

**JOINT PROCUREMENT OF PHARMACEUTICALS BY  
VA AND DOD**

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**HEARING**  
BEFORE THE  
SUBCOMMITTEE OVERSIGHT AND INVESTIGATIONS  
OF THE  
COMMITTEE ON VETERANS' AFFAIRS  
HOUSE OF REPRESENTATIVES  
ONE HUNDRED SIXTH CONGRESS  
SECOND SESSION

—————  
MAY 25, 2000  
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Printed for the use of the Committee on Veterans' Affairs

**Serial No. 106-41**



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U.S. GOVERNMENT PRINTING OFFICE  
WASHINGTON : 2001

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# JOINT PROCUREMENT OF PHARMACEUTICALS BY VA AND DOD

THURSDAY, MAY 25, 2000

U.S. HOUSE OF REPRESENTATIVES,  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,  
COMMITTEE ON VETERANS' AFFAIRS,  
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 10:08 a.m., in room 334, Cannon House Office Building, Hon. Terry Everett (chairman of the subcommittee) presiding.

Present: Representatives Everett, Stump, Spence, Buyer, Hill, and Udall.

Ex officio present: Representative Evans.

## OPENING STATEMENT OF CHAIRMAN EVERETT

Mr. EVERETT. The hearing will come to order. First, let me apologize. This is the first time in 6 years I've started a hearing late. I follow the example of my Chairman, Mr. Stump, and I like to start them on time, though I do apologize for being late.

Good morning. This Oversight and Investigations Subcommittee hearing will examine the progress VA and DOD have made with jointly procuring pharmaceuticals, as well as the potential of VA pharmacy centers to deliver military pharmacy refills.

For the VA, jointly procuring pharmaceuticals with DOD has been a long time in coming, and I hope that implementation of the memorandum of agreement with DOD, which we will hear about today, will not take so long.

According to the GAO statement for the record, the annual savings from this joint procurement of drugs alone could be between \$150 million and \$300 million. This translates to as much as \$1.5 billion over the next 5 years.

This money, potentially a lot of money, could be reinvested in improved health care for our active duty service members and their families, military retirees, and veterans.

As the late Everett Dirksen once observed, "A few million here, a few million there, and you're talking about real money all of a sudden."

VA/DOD sharing is a matter of bipartisan congressional interest. This week, Chairman Stearns of our Subcommittee on Health held a hearing on VA/DOD joint delivery. At that hearing, GAO testified that, of the departments' combined health care budgets of \$35 billion, only \$60 million, or 2/10ths of 1 percent, is shared. After 18 years of sharing legislation, that is just plain pitiful.

I do not want to see such a leisurely pace with regard to pharmaceuticals. The opportunity is just far too great; so the purpose of this hearing is to drill down on the issue and follow through.

Our witnesses today will be Mr. Kim Wincup, who is vice chairman of the Congressional Commission on Servicemembers and Veterans Transition Assistance and representatives from the General Accounting Office, the Department of Defense Inspector General's Office, and Department of Veterans Affairs, and Defense. We look forward to the testimony.

At this point, I would like to recognize Congressman Hill, who is sitting in for our ranking member, Ms. Brown.

#### OPENING STATEMENT OF BARON P. HILL

Mr. HILL. Thank you, Mr. Chairman. I want to thank you and Ranking Democratic Member Corrine Brown for holding this hearing.

This subcommittee has an important responsibility to explore the economies and efficiencies of interdepartmental sharing. Today we are focusing on the Departments of Defense and Veterans Affairs to see how they might better use their joint market power to purchase medical products and their synergy to improve the distribution of prescription drug refills.

Procurement and distribution of medical items is a billion-dollar business for both departments. Both departments have common lists of high-use drugs and a great number of customers with similar profiles. Retirees, after all, are veterans.

Unfortunately, DOD and VA have too frequently seen themselves as rivals, with different cultures and missions. Their data management systems don't even communicate.

With such a history of perceived differences, I am glad to see that the walls separating America's two largest federal departments are starting to come down, or at least be bridged, in the area of medical supplies. I must give a lot of credit for this advancement in better government to the work of our first panel.

The ground was broken several years ago by the DOD inspector general. The Transition Commission built on that foundation with its findings and recommendations 2 years ago, and now, most recently, we have a General Accounting Office assessment of the issue.

Mr. Chairman, realizing the significant potential for improved savings and services, I am pleased with how both departments have begun to respond to the various suggestions we will hear here today.

It is critical that DOD and VA be encouraged, and prodded as necessary, to seek innovative ways to resolve their differences, or at least to minimize them.

It is important for all of us to keep in mind that real differences do exist between DOD and VA.

Maybe those differences are not as great as the departments would have us believe at times, but then again, maybe they are not as easily reconciled as the GAO and IG would have us think. As is so often the case in life, the truth may very well lie somewhere in the middle.

This morning, we will be able to hear the issues presented and note the degree of progress being made. By our interest, both departments will see that we are serious in our support of their continued progress in sharing common activities and know that we want them to accelerate their pace.

As a vehicle for moving the sharing process along, I would encourage more piloting of inter-agency activities, like refill pharmacies, to see what works.

My number one interest, however, is that the two departments overcome the information technology barriers that now are preventing them from maximizing their effective potential and denying to their customers, and themselves, the benefits that could be derived from sharing.

I am impressed with DOD's movement to a web-based ordering system and VA's use of technology in its acquisitions. The two departments must find ways to integrate their data management programs.

Mr. Chairman, this is the third week in a row that we have talked about interdepartmental data linkage. Two weeks ago, at our information technology hearing, we sounded the data sharing refrain.

Last week, at the claims processing hearing, we voiced our concerns about the need for a common electronic veterans record. Today, I guess you might say that we are adding medical supplies as the next verse in this subcommittee's 21st century theme song.

In closing, Mr. Chairman, I would note, as a new member of this subcommittee, that a reason for our effectiveness under your leadership and that of Congresswoman Brown, is that we are always able to sing out of the same songbook, and usually in harmony.

Mr. EVERETT. Thank you very much, Mr. Hill. Mr. Stump, our full committee chairman.

#### **OPENING STATEMENT OF HON. BOB STUMP, CHAIRMAN, FULL COMMITTEE ON VETERANS' AFFAIRS**

Mr. STUMP. Thank you, Mr. Chairman.

Let me thank you for calling this meeting this morning and welcome our witnesses here, especially Kim Wincup, who served as the vice chairman of our veterans' transition team—or the Principi Commission, I believe we called it—once again, for the great job they did, and we appreciate you being here.

Mr. Chairman, I think it's been the opinion of this committee, the VA Committee, for quite some time, that there has not been enough sharing between DOD and VA, and hopefully, this hearing this morning will lead to a little more of that.

We've had, of course, in a couple of our hospitals, namely at the one out in Nellis, to a more limited scale, probably, the one at Tripler in Hawaii, but perhaps if we could get together on some joint purchasing on these pharmaceuticals, it could lead to big savings that we could then return back to try to help our veterans.

Thank you, Mr. Chairman.

Mr. EVERETT. Thank you. And now, Chairman of our Personnel, House Armed Services Committee, who is shaking his head no. Okay.

I'd like to recognize Lane Evans, who is the ranking— while he's not a member of this subcommittee, he's always welcome—he's the ranking member on our Veterans' full committee.

Mr. EVANS. Thank you, Mr. Chairman. I just wanted to say thank you for holding this important hearing, and I have an opening statement that I'd like to insert into the record.

Mr. EVERETT. Without objection.

Mr. EVANS. Thank you.

[The prepared statement of Congressman Evans follows:]

PREPARED STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. Chairman, I want to thank you for holding this hearing. As a Member of both the Armed Services and Veterans' Affairs Committees, I am doubly interested in ways the Departments of Defense and Veterans Affairs can join together for their mutual benefit and for the improvement of services to their customers—many of whom they share in common.

I certainly am aware of the different cultures and missions of the two departments. DOD fights wars and the primary mission of its medical component is to support the warfighter. The primary mission of VA's medical component, on the other hand, is to provide healthcare to eligible veterans in need.

The General Accounting Office noted that the differing missions and cultures create rivalries making it difficult for DOD and VA to work together on mutually beneficial tasks. GAO believes that interventions may be needed to help bring about successful agency interactions. I would want to keep such interventions to a bare minimum.

However, I stand ready to step in where and when needed to achieve essential cooperation. With potentially large savings and possible service improvements at stake, unproductive interdepartmental rivalries must be overcome—if not by the departments themselves, then by Congress.

I appreciate the fine work in this area that has been done by the DOD Inspector General and by the GAO. I want to give special thanks, however, to my friend Kim Wincup for his contribution and that of the Transition Commission he represents this morning.

Kim's experience both on the Hill and in the Pentagon allowed him a unique perspective for a realistic assessment of the possible. Mr. Chairman, Kim Wincup's conclusion that a true partnership between VA and DOD healthcare systems offers the best hope for millions of beneficiaries of both departments resonates strongly with me. I look forward to hearing how such a true partnership can be achieved.

Thank you, Mr. Chairman. I look forward to hearing from our witnesses.

Mr. EVERETT. I asked the witnesses today to limit their oral testimony to 5 minutes. I recognize that it may be a little complex, and we'll try to give a little bit on that if we need to.

Your complete written statement will be made a part of the official hearing record, and the panel will please hold their questions until the entire panel here has testified.

I'd like to now recognize Kim Wincup, the Vice Chairman of the Congressional Commission on Servicemembers and Veterans Transition Assistance; Mr. Steve Backhus, Director, Veterans' Affairs and Military Health Care issues, GAO; and Mr. Robert Lieberman, Assistant Inspector General of the Department of Defense.

I want to particularly extend a warm welcome to Mr. Kim Wincup, who is well-known to us as former chief counsel of the House Armed Services Committee and the former Assistant Secretary of the Department of Defense.

Gentlemen, if you will, starting with Mr. Wincup, if you will begin your testimony.

**STATEMENTS OF G. KIM WINCUP, VICE CHAIRMAN, CONGRESSIONAL COMMISSION ON SERVICEMEMBERS AND VETERANS TRANSITION ASSISTANCE; STEPHEN P. BACKHUS, DIRECTOR, VETERANS' AFFAIRS AND MILITARY HEALTH CARE ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, GENERAL ACCOUNTING OFFICE; AND ROBERT J. LIEBERMAN, ASSISTANT INSPECTOR GENERAL FOR AUDITING, DEPARTMENT OF DEFENSE**

**STATEMENT OF G. KIM WINCUP**

Mr. WINCUP. Thank you very much, Mr. Chairman. It's a real privilege to be back here.

I not only had the pleasure of working for the Armed Services Committee, but I actually worked for this committee at one point, so it's a real pleasure to be here, and it's a privilege to represent the Commission on Servicemembers and Veterans Transition Assistance before this committee.

You have been instrumental in congressional activities in terms of DOD/VA cost-sharing across the board and your activities are the only reason this is occurring, to be honest, sir.

But obviously, the other point is, a number of the members here serve on the Armed Services Committee, so there are great opportunities here for some good government.

I'll try and return some of that 5 minutes, Mr. Chairman, to some of the other witnesses.

As you recall, the Commission looked at the transition assistance process, which inevitably was the relationship between the two departments, and so we spent a lot of time looking at the relationships and how they interact, and frankly, it wasn't comforting, although there are efforts and there are certainly people, good people, on both sides, trying to work this issue.

The issue you've asked us to testify on this morning, among 100 issues that the Commission recommended, relates to health care in particular, and with respect to the joint procurement of pharmaceuticals and medical supplies, particularly pharmaceuticals.

In that regard, the Commission did, in fact, recommend that a joint procurement office between DOD and VA actually led to some enormous potential for savings, as you've indicated, sir, and as I know the GAO has done a much better job of costing.

There are some great opportunities for savings that can be returned to be used for health care in both departments, where it's sorely needed.

The Commission also recommended that there be a development of a joint clinical formulary between the departments, because that will allow more joint procurement of pharmaceuticals; and then we also talked about uniform product numbers for the medical supplies, because again, that would allow enormous steps forward, in terms of sharing of procurement activities, in savings to the Government.

As I mentioned, it is the Congress that has caused this sharing to occur.

It is this committee, in particular, that has caused this sharing to occur between the two departments, and it's your interest in and

incentivization of those two departments that will allow it to continue.

I also had the pleasure of serving on Secretary Cohen's Defense Reform Task Force about a year-and-a-half ago, where he tasked us to look at issues that he called the "revolution in business affairs" within the Department of Defense.

And while we didn't look at this issue specifically, I'm confident this is exactly the kind of thing the Secretary was looking for, where commercial business practices, which is, of course, what the large companies do now in terms of volume buying, could be applied to the Government.

So I would say it's a great privilege for me to be here. This is a great opportunity to save money for the Government, in many ways, what I guess you might call low-hanging fruit that can be returned in a way that will greatly benefit a number of important people in the health care system in both departments.

Thank you again, sir, and I'll be glad to work with you in the future.

[The prepared statement of Mr. Wincup appears on p. 35.]

Mr. EVERETT. Thank you very much, Mr. Wincup. I understand I added an "e" into your last name, for which I apologize.

Mr. Backhus.

#### STATEMENT OF STEPHEN P. BACKHUS

Mr. BACKHUS. Good morning, Mr. Chairman, and members of the subcommittee. I'm pleased to be here today to discuss what VA and DOD have done and what more they can do to reduce drug prices and dispensing costs.

In fiscal year 1999, DOD and VA together spent \$2.4 billion on 140 million prescriptions for active duty, veterans, and other military beneficiaries.

The need to aggressively manage drug costs is borne out in the next slide.

As you can see, between 1995 and 1999, VA and DOD drug expenditures rose 75 and 63 percent respectively, 10 times greater than the rise in their overall health care costs. The driving expectation here is that, as the two agencies buy more of a particular drug, their leverage will enable them to obtain greater discounts from drug manufacturers.

Encouraging the use of such drugs will also lead to more consistent treatment of patients systemwide.

At your request, my testimony focuses on the extent of joint DOD and VA contracting thus far, and prospects for further contracting. I will also discuss the prospects for DOD using VA's mail pharmacy centers to handle the military's prescription refill workload.

As you know, our work is still underway, and we plan to issue a report to you and other requesters later this year.

Turning to the next slide, you will see that the VA and DOD have awarded joint national contracts representing 2 percent of their combined drug expenditures. There are 18 such contracts. They also have separate national contracts amounting to about 17 percent of their expenditures.

The vast majority of purchasing, though, is through negotiated, non-competed supply schedule contracts.

The next slide depicts the extent of the discounts both agencies are currently obtaining.

As you can see, on average, joint procurements yield a 94 percent discount below average wholesale prices, and the discounts on drugs purchased under separate national contracts average 79 percent, but the discounts are much lower for drugs purchased through their schedules—on average, 58 percent.

Put differently, as you can see now, the bulk of drug purchases are made using the least cost-effective means.

We believe there is potential for much more joint purchasing, and thus, savings.

For example, we identified 30 drug classes that included one or more groups of therapeutically equivalent drugs in each class. Equivalency would allow VA and DOD to shift the majority of their patients to one or two drugs without compromising clinical outcomes.

Such drugs, therefore, seem to be good candidates for clinical review in potentially competitive national contracting.

As you can see in the graphic, the potential from joint contracting in these 30 classes increases from the current 2 percent to 66 percent, or \$1.6 billion.

Savings are very difficult to estimate, because of the variability of drug market pricing and limits on discounts by manufacturers, but for illustrative purposes, we hypothesized, as shown in the next slide, that if the agencies jointly contracted in the 30 classes and could achieve just one-quarter of the savings rate realized by moving from the schedule price to contracts, they would save \$150 million annually. If they could achieve 50 percent, they would save \$300 million annually.

I would now like to turn to how VA and DOD might collaborate to achieve dispensing efficiencies.

DOD is currently considering contracting with a private vendor to handle the military pharmacy refill workload by mail—about 23 million prescriptions annually.

VA already has such capability, though, through its consolidated mail outpatient pharmacies, or CMOPs, and documentation shows that CMOP refills cost about one-half of DOD's current costs, potentially less than what DOD would pay a private vendor, based on information from some companies about their charges.

CMOPs potentially would reduce military pharmacy refill dispensing costs by about \$45 million annually.

DOD officials told us that they are concerned about CMOPs' production capacity, computer systems compatibility, and an adverse effect on military medical readiness by reducing their prime vendor sales market—all issues that would require resolution with private contractors as well.

DOD's concerns seem resolvable. VA officials told us that if need be, they could expand CMOP production to accommodate the military workload. They suggested pilot testing to assess any computer system concerns and provide a basis to estimate the costs and benefits of such an arrangement.

DOD readiness concerns could be alleviated by using DOD's prime vendors to supply drugs to the CMOP. For these reasons, we

believe DOD should include CMOPs in its consideration of potential contractors to handle their refill workload.

Mr. Chairman, this concludes my statement. I'll be happy to answer any questions you or other members of the subcommittee may have.

[The prepared statement of Mr. Backhus appears on p. 38.]

Mr. EVERETT. Thank you very much. Mr. Lieberman.

#### STATEMENT OF ROBERT J. LIEBERMAN

Mr. LIEBERMAN. Thank you, Mr. Chairman. I appreciate the opportunity to be here this morning.

During the past few years, we have conducted several audits at the request of Department of Defense logistics managers on the need to continue Defense Logistics Agency contracting for commercially available items when other federal agencies have centralized contracting for the same things.

Examples include office supplies, photographic film, kitchen equipment, batteries, and medical items.

In all cases, the principal concerns have been, first, how can DOD get the best price and supplier service; and second, does DOD need to tie up scarce acquisition personnel resources in a separate purchasing operation?

My written testimony discusses, in some detail, the results of our audit on medical items with emphasis on pharmaceuticals. The audit was performed between July 1997 and February 1998.

We found extensive overlap between the Defense and Veterans Affairs purchasing programs. By matching national drug codes, we identified nearly 16,000 pharmaceutical products being purchased by both organizations. About two-thirds of the products purchased by Defense are also purchased by VA.

We performed a price comparison for 200 of those products. The Veterans Affairs price for customers was typically lower, or to be more exact, lower for 165 of the 200 items, mostly because its surcharge was less than DLA's.

We also determined that the two departments used very similar acquisition strategies. They both contracted with prime vendors for direct delivery to users, who placed their own orders and usually received next-day delivery.

The use of prime vendors and direct delivery are considered best commercial practices. In fact, the DLA pharmaceutical program was one of the first and most successful DOD applications of those practices.

We found it difficult to cost out the potential for contract price reductions, although the GAO has pursued that particular issue.

We asked suppliers if the dual acquisition mode was efficient from their standpoint. They emphatically said no, and asserted they incurred additional administrative expenses when dealing with multiple Government agencies. These costs are presumably passed along to the Government, or are at least an inhibitor to deeper price discounting.

We also discussed the issue of purchasing pharmaceuticals with nine military treatment facilities. These users are clearly more concerned with price and service, especially timely delivery, than with who places contracts with the vendors. Three of these hospitals

were primarily using Veterans Affairs prime vendor contracts and six were using Defense prime vendor contracts.

Although we agree that Defense should retain responsibility for determining military readiness provisions for a small number of critical pharmaceuticals, a strong case can be made for merging the Defense and Veterans Affairs purchasing activities in some fashion.

Our June 1998 report, in fact, recommended that DOD transfer acquisition responsibility for medical items to Veterans Affairs, except for militarily unique items.

The department responded that it partially agreed, and was willing to form a team to work with Veterans Affairs to expand cooperation, especially in terms of achieving one face to industry on pricing issues.

Last year, an agreement was signed between the two departments. We accepted its terms as being generally responsive to the audit finding, as long as they are fully and aggressively implemented.

The agreement allows each department to continue contracting for pharmaceuticals but requires a sharing of pricing information and contracts. There is also an important and explicit commitment to expand joint contracting as much as possible.

We understand that the Defense Logistics Agency expects annual savings of \$50 million from the initiatives taken so far with additional savings for Veterans Affairs. This is a good start.

The overall DOD acquisition work force has been cut in half over the past several years, with no proportional decrease in the workload.

In our view, Defense should not retain any more pharmaceutical procurement workload than absolutely necessary to handle unique DOD management problems that Veterans Affairs or a joint contracting office would lack the resources and expertise to handle.

The main opportunity for cost reduction, however, lies in achieving the best possible prices. We are encouraged by reports of progress in that regard.

The ongoing effort to implement the recent agreement should be monitored closely to ensure that both sides are genuinely committed to minimizing duplication, enhancing the Government's best interest, and reducing customer costs.

Thank you again for your interest in our views on this matter.

[The prepared statement of Mr. Lieberman appears on p. 57.]

Mr. EVERETT. Thank you very much.

Mr. Wincup, according to the Commission's findings, how much joint procurement of pharmaceuticals, how much would it enhance VA and DOD health care efficiency?

Mr. WINCUP. Mr. Chairman, enormously, I think in a general sense. In a specific sense, our own estimates, which I think probably are not as precise as GAO's were, there was a potential savings of \$300 million a year from the joint procurement of pharmaceuticals and medical supplies, considerably larger amounts over time.

Mr. EVERETT. Do you see any down side, separately, of VA separately and DOD separately?

Mr. WINCUP. Well, sir, I think the department raises the readiness issue as an appropriate issue to be concerned about, but my

own experience is that the readiness issue is oftentimes a cloak for uncertainty themselves about how much they actually need to be careful about.

There are enormous overlaps between these two agencies, where it doesn't seem to me that readiness is a particular issue to be concerned about.

Mr. EVERETT. You've been in Washington a long time. Is this something that's doable, or is this just some pie-in-the-sky idea?

Mr. WINCUP. Mr. Chairman, this one is very do-able, but I guess I would tell you it won't happen, my experience is it will not happen unless this committee pushes the departments very hard.

Mr. EVERETT. Mr. Backhus, is it correct to assume that, from your statement, that you basically agree with the findings and conclusions of the Congressional Commission?

Mr. BACKHUS. We do, most certainly. We think their call for more jointness is what's necessary here. Segmentation and duplication are wasteful and really don't make any sense.

Ultimately, I also agree that a single procurement activity would be worth pursuing.

We have, in the past, looked positively on moving toward a joint formulary, and ultimately, either joint or matching formularies, there is not much difference, but it is something that we would see as beneficial to both departments, and I really don't think that there are readiness issues that can't be overcome here.

The driving force in the Department of Defense on readiness issues has to do with the distribution system they have for medications and what they do when there's a need for a surge in an activity, and I think much of that can stay in place to achieve those goals and those needs on readiness.

So I do agree with all of those items that the Commission recommended.

Mr. EVERETT. What about barriers? What barriers would you see?

Mr. BACKHUS. Well, there's a number of them, from some that are probably relatively small to some that are substantial.

For example, staff are located in many different locations. Ultimately, if they're going to work together, they should probably be co-located, staff from the two departments, in this case, I'm talking about.

I know the Department of Defense is in the middle of trying to redesign their pharmacy benefit, and the benefits are quite different than in the VA, so they need to be able to get some stability there and move more toward a national formulary similar to what the VA has. We recommended that in the past. Right now, that's an obstacle to coming together.

I believe that the activity that the two have today, through a steering committee made up of representatives from both agencies, while a positive step, needs to be more active.

They need to produce some goals and some annual plans that they can try to achieve and strive for and have these objectives in mind so during the year they can measure their progress and ultimately obtain success in more jointness.

Mr. EVERETT. Let me just get one more question in, and Mr. Lieberman, first of all, let me thank you for the work that your organization has done on this, as well as our other two panelists.

What do you see as the barriers? One of the things that worries me is something I've seen since I've been up here, in 6 years in Congress, and frankly, it's just turf battles. We see an awful lot of turf battles.

We've seen it in our computer modernization program, starting back in 1994, and I think it's been a real problem in our information technology advancement.

But getting specifically to this point, do you see turf battles as being in the way, or any other barriers?

Mr. LIEBERMAN. Well, there clearly is resistance to change, not only in this area, but in any area where you seek to adopt a unified purchasing strategy, you often find all sorts of reasons for why that's impossible.

Within the Department of Defense, we see this all the time, and in fact, it's rather ironic, because the Defense Logistics Agency has been a leader in some other areas in terms of adopting a unified contacting approach.

I can point to success in areas like spare parts procurement and depot repair contracts.

There are many areas where, initially, you'll find a situation in which a contractor is getting multiple Government contracts to do the same type of thing or provide the same kind of product. The contract terms are different, the ordering activities don't coordinate with each other, you lose purchasing power, and you also incur a lot of extra administrative cost.

I don't really see any difference between those kinds of scenarios and this one here, except we're talking about two different Government agencies.

