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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D C. 20548

HUMAN RESOURCES DIVISION

September 27, 1983

B-207930

The Honorable Harry N. Walters
Administrator of Veterans Affairs

Dear Mr. Walters:

Subject: Opportunities to Reduce Fee-Basis Pharmacy Costs (GAO/HRD-83-83)

We have completed a review of the Veterans Administration's (VA's) efforts to reduce the number and cost of prescriptions filled by private pharmacies on a VA-reimbursable fee-for-service basis. Our review included 17 of the 80 VA facilities responsible for administering the fee-basis program.[1]

In fiscal year 1982, VA paid private pharmacies about $10.5 million to fill prescriptions for veterans with service-connected disabilities. VA could significantly reduce such payments without increasing VA pharmacies' staffing or facilities by

--strengthening efforts to identify prescriptions filled by private pharmacies that should have been filled at less costly VA pharmacies;

--denying payment if veterans, after being asked to use a VA pharmacy for nonemergency prescriptions, continue to have such prescriptions filled by private pharmacies;

--limiting the number of prescriptions provided to veterans with no service-connected disabilities; and

--setting limits on payments to private pharmacies consistent with those used by the Department of Health and Human Services' Medicaid program.

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[1]See page 2 of enclosure I for details on our objectives, scope, and methodology.

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Veterans with service-connected disabilities may obtain care from private (fee-basis) physicians on a VA-reimbursable fee-for-service basis under certain conditions (see p. 1 of enc. I). However, prescriptions written by such physicians are, to the extent practicable, to be filled by VA pharmacies. When it is not practicable to use a VA pharmacy, such as in the case of a medical emergency, veterans may have their prescriptions filled by a private (fee-basis) pharmacy at VA expense. VA's Inspector General determined that only about 5 percent of the fee-basis prescriptions need to be filled by private pharmacies. Such prescriptions cost VA about twice as much as prescriptions filled through VA pharmacies. (See pp. 6 and 7 of enc. I.)

VA has made progress in reducing the percent of fee-basis prescriptions filled by private pharmacies--the percentage dropped from about 21 in fiscal year 1981 to 13 in the first half of fiscal year 1983. However, private pharmacies still filled over 20 percent of the fee-basis prescriptions at 6 of the 17 facilities we contacted.

The success the 17 facilities had in reducing the percentage of prescriptions filled by private pharmacies depended largely on whether the facility (1) had pharmacists review private pharmacy prescriptions to identify those that should have been filled by the VA pharmacy and (2) denied payment for such prescriptions if veterans continued to have them filled by private pharmacies after being asked to send or bring them to a VA pharmacy.

During the first half of fiscal year 1983, private pharmacies filled

--11 percent or more of the fee-basis prescriptions at seven of the nine facilities that did not have a pharmacist routinely review fee-basis prescriptions to identify those that should have been filled by a VA pharmacy, but at only one of the eight facilities where pharmacists routinely reviewed fee-basis prescriptions, and

--6 percent or less of the fee-basis prescriptions at 8 of the 14 facilities that denied payment, under certain conditions, for prescriptions the facility identified as being for nonemergencies, but from 23 to 35 percent at the 3 facilities that had not denied payment.

The success of two of the facilities (Los Angeles and Shreveport) we contacted in reducing the number of prescriptions filled by private pharmacies demonstrated the potential for reducing the number of such prescriptions systemwide. In fiscal year 1980, private pharmacies filled about 36 and 27 percent of the fee-basis prescriptions at the Los Angeles and Shreveport facilities, respectively. Both facilities subsequently began aggressive efforts to identify nonemergency prescriptions that should be filled by the VA pharmacy and encouraged veterans and pharmacists to bring or send such prescriptions to VA for filling. Both began denying payment for nonemergency prescriptions when veterans did not heed repeated requests to send their prescriptions to VA. In fiscal year 1982, private pharmacies filled only about 3 percent of the fee-basis prescriptions at the two facilities. (See pp. 7 to 16 of enc. I.)

VA pharmacies could have filled all of the approximately 885,000 private pharmacy prescriptions for veterans with service-connected disabilities without increased staffing by reducing the number of prescriptions provided to veterans with no service-connected disabilities (about 16.5 million) by 6 percent. Such veterans are entitled to VA care only to the extent that facilities and staff are available after services have been provided to veterans with service-connected disabilities and only if they are age 65 or older or unable to defray the cost of hospital or nursing home care from private sources. We believe the most equitable way to accomplish any necessary reduction in the number of prescriptions provided to veterans with no service-connected disabilities would be to establish priorities for providing outpatient prescriptions to such veterans based on their ability to pay for prescriptions from private sources. (See pp. 16 to 18 of enc. I.)

VA could also reduce the cost of prescriptions which must, because of medical emergency, be filled by private pharmacies by adopting the fixed dispensing fees and "maximum allowable cost" provisions of the Medicaid reimbursement policies. Based on a field test completed in May 1981, VA estimated that it could save about $463,000 a year by adopting the fixed dispensing fees. VA officials said that an "Interim issue" implementing the fixed dispensing fees was issued in April 1983.

However, VA did not incorporate another cost containment provision of the Medicaid reimbursement limits. Medicaid has established "maximum allowable cost" limits on what it will pay for 51 different drug items available generically from

several manufacturers. Under VA's current reimbursement limits, VA would pay private pharmacies up to $766 for filling 51 prescriptions that would cost $327 if VA adopted the "maximum allowable cost" limits. (See pp. 22 to 25.)

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that you, through the Chief Medical Director:

--Direct VA clinics of jurisdiction to have pharmacists review fee pharmacy prescriptions to identify duplicate prescriptions, excessive quantities of drugs, and prescriptions that should have been filled by the VA pharmacy.

--Reemphasize, to clinics of jurisdiction, the importance of having Medical Administration Service clerks review fee pharmacy prescriptions to ensure that payments do not exceed the limits established by the VA prescription schedule.

--Revise the fee-basis manual to direct VA clinics of jurisdiction to instruct veterans to send prescriptions for nonemergencies to VA for filling and to deny payment for subsequent prescriptions if veterans disregard the request.

--Revise VA drug reimbursement policies to incorporate Medicaid "maximum allowable cost" provisions.

--Direct VA clinics of jurisdiction to fill prescriptions for nonservice-connected conditions only if the clinic's staff and facilities are not needed to fill prescriptions for veterans with service-connected conditions, including those fee-basis prescriptions for nonemergencies.

--Establish priorities for providing outpatient prescriptions to veterans with no service-connected conditions based on the veterans' ability to pay for prescriptions from private sources.

