VA Recommendations to the

ASSET AND INFRASTRUCTURE REVIEW COMMISSION

March 2022

Appendix E

Section 203 Criteria Methodology

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Executive Summary

Section 203 of the MISSION Act required the Department of Veterans Affairs (VA) to develop criteria to be used by the Secretary to make recommendations for the modernization or realignment of Veterans Health Administration (VHA) facilities. As required by the law and to make sure the criteria reflected insights from Veterans and other key stakeholders, VA took steps to ensure that both the public and Veteran Service Organizations (VSOs) had the opportunity to provide input on the development of the criteria. Draft criteria were published online on February 1, 2021, and published in the Federal Register on February 2, 2021 to allow for 90 days of public comment. In addition, VA held a series of meetings with both VSOs and Community Veterans Engagement Boards (CVEBs) to receive input on the criteria. Final criteria were published May 28, 2021.

The Section 203 criteria were used to evaluate the future state high-performing integrated delivery network (HPIDN) recommendations across six domains: Access, Demand, Quality, Mission, Cost Effectiveness, and Sustainability. VA identified key measures aligned to the sub-criteria underlying each domain. An analysis was performed at scale to evaluate if the holistic recommendation for each market was consistent with the criteria. Recommendations determined to be inconsistent with the criteria required adjustment. All recommendations submitted by the Secretary were determined to be consistent with the Section 203 criteria.

This document outlines the methodology used to evaluate the consistency of the recommendations with the Section 203 criteria.

Access

Background

The Access domain has one main criterion and six sub-criteria, as shown below.

Criterion	Sub-criteria:
The recommendation maintains or improves Veteran access to care.	1. *Aligns VA points of care and services with projected Veteran need across demographics and geography* 2. *Ensures Veterans are provided a range of integrated health care options and the opportunity to choose the care they trust throughout their lifetime* 3. *Enables VA to serve as the coordinator of each Veteran's health care, whether provided within or beyond VA* 4. *Considers health equity, defined as the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality* 5. *Reflects consideration of factors underpinning observed access patterns regarding conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health functioning, and quality-of-life outcomes and risks* 6. *Incorporates trends in the evolution of U.S. health care*

Access Approach

The access criterion and associated sub-criteria assess the impact recommendations have on Veteran access to care provided by the HPIDN, which includes VA and community providers meeting specific quality criteria.

Access Sub-criteria 1 – 5

The following measure determines if the recommendation passes sub-criteria 1-5 for all service lines except Blind Rehabilitation, Residential Rehabilitation Treatment Program (RRTP), and Spinal Cord Injury and Disorder (SCI/D).

% of projected enrollees within XX-minute drive time (Future State per VA recommendation)*	*≥*[1]	*% of projected enrollees within XX-minute drive time* (Current State or Status Quo)*

*Table 1 shows the drive time standard by service line
[1]A failure occurs if the tens place percentage decreases by one percentage point or more
Note: Excludes Blind Rehabilitation, RRTP, and SCI/D

Sub-criteria 1-3 focus on access to care for the entire Veteran enrollee population, while sub-criteria 4-5 evaluate if the recommendation equitably impacts access to care for subpopulations who have historically experienced barriers accessing care. Working with the Office of Health Equity, VA determined that access to care for select enrollee subpopulations should be measured to assess sub-criteria 4-5:

- 65-and-older enrollees

- Women enrollees
- Rural enrollees
- Enrollees living in disadvantaged neighborhoods
- Minority enrollees
- High service-connected disability rating enrollees

To pass, the future state recommendation must maintain or improve the percentage (based on the tens place) of enrollees within the drive time compared to the current state across all population cohorts. The recommendation fails if the percentage of enrollees decreases by one percentage point or more, when compared to the current state.

Blind Rehabilitation, RRTP, and SCI/D do not have a MISSION Act drive time standard. These services draw enrollees from larger regions as opposed to drive time catchments. For a recommendation to pass, VA capability for these services must continue to exist in the VISN's future state if it existed in the VISN's current state.

Access Sub-criterion 6

Sub-criterion 6 measures if the recommendation incorporates trends in the evolution of U.S. health care. To pass, the recommendation must incorporate at least one trend from any of the 203 domains (i.e., Access, Demand, Quality, Sustainability, Cost, and Mission). Below is the subset of trends from the full trend menu related to the Access domain.

- Forms partnerships/alliances to maximize health care access? (Y/N)
- Considers patient centricity: Leverages Veteran residential location to optimize future state facility locations? (Y/N)
- Leverages telehealth to expand access in rural areas? (Y/N)

Access Assumptions

Enrollee Demographics

- Enrollees Living in Disadvantaged Neighborhoods: Veteran enrollees living in census block groups with an Area Deprivation Index of 70th percentile or greater live in disadvantaged neighborhoods. The Area Deprivation Index (ADI) is a multidimensional evaluation of a region's socioeconomic conditions. ADI scores have been linked to health outcomes (Andrew R. Maroko, et al., 2016).
- Minority Enrollees: Veteran enrollees who self-identify as having a race other than white or having Hispanic / Latino ethnicity.
- High Service-connected Disability Rating Enrollees: Veterans enrolled in Priority Group 1 have a high service-connected disability rating. VA defines Priority Group 1 Veterans as having a service-connected disability that VA rates as 50% or more disabling, or that VA has concluded makes one unable to work (VA, 2021).

Population Projections

- The distribution of enrollees at the county level will remain the same in the future (FY29); however, enrollee populations in each county will grow or decline in alignment with the Enrollee

Health Care Projection Model (EHCPM) change rate. This approach accounts for projected population change when comparing access to care in the current and future state.

Provider Inclusion / Exclusion

- Within 10 years the Veterans Community Care Program (VCCP) will grow to include providers who meet the quality criteria detailed in Table 4.
- Within 10 years there will be limited RRTP, SCI/D, and Blind Rehabilitation community providers added to the VCCP, as community providers offer only a portion of the full continuum of care offered by each VA facility.
- The distribution of advanced practice practitioners (APP) across certification areas will be maintained in the future. Nurse Practitioners' (NPs) and Physician Assistants' (PAs) specialty assignments are based on historical distribution across primary certification areas. The respective distributions for NPs come from the American Association of Nurse Practitioners (American Association of Nurse Practitioners, 2021). The respective distributions for PAs come from the National Commission on Certification of Physicians Assistants (National Commission on Certification of Physicians Assistants, 2017).

