CA	19
Salt Lake City, UT	19
Big Spring, TX	20

(continued)

VA facility location	Percentage of pharmacy workload for OTC products
Canandaigua, NY	20
Biloxi, MS	20
Tucson, AZ	20
Bath, NY	20
Baltimore, MD	20
Beckley, WV	20
Louisville, KY	20
Fayetteville, AR	20
Chillicothe, OH	20
Albany, NY	20
Reno, NV	20
Phoenix, AZ	20
Philadelphia, PA	20
Memphis, TN	21
Battle Creek, MI	21
Amarillo, TX	21
Hines, IL	21
Grand Junction, CO	21
White River Junction, VT	21
Altoona, PA	21
Erie, PA	21
Wichita, KS	21
Birmingham, AL	21
West Los Angeles (Wadsworth), CA	21
Little Rock, AR	21
Togus, ME	21
Albuquerque, NM	21
Knoxville, IA	22
Leavenworth, KS	22
Montrose, NY	22
Mountain Home, TN	22
Walla Walla, WA	22
Lyons, NJ	22
Marion, IL	22
Montgomery, AL	22
Fort Lyon, CO	22
Durham, NC	22

(continued)

VA facility location	Percentage of pharmacy workload for OTC products
Bay Pines, FL	22
American Lake and Seattle, WA	22
Danville, IL	22
Fort Wayne, IN	23
Cincinnati, OH	23
Boise, ID	23
Dallas, TX	23
Boston, MA	23
Dublin, GA	23
Brooklyn, NY	23
Northampton, MA	23
Coatesville, PA	23
Cheyenne, WY	23
Huntington, WV	23
Lexington, KY	23
Kansas City, MO	23
Lake City, FL	23
Chicago (Lakeside), IL	23
Palo Alto, CA	24
Jackson, MS	24
Bedford, MA	24
Tomah, WI	24
Omaha, NE	24
Dayton, OH	24
Marion, IN	24
Grand Island, NE	24
Fort Meade, SD	24
Clarksburg, WV	24
Syracuse, NY	24
Sepulveda, CA	24
Salisbury, NC	24
Cleveland, OH	24
Sioux Falls, SD	25
San Antonio, TX	25
Brockton/West Roxbury, MA	25
Spokane, WA	25
Lincoln, NE	25

(continued)

VA facility location	Percentage of pharmacy workload for OTC products
Iowa City, IA	25
New York, NY	25
Bonham, TX	25
North Chicago (Downey), IL	25
St. Louis, MO	26
Manchester, NH	26
St. Cloud, MN	26
Charleston, SC	26
Washington, DC	26
East Orange, NJ	26
Oklahoma City, OK	27
Tampa, FL	27
Wilmington, DE	27
Butler, PA	27
Prescott, AZ	27
Augusta, GA	27
Fayetteville, NC	27
Tuskegee, AL	27
Indianapolis, IN	27
Wilkes-Barre, PA	28
Pittsburgh (UD), PA	28
Columbia, MO	28
Hot Springs, SD	28
Houston, TX	28
Portland, OR	29
Milwaukee, WI	30
Richmond, VA	30
Miami, FL	30
Bronx, NY	31
Long Beach, CA	32
Gainesville, FL	32
Nashville, TN	32
Murfreesboro, TN	32
Topeka, KS	33
Chicago (Westside), IL	33
Martinsburg, WV	33
Castle Point, NY	34

(continued)

VA facility location	Percentage of pharmacy workload for OTC products
Columbia, SC	34
Lebanon, PA	41
Iron Mountain, MI	47

Notes: We calculated the percentage of pharmacy workload for OTC products for facilities that responded to our OTC questionnaire.

HD = facility on Highland Drive, Pittsburgh; UD = facility on University Drive, Pittsburgh.

Source: GAO calculations based on Department of Veterans Affairs and GAO survey data.