--Establish a system for periodically monitoring clinics of jurisdiction compliance with fee-basis pharmacy policies and procedures.

As you know, 31 U.S.C. 720 requires that the head of a federal agency submit a written statement on actions taken on our recommendations to the House Committee on Government Operations and the Senate Committee on Governmental Affairs not later than 60 days after the date of the report and to the House and Senate Committees on Appropriations with the agency's first request for appropriations made more than 60 days after the date of the report.

We are sending copies of this report to the Chairmen of the above-mentioned Committees and the Senate and House Committees on Veterans' Affairs, and the Director, Office of Management and Budget.

Sincerely yours,

Richard L. Fogel
Director

Enclosure

Contents

ABBREVIATIONS

AMIS	Automated Management Information System
GAO	General Accounting Office
HHS	Department of Health and Human Services
IG	Inspector General
MAC	maximum allowable cost
VA	Veterans Administration

ENCLOSURE I

STRONGER ACTIONS NEEDED TO REDUCE FEE-BASIS PHARMACY COSTS

BACKGROUND

The Veterans Administration's (VA's) medical services include treatment of acute and chronic illnesses in hospital and ambulatory care settings. During fiscal year 1982, VA reported that it spent about $7 billion to treat patients in VA facilities (including 1.3 million inpatients and 16 million outpatient visits). Total expenditures reported by VA for drugs and related supplies at all VA pharmacies during the same year were about $381 million.

At one time most veterans could receive care for non-service-connected conditions only if they were hospitalized. Veterans were generally eligible for outpatient care for non-service-connected conditions only as a followup to inpatient care. Escalating hospital costs and the recognition that many cases could be more effectively cared for on an ambulatory basis prompted the Congress to enact legislation in August 1973 (Public Law 93-82), which allowed VA hospitals to treat eligible veterans for nonservice-connected conditions on an outpatient basis if such treatment would obviate the need for hospitalization.

The demand for ambulatory care for nonservice-connected conditions increased markedly, especially for pharmacy services. For example, the number of outpatient prescriptions filled by VA pharmacies increased from about 16 million in fiscal year 1973 to about 39.2 million in fiscal year 1982, a 145-percent increase.

A veteran with a service-connected disability may obtain care from a private physician on a VA-reimbursable fee-for-service basis if the veteran does not live near a VA facility or is unable to obtain the required care or service from the VA facility. According to the VA manual, prescriptions written by private (fee-basis) physicians are, to the extent practicable, to be filled by VA pharmacies. The manual authorizes veterans to have prescriptions written by fee-basis physicians filled by private (fee-basis) pharmacies at VA's expense when it is not practicable to use a VA pharmacy, for example, in the case of a medical emergency.

VA requires that the Medical Administration Service staff review and process for payment the invoices and supporting

prescriptions submitted by fee-basis pharmacies. The staff review the reasonableness of the fees charged by private pharmacies using the VA "Prescription Schedule." In addition, the Medical Administration Service staff review fee pharmacy prescriptions to (1) determine whether the medication prescribed was for a disability approved for treatment and (2) identify, with assistance of Pharmacy Service staff, prescriptions for nonemergencies (i.e., prescriptions for stabilized conditions and/or of a recurring nature) which could be provided more economically by VA. Payment should be made only for prescriptions for disabilities approved for treatment. When fee pharmacy prescriptions for nonemergencies are received, the prescribing physician and/or the patient are contacted and "encouraged" to bring or send such prescriptions to VA for filling. Under VA's mailout program, VA pharmacies are to fill and mail prescriptions within 2 workdays after receipt.

The fee-basis pharmacy program is administered by 80 VA medical centers designated "clinics of jurisdiction." Each clinic of jurisdiction is responsible for authorizing fee-basis care for veterans living within a designated geographical area and reviewing and processing claims for services, including prescriptions, provided to those veterans. During fiscal year 1982, VA filled about 5,087,000 fee-basis prescriptions through its outpatient pharmacies and paid private pharmacies about $10.5 million to fill about 885,000 fee-basis prescriptions.

OBJECTIVES, SCOPE, AND METHODOLOGY

In March 1981 we began a survey of VA's outpatient pharmacy program at the Seattle VA medical center. Because VA's Inspector General (IG) was reviewing the management of the fee-basis pharmacy program, we suspended work on our survey in July 1981.

The IG completed fieldwork at 11 clinics of jurisdiction; briefed VA central office pharmacy service officials and prepared a draft report on its overall findings, conclusions, and recommendations; and issued reports to 5 of the 11 clinics. The IG did not issue an overall report or individual reports to the other six clinics. According to VA's acting assistant inspector general for audits, such reports were not issued because (1) the data were outdated and (2) adequate review work had not been conducted to demonstrate that it would be cost effective to increase the number of prescriptions filled by VA pharmacies (i.e., would increased staffing costs offset any savings realized by reducing the number of prescriptions filled by private pharmacies).

We resumed our review in May 1982 to determine whether the problems identified during the IG's review and our earlier survey work still existed. Specifically, our objectives were to determine

--the extent to which veterans were using fee-basis pharmacies to fill prescriptions for nonemergencies,

--whether it would be less costly to fill fee-basis prescriptions through VA pharmacies,

--the effectiveness of VA efforts to identify prescriptions for nonemergencies which were filled by private physicians and to encourage fee-basis physicians and veterans to bring or send such prescriptions to VA for filling,

--the effectiveness of VA efforts to review the appropriateness of the drug prescribed and the payment sought, and

--whether drug reimbursement limits set by VA were comparable to those set by the Department of Health and Human Services (HHS) for the Medicaid program.

We analyzed computer data on VA fee-basis prescriptions to determine the extent to which veterans were using private pharmacies to fill fee-basis prescriptions; contacted 17 VA clinics of jurisdiction (see p. 10) to determine how they keep files on and review fee-basis prescriptions filled by private pharmacies; reviewed IG efforts relating to the fee pharmacy program; interviewed agency officials to identify planned changes in the fee program; and reviewed laws, regulations, and VA policy manuals governing the pharmacy program.

The 17 clinics of jurisdiction in our review accounted for about 50 percent of the fee-basis prescriptions filled by private pharmacies during fiscal years 1980-82. These included the 11 clinics covered by the IG's review so that we could determine the actions taken subsequent to the IG's review. We selected five additional clinics where (1) there was a high volume of fee-basis prescriptions and (2) private pharmacies had filled at least 10 percent of the fee prescriptions in the first three quarters of fiscal year 1982. We also revisited the Seattle clinic to evaluate actions taken since our survey was suspended.

