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Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans

Audit

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Executive Summary

In 2016, the Centers for Disease Control and Prevention (CDC) reported that the rate of opioid-related deaths had increased over the past decade, and most fatal opioid overdoses were associated with patients who received opioid prescriptions from multiple healthcare providers.¹ In response to the opioid epidemic, the US Department of Health and Human Services declared a public health emergency in 2017.² Despite the recent national focus on this public health crisis, the CDC reported approximately 75,700 opioid-related deaths in the 12-month period ending in April 2021, a 35 percent increase from the 56,100 opioid-related deaths the year before.³

Compared to the general population, veterans have a higher risk of opioid overdose due to many contributing factors, along with a higher incidence of medical conditions that increase the risk for opioid use disorder.⁴ VA issued almost 3.2 million opioid prescriptions to approximately 577,000 veterans in fiscal year (FY) 2021, which included about 146,000 opioid prescriptions issued by non-VA healthcare providers through VA's community care program to approximately 48,100 veterans.⁵

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 extends care for eligible veterans into the community, consolidates VA community care programs, and addresses concerns about the effect of the opioid epidemic on veterans.⁶ The MISSION Act requires the VA Secretary to ensure that all covered healthcare providers are provided a copy of and certify they have reviewed the evidence-based guidelines in the *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain* for prescribing opioids (also known as the

¹ Deborah Dowell, Tamara M. Haegerich, and Roger Chou, "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016," *MMWR*, 65, no. 1 (March 18, 2016): 1–49, <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>.

² Eric D. Hargan, acting secretary of the US Department of Health and Human Services, "Determination That a Public Health Emergency Exists," October 26, 2017.

³ CDC, "Drug Overdose Deaths in the U.S. Top 100,000 Annually," news release, November 17, 2021, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm. The CDC data pertains to the general United States population, not the veteran population. In response to the VA technical comments received during the reply period, the team explained the calculation of the percentage in the sentence and added the clarification in the footnote regarding the CDC data.

⁴ John Hudak, "Assessing and improving the government's response to the veterans' opioid crisis," Brookings Institution (July 2020); VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, May 2022. In response to the VA technical comments received during the reply period, the team added "many other contributing factors" to this sentence and updated the reference.

⁵ Opioid prescription and veteran data were extracted from VHA's corporate data warehouse for FY 2021.

⁶ VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018). See appendix A for a summary of responsibilities under the MISSION Act for VA, third-party administrators, and non-VA providers.

Opioid Safety Initiative [OSI] guidelines).⁷ The OSI guidelines provide opioid risk-mitigation strategies to prescribers for patients with chronic pain who are receiving or being considered for long-term opioid therapy. VA’s Office of Integrated Veteran Care (IVC) is the program office responsible for overseeing the implementation of the MISSION Act OSI guidelines requirements.⁸ VA has contracts with two third-party administrators—Optum Public Sector Solutions (Optum) and TriWest Healthcare Alliance (TriWest)—to manage non-VA providers in VA’s Community Care Network (CCN).⁹ IVC contracting officer representatives coordinate with VA contracting officers to ensure compliance with contract requirements.

The Veterans Health Administration (VHA) considers state prescription drug monitoring programs (PDMPs), which are electronic databases that track controlled substance prescriptions, “a crucial tool in addressing the opioid crisis in our Nation by reducing and preventing prescription drug abuse and drug overdose.”¹⁰ Checking state PDMPs is a risk-mitigation strategy identified in the OSI guidelines and is also a VA policy requirement for VA providers.¹¹ According to the OSI guidelines, from the 1990s until about 2008, the proportion of pain visits where patients received opioids significantly increased, as did the number of opioid-related deaths and substance abuse disorder treatment admissions. From 2008 until 2018, the annual percentage of filled opioid prescriptions significantly decreased; this decline might be attributed in part to the implementation of opioid-prescribing guidelines and use of PDMPs.¹²

The contracts for both TriWest and Optum require them to ensure that all CCN providers comply with applicable federal and state laws. Although many state laws mandate that healthcare providers conduct PDMP queries before prescribing opioids to patients, some states exempt this

⁷ MISSION Act § 131, 38 U.S.C. § 1701 note; VA and Department of Defense (DoD), VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, February 2017. The VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain was updated in May 2022, after the review period, and was renamed the VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain. This report refers to this document as the Opioid Safety Initiative (OSI) guidelines.

⁸ In September 2021, VHA integrated the Office of Community Care, Office for Veterans Access to Care, and Office of Finance into one office called IVC to help VHA better coordinate care while also streamlining and simplifying access processes. Although the Office of Community Care was the program oversight office at the time of the audit, the OIG refers to IVC throughout this report since the consolidation of the offices occurred before the publication of this report.

⁹ For the purposes of this report, the term “contract” refers to CCN contracts with third-party administrators. The contracts between VA and Optum apply to regions 1–3. The contract between VA and TriWest applies to region 4. The contract for region 5, also with TriWest, did not fall in the team’s sample. See appendix B and C for more details on the scope of this audit.

¹⁰ Assistant under secretary for health for operations, *Compliance with VHA Directive 1306(1), Querying State Prescription Drug Monitoring Programs*, memorandum to Veterans Integrated Service Network directors and medical center directors, June 15, 2020.

¹¹ VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, February 2017; VHA Directive 1306(1), Querying State Prescription Drug Monitoring Programs, amended October 21, 2019.

¹² VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain, May 2022, p. 10. A 2019 OIG audit found that VA clinicians did not conduct required annual PDMP queries for about 73 percent of prescribed opioids during a one-year period. Following this audit, VA’s assistant under secretary for health for operations issued a memorandum that not only reiterated the importance of PDMP queries but called for all VA medical facilities to reach 75 percent compliance with PDMP queries for new prescriptions for controlled substances by the end of 2020. VA OIG, [State Prescription Monitoring Programs Need Increased Use and Oversight](#), Report No. 18-02830-164, September 23, 2019; Assistant under secretary for health for operations, *Compliance with VHA Directive 1306(1), Querying State Prescription Drug Monitoring Programs*.

requirement for urgent/emergent opioid prescriptions. However, the contracts require CCN providers to check the state's prescription monitoring program prior to writing an urgent/emergent prescription for a controlled substance.¹³ This contract requirement to perform PDMP queries for urgent/emergent opioid prescriptions is regardless of any state law exemption.¹⁴

The VA Office of Inspector General (OIG) initiated this audit to determine whether VA, as required by the MISSION Act, ensured non-VA providers were provided a copy of the OSI guidelines and certified that they have reviewed them. Specifically, the team reviewed a sample of veterans who received non-VA opioid prescriptions in FY 2021 and assessed whether the providers who prescribed the opioids completed VA's OSI training module. IVC created this module specifically to facilitate non-VA providers' certification that they reviewed the OSI guidelines, helping ensure compliance with the MISSION Act requirement. In addition, the team assessed the sample to determine whether the non-VA providers completed PDMP queries in accordance with applicable state laws, CCN contract requirements for urgent/emergent prescriptions, and guidance in the third-party administrators' provider manuals. Lastly, the team determined if the sampled veterans' medical records included opioid prescription information in compliance with the MISSION Act.¹⁵

What the Audit Found

Although VA is responsible for compliance with MISSION Act requirements, IVC did not provide adequate oversight of the third-party administrators with respect to ensuring non-VA providers received and certified they reviewed the OSI guidelines.¹⁶ The audit team estimated that about 14,700 of approximately 18,200 non-VA providers in the CCN who prescribed opioids to veterans in FY 2021 have not completed VA's OSI training module and have not certified they have received and reviewed the OSI guidelines.

IVC's acting deputy chief for contract administration believed that the third-party administrators were responsible for ensuring their providers completed the training module and certified they thereby reviewed the OSI guidelines. Although VA's CCN contract with TriWest required it to

¹³ Although the contract is clear that PDMP checks are required for all urgent/emergent controlled substances (including opioids), the language could be read more broadly to require PDMP queries for all controlled substance prescriptions. Optum interprets the contract language broadly and requires its providers to run PDMPs for all controlled substance prescriptions. TriWest requires their providers to comply with all applicable laws, regulations, and requirements, including terms and conditions in their provider manuals, which includes PDMP state laws.

¹⁴ IVC contends that the contract requirement to complete PDMP queries is for all controlled substances and not just for urgent/emergent prescriptions. The audit team took a conservative approach and applied the PDMP query requirement for urgent/emergent prescriptions because it is unclear in the contract if the requirement to conduct PDMP queries applies to only urgent/emergent prescriptions or whether it also applies to routine/maintenance controlled substance prescriptions.

¹⁵ MISSION Act § 131(c)(2)(A), 38 U.S.C. § 1701 note.

¹⁶ In response to the VA technical comments received during the reply period, the team clarified that IVC is responsible for the oversight of the third-party administrators and the third-party administrators oversee the non-VA providers.

ensure prescribing providers certified they reviewed the OSI guidelines, Optum's contract did not contain a similar provision.¹⁷ Moreover, the contracts did not specifically require the third-party administrator to monitor providers to ensure they certified their review of the OSI guidelines when the OSI training module transmitted the providers' certifications of training completion back to IVC. Both contracts, however, did require that the third-party administrators' outreach and education programs include network participation requirements, such as compliance with OSI guidelines.

Based on this, IVC believed that the contracts required prescribing providers to complete VA's OSI training in order to join the networks. Thus, the IVC acting deputy chief for contract administration asserted the contracts made third-party administrators responsible for ensuring all their prescribing providers completed the training module. However, the contracts do not specifically state that providers are required to complete VA's OSI training. As a result, although TriWest and Optum officials were responsible for including the OSI guidelines in their education programs, neither third-party administrator made completing VA's OSI training a condition to join the network. Furthermore, TriWest officials disagreed with the IVC acting deputy chief for contract administration's assertion that the third-party administrators were responsible for monitoring OSI training completion and provider certifications and instead contended this was VA's responsibility.

Consequently, neither VA nor the third-party administrators monitored training completion. VA contracting officers for the CCN contracts stated that the contract provisions were not in compliance with the MISSION Act OSI training requirements and that the third-party administrators were in compliance with the contracts as currently written because they were only required to make the training available. The IVC deputy executive director for external networks stated IVC is planning to work with the contracting office to modify the contracts with the third-party administrators to improve compliance. As of October 2022, VA contracting officers were still attempting to modify the OSI training requirements in the Optum contract and had not started modifying the TriWest contract.