Service Offerings at New or Upgraded VA Facilities

- The approach assumes that specialty care services offered at new or upgraded Multi-specialty Community-based Outpatient Clinics (MS CBOC) and Health Care Centers (HCC) will align with the specialty assignments outlined by VA central offices responsible for the oversight of each service line. To determine outpatient specialties offered at new or upgraded facilities, the count of enrollees within a 60-minute drive time is used. These specialties were then mapped to a corresponding 203 Specialty Output Group to determine the services offered in the future state.

CBOC: 0 On-Site Specialties
  - Primary Care
  - Mental Health

Small MS CBOC (≥ 4,300 enrollees within 60 minutes): 2-3 Total Specialties
  - Optometry
  - Audiology
  - Physical Therapy

Medium MS CBOC (≥ 7,300 enrollees within 60 minutes): 4-5 Total Specialties. In addition to Small MS CBOC specialties, Medium MS CBOCs include the following:
  - Podiatry
  - Critical Care/Pulmonology
  - Dermatology
  - Cardiology
  - Ophthalmology

Large MS CBOC (≥ 8,600 enrollees within 60 minutes): 6-8 Total Specialties. In addition to Small and Medium MS CBOC specialties, Large MS CBOCs include the following:

- Dental
- Orthopedics
- Urology
- Endocrinology
- Surgery
- Gastroenterology

HCC (≥ 34,000 enrollees within 60 minutes): 9-23 Total Specialties. In addition to the Large MS CBOC specialties, HCCs include the following:

- Specialties assigned to the "Outpatient Surgical Specialty / Outpatient Surgery" 203 Specialty Output Group as defined in Table 2.

VAMC:

- All specialties

Definitions and Mapping

HPIDN Quality Inclusion / Exclusion Criteria

Table 1 outlines the current and future state definitions of the HPIDN. The current HPIDN includes all VA facilities in the current state, plus facilities/providers in the VCCP. The future state definition of the HPIDN includes all VA facilities in the future state, plus facilities/providers in the VCCP, plus any facilities/providers which meet the quality criteria outlined in Table 1.

Table 1: HPIDN Criteria for Current and Future State

Service Line (Drivetime)	HPIDN Current State Definition	HPIDN Future State Definition
Inpatient Medicine (IP Med) (60m)	All VA VAMCs, VCCP short-term acute and critical access hospitals	All VA VAMCs, VCCP facilities, and non-VCCP active short-term acute and critical access hospitals with 3-star-plus Centers for Medicare & Medicaid Services (CMS) Hospital Compare rating, The Joint Commission (TJC) accreditation, and readmission rates less than 20% for two out of three years (2017-2019)
Inpatient Surgery (IP Surg) (60m)	All VA VAMCs, VCCP short-term acute and critical access hospitals	All VA VAMCs, VCCP facilities, and non-VCCP active short-term acute and critical access hospitals with 3-star-plus CMS Hospital Compare rating, TJC accreditation, and readmission rates less than 20% for two out of three years (2017-2019)
Inpatient Mental Health (IP MH) (60m)	All VA VAMCs, VCCP short-term acute and critical access hospitals with psychiatric beds, and VCCP psychiatric hospitals	All VA VAMCs, VCCP facilities with psychiatric beds, and non-VCCP active short-term acute and critical access hospitals with 3-star-plus CMS Hospital Compare rating, TJC accreditation, and readmission rates less than 20% for two out of three years (2017-2019) that have psychiatric beds, and TJC accredited psychiatric hospitals

Service Line (Drivetime)	HPIDN Current State Definition	HPIDN Future State Definition
Inpatient Community Living Center (IP CLC) (30m urban) * (60m rural) *	All VA CLCs and VCCP Skilled Nursing Facilities (SNFs) and State Veterans Homes	All VA CLCs, VCCP SNFs and State Veterans Homes, and non-VCCP active SNFs with 3-star-plus overall rating, or 2-star-plus overall rating with 4-star-plus quality rating per Nursing Home Compare
Inpatient Residential Rehabilitation Treatment Program (IP RRTP) (VISN)	All VA RRTPs	All VA RRTPs
Inpatient Blind Rehab (IP BR) (VISN)	Al VA Blind Rehab Centers	Al VA Blind Rehab Centers
Inpatient Spinal Cord Injuries and Disorders (IP SCI/D) (VISN)	All VA SCI/D Centers	All VA SCI/D Centers
Primary Care (PC) (30m)	All VA PC providers and VCCP PC Providers	All VA PC providers, VCCP PC Providers, and non-VCCP PC providers who participate in the CMS Merit Incentive-based Payment System (MIPS). Note: MIPS participation only applied when a specialty has significant participation (1,000 or more providers). NPs/PAs included regardless of MIPS participation.
Mental Health (MH) (30m)	All VA MH providers and VCCP MH Providers	All VA MH providers, VCCP MH Providers, and non-VCCP MH providers who participate in MIPS. Note: MIPS participation only applied when a specialty has significant participation (1,000 or more providers). NPs/PAs included regardless of MIPS participation.
Emergency Department / Urgent Care (ED/UC) (60m)	All VA and VCCP ED/UC providers	All VA, VCCP ED/UCs, and non-VCCP ED/UC providers who participate in MIPS. Note: MIPS participation only applied when a specialty has significant participation (1,000 or more providers). NPs/PAs included regardless of MIPS participation.
Outpatient Surgery (OP Surg) (60m)	All VA providers with surgical capability and VCCP surgical providers	All VA providers with surgical capability, VCCP surgical providers, and non-VCCP surgical providers who participate in MIPS. Note: MIPS participation only applied when a specialty has significant participation (1,000 or more providers). NPs/PAs included regardless of MIPS participation.
Outpatient Specialist Medical (OP Spec Med) (60m)	All VA and VCCP medical providers	All VA medical providers, VCCP medical providers, and non-VCCP medical providers who participate in MIPS. Note: MIPS participation only applied when a specialty has significant participation (1,000 or more providers). NPs/PAs included regardless of MIPS participation.
Outpatient Specialist Surgery (OP Spec Surg)	All VA and VCCP surgical providers	All VA surgical providers, VCCP surgical providers, and non-VCCP surgical providers who participate in MIPS. Note: MIPS participation only applied when a specialty has significant participation (1,000 or more providers). NPs/PAs included regardless of MIPS participation.

