

# DAY ONE PROJECT

Expanding the Health Policy Mission  
of the Veterans Health Administration

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July 2020

## Summary

The next administration should treat the Department of Veterans Affairs (VA) as a major health policy stakeholder, coordinating VA resources with the Department of Health and Human Services (HHS) to accelerate the adoption of high-quality healthcare.

With 1,255 VA medical facilities serving over 9 million veterans each year, the VA—through its Veterans Health Administration—maintains the largest integrated healthcare system in the United States.<sup>1</sup> The VA is a national leader in delivering quality health services and driving innovation in high-priority healthcare issues including telehealth, precision medicine, suicide prevention, and opioid safety.<sup>2</sup> Yet the VA remains an underappreciated and underutilized health policy stakeholder, minimally involved in interactions with other federal health agencies and exerting limited influence on the private healthcare system. This is a mistake. The VA is a robust healthcare provider with innovative clinical and operational practices that should be firmly entrenched in the national health policy conversation.

As a remedy, we propose strategically coordinating and consolidating the healthcare innovation, demonstration, and implementation capacities of the VA and HHS in order to ensure care of the highest possible quality across urgent issues. Elevating the VA as a major healthcare policy stakeholder will demonstrate the value of government-run healthcare, promote best practices for building an effective and forward-thinking healthcare system, and advance the VA's "fourth mission" of supporting national preparedness.

## Challenge and Opportunity

The U.S. health policy landscape is dominated by federal stakeholders that take on different roles to influence healthcare delivery across the country. Roles include providers, payers, regulators, funders, standard-setters, and conveners. The Department of Health and Human Services (HHS) has operating divisions that serve many of these functions, though no part of HHS acts as a direct healthcare provider.

By contrast, the Veterans Health Administration (VHA), a component of the Department of Veterans Affairs (VA), serves mainly as a direct healthcare provider. Passage of the MISSION Act in 2018 expanded the authority and function of the VA as a payer, regulator, funder, and standard-setter for its health system as well as for non-VA healthcare providers. Since the VA and HHS both use their authorities to incentivize high-quality healthcare, there is a ripe opportunity for the two entities to work together.

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<sup>1</sup> Veteran's Health Administration, "About VHA": <https://www.va.gov/health/aboutvha.asp>.

<sup>2</sup> Weeks, W.B.; West, A.N. (2019). "Veterans Health Administration Hospitals Outperform Non-Veterans Health Administration Hospitals in Most Health Care Markets." *Annals of Internal Medicine*, 170(6): 426–428; Price, R.A; et al. (2018). "Comparing Quality of Care in Veterans Affairs and Non-Veterans Affairs Settings." *Journal of General Internal Medicine*, 33(10): 1631–1638.

Three examples illustrate the need for the VA and HHS to consolidate and coordinate their respective health policy efforts:

1) Legacy of the Affordable Care Act (ACA). The ACA is the nation's most comprehensive healthcare legislation. Since being signed into law in 2010, the ACA has spurred creation of new organizations to guide healthcare delivery including the Patient-Centered Outcomes Research Initiative which funds research on healthcare delivery. As the nation's largest integrated healthcare system, the VA should be a key part putting the strategic agendas and research developed by such organizations into action.

2) Implementation of the MISSION Act. The 2018 MISSION Act strengthened the VA's authority to engage with non-VA healthcare providers. The legislation essentially re-established the VA as not only a provider, but also as a payer for services at non-VA medical facilities. This authority enables the VA to regulate non-VA providers through community standards and rulemaking, just as the Centers for Medicare & Medicaid Services (CMS) does for the broader health care system through HHS. New similarities between the roles of VA and CMS call for increased collaboration between the two entities.

3) Universality of interagency healthcare moonshots and challenges. The past decade has seen the advent of multiple cross-agency initiatives—such as the [Cancer Moonshot<sup>SM</sup>](#), the [BRAIN Initiative<sup>®</sup>](#), and [KidneyX](#)—to tackle some of the nation's greatest healthcare challenges. Such efforts are often coordinated by the White House Office of Science and Technology Policy (OSTP) and run by HHS entities. Extending such initiatives to include the VA will leverage the VA's value as an integrated healthcare system that can spread and scale new technologies quickly.

