VA Recommendations to the

ASSET AND INFRASTRUCTURE REVIEW COMMISSION

March 2022

Appendix H

Cost Benefit Analysis – VISN 22

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The recommendations for modernization and realignment of VHA infrastructure submitted by the Secretary of the Department of Veterans Affairs to the Asset and Infrastructure Review (AIR) Commission are focused on allowing VA to provide accessible, timely, and high-quality health care for Veterans now and in the future. To inform the recommendations, VA conducted a Cost Benefit Analysis (CBA) that examines the cost-efficiency and benefits to Veterans of various courses of action (COAs) within each market. The CBA compares the costs and benefits associated with maintaining the current facilities, modernizing the current facilities, or strategically realigning and modernizing facilities in each market to inform the identification of a preferred COA.

The CBA aligns with requirements outlined in Section 1703C of Title 38, United States Code (U.S.C.), as added by Section 203 of the VA MISSION Act of 2018.

> *VA MISSION Act, Section 203(2)(F)*
>
> *"In making recommendations under this subsection, the Secretary shall consider…the extent and timing of potential costs and savings, including the number of years such costs or savings will be incurred, beginning with the date of completion of the proposed recommendation."*

This CBA summary document defines the COAs, provides a brief overview of the methodology, and outlines the results of the CBA and the associated sensitivity analysis.

Overview of COAs and Methodology

The Cost Benefit Analysis (CBA) reviews, analyzes, and compares the costs and benefits of three distinct courses of action (COA):

- maintaining VA's current facilities assuming no changes or additional modernization to current facilities, programs, and infrastructure (COA Name: Status Quo)
- modernizing the current facilities without strategically realigning facilities (COA Name: Modernization)
- strategically realigning and modernizing facilities (COA Name: VA Recommendation to the AIR Commission)

To evaluate these courses of action, VA examined the combined cost and benefits of each COA for each market. The CBA was 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 CBI equals the total life-cycle cost (PV) of each COA in PV dollars, divided by the Benefits Analysis score for that COA's non-financial benefits normalized to the billions place. The COA with the lowest CBI score is the preferred COA.

Summary of Results

The VA Recommendation COA is the leading COA analyzed in the VISN 22 Loma Linda Market due to its leading Cost Benefit Index (CBI) score. The CBI score for the VA Recommendation COA (1.64) is 31.6% lower than the Status Quo COA (2.39) and 19.7% lower than the Modernization COA (2.04).

The VA Recommendation COA is $1.4 B (6.3%) more expensive than the Status Quo COA and $479.8 M (2.1%) more expensive than the Modernization COA. While the VA Recommendation COA increases cost compared to the Status Quo and Modernization COAs, it also increases benefits as seen by a 14-point benefits score compared to 9 for the Status Quo COA and 11 for the Modernization COA.

The tables below detail the present values, benefit scores, and CBIs for each COA.

Table 1 – CBI Scores by COA

	Status Quo	Modernization	VA Recommendation
COA PV ($)	($21,553,317,485)	($22,441,804,116)	($22,921,617,875)
Benefit Analysis Score	9	11	14
CBI (Normalized in $Billions)	2.39	2.04	1.64
CBI % Change vs. Status Quo	N/A	-14.8%	-31.6%
CBI % Change vs. Modernization	N/A	N/A	-19.7%

Table 2 – Cost Analysis Cost Variance by COA

Cost Variance	Status Quo	Modernization	VA Recommendation
Capital Cost Variance vs. Status Quo	N/A	($888,486,631)	($1,368,300,389)
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($888,486,631)	($1,368,300,389)
Estimated Total Cost Variance vs. Modernization	N/A	N/A	($479,813,759)

Note: Operational unit costs were provided at the parent facility level not at the facility level. Therefore, the analysis does not estimate the changes in operational costs stemming from new, expanded, or removed points of care (POC). The analysis only shows changes to operational costs when a service line is shifted, at the parent facility level, from VA care to non-VA care.