IVC also did not monitor third-party administrators to ensure non-VA providers are completing PDMP queries as required. IVC relies on third-party administrators to ensure non-VA providers complete PDMP queries required by state law and by the CCN contracts. However, the third-party administrators did not monitor their providers' compliance with PDMP queries and expected their providers to comply with PDMP and state law requirements. The audit team reviewed 44 randomly selected opioid prescriptions issued by non-VA providers during the

¹⁷ As stated above, the audit scope included the contract between VA and TriWest Healthcare for region 4 only. TriWest's contract for region 5 did not fall in the team's sample.

12-month period ending on September 30, 2021, and found that providers had not completed required PDMP queries for 17 prescriptions.¹⁸

During interviews with the team, providers and their staff often did not know or could not determine after reviewing their records why PDMP queries were not completed. Other providers who acknowledged they did not complete these queries seemed unaware of Optum's and TriWest's PDMP requirements or were unfamiliar with some of the PDMP requirements in their state laws.

Most state laws for the sampled medical facilities require PDMP queries for non-urgent/emergent prescriptions, and third-party administrators must ensure or confirm providers comply with state law. Although state laws often exempt PDMP queries for urgent/emergent prescriptions, the CCN contracts require these queries.¹⁹ Third-party administrators communicate PDMP requirements to their providers in their provider manuals and expect compliance. Optum's position, as outlined in its provider manual, requires providers to complete PDMP queries for all controlled substances prescribed to veterans. The TriWest manual includes similar language as the Optum manual in a section called Urgent/Emergent Medicine.

CCN contracts require non-urgent/emergent non-VA opioid prescriptions for more than seven days to be dispensed at VA pharmacies. This requirement helps IVC monitor non-VA opioid prescriptions, and some VA medical facilities also require their pharmacy staff to perform PDMP queries when they fill opioid prescriptions from non-VA providers.²⁰ Although these practices may mitigate some risk to veterans if non-VA providers do not perform required PDMP queries, they do not replace IVC's oversight responsibility of monitoring third-party administrators' compliance with the terms and conditions in the CCN contracts, including ensuring their network providers comply with state law and contract PDMP requirements.

Finally, the team assessed whether veterans' medical records included opioid prescription information in accordance with the MISSION Act. After reviewing the electronic health records of the veterans in the sample, including medication lists, reconciliation notes, and scanned images of non-VA consults, the team found that the medical records generally contained the sampled non-VA provider opioid prescription information as required. However, this information was documented in different sections of the VA medical records. Specifically,

¹⁸ The team was able to reach only 39 of the 65 providers or their staff for 44 of 70 sampled prescriptions to determine if the provider had completed PDMP queries. Some providers issued more than one prescription in the sample. For more information about the audit's scope and methodology, see appendixes B and C.

¹⁹ The CCN contracts describe urgent/emergent prescriptions as medications listed in the VA Urgent/Emergent National Formulary and opioid prescriptions with an allowed maximum of up to seven days' supply or the state limit, whichever is fewer days. Not all short-term prescriptions (fewer than seven days) are considered urgent/emergent prescriptions.

²⁰ CCN contracts allow urgent/emergent prescriptions for a maximum of 14 days without refills. Urgent/emergent prescriptions for opioids are allowed up to seven days (or the state limit), whichever is fewer, with an allowance for a second refill up to seven days (within 30 days).

non-VA opioid prescriptions were not always captured in the non-VA medication section of the medication profile, which is a VA policy requirement, and this may make it difficult for providers to access this critical information.²¹

What the OIG Recommended

The OIG made the following recommendations to the under secretary for health:

1. Clarify roles and responsibilities of the Office of Integrated Veteran Care and third-party administrators with respect to ensuring non-VA providers receive and certify they have reviewed the Opioid Safety Initiative guidelines in accordance with the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 and collaborate with the contracting office to modify the contracts as appropriate.
2. Ensure the Office of Integrated Veteran Care strengthens controls to monitor the third-party administrators to ensure non-VA providers' completion of the VA Opioid Safety Initiative training module.
3. Ensure the Office of Integrated Veteran Care strengthens controls to monitor the third-party administrators to ensure non-VA providers' completion of required prescription drug monitoring program queries.

VA Comments and OIG Response

The under secretary for health, in collaboration with IVC, concurred with all the report's findings and recommendations, and submitted action plans.²² In response to VA technical comments received during the reply period, the OIG incorporated requested clarifying language and information to enhance the accuracy of the report. Appendix D provides the full text of the under secretary's comments.

²¹ VHA Handbook 1108.05(2), *Outpatient Pharmacy Services*, revised August 1, 2016. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022. Both the 2016 handbook and the 2022 directive contain the requirement to document non-VA prescriptions specifically in the non-VA medications list or section of the electronic health record. This audit report refrains from providing a recommendation for this issue because an ongoing OIG healthcare inspection review is examining the inclusion of controlled substances in non-VA medication lists.

²² The under secretary for health provided a response on June 23, 2023, and at that time, the OIG incorporated the response into this report.

Overall, the proposed corrective measures in VA's action plans appear to be responsive to the recommendations. The OIG will monitor the implementation of the recommendations until all stated actions are documented as completed.



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Abbreviations

CCN	Community Care Network
CDC	Centers for Disease Control and Prevention
FY	fiscal year
IVC	Office of Integrated Veteran Care
OIG	Office of Inspector General
OSI	Opioid Safety Initiative
PDMP	prescription drug monitoring program
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

In 2016, the Centers for Disease Control and Prevention (CDC) reported that the rate of opioid-related deaths had increased over the past decade, and most fatal opioid overdoses were associated with patients who received opioid prescriptions from multiple healthcare providers.²³ To combat the opioid epidemic, the US Department of Health and Human Services declared a public health emergency in 2017.²⁴ Despite the recent national focus on this public health crisis, approximately 75,700 people died of opioid overdose in the 12-month period ending in April 2021, up from about 56,100 opioid-related deaths during the year before (35 percent).²⁵ Overall, opioid-related deaths accounted for 75 percent of all drug overdose deaths in the US in 2021.²⁶

Veterans are more likely to die of opioid overdose than civilians because, along with the many other factors that contribute to overdoses, veterans have a higher incidence of medical conditions that increase the risk of opioid use disorder.²⁷ In fiscal year (FY) 2021, approximately 577,000 veterans receiving care through VA had received almost 3.2 million opioid prescriptions. This total includes about 146,000 opioid prescriptions written by non-VA providers for approximately 48,100 veterans. VA's FY 2022 budget requested \$621 million for addressing opioid use disorder, opioid safety, and opioid reduction efforts, an increase from FY 2021's \$473 million.²⁸

Because of VA's ongoing efforts to combat opioid use disorder, overmedication, and opioid-related deaths among veterans, the VA Office of Inspector General (OIG) conducted this audit to determine whether VA met requirements of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 related to opioid prescriptions and whether VA's Office of Integrated Veteran Care (IVC) monitored third-party administrators to ensure their network

²³ Deborah Dowell, Tamara M. Haegerich, and Roger Chou, "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016," *MMWR*, 65, no. 1 (March 18, 2016): 1–49, <https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm>.

²⁴ Eric D. Hargan, acting secretary of the US Department of Health and Human Services, "Determination That a Public Health Emergency Exists," October 26, 2017.

²⁵ Centers for Disease Control and Prevention (CDC), "Drug Overdose Deaths in the U.S. Top 100,000 Annually," news release, November 17, 2021, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2021/20211117.htm. The CDC data pertain to the general United States population, not the veteran population. In response to the VA technical comments received during the reply period, the team explained the calculation of the percentage in the sentence and added the clarification in the footnote regarding the CDC data.

²⁶ CDC, "U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020 – But Are Still Up 15%," news release, May 11, 2022, https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.

²⁷ John Hudak, "Assessing and improving the government's response to the veterans' opioid crisis," Brookings Institution (July 2020). VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, May 2022. In response to the VA technical comments received during the reply period, the team added "many other contributing factors" to this sentence and updated the reference.

²⁸ Opioid prescription and veteran data from FY 2021 were extracted from VHA's corporate data warehouse.

providers complied with applicable prescription drug monitoring program (PDMP) state and contract requirements.²⁹ The team assessed whether non-VA healthcare providers received and certified they reviewed the *VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain* (also known as the Opioid Safety Initiative [OSI] guidelines), as required by the MISSION Act, for a sample of veterans who received opioid prescriptions from non-VA providers in FY 2021.³⁰ The OSI guidelines are intended to serve as a reference document on available opioid risk-mitigation strategies and to give providers a framework to evaluate, treat, and manage the needs and preferences of patients with chronic pain who are receiving or being considered for long-term opioid therapy. As part of this framework, the OSI guidelines recommend PDMP queries as a mitigation strategy that can help decrease the risk of opioid-related deaths and substance use disorder among veterans. The team also reviewed the sample for non-VA providers' completion of PDMP queries, which are required by VA's Community Care Network (CCN) contracts and most state laws.³¹ Finally, the team evaluated whether MISSION Act documentation requirements for opioid prescription information were met.

VA MISSION Act Requirements for Non-VA Providers Who Prescribe Opioids to Veterans

The MISSION Act extends care for eligible veterans into the community, consolidates VA community care programs, and addresses concerns about the effect of the opioid epidemic on veterans. According to the MISSION Act, VA must establish certain controls to help ensure providers engage in safe opioid-prescribing practices. These controls include requiring the VA Secretary to “ensure that all covered health care providers are provided a copy of and certify that they have reviewed the evidence-based guidelines for prescribing opioids set forth by the Opioid Safety Initiative of the Department of Veterans Affairs.”³²

The MISSION Act also places the responsibility on VA to require non-VA providers to submit documentation, including records of all opioid prescriptions, to VA for any care or services received by veterans. VA must then record this information in the veterans' electronic health records.³³ However, the MISSION Act does not explicitly state this documentation must include evidence of completed PDMP queries.

²⁹ VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 (2018).

³⁰ MISSION Act § 131, 38 U.S.C. § 1701 note; VA and Department of Defense (DoD), *VA/DoD Clinical Practice Guideline Opioid Therapy for Chronic Pain*, February 2017. The *VA/DoD Clinical Practice Guideline Opioid Therapy for Chronic Pain* was updated in May 2022, after the review period, and was renamed the *VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain*. This report refers to these guidelines as the Opioid Safety Initiative (OSI) guidelines.

³¹ For this report, the term “contract” refers to CCN contracts the Veterans Health Administration (VHA) has with third-party administrators.

³² MISSION Act §131.

