Department of Veterans Affairs

Office of Inspector General

AUDIT OF VETERANS HEALTH ADMINISTRATION (VHA) PHARMACY CO-PAYMENT LEVELS AND RESTRICTIONS ON FILLING PRIVATELY WRITTEN PRESCRIPTIONS FOR PRIORITY GROUP 7 VETERANS

VHA can reduce the cost impact of providing prescriptions to priority group 7 veterans, make additional resources available for veteran healthcare, and enhance the delivery of prescription services to veterans.

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Date: December 20, 2000

Office of Inspector General
Washington DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

Memorandum to the Under Secretary for Health (10)

Audit of Veterans Health Administration (VHA) Pharmacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans

1. The audit was conducted to: (1) quantify the number of priority group 7 veterans that use the Florida/Puerto Rico Veterans Integrated Service Network's (VISN 8) healthcare facilities for the purpose of filling prescriptions that are ordered by their private physicians, and (2) evaluate the process used by Department of Veterans Affairs (VA) medical facilities to fill prescriptions written by private sector physicians. The audit was completed as part of a broader ongoing audit of the Adequacy and Availability of Healthcare Services in VISN 8 (OIG Project No. 1999-57-D2-184).

2. In accordance with the provisions of the "Veterans Health Care Eligibility Reform Act of 1996" (Public Law 104-262), VHA has implemented a patient enrollment system to manage the delivery of healthcare services to eligible veterans. The enrollment system categorizes veterans into one of seven groups – with priority groups 1 through 6 representing veterans with service-connected disabilities, low incomes, and special categories (e.g., former prisoners of war). Generally, veterans in priority group 7 are not being treated for service connected disabilities and have incomes above the limits needed to qualify for entirely free care. Once enrolled, priority group 7 veterans share equal access with all other priority groups to the healthcare services offered in VA's Medical Benefits Package including VA supplied prescription drugs and supplies. However, priority group 7 veterans currently pay $2 to VA for each 30-day supply of prescription drugs filled, as do veterans who are less than 50 percent service connected and receiving prescriptions for their non-service connected conditions.

3. The audit found that VHA can reduce the cost impact of providing prescriptions to priority group 7 veterans, make additional resources available for veteran healthcare, and enhance the delivery of prescription services to veterans. The following key findings were identified.

- The current pharmacy co-payment level needs to be increased to more appropriately recover the increasing direct cost of prescriptions.
- The current process of filling prescriptions written by enrolled veterans private physicians needs to be streamlined to provide a more efficient use of resources.

4. We found that the potential monetary impact of these findings to the Department is significant. Although a VHA workgroup has recently recommended raising the co-pay level to $5, we believe a $10 co-pay level is supported by prescription cost data and is more in-line with private sector medical insurance coverage. This higher co-pay level would still allow priority group 7 veterans to obtain their prescription medications from VA at costs substantially lower

than non-veterans or from private sources. A $10 co-pay level will allow VHA to increase its annual pharmacy co-pay collections VA-wide from $75 million to over $567 million and will provide the opportunity to recover a greater proportion of the average direct cost of each prescription (which we estimate to be approximately $20 per fill). We found that, in addition to the direct costs of the prescriptions themselves, the costs of re-examining the veteran in order to fill the privately written prescriptions are significant and could be reduced with a more streamlined process. The costs include clinical staff-time, exams, tests, and other resources involved in the "re-writing" of the prescriptions that veterans obtain from their private healthcare providers and bring to VA to have filled. We estimate that in Fiscal Year (FY) 1999 these costs totaled approximately $113.9 million for VISN 8 and as much as $879 million VHA-wide. For FY 2001, we estimate that the VHA-wide costs for re-examining these veterans will increase to $1.3 billion.

As a result of these findings, we recommended that the Under Secretary for Health:

- Increase the pharmacy co-pay level for priority group 7 veterans from the current $2 for each 30-day prescription supply to $10, and evaluate the future use of a tiered co-pay approach.
- Seek a legislative change to Title 38 USC, Chapter 17 to permit the filling of private prescriptions written for enrolled veterans.
- Develop appropriate quality assurance systems to monitor private prescription fills.

5. The Under Secretary for Health provided comments that agreed with our concerns about the inefficiencies associated with the current system of filling privately written prescriptions for priority group 7 veterans. The Under Secretary advised that "Because of the complexity of the issues involved, which go far beyond the cost considerations identified in the report, we defer concurrence or non-concurrence in your recommendations pending more focused attention and direction by VHA's National Leadership Board." The Under Secretary indicated that options to the current co-payment structure will be considered and VHA will further explore the issues we identified concerning VA's filling of prescriptions written by enrolled veterans private physicians. We recognize that these issues represent significant policy and budget considerations for the Department that require careful review of alternatives. We also recognize that a decision to continue the current policies results in inefficiency and waste that we estimate annually costs the Department over $1 billion in resources that could be better used in the delivery of healthcare services to veterans.

6. Given the significance of the issues discussed in this report and the opportunity for enhanced delivery of services to veterans, the Department needs to take appropriate corrective action as soon as possible. The audit clearly shows that the Department has an opportunity to reduce the cost impact of providing prescriptions to priority group 7 veterans, make additional resources available for veteran healthcare, and enhance the delivery of prescription services to veterans. Based on the Under Secretary's response, we consider the recommendations unresolved until VHA's review of these issues is completed and specific implementation actions are provided that

meet the intent of our recommendations. We will follow up on VHA's planned review and analysis effort until it has been completed.