Table 3 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3
Access	2	2	3
Quality	3	3	3
Facilities and Sustainability	1	2	2
Mission	2	2	3
Total Benefit Score	**9**	**11**	**14**

VA Recommendation

The VA Recommendation for the VISN 22 Loma Linda Market COA is detailed below.

- Modernize and realign the Loma Linda VAMC by modernizing the inpatient medical and surgical units at the Loma Linda VAMC
- Modernizing by establishing a new stand-alone RRTP in the vicinity of Loma Linda, California
- Modernize and realign outpatient facilities in the market by:
    - Relocating the Murrieta CBOC to a new site in the vicinity of Murrieta, California, and closing the Murrieta CBOC
    - Relocating the Palm Desert CBOC to a new site in the vicinity of Palm Desert, California, and closing the Palm Desert CBOC
    - Relocating the Rancho Cucamonga CBOC to a new site in the vicinity of Rancho Cucamonga, California, and closing the Rancho Cucamonga CBOC
    - Relocating the Corona CBOC to a new site in the vicinity of Corona, California, and closing the Corona CBOC
    - Relocating the Victorville CBOC to a new site in the vicinity of Victorville, California, and closing the Victorville CBOC

Cost Analysis

The Cost Analysis highlighted the estimated Present Value (PV) of each COA for the VISN 22 Loma Linda Market across a 30-year horizon. The cost of the VA Recommendation COA ($22.9 B) was higher than the Status Quo COA ($21.6 B) and the Modernization COA ($22.4 B).

For the VISN 22 Loma Linda Market, the VA Recommendation COA is $1.4 B (6.3%) more expensive than the Status Quo COA and $479.8 M (2.1%) more expensive than the Modernization COA. The cost difference between the VA Recommendation COA and Status Quo COA can be attributed to new facilities, closing or modernizing existing facilities, and scaling capacity of existing facilities up or down to meet future Veteran in-house demand to accommodate changes in demand.

The table below outlines the costs associated with each of the COAs. For more detail refer to Appendix A – VISN 22 Loma Linda: Capital and Operational Costs Detail.

Table 4 – Total Cost Summary by COA

	Status Quo	Modernization	VA Recommendation
Total Costs (PV)	($21,553,317,485)	($22,441,804,116)	($22,921,617,875)
Capital Cost Variance vs. Status Quo	N/A	($888,486,631)	($1,368,300,389)
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Non-VA Care Operational Cost Variance	N/A	$0	$0
VA Care Operational Cost Variance	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($888,486,631)	($1,350,859,500)
Estimated Total Cost Variance vs. Modernization	N/A	N/A	($479,813,759)

Benefit Analysis

This section describes the non-financial benefit analysis results for the VISN 22 Loma Linda Market across five domains: Demand and Supply, Access, Quality, Facilities and Sustainability, and Mission. The results indicate that the VA Recommendation COA provides the most benefit (greatest Total Benefit Score) in comparison to the Status Quo and Modernization COAs.

Table 5 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3
Access	2	2	3
Quality	3	3	3
Facilities and Sustainability	1	2	2

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Mission	2	2	3
Total Benefit Score	**9**	**11**	**14**

The scoring and rationale within each domain are described in the following sections. The data underlying the analysis is provided in Appendix B – VISN 22 Loma Linda: Benefits Analysis Key Data. Additional information regarding the scoring methodology is provided in the CBA Methodology.

Demand and Supply

Within the Demand and Supply domain, the CBA considers how each COA impacts VA's ability to meet Veteran demand in the future. Each COA is assessed on two benefit components: (1) the ability to balance demand and supply; (2) the changes to facility placement or service offerings that improve VA's ability to meet future demand.

The table below shows the scores for VISN 22 Loma Linda for this domain.

Table 6 – Demand and Supply Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3

Status Quo: The COA received a score of 1 because at least one inpatient service line was over/under supplied, or more than 50% of specialties were inadequately supplied when compared to future Veteran in-house demand. Additionally, no changes to facilities or services were introduced that improve VA's ability to meet the future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, expansion of services).