Some of the items I mentioned in the beginning of my oral remarks are common items where Defense and GSA have had the same kind of ongoing dialogue for many years. In that area, I think we've actually made much progress in terms of Defense turning over items to GSA, even though initially we had all the same arguments about why it was just too hard to do and why unique Defense interests would not be protected.

Mr. EVERETT. Thank you very much. Mr. Hill.

Mr. HILL. Thank you, Mr. Chairman. Mr. Wincup, we might as well ask you your view about the barriers, too. What's your view in the Transition Commission?

Mr. WINCUP. Well, Mr. Chairman, there's no doubt that the breakage of china is a big issue here. It always is in bureaucratic organizations.

These are actually two very high-performing organizations that have good people in both, and they both believe that what they're doing is right, so it's hard for them to give something up.

There is little incentive across agency, is the problem. They can't see that there's benefits to going across-agency, and that's where the Congress can play an enormous role here in terms of ensuring that this money can get to a place where it's sorely needed.

Mr. HILL. Mr. Backhus, this chart on Page 3 is really kind of startling, about the percentage of increases in the expenditures.

Are these expenditures due to usage or to price?

Mr. BACKHUS. The increase in pharmaceutical costs is due to a combination of things. Utilization is one of them. New more expensive drugs on the market that people seek is another reason. Also, prices escalate, as a matter of inflation.

Mr. HILL. What is the inflationary rate for these prescription drugs, do you know?

Mr. BACKHUS. About 12 percent a year. (Note: The chart on page 3 shows that pharmacy expenditures rose 12 percent per year between 1995-1999.)

Mr. HILL. Twelve percent a year?

Mr. BACKHUS. Yes.

Mr. HILL. Go ahead, if you wish.

Mr. BACKHUS. Well, that's essentially it. Those are the principal factors.

Mr. HILL. I appreciated your analysis of today's issue, and your observation that Government could save some big bucks if DOD and VA would enter into more national contracts together.

In the second panel that's coming up, however, Captain Hostettler is going to be testifying, and he will testify in some detail as to why it's not feasible or desirable to jointly contract for a lot of drugs like the two departments use.

He talks about closed-class contracts and open-class contracts, differences in physician preferences, patient choices.

Could you put these explanations in perspective? How valid are these barriers? What degree of difficulty do they really present, and what percentage of the drugs used by VA and DOD are realistically blocked by these barriers?

Mr. BACKHUS. Well, I can try. I may have to call on some of my help back here, if need be.

We're not suggesting that all of this is easy, okay, and we expect this to take some number of years to maximize, to achieve the maximum savings that we're talking about here.

So we approach this in a way that permits us to sort of prioritize the order in which this joint procurement initiative should flow.

There are some classes of drugs which naturally lend themselves to joint procurement. There are therapeutically equivalent drugs that the two can unite on, commit to a certain level of use with the manufacturers and obtain the discounts. And those are the things and the items that we think they should pursue first and foremost.

There is not as much debate in this category of drugs. We think that there's, over the next year or two, the possibility of achieving maybe \$35 to \$75 million worth of savings in just these areas.

But there's a second tier of drugs—this is more what Captain Hostettler is talking about here—where there isn't full agreement, there isn't consensus on the equivalency of many of the drugs in the classes, so they require, in this case, additional clinical review.

The committees—the clinicians, if you will, from each of the departments, need to be able to come together, review the particular drugs, determine which are appropriate for their populations, and hopefully come to agreement on what they might be able to commit to.

None of the ones that we have suggested—I should say, let me rephrase that. All of the ones we have suggested have commitments in existence in the private sector.

In other words, these are things that are going on elsewhere. They may not be easy, but it is being achieved in other places.

There's a third tier of drugs we've talked about, which are the most difficult to agree upon. "We see those as maybe things that need to be pursued third and last of the priorities, and maybe even 4 or 5 years from now.

So it's a sequential process that they have to go through. There are some tough issues to work through, but we think that because this has been done elsewhere, that it's the right thing to do for these agencies to put their heads together on it.

Mr. HILL. Okay. Mr. Lieberman—

Mr. WINCUP. Could I just tack onto that briefly, sir?

Mr. HILL. Yes.

Mr. WINCUP. Excuse me. I want to just point out, I believe there are, in fact, some significant complexities here, but one of the reasons they continue to be complex is there hasn't been an effort to work through them. There hasn't been enough incentive to work through those problems.

I would just comment that both Chairman Stump and Mr. Evans will recall there was a legislation that the Congress considered to try and push, within the Department of Defense, the Goldwater-Nichols bill.

The sky was going to fall, as far as the Department of Defense was concerned, when that legislation was considered. They now view it as the greatest thing that's ever happened to the department and take credit for its enactment.

I feel reasonably confident that these two agencies, given time to work through this, will be before you within a couple of years saying that this was a great thing to happen.

Mr. HILL. I see my time is up, Mr. Chairman.

Mr. EVERETT. Mr. Stump.

Mr. STUMP. I don't have any questions.

Mr. EVERETT. Mr. Buyer.

#### OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Gentlemen, I want to thank you for your work. As you know, we've worked on the revitalization of the pharmacy program in DOD now for some years.

I want to urge some caution here. I mean, let's not get too excited running in this direction.

I'm very concerned, when we start using words about joint clinical formularies, I'm very concerned, because we have two distinct populations which we serve.

So we talk about military medical readiness, and that's a distinct population for which it serves, and it's completely different than the veteran population.

I would be interested in your views on that, because to actually sit down and talk about how they can move toward joint contracts for the purchasing of a particular drug because it increases their buying power, that's one thing.

But it's completely different to say that we should have joint clinical formularies.

I'm interested in your view.

Mr. BACKHUS. There's no question that in this case—for example, women and children don't make up the population that the VA serves; but clearly, there is a lot of overlap.

Retirees, obviously, are becoming, and always have been, but even more so now, a significant patient population in the DOD, and obviously they are in the VA; than that whole group of people in middle age and younger the DOD serves.

But there are differences, legitimate differences that exist, and you wouldn't expect to have necessarily the same drugs for those people.

It is true, though, also, that for eight of the top 10 classes of drugs, they're similar. The top 10 drug class purchases in the VA and the top 10 drug class purchases in the DOD, eight of them match.

So there is substantial overlap in the drugs that these two departments purchase.

Mr. BUYER. Mr. Backhus, there's nothing wrong with that. That's completely different than saying that you should have joint clinical formularies, wouldn't you agree?

Mr. BACKHUS. I think we're suggesting only that there's the possibility for more of these to work toward something like that. Ultimately, whether they can achieve it or not is obviously debatable.

Mr. BUYER. I believe the numbers that you've presented might be a snapshot in time for today, but when you add the military retiree benefit that I designed in the Personnel Subcommittee, this thing is very large.

You take the 1.4 million military retiree population, 600,000 of them have access today, which means I'm going to reduce the barriers and we're going to gain access to another 800,000. That's a lot.

And by the time that this program gets kicked in. CBO scores it over 5 years with outlays of \$575 million and budget authority of \$595 million a year. I mean, this program is going to become large, quick.

So I am—I'm very attentive to the discussions about joint purchasing power, because DOD is going to be in the drug business in an even bigger way when you double that population.

Mr. BACKHUS. We see the same thing. We see the potential for jointness in savings is ultimately being something that the DOD would benefit from because of this additional benefit that these folks are going to have.

Mr. BUYER. So let me just say this. I recognize that DOD now is going to be also serving a yes, more elderly population than it is today. Okay? So I can understand these discussions about this joint clinical formulary.

But I think we always have to keep our eye on the ball of what is the purpose of our military health delivery system, and it's medical military readiness and combat wounds. And so I'm very concerned about that.

Mr. Wincup?

Mr. WINCUP. Sir, thank you. I think your caution is very well placed in this regard. This can be overdone, and this suggestion is not a universal suggestion, by any means. It's joint where it makes sense.

But the Commission was quite concerned about the points that you made, and in fact had a health care advisory group to try and look at specifically this.

On it was a former surgeon general of the Army, former Under Secretary of VA for health care, as well as the former chairman of this committee, Mr. Montgomery and Congressman Gradison, as well as a number of experts in the field, and they were, in fact, the ones that made this recommendation for a joint formulary—again, not universal, but where there was overlap, that it made sense.

Mr. EVERETT. Mr. Evans is no longer here.

Mr. Wincup, would you, or any of you, would you agree that the issue is more focused on what type drugs we're using and not who is using those drugs?

Mr. WINCUP. Yes, sir, I think that's exactly right. It's classes of pharmacy goods that can be dealt with here.

Mr. EVERETT. Mr. Backhus?

Mr. BACKHUS. I don't think I heard the question.

Mr. EVERETT. Would you agree that the issue is what type drugs are being bought, rather than who is using those drugs?

Mr. BACKHUS. Principally, yes. We're talking about the type of drugs that both agencies currently procure, no matter what the populations are, though differences exist, the fact is that there's a tremendous amount of overlap in what's bought, and that means the type of drugs.

Mr. EVERETT. Mr. Lieberman?

Mr. LIEBERMAN. Yes, I certainly agree. What we're interested in is the procurement strategy, regardless of who is going to be the user.

Mr. EVERETT. Would—

Mr. BUYER. Will the gentleman yield to me on that point? I want to—

Mr. EVERETT. Okay, go ahead.

Mr. BUYER. No, you brought up a point to say, "Excuse me, Steve, what we're talking about is the purchase of specific drugs, not necessarily a population."

Clinical formulary management is different from going out and purchasing specific drugs. That's the point that I'm making.

So we have to keep focused, Mr. Chairman, I believe, in our DOD military health system with regard to its military medical readiness issues. I just want to lay that out as my concern.

Mr. EVERETT. I would agree with the gentleman completely.

I would think that it would be to DOD's advantage, for instance, to look for the best price, not—that may not be for the VA system, you know, but look for the best price, and keeping in mind the readiness issue, which is the first issue.

Thank you, Mr. Hill, do you have any more questions?

Mr. HILL. Yes. Mr. Lieberman, how do you respond to Captain Hostettler's concerns about implementing this, in terms of his comments about closed-class contracts and open-class contracts, differences in physician preferences and patient choices?

What's your view on his thoughts about that?

Mr. LIEBERMAN. Well, frankly, those points were not brought up a year-and-a-half ago when we were discussing our report, at least in that level of specificity.

But one of the reasons why, essentially, I agreed to a compromise with the department and an incremental approach, was that the deputy director of DLA and I sat down and he said: "Look, we can make progress. There certainly ought to be more joint effort than there is now. There are various concerns about different classes of items that need to be handled differently."

I accepted that as being a logical premise.

So I've read the Captains' testimony and what he says sounds logical to me.

But this is not a reason for doing nothing, because as Mr. Backhus says, we have several different categories of items here, and if we take the easiest ones first and work through them, I think we can still make an awful lot of progress without running into things that are absolute show-stoppers.

As for readiness items, I agree completely with Mr. Buyer's point. They should be off the table.

But I would point out, the military departments told us that only 4 percent of these items are critical in terms of military readiness, so we should not lose sight of the fact that the readiness argument does not apply to this vast array of different items being purchased.

Mr. HILL. Let me move on to a different question, then, Mr. Lieberman.

You said that your audit found extensive overlap between DOD and VA?

Mr. LIEBERMAN. Yes, sir.

Mr. HILL. And that a price comparison of 200 items showed VA's price was lower on 165 of those items.

Since manufacturers must incur additional administrative expenses dealing with multiple Government agencies, what do you think is the real barrier, then, to joint contract procurement?

Mr. LIEBERMAN. The real barrier right now is the perception that different contract terms are needed, and therefore, you need different contracting officers to negotiate different contracts.

I think what we're saying this morning is that those presumptions are not necessarily true.

A contracting office ought to be able to accommodate different types of requirements coming in from the program offices. We see this all the time in other areas, and I think that's a psychological barrier more than a real barrier.

Mr. HILL. Mr. Backhus, generally, how firm are you about the drug classes and groupings you propose for clinical review and joint contracting by VA and DOD? Are you proposing that these are absolutes, or more as a starting point?

Mr. BACKHUS. No, we see this as a starting point, that there's flexibility here. It's the concept we're trying to get across, and the potential that seems to exist.

However, I will say this, the items in the classes that we have identified are ones that we have found elsewhere, have been contracted for by other organizations.

So we see this as an opportunity for the two agencies to begin more aggressively working together over the next several years and much of it achievable.

Mr. HILL. In terms of buying drugs, then, how would you assess the progress of VA and DOD thus far in jointly buying drugs?

Mr. BACKHUS. I would say they're off to a good start. They obviously are obtaining very good discounts on many of their purchases. Access has probably, I would say, improved as a result of the money that they've saved, and able to apply it in other areas.

However, I really think the potential is so much greater than what we've seen thus far, that they need to really put more focus on this and begin in a more aggressive way.

Mr. HILL. Thank you, Mr. Chairman.

Mr. EVERETT. Let me thank the Commission and GAO and DOD IG for the work that you've done on this subject, and we appreciate it very much. You made a great contribution to us.

You're now dismissed, and we'll call the second panel.

Mr. WINCUP. Thank you, Mr. Chairman.

Mr. BACKHUS. Thank you.

Mr. EVERETT. Mr. Gary Krump, Deputy Assistant Secretary for Acquisition and Materiel Management, VA, and I'll ask him to introduce his staff.

John Ogden, Chief, Pharmacy Benefits Management Group, VHA.

Brigadier General Daniel Mongeon, Commander, Defense Supply Center Philadelphia, DOD, and ask him to introduce his staff.

Captain Charles Hostettler, Director of DOD Pharmacy Programs.

Before we begin this panel's testimony, the Department of Veterans Affairs gets a trip to the woodshed for the late submission of testimony. We'll have to ask you why we didn't get it.

Mr. Krump, when you get seated, we want to ask you a question, why we got it late.

Good morning, Mr. Krump. Let me ask you, we did not receive the VA's testimony until this morning. We have kind of been over this before with the VA, and we don't like for that to happen. It doesn't give us the information we need to properly conduct oversight hearings.

I would hope that you would take my message back to VA that we expect the testimony to arrive on time.

If you will start your testimony, we would appreciate it.

**STATEMENTS OF GARY J. KRUMP, DEPUTY ASSISTANT SECRETARY FOR ACQUISITIONS AND MATERIEL MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JOHN E. OGDEN, CHIEF CONSULTANT FOR PHARMACY BENEFITS MANAGEMENT, DEPARTMENT OF VETERANS AFFAIRS, DAVID S. DERR, ASSOCIATE DEPUTY ASSISTANT SECRETARY FOR ACQUISITIONS, DEPARTMENT OF VETERANS AFFAIRS, AND STEVEN A. THOMAS, DIRECTOR, NATIONAL CONTRACT SERVICE, NATIONAL ACQUISITIONS CENTER, DEPARTMENT OF VETERANS AFFAIRS; AND BRIG. GEN. DANIEL MONGEON, U.S. ARMY, COMMANDER, DEFENSE SUPPLY CENTER PHILADELPHIA, DEPARTMENT OF DEFENSE, ACCOMPANIED BY COL. STU MERVIS, MSC, USA, DIRECTOR, MEDICAL DIRECTORATE, DEFENSE SUPPLY CENTER PHILADELPHIA, DEPARTMENT OF DEFENSE, AND CAPT. CHARLES HOSTETTLER, MSC, USN, DIRECTOR, DOD PHARMACY PROGRAMS, TRICARE MANAGEMENT ACTIVITY, DEPARTMENT OF DEFENSE**

#### **STATEMENT OF GARY J. KRUMP**

Mr. KRUMP. Mr. Chairman and members of the subcommittee, I am pleased to be here today to discuss the implementation of the memorandum of agreement, or MOA, between the Department of Veterans Affairs and the Department of Defense for the procurement of health care-related commodities.

I'm accompanied today by Mr. John Ogden, Chief Consultant, Veterans' Health Administration, Pharmacy Benefits Management Strategic Health Care Group; Dave Derr, Associate Deputy Assistant Secretary for Acquisitions; and Mr. Steven Thomas, Director, National Contract Service, whose programmatic responsibilities include VA's administration of the MOA.

VA fully supports joint federal health care acquisition activities as a means to improve the quality and efficiency of services provided to federal beneficiaries and to reduce costs to the taxpayer.

The DOD is our single largest sharing partner, and we welcome opportunities to extend VA's excellent health care commodity pricing, especially in pharmaceuticals, to the DOD, and to reduce unnecessary administrative burdens.

VA is delegated the authority by the General Services Administration (GSA) to establish and administer the Federal Supply Schedule (FSS) contracts for health-related needs for the Federal Government.

The FSS program is a multiple award schedule (MAS), with indefinite delivery—indefinite quantity (IDIQ) type contracts which are national in scope and available for use to all Federal agencies.

Prices are negotiated with the goal of obtaining equal to or better than Most Favored Commercial Customer (MFC) prices. The established relationship is ensured for the life of the multi-year contract based on commercial market pricing trends. When using an FSS Schedule, the customer evaluates price lists and identifies the contractors that appear to offer the best overall value.

VA also monitors Section 603 of the Veterans Health Care Act of 1992, which prescribes Master Agreements and Pharmaceutical Pricing Agreements with manufacturers that set Federal Ceiling

Prices (FCP) for the four major Federal Agencies that procure pharmaceuticals (VA, DOD, portions of HHS, and the Coast Guard).

Section 603 requires that the price of a "covered drug" not be more than 76 percent of the Non-Federal Average Manufacturer Price (Non-FAMP), and in some instances, VA obtains pricing lower than 76 percent of Non-FAMP.

Covered drugs include single source drugs; innovator multiple source drugs, and biological products (e.g. vaccines).

The VA Office of Acquisition and Materiel Management (OA&MM) has been working with VA's Pharmacy Benefits Management Group (PBM/SHG) since 1995 to consolidate pharmaceutical requirements into separate, competed national contracts. VA estimates its cumulative savings in pharmaceutical expenditures to total \$654 million since 1996, solely through the use of national contracts.

The Defense Supply Center Philadelphia (DSCP), as part of the Defense Logistics Agency (DLA), procures medical supplies and equipment for the DOD. It also establishes distribution networks.

DSCP enters into Distribution and Pricing Agreements (DAPAs), with manufacturers and distributors. These DAPAs are utilized as multi-source purchasing vehicles for DOD customers.

For pharmaceuticals, the DAPA price is usually the statutory Section 603 price or the negotiated MFC price borrowed from the manufacturer's FSS contract.

The Congressional Commission on Servicemembers and Veterans Transition Assistance (Transition Commission Report) recommended that Congress enact legislation to require "DOD and VA to establish a joint procurement office to purchase in the most cost-effective manner possible, VA/DOD pharmaceuticals, as well as medical/surgical supplies and equipment." That report provided additional impetus to DOD's and VA's efforts to finalize the MOA which is designed to combine the purchasing power of the two Departments and eliminate redundancies.

The MOA has two appendices, one dealing with pharmaceuticals, the second encompassing medical and surgical supplies.

A third appendix, dealing with high-tech medical equipment, is under consideration.

The MOA has two main emphases pertaining to the pharmaceutical appendix, which is the focus of my testimony: (1) joint national procurement contracting; and (2) DAPA conversion to FSS.

In accordance with the MOA, DAPAs are to be canceled and FSS pharmaceutical contracts are to be used by DOD medical activities whenever the FSS price is equal to or less than the DAPA price. Savings from these efforts help both Departments reduce health care costs.

Joint contracting efforts predate the signing of the MOA. Since October of 1998, VA and DOD have awarded 18 joint national contracts. Through joint committed use volume contracts, VA and DOD have realized over \$29 million in annual savings.

The Federal Pharmacy Executive Steering Committee (FPESC), made up of VA and DOD leadership, created a subgroup composed of representatives of VA's National Acquisition Center (NAC), Vet-

erans Health Administration PBM/SHG, DOD's Pharmacoeconomic Center (PEC), and DSCP.

This subgroup meets quarterly to discuss joint future contracting activities. A "running issues" list currently defines 40 future contracting initiatives. Other witnesses will provide additional details about these opportunities.

The second area of emphasis is DAPA cancellation, which is to occur upon completion of successful negotiations of an FSS contract for a given item.

The subsequent conversion to FSS contracts is critical, because it combines identical medical related items, and leverages volumes to increase our ability to negotiate better pricing, thereby eliminating duplication of contracting efforts and broadening the product availability for both VA and DOD, all while allowing the customers to select the product and pricing that best meets their needs.

We agreed to work together on existing FSS contracts with pharmaceuticals first, which were selected because of advanced data management capabilities for national drug codes which ease comparisons of drugs and pricing.

The procedure for converting DAPAs begins by VA contracting staff receiving DAPA pricing from DSCP. The difference between DAPA and VA prices is usually the one-half of 1 percent, the cost recovery fee that's added onto raw FSS pricing.

This is pursuant to GSA's policy that FSS contracting be paid for through an industrial funding fee, and VA adopted the fee at the level of 0.5 percent for the schedules that it manages. DSCP places its cost recovery fee on the ultimate delivery invoices submitted by its pharmaceutical prime vendors.

VA staff then negotiate and contact contractors to inform them of the conversion process and to begin negotiations to reduce their FSS prices by at least the amount of the 0.5 percent fee, so DAPA and FSS pricing become equal.

VA staff electronically communicate these items and new pricing to DSCP, which downloads the data onto its DAPA management system (DMS) and then cancels the DAPA.

As of May 8, 2000, VA has contacted all of its 255 contract holders, and as a result of these contacts, 112 negotiations have been successful; 82 negotiations are pending; and 61 contractors have indicated an unwillingness to convert at this time.

We are again in the process of contracting these 61 contractors to encourage participation, and we believe that during the same time period, DOD has placed into its DMS 82 conversions and canceled 43 DAPAs.

Where DAPA items are not currently appearing on FSS contracts, the VA NAC people are now contacting those vendors as well, to attempt to attract them to the FSS.

The joint procurement process is progressing smoothly with demonstrable results. The DAPA conversion process, however, has been more challenging. Most significantly, the inability to electronically interface VA and DOD's data management systems has hindered that process.

We are currently working with the DOD to resolve problems that arose in fiscal year 1999 due to these diverging business practices. VA and DOD have just agreed to establish an Information Tech-

nology/Business Process Group to improve the data systems interface.

Weekly conference calls take place to support communications between VA and DOD; and standing reports and formal notes of each call are forwarded to stakeholders, including the General Accounting Office.

VA is confident that, with DOD's cooperation and resolution of current challenges, a longstanding and beneficial relationship can evolve for the benefit of both the taxpayers and the patients that we serve.

VA remains committed to increasing joint federal health care acquisition activities. We stand prepared to extend our expertise and further realize economies of scale by applying the Transition Commission's report recommendations to the procurement of medical/surgical supplies and equipment.

Sir, that concludes my statement. I will be pleased to answer any questions or to pass it to Mr. Ogden.

[The prepared statement of Mr. Krump appears on p. 68.]

Mr. EVERETT. Thank you very much. Mr. Ogden.

#### STATEMENT OF JOHN E. OGDEN

Mr. OGDEN. Thank you, Mr. Chairman and members of the subcommittee.

I am pleased to be here this morning to discuss a wonderful success story—the Veterans' Health Administration's Consolidated Mail Outpatient Pharmacy Program, or CMOP, for short.

For over four decades, VA has provided mail prescription services to veterans as an adjunct to its health benefit. During the 1970s and 1980s consolidation of mail prescription workloads from multiple VA medical centers into centralized operations was initialized on a limited basis.

In 1994, the CMOP program at Leavenworth, KS began processing high-volume prescription workloads using an integrated, automated dispensing system. Since that time, VA has expanded the program to include a total of seven facilities located in Leavenworth; West Los Angeles, CA; Bedford, MA; Dallas, TX; Murfreesboro, TN; Hines, IL; and Charleston, SC.

In fiscal year 1999, those facilities processed workloads exceeding 40 million prescriptions. They are on track to process 50 million prescriptions in fiscal year 2000.

The CMOP program serves each participating VA medical center or outpatient clinic as an integrated extension of each of those sites and has been a vehicle of change in the Veterans' Health Administration as well as in the standardization of drug nomenclature, the standardization of dispensing units, and the standardization of pharmaceutical and medical supply product selection.

What are the costs associated with this program?

In fiscal year 2000, to date, the average non-drug CMOP cost aggregated across the seven facilities is \$2 per prescription and the drug or product cost is \$20.33 per prescription—excellent figures, by the way.

As indicated above, the estimated workload that will be processed this year is 50 million prescriptions. This translates into

roughly \$1 billion in drugs and medical products and \$100 million in non-drug expenses.

What is the relationship between quality of care and CMOP operations?