100 Commonly Dispensed OTC Products That Accounted for About 70 Percent of the OTC Workload, Fiscal Year 1995

	OTC Products	Total times dispensed	Total estimated OTC costs
	OTC Medications		
1	ASPIRIN 325MG TAB,EC	1,314,602	$4,804,000
2	ACETAMINOPHEN 325MG TAB	928,470	3,757,000
3	INSULIN,NPH,HUMAN 100UNT/ML INJ	480,164	7,747,000
4	ACETAMINOPHEN 500MG TAB	440,370	1,980,000
5	DOCUSATE NA 100MG CAP	399,622	1,641,000
6	PSYLLIUM PWDR,ORAL	313,682	4,443,000
7	AL OH 400MG/MG OH 400MG/SIMETHICONE 40MG/5ML LIQUID	256,584	2,174,000
8	HYDROCORTISONE 1% CREAM,TOP	230,735	1,164,000
9	DIPHENHYDRAMINE HCL 25MG CAP	227,098	840,000
10	QUININE SO4 325MG CAP	215,600	1,199,000
11	MULTIVITAMIN TAB	205,121	822,000
12	AL OH 500MG/MG OH 450MG/SIMETHICONE 40MG/5ML SUSP,ORAL	203,956	1,399,000
13	INSULIN,REGULAR,HUMAN 100UNT/ML INJ	191,210	2,133,000
14	FERROUS SO4 325MG TAB	175,671	654,000
15	DIPHENHYDRAMINE HCL 50MG CAP	173,979	629,000
16	THIAMINE HCL 100MG TAB	133,219	492,000
17	GUAIFENESIN 100MG/5ML SYRUP	133,157	796,000
18	INSULIN,NPH 70UNT/REGULAR 30UNT/ML HUMAN INJ	118,355	2,228,000
19	DOCUSATE NA 250MG CAP	117,400	515,000
20	ASPIRIN 81MG TAB,CHEWABLE	105,615	476,000
21	CHLORPHENIRAMINE MALEATE 4MG TAB	103,098	355,000
22	ASPIRIN 325MG TAB	91,134	315,000
23	INSULIN NPH HUMAN 100 U/ML INJ HUMULIN N	87,967	1,377,000
24	SODIUM CHLORIDE 0.9% SOLN,IRRG	84,986	1,071,000
25	POLYVINYL ALCOHOL 1.4% SOLN,OPH	84,537	445,000
26	MECLIZINE HCL 25MG TAB	80,814	344,000
27	SIMETHICONE 80MG TAB,CHEW	77,974	419,000
28	PSEUDOEPHEDRINE HCL 60MG TAB	75,271	325,000
29	MULTIVITAMINS/MINERALS TAB	69,383	302,000
30	BACITRACIN 500UNT/GM OINT,TOP	69,236	297,000
31	DOCUSATE CA 240MG CAP	68,517	359,000