Modernization: The COA received a score of 2 because, while Modernization right-sizes services to meet future Veteran in-house demand, the COA does not include changes to facilities or services that improve VA's ability to meet the future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, addition of new services).

VA Recommendation: The COA received a score of 3 because it right-sizes services to meet future Veteran enrollee demand and includes changes to facilities or services that improve VA's ability to meet future Veteran enrollee demand based on guidelines established in the CBA methodology. These changes include the following:

- Establishes a new Loma Linda RRTP to provide inpatient residential rehabilitative services; 96,309 enrollees live within 60 minutes of the proposed facility
- Expands the Murrieta CBOC to a MS CBOC, adding specialty care services.
- Expands the Palm Desert CBOC to a MS CBOC, adding specialty care services.
- Expands the Rancho Cucamonga CBOC to a MS CBOC, adding specialty care services.

Access

Within the Access domain, the CBA considers how each COA impacts Veteran access to care in the future. Each COA is assessed on the change in enrollee proximity to VA-provided primary care, specialty care, and outpatient mental health care. The table below shows the CBA access scores for VISN 22 Loma Linda for this domain.

Table 7 – Access Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Access	2	2	3

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (inclusive of VA, Community Care Network providers, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future high-performing integrated delivery network (HPIDN).

Status Quo: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

Modernization: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

VA Recommendation: The COA received a score of 3 because access to VA-provided primary care was maintained within 1%, specialty care increased 1% or more, and outpatient mental health care was maintained within 1%.

Quality

Within the Quality domain, the CBA considers how each COA impacts the quality of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the ability of the main patient care facilities to support modern healthcare; (2) the ability of demand to support clinical competency.

The table below shows the scores for VISN 22 Loma Linda for this domain.

Table 8 – Quality Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Quality	3	3	3

Status Quo: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Modernization: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of

care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

VA Recommendation: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Facilities and Sustainability

Within the Facilities and Sustainability domain, the CBA considers how each COA impacts the sustainability of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the useful life of the main patient care facilities; (2) changes that strengthen VA's ability to recruit and retain providers.

The table below shows the scores for VISN 22 Loma Linda for this domain.

Table 9 – Facilities and Sustainability Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Facilities and Sustainability	1	2	2

Note: The American Hospital Association estimates that a hospital's useful life, a measure which predicts the productive period of a typical capital asset before it becomes obsolete or needs replacement, is currently 40 years.

Status Quo: The COA received a score of 1 for two reasons. First, the COA includes at least one main patient care facility that exceeds its useful life as defined by the American Hospital Association, indicating it may be obsolete or need replacement. Second, the COA does not include changes that strengthen VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Modernization: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

VA Recommendation: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract

providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Mission

Within the Mission domain, the CBA considers how each COA impacts VA's ability to support its statutory missions of Education, Research, and Emergency Preparedness in the future. Each COA is assessed on three benefit components: (1) the impact on training programs; (2) the impact on research programs; (3) the impact on emergency preparedness.

A COA's overall score in the Mission domain is determined by the rounded average (unweighted) of its component (e.g., Education, Research, Emergency Preparedness) scores. The table below shows the scores for VISN 22 Loma Linda for this domain.

Table 10 – Mission Scoring Summary

Subdomain	Status Quo	Modernization	VA Recommendation
Education	2	2	3
Research	2	2	3
Emergency Preparedness	2	2	2
Overall Mission Score (Rounded Average)	**2**	**2**	**3**

Status Quo: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Modernization: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

VA Recommendation: The COA received a score of 3 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 3 because inpatient acute services remain VA-delivered and thus the COA maintains existing training programs. Additionally, the COA includes new (not replacement) infrastructure that creates new opportunities for training within the market.
- **Research:** The COA received a score of 3 because it maintains all research programs and builds new (not replacement) infrastructure to support additional research space.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Sensitivity Analysis

A sensitivity analyses study shows how various sources of uncertainty in a mathematical model contribute to the model's overall uncertainty. The market is considered sensitive to a scenario when the VA Recommendation is no longer the leading COA due to changes in benefit scores, VA capital costs, VA operational costs, or non-VA operational costs.