The CMOP program is strongly vested in quality and has extensive quality assurance and performance measures in place. The automation of the dispensing process changed how we do business, and instead of a classic one or two checks historically associated with prescription dispensing, the automated dispensing process has numerous checks with the newest system having no less than seven checks or validations during the dispensing process.

In fact, the program has an overall accuracy or problem-free rate above 99.99 percent, which is remarkable when you consider all the complexity and logistical issues that occur on a daily basis at these facilities.

In another quality action, VHA partnered with the National Industries for the Blind to develop a clear prescription vial for use in the CMOP program that meets FDA and USP ultraviolet light reflection standards.

The partnership produced a vial that enhances patient safety during the checking process and employee safety through the reduction of the occurrence of carpal tunnel syndrome.

What is the capacity of the CMOP program?

Today, the estimated annual capacity of the seven operating CMOPs is roughly 55 million prescriptions, while actual processing workloads are approaching 50 million prescriptions, as I indicated.

Redundancy and sufficient reserve capacity to respond to disaster or emergent circumstances is essential in assuring uninterrupted provision of care to our patients.

While disaster planning is an integral part of the CMOP program, it is easy to assume that the plans will never be needed. However, emergent situations occurred at no less than five of the CMOPs during the past fiscal year, which resulted in the temporary transfer of workload to alternate CMOP locations due to circumstances that included electrical fire, hurricane evacuation, Y2K upgrades, and new system activation.

What are our plans for the future?

In the testimony, it lays out some short-term and mid-term and long-term goals, and I won't go into them, but just to say that we have developed plans to meet current and future VA prescription workloads.

The model that we're currently emulating by current and future VA facilities includes a total of 75,000 square feet and a total capacity of 60,000 prescriptions per day, operating daily at levels of approximately 80 percent total capacity or roughly 48,000 prescriptions per day.

I'd like to close with one other excellent example of what the CMOP program has been able to do.

The CHAMPVA Meds-By-Mail program is a partnership between the Leavenworth CMOP, the VA Medical Center in Cheyenne, and the CHAMPVA database in Denver, CO. The partnership provides mail prescriptions to CHAMPVA beneficiaries across the United States.

This relatively small program produces savings of approximately \$1.6 million per year. However, it is an excellent example of mutually beneficial partnerships possible within government while providing quality, cost-effective care to eligible beneficiaries.

In summary, in the year 2000, the CMOP program has served and continues to serve as a living lesson in persistence, in patience, continuous improvement, in team-building, in efficiency, in productivity, in partnering, and is an excellent example of cost-effective government that cares.

Thank you. I will be pleased to answer any questions.

[The prepared statement of Mr. Ogden appears on p. 72.]

Mr. EVERETT. Thank you very much. General Mongeon.

#### STATEMENT OF BRIG. GEN. DANIEL MONGEON

General MONGEON. Good morning, Mr. Chairman and distinguished members. I appreciate the opportunity to appear before the subcommittee to address the questions concerning the Department of Defense and the Department of Veterans Affairs joint pharmacy procurement.

I would like to begin with some background information on the Defense Supply Center Philadelphia and our medical materiel mission.

The Defense Supply Center Philadelphia is one of the Defense Logistics Agency's supply management centers. Our mission is to ensure the combat readiness and sustainment of America's war fighting forces by providing world-class logistical support in peace and war.

We are the providers of pharmaceuticals and medical supplies, food, general and industrial items, clothing and textile products.

Our mission ranges from support of operations other than war, such as disaster relief and humanitarian aid, to support of traditional military endeavors that can range from small-scale conflicts to major theater war, seamlessly transitioning from everyday support requirements to the rapidly escalating dimensions of crisis events.

In effect, a military unit anywhere in the world can launch a supply request which will be electronically transmitted to our center with the result of materiel from a commercial or industrial supply partner occurring in a fast and precise manner.

To further ensure our link to the war-fighting commands, we maintain 33 branch offices spread throughout the United States, Europe, and the Pacific. These elements form a forward presence of our Philadelphia-based operation and provide on-site representation in the computation of requirements and execution of support missions.

The services are also significantly revising their medical material sustainment plans and doctrine, relying increasingly on the contingency materiel programs that we have been able to put in place.

Furthermore, our business practices have received some very strong endorsements, to include GAO's description of our medical material business as a model for DOD's shift to commercial practices, and our recent receipt of the President's award on quality improvement.

Ultimately, what we do comes down to getting medical supplies to the soldier, sailor, airman, and Marine that is on point around the world. We absolutely believe that peacetime business, in effect, buys wartime readiness.

An important part of our business and readiness strategy is to partner with government agencies whenever the partnership adds to our operational readiness capabilities and makes economic sense for the Department of Defense. In other words, the partnership achieves for us improved readiness at reduced cost.

Clearly, pharmaceutical pricing is part of our overall medical materiel mission that we believe can be enhanced by the right partnership with the Department of Veterans Affairs. Our interagency memorandum agreement with the VA is designed to accomplish that partnership goal.

As you have heard from Mr. Krump, we already have many important results from these efforts. DSCP and the VA have 18 joint pharmaceutical contracts for high demand items, and these contracts are expected to yield \$29 million in cost reductions.

Defense Supply Center Philadelphia has other DOD national contracts that will provide us with additional \$54 million in cost reductions for the DOD during this fiscal year. As these five contracts reach their conclusion, our requirements will be merged with the VA requirements in order to form additional joint contracts. DSCP and the VA staffs are now working together on 40 additional candidates.

In our broader pricing programs, 112 out of 255 pharmaceutical distribution and pricing agreements with manufacturers have been identified for conversion to the VA's Federal Supply Schedule.

We believe that over the next year, a number of manufacturers that initially deferred action to convert to the DOD pricing agreements to Federal Supply Schedule will be ready to work with us in the conversion process. We will aggressively work with the VA to accomplish this goal.

We have resolved a number of initial data management issues caused by our agencies' different operating systems and we are now forming a more elaborate data management working group to further examine the measures that we can both take advantage of in the synergism.

In closing, Mr. Chairman, I believe that our partnership with the VA is smart and offers significant potential for future cooperative efforts.

I will be happy to answer any questions that you may have.

[The prepared statement of General Mongeon appears on p. 82.]

Mr. EVERETT. Thank you very much. Captain Hostettler.

#### STATEMENT OF CAPT. CHARLES HOSTETTLER

Captain HOSTETTLER. Thank you, Mr. Chairman, distinguished members of the committee. It's my pleasure to appear before the committee today.

I have provided written testimony on two important DOD pharmacy programs, our National Mail Order Pharmacy Program and our Joint Pharmaceutical Contract Activities with the VA. Today I want to highlight for you the current refill process in the DOD

military treatment facilities and our vision for improvements to that process.

Today, DOD beneficiaries take new prescriptions of military pharmacies and return to the same military pharmacy for refills on the prescription. The new prescriptions that patients can bring to military pharmacies are not restricted to military physicians, but include prescriptions written by providers outside the military health system.

Although in recent years, we have significantly streamlined the refill process through call-in refill order systems and drive-through pharmacies on our military installations, we believe we can further improve this process.

The DOD Pharmacy Board of Directors and I have explored several options toward this end, including: (1) utilizing the VA's Consolidated Mail Outpatient Pharmacy, also called CMOPs; (2) the Department of Defense and the VA jointly funding and building new CMOPs facilities; the DOD developing its own CMOPs-like program utilizing existing DOD resources; and (4) buying a centralized refill mailout program on the commercial market.

The first option we had studied is to adopt the centralized refill mailout process currently operated by the VA. In this process, the original prescription is taken to a VA pharmacy—in our case, it would be a military treatment facility pharmacy—for the first fill, and then is electronically transferred to a central refill center for subsequent refills to be mailed to the patient's home.

Let me emphasize that, unlike DOD's National Mail Order Pharmacy Program, CMOPs do not fill new prescriptions sent in directly by the patient. DOD does not intend to terminate our full-service National Mail Order Program, but as mentioned before, is looking for ways to improve and streamline our refill processes at our military treatment facilities.

With the VA's approval, we have explored all aspects of the CMOPs process. However, it has been validated by the VA. There is little or no additional capacity available in the existing CMOPs facilities.

Furthermore, we discovered a major obstacle in utilizing the CMOPs by DOD facilities is in the requirement to develop a secure bi-directional interface between the MTFs and the CMOPs.

The second option we explored is for the DOD and the VA to jointly build additional CMOPs facilities. This technology interface issue remains an obstacle as well as initial capitalization and funding.

The third option is still under study, and involves DOD using existing resources, such as robotics and other in-place pharmacy automation to take refills out of military treatment facilities and to centralize processing and mailing to patients.

The fourth option is to purchase this capability from the commercial market. A request for information was published in March of 2000, and responses from commercial vendors show little interest in pursuing this concept.

Reasons cited for the lack of interest include potential legal complexities resulting from state laws concerning the electronic transmission of prescriptions across state lines. Most commercial vendors suggest having the physician write two prescriptions, one to

be filled at the military pharmacy, the other to be mailed in to the mail order facility.

This option is already in place today through our national mail order pharmacy program and offers no improvement over our current process.

In closing, Mr. Chairman, I would like to emphasize the cooperative efforts between senior pharmacy leadership in the VA and DOD. Our joint goal is a simple one: to provide the best pharmaceutical care possible to our beneficiaries.

I look forward to working further with my colleagues in the VA, identifying areas of commonality for practical solutions to the complex and costly issues for both departments.

I will be happy to answer any questions you may have for me.

[The prepared statement of Captain Hostettler appears on p. 87.]

Mr. EVERETT. Thank you very much.

Mr. Krump, what does the memorandum of understanding provide for, exactly?

Mr. KRUMP. Well, sir, I could defer to Mr. Dave Derr, who assisted in negotiating it directly, but for the most part what it provides is that we will work together with the Department of Defense in order to obtain the best possible pricing on pharmaceutical contracts as the first appendix; and second, we're working on a medical/surgical appendix right now, and we have under consideration an equipment appendix, as well.

The intent is to combine the purchasing power of the two departments and leverage that purchasing power to obtain better discounts and service and pricing terms—in other words, a best-value contract.

Mr. EVERETT. What do you see as the barriers between this joint venture?

Mr. KRUMP. Well, sir, I think the principal one that we've run into so far is the data systems, the interfaces that we have with the data systems and the continued work that will be required in that area.

As several of the other witnesses have testified, that is no small barrier, in and of itself, and as we continue to work that issue, there are several work-arounds that both of the departments have been able to come up with, but ultimately, I believe that the primary goal would be a fully integrated data system.

Mr. EVERETT. General, what do you see as the barriers?

General MONGEON. I would totally concur with Mr. Krump's comments.

I think the data interface is very, very critical. The data that we use feeds very critical databases for the services, but that is something that we can work together and solve.

In fact, we do have an ongoing working group that will meet regularly to resolve those issues, and our goals and objectives for that are to complete that within the year.

Mr. EVERETT. Captain?

Captain HOSTETTLER. Yes, sir.

Mr. EVERETT. Do you have comments on what barriers you see?

Captain HOSTETTLER. As to the procurement, that's really the general's area of expertise, and no, sir.

Mr. EVERETT. Mr. Ogden?

Mr. OGDEN. I think one of the issues that we've come up against is the federal procurement regulations, and in the context of some of these classes that the GAO showed you a while ago, if we would have been able to just add on the DOD requirements, for example, to existing VA national contracts, then it's possible that we could have lowered the price for DOD at that point in time, but the federal procurement regulations won't allow us to just do that.

The problem for us is we have contracts. We've made a concerted effort over the last 5 to 10 years to do the kinds of things that you've asked about today and that the GAO has testified about. We have an excellent track record.

The problem is, we have contracts, and if we stop in the middle of a contract, if you will, aggregate our requirements in some of these classes that the GAO has testified about, the potential for us converting patients, the therapeutic interchange, if you will, of patients, becomes greater.

So we're very careful, as well as the Department of Defense is very careful when they're making those decisions inside a therapeutic class, we're very careful about repeated patient conversions.

So if you want to say that's a barrier, it's a barrier, but I think it's a realistic consideration that we all can appreciate.

Mr. EVERETT. Do we need legislation to correct the federal regs so that you will be able to move into this area?

Mr. OGDEN. Well, I have to defer to the logisticians here, because my perspective—

Mr. EVERETT. Well, in short, how do we solve the problem?

Mr. KRUMP. Sir, I think probably the best view that I could give on that is that there are ways to approach that particular issue which are really not Federal Acquisition Regulation-unique requirements.

You have some issues that are specific legal issues in terms of the scope of the contract, the actual bid that was put out, the requirement that was placed before industry; depending if you were halfway through a process, for example, halfway through a contract year, and then you immediately double the scope of the contract, you have, e.g., a number of issues with other companies that would have bid initially had they known what the scope of the contract was.

Once you get to a cardinal change in a contract like that, they're not so much procurement issues as they are legal issues as to the capability under the law to do it, and as to the capability of industry or different players in industry to respond to a solicitation like that.

Now, in the event that we would be in a position to terminate a contract at a particular point in time and go out and re-solicit the requirement, (very often, where we have a base year contract plus 4 option years), we will continue to work on the new contract and not exercise the option, so you still wind up having to go to the end of a contract year.

If the problem that Mr. Ogden identifies occurs early in a contract year, you may have 7, 8, 9 months before you can implement the new contract, but that's not so much peculiar to the Federal Acquisition Regulation as it is to contracting in general, and capabilities of distributors and manufacturers.

Mr. EVERETT. Mr. Hill?

Mr. HILL. As I noted in my opening statement, my number one interest is that the two departments overcome their information technology barriers. These barriers stop needed partnering on a number of critical fronts.

Captain, you say that a major obstacle to DOD use of CMOPs is the lack of a technology interface and integrated information system between the two organizations.

You also note that VA has a completely separate system that is not compatible with national pharmacy data transaction standards.

What actions are being taken to resolve this problem, what needs to be done, and when can we expect it to be fixed?

Captain HOSTETTLER. We are working very closely right now with Mr. Ogden's office and Dr. Ramirez, from his office, as well, trying to resolve some of these incompatibilities between the two systems and being able to share data for workload that's being done within the VA with the workload that's being done within the DOD and vice versa.

Specifically, back to the CMOPs, no matter which type of automation we would choose to do, either it be what the VA has in place today or if we went a different path, there would still be an interface issue between our computer system inside DOD and that with which we would interface with for the automation, and it's an obstacle that's there regardless of which path we choose to take. There has to be the interface and exchange.

Mr. HILL. Resolvable?

Captain HOSTETTLER. Yes, sir.

Mr. HILL. Mr. Ogden, what's your point of view?

Mr. OGDEN. We experienced similar issues within the VHA. As we developed the CMOP program, the need for that interface between the existing VA computer systems and the commercial vendors' operating systems that drives our CMOPs was present.

We did develop that interface, and each day we transmit millions, millions of bits and bites of information back and forth between our medical centers and our CMOPs.

So I have to give our information technology people a lot of credit in VA. We wouldn't be sitting here talking about processing 50 million prescriptions if it wasn't for those folks. They've done an outstanding job in the decade of the 1990s.

Mr. HILL. Captain, I was glad to hear that you have explored with VA the possibility of using CMOPs and would consider such an option for some of your refill workload.

From your testimony, however, it sounded as if you stopped considering the CMOP option once you concluded that there was no additional capacity in that system to accommodate you.

Did I understand you correctly?

Captain HOSTETTLER. Well, I wouldn't say exactly that. I don't think that we have written off utilizing the CMOPs. It's very difficult to use CMOPs when there is no capacity there to use.

It takes us to the second option I spoke to in my oral testimony, that we're looking at trying to do something jointly with the VA, and that they've recognized a need to expand their own capacity, and we have a need to do something.

So if we can do that together, then let's move in that direction and see if that's possible.

Mr. HILL. Okay.

Captain HOSTETTLER. And whatever it will take to get down that road, we identify the issues and begin to work around those hurdles.

Mr. HILL. Mr. Ogden, would there be some additional capacity in any of your CMOPs with which you might run a pilot test to test how well DOD and VA could interface?

Mr. OGDEN. I think we have the capacity to run a pilot test, but anything beyond a pilot test would require additional capacity.

In fact, I believe the GAO, in their review of this issue, has essentially recommended that two additional CMOPs would be required, to process the 23 million prescription refills that the Department of Defense has at their medical treatment facilities.

So we probably could do a pilot, but beyond a pilot would require some additional capacity, certainly additional capacity.

Mr. HILL. Captain, if the VA has sufficient capacity in one of its CMOPs to run a pilot, how receptive are you to giving it a try, to check out the feasibility of such a joint venture?

In the coming years, VA will have to expand its CMOP program to keep up with its increasing demand. If a joint venture with DOD for refills is found to be feasible through a pilot, an expansion of the CMOP program would have even greater justification, wouldn't it?

Captain HOSTETTLER. Yes, sir. I think we're receptive to trying to test those waters and make sure that it's feasible to go down that road.

My gut reaction is, I don't think we have a reason to believe it won't work; it's a matter of how can we make it work and is there going to be capacity there, how can we get the capacity there to make it work, and so forth.

So it has other benefits for us, to be able to move that workload from the MTF to the CMOP. Right now, in these times of very short staffing, et cetera, we're looking for ways to help ourselves care for our patients better.

Mr. HILL. I believe you were in the room for the first panel and heard both the DOD Inspector General and the General Accounting Office counter your explanations of why it would not be feasible or desirable for DOD and VA to contract jointly for all pharmaceuticals, so I'd like for you to respond.

Captain HOSTETTLER. Yes, sir, I did hear that, and we've had several discussions along those lines, as well.

I think the issue is really what drives what, to some degree. Contracting is not just we decide to contract for Drug X, Y, or Z. It's a matter of back to what Mr. Buyer was speaking about, a formulary.

Formulary decisions drive your requirement, and the formulary controls the choice and will also set up, depending upon, as Mr. Ogden just stated, if we create change in the interim, therapeutic changes for patients, which is a great dissatisfier for patients and providers, and then keeping in mind the differences between DOD's system and VA's system.

VA is a closed, self-sustaining system. DOD has an open system, TRICARE, as well as a closed system, MTFs and so we are taking care of patients from the civilian sector as well as our military sector.

The clinical decisions that drive the formulary decisions are the hard part of all of those therapeutic categories where they are not generically equivalent products. Do you understand what I mean by generic equivalent?

Mr. HILL. Yes.

Captain HOSTETTLER. One drug is as good as the other, according to the FDA. Those are easy to compete, and those are basically the 18 that have been competed today. I think we're actually up to 20 now. That was March data. And there was another identification just recently of another 40 items that we can most likely, as contracts go away and new ones need to be started, can move in that direction. Those are easy ones.

Pursuing the 36 therapeutic categories recommended by the GAO is very difficult for clinical reasons.

Mr. HILL. A question to Mr. Ogden and Captain Hostettler.

DOD has been legislatively mandated to develop a national formulary. When will this be completed?

Mr. OGDEN. I can't comment on where DOD is with their move to a national formulary.

Captain HOSTETTLER. I'd have to, if I could, take that back and research the answer better for you and provide that to you later. I'd appreciate that.

Mr. HILL. I have a couple more questions.

Captain, GAO believes that approximately 66 percent of the drugs used by DOD and VA could be purchased under joint national contracts. This would be up considerably from the current 2 percent. What is your response to this?

Captain HOSTETTLER. It goes along the lines of what I was just saying, that most of the drugs they've identified are in therapeutic categories where those drugs are not genetically equivalent—they are somewhat therapeutically equivalent. They have the same actions, but they are not interchangeable, 100 percent of the time.

For example, I believe that you'll find on their list the non-sedating antihistamines, of which there's two. They even have it listed as a first priority, something we should be pursuing right away.

It's my understanding, as a pharmacist, that only about 60 percent of the patients would be taken care of if only one of those were chosen as your formulary agent. What do we do for the other 40 percent?

That is the issue, then, that immediately comes to the table. If you choose just one of those two non-sedating antihistamines as your formulary item, which then gives the market share that you will then compete, that drives the price down, you'll get a low price, but you only get 60 percent of your patients covered.

That's a difficult position for the providers to be in who have to see and treat patients. Therefore it's very difficult to get the needed consensus across our entire health system for that type of a contract.

Mr. HILL. Do you have an opinion, then, about what percentage increase could be created by implementing this kind of a system?

Captain HOSTETTLER. I don't have it in terms of a percentage, no, sir.

Mr. HILL. Have you got an idea, a guess?

Captain HOSTETTLER. I think that we can look for those areas of commonality in our generically equivalent products, and that's where we've been concentrating our efforts to date, and as those become available for contracting, we put those into a joint mode, because if the VA has requirements for a generically equivalent product, as well as the DOD, then it's feasible to combine those requirements.

Mr. HILL. I have one last question, Mr. Chairman, if it's okay.

Mr. Ogden, first, what is your reaction to Captain Hostettler's response regarding barriers to joint national contracts, and second, what is your reaction to the GAO estimate that two-thirds of your pharmaceuticals could be purchased through the joint national contracts?

Mr. OGDEN. I have real problems with that two-thirds estimate, and we've spent a lot of time with the General Accounting Office talking about why we do what we do and where we've been and where we think we're going. I have a real problem with the 66 percent figure.

I will say Mr. Backhus did clarify for you that joint contracting of pharmaceuticals isn't an easy process, that that number isn't hard and fast. That's just an estimate that they came up with, but I have real concerns about that.

Let me just tack onto what Captain Hostettler said. We in the VA have been working at this contracting, better contracting of pharmaceuticals, if you will, for a long time, and in many cases, we have moved on therapeutic classes that are listed on that list, and we have contracts in place.

The hard part for us is, as I indicated earlier, is if we call time out, does VA call time out, merge the requirements of DOD, go out and negotiate a new contract, potentially have to convert patients once again to another drug?

I think that's something we have to weigh, we all have to weigh, in doing it.

I think another thing I'd like to say is, Mr. Backhus mentioned the AWP as a benchmark, and percent off AWP—as indicative of impressive price reductions achieved to date. I would like to suggest to this group and this committee that a better way to depict price reductions is to look at VA contracts, DOD contracts, joint contracts, and FSS contracts, to pit those against the federal ceiling price as defined in the public law, and then let's take a look at percent off of the federal ceiling price as opposed to percent off the average wholesale price.

I think we'll get a totally different picture, because I think a picture that you may have is that we haven't done anything, that we're not doing what we can do.

I talked to the consultant for the General Accounting Office on this project, and his quote to me was, "We would have killed for these prices in the private sector."

So the fact is, we have good pricing. Can we get better pricing in some cases? The answer is yes, and I think, through our efforts, we're moving toward that, but this is not an easy process.

A good example is, we only have four classes in the VA that we closed their contracting, because we're concerned about therapeutic interchange and converting patients, notwithstanding the political pressure that we've encountered in moving to close those classes.

Because of what we've done clinically, the protests that have been filed on those contracts have been upheld by the General Accounting Office in all cases in our situation, except one case, and that's where we had a pricing piece wrong in the bid proposal.

So this is not low-hanging fruit. I heard the term low-hanging fruit earlier. Believe me, this is not low-hanging fruit, because it takes a lot of buy-in, a lot of buy-in from clinicians and a lot of buy-in from patients, to make this work.

The VA could not have treated 600,000 more veterans between 1995 and the year 2000 unless we had done something, made some inroads in pharmaceutical contracting.

Mr. EVERETT. I think we've got that answer now, Mr. Ogden.

Mr. OGDEN. Okay.

Mr. EVERETT. Let me ask you this. If two-thirds is too much, can you give us any figure at all?

Mr. OGDEN. I cannot give you a figure.

Mr. EVERETT. You know, we're dealing with soft numbers.

Mr. OGDEN. Yes, sir.

Mr. EVERETT. The Health Care and Benefits Act requires VA and DOD to submit a joint report in July on how joint pharmaceutical procurement can be enhanced and cost reductions can be realized over the next 4 years.

Will this report be on time and provide a timeline in achieving these savings?

Mr. OGDEN. The report will be on time, and we'll take every class that the General Accounting Office put before us today, and we will go through every class and give you a status report on what our plans are for those particular products.

Mr. EVERETT. Okay. Thank you very much. I want to thank the panel. We will have additional questions that we would ask and submit for the record.

GAO and the Transition Commission's testimony this morning demonstrates how great the opportunity is for VA and DOD to do more joint buying of pharmaceuticals, as much as \$1.5 billion over 5 years.

Currently, VA and DOD only share a tiny 2 percent of their combined pharmaceutical budgets of \$2.4 billion. DOD's own IG says this combined purchasing makes good sense. The VA and DOD agree that they could do more.

As they are today, the Government health care systems for veterans and service members fail to obtain the best possible price in the pharmaceutical market.