For the Assistant Inspector General for Auditing

(Original signed by:)

Stephen L. Gaskell
Director, Central Office Operations Division

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RESULTS AND RECOMMENDATIONS

1. VHA Needs To Increase The Current Pharmacy Co-Payment Levels

The "Veterans Health Care Eligibility Reform Act of 1996" required VA to enroll veterans annually according to seven priority groups. Priority group 1 is comprised of veterans with significant service-connected disabilities while priority group 7 is comprised of veterans without service-connected disabilities and incomes above prescribed limits. Once enrolled, all veterans, regardless of their priority grouping, have access to all of the health services described in VA's basic Medical Benefits Package, which includes prescription drugs and supplies. However, unlike veterans in priority groups 1 through 6, priority group 7 veterans must agree to a co-payment to be paid directly to VA. This is currently $50.80 per outpatient visit (regardless of the number of clinics scheduled during a visit) and $2 for each 30-day supply of prescribed medications. While veterans' insurance companies can be billed for any costs not covered by the outpatient co-pay amount, their insurance companies are not billed for costs of prescription medications above the $2 co-pay amount.

Based on our review, the direct cost (excluding handling and mailing) to the Veterans Integrated Service Network (VISN) 8 in Calendar Year (CY) 1999 of providing prescription medications to priority group 7 veterans was approximately $20 per fill (which usually represents a 30 to 60 day supply). As a result, we estimate that the total direct costs to the Network of providing prescriptions to priority group 7 veterans during Fiscal Year (FY) 1999 was as much as $27.5 million. During the same timeframe, the Network collected $4.8 million as a result of pharmacy co-pay billings (17.5 percent of the direct costs).

In addition, as many as 90 percent of the Network's 52,570 priority group 7 veterans have access to private non-VA healthcare and/or have statements recorded in their medical records that their sole or primary purpose of using VA healthcare services was to have private prescriptions filled. As a result, we concluded that the primary reason that the majority of priority group 7 veterans use VA healthcare services is to use the "prescription drug benefit" with its low $2 co-pay.

The majority of priority group 7 veterans in VISN 8 use VA for the sole or primary purpose of filling prescriptions from their private physicians

Our review identified 13,019 priority group 7 veterans in VISN 8 who had at least 1 visit to a Network facility during FY 1999 and had at least 4 active prescriptions during that same year. We selected 949 of these veterans with 3 or fewer visits and asked each VA medical center's (VAMC) medical records staff to locate the medical and administrative records and make these available to us for review. We asked each VAMC's Health Information Officer to provide a "Health Summary" for each selected case. The Health Summary contained a synopsis of the information contained in each patient's computerized medical record. We then reviewed each selected case and sorted them into one of the following 6 categories:

(1) Veteran has: (a) a private physician, AND (b) health insurance AND/OR Medicare/Medicaid with medigap insurance, AND (c) a clear statement in the medical record that the sole/primary reason that his/her use of VA is to have private prescriptions filled.

(2) Veteran has: (a) a private physician, AND (b) health insurance &/or Medicare/Medicaid with medigap insurance…but no clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled.

(3) Veteran has: (a) health insurance AND/OR Medicare/Medicaid with medigap insurance, AND (b) a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled…but no reference to a specific private physician.

(4) Veteran has: (a) health insurance AND/OR Medicare/Medicaid with medigap insurance...but no clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled…and no reference to a specific private physician.

(5) Veteran has: (a) a private physician, AND/OR (b) a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled…but no indication of private insurance or medigap coverage...although he/she may have Medicare/Medicaid eligibility.

(6) Veteran does not have a private physician, or health or medigap insurance, or a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled.

Almost 90 percent of the cases reviewed, representing a projected $24.5 million annually in direct prescription costs to the Network, had at least one of the criteria indicating that the patient had access to private non-VA health care and/or that their use of VA was solely or primarily for the purpose of filling prescriptions. Forty three percent, representing a projected $11.9 million annually in direct prescription costs contained recorded statements or other clear evidence that the use of VA was for the sole or primary purpose of filling prescriptions and that primary and other specialty care was obtained from non-VA (private) health care providers. *(A summary of VISN 8 case review results and costs by individual facility is presented in Appendix III on pages 17-18.)* These costs do not take into consideration an offsetting $2 co-payment that is billed and collected directly from patients. A summary of the review results and cost projections for the Network are shown in the following chart:

VISN 8 Direct Cost Projections of Prescriptions For Priority Group 7 Veterans Who Have Access to Private Health Care and/or Use VA to Fill Private Prescriptions

	VISN 8 Totals
Priority group 7 veterans cases reviewed.	949
Average annual cost per patient ($551.70 for sampled cases versus $523.72 for all cases).	$523.72
Category 1 -- Veteran has: (a) a private physician, AND (b) health insurance &/or Medicare/Medicaid with medigap insurance, AND (c) a clear statement in the medical record that the sole/primary reason that his/her use of VA is to have private prescriptions filled.	249
Category 3 -- Veteran has: (a) health insurance AND/OR Medicare/Medicaid with medigap insurance, AND (b) a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled…but no reference to a specific private physician.	24
Category 5 -- Veteran has: (a) a private physician, AND (b) a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled…but no indication of private insurance or medigap coverage...although he/she may have Medicare/Medicaid eligibility.	138
Sub Total (Categories 1, 3, 5) –- Records contain direct statements or other clear evidence that the use of VA was for the sole or primary purpose of filling prescriptions and that primary and other specialty care was obtained from non-VA (private) health care providers.	411 (43.31%)
Total population of priority group 7 Veterans during FY 1999.	52,570
Annual Cost of Prescriptions = ($523.72)*(52,570)*(43.31%).	$11.9 million
Category 2 -- Veteran has: (a) a private physician, AND (b) health insurance AND/OR Medicare/Medicaid with medigap insurance…but no clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled.	260
Category 4 -- Veteran has: (a) health insurance AND/OR Medicare/Medicaid with medigap insurance...but no clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled…and no reference to a specific private physician.	175
Sub Total (Categories 2, 4) –- Veteran has private physician AND/OR health insurance AND/OR Medicare/Medicaid with medigap insurance.	435 (45.84%)

