



VA Recommendations to the

# ASSET AND INFRASTRUCTURE REVIEW COMMISSION

March 2022



# Volume I

Introduction, Approach and Methodology,  
and Outcomes



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# Foreword

*By Denis McDonough, Secretary of Veterans Affairs*

On behalf of the Department of Veterans Affairs (VA), I am proud to submit this report for consideration by the public, Congress and a Presidentially appointed Asset and Infrastructure Review (AIR) Commission. Undertaking a modernization effort this large is a monumental and critical task. I am grateful for the many VA employees who worked tirelessly over the past several years to develop these recommendations, the Veterans Service Organizations and state partners who provided guidance and the support of Congress throughout this process. Most important, I am grateful to the Veterans we serve—for their honest feedback and comments about their health care, for their advocacy and passion to improve VA as an institution and above all, for the sacrifices they have made on behalf of our Nation.

The recommendations within this report are the result of years of research and analysis studying VA's health care system and the Veteran population. We solicited feedback from Veterans, collected and pored over data, visited VA facilities, talked to VA employees across the country and asked ourselves one question above all else: *What's best for the Veterans we serve?*

The result of asking that question repeatedly, in markets across the country, is a set of recommendations that will:

- Cement VA as the primary, world-class provider, integrator and coordinator of Veterans' health care for generations to come;
- Build a health care network with the right facilities, in the right places, to provide the right care for Veterans in every part of the country;
- Ensure that the infrastructure that makes up VA in the decades ahead reflects the needs of 21st century Veterans—not the needs and challenges of a health care system that was built, in many cases, 80 years ago; and
- Strengthen VA's dual roles as the leading health care researchers in America, and the leading health care training institution in America.

In short, these recommendations represent a massive investment that will make VA stronger—and fortify our ability to deliver the timely, world-class health care that Veterans so rightly deserve.

Now, there are recommended changes in markets across the country, but make no mistake: we are staying in *every* market. Between outpatient care, strategic collaborations, with partners like the Department of Defense and the Indian Health Service and referrals to the community, we will continue to deliver timely access to world-class care to every Veteran in every corner of the country. In the places where there are changes, we will be shifting towards new or different infrastructure that accounts for how health care has changed, matches the needs of a market, strengthens our research and education missions, and ensures that the Veterans will have access to the world-class care they need, when and where they need it.

In some markets, the Veteran population is rapidly increasing, so we are adding new medical centers, community-based outpatient clinics and other facilities to meet that ever-growing demand. In other markets, the opposite is happening—the number of Veterans is decreasing—but even in those markets, we are investing in new facilities that better address the needs of the Veterans who live there. We are also investing heavily in community living centers, so our aging Veteran population can age where they

want to: at home or near home. We are also adding new facilities in new places based on projected demand for specific issues—like the number of Veterans struggling with issues such as homelessness or substance use—to make sure those Veterans have access to the care they need.

These recommendations will also help modernize VA's infrastructure, replacing old, outdated, run-down facilities with state-of-the-art facilities designed with Veterans and VA employees in mind. This is a sorely needed upgrade: the average age of a VA hospital is nearly 60 years, compared to just 8.5 years in the private sector. Many of our facilities were built before women were even allowed to serve in the military, so we are building new facilities specifically designed to deliver care that is inclusive and respects the dignity and uniqueness of each Veteran in our care. Many of our current facilities are also too old to sustain strong broadband internet connections, making it difficult to meet the ever-increasing demand for telehealth. Additionally, many VA hospitals were built in a time when inpatient care, not outpatient care, was predominant—a trend that has since flipped as medical advancements have allowed Veterans to recover at home. Simply put, health care has evolved, and these recommendations will help VA evolve with it.

If approved, these recommendations would also invest heavily in VA employees, who are VA's number one asset. After years of working in outdated facilities, VA employees would finally be able to work in modern facilities with the modern tools they need to deliver on the mission they so diligently strive to execute every day. These investments would result in better working conditions for those employees, and better care for the Veterans they serve.

The bottom line is that all the recommended changes—if approved—will add up to the one thing that matters most: more care, and better care, for Veterans. If we implement these recommendations, for example, nearly 150,000 more Veterans will have primary care within 30 minutes; nearly 200,000 more Veterans will have mental health care within 30 minutes; and over 375,000 more Veterans will have access to outpatient specialty care within 60 minutes. In summary, all of that care will be delivered in modern, state-of-the-art facilities that Veterans deserve and will result in more Veterans' lives saved, and improved, by the work VA does—which is precisely what these recommendations strive to accomplish.

At VA, it's our job to give Veterans, their families, caregivers and survivors the very best. If approved, these recommendations will help us do exactly that—empowering us to continue providing Veterans with timely, world-class access to care for generations to come. I appreciate the consideration of these recommendations by the AIR commission, President Biden and Congress, and I look forward to continuing to work together to serve Veterans as well as they have served our Nation.



Denis McDonough



# Executive Summary

## Introduction

The Department of Veterans Affairs (VA) has served Veterans and the Nation for decades by providing high-quality health care, training the Nation’s health care workforce, spurring innovation and medical discoveries, and – as shown powerfully during the coronavirus disease (COVID-19) pandemic – serving as the backstop for the U.S. health care system in times of emergency. We are proud to offer health care services to the approximately nine million Veterans enrolled to receive care from VA through the commitment of our hundreds of thousands of talented employees across the Nation.

The John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) requires that VA undertake an Asset and Infrastructure Review (AIR) — an initiative to study the current and future health care needs of Veterans across America, and to evaluate VA’s health care infrastructure to ensure VA has the resources needed to continue providing Veterans with world-class access and outcomes. AIR is a congressionally mandated process designed to modernize and realign VA’s aging health care infrastructure.

VA welcomes the opportunity to provide this report to the AIR Commission outlining recommendations to modernize and realign the VA health care system. VA came to our recommendations to the AIR Commission by asking ourselves one question above all else: *what is best for the Veterans we serve?* These recommendations will help VA serve as the primary world class provider, integrator, and coordinator of Veterans’ health care; operate a network with the right facilities, in the right places, with the right services; ensure that infrastructure reflects the needs of 21st century Veterans; and strengthen our roles as the leading health care research and training institution in the Nation.

VA has been preparing for this moment for several years – analyzing extensive data, conducting interviews with leaders at every VA medical center (VAMC) across the country, conducting listening sessions with Veterans and other stakeholders, and consulting with Veterans Service Organizations (VSOs).

The recommendations contained in this report meet the requirements of two sections in the MISSION Act: Section 106(a), which requires VA to conduct quadrennial market assessments in support of improving health care delivery; and Section 203(b), which establishes the AIR Commission and requires VA to conduct market assessments in support of improving VA facilities and infrastructure.

The report includes two volumes. Volume I outlines the legislative history, present and future of VA health care, methodology used to conduct the market assessments, and a national summary of the recommendations. Volume II outlines the recommendations, which are designed to improve each market’s health care service delivery and infrastructure over the coming decades. Appendices for Volumes I and II provide further detail on market assessment development and analysis methodology.

## The System Today

VA is the largest integrated health care system in the Nation. The Department provides high-quality health care to Veterans across the country through its 171 medical facilities and more than 1,000 outpatient points of care, as well as through academic affiliates, the Department of Defense (DoD), other Federal partners, and more than 1.2 million community providers participating in the Veterans Community Care Program (VCCP).

VA serves a population with demographic characteristics distinct from the U.S. population and strives to provide Veterans with health care tailored to their specific needs and experiences. Compared to the general U.S. population, the Veteran population is on average older, has more chronic health conditions, and is more rural.<sup>1,2</sup> Veterans may also have health care needs stemming from their service that VA providers are uniquely prepared to treat. These characteristics influence where VA provides health care, what health care services VA invests in, and how VA delivers care and services.

## Need for Infrastructure Transformation

VA serves a unique role in the U.S. health care system – not only providing high-quality care to Veterans but also educating the country’s health care workforce, advancing health care research, and contributing to Federal response and recovery efforts in times of national emergencies. As both the Veteran population and the larger U.S. health care system evolve over time, VA must ensure that it continues to transform its infrastructure and operations to strengthen its ability to meet all four of its health-related statutory missions. VA infrastructure requires significant modernization to continue to be effective for today’s Veterans and the Veterans of the future. The median age of VA facilities is nearly 60 years old, compared to a median age of 8.5 years for U.S. private sector hospitals. In addition, 69% of VA hospitals are over 50 years old.<sup>3</sup> Maintaining the safety of these deteriorating facilities requires VA to invest significant resources each year that could be better spent on providing services to Veterans. Deferred maintenance and delayed construction of modern facilities is costly to our Veterans and our Nation. The transformation of VA’s infrastructure will allow VA to provide high-quality, accessible health care to Veterans long into the future and strengthen the Department’s ability to execute its other health-related statutory missions that serve the Nation. As it transforms, VA must take into account several key considerations, including:

- **Evolving needs of Veterans:** The future Veteran enrollee population will be different from today’s population as it shifts in size and geography and grows in diversity. While the number of Veteran enrollees is expected to decline slightly over the next decades, save any influences of major policy changes or any potential military conflicts, there is significant regional variation and demographic differences among enrollees. As a result, many VA facilities are not well-placed to serve the shifting Veteran population and their changing health care needs. Restructuring VA’s care delivery system to effectively support Veterans must consider not only geographic access issues, but also access barriers related to age, race, ethnicity, income, education, life experience, social context, disability, functional needs, gender, sexual orientation, gender identity, and other factors.
- **Innovations in health care delivery, including increased use of outpatient care:** The health care environment in which VA operates has changed significantly over the last fifty years since much of the system’s infrastructure was designed and built. Advances in clinical approaches and technologies and changes in payment models have solidified the shift from a higher reliance on inpatient care to the delivery of the same care in outpatient settings. This change has occurred across the broader U.S. health care system and VA alike, and the results of this shift can be seen in VA’s demand projections. Thirteen of VA’s 18 Veterans Integrated Services Networks (VISNs), or regional systems of care, are projected to experience a decrease in Veteran demand for inpatient medical and surgical services by fiscal year (FY) 2029 – yet all are projected to experience an increase in demand for outpatient services. Nationally, demand for outpatient services is projected to increase by nearly 50% by FY 2029. As a result of this shift, VA has more inpatient infrastructure designed to provide inpatient care than it needs to deliver care to

today's Veterans. Additionally, innovation in telehealth has helped bring medical expertise directly into Veterans' homes and other convenient locations, further diminishing reliance on in-person visits. VA's infrastructure must evolve to effectively leverage these innovations in health care delivery and to accommodate changing consumer choices.

- **VA's responsibility to execute all four of its health-related statutory missions:** In addition to providing high-quality health care to Veterans, VA must fulfill its second, third, and fourth statutory missions: education, research, and emergency preparedness. VA is the Nation's largest medical education source for physician residents and other health professionals-in-training, conducts cutting-edge research, and serves as the emergency backstop for the U.S. health care system. The Department must strengthen its ability to execute all its health-related statutory missions.
- **A global pandemic:** VA conducted its planning amidst the COVID-19 pandemic, which has changed the future of U.S. health care. As the private sector struggled to meet the overwhelming demand for COVID-19 related care, VA served as the backstop to the Nation's health care system by providing personal protective equipment, staff, and hundreds of beds for COVID-19 patients without once denying a bed to a Veteran. As it plans for the future, VA must consider the Department's role in the Nation's response to COVID-19, acknowledge the uncertainty about what COVID-19 will mean for health care delivery over the long term, and preserve VA's ability to serve the U.S. health care system in times of emergency in the future.

## The Future of VA Health Care

VA's recommendations to the AIR Commission are focused on designing high-performing integrated delivery networks (HPIDNs) of care that will allow VA to provide equitable access to quality care for Veterans now and in the future. These networks include care provided by VA, as well as supplemental care provided by DoD, Federally Qualified Health Centers (FQHCs), other Federal partners, teaching hospitals, and community providers across the country. VA will remain the primary, world-class provider and coordinator of Veterans' health care for generations to come.

An overview of VA's key objectives for planning is provided below:

### **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:**

- Invest in expanded ambulatory (outpatient) sites offering primary care, mental health, and lower acuity specialty services to better distribute care and relocate some outpatient care from crowded medical center campuses to modern, conveniently located outpatient points of care.

### **Enhance VA's unique strengths in caring for Veterans with complex needs:**

- Enhance inpatient mental health services within VA-owned facilities and through partnerships;
- Invest in modern community living center (CLC) facilities to improve facilities-based care for eligible Veterans with the most complex needs. This investment is balanced with VA's commitment – aligned with broader U.S. health care trends and patient preferences – to expand Veterans' ability to remain independent as long as possible and age in place, in their homes;
- Invest in modern, geographically distributed, and accessible residential rehabilitation treatment program (RRTP) facilities to provide care not readily available in the community; and



- Align spinal cord injuries and disorders (SCI/D) inpatient infrastructure with the needs of Veterans – rebalancing acute/sustaining and long-term care beds as demand shifts and the SCI/D population ages.

**Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care:**

- Invest in sustainable programs within VA facilities, expand utilization of partnerships that facilitate VA delivered care in non-VA facilities, and utilize virtual care to provide inpatient medical and surgical care when appropriate.

**Strengthen VA’s ability to execute its second, third, and fourth health-related missions: education, research, and emergency preparedness:**

- Strengthen VA’s ability to carry out its mission to educate the Nation’s health care workforce – serving as the largest provider of health care training;
- Strengthen VA’s ability to advance cutting edge health care research, including in health services, biomedicine, clinical science, and rehabilitation – with particular emphasis on service-connected conditions; and
- Strengthen VA’s ability to serve as the emergency backstop for the U.S. health care system – continuously serving Veterans during disasters and emergencies and supporting emergency management at national, state, and local levels.

## Approach and Methodology

As required by the MISSION Act, VA’s recommendations to the AIR Commission are supported by market assessments conducted in 95\* markets across the country. The market assessments provided VA with an unprecedented understanding of its system. Key elements of the approach contributing to the final recommendations are provided below. At every step of the process, it was critical to incorporate the knowledge and expertise of those in the field and Veteran feedback.

- **Extensive data, validated by local market experts:** VA assembled comprehensive Data Discovery and Findings (DD&F) documents based on extensive data with information in the following areas: Geography and Demographics, Demand, Supply, Access, Quality and Satisfaction, Facilities, Mission, and Cost. The data includes VA centrally and locally provided data, Defense Health Agency (DHA) data, and commercial data. Subject matter experts at the VISN and facility level reviewed the data and identified data issues were addressed. Based on the reviews by their teams, all Network Directors certified the data as an “acceptable foundation for market assessment analysis.”
- **Interviews with every VISN and VAMC leadership team across the country:** VA conducted more than 1,800 interviews with leaders at every VISN office and VAMC across the country in order to incorporate the knowledge and expertise of those in the field who know their markets best.
- **More than 50 Veteran listening sessions, as well as VSO collaboration sessions:** Between March and June 2021, VA conducted 56 listening sessions, including four nationwide evening sessions and one session conducted in Spanish, to engage with Veterans and other local

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\* The VISN 02 Finger Lakes and Southern Tier markets merged in 2019 during the market assessments, changing the count of markets assessed from 96 to 95.

stakeholders to better understand how VA may best meet the needs of Veterans in the future. In addition, VA conducted collaboration sessions with national VSO representatives to gather input on their and their members' experiences with VA health care and perspectives on its future. VA considered the feedback from the listening sessions and VSOs as it finalized the recommendations.

- **Extensive reviews by leaders at the VISN, Veterans Health Administration (VHA), and VA level:** While the recommendations are ultimately those of the Secretary, they reflect extensive coordination with leaders across the system. VISN and VHA leadership, who understand the intricacies of each of the markets across the country, support the recommendations.

VA recognizes that the market assessments faced certain constraints. While the market assessments relied on data commonly used for VA operations and health care research, the data had limitations. In addition, the final phases of the market assessments took place during an almost unprecedented global pandemic caused by COVID-19, highlighting the dynamic nature of the health care environment in which the Department operates. To address these limitations and ensure that VA continues to respond to a changing environment, VA will continue to refine our data governance, conduct additional analysis to better understand the long-term impact of emerging health care trends and shifting requirements related to the pandemic, and work with the AIR Commission to identify data limitations that will inform and assist the Commission during the review process. In addition, VA is also planning to conduct an additional analysis related to the COVID-19 pandemic and will provide the Commission with updated findings in the months ahead.

## Section 203 Criteria

Section 203 of the MISSION Act required VA to develop criteria to be used by the Secretary to make recommendations for the modernization or realignment of VHA facilities. VA took steps to ensure that both the public and VSOs had the opportunity to provide input on the development of the criteria. Draft criteria, informed by factors outlined in the MISSION Act, were published online on February 1, 2021, and published in the Federal Register\* on February 2, 2021, to allow for 90 days of public comment. A total of 123 comments were received and addressed by the end of the public comment period. In addition, VA held a series of meetings with both VSOs and Community Veterans Engagement Boards (CVEBs) to receive input on the criteria. Final criteria were published on May 28, 2021.

Section 203 Final Criteria
Veterans' Need for Care & Services and the Market's Capacity to Provide Them (Demand)
Accessibility of Care for Veterans (Access)
Impact on Mission
Providing the Highest Quality Whole Health Care (Quality)
Effective Use of Resources for Veteran Care (Cost Effectiveness)
Ensuring a Safe and Welcoming Health Care Environment of Care (Sustainability)

The Section 203 criteria were used to evaluate recommendations across *Demand, Access, Impact on Mission, Quality, Cost Effectiveness, and Sustainability*. VA identified key measures aligned to the criteria, as explained further in Section 5.4. Based on standardized analyses, all of the market recommendations submitted by the Secretary are consistent with the Section 203 criteria.

\* Please see Appendix C for the appropriate Federal Register notice.

## Overview of VA's Recommendations to the AIR Commission

VA's recommendations to the AIR Commission improve Veteran access to outpatient and inpatient care – providing care closer to where Veterans live in modern facilities. An overview of the anticipated outcomes of the recommendations is provided below:

### VA-delivered Outpatient Care:

- **Improved primary care access:** The number of Veteran enrollees within 30 minutes of VA-delivered primary care will increase by 146,540 (from 7,162,145 to 7,308,685).
- **Improved outpatient mental health access:** The number of Veteran enrollees within 30 minutes of VA-delivered outpatient mental health care will increase by 187,259 (from 7,028,260 to 7,215,519).
- **Improved specialty care access:** The number of Veteran enrollees within 60 minutes of VA-delivered specialty care will increase by 378,294 (from 7,630,411 to 8,008,705).

### VA-delivered Inpatient Care:

- **Improved inpatient medical and surgical care access:** Sites providing inpatient medical services will increase from 134 to 140, and the number of Veteran enrollees within 60 minutes of VA-delivered inpatient medical care will increase by 130,857 (from 5,712,366 to 5,843,223). Sites providing both inpatient medical and surgical services will increase from 114 to 134.
- **Improved inpatient mental health care access:** Inpatient mental health sites will increase from 117 to 118, and the number of Veteran enrollees within 60 minutes of VA-delivered inpatient mental health care will increase by 148,031 (from 5,379,933 to 5,527,964).
- **Improved CLC care access:** CLC sites will increase from 134 to 156, and the number of Veteran enrollees within 30 minutes of VA-delivered CLC care will increase by 545,639 (from 2,985,196 to 3,530,835).
- **RRTP:** The number of RRTP facilities will increase by 12, and all 18 VISNs will continue to have an RRTP.
- **SCI/D:** The number of SCI/D Centers will decrease by 4, but all 15 VISNs that currently have an SCI/D Center will continue to have an SCI/D Center.
- **Blind rehabilitation:** The number of Blind Rehabilitation Centers will decrease by two, but all five Blind Rehabilitation Regions that currently have a Blind Rehabilitation Center will continue to have a Blind Rehabilitation Center.

The recommendations also strengthen VA's ability to execute its second, third, and fourth health-related missions: education, research, and emergency preparedness.

## Legislative Proposals

Some of VA's recommendations to the AIR Commission may require that new legislation be passed to enable implementation. Legislative proposals related to VA's recommendations include two categories: capital-related proposals and workforce-related proposals. The capital proposals will allow flexibility for VA to modernize and realign its facilities. The workforce proposals are focused on facilitating the recruitment and retention of staff in facilities across the country. Modernizing VA's recruitment and

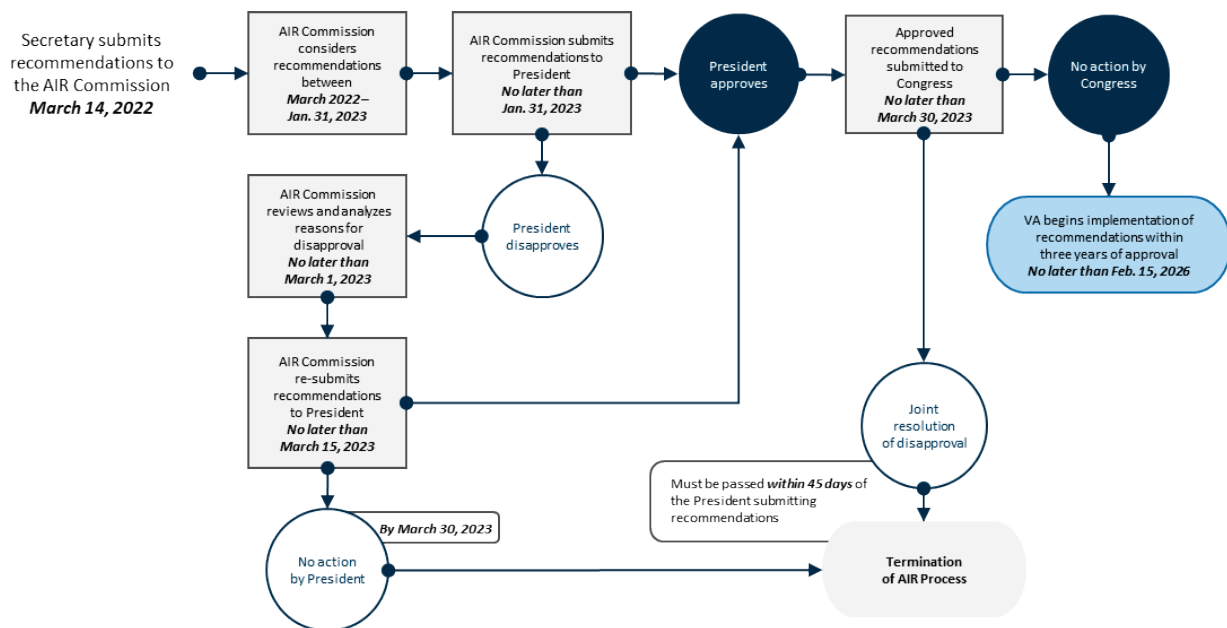
compensation authorities, given the competitive health care market, strengthens VA’s ability to recruit and retain staff and providers. Timely consideration of legislative proposals will be crucial to the successful implementation of the Secretary’s recommendations.

### Actions Following Submission of the Recommendations

Following VA’s submission of this report, the AIR Commission will assess the recommendations, conduct public hearings in regions affected by recommendations, and transmit its own recommendations to the President by January 31, 2023. At the same time, a copy of this transmission to the President will be delivered to appropriate congressional committees. The Commission’s transmission will include a review and analysis of its findings and conclusions. The Commission’s recommendations may deviate from the VA’s recommendations only if the Commission (1) determines that the VA deviated substantially from the final criteria; (2) determines that the change is consistent with the final criteria; (3) publishes a notice of the proposed change in the Federal Register not less than 45 days before transmitting its recommendations to the President; and (4) conducts public hearings on the proposed change.

The President must submit to both the AIR Commission and to Congress the President’s approval or disapproval of the AIR Commission’s recommendations no later than February 15, 2023. If, by March 30, 2023, the President does not submit the approved recommendations and a certification of approval to Congress, the process for modernizing or realigning VA facilities under the MISSION Act terminates. Upon presidential submission to Congress, Congress has five days to introduce a resolution of disapproval for consideration, which must pass within 45 days of presidential submission (see Figure 1).

**Figure 1: Submission Timeline**



However, if Congress does not pass a resolution of disapproval, the recommendations as submitted by the President are considered final. VA is then authorized by the MISSION Act to begin implementation of the approved recommendations. VA must begin implementation no later than three years after the final approval.

VA looks forward to supporting the AIR Commission as it assesses the recommendations and transmits its own recommendations to the President.



# 1. Introduction

The Department of Veterans Affairs (VA) is proud to share its recommendations with the Asset and Infrastructure Review (AIR) Commission for review as we work to design VA health care that will support future generations of Veterans throughout their lives. VA has served the Nation for decades by providing high-quality health care, training the Nation's health care workforce, spurring innovation and medical discoveries, and serving as the backstop for the U.S. health care system in times of emergency. We are proud to offer health care services to the approximately nine million Veterans who are enrolled to receive care from VA through the commitment of our hundreds of thousands of talented employees across the Nation.

As both the Veteran population and the larger U.S. health care system evolve over time, VA must continue to adapt its operations and infrastructure to keep pace with innovations and continue to provide excellent, accessible health care to all enrolled Veterans in the future. The recommendations submitted in this report are a significant step towards transforming VA and ensuring Veterans can continue to access quality care in safe, modern facilities over the course of their lives.

VA came to our recommendations to the AIR Commission by asking ourselves one question above all else: *what is best for the Veterans we serve?*

This report fulfills the legislative requirements contained in Section 106(a) and 203(b) of the John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act; P.L. 115-182).

