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Report to Congressional Requesters

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DOD AND VA PHARMACY

Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs

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Abbreviations

ACEI	angiotensin converting enzyme inhibitor
AMCP	Academy of Managed Care Pharmacy
BPA	blanket purchase agreement
CMOP	consolidated mail outpatient pharmacy
DAPA	distribution and pricing agreement
DOD	Department of Defense
EENT	ear, eye, nose, and throat
FSS	federal supply schedule
GI	gastrointestinal
HMG CoA RI	hydroxymethylglutaryl coenzyme A reductase inhibitor
IOM	Institute of Medicine
LHRH	luteinizing hormone-releasing hormone
MOA	memorandum of agreement
NSA	nonsedating antihistamine
PPI	proton pump inhibitor
SSRI	selective serotonin reuptake inhibitor
VA	Department of Veterans Affairs

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United States General Accounting Office
Washington, DC 20548

May 25, 2001

The Honorable Steve Buyer
Chairman
The Honorable Vic Snyder
Ranking Minority Member
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
House of Representatives

The Honorable Christopher Shays
Chairman
Subcommittee on National Security,
Veterans Affairs and International Relations
Committee on Government Reform
House of Representatives

The Honorable Terry Everett
House of Representatives

The Honorable Corrine Brown
House of Representatives

In fiscal year 2000, the Department of Veterans Affairs (VA) and the Department of Defense (DOD) together spent about $3.2 billion on prescription drugs for beneficiaries. Reflecting national trends, VA and DOD drug expenditures have risen significantly, consuming an increasing percentage of their health care budgets. Newly legislated initiatives are projected to further boost DOD's annual drug costs by $800 million in fiscal year 2002. To help control these expenditures, VA and DOD have separately and, more recently, jointly contracted for pharmaceuticals to obtain large discounts from drug manufacturers.[1] Considerable leverage can be exerted when the departments commit to buy increased volumes of

[1]Most VA and DOD pharmaceuticals are purchased at below commercial market prices through multiple arrangements with drug companies. For larger discounts, VA and DOD have been using national requirements contracts, whereby they commit to give priority to using the contract drug rather than equivalent substitutes, to guarantee drug companies a higher volume of sales. These fixed-price contracts are usually for 1 year, plus four 1-year option periods.

a particular drug when there are generic drugs or brand name drugs[2] that are interchangeable in efficacy, safety, and outcomes. The departments' ability to commit to jointly buy more of a particular drug depends largely on their ability to influence provider prescribing practices through the use of formularies.[3]

Since the early 1980s, the Congress has urged VA and DOD to achieve greater efficiencies through increased collaboration. In May 2000, we testified before the House Committee on Veterans Affairs' Subcommittee on Oversight and Investigations on VA and DOD's joint pharmaceutical procurement and distribution.[4] We identified a number of high-expenditure drug classes[5] and encouraged the departments to review them for clinical appropriateness and potential cost-effectiveness for joint procurement. We also urged DOD to consider using VA's highly efficient consolidated mail outpatient pharmacy (CMOP) centers[6] to handle DOD's military pharmacies' refill prescription workloads. The departments generally agreed with both proposals. As part of your continuing oversight of these efforts, you asked us to report on (1) VA's and DOD's efforts to increase joint pharmaceutical procurement, (2) challenges cited by VA and DOD in doing so, and (3) the status of their efforts to pilot test CMOP use at DOD.

[2]Brand name drugs generally have a patent on their chemical formulation or manufacturing process. After the patent expires, other drug makers can make generic copies with the same active ingredient(s), strength, concentration, dosage form, and administration. Generic drugs are often copied by multiple manufacturers, resulting in much more competition and much lower prices than brand name drugs.

[3]Formularies are lists of medications that health care organizations encourage or require their providers to use when they write prescriptions for patients. By concentrating their purchases on particular drugs, organizations can secure better prices.

[4]*DOD and VA Health Care: Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars* (GAO/T-HEHS-00-121, May 25, 2000).

[5]A drug class is a group of drugs that are similar in chemistry, method of action, and purpose of use. For example, four selective serotonin reuptake inhibitors (SSRI)—citalopram (Celexa), fluoxetine (Prozac), paroxetine (Paxil), and sertraline (Zoloft)—are grouped in the antidepressant drug class.

[6]To achieve efficiencies in its pharmacy program, VA has established seven CMOP centers to process high-volume prescription workloads using an integrated, automated dispensing system. While veterans can still elect to refill their prescriptions in person at VA pharmacies, last year about 60 percent of—or 50 million—veterans' refill prescriptions were electronically sent from VA pharmacies to the CMOP centers and then mailed to veterans.

To conduct our work, we interviewed VA and DOD pharmacy policy and acquisition officials and reviewed records on procurement, policy, and mail-out operations. We reviewed DOD's and VA's preliminary comments, joint procurement plans, and cost avoidance estimates related to the drug classes and individual drugs we identified as potential joint procurement candidates. DOD and VA define cost avoidance as the difference between the theoretical cost that would have occurred if contracts were not awarded and the actual cost incurred for the drugs affected by each contract.[7] To learn more about the joint procurement potential of drugs in these classes, we consulted with a managed care pharmacist and obtained the views of academic and private sector managed care pharmacy experts.[8] Regarding the CMOP pilot, we interviewed DOD and VA officials and reviewed records concerning interagency software needs and costs to establish an electronic link between military pharmacy and CMOP center computers, as well as other issues affecting the pilot's progress. We also visited two VA and DOD medical centers to observe pharmacy computer systems and to discuss links with CMOPs for electronically transmitting refill prescriptions for processing and mailing to beneficiaries. We conducted our work from June 2000 through April 2001 in accordance with generally accepted government auditing standards.[9]

Results in Brief

VA and DOD have made important progress—particularly this past year—to increase their joint procurement activities. From October 1998 through April 2000, VA and DOD awarded 18 joint pharmaceutical contracts, which they estimated to yield $40 million in fiscal year 2000 cost avoidance. Since then, VA and DOD have awarded another 12 joint contracts and as of January 2001 have solicited another 14 joint contracts; they estimate

[7]The departments estimated the theoretical cost by multiplying the weighted average price per unit before the contract took effect, by the quantity purchased in fiscal year 2000. For example, the departments' estimated cost avoidance for cholesterol-lowering drugs takes account of expenditures for all six such brand name drugs, not just the two each department has contracted. In our view, this is a reasonable estimating methodology.

[8]Our consultant, Dr. Peter M. Penna, has extensive experience in managed care pharmacy operations and is a founding member and past president of the Academy of Managed Care Pharmacy (AMCP). We also obtained the views of academic and private sector pharmacy benefit management experts affiliated with (1) AMCP, (2) the Institute of Medicine's (IOM) VA Pharmacy Formulary Analysis Committee, and (3) Rx Health Value (a national organization supporting research, public education, and private sector and public sector policies on the health and economic values of prescription drugs).

[9]This work followed on that which we performed from August 1999 through May 2000 for our testimony.

additional annual cost avoidance of more than $30 million. Over the next few years, the departments plan to target for joint procurement 112 generic and brand name drugs from among the classes that we urged them to review in our May 2000 testimony. Also, they plan to merge their separate national contracts, which they estimate now yield over $184 million per year in cost avoidance, as the contracts expire. The departments estimate that cost avoidance from such activities will be an additional $100 million per year, although they have not yet projected cost avoidance from joining their separate contracts or for some later year procurements. Other recent actions demonstrate the departments' commitment to increasing their joint procurement activities. For example, their pharmacy policy and acquisition officials are now meeting regularly, and a detailed interagency report to track joint procurement progress and results has been developed.

Thus far, most VA and DOD joint procurements have been for generic drugs, and the departments cite challenges to their jointly procuring more brand name drugs. But contracting for brand name drugs can yield the largest financial benefits because most of the departments' drug dollars—91 percent in VA's case—is spent on brand name drugs. Yet unlike generic drugs, contracting for brand name drugs can be challenging and contentious because limiting beneficiary choice requires gaining clinical agreement on competing drugs' therapeutic interchangeability. VA and DOD officials told us such considerations are further exacerbated by their separate health care systems' unique pharmacy policies and clinical requirements. For example, VA and DOD told us that the drug needs of their different patient populations—VA beneficiaries are mostly male and elderly, while DOD beneficiaries are younger and include women and children—vary widely, requiring their national formularies to differ in scope and selection of preferred drugs. DOD officials also told us it is challenging to persuade nonmilitary doctors participating in TRICARE—the department's managed care and fee-for-service health care program—to prescribe a contracted drug and, thus, meet the commitment to more exclusive use of a drug.

However, certain evolving circumstances and additional actions the departments can take may help mitigate the challenges they cite. For example, differences in VA's and DOD's beneficiary populations are lessening as the percentage of DOD beneficiaries who are retirees continues to increase, and these retirees require drugs more similar to VA's population. Differences will further diminish since DOD's pharmacy benefit for retirees 65 and older expanded in April 2001. Further, changes under way in both agencies' formularies should provide more

opportunities for VA and DOD to work together on joint procurement. Recent legislation is prompting DOD to expand its formulary, which should make it more comprehensive in scope like VA's formulary. Moreover, VA and DOD have successfully collaborated in developing two joint procurement solicitations that preserve their separate pharmacy policies and clinical requirements. To help influence nonmilitary providers and their patients to use contracted drugs, DOD can build on its experience with TRICARE to better inform these groups. Finally, in our view, the departments' joint procurement efforts might also benefit from periodically conferring with private sector experts and annually reporting progress to the Congress given its long-standing interest in these activities.

VA and DOD have also made progress in their efforts to assess the feasibility of conducting a CMOP pilot. In our May 2000 testimony, we reported that DOD's use of VA's CMOP centers could cut current dispensing costs and yield other operational improvements, such as patient safety and convenience. In January 2001, DOD determined that it is feasible to develop the necessary computer interface between military pharmacies and CMOP centers and intends to seek money to pilot test the mailing of military pharmacies' prescription refills. DOD officials estimate that developing the computer interface should require about 9 months. However, other critical operational and financial issues—and time frames for fielding the pilot—have not yet been developed. If implemented promptly, the pilot would provide needed lead time to build new CMOP facilities to accommodate DOD's workload in the event that DOD decides to use CMOPs systemwide.

In view of the leadership changes under way at both departments under the new administration and to help ensure that the departments continue to build on the progress already made in their joint procurement and distribution efforts, we are making several recommendations. In reviewing a draft of this report, DOD and VA provided separate comments in which they both concurred with the report and our recommendations.

Background

Reflecting national trends, VA and DOD prescription drug expenditures have increased substantially in recent years and at a much higher rate than their overall health care expenditures. (See figure 1.)[10] In fiscal year 2000,

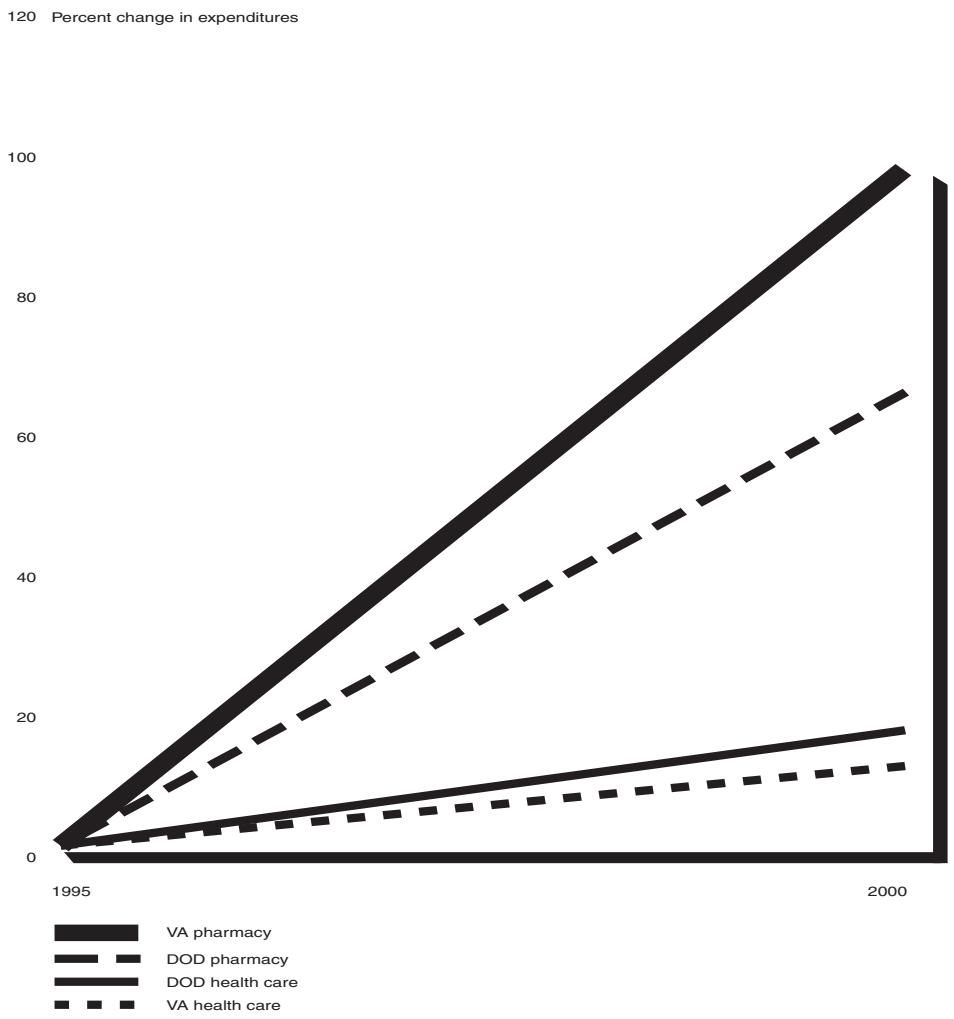
[10]The national rise in drug outlays has occurred for a number of reasons, including increased use of drugs, the substitution of higher-priced new drugs for lower-priced existing ones, and more direct-to-consumer advertising by manufacturers.