Service Line (Drivetime)	HPIDN Current State Definition	HPIDN Future State Definition
Outpatient Specialist Rehab (OP Spec Rehab)	All VA specialty rehabilitation providers and VCCP surgical providers	All VA specialty rehabilitation providers, VCCP specialty rehabilitation providers, and non-VCCP specialty rehabilitation providers who participate in MIPS. Note: MIPS participation only applied when a specialty has significant participation (1,000 or more providers). NPs/PAs included regardless of MIPS participation.

*VA CLC sites use the Rural Urban Commuting Area (RUCA) code associated with site's zip codes to determine rurality classification. Existing site is based on VHA Site Tracking System (VAST) data. Newly proposed sites with RUCA codes of 1 and 1.1 receive urban classification. Sites with any other code receive rural classification. Community site rurality classification is based on the geographic classification provided in the Definitive Healthcare database of skilled of nursing facilities.

Outpatient Specialty Mapping Across VA and Community

VA and community provider data sources do not use the same specialty nomenclature. Table 2 details the mapping of specialties from VA to community, and to their ultimate 203 Specialty Output Group.

Table 2: Provider Specialty Mapping

VA Specialty	Community Specialty	203 Specialty Output Group
Primary Care	Internal Medicine	Outpatient Primary Care
Primary Care	Adult Medicine	Outpatient Primary Care
Primary Care	Preventive Medicine	Outpatient Primary Care
Primary Care	Family Practice	Outpatient Primary Care
Primary Care	General Practice	Outpatient Primary Care
Primary Care	Geriatric Medicine	Outpatient Primary Care
Mental Health	Psychiatry	Outpatient Mental Health
Mental Health	Psychiatry - Addiction	Outpatient Mental Health
Mental Health	Psychotherapist	Outpatient Mental Health
Mental Health	Therapist	Outpatient Mental Health
Mental Health	Psychiatry - Geriatric Psychiatry	Outpatient Mental Health
Mental Health	Psychiatry - Neuropsychiatry	Outpatient Mental Health
Mental Health	Psychology - Clinical Neuropsychologist	Outpatient Mental Health
Mental Health	Psychiatry - Forensic	Outpatient Mental Health
Mental Health	Psychology - Clinical Psychologist	Outpatient Mental Health
Mental Health	Psychology - Psychologist	Outpatient Mental Health
Mental Health	Social Worker	Outpatient Mental Health
Mental Health	Clinical Social Worker	Outpatient Mental Health
Mental Health	Psychosomatic Medicine	Outpatient Mental Health
Mental Health	Addiction Medicine	Outpatient Mental Health

VA Specialty	Community Specialty	203 Specialty Output Group
Mental Health	Social Worker - Licensed Graduate Social Worker	Outpatient Mental Health
Mental Health	Social Worker - Licensed Clinical Social Worker	Outpatient Mental Health
Emergency Department / Urgent Care	Emergency Medicine	Outpatient Emergency Department / Urgent Care
Allergy and Immunology	Allergy/Immunology	Outpatient Medical Specialty
Cardiology	Cardiology - Cardiac Electrophysiology	Outpatient Medical Specialty
Cardiology	Cardiology - Interventional Cardiology	Outpatient Medical Specialty
Cardiology	Cardiology - Cardiologist	Outpatient Medical Specialty
Cardiology	Cardiology - Peripheral Vascular Disease	Outpatient Medical Specialty
Cardiology	Cardiology - Cardiac Surgery	Outpatient Medical Specialty
Chiropracty	Chiropractic	Outpatient Medical Specialty
Critical Care / Pulmonary Disease	Critical Care (Intensivists)	Outpatient Medical Specialty
Critical Care / Pulmonary Disease	Pulmonary Disease	Outpatient Medical Specialty
Dermatology	Dermatology	Outpatient Medical Specialty
Emergency Medicine	Emergency Medicine	Outpatient Medical Specialty
Endocrinology	Endocrinology	Outpatient Medical Specialty
Endocrinology	Endocrinology - Reproductive	Outpatient Medical Specialty
Gastroenterology	Gastroenterology	Outpatient Medical Specialty
Hematology-Oncology	Oncology - Gynecological/Oncology	Outpatient Medical Specialty
Hematology-Oncology	Oncology - Hematology/Oncology	Outpatient Medical Specialty
Hematology-Oncology	Oncology - Medical Oncology	Outpatient Medical Specialty
Hematology-Oncology	Hematology	Outpatient Medical Specialty
Infectious Disease	Infectious Disease	Outpatient Medical Specialty
Nephrology	Nephrology	Outpatient Medical Specialty
Neurology	Neurology	Outpatient Medical Specialty
Optometry	Optometry	Outpatient Medical Specialty
Pain Medicine	Pain Management	Outpatient Medical Specialty
Pain Medicine	Pain Management - Interventional Pain Management	Outpatient Medical Specialty
Physical Medicine & Rehabilitation	Physical Medicine and Rehabilitation	Outpatient Medical Specialty
Rheumatology	Rheumatology	Outpatient Medical Specialty
Audiology	Audiologist	Outpatient Rehab Specialty
Occupational Health	Occupational Medicine	Outpatient Rehab Specialty
Occupational Health	Therapy - Occupational Therapy Assistant	Outpatient Rehab Specialty