The report includes the following content:

- **Volume I:** Volume I of this report outlines the legislative history, trends in Veteran population demographics that influence health care delivery, need for VA health care transformation, and the future of VA health care. Volume I also describes how the market assessments that informed VA's recommendations were conducted, how the recommendation for each market was developed and approved across VA leadership, and how VA plans to move forward in implementing these recommendations in line with AIR Commission, presidential, and congressional review and approval.
- **Volume II:** Volume II contains the recommendations, which are designed to realign and modernize VA health care facility infrastructure to improve access and outcomes for current and future generations of Veterans. Each market recommendation also includes a cost-benefit analysis and an analysis of how each recommendation satisfies the selection criteria developed by VA in line with requirements from Section 203 of the MISSION Act.
- **Appendices:** Appendices provide further detail on recommendation development methodology and analysis.

Together, the recommendations contained in this report are the foundation for developing a modern, flexible health care network that seeks to harness the best health care resources available in each market to allow Veteran enrollees to access high-quality, excellent care. Market by market, region by region, VA looks forward to implementing these recommendations in line with AIR Commission, Presidential, and congressional approval.

## 2. Legislative History

### 2.1 Introduction

The recommendations contained in this report meet the requirements contained in two separate sections of the MISSION Act: Section 106(a), which requires VA to conduct quadrennial market assessments in support of improving health care delivery; and Section 203(b), which requires VA to conduct market assessments and make recommendations to modernize and realign VA's facilities and infrastructure.

VA has a history of health care planning efforts that extend well before the MISSION Act was signed into law. This section describes the requirements contained in the MISSION Act that this report fulfills and outlines previous planning efforts and legislative history.

### 2.2 The MISSION Act of 2018

Signed into law on June 6, 2018, the MISSION Act requires VA to conduct market assessments every four years. It separately requires the Secretary of VA to develop recommendations for the modernization and realignment of medical facilities. Recommendations are to be submitted to the AIR Commission, established in the MISSION Act, for its consideration following the process detailed in the law. This process will allow VA to recapitalize and transform its health care system for future generations of Veterans.

#### Section 106(a): Quadrennial Market Area Assessment

Among its provisions designed to improve Veteran access to VA health care services, Title I, Section 106(a) of the MISSION Act requires VA to conduct market assessments. These assessments are designed to assist VA's health care planning efforts, ensuring that the Department can regularly assess its health care services and respond to changes in Veteran needs and demands across the country. They are intended to provide data needed to establish and manage community provider networks, inform VA's budget, and assess the appropriateness of access and quality standards. Section 106(a) requires VA to include the following within its assessments:

1. An assessment of Veteran demand for health care by geographic market areas;
2. An inventory of VA's own health care delivery capacity;
3. An assessment of the health care capacity to be provided by networks of community care providers, including the number of providers, their location, and the categories of service provided;
4. An assessment of the capacity of other Federal health care delivery systems to provide care to Veterans;
5. An assessment of the health care capacity of non-contracted providers, where there is insufficient network supply;
6. An assessment of the capacity of academic affiliates and other collaborations to provide health care to Veterans;
7. An assessment of the effects on health care capacity of access and quality standards established by the MISSION Act; and

8. The number of Veterans' health care appointments, both at VA facilities and with non-VA providers.

VA's first market assessments, as described in Section 106(a) of the MISSION Act, and the recommendations resulting from these assessments, which also meet the requirements of Section 203(b), are presented in Volume II of this report.

## **Section 203: The AIR Commission**

Title II of the MISSION Act created the bi-partisan AIR Commission to review VA's recommendations to modernize and realign facilities of the Veterans Health Administration (VHA). The AIR Commission consists of nine members appointed by the President with the advice and consent of the Senate. The Commission will meet only in calendar years 2022 and 2023. All meetings will be public and have open participation.

### **Section 203(a): Selection Criteria for VA Recommendations**

Section 203(a) requires the Secretary, after consulting with Veterans Service Organizations (VSOs), to publish in the Federal Register\* the criteria proposed to be used by the Department in assessing and making recommendations regarding the modernization or realignment of VA facilities.

### **Section 203(b): The AIR Commission Report**

Section 203(b) outlines the process through which the Secretary must develop his recommendations for AIR Commission review.

The law requires the Secretary of VA to consider a variety of factors when developing recommendations. These factors include:

- A. The degree to which any health care delivery or other site for providing services to Veterans reflect the metrics of the Department of Veterans Affairs regarding market area health system planning.
- B. The provision of effective and efficient access to high-quality health care and services for Veterans.
- C. The extent to which the real property that no longer meets the needs of the Federal Government could be reconfigured, repurposed, consolidated, realigned, exchanged, out leased, replaced, sold, or disposed.
- D. The need of the Veterans Health Administration to acquire infrastructure or facilities that will be used for the provision of health care and services to Veterans.
- E. The extent to which the operating and maintenance costs are reduced through consolidating, collocating, and reconfiguring space, and through realizing other operational efficiencies.
- F. The extent and timing of potential costs and savings, including the number of years such costs or savings will be incurred, beginning with the date of completion of the proposed recommendation.
- G. The extent to which the real property aligns with the mission of the Department of Veterans Affairs.

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\* Please see Appendix C for the appropriate Federal Register notice.

- H. The extent to which any action would impact other missions of the Department (including education, research, or emergency preparedness).
- I. Local stakeholder inputs and any factors identified through public field hearings.
- J. The assessments under paragraph (3) [Capacity and commercial market assessments, discussed below].
- K. The extent to which the Veterans Health Administration has appropriately staffed the medical facility, including determinations whether there has been insufficient resource allocation or deliberate understaffing.
- L. Any other such factors the Secretary determines appropriate.

Notably, Factor (J) requires VA to conduct a Capacity and Commercial Market Assessments to inform the recommendations submitted to the AIR Commission. These market assessments have distinct requirements from the market assessments required in Section 106(a). Capacity and Commercial Market Assessments outlined in Section 203(b) must:

- i. Identify gaps in furnishing such care or services at such Veterans Integrated Service Network or medical facility;
- ii. Identify how such gaps can be filled by entering into contracts or agreements with network providers under this section or with entities under other provisions of law; making changes in the way such care and services are furnished at such Veterans Integrated Service Network or medical facility, including extending hours of operation, adding personnel, or expanding space through the construction, leasing, or sharing of health care facilities; and the building or realignment of Department resources or personnel;
- iii. Forecast, based on future projections and historical trends, both the short- and long-term demand in furnishing care or services at such Veterans Integrated Service Network or medical facility and assess how such demand affects the needs to use such network providers;
- iv. Include a commercial health care market assessment of designated catchment areas in the United States conducted by a non-governmental entity; and
- v. Consider the unique ability of the Federal Government to retain a presence in an area otherwise devoid of commercial health care providers or from which such providers are at risk of leaving.

VA conducted market assessments to meet the requirements of both Sections 106(a) and 203(b), combining requirements into the market assessment process, which provides analysis and insights that will inform national VA health care planning. The market assessment process and methodology, including how each requirement is included within the market assessments, is discussed further in Section 5, Approach and Methodology, of this report.

## 2.3 Previous VA Planning Efforts

VA's current infrastructure to provide health care to Veterans was developed largely in the mid-20th century as a response to World War II and other conflicts. By 1989, when VA was elevated to Cabinet-level status, VA was operating the most extensive integrated health care delivery system in the country. By the late 20th century, even as VA had expanded its footprint and bed count, the Veteran population, and the nature of medical care itself was changing.



To adapt the Veteran health care system in the face of these changes, VA undertook several planning efforts, including some mandated by law, that introduced new reforms, programs, and processes across VA's care delivery networks. This section outlines some of these planning efforts, upon which the MISSION Act builds.

## **Capital Asset Realignment for Enhanced Services**

The Capital Asset Realignment for Enhanced Services (CARES) process was designed to assist VA in managing its infrastructure portfolio. In the late 1990s, VA began this one-time initiative that resulted in "a set of tools and processes that allow VA to continually determine the future resources needed to provide health care to our Nation's Veterans."<sup>4</sup> CARES assessments identified Veterans' current and forecasted needs within defined market areas and developed plans for meeting those identified needs through infrastructure expansion or realignment. These assessments were submitted to a commission for review in 2003, although many plans were not fully implemented upon approval.

## **Veterans Access, Choice, and Accountability Act of 2014**

To assist Veterans in receiving timely care, Congress passed the Veterans Access, Choice, and Accountability Act (VACAA; P.L. 113-146) in 2014, also known as the Choice Act. The Choice Act, among other provisions, expanded eligible Veterans' access to private sector care paid for by VA when that care was not quickly available within a VA facility. This program would later be modified and made permanent through the MISSION Act as the Veterans Community Care Program (VCCP).

In addition, the Choice Act commissioned an Independent Assessment of VA and created a Commission on Care to review the assessment, engage in other fact-finding activities, and make recommendations towards improving the entire VA health system.

## **The Commission on Care (2014-16)**

The Choice Act empowered the Commission on Care to "examine the access of Veterans to health care from VA and strategically examine how best to organize the VHA, locate health care resources, and deliver health care to Veterans during the 20-year period beginning on the date of the enactment of [VACAA]."<sup>5</sup> In its report, developed after a year of review, the Commission on Care reiterated its support for VA's plan to transform its health care delivery system through the development of high-performing care networks.

*Recommendation #1: "Across the United States, with local input and knowledge, VHA should establish high-performing, integrated community-based health care networks, to be known as the VHA Care System, from which Veterans will access high-quality health care services."*

The Commission on Care also recommended that VA "develop and implement a robust strategy for meeting and managing VA's facility and capital-asset needs."<sup>6</sup> As part of this recommendation, the Commission on Care noted that the establishment of an independent commission "charged with developing a national capital asset realignment plan" would support such a strategy.<sup>6</sup> The AIR Commission, as established in the MISSION Act, fulfills this recommendation.

## 3. Caring for Our Nation's Veterans

VA serves a population with demographic characteristics distinct from the U.S. population and strives to provide Veterans with health care tailored to their specific needs and experiences. Compared to the general U.S. population, the Veteran population is on average older, has more chronic health conditions, and is more rural.<sup>7,8</sup> Veterans may also have health care needs stemming from their service that VA providers are uniquely prepared to treat. These characteristics influence where VA provides health care, what health care services it invests in, and how VA delivers that care.

As both the Veteran population and the larger U.S. health care system evolve over time, VA has had to adapt operations to keep pace with innovations in care delivery, including shifting settings of care, changes in how health care is consumed, community health care provider consolidation, and medical technology advancement. This evolution continues today. There is a pressing need for VA infrastructure transformation to serve the evolving needs of Veterans and adapt to changes in health care delivery.

VA's recommendations to the AIR Commission, informed by the market assessments, are designed to help VA execute the transformation needed to meet the needs of Veterans for generations to come.

The following section provides an overview of the VA health care delivery system, as well as a description of the current U.S. Veteran population. This section also discusses in-depth the challenges facing VA care delivery. Subsequent sections discuss the future of VA health care, as well as the process for conducting the market assessments that informed VA's recommendations to the AIR Commission.

### 3.1 The VA Health Care System

VHA is the Nation's largest integrated health system, with approximately 9 million Veterans enrolled and approximately 6.5 million Veterans served in fiscal year (FY) 2021. VA operates 171 medical facilities and more than 1,000 outpatient points of care.<sup>9</sup> VA also coordinates care for Veterans through academic affiliates, the Department of Defense (DoD), other Federal partners, and community providers participating in the VCCP.

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VA operates **171 medical facilities** and **1,000+ outpatient sites** of care.

**Approximately 9 million Veterans are enrolled to receive VA care.**

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VHA's mission is "to honor America's Veterans by providing exceptional health care that improves their health and well-being," a mission that extends back to the Civil War, where the Nation's commitment to caring for our Veterans was first formalized.<sup>9</sup> VHA traces its origins to the establishment of care facilities for Union Army Veterans shortly after the end of the Civil War. In 1865, President Abraham Lincoln signed a law that authorized care for disabled Service members in what became 10 facilities stretching from Maine to California. These facilities later became National Homes for Disabled Volunteer Soldiers, which provided medical care and housing for Civil War Veterans and formed the basis of a nationwide network of Veterans' health care services. In 1921, Congress established the Veterans Bureau, and hospitals were constructed to care for World War I Veterans. Further consolidation occurred under President Herbert Hoover, who created the Veterans Administration in 1930.<sup>10</sup>

During World War II, advances in battlefield medicine and disease treatment allowed more Service members to return home than in previous conflicts.

Consequently, Veterans needed complex care for injuries that had once been considered fatal. To meet the needs of the nearly 16 million World War II Veterans, General Omar Bradley, then head of the Veterans Administration, launched a transformation of VA's role in Veteran care.

In 1946, Congress enacted legislation that established VA's Department of Medicine and Surgery. This transformation included establishing new VA hospitals, associating with medical schools to promote research and encourage Veterans to become medical professionals, committing significant resources to research and development, and establishing the VA Voluntary Service to boost VA's medical services and support medical staff. Many of the facilities created during this era are still in use today.

Today, VA fulfills four statutory missions: providing health care to our Nation's Veterans, educating the country's health care workforce, advancing health care research, and contributing to Federal response and recovery efforts in times of national emergencies. These mission components continuously shape VA's influence on the health of our Nation's Veterans, as well as health care for the Nation as a whole.

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### **VA Statutory Missions**

Providing health care to our Nation's Veterans

Educating the country's health care workforce

Advancing health care research

Contributing to Federal emergency response and recovery efforts in times of national emergencies

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## **VA's Health Care Mission**

VA delivers care to Veterans through a comprehensive array of health and social support services. VA upholds a reputation for providing high-quality care to the Nation's Veterans. While variations across VA health care facilities exist and indicate a potential need for targeted quality improvement, a series of studies have shown that VA performed similarly or better than other health care systems on most of the nationally recognized measures of inpatient and outpatient care quality.<sup>11,12,13</sup>

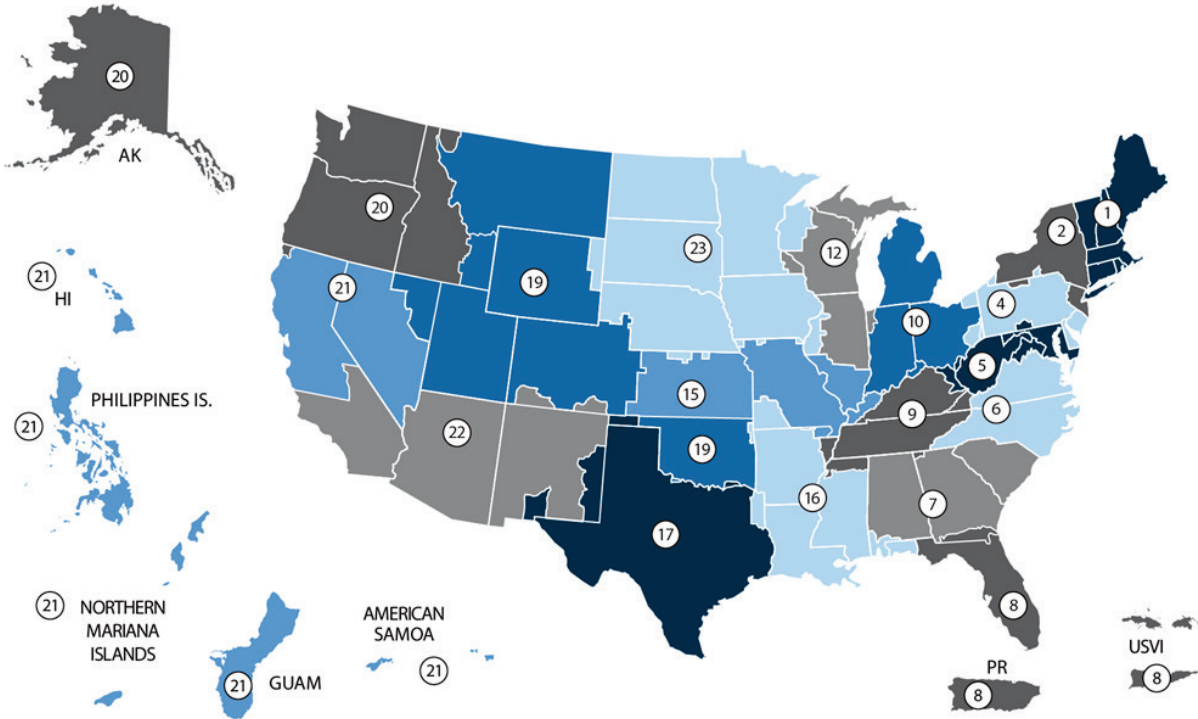
VA provides health care services in medical centers and clinics across all 50 states and the District of Columbia, U.S. Territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands), and the Philippines. VA health care is organized into 18 Veterans Integrated Services Networks (VISNs) (see Figure 1). VA assessed 95\* markets as part of the market assessment process. Markets providing health care to Veterans outside the United States and its territories were not reviewed as part of the market assessments.

Together, these markets contain 171 VA medical centers (VAMCs), which provide at least two of the following types of care: inpatient, outpatient, residential, or institutional extended care.<sup>14</sup> VAMCs may or may not provide acute inpatient services. Other inpatient facilities include stand-alone residential rehabilitation treatment programs (R RTPs) and community living centers (CLCs). In addition to VAMCs, R RTPs, and CLCs, VA operates outpatient clinics of various complexities. These clinics allow patients to access common outpatient care services, such as health and wellness visits, without needing to visit a large VAMC.

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\* The VISN 02 Finger Lakes and Southern Tier markets merged in 2019 during the market assessments, changing the count of markets assessed from 96 to 95.

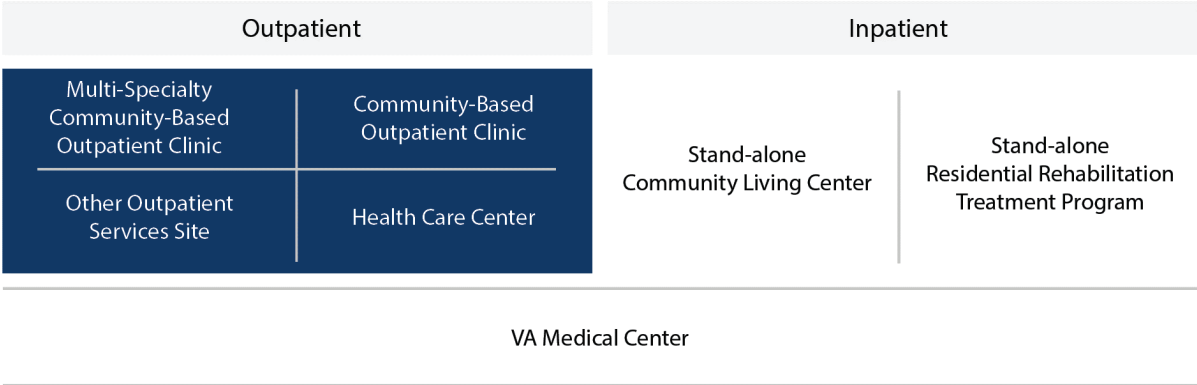
Figure 1: VA VISN Map<sup>14</sup>



There are multiple types of outpatient clinics. Community-based outpatient clinics (CBOCs) offer primary care services on-site and mental health care services either onsite or via telehealth programs. CBOCs may also offer support services such as pharmacy care.

Multi-specialty community-based outpatient clinics (MS CBOCs) provide both primary care and mental health care services as well as specialty care services. VA also operates health care centers (HCCs) that provide primary care, mental health care, outpatient specialty services, and ambulatory surgery or invasive procedures. Other outpatient services (OOS) sites provide services such as social services, homelessness outreach services, and some clinical care to Veterans.<sup>15</sup> Figure 2 illustrates VA points of care.

Figure 2: VA Points of Care



VA health care provides a range of clinical and support services to Veterans across the Nation. VA's focus on the Veteran experience allows for health care singularly tailored to Veteran needs. Clinical services range from primary care and outpatient mental health services, which are offered at all clinics, to highly specialized care offered at a limited number of VAMCs. VA provides access to service lines both through care provided in person and virtually. VA has increased access to virtual health services by over 1,700% in response to the COVID-19 pandemic.<sup>16</sup>

**Outpatient care:** VA offers primary care, outpatient mental health care, outpatient specialty care, outpatient surgical care, emergency care, and urgent care services to Veteran enrollees. VA has incorporated approaches to outpatient service delivery tailored to best serve Veterans such as embedding mental health care in primary care through the Primary Care-Mental Health Integration program, which allows more Veterans to access mental health services within the primary care setting. VA also provides Veterans with adult day health care, home health aides, home-based primary care, and virtual care.

**Inpatient care:** VA provides inpatient medical and surgical care and inpatient services specially focused around the needs of Veterans, including mental health and both short and long-term rehabilitative care, and custodial care. Rehabilitation services provide options for Veterans dealing with psychological or medical conditions. RRTPs provide a wide array of treatment options for Veterans with mental health diagnoses such as posttraumatic stress disorder (PTSD) and substance abuse disorders. Some RRTP programs also provide shelter for homeless Veterans. The continuum of mental health care extends to acute inpatient mental health services. VA also provides blind rehabilitation for Veterans with visual impairment. Finally, VA provides care to Veterans in CLCs, particularly for those Veterans with complex needs that cannot be met in community settings. VA increasingly leverages complex virtual services such as TeleOncology and TeleCritical Care to provide acute care to Veterans in an inpatient setting. Through TeleOncology, cancer care providers can reach Veterans regardless of where they are located. TeleCritical Care is transforming the intensive care unit (ICU). At the push of a button, clinical staff of an ICU with TeleCritical Care can connect with clinical support from an intensivist or ICU nurse.

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As a Veteran receiving mental health care in Rochester commented:

*“Only the VA is able to be see and understand the bad PTSD that many of us have... My counselor I have been dealing with in Rochester is a former Marine Officer and he is phenomenal... That is something that I could not get on the outside. My outside doctors have no clue of what Veterans have gone through.”*

—VA Listening Session, 2021

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To increase access to care, VA provides opportunities for Veterans to receive care from community providers through its VCCP, comprised of five regional networks.<sup>17</sup> Key aspects of VCCP eligibility for a Veteran include:<sup>18</sup>

- The Veteran needs a service not available at a VA medical facility;
- The Veteran lives in a U.S. state or territory without a full-service VA medical facility;
- The Veteran qualifies under the “grandfather” provision related to distance eligibility for the Veterans Community Choice Program;
- VA cannot furnish care within certain designated access standards;
- It is in the Veteran’s best medical interest; or
- A VA service line does not meet certain quality standards.

VCCP is the preferred national network VA uses to purchase care for Veterans in their community. VA also continues to partner with external health care entities, including academic institutions, Federally Qualified Health Centers (FQHCs), Indian Health Service (IHS), and DoD. These partnerships aid VHA in delivering comprehensive, high-quality care to patients.<sup>19,20</sup> As noted above, VA did not conduct market assessments for VA care provided internationally.

## **VA's Research and Education Mission**

VA's health care mission is deeply integrated with its academic research and education missions. This is a unique characteristic specific to VA that sets it apart from private or public health systems.<sup>21</sup> Research and clinical staff often hold joint appointments with VA and academic affiliates, allowing VA to recruit staff and enhance the quality of its Veteran-focused health care and research. Consideration of research partnerships and physical space needs is key to the development of high-performing integrated delivery networks (HPIDNs). VA is the Nation's largest medical education source for physician residents and other health professionals-in-training; nearly 70% of physicians have completed at least part of their training at a VA hospital.<sup>22</sup> In addition, over 72% of VA podiatrists and psychologists, over 81% of VA optometrists, and over 64% of VA physicians participated in VA training programs prior to employment.<sup>23</sup> Therefore, current and future educational partnerships will be an important component of VA's health care system. The synergy between health care, education, and research has empowered VA to continue advancing health care innovation for both Veterans and non-Veterans alike.

With a rich 95-year research history, VA conducts and funds research in health services, biomedicine, clinical science, and rehabilitation, most prominently within service-connected health issue areas such as spinal cord injuries and disorders (SCI/D) and PTSD.<sup>24</sup> VA has also pioneered multiple medical innovations that have revolutionized patient care more broadly, including conducting the first successful liver transplant in 1963 and driving innovation in prosthetic medicine.<sup>25</sup> Two VA researchers received Nobel prizes for their work with peptide hormones.<sup>26,27</sup> In addition, through its Diffusion of Excellence, the VA Center for Innovation invites VHA employees to submit cutting-edge practices that they have successfully implemented within their VA facilities that might benefit facilities across the country.<sup>25</sup> VA is the largest integrated health systems in the nation, VA also leads a national research program, the Million Veteran Program (MVP), which is the country's largest genomic biobank. MVP data is currently being used for health research on a broad range of health conditions.<sup>28</sup> This program is unique because it includes both genomic and longitudinal clinical information for all participants. VHA's medical research capabilities are further propelled by private and Federal grants, bringing total annual resources to an estimated \$1.8 billion.<sup>25</sup> VA's concerted focus on Veteran health needs and service-connected conditions, in concert with its research and education missions, has positioned the Department as a leader in health care innovation among both public and private sector entities.