VA purchased about $2.1 billion in pharmaceuticals—$256 million more than in fiscal year 1999—to provide 86 million prescriptions for veterans. In the same year, DOD purchased about $1.14 billion in pharmaceuticals—an increase of $174 million from fiscal year 1999—to provide 54 million military pharmacy and mail-order prescriptions for active duty and retired military service members and their families. Similarly, DOD's TRICARE retail pharmacy program costs have skyrocketed—averaging 34 percent increases each year since 1995.[11] A number of factors are likely to further drive up pharmaceutical spending, such as a decrease in private insurance pharmaceutical coverage for individuals eligible for VA or DOD benefits. This is particularly so for DOD—as of April 1, 2001, approximately 1.4 million retirees and their dependents received new retail and mail-order pharmacy benefits at an additional cost of about $800 million annually.[12]

[11]The direct care system of Army, Navy, and Air Force medical facilities is supplemented by DOD's regional TRICARE managed care support contracts, under which retail pharmacy benefits are provided to eligible DOD beneficiaries. In fiscal year 2000, DOD beneficiaries obtained 12 million retail pharmacy prescriptions, which cost TRICARE contractors $455 million.

[12]Beneficiaries 65 years of age and older received new pharmacy benefits under the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (P.L. 106-398). In the past, these beneficiaries have found it difficult to obtain necessary medications at military pharmacies due to DOD's limited formulary. The new program will limit their out-of-pocket costs and increase their access to DOD's mail-order pharmacy program and 28,000 TRICARE retail pharmacies.

Figure 1: Rise in VA and DOD Pharmacy and Health Care Expenditures, 1995-2000



Source: GAO analysis of DOD and VA information.

Since 1997, VA and DOD have each adopted centralized formularies to help ensure that certain drugs are available at all veterans' and military health care facilities as well as to control pharmacy benefit costs. VA's national formulary currently lists about 1,100 drugs representing 254

classes, while DOD's basic core formulary lists 175 drugs in 71 classes.[13] Most of the drug classes in both VA national and DOD core formularies are open—that is, there are no restrictions on provider's choice of which drug to prescribe for a patient. However, a few drug classes are closed or preferred, meaning that VA and DOD have varying restrictions on providers' choice of drugs after determining that certain brand name drugs are therapeutic alternatives—that is, interchangeable in terms of efficacy, safety, and outcomes.

Having closed or preferred classes allows VA and DOD to competitively award requirements contracts for the lowest-priced drugs.[14] In closed classes, VA and DOD providers must prescribe and pharmacies must dispense the contract drug, instead of therapeutic alternatives, to meet the terms of the contract and guarantee drug companies a high market share. Case-by-case exceptions are allowed, such as those for medical necessity. In preferred classes, VA and DOD providers and pharmacies are encouraged to use the preferred drug but may prescribe or dispense other drugs in the same class without obtaining an exception. Due to the complexity of the care issues and the need to garner clinical acceptance and support, VA and DOD can take as long as a year between the date their respective class reviews establish therapeutic interchangeability of competing brand name drugs and the date a contract is awarded. Generic drug contracts do not require drug class reviews—since competing products are already known to be chemically and therapeutically alike—and, therefore, take less effort and time—about 120 days.

VA and military pharmacies use a number of purchasing vehicles to buy prescription drugs at substantial discounts from market prices. (See table 1.) For example, in 1999, about 81 percent of VA and DOD's combined $2.4 billion in drug expenditures was for drugs bought through the federal

[13]VA's national formulary includes drugs used for inpatient and outpatient care, whereas the DOD basic core formulary is the minimum list of drugs used for outpatient care that all military pharmacies must make available at each facility. Locally, veterans and military medical centers, hospitals, and clinic pharmacies can add drugs to their respective national and basic core formularies based on their clinical services and the scope of inpatient and outpatient care provided.

[14]VA and DOD refer to these as committed-use contracts. About 2 percent of the classes on VA's national formulary are closed or preferred. Less than 10 percent of the classes on DOD's basic core formulary are closed or preferred.

supply schedule (FSS) for pharmaceuticals.[15] The remaining expenditures were for purchases associated with the different requirements contracts VA and DOD have with drug manufacturers—each using leverage with manufacturers to achieve the lowest-priced product on its formulary.

Table 1: VA and DOD Pharmaceutical Purchasing Vehicles

Purchasing vehicle	Description	Discount
FSS for pharmaceuticals	VA negotiates multiple award contracts with drug companies to set prices available to all federal purchasers. FSS prices are intended to be no more than the prices manufacturers charge their most-favored nonfederal customers under comparable terms and conditions. Under federal law,[a] drug manufacturers must list their brand name drugs on the FSS to receive reimbursement for drugs covered by Medicaid.	About 50 to 58 percent lower than average wholesale price.[b]
FSS blanket purchase agreements (BPA)	FSS contracts with drug manufacturers contain BPA provisions so that VA and DOD can negotiate additional discounts. Sometimes the lower prices are dependent on specific volumes being purchased by particular facilities, such as one or more VA or military hospitals. VA and DOD have negotiated a few BPAs for preferred status on their respective national formularies.	Variable discounts below FSS prices.
Requirements contracts	VA and DOD brand name drug and generic drug requirements contracts differ as follows. After performing drug class reviews, VA and DOD determine that some brand name drugs are therapeutic alternatives. This determination allows VA and DOD to conduct a competition among the equivalent drugs and to select one winner based on price alone. VA and DOD commit to use the selected drug on their respective national formularies and close the class. Providers must prescribe and VA and DOD pharmacies must dispense the contract drug, instead of therapeutic alternatives, to guarantee drug companies a high volume of use. Case-by-case exceptions are allowed under certain circumstances, such as for medical necessity. In some cases, brand name drug requirements contracts are also based on competitions among drugs that have been determined to be therapeutic alternatives. Here, however, VA and DOD list the contracted drugs as preferred agents on their respective national formularies, but do not close the class. Individual VA and military pharmacies may add and use other drugs in the same class on their local formularies. For generic drugs, VA and DOD conduct a competition for an exclusive contract with one manufacturer. Contracted items are usually selected from among generic products approved by the Food and Drug Administration that are tested against a standard of bioequivalence to the original brand name version.	Average 33 percent lower than FSS prices.

[a]The Veterans Health Care Act of 1992 (P.L. 102-585).

[15]Administered by VA through multiple award contracts with manufacturers, the FSS for pharmaceuticals is a list of over 17,000 brand name and generic drug products and their prices.

[b]Average wholesale price is what a manufacturer suggests wholesalers charge pharmacies. Typically less than the retail price, average wholesale price is referred to as a sticker price because it is not the actual price that large purchasers normally pay. For example, in a 1997 study of prices paid by retail pharmacies in 11 states, the average acquisition price was 18.3 percent below average wholesale price (Office of the Inspector General, Medicaid Pharmacy—Actual Acquisition Cost of Prescription Drug Products for Brand Name Drugs (Washington, D.C.: Health and Human Services, Apr. 1997). Discounts for health maintenance organizations and other large purchasers can be even greater.

Sources: *Prescription Drugs: Expanding Access to Federal Prices Could Cause Other Price Changes* (GAO/HEHS-00-118, Aug. 7, 2000) and GAO analysis of DOD and VA information.

For nearly 2 decades, the Congress has urged VA and DOD to maximize federal dollars by sharing their health care resources. In May 1982, the Congress enacted the VA and DOD Health Resources Sharing and Emergency Operations Act (P.L. 97-174), which generally encouraged the two departments to enter into agreements to share health care services in existing or newly built health care facilities. In 1996, the Congress began to specifically target cooperation in the purchasing and distributing of pharmaceuticals for the departments' respective beneficiaries. A 1999 report by a congressional commission concluded that DOD and VA should combine their market power to get better pharmaceutical prices through joint contracts.[16] More recently, the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) required VA and DOD to submit a report on how joint pharmaceutical procurement can be enhanced and cost reductions realized by fiscal year 2004. In January 2001, VA and DOD submitted this report on efforts under way to maximize efficiencies in health care systems. Finally, the Veterans Benefits and Health Care Improvement Act of 2000 (P.L. 106-419) included a provision encouraging VA and DOD to increase to the maximum extent consistent with their respective missions their level of cooperation in the procurement and management of prescription drugs.

VA and DOD Have Markedly Increased Their Joint Procurement Activities

VA and DOD have made important progress, especially this past year, to increase their joint pharmaceutical procurement activities. By May 2001, the departments expect to have more than doubled the number of joint procurement contracts entered into since our May 2000 testimony. And the departments estimate substantial cost avoidance from current and planned joint procurements—about $170 million per year. VA and DOD's improved communication and collaboration on these efforts should further enhance their future performance.

[16]The Congressional Commission on Servicemembers and Veterans Transition Assistance report made numerous recommendations to improve the effectiveness of DOD and VA programs providing benefits and services to active duty military personnel and veterans.

Joint Drug Procurements Have Substantially Increased, and Many More Are Planned for the Next Few Years

From October 1998 through April 2000, VA and DOD awarded joint contracts for 18 products, which accounted for about $62 million in combined drug expenditures in fiscal year 2000. (See table 4 in appendix I.) Although these drugs account for just 1.9 percent of the departments' combined $3.2 billion drug spending in 2000, VA and DOD estimate these joint procurement discounts achieved sizeable cost avoidance—about $40 million in 2000. This is in addition to the significant cost avoidance the departments are already experiencing from their separate contracts. Last year, the departments began developing plans to merge these contracts as they expire and undertook other collaborative actions that will increase the number of joint procurements in the future.

In May 2000, we testified that VA and DOD could significantly increase savings with expanded use of joint pharmaceutical procurement, especially for products in high-expenditure drug classes—a number of which we identified. Since that time, the departments have moved to more than double their joint pharmaceutical procurements and the expected financial benefits from these joint activities. As of January 2001, for example, VA and DOD have awarded an additional 12 joint contracts for commonly used generic drugs and are in the process of awarding another 14 joint contracts—including one for a brand name nonsedating antihistamine drug. (See tables 5 and 6 in appendix I.) In 1999, these drugs accounted for about $123 million of combined VA and DOD purchases. The departments estimate substantial discounts from these new joint procurements—an additional $30 million in drug purchasing cost avoidance each year for the 12 contracts already under way—and millions more should stem from the 14 solicitations that are under way.

As of December 2000, VA and DOD had preliminarily reviewed the high-expenditure classes that we suggested could provide opportunities for additional joint procurements. As a result, they plan over the next few years to target for joint procurement 112 drugs—which accounted for about $400 million of their combined expenditures in 1999. (See table 2 for the major therapeutic areas and appendix II for details.) Further, VA and DOD plan to propose more joint procurements after they complete their analysis of the suggested classes. Most of these planned procurements are for generic drugs, but some are for brand name drugs. For example, VA and DOD also recently completed class reviews on the therapeutic interchangeability of several brand name drugs used to treat sinus congestion and have found sufficient clinical basis to pursue one or two joint procurements.

Table 2: Therapeutic Areas We Suggested and VA and DOD Targeted for Joint Procurement in the Future

Dollars in millions

Major therapeutic area	VA/DOD purchases that can be contracted	Estimated cost avoidance for VA/DOD
Antihistamines	$15.0	$2.4
Anti-infective agents	39.7	5.7
Antineoplastic (anticancer) agents	28.9	5.1
Blood formation and coagulation	26.6	4.4
Cardiovascular drugs	16.1	2.5
Central nervous system agents	128.7	48.9
Diagnostic agents	36.1	3.6
Gastrointestinal drugs	7.7	2.1
Hormones and synthetic substitutes	79.7	22.7
Serums, toxoids, and vaccines	15.9	0.06
Unclassified therapeutic agents	6.9	2.1
Totals	**$401.1**	**$99.5**

Notes: These major therapeutic areas were among those that we suggested the departments perform reviews, class-by-class, of their purchased drugs to identify candidates for joint procurement. See appendix II in *DOD and VA Health Care: Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars* (GAO/T-HEHS-00-121, May 25, 2000). Also, dollars do not equal total due to rounding.

Source: GAO analysis of VA and DOD information.

The departments estimate that discounts from joint procurements in the targeted classes will yield about $100 million in additional annual cost avoidance although they have not yet estimated cost avoidance for some later year procurements. Also, DOD and VA agreed to merge 52 existing VA-only and DOD-only contracts as these contracts expire. (See table 7 in appendix I.) For example, the departments plan to merge their eight separate contracts for brand name drugs used to lower cholesterol, treat gastrointestinal problems, and control high blood pressure. These contracts yielded cost avoidance in excess of $184 million in fiscal year 2000, which will likely increase as the contracts are consolidated. But, the departments have not yet estimated the consequent potential additional cost avoidance. While potential cost avoidance is difficult to estimate—especially given the high variability in drug market competition—it is likely that the more joint procurements VA and DOD enter into, the greater the financial benefits they will realize.