	OTC Products	Total times dispensed	Total estimated OTC costs
32	CAPSAICIN 0.025% CREAM,TOP	66,021	$1,569,000
33	LUBRICATING JELLY,TOP	65,931	405,000
34	SODIUM CHLORIDE 0.65% SOLN,NASAL	65,901	370,000
35	MULTIVITAMINS TAB	65,728	266,000
36	EUCERIN CREAM,TOP	64,736	4,058,000
37	BISACODYL 5MG TAB,EC	64,170	225,000
38	ASCORBIC ACID 500MG TAB	62,951	293,000
39	PSEUDOEPHEDRINE 60MG/TRIPROLIDINE 2.5MG TAB	61,020	263,000
40	ALUMINUM HYDROXIDE 225MG/MAGNESIUM HYDROXIDE 200MG/5ML SUSP,ORAL	58,519	607,000
41	BISACODYL 10MG SUPP,RTL	54,436	225,000
42	HEXAVITAMIN TAB	52,374	191,000
43	HYDROXYPROPYL METHYLCELLULOSE 0.5% SOLN,OPH	51,935	298,000
44	VITAMIN E 400UNT CAP	48,400	246,000
45	MAGNESIUM HYDROXIDE 405MG/5ML LIQUID	48,118	483,000
46	PYRIDOXINE HCL 50MG TAB	46,346	174,000
47	NIACIN 500MG TAB	46,198	241,000
48	HEMORRHOIDAL SUPP,RTL	45,250	293,000
49	DEXTROMETHORPHAN 15MG/GUAIFENESIN 100MG/5ML SYRUP	44,790	464,000
50	SODIUM BIPHOSPHATE 19GM/SODIUM PHOSPHATE 7GM ENEMA	43,934	253,000
51	CALCIUM CARBONATE 650MG TAB	40,954	182,000
52	MULTIVITAMINS/MINERALS,THERAPEUTIC TAB	39,337	177,000
53	AL OH 200MG/MG OH 200MG/SIMETHICONE 20MG/5ML LIQUID	39,183	391,000
54	INSULIN REG HUMAN 100 U/ML INJ HUMULIN R	39,109	428,000
55	ALGINIC ACID 200MG/AL OH 80MG/MG TRISIL 20MG/NA BICARB TAB,CHEW	36,796	278,000
56	AQUAPHOR OINT,TOP	36,774	642,000
57	SODIUM CHLORIDE 0.9% INHL 5ML	33,851	423,000
58	MOISTURIZING LOTION	32,774	225,000
59	POLYVINYL ALCOHOL 1% SOLN,OPH	32,230	260,000
60	SALICYLIC ACID 2%/SULFUR 2% SHAMPOO	31,374	162,000
61	COAL TAR,COLLOIDAL 1% SHAMPOO	30,921	720,000
62	CALCIUM CARBONATE 1.25GM TAB	30,689	162,000
63	CASANTHRANOL 30MG/DOCUSATE NA 100MG CAP	30,668	128,000
64	B-TRACIN 400UNT/N-MYCIN 3.5MG/POLYMYX 5000UNT/GM OINT,TOP	30,216	137,000

	OTC Products	Total times dispensed	Total estimated OTC costs
65	INSULIN HUMULIN 70/30 (NPH/REG) INJ LILY	29,520	$551,000
66	ASPIRIN 81MG TAB,EC	28,524	131,000
67	PSYLLIUM 50%/DEXTROSE 50% PWDR,ORAL	27,719	209,000
68	BACITRACIN ZINC 500UNT/POLYMYXIN B SO4 10000UNT/GM OINT,TOP	27,561	159,000
69	UREA 10% LOTION	27,384	198,000
70	UREA 20% CREAM,TOP	27,256	555,000
71	DEXTROMETHORPHAN 10MG/GUAIFENESIN 100MG/5ML SYRUP	26,357	385,000
72	ASPIRIN 325MG BUFFERED TAB	26,115	102,000
73	MULTIVITAMINS W/MINERALS TAB	26,067	105,000
74	PSYLLIUM SUGAR FREE PWDR,ORAL	26,023	523,000
75	PSEUDOEPHEDRINE HCL 30MG TAB	25,667	97,000
76	MAGNESIUM CITRATE LIQUID,ORAL	25,206	310,000
77	COAL TAR 0.5%/SALICYLIC ACID 2%/SULFUR 2% SHAMPOO	24,947	680,000
78	INSULIN,LENTE,HUMAN 100UNT/ML INJ	24,406	467,000
79	ACETAMINOPHEN 325MG/PHENYLTOLOXAMINE 30MG TAB	22,941	119,000
80	LANOLIN/MINERAL OIL 42.5%/PETROLATUM 55% OINT,OPH	22,537	150,000
81	MAGNESIUM OXIDE 420MG TAB	22,503	193,000
82	TOLNAFTATE 1% PWDR,TOP	21,785	113,000
	OTC Medical Supplies		
83	ALCOHOL PREP PAD	361,955	1,608,000
84	LANCET	264,157	2,248,000
85	CHEMSTRIP BG (GLUCOSE) TEST STRIP	230,056	13,760,000
86	ONE TOUCH (GLUCOSE) TEST STRIP	149,834	6,247,000
87	INSULIN SYRINGE 1ML 28G 0.5IN	95,290	972,000
88	GLUCOFILM (GLUCOSE) TEST STRIP	53,667	2,080,000
89	CHEMSTRIP BG ACCU-CHEK/VISUAL TEST STRIP	49,524	2,688,000
90	EASY (GLUCOSE) TEST STRIP	27,409	1,262,000
91	INSULIN SYRINGE 0.5ML 28G 0.5IN	27,240	515,000
92	GLUCOSTIX (GLUCOSE) TEST STRIP	21,708	809,000
93	KETO-DIASTIX (GLUCOSE,KETONE) TEST STRIP	16,712	313,000