## **VA's Emergency Preparedness Mission**

The VA system serves as the emergency backstop for the U.S. health care system, to continuously serve Veterans during disasters and emergencies and support emergency management at national, state, and local levels. VA's "Fourth Mission" is to advance the Nation's preparedness for war, terrorism, natural disasters, and other national emergencies.<sup>29</sup> The Fourth Mission also supports public health, safety, and homeland security efforts throughout the Nation. VA sustains a commitment to the Fourth Mission daily; the Office of Emergency Management (OEM) develops and implements policies and programs to provide protection of people and assets and build a culture of preparedness and responsiveness within the VA health care system. Further, VA is the primary medical back-up system to DoD. The National

Response Framework designates VA as the leader of efforts that address Veteran needs and filling gaps in community services wherever necessary.<sup>30</sup> In times of crisis, VA works with other government agencies supporting Veterans at state, local, territorial, and tribal levels.<sup>31</sup>

The Department's response to the COVID-19 pandemic exemplifies its Fourth Mission responsibilities.<sup>32</sup> VA has provided over 937,700 pieces of personal protective equipment (PPE) to the community to protect against the spread of the virus. Further, as of February 24, 2022, VHA facilities have admitted at least 685 non-Veteran patients for COVID-19 care. In response to nationwide demand for increased support and services, VA deployed personnel in coordination with the Federal Emergency Management agency (FEMA) and the Department of Health and Human Services (HHS). These personnel were deployed to other VAMCs as well as to State Veterans Homes and community nursing homes, and these mission supports have included direct patient clinical care, education, training, and testing. VA has performed COVID-19 testing across state health departments, community nursing homes, and State Veterans Homes to prevent and contain outbreaks of the virus.<sup>32,33</sup>

## 3.2 The Veteran Population Today and in the Future

As VA has transformed over the decades, so too has the Veteran population it serves. The demographic profile of today's Veteran population is substantially different from the post-World War II Veteran population that shaped prior generations of VA health care transformation; the Veteran population of the future will further evolve from the Veteran population that VA is serving today. In comparison with past Veteran populations, today's Veterans are fewer in number; different in racial, gender, and socioeconomic composition; and face different health challenges than previous generations of Veterans.

The nature of military service and war itself has changed, including the transition to an all-volunteer force in 1973, the inclusion of women in combat roles in 2013, and the reduction in the size of the military. This has a direct impact on the size and make-up of the Veteran population. Advances in military technology and battlefield medicine have also impacted the types of service-connected conditions that Veterans may be facing. For example, vastly improved battlefield medicine for Service members who deployed to Iraq and Afghanistan saved the lives of tens of thousands who would have died in earlier eras of combat. At the same time, as military technology has advanced, Service members face different threats on the battlefield and may face novel service-connected injuries that VA must be able to adapt to and treat. To provide Veterans with the highest-quality care regardless of their service, VA must maintain a flexible health delivery infrastructure capable of responding to changing Veteran demand.

### Defining the Veteran Population

According to statute, a Veteran is "a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable."<sup>34</sup> Not every Veteran is eligible to enroll in the VA health care system: as defined in 38 U.S.C. § 1710, there are requirements for Veterans to be eligible to receive health care.\* In addition, not every enrollee chooses to receive significant levels of VA care.†

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\* The current statute was established by the Veterans Health Care Eligibility Reform Act of 1996.

† In certain circumstances a Veteran's dependents may also be deemed eligible to receive VA health care. The number of enrolled dependents is small compared to the total enrollee population and will not be considered in this section.

The statute broadly mandates health care for Veterans with service-connected disabilities as well as for those without the ability to pay for medical care. However, there are additional criteria for certain medical services, and eligibility can change based on the discretion of the Secretary of VA and the availability of appropriated funding. If a Veteran is eligible to receive care and enrolls to receive care from VA, the Veteran is referred to as an enrolled Veteran.

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*Counting Veterans, Enrollees, and Patients*

**Veteran counts** include estimates of the total number of Veterans, whether or not they are enrolled in VHA for health care. This includes Veterans who are not eligible to enroll in VA due to income level thresholds.

**Eligible Veterans** are a subset of the total Veteran count including only those Veterans who are eligible to enroll in VHA. This count is produced using actuarial methods.

**Enrolled Veterans** are those Veterans enrolled in VA for health care.

*Enrollees can be counted in several ways:*

**Unique Enrollee** counts include Veterans enrolled at any time during the year, so includes all new enrollment during the year and enrollees who died during the year. This count is used to compare to unique patient counts.

**End-of-Year (EOY) Enrollee** counts are the number of enrollees at a point in time, so is lower than the unique enrollee count. This count is used to compare to Veteran Population Model end-of-year total Veterans and eligible Veterans.

**Patient or User Counts** are unique enrolled Veterans who used VA health care services at any time during the year.

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Most enrolled Veterans do not use VA for all their health care needs. Some enrollees may use VA for most of their care, while others may only use a few services, and enrollees may use care one year but not the next. Therefore, when projecting future health care utilization and resource requirements, VA considers the full enrollee population and factors in how much of their care they will receive from VA. Using service-connected disability ratings, income, and other factors, VA categorizes Veterans into one of eight priority groups. These groups determine the level of health care benefit and whether the Veteran shares financial responsibility for treatment in the form of a copayment. Eligibility requirements for each priority group are provided in Table 1.



**Table 1: Eligibility Requirements**

Priority Group	Eligibility Requirements
1	<ul style="list-style-type: none"> <li>• Veteran has a service-connected disability rated as 50% or more disabling, or</li> <li>• Veteran has a service-connected disability VA concluded makes the Veteran unemployable, or</li> <li>• Veteran received the Medal of Honor.</li> </ul>
2	<ul style="list-style-type: none"> <li>• Veteran has a service-connected disability rated as 30% or 40% disabling.</li> </ul>
3	<ul style="list-style-type: none"> <li>• Veteran is a former prisoner of war, or</li> <li>• Veteran received the Purple Heart medal, or</li> <li>• Veteran was discharged for a disability caused by, or got worse because of, active-duty service, or</li> <li>• Veteran has a service-connected disability rated as 10% or 20% disabling, or</li> <li>• Veteran was awarded special eligibility classification under Title 38, U.S.C. § 1151, "Benefits for individuals disabled by treatment or vocational rehabilitation."</li> </ul>
4	<ul style="list-style-type: none"> <li>• Veteran is receiving VA aid and attendance or housebound benefits, or</li> <li>• Veteran received a VA determination of catastrophic disability.</li> </ul>
5	<ul style="list-style-type: none"> <li>• Veteran has no service-connected disability, or a non-compensable service-connected disability rated as 0% disabling, and an annual income level below adjusted income limits (based on resident zip code), or</li> <li>• Veteran is receiving VA pension benefits, or</li> <li>• Veteran is eligible for Medicaid programs.</li> </ul>
6	<ul style="list-style-type: none"> <li>• Veteran has compensable service-connected disability rated as 0% disabling, or</li> <li>• Veteran was exposed to ionizing radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki, or</li> <li>• Veteran is participating in Project 112/SHAD, or</li> <li>• Veteran served in the Republic of Vietnam between Jan. 9, 1962, and May 7, 1975, or</li> <li>• Veteran served in the Persian Gulf War between Aug. 2, 1990, and Nov. 11, 1998, or</li> <li>• Veteran served on active duty at Camp Lejeune for at least 30 days between Aug 1, 1953, and Dec 31, 1987, or</li> <li>• Veteran is currently or newly enrolled in VA health care and served in a theater of combat operations after Nov. 11, 1998 or was discharged from active duty on or after Jan. 28, 2003; and was discharged less than five years ago.</li> </ul>
7	<ul style="list-style-type: none"> <li>• Veteran's gross household income is below geographically adjusted income limits (GMT) where the Veteran lives and the Veteran agrees to pay copays.</li> </ul>
8	<ul style="list-style-type: none"> <li>• Veteran's gross household income is above GMT where the Veteran lives and the Veteran agrees to pay copays.</li> </ul>

## The Future Veteran Population

By FY 2029 and continuing through FY 2039, VA anticipates a smaller population of enrolled and eligible Veterans, an increase in the proportion of women and racial diversity among Veterans, and a decrease in the average age of enrolled Veterans. VA also projects that the Veteran population will continue to be on average more rural and have a higher prevalence of chronic health conditions than the general U.S. population.<sup>35</sup>

VA uses an actuarial model, the Enrollee Health Care Projection Model (EHCPM), to make projections about the enrollee population the Department may be caring for in the coming decades. While the number of Veteran enrollees is decreasing nationally, there is significant regional variation. Some VISNs will see modest increases in total enrollees, and some markets within VISNs may see significant growth while neighboring markets may see declines.

Broadly, Veteran populations are declining in the Northeast and growing in the South and Southwest. These changes are largely driven by the aging of the Veteran population and the predicted pattern of military separations near military bases. Notably, even as enrollee populations are projected to decline, demand for outpatient services and long-term support services, such as nursing home care, is projected to increase by nearly 50% in relative value units (RVUs) and 6% in average daily census (ADC), respectively.

### *What is the EHCPM?*

The VA EHCPM is an actuarial health care demand projection model that VA uses to project enrollment, utilization, and expenditures for the enrolled Veteran population for 10 and 20 years into the future. The EHCPM first determines how many Veterans will be enrolled each year and their age, priority, and geographic location. Next, the EHCPM projects the total health care services needed by those enrollees and then estimates the portion of that care that those enrollees will demand from VA. Finally, the EHCPM projects the anticipated costs associated with the projected utilization of health care services (not the projected number of patients).

**Table 2: National Enrollee and Eligible Veteran EHCPM Projections**

	FY 2019	FY 2029	10-Year Change	FY 2039	20-Year Change
<b>EOY Enrollees</b>	8,846,627	8,732,890	-1.3%	8,115,865	-8.3%
<b>Total Eligible Veterans</b>	13,732,007	11,695,660	-14.8%	10,032,027	-26.9%

Note: EOY Enrollees include the number of enrollees at a point in time, which is lower than the number of Veterans enrolled at any time during the year.

*For what does the EHCPM account?*

- Enrollee age, gender, income, travel distance to VA facilities, and geographic migration patterns;
- Significant morbidity of the enrolled Veteran population, particularly for mental health services;
- Economic conditions, including changes in local unemployment rates and home values (as a proxy for asset values) and the long-term downward trend in labor force participation, particularly for high school educated males;
- Enrollee transition between enrollment priorities as a result of movement into service-connected priorities or changes in income;
- Enrollee reliance on VA health care versus the other health care options available to them, i.e., Medicare, Medicaid, TRICARE, and commercial insurance;
- Unique health care utilization patterns of post-9/11 era combat Veterans, women, new enrollees, and other enrollee cohorts with unique utilization patterns for particular services;
- New policies, regulations, and legislation, such as the implementation of the MISSION Act of 2018;
- VA health care initiatives, such as the mental health capacity improvement initiative;
- A continually evolving VA health care system, i.e., quality and efficiency initiatives; and
- Changes in health care practice and technology such as new diagnostics, drugs, and treatments.

Military deployments also directly affect age and gender demographics of the Veteran population. The Vietnam-era draft resulted in a large Veteran population, and aging Vietnam War Veterans now make up 40% of VA enrollees receiving care. But as the draft ended, subsequent deployments such as the Gulf War and post-9/11 conflicts have used smaller troop numbers.\* The Veteran enrollee population is older than the general population, with 47.5% of VA's patient enrollee population over the age of 65.

The future Veteran population is shifting in gender, ethnicity, and rurality, and this shift will have significant effects on health care planning efforts. For example, although women Veterans comprise a smaller portion of the Veteran population, the total women Veteran enrollees are projected to increase by 32.5% (from 805,650 to 1,067,799) nationally between FY 2019 and FY 2029.<sup>36</sup> Women Veterans have distinct health care needs and need access to sex- and gender-specific services such as gynecological care, mammography, and specialized behavioral health services. The relative increase in women enrollees may require VA to significantly increase its capacity to provide sex- and gender-specific care.

Women Veterans comprise a smaller portion of the Veteran population, but total women Veteran enrollees are projected to increase by **32.5%** nationally between FY 2019-29.

\* These Veterans also have service-specific health care needs that will be discussed in Section 3.3.

## The Health Care Needs of Veterans and VA Enrollees

Both Veterans and VA enrollees are more likely to have a higher prevalence of commonly diagnosed health conditions than the general population. Veterans with chronic health conditions are more likely to rely on VA care and, among enrolled Veterans, the prevalence of common chronic health conditions is more than 50% higher for VA patients compared to Veterans who do not use VA care.<sup>37,38</sup> Conditions with a higher prevalence among Veterans than civilians include cancer, chronic obstructive pulmonary disease (COPD), and diabetes.<sup>39</sup> As the Veteran population ages and continues to have unique health needs, Veteran enrollees will require more health care services, including long term care and rehabilitative care. The prevalence of conditions related to combat—including PTSD, amputation, traumatic brain injury (TBI), visual impairments, environmental exposures, and severe burns—is naturally higher within the Veteran population. VA has specialized expertise in these areas to meet Veteran needs. Longitudinal studies focused on Gulf War Veterans have found that Veterans who have been in combat report higher prevalence of functional impairment, medical conditions, and health care utilization.<sup>40</sup> Demographic models also project that younger Veterans with combat-related conditions will consume a greater proportion of health care resources in the coming decades as a consequence of recent life-saving advances in battlefield medicine.<sup>41</sup>

Mental health and suicide prevention are particular areas of focus for VA health care. While both Veterans and the general population experience mental health issues, Veterans experience these issues at a higher rate. For example, Veterans are more likely to die by suicide than the general population: in 2019, Veterans reflected a suicide rate 52.3% higher than non-Veterans in the U.S.<sup>42</sup> VA continues to address Veterans' comparatively higher risk of suicide and other mental health issues through a variety of tailored programs, including through the Veterans Crisis Line, RRTPs, and outpatient mental health services, among others. Though most mental health conditions are generally equally prevalent in the Veteran and non-Veteran populations, the mix of chronic issues Veterans tend to face together with mental illness can create a particularly complex patient base.<sup>43</sup> VA plays a critical role in delivering health care for the most vulnerable Veterans, including those who show disruptive behavior, who the civilian health care system may be unwilling to serve.

### 3.3 Need for Infrastructure Transformation

As VA strives to fulfill its missions in the 21st century, VA faces a growing need for infrastructure and operational transformation to continue serving our Nation's Veterans. As the Department undertakes this transformation, we will always focus on doing what is best for the Veterans we serve. In the future, VA must serve as the primary world class provider, integrator, and coordinator of Veterans' health care; operate a network with the right facilities, in the right places, with the right services; ensure that

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The largest age group of the Veteran population is expected to **change from 65-84 to 45-64**, although there will be considerable regional variability in Veteran ages.

The Veteran population will continue to have a **significant number of rural residents**.

The prevalence among Veterans of **chronic health conditions** such as TBI, amputations, severe burns, and PTSD **will considerably exceed that of the non-Veteran population**.

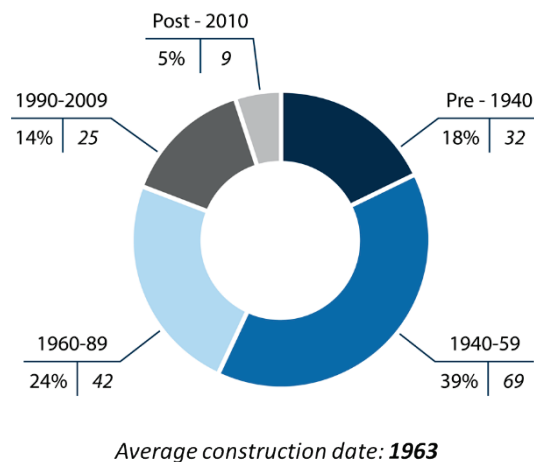
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infrastructure reflects the needs of 21st century Veterans; and strengthen our roles as the leading health care research and training institution in the Nation.

Current VA infrastructure requires significant modernization to continue to be effective for today's Veterans and the Veterans of the future. The median age of VA hospitals is nearly 60 years old, compared to an 8.5-year median age for U.S. private sector hospitals. In addition, 69% of VA hospitals are over 50 years old.<sup>44</sup> These facilities were not designed to meet modern health care standards, which limits VA's agility and ability to meet evolving Veteran care needs, and basic environment of care expectations. Aging infrastructure also affects the VA workforce and may not provide them with the spaces or tools they need to best meet the needs of Veterans.

The average Facility Condition Index (FCI), the ratio of cost of repairing a facility to the cost of replacing that facility, for VA-owned facilities currently exceeds 21% and is increasing each year as the VA capital asset portfolio ages and investments in building infrastructure do not keep pace with maintenance and repair needs. VA's FCI significantly exceeds industry targets, which are 5% for critical function facilities (hospital, surgicenters) and 10% for less critical function facilities (outpatient clinics, medical administration). Maintaining the safety of these aged facilities requires VA to invest significant resources each year to improve, maintain, and operate deteriorating facilities that could be better spent on providing services to Veterans in new, modern, and appropriately designed buildings.

**Figure 3: VA Facility Construction Dates**



VA's recommendations to the AIR Commission provide an opportunity for VA to transform its infrastructure. As it transforms, VA must take into account several key considerations, including the evolving needs of Veterans and significant ongoing changes in health care delivery.

### Evolving Needs of Veterans

As discussed in Section 3.2, the future Veteran enrollee population will be different than today's population as it declines in size and grows in diversity and as the results from the pandemic and any future conflicts manifest.

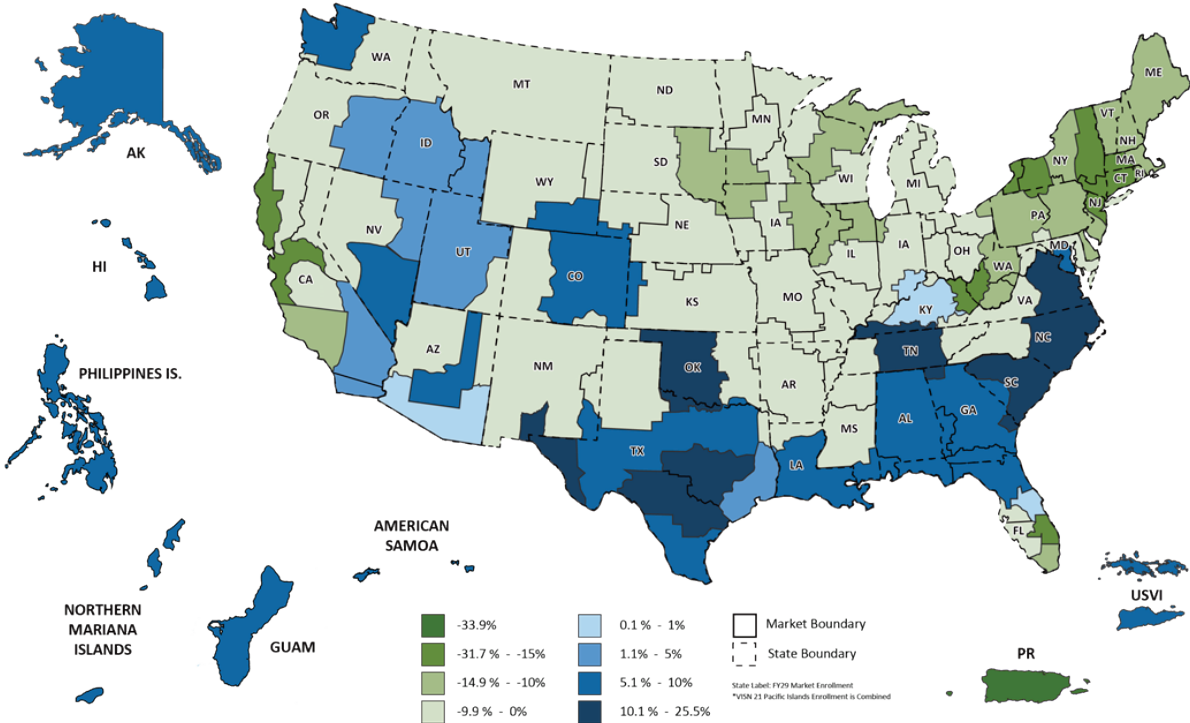
The decline in VA's Veteran enrollee population is a direct result of how military operations have unfolded over the past several decades. A smaller military force creates a smaller future base of potential Veterans eligible for VA health care; the Vietnam-era draft resulted in the largest post-World War II Veteran population that may ever exist in the Nation, barring a future draft.

The decline in enrollee population creates challenges for VA in maintaining sufficient patient volume to operate specialty services in certain areas while maintaining patient safety and provider competencies. VA must be able to adapt to this decreasing Veteran population, innovating to enhance access to high-quality care.

### Veteran Geographic Shifts

Many VA facilities are not well-placed to serve the shifting Veteran population, which has grown and declined in different areas around the country across decades.\* A facility that is well-placed when it was originally built may no longer provide the best possible access to Veterans. Currently, 50% of all Veterans live in just 10 states.<sup>45</sup> As Figure 4 illustrates, Veteran populations are projected to increase in many areas of the South and Southwest, while declining in the Northeast and Midwest. VA is committed to improving access and outcomes in every market – including in rural areas where populations are smaller than more urban areas.

Figure 4: National Color Map Showing Projected Changes in Enrollee Population



### Changing Veteran Demographics

The Veteran enrollee profile is growing more diverse. For example, the lifting of laws that had previously led to a pre-Vietnam U.S. military that was under 2% women, has resulted in women comprising over 19% of active duty military today.

As the population shifts, VA’s Veteran enrollee population’s health care needs may vary based not only on service-connected conditions but also on demographic differences and social determinants of health.<sup>46,†</sup> Restructuring VA’s care delivery system to effectively support Veterans across their lives must

\* The challenge of changing Veteran demography is further discussed in the following sections.  
† Social determinants as defined by the HHS are “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”

consider not only geographic access issues, but also access barriers related to age, race, ethnicity, income, education, life experience, social context, disability, functional needs, gender, sexual orientation and gender identity, and other factors. Given the growing diversity, more inclusive health care offerings are needed so that every Veteran receives the care they seek and need. VA will need to build on its current health equity efforts and continue to increase the cultural and clinical competencies of its health care workforce to meet the future needs of diverse Veterans.

### Health Equity for Veterans

A Veteran's health care experience and ability to access care are influenced by the Veteran's rurality, income, chronic health conditions, and more. While VA can address some of these factors by adjusting the mix of services available at VA points of care, VA will also need to change the physical configuration of VA facilities. Providing an environment of care with adequate and equitable privacy, safety, and comfort can improve the patient experience for Veterans, their families, and their caretakers.

Achieving health equity, when every Veteran can reach their full health potential, will involve training all levels of VA staff, including physicians and nurses, to create a diverse and inclusive environment where every Veteran and employee can be their authentic selves and receive the respect and consideration they are owed. It will require the seamless integration of clinical and social services so that the specific challenges of different Veteran populations can be overcome. It will incorporate universal mindfulness to equity in the design and implementation of care processes, policies, and facilities. Health equity considerations are a critical part of providing responsive, appropriate, and tailored care to every Veteran VA serves, both now and in the future.

### Veteran-Specific Health Care Needs

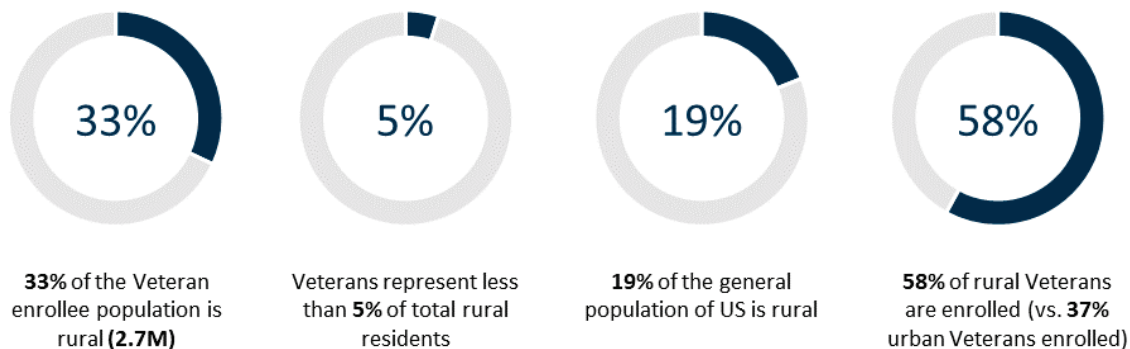
Veteran enrollees experience chronic health needs that are common among non-Veteran populations, but many Veterans also have specific health care needs related to their service. Enrollees with conditions such as TBI, SCI/D, amputation and prosthetic use, severe burns, infertility, PTSD, and other mental and behavioral conditions sometimes acquire them during their time in service. Other conditions emerge decades after active service, such as the effects of Agent Orange or burn pit exposure. Of VA's approximately nine million enrolled Veterans, 56% are in service-connected priority groups. While Veterans with common conditions may be well-served both by VA and non-VA providers, VA has a special obligation to provide holistic care and services to those with Veteran-specific conditions. For example, when treating Veterans with Agent Orange Exposure and PTSD who are diagnosed with sepsis, VA must treat the sepsis with evidence-based protocol excellence while also incorporating the clinical context and wraparound services necessary to address the Agent Orange Exposure and PTSD.

The Veteran-specific health care needs of future enrollees are unpredictable, as they are dependent on the tactics and technologies of future armed conflicts. For example, the use of improvised explosive devices in the Afghanistan and Iraq deployments and advances in battlefield medicine, which saved the lives of servicemen and women who would have perished in earlier conflicts, contributed to Veterans with amputation, TBI, infertility, genitourinary injuries,<sup>47</sup> and other conditions that strained VA capacity.<sup>48</sup> VA cannot foresee the service-connected conditions for future Veterans. Given this uncertainty, VA must be able to rapidly innovate and adapt to care for Veterans regardless of the health concerns they face.

## Rural Veteran Access Needs

Nearly 33% of VA's enrollee population live in rural or highly rural areas compared to 19% of the general population,<sup>49</sup> emphasizing the need for innovative, sustainable rural health solutions nationwide. While VA and community providers alike will continue to have difficulty recruiting and retaining staff in rural areas – 136 rural community hospitals have closed between 2010 and 2021<sup>50</sup> – VA is committed to providing accessible VA health care through new points of care, partnerships, telehealth and virtual care, and other modalities. Meeting the needs of rural Veterans will also require robust collaboration with Federal, state, and strategic partners.