Improved Collaboration Should Enhance Future Joint Procurement Performance

Prior to May 2000, VA and DOD had primarily used interagency sharing agreements and work groups to collaborate on joint procurement activities. In 1998, for example, the DOD/VA Federal Pharmacy Executive Steering Committee was established to increase the uniformity and cost effectiveness of drug therapy in their separate health systems, including overseeing joint contracts for high-dollar and high-volume drugs. But the geographical separation of the departments' key pharmacy policy and acquisition staffs continued to hamper their day-to-day communications on joint drug activities and complicate their working relationships.[17] Since May 2000, however, the departments have sought to remedy this. As a result, their key pharmacy officials now meet regularly at hub locations to discuss and further their joint procurement activities, and have developed a continually updated interagency report on their joint procurement activities.

In August 2000, the DOD/VA Federal Pharmacy Executive Steering Committee began meeting regularly in San Antonio, Texas; Falls Church, Virginia; or Chicago, Illinois, to identify drugs or classes for joint contracting and discuss strategies based on ongoing clinical and formulary decisions. VA and DOD pharmacy policy and acquisition center staff also started holding frequent subcommittee meetings to focus on joint procurement issues.

Similarly, in July 2000 VA and DOD acquisition center executives and managers began meeting regularly in Philadelphia or Chicago to review progress under a memorandum of agreement (MOA) to combine their buying power, reduce medical materiel costs, and eliminate contracting redundancies.[18] In addition to implementing joint contracting decisions, the MOA provided that the departments also work together to cancel DOD's distribution and pricing agreements (DAPA) with drug companies

[17]DOD's Pharmacoeconomic Center is in San Antonio, Texas, and its acquisition center is in Philadelphia, Pennsylvania. VA's counterpart clinical and acquisition groups are in Hines (Chicago), Illinois.

[18]The MOA, signed in 1999, provides that the responsibilities of DOD and VA will be tailored for each medical product line and service in appendixes that are separately coordinated by the appropriate offices. Current appendixes are medical-surgical products and pharmaceutical products (a medical equipment appendix is being developed), with other areas to be added as needed.

by converting them to VA's FSS prices.[19] Since the May 2000 hearing, a number of issues impeding progress on converting DAPA to FSS prices have been resolved. For example, a needed computer interface was established between the acquisition centers to expedite uploading FSS prices into DOD's pharmaceutical ordering and purchasing system, and VA agreed to offset its normal surcharge on all FSS sales[20] to military pharmacies. By January 2001, DOD was able to convert its DAPAs and now both agencies use the same FSS prices. As a result of last year's progress on the MOA, DOD's acquisition officials expect to reassign some of their employees to work on additional joint pharmaceutical contracting with VA.

Finally, VA and DOD's new Joint Contract Status report, which is maintained by VA's pharmacy policy staff, details every drug and drug class with combined purchase potential. VA and DOD pharmacy policy and procurement staff use the report to monitor joint procurement progress and track results. The report is continually updated to list all current joint and separate (VA-only and DOD-only) contracts and those potential procurements that are dependent on clinical and formulary decisions. A November 2000 update to the report details about 140 unique drugs and drug classes providing the contracting status for existing joint and separate contracts and, for many of these, estimates of award values and annual cost avoidance. The report also lists proposed and pending joint contracts—including several we had identified earlier as potential candidates—and the time frames for the various procurement stages. Projected time frames for when the departments' separate national contracts can be merged are also included.

[19]Historically, VA and DOD had about 250 differing price arrangements for thousands of pharmaceutical products with many of the same companies. In practice, DOD adopted the FSS price as the starting point for negotiations on DAPAs. By converting the DAPAs, both agencies would pay the same FSS prices to drug makers and some small administrative efficiencies would follow.

[20]To recover administrative costs associated with managing the FSS, VA began collecting a fee of 0.5 percent on drug manufacturers' FSS sales in 1995, which resulted in DAPA prices becoming slightly lower than FSS prices. According to a DOD acquisition official, initial response from drug manufacturers was to adjust both FSS and DAPA prices upward by 0.5 percent. However, DOD determined that manufacturers had no legal basis to raise DAPA prices and notified manufacturers that it would no longer accept DAPA prices equal to FSS. Under the MOA, DOD was concerned that the conversion to FSS prices would potentially drive up military pharmacies' purchasing costs by $2 million. To avoid this, VA agreed to refund to DOD FSS surcharges for the first year of the MOA, which was implemented in January 2001.

VA and DOD Cite Challenges to Jointly Procuring Brand Name Drugs

Most VA and DOD joint procurements have been for low-cost generic drugs. While these drugs make up a larger share of the departments' combined drug volume than brand name drugs, brand name drugs make up a far higher share of expenditures. For example, VA's brand name drug purchases are 36 percent of volume but 91 percent of expenditures.[21] Although in jointly procuring brand name drugs it can be more complex and time-consuming to garner clinical support and provider acceptance on therapeutic interchangeability, the cumulative financial benefit potential is far greater. Along with such inherent difficulties, VA and DOD cite such challenges as differences in their beneficiary populations and formularies that make it difficult for them to jointly procure brand name drugs. However, some of these differences are diminishing, and the departments have already demonstrated in two cases that they can jointly procure brand name drugs and still meet their unique clinical and administrative needs. Also, the departments can take such actions as periodically seeking input from experts and providing annual reports to the Congress on their joint procurement activities to help enhance their efforts to address these challenges.

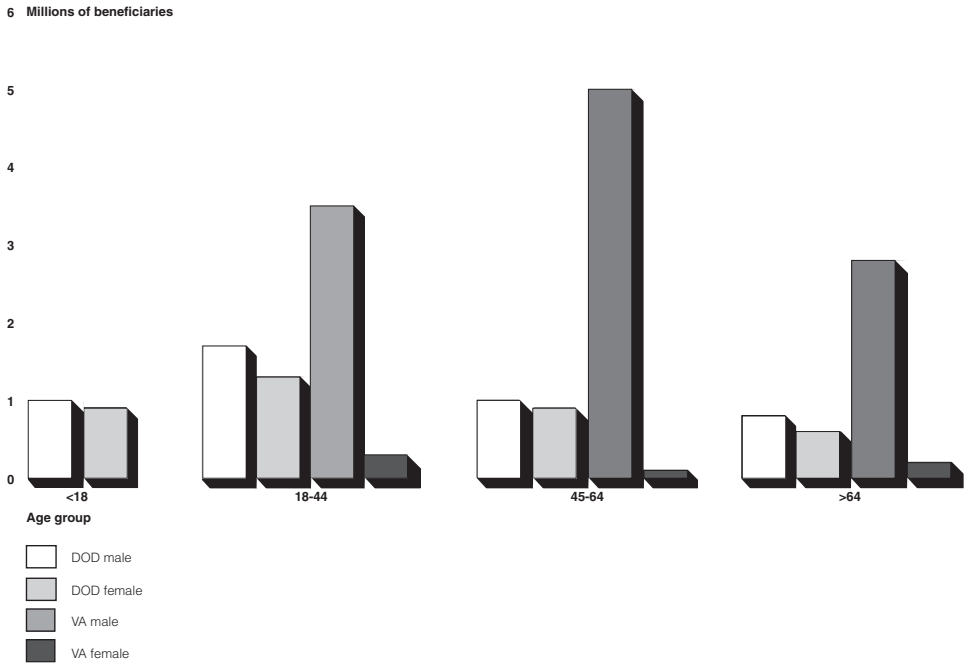
Departments Cite Differing Beneficiaries, Formularies, Clinical Needs, and Provider Prescribing Practices as Complicating Jointly Buying Brand Name Drugs

According to VA and DOD officials, several aspects of their health care systems create challenges that limit their opportunities to jointly procure brand name drugs:

- VA and DOD officials cite differences in their patient populations—VA serves mostly older men, while DOD also serves younger men and women and children—as shown in figure 2. They said that the different populations result in dissimilar patterns of drug use and demand among their respective beneficiaries, resulting in fewer opportunities to combine drug requirements and solicit joint contracts.

[21]According to DOD, an estimated 40 percent of military pharmacies' prescription volume in 1999 and 2000 was for brand name drugs; however, data are unavailable on brand name versus generic drug costs.

Figure 2: DOD and VA Beneficiary Populations—1999



Source: GAO analysis of *1999 Federal Market Facts*, U.S. Medicine.

- VA and DOD officials told us that differences in the scope of their national formularies also limit opportunities for joint drug procurements. VA's national formulary currently lists about 1,100 drugs for inpatient and outpatient care representing 254 classes, while DOD's basic core formulary lists 175 drugs for outpatient care in only 71 classes. Also, DOD's military pharmacy formularies currently limit the drugs available to beneficiaries seeking them whereas its TRICARE retail formularies are unrestricted such that virtually any drug can be obtained. DOD officials are concerned that joint contracts for particular brand name drugs would further restrict drug choice at military pharmacies, which, in turn, could cause beneficiaries to use the retail pharmacies for their drugs. This could drive up DOD's overall pharmacy costs because its contractors' drug costs are greater than its discounted military pharmacy drugs.[22]

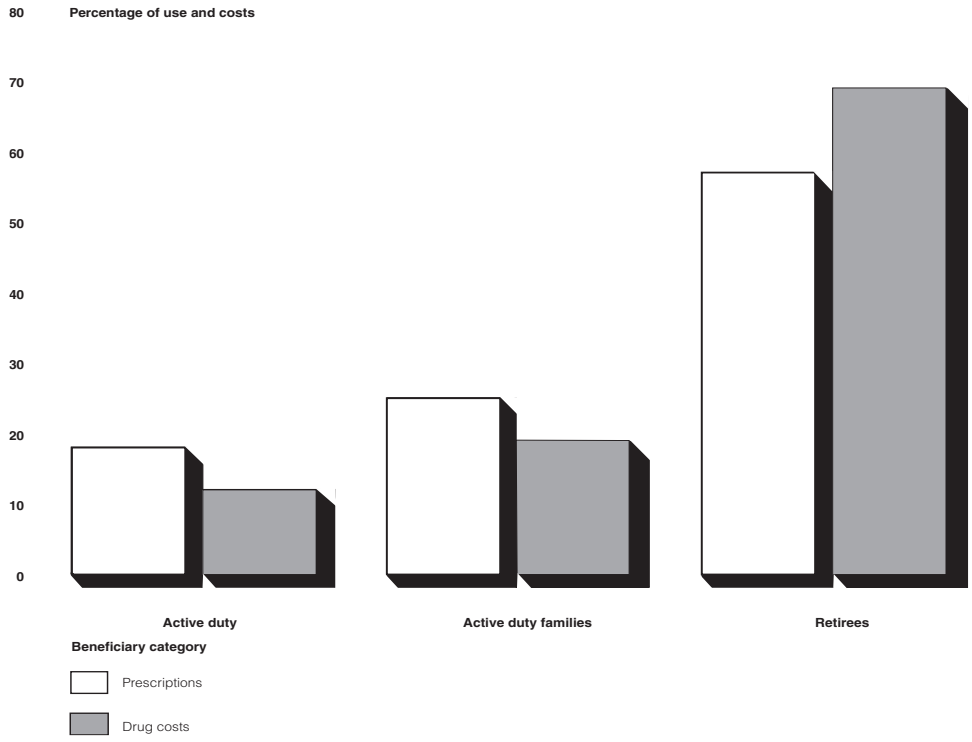
[22]DOD's drug price discounts under its FSS and requirements contracts with drug manufacturers reduce drug costs far below prices paid by TRICARE contractors for retail pharmacy prescriptions—which, on average, cost 40 percent more.

- VA and DOD officials are also concerned that closing some classes would be clinically unacceptable for certain populations or individuals with certain conditions. For example, VA and DOD have been reluctant to seek joint contracts for orally inhaled corticosteroids (to treat asthma) because some DOD clinicians would not accept limiting drug choices in the oral inhaler class for clinical reasons, such as the special needs of children. Similarly, VA and DOD clinicians said they would not accept closing the selective serotonin reuptake inhibitor (SSRI) antidepressant class because they already have many patients maintained on one SSRI, and switching their SSRI drug therapy could have adverse treatment effects.
- Finally, DOD is concerned that its limited control of private provider prescribing practices could result in significant costs to educate and persuade these providers to prescribe drugs contracted under joint procurements. Unlike VA beneficiary prescriptions, which are all written by VA providers and dispensed by VA pharmacies, DOD beneficiary prescriptions are written by both military and private providers and dispensed by both military and retail pharmacies. In fiscal year 2000, about half of the 52 million prescriptions filled by military pharmacies were written by private providers and TRICARE retail pharmacies filled 12 million prescriptions for DOD beneficiaries.

Increasing Numbers of Military Retirees and Expanded DOD Benefits Are Lessening Differences Between DOD and VA Drug Needs

Over the past decade, DOD's patient profile and drug demands have become more similar to VA's. DOD retirees now make up over 50 percent of DOD's beneficiary population—a trend that is projected to continue—and account for most of DOD's drug costs. In fiscal year 2000, close to 70 percent of military pharmacies' drug costs was for retirees' prescriptions. (See figure 3.) Further, DOD's pharmacy benefits for 1.4 million retirees 65 and older expanded in April 2001, which will add an estimated $800 million dollars per year to DOD's pharmacy expenditures.

Figure 3: DOD Prescription Drug Use and Costs by Beneficiary Category, Fiscal Year 2000



Source: GAO analysis of DOD information.