	OTC Products	Total times dispensed	Total estimated OTC costs
	OTC Dietary Supplements		
94	SUSTACAL VANILLA	9,741	$327,000
95	ENSURE PWDR VANILLA	6,300	289,000
96	ENSURE PLUS LIQUID VANILLA	5,705	252,000
97	ENSURE LIQUID VANILLA	4,679	158,000
98	OSMOLITE LIQUID	3,239	197,000
99	SUSTACAL PWDR VANILLA	3,217	112,000
100	OSMOLITE HN LIQUID	2,478	207,000

Source: Department of Veterans Affairs.

Department of Veterans Affairs Office of General Counsel's Opinion on the Low Income Exemption From the Pharmacy Copayment

Department of Veterans Affairs **Memorandum**

Date: MAY 2 3 1996

From: General Counsel (02)

Subj: Low Income Exemption From the Pharmacy Copayment

To: Under Secretary for Health (174)

QUESTION PRESENTED:

What income threshold is VA legally required to use for determining whether a nonservice-connected veteran is exempt from paying the pharmacy copayment required by 38 U.S.C. § 1722A?

DISCUSSION:

1. In 1990, Congress added a new section 1722A to title 38, United States Code, requiring that VA collect a $2.00 copayment from veterans for each 30-day or less supply of medication furnished on an outpatient basis for a nonservice-connected condition. The law exempted any veteran with a service-connected disability rated at least 50% from having to pay the copayment. In 1992, Congress amended section 1722A to add an additional exemption for certain low income veterans. The Veterans Health Administration (VHA) implemented that amendment in 1993 by promulgating a directive. It has come to our attention that the directive incorrectly implemented the law.

2. Section 1722A of title 38, United States Code, provides that the pharmacy copayment requirement does not apply to veterans whose annual income "does not exceed the maximum annual rate of pension" payable to the veteran if the veteran were eligible for pension benefits "under section 1521 of this title." 38 U.S.C. § 1722A(a)(3)(B). VHA Directive 10-93-046, issued on April 22, 1993, implemented that provision of law. The directive provides that the income threshold for determining whether a veteran is exempt from the copayment should be the aid and attendance rate of pension that would be payable to that veteran if the veteran were otherwise eligible for pension benefits. The aid and attendance rate is established in 38 U.S.C. § 1521(d). The

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2.

Under Secretary for Health (174)

aid and attendance rate of pension is a higher amount then regular pension rate. In our view, the income threshold in most cases should be the regular rate of pension, not the aid and attendance rate. The aid and attendance rate should be used only in cases when the veteran does in fact require aid and attendance.

3. The language Congress used in 38 U.S.C. § 1722A(3)(B) to establish the income threshold appears to have been patterned after similar language used in 38 U.S.C. § 1712(a)(1)(B). The section 1712 language, which sets an income threshold for eligibility for outpatient care, reads:

> (B) to any veteran . . . whose annual income . . . does not exceed the maximum annual rate of pension that would be applicable to the veteran if the veteran were eligible for pension under section 1521(d) of this title. *Emphasis added.*

38 U.S.C. § 1712(a)(2)(B). Subsection (d) of section 1521 establishes the rate of pension for veterans needing aid and attendance. In section 1722A, Congress used slightly different language stating that the pharmacy copayment does not apply:

> (B) to a veteran whose annual income (as determined under section 1503 of this title) does not exceed the maximum annual rate of pension which would be payable to such veteran if such veteran were eligible for pension under section 1521 of this title. *Emphasis added.*

38 U.S.C. § 1722A(a)(3)(B). By failing to make reference to subsection (d) of section 1521 in section 1722A, Congress required VA to use the regular pension rate as the threshold, not the aid and attendance rate.

