VA Recommendations to the

ASSET AND INFRASTRUCTURE REVIEW COMMISSION

March 2022

VISN 02

Market Recommendations

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VISN 02 Eastern Market

The Veterans Integrated Service Network (VISN) 02 Eastern Market serves Veterans in northeastern New York State. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[1]

VA's Commitment to Veterans in the Eastern Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 02's Eastern Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also ensures that VA can continue to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Eastern Market is facing markedly decreasing enrollment. Demand for inpatient medical and surgical services is decreasing, while demand for inpatient mental health, long-term care, and outpatient care is increasing. There is need to replace the aging Albany VAMC and expand access to outpatient care, long-term care, and mental health care. Inpatient medical and surgical services will be transitioned to the nearby academic affiliate through an expanded partnership that allows VA providers to deliver inpatient care at the partner facility. The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation addresses the increased demand for outpatient services and improves access to care by investing in modern facilities close to where Veterans live. The recommendation establishes one new community-based outpatient clinic (CBOC) in the vicinity of Saratoga Springs, New York, offering primary care, mental health, and specialty care services closer to where Veterans live, while closing one existing CBOC in Glens Falls, New York. The recommendation also consolidates the Clifton Park

[1] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

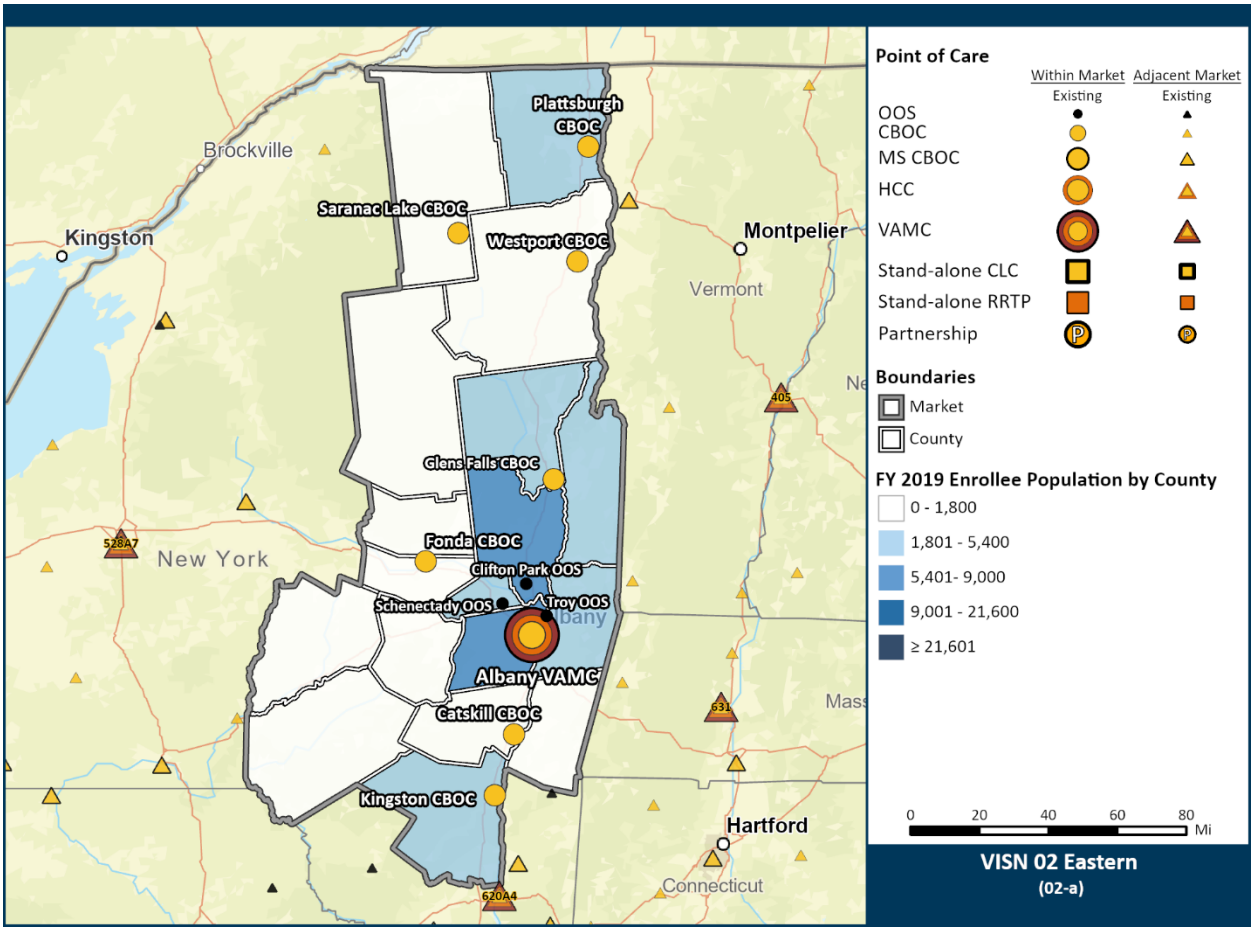
other outpatient services (OOS) site, the Troy OOS, and the Schenectady OOS into the new Albany VAMC, providing Veterans with one convenient access point.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in a new, modernized Albany VAMC to provide inpatient mental health, community living center (CLC), and residential rehabilitation treatment program (RRTP) services not readily available in the community. The Eastern Market currently offers primary care for inpatient spinal cord injuries and disorders (SCI/D) services and refers Veterans to SCI/D hubs in the region for acute, sustaining, and rehabilitative care. Demand for inpatient blind rehabilitation services will be met at the West Haven, Connecticut VAMC (VISN 01).
- **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 recommendation maintains quality inpatient medical and surgical care by expanding the Albany VAMC's partnership with its academic affiliate, the Albany Medical Center. The partnership will allow VA providers to deliver care at the partner facility.

Market Overview

The market overview includes a map of the Eastern Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has one VAMC (Albany), seven CBOCs, and three OOS sites.

Enrollees: In fiscal year (FY) 2019, the market had 47,356 enrollees and is projected to experience a 16.1% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Albany, Saratoga, and Rensselaer, New York.

Demand: Demand[2] in the market for inpatient medical and surgical services is projected to decrease by 4.6% and demand for inpatient mental health services is projected to increase by 5.6% between FY 2019 and FY 2029. Demand for long-term care[3] is projected to increase by 20.8%. Demand for all outpatient

[2] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[3] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

services,[4] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 51.0% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 72.4% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 69.3% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[5] in the market within a 60-minute drive time of the VAMC have an inpatient acute occupancy rate[6] of 66.2% (499 available beds) [7] and an inpatient mental health occupancy rate of 67.0% (26 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an occupancy rate of 93.5% (47 available beds). Community residential rehabilitation programs[8] that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include the Albany Medical College. The Albany VAMC is ranked 68 out of 154 VA training sites based on the number of trainees and is ranked 63 out of 103 VAMCs with research funding. The Albany VAMC is designated as a Federal Coordinating Center.[9]

Facility Overview

Albany VAMC: The Albany VAMC is located in Albany, New York, and offers inpatient medical and surgical services, inpatient mental health, CLC, RRTP, and outpatient services. In FY 2019, the Albany VAMC had an inpatient medical and surgical average daily census (ADC) of 35.3, an inpatient mental health ADC of 9.0, a CLC ADC of 45.3, and an RRTP ADC of 9.8.

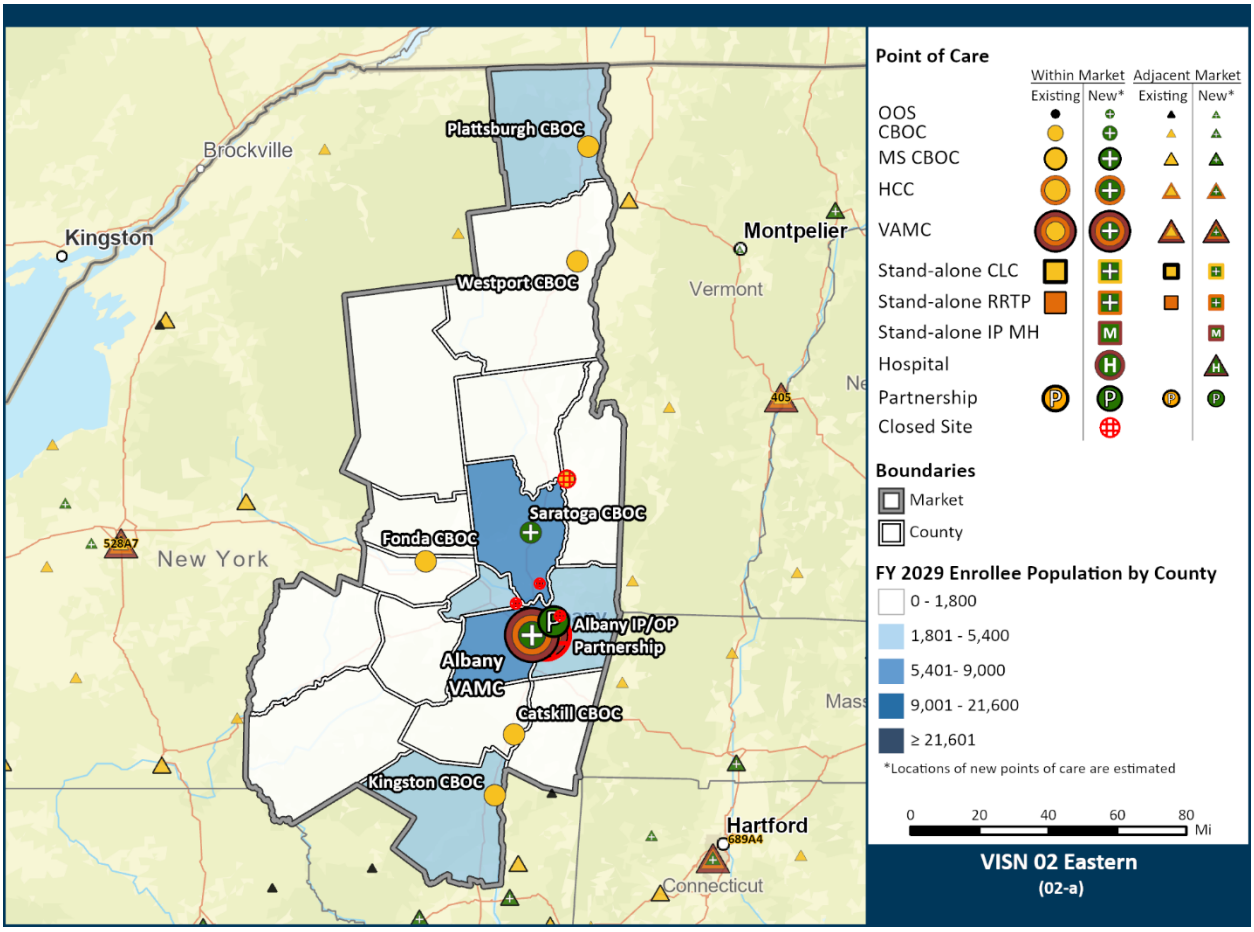
The Albany VAMC was built in 1951 on 29.0 acres. The VAMC was last renovated in 1985. Facility condition assessment (FCA) deficiencies are approximately $222.4M, and annual operations and maintenance costs are an estimated $8.7M.

[4] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[5] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[6] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[7] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[8] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[9] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

Recommendation and Justification

This section details the VISN 02 Eastern Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Albany VAMC by:***

   1.1. **Establishing a strategic collaboration to provide inpatient medical and surgical and outpatient surgical services and discontinuing these services at the Albany VAMC. If unable to enter into a strategic collaboration, the Albany VAMC will maintain the services at the existing Albany VAMC:** The in-house and community demand for inpatient medical and surgical services is projected to decrease by 4.6% across the market and decrease by 10.5% at the Albany VAMC. The Albany VAMC is located adjacent to the Albany Medical Center, which is a current academic affiliate and a Level 1 Trauma Center.[10] The relationship with the Albany Medical Center will be extended to include use of their facility to offer inpatient medical and surgical,

[10] Trauma center levels refer to the kinds of resources available in a trauma center and the number of patients admitted yearly. A Level 1 Trauma Center is a comprehensive regional resource that is capable of providing total care for every aspect of injury- from prevention through rehabilitation.

emergency, and outpatient surgical services. The academic and research missions will continue. With the projected in-house and community demand decrease of inpatient medical and surgical services in the market, relocating these services to the Albany Medical Center allows the proposed replacement Albany VAMC to focus on meeting the projected demand increase for subacute services.

1.2. Constructing a new VAMC with inpatient mental health, CLC, RRTP, urgent care, primary care, outpatient specialty care, and outpatient mental health services in the vicinity of Albany, New York, if an inpatient medical surgical strategic collaboration is established: The Albany VAMC campus was built in 1951 and over time, the hospital building's use has evolved to include inpatient medical and surgical, inpatient mental health, CLC, and outpatient care. Both the current infrastructure and layout do not meet modern health care standards, and the existing facility requires significant capital investment. The VAMC has an estimated total of $222.4M in FCA deficiencies, and annual operations and maintenance costs are an estimated $8.7M. There are an estimated 29,187 enrollees within 60 minutes.

At the Albany VAMC, inpatient mental health, CLC, and RRTP demand increased by 8.4%, 27.6%, and 11.4%, respectively, between FY 2017 and FY 2019, while inpatient medical and surgical demand remained flat over the same time period. Inpatient medical and surgical and RRTP demand is projected to decrease between FY 2019 and FY 2029, while demand for inpatient mental health and CLC services is projected to increase from an FY 2019 ADC of 9.0 and 45.3 to an FY 2029 ADC of 9.9 and 49.7, respectively.

VA recommends a new Albany VAMC as a subacute campus, which will enhance quality and efficiency of health care delivery for the enrollee population. The modernized VAMC will provide inpatient mental health services, CLC, an expanded RRTP (including support of the Central Market for residential substance use disorder (SUD) services), urgent care, primary care, outpatient specialty care, and outpatient mental health care. The RRTP expansion will include 9 General Domiciliary beds and 16 SUD beds. The CLC program will also expand from 50 to 58 beds to meet the projected Veteran demand for CLC services in the Eastern Market.

This recommendation is contingent on the outcome of the proposed inpatient medical and surgical strategic collaboration. In the event a strategic collaboration is not successful, all current services will be maintained at the existing Albany VAMC.

1.3. Relocating emergency department services from the Albany VAMC to community providers and discontinuing these services at the Albany VAMC: The new Albany VAMC will operate an urgent care center. Relocating emergency department services from the existing Albany VAMC to the affiliate and community providers will deliver ample emergency and urgent care to the enrollee population. Between FY 2015 and FY 2018, an estimated 85% of emergency department encounters occurred between 8:00 A.M. and 10:00 P.M.

1.4. Closing the Albany VAMC: Following the realignment of services to the new Albany VAMC and community providers, the current VAMC will be closed.

2. ***Modernize and realign outpatient facilities in the market by:***

2.1. Establishing a new CBOC in the vicinity of Saratoga Springs, New York: The Glens Falls CBOC is located in Warren County, near the intersection of Warren, Washington, and Saratoga counties.

The Glens Falls CBOC had 5,187 enrollees within 30 minutes and served 3,383 core uniques[11] in FY 2019. In FY 2019, Warren County had 2,094 enrollees, Washington County had 2,069 enrollees, and Saratoga County had 6,278 enrollees. Moving this CBOC to Saratoga Springs, New York (Saratoga County) extends access to more Veterans. In FY 2019, there were 8,207 enrollees within 30 minutes of the vicinity of Saratoga Springs.

2.2. **Relocating all services to the proposed Saratoga Springs CBOC and closing the Glens Falls CBOC:** Relocating care from the Glens Falls CBOC to the proposed Saratoga Springs CBOC will increase access to outpatient services for a larger population of Veteran enrollees, allowing for the closure of the Glens Falls CBOC.

2.3. **Relocating all services to the proposed replacement Albany VAMC and closing the Clifton Park OOS:** The Clifton Park OOS had 16,419 enrollees within 30 minutes in FY 2019 and served 1,926 core uniques in FY 2019. The Schenectady, Troy, and Clifton Park OOS sites are all located within 30 minutes of each other and the Clifton Park OOS is an estimated 22 miles from the Albany VAMC. The Clifton Park OOS has low demand and offers limited services. Consolidating this site within the new Albany VAMC will offer Veterans access to a wider array of specialty care.

2.4. **Relocating all services to the proposed replacement Albany VAMC and closing the Troy OOS:** The Troy OOS served 1,199 core uniques in FY 2019. The Clifton Park, Troy, and Schenectady OOS sites are all located within 30 minutes of each other, and the Troy OOS is an estimated 10 miles from the Albany VAMC. The Troy OOS has low demand and offers limited services. Consolidating this site within the new Albany VAMC will offer Veterans access to a wider array of specialty care.

2.5. **Relocating all services to the proposed replacement Albany VAMC and closing the Schenectady OOS:** The Schenectady OOS served 1,773 core uniques in FY 2019. The Clifton Park, Troy, and Schenectady OOS sites are all located within 30 minutes of each other, and the Schenectady OOS is an estimated 20 miles from the Albany VAMC. The Schenectady OOS has low demand and offers limited services. Consolidating this site within the new Albany VAMC will offer Veterans access to a wider array of specialty care.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

Eastern Market

- **Realign Franklin County to the VISN 02 Central Market from the VISN 02 Eastern Market to reflect referral and usage patterns:** A large portion of Veterans from Franklin County go to the Massena CBOC located in St. Lawrence County (part of the Central Market) for primary care and outpatient mental health. Additionally, the majority of Veterans from Franklin County go to the

[11] VA core unique patients exclude Veterans who have used only VA telephone triage, pharmacy, and laboratory services.

Syracuse VAMC for inpatient medical and surgical care, not the Albany VAMC. Realigning the county will better reflect service use patterns.

- **Increase availability of allergy/immunology services across the Eastern Market to address the potential lack of high-quality allergists/immunologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality allergists/immunologists. Increased availability may be achieved through a variety of tactics, such as telehealth, Veterans Community Care Program (VCCP) recruitment, and hiring additional VA providers, as appropriate.

Albany VAMC

- **Create a partnership with community providers and health systems in the Eastern Market to improve specialty care access to northern counties:** Franklin, Clinton, Essex, and Hamilton counties are highly rural. The remote location and small population make these suboptimal locations for a VA-provided health care service expansion. Community collaborations within these counties will improve access to care for rural enrollees.
- **Ensure there is adequate space to support the research initiative at the proposed new Albany VAMC (Albany County):** The Office of Research and Development (ORD) will be consulted in the planning for the proposed replacement Albany VAMC to ensure adequate space to maintain existing research programs and education capabilities in the Eastern Market area.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 02 Eastern Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[12] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational costs included direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate the Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI score is

[12] The present value cost is the current value of future costs discounted at the defined discount rate.

the preferred COA. The results of the CBA for the VISN 02 Eastern Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 02 Eastern Market	Status Quo	Modernization	VA Recommendation
Total Cost	$7,922,544,011	$8,175,990,329	$7,800,663,105
Capital Cost	$989,890,409	$1,243,336,726	$1,498,423,504
Operational Cost	$6,932,653,603	$6,932,653,603	$6,302,239,601
Total Benefit Score	8	11	13
CBI (normalized in $B)	**0.99**	**0.74**	**0.60**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand

This recommendation is consistent with the Demand criterion, aligning 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.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient**: Outpatient demand will be met through eight VA points of care offering outpatient services, including the proposed new Saratoga, New York CBOC; the partnership in Albany, New York; and the proposed replacement Albany, New York VAMC; as well as community providers in the market.
- **CLC**: Long-term care demand will be met through the proposed replacement Albany, New York VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D**: Demand for inpatient SCI/D will be met through the SCI/D Hub at the Bronx, New York VAMC.
- **RRTP**: RRTP demand will be met through the proposed replacement Albany, New York VAMC, and the other facilities within VISN 02 offering RRTP, including the Montrose, New York VAMC; the Lyons, New Jersey VAMC; the proposed new St. Albans, New York VAMC; the Canandaigua, New York VAMC; the Batavia, New York VAMC; and the RRTP at the proposed replacement VAMC in Buffalo, New York.
- **Blind rehabilitation**: Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01), the proposed new King of Prussia, Pennsylvania VAMC (VISN 04), and the Cleveland, Ohio VAMC (VISN 10).