To determine the extent to which veterans were continuing to use private pharmacies to fill prescriptions for nonemergencies, we

--reviewed and updated data on the 11 clinics of jurisdiction included in the IG's review,

--analyzed pharmacy activity reports generated by VA's Automated Management Information System (AMIS) for fiscal years 1980 through the first two quarters of fiscal year 1983,[1] and

--analyzed pharmacy cumulative files[2] generated at VA's Austin Data Processing Center from October 1, 1980, through June 30, 1982.

Because of actions VA has taken to improve the administration and control of automated fee-basis records at the clinics of jurisdiction and the Austin Data Processing Center following a 1979 IG audit and discussions with VA officials in which they indicated that the reliability of the data has improved, we did not verify the accuracy or completeness of the computerized pharmacy data.

To determine whether it would be less costly to fill fee-basis prescriptions through VA's outpatient pharmacies than through private pharmacies, we reviewed reports prepared by VA's Shreveport and Little Rock outpatient pharmacies comparing the fiscal year 1982 costs for filling fee-basis prescriptions to fee pharmacy charges at those clinics of jurisdiction.

To determine whether VA clinics of jurisdiction were (1) identifying prescriptions for nonemergencies that were filled by private pharmacies, (2) encouraging fee-basis physicians and veterans to send prescriptions for nonemergencies to VA for filling, and (3) reviewing the appropriateness of the drug prescribed and the payment sought, we

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[1]The AMIS reports include quarterly data on all fee-basis prescriptions processed for payment by the 80 clinics of jurisdiction.

[2]The pharmacy cumulative files are computerized records of actual payments to pharmacies, but exclude payments made (1) by eight clinics of jurisdiction and (2) directly to veterans for fee-basis prescriptions.

--reviewed data gathered during the IG's 1980 and 1981 audits of the fee-basis pharmacy programs;

--contacted, in May 1983, the 11 clinics of jurisdiction included in the IG's 1981 review to identify any changes they instituted;

--contacted, in May 1983, six clinics of jurisdiction not included in the IG's 1981 review to determine how they keep files on and review fee-basis prescriptions and encourage veterans to send prescriptions for nonemergencies to VA for filling;

--reviewed VA policies and procedures regarding denying payment for prescriptions for nonemergencies; and

--reviewed the actions taken by the Los Angeles, Shreveport, Portland, and Seattle clinics to reduce fee prescriptions for nonemergencies.

To determine whether drug reimbursement limits set by VA were comparable to those HHS set under the Medicaid program, we

--reviewed VA's and HHS' reimbursement policies and a draft revision of VA's policy and

--compared the VA reimbursement limits for 51 brand name drugs to HHS "Maximum Allowable Cost" (MAC) limits under the Medicaid program for their generic equivalents.

To determine whether VA clinics of jurisdiction had placed appropriate priority on filling fee-basis prescriptions, we

--reviewed laws, regulations, and policies concerning eligibility for and entitlement to outpatient prescriptions and

--estimated the extent to which outpatient pharmacy services were being provided to nonservice-connected veterans.

Our review was performed in accordance with generally accepted government auditing standards.

PRIVATE PHARMACY PRESCRIPTIONS ARE MORE COSTLY

Several studies by VA and GAO have shown that prescriptions filled by private pharmacies are more costly than those filled by VA. In 1975, we reported (MWD-76-46, Dec. 5, 1975) that fee-basis prescriptions filled by private pharmacies cost, on the average, about 71 percent more than prescriptions filled by VA pharmacies. We concluded that the average cost of a VA prescription at the eight VA facilities visited was $4.57 compared to an average cost of $7.82 for prescriptions filled by fee pharmacies. Although our analysis did not include postage and administrative costs, the Administrator of Veterans Affairs agreed with our analysis and said that he believed that the administrative costs associated with processing fee-basis prescriptions exceed the mailing costs for VA-filled prescriptions.

In an August 9, 1979, report (HRD-79-109), we commented on a VA report on a bill that would have provided nonhospitalized veterans with freedom of choice in obtaining prescription drugs. We agreed with VA that enacting the proposed legislation would increase the cost of dispensing drugs if more prescriptions were filled by private pharmacies.

VA's report stated that the 4.2 million fee-basis prescriptions filled by VA pharmacies in fiscal year 1976 cost an average of $4.49 compared to an average of $8.45 for the 1.1 million fee-basis prescriptions filled by private pharmacies. VA estimated the cost of implementing the legislation by assuming that all 5.3 million fee-basis prescriptions would have been filled by private pharmacies at a cost of $8.45 per prescription or a total of $44.8 million. When compared with the actual cost incurred in 1976 of $28.3 million, the legislation would have resulted in an increased cost of $16.5 million.

In our 1979 report we noted that it was doubtful that all of the fee prescriptions would be filled by private pharmacies if the legislation were enacted, but agreed with VA that the cost of providing prescriptions through fee-basis pharmacies would be substantially greater than through VA pharmacies.

VA's Pharmacy Service had the Little Rock and Shreveport Medical Centers compare the costs of fee-basis prescriptions filled by VA and fee-basis pharmacies at those two clinics of jurisdiction during fiscal year 1982. The Little Rock Medical Center found that fee-basis prescriptions filled by private

pharmacies cost an average of $10.98 for a 15-day supply compared to an average cost of $8.22 for a 30-day supply from the VA pharmacy. Similarly, the Shreveport Medical Center found that the average charge of private pharmacies was $12.21 per prescription (not to exceed a 14-day supply) compared to $7.89 for a 30-day prescription at the VA pharmacy.

While the two analyses reasonably estimate the cost of filling a prescription at the VA outpatient pharmacy,[3] they do not reflect the cost of filling a fee-basis prescription because most such prescriptions are filled through the mailout program.

VA Pharmacy Service officials said that the cost of filling fee-basis prescriptions at VA pharmacies does not include the administrative cost incurred in confirming eligibility and authorizing fee-basis care. However, they agreed that the same administrative costs should be included in the cost of filling fee-basis prescriptions at private pharmacies. In addition, the administrative costs to review and process fee pharmacy prescriptions were not included in the estimates, thus understating the cost of fee pharmacy prescriptions.

Even after certain adjustments we considered necessary, the cost of filling a fee-basis prescription for a 30-day supply through the mailout program was less than the average paid to private pharmacies by the two clinics for 14- or 15-day supplies.