The table below outlines the sensitivity analysis scenarios completed.

Table 11 – Sensitivity Analysis Scenarios

Sensitivity Analysis Scenarios
Increase Benefit Scores for Status Quo and Modernization in increments of one from 1 to 3 points
Increase VA Capital Costs in 50% increments from 0% to 300%
Increase VA Operational Costs in 50% increments from 0% to 300%
Increase Non-VA Operational Costs in 50% increments from 0% to 300%

Sensitivity Analysis Results Summary

In the VISN 22 Loma Linda Market, one scenario changed the outcome of the CBA:

- Increasing the Modernization benefits score by three points

Sensitivity Analysis Full Results

The below tables show the results across all sensitivity analysis scenarios.

Table 12 – Sensitivity Analyses – Benefit Score Increase

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+0	2.39	2.04	1.64	VA Recommendation

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+1	2.16	1.87	1.64	VA Recommendation
+2	1.96	1.73	1.64	VA Recommendation
+3	1.80	1.60	1.64	Modernization

Table 13 – Sensitivity Analyses – VA Capital Cost Increase

VA Capital Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	2.39	2.04	1.64	VA Recommendation
50%	2.45	2.12	1.72	VA Recommendation
100%	2.50	2.20	1.80	VA Recommendation
150%	2.55	2.28	1.88	VA Recommendation
200%	2.60	2.37	1.96	VA Recommendation
250%	2.65	2.45	2.04	VA Recommendation
300%	2.70	2.53	2.12	VA Recommendation

Table 14 – Sensitivity Analyses – VA Operational Cost Increase

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	2.39	2.04	1.64	VA Recommendation

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
50%	3.24	2.73	2.18	VA Recommendation
100%	4.09	3.43	2.72	VA Recommendation
150%	4.93	4.12	3.27	VA Recommendation
200%	5.78	4.81	3.81	VA Recommendation
250%	6.63	5.50	4.36	VA Recommendation
300%	7.47	6.20	4.90	VA Recommendation

Table 15 – Sensitivity Analyses – Non-VA Operational Cost Increase

Non-VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	2.39	2.04	1.64	VA Recommendation
50%	2.70	2.29	1.83	VA Recommendation
100%	3.00	2.53	2.02	VA Recommendation
150%	3.30	2.78	2.22	VA Recommendation
200%	3.60	3.02	2.41	VA Recommendation
250%	3.90	3.27	2.60	VA Recommendation
300%	4.20	3.52	2.80	VA Recommendation

Appendix A – VISN 22 Loma Linda: Capital and Operational Costs Detail

Table 16 – Capital Costs by COA

	Status Quo	Modernization	VA Recommendation
VAMC Ideal Square Footage	-	1,468,307	1,532,524
Build New GSF	-	388,004	435,572
Renovate In Place GSF	-	649,076	642,397
Matched Convert To GSF	-	295,426	302,105
Demolition GSF	-	-	-
Total Build New Cost	$0	($472,852,247)	($519,165,609)
Total Renovate In Place Cost	$0	($270,750,512)	($267,198,888)
Total Matched Convert To Cost	$0	($139,467,315)	($143,133,144)
Total Demolition Cost	$0	$0	$0
Total Lease Build-Out Cost	$0	($26,377,925)	($94,489,926)
Total New Lease Cost	$0	($124,008,532)	($444,456,946)
Total Existing Lease Cost	($217,154,805)	($217,154,800)	($217,154,805)
NRM Costs for Owned Facilities	($566,794,682)	($171,414,041)	($178,910,877)
FCA Correction Cost	($113,780,728)	N/A	N/A
Estimated Base Modernization Cost	($897,730,215)	($1,422,025,371)	($1,864,510,196)
Additional Common/Lobby Space Needed (GSF)	-	135,801	152,450
Cost of Additional Common/Lobby Space	$0	($126,719,448)	($142,254,831)
Additional Parking Cost	$0	($33,314,387)	($49,865,031)