A significant portion of VA and DOD's combined drug expenditures is already spent on drugs in classes used primarily to treat older patients. For example, in 1999, 8 of the top 10 high-dollar drug classes in each department were the same. (See table 3.) Most of the matching therapeutic classes are widely used to treat health conditions common to the elderly: high blood pressure, depression, ulcers, diabetes, and high cholesterol. As DOD's older beneficiary population continues to increase, the use of drugs in these and similar classes and their related expenditures will increase as well.

Table 3: Matching VA and DOD High-Dollar Drug Classes in 1999

Drug class and treatment condition	Ranking VA	Ranking DOD	VA/DOD expenditures[a]
Gastrointestinal agents (for ulcers and acid reflux)	1	2	$197.9
Antilipemics (for high cholesterol)	2	1	195.7
Antidepressants	3	3	158.3
Calcium channel blockers (for high blood pressure)	5	4	120.3
Antivirals (for herpes, hepatitis, human immunodeficiency virus, and acquired immunodeficiency syndrome)	6	9	92.7
Antidiabetics-oral hypoglycemics	8	8	74.1
Angiotensin converting enzyme inhibitors (ACEI) (for high blood pressure)	9	7	69.8
Anticancer drugs[b] (for cancers such as breast, lung, and prostate)	10	10	55.7
Total			**$964.5**

[a]In millions of dollars.

[b]Excludes $32 million VA and DOD expenditures on leutinizing hormone-releasing hormones (used to treat prostate cancer) ranked in a separate class.

Source: GAO analysis of VA and DOD information.

Ongoing Changes to DOD's and VA's Formularies Should Increase Joint Procurement Opportunities

DOD and VA are expected to revise their formularies, which could increase the number of closed and preferred drug classes used in their health care systems. The larger their formularies, the greater the chance they will overlap and provide the two departments more opportunities to jointly procure brand name drugs.

Recent legislation has prompted DOD to make plans to increase the number of drugs on its basic core formulary. In 1999, the Congress enacted legislation requiring DOD to establish a preferred drug formulary by October 2000, applicable to both military pharmacies and TRICARE retail and mail-order pharmacies.[23] DOD missed this deadline and is developing regulations to implement this requirement later this year. The legislation also allows DOD to develop and implement a tiered retail and mail-order pharmacy copayment system that creates financial incentives for beneficiaries to use less costly formulary brand name and generic drugs. Once implemented, DOD beneficiaries would have full access to nonformulary brand name drugs but would be financially encouraged to choose less costly formulary brand name drugs available for free at

[23]As required by the National Defense Authorization Act for Fiscal Year 2000 (P.L. 106-65), by October 1, 2000, DOD was to have established a uniform formulary. Formulary drug selection is to take into account relative clinical and cost effectiveness by drug class.

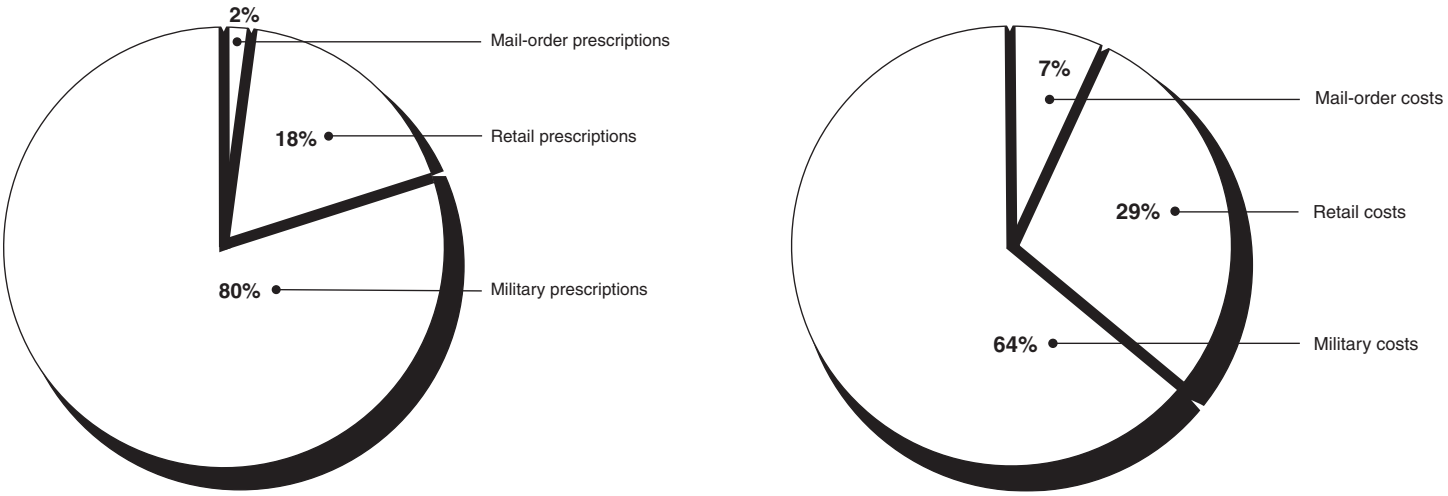
military pharmacies or at lower out-of-pocket costs through mail-order or retail pharmacies.[24] TRICARE contractor representatives told us that a uniform formulary—one that applies to both military and TRICARE pharmacies—and adequately tiered retail and mail-order pharmacy copayments are critically needed to help them and DOD better manage pharmacy benefit costs by steering use to less costly drugs.

In addition, the Congress enacted legislation in 2000[25] requiring DOD to allow beneficiaries age 65 and older access to its retail and mail-order pharmacy benefits—in addition to their continued eligibility to use military pharmacies to obtain free medications. For the first time starting in April 2001, all beneficiaries are eligible for DOD's comprehensive pharmacy benefits at the same copayment rates. However, DOD's retail and mail-order pharmacies are comparatively more costly sources for the same drugs than its military pharmacies. (See figure 4.) An expanded basic core formulary would encourage all beneficiaries to obtain more of their prescriptions at the military pharmacies.

[24]As of April 1, 2001, all nonactive duty DOD beneficiaries can obtain up to 90-day supplies of generic and brand name prescription drugs from the mail order pharmacy for $3 and $9, respectively. If beneficiaries use TRICARE's retail network pharmacies, they pay $3 and $9 for up to 30-day supplies. DOD has not established a third-tier copayment for supplies of nonformulary brand name prescription drugs, but it expects to do so later this year as part of implementing the uniform formulary.

[25]The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (P.L. 106-398).

Figure 4: DOD Prescriptions and Costs by Pharmacy Source, Fiscal Year 2000



Source: GAO analysis of DOD information.

VA is also revising its formulary management processes and will continue to change its formulary based, in part, on our earlier reviews[26] and a study by the Institute of Medicine (IOM).[27] The IOM study was done in response to congressional concerns that VA's formulary may have been overly restrictive, with potentially negative effects on health care cost and quality. IOM's study dispelled such concerns, concluding that VA was justified in creating its formulary and that well-managed formularies are a key part of modern health systems having positive effects on cost and quality. IOM recommended in part that VA continue to prudently establish closed and preferred classes on its formulary and to use more contracts to carefully limit drug choices in more classes, based on quality and cost considerations. As VA's and DOD's formularies continue to evolve, the number of overlapping classes should increase, providing more candidates for joint brand name drug contracts.

[26] *VA Health Care: VA's Management of Drugs on Its National Formulary* (GAO/HEHS-00-34, Dec. 14, 1999) and *VA Drug Formulary: Better Oversight Is Required, But Veterans Are Getting Needed Drugs* (GAO-01-183, Jan. 29, 2001).

[27] *Description and Analysis of the VA National Formulary*, Institute of Medicine, National Academy Press, 2000.

Flexible Procurement Approaches Can Help Preserve Drug Choice While Reaping Discounts

VA and DOD have recently demonstrated in a few cases that, with flexible arrangements, they can procure brand name drugs at maximum discounts, while still allowing one or both departments to preserve drug choice.

- In August 2000, VA and DOD solicited bids for a joint procurement for one of two nonsedating antihistamines (NSA)—loratadine (Claritin) and fexofenadine (Allegra). To address a DOD concern and ensure that DOD beneficiaries would not have to change their current medications, the solicitation specifies that DOD beneficiaries already using an NSA would not have to switch if the departments jointly contracted for the other drug. Military pharmacies will only have to dispense the contracted drug for new patient prescriptions.
- For the nicotine patch class (for smoking cessation), VA and DOD have awarded a joint contract that requires only those VA and DOD facilities offering smoking cessation programs to use the contracted drug. Simply adding the contracted product to their formularies would have required VA and DOD facilities without such programs to stock the patches. The joint procurement allowed VA and DOD to realize an estimated $2.4 million in annual cost avoidance.
- For the angiotensin converting enzyme inhibitor (ACEI) and calcium channel blocker classes, DOD and VA have awarded contracts for preferred formulary drugs without closing the classes.[28] While these contracts encourage providers to prescribe less costly contracted drugs for their patients, providers are free to prescribe noncontracted drugs without having to justify medical necessity. These contracts have resulted in an estimated $13 million in annual cost avoidance.
- For the leutinizing hormone-releasing hormone (LHRH) class of anticancer drugs,[29] DOD negotiated a blanket purchase agreement (BPA) to receive the same price as VA's contract price for Zoladex—a 33 percent discount off old prices.[30] In return, DOD has agreed to the preferential use of Zoladex to treat a subset of DOD's population—adult prostate cancer

[28]ACEIs and calcium channel blockers are different classes of cardiovascular drugs used to treat high blood pressure and related conditions. DOD's preferred ACEIs are captopril (Capoten) and lisinopril (Zestril). VA's preferred dihydropyridine-type calcium channel blocker is nifedipine sustained release tablets (Adalat CC).

[29]The LHRH class includes goserelin (Zoladex) and leuprolide (Lupron).

[30]FSS contracts contain BPA provisions so that DOD can negotiate additional discounts in return for specific volumes being purchased by military hospitals. To retain the 33-percent discount below current DOD prices, the Zoladex BPA calls for achieving an overall military pharmacy market share of 80 percent of prescriptions for adult prostate cancer patients (age 18 years and older) by September 2001.

patients. However, the BPA does not limit providers' choice in prescribing LHRH drugs for women and children—a clinical concern that had caused DOD to avoid closing this class.[31] DOD's preferential use of Zoladex should achieve substantial cost avoidance. VA's separate national contract on Zoladex—which closed the class on VA's formulary—is achieving an estimated $22 million in annual cost avoidance.

In addition, if VA and DOD determine that joint contracting for certain classes is not advantageous, they can use joint BPAs to achieve greater discounts without the more stringent use and time commitments required under a contract. For example, drugs under a joint BPA could be assigned preferential status on the departments' formularies to encourage—but not require—providers to use the drugs. Competing drugs could also have equal status under multiple joint BPAs rather than closing a class. For example, VA negotiated discounts for SSRI antidepressants with three drug companies under individual BPAs.[32] These BPAs were subsequently extended to DOD. Unlike contracts, BPAs do not require long-term commitments. VA, DOD, or the manufacturer can terminate BPAs with 30 days' notice. While joint BPAs may not always realize the deep discounts provided under joint contracts, they could reduce costs nonetheless.

DOD Can Work With TRICARE Contractors to Influence Providers' Prescribing Practices

DOD can work with its TRICARE managed care support contractors to encourage nonmilitary providers to prescribe the contracted drugs included in DOD's developing uniform formulary as well as inform beneficiaries about the cost benefit to them. About half of the 52 million prescriptions dispensed by military pharmacies in fiscal year 2000 were written by nonmilitary providers treating DOD beneficiaries.

DOD's TRICARE contractors have large, nationwide networks of providers;[33] they also administer benefits and pay claims to non-network providers caring for DOD beneficiaries. Contractor representatives told us that they could disseminate key information about DOD's uniform formulary, once it is developed and implemented, on their provider Web sites and provide beneficiaries with formulary pocket cards to take along on their medical appointments. Patients would also be motivated to use

[31]In addition to being used to treat prostate cancer, LHRH drugs may also be used to treat breast cancer, endometriosis, and precocious puberty.

[32]As of March 2001, BPA discounts on Celexa, Prozac, and Zoloft range between 9.8 percent and 63.5 percent below FSS prices. Paxil is available at FSS prices.

[33]Currently, DOD has 161,000 civilian TRICARE network providers.

drugs on the formulary because such use reduces their out-of-pocket costs.

Other managed care pharmacy experts told us that these types of outreach efforts are a necessary and routine part of pharmacy benefit management. According to these experts, the additional administrative effort and cost to reach out to providers and beneficiaries will be more than offset by the financial benefits of less costly drug procurement and utilization.

Conferring With Private Sector Experts and External Reporting Could Further Enhance VA and DOD's Joint Activities

In our view, periodic expert input and congressional review could help sustain the important progress VA and DOD have made to address the challenges they face in jointly procuring drugs. While various experts in managed care pharmacy—including several responsible for the IOM study[34]—agreed that the differences in VA's and DOD's demographics and health systems are not insurmountable obstacles to joint procurements, they were generally sympathetic to the clinical and operating challenges ahead as the departments continue to expand their efforts. Also, several experts told us that the departments' efforts might be enhanced by periodically conferring with private managed care pharmacy experts in order to exchange information, experiences, and lessons learned that are relevant to the departments' joint procurement plans and efforts.

External reporting could also help bolster VA and DOD's efforts to enhance their joint procurement activities—a general finding we reported to the Congress in May 2000.[35] At that time, we recommended that the departments provide information to the Congress on their resource sharing activities—including initiatives such as joint purchasing of pharmaceuticals—to help the Congress and the departments weigh the advantages of such joint activities from a federal perspective rather than

[34]The IOM study was performed by professional staff working with a 14-member committee. Membership included several individuals with expertise in geriatrics and general medicine, directors of major clinical and health care policy academic units, and leaders of institutional or managed care organization formularies and pharmacy benefit plans.