Annual cost of prescriptions = ($523.72)*(52,570)*(45.84%).	$12.6 million
Total (Categories 1 – 5) – Veteran had at least one of the criteria indicating that he/she had access to private non-VA health care AND/OR that their use of VA was solely or primarily for the purpose of filling prescriptions.	846 (89.15%)
Projected annual direct cost of prescriptions for priority group 7 veterans who have access to private healthcare and/or use VA to fill private prescriptions.	$24.5 million

Estimated VHA-wide direct-cost projections show the significant current and future economic impact of priority group 7 prescriptions

The following chart shows the potential VHA-wide annual budget impact of the direct costs for priority group 7 veterans use of VA for the sole or primary purpose of filling prescriptions and/or who have access to private healthcare. The "Upper Limit Range" ($199.5 million in FY 1999 to $301.8 million in FY 2001) is the projected impact for the entire population of priority group 7 veterans based on the average number of prescriptions that were active sometime during FY 1999 and the average cost per prescription (not per fill). The "Lower Limit Range" ($49.4 million in FY 1999 to $74.7 million in FY 2001) is based only on the population of priority group 7 veterans with 4 or more active prescriptions.

VHA-wide Direct Cost Projections

Note: The upper limit range of estimated costs are based on all priority group 7 veterans (including those with fewer than 4 active prescriptions) using VA solely or primarily to fill their prescriptions at the same rate as identified in our sample (89.15%)

	FY 1999	**FY 2001**
	Direct Costs	**Direct Costs**
A. Number of priority group 7 veterans actively using VA health care services (nationwide).	405,718	613,671
B. Average number of active prescriptions (based on VISN 8 sample).	14.18	14.18
C. Average cost per prescription (Based on VISN 8 sample).	$38.90	$38.90
D. Percent of priority group 7 patients who use VA solely or primarily to fill their prescriptions and/or who have access to private healthcare (Based on VISN 8 sample) .	89.15%	89.15%
E. Upper limit range of estimated costs [(A)x(B)x(C)x(D)].	$199,513,118	$301,774,668
F. Percent of priority group 7 patients who have at least 4 active prescriptions.	24.77%	24.77%
G. Lower limit range of estimated costs [(A)x(B)x(C)x(D)x(F)].	$49,419,399	$74,749,585

An increase in the veteran co-payment would still provide a substantial discount in the cost of drugs

To determine the pharmacy costs for priority group 7 veterans in VISN 8, we worked with the Network's Information Resources Management staff to identify the 13,019 veterans who had at least 1 visit to a Network facility during FY 1999 and had at least 4 active prescriptions during that same year. We then obtained a computer file of all pharmacy costs associated with these veterans and determined that the average cost for each fill was $20.02. These costs do not include any administrative costs such as handling and mailing, nor do they reflect the costs that would be incurred if these drugs were purchased directly by veterans from private sources. However, recent GAO Congressional testimony on "DoD and VA Joint Buying and Mailing of Pharmaceuticals" (GAO/T-HEHS-00-121) indicates VA's costs are from 58 percent to 94 percent below the average wholesale prices charged by pharmaceutical suppliers. This equates to a per-fill cost to the veteran of at least $47.67 should these prescriptions be filled at wholesale prices.

VHA's current proposal to raise the pharmacy co-pay to $5 is not based on actual pharmaceutical cost data

Prior to enactment of the "Veterans Millennium Healthcare and Benefits Act" (Public Law 106-117) in November 1999, VHA convened a workgroup to study co-pay issues. A consultant was hired by VA to conduct a "literature review" which resulted in the identification of a range of co-pay levels that were used by private insurers. This range was found to be from $5 to $12 per fill. A member of the workgroup explained that the VHA Pharmacy Board had recommended a $10 level for priority 7's to "discourage people coming in with handfuls of scripts." However, the lowest co-pay of $5 was selected because it was felt that even this amount represented a 250 percent increase over the existing rate of $2 and that additional yearly increases could be made if needed. The proposed regulatory change is to be published for public comment with the expectation that final implementation will be by December 2000.

In FY 1999, VHA collected over $75 million from priority group 7 veterans in pharmacy co-payments. Raising the co-pay amount to $10 would increase collections to $375 million based on FY 1999 data and to over $567 million in FY 2001 (based on VHA's projected increase of 51.26 percent in the number of priority group 7 veterans expected to enroll for care). *(A summary of VHA-wide potential increased co-pay collections is presented in Appendix IV on page 19.)*

In response to an Advisory Letter we issued to the VISN 8 Network Director, he agreed with our conclusion that a pharmacy co-pay level of $10 was supported by both industry patterns and VA experience. However, he suggested that the co-pay should be tiered to reflect the differences in processing costs between mail-outs and person-to-person services provided at the pharmacy window. This would promote the use of VA's prescription mail system. He also suggested that a lower co-pay for over-the-counter (OTC) drugs would provide an incentive to prescribe a less expensive OTC drug where appropriate, while ensuring inclusion of OTC drugs in VHA's electronic medical records. We believe that the Director's suggestions should be considered as part of an overall increase in the co-pay level.

Conclusion

We believe that increasing the co-pay level to $10 is appropriate based on the direct costs to VHA and would provide a substantial discount below what the same drugs would cost veterans from non-VA sources.

Recommendation 1:

We recommend that the Under Secretary for Health increase the pharmacy co-pay level for priority group 7 veterans from the current $2 for each 30-day prescription supply to $10, and evaluate the future use of a tiered co-pay approach.

Under Secretary for Health Comments

The Under Secretary for Health deferred concurrence or non-concurrence with the recommendation pending more focused attention and direction by VHA's National Leadership Board.