VETERANS CONTINUE TO USE PRIVATE PHARMACIES TO FILL PRESCRIPTIONS FOR NONEMERGENCIES

Private pharmacies continue to fill more prescriptions for veterans than appear necessary at some clinics. Although the percentage of prescriptions filled by private pharmacies dropped from about 21 percent in fiscal year 1981 to 13 percent in the first 6 months of fiscal year 1983, the IG determined that about 5 percent was the level of fee-basis prescriptions that needed to be filled by private pharmacies.

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[3]Both the Shreveport and Little Rock clinics of jurisdiction allocated postage costs to all prescriptions filled by the outpatient pharmacy (including those filled at the walkup window). This results in an overstatement (by about $0.40) in the cost of filling prescriptions at the outpatient pharmacies' walkup windows and an understatement (by about $2.10) in the cost of filling prescriptions through the mailout program.

At each of the 11 clinics of jurisdiction included in the IG's 1981 review, a pharmacist reviewed a statistical sample of prescriptions filled by fee-basis pharmacies during fiscal year 1980 to determine whether the prescription was for a non-emergency (i.e., was for a stabilized condition and/or for a recurring condition). As shown by the table on the next page, the IG estimated that VA pharmacies should have filled from about 46 to 100 percent of the prescriptions that had been filled by fee-basis pharmacies and estimated that VA would have saved from about $917,000 to about $1,457,000 if the prescriptions had been filled by the 11 VA pharmacies.

The IG auditors briefed Pharmacy Service officials in July 1981 that only about 5 percent of fee-basis prescriptions needed to be filled by private pharmacies and estimated that VA could realize annual savings of $2.1 million to $2.8 million if the 80 clinics of jurisdiction filled the prescriptions for nonemergencies. In computing the estimated savings, the IG considered the additional staff, overhead, and ingredient costs to fill the fee-basis prescriptions at VA pharmacies.

Most clinics included in the IG's review have had success in reducing fee pharmacy prescriptions. Seven of the 11 clinics of jurisdiction included in the IG's review had private pharmacies fill 6 percent or less of their fee-basis prescriptions during the first half of fiscal year 1983. Only two clinics still had private pharmacies fill over 25 percent of the fee-basis prescriptions. (See table on p. 10.)

However, at three of the six additional clinics we contacted, the percentage of fee-basis prescriptions filled by private pharmacies had increased since fiscal year 1980. Although two other clinics had reduced private pharmacy prescriptions, such pharmacies still filled over 14 percent of the fee-basis prescriptions during the first half of fiscal year 1983. Only the Seattle clinic had private pharmacies fill less than 5 percent of the fee-basis prescriptions.

Clinic of jurisdiction	Number of fee written prescriptions	Number filled by fee pharmacies		Number of fee pharmacy prescriptions that should have been filled by VA pharmacies		Projected savings From	Projected savings To	Percent of prescriptions that should have been filled by VA
Bay Pines	502,849	150,505	(29.9%)	135,177	(89.8%)	$344,880	$ 546,967	97%
Columbia	88,355	23,807	(26.9%)	14,390	(60.4%)	32,951	63,798	89.3
Decatur	566,066	72,716	(12.8%)	33,388	(45.9%)	100,621	242,304	93.1
Kansas City	83,588	26,321	(31.5%)	25,975	(98.7%)	116,881	154,159	99.6
Lebanon	60,949	9,952	(16.6%)	8,091	(81.3%)	39,831	55,120	96.9
Los Angeles	115,449	44,665	(38.7%)	31,700	(71.0%)	59,000	66,000	88.8
Portland	84,243	23,735	(28.2%)	18,805	(79.2%)	90,000	127,000	94.2
San Diego	20,061	3,085	(15.4%)	2,129	(69.0%)	1,502	2,925	95.2
Shreveport	53,192	13,390	(26.7%)	11,167	(83.4%)	44,394	64,619	93.3
Chicago (Westside)	139,855	24,230	(17.3%)	24,230	(100%)	41,340	72,399	100
Wilkes-Barre	263,486	16,040	(6.1%)	13,057	(81.4%)	45,118	61,974	98.9
	1,978,093	408,446	(22.7%)	318,109	(77.9%)	$916,518	$1,457,256	95.2

ENCLOSURE I

Progress of Clinics Included in IG Review

Clinics of jurisdiction	Percent of fee-basis prescriptions filled by private pharmacies			
	FY 1980 (IG review period)	Fiscal year 1981	1982	1983[a]
Bay Pines, Fla.	29.4	27.3	26.7	27.6
Atlanta, Ga.	29.5	29.6	32.4	26.1
Kansas City, Mo.	31.5	26.1	30.2	2.9
Portland, Oreg.	29.4	20.8	21.7	10.2
Chicago, Ill.	16.3	15.9	11.1	2.0
Wilkes Barre, Pa.	23.2	23.7	20.3	6.0
Columbia, S.C.	25.5	22.2	15.0	11.9
Lebanon, Pa.	16.3	12.2	9.5	5.8
San Diego, Calif.	11.7	12.2	7.6	3.5
Los Angeles, Calif.	36.4	24.5	3.4	2.0
Shreveport, La.	26.7	12.0	2.1	3.0
Progress of Clinics Not Included in IG Review				
Seattle, Wash.	6.4	7.3	6.2	4.8
Allen Park, Mich.	25.3	29.8	20.2	34.9
San Juan, P.R.	14.0	22.3	21.1	22.3
San Francisco, Calif.	19.7	21.5	23.1	25.0
Montgomery, Ala.	28.6	25.0	23.3	23.3
Wood, Wis.	20.7	23.5	20.4	14.4

[a]Through March 31, 1983.

To identify the extent to which veterans were using fee-basis pharmacies to fill recurring prescriptions that should have been brought or sent to VA for filling, we analyzed computerized payment data maintained for 71 of VA's 80 clinics of jurisdiction[4] for the 33-month period from October 1, 1979, through June 30, 1982. During that period, the 71 clinics paid private pharmacies for filling 2,064,429 fee-basis prescriptions. The data showed that 527,930 (26 percent) of these prescriptions were refills under the same prescription number.

[4]Other clinics of jurisdiction report fee-basis payment under a different computer system which does not contain adequate data to permit identification of refills.

VA's Pharmacy Service director agreed that further reductions are needed in the number of fee pharmacy prescriptions, but said that he doubts that they will ever reach the 5-percent level suggested by the IG. He said that reductions depend, in part, on VA's ability to influence fee-basis physicians' prescribing habits.