VA Specialty	Community Specialty	203 Specialty Output Group
Occupational Health	Therapy - Occupational Therapist	Outpatient Rehab Specialty
Physical Medicine & Rehabilitation	Therapy - Physical Therapist	Outpatient Rehab Specialty
Speech Pathology	Therapy - Speech Language Pathologist	Outpatient Rehab Specialty
Neurological Surgery	Surgery - Neurosurgery	Outpatient Surgical Specialty / Outpatient Surgery
Obstetrics & Gynecology	Obstetrics/Gynecology	Outpatient Surgical Specialty / Outpatient Surgery
Obstetrics & Gynecology	Obstetrics/Gynecology - Maternal & Fetal Medicine	Outpatient Surgical Specialty / Outpatient Surgery
Orthopaedic Surgery	Surgery - Orthopedic Surgery	Outpatient Surgical Specialty / Outpatient Surgery
Orthopaedic Surgery	Surgery - Orthopedic Spine Surgery	Outpatient Surgical Specialty / Outpatient Surgery
Otolaryngology	Surgery - Otolaryngology/Facial Plastic Surgery	Outpatient Surgical Specialty / Outpatient Surgery
Otolaryngology	Otolaryngology	Outpatient Surgical Specialty / Outpatient Surgery
Plastic Surgery	Surgery - Plastic and Reconstructive Surgery	Outpatient Surgical Specialty / Outpatient Surgery
Podiatry	Surgery - Foot and Ankle	Outpatient Surgical Specialty / Outpatient Surgery
Podiatry	Podiatry	Outpatient Surgical Specialty / Outpatient Surgery
Surgery	Surgery - Trauma	Outpatient Surgical Specialty / Outpatient Surgery
Surgery	Surgery - General Surgery	Outpatient Surgical Specialty / Outpatient Surgery
Surgery	Surgery - Colorectal Surgery (formerly proctology)	Outpatient Surgical Specialty / Outpatient Surgery
Surgery	Surgery - Surgical Oncology	Outpatient Surgical Specialty / Outpatient Surgery
Thoracic Surgery	Surgery - Thoracic Surgery	Outpatient Surgical Specialty / Outpatient Surgery
Urology	Urology	Outpatient Surgical Specialty / Outpatient Surgery
Vascular Surgery	Surgery - Vascular Surgery	Outpatient Surgical Specialty / Outpatient Surgery
Ophthalmology	Ophthalmology	Outpatient Surgical Specialty / Outpatient Surgery

Demand

Background

The Demand domain has one main criterion and three sub-criteria, as shown below.

Criterion	Sub-criteria:
The recommendation aligns VA's high performing integrated network resources to effectively meet the future health care demand of the Veteran enrollee population with the capacity in the Market.	1. *Aligns the quality and delivery of integrated care and services with projected Veteran demand across demographics and geography* 2. *Retains or improves VA's ability to meet projected demand* 3. *Incorporates trends in the evolution of U.S. health care*

Demand Approach

Demand Sub-criteria 1-2

The measure for sub-criteria 1-2 assesses if the HPIDN's capacity sufficiently meets projected Veteran demand per the 10-year EHCPM. Recommendations were assessed at the market, VISN, and Blind Rehabilitation Region level depending on the service line analyzed. The inpatient measure unit is bed days of care (BDOC), while the outpatient unit is relative value units (GRVU for VA or RVU for community providers).

Service	Analysis Level	Measure		
IP Med/Surg, MH, CLC	Market	*Total IP Projected Veteran Demand (BDOC)*	≤	*Quality HPIDN Capacity (Total VA Capacity + Available Quality Community Capacity) (BDOC)*
IP RRTP, SCI/D	VISN	*Total IP Projected Veteran Demand (BDOC)*	≤	*Total VA Capacity (BDOC)*
IP Blind Rehab	Blind Rehab Region	*Total IP Projected Veteran Demand (BDOC)*	≤	*Total VA Capacity (BDOC)*
OP Primary and Specialty Care	Market	*Total OP Projected Veteran Demand (GRVU)*	≤	*Quality HPIDN Capacity (Total VA Capacity (GRVU) + Available Quality Community Capacity (RVU))*

To pass, the HPIDN Capacity must meet or exceed projected Veteran demand.

Demand Sub-criterion 3

Sub-criterion 3 measures if the recommendation incorporates trends in the evolution of U.S. health care. To pass, the recommendation must incorporate at least one trend from any of the 203 domains (i.e., Access, Demand, Quality, Sustainability, Cost, and Mission). Below is the subset of trends from the full trend menu that are related to the Demand domain.

- Forms partnerships/alliances to maximize capacity? (Y/N)
- Leverages telehealth to expand capacity in rural areas? (Y/N)
- Establishes Small House Model to evolve CLC capacity, patient experience, and quality? (Y/N)
- Establishes standalone ambulatory surgery centers (ASC) to meet outpatient surgical workload? (Y/N)
- Increases capacity for ambulatory care delivery? (Y/N)

Demand Assumptions

Provider Inclusion / Exclusion

- Within 10 years the VCCP will grow to include providers who meet the quality criteria detailed in Table 4.
- Within 10 years there will be limited RRTP, SCI/D, and Blind Rehabilitation community providers added to the network as they offer only a portion of the full continuum of care offered by each VA facility.
- Primary and specialty care APPs should be included from a capacity perspective. APPs form a significant portion of the workforce and their corresponding location, specialization, and capacity should be incorporated into the future HPIDN. Nurse Practitioners (NPs) and Physician Assistants (PAs) specialty assignment is based on historical distribution across primary certification areas. The respective distributions for NPs come from the American Association of Nurse Practitioners (American Association of Nurse Practitioners, 2021). The respective distributions for PAs come from the National Commission on Certification of Physicians Assistants (National Commission on Certification of Physicians Assistants, 2017).

Likelihood of Community Provider Acceptance

The approach assumes that only a small portion of community provider capacity will be available to enrollees as a result of limited patient acceptance in the community. The below assumptions were made to account for likelihood of enrollee patient acceptance:

- Federal providers (e.g., Department of Defense, Indian Health Service), as well as providers in the VCCP accept Veterans as patients.
- For inpatient care among non-Federal/non-VCCP providers, only providers who participate in Medicare and accept Medicare as payment in full will accept Veteran patients.
- For outpatient care among non-Federal/non-VCCP providers, a Medicare opt-out rate of 7%. This assumption was based on a recent Kaiser Family Foundation study which found that 7% was the highest Medicare opt-out rate across all specialties in 2020 (Nancy Ochieng, 2020). The market assessments applied the 7% opt-out rate as a conservative estimate for all specialties. As a result, only 93% of the total outpatient community provider pool meeting the quality inclusion criteria is included in the future HPIDN.