## Plan of Action

Adopting healthcare services proceeds via three stages: innovation, demonstration, and implementation. The innovation stage involves ideation, convening, and planning; the demonstration stage involves testing and iterating; lastly, the implementation phase involves spreading, scaling, and standardizing. The following actions will accelerate healthcare service adoption by aligning federal agency efforts at each stage.

Action 1. Consolidate and Coordinate VA and HHS Authorities. To ensure the most effective use of resources, we recommend consolidating and coordinating VA and HHS innovation, demonstration, and implementation authorities to form a Healthcare Delivery Coalition. This coalition will perform three primary functions:

- a) Share data and conclusions from innovation projects to evaluate overlapping agendas, foster collaboration, and generate new ideas. One health issue that would particularly benefit from this activity is addressing social determinants of health (SDOH). The VA

# DAY ONE PROJECT

has robust patient data related to SDOH and an agency infrastructure that integrates healthcare and social services. These data could be shared with HHS entities to develop and test new SDOH interventions in the VA system. Successful interventions could be translated to new settings via HHS policy levers such as rulemaking, guidelines, and funding.

- b) Share evidence-based healthcare delivery practices proven successful in one setting to encourage other agencies to test or implement those practices under their own authorities. To illustrate, if the VA tests and implements new clinical practice guidelines surrounding kidney care that lead to better outcomes and lower costs, CMS could pilot those practices within the systems that it works with and the Centers for Disease Control and Prevention (CDC) may decide to write new clinical guidelines for national release. Alternatively, if entities within HHS develop a new method to treat a rare disease, they could leverage VA's infrastructure as a nationwide healthcare system to test and demonstrate the intervention's utility in a multi-site trial.
- c) Accelerate active collaboration on urgent health issues through joint funding and strategy setting. To demonstrate the value of HHS-VA coordination, the Healthcare Delivery Coalition should be piloted on an urgent health issue of importance to both agencies. The VA and HHS could work together to develop a strategy that leverages their respective policy levers to achieve common objectives. Efforts to address the opioid epidemic serve as an excellent example of how the Healthcare Delivery Coalition could be applied at each stage of the healthcare service adoption pipeline. Within innovation, both the VA and the National Institutes of Health (NIH)<sup>3</sup> fund robust research portfolios on opioid safety and addiction. Improved coordination would maximize the impact of these research investments. Within demonstration, VA supports joint projects between providers and researchers to test new clinical practices such as stepped-care for opioid use disorder (OUD), while CMS funds demonstration projects to increase access to medication for OUD. Improved coordination would eliminate redundancy and facilitate information exchange among related efforts. Within implementation, CMS provides Medicare coverage to certain opioid treatment programs, and both the CDC and VA issue clinical practice guidelines. Improved collaboration would ensure standardized guidelines and promote adoption of best practices within the VA and nationwide.

Action 2. Bridge VA-HHS Strategic Activity. This action comprises two parts.

- a) The VA should be added to strategic interagency health policy coalitions including the ACA interagency working group on healthcare quality, Healthy People 2030, and the Advancing American Kidney Health initiative. As the only federal agency that acts as a direct healthcare provider with a robust intramural research program, the VHA can provide a unique value-add to such coalitions. Bringing the VA to the table would

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<sup>3</sup> NIH is part of HHS.

# DAY ONE PROJECT

expedite and improve collaboration and would broaden recognition of the VA as a key federal health policy stakeholder.

- b) To formalize and normalize strategic cooperation between the VA and HHS, Congress should require that the VA and HHS entities regularly report to a special joint committee that includes members from Congressional committees on health and on Veterans Affairs. Recent hearings in the Senate Committee on Health, Education, Labor & Pensions (HELP) would have benefited from the VA's perspective. These include hearings on 'Making Electronic Health Information Available to Patients and Providers', 'Managing Pain During the Opioid Crisis', and 'How Primary Care Affects Health Costs and Outcomes'. Each of these topics is one in which the VHA excels yet is consistently left out of the conversation.