Implementation Plan

On October 19, 2000, subsequent to the issuance of this report, VHA's Policy Board approved a new prescription co-payment rate of $5 for all veteran categories. Although the $10 increase recommended by OIG does not appear unreasonable, we think that other considerations must be factored in before decisions are made about possible co-payment increases in the future. We agree that incentives to utilize less expensive therapies and mailout prescription filling versus window service should be factors in determining a co-payment structure, and are considering all such options. Key to these options, however, are fundamental questions about the legality of establishing pharmacy co-payment rates for different priority level veterans.

(See Appendix VI on pages 23-24 for the full text of the Under Secretary's comments.)

Office of Inspector General Comments

Based on the Under Secretary's comments, we consider the recommendation unresolved and will follow up on VHA's planned review and analysis effort until it has been completed.

Based on the actual cost to VA for medications, and considering current private sector prescription co-payment rates, we continue to believe that a $10 co-payment is appropriate. The co-payment rate does not affect low-income veterans or those being treated for service connected conditions. The co-payment applies only to veterans being treated for non-service connected conditions of whom the vast majority are priority group 7 veterans whose incomes are above the limits that allow VA to provide entirely free care. Because the resources to subsidize an unreasonably low co-payment rate must come directly from VAMC medical care program budgets, veterans with service connected conditions and low-income veterans are, in effect, subsidizing the medications for higher income non-service connected veterans. We believe that VHA can minimize this by basing the co-payment rates on actual costs of medications and the average pharmacy co-payment rates established throughout the healthcare insurance industry.

We also want to respond the Under Secretary's concerns about the legality of establishing pharmacy co-payment rates for different priority level veterans. Our report recommendation focused on the need to raise the co-payment rate for priority group 7 veterans who are the majority of veterans being treated for non-service connected conditions that are subject to the pharmacy co-payment rate. We would expect that the same co-payment rate would also apply to those veterans in other priority groups that are subject to pharmacy co-payments for treatment of non-service connected conditions.

2. VHA Should Streamline Its Current Process Of Filling Prescriptions Written By Enrolled Veterans Private Physicians

VA regulations found at 38 CFR §17.96 do not allow VA pharmacies to fill prescriptions issued by private physicians except in limited circumstances (e.g., for veterans who are housebound or are receiving Aid and Attendance benefits from VA or live in Alaska). However, as discussed in the previous section, we found that almost 90 percent of the priority group 7 veterans included in our review in VISN 8 had at least one of the criteria indicating that the patient had access to private non-VA health care and/or that their use of VA was solely or primarily for the purpose of filling prescriptions originally written by private physicians. We found that these veterans are scheduled for exams by VA staff physicians who then routinely review and approve the orders of the private physicians. These prescriptions are filled provided the drugs are listed in VA's drug formulary. When not listed in the formulary, a substitute/alternative is issued in consultation with the private physician. We also found that these exams frequently duplicate tests and exams that have already been performed by the patient's private physician and are conducted to allow the VA physician to support filling a prescription that the patient has brought in from his/her private physician. In fact, we have been advised that in at least one Network VAMC, special prescription "re-write clinics" have been established to focus solely on providing a more streamlined process to fill privately written prescriptions.

The indirect costs of re-writing private prescriptions that are filled by VA pharmacies exceed the direct costs of the prescriptions themselves

While the direct costs of the prescriptions are relatively simple to quantify, the "indirect" costs of completing exams and tests associated with filling these prescriptions are more difficult to measure. The most straightforward way we found to quantify the cost impact was to identify the number of visits involved and apply an average cost per visit. In FY 1999, VHA billed veterans insurance companies $254 for each outpatient visit, of which the veteran was responsible for up to $50.80 (20 percent) as a co-payment amount. Using the $254 billing amount as a cost basis, we estimate that the costs to VISN 8 of providing exams and clinical tests in order to meet VHA regulatory requirements for re-writing private prescriptions to be $113.9 million annually. Although we believe this fairly represents the total resources involved, the actual net cost to the Network would be less since the Network collects some portion of these costs from veterans and their insurers. The exact portion is not known since inpatient collections and outpatient collections are not separately identified by VHA. The chart on the next page shows the estimated indirect costs by category projected to the VISN's total priority group 7 population:

VISN 8 Cost Projections of Medical Examinations For Priority Group 7 Veterans Who Have Access to Private Health Care and/or Use VA to Fill Private Prescriptions

	VISN 8 Totals
Average cost per outpatient visit (VHA 3rd party billing rate).	$254
Average number of visits per patient per year (total for the entire priority group 7 Population).	9.57*
Sub Total (Categories 1, 3, 5) –- Records contain direct statements or other clear evidence that the use of VA was for the sole or primary purpose of filling prescriptions and that primary and other specialty care was obtained from non-VA (private) health care providers.	43.31%
Total population of priority group 7 veterans during FY 1999.	52,570
Annual cost of prescriptions = ($254)*(52,570)*(9.57)*(43.31%).	$55.3 million
Sub Total (Categories 2, 4) –- Veteran has a private physician and/or health insurance and/or Medicare/Medicaid with medigap insurance.	45.84%
Annual cost of prescriptions = ($254)*(52,570)*(9.57)*(45.84%).	$58.6 million
Total (Categories 1 – 5) --- Veteran had at least one of the criteria indicating that he/she had access to private non-VA health care and/or that their use of VA was solely or primarily for the purpose of filling prescriptions.	89.15%
Projected annual indirect cost of prescriptions ($254)*(52,570)*(9.57)*(89.15%).	$113.9 million

* Note: Although the average number of visits for the total population of priority group 7 veterans (9.57) is higher than the criteria used to select our review group (i.e., fewer than 3 visits), the review group was found to have substantially more visits as a result of the time lapse between their selection and our review of their records. As a result, we do not believe there is a material difference between our review group and the priority group 7 population as a whole.