Provider Capacity

- The approach assumes that the maximum outpatient community provider (Medicare-accepting clinicians meeting quality criteria only) capacity made available to enrollees will be equal to the

proportion they make up of the general population. According to the US Census there are 255,042,109 adults in the US as of July 1, 2019 (United States Census Bureau, 2019). The number of enrollees in FY19 according to the EHCPM was 8,846,627. Therefore, approximately 3.5% of the US adult population are Veteran Enrollees. Thus, the evaluation assumes that enrollees will have access to 3.5% of the total capacity among community providers who meet the quality criteria and accept Medicare.

- The approach assumes that any proposed new facilities will produce workload at or above the 58.5th percentile of FY29 GRVUs when compared against VA sites of equivalent classification and rurality.
- This approach assumes Nurse Practitioners (NPs) and Physician Assistants (PAs) are as productive as the median physician in their respective certification area. Studies show that the APP patient volume is equivalent to physicians; however, productivity is often attributed to physician-level providers, and it is therefore difficult to determine the full productivity of APPs (Sondra DePalma, 2020) (Todd Pickard, 2014). Consequently, in the analysis, APPs inherit the median productivity level of their physician counterpart by specialty.

Capacity Assumptions by Service Line

For inpatient care, an occupancy rate assumption is made to determine the total number of available staffed beds occupied at any given time. This sets the total number of beds from which an average daily census may be subtracted. For outpatient care, it is assumed that Medicare acceptance is a reasonable proxy for Veteran acceptance. Additionally, an assumption is made that the total outpatient capacity will never exceed the proportion of Veteran enrollees to the general population (enrollees account for 3.5% of the general population). The assumptions by service line are shown in the Table 3.

Table 3: Future State HPIDN Capacity Assumptions

Service Line	Community Capacity Definition
IP Med/Surg (Market)	Occupancy Rate: 80%
IP MH (Market)	Occupancy Rate: 80%
IP CLC (Market)	Occupancy Rate: 90%
RRTP* (VISN)	Occupancy Rate: 100%
IP Blind Rehab (Region)	Occupancy Rate: 100%
IP SCI/D (VISN)	Occupancy Rate: 100%
PC (Market)	Medicare Opt-out Rate: 7% Portion of Total Capacity Available to Veteran Enrollees: 3.5%
MH (Market)	Medicare Opt-out Rate: 7% Portion of Total Capacity Available to Veteran Enrollees: 3.5%
ED/UC (Market)	Medicare Opt-out Rate: 7% Portion of Total Capacity Available to Veteran Enrollees: 3.5%
OP Surg (Market)	Medicare Opt-out Rate: 7% Portion of Total Capacity Available to Veteran Enrollees: 3.5%
OP Specialty Care (Market)	Medicare Opt-out Rate: 7% Portion of Total Capacity Available to Veteran Enrollees: 3.5%

Demand Stepwise Calculations

Inpatient Demand: Inpatient Medical, Surgical, Mental Health, CLC

Step 1: Calculate total projected Veteran demand by market-based EHCPM projections across all Health Service Planning Groups (HSPGs).

- Divide total BDOC by 365 for each service to calculate average daily census (ADC)

Step 2: Calculate community capacity as of 2019

- Remove community providers:
  - Failing to meet the quality criteria in Table 4
  - Closed as of August 2021
- *Current Community Capacity = (Occupancy Rate x Total Beds in Community) - Current ADC*.
  - *Note*: An individual hospital's capacity is transformed to zero if negative prior to summing capacity in the market

Step 3: Calculate VA Future State Capacity

- Collect total bed counts by service type in the future state per VA recommendations.

Step 4: Calculate Total HPIDN Capacity

- *HPIDN Capacity = Total VA Future State Capacity + Current Community Capacity*

Step 5: Calculate 203 Result

- *HPIDN Capacity ≥ Projected Veteran Demand = "PASS"*
- *HPIDN Capacity < Projected Veteran Demand = "FAIL"*

Inpatient Demand: RRTP, SCI/D, Blind Rehabilitation

Step 1: Calculate total future Veteran demand by specific service area (VISN, Blind Rehabilitation Region) based on EHCPM projections across all HSPGs.

- Assign each facility/market to their respective service area for RRTP, SCI/D, and Blind Rehabilitation
- Aggregate total BDOC by service area
- Divide total BDOC by 365 for each service to calculate ADC

Step 2: Calculate VA Future State Capacity

- Collect total bed counts by service type in the future state for the entire service area per VA recommendations.

Step 3: Calculate 203 Result

- *VA Capacity ≥ Projected Veteran Demand = "PASS"*
- *VA Capacity < Projected Veteran Demand = "FAIL"*

Outpatient Demand

Step 1: Calculate total future Veteran demand by market based on EHCPM projections for Primary Care, Mental Health, ED/UCC, and all specialties.

Step 2: Calculate community capacity by specialty as of 2019

- Remove community providers:

  - Failing to meet the quality criteria in Table 4
- *Current Community Capacity = ((Total # of Quality Providers in the community x .93)* x Medical Group Management Association *RVU Median of Anchor Specialty) x 0.035*
  - Note: Quality inclusion criteria are described in Table 4.

Step 3: Calculate VA Future State Capacity

- Summarize GRVU projected demand by outpatient service and market
- Apply changes based on the proposed future state for each market.
  - For new/upgraded facilities, add rurality adjusted FY29 58.5th percentile GRVU production based on facility classification (OOS, CBOC, MS CBOC, HCC, VAMC).
  - Subtract GRVUs for facilities proposed to close or downgrade (losing specific services).
- *Total VA Capacity = (Maintained Facilities Capacity + New/Upgraded Facilities Capacity – Closed/Downgraded Facilities Capacity)*

Step 4: Calculate Total HPIDN Capacity

- *HPIDN Capacity = (VA Future State Capacity + Current Community Capacity)*

Step 5: Calculate 203 Result

- *HPIDN Capacity ≥ Projected Veteran Demand = "PASS"*
- *HPIDN Capacity < Projected Veteran Demand = "FAIL"*

Quality

Background

The Quality domain has one main criterion and four sub-criteria, as shown below.