**Figure 5: Veteran Rurality**



VA's obligation to rural Veterans is no different than its obligation to suburban and urban Veterans, but the relatively low density of Veteran demand in rural areas challenges VA's ability to open and staff sustainable points of care. VA's challenges in caring for rural Veterans reflect broader national health care challenges. Almost by definition, rural Veterans are likely to be farther away from VA points of care than their non-rural counterparts and experience a higher rate of chronic health conditions. This geographic fact translates into greater drive times for rural Veterans for both primary and specialty care and is of particular concern for rural Veterans who do not have vehicles and rely on other methods of transportation.

## Staffing for Veteran Needs

Meeting these evolving needs of Veterans depends upon an appropriately sized and adequately trained clinical and administrative workforce. Across the system, thousands of VA employees provide excellent care to our Veterans each and every day. However, in some markets, VA struggles to recruit and retain the workforce required to care for its Veteran population. This can be for a variety of market-dependent reasons: in urban markets with high costs of living, VA may struggle to match private sector compensation levels, while in rural markets, VA may struggle to recruit providers who are willing to deliver care in the area. Recruitment and retention challenges can increase wait times for Veterans, creating access issues. This challenge is not unique to VA, as non-VA providers also face similar recruitment and retention challenges with similar causes. Similarly, the COVID-19 pandemic affected staff attrition at both VA and non-VA providers as a result of increased demand, stress, and staff or coworkers testing positive for COVID-19.



Across all workforce categories, VA competes with private sector employers for talented and dedicated staff. Competition is especially strong for doctors and nurses. By 2033, there will be an estimated nationwide shortage of between 21,400 and 55,200 primary care physicians and between 33,700 and 86,700 non-primary care specialty physicians.<sup>51</sup> By 2024, the U.S. faces a projected shortage of between 14,280 and 31,091 psychiatrists, and 77% of counties had a severe shortage of mental health providers.<sup>52</sup> The projected shortages will affect rural areas more than urban areas. The American Association of Colleges of Nursing also projects a significant shortage of registered nurses.<sup>53</sup> In the face of a limited supply of providers, VA is often unable to compete with private sector salaries, particularly for specialist physicians. While provider shortage is nationwide, it is not equally distributed, affecting rural areas to a greater degree. This affects both non-VA providers and VA, complicating VA's referrals to community providers in underserved areas.

## **Innovation in Health Care Delivery and Movement to Outpatient Care**

Nationwide, integrated health care systems are increasingly moving care from inpatient settings to outpatient clinics, virtual care, ambulatory surgical centers, and home-based services. Many medical, surgical, and diagnostic procedures that once required a hospital stay are now performed safely in the outpatient setting, and telehealth and teleservice delivery can bring medical expertise directly into patients' homes or to an otherwise convenient location. The industry is also seeing rapid rise in retail health care and consumerism. Together with advancements in technology, health systems and large retailers are investing in models of care such as free-standing emergency rooms, immediate care centers, and micro-hospitals across the U.S. Leading health systems are also investing in at-home care that allows patients to move out of the hospital setting to their homes, which patients tend to prefer. VA is exploring unique, forward-thinking partnerships with health systems and retailers to increase health care access and quality for Veterans.

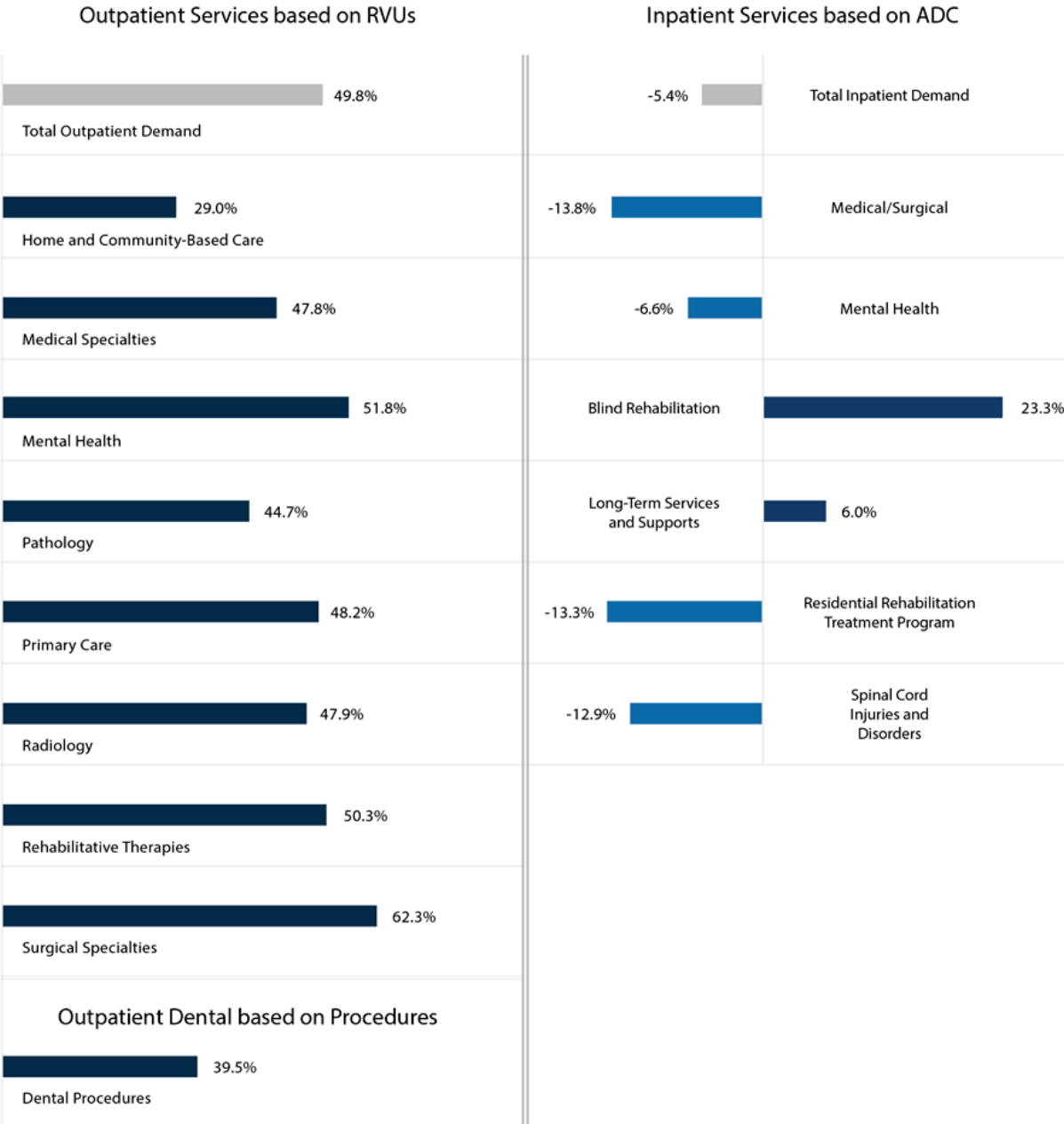
The shift in demand from inpatient to outpatient care within VA aligns with what is occurring in the broader U.S. health care system. Veteran demand for inpatient medical, surgical, and mental health care is declining nationally, while demand for outpatient services is increasing. Of VA's 18 VISNs, 13 are projected to experience a decrease in inpatient medical and surgical services demand by FY 2029 – but all 18 are projected to experience an increase in outpatient service demand.

VA expanded its outpatient care delivery system in earnest in the 1990s, including the decommissioning of tens of thousands of inpatient beds; however, VA maintains substantial traditional inpatient acute care hospital infrastructure, whether these facilities continue to provide inpatient care or have been retrofitted to provide outpatient care and other support services. Many VA outpatient sites have been converted from underutilized and outdated inpatient spaces and are not optimized for outpatient specific needs. VA's infrastructure is not currently equipped to effectively adapt to innovations in health care delivery.

At the same time VA – like the broader health care industry – is seeing a shift in care from the inpatient to the outpatient setting, it is also seeing a shift from in-person visits to virtual visits. VA has a significant digital and telehealth infrastructure in place, has an innovative workforce empowered to deliver care virtually, and has an enrollee population who has demonstrated their appreciation for VA's virtual care options. Despite VA's significant progress in the implementation of virtual care platforms, there remain opportunities to accelerate the integration of connected care services across VA. This acceleration is critical to prepare VA to compete in a growing digital marketplace, to help VA address increased

demand for services, to deliver integrated care despite geographic limitations, to enhance quality, and to better address Veteran health care needs in real-time.

Figure 6: Projected Change in Demand from FY 2019-29



## 4. Future of VA Health Care

As VA looks to the future, the Department remains committed to a core set of immutable values that empower, strengthen, and encourage a vibrant and healthy Veteran community. At the forefront of every decision VA makes is a commitment to serving as an integrated system to provide Veterans with coordinated, lifelong, world-class health care and services that leverage cutting-edge research and equitable access to the Nation's top health care professionals. VA's future will be built on a foundation of inclusion, honor, and respect for every Veteran's unique experience.

VA will provide state-of-the-art care and services through the most accessible and convenient system in VA's history, delivering an optimal experience of care and services directly and through an extensive network of strategic partners, including Federal agencies, academic affiliates, and community providers. VA aims to remain the primary provider and coordinator of Veteran care, allowing VA to provide the same high-quality, evidence-based standards of care regardless of where, or by which modality, a Veteran chooses to receive care.

An overview of VA's key health care planning objectives is provided in Figure 7:

**Figure 7: VA Health Care Planning Objectives**

- 1 Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care.
- 2 Enhance VA's unique strengths in caring for Veterans with complex needs.
- 3 Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care.
- 4 Strengthen VA's ability to execute its second, third, and fourth health-related missions: education, research, and emergency preparedness.

### *Objective 1 – Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care.*

Because effective care coordination is largely managed in the primary care setting, VA will invest in expanded ambulatory (outpatient) sites offering primary care, mental health, and specialty services. These facilities will allow VA to better distribute care and relocate some outpatient care from crowded medical center campuses to modern, conveniently located outpatient points of care. All new facilities will be built or leased based on VA's latest design and facility standards to enable high-quality patient care.\* In cases where there may not be sufficient demand to support a VA-staffed point of care, VA will still seek to provide equitable access to each enrolled Veteran, leveraging telehealth, partnerships, community providers, and ongoing care coordination.

\* These numbers include CBOCs, MS CBOCs, and HCCs but do not include OOS sites.

*Objective 2 – Enhance VA’s unique strengths in caring for Veterans with complex needs.*

There are certain services for which the continuum of care offered at VA is not fully replicated in the community. As a result, VA must ensure that it has sufficient internal capacity to meet current and future Veteran demand. These services include RRTP, blind rehabilitation, and SCI/D treatment. In addition, while there are similar services available in the community, commercial mental health facilities and long-term care facilities may not always be fully able to meet the needs of VA’s more complex patients. As a result, VA must maintain appropriate internal capacity to meet the demand of these more complex Veteran patients. While VA provides facility-based and virtual care for a far broader range of Veteran-specific conditions, the clinical programs discussed in this objective were identified because they require significant program-specific infrastructures to operate.

A listing of the tactics associated with this objective are provided below:

- Enhance inpatient mental health services within VA-owned facilities and through partnerships;
- Invest in modern CLC facilities to improve facilities-based care for eligible Veterans with the most complex needs. This investment is balanced with VA’s commitment – aligned with broader U.S. health care trends and patient preferences – to expand Veterans’ ability to remain independent as long as possible and age in place, in their homes;
- Invest in modern, geographically distributed, and accessible RRTP facilities to provide care not readily available in the community; and
- Align SCI/D inpatient infrastructure with the needs of Veterans – rebalancing acute/sustaining and long-term care beds as demand shifts and the SCI/D population ages.

*Objective 3 – Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care.*

VA’s inpatient medical and surgical provision varies greatly across the system. Some of VA’s programs are robust and are linked with some of the finest academic medical programs in the country. Others are small, caring for fewer than 20 patients on average each day. Studies have shown that higher volumes are associated with higher quality. Lower volume programs present risk to competency sustainment throughout the care team and may result in reduced quality and safety – assuming the care team’s experience is limited to that site. Low volume programs also frequently encounter physician and nursing recruitment and retention challenges. In areas with VA facilities with low patient volumes, VA will find new ways to make sure Veterans have access to high-quality inpatient medical and surgical services, including through partnerships with DoD, academic facilities, virtual care augmentation, and community providers. In all cases where VA is recommending utilizing community providers, the Department will conduct further analysis to ensure there is adequate capacity with quality providers to meet projected demand.

*Objective 4 – Strengthen VA’s ability to execute its second, third, and fourth health-related missions: education, research, and emergency preparedness.*

VA must maintain its critical role as a backstop to the U.S. health care system and foremost leader in health care training and research. To meet the needs of Veterans today and in the future, VA will implement innovative strategic collaborations with DoD, other Federal health care organizations,

academic affiliates, and quality community providers. VA is also well-positioned to lead transformative changes in how and where education and research are conducted. Health care delivery will continue to transition from a predominant focus on acute inpatient care to a system that is organized around individuals' needs and preferences. In addition to focusing learning where most Veterans will receive care, advances in communications and information technologies are now driving the shift to providing services closer to or in Veterans' homes, including virtual clinician-patient interactions, remote patient monitoring, and virtual rehabilitation services. These advances are already driving changes to how education and research are conducted – providing new opportunities in expanded outpatient settings and leveraging new technologies to allow learning and research to happen regardless of where the patient and provider are located. These partnerships and technologies will improve VA care coordination, expand Veteran access to care, advance research in clinical areas including service-connected conditions, and enable the education of health professionals. Importantly, the enhanced use of telehealth modalities in research is already helping to assure that all Veterans can participate in cutting-edge clinical trials irrespective of where they reside.

## 5. Approach and Methodology

VA conducted market assessments to inform the Secretary's recommendations to the AIR commission and support the design of a modern health care system to serve future generations of Veterans. This section describes how VA developed and applied the market assessment methodology in a consistent manner across the enterprise.

### 5.1 Organization

An integrated planning team (IPT) oversaw the execution of the market assessments. VHA senior leaders co-chaired the IPT, including the VHA Chief Medical Officer, the Chief Strategy Officer, and the Assistant Under Secretary for Health (AUSH) for Community Care.

To comprehensively conduct market assessments, VA implemented a collaborative organizational structure that included VA national, regional, and local entities. In addition to IPT leadership, the offices involved in the project's organizational structure included the Office of Policy and Planning (OPP) (later the Chief Strategy Office [CSO]), Office of Community Care (OCC), Office of the Deputy Under Secretary for Health for Operations and Management (later the Assistant Under Secretary for Health for Operations), Office of Construction and Facilities Management (CFM), Office of Capital Asset Management Services (OCAMS), Office of Asset Enterprise Management (OAEM), and Office of VA/DoD Health Affairs (OHA).

To conduct the market assessments, the Veterans Administration Central Office (VACO) formed six market assessment teams that included subject matter experts from CSO and CFM.

Local teams from each VISN and market were also assembled to closely coordinate with the VACO teams. VISN teams consisted of the executive leadership team, clinical representative, VISN Planner, Capital Asset Manager, Business Implementation Manager, Financial Representative, Public Affairs Officer (PAO), and data analysts. Market teams included VAMC executive leadership team(s), clinical representatives, medical center planners, community care representatives, financial representatives, PAOs, data analysts, and Defense Health Agency (DHA) liaisons in markets that have a significant DoD presence. (See Table 3).

**Table 3: Market Assessment Team Structure**

Group	Representatives
<b>VAMC-level</b>	<ul style="list-style-type: none"> <li>• Executive Leadership Team (Facility)</li> <li>• Clinical Representative</li> <li>• Medical Center Planner</li> <li>• Community Care Representative</li> <li>• Financial Representative</li> <li>• Public Affairs Office (PAO)</li> <li>• Data Analyst</li> </ul>
<b>VISN-level</b>	<ul style="list-style-type: none"> <li>• Executive Leadership Team</li> <li>• Clinical Representative</li> <li>• VISN Planner</li> <li>• Capital Asset Manager</li> <li>• Business Implementation Manager (BIM)</li> <li>• Financial Representative</li> <li>• Public Affairs Office (PAO)</li> <li>• Data Analyst</li> </ul>
<b>Central Office</b>	<ul style="list-style-type: none"> <li>• Market Assessment IPT (Guidance and Oversight)</li> <li>• Chief Strategy Office (CSO) Strategic Analysis Service (SAS) (Project Management)</li> <li>• CSO VISN Liaison</li> <li>• Office of Community Care (OCC) Representative</li> <li>• Office of the Deputy Under Secretary for Health for Operations Representative</li> <li>• Office of Capital Asset Management Services (OCAMS) Representative</li> <li>• Office of Asset Enterprise Management (OAEM) Representative</li> </ul>

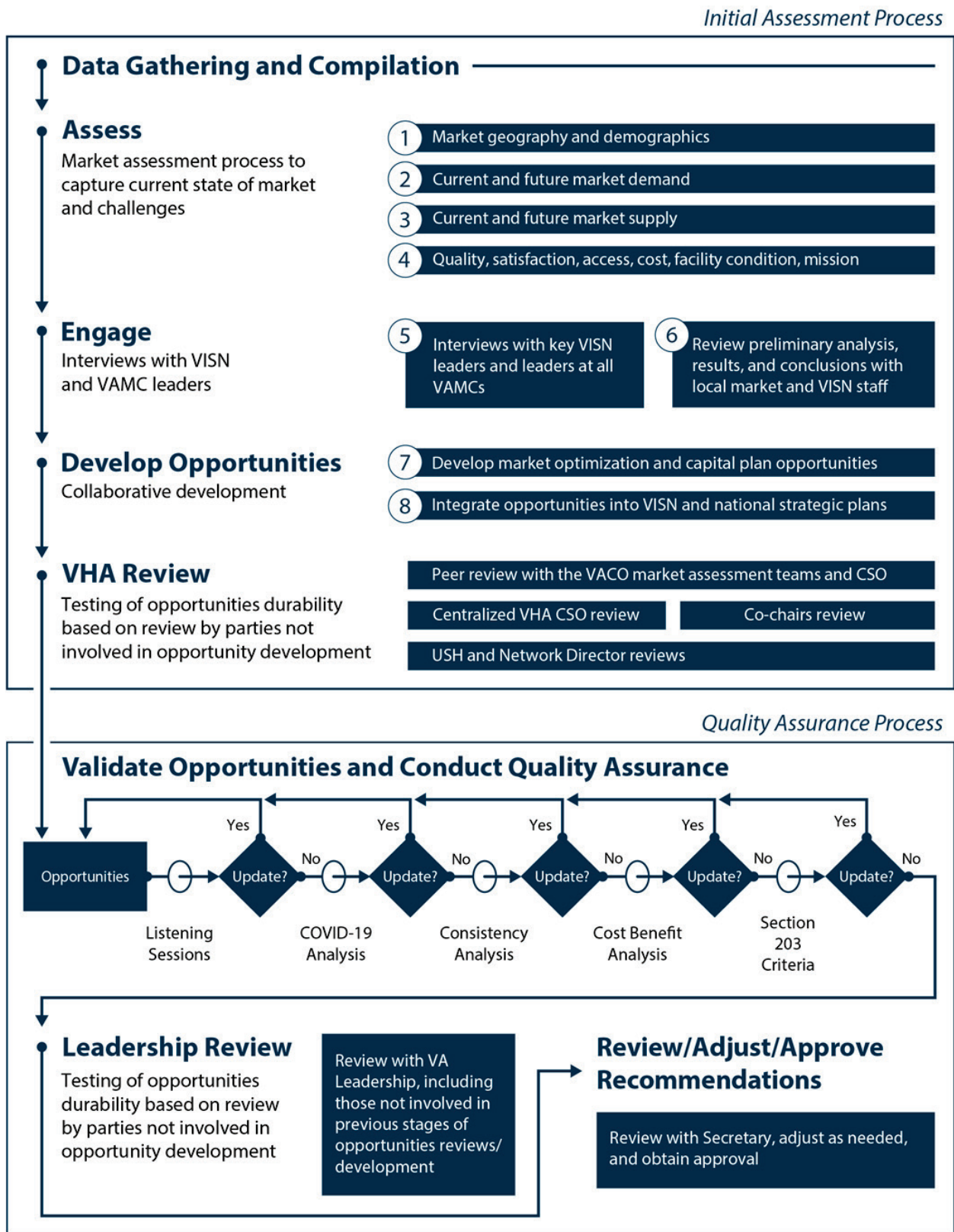
To test the methodology, VA conducted project pilots in 2017. These pilots were critical to provide proof of concept for assessment methodology and its ability to appropriately assess VA internal capacity along with commercial capacity in a relevant market. VA identified VISN 06 Southeast, VISN 07 Georgia, and VISN 20 Inland North as the three pilot markets because together, they illustrated a wide breadth of market characteristics, ensuring the standardized methodology could be consistently applied across all markets nationally. One significant finding of the pilot process was the importance of sharing data with the field preceding the assessments. VA learned that sharing data with field-based assessment teams early in the process would better facilitate engagement with the markets and allow field assessment teams to provide insightful input throughout the assessment process. As national implementation began, VA incorporated early and frequent data sharing into the broader market assessment methodology.

## 5.2 Market Assessment Process Overview

To conduct the market assessments consistently across the 95 markets, VA developed a standardized methodology. As noted above, the methodology allowed each market assessment to adhere to the requirements in Section 106(a) and 203(b) of the MISSION Act, which are described in Section 2 of this report.

An overview of the market assessment methodology is provided in Figure 8. VA divided the market assessment methodology into two overarching components: an initial assessment process and a quality assurance process.

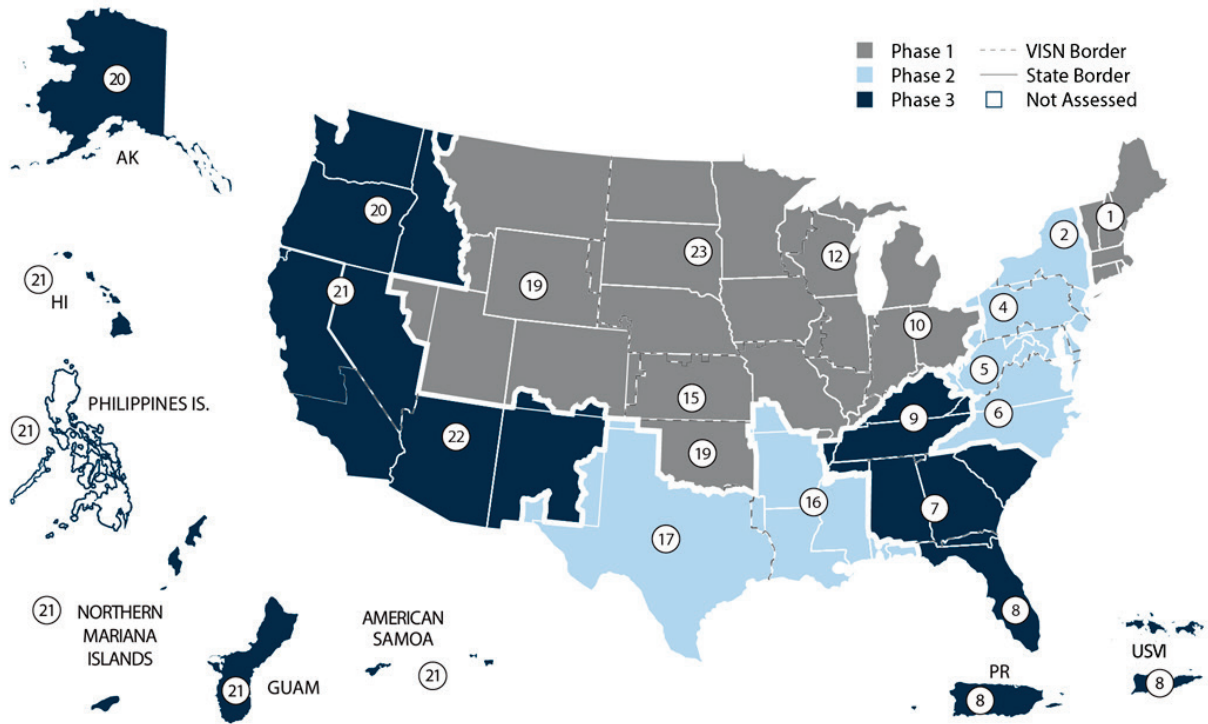
Figure 8: Market Assessment Process High Concept Flow Chart



### 5.3 Initial Assessment Process

Market assessment teams conducted the initial market assessments in three phases, with six of 18 VISNs assessed in each phase. Phase 1, which took place in 2019, included VISNs 02, 04, 05, 06, 16, and 17. Phase 2, which took place in 2019, included VISNs 01, 10, 12, 15, 19, and 23. Phase 3, which took place in 2020 and 2021, included VISNs 07, 08, 09, 20, 21, and 22 (see Figure 9).

Figure 9: Phases of the Assessment Process



Sustained collaboration with VISN and market level leadership was critical throughout the execution of the market assessment methodology. Ongoing communication between the field and VACO began early in each phase. VISN Network Directors and the Acting Under Secretary for Health (USH) together reviewed all opportunities – actions that informed VA recommendations to the AIR Commission – as described in Step 7. Several key tasks, carried out within each phase, ensured ongoing collaboration with VISN and market level leaders.

- Phase Kick-Off Briefing:** For each phase, market assessment teams scheduled a kick-off briefing with VISN leaders to provide information on the market assessment process and an opportunity to answer any questions that might arise.
- Review of Data Provided by VISNs and VAMCs:** In addition to the centrally provided data included in the Data Discovery and Findings (DD&F) data book, the market assessment team reviewed a standardized set of locally provided data that gave important context not available from the centrally provided data.

