Amidst ongoing large-scale transformation in the broader healthcare marketplace, the Veterans Health Administration (VA) is undergoing its own metamorphosis. VA is the largest integrated healthcare system in the United States, serving 9 million Veterans at 1,200 VA medical centers and clinics (1). While VA has long contracted with community providers, the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 establishes a new permanent discretionary community care program (the “Veterans Community Care Program”) (2). Here, we present a brief history of VA community care, review key elements of the Veterans Community Care Program, and explain how care delivery transformation in VA will impact community gastroenterologists.

VA COMMUNITY CARE: A BRIEF HISTORY
VA has contracted for community care since the early 1920s when Congress, through the World War Veterans Act, first narrowly authorized VA to contract with community providers in “exceptional cases” (3). Thereafter, Congress passed additional legislation authorizing VA to provide certain outpatient, inpatient, and emergency care to Veterans with and without service-connected disabilities through non-VA providers, resulting in a complicated web of programs, each with specific eligibility requirements (3). In 2014, public outrage regarding alleged wait time manipulation at the Phoenix VA and elsewhere fueled passage of the Veterans Choice Act, which established a temporary community care program (“Veterans Choice Program”) allowing eligible Veterans to access care in the community at VA expense. Roughly, 1/3rd of VA-enrolled Veterans currently participate in the Veterans Choice Program (3).

The VA MISSION Act of 2018 establishes a new permanent community care program, requiring VA to build a network of community providers through which Veterans can access care. It also consolidates and streamlines existing VA community care programs, as shown in Table 1. The vision is to create a high-performing, integrated network of VA and non-VA providers who seamlessly provide Veterans high-value care (4). An additional 640,000 VA-enrolled Veterans are estimated to be referred to the community in the initial years of MISSION implementation (5). A major potential driver of increased Veteran community care utilization is drive time eligibility (6). Given the significant number of rural Veterans and the concentration of VA specialty care in urban areas, many Veterans could logically choose to obtain even routine gastrointestinal care (such as screening colonoscopy and consultations for gastroesophageal reflux disease) in the community.

EXPANSION OF VA COMMUNITY CARE: WHAT COMMUNITY PROVIDERS NEED TO KNOW
A greater proportion of VA-enrolled Veterans use specialty care through community providers compared to primary care and mental health (7). Because gastroenterology is one of the most referred-to specialties (and gastroenterologists are among the most difficult to recruit VA specialists) (8,9), community gastroenterologists are very likely to be affected by the MISSION Act. Below are some important considerations for community gastroenterologists engaged in treating Veterans.

Recognizing the uniqueness of VA-enrolled Veterans
VA-enrolled Veterans (~42% of all Veterans) have unique healthcare needs and comorbidities (10). These Veterans have a higher prevalence of colorectal neoplasia than the general population, which may be explained in part by lifestyle risk factors including smoking (11). They also have disproportionate levels of comorbidity, disability, social isolation, and mental/physical impairment that may translate clinically to suboptimal bowel prep and increased “no show” rates necessitating more robust patient navigation/care management systems. Web-based training modules are available to community providers interested in learning about other unique aspects of treating Veterans (12).
Significant implementation challenges, supplemented by individual contracting/reimbursement to support an influx of Veterans into the local community.

While local VA medical centers may still contract directly with community providers in limited circumstances, these local provider agreements will require a special waiver from the VA Office of Community Care and will be approved only if there are not CCN providers in a particular market. One concern in developing a comprehensive CCN is that certain areas (e.g., rural areas, where a quarter of Veterans live) may lack an adequate provider network to support an influx of Veterans into the local community.

Participating community practices must be prepared to share certain information regarding care quality and access, as VA will implement competency-based standards for non-VA providers to ensure that comparable care quality is delivered across settings. Current VA policy requires monitoring of key colonoscopy quality metrics for all endoscopists performing colonoscopy within VA (including tracking of cecal intubation rates and adenoma detection rates, and bowel prep quality assessment), though additional measures may be added in the future. Final regulations establishing the specific quality and access standards used to guide community referrals were forthcoming at the time of this article’s acceptance, but should be available by the time of its publication.

VA increasingly will authorize community care through specialty-specific standardized episodes of care (SEOC), which outline the scope of approved services for a referred Veteran. For example, the “Upper Endoscopy and/or Colonoscopy” SEOC authorizes initial outpatient evaluation and treatment for the patient complaint referred for consultation (e.g., diarrhea or heartburn), any related diagnostic imaging/labs/pathology, relevant procedures and interventions (e.g., polypectomy or dilation), anesthesia consultation, pre-procedural medical clearance, and necessary follow-up visits and imaging related to the episode of care over a 180-day period. The purpose of SEOCs is to decrease the administrative burden on community providers by minimizing secondary authorization requests. The effect of these SEOCs on medical overuse is currently unknown—one concern is that they may in fact encourage duplicative testing/low-value care in that community providers are incentivized (under what essentially remains a fee-for-service model) to provide more care, such as repeating an upper endoscopy in a patient who had an unrevealing procedure in the VA 1 year earlier. VA aims to minimize such overuse by deploying dedicated care coordination teams to assist Veterans and community providers in exchanging critical health records and directing appropriate services. Eventually, VA hopes to transition to value-based payment, which may further reduce low-value care.