[35]*VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies* (GAO/HEHS-00-52, May 17, 2000). Since 1987, the departments have reported annually to the Congress on the status of their health care resource sharing program, as required under the VA and DOD Health Resources Sharing and Emergency Operations Act (P.L. 97-174). As of March 2001, the most recent report submitted to the Congress covered sharing activities as of fiscal year 1998; fiscal year 1999 and 2000 reports were being developed.

from each agency's standpoint. Moreover, as part of this reporting, VA and DOD could provide details on their ongoing and planned joint procurements relative to the departments' top-ranking drug classes by volume and expenditures. Also, they could report on the proportion that joint procurements represent of the departments' combined pharmaceutical expenditures and volume, including the annual cost avoidance due to joint procurements. Such reporting would help facilitate congressional oversight of the departments' efforts to increase their cooperation in the procurement and management of prescription drugs, which has been legislatively encouraged.

Despite Progress, Issues Need to Be Addressed to Get CMOP Pilot Under Way

VA and DOD have also made important progress in their efforts to conduct a DOD CMOP pilot for evaluating the merits and feasibility of using CMOP centers systemwide. In our May 2000 testimony, we suggested that DOD consider using VA's highly efficient CMOPs to reduce its dispensing costs.[36] In January 2001, DOD determined that it is feasible to develop the necessary computer interface between military pharmacies and CMOP centers, but other pilot details—including time frames for its implementation—have not yet been developed. If funded and done promptly, the pilot would provide VA needed lead time to plan for and begin building new CMOP facilities to accommodate DOD's workload in the event that DOD decides to use CMOPs systemwide.

DOD's Use of CMOPs Could Cut Drug Dispensing Costs and Have Other Benefits

In recent years, pharmacy officials have considered various options for moving DOD's 23 million per year refill prescription workload out of military pharmacies, including using VA's CMOP centers.[37] VA has realized significant financial and operating benefits by using its seven CMOP centers to handle its refill prescription workload instead of using VA hospitals. (See appendix III for a description of VA's CMOP operations.) In May 2000, we testified that DOD's use of VA's CMOP centers likewise could reduce drug dispensing costs and provide other operating benefits. DOD generally agreed with this proposition and with the proposed pilot

[36]Dispensing costs include pharmacy personnel salaries, utilities, housekeeping, furniture, and other equipment, but not the actual costs of the drugs.

[37]DOD had considered contracting with a commercial company to manage its refill prescription workload. This option was ruled out because there was limited response to DOD's request for information and there were indications of high cost.

test to use CMOPs to develop information on such matters for potential cost avoidance.

Also by using CMOPs, DOD would likely achieve operating benefits similar to those realized by VA. For example, CMOP automated technologies have enabled each full-time CMOP employee to dispense between 50,000 and 100,000 prescriptions annually compared to about 15,000 prescriptions dispensed by VA's pharmacy employees. Using CMOP centers to boost the efficiency of DOD's refill process might help offset the shortages of qualified pharmacists and other staff at its military pharmacies. DOD also expects that by freeing up its military pharmacists from the labor-intensive task of dispensing prescriptions, they would have more time to work with medical staff and patients toward safer, more effective drug use. CMOP centers also have the benefit of ensuring quality—with their bar-code technology, they have achieved a near error-free dispensing rate. Other potential benefits from using VA's CMOP centers include customer service. By reducing military pharmacies' refill workload, pharmacists would have more time to fill initial prescriptions and thus reduce customer waiting times. Beneficiaries have the convenience of receiving refills by mail rather than picking them up at military pharmacies.

Progress Made Toward Assessing Feasibility, but Other Issues Remain Before Pilot Is Undertaken

After conducting an assessment of the costs and time required to develop a computer interface between DOD's military pharmacies and VA's CMOP centers, DOD plans to seek funding for the project. However, DOD and VA have not developed plans for how or when to address other significant operational and financial issues that must be worked through to ensure a successful pilot program.

DOD had several concerns in deciding whether to conduct a CMOP pilot with VA. Primary among these concerns was determining the costs and time needed to develop an interface that would allow DOD to electronically transfer millions of refill prescriptions from its military pharmacies to the CMOP centers and allow the centers to confirm the status of each refill. In January 2001, DOD, in consultation with VA, completed a preliminary review of the information technology requirements and determined that this effort should take about 9 months of work by pharmacy information technology specialists and cost roughly $640,000. DOD's pharmacy programs director told us that, considering the reasonableness of the cost and time estimates, establishing a DOD-CMOP interface is no longer considered a major obstacle and that he is seeking internal funding for the interface.

According to VA and DOD, other significant operational and financial issues will need to be worked through if DOD decides to adopt CMOP use systemwide. For example, VA would have to plan for and build the equivalent of two new CMOP centers to accommodate DOD's estimated refill mail-out workload of more than 20 million prescriptions. According to VA officials, the two new CMOP centers for DOD would require 2 to 3 years to build and cost about $27 million. Yet both DOD and VA officials agree that such costs could be significantly reduced if existing VA- or DOD-owned building space could be retrofitted for CMOP's high-technology equipment and production lines. Unused warehouses and aircraft hangars, for example, might have the 75,000 square feet of open floor space VA's CMOP design requires. Another DOD concern is that adopting CMOP use could adversely affect military medical readiness. If, for example, DOD's prime vendors' drug sales to military pharmacies are reduced with CMOP use, then surcharge revenues generated by such sales and used for medical logistics and readiness planning would likewise be reduced.[38] As we testified in May 2000, this concern could be addressed if DOD's prime vendors directly supply the CMOPs with drugs needed to fill DOD beneficiaries' prescriptions—but the departments need to decide on a mutually acceptable course of action.

VA and DOD officials told us that an interagency memorandum of understanding or sharing agreement would need to be established to do the pilot program and address these and other joint operational and financial concerns. Such an agreement would cover the various details governing DOD's use of VA's CMOPs for processing and mailing-out military pharmacy refill prescriptions to DOD beneficiaries. For example, officials anticipate that an agreement will include provisions to accommodate DOD's medical readiness concerns.

However, DOD and VA have not established time frames for addressing the remaining issues in order to finish planning so that the pilot can begin. VA and DOD's existing sharing agreement governing their joint pharmaceutical and related medical procurement activities could be used

[38]Under the DOD prime vendor program, a wholesaler under contract to DOD buys drugs from a variety of manufacturers and the inventory is stored in commercial warehouses. A military pharmacy orders the drugs from the prime vendor, who ships most items to the pharmacy the next day. According to DOD, in return for the lucrative, large volume military pharmacy sales market, these prime vendors are financially induced to provide high levels of medical logistics support to Army, Navy, and Air Force units responsible for worldwide deployments and wartime readiness.

for the CMOP pilot. Signed in 1999, the MOA provided for such future joint department activities by executing and adding appendixes to spell out mutual commitments and responsibilities. Alternatively, a new agreement could be drawn up for the CMOP activity.

Conclusions

VA and DOD have made important progress, particularly this past year, in their collaborative efforts to jointly procure drugs to help control spiraling prescription drug costs. Their awarded joint contracts and planned joint procurements are expected to reduce the departments' total drug costs by almost $170 million a year. This is in addition to significant cost avoidance under the departments' separate contracts—cost avoidance that will likely increase as the contracts are combined in the future. While their joint procurement efforts have been impressive, to date the departments have largely targeted generic drugs, which make up less than 10 percent of their combined expenditures. More dramatic cost reductions could be realized through procurements of high-cost brand name drugs, although in doing so, it may be more complex and time-consuming to garner the necessary clinical support and provider acceptance on therapeutic interchangeability.

Nonetheless, DOD's greatly expanded retiree drug benefit, and both departments' developing formularies should provide added joint procurement opportunities for such drugs. In particular, DOD needs to complete development of a uniform formulary of preferred drugs among its health system's pharmacy sources to better manage and control drug use. Also, the departments' have demonstrated that flexible approaches to developing joint solicitations can take into account differences in their health systems while still maximizing drug discounts. And DOD can work with the TRICARE contractors to help influence nonmilitary providers and their patients to use contracted drugs. This will become particularly important once DOD develops its uniform formulary of preferred drugs. In our view, their joint activities could be further enhanced by periodically conferring with private managed care pharmacy experts and reporting to the Congress on their joint procurement activities. DOD and VA need to ensure that high-level attention remains focused on their joint drug procurement and distribution activities as leadership changes under the new administration occur at the departments.

In the same regard, VA and DOD have also made progress in their efforts to conduct a CMOP pilot. DOD's use of VA's CMOPs to handle its large prescription refill workload would result in drug dispensing cost reductions and better use of limited resources. To accelerate the pilot, however, VA and DOD need to develop an action plan with formal

commitments. The sooner the pilot proves feasible, the sooner DOD can begin to realize the financial and quality of care benefits associated with the transfer of its refill workload.

Recommendations for Executive Action

In view of the leadership changes under way at DOD and VA, we recommend that the departments sustain the momentum made this past year by jointly procuring all brand name and generic drugs for which such procurement is clinically appropriate and cost effective. Also, to help build on the departments' progress with joint drug procurement and distribution activities, we recommend that the Secretaries of Defense and Veterans Affairs ensure that the Acting Assistant Secretary of Defense (Health Affairs) and VA's Under Secretary for Health take the following actions:

- as part of the departments' annual reporting to the Congress on resource sharing activities, provide information on ongoing and planned joint procurements—including the volume and expenditures relative to the departments' top-ranking drug classes and total drug expenditures and the consequent annual cost avoidance—as well as on progress toward implementing a CMOP pilot;
- consider the benefits of periodically conferring with private, managed care pharmacy experts to exchange information, experiences, and lessons learned that could be relevant to the departments' joint drug procurement activities; and
- work together to move ahead promptly on the CMOP pilot and develop an interagency agreement governing the pilot's operation, including actions needed to provide added CMOP capacity should DOD decide to use the CMOPs systemwide.

To further mitigate the remaining challenges to joint drug procurement that are unique to the military health care system, we recommend that the Secretary of Defense ensure that the Acting Assistant Secretary of Defense (Health Affairs) take the following actions:

- complete the development and implementation of a uniform formulary of preferred brand name drugs applicable to military hospital, TRICARE retail, and mail-order pharmacy programs, including the use of tiered retail and mail-order pharmacy copayments to encourage providers and beneficiaries to use formulary drugs; and
- work with TRICARE contractors to better inform DOD nonmilitary providers and their patients about the uniform formulary in order to encourage providers to prescribe and beneficiaries to use less costly formulary drugs throughout the military health care system.

Agency Comments

DOD and VA reviewed and separately commented on a draft of this report. Each concurred with the report and its recommendations. The departments stated their commitment to sustaining and building on the progress already made in jointly procuring drugs whenever clinically feasible and cost effective and in their drug distribution activities.

The departments agreed, moreover, to annually report to the Congress on the status of their joint drug procurements and the CMOP pilot and to periodically confer with private, managed care pharmacy experts to exchange information and lessons learned relevant to their joint procurement activities. In particular, VA stated that a DOD/VA meeting with private managed care pharmacy representatives and buying groups will take place by November 2001 to discuss strategies for procuring pharmaceuticals.

The departments also stated their intention to move ahead promptly on the CMOP pilot and finalize an interagency agreement. VA anticipates this would be completed by July 2001. According to the departments, the agreement will outline plans and actions needed should DOD decide to use VA's CMOPs nationwide. Also, DOD has funded and expects to complete by March 2002 its work to establish a computer interface between a military pharmacy and a CMOP. Once the interface is developed, a pilot between a yet-to-be-designated military pharmacy and a VA CMOP is targeted to begin in March 2002, according to VA.

Lastly, DOD agreed to complete the development of a uniform formulary of drugs applicable to its military hospital, TRICARE retail, and mail order pharmacies. DOD also agreed to work with the TRICARE contractors to encourage DOD's nonmilitary providers and their patients to use the preferred, less costly formulary drugs.

The full texts of the departments' comments are reprinted as appendixes IV and V.

We are sending this report to the Honorable Donald H. Rumsfeld, Secretary of Defense; the Honorable Anthony J. Principi, Secretary of Veterans Affairs; appropriate congressional committees; and other interested parties. We will also make copies available to others upon request. Should you have any questions on matters discussed in this report, please contact me at (202) 512-7101. Other contacts and staff acknowledgments are listed in appendix VI.

Stephen P. Backhus
Director, Health Care—Veterans
and Military Health Care Issues

Appendix I: Status of VA and DOD Pharmaceutical Procurements

As reported in May 2000 testimony,[1] from October 1998 through April 2000, VA and DOD awarded 18 joint contracts—mostly for generic drugs. If not for these contracts, VA and DOD estimate that these purchases could have cost $102 million in fiscal year 2000. Instead, actual costs were $62 million—about 1.9 percent of the departments' combined $3.2 billion drug spending in fiscal year 2000—an overall cost avoidance of 39 percent. Table 4 presents information on the 18 contracts.