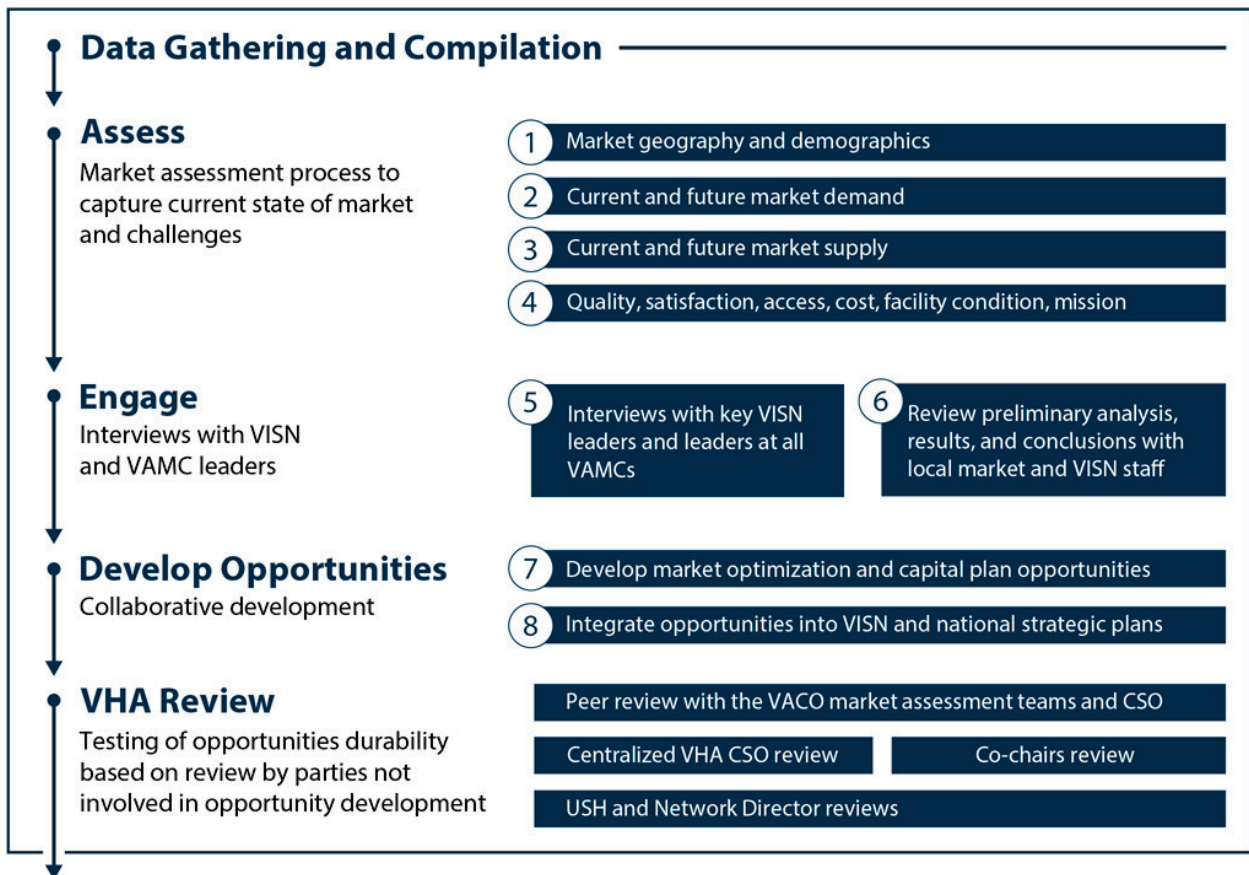


- **Weekly Calls Between the VACO Market Assessment Team and the VISN Planner:** Market assessment teams held weekly calls with the VISN Planner and members of the VACO market assessment team to plan for the coming week, discuss any questions that emerged from the field,\* and identify and address any issues preventing smooth execution of the market assessments.
- **Weekly Coordination Calls:** Market assessment teams held weekly calls with members of the VACO team, the VISN Planner, and the broader members of the field market assessment team to coordinate on a variety of topics throughout the course of each phase.
- **Network Director Participation in the USH/Network Director Reviews:** Network Directors participated in Acting USH opportunity review sessions.

As market assessments progressed across each phase, VA expanded the methodology to improve operations for the remaining phases. Methodology expansions that were instituted based on lessons learned between phases include providing training on best practices for opportunity development and adding debrief calls with each VAMC focused on interview day findings.

VA established an eight-step methodology to guide this initial assessment process (see Figure 10).

Figure 10: Initial Assessment Process



\* The field includes representatives at the local VISN level.

## Data Gathering and Compilation

Market assessments began with an in-depth data gathering and compilation process, drawing on data from VA, DoD, and commercial sources. For each market, the market assessment teams compiled a standardized data set on the following topics: market geography and demographics, market demand, market supply, access, quality and satisfaction, facilities, mission, and cost. Based on this data, a DD&F document was created for each market. Each DD&F included between 150 and 500 pages of data and maps. DD&Fs are included in Volume II, Appendix F.

After compiling the DD&F documents, CSO distributed them to the field to validate. This process allowed field assessment teams to identify discrepancies between locally and centrally collected data, and to request corrections and updates to relevant data, as necessary. Issues were reviewed by the VISN Planner and CSO, and DD&F documents were updated as needed. This ensured each assessment team had access to the most up-to-date data throughout the assessment process. Following the review process, VISN leaders certified that the data contained within the DD&Fs, along with the VISN-provided data issues log, constituted an acceptable foundation for market assessment analysis.

### Certification of Accuracy

Each VA Under Secretary, each VISN Director, each VAMC Director, each director of a VA program office, and each person who is in a position the duties of which include personal and substantial involvement in the preparation and submission of information and recommendations concerning the modernization or realignment of facilities of the VHA has certified that the information provided to the Secretary and the AIR Commission is accurate and complete to the best of that person’s knowledge and belief.

## Eight-Step Assessment Methodology

### *Step 1: Evaluate Market Geography and Demographics*

Evaluating the geography and demographics of each market helped assessment teams understand where eligible and enrolled Veterans live in each market, the care facilities available to them, and the projected demographic trends that might impact future health care requirements. Teams referenced additional demographic data to shape profiles of Veteran and non-Veteran populations’ service needs at the local, regional, and national levels. Key data points are listed in Table 4.

**Table 4: Demographic Data Points**

Data Element	Detail
<b>Demographics</b>	<ul style="list-style-type: none"> <li>• Current and projected enrollees by market, sector, and county</li> <li>• County rurality (# and % of enrollees residing in rural areas)</li> <li>• Current and projected enrollees by age, gender, and priority</li> </ul>

### *Step 2: Estimate Current and Future Market Demand*

Market assessment teams analyzed current and projected future market demand in every market to understand what services Veterans use today, and what services they may require in the future using information from VA’s EHCPM. Teams also analyzed commercial market demand and validated demand data and projections with VA market leaders, VISN leaders, and VISN Planners. The EHCPM projections

were developed prior to the COVID-19 pandemic, which introduced increased levels of uncertainty given the rapid changes to health care accelerated by the pandemic. Key data points are listed in Table 5.

**Table 5: Demand Data Points**

Data Element	Detail
<b>Outpatient Demand</b>	<ul style="list-style-type: none"> <li>Trending VA demand (unique patients, encounters, RVUs) by VA facility and by specialty</li> <li>Trending outpatient surgical demand (surgical cases)</li> <li>Projected VA demand (RVUs) by market and by specialty</li> </ul>
<b>Inpatient Demand</b>	<ul style="list-style-type: none"> <li>Trending VA demand (ADC) by facility and service</li> <li>Projected VA In-house and Community demand (ADC) by market and parent facility</li> <li>Current and projected commercial demand in the VAMC area by service line</li> </ul>

### *Step 3: Estimate Current and Future Total Market Supply*

An estimation of current and future total market supply allowed market assessment teams to understand if each market had the capacity to meet the demand estimated in Step 2. To complete Step 3, market assessment teams developed estimates of current and future VA capacity as well as current and future community capacity and reviewed Veterans' access to care through VA facilities, Federal partners, and community providers. VA facilities self-reported their current VA bed counts, and the field validated all listed points of care. Key data points are listed in Table 6.

**Table 6: Supply Data Points**

Data Element	Detail
<b>Outpatient Supply</b>	<ul style="list-style-type: none"> <li>Current VA supply in RVUs (full-time equivalent (FTE) x RVU Productivity target)</li> <li>Current community provider supply (FTE)</li> </ul>
<b>Inpatient Supply</b>	<ul style="list-style-type: none"> <li>Current VA supply (beds) by facility and service</li> <li>Current community supply (beds) in the VAMC area by facility and service</li> </ul>

### *Step 4: Assess Quality and Satisfaction, Access, Cost, Facility Condition, and Impact on Mission*

Teams assessed a variety of factors to understand current and future market conditions: access, quality, and patient satisfaction with VA and community facilities, cost, facility conditions, current and future projects, the scope and nature of education and research programs, and capability to provide modern health care services. Key data points are listed in Table 7.

**Table 7: Quality and Satisfaction, Access, Cost, Facility Condition, and Mission Data Points**

Data Element	Detail
<b>Quality and Satisfaction</b>	<ul style="list-style-type: none"> <li>• Strategic Analytics for Improvement and Learning (SAIL) scorecards</li> <li>• VA patient satisfaction by facility and service</li> <li>• VA patient satisfaction of Community Care</li> <li>• Quality of commercial hospitals in the VAMC area Centers for Medicare &amp; Medicaid Services (CMS) Star Rating, awards, and recognition)</li> </ul>
<b>Access</b>	<ul style="list-style-type: none"> <li>• Enrollment proximity (# of enrollees within 30 and 60 minutes) by VA site</li> <li>• Drive time summary (# of enrollees within 30 and 60 minutes) to primary and secondary care across the market</li> <li>• Wait time for new and established patients by facility and service</li> </ul>
<b>Cost</b>	<ul style="list-style-type: none"> <li>• Comparison of the VA average adjusted total cost per discharge to the average Medicare reimbursement per discharge and Community Care purchase cost per discharge for top VA Diagnosis Related Group</li> </ul>
<b>Facility Condition</b>	<ul style="list-style-type: none"> <li>• Main patient care facility construction date and date of most recent major renovation</li> <li>• Summary of VAMC architectural and engineering challenges</li> <li>• Property size (total acres and acres available)</li> <li>• Facilities Condition Assessment (FCA) total and by owned building</li> <li>• Leased building inventory (clinical sq. ft, lease termination date)</li> <li>• Active and planned projects</li> </ul>
<b>Mission</b>	<ul style="list-style-type: none"> <li>• Number of academic training positions by sponsoring facility, program type, and specialty</li> <li>• Total Research Veterans Equitable Resource Allocation (VERA) in dollars</li> </ul>

Upon the conclusion of Steps 1-4, assessment teams identified areas of potential opportunity development based upon the concluded data analysis. Teams further explored and iterated on these potential areas of opportunity development throughout Steps 5-8.

### *Step 5: Conduct Site Visits and Interviews*

While quantitative data was a key piece of the market assessments, it was critical that opportunities reflected the knowledge and expertise of those in the field who know their markets best. Inclusion of this type of input is aligned with the principles of a high reliability organization. As a result, VA conducted more than 1,800 interviews with leaders at every VISN office and VAMC across the country. In Phases 1 and 2 (prior to COVID-19), VA conducted the interviews in person, and in Phase 3, VA conducted the interviews virtually. In markets where there is a substantial DoD presence, VA also conducted interviews with DoD leaders. In advance of the interviews, VISN Planners were provided with a “Leadership Questionnaire” for both the VISN and facility level. This guide provided context to the interviewees on the types of questions that may be asked during the interviews. The leadership questionnaire (Appendix B) was not used as a script during the site visits and no written response was required to the questions. Interviews took approximately 50-55 minutes and explored domains including vision and strategy, operations, partnerships, quality, and facilities. Table 8 lists interview participants by organization type; participants slightly varied based on the different programs present within each medical center.

**Table 8: Site Visit Interview Participants**

Interview Type	Interview Participants
<b>VISN</b>	<ul style="list-style-type: none"> <li>• Network Director</li> <li>• Deputy Network Director</li> <li>• Chief Medical Officer</li> <li>• VISN Planner</li> <li>• Capital Asset Manager</li> <li>• VISN Business Implementation Manager</li> </ul>
<b>VAMC</b>	<ul style="list-style-type: none"> <li>• Director</li> <li>• Chief of Staff</li> <li>• Associate Director for Patient Care Services</li> <li>• Associate Director</li> <li>• Assistant Director</li> <li>• Chief of Community Care</li> <li>• Group Practice Manager</li> <li>• Chief or Director of Primary Care</li> <li>• Chief or Director of Mental Health</li> <li>• Chief or Director of Medicine</li> <li>• Chief or Director of Surgery</li> <li>• Associate Chief of Staff for Research and Education</li> <li>• Chief or Director of Extended Care</li> <li>• Chief or Director of Physical Medicine &amp; Rehabilitation</li> <li>• Facility Planner</li> <li>• Chief Engineer or Chief of Facilities</li> </ul>
<b>Key Health Care Centers</b>	<ul style="list-style-type: none"> <li>• Facility Administrator or equivalent</li> <li>• Chief of Staff, Chief of Medicine, or equivalent</li> </ul>

In addition to the interviews, VA conducted facility tours for Phases 1 and 2 of the market assessments. Site visits provided assessment teams with an understanding of physical and qualitative factors related to the health care delivery landscape, such as facility access, facility condition, the environment of care, and functionality. While Phase 3 did not include tours due to the COVID-19 pandemic, planning teams reviewed existing floorplans, building ages, and building conditions to understand the campuses.

During Phases 1 and 2, in-person site visits took place at every major VA health care facility within a market. Representatives from CFM, CSO, and the contractor executed the site visits. For some site visits, VISNs planners, regional or facility leadership, OCAMS representatives and/or DoD representatives also participated. The site visits included facility and campus tours led by key facility personnel. While key facility personnel leading tours varied at each site according to availability, many site tours included the Chief Engineer and Facility Planner. The tours focused on capability and functionality in facility areas in need of renovation, areas that had already undergone renovation, and areas that the facility considered especially well-functioning. The decision on which portions of the campus were included on the tour was based on clinical operations; available facility plans, reports, or drawings; the facility's submission of architectural challenges; and discussions conducted with the Facility Planner or Chief Engineer prior to arriving on site. The following facilities elements were considered:

- Year of construction, general state of repair, ongoing and upcoming non-recurring maintenance, minor, and major projects;

- Patient and staff flow, including wayfinding;
- Environment of care;
- Departmental space allocations;
- Floor to ceiling heights;
- Column widths;
- Availability of interstitial or plenum space;
- Functional adjacencies; and
- Availability of single patient rooms.

Market assessment teams combined information learned from the interviews and tours with the data assessed in Steps 1-4 to develop a set of key themes for every market. These key themes highlighted major findings for each market. Market assessment teams developed key themes across the following domains:

- **Overarching Themes/Future Vision for the Market and Facility:** Describes high-level challenges and successes of the market's operations, as well as how it may evolve in the future and key areas of focus for care delivery.
- **Demographics and Demand:** Describes the major demographic and demand trends for the market and each facility.
- **Supply:** Describes the major supply trends for the market and each facility.
- **Quality/Satisfaction/Access/Cost/Mission:** Describes access issues or challenges, high-level findings related to quality of care and the patient experience, the cost of delivering care in each market, and how the market and facility meets its research, education, and/or emergency preparedness missions.
- **Facility:** Summarizes the facility condition, including but not limited to age, infrastructure challenges, environment of care issues, ongoing or planned construction projects, campus size, and other relevant findings.

In Phases 2 and 3, prior to the development of key themes, VA also conducted debriefs with key stakeholders from each VAMC to review findings from the interviews. This step of the methodology was added based on lessons learned in Phase 1 and served to validate qualitative and quantitative key themes for the market.

### *Step 6: Review Preliminary Analysis, Results, and Conclusions with Local Market and VISN Staff*

Step 6 served as the intermediary point between the data analysis of the DD&F documents, the information gathered during the site interviews and tour, and the final development of opportunities outlined in Step 7.

In this step, each market assessment team conducted quantitative and qualitative data integration. Market assessment teams worked closely with local market and VISN teams to explore findings from the DD&F documents, locally submitted data, site visits and interviews, and key theme developments. Assessment teams also worked to update their opportunities, based on the findings from Step 5 in advance of Steps 7-8.

As part of Step 6, VAMC assessment teams developed their own sets of potential opportunities. The VISN then reviewed each of these opportunities and was given the chance to endorse each VAMC opportunity. All opportunities developed by the VAMC assessment teams, both those that were endorsed by the VISN and those that were not, were submitted to the VACO market assessment team. After the field submitted their potential opportunities, market assessment teams reviewed them as inputs into the opportunity development process.

*Step 7: Develop Market Optimization and Capital Plan Opportunities Based on Enterprise Guiding Principles, Mission, and Performance Against Quality and Satisfaction, Access, and Cost Standards*

Following the data analysis, site visits, interviews, and field collaboration process outlined in Steps 1-6, market assessment teams integrated the qualitative and quantitative findings for each market to develop opportunities that create HPIDNs for Veterans.

During opportunity development, market assessment teams meticulously reviewed the qualitative and quantitative data from interviews, the DD&F documents, and a catalog of locally furnished data. The teams examined each main campus in the market, carefully considering each major inpatient and outpatient program across the continuum of care. The teams then examined the complement of outpatient facilities across the market to ensure that Veterans have appropriate access to primary care, mental health, and other ambulatory services. From this analysis, opportunities were developed.

Opportunity development also took into account priorities identified during interviews with key program offices. Detailed rationales were developed for each opportunity. Following development of draft opportunities, they underwent significant review by VA leadership, including CSO, the market assessment IPT co-chairs, and the Acting USH and Network Director after each phase.



**Enterprise Guiding Principles**

VHA leadership developed a set of guiding principles to guide the development of market assessment opportunities:

- Design HPIDNs to better meet the health care needs of Veterans in terms of access, quality, outcomes, and satisfaction, in accordance with the requirements outlined in the MISSION Act and the market assessment initiative.
- Retain or improve health care services for Veterans in all HPIDNs.
- Ensure VA offers an optimal level of primary services on-site and that VA will be the coordinator of all health care whether provided in VA or in the community.
- Apply comparative data for performance, quality, patient satisfaction, and health outcomes, where available.
- Utilize data from the market assessments, adjacent markets and VISNs, and across the national marketplace to facilitate the enhancement of HPIDNs.

- Ensure Veterans are provided the opportunity to choose care they trust throughout their lifetime.
- Optimize health care services for Veterans in each market using a mix of VA care first, supplemented by DoD, academic affiliates, FQHCs, and community providers. Options should include consideration of innovative alternatives such as sharing arrangements and public-private partnerships (P3s).
- Allow Veterans to choose long-term care they trust, in the setting most appropriate for their needs, to the greatest extent possible, and when eligible.
- Maximize productivity, strategically prioritize investments, and leverage virtual care modalities and partnerships rather than build facilities, when possible.
- Complete market assessments in partnership with local VA health care market leaders and a team of consultants who will collectively assess VA capabilities, community resources, and provide objectivity and external validation in collaborative application of the standardized, data-driven, principles-based methodology.

An eleventh guiding principle was added in 2021:

- Plan for the continuing evolution of Veteran health care, incorporating major trends and events in the national and global health ecosystem.

## Major Drivers, Directional Criteria, and Key Metrics

In order to ensure all recommendations resulting from the assessment process worked toward building HPIDNs in line with the guiding principles, several major decision-making drivers and associated directional criteria were identified to guide opportunity development. The major drivers and their associated directional criteria are listed in Table 9.

**Table 9: Major Drivers and Directional Change**

Major Drivers	Directional Criteria
<b>Population and Demographics</b>	<ul style="list-style-type: none"> <li>• Aligns care with projected shifts in needs based on Veteran population attributes, including age, sex, priority group, place of residence.</li> </ul>
<b>Demand</b>	<ul style="list-style-type: none"> <li>• Aligns care with projected number of enrollees and demand for services based on MISSION Act-defined access standards.</li> </ul>
<b>Capacity</b>	<ul style="list-style-type: none"> <li>• Optimizes types and amounts of care available through VA, supplemented by DoD, academic affiliates, FQHCs, and community providers.</li> <li>• Reflects consideration of the care available in adjacent markets and VISNs, as applicable.</li> </ul>
<b>Access</b>	<ul style="list-style-type: none"> <li>• Appropriately locates VA points of care based on projected Veteran population centers and analysis of where patients choose to receive care in the health care market (based on Hospital Referral Regions and Hospital Service Areas).</li> <li>• Ensures that VA offers an optimal level of primary services on-site and that VA will be the coordinator and integrator of all health care whether provided in VA or in the community.</li> <li>• Retains or improves health care services for Veterans.</li> <li>• Ensures Veterans are provided the opportunity to choose care they trust throughout their lifetime.</li> <li>• Allows Veterans to choose long-term care they trust, in the setting most appropriate for their needs, to the greatest extent possible, and when eligible.</li> </ul>



<b>Quality and Satisfaction</b>	<ul style="list-style-type: none"> <li>Provides access to services/programs that meet VA quality, outcomes, and satisfaction standards, both when provided within VA and within community settings.</li> </ul>
<b>Staffing</b>	<ul style="list-style-type: none"> <li>Reflects VA’s ability to staff this service/program appropriately and consistently.</li> </ul>
<b>Facilities Sustainability</b>	<ul style="list-style-type: none"> <li>Allows VA to operate points of care that meet modern-day health care facility standards.</li> </ul>
<b>Mission</b>	<ul style="list-style-type: none"> <li>Appropriately supports VA’s education, research, and emergency preparedness missions.</li> </ul>
<b>Cost Effectiveness</b>	<ul style="list-style-type: none"> <li>Maximizes non-capital solutions (e.g., maximizing productivity, leveraging telehealth) and partnerships over building facilities, when possible.</li> <li>Considers cost/benefit analysis examining infrastructure costs associated with appropriate health care realignment versus the infrastructure costs associated with modernizing the full VA system with no health care realignment.</li> <li>Reflects consideration of innovative alternatives such as “hospital within a hospital” ventures and P3s.</li> </ul>
<b>National Strategies</b>	<ul style="list-style-type: none"> <li>Aligns with VA national strategies for certain major services and programs.</li> </ul>
<b>Innovation</b>	<ul style="list-style-type: none"> <li>Aligns with broader trends in the U.S. health care system (e.g., movement from inpatient to ambulatory settings, focus on care coordination, leveraging new technologies for connected health).</li> </ul>
<b>Collaborative Implementation of Standardized Methodology</b>	<ul style="list-style-type: none"> <li>Reflects collaborative application of standardized, data-driven, principles-based methodology, applying comparative data for performance, quality, patient satisfaction, and health outcomes, when applicable.</li> </ul>

To allow for standardized assessment across markets, key metrics were also identified in alignment with the directional criteria. A list of key metrics by service line and facility type is provided in Tables 10, 11, and 12. Data was considered holistically and included the qualitative data gathered through interviews. No single data point drove the development of opportunities.