4. We recommend that you take steps to amend the Department's implementing instructions consistent with this opinion.

3.

Under Secretary for Health (174)

HELD:

A veteran is exempt from the pharmacy copayment required by 38 U.S.C. § 1722A if annual income is below a dollar threshold which is the amount of VA pension that particular veteran would receive if the veteran were otherwise eligible for VA pension. That amount will vary depending on the number of dependents the veteran has, if any, and whether the veteran is in need of regular aid and attendance.

Mary Lou Keener

Comments From the Department of Veterans Affairs

DEPARTMENT OF VETERANS AFFAIRS
UNDER SECRETARY FOR HEALTH
WASHINGTON DC 20420

AUG 29 1996

Mr. David P. Baine
Director, Health Care Delivery and Quality Issues
Health, Education, and Human Services Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Baine:

VHA program officials have reviewed the GAO Draft Report, ***VA Health Care: Opportunities to Significantly Reduce Outpatient Pharmacy Costs*** (GAO/HEHS-96-189). While VHA is already taking a number of specific actions to strengthen overall systemwide management of drug expenditures, and to achieve a higher level of consistency in prescribing practices among our facilities, VHA does not agree with your recommendations about limiting the availability of medically-necessary, over-the-counter (OTC) drugs in achieving these goals. Neither does VHA accept your recommendations to restrict the prescription mailout service and to require veterans to make prescription copayments at the time the OTC products are dispensed.

The report endorses provision of OTC products only to veterans meeting narrowly-defined eligibility requirements and to patients whose nonservice-connected conditions are either related to VA hospitalization or could potentially lead to hospitalization if the products weren't provided. VHA's policy has been and continues to be to provide all patients with medications, supplies and dietary supplements that their physicians determine to be medically-necessary. This applies to OTC products as well as to prescription items. Implementation of the recommendations to restrict OTC products to certain veterans would likely lead to fragmentation of care. The restrictions could also potentially result in an overall increase in health care costs since many VA patients simply are unable to purchase needed OTC supplies on their own. Failure to provide cheaper OTC products may well lead to a worsening of associated health problems that later lead to a need for additional medical care. This is the proverbial "penny wise, pound foolish."

In addition, patient satisfaction and customer service are goals that we stress in all aspects of health care delivery. Your recommendations to limit mailout prescriptions and to require veterans to make copayments at the time of OTC product dispensing undermine these important goals. The mailout program is provided as a service for veterans. Not only does it promote high levels of customer satisfaction, it also helps to reduce daily crowding and congestion in ambulatory care and parking areas of our treatment facilities. To mail only prescription items, thereby forcing the patient to make an added trip for needed

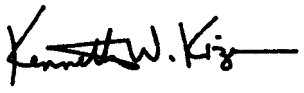
2. Mr. David P. Baine

OTC items, is both impractical and inconsiderate. In support of our commitment to customer service,we will also not deny a medically-necessary product if copayment cannot be made at the time of dispensing, even though veterans are encouraged to provide copayment at this time.

We are specifically addressing issues raised in this report and will be establishing a uniform national policy regarding the provision of OTC products. As detailed in the accompanying action plan, a work group will be convened in the near future to evaluate utilization data of OTC products and to recommend items for inclusion in VHA's national formulary, which will be established in all facilities no later than May 1, 1997. In anticipation of this consolidation, each VISN has already established a network formulary, thereby moving the system from 159 individual medical facility formularies to the current 22. The national formulary will standardize available OTC products in all facilities and it is anticipated that OTC inclusions will be significantly reduced. However, we want to emphasize that only 100 OTC items represent 80% of total dispensing activity, and most of these products are medically-necessary and obviate the need for hospitalization. For example, a significant number of items are routinely distributed to diabetic patients. Spinal cord injured patients also require extensive amounts of OTC medical/surgical supplies, as do dialysis and cardiac patients. Quality of care could be seriously compromised for many of these chronically ill veterans if their current access to needed medications and supplies were curtailed.