VHA-wide indirect-cost projections show the significant current and future economic impact of priority group 7 prescriptions

The chart below shows the potential VHA-wide annual budget impact of the indirect costs for priority group 7 veterans use of VA for the sole or primary purpose of filling prescriptions and/or who have access to private healthcare. The "Upper Limit Range" ($879.2 million in FY 1999 to $1.3 billion in FY 2001) is the projected impact for the entire population of priority group 7 users based on the average number of visits per patient during FY 1999 and the 3rd party insurer billing rate per outpatient visit. The "Lower Limit Range" ($217.8 million in FY 1999 to $329.4 million in FY 2001) is based only on the population of priority group 7 veterans with 4 or more active prescriptions.

VHA-wide Indirect Cost Projections

Note: The upper limit range of estimated costs are based on all priority group 7 veterans (including those with fewer than 4 active prescriptions) using VA solely or primarily to fill their prescriptions at the same rate as identified in our sample (89.15%)

	FY 1999	FY 2001
	Indirect Costs	Indirect Costs
A. Number of priority group 7 veterans actively using VA health care services.	405,718	613,671
B. Average annual number of visits per patient.	9.57	9.57
C. Average cost (reimbursement) per visit.	$254	$254
D. Percent of priority group 7 patients who use VA solely or primarily to fill their prescriptions and/or who have access to private healthcare.	89.15%	89.15%

E. Upper limit range of estimated costs [(A)x(B)x(C)x(D)].	$879,207,285	$1,329,849,831
F. Percent of priority group 7 patients who have at least 4 active prescriptions.	24.77%	24.77%
G. Lower limit range of estimated costs [(A)x(B)x(C)x(D)x(F)].	$217,779,644	$329,403,803

VHA's regulations restricting the filling of private prescriptions and the practices that have been developed by VA physicians to avoid these restrictions is inefficient and adversely affects veterans' timely access to VA healthcare

Based on the results of our review, we believe the pharmacy benefit, with its low $2 co-payment requirement, is the primary reason that the majority of priority group 7 veterans use VA health care services. As noted earlier, these veterans are not being treated for service connected disabilities and have incomes above the limits needed to qualify for entirely free care. However, once enrolled, they, like all veterans in the other 6 priority groups, have full access to all of the health services described in VA's Medical Benefits Package, which includes prescription drugs and supplies. Although these veterans have higher incomes, and their existing private insurance and/or Medicare eligibility allow them access to private physicians, they rarely have coverage for the drugs and other medical supplies prescribed by their physicians. As a result, they come to VA with their prescriptions already written and in-hand. We noted frequent comments in patient medical records reflecting the frustration of veterans in having to go through VA's extended process of scheduling exams and tests and then spending sometimes the entire day at the medical center solely, from their perspective, to have their prescriptions filled or refilled.

Although our review was limited to priority 7 veterans, the impact of VHA's policy to fill only prescriptions written by VA physicians and the processes that have been developed to comply with this policy affects all veterans receiving or eligible for VA healthcare. For example, veterans in priority groups 1 – 6 are also restricted to having only those prescriptions filled that are written by VA physicians. We do not believe the percentage of these veterans who use VA healthcare services to have private prescriptions filled are as great as priority 7 veterans since, by definition, priority 7 veterans are more likely to have access to private healthcare. However, there are no doubt some number of the priority group 1 through 6 veterans who have private physicians and would benefit from a more efficient process to have their privately written prescriptions filled by VA. Further, all enrolled veterans are affected by increased waiting times for appointments and overcrowded clinics. Our audit of healthcare services in VISN 8 identified numerous clinical services and activities with extended waiting times and restricted access. Reducing the workload associated with re-writing private prescriptions would provide the opportunity to alleviate some of these delays and restrictions to access to care.

Controls over quality of care and other concerns can be addressed

We believe that streamlining the process of filling prescriptions written by private physicians could be achieved without adversely affecting quality of care and costs control. In this regard, GAO reported that their recent and ongoing reviews of Department of Defense (DoD) pharmacy issues indicates that, like VA, the pharmacy benefit is the health care service that is most in demand by military beneficiaries and that DoD has implemented a quality assurance system for the private prescriptions it fills. GAO has suggested to us that there is an opportunity for VA and DoD to coordinate their efforts his area.

Conclusion

Our review showed that the pharmacy benefit is the healthcare service that the majority of priority group 7 veterans want. We believe that the processes VHA uses to restrict pharmacy services to only those veterans for whom it provides direct medical care is inefficient. Veterans with Medicare eligibility and/or private insurance coverage who chose to be treated by private non-VA health care providers must frequently, as a result of these processes, submit to duplicate exams, tests, and procedures by VHA simply in order to receive their prescriptions. As a result, VAMCs frequently end up spending more on scarce clinical resources to "re-write" prescriptions than the prescriptions themselves cost.

Recommendation 2:

We recommend that the Under Secretary for Health:

a. Seek a legislative change to Title 38 USC, Chapter 17, and the implementing regulations found in 38 CFR, to permit the filling of private prescriptions written for enrolled veterans.

b. Develop appropriate quality assurance systems to monitor private prescription fills.

Under Secretary for Health Comments

The Under Secretary for Health deferred concurrence or non-concurrence with the recommendations pending more focused attention and direction by VHA's National Leadership Board.

Implementation Plan

The Under Secretary indicated that VHA's National Leadership Board will initially address the topic during its next meeting in mid-January 2001. Shortly thereafter, a position paper will be developed.

(See Appendix VI on pages 23-24 for the full text of the Under Secretary's comments.)

Office of Inspector General Comments

Based on the Under Secretary's response, we consider the recommendations unresolved until VHA's review of these issues is completed and specific implementation actions are provided that meet the intent of our recommendations.