**Table 10: Key Metrics by Service Line**

Criteria	Inpatient Medical and Surgical	Inpatient Mental Health	Community Living Centers
<b>Demographics</b>	<ol style="list-style-type: none"> <li># of enrollees (FY 2019) and projected growth in market and/or area (FY 2019-29)</li> <li>Market reliance on VA and community inpatient medical and surgical</li> </ol>	<ol style="list-style-type: none"> <li># of enrollees (FY 2019) and projected growth in market and/or area (FY 2019-29)</li> <li>Market reliance on VA and community inpatient mental health</li> </ol>	<ol style="list-style-type: none"> <li># of enrollees (FY 2019) and projected growth in market and/or area (FY 2019-29)</li> <li>Market age breakdown/average age/growth rates by age group/priority group</li> </ol>
<b>Demand</b>	<ol style="list-style-type: none"> <li># of medical and surgical beds; ADC; Any relevant shift(s) between FY; case mix index (CMI)</li> <li>Medical and surgical projections (FY 2029)</li> <li>Care purchased in community</li> <li>Surgical case volume and trends</li> </ol>	<ol style="list-style-type: none"> <li># of mental health beds; ADC; Occupancy Rate; Any relevant shift(s) between FY; CMI</li> <li>Inpatient mental health projections (FY 2029)</li> <li>Care purchased in community</li> </ol>	<ol style="list-style-type: none"> <li># of CLC beds at current and/or proposed VA facility</li> <li>Current ADC (FY 2019), historic shifts (FY 2015-19), and future projections (FY 2019-29)</li> <li>Care purchased (fee-basis long-term care) in community</li> <li>Market projections for CLC/community nursing home need</li> </ol>

Criteria	Inpatient Medical and Surgical	Inpatient Mental Health	Community Living Centers
			5. Short stay versus long stay bed and demand breakdown
<b>Supply/Capacity</b>	<ol style="list-style-type: none"> <li># of commercial hospital beds; Occupancy Rate; CMI</li> <li>Local VAMC / Partnerships</li> <li>Future inpatient projections / conceptual surplus</li> </ol>	<ol style="list-style-type: none"> <li># of commercial hospital beds; occupancy rate; CMI</li> <li>Local VAMC / Partnerships</li> <li>Future inpatient projections / conceptual surplus</li> </ol>	<ol style="list-style-type: none"> <li>Other VA CLCs and community nursing homes in the area</li> <li>State Veteran Homes in the area</li> <li>Community nursing home ADC, # of beds, occupancy rate / # excess beds (FY 2019)</li> <li>Availability (surplus/deficit) of community nursing homes</li> </ol>
<b>Access</b>	<ol style="list-style-type: none"> <li># and % of enrollees within a 60-minute drive time of medical and surgical point of care</li> <li>Proximity to enrollee population density centers / proximity relative to hospital referral region (HRR)</li> <li>Physical access to proposed site / access to major highway(s)</li> </ol>	<ol style="list-style-type: none"> <li># and % of enrollees within a 60-minute drive time of current facility and/or proposed facility</li> <li>Proximity to enrollee population density centers / proximity relative to HRR</li> <li>Distance to potential community partner or VAMC</li> </ol>	<ol style="list-style-type: none"> <li># and % of enrollees within a 30-minute drive time of current facility and/or proposed facility</li> <li>Proximity to nearest VA staffed CLC and potential partners</li> <li>Physical access to proposed site / access to major highway(s)</li> <li>Proximity to enrollee population density centers / proximity relative to HRR</li> </ol>
<b>Quality and Satisfaction</b>	<ol style="list-style-type: none"> <li>Quality of community, partner, and/or VAMC</li> <li>VA SAIL data (Readmissions; Mortality; Admission, Continued stay)</li> </ol>	<ol style="list-style-type: none"> <li>Quality of community, partner, and/or VAMC where mental health beds currently are or are proposed to go</li> </ol>	<ol style="list-style-type: none"> <li>CLC overall quality score</li> <li>VA SAIL data</li> </ol>
<b>Staffing</b>	<ol style="list-style-type: none"> <li>Ability to recruit and retain providers and nurses</li> </ol>	<ol style="list-style-type: none"> <li>Ability to recruit and retain providers</li> <li># of dually/multiple appointed providers</li> </ol>	<ol style="list-style-type: none"> <li>Ability to recruit and retain VA physicians and nurses</li> </ol>
<b>Facility</b>	<ol style="list-style-type: none"> <li>Condition of facility and infrastructure</li> <li>FCA, Modernization Cost, inpatient medical and surgical or main facility related engineering challenges</li> </ol>	<ol style="list-style-type: none"> <li>Condition of facility and infrastructure</li> <li>FCA, Modernization Cost, inpatient mental health related engineering challenges</li> </ol>	<ol style="list-style-type: none"> <li>Condition of facility and infrastructure (age, expansion capabilities, appropriateness of small house model)</li> <li>Semiprivate and multi-bed patient rooms</li> <li>Square footage (DGSF)</li> <li>FCA (overall, by user, per square feet)</li> </ol>
<b>Mission</b>	<ol style="list-style-type: none"> <li># of residents and advanced fellows</li> <li>VERA research allocation total funding</li> <li>Emergency preparedness designation</li> </ol>	<ol style="list-style-type: none"> <li># of residents and advanced fellows</li> <li>VERA research allocation total funding</li> <li>Emergency preparedness designation</li> </ol>	
<b>Cost Effectiveness</b>	<ol style="list-style-type: none"> <li>Cost per inpatient case / total cost of care for selected services</li> </ol>	<ol style="list-style-type: none"> <li>Cost per inpatient case / total cost of care</li> </ol>	

Table 11: Key Metrics by Service Line (continued)

Criteria	Residential Rehabilitation Treatment Program	Emergency Department/Urgent Care	Outpatient Surgery
<b>Demographics</b>	1. # of enrollees (FY 2019) and projected growth in market and/or area (FY 2019-29)	1. # of enrollees (FY 2019) and projected growth in market and/or area (FY 2019-29)	1. # of enrollees (FY 2019) and projected growth in market and/or area (FY 2019- 29)
<b>Demand</b>	1. # of RRTP beds at current and/or proposed VA facility 2. VA facility current ADC (FY 2019), historic shifts (FY 2015-19), and future projections (FY 2019-29) 3. Program specificity of RRTP beds in VA facility	1. # of ED Encounters; % change FY 2015-18 2. % Transfers, % Admitted 3. Acuity 4. # or % of encounters between 8am-8pm or on weekdays vs. weekends 5. Outpatient Utilization Projections (RVUs) for emergency medicine 6. Historical demand purchased in the community (VCCP)	1. # of outpatient surgical cases 2. Historical growth of outpatient surgical cases, by specialty (FY 2015-19) 3. Projected RVU growth for surgical services (FY 2019-29) 4. Care purchased in community
<b>Supply/Capacity</b>	1. Availability of RRTP or like services in the community 2. Availability (surplus/deficit) of community providers	1. Local VAMC / Partnerships	1. Local VAMC / Partnerships 2. Commercial hospital ADC, # of beds; occupancy rate / # excess beds; current CMI (FY 2019) 3. Availability (surplus/deficit) of community providers by specialty
<b>Access</b>	1. # and % of enrollees within a 60-minute drive time of current facility and/or proposed facility 2. Proximity to nearest VA staffed RRTP 3. Physical access to proposed site / Access to major highway(s) 4. Proximity to enrollee population density centers / proximity relative to HRR	1. # and % of enrollees within a 30-minute drive time of current facility and/or proposed facility 2. Diversion hours 3. Drive time to nearest VA staffed site/partner/community hospitals providing services	1. # and % of enrollees within a 60-minute drive time of current facility and/or proposed facility 2. Drive time to nearest VA staffed site/partner/community hospitals providing services 3. Proximity to enrollee population density centers
<b>Quality and Satisfaction</b>	1. VA SAIL data	1. Quality of Community/Partner (ED volume and throughput) 2. ED capabilities at community provider(s) (e.g., Trauma Center level)	1. Mortality rate, avoidable adverse events, in-hospital complication rate, infection rate
<b>Staffing</b>	1. Ability to recruit and retain VA physicians and nurses	1. Ability to recruit and retain providers and nurses	1. Ability to recruit and retain VA physicians and nurses
<b>Facility</b>	1. Condition of facility and infrastructure (age, expansion capabilities) 2. Square footage (DGSF) 3. FCA (overall, by user, per square feet) 4. Modernization cost	1. Square footage allocation 2. Condition, flow, and environment of care of facility and infrastructure 3. FCA	1. Condition, flow, and environment of care of facility and infrastructure 2. FCA

Criteria	Residential Rehabilitation Treatment Program	Emergency Department/Urgent Care	Outpatient Surgery
<b>Mission</b>		1. Emergency preparedness designation	1. # of residents and advanced fellows
<b>Cost Effectiveness</b>		1. Distance to potential community partner or VAMC 2. Cost per inpatient case / total cost of care	
<b>National Strategies</b>	1. RRTP market analysis conducted by VA		

Table 12: Key Metrics by Outpatient Service Type

Criteria	Community-Based Outpatient Clinic, Multi-Specialty Community-Based Outpatient Clinic, Health Care Center, Other Outpatient Services
<b>Demographics</b>	1. # of enrollees (FY 2019); projected growth of current and/or proposed county (FY 2019-29) 2. % rural 3. % women enrollees
<b>Demand</b>	1. # of core uniques;* # of primary care uniques; # of non-overlapping enrollees within 30/60-minutes of current and/or proposed location (FY 2019) 2. Historic growth of core uniques by service line and primary care uniques (FY 2015-19) 3. Projected RVU growth by service line (FY 2019-29) 4. Referral patterns 5. VCCP FY 2019 – Outpatient Current Procedural Terminology CPT Authorizations by county
<b>Supply/Capacity</b>	1. Availability of high-quality community providers and hospitals 2. FQHCs, DoD, and IHS facilities in the area that could help meet demand
<b>Access</b>	1. # of enrollees within a 30/60-minute drive time of current facility and/or proposed facility 2. Proximity to nearest VA-staffed site providing these services 3. Proximity to enrollee population density centers/proximity relative to HRR 4. Physical access to proposed site/access to major highway(s)
<b>Staffing</b>	1. Ability to recruit and retain primary care, mental health, or specialty providers 2. If decompressing campus: # of PACTs and providers at the current location and the number of PACTs and providers relocating to the new VA site
<b>Facility</b>	1. Lease expiration date (only if pertinent to opportunity) 2. Condition of facility and infrastructure (only if pertinent to opportunity) 3. Space to accommodate additional volume 4. Square footage

### Key Planning Questions

The key planning questions associated with the major decision-making drivers, listed in Table 13, also assisted in the opportunity development process to inform the design of Veteran-centric HPIDNs.

\* VA core unique patients exclude Veterans who have used only VA telephone triage, pharmacy, and laboratory services.

**Table 13: Key Planning Questions**

Major Drivers	Key Planning Question
<b>Geography and Demographics</b>	<ul style="list-style-type: none"> <li>Where do Veterans live now and where will they live in the future?</li> </ul>
<b>Demand</b>	<ul style="list-style-type: none"> <li>What services do Veterans need currently and in the future?</li> <li>Can the current VA medical programs be sustained in the future?</li> </ul>
<b>Capacity</b>	<ul style="list-style-type: none"> <li>What is the current and potential future supply at VA and other Federal and commercial facilities?</li> </ul>
<b>Access</b>	<ul style="list-style-type: none"> <li>Do Veterans have convenient access to high-quality care?</li> <li>Are there access gaps?</li> </ul>
<b>Quality and Satisfaction</b>	<ul style="list-style-type: none"> <li>Do internal and external providers meet VA care standards?</li> </ul>
<b>Staffing</b>	<ul style="list-style-type: none"> <li>Can VA appropriately and consistently staff its clinical programs?</li> </ul>
<b>Facilities</b>	<ul style="list-style-type: none"> <li>Are the current facility conditions and infrastructure capable of providing a safe environment of care that meets current design standards?</li> </ul>
<b>Mission</b>	<ul style="list-style-type: none"> <li>Would opportunities alter VA's ability to meet its education, research, or emergency preparedness missions?</li> </ul>

Accounting for these factors in conjunction with the qualitative and quantitative analysis conducted in Steps 1-6, the teams then drafted opportunities using standardized templates. Examples of these opportunities included, but were not limited to:

- **Service line or programmatic VA vs. VCCP (make vs. buy) opportunities;**
  - Example: Opportunity to expand primary care services at a facility.
- **Non-capital improvements, such as improved efficiencies, policy changes, evening hours, virtual care options;**
  - Example: Opportunity to expand telehealth capabilities.
- **Partnership opportunities to deliver care in coordination with Federal, academic, and/or community providers; and**
  - Example: Opportunity to partner with a DoD facility to deliver specific or specialized care.
- **Proposed investments in capital (leasing, construction, renovations) and closure (demolition, sale) of existing VHA assets.**
  - Example: Opportunity to build a new point of care for a high-demand service.

Each opportunity included a detailed rationale, which explained the reasoning behind each opportunity. These rationales drew heavily on the associated key metrics from the DD&F documents and linked to the major drivers and directional criteria to ensure the opportunity was in line with market assessment guiding principles.

## VHA Review

Following the development of the opportunities and rationale, VHA executed a series of review sessions to ensure that opportunities were consistent with and reflective of VHA leadership’s objectives. The opportunities underwent significant review by VHA leadership, including CSO, the market assessment IPT co-chairs, the Acting USH and the relevant VISN Network Director. The flow chart in Figure 11 depicts the process of reviews. This was one of two extensive review processes with VA leaders. Following the COVID-19 pandemic, reviews with the Acting USH and Network Director included consideration of the impact of the pandemic. The pandemic’s impact was further considered during the review conducted by leaders during the quality assurance phase.

**Figure 11: VHA Review Process**



### *Peer Review with VACO Market Assessment Teams*

During a series of meetings for the six market assessment teams, teams presented major opportunities for all market assessments, defined as opportunities that would have substantial impact on current health care operations within a market. Market assessment teams completed a peer review process, reviewing other assessment teams’ opportunities in advance of the meeting. In each review, participants from all teams had the opportunity to probe and challenge the team responsible for developing the opportunities. Assessment teams then made revisions based on the feedback received, and the full group re-reviewed the opportunities as required.

### *Centralized CSO Review*

A select group of CSO subject matter experts conducted an extensive review of the market assessment opportunities. Specifically, CSO reviewed each market’s set of opportunities for congruence, ease of comprehension, and valid application of data. Members of the CSO group also checked the narrative for accuracy and cross-market consistency. CSO provided feedback, and the market assessment teams made revisions as needed.

### *Co-Chair Review*

The market assessment teams presented all markets to the market assessment IPT co-chairs and updated them based on feedback. The co-chairs carefully reviewed the opportunities and rationales, challenged opportunities requiring additional support and requested revisions as needed. If updates were required, teams revised opportunities based on co-chair feedback and re-reviewed them with the co-chairs to ensure acceptance.

### *Acting Under Secretary for Health and VISN Director Review*

Market assessment teams presented all opportunities for each market to the Acting USH, VISN Network Director for the VISN being reviewed, and other members of VHA leadership. Opportunities were updated based on any feedback received.

### *Updates to Opportunities*

Market assessment teams updated the opportunities based on the outcomes of each of the review sessions. Although the opportunities had gone through several rounds of review, the market

assessments and their associated opportunities remained as drafts, dependent on quality assurance and Secretary approval to become final recommendations.

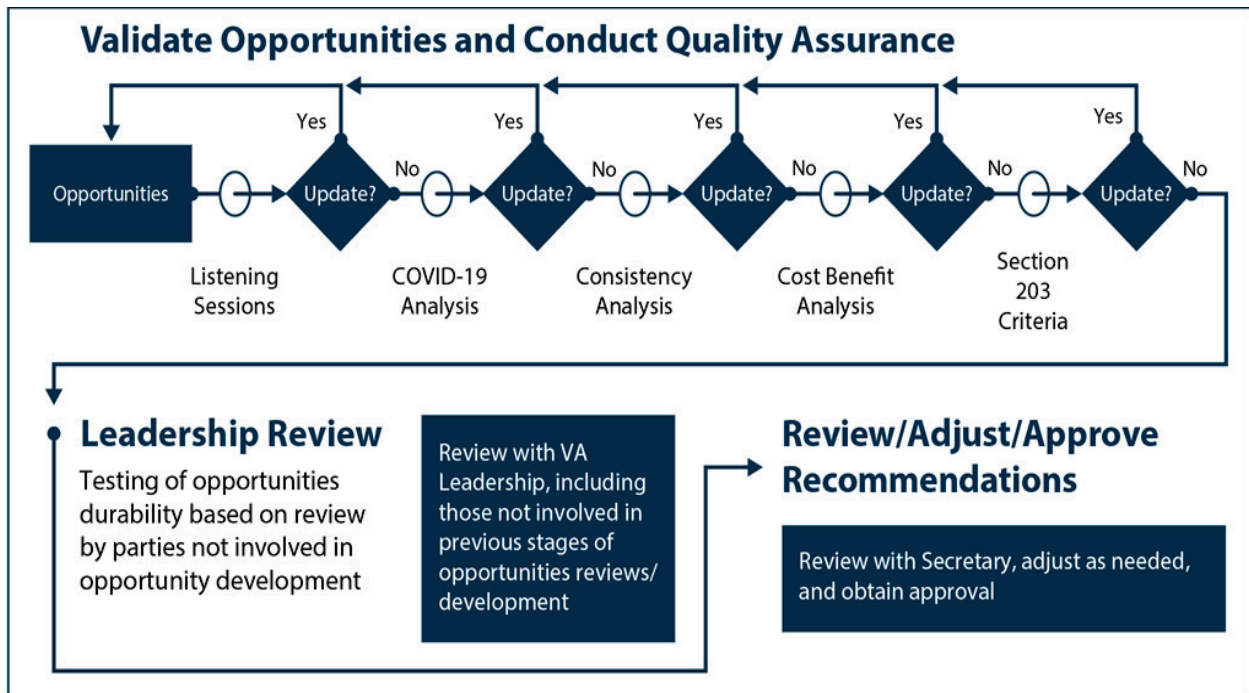
**Step 8: Integrate Market Optimization Opportunities into VISN and National Strategic Plans**

After the teams completed Step 1 through 7 of its market assessment methodology, market assessments progressed to the final step of the market optimization work, integrating the market optimization opportunities into VISN and national strategic plans. The teams conducted this step as part of the quality assurance process, which is discussed below.

**5.4 Quality Assurance Process**

In the second stage of the market assessment work, market assessment teams reviewed the opportunities so that they aligned with other inputs and criteria. These inputs included local stakeholder listening sessions, COVID-19 analyses, cross-VISN and consistency analyses, cost benefit analyses, and the Section 203 criteria. Recognizing the passage of time since the original market assessment phases were conducted, VA gathered more recent data for key data points for use in the quality assurance process. Because the COVID-19 pandemic affected FY 2020 and FY 2021 data, 2019 was the most recent fiscal year incorporated for most data elements. This data is included as an addendum to the original DD&F in Appendix F. Upon conclusion of this refinement process, the opportunities were reviewed again by senior VA leadership and there was robust discussion with the Network Directors. The opportunities became draft recommendations that the Secretary reviewed, discussed in depth with each VISN Director, and approved or requested be revised prior to approval (Figure 12). As part of the quality assurance process, VA also appreciated receiving valuable insights from oversight reports – including from the Government Accountability Office (GAO) – which the Department incorporated as it finalized recommendations. Finally, during this period VA also coordinated with DoD regarding potential opportunities for strategic collaboration between the Departments.

Figure 12: Quality Assurance Process



## Local Stakeholder Listening Sessions

As VA conducted its planning, it was critical to incorporate input from the Veterans served across the system. To do so, VA engaged local stakeholders as part of the market assessment process. VISNs and VAMCs partnered to conduct virtual listening sessions from March 2021 through June 2021. The listening sessions gathered valuable feedback on Veterans' experience with VA health care and their vision for its future. Specifically, VA designed the sessions to learn how Veterans want their care to be delivered in the future. VA also sought to gather Veterans' perceptions of the quality of health care and their experiences accessing care at VA and through VA's community providers, satisfaction with the condition and location of VA facilities, and perspectives on VA's role in research, education, and emergency preparedness.

VA announced these listening sessions through a webpage and Federal Register notice, and VAMCs and national VSOs conducted their own outreach for the sessions. For each listening session, VA tasked the VAMCs with marketing the events through press releases, social media posts, and web postings. VA also provided the VAMCs with digital signage, a fact sheet, letters, website features, and newsletter content for use at their discretion. On a national level, VA utilized outreach mechanisms and reminder notifications to invite state and tribal governments, congressional staff, VSOs, and Community Veteran Engagement Boards (CVEBs) to the sessions and encouraged them to invite their constituents and members. To keep the development of opportunities aligned with Veterans' needs and preferences, VA also engaged with VSOs to take Veteran feedback into account. VA regularly briefed national VSOs through events such as VSO breakfasts to keep them updated on the overarching market assessment methodology and the progress of the draft Section 203 criteria.

On March 8, 2021, at the beginning of the series, VA released a national blog post<sup>54</sup> announcing the local listening sessions. VA grouped markets together based on geography and demographics for these listening sessions. In addition to market-based listening sessions, VA also conducted one national Spanish-language session and four national evening sessions in different time zones.<sup>55</sup> The intent was to provide as many opportunities as possible for Veterans and stakeholders to share their experience and perspective. In total, 56 listening sessions were held. A VA webpage housed the full schedule and included links to register for all local sessions through June.

Across all the listening sessions, VA asked stakeholders to share their experiences with VA health care and VA's VCCP. VA asked Veterans open-ended questions regarding improvements that could be made to VA health care and how they would like to receive care through VA in the future. All listening sessions were available to the public and held on a virtual platform that included the option to call in by telephone. Between March 2021 and June 2021, 3,360 attendees joined 56 listening sessions, providing 3,028 verbal or written comments and 6,683 responses to poll questions.

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**VA engaged with VSOs to take Veteran feedback into account.** VA regularly briefed national VSOs through events such as VSO breakfasts to keep them updated on the overarching market assessment methodology and the progress of the draft Section 203 criteria.

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**Between March 2021 and June 2021, 3,360 attendees joined 56 listening sessions, providing 3,028 comments and 6,683 responses to poll questions.**

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VA designed each session, hosted by a member of the VISN or VAMC staff, to draw feedback from Veterans and other stakeholders on their personal experiences and perspectives on how to improve their experience with VA health care. In each session, local VISN and VAMC leaders provided introductions, and CSO made a short presentation on the market assessments and the timeline of the AIR Commission. An overview of the listening session procedures and an open discussion based on a standard set of poll and discussion questions followed the introductions and presentation. The open discussion included a poll and discussion questions, shown in Table 14, focused on VA services, VCCP providers, facility infrastructure, and mission. Each poll question consisted of a 'Yes/No' response.

**Table 14: Listening Session Poll and Discussion Questions**

Poll Questions	Discussion Questions
<ul style="list-style-type: none"> <li>Does VA provide the types of health care services Veterans need?</li> </ul>	<ul style="list-style-type: none"> <li>How can VA change its services to better fit Veterans' needs?</li> </ul>
<ul style="list-style-type: none"> <li>Are you satisfied with the quality of health care services and providers at VA?</li> </ul>	<ul style="list-style-type: none"> <li>What has been your experience with the quality of care provided by VA or through VA's Community Care Network?</li> </ul>
<ul style="list-style-type: none"> <li>Are you satisfied with the quality of health care services and providers through VA's Community Care Network?</li> </ul>	<ul style="list-style-type: none"> <li>What challenges do you encounter most often getting care at VA facilities?</li> </ul>
<ul style="list-style-type: none"> <li>Are you satisfied with your ability to get care from VA?</li> </ul>	<ul style="list-style-type: none"> <li>What challenges do you encounter most often when getting care through VA's Community Care Network?</li> </ul>
<ul style="list-style-type: none"> <li>Are you satisfied with your ability to get care through VA's Community Care Network?</li> </ul>	<ul style="list-style-type: none"> <li>What improvements would you like to see at your local facility?</li> </ul>
<ul style="list-style-type: none"> <li>Are you satisfied with the condition of VA's facilities?</li> </ul>	<ul style="list-style-type: none"> <li>What do you think VA's role in the community should be?</li> </ul>
<ul style="list-style-type: none"> <li>Do you feel VA has a broader role in the community aside from providing health care?</li> </ul>	

Additionally, VA shared a national email address in each listening session. Participants were given the opportunity to provide additional comments or feedback following their sessions, or at any point. VA also included the email address in many of the public communication materials about the listening sessions so participants who were not able to attend a session could submit written feedback. VA reviewed feedback from emails along with the session feedback.

### *Session Feedback*

VA collected and analyzed all feedback, written and oral, gathered in each listening session and compiled it into a final listening session report. Among the 3,028 verbal or written comments providing feedback on the future of VA health care, common themes emerged across markets and VISNs. VA grouped findings by major themes across markets and VISNs; these themes included communication, access to care, Veteran experience, barriers to care, care coordination, and community care, and are summarized below. The final report examined listening session feedback, and Veteran opinions and data conducted outside of the Veteran listening sessions including the VA's Survey of Veteran Enrollees Health and Use of Health Care, VA Customer Profile and Veteran Signals Survey, and Veterans of Foreign Wars Our Care 2019 Survey.

## Communication

Communication was the most frequently discussed topic throughout the listening sessions, comprising 11% of the comments. Many Veterans shared feedback about communications to and from VA. Many of the comments focused on a desire for VA to be more proactive in using personalized communications that keep the Veteran informed of appointment changes, turnover in clinical staff, or other changes that impact the Veteran's ability to access care. Some Veterans stated that communication should improve on all levels, encompassing VA's communication with Veterans, VA's communication with community providers, and VA's programs to educate Veterans on the benefits VA offers. Many Veterans are pleased with the ability to communicate with providers and refill prescriptions through MyHealtheVet.

## Access to Care

Veterans described a variety of topics that limit their access to VA care. Appointment scheduling was a source of frustration shared by numerous Veterans in comments covering scheduling through post-appointment procedures. Veterans also recommended opportunities for VA to expand its care services, suggested preferred types of facilities, and shared preferences related to telehealth.

Seven percent of Veteran listening session comments were related to facilities. Some Veterans requested facilities that better serve the needs of specific groups, such as the addition of more women's health clinics and more facilities for aging Veterans, including long-term care facilities. Five percent of Veteran listening session comments were related to rural access, and many rural Veterans expressed that they do not have consistent access to adequate transportation options and are often unable to receive care in the community close to where they live. Some Veterans recommended expanded services for dental, women's health, and dermatology. While many Veterans would like the ability to utilize telehealth moving forward, some Veterans would prefer not to use it for mental health services.

## Veteran Experience

While Veteran listening session participants were generally pleased with the quality of their care overall, there were several areas recommended for improvement. Throughout the listening sessions, many Veterans and stakeholders expressed concerns regarding a variety of issues related to their experience, including patient advocates, personalized care, mental health, women's health, clinical staffing, inclusivity, facility design, and consistency of care across facilities.

In addition, Veterans described opportunities to improve mental health service by expanding access to peer-to-peer support, leveraging family and marriage therapists, and providing calming waiting areas for Veterans with anxiety and other mental health concerns. Some Veterans would like facilities to be more accessible and easier to navigate.

## Barriers to Care

Veterans shared barriers they encounter during the care experience. Comments in this area primarily expressed frustration with travel distance and transportation options. Veterans mentioned the distance they must drive for VA care and stated they are often inconvenienced when they must drive between multiple facilities for care they could receive at one facility. In rural areas especially, Veterans feel VA should expand telehealth services. Veterans described inadequate transportation as a barrier to accessing care, especially for older Veterans, and asked VA to expand transportation options to include ride-sharing apps. Veterans also believe VA should improve parking, including adding more spaces for individuals with disabilities, and enhance shuttle services to support Veterans accessing care at local

VAMCs. In addition, several Veterans expressed concerns with travel reimbursement, including the length of time for reimbursement and the amount of paperwork required if a kiosk is not available.