Consolidating and coordinating operational and strategic activities of the VA and HHS will do much to improve healthcare in the United States. The actions outlined in this memo will enable the VA to build its reputation, gain bipartisan support, and contribute intellectual and project-management resources to help HHS accelerate adoption of effective healthcare services and tackle complicated health issues. Recognizing and treating the VA as a key health policy stakeholder will not only help the United States achieve short-term healthcare successes but will also pave the way for increased government activity in healthcare reform and prepare the nation to combat future public health crises.

## Frequently Asked Questions

### How does this expansion of VA activity align with its mission?

The VA has three different pillars that work together to fulfill its overall mission to serve and honor veterans. The Veterans Health Administration provides exceptional health care to improve the health and wellbeing of Veterans, the Veterans Benefits Administration provides a range of benefits to assist with the transition from military to civilian life, and the National Cemetery Administration provides dignified tributes to ensure those who served the nation are never forgotten. The VA's "Fourth Mission" is to improve the Nation's preparedness in response to war, terrorism, national emergencies, and natural disasters by serving veterans and supporting national, state, and local emergency management, public health, safety and homeland security efforts. The actions proposed in the Day One memo align with the VA's Fourth Mission, expanding the agency's role to include coordination of healthcare activities during times of peace.

### Why hasn't the VA historically been involved in health policy discussions and workgroups with HHS agencies and entities?

As outlined in the question above, the VA's mission is first and foremost to serve our nation's veterans. It is this culture of service that has limited the agency's ability, resources, and motivation to coordinate extensively with HHS entities. In addition, because the VA is funded by taxpayer dollars and must report to its own Congressional committees, the VA faces extensive oversight and political influence which makes stepping into the health policy spotlight challenging and fraught.

Beyond cultural limitations, practical constraints have also limited integration of the VA with the broader healthcare system. VA oversight is conducted by committees in the U.S. House of Representatives and U.S. Senate that are separate from the committees that write legislation related to healthcare. Hence VA representatives are rarely, if ever, at the table during critical healthcare discussions.

Lastly, while the VA has historically acted only as a healthcare provider, its role has recently expanded with the passage of legislation including the 2018 MISSION Act. This expansion, in combination with the advent of new value-based payment models at CMS and the recognition that certain problems facing veterans are not exclusive to that population (e.g., suicide, opioids misuse, prostate cancer) has provided incentive for the VA to engage more closely with HHS entities. Actions proposed in the Day One memo are designed to formalize and normalize such engagement.

### What is the most ambitious long-term vision for this proposal?

Elevating VA to a health policy stakeholder on par with HHS entities will enable the VA to participate in strategic planning for the implementation of clinical programs in order to address the nation's most important and urgent healthcare issues. In the short term, this can be achieved by including VA on relevant committees and task forces, including topic-specific groups focused on issues such as kidney care and COVID-19 efforts. In the long-term, the goal is to create a culture of collaboration wherein HHS and the VA regularly consult with each other on a wide range of healthcare issues both within and outside of standalone work groups. Ultimately, the VA and HHS should report to a joint healthcare quality task force consisting of members from Congressional committees on health and Veterans Affairs. A strong partnership between the VA and HHS will help us as a nation understand more about the value and challenges associated with government-run healthcare. This in turn will enable us to design healthcare systems that work better for civilians and veterans.

### **What precedent is there for the VA to set standards for non-VA medical facilities? Has it happened before?**

Yes. The 2018 MISSION Act set the first standards for community-care providers in the form of opioid-prescribing practices. Section 131 of the MISSION Act gives the VA the authority to ensure that all non-VA healthcare providers review the VA's evidence-based guidelines for prescribing opioids. The MISSION Act also gave the VA the authority to monitor provider adherence to those guidelines. If the provider does not satisfy the guidelines, the Secretary of the Veterans Affairs may remove the provider from its network of community care facilities. Finally, the MISSION Act grants the VA the authority to set competency standards for non-VA healthcare providers and to make rules that expand successful pilot programs. In other words, the VA has previously exercised its authority to set standards for non-VA medical facilities, and mechanisms are in place to allow the VA to do so again in the future.