Demand

- **Inpatient acute**: Inpatient medicine and surgery demand will be met through the proposed new partnership in Albany, New York, as well as through community providers; inpatient mental health demand will be met through the proposed replacement Albany, New York VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 37,599 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 37,612 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 02. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with Albany Medical College.
- **Research:** This recommendation does not impact the research mission in the market and allows the Albany, New York VAMC to maintain the current research mission by relocating research programs to the proposed replacement Albany, New York VAMC.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Albany, New York VAMC is not designated as a Primary Receiving Center.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Saratoga, New York CBOC; the partnership in Albany, New York; and the proposed replacement Albany, New York VAMC. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI**: The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (0.60 for VA Recommendation versus 0.99 for Status Quo), indicating that VA Recommendation is more cost-effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Saratoga, New York CBOC; partnership in Albany, New York; and the proposed replacement Albany, New York VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnership will also help VA in recruiting and retaining staff by embedding providers in community partner space.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($7.8B for VA Recommendation versus $8.2B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (0.60 for VA Recommendation versus 0.74 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 02 Central Market

The Veterans Integrated Service Network (VISN) 02 Central Market serves Veterans in central New York. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[13]

VA's Commitment to Veterans in the Central Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 02's Central Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Central Market is facing markedly decreasing enrollment. Demand for inpatient medical and surgical services and spinal cord injuries and disorders (SCI/D) care is decreasing while demand for inpatient mental health, long-term care, and outpatient care is increasing. There is need to invest in new outpatient facilities to meet existing and projected Veteran demand while rightsizing services at the Syracuse VAMC. The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation establishes two new community-based outpatient clinics (CBOCs) in Onondaga County to improve access to care and better distribute primary care and mental health care services closer to where Veterans live.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation maintains inpatient mental health and community living center (CLC) services within VA-owned facilities. The recommendation consolidates inpatient SCI/D care to the Bronx VAMC to ensure quality of care for Veterans. The recommendation also leverages the Bronx

[13] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

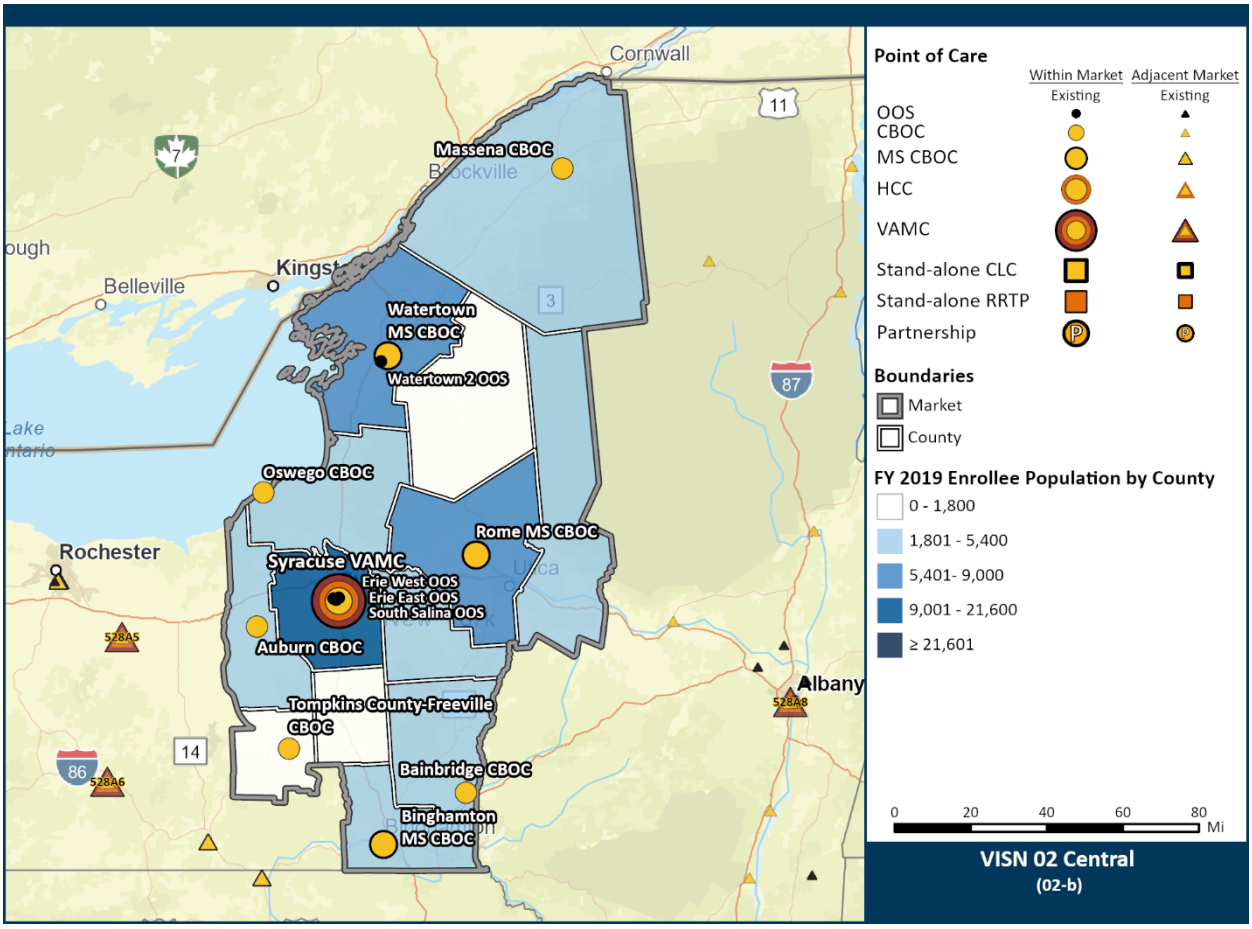
VAMC's notable clinical and research programs for SCI/D. Demand for inpatient blind rehabilitation services will be met at the West Haven, Connecticut VAMC (VISN 01).

- **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 recommendation maintains sustainable inpatient medical and surgical programs at the Syracuse VAMC.

Market Overview

The market overview includes a map of the Central Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has one VAMC (Syracuse), three multi-specialty community-based outpatient clinics (MS CBOCs), five CBOCs, and four other outpatient services (OOS) sites.

Enrollees: In fiscal year (FY) 2019, the market had 51,515 enrollees and is projected to experience an 11.8% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Onondaga, Oneida, and Jefferson, New York.

Demand: Demand[14] in the market for inpatient medical and surgical services is projected to decrease by 10.2%, and demand for inpatient mental health services is projected to increase by 7.6% between FY 2019 and FY 2029. Demand for long-term care[15] is projected to increase by 10.4%. Demand for all outpatient services,[16] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 57.5% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 79.9% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 57.4% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[17] in the market within a 60-minute drive time of the VAMCs have an average inpatient acute occupancy rate[18] of 57.2% (524 available beds)[19] and an average inpatient mental health occupancy rate of 61.1% (21 available beds). Community nursing homes within a 30-minute drive time of the VAMC were operating at an average occupancy rate of 91.8% (49 available beds), indicating very limited availability in the community. Community residential rehabilitation programs[20] that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include the State University of New York (SUNY) Upstate Medical University. The Syracuse VAMC is ranked 51 out of 154 VA training sites based on the number of trainees and is ranked 70 out of 103 VAMCs with research funding. The Syracuse VAMC is designated as both a Federal Coordinating Center and a Primary Receiving Center.[21]

Facility Overview

Syracuse VAMC: The Syracuse VAMC is located in Syracuse, New York, and offers inpatient medical and surgical services, inpatient mental health care, CLC, SCI/D, rehabilitation medicine, and outpatient

[14] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[15] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.
[16] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[17] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[18] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[19] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[20] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[21] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

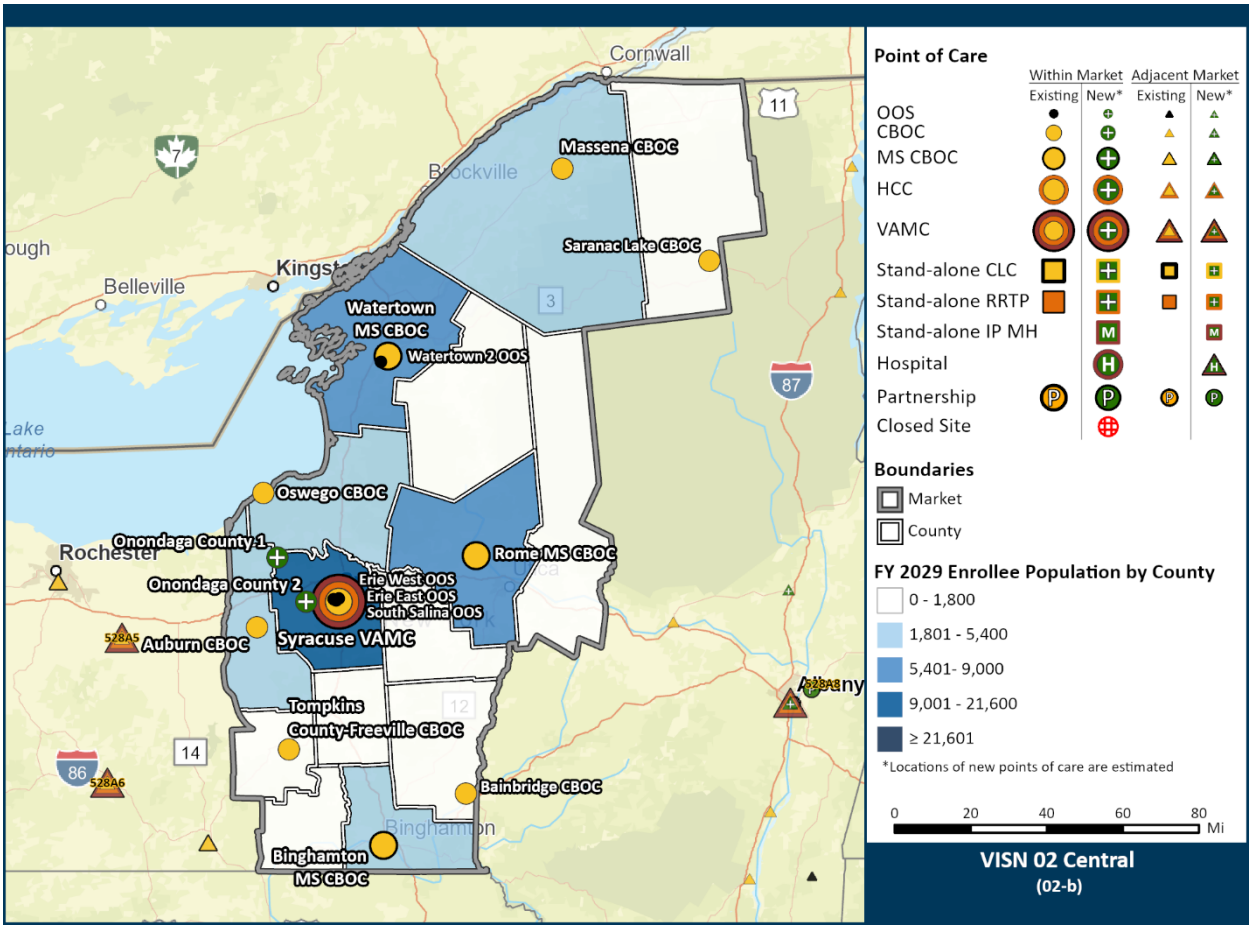
services. In FY 2019, the Syracuse VAMC had an inpatient medical and surgical average daily census (ADC) of 57.6, an inpatient mental health ADC of 12.6, a CLC ADC of 37.2, an SCI/D ADC of 13.4, and a rehabilitation medicine ADC of 3.1.

The Syracuse VAMC was built in 1952 on 15.0 acres; zero acres are available for additional development. It was most recently renovated in 1985. Facility condition assessment (FCA) deficiencies are approximately $46.3M, and annual operations and maintenance costs are an estimated $10.3M.

Recommendation and Justification

This section details the VISN 02 Central Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Syracuse VAMC by relocating SCI/D services at the Syracuse VAMC to current or future VA facilities and discontinuing these services at the Syracuse VAMC:*** Enrollment in the Central Market is projected to decrease by 11.8% from 51,515 enrollees in FY 2019 to 45,428 enrollees in FY 2029. In FY 2019, there were 25 SCI/D beds at the Syracuse VAMC with an ADC of 13.4. In FY 2019, the total market SCI/D ADC was 9.2 with a projected FY 2029 ADC of 6.7. The SCI/D beds at the Syracuse VAMC will be consolidated into the state-of-the-art SCI/D facility at the Bronx

VAMC. On a campus that is landlocked, reuse of SCI/D units will be focused on inpatient services that have projected demand increases, such as CLC and mental health.

2. ***Modernize and realign outpatient facilities in the market by:***

   2.1. Establishing a new CBOC in the vicinity of Lysander, New York (Onondaga County 1): Demand for outpatient services is projected to increase across the market. In FY 2019, there were 12,054 enrollees within 30 minutes of the proposed site. Establishing a new CBOC will meet increasing demand for primary care services, enhance convenience, and help alleviate space constraints at the Syracuse VAMC.

   2.2. Establishing a new CBOC in the vicinity of Camillus, New York (Onondaga County 2): Demand for outpatient services is projected to increase across the market. In FY 2019, there were 13,779 enrollees within 30 minutes of the proposed site. Establishing a new CBOC will meet increasing demand for primary care services, enhance convenience, and help alleviate space constraints at the Syracuse VAMC.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

Central Market

- **Realign Franklin County to the VISN 02 Central Market from the VISN 02 Eastern Market to reflect referral and usage patterns:** A large portion of Veterans residing in Franklin County receive their care at the Massena CBOC in the Central Market. The Massena CBOC is the closest VA point of care for specialty services for these Veterans. The Massena CBOC 30-minute drive time extends into the northwest region of Franklin County, near a region with moderate population density. This realignment will better reflect enrollees' service use.
- **Realign Tioga County to the VISN 02 Central Market from the VISN 04 Eastern Market to reflect referral and usage patterns:** A large portion of Veterans residing in Tioga County, New York, in the Eastern Market (VISN 04), are going to the Syracuse VAMC in the Central Market for inpatient medical and surgical services and inpatient mental health services. This realignment will better reflect enrollees' service use.
- **Increase availability of physical medicine and rehabilitation across the Central Market to address the potential lack of high-quality physical medicine and rehabilitation specialists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality physical medicine and rehabilitation specialists. Increased availability may be achieved through a variety of tactics, such as telehealth, Veterans Community Care Program (VCCP) recruitment, and hiring additional VA providers, as appropriate.

Syracuse VAMC

- **Explore a strategic collaboration with the Indian Health Service (IHS) for primary care, outpatient mental health, and dental services to extend care for Veterans in the Rome, New York, community:** Primary care, medical specialties, and dental utilization are all projected to increase between FY 2019 and FY 2029; the Oneida County enrollee population is projected to decrease by 15.0% between FY 2019 and FY 2029. Oneida Indian Nation Health Services and Oneida Nation Family Services are an estimated 20 miles from the Rome MS CBOC; both facilities will be an accessible location for care for both Native American and non-Native Veterans. Partnering for services enhances use of existing Federal health care resources.
- **Establish a strategic collaboration with SUNY Upstate in the northern region of the market to improve access to services, including surgical care, in localities with low population density (Potsdam, Lowville, Ogdensburg, and Hamilton):** VA has limited points of care in the northern region of the market. Fostering this collaboration will leverage the SUNY Upstate network to expand service coverage in the northern region.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 02 Central Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[22] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational costs included direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate the Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI score is the preferred COA. The results of the CBA for the VISN 02 Central Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

[22] The present value cost is the current value of future costs discounted at the defined discount rate.

VISN 02 Central Market	Status Quo	Modernization	VA Recommendation
Total Cost	$10,601,569,446	$11,835,978,488	$11,817,319,225
Capital Cost	$396,740,735	$1,631,149,777	$1,612,490,513
Operational Cost	$10,204,828,711	$10,204,828,711	$10,204,828,711
Total Benefit Score	8	11	11
CBI (normalized in $B)	**1.33**	**1.08**	**1.07**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand

This recommendation is consistent with the Demand criterion, aligning 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.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 16 VA points of care offering outpatient services, including the proposed new Onondaga County, New York CBOC 1 and the Onondaga County, New York CBOC 2, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Syracuse, New York VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Bronx, New York VAMC.
- **RRTP:** RRTP demand will be met through the facilities within VISN 02 offering RRTP, including the Canandaigua, New York VAMC; the Batavia, New York VAMC; the proposed replacement Buffalo, New York VAMC; the proposed replacement Albany, New York VAMC; the Montrose, New York VAMC; the proposed replacement St. Albans, New York VAMC; and the Lyons, New Jersey VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01), the proposed new King of Prussia, Pennsylvania VAMC (VISN 04), and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the Syracuse, New York VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 48,405 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 48,509 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 02. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the State University of New York Upstate Medical University.
- **Research:** This recommendation does not impact the research mission in the market and allows the Syracuse, New York VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Syracuse, New York VAMC will maintain its status as a Primary Receiving Center.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Onondaga County, New York CBOC 1, and Onondaga County, New York CBOC 2. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (1.07 for VA Recommendation versus 1.33 for Status Quo), indicating that VA Recommendation is more cost-effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Onondaga County, New York CBOC 1, and the Onondaga County New York CBOC 2. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($11.82B for VA Recommendation versus $11.84B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (1.07 for VA Recommendation versus 1.08 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 02 Western Market

The Veterans Integrated Service Network (VISN) 02 Western Market serves Veterans in western New York. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[23]

VA's Commitment to Veterans in the Western Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 02's Western Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Western Market is facing markedly decreasing enrollment. Demand for inpatient medical and surgical care, inpatient mental health care, and residential rehabilitation treatment program (RRTP) services is decreasing, while demand for long-term care and outpatient care is increasing. The aging Buffalo VAMC will be replaced with a rightsized facility proximate to Buffalo's health care corridor in order to increase synergies with neighboring providers and resources. Outpatient capacity will be both consolidated and expanded to meet current and future Veteran demand. The strategy for the Western Market is intended to provide Veterans with access to high quality and conveniently located care in modern infrastructure. Key elements of the market strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation invests in an expanded, modernized outpatient space at the Batavia VAMC to improve the standard of care and better the patient experience. The recommendation consolidates two small clinics in Buffalo, the Buffalo-Main Street other outpatient services (OOS) site and the Packard- Buffalo OOS, to the proposed replacement Buffalo VAMC in downtown Buffalo to provide Veterans with access to a wider array of services at a single location.