The VA and DOD must improve their purchase habits. Otherwise, huge amounts of money will continue to be wasted by paying too much for drugs, when these dollars saved could be re-invested in improving health care for veterans, military retirees, service members, and their families.

Working with our committee leadership, I expect to continue oversight of VA and DOD progress in sharing. I expect real progress to emerge from this.

Therefore, I'm asking the GAO to continue reporting to Congress. Public Law 106-117 requires VA and DOD to make a joint report in July 2000 on enhancing joint procurement of pharmaceuticals and achieving cost reductions by fiscal year 2004. I would hope that we could really move faster than that.

Also, I really agree with Mr. Hill. The idea of a pilot project for DOD's use of VA's pharmacy system could be explored further, and I would like for the VA and DOD to report to the subcommittee within 90 days on that possibility.

Without objection, members will have 5 legislative days to submit statements for the record, and this hearing is adjourned. Thank you all very much.

[Whereupon, at 11:43 a.m., the subcommittee was adjourned.]



**A P P E N D I X**

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**STATEMENT OF KIM WINCUP  
VICE CHAIRMAN  
CONGRESSIONAL COMMISSION ON SERVICEMEMBERS  
AND VETERANS TRANSITION ASSISTANCE****MAY 25, 2000**

Mr. Chairman and Members of the Committee, it is a privilege to appear before you this morning to testify on a specific aspect of the healthcare findings and recommendations of the Commission on Servicemembers and Veterans Transition Assistance.

You have likely heard the saying that there is nothing constant in this world except for change. And many things have changed over the years gone by and many more will change in the years to come. Change is one reason the Congress created our Commission. Many of the benefits and services provided to the men and women now leaving the Armed Forces and the organizational structures designed to meet them are rooted in the closing days of World War II, more than a half century ago. Our Commission looked at how the country has changed: in the military, in the civilian world and in the Americans who make the transition from one to the other.

We found in some cases benefits and services have become so outdated and program management so ineffective they break faith with those who served and currently serve in uniform. Consistent with these findings, we proposed fundamental and far-reaching reforms to both programs and the governmental organizations delivering them. Our report was without dissent.

The Commission found that access to high quality healthcare is of critical importance to active duty servicemembers and veterans. They consider healthcare to be one of the most important benefits they receive from their military service. We were very impressed with the quality of care provided to servicemembers and veterans and consider both systems to be unique and irreplaceable national resources, critical to the nation and its citizens.

At the same time, however, the Commissioners found that changing healthcare practices, an evolving patient population, infrastructure built for another era and increasing healthcare costs in a time of budgetary pressure will challenge the ability of the two systems, as currently structured, to meet the healthcare needs of their beneficiaries in this new century. We found a true partnership between the VA and DoD healthcare systems offers the best hope for continued access to a continuum of high quality care for the millions of beneficiaries of both Departments. A partnership would allow them to better serve their beneficiaries by making their combined resources accessible to all beneficiaries and allowing the Departments to realize efficiencies from more efficient utilization of their limited resources.

The Commission recognizes the efforts that have been made to establish sharing agreements drawing on the strengths of each Department, but considered in the context of the total beneficiary population and the combined budgets of both Departments, sharing has been incremental and marginal at best. There are several reasons for this:

- Differing administrative, budgetary and personnel systems.
- Each uniformed service's desire to have its own specific providers.
- National traditions and corporate culture.
- Differing catchment areas for DoD and VA facilities.
- Differing eligibility rules and priorities for beneficiaries.

These institutional and cultural barriers to increased cooperation and sharing are part of the reason the Departments project only \$62 million of their \$33 billion combined budgets will be transferred between Departments as a result of sharing agreements in FY 2002. With specific regard to pharmaceuticals and medical products, the Commission found that VA and DoD procured nearly \$3.7 billion in FY 1997. Currently however, I understand that through a recent Memorandum of Agreement, VA and DoD jointly procure some drugs, but this effort amounts to less than 3% of their joint budgets allocated to pharmaceuticals.

The Commissioners believed that the Departments can do better, indeed must do better, if the systems are to remain strong and viable well into this century. Difficult decisions will have to be made within the Departments and the Congress to lower the barriers that impede the creation of a true partnership between DoD and VA. Failure to act will be paid by increasing numbers of beneficiaries who will be forced to turn elsewhere for their healthcare. The Commission has drafted a blueprint that, if adopted, will create the framework for that partnership. A partnership that would maximize the return on the human and physical resources of DoD and VA and increase the number of beneficiaries they treat.

In the short time allotted, it is impossible to cover in any detail the many Commission findings and recommendations to create a partnership in healthcare between DoD and the VA. I will just highlight a few related to joint procurement.

- Segmented purchasing by the federal healthcare sector is wasteful and makes no sense when it results in the loss of the quantity discounts that the private sector has demonstrated are possible.
- DoD and VA could apply the savings realized from combining their purchasing power for pharmaceuticals, as well as medical/surgical supplies and equipment, to increase the amount of healthcare provided to their beneficiaries. Joint purchasing should not affect military readiness because readiness seems tied much more closely to distribution than to purchasing capability.
- Joint purchasing of pharmaceuticals, as well as medical/surgical supplies and equipment, would allow the departments to develop additional procurement leverage for wartime and military readiness contractual requirements (e.g. surge and distribution requirements).

- A clinically based joint DoD/VA formulary would improve cost-effectiveness of pharmacy operations without compromising healthcare for beneficiaries.
- The use of combined purchasing power of both Departments for the procurement of VA-DoD pharmaceuticals, medical surgical supplies and equipment, and require the establishment of a joint formulary and universal product numbers. Projected savings of \$374 million annually. A DoD Inspector General report recommended that DoD use VA contracts and administration for such purchasing.

Servicemembers and veterans will be the beneficiaries of these recommendations if the Departments and the Congress accept the challenges offered by the changing times and the healthcare recommendations formulated by the Commission in response to them.

Thank you.

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United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Oversight and Investigations,  
Committee on Veterans' Affairs, House of Representatives

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For Release on Delivery  
Expected at 10:00 a.m.  
Thursday, May 25, 2000

## DOD AND VA HEALTH CARE

### Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars

Statement of Stephen P. Backhus, Director  
Veterans' Affairs and Military Health Care Issues  
Health, Education, and Human Services Division



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GAO/T-HEHS-00-121

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss what the Departments of Veterans Affairs (VA) and Defense (DOD) have done and what more they could do to reduce drug prices and dispensing costs. In fiscal year 1999, VA and DOD together spent about \$2.4 billion—or about 2 percent of all domestic drug sales—for about 140 million prescriptions for veterans, and for active duty and retired military and their families. Recently, soaring drug costs have focused attention on the merits of having the agencies procure their drugs jointly, and better manage their pharmacy operations. The driving expectation is that, as the two agencies buy more of a particular drug, their leverage—particularly under competitively bid committed-use contracts—will permit them to exact discounts from drug manufacturers.<sup>1</sup> Committed-use contracts establish a fixed price for one or two products in a particular therapeutic class. In exchange for a low price, the Departments commit to use the drugs to treat patients in their health care systems. This commitment encourages the prescribing and use of contract drugs and will also lead the Departments' medical systems to treat their patients consistently. Medical necessity would require that some patients be allowed to use alternate drugs.

At your request, my testimony focuses on the extent of joint DOD and VA drug contracting thus far and the prospects for further contracting, as well as for DOD using VA's consolidated mail outpatient pharmacy (CMOP) centers to handle its hospital outpatient pharmacy refill workload that could be mailed to beneficiaries. Also, I will briefly discuss the possible need for measures to facilitate such joint actions to bring about further improvements. As you know, our work is still underway and we plan to issue a report to you and other requesters later this year.

In summary, by April 2000, VA and DOD had awarded 18 joint, national committed-use contracts amounting to about 2 percent of their combined drug expenditures. The joint contracts largely were due to a 1999 VA/DOD agreement to work toward combining their like medical supply needs. The Departments also have separate national contracts amounting to about 17 percent of their combined expenditures. The remainder, or about 81 percent of their combined expenditures, are for drugs they buy at negotiated, noncompeted, supply schedule prices, at far smaller discounts than the contracts afford.

While the drug discounts DOD and VA have gotten are impressive, only about 19 percent of their combined purchases are now made through the most cost-effective mechanism—national, committed-use contracting with a supplier. If DOD and VA could do most of their drug spending through such contracts, preferably joint contracts, we estimate they could save from about \$150 million to \$300 million, or about 6 to 12 percent of their annual combined drug spending. The Departments would need some time to clinically plan and award the contracts to achieve this annual savings level. Of course, we acknowledge the variability of drug market pricing and that drug makers may have discount limits and may or may not choose to bid on such contracts. However we believe such savings are possible based on existing data.

VA and DOD officials told us that the prospects for more joint contracting are limited because their patient populations differ and their drug needs vary widely. However, our analysis showed that about 30 high-dollar drug classes now comprise about 66 percent of VA's and DOD's combined annual drug purchases.<sup>2</sup> Each of the classes includes a number of therapeutically interchangeable drugs such that the classes could be jointly

<sup>1</sup>A health plan can exert considerable leverage in negotiating drug prices when there is a choice among competing drugs that are therapeutically equivalent and the plan can choose which one or ones to purchase. The plan will have additional leverage based on its ability to influence the volume used.

Generally, VA and DOD national committed-use contracts establish a fixed price for one or two products in a particular therapeutic class for 1 year, plus four 1-year option periods. By including the contracted drugs on their respective national and basic core formularies, VA and DOD commit to use the drugs to treat patients in their health care systems. The ability to offer a high volume of use of a particular drug enables VA and DOD to obtain the lowest prices from drug companies.

<sup>2</sup>For purposes of our analysis, we used the widely recognized AHFS Pharmacologic-Therapeutic Classification©, which lists 204 classes of drugs and related products in its AHFS Drug Information© 2000 edition.

contracted. The officials also told us that DOD lacks a national formulary (a list of prescription drugs, grouped by therapeutic class, that are selected for their medical value and price).<sup>3</sup> The lack of such a formulary limits DOD's ability to enter into and thus commit to a particular drug's usage under such contracts so that the higher discounts can be achieved. However, DOD has met its usage commitments under its 18 joint contracts with VA and 6 separate contracts and, in our view, could continue awarding such cost-effective contracts. Also, DOD recently was legislatively mandated to develop a national formulary and is now doing so.<sup>4</sup>

Regarding DOD's possible use of VA's CMOPs to reduce dispensing costs, DOD is currently exploring commercial contracts as a way to handle its hospital outpatient pharmacy refill workload that could be mailed to beneficiaries. Our work showed that VA's CMOPs now perform most of VA's drug refill functions in a highly efficient, low-cost way. Also, based on VA information, CMOPs would likely cost DOD less than a commercial mail-service pharmacy and may save an estimated \$45 million in current dispensing costs. However, VA and DOD officials have had a number of discussions—to date, to little effect—about using the CMOPs for DOD's refill needs.

In this regard, DOD and VA officials told us that their differing missions and cultures create rivalries, making it difficult for them to work together on mutually beneficial tasks. Given the potential savings at stake through joint contracting, through DOD possibly using the CMOPs, and through other joint activities, we believe interventions by the Congress may be needed to help bring about successful agency interactions.

#### Scope and Methodology

My statement is based on work we did at VA and DOD from August 1999 to the present date. We interviewed VA and DOD drug contracting, benefit management, and mail pharmacy officials in Philadelphia, Pennsylvania; San Antonio, Texas; Falls Church, Virginia; Hines, Illinois; Washington, D.C.; Charleston, South Carolina; Leavenworth, Kansas; and Los Angeles, California. We obtained and reviewed relevant reports, plans, interagency agreements, and other related documents. We also interviewed academic and private-sector experts in pharmacy benefit management and formulary and mail pharmacy use.

We also analyzed VA and DOD fiscal year 1999 pharmaceutical prime vendor data on \$2.4 billion in purchases for veterans and military pharmacies.<sup>5</sup> We grouped and ranked each drug by therapeutic class and the dollar-volume purchased. We engaged a consulting pharmacist and he and we, in turn, consulted with other pharmaceutical experts, to review our rankings and help identify classes with therapeutically equivalent drugs that might be competitively contracted at lower costs.<sup>6</sup> Lastly, we consulted with Congressional Budget Office (CBO) analysts on our estimating methods and results.

<sup>3</sup>A common technique used by health care system purchasers to help control their prescription drug spending is to establish a formulary, which can be used to reduce the number of products the purchaser will cover and to focus their use. A formulary is a list of drugs, grouped by therapeutic class, that the purchaser prefers its physicians to prescribe for patients. Drugs are included on the formulary based on their medical value and price.

<sup>4</sup>As required by the National Defense Authorization Act for Fiscal Year 2000, DOD is developing a national formulary. In a June 1998 report, we recommended that DOD establish a national formulary for its pharmacy programs. See Defense Health Care: Fully Integrated Pharmacy System Would Improve Service and Cost Effectiveness (GAO/HEHS-98-176, June 12, 1998).

<sup>5</sup>Under VA's and DOD's prime vendor process, a wholesaler buys drugs from a variety of manufacturers and the inventory is stored in commercial warehouses. A VA or DOD pharmacy orders the drugs from the prime vendor using electronic ordering systems at prices pre-negotiated by either VA or DOD. The prime vendor ships most items to the pharmacy the next day.

<sup>6</sup>Dr. Peter M. Penna has had extensive professional experience in managed care pharmacy operations. Most recently Vice-president of Managed Pharmacy for Cigna HealthCare (a 6-million member managed care organization), Dr. Penna is also a founding member and past president of the Academy of Managed Care Pharmacy.

## BACKGROUND

The DOD and VA health care systems collectively comprise hundreds of hospitals, clinics, and health-care facilities worldwide that provide services to more than 12 million beneficiaries. In 1999, VA spent about \$15.5 billion for veterans' health care and DOD spent \$16.2 billion for active duty and retired military, and their families. Generally, DOD and VA pharmacies allow their respective beneficiaries to obtain directly up to 90-day supplies of free prescription drugs directly or by mail.<sup>7</sup>

VA and DOD operate their hospital and clinic outpatient pharmacies and formularies under different rules. VA has a national formulary, supplemented by 22 regional formularies, that somewhat limits the availability of nonformulary items and fills only prescriptions written by its own providers.<sup>8</sup> DOD's hospitals and its national mail pharmacy maintain their own separate formularies that restrict the drugs available to varying degrees, but also fill prescriptions written by military and private physicians.<sup>9</sup> DOD also has nationwide contractors that supplement its hospital care and provide drugs at retail outlets with few restrictions on drug choice.<sup>10</sup> Reflecting national trends, between 1995 and 1999, VA and DOD drug expenditures respectively rose about 75 percent and 63 percent, while their health budgets rose 7 percent and 5 percent.

In 1999, VA and DOD purchased most of their drug supplies through their separate drug supply schedules. VA administers the federal supply schedule (FSS) for brand-name and generic drugs and has noncompetitive FSS contracts with about 250 drug manufacturers covering over 17,000 products. In effect, drug manufacturers are invited to negotiate and commit to product prices for VA and other federal purchasers during the contract period.<sup>11</sup> DOD also has its own distribution and pricing agreements (DAPAs) with the same drug manufacturers. The DAPAs also establish purchase prices for certain periods based on negotiations with manufacturers. DAPA prices are generally the same as FSS prices.

In 1999, VA and DOD pharmacies also purchased some drugs through national fixed-price competitive contracts. Because these contracts are based on competitive bids for products that are therapeutically or generically equivalent to others on the market, VA and DOD can choose to purchase the drugs with the lowest prices. As a result, the agencies achieve deeper discounts than under FSS and DAPA. By mandating that the contracted drugs are preferred over competing drugs and by not listing the competing

<sup>7</sup>Some veterans have a \$2 copayment for each 30-day supply from VA, while some DOD beneficiaries have up to a \$8 copayment for a 90-day supply through the DOD mail program.

<sup>8</sup>Currently, there are about 1,100 drugs and related items on the national formulary. Drugs not on the national formulary may be available to veterans through independent formularies maintained by VA's regional networks and some medical centers. See *VA Health Care: VA's Management of Drugs on Its National Formulary* (GAO/HEHS-00-34, Dec. 14, 1999).

<sup>9</sup>DOD has a basic core formulary policy that dictates a minimum of drugs to be on all military pharmacies' formularies. Currently, there are 168 drugs and drug devices on the basic core formulary.

<sup>10</sup>The direct care system of Army, Navy, and Air Force medical facilities is supplemented by DOD's regional TRICARE managed care support contracts, under which retail pharmacy benefits are provided to eligible military beneficiaries. TRICARE contractors offer both network and non-network retail pharmacy services; 1999 retail pharmacy expenditures were \$349 million.

<sup>11</sup>The method VA uses to obtain FSS price discounts takes advantage of "most-favored customer" discounts drug manufacturers have negotiated in the private sector. Under procurement regulations, the FSS price should generally represent the same discount off a drug's list price that the manufacturer offers its most-favored nonfederal customer. FSS prices are also affected by the Veterans Health Care Act of 1992, as amended (P.L. 102-686). The act requires drug manufacturers to sell brand-name drugs covered by the act to four agencies—VA, DOD, the Public Health Service, and the Coast Guard—at a minimum of 24 percent off the nonfederal average manufacturer price, a level referred to as the federal ceiling price. The FSS price may be higher or lower than the ceiling. If it is higher, the protected purchasers pay no more than the ceiling price.

drugs on their formularies, VA and DOD can ensure greater use of the selected manufacturers' drugs in their systems and, thus, get higher discounts from suppliers.<sup>12</sup>

Since 1996, the Congress has acted to urge VA and DOD to cooperate in procuring and managing pharmaceuticals. A study mandated by the Veterans' Benefits Improvements Act of 1996 (P.L. 104-275) concluded that DOD and VA should combine their market power to get better pharmaceutical prices through committed-use contracts.<sup>13</sup> Further, the 1999 National Defense Authorization Act (P.L. 105-261) directed the Departments to jointly review and report on DOD's current methods for contracting for and distributing drugs, and for dispensing drugs by mail. This review is still under way with a report due 60 days after the review is completed. Most recently, the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) requires VA and DOD to submit a joint report in July 2000 on how joint pharmaceutical procurement can be enhanced and cost reductions realized by fiscal year 2004.

**DOD/VA HAVE AWARDED SOME NATIONAL CONTRACTS BUT MORE CONTRACTING COULD ACHIEVE SUBSTANTIAL SAVINGS**

Responding to congressional pressures and to rising drug costs and demands, VA and DOD have taken steps to collaborate on drug procurement. Between October 1998 and April 2000, VA and DOD awarded 18 joint national pharmaceutical contracts—mostly for the generic drugs—amounting to about \$46 million for 1999 (See app. I). This amount is about 2 percent of the Departments' combined \$2.4 billion drug spending. On average, the discount below average wholesale price (AWP) on such drug purchases has been about 94 percent overall – and about 85 percent for the brand-name drugs for which there are no generic equivalents on the market.<sup>14</sup> (See table 1). Agency officials told us their collaboration was prompted by a VA and DOD executive council, along with the 1999 interagency agreement.<sup>15</sup>

Also, as of January 2000, VA and DOD respectively had 46 and 5 separate national contracts that amount to \$413 million, or 17 percent of their combined drug spending. On average, the comparable discount for VA on such drug purchases has been about 82 percent off AWP, and for DOD 68 percent. The remaining 81 percent of DOD and VA combined drug expenditures are for drugs bought through their negotiated, noncompeted supply schedule and DAPA arrangements. On average, the discount below AWP on 33 of VA's and 37 of DOD's high dollar purchases in this category was about 58 percent.

<sup>12</sup>Case-by-case exceptions allow VA and DOD facilities to dispense nonformulary products according to medical necessity.

<sup>13</sup>VA also currently purchases drugs for the Indian Health Service and the Federal Bureau of Prisons to support each agency's health-care mission. VA has used national committed-use contracts for this purpose, distributing the drugs to Indian Health Service and Bureau of Prison facilities through its pharmaceutical prime vendor. In 1999, these agencies purchased about \$280 million in drugs from VA's prime vendor.

<sup>14</sup>Discounts can be expressed in different ways including as a percentage below a given benchmark, such as the AWP. The AWP for a product is an average of the list prices that drug manufacturers suggest wholesalers charge pharmacies.

<sup>15</sup>Active since February 1998, the council coordinates health care matters and oversees a variety of national initiatives. The executive council consists of chief VA and DOD health officers, key deputies, and the surgeons general from the Air Force, Army, and Navy. In May 1998 the council chartered a Federal Pharmacy Executive Steering Committee to expand joint clinical and economic evaluations to support contracts for high-dollar and high-volume pharmaceuticals. The committee is comprised of VA and DOD chief pharmacy benefit management officials and other clinical, contracting, and financial management staff from each department.

**Table 1: Average VA and DOD Joint Contract Drug Prices Versus Average Wholesale Prices, as of March 2000**

Contract product (selected strength and package size) <sup>1</sup>	Generic or brand name	VA/DOD contract price (dollars)	Average wholesale price (AWP) <sup>1</sup> (dollars)	Percent discount off AWP
Albuterol (0.09 gr/inhaler 17 gm)	Generic	\$1.66	\$21.50	92.3
Amantadine (100 mg capsules, 100)	generic	5.50	98.19	94.4
Captopen® (captopril) (12.5 mg tabs, 100)	Branded generic	1.17	90.94	98.7
Cimetidine (300 mg tabs, 100)	Generic	3.12	84.50	96.3
Fluocinonide (0.05% 15 gm topical)	Generic	1.00	8.97	88.9
Gemfibrozil (600 mg tabs, 90)	Generic	3.63	60.65	94.1
Levobunolol ophthalmic (0.25% sol, 5 ml)	Generic	1.82	14.08	88.5
Nortriptyline (10 mg capsules, 100)	Generic	1.83	38.65	96.3
Novolin® (human insulin) (100 u/ml, 10ml)	Brand name	4.49	22.94	80.4
Prasosin (1 mg capsules, 100)	Generic	1.90	26.50	92.9
Ranitidine (150 mg tab, 500)	Generic	13.67	740.00	98.2
Salsalate (500 mg tab, 500)	Generic	11.70	99.50	88.2
Tiamac® (diltiazem) (240 mg capsules, 100)	Branded generic	27.00	158.48	83.0
Timoptic® (timolol ophthalmic solution) (10 ml)	Brand name	1.94	27.07	92.8
Timoptic-XE® (timolol ophthalmic gel) (5 ml)	Brand name	5.04	26.19	80.0
Trimox® (amoxicillin) (250 mg capsules, 100)	Branded generic	2.65	23.89	88.9
Verapamil (120 mg tab, 100)	Generic	12.99	86.21	84.9
Average discount				94.4

<sup>1</sup> Does not include the joint contract for Habitrol® (nicotine patches), awarded April 2000.

<sup>1</sup> For contracted generics, we compared VA/DOD contract prices with the AWP's listed for those companies' generic products and their dosages and package sizes.

Sources: AWP from *Red Book: Pharmacy's Fundamental Reference March 2000 Update*, (Medical Economics Company, Inc., Montvale, NJ) and GAO analysis.

### **Additional Use of Joint National Contracting Could Save Millions of Dollars**

If DOD and VA could purchase many more of their pharmaceuticals through national, committed-use contracts—particularly joint contracts—we estimate they could save substantial sums each year. Our savings projections take into account the discounts VA and DOD have received on their current national committed-use contracts.

To project the possible savings, we began by ranking DOD's and VA's drug classes by combined dollar volume purchased. Our consultant identified 30 top-ranking classes that included one or more groups of therapeutically equivalent drugs in each class and thus could be good candidates for competitive, national contracting. The 30 classes represent about 66 percent or \$1.6 billion of DOD and VA combined 1999 drug expenditures. However, some of the 30 classes would be easier to plan and contract for and have potentially greater savings than others. Therefore, we divided the 30 drug classes into 3 tiers, based largely on the expected level of difficulty the agencies would have garnering clinical agreement on encouraging the committed use of one or more drugs within the classes. (See app. II).

Also, among as many as 30 classes, the question becomes advisedly, which should the agencies focus on first, next, and so forth. Thus, the tiers represent the priority order in which we suggest DOD and VA perform clinical reviews and pursue further joint contracts. The first tier are classes we judged to be highly susceptible to competitive contracting, because the competing drugs are widely held to be therapeutically equivalent and providers and patients would more likely accept one or two drug choices per class. Examples are the non-sedating antihistamines Claritin® versus Allegra® and the angiotensin converting enzyme (ACE) inhibitors Prinivil®, Zestril®, Monopril®, Accupril®, and Vasotec®. The second tier are classes whose drugs' therapeutic equivalency is less widely accepted, or whose high demand drugs are new and the older substitute drugs are less preferred by physicians and patients. This tier of drug classes may require VA and DOD to do much more clinical study to support joint contracting because the choices would be tougher. Second-tier examples include the anti-migraines AmERGE®, Imitrex®, and Zomig® and such antidepressants as Celebra®, Paxil®, Prozac®, and Zoloft®. The third tier are classes whose drugs' equivalencies are more controversial, and thus providers and patients would likely be more resistant if their pharmaceutical choice was restricted to just one or a few drugs in these classes. Examples include the cephalosporins (anti-infectives) Cipro®, Floxin®, Levaquin®, and Tequin®; and the anxiety and sleep disorder (benzodiazepine) agents Ambien®, Buspar®, and Sonata®.

