United States Senate

WASHINGTON, DC 20510

December 15, 2023

The Honorable Denis R. McDonough
Secretary of Veterans Affairs
810 Vermont Ave NW
Washington, DC 20420

Dear Secretary McDonough,

We write today to discuss our concerns with the Department of Veterans Affairs' (VA) oversight of non-VA providers who prescribe opioids to veterans. We are particularly concerned with providers participating in the Veterans Community Care Network (CCN) not querying state prescription drug monitoring programs (PDMPs) before prescribing opioids to veterans, creating life-threatening patient safety concerns. In Fiscal Year 2022, the Department spent more than $27 billion in the community for health care services for veterans. VA must ensure the dollars it spends result in high-quality, safe care for veterans.

Background

In 2017, the U.S. Department of Health and Human Services declared deaths involving illicit drugs and prescription opioids a public health emergency. In recognizing this epidemic, Congress included a provision in Section 131 of Public Law 115-182, the VA MISSION Act of 2018, which obligates the Department to ensure all covered non-VA health care providers certify they have reviewed the evidence-based guidelines enumerated by VA's Opioid Safety Initiative (OSI). Section 131 was included in the law as part of Congress' emphasis that non-VA providers should be informed of VA best practices and guidelines when prescribing opioids. Studies at the time indicated veterans were twice as likely to die from accidental opioid overdoses than non-veterans.

VA requires its in-house providers to check state prescription drug monitoring programs (PDMPs) to mitigate prescription drug abuse and overdose. To address the risk of overdose and misuse by veterans utilizing community care, VA extended this requirement to its community partners. To satisfy the terms of their contracts, the third-party administrators (TPAs) responsible for contracting with community care providers – Optum Public Sector Solutions, Inc., (Optum) and TriWest Health Care Alliance (TriWest) – must require CCN providers to check their state's PDMP prior to writing an urgent/emergent prescription for a controlled substance, regardless of any state law exemption. Veterans sent to VA's community care partners should never worry that providers are not in compliance with the contracts governing their care.

Oversight of Non-VA Opioid Prescribers

In a September 2023 report titled *Oversight Could Be Strengthened for Non-VA Healthcare Providers Who Prescribe Opioids to Veterans (Oversight Could Be Strengthened),* an audit by the VA Office of the Inspector General (OIG) found VA's Office of Integrated Veteran Care (IVC) did not ensure TPAs were diligently checking if non-VA providers were completing and certifying VA's OSI training module, thus failing to provide adequate oversight of CCN providers. In a separate September 2023 report titled *Review of VHA's Oversight of Community Care Providers' Opioid Prescribing at the Eastern Kansas Health Care System in Topeka and*

Leavenworth (Review of Community Opioid Prescribing), the OIG found a similar lapse in oversight resulted in patients being dually prescribed opioids and benzodiazepines from a combination of VA and CCN providers, thereby increasing patients' risk of sedation and overdose.

It is clear VA and its contracted TPAs failed to do their due diligence in ensuring the health and safety of the veterans in their care. Risk-mitigation is one of the most important steps in preventing opioid addiction. VA owes it to those in its care to take every precaution necessary as our country faces the ravages of the opioid epidemic. As stated many times before, we feel if there is an issue at one location, it will likely occur elsewhere. The Department must work not only to address the shortcomings outlined in these OIG reports but also to ensure lessons learned are implemented system-wide. This is especially true as VA starts to negotiate the contractual requirements for the second-generation CCN contracts.

The *Oversight Could Be Strengthened* audit found that, while VA's CCN contract with TriWest requires the TPA to ensure prescribing providers certified they reviewed the OSI guidelines, Optum's contract does not. Both TPAs' contracts require their outreach and education programs to include network participation requirements, including acknowledging receipt of and adherence to the OSI guidelines. However, both contracts did not require the TPAs to monitor and ensure providers actually certified their review of the OSI guidelines; therefore, neither TPA made completing VA's OSI training a condition to CCN participation. The audit found the IVC believed the TPAs' contracts required providers' completion of OSI training. Consequently, neither VA nor the TPAs monitored training completion. This miscommunication constitutes an unacceptable oversight. How does VA plan to address this specific oversight failure, and how does VA plan to avoid such situations in the future?

That same audit found approximately 14,700 of 18,200 non-VA providers in the CCN who prescribed opioids to veterans in FY 2021 had not completed VA's OSI training module and did not certify their mandated review of VA's OSI guidelines. As of August 2022, VA had just under 10,000 CCN providers across all CCN regions documented for completion of OSI training; this represents only 1.5 % of active providers targeted for OSI compliance. This unacceptable lack of adherence to OSI guidelines cannot go unchecked. To that end, the Department must do more to oversee the TPAs. What steps has VA taken to correct this oversight failure and increase OSI training completion?

The *Review of Community Opioid Prescribing* report highlighted incomplete and delayed documentation from CCN providers, including a failure to provide VA with documentation pertaining to controlled substances prescribed – such as the type of medication prescribed (e.g. opioids or benzodiazepines), the rationale for the medication, and dosing parameters. The OIG also highlighted a lack of CCN provider documentation of OSI risk-mitigation strategies. Examples where patients received multiple controlled substance prescriptions from VA and non-VA providers were also uncovered. What are VA's plans to: 1) ensure community providers query state PDMPs, 2) require provider documentation of OSI risk mitigation strategies and 3) improve care coordination through the return of medical records from community providers? The findings in this report were similar to those identified in a 2017 OIG report, *Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care*. These issues have not been adequately resolved in the five years since that report was published – VA must work more aggressively to address these concerns.

It is the responsibility of VA to ensure the veterans in its care, or that of its community partners, are being provided high-quality care. We urge VA to act to ensure our nation's veterans are not put at risk when seeking care in the community. To that end, we request VA re-examine its non-concurrence with Recommendation 5 in the *Review of Community Opioid Prescribing* report. This recommendation directed the Under Secretary for Health to consider issuing formal guidance to all VA pharmacy staff regarding best practices for conducting PDMP queries upon receipt of controlled substance prescriptions from CCN providers. VA did not concur with this recommendation, stating "This recommendation is based on review in one state. State requirements for private sector prescriber PDMP reporting vary significantly, and specific geographical nuances do not necessarily indicate a perpetual challenge across the enterprise." Too often we have seen findings in one hospital, one state, or one VISN point to a larger problem across the system. Given community providers are not consistently querying PDMPs themselves, VA must step in to protect veterans. VA can outsource the work – but it cannot outsource the responsibility for taking care of veterans. We look forward to your re-examination of this recommendation.

The OIG made three recommendations in the *Oversight Could Be Strengthened* audit, including clarification of IVC and TPA roles with respect to ensuring OSI compliance, ensuring IVC strengthens its monitoring controls over TPAs in regards to OSI compliance, and ensuring IVC more effectively monitors CCN providers' completion of required prescription drug monitoring program queries. The IVC agreed with these recommendations and has submitted action plans. We request an update on implementing these action plans no later than February 16, 2024.

We look forward to your response and thank you for your continued support of veterans.

Sincerely,

Jon Tester

Patty Murray

Mazie K. Hirono

Angus King

Tammy Baldwin

Jacky Rosen