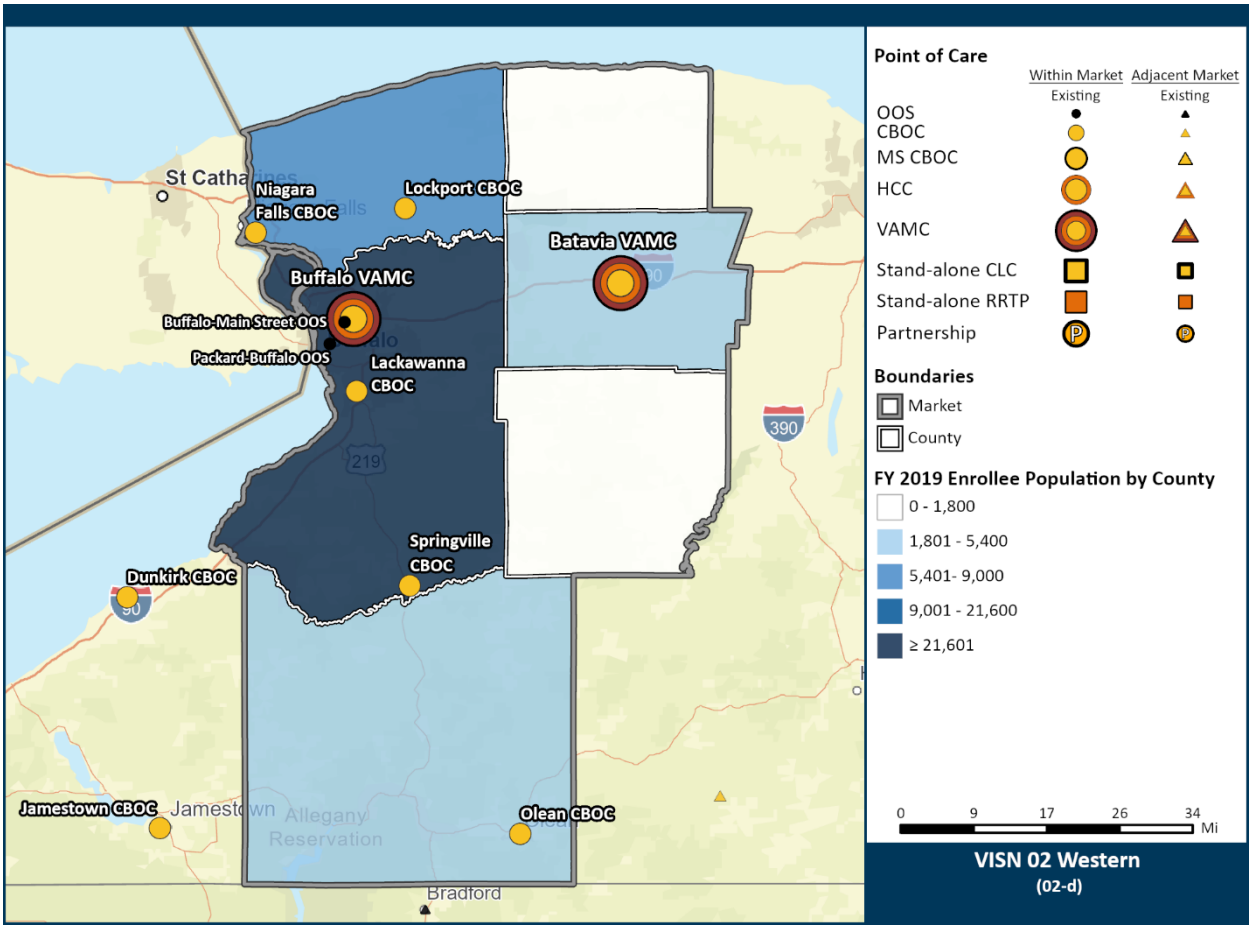
[23] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in a modernized Buffalo VAMC with inpatient mental health, community living center (CLC), and RRTP services to maintain care for Veterans with the most complex needs and to provide comprehensive care that may not be readily available in the community. With the expansion of RRTP services in Buffalo, the Batavia VAMC's RRTP service will be rightsized and rescoped as the post-traumatic stress disorder (PTSD) hub for the VISN. The recommendation also relocates the Buffalo VAMC downtown, proximate to the Buffalo Niagara Medical Campus, enhancing collaboration and research opportunities for Veterans with complex needs. The Western Market currently offers primary care for inpatient spinal cord injuries and disorders (SCI/D) and refers Veterans to SCI/D hubs in the region for acute, sustaining, and rehabilitative care. Demand for inpatient blind rehabilitation services will be met at the Cleveland, Ohio VAMC (VISN 10).
- **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 recommendation invests in a modernized Buffalo VAMC that will deliver rightsized inpatient medical and surgical services for Veterans.

Market Overview

The market overview includes a map of the Western Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has two VAMCs (Buffalo and Batavia), seven community-based outpatient clinics (CBOCs), and two OOS sites.

Enrollees: In fiscal year (FY) 2019, the market had 40,444 enrollees and is projected to experience a 15.8% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Erie, Niagara, and Cattaraugus, New York.

Demand: Demand[24] in the market for inpatient medical and surgical services is projected to decrease by 13.9% and demand for inpatient mental health services is projected to decrease by 11.0% between FY 2019 and FY 2029. Demand for long-term care[25] is projected to increase by 0.6%. Demand for all

[24] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[25] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

outpatient services,[26] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 31.3% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 95.3% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 90.7% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[27] in the market within a 60-minute drive time of the VAMCs have an average inpatient acute occupancy rate[28] of 75.1% (566 available beds)[29] and an average inpatient mental health occupancy rate of 77.0% (23 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an average occupancy rate of 91.5% (67 available beds). Community residential rehabilitation programs[30] that match the breadth of services provided by VA are not widely available in the market.[31]

Mission: VA has academic affiliations in the market that include the State University of New York at Buffalo. The Buffalo VAMC is ranked 38 out of 154 VA training sites based on the number of trainees and the Batavia VAMC has no training program. The Buffalo VAMC is ranked 44 out of 103 VAMCs with research funding, and the Batavia VAMC conducts limited or no research. The VAMCs do not have an emergency designation.

Facility Overviews

Buffalo VAMC: The Buffalo VAMC is located in Buffalo, New York, and offers inpatient medical and surgical services, inpatient mental health care, CLC, RRTP, and outpatient services. In FY 2019, the Buffalo VAMC had an inpatient medical and surgical average daily census (ADC) of 61.7, an inpatient mental health ADC of 12.7, a CLC ADC of 17.6, and an RRTP ADC of 17.4.

The Buffalo VAMC was built in 1949 on 17.0 acres and does not meet current design standards.[32] The VAMC's last major renovation was in 1990. Facility condition assessment (FCA) deficiencies are approximately $260.9M, and annual operations and maintenance costs are an estimated $14.1M.

Batavia VAMC: The Batavia VAMC is located in Batavia, New York, and offers long-term care, RRTP, and outpatient services. The Batavia VAMC has 80 CLC beds and 32 RRTP beds. In FY 2019, the Batavia VAMC had a CLC ADC of 59.8 and an RRTP ADC of 23.4.

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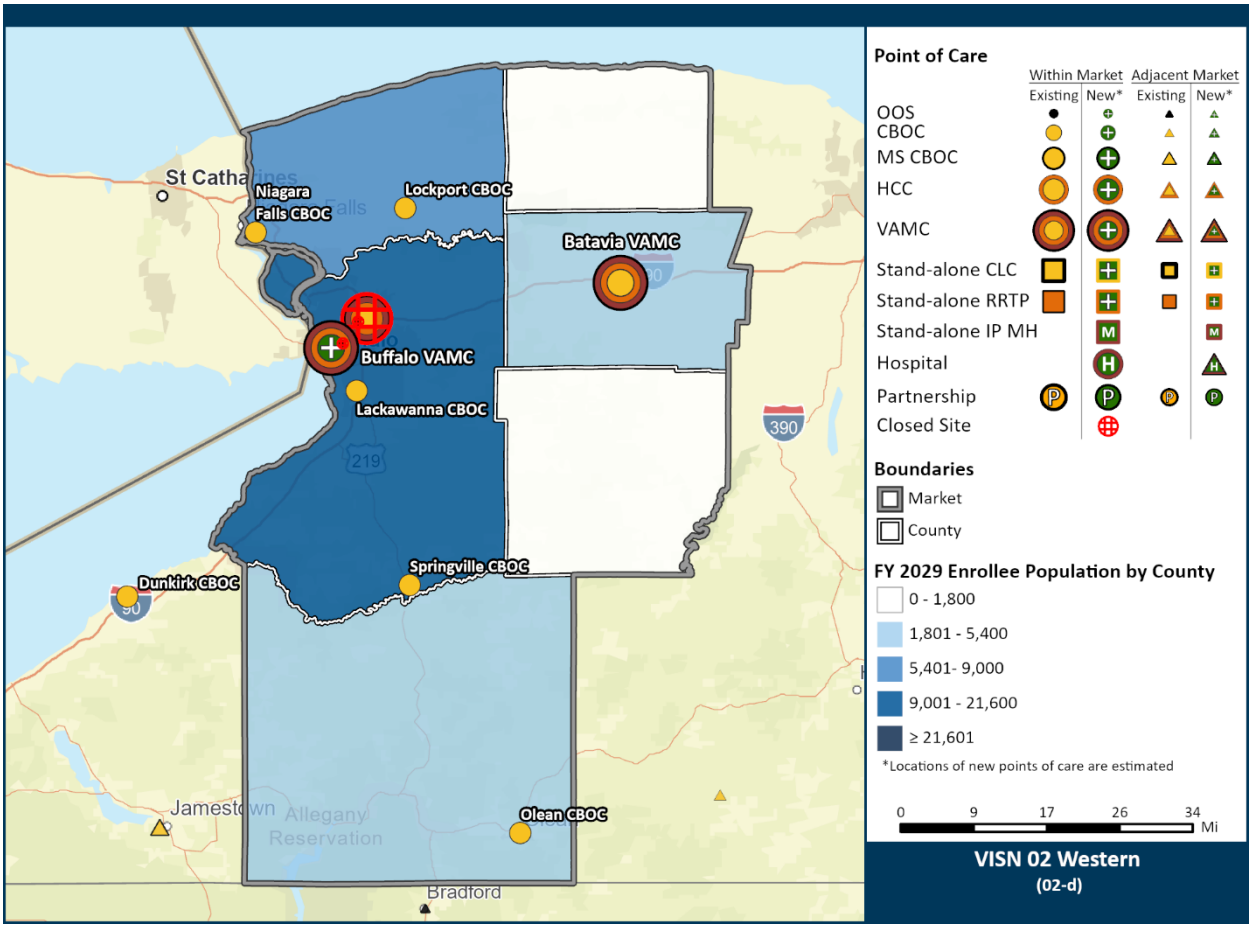
[26] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[27] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[28] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[29] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[30] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[31] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.
[32] Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, columns spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be conducive or ideal for the delivery of modern health care.

The Batavia VAMC was built in 1932 on 46.0 acres and does not meet current design standards. FCA deficiencies are approximately $31.8M, and annual operations and maintenance costs are an estimated $4.1M.

Recommendation and Justification

This section details the VISN 02 Western Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Buffalo VAMC by:***

   1.1. **Constructing a new VAMC with inpatient medical and surgical, inpatient mental health, CLC, RRTP, primary care, outpatient mental health, specialty care, emergency department, and ambulatory surgery services in the vicinity of Buffalo, New York:** The Buffalo VAMC was built in 1949 and is located on a landlocked campus, with no acreage available for additional development. The campus has significant parking limitations, failing infrastructure systems, and an outdated building. The VAMC's FCA deficiencies are approximately $260.9M, and its annual operations and maintenance costs total an estimated $14.1M. The Buffalo VAMC's current location is sub-optimal; it is not proximate to the medical corridor in downtown Buffalo, which

was created to foster collaboration among member institutions, their employees, and the community. Relocating the Buffalo VAMC near or in the Buffalo Niagara Medical Campus will enhance innovation, collaborative care, research, and educational opportunities with local community institutions, including with VA's academic affiliate, the State University of New York (SUNY) at Buffalo. In FY 2019, the Buffalo VAMC had 93 medical and surgical beds with an ADC of 61.7 and an in-house projected FY 2029 ADC of 50.7. Additionally, the Buffalo VAMC had 20 RRTP beds with an ADC of 17.4 in FY 2019 and a projected FY 2028 bed need of 31.

The proposed replacement Buffalo VAMC will include inpatient medical and surgical services, inpatient mental health, a short-term CLC, an expanded RRTP, primary care, outpatient mental health, specialty care, an emergency department, and ambulatory surgery services. The RRTP expansion will include 10 General Domiciliary beds, 10 Domiciliary Care for Homeless Veterans (DCHV) beds, and 20 substance use disorder (SUD) beds.

1.2. **Closing the Buffalo VAMC:** Following the realignment of services to the proposed replacement Buffalo VAMC, the existing facility will be closed.

2. ***Modernize and realign the Batavia VAMC by modernizing the outpatient space at the Batavia VAMC:*** The Batavia VAMC was built in 1932, with FCA deficiencies totaling approximately $31.8M and annual operations and maintenance costs totaling an estimated $4.1M. In FY 2019, there were 54,134 enrollees within 60 minutes of the Batavia VAMC. The primary care and specialty care clinic at the Batavia VAMC is space-constrained and not designed to support patient-aligned care teams (PACTs); the current infrastructure and layout do not meet modern health care standards. As outpatient service demand is projected to increase across the market, the existing facility is inadequate to meet demand and insufficient to support functional space requirements. The Batavia VAMC has 12.0 acres available for additional development. Relocating and expanding outpatient services to a purpose-built, rightsized facility on the Batavia VAMC campus will meet the growing needs of the Veteran population.

3. ***Modernize and realign outpatient facilities in the market by:***

3.1. **Relocating all services to the proposed replacement Buffalo VAMC and closing the Buffalo-Main Street OOS:** The Buffalo-Main Street OOS served 559 core uniques[33] in FY 2019. The proposed replacement Buffalo VAMC, which is an estimated two miles away, will be able to absorb this demand from the OOS. Consolidating services at the proposed replacement Buffalo VAMC will then allow for the closure of the Buffalo-Main Street OOS.

3.2. **Relocating all services to the proposed replacement Buffalo VAMC and closing the Packard-Buffalo OOS:** The Packard Buffalo OOS served 926 core uniques in FY 2019. The proposed replacement Buffalo VAMC, which is an estimated five miles away, will be able to absorb this demand from the OOS. Consolidating services at the proposed replacement Buffalo VAMC will then allow for the closure of the Packard- Buffalo OOS.

[33] VA core unique patients exclude Veterans who have used only VA telephone triage, pharmacy, and laboratory services.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

Western Market

- **Realign the Jamestown CBOC (Chautauqua County, New York) to the Erie VAMC (Erie County, Pennsylvania) in the VISN 04 Western Market:** The Jamestown CBOC is part of the Erie hospital referral region. The Erie VAMC is within an estimated 48 miles of the Jamestown CBOC, whereas the Buffalo VAMC is an estimated 77 miles away. This realignment will better reflect enrollee use patterns.

Buffalo VAMC

- **Ensure there is adequate space to support the research initiative at the proposed new replacement Buffalo VAMC (Erie County, New York) to maintain all existing programs:** The Office of Research and Development (ORD) will be consulted in the planning for the proposed replacement Buffalo VAMC to ensure adequate space to maintain existing research programs and education capabilities in the Western Market area.

Batavia VAMC

- **Reduce the RRTP capacity at the Batavia VAMC (Genesee County, New York):** In FY 2019, the Batavia VAMC had 32 PTSD beds and an ADC of 23.1. Reducing PTSD beds at the Batavia VAMC from 32 to 28 will better address current and projected demand.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 02 Western Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[34] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational costs included direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).

[34] The present value cost is the current value of future costs discounted at the defined discount rate.

- **Benefits:** Benefits were evaluated based on five domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate the Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI score is the preferred COA. The results of the CBA for the VISN 02 Western Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 02 Western Market	Status Quo	Modernization	VA Recommendation
Total Cost	$10,296,647,548	$10,630,736,302	$11,417,821,369
Capital Cost	$1,412,071,400	$1,746,160,154	$2,533,245,221
Operational Cost	$8,884,576,148	$8,884,576,148	$8,884,576,148
Total Benefit Score	8	11	12
CBI (normalized in $B)	**1.29**	**0.97**	**0.95**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand

This recommendation is consistent with the Demand criterion, aligning 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.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through eight VA points of care offering outpatient services, including the proposed replacement Buffalo, New York VAMC, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Batavia, New York VAMC and proposed replacement Buffalo, New York VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Bronx, New York VAMC.
- **RRTP:** RRTP demand will be met through the proposed replacement Buffalo, New York VAMC; the Batavia, New York VAMC; and the other facilities within VISN 02 offering RRTP, including the Canandaigua, New York

Demand

VAMC; the proposed replacement Albany, New York VAMC; the Montrose, New York VAMC; the Lyons, New Jersey VAMC; and the proposed new St. Albans, New York VAMC.

- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01), the proposed new King of Prussia, Pennsylvania VAMC (VISN 04), and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine, surgery, and mental health demand will be met through the proposed replacement Buffalo, New York VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 34,376 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 34,369 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 02. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the State University of New York at Buffalo.
- **Research:** This recommendation does not impact the research mission in the market and allows the Buffalo, New York VAMC to maintain the current research mission by ensuring there is adequate space to support research at the proposed replacement Buffalo, New York VAMC to maintain all existing programs.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Buffalo, New York VAMC and the Batavia, New York VAMC are not designated as Primary Receiving Centers.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed replacement Buffalo, New York VAMC. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (0.95 for VA Recommendation versus 1.29 for Status Quo), indicating that VA Recommendation is more cost-effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed replacement Buffalo, New York VAMC, and the modernization of the outpatient space at the Batavia, New York VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff.
- **Reflects stewardship of taxpayer dollars:** While the cost of the market recommendation is more than the cost to modernize facilities in the market today ($11.4B for VA Recommendation versus $10.6B for Modernization), there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (0.95 for VA Recommendation versus 0.97 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 02 Finger Lakes Market

The Veterans Integrated Service Network (VISN) 02 Finger Lakes Market serves Veterans in central New York state and northern Pennsylvania. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[35]

VA's Commitment to Veterans in the Finger Lakes Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 02's Finger Lakes Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Finger Lakes Market is facing markedly decreasing enrollment. While demand for inpatient mental health, long-term care, and residential rehabilitation treatment program (RRTP) is decreasing, demand for inpatient medical and surgical care and outpatient care is. The two VAMC facilities will be modernized and realigned to support current and future Veteran demand for sustainable subacute services. Inpatient medical services will transition to the community. The strategy for the market is intended to provide Veterans today and in the future with access to high quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation modernizes the outpatient space on the Canandaigua VAMC campus. The recommendation also consolidates two clinics in Rochester, the Clinton Crossings multi-specialty community-based outpatient clinic (MS CBOC) and the Mount Hope other outpatient services (OOS) site, into a single convenient access point at the new Rochester MS CBOC.

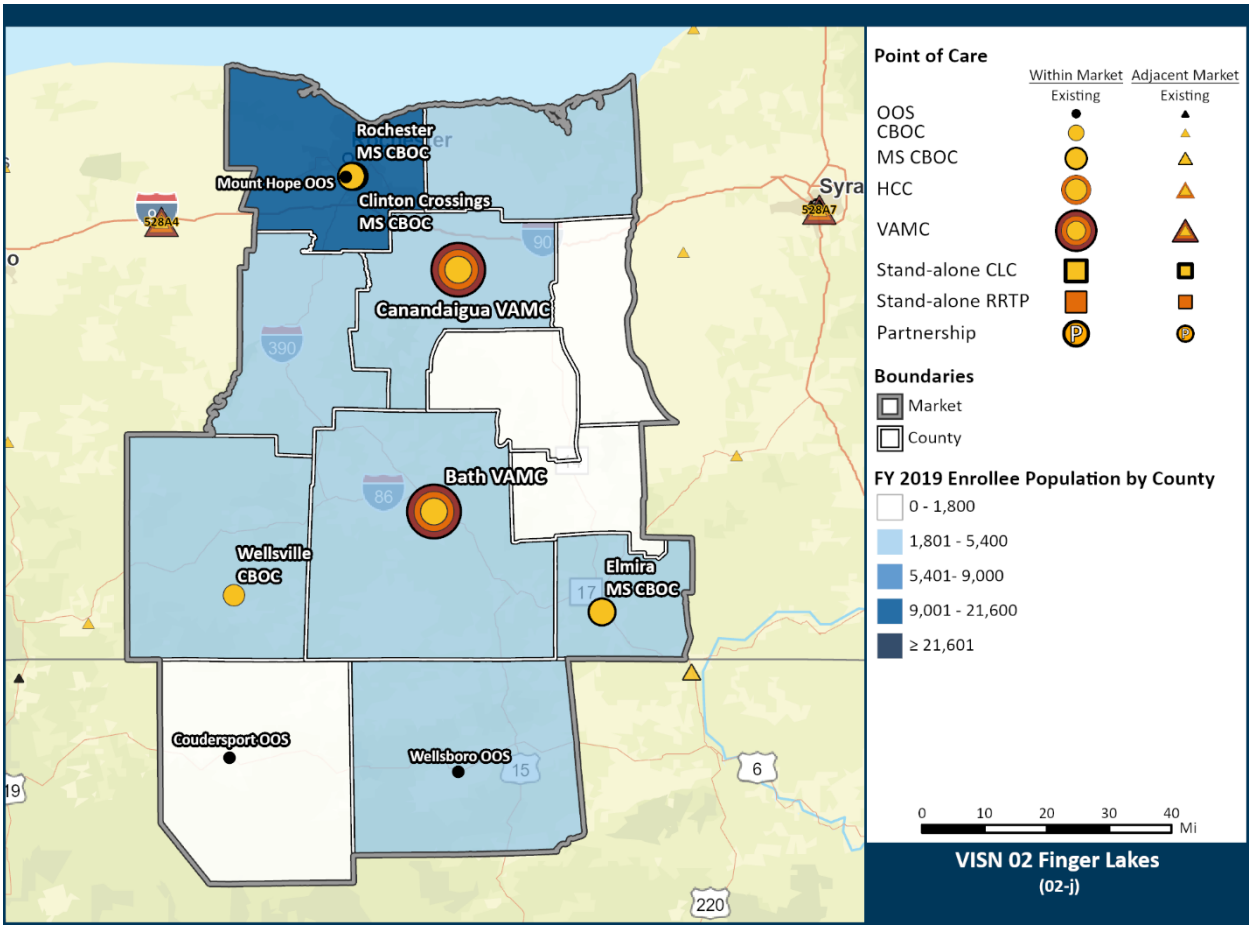
[35] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation modernizes community living center (CLC) services at the Canandaigua VAMC and maintains sustainable CLC services within the Bath VAMC. The recommendation consolidates residential rehabilitation treatment program (RRTP) services from the Bath VAMC to the Canandaigua VAMC to enhance the sustainability of the program. The Finger Lakes Market currently offers primary care for inpatient spinal cord injuries and disorders (SCI/D) services and refers Veterans to SCI/D hubs in the region for acute, sustaining, and rehabilitative care. Demand for inpatient blind rehabilitation services will be met at the Cleveland, Ohio VAMC (VISN 10).
- **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 recommendation ensures quality, sustainable inpatient medical care by relocating these services to community providers with ongoing care coordination by VA.