Further, our consultant identified a fourth group of high-dollar drug classes that are the least susceptible now among the classes we identified to competitive contracting. Nonetheless, given the rapid and continuing introduction of new drugs on the market and the steady rise in drug costs, we believe this group of drug classes should be closely monitored for future joint contracting opportunities. The group includes six classes whose drugs' therapeutic equivalencies are not now generally accepted. Also, at this time serious and complex clinical issues exist regarding patient outcomes and safety such that contracting for just one or a few drugs in the classes is not now clinically feasible. One group example is the anticonvulsants Depakote®, Dilantin®, Klonopin®, etc. We excluded this fourth group from our savings projections.

As discussed, DOD and VA will face varying levels of difficulty in attempting to clinically justify and contract for the 30 classes of drugs. In addition to the degree of competition among drugs in a class, manufacturers' pricing strategies can also play a significant role in the discounts they are willing to offer the government. Nevertheless, we hypothesized that if the agencies could achieve one-quarter of the savings rate achieved by moving from the FSS to contracts, they would save about \$160 million or 6 percent of their combined expenditures annually. If they could save 50 percent of that average savings, they would save about \$300 million or 12 percent of such expenditures. (See table 2.) While some savings would begin to accrue during the first year of this effort, maximum savings would not be fully realized for several years because DOD and VA will need time to clinically plan and award joint contracts for drug classes in the tiers we have suggested.

Table 2: GAO's Estimate of Potential Savings from Expanded Joint Contracting

(Dollars in millions)

Agency	1999 purchases	Purchases in 30 high-dollar classes	Noncontracted purchases in 30 high-dollar classes	Estimated savings--joint contracts <sup>a</sup>
VA	\$1,531.5	\$996.7	\$617.0	\$91-\$183
DOD	\$869.5	\$590.7	\$418.7	\$56-\$112
<b>Totals</b>	<b>\$2,401.0</b>	<b>\$1,587.4</b>	<b>\$1,035.7</b>	<b>\$147-\$295</b>

<sup>a</sup>Savings possible if agencies can achieve from one-quarter to one-half of the savings rate achieved by moving from FSS to contracts.

Source: GAO analysis.

Again it is important to emphasize that the amount of savings is difficult to predict. We know that drug market pricing is highly variable and that drug makers may have discount limits and can choose to bid or not on competed contracts. Current DOD and VA joint contracts are mostly on generic drugs and thus do not cover their highest-dollar or highest-volume drugs. Because those contracts may have been easier to award than would those for the classes we have identified, the savings rates may be less with future contracts. In addition, certain offsetting costs may occur, such as the administrative costs to handle increased requests to approve the use of drugs other than those jointly contracted for. Nevertheless these estimates suggest that significant savings are likely with even modest increases in discounts.

Moreover, others have estimated significant savings should the Departments leverage their buying power. In 1999, a commission established by the Congress reported among other things on its review of the merits of VA and DOD jointly buying drugs and other medical supplies.<sup>14</sup> The commission estimated the agencies could save \$1.9 billion cumulatively over five years, or about \$383 million per year, but did not separately estimate savings due to joint pharmaceutical purchases. Since then, DOD and VA have had more experience awarding joint and separate contracts. Also, in a March 2000 report, the CBO estimated that the agencies could save millions of dollars by further collaborating on their drug pricing. CBO also reported that a major impediment to their jointly buying drugs was their differing formularies.<sup>15</sup>

VA and DOD officials generally agree that the best prices are available through joint national contracts and that they have already made much progress with the current joint contracts. They told us the prospects for future joint contracts are limited because DOD lacks a comprehensive national formulary. This limits DOD's ability to enter into and thus commit to a particular drug's usage under such contracts. We agree this is a serious limitation and in 1999, DOD was legislatively mandated to establish a national formulary and is now in the process of doing so.

Moreover, DOD fully meets its drug usage commitments by mandating that the drugs used in its hospital and national mail pharmacies be the ones contracted for under the existing 18 joint contracts with VA and the 5 separate national contracts. Thus, we believe DOD should continue awarding such cost-effective contracts. In our view, the prospects of greater joint contracting with VA may help both agencies in refining their formularies toward greater uniformity across the systems. This way, patients with similar drug needs could be treated consistently and far greater savings could be achieved than are now possible. Admittedly, both agencies need to make more progress before this becomes a reality.

<sup>14</sup>In January 1999, the Congressional Commission on Servicemembers and Veterans Transition Assistance issued a report and made numerous recommendations to improve the effectiveness of programs providing benefits and services to active duty military personnel and veterans.

<sup>15</sup>Budget Options for National Defense, Congressional Budget Office, March 2000.

DOD and VA officials also told us their client populations differ significantly and have different drug needs—from women and children beneficiaries in DOD facilities to elderly veterans in VA facilities. We found, however, that 8 of the top 10 high-dollar drug classes in each department are the same. (See table 3). Further, retirees continue to increase as a percentage of DOD's client load, creating drug demands increasingly similar to VA's. And, 30 drug classes now consume about 66 percent of VA's and DOD's combined annual drug purchases—the high-dollar classes we are nominating for clinical reviews and joint contracting opportunities.

Table 3. Matching VA and DOD Top-Ten Drug Classes in 1999

Drug class	VA ranking	DOD ranking	VA purchases <sup>a</sup>	DOD Purchases <sup>a</sup>	Total VA/DOD purchases <sup>a</sup>
Antivirals <sup>b</sup>	6	9	\$72.7	\$16.9	\$82.7
Anticancer drugs <sup>c</sup>	10	10	38.7	17.0	55.7
Calcium channel blockers	5	4	80.2	40.1	120.3
ACE inhibitors	9	7	30.2	30.6	60.8
Antilipemics	2	1	117.5	78.2	195.7
Antidepressants	3	3	110.5	47.8	158.3
Miscellaneous gastrointestinal agents	1	2	120.2	77.8	197.9
Antidiabetics-oral hypoglycemics	8	8	46.3	27.8	74.1
<b>Totals</b>			<b>\$625.3</b>	<b>\$330.2</b>	<b>\$964.5</b>

<sup>a</sup>In millions of dollars.

<sup>b</sup>Excludes herpes drugs.

<sup>c</sup>Excludes prostate cancer drugs.

Source: GAO analysis of VA and DOD information.

The geographic separation of the key DOD and VA pharmacy policy and procurement staff is a complicating factor affecting joint contracting, according to DOD and VA officials. DOD's Pharmacoeconomic Center is in San Antonio, Texas, and its procurement staff are in Philadelphia, Pennsylvania. VA's counterpart clinical and procurement groups are in Chicago, Illinois. Officials told us this seriously hampers communication and working relationships among the groups. We tend to agree; the organizations were created for separate organizational functions and not the joint drug contracting that we believe they need to diligently pursue in the future.

#### DOD SHOULD CONSIDER USING VA'S MAIL-OUT CENTERS TO REDUCE DISPENSING COSTS FOR REFILLS

My second topic also illustrates how DOD and VA might collaborate to achieve dispensing efficiencies in their pharmacy programs. DOD is currently considering contracting with a private vendor to handle its hospital outpatient pharmacy refill workload that could be mailed to beneficiaries. One reason DOD is considering this is to free military hospital pharmacists from the labor-intensive task of dispensing prescriptions so they can work with patients and medical staff toward safer, more effective drug use. Another reason is that DOD wants to replace its current Merck-Medco contract with one that also covers retail pharmacy services. In 1999, Merck-Medco filled and mailed about 1.3 million prescriptions and provided other services.<sup>18</sup> In 1999, DOD beneficiaries obtained 50 million prescriptions by visiting military pharmacies. An estimated 45 percent of such prescriptions were refills. In fiscal year 1997, military pharmacies' dispensing costs, on average, were about \$5.55 per prescription.<sup>19</sup> According to DOD officials, refill dispensing costs are lower than the first-fill dispensing costs because screening for eligibility and drug interactions need not be repeated.<sup>20</sup>

In February 2000, DOD officials solicited comments from pharmacy benefit management companies on whether they could dispense and mail refills for prescriptions first filled at

<sup>18</sup>DOD pays Merck-Medco a dispensing fee of \$9.85 for each prescription dispensed, but does not have to pay Merck-Medco for the cost of the drugs (drugs for this program are supplied to Merck-Medco by the Defense Supply Center Philadelphia through a prime vendor). The contract requires extensive services, such as receiving paper prescriptions through the mail from beneficiaries, verifying eligibility, and clinical drug utilization reviews in addition to dispensing and mailing the prescription.

<sup>19</sup>Dispensing costs do not include the actual cost of the drug, but rather pharmacy personnel salaries, utilities, housekeeping, furniture, and other equipment.

<sup>20</sup>According to one estimate, refill costs are about 40 percent less than first-fill costs.

military pharmacies.<sup>21</sup> Cost proposals were not solicited. The workload was estimated to be about 23 million prescriptions annually. As of April 2000, DOD officials were reviewing the comments received. Earlier, VA's CMOP and DOD officials had a number of discussions about using CMOPs to meet DOD's refill needs. However, DOD has not followed through on the idea.

VA estimates that its CMOPs have saved millions of dollars in dispensing costs.<sup>22</sup> VA officials provided documentation supporting that 1999 CMOP refills cost VA pharmacies \$1.87 per prescription to dispense, on average, including \$0.78, on average, for mailing costs. Because of the CMOPs' growing workload, VA expects the dispensing costs to drop to \$1.71 per prescription this year.<sup>23</sup> CMOPs' low refill cost is largely due to its use of automated technologies that enable each full-time employee to dispense 100,000 prescriptions annually compared to about 15,000 prescriptions per year dispensed by VA's pharmacy employees. By 2005, VA plans to finish expanding the seven existing CMOPs and is also considering building another. That way, about 75 percent or about 90 to 100 million VA prescriptions could be filled by CMOPs.

#### DOD's Concerns about CMOPs Seem Resolvable

DOD officials told us they are concerned whether the CMOPs could expand production to handle about an added 23 million military pharmacy refill prescriptions and whether VA would charge military pharmacies the same low rates. DOD officials questioned the difficulties and costs faced in making military pharmacy computer systems compatible with CMOPs' computer systems. DOD officials told us that the ability to accurately and timely transfer millions of DOD refill prescriptions electronically to CMOPs would be critical to such a system. Finally, DOD officials told us that shifting military pharmacy prescription workload to VA CMOPs would undercut medical readiness by reducing their prime vendor sales market.<sup>24</sup> However, the same concerns would be raised if a private contractor was engaged for this task. Also, DOD's prime vendors could supply drugs to the CMOPs as they now do to Merck-Medco.

VA officials told us they are aware of DOD's concerns and believe each can be satisfactorily resolved. VA officials told us that, if need be, they could expand CMOP production to accommodate about an added 23 million military pharmacy prescriptions. As mentioned above, VA already plans to double CMOP capacity at eight facilities by 2005 to dispense up to 100 million VA prescriptions per year. They pointed out that between 1996 and 2000, the CMOPs will have increased their prescription processing by 30 percent per year. VA officials told us they had discussed with DOD pilot testing the use of the Charleston, South Carolina, CMOP with the nearby Navy pharmacy at Camp Lejeune, North Carolina. They said the pilot would enable both parties to assess any

<sup>21</sup>In the private sector, pharmacy benefit managers (PBMs) administer prescription drug coverage on behalf of health plan sponsors. PBMs provide their customers with services such as formulary development and management, retail pharmacy networks and mail service, claims processing, and drug utilization review.

DOD asked the industry to submit comments on processing MTF refill requests that would be transmitted electronically to a contractor's mail service facility. The military pharmacy would have already screened for beneficiary eligibility and clinical drug utilization review before the contractor would receive any prescription. The contractor would not be responsible for performing those tasks, but only for processing the refill (correct drug, patient, and address) and mailing the prescription to the beneficiary.

<sup>22</sup>Since 1994, VA has established seven CMOPs and expects to fill 50 million, or about 60 percent, of VA prescriptions in fiscal 2000. While veterans can still elect to refill their prescriptions in person at VA pharmacies, in 1999, 62 percent—or 40 million veterans' prescriptions—were electronically sent from VA pharmacies to the CMOPs for refills, which were mailed to the veterans.

<sup>23</sup>In addition to drug costs, CMOPs generally charge the VA pharmacies current operating costs, not fixed facility costs such as building and equipping the automated CMOP facility. In fiscal year 2000, VA estimates total CMOP operating costs to be \$86 million (\$36 million (mail); \$33 million (salaries); and \$17 million (utilities, lease, pharmacy and office supplies, etc.).

<sup>24</sup>The Defense Supply Center Philadelphia's operations are funded by surcharges on its prime vendor sales to military pharmacies. The revenue is also used to fund DOD-wide medical materiel planning and readiness to respond worldwide military deployments and related missions.

computer system concerns and provide a basis to estimate the costs and benefits of such a permanent arrangement. However, DOD has not yet pursued the idea.

CMOPs appear to be a cost-competitive option for DOD to meet its military prescription refills-by-mail requirements. Also, their use by DOD would be compatible with legislation to promote more cost effective use of DOD and VA medical resources and the more efficient delivery of care.<sup>28</sup> Specifically the legislation authorizes VA and DOD medical facilities to become partners and enter into sharing agreements to buy, sell, and barter medical and support services. Based on data provided by VA moreover, we estimate that CMOPs would likely charge military pharmacies, on average, about \$2.10 per prescription.<sup>29</sup> This would cut the average military pharmacy refill dispensing costs almost in half, resulting in annual cost savings of about \$45 million. To provide enough capacity for DOD's added 23 million prescriptions, VA would have to build or lease and equip the equivalent of two new CMOPs. We asked several commercial mail service pharmacies what dispensing fee they might charge military pharmacies to handle 23 million military refill prescriptions. The companies told us they likely would charge between \$5 and \$20 per prescription. Thus, in addition to considering commercial contractors, we believe DOD should give serious consideration to using VA CMOPs to handle their hospital pharmacies refills-by-mail workloads.

#### DOD AND VA RIVALRIES MAY NECESSITATE INTERVENTIONS TO FACILITATE JOINT ACTIONS

DOD and VA officials told us that their differing missions and cultures have created rivalries that make it difficult for them to act together on mutually beneficial tasks. We believe, however, ways can and must be found to bring about successful agency relationships where one organization seeks to help the other and both benefit.

To illustrate the difficulties, last year's interagency agreement provided that the departments would work together, although without a deadline, to cancel DOD's DAPAs with drug companies by converting them to VA's equal or lower FSS prices. As discussed above, VA and DOD have differing price arrangements with many of the same companies. By converting the DAPAs, some small economies would follow and both agencies would pay the same FSS prices to drug makers. As of April, however, only about 43 of the 248 extant DAPAs have been converted. Moreover, serious disagreements between the agencies' procurement groups have soured relations and the process may be in jeopardy. In short, the conversion exercise may have raised the agencies' apparent antagonism toward one another to an even greater level.

Given the potential savings from joint contracting and possibly from DOD using the CMOPs, we believe the Congress may need to intervene to help bring about successful agency interactions. Such actions could include assigning the agencies a deadline to complete clinical reviews and joint contracting on the selected high-dollar drug classes. Another might be to establish an independent board to review VA's and DOD's progress toward these objectives. We plan in our final report to more fully address such possible courses of action.

#### CONCLUSIONS

Nationally, prescription drug spending is increasing by about 12 percent per year—twice as fast as the general health care spending rate. However, large pharmaceutical users can realize huge price discounts by contracting with drug makers to use therapeutically acceptable drug brands within their health systems.

VA and DOD are the largest direct federal drug purchasers, though their combined purchases are less than 2 percent of total domestic drug sales. The Departments already

<sup>28</sup> The VA and DOD Health Resources Sharing and Emergency Operations Act (Sharing Act) (P.L. 97-174, 96 Stat. 70). See *VA and Defense Health Care: Evolving Health Care Systems Require Rethinking of Resource Sharing Strategies* (GAO/HEHS-00-62, May 17, 2000).

<sup>29</sup> This would include an estimated \$1.71 (salaries, mail, utilities, and other operating costs), \$0.20 (other VA overhead costs), and \$0.17 (building and equipment depreciation).

enjoy varying, though significant, discounts on their drug purchases. Their largest discounts have occurred when they contracted jointly to purchase the same drugs for their systems and through their separate national contracts with drug makers. However, the joint and separate contracting has been limited. Only about 19 percent of DOD and VA combined drug purchases are made through such contracts. Most of their drug purchases are made at far smaller discounts. If the agencies could jointly contract for most of 30 drug classes that now make up about 66 percent of their combined drug purchases, we estimate they could save hundreds of millions of dollars annually.

There are obstacles to overcome before joint contracting and other joint activities can be routinely and vigorously pursued, including DOD's need to develop a national drug formulary. In the interim, DOD can build upon its successful performance under its current national contracts and continue seeking to award such contracts. In addition, the Departments need to mitigate their institutional competitiveness and steadfastly pursue such joint actions as drug contracting. For example, DOD is considering commercially contracting for its hospital pharmacies refills-by-mail workloads, even though VA has available a highly efficient system that could meet DOD's needs and achieve savings in the process. Our concern is that agency rivalries could keep DOD from also seriously considering, as it is commercial vendors, the use of VA's CMOPs to handle its prescription drug refill needs.

In the end, interventions may be needed to facilitate effective agency interactions on these issues. Mr. Chairman, this concludes my prepared statement. I will be happy to answer questions you or other Subcommittee members may have.

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#### GAO Contacts and Acknowledgments

For more information regarding this testimony, please call Stephen P. Backhus at (202) 512-7101. Key contributors include Daniel M. Brier, Carolyn R. Kirby, Lawrence L. Moore, Allan C. Richardson, and Richard J. Wade.

## JOINT VA AND DOD NATIONAL PHARMACEUTICAL CONTRACTS AS OF APRIL 2000

Product	Class (use)	Manufacturer	Award date	Contracting agency
<b>Anti-infective agents</b>				
Trimox® (amoxicillin)	Penicillins (antibiotic)	Apothecon	July 6, 1999	VA
Amantadine	Antivirals (influenza)	Invmad, Inc.	August 8, 1999	VA
<b>Autonomic drugs</b>				
Albuterol inhaler	Inhaled bronchodilators (asthma)	Warrick Pharmaceuticals	October 2, 1998	DOD
Habitrol® (nicotine patch)	Miscellaneous autonomic (smoking cessation)	Novartis	April 20, 2000	DOD
<b>Cardiovascular drugs</b>				
Tiazac® (diltiazem)	Calcium channel blockers (high blood pressure)	Forrest Labs	November 12, 1998	VA
Verapamil	Calcium channel blockers (high blood pressure)	Zenith/Goldline	December 1, 1999	VA
Capoten® (captopril)	ACE inhibitors (high blood pressure)	Bristol-Myers Squibb, Apothecon	September 1, 1999	VA
Gemfibrozil	Antilipemics (cholesterol reducer)	Warner Chilcott	December 8, 1999	VA
Prazosin	Hypotensive agents (high blood pressure)	Zenith/Goldline	October 7, 1998	VA
<b>Central nervous system agents</b>				
Salsalate	Nonsteroidal anti-inflammatory agents (arthritis)	Able	February 1, 2000	VA
Nortriptyline	Antidepressants	Teva Pharmaceuticals	August 31, 1999	VA
<b>Eye, ear, nose, and throat (EENT) preparations</b>				
Timoptic® (timolol ophthalmic solution)	Miscellaneous EENT (anti-glaucoma)	Alcon Laboratories	November 26, 1999	VA
Timoptic-XE® (timolol ophthalmic gel)	Miscellaneous EENT (anti-glaucoma)	Merck & Co.	November 26, 1999	VA
Levobunolol	Miscellaneous EENT (anti-glaucoma)	Bausch & Lomb	November 26, 1999	VA
<b>Gastrointestinal agents</b>				
Cimetidine	Miscellaneous (H2 receptor antagonists) (ulcers, esophageal reflux)	Sidnak Labs	October 2, 1998	VA
Ranitidine	Miscellaneous (H2 receptor antagonists) (ulcers, esophageal reflux)	Geneva Pharmaceuticals	October 2, 1998	VA
<b>Hormones and synthetic substitutes</b>				
Novolin® (human insulin)	Antidiabetic agents (insulin)	Novo Nordisk Pharmaceuticals	October 1, 1999	DOD
<b>Skin and mucous membrane agents</b>				
Fluocinonide	Anti-inflammatory agents (topical)	Teva Pharmaceuticals	August 3, 1999	VA

APPENDIX I

APPENDIX I

Product	Class (use)	Manufacturer	Award date	Contracting agency
	corticosteroid)			

Sources: VA and DOD.

**PROPOSED HIGH-DOLLAR DRUG CLASSES FOR JOINT VA-DOD NATIONAL CONTRACTING**

The table below lists the high-dollar classes that could be candidates for VA and DOD joint drug class reviews and committed-use contracting. Based on the judgments of our consultant and other private sector pharmacists, the drugs in the different classes have varying degrees of clinical acceptance on therapeutic interchangeability and different priorities with respect to additional VA and DOD joint contracting.