³³ MISSION Act § 131(c)(2)(A), 38 U.S.C. § 1701 note.

CCN Contracts

In September 2021, the Veterans Health Administration (VHA) integrated the Office of Community Care, the Office for Veterans Access to Care, and the Office of Finance into IVC to help VHA better coordinate care while also streamlining and simplifying access to VA health care.³⁴ IVC oversees VA’s coordination with community providers to ensure veterans receive timely care.

VA established the CCN contracts to provide more choices and accessibility to health care outside VA. Non-VA providers in VHA’s CCN facilitate timely and quality services for veterans who do not live near a VHA facility, who experience lengthy wait times for an appointment at a VHA facility, or for whom community care is in their best interest.³⁵

The CCN consists of five regional networks covering all US states and territories (figure 1). VA contracts with two third-party administrators to manage these five regions. Regions 1–3 are administered by Optum Public Sector Solutions (Optum), and regions 4–5 are administered by TriWest Healthcare Alliance (TriWest).

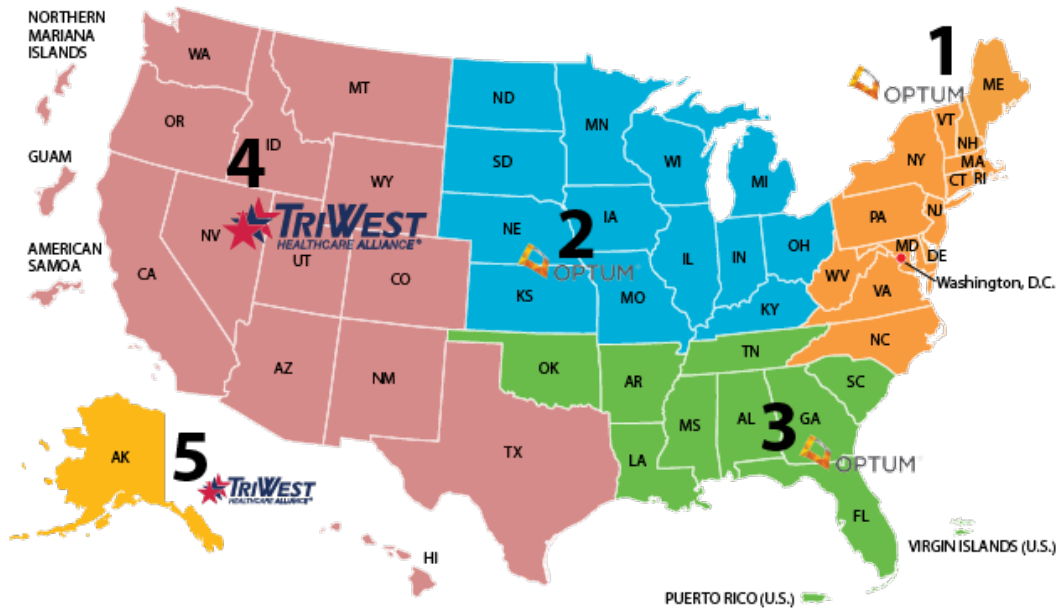


Figure 1. Five regional networks that comprise VA’s CCN.

Source: VA.gov

³⁴ The Office of Community Care was the program oversight office at the time of the audit, but it is referred to as IVC throughout this report because of the reorganization of these offices.

³⁵ The Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), Pub. L. No. 113-146, 128 Stat. 1754 (2014); VA MISSION Act of 2018, § 132; “Community Care” (web page), VA, accessed December 9, 2022, https://www.va.gov/COMMUNITYCARE/programs/veterans/General_Care.asp#Appointments. The Choice Act established the framework for increasing veterans’ access to care in their community through the Veterans Choice Program. The MISSION Act of 2018 officially ended the Choice Program on June 6, 2019, but continued veterans’ ability to seek care locally with some adjustments to eligibility requirements. The Veterans Choice Program was replaced by the new Veterans Community Care Program with more choices of care in the community.

VA contracting officers from the Strategic Acquisition Center in the Office of Acquisition, Logistics, and Construction administer the CCN contracts with the third-party administrators. The third-party administrators, in turn, contract with the non-VA providers in their networks. IVC contracting officer representatives coordinate with VA's contracting officers to ensure compliance with CCN contract requirements. In addition, both third-party administrators use provider manuals to communicate guidance and requirements to the providers in their networks. According to the third-party administrators, the terms of these manuals are mandatory for their non-VA providers. See appendix A for a summary of responsibilities under the MISSION Act for VA, third-party administrators, and non-VA providers.

PDMP Overview

Statewide PDMP databases are an oversight tool used by health authorities, such as VA. These electronic databases track controlled substances prescribed and dispensed to patients within each state and capture medication information for controlled substances, such as the drug name, dosage, quantity, dates dispensed, prescriber name, pharmacy that filled the prescription, and frequency. According to the CDC, PDMPs are one of the most promising state-level interventions to improve opioid prescribing, inform clinical practice, and protect at-risk patients.³⁶ PDMP queries are so important that in 2019, the Centers for Medicare & Medicaid Services began allowing hospitals to receive credit toward payment incentives if they attested to conducting PDMP queries.³⁷

The MISSION Act also recognizes that completing PDMP queries helps providers safely and effectively prescribe controlled substances to veterans. Per the MISSION Act, "Any licensed health care provider or delegate of such a provider shall be considered an authorized recipient or user for the purpose of querying and receiving data from the national network of State-based prescription drug monitoring programs to support the safe and effective prescribing of controlled substances to covered patients."³⁸

Because VHA considers PDMPs a crucial tool to address the opioid crisis and reduce and prevent substance use disorder and overdoses among veterans, VHA implemented PDMP policies and training for VA providers.³⁹ VA and the Department of Defense also included

³⁶ "Prescription Drug Monitoring Programs (PDMPs)" (web page), May 2021, accessed on July 26, 2021, <https://www.cdc.gov/drugoverdose/pdmp/index.html>.

³⁷ As part of the Centers for Medicare & Medicaid Services Interoperability Program, eligible hospitals must receive a minimum of 50 points for using certified electronic health record technology or risk a downward payment adjustment. Querying PDMPs is currently optional for hospitals and worth five bonus points toward the performance requirement.

³⁸ MISSION Act § 134, 38 U.S.C. § 1730B.

³⁹ Assistant under secretary for health for operations, "Compliance with VHA Directive 1306(1), Querying State Prescription Drug Monitoring Programs," memorandum to the Veterans Integrated Service Network Directors and Medical Center Directors, June 15, 2020; VHA Directive 1306(1), *Querying State Prescription Drug Monitoring Programs*, amended October 21, 2019. The Pharmacy Benefits Management Academic Detailing Services and Pain Management, Opioid Safety, and PDMP Program Office have placed several web-based trainings regarding PDMPs on their SharePoint sites for VA providers.

PDMP queries as one of 18 recommended risk-mitigation strategies in the OSI guidelines. According to the OSI guidelines, from the 1990s until about 2008, the proportion of pain visits where patients received opioids significantly increased, as did the number of opioid-related deaths and substance abuse disorder treatment admissions. However, from 2008 to 2018, the annual percentage of filled opioid prescriptions declined by 31 percent, which might be attributed to the implementation of opioid-prescribing guidelines, use of PDMPs, and quality improvement initiatives.⁴⁰

State PDMP Requirements for Healthcare Providers

CCN contracts require third-party administrators to ensure or confirm that their network providers comply with applicable state laws, including PDMP laws. According to the CCN contract with Optum, “The Contractor must always confirm that all ... Network practitioners are in compliance with all applicable federal and state laws.”⁴¹ Similarly, the CCN contract with TriWest declares, “The contractor shall ensure that all services, facilities, and CCN providers are in compliance with ... applicable Federal and State laws.”⁴² All seven of the states in the team’s sample required providers to complete PDMP queries before prescribing opioids unless the state granted the prescription an exemption. State exemptions may include certain categories of prescriptions such as those issued in urgent/emergent situations or issued to patients with cancer or in hospice.

CCN Contract PDMP Requirements

In addition to ensuring or confirming that all providers comply with applicable federal and state laws, the CCN contracts also include a requirement for PDMP queries. In a section titled “Urgent/Emergent Prescriptions,” the contracts state the contractor must require or instruct its non-VA providers to check with the state’s prescription monitoring program for any controlled substance use before writing a controlled substance prescription for a veteran to ensure appropriate opioid/controlled substance use.⁴³ Notably, many state laws do not require PDMP checks for urgent/emergent opioid prescriptions, but the CCN contracts explicitly require checks in urgent/emergent situations.

The language in the CCN contracts does not limit the requirement to conduct PDMP queries for only urgent/emergent prescriptions, although the requirement is listed in the urgent/emergent section of the contracts. Optum officials reported they interpret the contract language broadly

⁴⁰ VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain, May 2022, p. 10.

⁴¹ Contract between VA and Optum Public Sector Solutions, Inc., Region 1, p. 59; Region 2, p. 60; Region 3, p. 61.

⁴² CCN contract between VA and TriWest Healthcare Alliance, Region 4, p. 28. Region 5 did not fall in the audit team’s sample.

⁴³ The CCN contracts describe urgent/emergent prescriptions as medications listed in the VA Urgent/Emergent National Formulary and opioid prescriptions with an allowed maximum of up to seven days’ supply or the state limit, whichever is fewer days. Not all short-term prescriptions (fewer than seven days) are considered urgent/emergent prescriptions.

and require their providers to conduct PDMP queries for all opioid prescriptions—not only urgent/emergent prescriptions. Accordingly, the Optum’s provider manual states, “Before prescribing controlled substances for a Veteran, VA requires providers to check their state’s prescription-monitoring program to see if the Veteran has been prescribed other controlled substances.” This interpretation is consistent with the obligation of the third-party administrators to require providers to adhere to state law, and the interpretation is not prohibited by any contract language. The urgent/emergent section of TriWest’s provider manual includes similar language.⁴⁴ Most of the sampled state laws reviewed require PDMP queries for non-urgent/emergent prescriptions, and the third-party administrators must ensure or confirm providers comply with state law.