The enclosed action plan provides a detailed response to each report recommendation, including those dealing with multimonth dispensing and adjustment of the statutory income threshold for medication copayments. If additional information is required, please contact Paul C. Gibert, Jr., Director, Management Review Service, at 273.8355.

Sincerely,



Kenneth W. Kizer, M.D., M.P.H.
Under Secretary for Health

Enclosure

Action Plan in Response to OIG/GAO/MI Audits/Program Evaluations/Reviews

Name of Report: GAO Draft Report: ***VA HEALTH CARE: Opportunities to Significantly Reduce Outpatient Pharmacy Costs.***

Report Number: GAO/HEHS-96-189

Date of Report: July 1996

Recommendations/ Actions	Status	Completion Date

We recommend that the Secretary of Veterans Affairs require the Under Secretary for Health to

--- limit OTC products for nonservice-connected conditions to those most directly related to VA hospitalizations or those considered most essential to obviate hospitalization;

Non-Concur

Although we agree conceptually, in part, with this recommendation, the concept cannot be universally applied. VHA's policy of providing drugs to enrolled patients, including over-the-counter medications, supplies and dietary supplements, is based on the clinical determination that these items are medically necessary. Provision of continuity of care is a cornerstone of primary care practice, with emphasis on preventive care. Implementation of this recommendation would probably lead to providing fragmented care. Fragmentation of care can lead to an overall increase in health care costs. If a patient fails to follow through and purchase needed over-the-counter medications (a likely situation in the case of many VA patients), other health problems could result. Restriction of OTC products could also lead to a shift in prescribing patterns. In order to assure that the patient will actually be provided with the needed medication, more expensive prescription items may well be ordered, a practice leading to increased overall expenditures.

VHA is in the process of implementing significant controls that will enhance the systemwide management of drug distribution and expenditures without compromising the quality of care delivery. For example, each VISN has established a networkwide formulary and a national formulary will be in place no later than May 1, 1997. These

actions will enhance efforts already underway to further standardize the availability of pharmaceutical products across the system. Establishment of a national formulary should also have a positive, downward unit price impact on pharmaceutical contracting efforts. In addition, we continue the expansion of our consolidated mail outpatient pharmacy program and have created a national medical advisory panel to guide in the development of drug treatment guidelines for use throughout the system. Continued emphasis is also being placed on dispensing multimonth prescriptions for patients with chronic illnesses.

In Process **Ongoing**

--- ensure that VA pharmacies stock the same OTC products systemwide;

Concur

VHA plans to establish a national policy regarding the provision of OTC products and will standardize the availability of OTC products throughout the system with the establishment of a national formulary. The national formulary will be effective in all facilities no later than May 1, 1997. In anticipation of the move towards a national formulary, all of the VISNs have already established network formularies. We have therefore moved from 159 individual medical facility formularies to the current 22. These formularies include medically necessary over-the-counter products, routine medical supplies and dietary supplements. The evolution to a national formulary will ensure a measure of systemwide consistency in the provision of these products to eligible veterans. In both instances, we realize that formulary management is a dynamic and ongoing process. However, through the actions of our newly created Pharmacy Benefits Management (PBM) product line, we plan to utilize drug treatment guidelines to assist in managing the ongoing changes brought about by new products, research and treatment modalities and provide for the recognized need for more systematic consistency.

The Patient Care Services program office will establish a work group consisting of Network clinical managers/formulary liaisons and patient care services representatives to review national utilization data of OTC pharmaceuticals and dietary products and recommend items for the national formulary. This task will be completed by November 30, 1996. Another work group will focus on medical/surgical products and make recommendations about national formulary inclusions. It is anticipated that approval of the recommended formulary items will be completed by January 1, 1997.