	Status Quo	Modernization	VA Recommendation
Potential Land Acquisition Cost	$0	($119,549)	($1,203,015)
Seismic Correction Cost	($846,851)	($846,850)	($846,851)
Non-Building FCA Correction Cost	($6,621,390)	($6,621,389)	($6,621,390)
Activation Costs	$0	($204,038,092)	($208,197,532)
Estimated Additional Costs for Modernization	($7,468,240)	($371,659,715)	($408,988,649)
Cost Adjustment: In-Progress Construction	N/A	N/A	$0
Cost Adjustment: In-Progress Lease	N/A	N/A	$0
Estimated Facilities Costs (PV)	($905,198,455)	($1,793,685,086)	($2,273,498,845)

Table 17 – Operational Costs by COA

	Status Quo	Modernization	VA Recommendation
VA Direct	($9,049,374,379)	($9,049,374,379)	($9,049,374,379)
Fixed Direct	($1,264,875,196)	($1,264,875,196)	($1,264,875,196)
VA Specific Direct	($290,916,153)	($290,916,153)	($290,916,153)
Indirect	($3,459,652,340)	($3,459,652,340)	($3,459,652,340)
VA Specific Indirect	($436,260,083)	($436,260,083)	($436,260,083)
Research and Education	($1,942,316)	($1,942,316)	($1,942,316)
VA Overhead	($734,825,840)	($734,825,840)	($734,825,840)
VA Care Operational Cost Total (PV)	($15,237,846,307)	($15,237,846,307)	($15,237,846,307)
CC Direct	($2,799,451,214)	($2,799,451,214)	($2,799,451,214)
Delivery and Operations	($116,713,018)	($116,713,018)	($116,713,018)

	Status Quo	Modernization	VA Recommendation
Care Coordination	($108,651,716)	($108,651,716)	($108,651,716)
CC Overhead	($145,690,046)	($145,690,046)	($145,690,046)
Admin PMPM	($2,239,766,729)	($2,239,766,729)	($2,239,766,729)
Non-VA Care Operational Cost Total (PV)	($5,410,272,723)	($5,410,272,723)	($5,410,272,723)
Estimated Operational Costs (PV)	($20,648,119,030)	($20,648,119,030)	($20,648,119,030)

Appendix B – VISN 22 Loma Linda: Benefits Analysis Key Data

Below are key data points used in the benefit analysis, summarized in the above Benefit Analysis section.

Demand and Supply

Inpatient

Table 18 – Demand and Supply Key Data Points for Scoring – Inpatient (IP)

Service Line	100% of FY29 In-house Bed Need	120% of FY29 In-house Bed Need	Operating Beds	Supply Adequacy (within 100-120% of in-house demand)
IP CLC	92	110	86	Under Supplied
IP Med/Surg	82	98	132	Over Supplied
IP MH	26	31	34	Over Supplied

Note: Community Living Center (CLC); Medicine (Med); Surgery (Surg); Mental Health (MH)

Source: Enrollee Healthcare Projection Model Base Year 2019

Outpatient

Table 19 – Demand and Supply Key Data Points for Scoring – Outpatient (OP)

Physician Supply Adequacy	Count of Specialties	Percentage
Adequately Supplied	10	37%
Under Supplied	17	63%

Note: VA supply in the Status Quo COA is quantitatively evaluated based on the data above. It is assumed the Modernization COA scales the capacity of existing facilities up or down to meet future Veteran in-house demand. Similar to the Modernization COA, it is assumed the VA Recommendation COA scales the capacity of existing and proposed facilities up or down to meet future Veteran in-house demand. However, the VA Recommendation COA may account for factors that demand projections do not consider that may shift the future balance of in-house and community workload, such as:

- Areas with unmet Veteran demand that may warrant a net new point of care
- Low-census inpatient acute programs that may pose risks to quality and training programs, potentially warranting a shift to community providers
- Community capacity factors that may warrant changes to VA capacity

Source: Office of Productivity, Efficiency and Staffing 2019 Capacity Report

Table 20 – New Facility Demand Guidelines

Facility or Service	Guideline
Inpatient Acute VAMCs	Greater than or equal to 35,000 overlapping enrollees
Inpatient CLC	Greater than or equal to 21,000 overlapping enrollees
Health Care Center	Greater than or equal to 34,000 overlapping enrollees
MS CBOC	Greater than or equal to 4,300 non-overlapping enrollees
CBOC	Greater than or equal to 2,500 non-overlapping enrollees

Note: The above guidelines are used to determine whether a new (not replacement) point of care or service proposed in the VA recommendation had adequate demand.