Class	Selected brand-name products	VA and DOD pharmacy prime vendor purchases (1990)	Suggested priority, joint contracting	Current status of all brand-name and generic drug contracts (April 2000)
<b>Antihistamine drugs (\$48.0)*</b>				
Antihistamines (Particularly non-sedating.)	Allergon® Claritin®	\$48.0	First	VA - promethazine
<b>Anti-infective agents (\$223.5)*</b>				
Antifungals (Particularly agents used for fungal infections of the respiratory.)	Lamisil® Sporonox®	\$59.4	First	FSS or DAFA prices only
Cephalosporins (Particularly oral.)	Ceftin® Ceftin® Cedex® Lorabid® Omnicid® Spectrace®	\$18.7	Second	VA - Zolice® Injection VA - cephalexin VA - ceftriaxone
Penicillins	Augmentin® Unasyn® Zosyn®	\$28.7	Third	VA - Penicillin V-K® VA - dicloxacillin Joliet - Trimox®
Macrolides (Particularly newer, parent agents.)	Blisox® Ergonomax®	\$19.0	Second	FSS or DAFA prices only
Quinolones	Avelox® Cipro® Floxin® Levaquin® Tymoxin®	\$29.5	Third	FSS or DAFA prices only
Antivirals (herpes virus) (Particularly generics or generic prices on Valtrex®, branded generic of acyclovir.)	Valtrex® Zovirax®	\$4.7	Second	Joint contract pending - acyclovir
Antivirals (AIDS virus)	Combivir® Crixivan® Epivir® Raltivir® Viracept®	\$22.7	Closely monitor	FSS or DAFA prices only
<b>Antineoplastic (cancer) agents (\$88.2)*</b>				
Antineoplastics (prostate cancer)	Lapron® Zoladex®	\$32.5	Third	VA-Zoladex®
Antineoplastics (other cancers) (Particularly Capecitabine® versus Eloxatin®. As the science of antineoplastics changes, new contracting opportunities may arise.)	Capecitabine® Eloxatin® Nolvaday® Tamoxifen® Tumol®	\$55.7	Closely monitor	FSS or DAFA prices only
<b>Autonomic (regulates autonomous nervous system) drugs (\$97.3)*</b>				
Antiparkinson drugs	Mirapex® Risperid®	\$14.4	Closely monitor	VA - Trihexyphenidyl-30 VA - bismotropine mesylate VA - carbidopa/ Levodopa
Antimuscarinics (Inhaled drugs for asthma and related diseases) (Particularly generic versions of Atrovent®.)	Atrovent® Combivent®	\$38.4	Third	FSS or DAFA prices only

## APPENDIX II

## APPENDIX II

Class	Selected brand-name products	VA and DOD pharmacy prime vendor purchases (1999)	Suggested priority, joint contracting	Current status of all brand-name and generic drug contracts (April 2000)
Sympathomimetic adrenergic agents  (beta agonist inhalers used to treat asthma)	Provent® Ventolin® Xopenex®	\$34.4	First	Joint - albuterol inhaler
<b>Blood formation and coagulation (\$99.2)*</b>				
Anticoagulants (to prevent clotting)  (Particularly generic warfarin (Coumadin®) and also heparin/low molecular weight heparins.)	Coumadin® Flavix®  Lovenox® (heparin)	\$60.5	Second	PSS or DAPA prices only
Hematopoietic agents (blood building for AIDS, chemotherapy, kidney dialysis)	Epreo® Procrit®	\$48.7	Second	PSS or DAPA prices only
<b>Cardiovascular drugs (\$421.7)*</b>				
Antiarrhythmics	Cardorone® Pacerone® Rhythmol®	\$15.4	Closely monitor	Joint contract pending - amiodarone
ACE inhibitors and ACE IIs (to treat high blood pressure)	Accupril® Lotensin® Monopril® Prinivil® Vasotec® Zestril®  Atacand® Avapro® Cosart® Diovan® Hyssar® Micardis®	\$69.8	First	Joint - Capoten® VA - Monopril® VA - Prinivil® DOD - Zestril®
Beta blockers (to treat high blood pressure, migraines, arrhythmias, etc.)  (Particularly widely available generics.)	Coreg® NORMODYNE®	\$20.4	Second	VA - atenolol VA - metoprolol VA - pindolol
Calcium channel blockers (to treat high blood pressure)	Cardene® Diltac® Norvasc® Plendil® Tiasac® (diltiazem)  Adalat CC® Procardia-XL®	\$120.3	First	Joint - Tiasac® Joint - verapamil VA - Adalat CC® VA - diltiazem VA - nifedipine
Antilipemic drugs (to lower cholesterol)  (Particularly HMG-CoA reductase inhibitors)	Baycol® Lescol® Lipitor® Mevacor® Pravachol® Zocor®	\$196.7	First	DOD - Baycol DOD - Zocor VA - Mevacor VA - Zocor
<b>Central nervous system agents (\$447.5)*</b>				
Nonsteroidal anti-inflammatory agents (NSAIDs)  (used to treat arthritis, relieve pain)  (Particularly newer COXII agents and continue joint contracting on older NSAIDs.)	Celebrex® Vioxx®	\$33.1	Second	Joint - salicylate  Joint contract pending - tolmetin  Joint contract pending - naproxen  VA - Ibuprofen VA - Indomethacin VA - naproxen VA - sulindac
Opiate agonists (painkillers)	Duragesic® Oxycontin®	\$30.2	Third	PSS or DAPA prices only

## APPENDIX II

## APPENDIX II

Class	Selected brand-name products	VA and DOD pharmacy prime vendor purchases (1999)	Suggested priority, joint contracting	Current status of all brand-name and generic drug contracts (April 2000)
Anticonvulsants (used to treat a variety of convulsive disorders, such as epilepsy, also pain, migraines, and attention deficit disorder)	Divalproe® Dilantin® Ekonopto® Lamictal® Neurolog® Progabate®	\$72.5	Closely monitor	FBI or DAPA prices only
Antidepressants (Particularly selective serotonin reuptake inhibitors and combine joint contracting on generics.)	Celeza® Effexor® Laroxyl® Paxil® Pzac® Remeron® Zoloft®	\$185.3	Second	Joint - nortriptyline VA - amitriptyline VA - amitriptyline/ Perphenazine VA - amitriptyline VA - imipramine VA - imipramine VA - imipramine
Antipsychotic agents (used to treat schizophrenia and other psychiatric disorders)	Risperdal® Seroquel® Zyprexa®	\$97.7	Third	VA - chlorpromazine VA - haloperidol VA - thioridazine VA - perphenazine VA - thioridazine VA - trifluoperazine
Barbiturates (sedative and other anti-anxiety agents)	Ambien® Buflor® Xanax®	\$37.3	Third	VA - Secobarbital
Migraine drugs (Particularly the generally newer anti-nausea agents.)	Ameg® Ibuprofen® Migranal® Zenice®	\$15.3	Second	FBI or DAPA prices only
<b>Diagnostic agents (\$40.3)*</b>				
Diabetes (used to test blood glucose levels)	Accu-Check® Advantage® One Touch® Precision Q1-D®	\$40.2	Second	FBI or DAPA prices only
<b>Gastrointestinal (GI) drugs (\$197.9)*</b>				
Miscellaneous GI drugs (for ulcers, esophageal reflux)  (Particularly proton pump inhibitors and combine joint contracting of generic H2 receptor antagonists.)	Aciphex® Prelisac® Prevacid® Protonix®	\$197.3	First	Joint - cimetidine Joint - ranitidine  VA - Prevacid® VA - metoclopramide  DOD - Prelisac®
<b>Hormones and synthetic substitutes (\$142.1)*</b>				
Bronchial steroids (for asthma)	Aerobid® Amaxcor® Becloven® Flovent® Pulmicort® Vancor®	\$19.3	First	FBI or DAPA prices only
Nasal steroids (for allergies, sinus congestion)	Becortone® Flonase® Mometas® Nasonex® Vancenase®	\$18.0	Second	VA - Vancenase®
Oral contraceptives (birth control)	Desogen® Lo-Ovral® Ortho-Cept® Ortho-Cycle® Ortho-Novum® Norgayl®	\$16.2	Second	FBI or DAPA prices only
Estrogens (osteoporosis prevention, menopause symptoms)  (Particularly patches and oral agents.)	Climacore® Vivelle®  BimTab® Premarin® Prempo®	\$16.0	Third	Joint contract pending
Antibiotic agents  (Particularly newer agents for non-insulin dependent diabetes in the fast evolving "diabetes" market.)	Actos® Avandia®	\$74.1	First	VA - glyburide
<b>Serums, toxoids, vaccines (\$42.6)*</b>				

## APPENDIX II

## APPENDIX II

Class	Selected brand-name products	VA and DOD pharmacy prime vendor purchases (1999)	Suggested priority, joint contracting	Current status of all brand-name and generic drug contracts (April 2000)
Vaccines (Several companies make the bulk of these products, with significant overlap. Several such products could be consolidated for contracting.) purposes)	Diphtheria/pertussis/ Tetanus Hemophilus B Hepatitis A Hepatitis B Influenza Measles/mumps/ Rubella Pneumococcal Tetanus Varicella	\$42.6	3*	DOD - Vaxqa® (for hepatitis A)
<b>Unclassified therapeutic agents (\$28.5)*</b>				
Immunosuppressives (antirejection drugs used for transplant patients)	Cellcept® Prograf® Neoral® Sandimmune®	\$28.5	Closely monitor	FIS or DAPA prices only

\* All dollars in millions.

Source: GAO analysis of VA and DOD information.

After performing drug class reviews to determine that some brand-name drugs in a class are therapeutically interchangeable, VA can use its national formulary and DOD its basic core formulary policies to encourage use of the drugs. This enables them to obtain better prices for the drugs through competitive bidding aimed at closing—or partially closing—a class to contracted drugs only. The closed class—or its particular segment that is partially closed—usually contains brand name drugs that have a high volume of use or are high cost. To close a class, VA and DOD evaluate the clinical evidence to determine whether a class' brand-name drugs are basically equivalent in terms of efficacy, safety, and outcomes and thus generally have the same therapeutic effect. Once VA and DOD decide to close a class, the drugs determined to be therapeutically interchangeable are referred for contracting purposes to either the National Acquisition Center or the Defense Supply Center Philadelphia. Also, VA and DOD may solicit separate national committed-use contracts to get lower prices on generic drugs, but in those cases drug class reviews are not needed since the competing products are chemically and therapeutically alike.

(101630)

Hold for Release  
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Expected 10:00 a.m.  
May 25, 2000

Statement by

**Robert J. Lieberman**  
Assistant Inspector General for Auditing  
Department of Defense



before the

**Subcommittee on Oversight and Investigations**  
**House Committee on Veterans' Affairs**

on

**Procuring Pharmaceuticals for the**  
**Department of Defense**

**May 25, 2000**

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to be here this morning to discuss the views of the Office of the Inspector General, Department of Defense, regarding the procurement of pharmaceutical products by the Departments of Defense and Veterans Affairs.

The Defense Logistics Agency supports the Military Departments with medical items through its subordinate agency, the Defense Supply Center Philadelphia. The Supply Center purchases items for either direct delivery to the customer or delivery to a Defense depot for storage until they are needed. The Defense Logistics Agency recovers administrative and overhead costs by charging customers a surcharge on each item. Although military treatment facilities also purchase some items on local contracts or by using credit cards for small purchases, the bulk of the Defense procurement activity for pharmaceuticals is by the Defense Supply Center Philadelphia.

Review of Medical Items

In June 1998, we issued an audit report<sup>1</sup> that addressed purchases of medical items by the Defense Logistics Agency and Department of Veterans Affairs. The intent of our review was to look at the extent of medical items available through the Department of Veterans Affairs that were also managed and purchased by the Defense Logistics Agency. For this hearing, I will focus on the audit results related to pharmaceuticals. The following Table shows the scope and complexity of Defense Logistics Agency and Department of Veterans Affairs pharmaceutical procurement activity in FY 1997, when the audit was performed.

	<u>Defense Logistics Agency</u>	<u>Department of Veterans Affairs</u>
Expenditures	\$751 M	\$1,696 M
Line Items Acquired	25,102	21,666

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<sup>1</sup> 98-154, Acquisition of Medical Items, June 15, 1998. The report is available at [www.dodig.osd.mil](http://www.dodig.osd.mil).

During that timeframe, the Defense Logistics Agency had 106 personnel slots dedicated to pharmaceuticals acquisition and 65 to medical readiness item management, including both pharmaceuticals and other medical items.

We found extensive overlap between the Defense and Veterans Affairs purchasing programs. By matching National Drug Codes, we identified 15,727 pharmaceutical products being purchased by both organizations. There were thousands of other items, such as cremes, without a National Drug Code, so the duplication was likely much greater. Let me emphasize that I am referring to duplication in the sense of buying the same types of products, not making multiple procurements of the same items to fill the same customer orders.

We performed a price comparison for 200 pharmaceuticals purchased by both Departments. Our comparison showed that the Department of Veterans Affairs price was lower for 165 of 200 items (83 percent). For 123 of the 165 items, however, the price differences were less than 1 percent.

We also determined that the Defense Logistics Agency and Department of Veterans Affairs used very similar acquisition strategies. They both contracted with prime vendors for direct delivery to users, who placed their own orders and usually received next day delivery. The use of prime vendors and direct vendor delivery are considered best commercial practices and the Defense Logistics Agency pharmaceutical program was one of the first and most successful DoD applications of those practices. The use of prime vendors and direct vendor delivery means that the traditional logistics functions of centrally processing requisitions and maintaining stock on-hand in depots are usually no longer performed. The Defense Logistics Agency and the Department of Veterans Affairs essentially provided only a contracting role. In this role, we could discern no major difference between services provided to medical treatment facility customers by the Defense Logistics Agency and the Department of Veterans Affairs.

#### Industry Perspective

Most manufacturers and prime vendors viewed dual acquisition of medical items by the two Departments as inefficient. In response to our questionnaires, 11 of 15 manufacturers stated they

incurred additional administrative expenses dealing with multiple Government agencies. We also discussed the issue of dual procurements by the two Departments with the Health Industry Distributors Association and six prime vendor representatives. All were consistent in their criticism of dual acquisition of medical items, which also caused the distributors to incur additional administrative expense from bidding multiple contracts and maintaining separate records for both Departments.

#### Customer Perspective

We discussed the issue of purchasing pharmaceuticals with nine military treatment facilities. To obtain pharmaceuticals, six facilities used Defense Logistics Agency prime vendor contracts and three facilities used Department of Veterans Affairs prime vendor contracts. The prime vendors supplied 81 to 92 percent of the facilities' pharmaceuticals. The facilities expressed preferences for certain aspects of both Defense Logistics Agency and Department of Veterans Affairs contracting services. Their decisions to choose either a Defense Logistics Agency or Department of Veterans Affairs prime vendor contract were based more on precedent than on the result of in-depth evaluation.

Benefits of Separate Planning and Purchasing

Defense Logistics Agency officials asserted the need to retain their medical item acquisition capability by pointing to the requirements for performing a readiness function, providing better customer support, and using improved business practices.

The Military Departments have estimated that about 4 percent of medical items are critical and require special planning for military contingencies. A Defense Logistics Agency readiness group identifies special provisions needed for those critical items and the contracting group negotiates surge options with prime vendors or, in some instances, buys items for storage. This same group that identifies readiness provisions for operationally critical items could also furnish them to the Department of Veterans Affairs for negotiating surge requirements in contracts and purchasing items for storage.

We see no reason why Defense should not be able to rely on Veterans Affairs to provide responsive contract management support for contingency situations. The Army stated that Veterans Affairs successfully supported the deployment of Fort

Hood units to Kuwait in 1996 by exercising surge options in a prime vendor contract for pharmaceuticals.

We also concluded that the Department of Veterans Affairs and Defense Logistics Agency provided essentially the same level of customer support and used the same commercial-type business practices.

#### Benefits of Combined Purchasing

Although we agree that the Defense Logistics Agency should retain responsibility for determining military readiness provisions for critical pharmaceuticals, a strong case can be made for merging the Defense and Veterans Affairs purchasing activities. Benefits would include the following:

First, the Government would present one face to suppliers and cut the suppliers' administrative costs, enabling those savings to be reflected in prices.

Second, the Government would be able to cut its own administrative costs.

Third, the Government's negotiating leverage in the marketplace could be improved.

Fourth, Defense customers might get additional price breaks because of a lower Veterans Affairs surcharge.

Fifth, the Defense Logistics Agency could realign its resources to help compensate for major staffing reductions in other areas.

#### Response to Report

Our June 1998 report recommended that the Department of Defense transfer acquisition responsibility for medical items to the Department of Veterans Affairs except for militarily unique medical items. The Department of Defense responded that it partially agreed and would form a team to work with the Department of Veterans Affairs to expand cooperation, especially in terms of achieving one face to industry on pricing issues. Subsequently, a June 29, 1999, Memorandum of Agreement was signed between the Departments and we accepted its terms as being generally responsive to the audit finding.

The agreement allows each Department to continue contracting for pharmaceuticals, but requires a sharing of pricing information on contracts, migrates Defense medical facilities using Department of Veterans Affairs prime vendor contracts to Defense prime vendor contracts and prohibits each agency from marketing their prime vendor contracts to the other Department's medical facilities. Defense agreed to incorporate Department of Veterans Affairs pharmaceutical contract prices into its Defense Electronic Catalogs. Further, the Joint Federal Pharmacy Executive Steering Committee will identify requirements and negotiate committed use contracts for the use of both Departments. The intent is to establish one face to industry on pricing issues and expand joint contracting. We were informed on March 3, 2000, that the Defense Logistics Agency expects annual savings of \$50 million from the initiatives, with additional savings for the Department of Veterans Affairs. We have not reviewed the implementation of the Memorandum of Agreement and the joint initiatives or the savings estimate.

#### Conclusion

The overall DoD acquisition workforce has been cut in half over the past several years, with no proportionate decrease in

workload. The Defense Logistics Agency should not retain any more pharmaceutical procurement workload than absolutely necessary to handle unique DoD management problems that the Department of Veterans Affairs lacks the resources and expertise to handle. In our view, such unique requirements are minimal and we remain hopeful that Defense will gradually shift routine procurement workload to Veterans Affairs. The main opportunity for cost reduction, however, lies in achieving the best possible prices. We are encouraged by reports of progress in that regard. The ongoing effort to implement the 1999 Memorandum of Agreement should be monitored to ensure that both sides are genuinely committed to minimizing duplication, enhancing the Government's best interest, and reducing customer costs. Thank you for your interest in my office's views on this matter.

**STATEMENT OF  
THE HONORABLE GARY J. KRUMP  
DEPUTY ASSISTANT SECRETARY  
FOR ACQUISITION AND MATERIEL MANAGEMENT  
DEPARTMENT OF VETERANS AFFAIRS  
ON VA/DoD JOINT PHARMACY PROCUREMENT  
BEFORE THE  
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES  
May 25, 2000**

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Mr. Chairman and Members of the Subcommittee,

I am pleased to be here today to discuss the implementation of the Memorandum of Agreement (MOA) between the Department of Veterans Affairs (VA) and the Department of Defense (DoD) for the procurement of health care related commodities. I am accompanied today by John Ogden, Chief Consultant, Veterans Health Administration Pharmacy Benefits Management Strategic Healthcare Group (PBM/SHG); David Derr, Associate Deputy Assistant Secretary for Acquisitions; and Steven Thomas, Director, National Contract Service, whose programmatic responsibilities include VA's administration of the MOA.

VA fully supports joint Federal health care acquisition activities as a means to improve the quality and efficiency of services provided to Federal beneficiaries and to reduce costs to the taxpayer. The DoD is our single largest sharing partner. We welcome opportunities to extend VA's excellent health care commodity pricing, especially in pharmaceuticals, to the DoD, and to reduce unnecessary administrative overhead related to contracting activities.

**Background**

VA is delegated by the General Services Administration (GSA) the responsibility to establish and administer the Federal Supply Schedule (FSS) contracts for health care related commodities for the Federal Government. The FSS Program is a multiple award schedule (MAS), with indefinite delivery-indefinite quantity (IDIQ) type contracts, which are national in scope and available for use to all Federal Agencies. Prices are negotiated with the goal of obtaining equal to or better than Most Favored Commercial Customer (MFC) prices. The established relationship is ensured for the life of the multiyear contract based on commercial market pricing trends. When using an FSS Schedule, the customer evaluates price lists and identifies the contractors that appear to offer the best overall value.

VA also administers Section 603 of the Veterans Health Care Act of 1992, which prescribes Master Agreements and Pharmaceutical Pricing Agreements

with manufacturers that set Federal Ceiling Prices (FCP) for the four major Federal Agencies that procure pharmaceuticals (VA, DoD, portions of the Department of Health and Human Services, and the Coast Guard). Section 603 requires that the price of a "covered drug" not be more than 76 percent of the Non-Federal Average Manufacturer Price (Non-FAMP), and in some instances, VA obtains pricing lower than 76 percent of Non-FAMP. Covered drugs include single source drugs; innovator multiple source drugs and biological products (e.g., vaccines).

The VA Office of Acquisition and Materiel Management (OA&MM) has been working with VA's PBM/SHG since 1995 to consolidate pharmaceutical requirements into separate, competed national contracts. VA estimates its cumulative savings in pharmaceutical expenditures to total \$654 million since 1996, solely through the use of its national contracts.

The Defense Supply Center – Philadelphia (DSC-P), as part of the Defense Logistics Agency (DLA), procures medical supplies and equipment for the DoD. It also establishes distribution networks. DSC-P enters into Distribution and Pricing Agreements (DAPA) with manufacturers and distributors. These DAPAs are utilized as multi-source purchasing vehicles for DoD customers. For pharmaceuticals, the DAPA price is usually the statutory Section 603 price or the negotiated MFC price borrowed from the manufacturer's FSS contract.

The Congressional Commission on Servicemembers and Veterans Transition Assistance (Transition Commission) Report recommended that Congress enact legislation to require "DoD and VA to establish a joint DoD/VA procurement office to purchase, in the most cost-effective manner possible, VA/DoD pharmaceuticals, as well as medical/surgical supplies and equipment." That report provided additional impetus to DoD's and VA's efforts to finalize the MOA which is designed to combine the purchasing power of the two Departments and eliminate redundancies. The MOA has two appendices—one dealing with pharmaceuticals, the second encompassing medical and surgical supplies. A third appendix, dealing with high-tech medical equipment, is under consideration.

The MOA has two main emphases pertaining to the pharmaceutical appendix, which is the focus of this testimony: (1) joint national procurement contracting; and (2) DAPA conversion to FSS. In accordance with the MOA, DAPAs are to be cancelled and FSS pharmaceutical contracts are to be used by DoD medical activities whenever the FSS price is equal to or less than the DAPA price. Savings from these efforts help both Departments reduce health care costs.

#### Joint National Contracting

Joint contracting efforts pre-date the signing of the MOA. Since October 1998, VA and DoD have awarded eighteen joint national contracts. Through joint committed use volume contracts, VA and DoD have realized over \$29 million in annual savings.

The Federal Pharmacy Executive Steering Committee (FPESC), made up of VA and DoD leadership, created a subgroup composed of representatives from VA's National Acquisition Center (NAC), Veterans Health Administration's PBM/SHG, DoD's Pharmacoeconomic Center (PEC) and DSC-P. This subgroup meets quarterly to discuss future joint contracting activities. A running issues list currently identifies 40 future contracting initiatives, other witnesses will provide additional details about these joint contracting opportunities.

#### DAPA Conversion

DAPA cancellation is to occur upon completion of successful negotiations of an FSS contract for a given item. The subsequent conversion to FSS contracts is critical because it combines identical medical related items, leverages volume to enhance our ability to negotiate better prices, eliminates duplication of contracting efforts, and broadens the product availability for both VA and DoD, while allowing the customer to select the product and pricing that best meets their needs. VA NAC and DSC-P staff agreed to work on existing FSS contracts with pharmaceuticals first. Pharmaceuticals were selected because of advanced data management capabilities and National Drug Codes (NDCs), which ease comparisons of drugs and pricing.

The procedure for converting DAPAs begins by VA contracting staff receiving DAPA pricing data from DSC-P. The difference between DAPA and VA FSS prices is usually the .5% cost recovery fee that is added onto raw FSS prices. Pursuant to GSA's policy that FSS contracting be paid for through an industrial funding fee (IFF), VA adopted the fee at the level of .5% for the schedules it manages. (DSC-P places its cost recovery fee on the ultimate delivery invoices submitted by its pharmaceutical prime vendors.) VA staff then contacts contractors to inform them of the conversion process and begin negotiations to reduce their FSS prices by at least the amount of the .5 percent fee, so that DAPA and FSS prices become equal. VA staff electronically communicates the items and new pricing to DSC-P. DSC-P staff downloads the data into its DAPA Management System (DMS) and then cancels the DAPA.

As of May 8, 2000, VA has contacted all of its 255 contract holders. As a result of these VA contacts, 112 successful negotiations have been accomplished; 82 negotiations are pending and 61 contractors indicated an unwillingness to convert at this time. VA and DoD are in the process of again contacting these 61 contractors to encourage participation. During the same time period, DoD has placed into its DMS 82 conversions, and cancelled 43

DAPAs. Where DAPA items do not currently appear on FSS contracts, VA NAC staff will now begin contacting those vendors as well.

**Challenges and Efforts to implement the MOA**

The joint procurement process is progressing smoothly with demonstrable results. The DAPA conversion process, however, has been more challenging. Most significantly, the inability to electronically interface VA and DoD's data systems has hindered the process.

We are currently working with the DoD to resolve problems that arose in Fiscal Year 1999 due to these diverging business practices. VA and DoD have just agreed to establish an Information Technology (IT)/Business Process Group to improve the data systems interface. Weekly conference calls take place to support communications between VA and DoD. Standing reports and formal notes of each call are forwarded to stakeholders including the Government Accounting Office (GAO).

**Summary**

VA is confident that, with DoD's cooperation and resolution of current challenges, a longstanding and beneficial relationship can evolve for the benefit of both the taxpayers and the patients that we serve.

VA remains committed to increasing joint Federal health care acquisition activities. We stand prepared to extend our expertise and further realize economies of scale by applying the Transition Commission's Report recommendations to the procurement of medical/surgical supplies and equipment.

This concludes my statement. I will be pleased to answer any questions members of the Subcommittee may have.

Statement of  
John E. Ogden, M.S.  
Chief Consultant for Pharmacy Benefits Management  
Department of Veterans Affairs

**VA'S CONSOLIDATED MAIL OUTPATIENT PHARMACY PROGRAM**

Before the  
Subcommittee on Oversight and Investigations  
Committee on Veterans Affairs  
U.S. House of Representatives

May 25, 2000

Mr. Chairman and members of the Subcommittee,

I am pleased to be here this morning to discuss a wonderful success story...the Veterans Health Administration's (VHA) Consolidated Mail Outpatient Pharmacy Program (CMOP). I've also included information for the record that augments the testimony of the Honorable Gary Krump regarding joint contracting efforts for pharmaceuticals between the Department of Veterans Affairs (VA) and the Department of Defense.

**THE CMOP STORY**

For over four decades VA has provided mail prescription services to veterans as an adjunct to its health benefit. During the 1970s and 1980s, consolidation of mail prescription workloads from multiple VA medical centers into centralized operations was initiated on a limited basis. In 1994, the Consolidated Mail Outpatient Pharmacy (CMOP) at Leavenworth, Kansas began processing high volume mail prescription workloads using an integrated, automated dispensing system. Since that time, VA has expanded the program to include a total of seven (7) CMOPs located in Leavenworth, KS; West Los Angeles, CA; Bedford (Boston), MA;

Dallas, TX; Murfreesboro (Nashville), TN; Hines (Chicago), IL; and Charleston, SC. In Fiscal Year 1999, those facilities processed workloads exceeding 40 million prescriptions; they are on track to process 50 million prescriptions in Fiscal Year 2000.