In Process **May 1, 1997**

--- ensure that OTC products are provided only to veterans that meet the current eligibility rules;

Non-Concur

As we have reiterated throughout this response, fragmentation of care based on stringent adherence to cumbersome eligibility requirements severely hampers the ability to deliver quality health care. At the same time, such practices would not necessarily result in lower overall health care costs. The need for eligibility reform is well recognized and has been acknowledged by GAO. Successful resolution of current congressional activity in support of eligibility reform efforts is anticipated. Passage of eligibility reform legislation will provide a necessary and long overdue tool in VA's continuing development of a health care delivery system providing appropriate, effective, cost efficient care.

--- reduce VA's dispensing costs for OTC products by 1) providing, when appropriate, more economical quantities (more than a 90-day supply) of medications and supplies, and 2) limiting mail service to certain situations;

1. Concur with Qualifications

VHA is making a consistent effort to encourage multimonth dispensing systemwide in all instances where it is deemed to be clinically appropriate. Obviously, for those OTC products that are prescribed for acute conditions or on an as-needed basis, larger quantities are not justified. For medically necessary chronic medication or supplies, whether OTC or prescription items, quantity limitations must be based on quality of care considerations and the individual veteran's ability to comply with his or her medication regimen. Consideration must also be given to the stability of the drug in question. Thus, determination of the quantity prescribed is based on clinical judgment. The current medication renewal process often serves as a good opportunity for the patient to have personal contact with the health care providers and to be re-evaluated for medication compliance.

2. Non-Concur

This recommendation has been deleted from this report because of legislative changes to VA's eligibility rules passed by the Congress on September 28, 1996.

Page 4 **GAO/Outpatient Pharmacy Costs Action Plan**

Prescription mailout is provided to the veteran as a reasonable service that obviates burdensome and time-consuming trips to the medical facility for the sole purpose of picking up a prescription. Not only is this service of obvious benefit to the patient, but it also helps considerably in reducing crowding and congestion in the ambulatory care and parking areas. Outpatient waiting times are also reduced. In addition, by removing the travel obstacle, there is greater probability that patient compliance in utilizing a medically-necessary product will increase. To mail only prescription items, and force the patient to personally travel for OTC items, is impractical and inconsiderate. In fact, the majority of pharmacy mailouts of OTC products also include prescription items. Improved customer service is a key goal of VHA, and veterans have provided very positive feedback about the convenience of this program.

---require veterans to make copayments at the time OTC products are dispensed;

Non-Concur

To the fullest extent possible, veterans are encouraged to make copayments at the time OTC products are dispensed. An estimated 35% of prescription copayments are collected at the time of dispensing. Since approximately 50% of all outpatient prescriptions are mailed, it is obvious that copayment collection rates at the time of dispensing are already high. Again, collection decisions must be made on an individual basis. A veteran will not be denied a medically-necessary product if for some reason copayment cannot be made at the time the product is dispensed.

---direct facilities to use the statutory income threshold to determine which veterans owe medication copayments.

Concur

A General Counsel opinion was rendered on May 23, 1996 regarding adjustment in the income level for medication copayment exemptions. The income threshold will be the regular rate of pension and not the aid and attendance rate. It is estimated that most veterans who were previously exempt from the medication copayment due to their income levels will now be eligible for payment. Administrative guidelines and software enhancements are currently being developed to implement the new ruling. In their August 1996 national teleconference call to field staff, the Headquarters Health Administration Service will include this information on their agenda and provide an opportunity for discussion and clarification. In addition, the Medical Care Cost

Recovery Office will communicate information to the field about this legal opinion in upcoming conference calls and publications.

August 1996 Ongoing

GAO Contacts and Staff Acknowledgments

GAO Contacts

Paul Reynolds, Assistant Director, (202) 512-7101
Walter Gembacz, Senior Evaluator, (202) 512-6982

Acknowledgments

In addition to those named above, the following individuals made important contributions to this report: Mike O'Dell, Mark Trapani, Paul Wright, Deena El-Attar, and Joan Vogel.

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