Previous OIG Reports

Previous OIG reports have identified issues with non-VA providers’ opioid prescriptions, medical record documentation, and PDMP queries. In 2017, the OIG found risks existed for patients who received prescriptions from non-VA providers.⁴⁵ In the 2017 report, the OIG recommended requiring all non-VA providers to submit prescriptions directly to a VA pharmacy. This report also included a recommendation that all participating CCN providers receive and review the evidence-based guidelines for prescribing opioids outlined in the OSI guidelines. These recommendations preceded the MISSION Act requirements. In 2019, the OIG found that patients’ risk was exacerbated when information from these records and prescriptions were not shared between VA and non-VA providers. Lack of access to patient records also prevented timely, quality care for patients.⁴⁶

In a 2019 audit, the OIG found that VHA lacked national program controls and adequate training to ensure VA providers performed PDMP queries.⁴⁷ VA policy required VA providers to conduct PDMP queries when writing a new prescription for controlled substances and annually thereafter for patients who continued to receive these medications.⁴⁸ VA clinicians did not conduct required annual PDMP queries for about 73 percent of prescribed opioids from April 1, 2017, through March 31, 2018. In response to the report, VA’s assistant under secretary for health for

⁴⁴ TriWest’s provider manual states, “[CCN] providers must check with their state’s prescription monitoring program for any controlled substance utilization prior to writing any controlled substance prescription for a Veteran to ensure appropriate opioid/controlled substance use.” TriWest requires their providers to comply with all applicable laws, regulations, and requirements, including terms and conditions in their provider manuals, which includes PDMP state laws.

⁴⁵ VA OIG, [Healthcare Inspection: Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care](#), Report No. 17-01846-316, July 31, 2017.

⁴⁶ VA OIG, [Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center](#), Report No. 17-01757-50, January 28, 2019; VA OIG, [Healthcare Inspection: Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care](#).

⁴⁷ VA OIG, [State Prescription Monitoring Programs Need Increased Use and Oversight](#), Report No. 18-02830-164, September 23, 2019.

⁴⁸ VHA Directive 1306(1).

operations issued a memorandum in June 2020 reiterating the importance of PDMP queries. The memorandum required Veterans Integrated Service Networks (VISNs) and medical facilities to

- improve VA providers' performance by a minimum of 30 percent compared to their June 2020 rates or
- reach 75 percent compliance with PDMP queries for new prescriptions for controlled substances by the end of calendar year 2020.⁴⁹

VA also updated its training for VA providers to clarify when to conduct PDMP queries for controlled substance prescriptions and how to document the results.⁵⁰

Since then, VA PDMP query rates reported on the Academic Detailing Services' national dashboard have improved nationally, although some medical facilities remain below the benchmark.⁵¹ In FY 2020, only 31 of 141 medical facilities (22 percent) achieved a 75 percent or better completion rate for PDMP queries for new prescriptions.⁵² By 2021, 86 medical facilities (61 percent) met the benchmark. By the second quarter of FY 2022, 110 medical facilities (79 percent) met or exceeded the benchmark. Although VA providers have improved their use of PDMPs, the 2019 OIG report noted that receiving controlled substances from non-VA clinicians would increase veterans' risk as VA expanded care in the community in compliance with the MISSION Act.

⁴⁹ Assistant under secretary for health for operations, "Compliance with VHA Directive 1306(1), Querying State Prescription Drug Monitoring Programs," memorandum. VHA divides the United States into 18 VISNs—regional networks working together to better meet local healthcare needs and provide greater access to care.

⁵⁰ VHA Directive 1306(1). The VA Pain Management and Opioid Safety training course for VA providers was updated to specifically address this directive's query requirements and recommendations. All eight recommendations were closed on December 14, 2021, based on corrective action information provided on November 24, 2021, by VA's GAO/OIG Accountability Liaison Office.

⁵¹ Data were obtained from Pharmacy Benefits Management Academic Detailing, Report of New Medication Trial PDMP Trends for FY 2020, FY 2021, and quarter 2 of FY 2022. For FY 2021, the average was taken for the four-quarter reporting periods.

⁵² A new start prescription refers to the date a provider first prescribes a controlled substance to a veteran. This is different from regularly reoccurring prescriptions.

Results and Recommendations

Finding: MISSION Act OSI Requirements and CCN Contract Requirements for PDMP Queries Were Not Met

The audit team estimated that about 14,700 of the 18,200 non-VA providers in the TriWest and Optum networks have not certified they reviewed the OSI guidelines as required by the MISSION Act. Neither IVC nor the third-party administrators were aware that non-VA providers were not certifying they had reviewed the OSI guidelines. To help non-VA providers review these guidelines, IVC created an automated OSI training module but relied on the third-party administrators to ensure providers received and completed it. Because the contractual relationship between the non-VA providers and VA is through the third-party administrators, IVC expected the third-party administrators to monitor this requirement. Furthermore, the CCN contract did not clearly assign the third-party administrators monitoring responsibilities or require them to certify training completion, and the third-party administrators asserted that monitoring this training was IVC's responsibility. IVC has not implemented adequate measures to ensure non-VA providers complete VA's OSI training even though it agreed to in its response to a prior OIG report, and these oversight measures are necessary to comply with the MISSION Act.⁵³ As a result, VA has no assurance that non-VA providers are aware of these guidelines when veterans seek care in the community.

VHA also lacks assurance that non-VA providers are querying PDMPs when they prescribe opioids to veterans, even though the OSI guidelines recommend this risk-mitigation strategy, and VA's CCN contracts, third-party administrators' provider manuals, and state laws require PDMP queries. The team reviewed 44 randomly selected opioid prescriptions issued by non-VA providers during the 12-month period ending on September 30, 2021, and found that providers did not perform required PDMP queries for 17 prescriptions, seven which were urgent/emergent prescriptions that required queries under the CCN contracts and 10 where queries were required by state law.⁵⁴ During interviews with the team, some providers stated they were not aware that

⁵³ VA OIG, *State Prescription Monitoring Programs Need Increased Use and Oversight*. In response to this 2019 audit, the executive in charge for the Office of the Under Secretary for Health agreed that monitoring non-VA providers' medical licenses, OSI guidelines training, and opioid-prescribing practices are paramount to veteran safety and high-quality care. VHA reported they required providers to complete mandatory OSI guidelines training within 180 calendar days following entry into the contract or agreement, and validated OSI training completion.

⁵⁴ The audit team also determined that providers issued 10 of these prescriptions without completing PDMP queries that were required based on the guidance in their third-party administrators' provider manuals.

PDMP queries were required for urgent/emergent prescriptions.⁵⁵ Other providers did not seem to understand their state's PDMP requirements.

IVC relies on third-party administrators to ensure compliance with PDMP requirements, but the third-party administrators do not monitor providers' PDMP queries.⁵⁶ A TriWest official asserted they were not responsible for or able to effectively monitor these areas and that this was the responsibility of VA and other entities, such as the state medical or licensing boards. Regardless of the other entities and their responsibilities, the CCN contracts require third-party administrators to ensure or confirm their providers comply with state laws, including laws requiring PDMP queries. In sum, given the position of the third-party administrators, VHA is unaware of the extent to which non-VA providers use PDMP queries—a crucial tool it has identified in the effort to address the nation's opioid crisis—to guide treatment decisions and ensure patient safety.

Finally, the team found that non-VA provider opioid prescription information was generally captured in the sampled veterans' electronic health records, meeting the MISSION Act documentation requirements. However, these prescriptions were not always documented in the non-VA medication section of the medication profile, which VA policy required at the time of the audit.⁵⁷ Because this information was found in various sections of the VA medical records, VHA cannot be certain that this critical information can be easily accessed by providers who need to make informed treatment decisions.

What the OIG Did

The team assessed whether VA ensured non-VA providers are provided a copy of and certify they reviewed the OSI guidelines. Specifically, the team determined whether non-VA providers completed VA's OSI training to certify they had received and reviewed the guidelines. The team also reviewed applicable state laws, CCN contracts, provider manuals, and MISSION Act requirements related to prescribing opioids.⁵⁸

The team statistically selected seven VA medical facilities, one each in Hawaii, Louisiana, Mississippi, Nevada, New York, Ohio, and Texas, for review. The statistical sample was

⁵⁵ Some states exempt certain categories of prescriptions from PDMP requirements, such as prescriptions for urgent/emergent situations and for patients with cancer or in hospice. However, Optum's position, as outlined in their provider manual, requires PDMP queries to be conducted for all controlled substance prescriptions, including urgent/emergent prescriptions. TriWest requires its providers to comply with their state laws and specifically states that PDMP queries are required for urgent/emergent prescriptions.

⁵⁶ In response to the VA technical comments received during the reply period, the team clarified that IVC is responsible for the oversight of the third-party administrators and the third-party administrators oversee the non-VA providers.

⁵⁷ VHA Handbook 1108.05(2), *Outpatient Pharmacy Services*, amended on February 6, 2020. This handbook was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022. Both the handbook and the 2022 directive contain the requirement to document non-VA prescriptions in the non-VA medications listing or section of the electronic health record.

⁵⁸ See appendixes B and C for more details on the scope and methodology of this audit.

stratified to ensure that the number of facilities selected for each CCN region was roughly proportional to the number of opioids prescribed within the region during the audit period. The team statistically selected 10 opioid prescriptions issued by non-VA providers that were filled at each medical facility's pharmacy to obtain a total sample of 70 prescriptions for review.

The team also reviewed the applicable laws of the states in which each prescription was written, the CCN contracts, and provider manuals to determine if a PDMP query was required at the time the prescription was issued. If a query was required, the team interviewed the third-party administrators and attempted to interview the non-VA providers to verify whether the queries had been performed.

Additionally, the team obtained PDMP reports for the 70 veterans who received these prescriptions from non-VA providers to evaluate whether the veterans' non-VA opioid prescriptions found in the PDMP reports were included in their electronic health records in accordance with the MISSION Act.⁵⁹ The team looked for opioid prescription information in the sampled veterans' electronic health records, including medication lists, reconciliation notes, and scanned images of non-VA consults.

The following determinations formed the basis for the finding and led to the OIG's recommendations:

- Many non-VA providers had not completed the OSI training and certified they received and reviewed the OSI guidelines on safe opioid-prescribing practices.
- IVC did not monitor third-party administrators to ensure non-VA providers completed PDMP queries.

Many Non-VA Providers Had Not Completed the OSI Training on Safe Opioid-Prescribing Practices

IVC and third-party administrators did not ensure non-VA providers completed the OSI training to certify they had received and reviewed the OSI guidelines. The audit team reviewed VA's training records and found that 62 of 65 providers who issued the sampled prescriptions had not completed the training. Based on these results, the team estimated that about 14,700 of the approximately 18,200 non-VA providers in the TriWest and Optum networks who issued opioid prescriptions during the audit period had not reviewed the OSI guidelines and certified they completed VA's OSI training.