### **What mechanisms in this proposal will require cooperation between HHS and VA?**

Multiple mechanisms exist to ensure that cooperation between HHS and VA is effective and sustainable. The most forceful mechanism would be for Congress to require joint reporting from HHS and VA on important healthcare topic areas. This would create a framework that requires the two agencies to be in regular contact, especially on urgent issues. Joint funding for innovation prizes, demonstration projects, or implementation studies could be another strong influence for incentivizing HHS-VA collaboration. Lastly, urgent health issues like the COVID-19 pandemic could play an outsized role in fostering immediate, sustainable collaboration and coordination.

### **How does this proposal complement the establishment of a Health Advanced Research Projects Agency (HARPA)?**

# DAY ONE PROJECT

This proposal would follow one step after work that would come out of HARPA. HARPA aims to discover and develop biomedical innovation and interventions. This proposal would help coordinate and test the delivery of such discoveries through innovation, demonstration, and implementation. HARPA should be closely engaged as efforts in this proposal are carried out. The VA should also collaborate closely with HARPA as well as HHS given that the VA has an extensive intramural research program in biomedical, clinical, and rehabilitation science.

## **How does this proposal complement the MISSION Act?**

Both proponents and opponents of the MISSION Act agree that veterans deserve access to timely, high-quality health care. The MISSION Act gave veterans access to more community providers and granted the VA the authority to influence and regulate these community providers (non-VA medical facilities) through rulemaking, standard setting, and demonstration projects. Expanding VA's mission to regulate community providers not only improves care for Veterans, but also for the rest of the nation. This is akin to how CMS sets rules for hospitals that participate in their programs. New practices and standards adopted by CMS-participating hospitals benefit not only Medicare patients, but any other patients in those hospitals. Since CMS and the VA are newly similar in this regard, it makes sense for them to coordinate their activities.

## **The VA and CMS patient populations are really different, so how will HHS-VA coordination be relevant or useful?**

While the VA and CMS patient populations are indeed different, a number of conditions affect both in large numbers. For example, the opioid epidemic, heart disease, kidney disease, and other chronic diseases of aging, are quite prevalent in both populations. It seems likely that an intervention that is delivered well in one patient population will also do well in another. While the VA and CMS have different mechanisms for requiring the adoption of clinical practices in their respective medical facilities, the end result of improving quality of care is similar.

## **Why are the military health system and TriCare not included in this healthcare coordination?**

This proposal focuses on federal healthcare institutions that serve civilian populations. Military payers and providers are under different constraints that may or may not be applicable to civilian healthcare systems. The main mission of the military health system is to ready soldiers for battle, while the main mission of civilian health systems is to provide high-quality healthcare for diverse patient populations in diverse scenarios. There may also be cultural challenges in bridging military and civilian health systems. That said, the VA does work closely with the Department of Defense on many healthcare issues (e.g., suicide prevention), so there will be opportunities to develop future healthcare efforts that involve the Department of Defense more closely.





### About the Author

Steph Guerra is a biomedical scientist currently serving as an American Association for the Advancement of Science (AAAS) Science and Technology Policy Fellow at the Office of Research and Development of the Veterans Health Administration (VHA). Steph's work at the VHA focuses on building research and clinical infrastructure to support Veterans' access to opioids management and precision oncology care. She received her Ph.D. from Harvard University and believes that innovative medical technologies should be accessible to everyone.



### About the Day One Project

The Day One Project is dedicated to democratizing the policymaking process by working with new and expert voices across the science and technology community, helping to develop actionable policies that can improve the lives of all Americans, and readying them for Day One of a future presidential term. For more about the Day One Project, visit [dayoneproject.org](http://dayoneproject.org).