Table 4: Joint VA and DOD Drug Contracts as of April 2000

Product (brand name, if applicable)	Class (use)	Manufacturer (start date)	Theoretical cost, fiscal year 2000, if not contracted	Estimated cost avoidance, fiscal year 2000
Anti-infective agents				
Amoxicillin (Trimox)	Penicillins (antibiotic)	Apothecon (August 1999)	$861,000	$109,000
Amantadine	Antivirals (influenza)	Invamed, Inc. (August 1999)	259,000	25,000
Autonomic drugs				
Albuterol inhaler	Inhaled bronchodialators (asthma)	Warrick Pharmaceuticals, previously, now IVAX Pharmaceuticals[a]	8,961,000	1,299,000
Nicotine patch (Habitrol)	Miscellaneous autonomic (smoking cessation)	Novartis (June 2000[b])	2,475,000	270,000
Cardiovascular drugs				
Diltiazem (Tiazac)	Calcium channel blockers (high blood pressure)	Forrest Labs (December 1998)	42,181,000	24,235,000
Verapamil	Calcium channel blockers (high blood pressure)	IVAX Pharmaceuticals[c] (August 1999)	5,836,000	1,678,000
Captopril (Capoten)	Angiotensin converting enzyme inhibitors (ACEI) (high blood pressure)	Bristol-Myers Squibb, Apothecon (October 1999)	777,000	220,000
Gemfibrozil	Antilipemics (cholesterol reducer)	Warner Chilcott (January 2000)	2,694,000	258,000
Prazosin	Hypotensive agents (high blood pressure)	IVAX Pharmaceuticals[c] (October 1999)	627,000	36,000

[1] *DOD and VA Health Care: Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars* (GAO/T-HEHS-00-121, May 25, 2000).

Product (brand name, if applicable)	Class (use)	Manufacturer (start date)	Theoretical cost, fiscal year 2000, if not contracted	Estimated cost avoidance, fiscal year 2000
Central nervous system agents				
Salsalate	Nonsteroidal anti-inflammatory agents (arthritis)	Able (March 2000)	550,000	67,000
Nortriptyline	Antidepressants	Teva Pharmaceuticals (October 1999)	786,000	232,000
Eye, ear, nose, and throat (EENT) preparations				
Timolol opthalmic solution (Timoptic)	Miscellaneous EENT (antiglaucoma)	Alcon Laboratories (January 2000)	787,000	305,000
Timolol opthalmic gel (Timoptic-XE)	Miscellaneous EENT (antiglaucoma)	Merck & Co. (January 2000)	1,716,000	968,000
Levobunolol	Miscellaneous EENT (antiglaucoma)	Bausch & Lomb (January 2000)	211,000	43,000
Gastrointestinal agents				
Cimetidine	Miscellaneous (histamine2 receptor antagonists) (ulcers and acid reflux)	Sidmak Labs (November 1998)	2,601,000	1,173,000
Ranitidine	Miscellaneous (histamine2 receptor antagonists) (ulcers and acid reflux)	Geneva Pharmaceuticals (November 1998)	13,132,000	6,728,000
Hormones and synthetic substitutes				
Human insulin (Novolin)	Antidiabetic agents (insulin)	Novo Nordisk Pharmaceuticals (November 1999)	16,075,000	1,500,000
Skin and mucous membrane agents				
Fluocinonide	Anti-inflammatory agents (topical corticosteroid)	Teva Pharmaceuticals (September 1999)	1,305,000	510,000
Totals			**$101,835,000**	**$39,657,000**

[a]VA and DOD's joint contract with Warrick Pharmaceuticals expired in November 2000. At that time, a new joint contract with IVAX Pharmaceuticals (formerly Zenith/Goldline) for the same generic albuterol inhaler products took effect.

[b]Contract awarded in April 2000 with a June 2000 start date.

[c]Formerly Zenith/Goldline.

Source: GAO analysis of DOD and VA drug contracting data and information.

Since our May 2000 testimony, VA and DOD have more than doubled the number of joint procurements. That is, from May 2000 through April 2001, VA and DOD awarded or were soliciting 26 joint contracts. This includes joint procurements for 25 generic drugs and one brand name antihistamine

drug. Based on our analysis of VA/DOD 1999 pharmaceutical purchase data, these 26 drugs amounted to about $123 million in combined drug expenditures. Tables 5 and 6 present information on the 26 joint contracts and solicitations.

Table 5: New VA and DOD Joint Drug Contracts Taking Effect Since May 2000 (Status as of April 2001)

Product	Class (use)	Manufacturer	Effective date	1999 DOD/VA purchases	DOD/VA estimated annual cost avoidance
Anti-infective agents					
Rifampin	Antituberculosis agents	Geneva Pharmaceuticals	October 2000	$631,000	$146,000
Acyclovir	Antivirals (herpes)	IVAX Pharmaceuticals[a]	October 2000	2,619,000	238,000
Antineoplastic (anticancer) agents					
Hydroxyurea	Antineoplastic agents	Richmond Pharmaceuticals	October 2000	1,019,000	156,000
Autonomic (regulates autonomous nervous system) drugs					
Albuterol inhaler	Inhaled bronchodialators (asthma)	IVAX Pharmaceuticals[a]	November 2000	7,350,000	1,722,000
Blood formation and coagulation					
Pentoxifylline	Hemorrheologic agents (vascular disease)	Sidmak Laboratories	October 2000	3,407,000	8,000
Cardiovascular drugs					
Terazosin	Hypotensive agents (high blood pressure and prostate hyperplasia)	Geneva Pharmaceuticals	September 2000	28,300,000	22,640,000
Central nervous system agents					
Naproxen and naproxen sodium	Nonsteroidal anti-inflammatory agents (pain relief)	Geneva Pharmaceuticals	July 2000	6,450,000	1,669,000
Acetaminophen	Miscellaneous analgesics (pain relief and fever reducer)	JB Laboratories	January 2001	3,105,000	457,000
Gastrointestinal (GI) drugs					
Sucralfate	Miscellaneous GI drugs (ulcers)	Teva Pharmaceuticals	October 2000	1,661,000	430,000
Skin and mucous membrane agents					
Clotrimazole cream	Anti-infectives (antifungals for skin)	Taro Pharmaceuticals	February 2001	894,000	339,000

Product	Class (use)	Manufacturer	Effective date	1999 DOD/VA purchases	DOD/VA estimated annual cost avoidance
Unclassified therapeutic agents					
Azathioprine	Immunosuppressives (antirejection for organ transplant patients)	Mylan Pharmaceuticals	October 2000	3,117,000	1,274,000
Devices					
Insulin needle with syringe	Supplies (diabetic use with human insulin)	Becton Dickinson	May 2000	3,697,000	1,347,000
Totals				**$62,250,000**	**$30,426,000**

[a]Formerly Zenith/Goldline.

Source: GAO analysis of DOD and VA drug contracting data and related information.

Table 6: Pending VA and DOD Joint Drug Solicitations (Status as of April 2001)

Product	Class (use)	Solicitation month	1999 DOD/VA purchases
Fexofenadine (Allegra) or loratadine (Claritin)	Nonsedating antihistamines (allergy relief)	August 2000	$29,936,000
Diltiazem immediate release	Cardiac drugs (calcium channel blockers)	January 2001	2,473,000
Clonidine hydrochloride	Hypotensive agents (high blood pressure)	January 2001	4,793,000
Isosorbide mononitrate	Cardiac drugs (angina relief)	January 2001	2,024,000
Diclofenac	Nonsteroidal anti-inflammatory agents (arthritis and osteoarthritis)	January 2001	2,139,000
Etodolac	Nonsteroidal anti-inflammatory agents (pain relief, rheumatoid arthritis, and osteoarthritis)	January 2001	294,000
Valproic acid	Miscellaneous anticonvulsants (seizure disorders)	January 2001	659,000
Selegiline	Miscellaneous central nervous system agents (Parkinsonian syndrome relief)	January 2001	975,000
Hydrochlorothiazide	Diuretics (edema and high blood pressure)	January 2001	1,078,000
Spironolactone	Diuretics (edema, high blood pressure, and congestive heart failure)	January 2001	803,000
Prednisone tablets	Adrenals (anti-inflammatory and allergic conditions)	January 2001	410,000
Glipizide	Antidiabetic agents (sulfonylureas)	January 2001	7,312,000
Ketoconazole cream	Anti-infectives (antifungals for skin)	January 2001	1,848,000
Ticlopidine	Blood platelet aggregation inhibitor (reduce risk of thrombotic stroke)	January 2001	6,174,000
Total			**$60,918,000**

Source: GAO analysis of DOD and VA drug contracting data and related information.

Over the last several years, DOD and VA have awarded separate contracts for many different pharmaceuticals and related supplies. The following

table provides information on the separate contracts that the departments are planning to merge or combine as they expire.

Table 7: Separate DOD and VA Drug Contracts (Status as of April 2001)

Generic name (and brand name, if applicable)	Drug class (use)	Manufacturer	Expiration date of contract's current option year	Option years remaining	Estimated cost avoidance, fiscal year 2000 (if available)
DOD separate contracts					
Cerivastatin (Baycol)	Hydroxymethylglutaryl coenzyme A reductase inhibitor (HMG CoA RI) (to lower cholesterol)	Bayer	03/31/02	3	$22,316,000
Simvastatin (Zocor)		Merck			
Omeprazole (Prilosec)	Proton pump inhibitor (PPI) (ulcers and acid reflux)	AstraZeneca	09/30/01	1	19,429,000
Lisinopril (Zestril)	ACEI (high blood pressure)	AstraZeneca	07/31/01	1	10,073,000
Hepatitis A (Vaqta)	Vaccine (immunization)	Merck	09/17/01	1	1,675,000
VA separate contracts					
Lovastatin (Mevacor)	HMG CoA RI (to lower cholesterol)	Merck	06/01/01	1	31,311,000
Simvastatin (Zocor)					
Lansoprazole (Prevacid)	PPI (ulcers and acid reflux)	TAP Pharmaceuticals	02/05/02	0	43,924,000
Lisinopril (Prinivil)	ACEI (high blood pressure)	Merck	10/19/01	2	30,001,000
Goserelin acetate implant (Zoladex)	Luteinizing hormone-releasing hormone (LHRH) agonist (prostate cancer)	AstraZeneca	01/12/02	0	21,773,000
Nifedipine extended release (long-acting) (Adalat CC)	Calcium channel blocker (high blood pressure)	Bayer	11/30/01	1	3,009,000
Oxazepam	Benzodiazepines—sedative and anti-anxiety	Wyeth-Ayerst	01/14/02	2	534,000
Ondansetron (Zofran)	Antinausea (for chemotherapy patients)	GlaxoSmithKline	06/08/01	4	Not available
Amitriptyline	Antidepressant	CibaGeneva	09/25/01	0	Not available
Amitriptyline/ Perphenazine	Antidepressant	Mylan Pharmaceuticals	04/06/01	1	Not available
Amoxapine	Antidepressant	Schein	09/25/01	0	Not available
Atenolol	Beta blocker (high blood pressure)	CibaGeneva	04/06/02	0	Not available
Benztropine mesylate	Anti-Parkinson's disease	Par Pharmaceuticals	04/06/01	1	Not available
Carbidopa/Levodopa	Anti-Parkinson's disease	Teva Pharmaceuticals	04/06/01	1	Not available
Carisoprodol	Skeletal muscle relaxant	CibaGeneva	09/25/01	0	Not available

Generic name (and brand name, if applicable)	Drug class (use)	Manufacturer	Expiration date of contract's current option year	Option years remaining	Estimated cost avoidance, fiscal year 2000 (if available)
Cephalexin	Antibiotic (to treat a variety of respiratory infections)	Teva Pharmaceuticals	04/06/01	1	Not available
Chlorhexidine gluconate 4 percent topical solution (Dyna-Hex)	Supplies—topical antibacterial	Western	06/16/01	0	Not available
Chlorpromazine	Antipsychotic (schizophrenia)	CibaGeneva	04/06/01	1	Not available
Colchicine	Antigout agent	West-Ward	04/06/01	1	Not available
Cyclobenzaprine hydrochloride	Skeletal muscle relaxant	Mylan Pharmaceuticals	09/25/01	0	Not available
Desipramine	Antidepressant	Richmond	04/06/01	1	Not available
Fluphenazine hydrochloride	Antipsychotic (schizophrenia)	Mylan Pharmaceuticals	04/06/02	0	Not available
Fosinopril (Monopril)	ACEI (high blood pressure)	Bristol Myers Squibb	01/11/02	1	Not available
Gel, absorbent sponge (Gelfoam)	Supplies	Upjohn	09/30/01	2	Not available
Glyburide	Sulfonylurea (oral antidiabetic drug)	Teva Pharmaceuticals	03/21/01	1	Not available
Haloperidol	Antipsychotic (schizophrenia)	CibaGeneva	04/06/01	1	Not available
Hydrochlorothiazide (Triamterene)	Diuretic	CibaGeneva	04/06/01	1	Not available
Ibuprofen	Nonsteroidal anti-inflammatory drug (arthritis and pain relief)	Interpharm	04/06/01	1	Not available
Imipramine	Antidepressant	CibaGeneva	09/25/01	0	Not available
Indomethacin	Nonsteroidal anti-inflammatory drug (arthritis and pain relief)	Richmon	04/06/01	1	Not available
Isosorbide dinitrate	Cardiovascular (vasodilator)	CibaGeneva	09/25/01	0	Not available
Loperamide	Antidiarrhea	Teva Pharmaceuticals	09/25/01	0	Not available
Methocarbamol	Skeletal muscle relaxant	CibaGeneva	09/25/01	0	Not available
Metoprolol	Beta blocker (high blood pressure)	Teva Pharmaceuticals	09/25/01	0	Not available
Minoxidil	Antihypertensive (high blood pressure)	Par Pharmaceuticals	04/06/01	1	Not available
Nitroglycerin patches (Nitro Dur)	Antiangina	Schering	01/31/02	0	Not available
Penicillin VK	Antibiotic(to treat a variety of serious infections)	Teva Pharmaceuticals	04/06/01	1	Not available
Perphenazine	Antipsychotic (schizophrenia)	CibaGeneva	04/06/01	1	Not available
Pindolol	Beta blocker (high blood pressure)	Teva Pharmaceuticals	09/25/01	0	Not available