To comply with the MISSION Act and as recommended by a prior OIG report, IVC created an automated training module that covered OSI guidelines and expected the third-party administrators to ensure non-VA providers in their networks completed it. The training was a

⁵⁹ MISSION Act § 131(c)(2)(A), 38 U.S.C. § 1701 note.

two-page document summarizing the OSI guidelines with hyperlinks to additional information, including the OSI guidelines on VA's website. After reading the training document, providers click on a button to electronically sign or certify that they have reviewed the guidelines outlined in the OSI training module. The providers' training certifications are recorded in VA's Training Finder Real-Time Affiliate Integrated Network system, and IVC staff stated they use this system's information to update VHA's provider profile management system weekly to reflect the completed OSI training.

CCN Contract Language Does Not Adequately Address MISSION Act OSI Requirements

The team found the CCN contract language did not match IVC's expectations.⁶⁰ The contracts require the third-party administrators to develop and implement an outreach and education program for the network providers. The IVC acting deputy chief for contract administration told the team he expected third-party administrators to ensure that providers in their networks completed VA's OSI training as part of this outreach and education program. Both CCN contracts stated that provider outreach and education programs must include, at a minimum, "network participation requirements (e.g. compliance with VA Opioid Safety Initiative supplied by VA)." However, the CCN contracts did not specifically discuss how the third-party administrators should implement the training requirement and ensure providers completed it. For example, TriWest's contract only stated that

the contractor will ensure that all covered health care prescribing providers are provided a copy of and certify that they have reviewed the evidence-based guidelines for prescribing opioids set forth by the Opioid Safety Initiative of the Department of Veterans Affairs.

Thus, TriWest's contract required it to ensure prescribing providers certified their review of the guidelines, but it did not specify TriWest's role in the certification process. Optum's contract lacked a similar provision and was silent regarding OSI training requirements for providers. TriWest's provider manual informs providers that "Section 131 of the Department of Veterans Affairs (VA) MISSION Act of 2018 requires all CCN providers with a [Drug Enforcement Agency] number who can prescribe medications for Veterans to complete opioid safety training within 180 days of July 1, 2020." The manual also indicates the training is available on TriWest's website. The language in TriWest's manual shows TriWest's efforts to make providers aware of the training. Optum's provider manual required providers to complete any

⁶⁰ Due to the timing of the CCN contract awards, IVC stated that the inclusion of the MISSION Act opioid requirements was not completed in CCN contracts for regions 1-4, and IVC is attempting to modify the CCN contracts to include MISSION Act requirements.

applicable VA-required trainings but did not specifically mention the OSI guidelines or VA's OSI training.⁶¹

The IVC acting deputy chief for contract administration took the position that provider outreach and education program requirements in the CCN contracts and the contractual relationship between the non-VA providers and the third-party administrators made the third-party administrators responsible for ensuring non-VA providers completed the OSI training. Further, the IVC acting deputy chief for contract administration asserted that completing this training was a condition for providers to join the networks. The audit team found that the CCN contracts required the third-party administrators to offer providers training on VA program requirements, policies, procedures, and other areas as necessary for the performance of the CCN contracts. However, the CCN training requirements did not specifically state that completion of VA's OSI training is mandatory. Under this provision, TriWest and Optum officials were responsible for including VA's OSI guidelines in their education programs, but they disagreed with the IVC acting deputy chief for contract administration's position that it was the third-party administrator's obligation to ensure that non-VA providers completed the OSI training. TriWest officials believed it was VA's responsibility to monitor non-VA providers' certifications and OSI training compliance because the OSI training module transmitted the providers' certifications back to IVC, which VA officials acknowledged. Optum officials stated they had not fully implemented training requirements due to contract modifications in process. Furthermore, neither TriWest nor Optum made completing VA's OSI training a condition for non-VA providers to join the network.

VA's contracting officers for both the TriWest and Optum contracts stated,

The contractors are in compliance with the current contract. However, the Community Care Network (CCN) requirement/program is not in compliance with the Mission Act #131 Opioid Training Program. There are on-going efforts by Integrated Veterans Care (IVC) to implement the change to bring the requirement/program into compliance with the Mission Act.

These contracting officers also stated that the contracts only require the third-party administrators to make VA's OSI training available, and they have not received a final contract change request to make completing OSI training a network participation requirement. The audit team noted that IVC did not effectively follow up with the contracting officers and third-party administrators when non-VA providers did not certify they completed the OSI training. Thus,

⁶¹ The audit team reviewed language in the provider manuals to assess the third-party administrators' efforts to implement OSI provisions found in the CCN contracts.

these providers may not be aware of VA’s OSI guidelines and the importance of evidence-based risk-mitigation strategies, such as PDMP queries.

The Optum contract has been in place since December 2018. As of October 2022, IVC officials stated that the CCN contracts have not been modified. VA contracting officers stated they were working to add specific requirements to the Optum CCN contracts to ensure non-VA providers receive and review OSI guidelines. However, they stated they have not modified the TriWest contract for region 4, which also does not clearly state how the third-party administrator should certify that their network providers have addressed MISSION Act OSI requirements.

According to the IVC deputy executive director for external networks, IVC is trying to avoid imposing barriers to non-VA providers treating veterans:

If VA were to penalize providers by restricting referrals or obstructing association to the community provider network, it would be a detriment to network adequacy. Such a requirement would hinder Veteran access to care and would not function in Veterans’ best interests.

IVC also reported various steps and efforts to ensure non-VA providers receive and certify they reviewed the OSI guidelines. The deputy executive director stated that VA is trying to improve training compliance by actively creating education materials, interacting with non-VA providers to increase awareness of the OSI guidelines, and including the OSI guidelines in the welcome packets third-party administrators give new providers before they receive referrals for veterans.

IVC Needs to Strengthen Monitoring of Third-Party Administrators to Ensure PDMP Queries Are Completed

As previously stated, the CCN contracts require TPAs to ensure or confirm providers comply with federal and state laws, including state PDMP laws. Additionally, providers are required to complete PDMP queries for urgent/emergent prescriptions even if the prescription is exempt under the providers’ state laws. The language in the contracts does not specify if PDMP queries should be performed only for urgent/emergent prescriptions or for all controlled substance prescriptions.⁶²

According to Optum’s provider manual, “[B]efore prescribing controlled substances for a Veteran, VA requires providers to check their state’s prescription-monitoring program to see if the Veteran has been prescribed other controlled substances.” Optum officials stated that this applies to all controlled substance prescriptions and not just urgent/emergent prescriptions. TriWest includes similar language in the “Urgent/Emergent Medicine” section of its provider manual: “CCN providers must check with their state’s prescription monitoring program for any

⁶² IVC contends that the contract requirement to complete PDMP queries applies for all controlled substances. The audit team took a more conservative approach and applied this requirement to urgent/emergent prescriptions due to the contract being unclear regarding this requirement.

controlled substance utilization prior to writing any controlled substance prescription for a Veteran to ensure appropriate opioid/controlled substance use.” However, most state law requires such checks in non-emergent situations, and the third-party administrators must ensure or confirm providers comply with state law.

To determine whether non-VA providers are completing required PDMP queries, the team attempted to reach the 65 providers who issued the 70 sampled opioid prescriptions. Twenty-six of the providers either did not respond to the team’s inquiries, were not reached due to inaccurate contact information, or refused to speak with the team due to patient privacy concerns.⁶³ The team reached 39 providers or their office staff to confirm if PDMP queries were completed for 44 of the sampled prescriptions. Twenty-two of the providers reported they completed the required PDMP queries when they issued the sampled prescriptions. However, only eight providers were able to or chose to provide the team with supporting documentation to confirm the PDMP queries were completed, even though several of the states in the sample require providers to maintain documentation of PDMP queries.

The remaining providers who issued 17 prescriptions, seven of which were urgent/emergent, reported that they did not complete the required PDMP queries. This was not detected by either IVC or the third-party administrators because neither has established any mechanisms to monitor whether providers completed required queries.

Non-VA Providers Did Not Always Follow Third-Party Administrator and Applicable State and CCN PDMP Requirements

Of the 17 prescriptions that lacked required PDMP queries, the team determined that eight were issued by Optum providers, and nine were issued by TriWest providers. Moreover, only two of the TriWest providers had certified they received and reviewed the OSI guidelines.

Optum Providers

The eight Optum providers did not meet their state, CCN, or Optum PDMP requirements when they issued opioid prescriptions, including urgent/emergent prescriptions. For three of the prescriptions, the Optum providers did not meet their state’s PDMP query requirements. For the five remaining prescriptions, some providers were not aware that PDMP queries were still required for urgent/emergent prescriptions under the CCN contracts, even if some of their states exempted these types of prescriptions. All eight of these prescriptions, regardless of their state or CCN PDMP requirements, should have had a PDMP query conducted based on the guidance in Optum’s provider manual. The manual stated that all controlled substance prescriptions for

⁶³ The audit team made at least three attempts via telephone and/or email to contact non-VA providers or their office staff.

veterans required PDMP queries. Example 1 demonstrates an instance in which a provider did not understand Optum's PDMP requirements.

Example 1

A non-VA provider in Ohio prescribed a seven-day supply of hydrocodone to a veteran in October 2020. According to the provider, he typically does not conduct PDMP queries because he usually issues short-term urgent/emergent prescriptions (a supply for three to seven days), and under Ohio's law, the provider is not required to conduct PDMP queries for these types of prescriptions. He was unaware of the guidance in the Optum provider manual that required PDMP queries for all opioid prescriptions issued to veterans, including urgent/emergent opioid prescriptions. As a result, this provider issued the veteran two consecutive urgent/emergent prescriptions of hydrocodone for a total of 14 days without completing a PDMP query for either prescription.

TriWest Providers

For the nine sampled prescriptions where TriWest providers acknowledged it did not perform required PDMP queries, seven prescriptions required queries under state law and two urgent/emergent prescriptions should have had queries according to TriWest's CCN contract and provider manual. Some TriWest providers stated they were not aware of any PDMP requirements besides those in their state laws. They were unaware of the guidance in the provider manual that required PDMP queries for urgent/emergent prescriptions, which in most cases exceeded their state PDMP requirements. Similar to the Optum providers, the TriWest providers and their staff did not always know why the queries were not performed. One TriWest provider who worked in an emergency room admitted they only performed queries for about 80 percent of controlled substance prescriptions. Although most TriWest providers told the audit team that they were aware of their state laws, example 2 demonstrates how some providers did not understand whether their state law required PDMP queries.