#### HOW DO CMOPs OPERATE?

Patients are provided care by the VA medical centers or clinics with new or emergent prescriptions being dispensed directly from that medical center or clinic. Refill prescription requests or continuation of therapy prescription requests are received and processed at the individual VA sites on a daily basis. Once processed, the data are uploaded from multiple VA health care facilities to a CMOP for processing. CMOP dispenses the pharmaceuticals or products as determined by the participating site, delivers the completed prescriptions directly to the patient by mail and returns the dispensing data to the participating medical center or clinic electronically. Patients contact the medical center or clinic directly if there are any questions or problems, which are resolved by the participating site in coordination with the CMOP. Therefore, the VA model takes full advantage of economies of scale for mail prescription processing and distribution, while at the same time preserving the essential patient-provider relationship.

The CMOP program serves each participating VA medical center or outpatient clinic as an integrated extension of each of those sites and has been a vehicle of change in the standardization of drug nomenclature, the standardization of dispensing units, and the standardization of pharmaceutical and medical supply product selection. Staffing at the CMOP is at levels between 50,000 to 100,000 prescriptions per year per full-time employee equivalents (FTEE) which is several times more productive than traditional manual systems. The normal processing time for an order at the CMOP is less than 2 days with actual delivery time via the mail to the patient averaging 3 days, including Sundays.

#### CMOP Cost(s)

In Fiscal Year 2000 to date, the average non-drug CMOP cost aggregated across the seven CMOPs is \$2.00 per prescription and the drug or product cost is \$20.33 per prescription across the program. The non-drug cost includes \$0.77/Rx in personal services costs, \$0.40/Rx in operating costs and \$0.83/Rx in mailing costs, but does not include depreciation of equipment

nor cost of administrative oversight (VACO/VA organization). As indicated earlier, the estimated prescription workload that will be processed this year is 50,000,000 prescriptions. This translates into roughly \$1.0 billion in drugs and medical products and \$100 million in non-drug expenses. Through achievement of economies of scale and continuing improvements in technology, personal service costs and operating costs have decreased over time.

#### CMOP QUALITY

The CMOP program is strongly vested in quality and has extensive quality assurance and performance improvement measures in place. The automation of the dispensing process changed how we do business and instead of the classic one or two checks historically associated with prescription dispensing, the automated dispensing process has numerous checks with the newest system having no less than seven checks or validations during the dispensing process. As a result, there has been a ten-fold reduction in error rates. This fact was underscored by comments by JCAHO reviewers familiar with error rates at other mail prescription and healthcare facilities. The primary problems today are 1.) delays in the mails and 2.) damage during shipment to the patient. I am pleased to say that progress has been made in reducing these problem issues. The program has an overall accuracy or problem-free rate above 99.99%, which is remarkable considering all the complexities, and logistical issues that occur on a daily basis.

From day one of the initiative, VHA officials planned for the CMOP program to serve as a center of excellence in quality pharmacy practice. One of the most important goals of the CMOP program is the emphasis on delivering timely service of the highest possible quality. We not only stated our commitment to quality we delivered it through outcomes. As described above, the CMOP program operates with extensive quality assurance activities and continuous monitoring concerning the use of automation and bar-code technology. For example, first quarter Fiscal Year 2000 Quality Assurance reports documented an average rate of error (i.e. wrong product dispensed to patient) of 0.0013% or 1 per 76,466 prescriptions. The average rate of errors per package sent (i.e. product received by wrong patient) was 0.0027% or 1 per 60,618 outpatient prescriptions. No system is error free and to put these numbers in context, the professional literature cites medication error rates from 1 to 20%. The CMOP program is well below the lowest reported error rate due to the use of automated systems supported by bar code technology. In addition, the CMOPs are fully accredited by the Joint Commission on the

Accreditation of Health Care Organizations. Most of the CMOPs were accredited with commendation.

In another quality action, VHA partnered with the National Industries for the Blind to develop a "clear" prescription vial for use in the CMOP program that meets FDA/USP ultraviolet light reflection standards. The partnership produced a vial that enhances patient safety during the checking process and employee safety through reduction of the occurrence of carpal tunnel syndrome.

#### CMOP CAPACITY

Today, the total estimated annual capacity of the seven operating CMOPs is roughly 55 million prescriptions, while actual processing workloads are approaching 50 million prescriptions. Therefore, the overall program has capacity of roughly 5 million prescriptions in reserve which may sound sufficient until you realize that if one of the newer CMOPs, such as Murfreesboro, experiences downtime for whatever reason (i.e. fire, tornado, earthquake, hurricane, etc), only half of the 10 million Rx workloads at Murfreesboro could be processed by the combined remaining CMOP capacity. Redundancy and sufficient reserve capacity to respond to disaster or emergent circumstances is essential in assuring uninterrupted provision of care to our patients. While disaster planning is an integral part of the CMOP program, it is easy to assume that the plans will never be needed. However, emergent situations occurred at no less than five (5) CMOPs during the past fiscal year, which resulted in the temporary transfer of workload to alternate CMOP locations due to circumstances that included: 1.) electrical fire; 2.) hurricane evacuation; 3.) Y2K upgrades; and 4.) new system activation. The net result on patients was basically "no impact" and for most patients they did not even notice their prescriptions were processed at another CMOP site. Our point here is that total capacity of the CMOP program should never be less than 20% above actual workload or the reserve capacity above daily workloads should at least be equal to the workloads associated with the largest volume CMOP facility. Using this assumption, the CMOP program of today has only half of the necessary reserve capacity needed. It should also be noted that the workloads processed by the CMOP program have increased by 9 million prescriptions per year since 1997 with 23 million Rx in 97, 30 million Rx in 98, 40 million Rx in 99 and an estimated 50 million this year.

**CMOP PLANS FOR THE FUTURE**

The CMOP program has developed plans to meet current and future VA prescription workloads. The CMOP model to be emulated by current and future VA facilities includes a total of 75,000 SF and total capacity of 60,000 prescriptions per day operating daily at levels of approximately 80% total capacity or roughly 48,000 prescriptions per day.

**Short-term goals (1 year)** include the enhancement of the newest CMOP operations at Murfreesboro, TN; Hines, IL; Charleston, SC; and Leavenworth, KS to emulate this model. This can be and is being done through expansion of current lease arrangements, software improvements to existing dispensing equipment (estimated cost \$160,000 per site) and the full replacement of the Leavenworth operation, which is currently undergoing validation and acceptance.

**Medium-term goals (2-3 years)** include the full replacement of the oldest CMOP operations including new construction and new equipment utilizing the Enhanced Lease program at Bedford, MA and Los Angeles, CA plus the full expansion and upgrade of the Dallas, TX operation. The estimated cost of construction of a new 75,000 SF building on VA grounds is \$5.5 million per site; the estimated cost of a new 60,000 Rx/day automated dispensing system is \$6.0 million per system, the approximate cost for inventory is \$5.0 million (5-day supply/50+ turns per year), plus the cost of office furnishing and miscellaneous expenses would be less than \$1.0 million for a total new facility startup cost of \$17.5 million.

**Long-range goals (3-5 years)** include planning for additional CMOP facilities with interest having already been expressed in three areas of the country. A thorough RFP process is planned to determine future CMOP locations to ensure that factors such as cost of living, available workforce, transportation logistics, climate, patient demographics, and others are taken into account in making the best decision on future locations.

**Other planning** includes continued efforts in the standardization and streamlining of the seven individual, very customized CMOP operating facilities into a single organization unit. The continued development of new technologies including the expansion into 2-dimension bar codes that have numerous benefits over current barcode technologies such as also including the lot number and expiration as well as the National Drug Code identifier. In addition, new methodologies of data distribution and transport are being

reviewed for ways to improve workload balancing, potentially provide closest proximity to patient dispensing, dynamic workload shifting, paperless receiving and ordering, direct patient delivery from manufacturer of select products, product accountability through the supply chain, product storage condition monitoring through the supply chain and many other opportunities for improvement.

#### CHAMPVA MEDS-BY-MAIL

The ChampVA Meds-by-Mail program is a partnership between the Leavenworth CMOP, the VA Medical Center in Cheyenne, WY and the ChampVA database in Denver, CO. The partnership provides mail prescriptions to ChampVA beneficiaries across the United States. This relatively small program (80,000 prescriptions annually) produces savings of approximately \$1.6 million per year; it is an example of mutually beneficial partnerships possible within government while providing quality, cost-effective care to eligible beneficiaries. Meds-by-Mail was recently the recipient of the Deputy Secretary's Scissors Award and is an excellent example of possible creative uses and benefits that are possible with the CMOP program.

#### CMOP SUMMARY

In the year 2000, the CMOP program has served and continues to serve as a living lesson in persistence, in patience, in continuous improvement, in teambuilding, in efficiency, in productivity, in partnering, in community involvement, in system planning, in customer satisfaction, in employee involvement, in quality medical care, in value added services, in the continuum of care, and so much more, but ultimately it is an ongoing example of cost-effective government that 'cares'.

This concludes my statement. Please note, attached to this statement is the information for the record regarding the joint contracting for pharmaceuticals between VA and DoD that I mentioned at the beginning of my testimony. I will be happy to respond to any questions the Subcommittee may have.

**FOR THE RECORD: VA & DoD JOINT PHARMACEUTICAL CONTRACTING**

Joint pharmacy procurement is a viable and important program that represents one option that VA has pursued in our efforts to reduce the acquisition costs of pharmaceuticals. Joint procurement has been an active program since the 1970s; however, in recent years VA and DoD have been pursuing expanded opportunities for joint procurement as part of the VA/DoD Executive Council. In 1998, the Executive Council chartered the Federal Pharmacy Executive Steering Committee (FPESC) to further enhance these efforts. FPESC established a working group of staff from the VHA Pharmacy Benefit Management (PBM) Strategic Healthcare Group, the DoD Pharmacoeconomic Center (PEC), the VA National Acquisition Center (NAC) and the DoD Defense Supply Center- Philadelphia (DSCP) to explore opportunities for joint procurement. Since October 1998, eighteen (18) contracts have been awarded with estimated annual savings to VA of approximately \$19 million.

The working group has also identified an additional forty (40) drugs, some of which are already under contract by one or both organizations, as potential candidates for joint procurement. VA spends approximately \$139,722,160\* per year on the forty items. The potential drugs that are actively being considered, include:

Acetaminophen	Ketoconazole Cr
Acyclovir	Low Molecular Weight Heparins
Albuterol IR	Meclizine
Amitriptyline	Methocarbamol
Azathioprine	Naproxen
Bupropion	Nasal Steroids
Buspirone	Non-Sedating Antihistamines
Carbidopa/Levodopa SA	Oral Contraceptives
Carisoprodol	Pentoxifylline
Clozapine	Prednisone
Conjugated Estrogens	Returned Goods
Cyclosporin	Rifampin
Diclofenac	Selegiline
Etodolac	Sotalol
Furosemide	Sucralfate
Glipizide	Sulindac
Hydrochlorothiazide	Terazosin
Hydroxyurea	Ticlopidine
Imipramine HCL	Valproic Acid
Isosorbide	Verapamil IR

\* Estimate only. Depending on the final contracting options selected, some products may be excluded or additional ones may be included.

It is important to note that the above-listed drugs are being considered for joint contracting by two organizations that provide care for distinctively different patient populations and which provide that care through distinctly different delivery systems. For VA, clinical decisions drive the VHA formulary management and contracting processes, with a broad base of VHA healthcare providers actively participating in decision-making regarding which medications must be available throughout the VA healthcare system. Once clinical decisions are made, procurement options are explored. The option selected could include a national contract that puts branded products within the same therapeutic class against one another, blanket purchase agreements, and use of the Federal Supply Schedule (FSS) and/or joint procurement with DoD.

The final contracting option selected can vary greatly across therapeutic classes and while VA has been aggressive and very successful in reducing drug acquisition costs, national contracts and joint procurement are not options that are always selected. I'd like to provide the committee with some examples.

- In some therapeutic classes, VHA has determined that access to most or all of the drugs is clinically required and therefore most or all are listed on the VA national formulary. In this example, from the procurement prospective, there is no opportunity to compete the products amongst themselves. There also is little or no negotiation leverage with manufacturers, as market share cannot be appreciably driven to a specific subset of products, nor can an estimated volume be guaranteed. In these types of classes, VHA has not taken action either individually or jointly with DoD, as to do so would not be clinically appropriate. Examples of these types of classes are AIDS/HIV drugs, chemotherapy drugs, anticonvulsants, and atypical antipsychotics. For those cases, where VHA cannot leverage prices, in no instances does it pay greater than the Federal Ceiling Price, which is already a highly discounted price.
- In some classes, because of the differences in eligibility, and more importantly, because of pharmacy benefit design, VA and DoD have not and cannot always select the same procurement option. As an example, in the therapeutic subclass of antidepressants called selective serotonin reuptake inhibitors (SSRIs), VHA determined that all were clinically necessary and listed all the agents on the VHA national formulary after negotiating modest voluntary price reductions. In contrast, DoD chose to compete the products

against one another and ultimately selected one for the Medical Treatment Facility (MTF) formulary, while making the remaining SSRIs available via their mail prescription service. Hence, if a DoD beneficiary needed an SSRI other than the drug available at the MTF, the beneficiary had the option of utilizing the mail prescription program to obtain the drug. In February 2000, secondary to an infusion of allocated funds, DoD made the decision to add the remaining SSRIs to their MTF formularies.

- VA has awarded several multi-year contracts within a therapeutic class. Typically, for some portion of the VA population, these contracts result in a therapeutic interchange of the patients' medication. In a number of classes, VHA had already converted patients to a nationally contracted drug prior to the time DoD began their contracting actions. VHA officials made an intentional decision not to participate in a joint contract for those classes because of the potential to have to change patients' medications a second time within a relatively short period of time. While therapeutic interchange is an accepted practice within the US health care environment, VHA is sensitive to the impact that therapeutic interchange has on patients and providers. Additional examples of these types of classes include the cholesterol lowering drugs (HMGs), ACEIs for use in blood pressure control and heart failure and Proton Pump Inhibitors (PPIs) for acid suppression.
- Anticipated changes in the market also affect options. As mentioned above, VA had a multi-year award in place for the PPI drugs before DoD initiated their national contracting efforts with this therapeutic class. It is anticipated that a generic version of a branded PPI will be marketed in approximately one year. VA will avoid greater cost by waiting for the generic version to be available than by selecting any other option and cannot endorse a strategy in which potential conversions of patient's medications could occur in a relatively short timeframe. Given the patient and cost considerations described above, our strategy to continue the current contract until a generic product is available is the best course for this class of drugs.

Contracting for pharmaceuticals is a complex endeavor that demands careful planning and execution in order to prevent unintended consequences; it must never be uncoupled from a robust formulary and disease management process. Clinically responsible contracting begins with a thorough analysis of the medical literature by seasoned clinical staff who consider the available information within the framework of the specific clinical needs of the patient

population being treated. To promote high quality clinical care, contracting should be considered as an option to reduce drug acquisition costs only after safety, efficacy and clinical appropriateness have clearly been established.

VHA is regarded by many knowledgeable individuals in the national and international health care arenas as an organization that has been very aggressive and effective in reducing drug acquisition costs, while at the same time promoting high quality medical care. As an example, two countries that have been heralded as world leaders in controlling pharmaceutical expenditures have recently consulted with the PBM and VA's National Acquisition Center to learn how VA has been able to obtain such favorable prices for nationally contracted pharmaceuticals. It is our understanding that VA national contract prices are being considered as one component of the national pharmaceutical index for one of those countries.

In summary, I would like to reiterate that VHA is committed to the joint contracting process with DoD, and together with DoD has made significant progress during the time the joint contracting workgroup has been functioning. VA will continue to seek opportunities to reduce drug acquisition costs through joint contracting whenever and wherever it is clinically responsible to do so.

## STATEMENT OF

**BRIGADIER GENERAL DANIEL G. MONGEON, UNITED STATES ARMY****COMMANDER, DEFENSE SUPPLY CENTER PHILADELPHIA****BEFORE THE****SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS****HOUSE COMMITTEE ON VETERANS' AFFAIRS****MAY 25, 2000**

Good morning Mr. Chairman and distinguished members. I am Brigadier General Daniel G. Mongeon, Commander of the Defense Supply Center Philadelphia. I appreciate the opportunity to appear before this subcommittee to address questions concerning Department of Defense and Department of Veterans Affairs joint pharmacy procurement. I would like to begin with some background information on the Defense Supply Center Philadelphia and our medical materiel mission..

**DSCP and its MEDICAL MATERIEL MISSION**

The Defense Supply Center Philadelphia is one of the Defense Logistics Agency's supply management centers. Our mission is to ensure the combat readiness and sustainment of America's Fighting Forces by providing world class logistical support in peace and war. We also support other federal agencies and some foreign governments. We are the providers of pharmaceuticals and medical supplies, food, general and industrial items, and clothing and textile products. Our mission encompasses support to

the full spectrum of military operations. This support ranges from operations other than war such as disaster relief and humanitarian aid, to support of traditional military endeavors spanning an operational scale from small scale contingencies to major theater war. Most critically, our capabilities must be able to seamlessly transition from every day support requirements to the rapidly escalating dimensions of crisis events. Therefore, we maintain very carefully crafted information and operating systems which form the nucleus of our supply center operation. In effect, a military unit anywhere in the world can launch a supply request which will be electronically transmitted to our center with the resulting issue of materiel from a commercial or industrial supply partner occurring in a fast and precise manner. To further ensure our linkage to the warfighting commands we maintain 33 branch offices spread throughout the United States, Europe and the Pacific. These elements form a forward presence for our Philadelphia based operation and provide on site representation in the computation of requirements and execution of support missions. On an annual basis our supply center manages acquisition and supply distribution transactions, for the commodities I mentioned earlier, totally over \$5 billion. This large volume of daily, ongoing business activity creates a vital leverage in our marketplaces and motivates our commercial and industrial supply partners to support our specially designed contingency response programs. We absolutely believe that this peacetime business in effect "buys" wartime readiness. All of what I have described applies dramatically to our medical materiel mission. As a military supply center we have put in place the intricate information, distribution and readiness management capabilities that provide a simultaneous capability to support the every day requirements of a large, worldwide managed care health system and the medical materiel requirements associated with our Armed Forces' crisis response missions. Strikingly, we have accomplished this capability with an unusually high reliance on America's commercial and industrial medical materiel businesses. The same medical prime vendors and manufacturers that support our every day business are engaged with us in unique materiel readiness programs. Therefore, the same sources, systems, methods and personnel skills drive this complex, two dimensional, supply center capability. The strongest indicators of the effectiveness of our supply center state of operations are the rapidly increasing

total volume of transactions that we are processing, and the changing doctrine and logistics support plans emanating from the Military Services. Medical materiel transactions are particularly increasing at a high rate as DoD medical activities continue to eliminate previous, inefficient local purchase practices in favor of our supply center programs. The Services are also significantly revising their medical materiel sustainment plans, relying increasingly on the contingency materiel programs that we have been able to put in place. The Services gain increased operational flexibility to move medical materiel rapidly to engaged units or geographical hot spots; and achieve dramatic economic advantages caused by preventing the previously experienced loss of materiel due to potency dating or obsolescence. The combined effect of what our center and our suppliers are able to do has pushed us much farther "down" in the supply chain, closer to immediate supply requirements, and establishing a clear necessity that we be ready on day one of an operation to execute our sustainment programs. All of these factors have truly changed the nature of supply operations in today's world of military affairs. We strongly believe that our medical materiel capability is meeting the requirements of the warfighting commanders and fulfilling the Focused Logistics doctrine prescribed in our principal guidepost for the future, the Chairman of the Joint Chiefs' Joint Vision 2010. Furthermore, our business practices have received some strong endorsements to include the GAO's description of our medical materiel business as a model for DoD's shift to commercial practices, and our recent receipt of the President's Award for Quality Improvement, a highly coveted and competitive federal sector recognition sponsored by the Department of Commerce. Today, our medical directorate, working within the context of a DoD supply center operation, is a sophisticated supply chain manager, linking our customer base with their commercial and industrial suppliers; and providing the business intelligence, supply order fulfillment, distribution and readiness management imperative to support the complex array of medical support missions.

#### **JOINT PHARMACY PROCUREMENT**

An important part of our business and readiness strategy is to partner with other government agencies whenever the partnership adds to our operational readiness

capability and makes economic sense for the Department of Defense. In other words, the partnership achieves for us improved readiness at reduced cost. Clearly, pharmaceutical pricing is a part of our overall medical materiel mission that we believe can be enhanced by the right partnership with the Department of Veterans Affairs. Our interagency Memorandum of Agreement with the VA is designed to accomplish our partnership goal. The health care activities of both Departments procure a substantial amount of pharmaceuticals. During our last fiscal year DoD activities procured \$1B of pharmaceuticals, it is the largest part of our medical materiel mission. This year the amount is likely to reach \$1.4B. We believe that smart partnering with the VA is leading to reductions in product prices. In fact, the Federal Pharmacy Executive Steering Committee, consisting of pharmacy management executives from both the DoD and the VA, has been working even before the signing of the MOA on joint procurement objectives and guidelines. The MOA between our Departments further solidifies our partnering relationship. There already have been important results from these efforts. DSCP and the VA have 18 joint pharmaceutical contracts for high demand items. These contracts are expected to yield \$29M in combined cost reductions this year for both agencies. DSCP has 5 other DoD national contracts that will provide us an additional \$54M in cost reductions for DoD during this fiscal year. As these 5 contracts reach their conclusion our requirement will be merged with the VA requirement in order to form additional joint contracts. The DSCP and VA staffs are now working together on 40 additional drug candidates that we will pursue for joint contract award. The cost reduction value from contracts for these additional items will be substantial. In our broader pricing program, 112 of our 255 pharmaceutical Distribution and Pricing Agreements with manufacturers have been identified for conversion to the VA's Federal Supply Schedule. Of these 112 agreements, the conversion process is complete for 82 agreements. There is now one Federal price in effect for these 82 manufacturers. The conversion process for the additional 30 agreements, completing the 112 approved for conversion to date, will be concluded soon. We believe that over the next year a number of manufacturers that initially deferred action to convert the DoD pricing agreement to the Federal Supply Schedule will be ready to work with us in the conversion process.

We will aggressively work with the VA to accomplish that goal. Also related to the conversion process, we have resolved a number of initial data management issues caused by our agencies' different operating systems, and we are now forming a more elaborate data management working group to further examine measures we both can take to synchronize our data and information management requirements. In summary, I believe our actions on joint contracts, on the DoD to VA price conversion, on working the data management issues, on forming a monthly in process review schedule and in making joint presentations on this matter to government and industry groups; we are on the right path to achieving the best federal price for pharmaceuticals for the DoD and VA health care activities.

#### CONCLUSION

In closing Mr. Chairman, I believe our partnership with the VA is smart and offers significant potential for future cooperative efforts. Most importantly, our joint pharmacy procurement efforts are reducing product prices and providing our patient care providers the opportunity to extend the value of their critical financial resources. I look forward to continued, very positive efforts with the VA to make this partnership even more effective. I will be happy to answer any questions that you may have for me.

PREPARED STATEMENT BY CAPT CHARLES F. HOSTETTLER, MSC,  
USN, DIRECTOR, DOD PHARMACY PROGRAMS, TRICARE MAN-  
AGEMENT ACTIVITY, DEPARTMENT OF DEFENSE

Mr. Chairman, Distinguished Members of the Committees, it's my pleasure to appear before the Committee today and share with you an overview of two very important pharmacy programs. Those two programs are: The National Mail Order program and the joint DOD/VA contracting initiative.

The first is the Department of Defense's (DOD) National Mail Order Pharmacy, or NMOP, program. This program has its roots in a test directed by Congress back in the early Nineties, where DOD was to implement a commercial Mail Order Pharmacy demonstration program in two three-state regions to assess whether such a program was a viable and economic option for supplementing the healthcare provided to DOD beneficiaries. This test was later expanded to include a number of other sites affected by closures of military medical treatment facilities as a result of the Base Realignment and Closure commission actions.

We completed an analysis of this test program and concluded it was a viable and money saving program for DOD, especially for beneficiaries who had been getting their prescriptions using the CHAMPUS or TRICARE Managed Care programs. Therefore, the demonstration program was terminated and the National Mail Order Pharmacy program was initiated in October 1997.