Generic name (and brand name, if applicable)	Drug class (use)	Manufacturer	Expiration date of contract's current option year	Option years remaining	Estimated cost avoidance, fiscal year 2000 (if available)
Promethazine	Antihistamine	CibaGeneva	04/06/01	1	Not available
Shampoo, coal tar (Tar Plus)	Skin agent	CTC Cayuga	08/31/01	1	Not available
Sulindac	Nonsteroidal anti-inflammatory drug (arthritis and osteoarthritis)	CibaGeneva	09/25/01	0	Not available
Thiothixene	Antipsychotic (schizophrenia)	CibaGeneva	04/06/01	1	Not available
Trazodone	Antidepressant	Schein	04/06/02	0	Not available
Trifluoperazine hydrochloride	Antipsychotic (schizophrenia)	CibaGeneva	04/06/01	1	Not available
Trihexyphenidyl hydrochloride	Anti-Parkinson's disease	Schein	04/06/02	0	Not available
Verapamil hydrochloride	Calcium channel blocker (high blood pressure)	CibaGeneva	09/25/01	0	Not available
Total					**$184,043,000**

Source: GAO analysis of contracting data in the DOD-VA Joint Contract Status report (November 2000 update) and related information

Appendix II: Planned DOD and VA Joint Procurements

In December 2000, DOD and VA pharmacy officials completed their preliminary review of drugs in the high-expenditure classes we had suggested as future candidates for joint procurement.[1] Table 8 is a list of the drugs for which the departments told us they plan to pursue joint procurements in the near future, as well as their data on expenditures and estimates of annual cost avoidance that would stem from the procurements. VA and DOD pharmacy officials told us that they may identify additional drugs and classes for joint procurement once they complete their reviews.

Table 8: Planned Joint Procurements in Our Suggested Drug Classes as of December 2000

Brand name, if applicable	Generic name	Combined VA & DOD purchases, 1999	VA & DOD estimated cost avoidance
Antihistamine drugs			
Zyrtec	Cetirizine	$13,436,936	$2,284,279
Numerous generic sources	Hydroxyzine	899,451	44,973
Numerous generic sources	Diphenhydramine	663,146	33,157
Anti-infective agents			
Antifungals			
Numerous generic sources	Ketoconazole	1,724,950	86,248
Cephalosporins			
Ceftin	Cefuroxime (oral/injectable)	2,671,539	801,462
Suprax	Cefixime	469,072	140,722
Cefzil	Cefprozil	1,155,506	346,652
Lorabid	Loracarbef	124,443	37,333
Cedax	Ceftibutin	224	67
Omnicef	Cefdinir	4,356	1,307
Quinolones			
Levaquin	Levofloxacin (oral/injectable)	9,562,528	1,434,379
Cipro	Ciprofloxacin (oral/injectable)	12,546,398	1,881,960
Floxin	Ofloxacin (oral/injectable)	1,975,137	296,271
Trovan	Trovafloxacin (oral)	768,245	115,237
Trovan	Alatrofloxacin (injectable)	783,185	117,478
Noroxin	Norfloxacin	64,752	9,713
Other anti-infectives			
Numerous generic sources	Clindamycin	2,887,625	144,381
Numerous generic sources	Sulfamethoxazole/Trimethoprim	1,285,831	64,292
Numerous generic sources	Methenamine	380,327	19,016

[1]See appendix II in *DOD and VA Health Care: Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars* (GAO/T-HEHS-00-121, May 25, 2000).

Brand name, if applicable	Generic name	Combined VA & DOD purchases, 1999	VA & DOD estimated cost avoidance
Numerous generic sources	Nitrofurantoin	2,072,447	103,622
Numerous generic sources	Metronidazole (oral/injectable)	1,176,862	58,843
Antineoplastic agents (to treat various cancers)			
Casodex	Bicalutamide	9,584,228	1,437,634
Eulexin	Flutamide	6,035,939	905,391
Numerous generic sources	Cisplatin	2,362,369	354,355
Nilandron	Nilutamide	2,235,160	335,274
Nolvadex	Tamoxifen (pending availability of multiple generic sources)	6,549,821	1,964,946
Numerous generic sources	Doxorubicin	623,662	31,183
Numerous generic sources	Cyclophosphamide	502,522	25,126
Numerous generic sources	Mitomycin	292,365	14,618
Numerous generic sources	Bleomycin	397,512	19,876
Numerous generic sources	Daunorubicin	314,472	15,724
Blood formation and coagulation			
Anticoagulants			
Numerous generic sources	Warfarin	17,114,629	3,422,926
Lovenox	Enoxaparin	9,344,763	934,476
Fragmin	Dalteparin	153,425	15,342
Cardiovascular drugs			
Antiarrhythmics			
Numerous generic sources	Procainamide	765,625	38,281
Numerous generic sources	Quinidine	703,782	35,189
Numerous generic sources	Mexiletine	444,730	22,237
Numerous generic sources	Disopyramide	496,261	24,813
Angiotensin converting enzyme inhibitors (ACEI)			
Vasotec	Enalapril (pending availability of multiple generic sources)	1,527,934	458,380
Beta blockers			
Numerous generic sources	Sotalol	5,005,439	1,501,632
Numerous generic sources	Labetalol	1,573,565	157,356
Other cardiovascular drugs			
Numerous generic sources	Furosemide	1,630,777	81,539
Numerous generic sources	Isosorbide Mononitrate	1,620,024	81,001
Numerous generic sources	Hydralazine	674,814	33,741
Numerous generic sources	Bumetanide	487,739	24,387
Antihyperlipidemic drugs (cholesterol drugs)			
Numerous generic sources	Cholestyramine	1,166,412	58,321
Central nervous system agents			
Nonsteroidal anti-inflammatory agents			
Numerous generic sources	Tramadol	5,841,091	1,752,327
Numerous generic sources	Aspirin	1,768,906	88,445

Brand name, if applicable	Generic name	Combined VA & DOD purchases, 1999	VA & DOD estimated cost avoidance
Numerous generic sources	Ketorolac	2,560,703	128,035
Anticonvulsants			
Neurontin	Gabapentin (pending availability of multiple generic sources)	26,738,641	13,369,320
Numerous generic sources	Primidone	534,091	26,705
Antidepressants			
Prozac	Fluoxetine (pending availability of multiple generic sources)	48,395,578	24,197,789
Numerous generic sources	Bupropion IR	6,600,897	990,135
Numerous generic sources	Clomipramine	406,082	20,304
Antipsychotic agents			
Numerous generic sources	Clozapine	5,961,811	1,490,453
Numerous generic sources	Thioridazine	413,297	20,665
Sedative and other anti-anxiety agents			
Buspar	Buspirone (pending availability of multiple generic sources)	16,185,766	4,855,730
Antimigraine drugs			
Imitrex	Sumatriptan	12,935,098	1,940,265
Maxalt	Rizatriptan	236,950	35,542
Amerge	Naratriptan	109,002	16,350
Diagnostic Agents			
Diabetes (used to test blood glucose levels)			
Numerous brands available	Glucose test strips	36,074,109	3,607,411
Gastrointestinal (GI) drugs			
Miscellaneous GI drugs			
Pepcid	Famotidine (pending availability of multiple generic sources)	6,537,179	1,961,154
Numerous generic sources	Sulfasalazine	1,128,842	169,326
Hormones and synthetic substitutes			
Bronchial steroids (for asthma)			
Azmacort	Triamcinolone	7,662,025	383,101
Flovent	Fluticasone	5,982,060	299,103
Aerobid-M	Flunisolide	243,172	12,159
Pulmicort Turbuhaler	Budesonide	774,095	38,705
Nasal steroids (for allergies and sinus congestion)			
Flonase	Fluticasone	2,089,579	104,479
Nasacort	Triamcinolone	1,745,301	87,265
Multiple brand names available	Flunisolide	97,197	4,860
Rhinocort	Budesonide	109,993	5,500
Nasonex	Mometasone	441,404	22,070
Oral contraceptives			
Numerous generic sources	Ethinyl Estradiol/ Norethindrone	3,308,311	165,416
Ortho Tri-Cyclen	Ethinyl Estradiol/Norgestimate	2,274,929	123,746

Brand name, if applicable	Generic name	Combined VA & DOD purchases, 1999	VA & DOD estimated cost avoidance
Numerous generic sources	Ethinyl Estradiol/Norgestrel	3,117,758	155,888
Numerous generic sources	Desogestrel/Ethinyl Estradiol	1,623,634	81,182
Numerous generic sources	Ethinyl Estradiol/Levonorgestrel	622,247	31,112
Numerous generic sources	Desogestrel/Ethinyl Estradiol	238,727	11,936
Ortho-Cyclen	Ethinyl Estradiol/Norgestimate	841,502	42,075
Numerous generic sources	Ethinyl Estradiol/Norgestrel	499,565	24,978
Numerous generic sources	Mestranol/Norethindrone	58,294	2,915
Numerous generic sources	Ethinyl Estradiol/Norethindrone	20,232	1,012
Numerous generic sources	Ethinyl Estradiol/Levonorgestrel	94,322	4,716
Numerous generic sources	Levonorgestrel	257,557	12,878
Loestrin Fe	Ethinyl Estradiol/Ferrous Fumarate/Norethindrone	228,940	11,447
Numerous generic sources	Ethinyl Estradiol/Norethindrone	42,071	2,104
Numerous generic sources	Ethinyl Estradiol/Norethindrone	1,264,092	63,205
Numerous generic sources	Ethinyl Estradiol/Ethynodiol Diacetate	335,339	16,767
Ovrette	Norgestrel	112,667	5,633
Numerous generic sources	Ethinyl Estradiol/Levonorgestrel	62,678	3,134
Numerous generic sources	Ethinyl Estradiol/Norethindrone	64,348	3,217
Numerous generic sources	Ethinyl Estradiol/Norethindrone	37,353	1,868
Numerous generic sources	Ethinyl Estradiol/Norethindrone	13,381	669
Numerous generic sources	Ethinyl Estradiol/Levonorgestrel	273,042	13,652
Numerous generic sources	Ethinyl Estradiol/Levonorgestrel	84,429	4,221
Numerous generic sources	Desogestrel/Ethinyl Estradiol	10,597	530
Numerous generic sources	Ethinyl Estradiol/Norethindrone	873	44
Numerous generic sources	Ethinyl Estradiol/Norethindrone	1,322	66
Numerous generic sources	Mestranol/Norethindrone	63,680	3,184
Numerous generic sources	Mestranol/Norethindrone	944	47
Numerous generic sources	Ethinyl Estradiol/Norethindrone	16,115	806
Numerous generic sources	Ethinyl Estradiol/Levonorgestrel	235	12
Numerous generic sources	Ethinyl Estradiol/Norethindrone	177	9
Numerous generic sources	Ethinyl Estradiol/Levonorgestrel	924	46
Estrostep	Ethinyl Estradiol/Ferrous Fumarate/Norethindrone	2,299	115
Numerous generic sources	Ethinyl Estradiol/Norethindrone	133	7
Numerous generic sources	Mestranol/Norethindrone	130	7
Estrogens (osteoporosis prevention and menopause symptoms)			
Numerous generic sources	Medroxyprogesterone	3,671,195	367,120
Antidiabetic agents			
Glucophage	Metformin (pending availability of multiple generic sources)	41,085,310	20,542,655

Brand name, if applicable	Generic name	Combined VA & DOD purchases, 1999	VA & DOD estimated cost avoidance
Serums, Toxoids, and Vaccines			
Vaccines			
Multiple brands available	Hepatitis B	10,858,147[a]	49,505
Multiple brands available	Hepatitis A	4,990,355[a]	10,608
Unclassified therapeutic agents			
Immunosuppressive (antirejection drugs used for transplant patients)			
Numerous generic sources	Cyclosporine	6,884,250	2,065,275
Totals		**$401,095,902**	**$99,466,145**

[a]Military pharmacy purchases from pharmaceutical prime vendors. Excludes 1999 DOD purchases directly from manufacturers.

Source: GAO analysis of DOD and VA information.

Appendix III: VA's CMOP Program

CMOP History

VA was the first organization in the United States to deliver prescription medications to patients on a large scale by mail. After World War II, this service was started as a convenience to disabled, homebound veterans. By 1992, nearly all of VA's outpatient pharmacies provided mail service, but consolidation of mail prescription workloads from multiple VA hospitals into centralized operations had only been initiated on a limited basis.[1] In 1994, the first CMOP at Leavenworth, Kansas, began processing high volume mail prescription workloads using an integrated, automated dispensing system. Since that time, VA has expanded the program to include a total of seven CMOPs located in Leavenworth, Kansas; Los Angeles, California; Bedford, Massachusetts; Dallas, Texas; Murfreesboro, Tennessee; Hines, Illinois; and Charleston, South Carolina. In fiscal year 2000, those facilities processed about 50 million prescriptions.