DENYING PAYMENT CAN INCREASE COMPLIANCE AND REDUCE COSTS

Since they began denying payment for nonemergency prescriptions, the Los Angeles and Shreveport clinics of jurisdiction have increased the percentage of fee-basis prescriptions filled by their pharmacies to over 95 percent. The Seattle and Portland clinics of jurisdiction also reported improvements after they began denying payment for prescriptions for nonemergencies. Fourteen of the 17 clinics contacted had begun to deny payment for prescriptions for nonemergencies under certain conditions. However, other clinics do not deny payment because the fee-basis manual directs clinics not to deny payment even if a veteran fails to heed repeated requests to send prescriptions for nonemergencies to VA.

In fiscal year 1980, private pharmacies filled over 36 percent of the fee-basis prescriptions for the Los Angeles clinic of jurisdiction. According to a Los Angeles clinic official, in February 1981, the Los Angeles clinic sent letters to all veterans receiving fee-basis prescriptions and all fee-basis pharmacies advising that (1) prescriptions should be filled by VA unless needed immediately and (2) VA would not reimburse veterans or pharmacies for prescriptions not authorized by the directive. According to a clinic official, many veterans started to send their prescriptions to VA after receiving the letter, but a followup letter was sent to about one-third who continued to use private pharmacies to fill prescriptions for nonemergencies. He said that when the veterans continued to have prescriptions for nonemergencies filled by private pharmacies, VA denied payment to the pharmacy or veteran.

According to a clinic official, the actions taken to reduce fee pharmacy prescriptions resulted in the VA pharmacy filling about 50,000 prescriptions that, in the past, would have been filled by private pharmacies. In fiscal year 1982, the clinic filled about 97 percent of the fee-basis prescriptions. The clinic's pharmacy chief said that the clinic had been able to fill the additional prescriptions without extra

staff because the pharmacy files are computerized and the pharmacy has a centralized mailout program.

According to a clinic official, the clinic (1) relies on the fee-basis physician's judgment to determine whether a prescription is for an emergency and (2) denies payment only if the physician has not certified that the prescription is for an emergency. The official said he did not think the clinic had denied payment for many prescriptions. However, he believed that the clinics need to deny payment to convince veterans to send prescriptions for nonemergencies to VA.

According to Pharmacy Service officials, the success the Los Angeles clinic of jurisdiction has had in reducing fee pharmacy prescriptions may be attributed, in part, to its use of computers to assist in the review of fee pharmacy prescriptions. These officials said that as the pharmacies at other clinics of jurisdiction with high workloads of fee pharmacy prescriptions are computerized, they may be able to achieve similar reductions.

Private pharmacies filled about 26 percent of the fee-basis prescriptions at the Shreveport clinic of jurisdiction in fiscal year 1980. According to the clinic's Medical Administrative Service chief, the Shreveport clinic sent letters to veterans, physicians, and pharmacies in September 1980 advising them that prescriptions for nonemergencies should be sent to the VA pharmacy. He said that they sent letters to veterans twice and then denied payment when they continued to use private pharmacies to fill prescriptions for nonemergencies. He said the clinic denies payment for one or two prescriptions a month.

Unlike the Los Angeles clinic, Shreveport had a pharmacist review fee-basis prescriptions filled by private pharmacies. According to the clinic's pharmacy chief, many prescriptions for nonemergencies are identified that have been certified by fee-basis physicians as being for emergencies. She said that, before payment is denied, the pharmacist may also ask a VA physician to review the prescription to confirm that it is for a nonemergency. About 98 percent of the fee-basis prescriptions were filled by the Shreveport clinic's pharmacy in fiscal year 1982. According to the pharmacy chief, the clinic added about one-half full-time equivalent employee to fill the additional prescriptions.

When we visited the Seattle clinic of jurisdiction in March 1981, veterans were using private pharmacies to fill

prescriptions for nonemergencies despite an aggressive letter campaign which began in 1977 by the Seattle clinic to encourage veterans to send such prescriptions to VA. Fee program costs dropped from $204,000 in fiscal year 1977 to $72,000 in fiscal year 1980. According to the Seattle clinic's fee-basis section chief, the clinic initiated new procedures in October 1981 to further reduce fee pharmacy prescriptions. Under the clinic's new procedures, each fee prescription is reviewed to determine whether it was (1) for an emergency and (2) limited to a 15-day supply. If the prescription does not meet both criteria and the veteran has been notified by letter that prescriptions for nonemergencies should be sent to VA, the VA pharmacist is to recommend that payment be denied for all or a part of the prescription.

During the first half of fiscal year 1983, private pharmacies filled less than 5 percent of the Seattle clinic's fee-basis prescriptions. More importantly, as shown by the following examples, Seattle's policies have proven to be an effective means of encouraging veterans to send prescriptions for nonemergencies to VA.

--In June 1979, the Seattle clinic sent a letter to a veteran asking him to send prescriptions for nonemergencies to VA for filling. During the next 2 years, the veteran used private pharmacies to fill 74 prescriptions, 62 of which were, according to a VA pharmacist, for a recurring or stabilized condition. In February 1982, the clinic denied payment for a prescription for a nonemergency the veteran had filled at a private pharmacy. The veteran subsequently began sending prescriptions for nonemergencies to VA.

--In November 1981, the Seattle clinic sent a letter to a veteran instructing him that all prescriptions for nonemergencies should be sent to VA for filling. During the next 9 months, the veteran used private pharmacies to fill 22 prescriptions. As of September 3, 1982, the clinic had reviewed 15 of the 22 prescriptions and denied payment on 12 which it concluded were for nonemergencies. The veteran began sending prescriptions for nonemergencies to VA for filling.

Like Seattle, the Portland clinic of jurisdiction decided to take action to encourage veterans to send prescriptions for nonemergencies to VA for filling. According to a clinic official, the clinic began sending letters to veterans, fee physicians, and fee pharmacies in March 1982 advising them that VA

would deny payment if veterans used fee pharmacies to fill prescriptions for nonemergencies. As a result, the Portland clinic reduced the percentage of fee-basis prescriptions filled by private pharmacies from about 21 percent in fiscal year 1981 to about 10 percent in the first half of fiscal year 1983.

VA's fee-basis manual states that VA pharmacies will be used for filling staff and fee-basis physicians' prescriptions to the extent practicable, particularly recurring prescriptions in which the patients' medication needs can be determined sufficiently in advance to provide for uninterrupted prescription services from a VA pharmacy. The manual directs VA personnel (1) to review prescriptions to identify those for stabilized conditions and/or of a recurring nature and (2) to contact the prescribing physician and/or patient to encourage them to send such prescriptions to VA for filling. However, the manual also states that:

> "* * * previous requests or instructions for forwarding of prescriptions to the VA pharmacy will not be a basis for denial of payment or collection from the veteran or fee-basis physician for prescriptions filled by private pharmacies."