Market Overview

The market overview includes a map of the Finger Lakes Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has two VAMCs (Canandaigua and Bath), one community-based outpatient clinic (CBOC), three MS CBOCs, and three OOS sites.

Enrollees: In fiscal year (FY) 2019, the market had 40,442 enrollees and is projected to experience a 17.8% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Monroe, Steuben, and Ontario, New York.

Demand: Demand[36] in the market for inpatient medical and surgical services is projected to increase by 7.8% and demand for inpatient mental health services is projected to decrease by 3.0% between FY 2019 and FY 2029. Demand for long-term care[37] is projected to decrease by 4.4%. Demand for all

[36] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[37] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

outpatient services,[38] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 50.3% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 79.5% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 43.1% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[39] in the market within a 60-minute drive time of the VAMCs have an average inpatient acute occupancy rate[40] of 76.4% (398 available beds)[41] and an average inpatient mental health occupancy rate of 64.4% (44 available beds). Community nursing homes within a 30-minute drive time of the VAMCs are operating at an average occupancy rate of 89.7% (31 available beds). Community residential rehabilitation programs[42] that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include the University of Rochester. The Canandaigua VAMC is ranked 129 out of 154 VA training sites based on the number of trainees, and the Bath VAMC is ranked 149 out of 154 VA training sites. The Canandaigua VAMC is ranked 75 out of 103 VAMCs with research funding, and the Bath VAMC conducts limited or no research. The VAMCs do not have an emergency designation.[43]

Facility Overviews

Canandaigua VAMC: The Canandaigua VAMC is located in Canandaigua, New York, and offers RRTP, CLC, and outpatient services. In FY 2019, the Canandaigua VAMC had an RRTP ADC of 29.9 and a CLC ADC of 83.3.

The Canandaigua VAMC's main patient care facility was built in 1932, and some of its buildings date back to 1890. The VAMC was built on 163.0 acres; 30.0 acres are available for additional development. The VAMC has an ongoing major renovation project of its RRTP, CLC, and outpatient space. Facility condition assessment (FCA) deficiencies are approximately $104.4M, and annual operations and maintenance costs are an estimated $8.3M.

Bath VAMC: The Bath VAMC is located in Bath, New York, and offers inpatient medical, RRTP, rehabilitation medicine, CLC, and outpatient services. In FY 2019, the Bath VAMC had an inpatient medical ADC of 2.8, an RRTP ADC of 145.2, a rehabilitation medicine ADC of 0.0, and a CLC ADC of 68.4.

The Bath VAMC's main hospital building was built in 1937, and some of its buildings date back to 1877. The VAMC was built on 210.0 acres; 20.0 acres are available for additional development. The last major

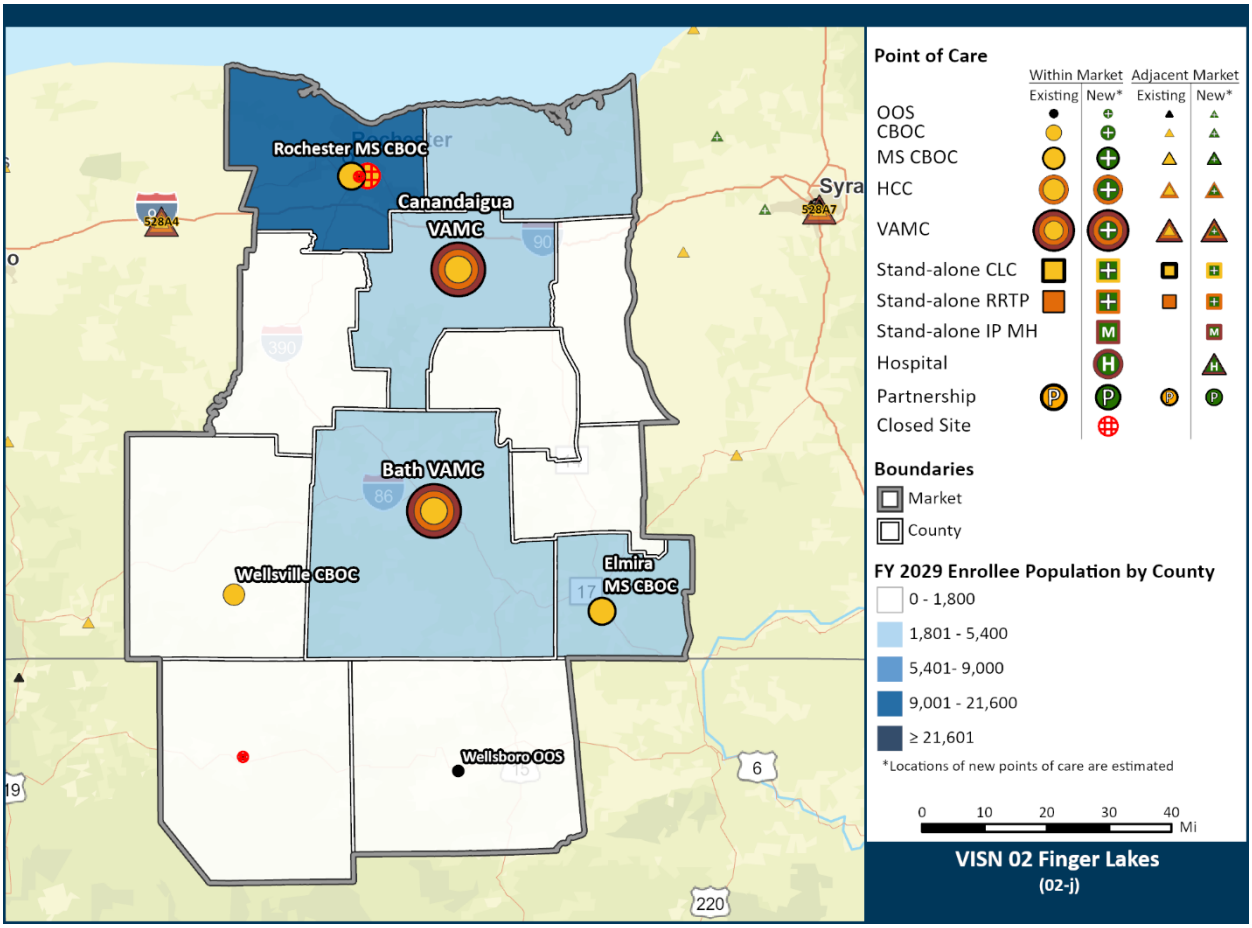
[38] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[39] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[40] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[41] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[42] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[43] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

renovation to the main hospital building was in 1960, and a renovation to the CLC building has recently completed. FCA deficiencies are approximately $128.8M, and annual operations and maintenance costs are an estimated $6.2M. The Bath National Cemetery is adjacent to the medical campus.

Recommendation and Justification

This section details the VISN 02 Finger Lakes Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Bath VAMC by:***

   1.1. **Relocating RRTP services to current or future VA facilities and discontinuing these services at the Bath VAMC:** In FY 2019, the Bath VAMC had 170 RRTP beds with an ADC of 145.2. In FY 2019, inpatient residential rehabilitation ADC in the market was 58.2 and is projected to decrease to 29.2 by FY 2028. The projected RRTP bed need for the Finger Lakes Market is 34. Relocating RRTP services to the Canandaigua VAMC will provide a rightsized program to meet the market's demand and take advantage of the major construction project to renovate 48 domiciliary beds.

1.2. Relocating inpatient medical and urgent care services from the Bath VAMC to community providers and discontinuing these services at the Bath VAMC: Enrollees in Steuben County, where the Bath VAMC is located, are projected to decrease by 21.0%, from 4,640 enrollees in FY 2019 to 3,666 in FY 2029. In FY 2019, the Bath VAMC had 10 inpatient medical beds with an ADC of 2.8. These low volumes pose a challenge to maintaining safe practices and ensuring staff competency. Utilization of these beds is mainly for detoxification and acute rehabilitation.

The VAMC does not have an emergency department or a surgical program. In situations where a patient clinically deteriorates, they must be stabilized and then transferred to the closest community provider for treatment. Community hospitals around Bath, New York, have capacity to accommodate VA demand. Within 60 minutes of the Bath VAMC, there are 211 community beds available with an inpatient medical and surgical occupancy rate of 58.7%. With the declining population and low demand, Veterans will be best served through community providers.

Urgent care encounters at the Bath VAMC have increased by 1.1%, from 5,123 in FY 2017 to 5,181 in FY 2019. The Bath VAMC continues to see strong demand for primary care services and can improve access by expanding primary care to include same-day appointment slots. Modifying the Bath VAMC by eliminating urgent care and expanding primary care will provide access to same-day care to better meet Veterans' needs.

2. ***Modernize and realign outpatient facilities in the market by:***

2.1. Relocating all services to the Rochester MS CBOC and closing the Clinton Crossings MS CBOC: The Clinton Crossings MS CBOC served 6,957 core uniques[44] in FY 2019. With the Rochester MS CBOC less than one mile away, care will best be provided there at the newer, rightsized, and consolidated site.

2.2. Relocating all services to the Rochester MS CBOC and closing the Mount Hope OOS: The Mount Hope OOS offers mental health and specialty care services but does not offer primary care services. The Mount Hope OOS served 1,144 core uniques in FY 2019. With the Rochester MS CBOC less than a mile away, care will best be provided there at the newer, rightsized, and consolidated site.

2.3. Relocating all services to the Wellsboro OOS and closing the Coudersport OOS: The Coudersport OOS had 768 enrollees within 30 minutes and served 373 core uniques in FY 2019. The enrollees in Potter County, Pennsylvania, where the Coudersport OOS is located, are projected to decrease by 17.5%, from 835 enrollees in FY 2019 to 689 enrollees in FY 2029. The Coudersport OOS does not currently offer outpatient mental health or specialty services and operates only two days per week. With this low utilization, deactivating the facility and shifting care to the Wellsboro OOS will provide care in one location that can then support five day/week services. Veterans will also have the option to access community providers in the Coudersport area.

[44] VA core unique patients exclude Veterans who have used only VA telephone triage, pharmacy, and laboratory services.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

Finger Lakes Market

- **Increase availability of ophthalmology across the Finger Lakes Market to address the potential lack of high-quality ophthalmologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality ophthalmologists. Increased availability may be achieved through a variety of tactics, such as telehealth, Veterans Community Care Program (VCCP) recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of optometry across the Finger Lakes Market to address the potential lack of high-quality optometrists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality optometrists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of gastroenterology across the Finger Lakes Market to address the potential lack of high-quality gastroenterologists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality gastroenterologists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.
- **Increase availability of podiatry across the Finger Lakes Market to address the potential lack of high-quality podiatrists:** As identified in the Section 203 criteria analysis, there is a potential lack of high-quality podiatrists. Increased availability may be achieved through a variety of tactics, such as telehealth, VCCP recruitment, and hiring additional VA providers, as appropriate.

Canandaigua VAMC

- **Approach the Canandaigua VAMC CLC (Ontario County) replacement as a phased project contingent on market demand, staffing, and budget (in progress):** The facility has begun constructing a new CLC on the campus. Alignment to market demand will be validated prior to starting future phases.
- **Reallocate the RRTP beds at the Canandaigua VAMC (Ontario County):** The Finger Lakes Market had a FY 2028 bed demand of 10 Domiciliary Care for Homeless Veterans (DCHV) beds, 3 post-traumatic stress disorder (PTSD) beds, 9 substance use disorder (SUD) beds, and 12 General Domiciliary beds. In FY 2019, the Canandaigua VAMC had 48 RRTP beds. As RRTP demand is projected to decrease, 28 General Domiciliary and 20 DCHV beds will meet Veteran demand. Additional RRTP service needs will be provided by the VISN 02 Western Market; the Buffalo VAMC will provide SUD beds, and the Batavia VAMC will provide PTSD beds.
- **Establish a new MS CBOC on the Canandaigua VAMC (Ontario County) campus in Canandaigua, New York, to expand access to primary care, outpatient mental health, and outpatient specialty care services (in progress):** The Canandaigua VAMC is building a new facility for outpatient services on campus that is due to open in August 2022. Enrollee

population in the market is projected to decrease by 17.8% between FY 2019 and FY 2029. In FY 2019, there were 6,169 enrollees within 30 minutes and 29,369 enrollees within 60 minutes of the Canandaigua VAMC.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 02 Finger Lakes Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[45] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational costs included direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate the Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI score is the preferred COA. The results of the CBA for the VISN 02 Finger Lakes Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 02 Finger Lakes Market	Status Quo	Modernization	VA Recommendation
Total Cost	$7,861,390,882	$8,045,756,420	$7,850,453,929
Capital Cost	$1,202,637,617	$1,387,003,155	$1,243,307,582
Operational Cost	$6,658,753,265	$6,658,753,265	$6,607,146,347
Total Benefit Score	7	10	10
CBI (normalized in $B)	**1.12**	**0.80**	**0.79**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

[45] The present value cost is the current value of future costs discounted at the defined discount rate.

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand

This recommendation is consistent with the Demand criterion, aligning 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.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through six VA points of care offering outpatient services, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Canandaigua, New York VAMC and the Bath, New York VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Bronx, New York VAMC.
- **RRTP:** RRTP demand will be met through the Canandaigua, New York VAMC, and the other facilities within VISN 02 offering RRTP, including the Batavia, New York VAMC; the proposed replacement Buffalo, New York VAMC; the proposed replacement Albany, New York VAMC; Montrose, New York VAMC; Lyons, New Jersey VAMC; and the proposed replacement St. Albans, New York VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01), the proposed new King of Prussia, Pennsylvania VAMC (VISN 04), and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient Acute:** Inpatient medicine, surgery, and mental health demand will be met through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 34,520 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 34,559 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 02. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the University of Rochester.
- **Research:** This recommendation does not impact the research mission in the market and allows the Canandaigua, New York VAMC to maintain the current mission. The Bath, New York VAMC does not have a research program.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Canandaigua, New York VAMC and the Bath, New York VAMC are not designated as primary receiving centers.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (0.79 for VA Recommendation versus 1.12 for Status Quo), indicating that VA Recommendation is more cost effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($7.9B for VA Recommendation versus $8.0B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (0.79 for VA Recommendation versus 0.80 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 02 Long Island Market

The Veterans Integrated Service Network (VISN) 02 Long Island Market serves Veterans in Long Island, New York. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[46]

VA's Commitment to Veterans in the Long Island Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 02's Long Island Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The Long Island Market is facing markedly decreasing enrollment. Inpatient service demand is decreasing, while outpatient demand is increasing. There is a need to invest in the ongoing community living center (CLC), inpatient mental health, and outpatient service needs of the Veteran population on Long Island. Inpatient medical and surgical services will be transitioned from the aging Northport VAMC to a partnership with the academic affiliate. Residential rehabilitation treatment program (RRTP) services will be transitioned to the modernized St. Albans VAMC, ensuring access and program sustainability. The strategy for the market is intended to provide Veterans today and in the future with access to high quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation considers the increased demand for these services and improves access to care in modern facilities by establishing a multi-specialty community-based outpatient clinic (MS CBOC) in a location in the vicinity of Commack, New York (Western Suffolk County). An MS CBOC in the vicinity of Commack, New York, will provide a new specialty care access point, reducing travel times to the Northport VAMC through a centrally located facility near the intersection of major highways.

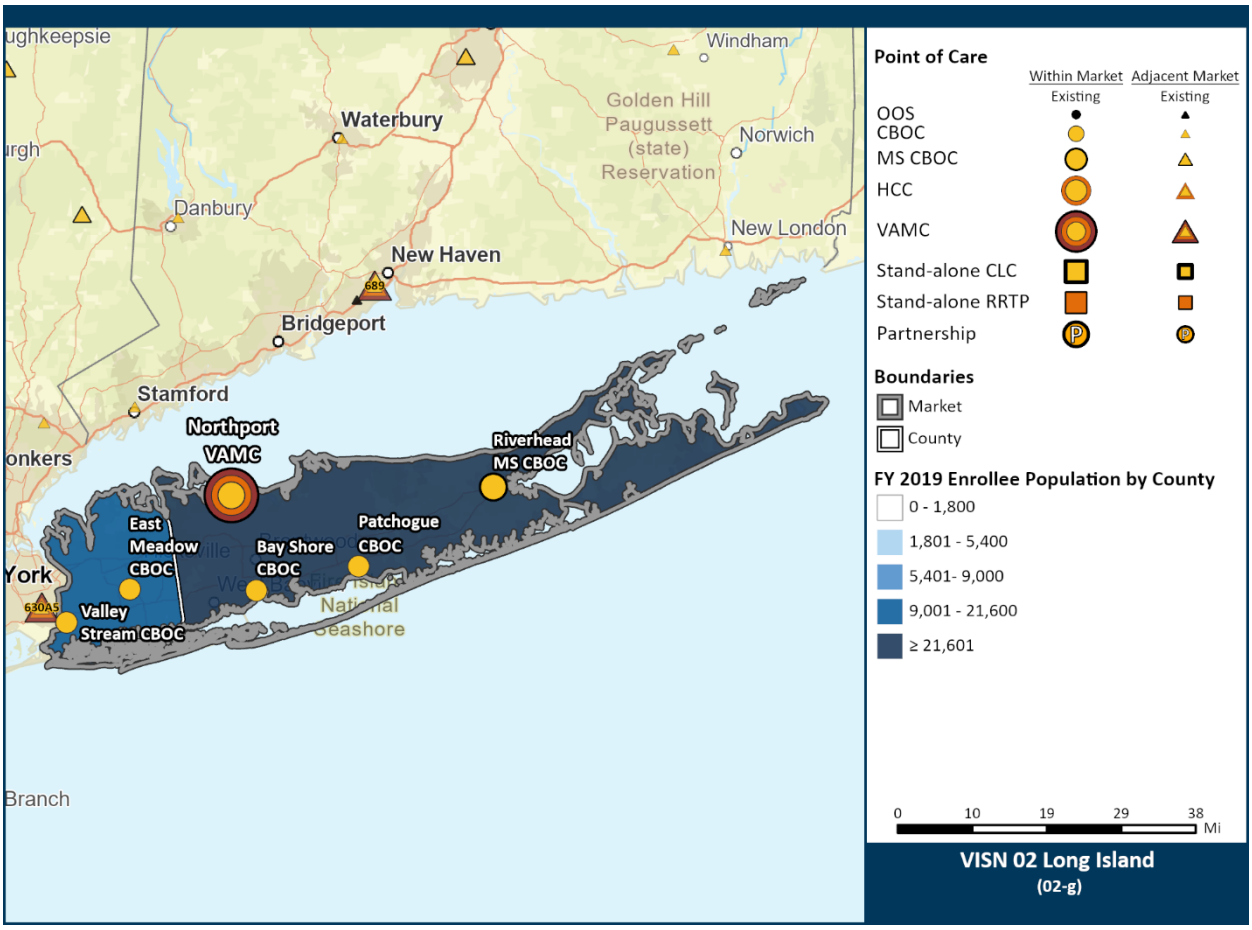
[46] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation invests in a modern subacute VAMC campus with inpatient mental health and CLC services. The recommendation consolidates RRTP services by shifting services to the St. Albans RRTP for enhanced program sustainability. The Long Island Market currently offers primary care for inpatient spinal cord injuries and disorders (SCI/D) services and refers Veterans to SCI/D hubs in the region for acute, sustaining, and rehabilitative care. Demand for inpatient blind rehabilitation services will be met at the West Haven, Connecticut VAMC (VISN 01).
- **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 recommendation maintains quality, sustainable inpatient medical and surgical care by relocating these services to an academic affiliate and allows VA providers to deliver inpatient care at the partner facility.