How CMOPs Operate

Patients are provided care by VA hospitals or clinics with new prescriptions being dispensed directly from those hospitals or clinics. Patients' refill prescription requests are received by telephone or in person and processed at the individual VA sites daily. Once processed, the refill prescription orders are sent electronically from multiple VA medical facilities to a CMOP for processing. The CMOP dispenses the pharmaceuticals as specified by the participating medical facility, delivers the completed prescriptions directly to the patient by mail, and returns the dispensing data to the participating hospital or clinic electronically. A patient contacts the hospital or clinic directly if there are any questions or problems. According to VA, the CMOP model takes advantage of economies of scale for mail prescription processing and distribution while at the same time preserving the patient-provider relationship.

VA data show that productivity at the CMOP is at levels between 50,000 and 100,000 prescriptions per year per full-time employee. According to VA, such productivity rates are several times greater than traditional hospital and clinic systems. Patients generally receive their medications by mail within 4 days of their orders going from the VA medical facility to a CMOP.

[1]For a description of VA mail-service pharmacy operations up through the early 1990s, see *VA Health Care: Modernizing VA's Mail-Service Pharmacies Should Save Millions of Dollars* (GAO/HRD-92-30, Jan. 22, 1992).

CMOP Costs to VA Medical Facilities

CMOPs charge VA medical facilities to recover direct operating costs to purchase pharmaceuticals and related supplies as well as to dispense, package, and mail prescriptions to patients. According to VA documents, in fiscal year 2000, the nondrug CMOP cost charged to VA medical facilities averaged $2.00 per prescription and the CMOP drug cost charged averaged $20.33 per prescription. For each prescription, the nondrug cost charged included $0.77 in personnel costs, $0.40 in operating costs, and $0.83 in mailing costs.[2] For fiscal year 2000, the CMOP workload was about 50 million prescriptions of about $1 billion in drug products and $100 million in nondrug expenses.

CMOP Quality

VA's business plan for the CMOPs includes performance improvement measures for prompt delivery, accurate dispensing, properly packaged prescriptions, safe work environments, reliable and appropriate equipment, right supplies of drugs on hand, and customer satisfaction. Also, using barcode technology in the automated dispensing process and other quality steps, the CMOP program has achieved an overall accuracy rate of 99.99 percent—which means getting the right drug—in the correct dosage, with the correct instructions—to the right people. In addition, the CMOPs are fully accredited by the Joint Commission on the Accreditation of Health Care Organizations.

[2]These charges exclude CMOP costs for building and equipment depreciation ($0.17) and other VA overhead costs ($0.20). VA centrally finances these costs with other internal funding sources.

Appendix IV: Comments From the Department of Defense

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

HEALTH AFFAIRS

MAY 17 2001

Mr. Stephen P. Backhus
Director, Veterans Affairs and Military Health Care Issues
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Backhus:

This is the Department of Defense's (DoD) response to the General Accounting Office (GAO) draft report, "DOD AND VA PHARMACY: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs,"(GAO-01-588).

DoD concurs with the report and its recommendations. The report accurately reflects the very positive joint procurement initiatives that are routinely conducted by the VA and DoD. These joint initiatives and the infrastructure that has been put in place to sustain them indicate the commitment DoD and the VA have toward continuing this progress into the future.

The enclosure provides specific responses to each of the draft report recommendations. My point of contact for this action is Colonel William Davies, (703) 681-0039.

Sincerely,

J. Jarrett Clinton, MD, MPH
Acting Assistant Secretary

Enclosure:
As Stated

GAO DRAFT REPORT – DATED APRIL 23, 2001
(GAO CODE 101630) OSD CASE 3077

"DOD AND VA PHARMACY: PROGRESS AND REMAINING CHALLENGES IN JOINTLY BUYING AND MAILING OUT DRUGS"

DEPARTMENT OF DEFENSE COMMENTS
TO THE GAO RECOMMENDATIONS

RECOMMENDATION 1: In view of the leadership changes underway at DoD and VA, the GAO recommended that the Departments sustain the momentum made this past year by jointly procuring all brandname and generic drugs for which doing so is clinically appropriate and cost effective. (p. 32/Draft Report)

DOD RESPONSE: Concur. The DoD and VA have established a substantial infrastructure through the Federal Pharmacy Executive Steering Committee. The Committee includes representatives from the offices of the Defense Supply Center, Philadelphia, the Pharmacoeconomic Center, the VA Pharmacy Benefits Management Office, and the National Acquisition Center; their efforts will enable continuation of past year's joint procurement successes into the future. The Department remains committed to sustaining and enhancing these efforts where clinically appropriate and cost-effective.

RECOMMENDATION 2: The GAO recommended that the Secretary of Defense provide as part of the Department's annual reporting to the Congress on resource sharing activities, information on ongoing and planned joint procurements including the volume and expenditures relative to the Departments' top-ranking drug classes and total drug expenditures and the consequent annual cost avoidance--as well as on progress toward implementing a CMOP pilot. (p. 32/Draft Report)

DOD RESPONSE: Concur. Joint DoD/VA pharmaceutical contracting and progress on the CMOP pilot should be included in the Department's annual reporting to the Congress.

RECOMMENDATION 3: The GAO recommended that the Secretary of Defense consider the benefits of periodically conferring with private, managed care pharmacy experts to exchange information, experiences, and lessons learned relevant to the Departments' joint drug procurement activities. (p. 32/Draft Report)

DOD RESPONSE: Concur. The Department shall continue monitoring the private sector's best business practices in pharmacy benefit management for their inclusion and adoption for DoD and VA. As in the past, this will be done with consideration to clinical appropriateness and consistency with contracting regulations.

RECOMMENDATION 4: The GAO recommended that the Secretary of Defense work together with VA to move ahead promptly on the CMOP pilot and develop an interagency agreement governing the pilot's operation including actions needed to provide added CMOP capacity should DoD decide to use the CMOPs system wide. (p.32/Draft Report)

DOD RESPONSE: Concur. The Department has funded the information system developmental changes required to commence a CMOP test. Work in this regard is scheduled to begin in June 2001 with anticipated completion by March 2002. The Departments have committed to development of a new annex to our existing Memorandum of Agreement to address CMOP pilot operation and follow on system wide implementation of CMOP or a CMOP variant. Progress in this regard will be monitored by the DoD/VA Executive Steering Committee.

RECOMMENDATION 5: The GAO recommended that the Secretary of Defense require that the Acting Assistant Secretary of Defense (Health Affairs) complete the development and implementation of a uniform formulary of preferred brand-name drugs applicable to military hospital, TRICARE retail, and mail order pharmacy programs, including the use of tiered retail and mail order pharmacy copayments to encourage providers and beneficiaries to use formulary drugs. (p.33/Draft Report)

DOD RESPONSE: Concur. The Department is in the process of developing the proposed rule for implementing the uniform formulary, as a requirement of section 1074g of title 10, United States Code enacted by section 701 of the Fiscal Year 2000 National Defense Authorization Act. On April 1, 2001, the Department implemented a two tiered co-pay structure to coincide with the implementation of the TRICARE Senior Pharmacy Program. These changes to the cost share structure partially implement the Pharmacy Benefits Program as authorized by section 1074g of title 10, United States Code, and lay the foundation for developing the uniform formulary. This simplification of cost shares for all beneficiaries to a formulary-based structure is intended to provide an incentive to use generics and the most cost-effective source for pharmacy services.

RECOMMENDATION 6: The GAO recommended that the Secretary of Defense require that the Acting Assistant Secretary of Defense (Health Affairs) work with TRICARE contractors to better inform DoD non-military providers and their patients about the uniform formulary toward the goal of encouraging providers to prescribe and beneficiaries to use less costly formulary drugs throughout the military health care system. (p.32/Draft Report)

DOD RESPONSE: Concur. As part of the implementation of the TRICARE Senior Pharmacy Program, the Department and our TRICARE contractors mounted an extensive marketing campaign targeting the benefits of the simplified cost shares. This marketing effort encouraged the use of the most cost-effective source of pharmaceutical services for both the patient and the military health care system, along with the savings achieved when generic products are selected in lieu of branded products. These efforts continue and will be incorporated into the implementation plan of the uniform formulary.

Appendix V: Comments From the Department of Veterans Affairs

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

May 14, 2001

Mr. Stephen P. Backhus
Director, Health Care—Veterans' and
Military Health Care Issues
U. S. General Accounting Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Backhus:

This is in response to your draft report, ***DOD AND VA PHARMACY: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs*** (GAO-01-588). I am pleased that the General Accounting Office (GAO) recognizes the Department of Veterans Affairs' (VA) position as both a world leader in the procurement of drugs and pharmaceuticals and as a leader in the pharmacy profession through our innovative work in automated mail prescription processing and delivery. More importantly, while improving our efficiency, VA has not compromised its longstanding goal to improve veterans' access to high quality pharmaceutical care.

VA remains committed to the goals of leveraging VA and DOD purchasing power whenever clinically feasible and to learn from the experiences of our pharmacy colleagues in the private managed care and academic sectors. We also plan to work through the technical details to realize the joint VA/Department of Defense (DOD) mail prescription pilot.

I agree with GAO's conclusions and recommendations. The enclosure details actions planned and taken to implement your recommendations. Thank you for the opportunity to comment on your draft report.

Sincerely yours,

Anthony J. Principi

Enclosure

Enclosure

DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO
GAO DRAFT REPORT,
DOD AND VA PHARMACY: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs
(GAO-01-588)

In view of the leadership changes underway at DOD and VA, GAO recommends that the Departments sustain the momentum made this past year by jointly procuring all brand name and generic drugs for which doing so is clinically appropriate and cost effective. Also to help build on the Departments' progress with joint drug procurement and distribution activities, GAO recommends that the Secretaries of Defense and Veterans Affairs require that the following actions be taken:

- **As part of the Departments' annual reporting to the Congress on resource sharing activities, provide information on ongoing and planned joint procurements – including the volume and expenditures relative to the Departments' top-ranking drug classes and total drug expenditures and the consequent annual cost avoidance – as well as on progress toward implementing a CMOP pilot.**

Concur - VA remains committed to the joint procurement of drugs and pharmaceuticals whenever clinically appropriate and to sustaining the current momentum. We will report the status of joint contracting and the Consolidated Mail Out Pharmacy (CMOP) pilot in the annual resource sharing report to Congress.

VA is making significant progress in jointly procuring drugs and pharmaceuticals with DOD. The VA/DOD joint procurement working group held its first meeting in May 1999, and when GAO began its review in August, VA and DOD had already successfully awarded 10 contracts.

Since May 1999, we have learned much in the area of joint procurement, and we are gaining process efficiency with each contract we award. As of April 2001, VA and DOD have awarded a total of 40 joint contracts; we have 34 contracts pending award; and we are preparing 21 joint solicitations. Further, 10 other contracts were not awarded as vendors offered prices higher than the Federal Supply Schedule.

- **Consider the benefits of periodically conferring with private, managed care pharmacy experts to exchange information, experiences, and lessons learned relevant to the Departments' joint drug procurement activities.**

Concur - For many years, VA officials have consulted with private experts as well as monitor private sector formulary management strategies to evaluate the applicability of

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DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO
GAO DRAFT REPORT,
DOD AND VA PHARMACY: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs
(GAO-01-588)
(Continued)

those strategies to VA and DOD delivery models. While our outreach has benefited all, we will strive to enhance communication. Additionally, VA officials have and will continue to respond to requests from private sector pharmacy professionals seeking information about advances made in VA's clinical pharmacy practice, formulary management, and automation of product delivery.

VA and DOD officials have routinely conferred with managed care pharmacy and buying group colleagues to discuss pharmaceutical procurement activities. A meeting will take place in the next 6 months with the primary goal of discussing strategies these individuals and their organizations use to enhance the procurement of pharmaceuticals. VA and DOD officials and their private sector counterparts realize that the ability of an organization to deliver market share for a particular product is one of the best strategies for enhanced pricing. To the extent these strategies are clinically appropriate for the beneficiaries served by VA and DOD, and are compatible with Federal Acquisition Regulations, VA and DOD officials will consider them.

- **Work together to move ahead promptly on the CMOP pilot and develop an interagency agreement governing the pilot's operation including actions needed to provide added CMOP capacity should DOD decide to use the CMOPs systemwide.**

Concur - VA is committed to a joint VA/DOD mail prescription pilot as a prelude to a full-scale operational agreement with DOD. VA is prepared to explore all possibilities, including a jointly operated facility; serving as a subcontractor to DOD; or, providing technical assistance in support of a DOD operated facility.

VA will work closely with DOD to develop an interagency agreement outlining plans to move forward with a CMOP pilot and actions needed should DOD decide to use VA's CMOPs nationwide. Our anticipated date for finalizing the interagency agreement is July 1, 2001.

As the most important initial action item, VA and DOD officials continue to discuss the technical details for the development of an interface between DOD's Composite Health Care System (CHCS) and VA's Veterans Health Information Systems and Technology

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DEPARTMENT OF VETERANS AFFAIRS COMMENTS TO
GAO DRAFT REPORT,
DOD AND VA PHARMACY: Progress and Remaining Challenges in Jointly Buying and Mailing Out Drugs
(GAO-01-588)
(Continued)

Architecture system. DOD officials recently advised that development of the CHCS systems interface would begin June 1, 2001, with completion expected by March 2002. Following the development of the interface, a pilot between a yet to be designated DOD Medical Treatment Facility and a VA CMOP facility is targeted to begin in March 2002.

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Appendix VI: GAO Contacts and Staff Acknowledgments

GAO Contacts

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Carolyn Kirby, (202) 512-9843

Staff Acknowledgments

In addition to those named above, the following staff made key contributions to this report: William Lew, Allan Richardson, Karen Sloan, and Richard Wade.

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