However, despite the wording in the fee-basis manual, the chief, ambulatory pharmacy service, told us that he had no objection to clinics denying payment for prescriptions for nonemergencies. He said that new wording on identification cards issued to veterans who are authorized fee-basis care provided better direction to clinics that want to deny payment. The new identification card states that prescriptions must be brought or mailed to VA for filling unless the physician certifies on the prescription that it is for an emergency. The card does not, however, state that VA will not pay for fee pharmacy prescriptions that lack the proper certification, and VA's Medical Administration Service had not told VA clinics to deny payment for prescriptions lacking the certification.

Of the 17 clinics of jurisdiction we contacted,

--7 said they deny payment only for prescriptions lacking the physician's certification that the drug is for an emergency,

--2 said that they deny payment if the prescription lacks the required certification or if the prescription was for vitamins or other drugs that are obviously for a nonemergency,

--5 said that they deny payment if the veteran continues to use private pharmacies to fill prescriptions for nonemergencies after being requested to send such prescriptions to VA, and

--3 said that they do not deny payment under any conditions (1 clinic said it pays the pharmacy but attempts to bill the patient for drugs for nonemergencies).

The success the clinics have in reducing fee pharmacy prescriptions appears to depend, in part, on the actions they take to deny payment for prescriptions for nonemergencies. At the three clinics of jurisdiction that have not denied payment, private pharmacies filled from about 23 to about 35 percent of the fee-basis prescriptions during the first half of fiscal year 1983. Although three of the seven clinics that deny payment for prescriptions that lack the physicians' certification had reduced private pharmacy prescriptions to 6 percent or less, the other four clinics still had private pharmacies fill from about 14 to about 28 percent of the fee-basis prescriptions. In contrast, five of the seven clinics that denied payment under other conditions had reduced private pharmacy prescriptions to less than 6 percent, and none exceeded 12 percent.

Comments received from officials of two of the clinics that do not deny payment further illustrates the need to revise VA manuals to authorize clinics to deny payment for prescriptions for nonemergencies.

--The fee-basis program chief at the San Francisco Medical Center said that the VA fee-basis manual does not clearly give the clinic authority to deny payment. He said that the clinic needs such authority to get veterans to send prescriptions to the VA pharmacy.

--The chief of pharmacy of the Allen Park, Michigan, Medical Center said that when his clinic identifies a veteran who is receiving an unusually high number of prescriptions, they send a letter encouraging the veteran to send prescriptions to VA for filling. According to the chief, if the veteran continues to get prescriptions filled at a private pharmacy, the clinic

will send the same letter up to four times. He said that, if they still do not get corrective action, they give up because they lack authority to force veterans to use the VA pharmacy.

A Medical Administration Service official said that he did not favor denying payment for nonemergency prescriptions because such actions are politically unpopular and increase administrative costs. We believe the cost savings from filling the prescriptions at VA pharmacies more than offset any increased administrative costs involved in denying payments. As shown on pages 11 and 12, the threat of payment denial may be sufficient to convince veterans to send or bring their nonemergency prescriptions to VA for filling. Because neither the Los Angeles nor Shreveport clinics has had to deny payment for large numbers of prescriptions, there has been little increase in administrative costs.

VA SHOULD PLACE HIGHER PRIORITY ON FILLING FEE-BASIS PRESCRIPTIONS

Eligible veterans with no service-connected disabilities are entitled to VA medical services only to the extent that staff and facilities are available after services have been provided to veterans with service-connected disabilities. Yet, according to a VA official, at least 16.5 million (44 percent) of the outpatient prescriptions[5] filled by VA pharmacies in fiscal year 1982 were for veterans with no service-connected disabilities. A 6-percent reduction in such prescriptions would have enabled VA clinics of jurisdiction to fill all of about 885,000 fee pharmacy prescriptions for veterans with service-connected conditions without additional staff, space, or equipment. We believe the most equitable way to accomplish any necessary reduction in the number of prescriptions provided to veterans with no service-connected conditions would be to establish priorities for providing outpatient prescriptions to such veterans based on their ability-to-pay for prescriptions from private sources.

Since the VA health care system's establishment, its primary mission has been to provide care to veterans with service-connected disabilities. VA's secondary mission has been to provide care, to the extent that facilities and staff are available, to veterans with nonservice-connected disabilities who are 65 or older or are unable to pay for care from private providers.

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[5]Excluding Methadone prescriptions.

Under 38 U.S.C. 612(1), VA's available resources should be used to provide medical services, including outpatient services, in the following priority order (unless compelling medical reasons require that such care be provided more expeditiously) to any veteran:

(1) For a service-connected disability.

(2) For a nonservice-connected condition if the veteran has a service-connected disability rated at 50 percent or more.

(3) For a nonservice-connected condition if the veteran has a service-connected disability rated at less than 50 percent.

(4) Of the Mexican border period or World War I or who is in receipt of increased pension or additional compensation or allowance.

Other eligible veterans with no service-connected conditions are entitled to care only to the extent that staff and facilities are available to provide the needed services.

When resources are not available to provide prescription services to all eligible nonservice-connected veterans, we believe VA should insure that those who are (1) receiving a VA pension, (2) Medicaid eligible, (3) age 65 or older, or (4) otherwise unable to defray the cost of prescriptions from private sources are given the highest priority for using the available resources.

We believe that veterans not eligible for needs-based programs, such as Medicaid or a VA pension, may be able to defray their prescription costs. VA pharmacy records do not show how many of the nonservice-connected outpatient prescriptions were provided to veterans receiving a VA pension, Medicaid eligible, or age 65 or older. However, about 54 percent[6] of the nonservice-connected veterans discharged from VA facilities during fiscal year 1982 were under age 65 and not receiving a VA pension. VA did not determine Medicaid eligibility of veterans applying for care.

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[6]Does not include veterans with service-connected conditions treated for nonservice-connected conditions.

A VA Medical Administration Service official did not agree that VA should limit the number of prescriptions filled for veterans with no service-connected conditions based on available resources. The official said that once a non-service-connected veteran is determined eligible for care, VA is obligated to provide all needed medical services, including prescriptions. A Pharmacy Service official said that VA could not reasonably write a prescription for a veteran and then refuse to fill it. He said that, if the veteran did not have the prescription filled at a private pharmacy, his or her condition might worsen leading to hospitalization at VA's expense.