Criterion	*Sub-criteria:*
The recommendation considers the quality and delivery of health care services available to Veterans, including the experience, safety, and appropriateness of care.	*1. Ensures the highest possible quality of care across demographics and geography* *2. Promotes recruitment of top clinical and non-clinical talent* *3. Maintains or enhances Veteran experience* *4. Incorporates trends in the evolution of U.S. health care*

Quality Approach

Quality Sub-criteria 1 and 3

The HPIDN must maintain or improve access and have sufficient capacity to meet projected Veteran demand using only high-quality providers. If a recommendation passes the Demand (sub-criteria 1-2) and Access (sub-criteria 1-5) evaluations, it indicates that access and capacity are met via high-quality providers. Table 4 shows the specific quality measures and corresponding rationale for each service line.

Quality Sub-criterion 2

For sub-criterion 2, two separate tests were performed to analyze whether the market recommendation promoted the recruitment of top clinical and non-clinical talent. It was determined that promoting top clinical talent could be achieved in two ways: (1) strengthening partnerships with academic affiliates, and (2) through building new or modernizing current VA infrastructure. Therefore, any market with recommendations to form or maintain partnerships with academic affiliations, build new, or modernize current VA infrastructure passed this sub-criterion. To pass this sub-criterion, the market recommendation must pass at least one of the sub-criterion's corresponding measures:

1. Maintains or creates partnerships with Academic Affiliates and/or other community providers when available? (Y/N)
2. Modernizes facilities to include state-of-the-art equipment and clinical space to attract providers and support staff? (Y/N)

Quality Sub-criterion 4

Sub-criterion 4 measures if the recommendation incorporates trends in the evolution of U.S. health care. To pass this sub-criterion, at least one trend from any of the 203 domains (i.e., Access, Demand, Quality, Sustainability, Cost, and Mission) must have been incorporated in the market recommendation. Below are the trends that pertain to the Quality domain.

- Forms partnerships/alliances to improve quality and coordination of care? (Y/N)
- Enables adoption of latest medical technology through facility modernization? (Y/N)

- Considers performance in nationally recognized quality reporting programs? (Y/N)
- Considers participation in nationally recognized reporting programs (Nursing Home Compare)? (Y/N)
- Establishes a Small House Model to improve patient experience and quality? (Y/N)

Quality Assumptions

Quality Inclusion Criteria

- The approach assumes all VA and VCCP providers are of high quality as VA performs regular internal quality checks on VA-delivered points of care as well as external quality checks on providers in the VCCP. More specific quality inclusion criteria, shown below, are utilized for non-VA / non-VCCP providers the HPIDN aspires to include in the network over the next 10 years.

Table 4: Quality Criteria and Rationale by Service Line

Service Line	Criteria	Rationale
IP Med, IP Surg	All VA VAMCs, VCCP facilities, and non-VCCP active short-term acute and critical access hospitals with 3-star-plus CMS Hospital Compare rating, TJC accreditation, and readmission rates less than 20% for two out of three years (2017-2019))? (Y/N)	• The proposed quality guidelines were developed in collaboration with the VA program office overseeing inpatient medicine • CMS Hospital Compare star rating is a composite measure of mortality, readmissions, safety, and patient experience and is widely accepted as an overall indicator of quality. • Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, a component of the CMS Hospital Compare star rating, are a widely accepted measure of patient satisfaction. • TJC is recognized as a leading accrediting body in the United States and is used in most areas of the country as a condition to receive reimbursement from Medicare and Medicaid. • The standard benchmark used by CMS is a 30-day readmission rate of < 20%. CMS penalizes hospitals with 30-day readmission rates > 20%.
IP MH	All VA VAMCs, VCCP facilities with psychiatric beds, and non-VCCP active short-term acute and critical access hospitals with 3-star-plus CMS Hospital Compare rating, TJC accreditation, and readmission rates less than 20% for two out of three years (2017-2019) that have psychiatric beds, and TJC accredited psychiatric hospitals? (Y/N)	Short-term Acute and Critical Access Hospitals with Psychiatric Beds • The proposed quality guidelines were developed in collaboration with the VA program office overseeing inpatient mental health. • CMS Hospital Compare star rating is a composite measure of mortality, readmissions, safety, and patient experience and is widely accepted as an overall indicator of quality. • HCAHPS scores, a component of the CMS Hospital Compare star rating, are a widely accepted measure of patient satisfaction. • The standard benchmark used by CMS is a 30-day readmission rate of < 20%. CMS penalizes hospitals with 30-day readmission rates > 20%. Freestanding • TJC is recognized as a leading accrediting body in the United States and is used in most areas of the country as a condition to receive reimbursement from Medicare and Medicaid.

CLC	All VA CLCs, VCCP SNFs, State Veterans Homes, and non-VCCP active SNFs with 3-star-plus overall rating, or 2-star-plus overall rating with 4-star-plus quality rating per Nursing Home Compare? (Y/N)	• The proposed quality guidelines were developed in collaboration with the Office of Geriatrics and Extended Care (GEC).
RRTP, SCI/D, Blind Rehab	These services are assumed to be maintained by VA in the future in some capacity, and therefore, quality and patient experience is maintained or improved through various VA quality programs.	• Some programs exist within VA which remain unmatched by community providers. It is assumed that accessing the full continuum of care that these programs offer would be difficult in the community, and offerings would vary. Therefore, the assumption is made that RRTP, SCI/D, and Blind Rehab services are provided by VA exclusively. • Quality and satisfaction are assumed to be maintained since these services are maintained, relocated, or transferred to other VAMCs and never transitioned to the community.
OP PC, MH, ED/UC, Surgery, Specialty Care	Clinicians participate in the CMS MIPS program? (Y/N)	• Over 800,000 clinicians participate in MIPS. • 96% of MIPS clinicians received an additional adjustment for exceptional performance or a positive payment adjustment in the 2019 Quality Payment Program performance year, indicating high-quality performance by CMS standards. • MIPS overall score takes quality and patient satisfaction (Hospital Consumer Assessment of Healthcare Providers and Systems) into consideration. • Only applied when the specialty has significant participation (1,000 or more providers). APPs included regardless of MIPS participation.

Mission

Background

The Mission domain has one main criterion and five sub-criteria, as shown below.