We recognize that these issues represent significant policy and budget considerations for the Department that require careful review of alternatives. We also recognize that a decision to continue the current policies results in inefficiency and waste that we estimate annually costs the Department over $1 billion in resources that could be better used in the delivery of healthcare services to veterans. Given the significance of the issues discussed in this report and the opportunity for enhanced delivery of services to veterans, the Department needs to take appropriate corrective action as soon as possible. The audit clearly shows that the Department has an opportunity to reduce the cost impact of providing prescriptions to priority group 7

veterans, make additional resources available for veteran healthcare, and enhance the delivery of prescription services to veterans.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The audit was conducted to: (1) quantify the number of priority group 7 veterans that use the Florida/Puerto Rico Veterans Integrated Service Network's (VISN 8) healthcare facilities for the purpose of filling prescriptions that are ordered by their private physicians, and (2) evaluate the process used by Department of Veterans Affairs (VA) medical facilities to fill prescriptions written by private sector physicians. The audit was completed as part of a broader ongoing audit of the Adequacy and Availability of Healthcare Services in VISN 8 (OIG Project No. 1999-57-D2-184). The results of our review of VISN 8 priority group 7 pharmacy services involve Veterans Health Administration (VHA) policies that are applicable to all VHA healthcare Networks and facilities.

Scope and Methodology

Work was performed at VISN 8 headquarters and at VA medical centers (VAMC) Bay Pines, West Palm Beach, Tampa, Gainesville, and Lake City, Florida. VAMC San Juan was excluded due to the small number of priority group 7 veterans enrolled for health care at the facility; and VAMC Miami was excluded due to an electrical explosion that closed the facility for several months during the review.

We asked the Network's Information Resources Management staff to create a computer file identifying all priority group 7 veterans who had at least 1 visit during Fiscal Year (FY) 1999 to one of the Network's medical centers or satellite/community clinics and who had at least 4 prescriptions that were active sometime during the period. The resulting file contained 13,019 names of which we selected 949 with 3 or fewer visits and asked each VAMC's medical records staff to locate the medical and administrative records and make these available to us. We asked each VAMC's Health Information Officer to provide a "Health Summary" for each selected case. The Health Summary contained a synopsis of the information contained in each patient's computerized medical record. For the direct cost of prescriptions, we obtained a computer file of all prescriptions and costs by patient for calendar year 1999 that had been developed by the Network's Pharmacy Policy Board. We then reviewed each selected case and sorted them into one of the following 6 categories:

(1) Veteran has: (a) a private physician, AND (b) health insurance &/or Medicare/Medicaid with medigap insurance, AND (c) a clear statement in the medical record that the sole/primary reason that his/her use of VA is to have private prescriptions filled.

(2) Veteran has: (a) a private physician, AND (b) health insurance &/or Medicare/Medicaid with medigap insurance…but no clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled.

(3) Veteran has: (a) health insurance AND/OR Medicare/Medicaid with medigap insurance, AND (b) a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled…but no reference to a specific private physician.

(4) Veteran has: (a) health insurance AND/OR Medicare/Medicaid with medigap insurance...but no clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled…and no reference to a specific private physician.

(5) Veteran has: (a) a private physician, AND/OR (b) a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled…but no indication of private insurance or medigap coverage...although he/she may have Medicare/Medicaid eligibility.

(6) Veteran does not have a private physician, or health or medigap insurance, or a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private prescriptions filled.

The audit was performed in accordance with generally accepted Government Auditing Standards.

BACKGROUND

The eligibility rules prescribed by the "Veterans Health Care Eligibility Reform Act of 1996" required VA to establish a system for enrolling veterans in VA health care and to use the system for managing the delivery of services. VA is required to enroll only those veterans for which it has sufficient resources to provide timely health care. Annually, VA enrolls veterans according to seven priority groups, with the highest priority for enrollment given to veterans with significant service-connected disabilities or low incomes (priority groups 1 through 6). Veterans in priority group 7 are not being treated for service connected disabilities and have incomes above the limits needed to qualify for entirely free care. However, once enrolled, priority group 7 veterans have full access to all of the health services described in VA's Medical Benefits Package, which includes prescription drugs and supplies. VA offsets some of these costs through the billing of private health care insurance and/or co-payments from the veterans themselves. Priority group 7 veterans currently pay $2 to VA for each 30-day supply of prescription drugs filled, as do veterans who are less than 50 percent service connected and receiving prescriptions for their non-service connected conditions. Although insurance companies are billed at a flat rate for inpatient stays and outpatient visits, they are not billed for any part of a veterans prescription since most have specific drug and pharmaceutical exclusions and because VA's automated billing systems focus on clinic stops and not on prescription issuance's.