Market Overview

The market overview includes a map of the Long Island Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has one VAMC (Northport), one MS CBOC, and four CBOCs.

Enrollees: In fiscal year (FY) 2019, the market had 50,121 enrollees and is projected to experience a 31.8% decrease in enrolled Veterans by FY 2029. The largest enrollee population is in Suffolk County, New York.

Demand: Demand[47] in the market for inpatient medical and surgical services is projected to decrease by 17.5% and demand for inpatient mental health services is projected to decrease by 8.8% between FY 2019 and FY 2029. Demand for long-term care[48] is projected to decrease by 11.0%. Demand for all

[47] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[48] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.

outpatient services,[49] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 1.7% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 98.1% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 96.2% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[50] in the market within a 60-minute drive time of the VAMC have an average inpatient medical and surgical occupancy rate[51] of 76.5% (722 available beds)[52] and an average inpatient mental health occupancy rate of 71.1% (102 available beds). Community nursing homes within a 30-minute drive time of the VAMC are operating at an average occupancy rate of 93.3% (22 available beds), indicating very limited community capacity availability. Community residential rehabilitation programs[53] that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include the State University of New York (SUNY) at Stony Brook. The Northport VAMC is ranked 48 out of 154 VA training sites based on the number of trainees and is ranked 64 out of 103 VAMCs with research funding. The Northport VAMC has no emergency designation.[54]

Facility Overview

Northport VAMC: The Northport VAMC is located in Northport, New York, and offers inpatient medical and surgical, inpatient mental health, RRTP, rehabilitation medicine, CLC, and outpatient services. In FY 2019, the Northport VAMC had an inpatient medical and surgical average daily census (ADC) of 26.7, an inpatient mental health ADC of 29.0, an RRTP ADC of 33.6, a rehabilitation medicine ADC of 1.8, and a CLC ADC of 122.7.

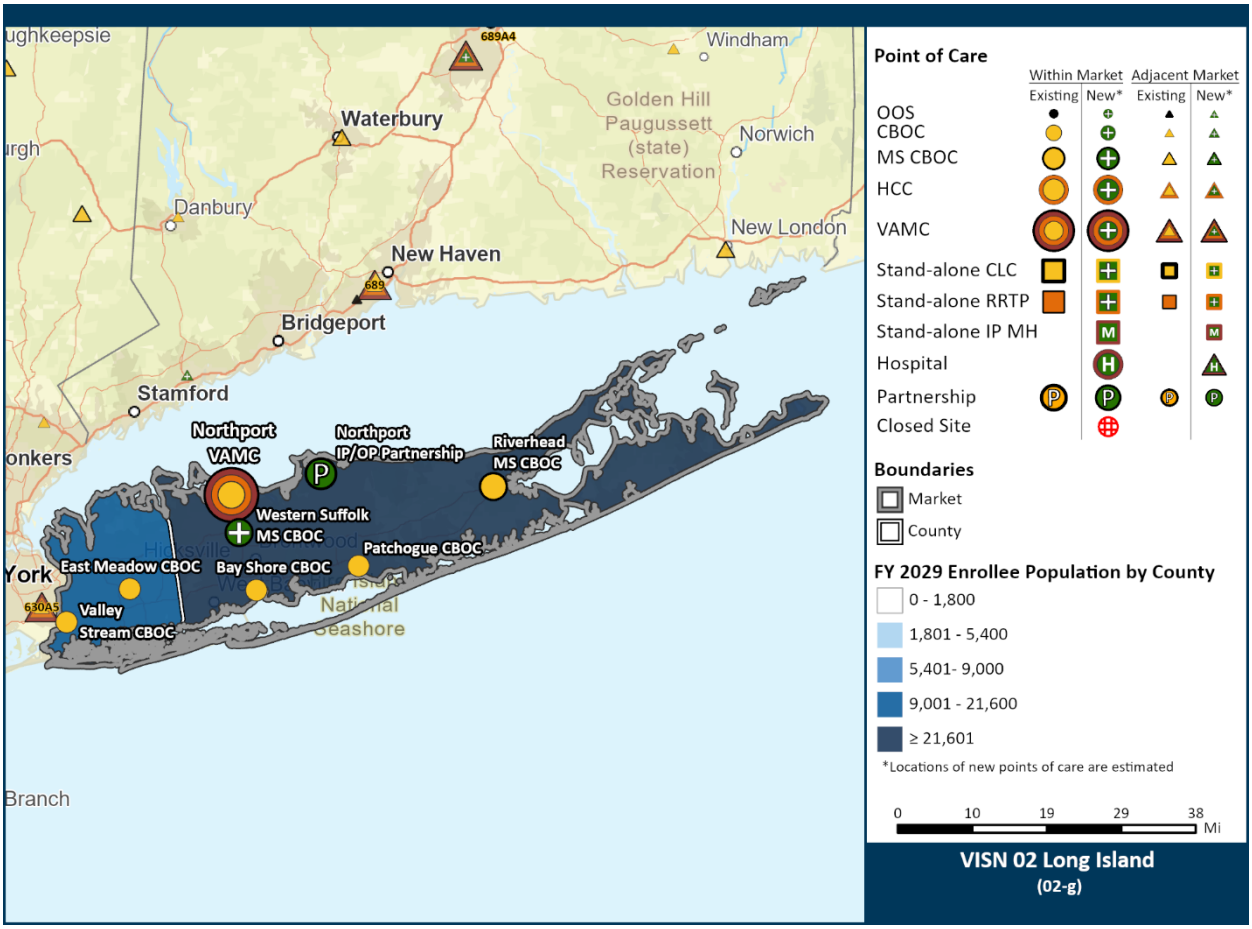
The Northport VAMC was established in the 1920s, and the main patient care facility was built in 1972. It is on a 268.0-acre campus that does not meet current design standards;[55] 20 acres are available for additional development. The last major renovation was in 1996. Facility condition assessment (FCA) deficiencies are approximately $610.9M, and annual operations and maintenance costs are an estimated $16.7M.

[49] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[50] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[51] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[52] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[53] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[54] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.
[55] Beginning in the late 1970s, modern health care design principles began to emerge and become more standard (e.g., floor-to-floor heights, corridor widths, columns spacing, and utility infrastructure requirements). While some buildings prior to this era can be in good condition, they may not be well-suited for the delivery of modern health care.

Recommendation and Justification

This section details the VISN 02 Long Island Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Northport VAMC by:***

   1.1. Modernizing the Northport VAMC: While the main hospital building was built in 1972, the Northport VAMC campus dates to the 1920s, has FCA deficiencies totaling approximately $610.9M, and has annual operations and maintenance costs totaling an estimated $16.7M. To provide a safe environment for care, extensive repairs to the wastewater treatment plant, boiler plant, heating ventilation and air conditioning (HVAC) systems, electrical systems, roads, parking lots, and sidewalks are all needed. This campus has 20 acres available for redevelopment.

   In FY 2019, there were 54,054 enrollees within 60 minutes of the Northport VAMC. VA recommends rebuilding the Northport VAMC as a subacute campus, which will enhance quality and efficiency of health care delivery for the enrollee population and alleviate the need for costly repairs of site conditions and mechanical, electrical, and plumbing systems. The

modernized VAMC will deliver inpatient mental health, CLC, and rehabilitation medicine services.

1.2. Establishing a strategic collaboration to provide inpatient medical and surgical and outpatient surgical services and discontinuing these services at the Northport VAMC. If unable to enter into a strategic collaboration, relocate care to current or future VA facilities or community providers: In FY 2019, there were 49 inpatient medical and surgical beds at the Northport VAMC with an ADC of 26.7. The ADC is projected to decrease to 21.3 by FY 2029. The VAMC had 2,150 surgical cases in FY 2019 which is a 4.4% decrease in surgical case volume over the prior four years. The market's enrollee population is projected to decrease by 31.8% between FY 2019 and FY 2029.

As of 2019, community providers within a 60-minute drive time of the Northport VAMC had an inpatient acute occupancy rate of 76.5%. The current academic affiliate hospital, Stony Brook University Hospital, has the capability to manage high complexity care and the capacity to accommodate VA's demand. Additionally, other high quality academic medical institutions have increased their presence on Long Island, creating multiple partnership opportunities for VA to enhance Veteran access. Furthermore, the recommendation will allow VA providers to deliver inpatient care at the partner facility. Veterans will also have the option to utilize surrounding VA sites of care for acute care services.

1.3. Relocating RRTP services to current or future VA facilities and discontinuing these services at the Northport VAMC: In FY 2019, the Northport VAMC had 38 RRTP beds with an ADC of 33.6. The proposed new St. Albans 84 bed RRTP will have the capacity to accommodate the demand from the Northport VAMC.

The St. Albans VAMC is an estimated 42 miles from the Northport VAMC. It will offer programs focused on subacute rehabilitation, substance use disorder, serious mental illness, post-traumatic stress disorder, and homelessness. Additionally, relocating outpatient and urgent care services from the Northport VAMC campus to the proposed new MS CBOC in Western Suffolk County will provide greater access in a convenient location.

1.4. Relocating emergency department services from the Northport VAMC to community providers and discontinuing these services at the Northport VAMC: The Northport VAMC had 10,531 emergency department encounters in FY 2019, which is a 16.9% decrease in emergency department encounters over three years. Three of the top five community hospitals in the Northport area have Level 1 Trauma Centers and one community hospital has a Level 2 Trauma Center.[56] Relocating the emergency department to community providers will deliver ample emergency services to the enrollee population. With no ability to admit patients due to the recommended relocation of inpatient medical and surgical services, the VAMC will discontinue emergency services.

[56] Trauma center levels refer to the kinds of resources available in a trauma center and the number of patients admitted yearly. A Level 1 Trauma Center is a comprehensive regional resource that is capable of providing total care for every aspect of injury- from prevention through rehabilitation. A Level 2 Trauma Center is able to initiate definitive care for all injured patients.

2. ***Modernize outpatient facilities in the market by establishing a new MS CBOC in the vicinity of Western Suffolk County, New York:*** The Northport VAMC is located north of the enrollee population center and not close to any major highways. Given the Western Suffolk area's proximity to major roadways, this area is favorable to use to provide outpatient and urgent care services. Establishing a new MS CBOC in the Western Suffolk County area will help meet projected increasing outpatient demand with a rightsized access point. The proposed facility in the vicinity of Western Suffolk County will have 69,723 Veteran enrollees within 60 minutes and 29,601 Veteran enrollees within 30 minutes.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

Northport VAMC

- **Establish a strategic collaboration with New York University (NYU) Winthrop to the west and SUNY Stony Brook to the east to improve specialty care access to augment Long Island Market coverage**: Both SUNY Stony Brook and NYU Winthrop have large outpatient specialty care footprints. A strategic collaboration with these entities will expand specialty care coverage for Veterans in the market.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 02 Long Island Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[57] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational costs included direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate the Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI score is

[57] The present value cost is the current value of future costs discounted at the defined discount rate.

the preferred COA. The results of the CBA for the VISN 02 Long Island Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 02 Long Island Market	Status Quo	Modernization	VA Recommendation
Total Cost	$9,058,114,713	$9,147,903,670	$8,561,228,363
Capital Cost	$1,716,677,232	$1,806,466,189	$1,517,385,394
Operational Cost	$7,341,437,481	$7,341,437,481	$7,043,842,968
Total Benefit Score	9	10	14
CBI (normalized in $B)	**1.01**	**0.91**	**0.61**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand

This recommendation is consistent with the Demand criterion, aligning 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.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through eight VA points of care offering outpatient services, including the proposed new Western Suffolk, New York MS CBOC and the partnership in Northport, New York, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Northport, New York VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Bronx, New York VAMC.
- **RRTP:** RRTP demand will be met through the facilities within VISN 02 offering RRTP, including the proposed replacement St. Albans, New York VAMC; Montrose, New York VAMC; Lyons, New Jersey VAMC; the proposed replacement Albany, New York VAMC; Canandaigua, New York VAMC; Batavia, New York VAMC; and RRTP at the proposed replacement Buffalo VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01), the proposed new King of Prussia, Pennsylvania VAMC (VISN 04), and the Cleveland, Ohio VAMC (VISN 10).

Demand

- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the proposed new Northport, New York partnership, as well as through community providers; inpatient mental health demand will be met through the Northport, New York VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 31,258 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 31,270 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 02. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with the State University of New York at Stony Brook.
- **Research:** This recommendation does not impact the research mission in the market and allows the Northport, New York VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Northport, New York VAMC is not designated as a Primary Receiving Center.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Western Suffolk, New York MS CBOC; the Northport, New York partnership; and the proposed new inpatient mental health, CLC, and rehabilitation medicine buildings at the Northport, New York VAMC. This new infrastructure will aid in improving the patient experience, with care delivery provided in modern spaces, and aid in the recruitment of staff, with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which support the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (0.61 for VA Recommendation versus 1.01 for Status Quo), indicating that the VA Recommendation is more cost-effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Western Suffolk, New York MS CBOC; the Northport, New York partnership, and inpatient mental health, CLC, and rehabilitation medicine buildings at the Northport, New York VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff. The proposed partnerships also help VA in recruiting and retaining staff, by embedding providers in community partner space.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($8.6B for VA Recommendation versus $9.1B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (0.61 for VA Recommendation versus 0.91 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 02 Metro New York Market

The Veterans Integrated Service Network (VISN) 02 Metro New York Market serves Veterans in the Metro New York area, including the five boroughs of New York City and several counties north of New York City. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[58]

VA's Commitment to Veterans in the Metro New York Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 02's Metro New York Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The market has six VAMCs. Four are in New York City (the Bronx VAMC, Manhattan VAMC, Brooklyn VAMC, and St. Albans VAMC), all within a 19-mile radius. North of New York City are the Montrose VAMC and the Castle Point VAMC. Over the next 10 years, the Metro New York Market enrollment is projected to decrease by 23.1%, suggesting the need for significantly fewer beds. All facilities face significant infrastructure concerns. Most of the facilities lack private rooms and amenities that have become the standard for high-quality, patient-centered health care. Additionally, current facility condition assessment (FCA) deficiencies are significant, with an estimated market total of $1.8B. The VAMCs, built between 1923 and 1980, have repurposed unneeded inpatient hospital infrastructure for outpatient, administrative, and other services.

To address challenges of demand, oversupply, and aging facilities, VA will reset the market utilizing an integrated approach that combines VA investments and the rich medical market's high-quality community providers, including VA's academic affiliates. VA will anchor the market with two acute medical centers by replacing and rightsizing the market's flagship Manhattan VAMC through an academic partnership and maintaining and modernizing in place the Bronx VAMC. All other facilities will be realigned to better address growing demand and access needs in outpatient and subacute care. The

[58] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

strategy will provide rightsized and purpose-built facilities to meet current and projected Veteran demand.

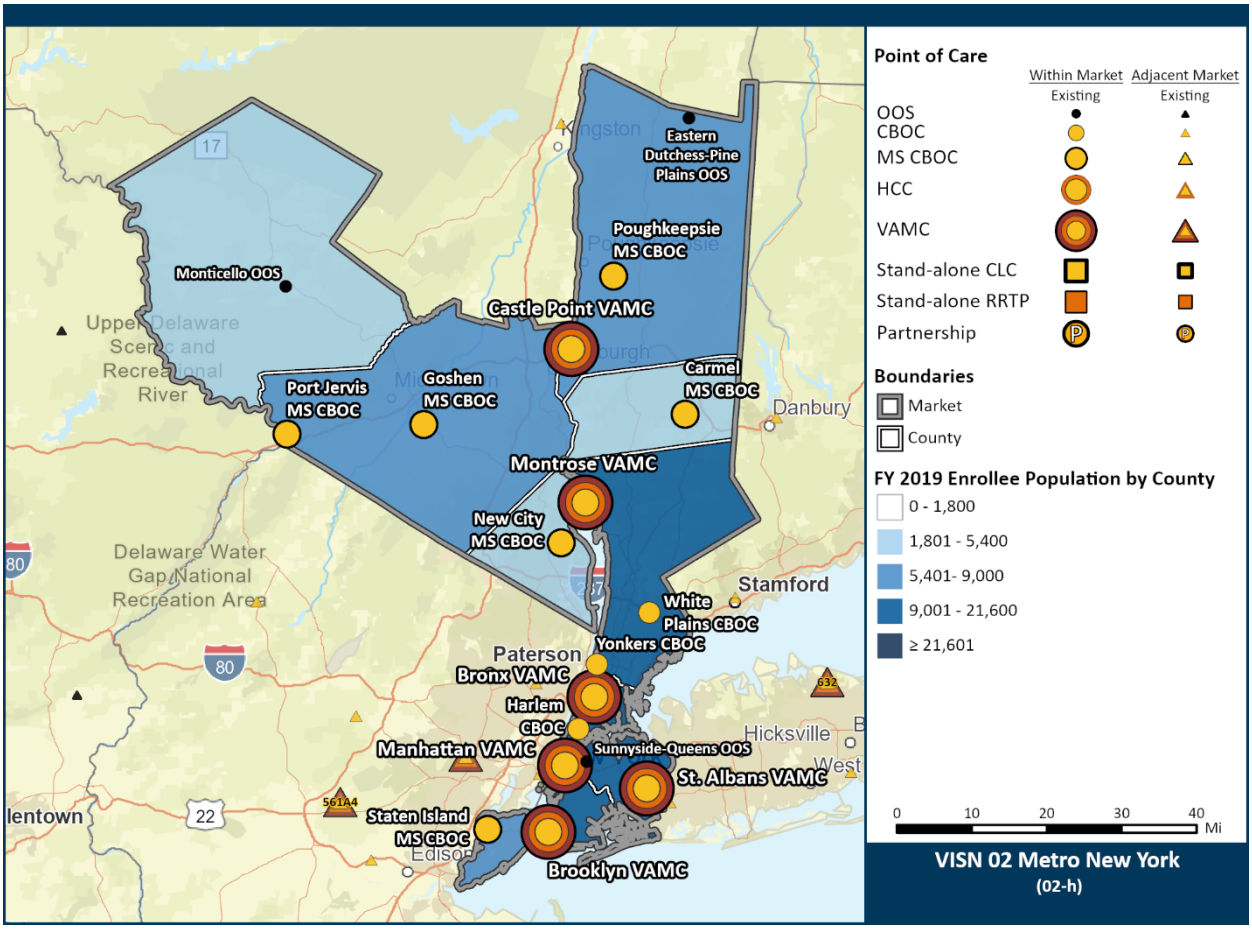
The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation invests in a rightsized, modernized Manhattan VAMC and two multi-specialty community-based outpatient clinics (MS CBOCs) in the vicinity of Brooklyn and Fishkill, New York, offering outpatient services. VA's recommendation also relocates two CBOCs more proximate to where Veterans live and closes one outpatient clinic that does not have sustainable demand, shifting care to community providers.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation provides quality, sustainable inpatient mental health, long-term care, and rehabilitation care by:
    - Manhattan VAMC – Partnering with an academic affiliate to establish a new facility offering inpatient mental health
    - Brooklyn VAMC – Transitioning residential rehabilitation treatment program (RRTP) services to the St. Albans VAMC
    - St. Albans VAMC – Expanding community living center (CLC) and RRTP services
    - The Bronx VAMC – Investing in modern inpatient mental health and CLC services
    - Montrose VAMC – Expanding inpatient mental health and CLC services; rightsizing RRTP services
    - Castle Point VAMC – Transitioning CLC services to the Montrose VAMC
- **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 recommendation provides quality, sustainable inpatient medical and surgical care by:
    - Manhattan VAMC – Partnering with an academic affiliate to establish a new facility offering inpatient medical and surgical services
    - Brooklyn VAMC – Partnering with an academic affiliate to allow VA providers to deliver inpatient medical and surgical services at the academic affiliate's facility
    - Bronx VAMC – Investing in modern inpatient medical and surgical services
    - Castle Point VAMC – Transitioning inpatient medical and surgical care to community providers with ongoing care coordination by VA

Market Overview

The market overview includes a map of the Metro New York Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has six VAMCs (Manhattan, Brooklyn, St. Albans (Queens), Bronx, Montrose, Castle Point), six MS CBOCs, three CBOCs, and three other outpatient services (OOS) sites.

