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Access to Mohs micrographic surgery through the Veterans Choice Program of the United States Department of Veterans Affairs

To the Editor: The Veterans Health Administration (VHA) is one of the largest health care systems in the United States, responsible for providing health care to veterans who meet eligibility requirements. This system includes 1600 facilities with more than 20,000 physicians and serves 9.1 million enrollees with an annual budget of more than $60 billion.[1]

Because of concerns about waiting times and quality of care at some Veterans Administration (VA) facilities, the Veterans Access, Choice, and Accountability Act of 2014 was enacted (Public Law 113-146)[2] to expand non-VA treatment options for eligible veterans to allow timely access to high-quality health care through the Veterans Choice Program (VCP).[3] This program, recently expanded by the VA Mission act with a budget of $55 billion, allows eligible veterans to receive care in the private sector if they have limited access due to geographic distance or if the VA is unable to provide the requested care within 30 days.

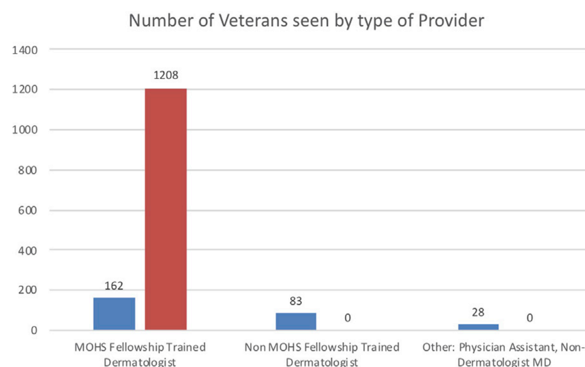

Fig 1. Distribution of patients referred for Mohs micrographic surgery from 2014 through 2017. The *blue bars* are patients who were referred for Mohs micrographic surgery to the private sector by the Veterans Choice Program. The *red bars* are the patients who received Mohs micrographic surgery within the Veterans Administration facility during the same time period.

In this cross-sectional observational study, we examined access to Mohs micrographic surgery at the VA Northern California Health Care System, (7 sites) to see whether the goals of the VCP to provide timely and high-quality care to veterans were met.

After review by the VA Mohs micrographic surgeon, patients with biopsy-proven skin cancers from October 1, 2014 through September 30, 2017, who met Mohs AUC[4] and for whom, after discussion of treatment alternatives, Mohs was deemed the appropriate therapy were referred to the private sector for Mohs micrographic surgery through the VCP if access to the VA was limited by geography or time. The outcomes recorded were provider training, time from referral to appointment, and type of procedure performed. Training and credentialing of the VCP provider was determined by cross-checking the American College of Mohs Surgery website and the Medical Board of California website.

Although the VA does not require its Mohs micrographic surgeons to be fellowship trained, 80% of VA Mohs micrographic surgeons are.[5] The law establishing the VCP states that providers must "maintain at least the same or similar credentials and licenses as those credentials and licenses that are required of health care providers of the Department"[3]; in practice, however, expertise is only self-reported (personal communication from Deputy Chief Medical Officer, TriWest Healthcare Alliance [third party administrator], 2019, to RRI).

Table I. Alternative treatments performed on patients who were referred for Mohs micrographic surgery

Variable	ED&C	Simple excision	Topical therapy	Observation	Radiation
Patients referred to					
Mohs fellowship-trained dermatologist	0	0	0	0	4
Non-Mohs fellowship-trained dermatologist	27	15	7	7	0
Non-Mohs fellowship-trained dermatologist and treated by physician extenders	9	0	4	6	0

ED&C, Electrodesiccation and curettage.

This study found that of the 273 veterans referred for Mohs micrographic surgery, 40% of patients were seen by providers who had not received fellowship training in Mohs micrographic surgery, including 6 nondermatologists and 22 physician assistants (Fig 1). Procedures other than Mohs micrographic surgery were performed in 60 patients (22%) (Table I), and 46 patients received additional unauthorized treatments unrelated to the referral, resulting in additional costs to the VCP. Furthermore, patients did not obtain more timely care than they would have within the VA system (73.7 days for VCP and 76.8 days for VA[3]).

For specialty services such as Mohs micrographic surgery, provision of care in the private sector through the VCP may not meet the stated goals of the program. Although there are limitations to this study, including lack of comparisons of long term results in the two groups, our experience with referral for Mohs micrographic surgery to non-VA providers nevertheless serves as an example of potential outcomes of the VCP. We encourage further examination of the consequences of increasing privatization of VA health care. Lessons learned from the VCP should be applied to newly formed iterations being developed for outsourcing VA care, or expanding resources for delivery of care within the VA system, to provide optimal care for United States veterans.

Supplemental expanded methods, results, and discussion can be accessed at Mendeley doi:10.17632/4bjghjtp5p.2.

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