Example 2

A non-VA provider for TriWest in Hawaii prescribed a 30-day supply of fentanyl to a veteran in April 2021. This prescription was one of 12 fentanyl prescriptions the provider issued to this veteran between October 1, 2020, and September 30, 2021. Under Hawaii's laws, the provider was required to query the PDMP before issuing this prescription. However, the provider stated he had not queried the PDMP for the veteran since July 15, 2020, or about nine months before the issuance of the sampled prescription. The provider stated he performed PDMP queries for prior prescriptions but did not conduct a query for this monthly

prescription because he did not consider the veteran a high-risk patient, and this was a routine prescription.

IVC Did Not Monitor Non-VA Provider Compliance with State or Contract PDMP Requirements

IVC did not monitor third-party administrators or establish other controls to ensure non-VA providers queried state PDMPs as required by state laws or the CCN contracts. According to the CCN contracts, Optum and TriWest are responsible for ensuring or confirming their providers meet state licensure requirements and follow state laws.⁶⁴ Optum and TriWest officials expected their providers to comply with state laws, as communicated in their provider manuals, but they stated they do not monitor the providers' completion of PDMP queries. One TriWest official assumed the providers are meeting their state PDMP requirements if they are licensed to practice in their states. He asserted that monitoring providers' compliance with PDMP requirements is the responsibility of state licensure boards or the Drug Enforcement Administration. Thus, the third-party administrators are not monitoring providers' compliance with PDMP requirements mandated by state law or as instructed in their provider manuals.

IVC officials contend that oversight of non-VA providers is delegated to the third-party administrators under the CCN contracts. However, IVC's contracting officer representatives and VA's contracting officers are responsible for monitoring the third-party administrators' contract performance and compliance with the contracts' provisions. Despite requirements that other entities, such as state boards or the Drug Enforcement Administration, may establish for providers, the third-party administrators still need to comply with contract provisions, including those requiring that providers adhere to state law. IVC did not coordinate with the contracting officers to ensure they monitored and evaluated the third-party administrators' oversight of their providers' compliance with state PDMP laws and the CCN contracts.

Furthermore, the team determined that although VHA has implemented controls to monitor non-VA opioid-prescribing practices in response to the 2019 OIG report, IVC has not implemented specific monitoring controls to ensure these providers conduct required PDMP queries.⁶⁵ In that 2019 report, the OIG recommended that VHA adhere to the OSI guidelines, including guidelines for PDMP queries; ensure non-VA providers comply with their state licensure requirements; and monitor non-VA providers to ensure appropriate corrective actions are taken when their prescribing practices are found to be inconsistent with the OSI guidelines.⁶⁶

⁶⁴ Contracts between VA and Optum Public Sector Solutions, Inc. Region 1, p. 54 and 59; Region 2, p. 54 and 60; Region 3, p. 55 and 61; and TriWest Healthcare Alliance, Region 4, p. 28 and 36.

⁶⁵ VA OIG, *State Prescription Drug Monitoring Programs Need Increased Use and Oversight*.

⁶⁶ VA OIG, *State Prescription Drug Monitoring Programs Need Increased Use and Oversight*. The MISSION Act went into effect after the audit time frame of this report, but it also required VA to take action, as appropriate, if it identifies prescribing practices that are inconsistent with OSI guidelines.

IVC concurred with these recommendations and reported in its action plan that it would develop a monthly review process to monitor non-VA provider opioid-prescribing data within each VISN. The team confirmed that VHA has established VISN community care oversight committees to review non-VA provider opioid-prescribing data, including types of opioid prescribed, dosages, and drug combinations with benzodiazepines. However, these committees do not review the non-VA care providers' compliance with their state and CCN contract PDMP requirements, and this was not a specific recommendation in the 2019 OIG report.

The checklist for the review of opioid-prescribing practices that the IVC provided the VISN community care oversight committees does not include a check to ensure non-VA providers conduct PDMP queries. According to IVC's clinical lead health system specialist, one of the reasons why the PDMP check was excluded from IVC's checklist was because VA does not have an electronic tool or mechanism to verify the queries have been completed without searching through medical records. Medical facility staff also expressed concerns to the team, stating they cannot confirm whether non-VA providers completed queries when documentation of non-VA healthcare for veterans is limited or not provided. Although the OIG recognizes the monitoring challenges VA faces in ensuring non-VA providers comply with state and CCN PDMP query requirements, VA should also revisit its efforts to develop PDMP-monitoring controls for non-VA providers.

CCN contracts require non-VA opioid prescriptions for more than seven days be dispensed at VA pharmacies.⁶⁷ Furthermore, some state laws and local VA medical facility policies require dispensing VA pharmacies to perform their own PDMP queries when filling opioid prescriptions. These practices may help mitigate the risks to veterans when non-VA providers do not perform required PDMP queries. However, these practices do not negate or replace IVC's and third-party administrators' oversight responsibilities and the need to comply with state and contract PDMP requirements.

Non-VA Prescriptions for Opioids Were Generally Found in Veterans' Medical Records, Meeting MISSION Act Documentation Requirements

The sampled non-VA opioid prescriptions were generally included in veterans' electronic health records in compliance with the MISSION Act. However, the team determined this information was not always in the non-VA medication section of the medication profile, as required by VA policy at the time of the audit.⁶⁸ Since this information was located in different sections of the VA medical records, VHA cannot be certain that providers can easily access this information.

⁶⁷ CCN contracts state that an urgent/emergent prescription is available for a maximum of 14 days with no refills. Opioids for urgent/emergent prescriptions are allowed up to seven days (or the state limit), whichever is fewer, with an allowance for a second refill up to seven days (within 30 days) for a total of 14 days.

⁶⁸ VHA Handbook 1108.05(2), *Outpatient Pharmacy Services*, amended on February 6, 2020. This handbook was effective during the audit's time frame. This handbook was rescinded and replaced by VHA Directive 1118.07, *General Pharmacy Service Requirements* (November 28, 2022), which also included the same requirement.

Given the CDC finding that most fatal opioid overdoses are associated with patients who receive prescriptions from multiple healthcare providers, it is critical that providers have easy access to prescription information to make informed treatment decisions.⁶⁹ The team did not make a recommendation for the non-VA opioid prescriptions that were not documented in the non-VA medication section of the medical records in accordance with VA policy because an OIG health care inspection team is reviewing this issue.

Conclusion

VA has not implemented effective monitoring mechanisms for third-party administrators or non-VA providers to promote safe opioid-prescribing practices in accordance with the MISSION Act when veterans receive care in the community. Based on the OIG team's results, an estimated 14,700 non-VA providers in the Optum and TriWest CCNs have not completed the OSI training to certify they received and reviewed the OSI guidelines. In addition, IVC has no assurance that non-VA providers are abiding by state laws or provider manuals and completing required PDMP queries when prescribing opioids to veterans. When non-VA providers prescribe opioids to veterans without conducting PDMP queries, they limit the information available to make treatment decisions for veterans and place those veterans at greater risk of potential drug interactions and adverse effects.

Recommendations 1–3

The OIG made the following recommendations to the under secretary for health:

1. Clarify roles and responsibilities of the Office of Integrated Veteran Care and third-party administrators with respect to ensuring non-VA providers receive and certify they have reviewed Opioid Safety Initiative guidelines in accordance with the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and

⁶⁹ CDC, "CDC Guideline for Prescribing Opioids for Chronic Pain – United States, 2016."

Strengthening Integrated Outside Networks Act of 2018 and collaborate with the contracting office to modify the contracts as appropriate.

2. Ensure the Office of Integrated Veteran Care strengthens controls to monitor the third-party administrators to ensure non-VA providers' completion of the VA Opioid Safety Initiative training module.
3. Ensure the Office of Integrated Veteran Care strengthens controls to monitor the third-party administrators to ensure non-VA providers' completion of required prescription drug monitoring program queries.

VA Management Comments

The under secretary for health, in collaboration with IVC, concurred with all three OIG recommendations and submitted action plans.⁷⁰ Appendix D provides the full text of the under secretary's comments.

In response to recommendation 1, IVC will evaluate current CCN contract requirements for reviewing the OSI guidelines and clarify roles and responsibilities, where applicable.

For recommendation 2, a team of stakeholders will review the effectiveness of existing controls over the third-party administrators' efforts to ensure non-VA providers complete VA OSI training. The team will analyze the information to determine if there are any areas for improvement and recommend a way forward. Follow-up will be conducted throughout the year.

For recommendation 3, a team of stakeholders will review the effectiveness of existing controls over the third-party administrators' efforts to ensure non-VA providers complete PDMP queries. The team will analyze the information to determine if there are any areas for improvement and recommend a way forward. Follow-up will be conducted throughout the year.

OIG Response

The under secretary for health, in coordination with IVC, provided technical comments during the reply period. The OIG revised this report when the comments enhanced the accuracy of the report. Such changes are footnoted throughout.

The OIG will assess the satisfactory completion of these claimed actions in conjunction with its routine recommendation follow-up. Overall, the proposed corrective measures in VA's action plans appear to be responsive to the recommendations, and the OIG will monitor the implementation of the recommendations until all actions are documented as completed.

⁷⁰ The under secretary for health provided a response on June 23, 2023; at that time, the OIG incorporated the response.

Appendix A: VA, Third-Party Administrators, and Non-VA Provider Responsibilities

MISSION Act Opioid Safety Initiative Guidelines Requirements

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 requires VA to ensure that all covered healthcare providers receive a copy of and certify that they have reviewed the Opioid Safety Initiative (OSI) guidelines. To fulfill this requirement, VA

- created Community Care Network (CCN) contracts with third-party administrators to manage the network and
- developed OSI training and made it available to third-party administrators for their network providers.

TriWest's CCN contract requires that "the Contractor will ensure that all covered health care prescribing providers are provided a copy of and certify that they have reviewed the evidence-based guidelines for prescribing opioids set forth by the Opioid Safety Initiative of the Department of Veterans Affairs." Furthermore, the contract states, "The Contractor's outreach and education program must include ... Network participation requirements (e.g., compliance with VA Opioid Safety Initiative supplied by VA)." To meet these requirements, TriWest

- created a provider manual to communicate requirements to their network providers;
- included language in the provider manual that states, "Section 131 of the Department of Veterans Affairs (VA) MISSION Act of 2018 requires all CCN providers with a [Drug Enforcement Agency] number who can prescribe medications for Veterans to complete opioid safety training within 180 days of July 1, 2020"; and
- included a link to OSI training in their provider manual and on their website.