Enrollees: In fiscal year (FY) 2019, the market had 112,767 enrollees and is projected to experience a 23.1% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Kings (Brooklyn), Queens, and Bronx, New York.

Demand: Demand[59] in the market for inpatient medical and surgical services is projected to decrease by 21.8% and demand for inpatient mental health services is projected to decrease by 20.1% between FY 2019 and FY 2029. Demand for long-term care[60] is projected to decrease by 22.1%. Demand for all outpatient services,[61] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 6.5% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 98.3% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 98.9% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of FY 2019, community providers[62] in the market within a 60-minute drive time of the VAMCs have an average inpatient acute occupancy rate[63] of 75.5% (2,961 available beds)[64] and an average inpatient mental health occupancy rate of 73.3% (333 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an average occupancy rate of 92.1% (1,150 available beds). Community residential rehabilitation programs[65] that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include New York University (NYU), the State University of New York (SUNY) Health Science Center, Mount Sinai, New York-Presbyterian, the Hospital for Special Surgery, and New York Medical College. The Manhattan VAMC is ranked 45 out of 154 training sites based on number of trainees, the Brooklyn VAMC is ranked 62, the Bronx VAMC is ranked 67, and the Montrose VAMC is ranked 120. The Manhattan VAMC is ranked 48 out of 103 VAMCs with research funding, the Brooklyn VAMC is ranked 73, and the Bronx VAMC is ranked 8. The other VAMCs conduct limited or no research.

The Brooklyn VAMC is a Primary Receiving Center and Federal Coordinating Center;[66] the other VAMCs in the market have no emergency designations.

[59] Projected market demand based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[60] Projected market demand for inpatient Long-Term Services and Supports (LTSS) as measured by BDOC and ADC.
[61] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[62] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[63] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[64] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[65] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[66] VAMCs designated as a Federal Coordinating Center are tasked with creating a patient reception area and coordinating a network of hospitals in the local area capable of providing definitive care for patients from other states. VAMCs designated as a Primary Receiving Center are tasked with coordinating and providing treatment to sick and wounded military personnel returning from armed conflict or national emergency.

Facility Overviews

Manhattan VAMC: The Manhattan VAMC is located in Manhattan, New York, and offers inpatient medical and surgical care, inpatient mental health care, rehabilitation medicine, and outpatient services. In FY 2019, the Manhattan VAMC had an inpatient medical and surgical average daily census (ADC) of 47.1, an inpatient mental health ADC of 32.3, and a rehabilitation medicine ADC of 1.3.

The Manhattan VAMC was built in 1954 on 6.4 acres. The last major renovation was in 1996; recent flood recovery investments are ongoing. Facility condition assessment (FCA) deficiencies are approximately $396.6M, and annual operations and maintenance costs are an estimated $19.3M.

Brooklyn VAMC: The Brooklyn VAMC is located in Brooklyn, New York, and offers inpatient medical and surgical care, RRTP, and outpatient services. In FY 2019, the Brooklyn VAMC had an inpatient medical and surgical ADC of 34.2 and an RRTP ADC of 52.9.

The Brooklyn VAMC was built in 1950 on 18.3 acres. FCA deficiencies are approximately $492.3M, and annual operations and maintenance costs are an estimated $16.3M.

St. Albans VAMC: The St. Albans VAMC is located in Queens, New York, and offers CLC and outpatient services. In FY 2019, the St. Albans VAMC had a CLC ADC of 137.7.

The St. Albans VAMC was built in 1948 on 52.0 acres; 10 acres are available for additional development. FCA deficiencies are approximately $194.3M, and annual operations and maintenance costs are an estimated $11.6M.

Bronx VAMC: The Bronx VAMC is located in the Bronx, New York, and offers inpatient medical and surgical, inpatient mental health, CLC, spinal cord injuries and disorders (SCI/D), rehabilitation medicine, and outpatient services. In FY 2019, the Bronx VAMC had an inpatient medical and surgical ADC of 40.6, an inpatient mental health ADC of 15.6, a CLC ADC of 55.5, an SCI/D ADC of 29.9, and a rehabilitation medicine ADC of 0.6.

The Bronx VAMC was built in 1980, but buildings on campus date to 1923. It is on a 29.8-acre campus; three acres are available for additional development. The last major renovation was in 2011. FCA deficiencies are approximately $378.9M, and annual operations and maintenance costs are an estimated $15.7M.

Montrose VAMC: The Montrose VAMC is located in Montrose, New York, and offers inpatient mental health, CLC, RRTP, and outpatient services. In FY 2019, the Montrose VAMC had an inpatient mental health ADC of 11.9, a CLC ADC of 83.1, and an RRTP ADC of 81.7.

The Montrose VAMC was built in 1947 on a 193.0-acre campus; 40 acres are available for additional development. The last major renovation was in 1982. FCA deficiencies are approximately $230.4M, and annual operations and maintenance costs are an estimated $12.3M.

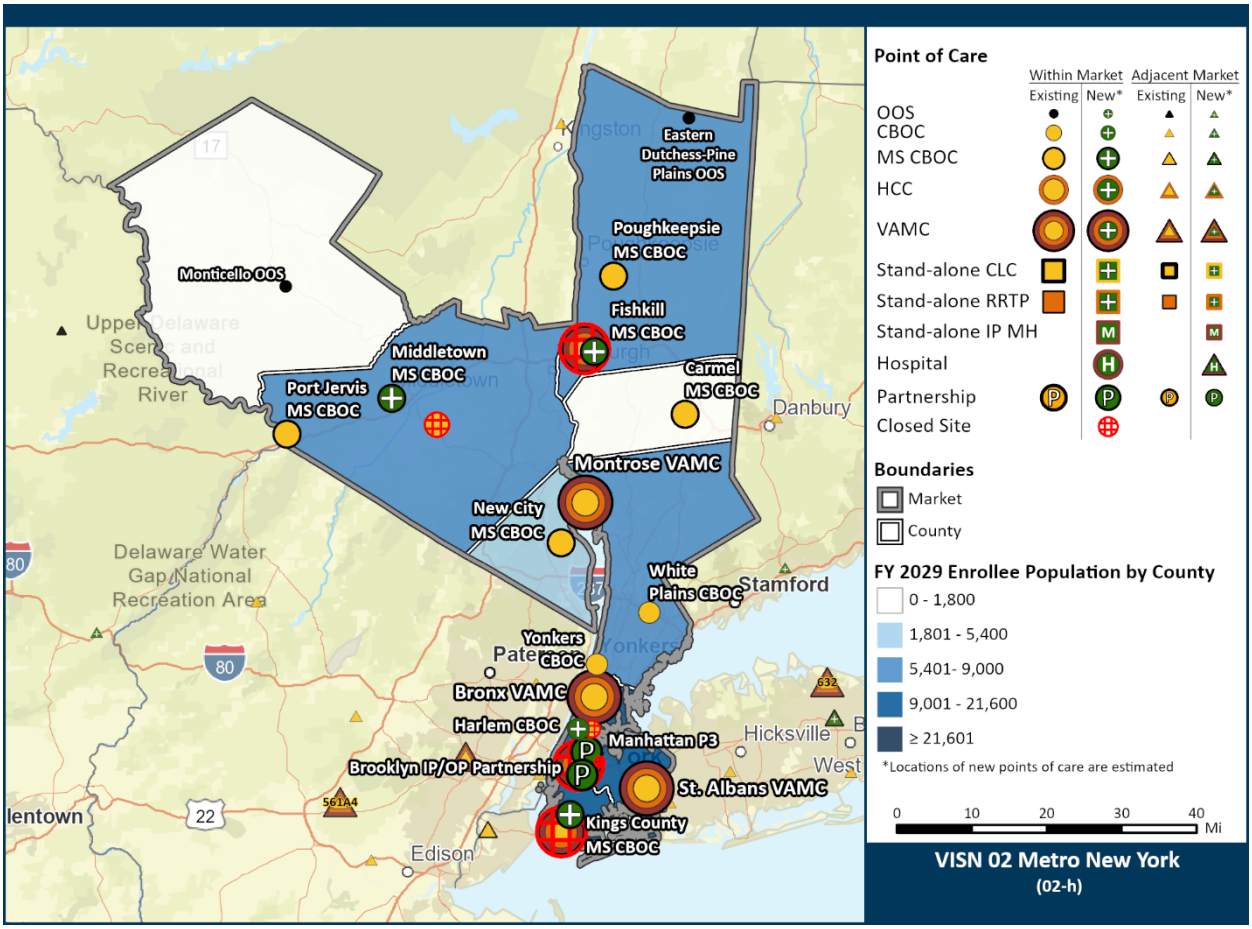
Castle Point VAMC: The Castle Point VAMC is located in Wappingers Falls, New York, and offers inpatient medical, CLC, and outpatient services. In FY 2019, the Castle Point VAMC had an inpatient medical ADC of 3.2 and a CLC ADC of 26.5.

The Castle Point VAMC was built in 1923 on a 105.0-acre campus; 40 acres are available for additional development. The last major renovation was in 1989. FCA deficiencies are approximately $115.5M, and annual operations and maintenance costs are an estimated $7.6M.

Recommendation and Justification

This section details the VISN 02 Metro New York Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the Manhattan VAMC by:***

   1.1. **Establishing a strategic collaboration to replace the VAMC and provide inpatient and outpatient services and discontinuing these services at the Manhattan VAMC. If unable to enter into a strategic collaboration, the Manhattan VAMC will maintain the services at the existing Manhattan VAMC:** Enrollment in New York County, where the Manhattan VAMC is located, is projected to decrease by 21.9%, from 13,594 enrollees in FY 2019 to 10,614 in FY 2029. As Veterans continue to migrate out of Manhattan, the Manhattan VAMC faces reduced demand and underutilization of its oversized, aged facility. The facility was built in 1954 and had its last major renovation in 1996. The current infrastructure and layout do not meet modern health care standards, and the existing facility requires significant capital investment. Even with substantial past investments, including flood recovery funds from Super Storm Sandy, there are still infrastructure deficiencies of $396.6M in FCA costs. Operating and

maintenance costs are an estimated $19.3M annually. Additionally, the Manhattan VAMC does not have parking, which limits accessibility.

Inpatient medical and surgical demand at the Manhattan VAMC has seen a historical decrease. In FY 2019, the in-house and community inpatient medical and surgical ADC in the market was 118.1, and it is projected to decrease to 92.4 by FY 2029. In FY 2019, the Manhattan VAMC had 75 inpatient medical and surgical beds with an ADC of 47.1. Surgical caseload has decreased by 4.4% since FY 2015, with 777 inpatient cases and 1,354 outpatient cases in FY 2019.

In FY 2019, the VAMC had 42 inpatient mental health beds with an ADC of 32.3. In FY 2019, total inpatient mental health ADC in the market was 57.1, and it is projected to decrease to 45.6 by FY 2029. The VAMC has eight rehabilitation medicine beds with an ADC of 1.3 in FY 2019.

Collaborating with an academic affiliate to build a rightsized, replacement facility in Manhattan offers an opportunity for VA to provide care and a better patient experience for Veterans living in the greater New York City area. This will also reduce cost, as the Manhattan VAMC is located in a high-cost area. The Manhattan VAMC sits on a desirable piece of land that could be valuable to a development partner. There are several potential options for high-quality partners, including academic affiliates. NYU serves as the Manhattan VAMC's academic affiliate and operates a quality community hospital in close proximity to the current Manhattan VAMC. New York-Presbyterian and Mount Sinai are academic affiliates of the Bronx VAMC.

The new Manhattan VAMC strategic collaboration will provide inpatient medical and surgical, inpatient mental health, outpatient surgery, and urgent care services and will become the Primary Receiving Center for the market. This recommendation is contingent on the outcome of the proposed strategic collaboration. In the event a strategic collaboration to replace the Manhattan VAMC and provide inpatient and outpatient services is not successful, these services will be maintained at the existing Manhattan VAMC.

1.2. Relocating emergency department services from the Manhattan VAMC to community providers and discontinuing these services at the Manhattan VAMC: In FY 2019, the Manhattan VAMC had 11,491 emergency department encounters. Encounter volume between FY 2017 and FY 2019 essentially remained unchanged, and half of the encounters were of low to moderate complexity. Emergency department services will be delivered by community providers, improving access and convenience for Veterans. A new urgent care center will be developed as part of the new collaboration.

1.3. Closing the Manhattan VAMC: Following the relocation of services to the strategic collaboration's replacement facility, the current Manhattan VAMC will be closed.

2. ***Modernize and realign the Brooklyn VAMC by:***

2.1. Establishing a strategic collaboration to provide inpatient medical and surgical, outpatient surgical, and emergency department services and discontinuing these services at the Brooklyn VAMC. If unable to enter into a strategic collaboration, the Brooklyn VAMC will relocate care to current or future facilities or community providers: The population served by the Brooklyn VAMC is declining. Enrollment in Kings County, where Brooklyn is located, is projected to decrease by 21.7%, from 20,484 enrollees in FY 2019 to 16,043 enrollees in FY

2029. The hospital is located on the southwestern tip of Brooklyn, while most Veterans live in Central and Eastern Brooklyn. As Veterans move to other areas, the Brooklyn VAMC faces reduced demand and underutilization of its oversized, aged facility. The rapid transit system is not proximate to the VAMC campus, which limits accessibility.

The Brooklyn VAMC campus was built in 1950. The current infrastructure does not meet modern health care standards, and the facility requires significant capital investment. FCA deficiencies total approximately $492.3M, and annual operations and maintenance costs total an estimated $16.3M.

In FY 2019, the Brooklyn VAMC had 46 inpatient medical and surgical beds with an ADC of 34.2. In addition, surgical caseload is declining, with 369 inpatient cases and 765 outpatient cases in FY 2019. In FY 2019, total inpatient medical and surgical ADC in the market was 118.1, and it is projected to decrease to 92.4 by FY 2029. Declining surgical caseloads pose a challenge to maintaining safe practices and ensuring staff competency.

Emergency department encounters at the Brooklyn VAMC remained flat, from 11,357 in FY 2017 to 11,504 in FY 2019. However, most of the visits in the emergency department were low complexity and occurred during normal operating hours for an urgent care center. Emergency department services will be delivered by a strategic collaboration to provide convenient access points to Veterans.

Dual-credentialing VA providers at an academic affiliate will allow VA providers to provide care at the affiliate facility. Partnered services will include inpatient medical and surgical, outpatient surgical, and emergency care. The partnership and a new MS CBOC in Brooklyn (recommendation 7.1) will allow VA to meet the future needs of the Veteran population and will allow access to modern facilities with high-quality care, while reducing the costly upkeep of the current VAMC.

The Brooklyn submarket has many community hospital beds, which provides VA with a choice of partners. There are approximately 28,343 beds within a 60-minute drive time of the Brooklyn VAMC with an average occupancy rate of 75.7%. Extending any partnership that is undertaken in Manhattan, if the partner has a community hospital presence in Brooklyn, will further integrate a high performing integrated delivery network for Veterans in VISN 02. Furthermore, Veterans will have the option to utilize surrounding VA sites of care for services.

2.2. Relocating RRTP services provided at the Brooklyn VAMC to current or future VA facilities and discontinuing these services at the Brooklyn VAMC: The in-house RRTP ADC at the Brooklyn VAMC was 52.9 in FY 2019. The total RRTP ADC across the market is projected to increase to 63.3 by FY 2028. The St. Albans VAMC is located an estimated 20 miles from the Brooklyn VAMC and will absorb Brooklyn's RRTP demand in a new rightsized facility.

2.3. Closing the Brooklyn VAMC: Following the relocation of services from the Brooklyn VAMC, the current Brooklyn VAMC will be closed.

3. ***Modernize and realign the St. Albans VAMC by constructing a new replacement VAMC with RRTP, CLC, primary care, outpatient specialty care, and outpatient mental health services:*** The 65-84 age group is currently the largest Veteran enrollee population in the Metro New York Market. The St. Albans VAMC maintains a large CLC program with 142 CLC beds, including a hospice program, and

will continue to serve as a CLC destination for the market. Additionally, RRTP services will be expanded, and primary care, outpatient specialty care, and geropsychiatry services will round out the subacute campus.

The St. Albans VAMC was built in 1948 and does not meet standards for delivering modern health care. The outdated facility has shared patient rooms with shared bathrooms. The VAMC's FCA deficiencies are approximately $194.3M, and annual operations and maintenance costs are an estimated $11.6M. The campus has 10 acres available for additional development.

In FY 2029, there is a total projected bed need of 262 CLC beds in the Metro New York market. The new St. Albans VAMC will specialize in geriatrics, subacute, and extended care and will develop a dedicated geropsychiatry program to meet demand for the aging Veteran population.

In FY 2028, there is a market projected RRTP ADC of 63.3. The new campus will have 84 RRTP beds to accommodate the market's RRTP bed needs, as well as RRTP demand from the Northport VAMC an estimated 42 miles away. This will include specialized tracks focused on subacute rehabilitation, substance use disorder, serious mental illness, post-traumatic stress disorder, and homelessness.

Between FY 2019 and FY 2029, primary care demand will increase by 40.5%, outpatient mental health demand will increase by 34.2%, and outpatient medical and surgical specialties demand will increase by 31.4% and 39.9% respectively for in-house and community facilities in the market. These services are currently offered at the St. Albans VAMC and will be expanded to meet increasing outpatient demand. In addition, opening same day access appointments for primary care will create a more convenient service for Veterans, without the need to establish an urgent care center.

The St. Albans VAMC is in the borough of Queens, a favorable location for the creation of a subacute campus for the five boroughs of New York City and Long Island. Establishing a new, modern facility on the St. Albans VAMC campus will build a rightsized facility that will deliver high quality subacute and outpatient care to the Metro New York market and improve the patient care experience.

4. ***Modernize and realign the Bronx VAMC by modernizing the inpatient acute units, inpatient mental health units, and the CLC:*** Converting inpatient medical and surgical, inpatient mental health, and CLC rooms to single-bedded rooms will meet the modern standard of care, improve Veteran satisfaction, and provide greater flexibility, privacy, and family engagement.

5. ***Modernize and realign the Montrose VAMC by:***

    5.1. **Relocating urgent care services from the Montrose VAMC to community providers and discontinuing these services at the Montrose VAMC:** Urgent care encounters at the Montrose VAMC have increased by 23.4%, from 1,783 encounters in FY 2017 to 2,201 in FY 2019. However, demand is below the threshold to have a dedicated urgent care center (5,975 encounters annually). To meet the needs for same day access, the Montrose VAMC has the capacity to expand primary care hours to include same-day appointments.

    5.2. **Modernizing the CLC and inpatient mental health space at the Montrose VAMC:** Given the proposed closure of the Castle Point VAMC, CLC beds will need to be consolidated with the larger CLC program at the Montrose VAMC. The Montrose VAMC campus has the space and capacity to modernize inpatient mental health and CLC and provide a better continuum of care for these programs.

The Montrose VAMC is currently the primary facility for inpatient mental health services in the northern part of the Metro New York Market. The facility serves the rural northern counties, as well as Westchester and Rockland counties, and has the space to accommodate more care.