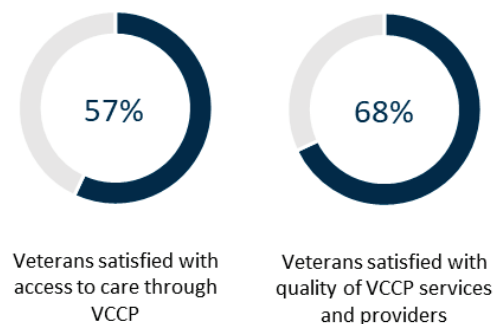
### Care Coordination

Veterans expressed VA should better integrate care for Veterans who seek care at multiple VA facilities. Some Veterans described frustration with the number of steps needed to make a single appointment, especially when a referral is required. Several Veterans described challenges coordinating prescriptions or medical issues between different providers or expressed desire for increased interoperability of their medical records between VA facilities, community providers, and DoD providers. Some Veterans requested VA help coordinate appointments for Veterans who require multiple appointments in the same timeframe, as opposed to treating each appointment as a separate piece of the process.

### Community Care

During the listening sessions, Veterans shared mixed feedback regarding their experiences with the community care program. The feedback ranged from positive to negative and oftentimes combined satisfaction and frustration. This is reflected in the poll results, with 57% of poll participants being satisfied with their ability to get care through VA's VCCP and 68% being satisfied with the quality of health services and providers through VA's VCCP. Challenges some Veterans raised include care coordination, referrals and timeliness, and billing. Veterans shared they would like to receive care closer to home and be able to access care that meets their needs. Some Veterans suggested community care be proactively offered to Veterans who live far from VA facilities or face delays in accessing services at VA.

**Figure 13: Community Care Feedback**



### Feedback Incorporation

An analysis of each listening session provided an additional quality analysis review of the market assessment findings. Based on review by the market assessment team, Veteran feedback regarding outpatient care, access, and facilities aligned with the strategic direction and findings of the market assessments. Accordingly, no changes were recommended to market assessment opportunities based on the listening sessions. Veterans also discussed operational improvements outside the scope of the market assessments that VA will have the chance to address outside of the market assessment process. The Veteran listening sessions report, included in Volume II, Appendix G and all listening session comments were reviewed by the market assessment teams and provided to the Secretary.

### COVID-19 Analysis

The COVID-19 pandemic transformed how health care providers across the Nation delivered care to patients, including at VA. To determine whether pandemic-related health care changes would require adjustments to opportunities, VA conducted a national analysis of COVID-19's impact on VA capacity and response from March 2020 through April 2021. VA analyzed internal data on COVID-19 cases and admissions to understand the influence of COVID-19 on relevant opportunities and examined VA's Fourth Mission Response. VA's analysis also considered VA, state, and regional demand and capacity,

noting the peak dates of cases through June 2021, acute inpatient census, overall ICU capacity and overall inpatient capacity on the peak dates, and availability of ventilators. VA also evaluated each state's ability to surge beds based on the maximum number of active ICU and inpatient beds for COVID-19.

After the emergence of an extended surge of COVID-19 cases caused by the Delta variant of the virus in the summer and fall of 2021, VA issued an additional survey of VAMC leadership in August 2021 with responses due in September 2021. The follow-up survey of VAMCs supplemented centralized information gathered through the previous COVID-19 analysis, market assessment data collection, and interviews to document VA's response to COVID-19. To supplement the survey, updated centralized data was gathered through multiple custom Bed Management Solution system reports between the timeframe of March 2020 through August 2021. The reports included:

1. Occupied Bed Type Peaks – L06 Report: Provided the staffed inpatient beds available by service type while the facility was experiencing peak capacity.
2. Bed Type Peaks – L05 Report: Provided the total inpatient beds available by service type while the facility was experiencing peak capacity.

The survey requested the following information:

- a. Describe what overall bed surge/increased capacity, if any, did your facility have as a result of COVID-19.
- b. Did your facility repurpose specific non-acute care units/services to increase capacity in anticipation of patient surges related to COVID-19?
- c. What was your peak inpatient census during COVID-19, and applicable date(s)?
- d. Please document operational impacts that resulted from COVID-19.
- e. What has the impact of COVID-19 been on virtual care/telehealth?
- f. What support was requested and/or did you provide to outside entities or the community, and what type of support?
- g. What were key lessons learned, to date, from the pandemic?
- h. What have been the effects of COVID-19 on your geographic location and facility enrollee population? What services have the new enrollees used?

VA then reviewed opportunities that may have required updating with the market assessment IPT co-chairs.

VA is also planning to conduct an additional analysis related to the COVID-19 pandemic and will provide the Commission with updated findings in the months ahead.

## Consistency Analysis

To ensure that VA was consistent in its planning approach across markets and enterprise-wide, VA conducted a consistency analysis.

The consistency analysis sought to provide an enterprise-wide approach to similar opportunities while balancing unique market characteristics to develop a viable, Veteran-centric market strategy. VA created decision models for select service and facility types using key discrete quantitative data elements. Where available, the decision models were informed by key metrics from VA's national planning strategies. No single data element determined a potential opportunity. VA also identified qualitative

data elements relevant to the decision-making model to provide a more complete understanding of each opportunity. Facility interviews and site tours provided qualitative data. Because qualitative data varied across sites, the decision model cannot incorporate all qualitative data collected about a facility or service line.

The consistency analyses helped identify opportunities needing additional review. In some instances, opportunities were changed as a result of the decision model, but in other instances, the decision model helped validate that these opportunities were justified by additional factors not in the model, such as quality and staffing. For example, VA carefully considered decisions regarding whether to maintain or discontinue low census inpatient medical and surgical units. VA considered not only the average daily census but also the availability of quality care in the community, potential impact on health equity, and market-specific factors like challenges associated with recruitment and retention.

Proposed actions were developed for the opportunities that were inconsistent. Proposed actions included maintaining opportunities as written, modifying or deleting opportunities, and creating new opportunities. The IPT co-chairs reviewed and adjudicated potential changes to opportunities resulting from the consistency analysis.

### **Cross-VISN/Market Analysis**

Some opportunities involve facilities that serve Veteran populations across VISN or market boundaries. To develop a coordinated and holistic national strategy that accounts for this overlap, VA developed a cross-VISN/market analysis. This analysis examined those opportunities and focused on ensuring care and services would continue to be provided to Veterans, regardless of those administrative boundaries. In addition, based on adjustment to VISN and market boundaries, an analysis was performed on regional programs, such as SCI/D, to ensure future care would be sustainably available.

The analysis considered opportunities proposing the administrative realignment of facilities to other VISNs as well as potential changes to health care service offerings based on openings, closings, or modifications of facilities within a 60-minute drive time of a VISN border. This effort was important for optimizing availability and access to care for Veterans, avoiding unnecessary duplication of services, and appropriately scaling care to meet the needs of the Veteran population. VA analyzed the cross-VISN/market opportunities using standardized data from the DD&F documents. When opportunities proposed administrative realignments, VA reviewed all opportunities and identified opportunities that include combining or splitting of markets; realigning counties or sectors between markets; and realigning facilities. For health care service changes, the analysis determined how each identified opportunity might increase or decrease Veteran access to those services. VA reviewed all opportunities and identified opportunities that included proposed new, closed, and modified/relocated sites within a 60-minute drive time of a VISN border. If an exact location for a new site was not identified in the opportunity, VA used the town center as the approximate location of the site.

VA then determined if the opportunities or rationale needed to be reevaluated, strengthened, or clarified based on input from the neighboring and impacted VISN(s) and documented previous and current discussion between VISN market assessment teams, noting recommendations for revision of opportunities and/or rationale.

## Cost Benefit Analysis

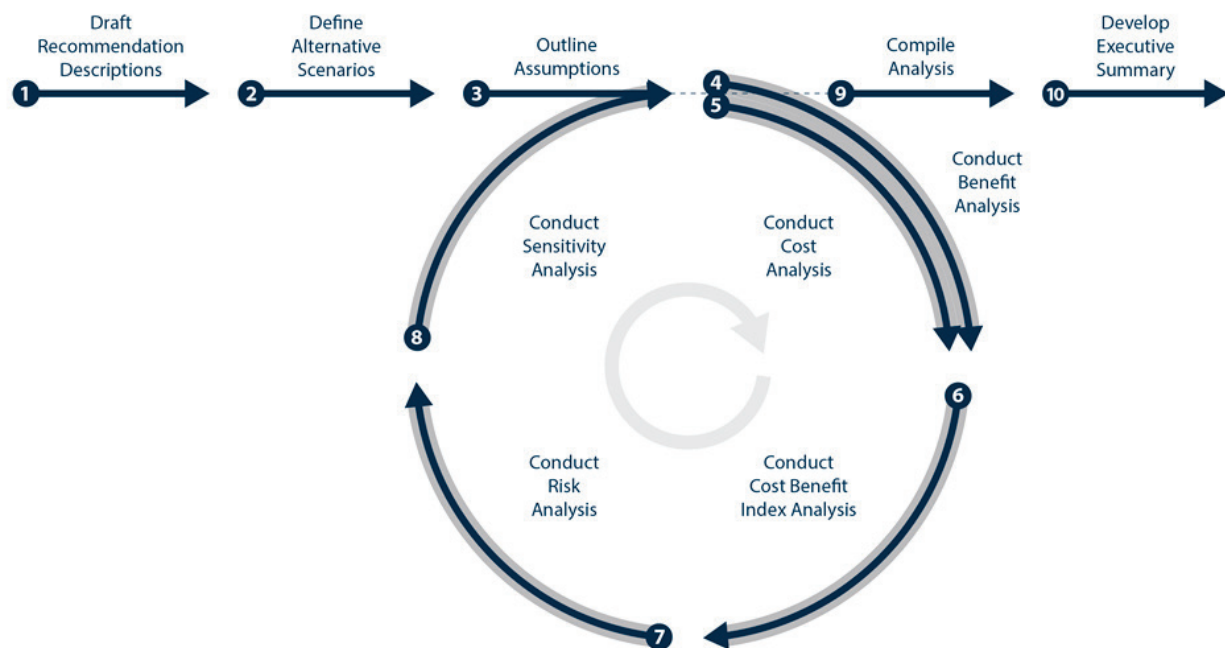
The MISSION Act required a cost benefit analysis (CBA) be conducted to determine the potential costs and savings of the recommendations submitted to the AIR Commission. VA conducted a cost benefit analysis as part of the Quality Assurance Process in order to review, analyze, and compare the costs and benefits of VA's recommendations for each market against alternative options. VA conducted this cost benefit analysis in line with the Office of Management and Budget (OMB)'s Circular A-94 for conducting high-quality, reliable cost benefit and cost effectiveness analyses.

VA applied the CBAs to the recommendations created in the market assessments. For each market, the CBAs included a qualitative narrative, a present value (PV) calculation, a benefits analysis, and a Cost Benefit Index (CBI) calculation to compare the net impact of the recommendation. VA packaged these components together to develop an analysis for each market.

### CBA Methodology

The project team developed the CBA methodology with review by staff at OMB. The ten-step methodology is shown in Figure 14 and detailed below.

**Figure 14: Cost Benefit Analysis Methodology**



#### 1. Draft Recommendation Descriptions

To begin the CBA, the actions outlined in the VA Recommendation to the AIR Commission were used to outline the strategic direction for modernization and realignment of health care facilities and services in the market.

## 2. Define Alternatives

Three alternative courses of action (COAs) were developed in each market. Each market CBA contains a detailed description of three COAs: “Status Quo,” “Modernization,” and “VA Recommendation to the AIR Commission.”

Descriptions of the three COAs are provided below:

- a. *COA 1 – Status Quo*: The Status Quo COA represents the annual capital and operational costs associated with the FY 2019 actual to FY 2029 projected workload, assuming costs associated with FCA deficiencies and no additional modernization to current facilities, programs, and infrastructure.
- b. *COA 2 – Modernization*: The Modernization COA represents the closure of facilities built pre-1970 and the rebuilding of these facilities to meet workload projections, as well as investments to keep facilities up to date, compliant, and safe. While the Modernization COA includes the existing operational construct and associated operational expenditures outlined in the Status Quo COA, it differs by including catch-up modernization capital funding followed by the annual sustainment funding needed to maintain the infrastructure and ensure optimal operation and performance.
- c. *COA 3 – VA Recommendation to the AIR Commission (VA Recommendation)*: This alternative COA is derived from the VA Recommendation to the AIR Commission for the market. The recommendation is focused on developing a high-performing integrated delivery network that balances VA-delivered care provided in VA-operated medical center campuses and facilities with care delivered through partnerships and the VCCP. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

## 3. Outline Assumptions

Assumptions were created and vetted at the enterprise level and applied across all analyses – these are contained in the CBA Methodology.

## 4. Conduct Cost Analysis

A PV calculation was conducted for each market. \* Each market’s PV outlines the costs associated with each COA, including capital and operational costs. All quantifiable estimated costs were discounted to current dollar values through PV calculations. The analysis also included considerations of the cost variance as shown in Table 15.

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\* The present value cost is the current value of future costs discounted at the defined discount rate. A 30-year time horizon was selected in accordance with OMB, CSO, and CFM guidance. A 30-year time horizon thus represents a realistic and appropriate scenario for considering value.

Table 15: Sample Cost Variance by COA

Cost Variance	Status Quo	Modernization	VA Recommendation
Capital Cost Variance	N/A	(\$3,975,936,676)	(\$5,473,074,098)
Operational Cost Variance	N/A	\$0	\$129,681,280
Non-VA Care Operational Cost Variance	N/A	\$0	(\$595,499,268)
VA Care Operational Cost Variance	N/A	\$0	\$725,180,547
Estimated Cost Variance	\$0	(\$3,975,936,676)	(\$5,343,392,818)

### 5. Conduct Benefit Analysis

A Benefits Analysis was conducted to evaluate the non-financial benefits of each COA across five key domains: Demand and Supply, Access, Quality, Facilities and Sustainability, and Mission, listed below:

- **Demand and Supply:** The CBA considers how a recommendation impacts VA’s capacity to meet Veteran demand for health care services in the future.
- **Access:** The CBA considers how a recommendation will impact the convenience and accessibility of VA care provided to Veterans in the future.
- **Quality:** The CBA considers how a recommendation will impact the quality of care for Veterans.
- **Facilities and Sustainability:** The CBA considers how a recommendation impacts VA’s ability to offer Veterans a welcoming and safe care environment that meets modern health care standards and ensures sustainability for future generations of Veterans.
- **Mission:** The CBA considers how a recommendation will impact VA’s ability to execute its statutory missions of education, research, and emergency preparedness in support of Veterans and the nation.

The Benefits Analysis score is based on an evaluation process that sets standardized measures for each of the domains. Each domain is scored on a scale of one (least beneficial) to three (most beneficial).

### 6. Conduct Cost Benefit Index Analysis

The CBI ratio is used to compare the three COAs under consideration. The index equals the total life-cycle cost (PV) of each COA in constant dollars, divided by the Benefits Analysis score for that COA’s non-financial benefits. The COA with the lowest CBI score is the preferred COA. An example is presented in Table 16.



Table 16: Example of CBI for each COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
COA Present Value (\$)	(\$36,192,188,287)	(\$38,178,753,244)	(\$39,080,042,093)
Benefit Analysis Score	10	14	15
CBI (Normalized in \$Billions)	3.62	2.73	2.61
CBI % Changed vs Status Quo	N/A	-24.7%	-28.0%
CBI % Change vs Modernization	N/A	N/A	-4.5%

### 7. Risk Analysis

The risk assessment identified relevant risks and considered broad impact to the implementation of the COAs. Risks are inherent in the implementation of the three COAs across all markets and may impact markets to varying degrees. A detailed risk analysis may be required at the time of implementation as VA moves from strategy to execution.

### 8. Sensitivity Analysis

The sensitivity analysis measured how uncertainties of one or more inputs can lead to variations in potential output. The benefit scores and the costs were varied to calculate an updated CBI to determine whether the preferred COA changed. If the preferred COA changed, the CBA may be considered sensitive.

### 9. Compile Analysis

The results of the PV, benefits analysis, sensitivity analysis, and CBI were compiled to provide measures of the cost and overall benefit of each COA. The COA with the lowest CBI becomes the preferred COA.

### 10. Develop Executive Summary

The executive summary narrative was completed at the end of the CBA and includes the following for each COA: (1) PV calculations, (2) Benefits Analysis scores, (3) CBI scores, (4) An outline of the preferred COA, (5) Sensitivity Analysis. The full CBA methodology and CBA narrative can be found in Appendix D.

## Section 203 Criteria Development and Analysis

Section 203 of the MISSION Act required the Secretary to develop criteria for determining which recommendations would be submitted to the AIR Commission. Factors outlined in Section 203(b)(2)A-F of the MISSION Act informed the criteria development.\* VA leadership consulted with national VSOs to develop the draft criteria and also held CVEB listening sessions to further inform development. In February 2021, VA published the draft criteria in the Federal Register for public comment. Upon closure of the comment period, VA leadership reviewed and considered the substantive comments. Following this consideration and revisions to the criteria, leadership submitted the final criteria to the Federal Register, which were published on May 31, 2021. The final criteria are found in Appendix C.

VA leadership organized the criteria into six domains: *Demand*, *Access*, *Impact on Mission*, *Quality*, *Cost Effectiveness*, and *Sustainability*. VA evaluated the potential effects of recommendations on each domain at the market level, as each recommendation is intended to develop a holistic strategy across the entire market rather than at an individual facility level.

Each domain contains one principal criterion and multiple sub-criteria. Table 17 contains the criteria included under each domain.

**Table 17: Section 203 Criteria**

Domain	Principal Criterion	Sub-Criteria
<b>Demand</b>	The recommendation aligns VA's high-performing integrated delivery network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the Market.	<ol style="list-style-type: none"> <li>1. Aligns the quality and delivery of integrated care and services with projected Veteran demand across demographics and geography</li> <li>2. Retains or improves VA's ability to meet projected demand</li> <li>3. Incorporates trends in the evolution of U.S. health care</li> </ol>
<b>Access</b>	The recommendation maintains or improves Veteran access to care.	<ol style="list-style-type: none"> <li>1. Aligns VA points of care and services with projected Veteran need across demographics and geography</li> <li>2. Ensures Veterans are provided a range of integrated health care options and the opportunity to choose the care they trust throughout their lifetime</li> <li>3. Enables VA to serve as the coordinator of each Veteran's health care, whether provided within or beyond VA</li> <li>4. Considers health equity, defined as the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality</li> <li>5. Reflects consideration of factors underpinning observed access patterns regarding conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risks</li> <li>6. Incorporates trends in the evolution of U.S. health care</li> </ol>
<b>Impact on Mission</b>	The recommendation provides for VA's second, third, and fourth health related statutory missions of	<ol style="list-style-type: none"> <li>1. Aligns resources to VA's education, research, and emergency preparedness missions across demographics and geography</li> <li>2. Education: Maintains or enhances VA's ability to execute its education mission</li> <li>3. Research: Maintains or enhances VA's ability to execute its research mission</li> </ol>

\* For more information on the factors, please see Section 2, Legislative History.

Domain	Principal Criterion	Sub-Criteria
	education, research, and emergency preparedness.	<ol style="list-style-type: none"> <li>Emergency Preparedness: Maintains or enhances VA's ability to execute its emergency preparedness mission</li> <li>Incorporates trends in the evolution of U.S. health care</li> </ol>
<b>Quality</b>	The recommendation considers the quality and delivery of health care services available to Veterans, including the experience, safety, and appropriateness of care.	<ol style="list-style-type: none"> <li>Ensures the highest possible quality of care across demographics and geography</li> <li>Promotes recruitment of top clinical and non-clinical talent</li> <li>Maintains or enhances Veteran experience</li> <li>Incorporates trends in the evolution of U.S. health care</li> </ol>
<b>Cost Effectiveness</b>	The recommendation provides a cost-effective means by which to provide Veterans with modern health care.	<ol style="list-style-type: none"> <li>Reflects stewardship of taxpayer dollars by optimizing investments and resources to achieve advancements in access and outcomes for Veterans</li> <li>Recognizes potential savings or efficiencies that may free resources for more impactful investment for Veterans</li> <li>Considers the value of Veteran and employee experience, innovation, and other intangible elements of value</li> </ol>
<b>Sustainability</b>	The recommendation creates a sustainable health care delivery system for Veterans.	<ol style="list-style-type: none"> <li>Aligns investment in care and services with projected Veteran care needs across demographics and geography</li> <li>Reflects stewardship of taxpayer dollars by creating a sustainable infrastructure system for Veterans</li> <li>Enables recruitment and retention of top clinical and non-clinical talent</li> <li>Incorporates trends in the evolution of U.S. health care</li> </ol>

An analysis was performed to evaluate if the holistic recommendation for each market was consistent with the criteria based on measures that are found in Appendix E. Recommendations determined to be inconsistent with the criteria required adjustment. All recommendations submitted by the Secretary were determined to be consistent with the Section 203 criteria.

To ensure that VA considered health equity in its analysis, VA assessed the access domain not only for the overall enrollee population but also for specific subpopulations that have historically faced barriers accessing care, including: 65-and-older enrollees, women enrollees, rural enrollees, enrollees living in disadvantaged neighborhoods, minority enrollees, and high service-connected disability rating enrollees.

## Leadership Review

### AIR Integrated Planning Team Review

The AIR Commission IPT is a high-level strategic decision-making body within VA and aligns with the intent of the MISSION Act and other applicable laws, rules, and regulations. The IPT is comprised of the critical stakeholders in this process, as its members establish governance for AIR Commission efforts and serve as the official review body for all VA recommendations to execute the MISSION Act mandate. The IPT's responsibilities include:

- Establishing governance for the process of developing and providing finalized official recommendations to the AIR Commission;
- Serving as an official review body for AIR Commission recommendations prior to submission to the Secretary;
- Acting as an escalation point for the resolution of issues; and

- Overseeing timely completion of key AIR Commission milestones and deliverables.

Members of the IPT include senior-level representatives that are authorized to make decisions on behalf of their organization. Members of the IPT include the following:

- Office of the Secretary (OSVA) Senior Advisors;
- Veterans Health Administration (VHA);
- VHA Chief Strategy Office (CSO);
- Office of Enterprise Integration (OEI);
- Office of General Counsel (OGC);
- Office of Construction and Facilities Management (CFM);
- Office of Management (OM);
- Office of Congressional and Legislative Affairs (OCLA);
- Human Resources and Administration/Operations (HR&A/OSP);
- Office of Acquisition, Logistics, and Construction (OALC);
- Office of Information and Technology (OIT); and
- Veterans Experience Office (VEO).

In addition to VA, the AIR IPT includes senior-level representatives from OMB. Rotating members from regional or local administrations were brought into IPT meetings on an as needed basis depending on the issue to provide perspectives or decision.

### Red Team Review and Oversight Reports

The Secretary directed that an independent “Red Team” be established to conduct an analysis of VA’s market assessment work and to assess potential COVID-19 pandemic impacts. The Secretary also requested the Red Team, consisting of external health care professionals and former VA Secretaries, assess a sampling of the recommendations currently under consideration. The Red Team met with VACO stakeholders and reviewed DD&F documents, select recommendations, and supporting materials. The Red Team’s insights provided valuable insight into how VA might address methodological limitations.

In addition, VA also appreciated receiving valuable insights from both VA’s Inspector General and GAO. VA incorporated insights from these reports as it finalized its recommendations.

Based on the Red Team Review and the oversight reports, VA will continue to refine our data governance, conduct additional analysis to better understand the long-term impact of emerging health care trends and shifting requirements related to the pandemic, and work with the AIR Commission to identify data limitations that will inform and assist the Commission during the review process. Limitations are further discussed in the next section.

### Secretary Review and Approval

Upon the completion of opportunity refinement according to the above inputs, the Acting USH, Network Directors, and the IPT re-reviewed all opportunities for approval. Once approved, the opportunities became draft recommendations. The Secretary reviewed the draft recommendations. Following extensive consultation with VA leadership, including Network Directors, and with DoD, the Secretary approved or requested revisions of the draft recommendations. Once finalized, the Secretary approved recommendations in accordance with Section 203 of the MISSION Act.

## 5.5 Assumptions and Limitations

### Assumptions

All market assessments relied on key assumptions in order to conduct consistent and thorough analyses. These assumptions not only aided in better understanding each market, but also allowed for accurate conclusions to be drawn. Major assumptions in each step of the process are listed below:

#### Overarching Assumptions

Market assessments will:

- Focus on a long-range planning horizon;
- Design high-performing market area networks that provide high-quality, readily accessible, cost-effective, Veteran-centric care through VA, Federal partners, academic affiliates, and other community providers; and
- Develop recommendations that represent a strategic direction to inform and guide VA's capital and certain non-capital investment. Once approved by the AIR Commission, each recommendation will require detailed planning prior to implementation, which must begin no later than 3 years after the President's approval.