Optum's CCN contract requires that "the Contractor's outreach and education program must include ... Network participation requirements (e.g., compliance with VA Opioid Safety Initiative supplied by VA)." Optum also created a provider manual to communicate requirements to their network providers. However, the provider manual is silent on OSI training and compliance with OSI guidelines as a requirement for network participation.

Non-VA providers are required to comply with the third-party administrators' provider manuals. Although both the TriWest and Optum manuals require providers to complete training, only TriWest's manual requires providers to complete VA's OSI training specifically.

Prescription Drug Monitoring Program Query Requirements

To manage pain in veteran patients while limiting the risks of opioid therapy, VA and the Department of Defense created the OSI guidelines, which include the use of prescription drug monitoring programs (PDMP) as a mitigation strategy. The CCN contracts require third-party administrators to ensure or confirm all non-VA providers abide by state laws. Most state laws require the completion of PDMP queries. Moreover, the “Urgent/Emergent Prescriptions,” sections of both the TriWest and Optum contracts state that the contractor must require or instruct CCN providers to check with their state’s prescription monitoring program for any controlled substance use before writing any controlled substance prescription for a veteran. This helps ensure appropriate opioid/controlled substance use. The third-party administrators communicate these contract requirements to providers in their provider manuals.

TriWest’s provider manual states that

- “all services, facilities, and CCN providers are in compliance with ... applicable Federal and State laws,” and
- regarding urgent/emergent medicine, “CCN providers must check with their state’s prescription monitoring program for any controlled substance utilization prior to writing any controlled substance prescription for a Veteran to ensure appropriate opioid/controlled substance use.”

Similarly, Optum’s provider manual states that

- “all services, facilities and providers must adhere to all applicable federal and state regulatory requirements,” and
- “before prescribing controlled substances for a Veteran, VA requires providers to check their state’s prescription-monitoring program to see if the Veteran has been prescribed other controlled substances. This can help providers and Veterans ensure appropriate use of controlled substances.”

Non-VA providers are required to comply with third-party administrators’ provider manuals, including abiding by state laws and conducting PDMP queries when prescribing opioids to veterans.

Appendix B: Scope and Methodology

Scope

The audit team conducted its work from January 2022 through April 2023 and performed virtual site visits at the following locations:

- VA Pacific Islands Health Care System (Honolulu, Hawaii)
- VA Southeast Louisiana Veterans Healthcare System (New Orleans, Louisiana)
- VA Gulf Coast VA Healthcare System (Biloxi, Mississippi)
- VA Chillicothe Healthcare System (Chillicothe, Ohio)
- VA Southern Nevada Healthcare System (Las Vegas, Nevada)
- VA Western New York Healthcare System (Buffalo, New York)
- El Paso VA Health Care System (El Paso, Texas)

Methodology

The team identified and reviewed applicable requirements from the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018; state laws; and community care contract regulations. The team also reviewed local policies, procedures, and guidelines related to prescription drug monitoring program (PDMP) queries and opioid prescription documentation.

In coordination with VA Office of Inspector General (OIG) statisticians, the team reviewed a sample of 10 prescriptions written by non-VA providers and filled at VA pharmacies for patients from seven VA medical facilities during the 12-month period ending on September 30, 2021, (total sample, 70 prescriptions).⁷¹ The team excluded states that did not have established PDMP laws for prescribers at the time of the audit. The team also excluded prescriptions for veterans in hospice or palliative care or who were actively receiving cancer treatment during the audit period. After applying contract, provider manual, and state PDMP query requirements to sampled prescriptions, the team interviewed non-VA providers to determine whether they performed PDMP queries and received Opioid Safety Initiative (OSI) training developed by VA's Office of Integrated Veteran Care (IVC). The team also reviewed IVC training records. Additionally, the team obtained the veterans' PDMP reports to determine if all non-VA opioid prescriptions were reported to VA and included in the veterans' health records.

⁷¹ From the 70 prescriptions reviewed, the audit team identified five non-VA providers prescribing more than one opioid medication in the sample.

The team replaced some medical facilities in its sample after staff at these medical facilities voiced concerns that obtaining PDMP queries for the team might violate their state PDMP disclosure laws. The OIG has the authority to access veteran health information necessary to carry out its oversight duties in all states because federal law supersedes any conflicting state laws. However, the team decided to replace these medical facilities because medical facilities in other states could provide the queries, and this decision would facilitate the timely receipt of the PDMP information needed to complete the audit.

Each state can structure its PDMP-reporting period and information differently. For this reason, the team adjusted the audit methodology during the review period with the data available from New York PDMP reports. While all the other states in the audit sample had PDMP reports that included two years of prescription data, New York's PDMP only included data going back for one calendar year. For this reason, the PDMP reports obtained from the New York PDMP database did not always include the full 12 months of the audit period ending on September 30, 2021. The team compared these PDMP reports with the information found in the patient records for the analysis.

The team made three attempts and enlisted the assistance of the third-party administrators to reach each non-VA provider (or their staff) who issued a sampled opioid prescription. The team attempted to reach the providers to ascertain if a query had been completed; if not, to determine why not; and to obtain any available supporting documentation. The team reached 39 of the 65 providers (60 percent) included in the sample of 70 opioid prescriptions, but considered these responses representative of the population and the rate of response sufficient for the purposes of the audit.

The team determined that with the adjusted methodology it could obtain sufficient, appropriate PDMP query information and evidence to meet the objectives of the audit and provide a reasonable basis for the audit's findings and conclusions.

Internal Controls

The team assessed IVC's internal controls that are significant to the audit's objective. This included an assessment of the five internal control components: control environment, risk assessment, control activities, information and communication, and monitoring.⁷² In addition, the team reviewed the principles of internal controls as associated with the objective. The team identified the following five components and eight principles as significant to the objective.⁷³

⁷² Government Accountability Office, *Standards for Internal Control in the Federal Government*, GAO-14-704G, September 2014.

⁷³ Because the audit was limited to the internal control components and underlying principles identified, it may not have disclosed all internal control deficiencies that may have existed at the time of this audit.

The team identified internal control weaknesses during this audit and proposed recommendations to address the following control deficiencies:

- Component: Control Environment
 - Principle 2: Exercise Oversight Responsibility
 - Principle 5: Enforce Accountability
- Component: Risk Assessment
 - Principle 7: Identify, Analyze, and Respond to Risk
- Component: Control Activities
 - Principle 10: Design Control Activities
 - Principle 12: Implement Control Activities
- Component: Information and Communication
 - Principle 14: Communicate Internally
- Component: Monitoring
 - Principle 16: Perform Monitoring Activities
 - Principle 17: Evaluate Issues and Remediate Deficiencies

Fraud Assessment

The audit team assessed the risk that fraud and noncompliance with provisions of laws, regulations, contracts, and grant agreements, significant within the context of the audit objectives, could occur during this audit. The team exercised due diligence in staying alert to any fraud indicators, including

- prescriptions issued after a patient's date of death and
- sampled non-VA providers excluded from the VA CCN program per the List of Excluded Individuals/Entities.

The OIG did not identify any instances of fraud or potential fraud during this audit.

Data Reliability

The team used computer-processed data from the Veterans Health Information Systems and Technology Architecture. To test for reliability, the team determined whether any data were missing from key fields or were outside the time frame requested and assessed whether the data were consistent with the intent of the project and contained obvious duplication of records. Furthermore, the team compared the sampled patients' names, social security numbers,

prescription medication names, and issued prescriptions and release dates with information in the patients' electronic health records.

Testing of the data disclosed that they were sufficiently reliable for the review objectives. Comparison of the data with information contained in the patients' medical health records did not disclose any problems with data reliability.

Government Standards

The OIG conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on audit objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the audit objectives.

Appendix C: Statistical Sampling Methodology

Approach

To accomplish the objective, the team reviewed a statistical sample of opioid prescriptions that were prescribed by non-VA providers and were filled at VA pharmacies for veterans during the 12-month period ending on September 30, 2021. In coordination with VA Office of Inspector General (OIG) statisticians, the team used statistical sampling to quantify the extent that a prescription drug monitoring program (PDMP) query was not conducted for that prescription by a non-VA provider. The team asked the facility to run a PDMP query for the sampled veterans during the audit period to determine if any opioid prescriptions were not found in the veteran health records.

Population

The review population comprised about 146,000 opioid prescriptions issued to approximately 48,100 veterans by non-VA providers from October 1, 2020, to September 30, 2021. The team evaluated whether non-VA providers performed required PDMP queries in accordance with state regulations and Community Care Network (CCN) contracts when prescribing opioids to veterans and if documentation requirements from the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 were met.

Sampling Design

The team used a stratified multi-staged sampling approach to select a statistical sample of 70 prescriptions. The population of opioid prescriptions was first stratified into four strata based on the five geographical regions assigned to the contracts (see table C.1). Although region 4 and region 5 were combined due to their size, only samples from region 4 were selected in the sample. Therefore, the CCN contract for region 5 was not selected in the sample. Within each stratum, stations were selected with probability proportional to the number of prescriptions associated with each station. This was done by first selecting one or more states per stratum and then selecting one station for each of these states. For these stations, prescriptions were selected systematically, after ordering prescriptions by their drug class schedule (classes II through IV) and the veteran associated with them. This methodology ensured that the team obtained a representative sample of opioid prescriptions written by non-VA providers for veterans across the population.

Table C.1. CCN Regions by Contract and Location

Region 1	Region 2	Region 3	Region 4	Region 5
Optum (stratum 1)	Optum (stratum 2)	Optum (stratum 3)	TriWest (stratum 4)	TriWest (stratum 4)
Connecticut	Illinois	Alabama	American Samoa	Alaska
Delaware	Indiana	Arkansas	Arizona	
District of Columbia	Iowa	Florida	California	
Maine	Kansas	Georgia	Colorado	
Maryland	Kentucky	Louisiana	Guam	
Massachusetts	Michigan	Mississippi	Hawaii	
New Hampshire	Minnesota	Oklahoma	Idaho	
New Jersey	Missouri	Puerto Rico	Montana	
New York	Nebraska	South Carolina	New Mexico	
North Carolina	North Dakota	Tennessee	Nevada	
Pennsylvania	Ohio	Virgin Islands (US)	Northern Mariana Islands	
Rhode Island	South Dakota		Oregon	
Vermont	Wisconsin		Texas	
Virginia			Utah	
West Virginia			Washington	
			Wyoming	

Source: VA OIG analysis based on sampling design from VA OIG statisticians and CCN contracts and community care information from VA.gov.