6. ***Modernize and realign the Castle Point VAMC by:***

   6.1. **Relocating inpatient medical and urgent care services from the Castle Point VAMC to community providers and discontinuing these services at the Castle Point VAMC:** Enrollment in Dutchess County, where the Castle Point VAMC is located, is projected to decrease by 22.3%, from 7,323 enrollees in FY 2019 to 5,688 in FY 2029. In FY 2019, the Castle Point VAMC had 26 inpatient medical beds with an ADC of 3.2; there were no inpatient surgical beds. In FY 2019, total inpatient medical and surgical ADC in the market was 118.1, and it is projected to decrease to 92.4 by FY 2029. The low inpatient medical demand at the Castle Point VAMC poses a challenge to maintaining program complexity, safe practices, and ensuring staff competencies.

   The Castle Point VAMC was built in 1923. The current infrastructure and layout do not meet modern health care standards, and the existing facility requires significant capital investment. FCA deficiencies total approximately $115.5M, and annual operations and maintenance costs total an estimated $7.6M. There are 4,998 beds within a 60-minute drive time of the VAMC with an average occupancy rate of 76.1%. With the declining population, low demand, substantial maintenance cost, and high-quality community partners for inpatient care nearby, Veterans can sustainably receive care in the community.

   Urgent care encounters at the Castle Point VAMC have increased by 28.0%, from 3,895 encounters in FY 2017 to 4,986 in FY 2019. Maintaining the facility for urgent care services does not meet the recommended threshold of 5,975 encounters annually for a dedicated urgent care center. Urgent care will be relocated to local community providers to enhance convenience.

   The current inpatient medical and urgent care demand at the Castle Point VAMC could be absorbed by community partners. Numerous specialty and full-service hospitals are located in the region; some are part of larger New York City-based systems that could offer additional integrated opportunities for care throughout the entire Metro New York Market. Additionally, specialty care will also be provided by quality community providers.

   6.2. **Relocating CLC services provided at the Castle Point VAMC to current or future VA facilities and discontinuing these services at the Castle Point VAMC:** In FY 2019, the Castle Point VAMC had 28 CLC beds with an ADC of 26.5. To better align service delivery for the market, current CLC beds will be consolidated with the larger CLC program at the Montrose VAMC. The Montrose VAMC campus, which is an estimated 27 miles from the Castle Point VAMC, has capacity to absorb Castle Point CLC demand and has made recent investments to modernize long-term care programs.

   6.3. **Closing the Castle Point VAMC:** Following the realignment of services, the current Castle Point VAMC will be closed.

7. ***Modernize and realign outpatient facilities in the market by:***

   7.1. Establishing a new MS CBOC in the vicinity of Brooklyn, New York: Demand for outpatient services is projected to increase by 34.8% between FY 2019 and FY 2029 across the Metro New York market. In FY 2019, there were 32,163 enrollees within 30 minutes and 140,012 enrollees within 60 minutes of downtown Brooklyn. The MS CBOC will accommodate the outpatient demand from the Brooklyn VAMC, which will be closed. Kings County has the highest number of Veteran enrollees in the market, the bulk of whom live in Central and Eastern Brooklyn, away from the current VAMC location. The new site will be more centrally located to the Veteran population and will be able to address current and future outpatient demand for the Brooklyn/Kings County region.

   7.2. Establishing a new MS CBOC in the vicinity of Fishkill, New York: Demand for outpatient services is projected to increase by 34.8% between FY 2019 and FY 2029 across the Metro New York market. In FY 2019, there were 11,613 enrollees within 30 minutes and 41,525 enrollees within 60 minutes of the proposed Fishkill MS CBOC. The location is an estimated five miles from the Castle Point VAMC and will meet the outpatient demand from the VAMC, which is proposed to be closed. The new site will be centrally located to the Veteran population and will be able to address current and future outpatient demand for the Hudson Valley Region, while eliminating operating and maintenance costs at the Castle Point VAMC.

   7.3. Relocating the Harlem CBOC to a new site in the vicinity of Harlem, New York, and closing the Harlem CBOC: In FY 2019, the Harlem CBOC served 1,002 core uniques.[67] In FY 2019, there were 48,732 enrollees within 30 minutes of the proposed site. Replacing the Harlem CBOC with a facility in the Harlem neighborhood of New York, New York (New York County) will provide enrollees with an accessible, convenient location.

   7.4. Relocating the Goshen CBOC to a new site in the vicinity of Middletown, New York, and closing the Goshen CBOC: In FY 2019, the Goshen CBOC served 2,414 core uniques, a 4.1% increase from core uniques in FY 2015. In FY 2019, there were 8,765 enrollees within 30 minutes of the proposed site; however, the existing facility is located outside the primary Veteran enrollee population. Upon the proposed closure of the Castle Point VAMC, replacing the Goshen CBOC with a facility in the vicinity of Middletown, New York (Orange County) will provide a more proximate access point for outpatient services, including specialty care.

   7.5. Relocating all services to the Bronx VAMC and closing the Sunnyside-Queens OOS: The Sunnyside-Queens OOS served 480 core uniques in FY 2019 and has seen a historical decrease in outpatient encounters. Mental health encounters at the Sunnyside-Queens OOS decreased by 79.1%, from 43 in FY 2017 to 9 in FY 2019 and specialty care encounters decreased by 61.6%, from 86 in FY 2017 to 33 in FY 2019. With this low utilization, deactivating the facility and relocating care to other VA facilities or community providers will provide the enrollee population with high quality, accessible care.

[67] Core uniques excludes uniques who have only used telephone triage, pharmacy, and lab.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

Manhattan VAMC

- **Realign the Staten Island MS CBOC (Staten Island County) and Staten Island County to the VISN 02 New Jersey Market:** Staten Island, New York is located between the New Jersey Market and Brooklyn submarket. Veterans are currently being sent to the Brooklyn VAMC for higher acuity care, which is proposed to be closed. The new Brooklyn MS CBOC, which will accommodate outpatient demand from the Brooklyn VAMC, is proposed to be located farther from the Staten Island MS CBOC. Realigning the Staten Island MS CBOC to the New Jersey Market will allow the market to better project Veteran demand and plan for resource needs.
- **Expand outpatient mental health services at the Staten Island MS CBOC (Staten Island County):** Expanding the MS CBOC will increase access to mental health care on Staten Island.
- **Ensure there is adequate space to support the research initiative at the proposed new replacement Manhattan VAMC (New York County), to maintain all existing programs:** The Office of Research and Development (ORD) will be consulted in the planning for the proposed Manhattan strategic collaboration to ensure adequate space to maintain existing research programs and education capabilities in the Metro New York Market area.

Brooklyn VAMC

- **Relocate the Primary Receiving Center designation from the Brooklyn VAMC (Kings County) to the Manhattan VAMC (New York County):** The Brooklyn Primary Receiving Center designation will be transferred to Manhattan VAMC under the guidance of the Office of Emergency Management (OEM) and the Department of Defense (DoD) to meet the emergency preparedness criteria. Minimal impact is anticipated as the VAMCs share the same commercial airport and are located within 60 minutes of each other. During implementation, OEM and the DoD will be consulted in planning regarding transitional guidance.
- **Relocate the research program currently at the Brooklyn VAMC (Kings County) to the Manhattan VAMC (New York County) or other facilities within VISN 02 as applicable:** The ORD will be consulted in the planning of the relocation of existing research programs and education capabilities at the Brooklyn VAMC to current or future VA sites within VISN 02.

St. Albans VAMC

- **Extend inpatient collaboration(s) to deliver inpatient medical and surgical services:** The travel between the St. Albans VAMC and the Manhattan VAMC can exceed the 60-minute drive time standard. Therefore, extending any collaboration that is undertaken in Manhattan and/or Brooklyn to community providers in Queens will further integrate a high performing network for Veterans in VISN 02.

Bronx VAMC

- **Strengthen wellness services, enhancing with additional complementary services (e.g., chiropractic and acupuncture services):** Rehabilitation therapies are projected to increase from FY 2019 to FY 2029 at the Bronx VAMC; expanding these services will increase access to care.
- **Relocate inpatient SCI/D services from the East Orange VAMC (Essex County) to the Bronx VAMC (Bronx County):** In FY 2019, the East Orange VAMC had 28 SCI/D beds with an SCI/D ADC of 12.3. The East Orange VAMC is located an estimated 27 miles from the Bronx VAMC. The state-of-the-art SCI/D facility in the Bronx VAMC has the capacity to absorb this demand. The recommendation to relocate SCI/D services from the East Orange VAMC to the Bronx VAMC is referenced in the VISN 02 New Jersey Market.
- **Create partnerships with VA's academic affiliate and community providers to deliver comprehensive women's health services, including maternity, diagnostic breast health, and genetic counseling:** The women Veteran enrollee population is projected to increase across the market. However, no VA facility in the market has sufficient demand to support a comprehensive women's health program. Partnering with VA's academic affiliate, a top Gynecology provider, and other quality community providers will increase access to integrated women's health care for Veteran enrollees.

Montrose VAMC

- **Expand Home-Based Primary Care (HBPC) in the Hudson Valley region:** Demand for HBPC is projected to continue to increase. Expanding services will increase access to care.
- **Develop an adequate Veterans Community Care Program (VCCP) for inpatient medical and surgical subspecialties in the Hudson Valley region to offer services closer to Veterans' homes:** There are numerous provider practices affiliated with New York City-based systems that could offer additional opportunities throughout the entire Metro New York Market.
- **Expand and increase use of telehealth, particularly video-telehealth, between the Hudson Valley sites and the Bronx VAMC (Bronx County):** There is a substantial enrollee population in the rural counties of Orange, Dutchess, Putnam, and Sullivan in New York. Expanded telehealth will improve access to care for Veterans in these more rural counties.
- **Reduce the RRTP capacity at the Montrose VAMC (Westchester County):** Market demand for RRTP services is projected to decrease by 29.7% between FY 2019 and FY 2029. Reducing RRTP capacity from 104 to 30 beds at the Montrose VAMC will better address current and projected RRTP demand. This will include 20 General Domiciliary beds and 10 Domiciliary Care for Homeless Veterans (DCHV) beds.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 02 Metro New York Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA

Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[68] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational cost includes direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs includes direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five key domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate the Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI score is the preferred COA. The results of the CBA for the VISN 02 Metro New York Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 02 Metro New York Market	Status Quo	Modernization	VA Recommendation
Total Cost	$36,408,179,278	$34,593,706,448	$29,020,179,694
Capital Cost	$6,876,597,961	$5,062,125,130	$2,944,917,666
Operational Cost	$29,531,581,317	$29,531,581,317	$26,075,262,028
Total Benefit Score	7	10	14
CBI (normalized in $B)	**5.20**	**3.46**	**2.07**

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand
This recommendation is consistent with the Demand criterion, aligning 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.

[68] The present value cost is the current value of future costs discounted at the defined discount rate.

Demand

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 17 VA points of care offering outpatient services, including the proposed new Manhattan, New York partnership; the Middletown, New York MS CBOC; the Kings County, New York MS CBOC; the Fishkill, New York MS CBOC; the partnership in Brooklyn, New York; and the proposed replacement Harlem, New York CBOC; as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Montrose, New York VAMC; the St. Albans, New York VAMC; and the Bronx, New York VAMC; as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Bronx, New York VAMC.
- **RRTP:** RRTP demand will be met through the Montrose, New York VAMC, the proposed replacement St. Albans, New York VAMC, and the other facilities within VISN 02 offering RRTP, including the Lyons, New Jersey VAMC; the proposed replacement Albany, New York VAMC; the Canandaigua, New York VAMC; the Batavia, New York VAMC; and the RRTP at the proposed replacement Buffalo, New York VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01), the proposed new King of Prussia, Pennsylvania VAMC (VISN 04), and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the proposed new Manhattan, New York partnership; the Bronx, New York VAMC; and the proposed new Brooklyn, New York partnership, as well as through community providers. Inpatient mental health demand will be met through the Bronx, New York VAMC; the Montrose, New York VAMC; and the proposed new Manhattan, New York partnership, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 73,498 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 73,504 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 02. The recommendation allows for continued relationships with key academic partners, including but not limited to, the New York University (NYU), the State University of New York (SUNY) Health Science Center, Mount Sinai, New York-Presbyterian, the Hospital for Special Surgery, and New York Medical College.
- **Research:** This recommendation does not impact the research mission in the market and allows the Bronx, New York, VAMC to maintain the current mission; allows the Manhattan, New York VAMC to maintain the current research mission by ensuring there is adequate space to support research at the proposed new Manhattan, New York partnership to maintain existing programs; and relocates the research program currently at the Brooklyn VAMC to the closest appropriate VA site, such as the proposed new Manhattan, New York partnership or other facilities within VISN 02 as applicable.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency preparedness mission; the Primary Receiving Center designation will transition from the Brooklyn, New York VAMC to the proposed new Manhattan, New York partnership.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Manhattan, New York partnership; the Middletown, New York MS CBOC; the Kings County, New York MS CBOC; the Fishkill, New York MS CBOC; the Brooklyn, New York partnership; the proposed replacement Harlem, New York CBOC; and the proposed replacement St. Albans, New York VAMC; as well as the modernization of the CLC and inpatient medical, surgical, and mental health rooms at the Bronx, New York VAMC. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (2.07 for VA Recommendation versus 5.20 for Status Quo), indicating that VA Recommendation is more cost-effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Manhattan, New York partnership; the Middletown, New York MS CBOC; the Kings County, New York MS CBOC; the Fishkill, New York MS CBOC; the Brooklyn, New York partnership; the proposed replacement Harlem, New York CBOC; and the proposed replacement St. Albans, New York VAMC; as well as the modernization of the CLC and inpatient medical, surgical, and mental health rooms at the Bronx, New York VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff.
- **Reflects stewardship of taxpayer dollars:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($29.0B for VA Recommendation versus $34.6B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (2.07 for VA Recommendation versus 3.46 for Modernization), reflecting effective stewardship of taxpayer dollars.

VISN 02 New Jersey Market

The Veterans Integrated Service Network (VISN) 02 New Jersey Market serves Veterans in northern and central New Jersey. The recommendation includes justification for the proposed action, the results of the cost benefit analysis, and an overview of how the market recommendation is consistent with the MISSION Act Section 203 selection criteria.[69]

VA's Commitment to Veterans in the New Jersey Market

The Department of Veterans Affairs (VA) is committed to providing equitable Veteran access to safe and high-quality care and services in VISN 02's New Jersey Market. We will operate a high-performing integrated delivery network that provides access to VA care, supplemented by care provided by Federal partners, academic affiliates, and community providers.

Based on substantial data analysis, interviews with VISN and VA medical center (VAMC) leaders, consultation with senior VA leadership, and the input received from Veterans and stakeholders, VA has developed a recommendation designed to ensure that Veterans today and for generations to come have access to the high-quality care they have earned. The recommendation also makes sure that VA continues to execute on its additional missions: education and training, research, and emergency preparedness. As VA considers implementing any recommendation approved by the Asset and Infrastructure Review (AIR) Commission, implementation will be carefully sequenced so that facilities or partnerships to which care will be realigned are fully established before the proposed realignment occurs.

Market Strategy

The New Jersey Market's Veteran enrollment is projected to markedly decrease. Demand for inpatient acute care is projected to decrease, while demand for long-term care and outpatient services is projected to increase. VA will maintain inpatient acute services and modernize and rightsize community living center (CLC) and residential rehabilitation treatment program (RRTP) services at the VAMCs. Outpatient services will be expanded. The strategy for the market is intended to provide Veterans today and in the future with access to high-quality and conveniently located care in modern infrastructure. Key elements of the strategy are described below:

- **Provide equitable access to outpatient care through modern facilities close to where Veterans live and through the integration of virtual care:** VA's recommendation maintains all sustainable outpatient points of care in the market, and realigns and expands the Staten Island MS CBOC from the Metro New York Market to the New Jersey Market.
- **Enhance VA's unique strengths in caring for Veterans with complex needs:** VA's recommendation maintains sustainable inpatient mental health and CLC services at the East Orange and Lyons VAMCs. The recommendation also transfers inpatient spinal cord injuries and disorders (SCI/D) services from the East Orange VAMC to the Bronx VAMC to ensure access and

[69] Please see the Volume II Reading Guide for more information concerning the purpose of each Market Recommendation section and key definitions.

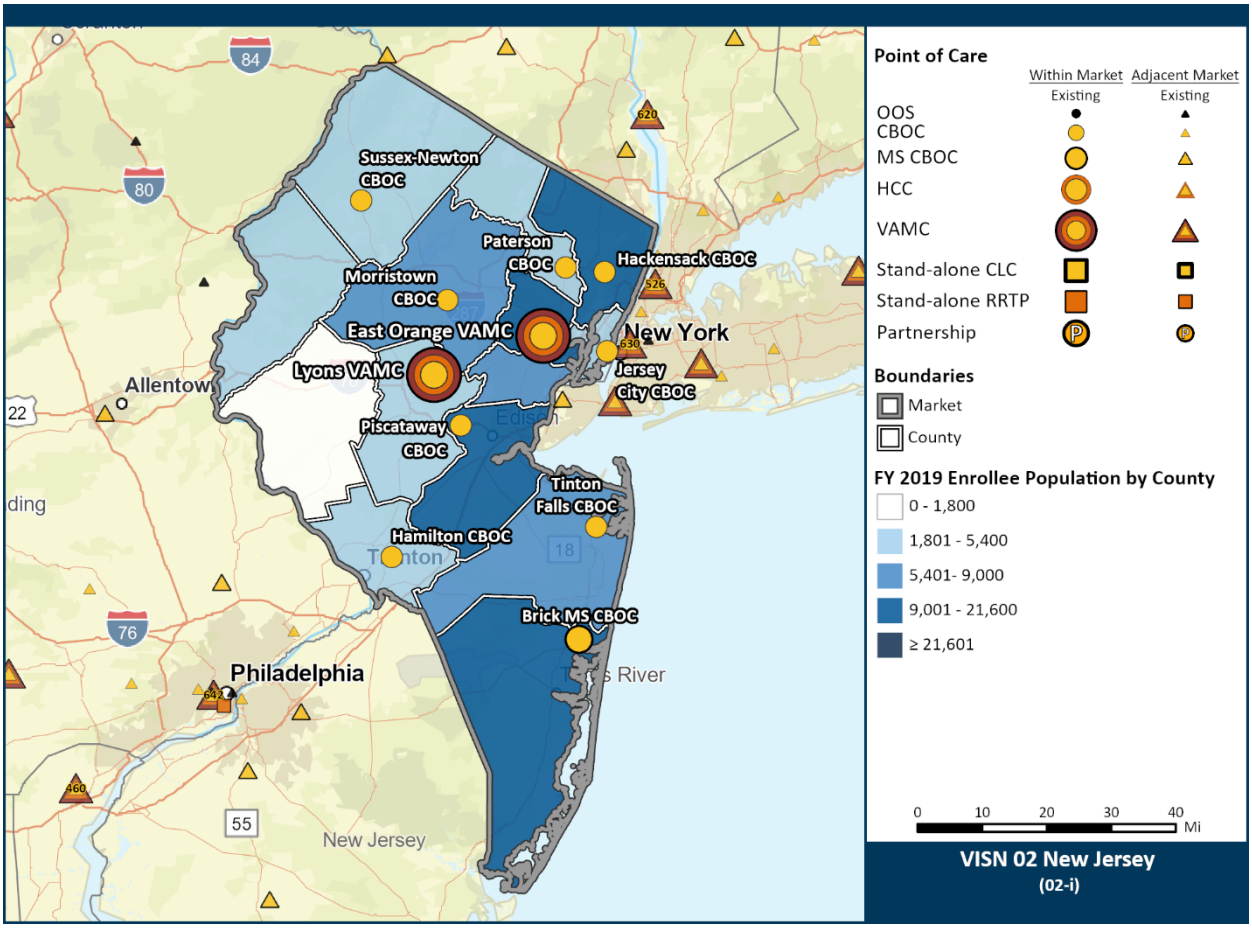
quality of care for Veterans. Demand for inpatient blind rehabilitation services will be met at the King of Prussia, Pennsylvania, VAMC (VISN 04).

- **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 recommendation maintains sustainable inpatient medical and surgical services at the East Orange VAMC.

Market Overview

The market overview includes a map of the New Jersey Market, key metrics for the market, and select considerations used in forming the market recommendation.