### Table 1. Comparison of VA Community Care Programs

<table>
<thead>
<tr>
<th></th>
<th>VA fee basis/non-VA medical care program</th>
<th>Veterans Choice Program</th>
<th>VA MISSION Act/VCCP</th>
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</thead>
<tbody>
<tr>
<td>Years</td>
<td>1947–Present</td>
<td>2014–2018</td>
<td>2019</td>
</tr>
<tr>
<td>Eligibility criteria</td>
<td>VA facility or services not “feasibly available”</td>
<td>Unable to schedule appointment at VA within 30 days (“wait time eligibility”) Lives &gt;40 miles from nearest VA facility (“distance eligibility”)</td>
<td>1) VA does not offer care at all or is unable to provide care within a specified wait time (proposed standard: 28 days for specialty clinics) (6); or 2) Veteran resides in a state lacking a full-service VA; or 3) Veteran lives beyond a maximum drive time from a VA facility offering the care needed (proposed standard: 60-minute average drive time for specialty care); or 4) VA cannot provide Veteran with care meeting specified VA quality standards; or 5) Veteran and primary care provider determine it is in Veterans’ “best medical interest” to receive care in the community*</td>
</tr>
<tr>
<td>Key points</td>
<td>• Individual contracting with local/regional providers • Pre-authorization required (except in emergency situations) • Each VA facility has separate criteria to determine eligibility • Claims for authorized care submitted within 6 years of service</td>
<td>• Primarily utilized 2 TPAs to coordinate care/create provider network • Significant implementation challenges, including delayed payment of claims</td>
<td>• 6 CCN regional provider networks facilitated by TPA contracts • Supplemented by individual contracting/local provider agreements • Access and quality standards to be defined in future regulations • Claims for payment submitted within 6 months of service • Payment mandated within 30 (electronic) or 45 days (paper)</td>
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CCN, Community Care Network; TPA, third-party administrator; VCP, veterans choice program; VCCP, veterans community care program.

*Patients meeting distance eligibility criteria for care under VCP also may qualify for community care under VCCP if not otherwise eligible under a legacy provision.
Under MISSION, community provider reimbursement cannot exceed Medicare rates, except in highly rural areas and states with an all-payer model (1). Provisions of the MISSION Act have sought to address some of the payment challenges that plagued the initial roll out of the Choice Program and led some providers to leave the program. A government report found that 60% of sampled claims were more than 30 days old, and the share of late payments increased with the program’s volume (14). To counter this, the MISSION Act mandates prompt payments to community providers (30 days for electronic and 45 days for paper claims).

Care coordination/referral management

While Veterans perceive that the Choice Program improved their access to care, they also reported significant challenges in navigating the process and varying levels of support in accessing community care (15). To support MISSION implementation, VA has selected a commercial software platform (HealthShare Referral Manager) to streamline referral and authorization management and to improve information-sharing between providers, which may enhance Veteran satisfaction. To promote continuity of care, community providers can request access to a web-based platform (Community Viewer) that will enable them to view the electronic health records of Veterans assigned to their care (13). Another communication tool (Virtru Pro) will allow VA to securely exchange information with community providers using encrypted email, eliminating the need for special software or accounts.

CONCLUSIONS

Successful expansion of VA community care will require enhanced coordination between VA and community providers to ensure delivery of high-quality care to Veterans across diverse settings. By recognizing the unique aspects of the Veteran population, gaining awareness of new quality and access standards, and understanding key elements of new platforms to streamline referral management and care coordination, and facilitate provider contracting and reimbursement, community providers will be well-prepared to welcome increasing numbers of Veterans into their practices and experience the rewards of serving this unique population.

ACKNOWLEDGMENTS

The authors wish to acknowledge the assistance of Dr. Clinton L. Greenstone (Deputy Executive Director of Clinical Integration, VA Office of Community Care) and Dr. Jason A. Dominitz (VA National Program Director for Gastroenterology) in reviewing and providing valuable feedback on earlier versions of this manuscript.

CONFLICTS OF INTEREST

 Guarantor of the article: Megan A. Adams, MD, JD, MSc. Specific author contributions: M.A.A.—article concept and design, drafting the manuscript; G.G.S.—critical revision of the manuscript for important intellectual content; S.D.S.—article design, critical revision of the manuscript for important intellectual content. All authors have reviewed and approved the final draft submitted.

Financial support: No specific funding for this article. However, M.A.A. is supported by an American College of Gastroenterology Junior Faculty Development Grant (2018-2021), and also currently serves as Researcher in Residence for the VA Office of Community Care, Office of Clinical Integration.

Potential competing interests: M.A.A.—currently serves as the Researcher in Residence for the VA Office of Community Care, Office of Clinical Integration, and also works clinically as a general gastroenterologist at the VA Ann Arbor Healthcare System; G.G.S.—nothing to disclose; S.D.S.—is also a general gastroenterologist at the VA Ann Arbor Healthcare System.

Disclaimer: The opinions expressed herein are personal to the authors and are not indicative of official VA positions.

REFERENCES