#### Data Assumptions

- The market assessments are informed by both quantitative and qualitative data;
- No single data point is used as the deciding factor in determining opportunities for markets;
- There will be no major changes in eligibility for VA care; and
- Demand estimates are based on the EHCPM. The model itself is based on a number of assumptions. The key EHCPM assumptions are:
  - Base Year (BY) 2017 Projections (used for the initial assessment process described in Section 5.3):
    - Veterans previously eligible under the Choice Act remained eligible under the MISSION Act for VA care after the expiration of the Choice Act on June 1, 2019.
    - The projected workload was allocated between VA direct care and community care based on the proportion of care provided in the two care locations in 2017.
    - As a result of Hurricanes Maria and Irma, the model assumed an enrollment impact for VISN 08 and Puerto Rico and a temporary impact on utilization at affected facilities.
  - BY 2019 Projections (used for quality assurance analyses as described in Section 5.4): BY 2019 included assumptions for several MISSION Act provisions that increased total demand for VA care (primarily through the VCCP) including:
    - Enrolled Veterans were eligible to access community care based on new geographic access standards: 30-minute drive time for primary and outpatient mental health care; 60-minute drive time for specialty care;
    - Veterans previously eligible under the Choice Act remained eligible under the MISSION Act;

- Veterans could receive urgent care visits in the community from in-network providers; and
- The projected workload was allocated between VA direct care and community care using the following assumptions:
  - The total projected growth in workload associated with the MISSION Act was allocated to community care.
  - Future (non-MISSION) workload growth due to demographics, trends, etc. was allocated based on the proportion of care provided in VA facilities and purchased in the community in 2019.

Additional assumptions relevant to each aspect of the methodology, such as the cost benefit analysis and the Section 203 criteria, are included within their respective methodology documents.

## Limitations

### *Uncertainty in Veteran Projections*

The demographic portrait of the current and future population of VA enrollees is the product of the data VA has gathered on the current Veteran and enrollee population and the application of VA's actuarial modeling. Although these projections are critical for planning purposes, the size and needs of the future Veteran population cannot be known with exact certainty. The future number of eligible and enrolled Veterans will continue to evolve as a result of future military force size and deployments, shifts in disease and injury prevalence associated with military services, and administrative and policy changes. Similarly, alternative options for health insurance, community providers, and changes in health care insurance coverage may affect how and when Veterans rely on VA care. These factors may affect the future population of Veterans and enrollees, and as a result, may change planned actions and outcomes. Historically, the most significant factors changing the EHCPM projections have been external and could not have been anticipated in advance. The EHCPM makes no assumptions regarding future military conflicts. However, when such events do occur the EHCPM is used to assess the effects of the conflict and those changes are incorporated into the annual model update.

### *Uncertainty in the Health Care Landscape*

The COVID-19 pandemic has driven significant uncertainty in the U.S. health care system. While it is clear that COVID-19 has changed the future of U.S. health care, the pandemic's ultimate effects remain unknown. VA is working, and will continue to work, diligently to understand the impact of COVID-19 on the delivery of health care to Veterans and reinvigorate our ability to recruit, educate and retain excellent, committed health care professionals to serve Veterans. VA's recommendations consider the Department's role in the Nation's response to COVID-19, reflect the uncertainty about what COVID-19 will mean for health care delivery over the long term, and preserve VA's ability to serve as the backstop for the U.S. health care system in times of emergency.

### *Data Limitations*

Since 2018, VA has executed a robust market assessment process to inform the Secretary's recommendations to the AIR Commission. This process has included conducting extensive data analysis and conducting interviews with the leadership teams at every VAMC and VISN office. Nevertheless, there are limitations VA would like to communicate to the AIR Commission:

1. **Age of Data:** VA's market assessments began in December 2018 and as a result, data in the original DD&F decks has aged. To mitigate this issue, VA compiled updated data for key data points that were major drivers of decisions and used this data for key components of the quality assurances analyses, including the Section 203 analysis and the consistency analysis. In most of these cases, FY 2019 data was used because more recent data was skewed due to the COVID-19 pandemic and would not have been an accurate basis for planning.
2. **COVID-19:** Market assessments began prior to the COVID-19 pandemic, and two of the three phases were completed prior to the first identified case. As previously noted, VA took steps to better understand the impact of COVID-19, including conducting an analysis based on centrally accessed data and a survey of VAMCs. Nevertheless, as evidenced by the emergence of the Omicron strain in late 2021, the final impact of the pandemic is not yet known. Because there is no way to predict how and where the next emergency will emerge, or how the resulting ailments may need to be treated, VA is focused on maintaining operational flexibility and the ability to surge capacity when needed. While there may be reduction of beds in select markets through closure of inpatient medical and surgical beds, VA will maintain its ability to respond to emergencies by integrating new approaches to providing care (providing flexibility to convert all beds to needed acuity, utilizing ambulatory space, and taking advantage of mobile beds) and deploying trained VA staff and mobile infrastructure where and when they are needed.
3. **Specialty Care Data:** The VA Office of Inspector General (OIG) audited the accuracy of selected data used to measure VA's capacity to provide specialty health care to Veterans. As part of its audit of 12 medical specialties at 10 randomly selected VA medical facilities, OIG identified incorrect coding that led to an overstatement of workload. OIG recommended the Acting USH perform additional analyses to ensure materially accurate specialty care workload data is used to implement recommendations to the AIR Commission. VHA's Health Informatics Management Office, in collaboration with the Office of Integrity and Compliance, the Office of Internal Audit, and other offices, will develop an action plan to assess coding accuracy of specialty care services identified by OIG and present recommendations to the Acting USH to implement the plan. To close this recommendation, VA will provide OIG with documentation of its approved plan and approved recommendations for implementation.
4. **Community Care Data:** The GAO conducted an audit of the market assessment process and noted "Incomplete Information on Non-VA Care." Based on their review, GAO made a recommendation that VA "should review the data on community care to identify any gaps and take steps to address data completeness." Over the last several years, VA has taken steps to improve data governance across the Department and to improve community care data. Based on GAO's finding, VA will review community care data and take steps to address data completeness.
5. **Data Completeness and Reliability:** As part of its audit GAO also noted that the market assessments "did not include steps to determine the reliability of data used" and recommended that VA "should externally communicate to the Commission information about the completeness and reliability of VA data used to inform the assessments and about how VA considered any data limitations in developing proposals for the modernization and realignment of VA facilities." The VA data used to develop the market assessments came from data sources that are subject to a rigorous testing, evaluation, and auditing process conducted by the data

owners. These data sources are the same sources VA relies for operational analyses and are regularly relied on for health care research. As noted by GAO, the market assessments also included a data validation process by which VISN Planners, VAMC planners, and subject matter expert in the data domains were asked to review and validate the data. Based on the reviews by their teams, all Network Directors certified the data as an “acceptable foundation for market assessment analysis.” Based on GAO’s recommendation, VA will provide the AIR Commission with information that outlines the completeness and reliability limitations of VA data used to develop VA’s recommendations.

Data in the health care environment is dynamic. VA’s strategy to mitigate this reality has centered on strengthening VA’s data governance and engaging with those collaborators that know the data best — the leaders and clinicians in the field. VA will continue to refine our data governance and work with the Commission to identify limitations that will inform and assist the Commission during the review process.

## 6. Overview of VA’s Recommendations to the AIR Commission

VA’s recommendations to the AIR Commission are based on consideration of one question above all else: what is best for the Veterans we serve? These recommendations will help VA serve as the primary world class provider of Veterans’ health care; operate a network with the right facilities, in the right places, with the right services; ensure that infrastructure reflects the needs of 21st century Veterans; and strengthen our roles as the leading health care researchers and training institution in America.

Implementation of VA’s recommendations is anticipated to lead to the following outcomes aligned with VA’s planning objectives.

### Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care.

VA’s recommendations call for significant investment in infrastructure to provide primary care, specialty care, and outpatient mental health care in modern facilities. These facilities are placed based on careful consideration of where Veterans live today and will live in the future. All new facilities will be built or leased based on VA’s latest design and facility standards and enable high-quality patient care. While the total number of outpatient points of care will decrease, relocation and expansion of facilities and services will increase Veteran access to VA care.\*

#### Investing in well-placed outpatient facilities that provide more services to Veterans:

- HCCs – which are capable of providing invasive procedures or ambulatory surgery – will nearly double (from 16 to 30).
- MS CBOCs will increase by 56% from 248 to 388.

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\* Note: All facility counts in this brief were based on the following: In August 2021, VA’s Site Tracking System (VAST) was queried to provide active sites and site classification. This information was validated with VISN planners and was used to establish the current state. The current state includes only active sites or sites that were planned to be active by 12/31/21. The future state includes active sites, sites proposed through VA recommendations, and sites were funded or had an active lease as of August 2021.



- CBOCs will decrease by 15% from 555 to 469.
- OOS facilities – facilities that typically have low volumes and may not have full time providers or a full range of services – will be reduced. The number of OOSs will decrease by 34% from 255 to 169.

#### Improving Veteran access to primary care, mental health, and specialty care:

- **Improved Primary Care Access:** The number of Veteran enrollees within 30 minutes of VA-delivered primary care will increase by 146,540 (from 7,162,145 to 7,308,685).
- **Improved Outpatient Mental Health Access:** The number of Veteran enrollees within 30 minutes of VA-delivered outpatient mental health care will increase by 187,259 (from 7,028,260 to 7,215,519).
- **Improved Specialty Care Access:** The number of Veteran enrollees within 60 minutes of VA-delivered specialty care will increase by 378,294 (from 7,630,411 to 8,008,705).

**Table 18: Changes to Enrollee Access for Veterans within 30/60 Minutes of VA-delivered Care**

Service Type	Current	Future	Net Change
Primary Care (30 minutes)	7,162,145	7,308,685	146,540
Outpatient Mental Health Care (30 minutes)	7,028,260	7,215,519	187,259
Outpatient Specialty Care (60 minutes)	7,630,411	8,008,705	378,294

**Table 19: Net Changes to the Number of VA Outpatient Points of Care by Service Type**

Outpatient Service Type	Current	Future	Net Change
Surgery	143	162	19
VA Facility	139	135	-4
Partnership	4	27	23
Emergency Department	113	95	-18
Primary Care	1,230	1,210	-20
Mental Health	999	1,056	57
Specialty Care	445	584	139
Urgent Care	35	48	13

### Enhance VA's unique strengths in care for Veterans with complex needs.

VA will continue to be the provider of specialty services for which VA is the standard bearer, including RRTP, SCI/D treatment, and blind rehabilitation. In addition, while there are services available in the community, commercial mental health facilities and institutional long-term care facilities may not always be fully able to meet the needs of VA's more complex patients. As a result, VA must maintain appropriate internal capacity and invest in modern infrastructure to meet the demand of these more complex patients.

#### **Increasing access to VA-delivered inpatient mental health care:**

- Inpatient mental health sites will increase from 117 to 118, and the number of Veteran enrollees within 60 minutes of VA-delivered inpatient mental health care will increase by 148,031 (from 5,379,933 to 5,527,964).
- The number of VA facilities providing inpatient mental health services will decrease from 114 to 108.
- The number of inpatient mental health partnerships will increase from 3 to 10.

#### **Expanding long-term care capabilities:**

- CLC sites will increase from 134 to 156, and the number of Veteran enrollees within 30 minutes of VA-delivered CLC care will increase by 545,639 (from 2,985,196 to 3,530,835).

#### **Maintaining access to VA's regional services – RRTP, blind rehabilitation, and SCI/D – by ensuring the regional distribution of services is balanced to meet Veterans' needs:**

- RRTP sites will increase from 117 to 129. All 18 VISNs will continue to have an RRTP.
- SCI/D sites will decrease from 27 to 23. All 15 VISNs that currently have an SCI/D Center will continue to have an SCI/D Center.
- Blind rehabilitation sites will decrease from 14 to 12. All five Blind Rehabilitation Regions that currently have a Blind Rehabilitation Center will continue to have a Blind Rehabilitation Center.

For each of these services, VA has conducted careful analysis to confirm that there is appropriate capacity to meet projected Veteran demand.

### Provide equitable access to quality inpatient medical and surgical care through the optimized use of care delivered in VA facilities and through partnerships, community providers, and virtual care.

The U.S. health care system has undergone significant transformation over the last 50 years – after many of VA's buildings were designed and constructed. One of the principal changes during this time has been significant reduction in the need for inpatient care and significant increase in need to provide outpatient care. The reduction in demand for inpatient services is based on changes in how care is provided in hospitals and across the health care continuum. Rapidly evolving technology and pharmacological advances have drastically changed care, enabling more services to be provided in outpatient settings. The shift to outpatient care improves convenience for patients, safety (through avoidance of hospital acquired infections), and – for private sector systems – cost efficacy. In addition, these changes have altered the requirements of inpatient facilities, which now must be able to provide

more complex and intervention-focused care through modern operating rooms, specialty procedure areas, and new technologies.

VA's recommendations will enable VA to meet Veteran needs for inpatient medical and surgical care. In markets where there is sufficient demand to support a VA inpatient mission, VA will make investments to replace or modernize infrastructure to meet contemporary design standards. In other markets VA will develop innovative strategic collaborations that will allow VA providers to continue to deliver inpatient medical and surgical care in partner facilities. Finally, in markets where there is not sufficient, concentrated Veteran demand, VA will enhance partnerships with DoD, other Federal facilities, and community providers – with ongoing care coordination by VA. No matter the venue in which they receive care, VA will work to ensure that Veterans have access to high-quality, convenient care in modern facilities.

#### Improving Veteran access to VA-delivered inpatient medical and surgical care services:

- Sites providing inpatient medical services will increase from 134 to 140, and the number of Veteran enrollees within 60 minutes of VA-delivered inpatient medical care will increase by 130,857 (from 5,712,366 to 5,843,223). Sites providing both inpatient medical and surgical services will increase from 114 to 134.
- The number of VA facilities\* providing inpatient medical or medical and surgical services will decrease from 127 to 90.
- The number of inpatient medical or medical and surgical partnerships will increase from 7 to 50.

**Table 20: Net Changes to the Number of Points of Care Providing VA-delivered Inpatient Services**

Inpatient Service Type	Current	Future	Net Change
<b>Medicine</b>	134	140	6
<i>VA Facility</i>	127	90	-37
<i>Partnership</i>	7	50	43
<b>Surgery</b>	114	134	20
<i>VA Facility</i>	107	87	-20
<i>Partnership</i>	7	47	40
<b>Mental Health</b>	117	118	1
<i>VA Facility</i>	114	108	-6

\* Excludes the Anchorage, Honolulu, and Martinez sites where inpatient medical and surgical services are delivered by DoD but the site is classified as VAMC.

Inpatient Service Type	Current	Future	Net Change
<i>Partnership</i>	3	10	7
Rehabilitation Medicine	28	26	-2
CLC	134	156	22
<i>VA Facility</i>	134	153	19
<i>Partnership</i>	0	3	3
RRTP	117	129	12
SCI/D	27	23	-4
Blind Rehabilitation Center	14	12	-2

### Strengthen VA's ability to execute its second, third, and fourth health-related missions: education, research, and emergency preparedness.

VA's recommendations will strengthen the Department's ability to carry out its other health-related statutory missions, including education, research, and emergency preparedness. To meet the needs of Veterans today and in the future, VA will implement innovative partnerships with DoD, other Federal health care organizations, academic affiliates, and quality commercial providers. These partnerships will improve VA care coordination, expand Veteran access to care, advance research on clinical areas including service-connected conditions, and enable education of health professionals.

- **Education:** The recommendations allow VA to maintain or enhance its ability to execute the education mission. This outcome is achieved by aligning training platforms to areas with greater enrollee demand, moving closer to academic affiliates, and adapting training platforms in areas with low demand to focus on training supported by services with sufficient demand. The recommendations also align with VA's broader long-term education strategy as the Department looks to expand ambulatory, telehealth, and advanced simulation training modalities.
- **Research:** The recommendations allow VA to maintain or enhance its ability to execute the research mission. This outcome is achieved by aligning infrastructure replacement investments with key research platforms and strengthening VA's proximity to its research affiliates.
- **Emergency Preparedness:** The recommendations allow VA to maintain its ability to execute its Fourth Mission by maintaining the same number of primary receiving centers across the country.

An overview of the net changes in the number of facilities by classification is provided in Table 21. The table compares the total number of current facilities by classification to the total number of future facilities by classification.

Table 21: Net Changes to the Number of Facilities by Classification

Classification	Current	Future	Net Change
VAMC	171	168	-3
Stand-alone CLC	2	29	27
Stand-alone RRTP	10	22	12
Inpatient Partnership	7	55	48
HCC	16	30	14
Outpatient Partnership	0	14	14
MS CBOC	248	388	140
CBOC	555	469	-86
OOS Clinic	255	169	-86
<b>Total</b>	<b>1,264</b>	<b>1,344</b>	<b>80</b>

In August 2021, VAST was queried to provide active sites and site classification. This information was validated with VISN planners and was used to establish the current state. The current state includes only active sites, or sites that were planned to be active by 12/31/21. The future state includes active sites, sites proposed through VA recommendations, and sites that VA is already planning to open in the near term.

## 7. Legislative Proposals

Some of VA's recommendations to the AIR Commission may require new legislative authorities to be enacted to enable implementation. Legislative proposals related to market assessment recommendations comprise two categories: capital-related and workforce-related proposals. The proposals will be submitted to Congress separately. A high-level description of the proposals is provided below.

### Capital

The capital proposals are focused on facilitating strategic collaborations, which are foundational to many of the market assessment recommendations. Appropriate collaborations can increase access and improve health care outcomes for Veterans. While VA is operating its many existing partnerships under current legal authorities, gaps in authority exist that may hinder VA's ability to execute certain new or strengthened partnerships. Legislative relief may be required to work with partners including Federal, academic, and community providers. Timely consideration of legislative proposals will be crucial to the successful implementation of market area recommendations.

**Legislative Proposals to Improve VA's Ability to Execute Strategic Collaborations:** VA will need the flexibility to enter into strategic collaborations to maximize VA's ability to expand access to care. There are five proposals to enable the recommendations and establish a regulatory environment that will

allow VA to fully leverage VA's partners. Strategic collaboration-related proposals would provide VA with the ability to:

- Convey land for public benefit;
- Exchange VA property for other property or in-kind considerations;
- Construct and renovate shared facilities;
- Sell and lease back a facility; and
- Collaborate with DoD to jointly plan/design/construct or lease joint VA/DoD shared medical facilities to include funds transfer.

## Workforce

The workforce proposals are focused on facilitating the recruitment and retention of staff in facilities across the country. Providing high-quality health care and excellent customer service to Veterans across the country requires staff who are committed to VA's mission. Modernizing VA's recruitment and compensation authorities, given the competitive health care market, strengthens VA's ability to recruit and retain staff and providers.

**Legislative Proposals to Improve VA's Ability to Recruit and Retain High-Quality VA Staff:** VA will need the flexibility to recruit and retain high-quality staff to meet the needs of Veterans. VA's efforts to recruit and retain providers are impacted by key factors within the Department and the broader health care environment.

- Overall shortage of physicians: The Association of American Medical Colleges projects that the U.S. will face a shortage of between 54,100 and 139,000 physicians by 2033 primarily based on an aging patient population that requires more specialty care and the retirement of more physicians;<sup>51</sup>
- Salary challenges: VA faces challenges due to lower salaries than commercial competitors in some markets;
- Rurality: Recruiting and retaining providers – particularly specialists – is challenging in rural areas, including those where VA operates;
- Virtual care: Increased use of virtual care means that health care providers can potentially be staffed outside of the market where Veteran patients live; and
- Shifts in care delivery: Care is shifting from the inpatient to outpatient setting and will require continued training and competency development.

There are eight proposals to improve VA's ability to recruit and retain high-quality VA staff. These include:

- New incentive/bonus authority for mission critical positions;
- Waiver authority for pay limitations;
- Expansion of coverage of the specialty education loan repayment program;
- Authority to remove locality pay limitations for remote employees;
- Increase of the pay cap for pharmacists;
- Increase of the pay rate for specialized and critical health care occupations and police;
- Expansion of coverage for nurse executive special pay; and
- Simplification of the process to recruit non-citizens for critical health care occupations.

## 8. Actions Following Submission of the Recommendations

As required by the MISSION Act, this report represents VA's submission to the AIR Commission, and is a critical step in revitalizing VA to serve the needs of the Veterans of today and of generations to come. But the delivery of the report is itself just the beginning of a larger and longer process that will eventually result in the evolution of VA care and services for future generations of Veterans. This section discusses the steps that follow the submission of the AIR Commission Report, including AIR Commission review, approval of recommendations, the implementation of recommendations, and the initiation of the next round of quadrennial market assessments.

### 8.1 AIR Commission Review

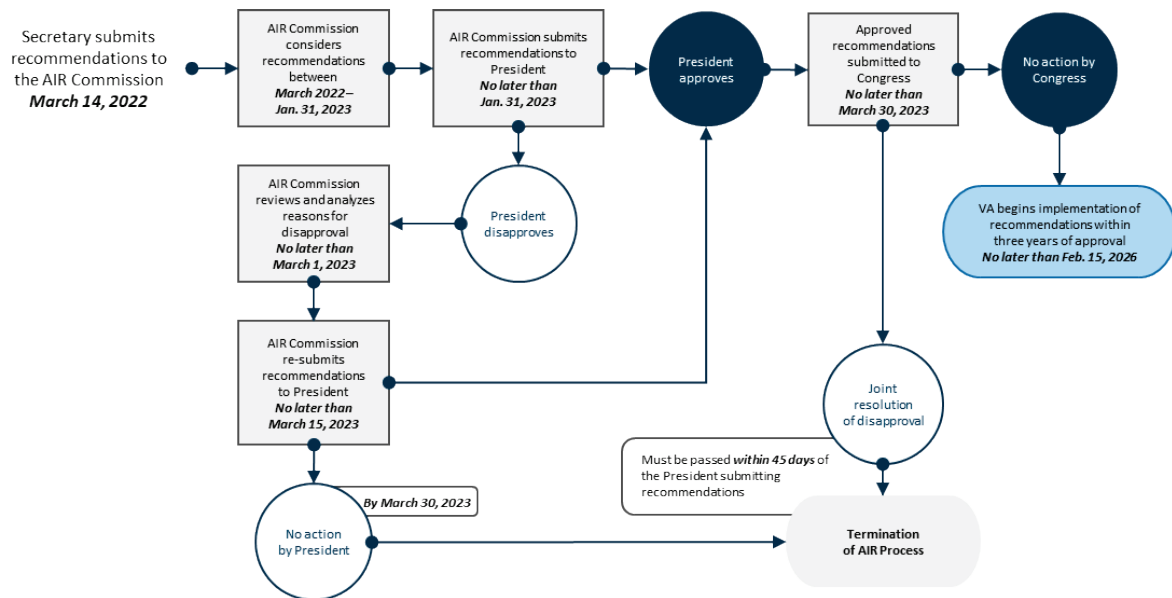
As mandated by the MISSION Act, the nine-member AIR Commission, consisting of members appointed by the President with the advice and consent of the Senate, will meet during calendar years 2022 and 2023. These proceedings will be open to the public. The purpose of the AIR Commission will be to assess VA's recommendations for asset and infrastructure modernization and realignment. In this report the totality of recommendations resulting from both 106(a) and 203(b) requirements have been compiled and presented for every market.

In reviewing the AIR Commission Report, the Commission must conduct public hearings during which the recommendations are discussed and presented to the public. The MISSION Act requires that, to the greatest extent possible, these hearings be held in regions that are affected by the recommendations contained in the report. To engage local stakeholders, the MISSION Act also requires that witnesses at these public hearings include a local elected official and a VHA enrollee identified by a local VSO.

No later than January 31, 2023, the Commission will transmit its own recommendations to the President. At the same time, a copy of this transmission to the President will be delivered to appropriate congressional committees. The Commission's transmission will include a review and analysis of its findings and conclusions. The Commission's recommendations may deviate from the VA's recommendations only if the Commission (1) determines that the VA deviated substantially from the final criteria; (2) determines that the change is consistent with the final criteria; (3) publishes a notice of the proposed change in the Federal Register not less than 45 days before transmitting its recommendations to the President; and (4) conducts public hearings on the proposed change.

No later than February 15, 2023, the President must submit to the Commission and to Congress the President's approval or disapproval of the Commission's recommendations. The President's response to the Commission initiates a process by which the President and the Commission can reach an agreement about any recommendations upon which the President initially expresses disapproval. If by March 30, 2023, the President has not submitted approved recommendations to Congress, then the process for modernizing or realigning VA facilities terminates (see Figure 15).

Figure 15: Timeline of Significant Next Steps



Upon presidential submission to Congress, Congress has five days to submit a resolution of disapproval for consideration, which must be passed within 45 days of presidential submission. However, if Congress does not pass a resolution of disapproval, the recommendations as submitted by the President are considered final. VA is then authorized by the MISSION Act to begin the implementation of the approved recommendations and must begin implementation within three years. Significant planning will take place to implement each recommendation due to the large capital and non-capital investments needed.

## 8.2 Conclusion

VA's recommendations to the AIR Commission are focused on what is best for the Veterans we serve. The recommendations will help us cement VA as the primary world-class provider and coordinator of Veterans' health care for generations to come. We will provide care through a health care network with the right facilities, in the right places, to provide the right care for Veterans in infrastructure that reflects the needs of 21st century Veterans. And we will strengthen VA's roles as the leading health care research and health care training institution in America. VA will continue to deliver timely access to world-class care to every Veteran in every market and community – from urban to rural – across the country.

VA recognizes that the publication of the Department's recommendations to the AIR Commission Report is only the first step in a long process. In the short run, there will be no effect on VA employees or services VA provides to Veterans. Many of the potential changes to VA's health care infrastructure may be several years away and are dependent on Commission, Presidential, and Congressional decisions, as well as robust stakeholder engagement and planning. Throughout this period VA will maintain transparency, provide updates to our workforce on the AIR Commission process, and ensure that members of our team have ample opportunity for their voices to be heard as the AIR Commission's work continues through the next year.

VA looks forward to supporting the AIR Commission as it assesses these recommendations and transmits its own recommendations to the President.





## Appendices

Appendix A: List of Acronyms

Appendix B: Leadership Questionnaire

Appendix C: Section 203 Criteria Federal Register Notice

Appendix D: Cost Benefit Analysis Methodology

Appendix E: Section 203 Criteria Methodology



## References

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