Market Map



Note: A partnership is a strategic collaboration between VA and a non-VA entity.

Facilities: The market has two VAMCs (East Orange and Lyons), one MS CBOC, and eight CBOCs.

Enrollees: In fiscal year (FY) 2019, the market had 89,584 enrollees and is projected to experience a 21.2% decrease in enrolled Veterans by FY 2029. The largest enrollee populations are in the counties of Ocean, Bergen, and Essex, New Jersey.

Demand: Demand[70] in the market for inpatient medical and surgical services is projected to decrease by 10.5% and demand for inpatient mental health services is projected to decrease by 8.6% between FY 2019 and FY 2029. Demand for long-term care[71] is projected to increase by 19.9%. Demand for all outpatient services,[72] including primary care, mental health, specialty care, dental care, and rehabilitation therapies, is projected to increase.

Rurality: 6.5% of enrollees in the market live in rural areas compared to the VA national average of 32.5%.

Access: 94.3% of enrollees in the market live within a 30-minute drive time of a VA primary care site and 82.3% of enrollees live within a 60-minute drive time of a VA secondary care site.

Community Capacity: As of 2019, community providers[73] in the market within a 60-minute drive time of the VAMCs had an average inpatient acute occupancy rate[74] of 74.8% (2,625 available beds)[75] and an average inpatient mental health occupancy rate of 73.0% (317 available beds). Community nursing homes within a 30-minute drive time of the VAMCs were operating at an average occupancy rate of 82.0% (1,599 available beds). Community residential rehabilitation programs[76] that match the breadth of services provided by VA are not widely available in the market.

Mission: VA has academic affiliations in the market that include Rutgers Health, Rutgers Robert Wood Johnson Medical School, and Hoboken University Medical Center. The East Orange VAMC is ranked 66 out of 154 training sites based on the number of trainees, and the Lyons VAMC has no training program. The East Orange VAMC is ranked 60 out of 103 VAMCs with research funding, and the Lyons VAMC conducts limited or no research. The East Orange VAMC has no emergency designation, and the Lyons VAMC is a Federal Coordinating Center.[77]

[70] Projected market demand for inpatient medical and surgical services is based on VA's Enrollee Health Care Projection Model (EHCPM) in bed days of care (BDOC).
[71] Projected market demand for inpatient Long-Term Services and Supports (LTSS) is based on VA's EHCPM in BDOC.
[72] Projected market demand for outpatient services is based on VA's EHCPM in relative value units (RVUs).
[73] Community providers include Veterans Community Care Program (VCCP) providers and potential VCCP providers.
[74] Occupancy rates are calculated by dividing the total average daily census (ADC) by the total number of operating beds. Beds at hospitals or nursing homes above the target occupancy rates are excluded.
[75] Available beds in the community are estimated using a target occupancy rate of 80% for hospitals and 90% for community nursing homes.
[76] Includes community residential rehabilitation programs similar to VA's RRTP, blind rehabilitation, and rehabilitative SCI/D services.
[77] VAMCs participating in the National Disaster Medical System are designated as Federal Coordinating Centers. Select Federal Coordinating Centers are also designated as Primary Receiving Centers.

Facility Overview

East Orange VAMC: The East Orange VAMC is located in East Orange, New Jersey, and offers inpatient medical and surgical, inpatient mental health, RRTP, SCI/D, and outpatient services. In FY 2019, the East Orange VAMC had an inpatient medical and surgical average daily census (ADC) of 34.3, an inpatient mental health ADC of 21.1, an RRTP ADC of 23.0, and a SCI/D ADC of 12.3.

The East Orange VAMC was built in 1950 on a 34.0-acre campus; three acres are available for additional development. The last major renovation was in 1985. Facility condition assessment (FCA) deficiencies are approximately $510.6M, and annual operations and maintenance costs are an estimated $13.3M. The ownership of the property the medical center occupies would revert to the donor if VA no longer used it for Veteran benefit.

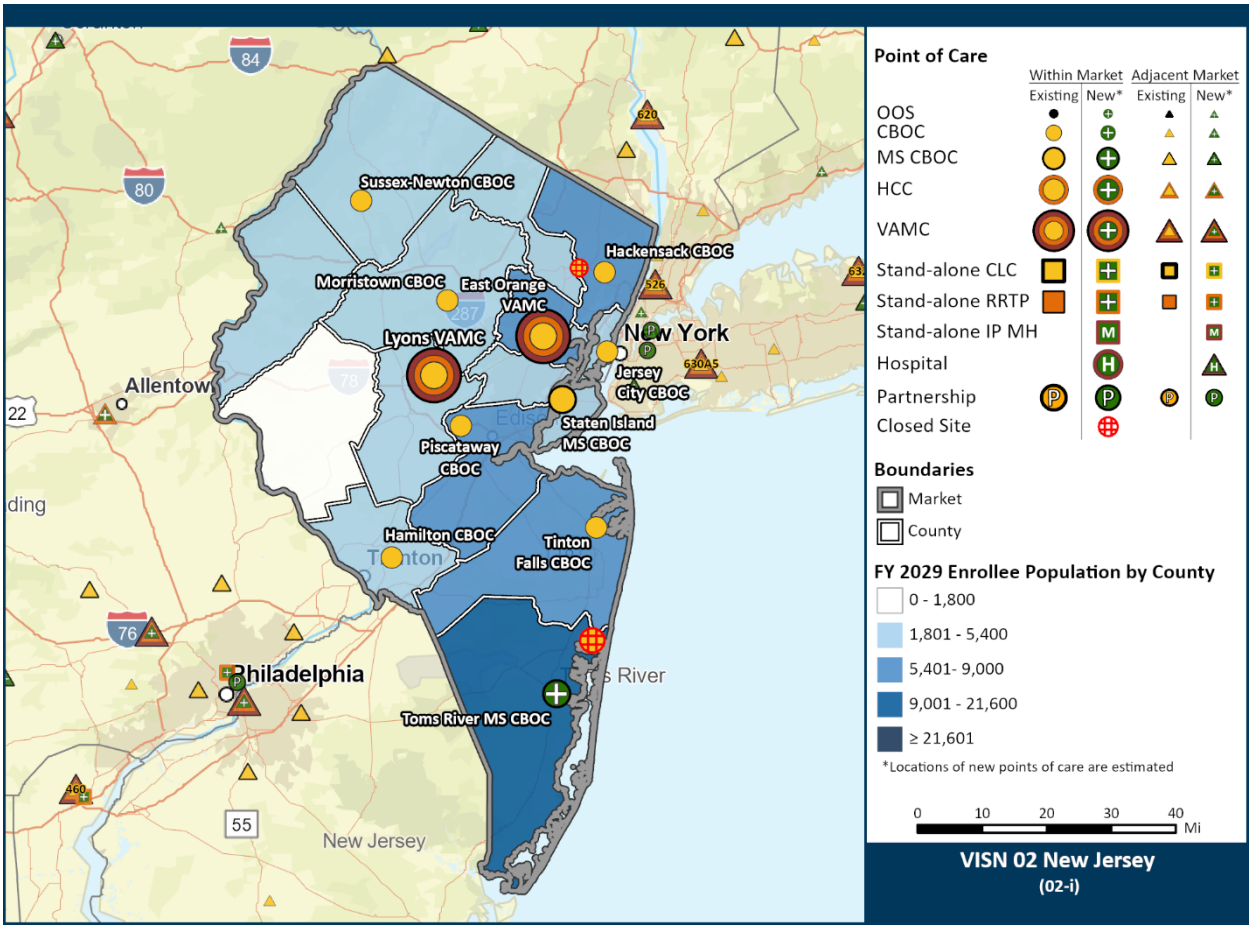
Lyons VAMC: The Lyons VAMC is located in Lyons, New Jersey, and offers inpatient mental health, CLC, RRTP, and outpatient services. In FY 2019, the Lyons VAMC had an inpatient mental health ADC of 26.9, a CLC ADC of 209.6, and an RRTP ADC of 132.9.

The Lyons VAMC was established in 1930, and the main patient care facility was built in 1997. On the 304.1-acre campus, 50 acres are available for additional development. FCA deficiencies are approximately $269.7M, and annual operations and maintenance costs are an estimated $16.0M.

Recommendation and Justification

This section details the VISN 02 New Jersey Market recommendation and justification for each element of the recommendation.

Future Market Map



1. ***Modernize and realign the East Orange VAMC by relocating SCI/D services from the East Orange VAMC to current or future VA facilities and discontinuing these services at the East Orange VAMC:*** Between FY 2019 and FY 2029 SCI/D demand in the New Jersey Market is projected to decrease 4.1% from 9.9 to 9.5. During the same time period, SCI/D demand in the Metro New York Market is projected to decrease by 31.0% from 21.3to 14.7. In FY 2019, there were 28 SCI/D beds at the East Orange VAMC with an ADC of 12.3, and there were 48 SCI/D beds at the Bronx VAMC with an ADC of 29.9. The East Orange VAMC is located approximately 41 minutes (25.8 miles) from the Bronx VAMC in the Metro New York Market. Due to the decline of SCI/D services throughout both markets and facilities, consolidating this service into a new state-of-the-art facility in the Bronx VAMC creates a sustainable SCI/D program in the region.

2. ***Modernize and realign the Lyons VAMC by modernizing the RRTP and CLC at the Lyons VAMC:*** The Lyons VAMC will operate all RRTP beds for the New Jersey Market. As the FY 2028 projected market level RRTP ADC is 35.4 beds, rightsizing the Lyons VAMC from a 138-bed to a 40-bed, modernized facility will meet current and projected demand. This will include 20 General Domiciliary beds, 10 Domiciliary Care for Homeless Veterans (DCHV) beds, and 10 substance use disorder (SUD) beds.

   In FY 2019, the Lyons VAMC had 264 CLC beds with an ADC of 209.6. There are two active minor CLC-related projects at Lyons VAMC in process that will update the facility to single beds units. Continuing with plans to modernize the unit and create private rooms will increase quality and patient satisfaction.

3. ***Modernize and realign outpatient facilities in the market by relocating all services to the Hackensack CBOC and closing the Paterson CBOC:*** In FY 2019, the Paterson CBOC served 1,385 core uniques,[78] a 17.4% decrease in core uniques since FY 2015. Additionally, enrollment in Passaic County, where the Paterson CBOC is located, is projected to decrease by 19.4%, from 5,176 enrollees in FY 2019 to 4,171 in FY 2029.The Hackensack CBOC, an estimated eight miles away, will offer Veterans access to care.

Complementary Strategy

In addition to the recommendation submitted for AIR Commission approval, VA also anticipates implementing a complementary strategy that supports a high-performing integrated delivery network:

New Jersey Market

- **Realign the Staten Island MS CBOC (Staten Island County) from the Metro New York Market to the VISN 02 New Jersey Market:** Staten Island is located between the New Jersey Market and the Southeast Metro New York submarket. The bulk of the Veteran population lives on the west side of Staten Island, which is closer to New Jersey. Veterans are currently being sent to the Brooklyn VAMC for complex care, but the proposed Brooklyn MS CBOC will optimally be more centrally located in Brooklyn, farther from Staten Island. Realigning the Staten Island CBOC to the New Jersey Market will shift care to the more proximate location for these enrollees.

East Orange VAMC

- **Construct a new MS CBOC in Toms River, New Jersey (Ocean County) (in progress):** Ocean County has the highest number of enrollees in the New Jersey Market. In FY 2019, the Brick MS CBOC had 26,431 primary care encounters, the highest number of primary care encounters out of the market's MS CBOCs and CBOCs. Replacing the Brick MS CBOC with the Toms River MS CBOC will increase access to care in a region of the market that has the most Veteran population. The project is currently in progress.
- **Expand outpatient mental health services at the Staten Island MS CBOC (Staten Island County):** Expanding mental health services will allow better integration of care for Veterans.

[78] VA core unique patients exclude Veterans who have used only VA telephone triage, pharmacy, and laboratory services.

Lyons VAMC

- **Develop a demand analysis for an expanded geropsychiatry program at Lyons VAMC (Somerset County):** The Lyons VAMC currently provides geropsychiatry as part of its inpatient mental health. As the aging population may demand more services, a demand analysis will help determine the service needs for the enrollee population.

Cost Benefit Analysis

The Cost Benefit Analysis (CBA) evaluated the costs and benefits of three courses of action (COAs) for the VISN 02 New Jersey Market: Status Quo, Modernization, and VA Recommendation. Status Quo includes costs associated with FCA deficiencies and represents no significant change in capital and operational costs. Modernization seeks to modernize all existing health care infrastructure. The VA Recommendation implements the market recommendation and seeks to modernize any remaining health care infrastructure.

- **Costs:** The present value cost[79] over a thirty-year period was calculated for each COA, inclusive of capital and operational costs. The capital cost includes costs associated with construction of new facilities, modernization of current facilities, leases, land acquisition, and demolition. VA operational costs included direct costs (e.g., medical service costs), indirect costs (e.g., administrative costs), and VA special direct costs (e.g., suicide prevention coordinators). Non-VA care costs include direct costs (e.g., payments for patient care), indirect costs (e.g., care coordination), overhead costs (e.g., national program costs), and administrative per member per month costs (e.g., third party administration of the Community Care Network).
- **Benefits:** Benefits were evaluated based on five domains: Demand and Supply, Access, Facilities and Sustainability, Quality, and Mission.

The CBA leveraged both the costs and benefits to generate the Cost Benefit Index (CBI) – a simple metric used to compare the costs and benefits associated with each COA. The COA with the lowest CBI score is the preferred COA. The results of the CBA for the VISN 02 New Jersey Market are provided in the following table. For more detailed information on the market CBA, please see Appendix H.

VISN 02 New Jersey Market	Status Quo	Modernization	VA Recommendation
Total Cost	$16,689,591,615	$16,800,093,933	$16,686,713,543
Capital Cost	$2,731,243,313	$2,841,745,631	$2,728,365,241
Operational Cost	$13,958,348,302	$13,958,348,302	$13,958,348,302
Total Benefit Score	8	11	14
CBI (normalized in $B)	**2.09**	**1.53**	**1.19**

[79] The present value cost is the current value of future costs discounted at the defined discount rate.

Note: Operational costs are shifted from VA to non-VA care only when a service line is relocated in totality to non-VA care at the parent facility level. Total cost is a sum of operational and capital costs rounded to the nearest dollar.

Section 203 Criteria Analysis

This section provides an overview of how this market recommendation is consistent with the Section 203 decision criteria as required by the MISSION Act. For more detailed information, please see Appendix I.

Demand

This recommendation is consistent with the Demand criterion, aligning 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.

- **Summary:** Following implementation of the recommendation, the capacity available through VA facilities and community providers would be able to support 100% of the projected enrollee demand.
- **Outpatient:** Outpatient demand will be met through 11 VA points of care offering outpatient services, including the proposed new Toms River, New Jersey MS CBOC, as well as community providers in the market.
- **CLC:** Long-term care demand will be met through the Lyons, New Jersey VAMC, as well as community nursing homes.

The recommendation ensures that projected demand for SCI/D, RRTP, and blind rehabilitation is sufficiently met through VA-only capacity in the respective VISN or blind rehabilitation region.

- **SCI/D:** Demand for inpatient SCI/D will be met through the SCI/D Hub at the Bronx, New York VAMC (VISN 02).
- **RRTP:** RRTP demand will be met through the Lyons, New Jersey VAMC and the other facilities within VISN 02 offering RRTP, including the proposed replacement St. Albans, New York VAMC; the Montrose, New York VAMC; the proposed replacement Albany, New York VAMC; the Canandaigua, New York VAMC; the Batavia, New York VAMC; and the RRTP at the proposed replacement Buffalo, New York VAMC.
- **Blind rehabilitation:** Inpatient blind rehabilitation demand will be met through the facilities in the Northeast Region, including the West Haven, Connecticut VAMC (VISN 01), the proposed new King of Prussia, Pennsylvania VAMC (VISN 04), and the Cleveland, Ohio VAMC (VISN 10).
- **Inpatient acute:** Inpatient medicine and surgery demand will be met through the East Orange, New Jersey VAMC, as well as through community providers; inpatient mental health demand will be met through the Lyons, New Jersey VAMC and the East Orange, New Jersey VAMC, as well as through community providers.

Access

This recommendation is consistent with the Access criterion, maintaining or improving Veteran access to care in the market and providing Veterans the opportunity to choose the care they trust throughout their lifetime. The Access criterion evaluates enrollee access to care in the current and proposed future state across multiple service lines. It is evaluated for both the overall enrollee population as well as for specific subpopulations of enrollees that traditionally face barriers to receiving appropriate care, including minority enrollees, enrollees over 65, women enrollees, rural enrollees, and enrollees living in disadvantaged neighborhoods. Below are the access results for both primary care and specialty care among the overall enrollee population.

- **Access to primary care:** Following implementation of the recommendation, the number of enrollees within 30 minutes of primary care available through VA facilities and community providers is projected to be maintained, with 71,362 enrollees within 30 minutes of primary care in the future state.
- **Access to specialty care:** Following implementation of the recommendation, the number of Veterans within 60 minutes of specialty care available through VA facilities and community providers is projected to be maintained, with 71,380 enrollees within 60 minutes of specialty care in the future state.

Mission

This recommendation is consistent with the Mission criterion, providing for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.

- **Education:** The recommendation for this market supports VA's ability to maintain its education mission in VISN 02. The recommendation allows for continued relationships with key academic partners, including but not limited to, the affiliation with Rutgers Health, Rutgers Robert Wood Johnson Medical School, and Hoboken University Medical Center.
- **Research:** This recommendation does not impact the research mission in the market and allows the East Orange, New Jersey VAMC to maintain the current research mission.
- **Emergency preparedness:** This recommendation maintains VA's ability to execute its emergency mission; no VAMCs in this market are designated as Primary Receiving Centers.

Quality

This recommendation is consistent with the Quality criterion, considering the quality and delivery of health care services available to Veterans in the market, including the experience, safety, and appropriateness of care.

- **Quality among providers:** The recommendation ensures that all providers included within the high-performing integrated delivery network meet the established quality standards by provider type (outlined in Appendix E).
- **Quality improvements through new infrastructure:** Quality is improved through the proposed new Toms River, New Jersey MS CBOC, as well as the modernization of the CLC and RRTP at the Lyons, New Jersey VAMC. This new infrastructure will aid in improving the patient experience with care delivery provided in modern spaces and aid in the recruitment of staff with facilities offering the latest technology.
- **Promoting recruitment of top clinical and non-clinical talent:** The recommendation maintains VA's academic and non-academic partnerships, which supports the recruitment and retention of top clinical and non-clinical talent.

Cost Effectiveness

This recommendation is consistent with the Cost Effectiveness criterion, providing a cost-effective means by which to provide Veterans with modern health care. The Cost Effectiveness criterion was assessed through a CBA summarized in the CBA section and detailed in Appendix H.

- **CBI:** The CBI is the primary metric for cost effectiveness. The CBI for the VA Recommendation COA is lower than the Status Quo COA (1.19 for VA Recommendation versus 2.09 for Status Quo), indicating that VA Recommendation is more cost-effective than the Status Quo.

Sustainability

This recommendation is consistent with the Sustainability criterion, creating a sustainable health care delivery system for Veterans. It ensures that the health care delivery system proposed for the market is aligned with future demand, allowing it to sustainably operate and provide a safe and welcoming health care environment that meets modern health care standards.

- **Aligns investment in care and services with projected Veteran care needs:** All facilities in the future state of this market meet the minimum demand threshold to support sustainable services.
- **Sustainability improvements through new infrastructure:** Within this recommendation, sustainability is improved through the proposed new Toms River, New Jersey MS CBOC, as well as the modernization of the CLC and RRTP at the Lyons, New Jersey VAMC. This new infrastructure modernizes VA facilities to include state-of-the-art equipment that will aid in the recruitment of providers and support staff.
- **Value:** The cost of the market recommendation is less than the cost to modernize facilities in the market today ($16.7B for VA Recommendation versus $16.8B for Modernization). In addition, there are benefits realized through the market recommendation in at least one of the five domains assessed by the CBA that are not realized through the modernization approach. As a result, the CBI score for the VA Recommendation COA is lower than the Modernization COA (1.19 for VA Recommendation versus 1.53 for Modernization), reflecting effective stewardship of taxpayer dollars.