The contract for this program was negotiated competitively using Best Value techniques, and was awarded to Merck-Medco, the acknowledged leader of the industry at that time. The contract was awarded and is administered by the Defense Supply Center Philadelphia, which has acted as our contracting agent for this program. The contract provides full spectrum pharmacy services, including: validation of prescriptions, verification of eligibility, checking for possible drug-to-drug interactions, consulting with prescribers, managing compliance with the formulary and managing the financial transactions and co-payments.

This program provides for home delivery of up to a 90 day supply of maintenance (chronic) drugs with low co-payments and convenient refill procedures. The formulary is managed by the DOD Pharmacy and Therapeutics Committee.

Participation in the NMOP program has exceeded all expectations and estimates. Merck-Medco is now filling over 120,000 prescriptions a month and is growing exponentially. In FY99, almost 1.3 million prescriptions were filled for DOD beneficiaries through the NMOP program. As a result of the sophisticated software we have developed to manage this program and the contractually required data we receive from Merck-Medco, we have very accurate data about all aspects of this program. We have found this program to be an extremely useful tool in augmenting our military treatment facility pharmacies and in managing the healthcare requirements of DOD beneficiaries world-wide.

The Department of Veterans Affairs (DVA) has a Centralized Mail Order Program (CMOPS). The CMOPS program is a refill mail-out program, i.e. the first time a prescription is filled, it must be filled at a VA facility and subsequent refills are mailed from one of the CMOPS locations. Unlike the DOD's NMOP which fills new prescriptions and prescriptions written by physicians who are not DOD physicians, the CMOPS fills only refills and does not fill any prescription written by a physician outside the VA system. With the VA's concurrence, the DOD Pharmacy Board of Directors and I have explored the possibility of utilizing the CMOPS. We have visited CMOPS facilities and have verified that CMOPS has no additional capacity and does not process new prescriptions. If capacity existed, DOD could possibly utilize CMOPS to accommodate some of the MTF refill workload, but clearly could not replace NMOP.

A major obstacle to DOD use of CMOPS is the lack of a technology interface and integrated information system between the two organizations. As you know, DOD has been working diligently for the past two years to implement an integrated pharmacy information system within DOD and has begun the alpha testing just this month. The VA has a completely separate system that is not compatible with national pharmacy data transaction standards. Other hurdles include initial capitalization and management control.

The second topic I will comment on briefly is the DOD/DVA Joint National Contract initiatives. From my point of view as the Director, DOD Pharmacy Programs, this program has been a great success, delivering millions of dollars in savings and helping to improve and standardize healthcare within the DOD system.

National pharmaceutical contracts are closely integrated with formulary management in the Department of Defense. National pharmaceutical contracts are classified as either "open" class or "closed" class contracts.

An open class contract involves competition between different companies all selling the same generically equivalent drug. The government agrees to buy the drug from only one company in exchange for a lower price.

To illustrate, the joint national pharmaceutical contract with Forrest Laboratories, Inc. for the Tiazac brand of diltiazem extended release tablets is an open class contract. Tiazac is in a class of drugs called calcium channel blockers. Military pharmacies may have other drugs on their formularies in the same class as Tiazac, but they cannot have other drugs on their formularies that are genetically identical to Tiazac. In summary, if VA/DOD facilities are going to dispense diltiazem, it must be the Tiazac brand.

A closed class contract, on the other hand, involves competition between generically different drugs within the same therapeutic drug class. To establish a closed class contract, the DOD Pharmacy and Therapeutics (P&T) Committee must determine that the vast majority of the DOD patient population can be successfully treated with a subset of the drugs with the best clinical and economic value. A process remains in place allowing physicians to justify prescribing a non-contracted drug for patients who cannot take the contracted drug.

The DOD contract with Astra-Zeneca Pharmaceuticals for omeprazole (brand name Prilosec) is an example of a closed class contract. Omeprazole is in the proton pump inhibitor drug class. The contract stipulates that omeprazole is the only proton pump inhibitor MTFs and the NMOP are allowed to have on their formularies.

A recurring question is: Why can't DOD and VA contract jointly for all pharmaceuticals under either open or closed class contracts?

The decision to contract jointly is dependent largely on the particular drug we seek to procure and our assessment of the clinical requirements.

While the DOD and VA have successfully established 18 joint open-class pharmaceutical contracts as of March 2000, it is not feasible or desirable to jointly contract for all pharmaceuticals for the following reasons:

a. Open class contracts can be established only when competition exists between two or more companies selling the same drug. If only one company sells a particular drug, there is no opportunity to establish an open class contract.

b. Closed class contracts can be established only when the vast majority of patients can be successfully treated with a subset of the drugs in a given class. Closed class contracts must successfully balance two opposing objectives:

- (1) maximize the use of the contracted drugs and minimize the use of non-contracted drugs;
- (2) provide access to an array of drugs that is large enough to meet the clinical needs of the patient population.

Very few drug classes are amenable to closed class contracts because the drugs usually are not therapeutically interchangeable to a sufficient degree for a subset of the drugs to meet the clinical needs of a vast majority of the patient population.

c. Closed class contracts are difficult even for a single agency to establish—as evidenced by the fact that the VA has closed only four classes and the DOD has closed only two classes to date. A joint agency closed class contract would be even more difficult to establish because of the differences in physician preferences in the VA and DOD health care systems and in the patient populations.

(1) The VA operates a relatively "closed" health care system that resembles a staff model HMO. Under TRICARE, the Military Health System offers its beneficiaries much more choice. DOD beneficiaries can obtain care from MTFs that operate like staff model HMOs, managed care support contractor provider networks (PPOs), or a virtually unlimited choice of providers under the indemnity insurance coverage of TRICARE standard. The greater choice in health care options afforded to DOD beneficiaries causes the DOD pharmacy benefit to be more "open" than in the VA. VA pharmacies do not fill prescriptions written by healthcare providers outside of the VA medical system. The DOD National Mail Order Program and retail pharmacy networks fill prescriptions written by providers across the United States and around the world. It is much more difficult to achieve sufficient consensus among this array of healthcare providers that a subset of the available drugs are sufficient to meet the clinical needs of DOD beneficiaries.

(2) We also believe that patient expectations among DOD beneficiaries are different than the expectations of VA beneficiaries. Patient choice is one of the basic tenets of TRICARE, and patients' demand for choice clearly extends to the DOD pharmacy benefit. This demand for patient choice constrains DOD's ability to easily implement closed class contracts as well or as easily as the VA.

**WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES**  
**CHAIRMAN EVERETT TO DEPARTMENT OF DEFENSE**

**QUESTIONS FOR THE RECORD (QFRs)**  
 Subcommittee on Investigations and Oversight  
 House Committee on Veterans' Affairs  
 May 25, 2000

**QUESTION 1:** In fiscal year 1999, how much did VA and DoD spend on the 34 generic drugs and the 5 drug classes which their working group identified as potential candidates for joint procurement? For each of the 34 generic drugs and the 5 drug classes, how much would VA and DoD save if the item or class were jointly procured? When will VA and DoD complete the procurements for these drugs and classes and when will the 39 new contracts take effect?

**ANSWER:** In 1999, the DoD spent approximately \$130,000,000 on the 34 generic drugs and 5 classes. As GAO pointed out in their May 25<sup>th</sup>, 2000 testimony, due to the many variables involved, it is difficult to predict the magnitude of savings for joint procurement. The completion date of the planned procurements follows:

DESCRIPTION	INITIATE CONTRACTING	PROJECTED AWARD DATE
Acetaminophen	07/00*	10/00*
Acyclovir	05/08/00	09/00*
Albuterol IR	08/00*	11/00*
Amitriptyline	08/00*	11/00*
Azathioprine	05/08/00	09/00*
Bupropion	08/00*	11/00*
Bupirone	08/00*	11/00*
Carbidopa/Levodopa SA	08/00*	11/00*
Carisoprodol	08/00*	11/00*
Clozapine	01/03/00	Protested
Conjugated Estrogens	Clinical Review Pending	Unknown
Cyclosporine	07/00*	10/00*
Diclofenac	08/00*	11/00*
Etodolac	05/08/00	09/00*
Furosemide	05/08/00	09/00*
Glipizide	05/08/00	09/00*
Hydrochlorothiazide	08/00*	11/00*
Hydroxyurea	05/08/00	09/00*
Imipramine HCL	08/00*	11/00*
Isosorbide	08/00*	11/00*
Ketoconazole Cr	08/00*	11/00*
Low Molecular Weight Heparins	Clinical Review Pending	Unknown
Meclizine	08/00*	11/00*

Methocarbamol	08/00*	11/00*
Naproxen	11/09/99	05/18/00
Nasal Steroids	Clinical Review Pending	Unknown
Non Sedating Antihistamines	07/00*	10/00*
Oral Contraceptives	Clinical Review Pending	Unknown
Pentoxifylline	05/08/00	09/00*
Prednisone	08/00*	11/00*
Return Goods	11/01/99	DOD??
Rifampin	05/08/00	09/00*
Selegiline	05/08/00	09/00*
Sotalol	08/00*	11/00*
Sucralfate	05/08/00	09/00*
Sulindac	08/00*	11/00*
Terazosin	03/13/00	07/00*
Ticlopidine	08/00*	11/00*
Valproic Acid	08/00*	11/00*
Verapamil IR	08/00*	11/00*
* Projected Dates		

Exact timelines are difficult to predict due to variables such as time needed for clinical reviews and for GAO to rule on protests. Once requirements are sent to a Contracting Officer, the usual time frame for completion of a generic contract is approximately 120 days. This does not take into account vendor protests that can delay the award up to an additional 100 days. For committed-use, closed class contracting, the time period from beginning a class review until an award is made, can be as long as one year. All contracts usually become effective 45 days post award.

QUESTION 2: Which of the 34 generic drugs and 5 drug classes being considered are not among the 36 high-dollar classes that GAC is interested for joint contracting?

ANSWER: The following 31 drugs and 1 drug class are not among those suggested by GAO for joint contracting:

Acetaminophen  
Albuterol IR  
Amitriptyline  
Azathioprine  
Bupropion

Meclizine  
Methocarbamol  
Naproxen  
Pentoxifylline  
Prednisone

Carbidopa/Levodopa SA	Rifampin
Carisoprodol	Selegiline
Clozapine	Sotalol
Diclofenac	Sucralfate
Etodolac	Sulindac
Furosemide	Terazosin
Glipizide	Ticlopidine
Hydrochlorothiazide	Valproic Acid
Hydroxyurea	Verapamil IR
Imipramine HCL	
Isoorbide	
Ketoconazole Cr	
Low Molecular Weight Heparins	

**QUESTION 3:** What other generic drugs or drug classes has the VA-DOD working group considered for joint procurement, but decided against? What were the reasons for not doing so?

**ANSWER:** The VA and DoD considered the following drugs or drug classes for joint procurement, but decided against for the reasons stated:

1. A contract for the Hematopoietic agents (Procrit<sup>®</sup>, Epogen<sup>®</sup>) was considered. Market research showed that the same vendor makes both products and a licensing agreement between the two prohibits them from bidding against each other for a committed-use contract.
2. Amiodarone was also considered as a joint contract, however, DoD elected not to participate for clinical reasons.
3. A joint contract for non-sedating antihistamines was also considered. DoD is not participating due to issues regarding pharmacy benefit design.
4. Early in the joint contracting process, the SSRIs were considered for joint contracting. VA opted out of the joint contract due to clinical concerns. DoD opted out due to pharmacy benefit design concerns where we have many prescriptions filled in our Military Treatment Facilities written by providers outside of the military.
5. VA and DoD also investigated whether or not DoD requirements for HMGs, PPIs, long-acting ACEIs and Alpha Blockers could be added to existing VA contracts. It was determined that such a change was not permissible because it significantly changed the scope of the contracts. Since the VA contracts were fairly new, and a resolicitation could expose beneficiaries to a second round of therapeutic interchange, VA prudently opted out and DoD established its own contracts for HMGs, PPIs and long-acting ACEIs. A joint alpha blocker contract is expected to be awarded in July 2000.
6. Estrogen replacement therapy: Concluded that prescribers and patients would probably not accept therapeutic interchange within this class of drugs, so there would not be sufficient competitive pressure to support a contract initiative.

7. Warfarin: Warfarin was also considered for joint procurement. In lieu of a joint contract, VA and DoD have incentive agreements in place which significantly reduce acquisition costs. The competitive environment for warfarin will continue to be monitored and a joint procurement initiative will begin if and when it is in the best interests of VA and DoD.

**QUESTION 4:** In their responses to Subcommittee questions about the memorandum of agreement, VA and DoD witnesses identified incompatible data systems as a principal barrier to combining and leveraging the two Departments' purchasing power to obtain better discounts and pricing terms. What is your plan for overcoming IT obstacles hindering DAPA-FSS conversion and refill distribution?

**ANSWER:** Regarding DAPA-FSS conversion: For the short term, DoD personnel are manually entering contract information into DoD systems, and when possible, use electronic spreadsheets. However, even these require a certain level of manual effort. Therefore, DoD and VA have established an interagency working group to address long term solutions to these data system compatibility issues. One possible solution which has been raised will be adapting existing DoD systems to pull vendor Federal Supply Schedule data directly into DoD systems. This will be a topic of discussion at the next MOA In Process Review, scheduled for July 19, 2000.

Regarding refill distribution: There has been active dialog between the DoD and VA concerning the use of the Consolidated Mail Order Programs (CMOPs) to process DoD refills. An interface between the DoD's medical information system, the Composite Health Care System (CHCS) and the VA CMOP must be built in order to transmit refill request to the CMOP and receive acknowledgement/status on the order by CHCS. Technical staff from the VA and DoD have met and discussed the requirements needed for the development of an interface. A request for analysis for a bi-directional interface has been submitted by DoD, through the Clinical Business Area, to determine the costs and timeline required for the development of such an interface for the CHCS.

**QUESTION 5:** Regarding DAPA conversion, what, if any, follow-up is planned for the approximately 61 companies that initially declined to convert their DAPAs to FSS pricing for DoD purchasers? Please identify these companies which declined to convert and also list their respective fiscal year 1999 sales to DoD purchasers.

**ANSWER:** The VA National Acquisition Center (NAC) and the Defense Supply Center, Philadelphia (DSCP) will revisit those DAPA holders currently declining to convert on a periodic basis.

Vendors declining to convert DAPAs to FSS pricing with respective FY99 sales:

Contractor	DAPA .	FY 99 SALES
3M Pharmaceuticals	SP020096H0002	\$786,788.34
Abbott Labs	DLA12093H0035	\$4,013,470.16
Alcon Laboratories	SP020094H0053	\$1,740,484.41

Allergan	DLA12093H0144	\$2,523,853.55
Alza Corporation	DLA12093H0012	\$312,558.87
Amgen, Inc.	DLA12093H0034	\$4,625,235.87
Astra Pharm	SP020095H0016	\$27,435,965.30
Aventis Pasteur, Inc.	SP020096H0088	\$4,155,479.60
B Braun Medical	SP020094H0067	\$335,897.20
Baxter Pharm Products	SP020094H0041	\$162,350.92
Berlex Laboratories	DLA12093H0037	\$2,840,333.60
Berna Products	SP020098H0060	\$90.07
Biogen	SP020096H0083	\$2,263,875.43
BMS - Apothecon	DLA12093H0169	\$2,733,155.60
BMS - Oncology	DLA12093H0179	\$51,522,877.53
BMS - Primary Care	SP020094H0062	\$27,266.27
BMS - Westwood	DLA12093H0169	\$2,733,155.60
Bradley Pharm	SP020094H0027	\$333,233.17
C.B. Fleet	SP020095H0017	\$94,220.21
Chiron Therapeutics	SP020095H0007	\$203,119.47
Ciba Vision	SP020095H0019	\$587,302.42
Cook, Inc.	SP020097H0037	\$117,077.38
DuPont Pharm	DLA12093H0002	\$6,656,492.77
Eli Lilly	DLA12093H0202	\$23,148,571.98
ESI Lederle	SP020096H0040	\$3,664,258.07
Ferring Pharmaceuticals	SP020095H0052	\$126,664.02
Genentech	DLA12093H0029	\$2,836,103.75
Genesis Products	SP020099H0073	\$833.76
Glaxo Wellcome	DLA12093H0015	\$28,698,143.76
Hill Dermaceuticals	SP020096H0044	\$40,962.39
J&J HCS - Janssen	DLA12093H0026	\$597,234.58
J&J HCS - Ortho-Clinical	DLA12093H0158	\$3,089,750.91
J&J HCS - Ortho-McNeil	DLA12093H0225	\$8,075,101.02
JB Williams	SP020095H0020	\$749,139.20
Johes Pharma, Inc.	SP020094H0023	\$209,268.99
Konsyl Pharmaceuticals	SP020094H0043	\$52,217.42
Kos Pharmaceuticals	SP020098H0031	\$26,571.37
Medicis Pharm	SP020098H0057	\$182,442.70
Medline Industries	DLA12093H0245	\$4,654.31
Merck & Company	DLA12093H0164	\$48,339,169.36
Mylan Pharmaceuticals	SP020094H0018	\$4,348,609.86
NABI	DLA12093H0112	\$38,387.50
Novo Nordisk Pharm	DLA12093H0030	\$1,159,364.74
Novopharm USA	SP020094H0065	\$1,686,845.11
Nycomed, Inc.	SP020097H0027	\$435,298.15
Ortho Biotech	DLA12093H0158	\$3,089,750.91
Par Pharmaceutical, Inc.	SP020095H0029	\$394,689.81

PathoGenesis Corp	SP020098H0086	\$297,268.59
Pfizer	DLA12093H0003	\$49,445,002.28
Pharmacia & Upjohn	DLA12093H0178	\$13,512,729.58
Procter & Gamble Distributing	SP020094H0034	\$100,623.58
Procter & Gamble Pharm	DLA12093H0215	\$2,146,462.66
Purdue Frederick	SP020095H0022	\$826,847.45
Qualitest Pharm	SP020094H0001	\$2,439,727.14
Rhone-Poulenc Rorer (Aventis)	DLA12093H0024	\$6,840,055.53
Roche Labs	DLA12093H0004	\$13,791,493.62
Sanofi Pharmaceuticals	SP020094H0017	\$1,181,360.77
Schering Corporation	DLA12093H0019	\$24,329,495.66
Schwarz	SP020094H0044	\$953,477.38
Sigma-Tau Pharm	DLA12093H0211	\$56,905.54
SmithKline Beecham	DLA12093H0151	\$20,348,968.24
SmithKline Consumer	SP020094H0021	\$1,236,032.41
Tap Pharmaceutical	SP020094H0059	\$8,383,494.25
Teva Pharmaceuticals	DLA12093H0025	\$2,352,567.10
Wyeth-Ayerst	DLA12093H0009	\$21,137,206.34
Zeneca Pharm	DLA12093H0162	\$12,509,992.10
		\$429,088,027.63

**QUESTION 6:** In written testimony, the VA chief pharmacy consultant identified non-sedating antihistamines as one of 5 drug classes and 34 generic drugs the VA-DoD working group identified for consideration for joint procurement. Yet, during oral testimony, DOD's director of pharmacy appeared to question why GAO included non-sedating antihistamines among the 36 high-dollar drug classes it suggested for joint procurement. We understand Captain Hostettler's testimony to be that the two non-sedating antihistamines are not 100 percent interchangeable, and thus, not suitable for joint procurement. Is there a difference of opinion between Captain Hostettler and the VA-DoD working group over non-sedating antihistamines?

**ANSWER:** There is no difference of opinion between Captain Hostettler and the VA-DoD working group over non-sedating antihistamines. The VA-DoD working group identified the non-sedating antihistamine drug class as a potential candidate for joint procurement, but clinical experts within the two agencies ultimately concluded that differences in pharmacy benefit design and drug distribution systems necessitate a different procurement approach by each agency in order to best meet the clinical needs of patients in both systems.

The VA Medical Advisory Panel (MAP) and the VISN Formulary Leaders Committee decided that a closed class contract for a single non-sedating antihistamine would work

best for the VA. Non-sedating antihistamines are not 100% interchangeable, and no single non-sedating antihistamine will adequately treat 100% of the patients. Successful implementation of a closed class contract will require careful therapeutic interchange to shift market share to the contracted drug while still providing sufficient access to the non-contracted drug for individual patients. The relatively "closed" nature of the VA pharmacy benefit design facilitates such therapeutic interchange. VA providers write almost all the prescriptions for VA beneficiaries, and essentially all the prescriptions are filled at VA pharmacies.

Civilian providers unassociated with DoD write a significant proportion of the prescriptions for DoD beneficiaries, and DoD beneficiaries can choose to have their prescriptions filled at military treatment facility (MTF) pharmacies, the National Mail Order Pharmacy (NMOP), an Managed Care Support Contractor retail network pharmacy, or a non-network pharmacy. The "open" nature of the DoD pharmacy benefit makes it much more difficult for DoD to perform the therapeutic interchange that would be essential for a non-sedating antihistamine closed class contract. The DoD Pharmacy and Therapeutics (P&T) Committee concluded that a closed class contract for a single non-sedating antihistamine would place an unacceptably large administrative burden on DoD beneficiaries and the health care providers and pharmacies (both DoD and non-DoD) that serve them. The DoD P&T Committee decided that the clinical needs of DoD beneficiaries will best be met by leaving the non-sedating antihistamine class "open" and seeking blanket purchase agreements or incentive price agreements.

**QUESTION 7:** When might DoD develop its national formulary? What is the timetable?

**ANSWER:** The FY 00 National Defense Authorization Act requires the Department to implement a Uniform Formulary (UF) not later than October 1, 2000. Specifically, the statute requires the Department to establish a DoD Pharmacy and Therapeutics Committee which will in turn establish a UF, and a Uniform Formulary Beneficiary Advisory Panel to review and comment on the UF. Procedures for establishing these committees are outlined in the Federal Advisory Committee Act (FACA). The process to establish Federal Advisory Committees is lengthy and involves in-depth coordination including the White House. We are advised that establishing committees of this type may take, at minimum, ten to 12 months.

The Department will implement a UF; however, we are unable to meet the October 1, 2000 implementation deadline for the UF due to the process required for establishment of Federal Advisory Committees. The establishment of the DoD P & T Committee and Advisory Panel is underway. We have completed Charters for the DoD P&T Committee and Advisory Panel. We have requested the Retiree Coalition and Alliance organizations to submit nominations of individuals to serve on the Advisory Panel to represent the DoD beneficiaries. Selection of seven members, three alternates and completion of the administrative process is expected to take several months. We anticipate the first meeting of the Advisory Panel to take place in October 2000 following

completion of the design of the Uniform Formulary by the DoD P&T Committee. A firm implementation date cannot be offered at this time.

**QUESTION 8:** When will a request for proposal (RFP) be issued for DoD's pharmacy refill operations and will the RFP cover military pharmacy refills as well as civilian retail pharmacy refills and the National Mail Order Pharmacy Program?

**ANSWER:** A Request for Proposal (RFP) is being drafted to consolidate the TRICARE retail pharmacy and mail order pharmacy programs under one management entity. Currently, the five TRICARE Managed Care Support contractors have individual pharmacy benefit management processes, and the National Mail Order Program has an additional management structure. The RFP will consolidate all 5 managed care retail programs and the NMOP under one program to be managed by DoD. There is no issue date for the RFP. It is not anticipated that the RFP will include the military medical treatment facility refill work. The VA CMOP is being explored as a filling source for military medical treatment facility refill work.

**QUESTION 9:** What obstacles might DoD have to overcome to achieve greater partnering with VA for its Medical treatment Facility (MTF) prescription needs?

**ANSWER:** Utilization of the VA Consolidated Mail Outpatient program (CMOP) by DoD MTFs to supply prescription refills is presently under evaluation. There are three primary issues to resolve: 1) The lack of capacity at the VA CMOP facilities to accommodate DoD's MTF refill workload, 2) The ability to interface the two computer systems (VA/DoD), and 3) Availability of funds to implement. The anticipated change from DoD's current computer system, CHCS, to the new CHCS II, and the potential implementation of the GCPR questions the cost effectiveness of developing an interface with a DoD system that will be replaced within the next 18 months. The DoD and VA are exploring the possibility of a limited demonstration. A joint DoD/VA report is due to the Veterans Subcommittee on Investigations and Oversight by the end of August 2000 on the feasibility of a demonstration.

**QUESTION 10:** What is the status of the Government Computerized Patient Record (GCPR) project and how might it facilitate more accurate addressing across VA and DoD?

**ANSWER:** The GCPR is an information sharing system that consolidates data from disparate government medical information systems for a display of information or data query. With modifications it would be possible for GCPR to query both VA and DoD systems for addresses and identify inconsistencies in these data. However, it is more appropriate for address information to be corrected on the source system prior to the transmission of a prescription refill request. This validation process can best be performed during the refill process, especially through the use of telephonic or web based refill systems interfaced to the source system.