Under 38 U.S.C. 612(f), outpatient services can be provided to any veteran eligible for hospital care

> "* * * where such services are reasonably necessary for, or (to the extent that facilities are available) to obviate the need of, hospital admission * * *." (Emphasis added.)

Eligibility for hospital care does not convey a guarantee that all needed services can be provided. Accordingly, we believe that prescriptions should be provided to nonservice-connected veterans only to the extent that available resources exceed those required to fill prescriptions for service-connected veterans, including all appropriate fee-basis prescriptions. By establishing priorities for providing prescriptions to nonservice-connected veterans based on their ability-to-pay for prescriptions from private sources, VA could lessen the likelihood that a veteran who cannot be provided prescriptions by a VA pharmacy would choose not to have the prescriptions filled by a private pharmacy.

REVIEW OF FEE PHARMACY PRESCRIPTIONS COULD REDUCE COSTS AND ABUSE

The Department of Medicine and Surgery needs to insure that its clinics of jurisdiction perform drug utilization reviews of fee pharmacy prescriptions. Although the 17 clinics of jurisdiction we contacted generally said that they were reviewing the appropriateness of charges, many did not review fee pharmacy prescriptions to identify prescriptions for non-emergencies, or inappropriate quantities or combinations of drugs.

VA's fee-basis manual requires that fee pharmacy prescriptions be

--reviewed by Medical Administration Service personnel, assisted by Pharmacy Service personnel, to identify prescriptions for nonemergencies;

--reviewed by Medical Administration Service personnel to determine the appropriateness of the fees charged; and

--filed alphabetically in the pharmacy.

VA's Pharmacy Service manual requires that the patient medication profile be reviewed before a VA pharmacy fills a prescription. However, the manual does not require that VA pharmacists review the medication profile for prescriptions filled by private pharmacies.

On March 5, 1980, the Director of the IG's Risk Analysis Group gave to the Deputy Chief Medical Director a draft report indicating that drug utilization review was the most practical quality and cost control for the fee-basis pharmacy program. It suggested that drug utilization reviews be used to identify

--veterans who could readily receive prescriptions from a VA pharmacy and encourage them to forward future prescriptions to VA for filling;

--inappropriate charges by private pharmacies;

--duplicate prescriptions by cross-matching prescriptions filled by VA with those filled by fee-basis pharmacies;

--inappropriate quantities of medications, including controlled substances;

--abuse of the fee-basis pharmacy program by ineligibles; and

--fee-basis physicians who needed to be encouraged to permit substitution of lower cost generic drugs for brand name drugs.

In a March 31, 1980, memorandum VA's Deputy Chief Medical Director notified the IG that the Department of Medicine and Surgery agreed with the IG's recommendation that "* * * the cost of fee-basis pharmacy prescriptions be substantially reduced through a continuing and effective use of Drug Utilization Reviews * * *." He said that the Department would continue its efforts to reduce the cost of the fee-basis pharmacy

programs by using drug utilization reviews, but said that substantial reductions may require using computers in concert with the monitoring of the fee-basis prescriptions filled inside and outside the VA system.

At a July 1981 briefing of central office pharmacy service officials, IG representatives stated that the clinics were not effectively reviewing fee pharmacy prescriptions. Specifically, the IG found that:

--Ten of 11 clinics did not have either Medical Administration Service or Pharmacy Service personnel review fee-basis prescriptions filled by private pharmacies to identify those for stabilized conditions and/or of a recurring nature.

--Ten of 11 clinics did not have pharmacists review prescriptions filled by fee-basis pharmacies to determine the appropriateness of the drug prescribed and the quantity of the drug dispensed.

--Seven of 11 clinics either did not review the reasonableness of prices charged by private pharmacies or had failed to document any actions that had been taken.

--Nine of 11 clinics were not maintaining fee pharmacy prescriptions alphabetically or in any other manner that would assist the clinic to perform utilization reviews.

At five clinics of jurisdiction (Bay Pines, Atlanta, Lebanon, San Diego, and Chicago) the IG had pharmacists perform drug utilization reviews of fee prescriptions filled by private pharmacies. Of the 149 files reviewed, 34 (23 percent) contained, according to the VA pharmacists, indications of

--excessive quantities of drugs,

--inappropriate combinations of drugs, or

--duplicate prescriptions.

For example, one veteran received eight prescriptions (a 165-day supply) of a controlled substance during a 53-day period. Of the eight prescriptions, five were filled by private pharmacies and three by the VA pharmacy. The same veteran received a 110-day supply of another controlled substance during a 27-day period.

Based on statistical samples of fee-basis prescriptions paid by the 11 clinics of jurisdiction during fiscal year 1980, the IG estimated that 30.8 percent of the prescriptions paid by the clinics exceeded the reimbursement allowed under VA's prescription schedule. According to the IG, the 11 clinics were overcharged from $207,774 to $381,579 during fiscal year 1980.

Department of Medicine and Surgery officials told us that the Department's fee-basis manual is being revised to strengthen review procedures. The revised manual would require that:

--The Medical Administration Service chief establish, with the collaboration of Pharmacy Service, local procedures for the review of fee-basis prescriptions filled by non-VA pharmacies to determine the appropriateness of medications being prescribed, identify prescriptions written for ineffective drugs, and any potential program abuses.

--Fee-basis prescriptions filled by non-VA pharmacies be forwarded to Pharmacy Service for inclusion in veterans' medication profile folders, which are kept alphabetically by patient name.

According to a VA official, the revised manual should be published around September 1983.

Changing the operations manual will not, by itself, insure that clinics of jurisdiction properly maintain and review fee pharmacy prescriptions. As stated on page 18, the manual already requires clinics of jurisdiction to identify nonemergency prescriptions, determine the appropriateness of the fees claimed, and maintain prescriptions alphabetically. However, we contacted 17 clinics of jurisdiction in May 1983 and were told that

--8 were not maintaining prescriptions alphabetically,

--9 did not have a pharmacist routinely review fee pharmacy prescriptions to identify prescriptions for nonemergencies and inappropriate quantities and combinations of drugs,

--3 did not have Medical Administration Service staff review fee pharmacy prescriptions to determine whether

the fee physician certified that the drug was for an emergency condition, and

--2 did not have Medical Administration Service staff routinely review the appropriateness of the fees charged by private pharmacies.

Similarly, although VA's pharmacy service manual states that prescriptions will be limited to five refills, computerized payment data for a 33-month period ended June 30, 1982, contained 29,868 prescriptions refilled 6 or more times, including 6,308 refilled over 10 times.