Note: For America Samoa, Guam, Puerto Rico, the US Virgin Islands, and the Northern Mariana Islands, PDMP laws either did not apply, or VA had not issued a CCN contract at the start of this audit. Therefore, the team excluded all US territories from the audit population. Missouri's state PDMP laws were just recently enacted, and their program was not fully implemented at the beginning of the audit period. Therefore, Missouri was also excluded from the audit population.

Weights

Samples were weighted to represent the population from which they were drawn, and the weights were used in the estimate calculations. For example, to estimate the number of providers who had not completed required training, the team first summed the sampling weights for all such providers in the sample, then divided that value by the sum of the weights for all sample records, and then multiplied this quotient by the known number of providers in the population.

Projections and Margins of Error

The projection is an estimate of the population value based on the sample. The associated margin of error and confidence interval show the precision of the estimate. If the OIG repeated this audit with multiple sets of samples, the confidence intervals would differ for each sample but would include the true population value approximately 90 percent of the time.

The OIG statistician employed statistical analysis software to calculate estimates, margins of error, and confidence intervals that account for the complexity of the sample design.

The sample size was determined after reviewing the expected precision of the projections based on the sample size, potential error rate, and logistical concerns of the sample review. While precision improves with larger samples, the rate of improvement decreases significantly as more records are added to the sample review.

Figure C.1 shows the effect of progressively larger sample sizes on the margin of error.

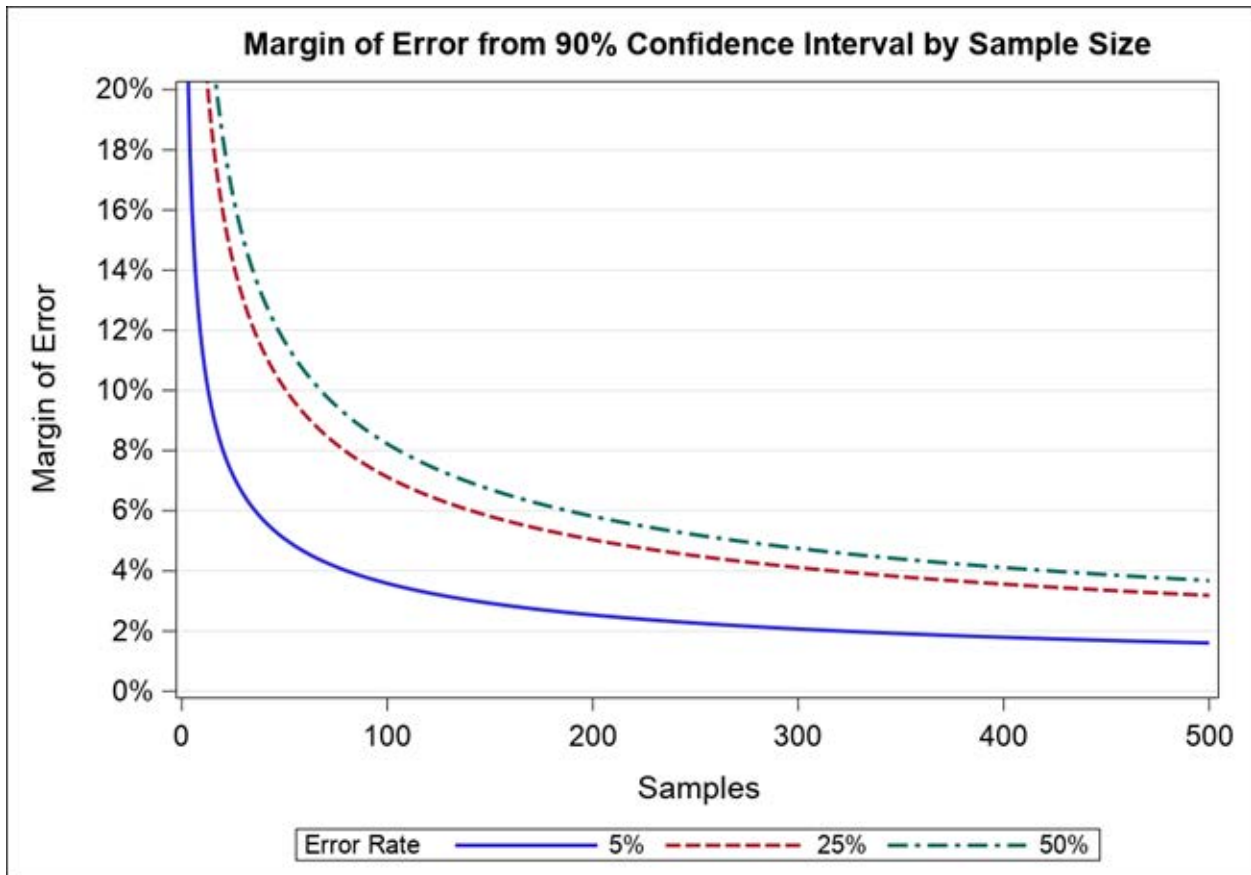


Figure C.1. Effect of sample size on margin of error.

Source: VA OIG statistician's analysis.

Projections

Table C.2 projects the number of non-VA care providers who prescribed an opioid to a veteran in fiscal year (FY) 2021 but did not complete the required Opioid Safety Initiative (OSI) training in FY 2021.

Table C.2. Statistical Projections for Non-VA Care Providers Who Prescribed an Opioid to Veterans but Did Not Complete OSI Training for FY 2021

No OSI training completed in FY 2021	Estimate number	90 percent confidence interval			Number of sampled providers without completed training	Total number of sampled providers
		Margin of error	Lower limit	Upper limit		
Non-VA Providers	14,703	3,373	11,329	18,076	62	65

Source: VA OIG statistician's projections for non-VA providers who prescribed an opioid to veterans in FY 2021 but did not complete required OSI training in FY 2021.

Appendix D: VA Management Comments

Department of Veterans Affairs Memorandum

Date: May 24, 2023

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Audit of Non-VA Healthcare Provider Practices When They Prescribe Veterans Opioids (2022-00414-AE-0024).

To: Assistant Inspector General for Audits and Evaluations (52)

1. Thank you for the opportunity to review and comment on the draft report “Audit of Non-VA Care Provider Practices When They Prescribe Veterans Opioids”. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.

2. VHA is committed to reducing opioid overdose and opioid use disorder among Veterans. In alignment with the Comprehensive Addiction Recovery Act of 2016 (Public Law 114-198), VHA’s Opioid Safety Initiative addresses providing safer prescribing and monitoring practices for management of Veterans’ chronic pain and moving towards a more Veteran-centric, biopsychosocial approach to caring for Veterans with chronic pain.

Part of that effort is informing and educating VA-affiliated community providers on safest and best practices through virtual training opportunities. VHA’s Office of Integrated Veteran Care (IVC) offers virtual training on Opioid Safety Initiative and Suicide Risk Screening. IVC publicizes these training opportunities through various communication channels; including 102,000 subscribers to VA’s Provider Advisor newsletter and other avenues managed by third party administrators, Optum and TriWest, since September 2022.

IVC is also enhancing its Community Provider Opioid Prescribing Process review requirements to ensure more stringent oversight of VA-affiliated community provider opioid prescribing practices. In the near term, VA will require Veterans Integrated Service Networks and facilities to complete regular reviews of these practices by Pain Management, Opioid Safety and Prescription Drug Monitoring Program (PMOP) committees. Using quarterly metrics consolidated on a virtual Opioid Safety Initiative dashboard, PMOP committee members will be able to examine data related to opioid and benzodiazepines, morphine equivalent doses and new long-term opioid therapies to review providers at high risk of being vulnerable to unsafe prescribing practices.

A memo detailing updated guidelines and tools to facilitate these reviews and clarifying guidance on how to regularly and closely monitor completions and results is anticipated for release in May 2023. Two communication campaigns focusing on enhancing acceptance of these training opportunities and understanding the robust audit process for providers who overprescribe opioids is scheduled to begin in June 2023.

The OIG removed point of contact information prior to publication.

(Original signed by)

Shereef Elnahal, MD, MBA

Attachment

VETERANS HEALTH ADMINISTRATION (VHA)

Action Plan

Audit of Non-VA Care Provider Practices When They Prescribe Veterans Opioids

(OIG 2022-00414-AE-0024)

Recommendation 1. Clarify roles and responsibilities of the Office of Integrated Veteran Care and third-party administrators with respect to ensuring non-VA providers receive and certify they have reviewed Opioid Safety Initiative guidelines in accordance with the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 and collaborate with the contracting office to modify the contracts as appropriate.

VHA Comments: Concur.

VHA Office of Integrated Veterans Care (IVC) recognizes the importance of clear roles and responsibilities for ensuring non-VA providers comply with the Opioid Safety Initiative (OSI). IVC will evaluate existing Community Care Network contract requirements pertaining to the OSI and clarify these roles and responsibilities, where applicable.

Status: In Progress

Target Completion Date: June 2024

Recommendation 2. Ensure the Office of Integrated Veteran Care strengthens controls to monitor the third-party administrators to ensure non-VA providers' completion of the VA Opioid Safety Initiative training module.

VHA Comments: Concur.

VHA IVC agrees that an opportunity exists to strengthen controls to monitor the Third-Party Administrators (TPA)s efforts to ensure non-VA providers' completion of the VA Opioid Safety Initiative training module. There are several options when setting up a system of internal controls. IVC will form an IPT of stakeholders to review the effectiveness of existing controls and determine if areas for improvement exist. The IPT will then analyze the information and recommend a way forward by December of 2023. Follow up will be conducted throughout the year.

Status: In Progress

Target Completion Date: June 2024

Recommendation 3. Ensure the Office of Integrated Veteran Care strengthens controls to monitor the third-party administrators to ensure non-VA providers' completion of required prescription drug monitoring program queries.

VHA Comments: Concur

Responsible opioid prescribing practices are essential to Veteran safety and high-quality care. VHA IVC agrees opportunity exists to strengthen controls to monitor the TPA's efforts to ensure non-VA providers complete required prescription drug monitoring program queries. There are several options when setting up a system of internal controls. IVC will form an IPT of stakeholders to review the effectiveness of

existing controls and determine if areas for improvement exist. The IPT will then analyze the information and recommend a way forward by December of 2023. Follow up will be conducted throughout the year.

Status: In Progress

Target Completion Date: June 2024

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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Pursuant to Pub. L. 117-263, section 5274, non-governmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference. The comments can be found on the [report summary page](#).

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