Criterion	Sub-criteria:
The recommendation provides for VA's second, third, and fourth health related statutory missions of education, research, and emergency preparedness.	1. *Aligns resources to VA's education, research, and emergency preparedness missions across demographics and geography* 2. *Education: Maintains or enhances VA's ability to execute its education mission* 3. *Research: Maintains or enhances VA's ability to execute its research mission* 4. *Emergency Preparedness: Maintains or enhances VA's ability to execute its emergency preparedness mission* 5. *Incorporates trends in the evolution of U.S. health care*

Mission Approach

The Mission domain studies the impact recommendations have on VA's second, third, and fourth health-related missions of education, research, and emergency preparedness. Measures were designed for each sub-criterion to determine an outcome.

Mission Sub-criteria 1 and 2 (Education)

With leadership from the Office of Academic Affiliations (OAA), VA identified and analyzed all VA facilities with training programs (154 sites) based on the Academic Year 2019-2020 Health Professions Trainees (HPT) data. The definitions and assumptions described below guided the qualitative analysis within this domain:

Definitions

- **Maintaining the Health Professions Education (HPE) mission:** a recommendation that provides VA with the ability to support a similar amount of HPE positions regionally (VISN level) in the future—even if HPE locations, program types, or partners change.
- **Enhancing the HPE mission**: a recommendation meets the maintenance criteria and includes net new services or infrastructure to increase VA's HPE capacity.

Assumptions

There were several key assumptions made in this analysis:

- The impact of changes in inpatient services on the HPE mission were on the basis of the numbers of physician and nursing HPTs, as these HPTs require significant inpatient training experiences
- Proposed VA-delivered partnerships will be as effective as current state
- The location of VA will remain proximate to the academic affiliate
- The majority of the HPE mission for certain professions will be outpatient
- The location of the new partner will not be significantly farther away from the affiliate

- When outlining potential alternative sites for HPTs, (1) negotiations with the affiliate to place the effected HPTs at one or more of the alternative sites will be successful and (2) funding for necessary transportation and housing for HPTs at these alternative sites will be secured

To pass, OAA's review must determine that the VA recommendations, per the definitions above, maintain or enhance VA's ability to execute the education mission at the VISN level.

Mission Sub-criteria 1 and 3 (Research)

With leadership from the Office of Research and Development (ORD), VA identified and analyzed all VA sites with research (103 sites), based on data from the Research and Development Information System (RDIS) as of 2022. The definitions and assumptions described below guided the qualitative analysis within this domain:

Definitions

- **Maintaining the research mission:** VA recommendation has limited to no impact on infrastructure supporting the research mission. If impact is expected, a plan for transition coordinated with ORD will be documented.
- **Enhancing the research mission:** VA recommendation meets maintenance criteria and provides for new modernized infrastructure which presents opportunities to enhance the research mission.

Assumptions

- ORD and the local research office must be involved in planning from the outset of the planning and implementation processes to achieve the goal of maintaining or enhancing VA's research mission.
- Proximity of a VA research program to its research affiliate is a key factor to ensure and sustain success.
- Efforts to modernize VA research infrastructure must include timely investment to close existing condition and space gaps and to provide state-of-the art major scientific equipment and IT/scientific computing capabilities.
- At a minimum, new modernized infrastructure and replacement will maintain the full capability (e.g., wet lab, dry lab, clinical research) of existing research facilities.

To pass, ORD's review must determine that the VA recommendations, per the definitions above, maintain or enhance VA's ability to execute the research mission at the market level.

Mission Sub-criteria 1 and 4 (Emergency Preparedness)

The evaluation of Emergency Preparedness was collaboratively developed with the Office of Emergency Management (OEM) to determine the most meaningful measure for this sub-criterion. There are two designation types for VA facilities participating in the National Disaster Medical System (NDMS): Federal Coordination Centers (FCC) and Primary Receiving Centers (PRC). The mission of an FCC is to receive, triage, stage, track and transport patients, affected by a disaster or national emergency, to a participating NDMS medical facility capable of providing the required definitive care. FCCs primarily serve as a coordinating function. PRCs are also responsible for triaging, staging, coordinating, and

tracking patients, and are also responsible for providing treatment to military patients returning from armed conflict or national emergency. PRCs are relied upon for their bed capacity to provide definitive care in the event of emergency. Given the uncertainty on the future of DoD Military Treatment Facilities across the country and need for flexibility in response efforts, OEM determined that ensuring PRC-designated VAMCs continue to exist in markets where they currently exist today is critical. OEM noted that prior to executing the strategy specified, VA should seek guidance from DoD to operationalize the strategy (e.g., establishing new PRC designations, transferring designations). The definitions and assumptions described below guided the qualitative analysis within this domain:

Definitions

- **Maintaining the research mission:** VA recommendation maintains the current count of PRC-designated VAMCs within the market.
- **Enhancing the research mission:** VA recommendation increases the current count of PRC-designated VAMCs within the market.

Assumptions

- Per the guidance from OEM, PRC-designated VAMCs may be relocated, as long as the relocated facility has the same acute care capabilities.
- The relocated PRC must be within 60 minutes of the current site and/or share the same commercial airport with the former site.

Mission Sub-criterion 5

Sub-criterion 5 measures if the recommendation incorporates trends in the evolution of U.S. health care. To pass this sub-criterion, at least one trend from any of the 203 domains (i.e., Access, Demand, Quality, Sustainability, Cost, and Mission) must have been incorporated in the market recommendation. Below are the trends related to the Mission domain.

- Creates / maintains / expands partnerships (local/State/Federal) to expand training mission? (Y/N)
- Creates / maintains / expands partnerships (local/State/Federal) to expand research mission? (Y/N)

Cost-effectiveness

Background

The Cost Effectiveness domain has one main criterion and three sub-criteria, as shown below.

Criterion	Sub-criteria:
The recommendation provides a cost-effective means by which to provide Veterans with modern health care.	1. *Reflects stewardship of taxpayer dollars by optimizing investments and resources to achieve advancements in access and outcomes for Veterans* 2. *Recognizes potential savings or efficiencies that may free resources for more impactful investment for Veterans* 3. *Considers the value of Veteran and employee experience, innovation, and other intangible elements of value.*

Cost-effectiveness Approach

The Cost-effectiveness domain assesses the 30-year total cost (capital and operational) and total benefits across three courses of action (COA) – Status Quo, Modernization, and the VA Recommendation – described below.