VA's Pharmacy Service director said that there are no clear criteria for determining when a prescription is needed for an emergency and that a pharmacist would have to review all fee pharmacy prescriptions to identify those that should have been filled by the VA pharmacy. He said that such a review would be costly and would at least partially offset any savings from filling the prescriptions at the VA pharmacy.

We agree that having a pharmacist review all fee pharmacy prescriptions would, initially, increase administrative costs of the fee program. However, as the reviews result in decreases in the number of fee-basis prescriptions filled by private pharmacies, there will be corresponding decreases in administrative costs. Further, the pharmacists' reviews are also needed to identify duplicate prescriptions and inappropriate quantities of medications.

DELAYS IN REVISING REIMBURSEMENT LIMITS COSTLY

VA agreed with an October 1980 IG recommendation that it revise its fee-basis reimbursement limits to bring them more in line with Medicaid rates and by July 1981 had developed and successfully field tested a new policy. However, the new policy was not implemented until April 1983. Delay in implementing the policy cost VA about $463,000 a year, based on estimates developed during the field test. Also, VA's policy needs to incorporate Medicaid provisions to limit reimbursement for drugs available generically from multiple manufacturers or distributors.

VA's procedures for determining the appropriateness of the fees claimed by private pharmacies had been complex and confusing. The VA prescription schedule required clinics to determine the average wholesale costs for the drugs using the

"Drug Topics Red Book" and add to that a markup of from 66 to 150 percent, depending on the quantity and cost of the medication dispensed. Because the correct percentage markup had to be individually determined and calculated, the procedure was time consuming and error prone.

In an October 1, 1980, memorandum to the Chief Medical Director, the IG recommended that VA's reimbursement policy be coordinated with HHS to develop a more uniform approach to reimbursement rates. The Chief Medical Director agreed with the recommendation and, in November 1980, authorized the Salisbury, North Carolina, clinic of jurisdiction to field test new pricing procedures.

The new pricing procedures consist of determining the average wholesale price of a drug and adding a fixed dispensing fee equal to that used by Medicaid. In the 67-day field test completed May 1, 1981, the Salisbury clinic reported savings of about $2,600 on about 6,300 claims processed. The clinic estimated nationwide savings of about $463,000 a year if the new pricing procedures were implemented. The simplified procedures for determining the reimbursement limits should result in additional savings because of the reduced time needed to review claims.

Based on the results of the Salisbury test, the Department of Medicine and Surgery, in July 1981, drafted a revised reimbursement policy identical to the policy tested by the Salisbury clinic, but the revised policy was not issued until April 1983. According to Medical Administration Service officials, the revised limits are part of overall revisions to the fee-basis manual. They said that, because the target completion date for the manual revisions has slipped a few times, an "Interim Issue" implementing the new reimbursement limits was issued in April 1983. The delay in issuing the revised policy cost VA over $810,000 between July 1981 and March 1983, based on the savings predicted as a result of the Salisbury field test.

While the draft of the revised policy adopted the Medicaid fixed dispensing fees, it did not include other cost-saving provisions of the Medicaid reimbursement policy. Under Medicaid, payment for outpatient drugs is limited to the lowest of

--maximum allowable costs plus a dispensing fee,

--estimated acquisition costs plus a dispensing fee, or

--the provider's usual and customary charges to the public.

The MAC program capitalizes on the price competition in the generic drug market by establishing limits on what will be paid for drugs available generically from more than one manufacturer or distributor. A MAC limit can be overridden only if the prescribing physician certifies that a particular brand of drug is medically necessary for the patient.

As of September 1982, 51 MAC limits had been established for different strengths, forms, and package sizes of 23 multiple source drugs. In a March 1983 article,[7] it was reported that MAC limits for 5 of the 23 drugs had resulted in savings of more than $900,000 in the five states reviewed, or nearly 1 percent of the total Medicaid drug reimbursements in those states.

To illustrate the potential cost savings from incorporating MAC provisions into the VA reimbursement policies, we compared the MAC limit under the Medicaid program to the average wholesale prices that VA would pay for brand name equivalents under its proposed reimbursement policy. VA would pay private pharmacies up to $766 for filling 51 prescriptions that would cost Medicaid $327. For example, Medicaid would pay $1.17 for 100 tablets of Meprobamate (400 milligram tablets) unless the physician certified that a brand name drug was medically necessary. VA would pay the average wholesale price of whatever brand of Meprobamate the pharmacist used to fill the prescription. If the prescription were filled with "Miltown," the most expensive brand, VA would pay $14.33 even if the physician did not prescribe by brand name. Both VA and Medicaid would pay the same dispensing fee.

In addition to the 51 federally established MAC limits, some states have established MAC limits for other drugs under Medicaid. For example, Washington established MAC limits for 126 drugs not covered by the federal MAC program. VA could reduce drug reimbursements by incorporating federal and state MAC limits in its reimbursement policy.

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[7]Lee, A. James; Hefner, Dennis; Dobson, Allen; and Hardy, Ralph Jr.; "Evaluation of the Maximum Allowable Cost Program;" Health Care Financing Review, March 1983, Volume 4, No. 3, pages 71 to 82.

A VA Medical Administration Service official agreed that VA should take a closer look at the possibility of adopting the Medicaid MAC provisions.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

We recommend that the Administrator, through the Chief Medical Director:

--Direct VA clinics of jurisdiction to have pharmacists review fee pharmacy prescriptions to identify duplicate prescriptions, excessive quantities of drugs, and prescriptions that should have been filled by the VA pharmacy.

--Revise the fee-basis manual to direct VA clinics of jurisdiction to instruct veterans to send prescriptions for nonemergencies to VA for filling and to deny payment for subsequent prescriptions if veterans disregard the request.

--Revise VA drug reimbursement policies to incorporate Medicaid MAC provisions.

--Direct VA clinics of jurisdiction to fill prescriptions for nonservice-connected conditions only if the clinic's staff and facilities are not needed to fill prescriptions for veterans with service-connected conditions, including those fee-basis prescriptions for nonemergencies.

--Reemphasize, to clinics of jurisdiction, the importance of having Medical Administration Service clerks review fee pharmacy prescriptions to ensure that payments do not exceed the limits established by the VA prescription schedule.

--Establish priorities for providing outpatient prescriptions to veterans with no service-connected conditions based on the veterans' "ability to pay" for prescriptions from private sources.

--Establish a system for periodically monitoring clinics of jurisdiction compliance with fee-basis pharmacy policies and procedures.