APPENDIX III

SUMMARY OF VISN 8 CASE REVIEW RESULTS AND COSTS

			Sample	Priority 7 Vets with at least 1 visit & 4 or more Rx's during FY 1999	1999 Priority 7 Population
		Total Number of Veterans	949	13019	52570
		Average annual # of visits (per VISN IRM records at the time of sample selection)	2.35	9.57	9.57
		Average annual # of active Rx's	14.18	13.63	13.63
		Average Annual # of 1st. Fills & refills	29.56	26.16	26.16
		Average cost per fill	$18.66	$20.02	$20.02
		Average Annual Rx Cost Per Pt	$551.70	$523.72	$523.72
	CATEGORY 1 -- Veteran has: (1) private MD, AND (2) health insurance &/or medicare/medicaide with medigap insurance, AND (3) a clear statement in the medical record that the sole/primary reason that his/her use of VA is to have private Rxs filled.		249	3416	13793
		% of population - Cat 1	26.24%	26.24%	26.24%
		Annual Costs of Rx's (Avg. Annual Rx $/Pt X # Cat 1)	$137,373	$1,789,028	$7,223,670
		Annual Costs for Visits (Avg. visits/yr. X $254 X # Cat 1)	$148,628	$8,303,544	$33,527,749
		Sub Total - Annual Costs of Rx's & Visits – Cat 1	$286,001	$10,092,572	$40,751,419
	CATEGORY 3 -- Veteran has: (1) health insurance &/or medicare/medicaide with medigap insurance, AND (2) a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private Rxs filled…but no reference to a specific private MD.		24	329	1329
		% of population - Cat 3	2.53%	2.53%	2.53%
		Annual Costs of Rx's (Avg. Annual Rx $/Pt X # Cat 3)	$13,241	$172,304	$696,024
		Annual Costs for Visits (Avg. visits/yr. X $254 X # Cat 3)	$14,326	$799,727	$3,230,507
		Sub Total – Annual Costs of Rx's & Visits – Cat 3	$27,566	$972,031	$3,926,531
	CATEGORY 5 – Veteran has: (1) a private MD, AND/OR (2) a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private Rxs filled…but no indication of private insurance or medigap coverage...although he/she may have medicare/medicaid eligibility.		138	1893	7645
		% of population - Cat 5	14.54%	14.54%	14.54%
		Annual Costs of Rx's (Avg. Annual Rx $/Pt X # Cat 5)	$76,135	$991,402	$4,003,839
		Annual Costs for Visits (Avg. visits/yr. X $254 X # Cat 5)	$82,372	$4,601,467	$18,583,313
		Sub Total – Annual Costs of Rx's & Visits – Cat 5	$158,507	$5,592,869	$22,587,153
SUBTOTAL OF CATEGORIES 1, 3, and 5 - Veterans records contains clear statement that the sole/primary reason for his/her use of VA healthcare is to have private Rxs filled, AND has private MD AND/OR public/private health insurance.			411	5,639	22,768
		% of population - Cat 1,3,5	43.31%	43.31%	43.31%
		Annual Costs of Rx's (Avg. Annual Rx $/Pt X # Cat 1,3,5)	$226,749	$2,953,010	$11,924,092
		Annual Costs for Visits (Avg. # visits/yr. X $254 X # Cat 1,3,5)	$245,326	$13,706,023	$55,344,162
		Sub Total – Annual Costs of Rx's & Visits – Cat 1,3,5	$472,075	$16,659,034	$67,268,254

	CATEGORY 2 – Veteran has: (1) private MD, AND (2) health insurance &/or medicare/medicaide with medigap insurance…but no clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private Rxs filled.		260	3567	14403
		% of population - Cat 2	27.40%	27.40%	27.40%
		Annual Costs of Rx's (Avg. Annual Rx $/Pt X # Cat 2)	$143,442	$1,868,109	$7,543,139
		Annual Costs for Visits (Avg. # visits/yr. X $254 X # Cat 2)	$155,194	$8,670,592	$35,010,524
		Sub Total – Annual Costs of Rx's & Visits – Cat 2	$298,636	$10,538,702	$42,553,664
	CATEGORY 4 – Veteran has: (1) health insurance AND/OR medicare/medicaide with medigap insurance...but no clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private Rxs filled…and no reference to a specific private MD.		175	2401	9694
		% of population - Cat 4	18.44%	18.44%	18.44%
		Annual Costs of Rx's (Avg. Annual Rx $/Pt X # Cat 4)	$96,548	$1,257,452	$5,076,942
		Annual Costs for Visits (Avg. # visits/yr. X $254 X # Cat 4)	$104,458	$5,836,303	$23,563,981
		Sub Total - Annual Costs of Rx's & Visits – Cat 4	$201,005	$7,093,755	$28,640,923
SUBTOTAL OF CATEGORIES 2 and 4 – veteran has private MD AND/OR public/private health insurance.			435	5968	24097
	% of population - Cat 2&5		45.84%	45.84%	45.84%
	Annual Costs of Rx's (Avg. Annual Rx $/Pt X # Cat 2&5)		$239,990	$3,125,561	$12,620,081
	Annual Costs for Visits (Avg. # visits/yr. X $254 X # Cat 2&5)		$259,652	$14,506,895	$58,574,506
	Sub Total - Annual Costs of Rx's & Visits – Cat 2&5		$499,641	$17,632,456	$71,194,587
	CATEGORY 6 -- Veteran does not have a private MD, or health or medigap insurance, or a clear statement in the medical record that the sole/primary reason for his/her use of VA is to have private Rxs filled.		103	1413	5706
		% of population - Cat 6	10.85%	10.85%	10.85%
		Annual Costs of Rx's (Avg. Annual Rx $/Pt X # Cat 6)	$56,825	$740,016	$2,988,346
		Annual Costs for Visits (Avg. # visits/yr. X $254 X # Cat 6)	$61,481	$3,434,692	$13,870,031
		Sub Total - Annual Costs of Rx's & Visits – Cat 6	$118,306	$4,174,709	$16,858,377
Grand Totals - Priority 7 Veterans					
		% of population	100.00%	100.00%	100.00%
		Annual Costs of Rx's (Avg. Annual Rx $/Pt X Cat 1-6)	$523,563	$6,818,311	$27,531,960
		Annual Costs for Visits (Avg. # visits/yr. X $254 X Cat 1-6)	$566,458	$31,646,325	$127,786,105
		Sub Total - Annual Costs of Rx's & Visits – Cat 1-6	$1,090,021	$38,464,636	$155,318,065