1. **Status Quo:** maintains VA's current facilities assuming no changes or additional modernization to current facilities, programs, and infrastructure
2. **Modernization:** modernizes and right-sizes existing facilities but does not strategically realign facilities
3. **VA Recommendation:** strategically realigns and modernizes facilities

The Cost Benefit Analysis (CBA) is conducted at the market level, rather than at the facility level, to allow for a holistic assessment of a COA's impact that considers optimization of the market across all health care facilities. The financial costs were assessed using a Present Value (PV) analysis while the non-financial benefits were assessed using a Benefits Analysis Scoring process. Ultimately, the CBA results in a Cost Benefit Index – a simple metric by which to compare the combined cost and non-financial benefits associated with each COA. The COA with the lowest Cost Benefit Index (CBI) score is the preferred COA.

The Cost-effectiveness domain leverages the CBI to determine if the VA recommendation is more cost effective than the Status Quo COA, as shown below.

VA Recommendation Cost Benefit Index (Future State) < Status Quo Cost Benefit Index (Current State)

Cost-effectiveness Assumptions

For assumptions underlying the Cost Benefit Analysis and its corresponding Cost Benefit Index, please reference the CBA methodology documentation.

Sustainability

Background

The Sustainability domain has one main criterion and four sub-criteria, as shown below.

Criterion	Sub-criteria:
The recommendation creates a sustainable health care delivery system for Veterans.	1. *Aligns investment in care and services with projected Veteran care needs across demographics and geography* 2. *Reflects stewardship of taxpayer dollars by creating a sustainable infrastructure system for Veterans* 3. *Enables recruitment and retention of top clinical and non-clinical talent* 4. *Incorporates trends in the evolution of U.S. health care*

Sustainability Approach

The Sustainability domain assesses the impact recommendations have on VA's ability to create a sustainable healthcare delivery system for Veterans.

Sustainability Sub-criterion 1

A key component to a sustainable healthcare delivery system is robust long-term demand, which supports the provision of care, training, and research at VA facilities. As a result, demand-based guidelines were used to analyze the sustainability of each VA facility, for both existing and proposed new sites. Each guideline aims to ensure the demand at each site will be sustainable over the long term. For a facility to pass, it must meet or exceed at least one of the guidelines in the menu corresponding to its facility classification. In instances where a facility is relocating or being replaced nearby, the performance values from the original facility are attributed to the new location. Other outpatient site (OOS) facilities, partnerships, and facilities with planned activation dates after 8/1/2020 are excluded from the analysis.

Table 5: Long-term Viability Demand Guideline Menu

Facility Classification	Viability Measure Menu
CBOC	• ≥ 1,200 core uniques • ≥ 2400 encounters • ≥ 2,500 overlapping enrollees within 30-minute drive time
MSCBOC	• ≥ 2 specialties with at least 500 encounters • ≥ 4,300 overlapping enrollees within 60-minute drive time
HCC	• ≥ 2,000 Surgical Cases (Inpatient and Outpatient) • ≥ 34,000 overlapping enrollees within a 60-minute drive time

VAMC	• Inpatient Medicine: ≥ 20 ADC
	• Surgery: ≥ 1,600 cases
	• Inpatient Mental Health: ≥ 9.6 ADC (Urban), 8.0 ADC (Rural)
	• CLC
	  ○ ≥ 14.4 ADC
	  ○ ≥ 21,000 overlapping enrollees within 60-minute drive time (urban)
	  ○ ≥ 24,000 overlapping enrollees within 60-minute drive time (rural)
	• RRTP: ≥ 13.6 ADC

	• ≥ 35,000 overlapping enrollees within 60-minute drive time

Standalone Sites	• CLC
	  ○ ≥ 14.4 ADC
	  ○ ≥ 21,000 overlapping enrollees within 60-minute drive time (urban)
	  ○ ≥ 24,000 overlapping enrollees within 60-minute drive time (rural)
	• RRTP: ≥ 13.6 ADC

In addition to demand-based viability guidelines, facilities identified as essential per the Access or Demand domain – a facility's location is essential to meet access or its capacity is essential to meet projected demand – are not required to meet or exceed long-term viability measures.

Sustainability Sub-criterion 2

Sub-criterion 2 measures the recommendation's stewardship of taxpayer dollars. Similar to the Cost-effectiveness domain, this sub-criterion is measured through a multi-part comparison of the Modernization and VA Recommendation COAs. First, the COAs are compared based on Present Value (total 30-year cost). To pass, the Present Value of the VA Recommendation should be lower than the Present Value of the Modernization COA. If the cost of the VA Recommendation COA exceeds the cost of the Modernization COA, the CBI of the VA Recommendation COA must be lower than the Modernization COA. In essence, if the cost of the VA Recommendation exceeds the cost of Modernization, the additional cost must be justified by attaining non-financial benefits that Modernization is unable to achieve.

VA Recommendation COA Present Value < Modernization COA Present Value? (Y/N)

If "No"

VA Recommendation CBI < Modernization CBI? (Y/N)

Sustainability Sub-criterion 3

For sub-criterion 3, two separate tests were performed to analyze whether the market recommendation promoted the recruitment of top clinical and non-clinical talent. It was determined that promoting top clinical talent could be achieved in two ways: (1) strengthening partnerships with academic affiliates, and (2) through building new or modernizing current VA infrastructure. Therefore, any market with recommendations to form or maintain partnerships with academic affiliations, build new, or modernize current VA infrastructure passed this sub-criterion. To pass this sub-criterion, the market recommendation must pass at least one of the sub-criterion's corresponding measures:

3. Maintains or creates partnerships with Academic Affiliates and/or other community providers when available? (Y/N)
4. Modernizes facilities to include state-of-the-art equipment and clinical space to attract providers and support staff? (Y/N)

Sustainability Sub-criterion 4

Sub-criterion 4 measures if trends in the evolution of U.S. health care were incorporated as part of the recommendation. To pass this sub-criterion, at least one trend from any of the 203 domains (i.e., Access, Demand, Quality, Sustainability, Cost, and Mission) must have been incorporated in the market recommendation. Below are the trends that pertain to the Sustainability domain.

- Supports providing inpatient care in private, single patient rooms? (Y/N)
- Establishes standalone ASC facilities to meet outpatient surgical workload? (Y/N)
- Increases use of Small House Model? (Y/N)
- Enables adoption of latest medical technology through facility modernization? (Y/N)

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