SUMMARY OF POTENTIAL VHA-WIDE INCREASED CO-PAY COLLECTIONS

Pharmacy Co-Payments

Current Collections (FY 1999)	**FY 1999 Pharmacy Co-Pay Collections VHA-Wide at $2 Per 30-Day Supply for Each Prescription.**	$75,041,000
Recommended By VHA Co-pay Workgroup	**Estimated Annual Pharmacy Co-Pay Collections VHA-Wide at $5 per 30-Day Supply for Each Prescription (Based on VHA Work Group Recommendation and VHA Projections of FY 2001 Priority Group 7 Enrollment Increases of 51.26 percent.**	$283,767,540
Recommended By OIG	**Projected Annual Pharmacy Co-Pay Collections VHA-Wide at $10 Per 30-Day Supply for Each Prescription (Based on OIG Recommendation and VHA Projections of FY 2001 Priority Group 7 Enrollment Increases of 51.26 percent.**	$567,535,080
Recommended Increase in Pharmacy Co-Payments	**Amount of Increase in Annual Collections by FY 2001.**	**$283,767,540**

MONETARY BENEFITS IN ACCORDANCE WITH IG ACT AMENDMENTS

REPORT TITLE: Audit of Veterans Health Administration (VHA) Pharmacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans

PROJECT NUMBER: 1999-57-D2-184

Recommendation Number	Category/Explanation of Benefits	Better Use of Funds	Cost Avoidance
1	Cost Avoidance (in FY 2001), by increasing the pharmacy co-pay level for priority group 7 veterans from the current $2 for each 30-day prescription supply to $10.		$283,767,540
2 (a & b)	Better Use of Funds (in FY 2001), by establishing a streamlined process VHA-wide to fill prescriptions written by enrolled veterans private physicians.	$1,329,849,831	
Total		$1,329,849,831	$283,767,540

Note: The potential monetary benefits are based on the total FY 2001 nationwide population of priority group 7 veterans projected by VHA. The potential monetary benefits may be larger based on the number of priority group 1-6 veterans who are also affected by pharmacy co-payment rates and who also use VA primarily to fill privately written prescriptions.

UNDER SECRETARY FOR HEALTH COMMENTS

Department of Veterans Affairs **Memorandum**

Date: November 20, 2000

From: Under Secretary for Health (10/105E)

Subj: OIG Draft Report: ***Audit of VHA's Pharmacy Co-Payment Levels and Restrictions on Filling Privately Written Prescriptions for Priority Group 7 Veterans***

To: Assistant Inspector General for Auditing (52)

1. The referenced report has been reviewed by relevant program officials. While there is overall agreement with your concerns about the fiscal and administrative inefficiencies that are associated with the current system of filling privately written prescriptions for priority 7 veterans, we believe there are multiple approaches to potential corrective actions. Because of the complexity of the issues involved, which go far beyond the cost considerations identified in the report, we defer concurrence or non-concurrence in your recommendations pending more focused attention and direction by VHA's National Leadership Board, which will initially address the topic during its next meeting in mid-January 2001. Shortly thereafter, a position paper will be developed. In addition, since any cost-avoidance that is achieved will be dependent upon the strategy we ultimately select, the passage of legislation, and the impact of that strategy upon patient utilization, meaningful cost-avoidance figures cannot be projected at this time. For that reason, we also cannot agree with the validity of your estimate of monetary benefits.

2. We would welcome an approach to this issue that examines broadly the benefits available to veterans, military retirees, and their dependents from the federal government. The coordination and clarification of those benefits could eliminate much of the redundant testing and examination of patients that occurs as they look to minimize their out of pocket expenses. Such enhanced coordination of benefits should lead to enhanced coordination of care with cost savings and improved quality. I do not believe that the unintended consequences of the complex interaction among the various federal programs can be remedied by changes only to Title 38 *in vacuo*.

3. You recommend that legislative change to Title 38 USC, Chapter 17 be pursued to permit filling of private prescriptions written for all enrolled veterans. There are significant quality-of-care and financial/workload implications associated with OIG's recommendations that must be carefully considered. In addition, we must analyze the potential incentives and disincentives within any Medicare drug benefit legislation. Depending on which direction VA and Medicare legislation takes, the care of the highest priority veterans could be diminished and other unintended incentives induced.

4. On October 19, 2000, subsequent to the issuance of this report, VHA's Policy Board approved a new prescription co-payment rate of $5 for all veteran categories. Although the $10 increase recommended by OIG does not appear unreasonable, we think that other considerations must be factored in before decisions are made about possible co-payment

UNDER SECRETARY FOR HEALTH COMMENTS

increases in the future. For example, VA Pharmacy officials have estimated that the current pharmacy administrative cost to fill a prescription is $5. In situations where inexpensive over-the-counter prescriptions are filled, the $10 co-payment could actually exceed the total cost to VA for filling the prescription, a situation that would be in violation of current legislation.

We agree that incentives to utilize less expensive therapies and mailout prescription filling versus window service should be factors in determing a co-payment structure, and are considering all such options. For example, VA co-payment for category 7 veterans could be structured as a $5 administrative fee plus a percentage of the medication cost. The administrative cost could also be re-calculated to include a broader range of functions, which would support the $10 co-payment increase. Another option might be to assess a higher administrative fee for window service and a lower fee for the mailout pharmacy in addition to a portion of the actual medication cost.

Key to all these options, however, are fundamental questions about the legality of establishing pharmacy co-payment rates for different priority level veterans. Informal advice by the General Counsel attorneys indicates that the Millennium Act only permits VA to increase the $2 co-payment amount. It does not authorize VA to establish different co-payment amounts based on priority group.

5. In conclusion, we agree with your findings that the costs of providing prescription drugs to priority group 7 veterans continue to escalate, and that current laws and practices lead to redundant evaluations that impact the timely delivery of services to other enrolled veterans. Because of the far-reaching implications of your recommendations to the VA health care system as a whole, additional exploration of these issues has been referred to our National Leadership Board. Although no definitive time frame can be set at this point, we all see the importance of this issue and will keep your office apprised of our progress.

6. If additional information is required, please contact Paul C. Gibert, Jr., Office of Policy and Planning (105E), at 273-8355.

/s/
Thomas L. Garthwaite, M.D.

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