Access

Table 21 – Access Key Data Points for Scoring

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of VA-provided OP Mental Health	88.8%	88.8%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of VA-provided OP Primary Care	89.2%	89.2%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of VA-provided OP Specialty Care	92.2%	92.2%	Maintained within 1%

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	98.8%	98.8%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.4%	99.4%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.9%	99.9%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Mental Health	88.8%	88.8%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Primary Care	89.2%	89.2%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of VA-provided OP Specialty Care	92.2%	92.2%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	98.8%	98.8%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.4%	99.4%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.9%	99.9%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Mental Health	88.8%	88.6%	Maintained within 1%

COA	Measure	Current	Future	Result
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Primary Care	89.2%	89.0%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of VA-provided OP Specialty Care	92.2%	95.9%	Increased 1% or more
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	98.8%	98.8%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.4%	99.4%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.9%	100.0%	Maintained within 1%

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (HPIDN) (inclusive of VA, Community Care Network, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future HPIDN. The table above shows the results for enrollee proximity to the full HPIDN as well as to VA-provided care in the market.

Source: Enrollee data from the FY19 Geocoded Enrollee File. Existing VA facility location data from VAST. Commercial provider location data from Definitive Healthcare.

Quality

Main Patient Care Facility Construction Date

Table 22 – Quality Key Data Points for Scoring – Age

Facility	Main Patient Care Facility Construction Date	Built Pre-1970?
(V22) (605) Loma Linda	1977	No

Source: Main patient care facility construction and renovation dates from CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Inpatient Acute Demand

Table 23 – Quality Key Data Points for Scoring – Inpatient Acute Demand

Facility	Service	Demand Guideline	Meets or Exceeds Guideline?	VA Recommendation
(V22) (605) Loma Linda	IP Med	20 ADC	Yes	Maintain
(V22) (605) Loma Linda	IP Surg	1,600 Cases	Yes	Maintain
(V22) (605) Loma Linda	IP MH	8 ADC	Yes	Maintain

Note: The Status Quo and Modernization COAs are assumed to maintain all current facilities and services. The VA Recommendation COA proposes maintaining, partnering, and divesting of services at each facility, shown in the last column titled “VA Recommendation”. To score a 3, the VA recommendation must partner or divest of all low-demand services.

Source: FY 2029 average daily census for inpatient services is based on Enrollee Healthcare Projection Model Base Year 2019. 2019 Total Surgical Cases is from the VA National Surgery Office.

Facilities and Sustainability

Table 24 – Facilities and Sustainability Key Data Points for Scoring

Facility	Main Patient Care Facility Construction Date	Most Recent Main Patient Care Facility Renovation Date	Exceeds Useful Life?
(V22) (605) Loma Linda	1977	1985	Yes

Note: Exceeding useful life is defined as 1) When a main patient care facility was built before 1970 it has exceeded its useful life, even if it has undergone major renovation in the last 40 years. 2) When a main patient care facility was built after 1970 but is still more than 40 years old (built on or after 1971 and before 1989), it must have undergone major renovation within the last 40 years to not exceed its useful life. 3) When a main patient care facility was built in or after 1989, it has not exceeded its useful life.

Source: From CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Table 25 – Key Data Points for Scoring - Recruitment and Retention

Facility	Expands VA's Ability to Recruit/Retain?
N/A	N/A

Mission

Table 26 – Mission Key Data Points for Scoring

The Status Quo and Modernization COAs are assumed to have no impact on VA's statutory missions. The impact of the VA Recommendation on VA's statutory missions is shown in the table below:

Facility	Training Impact	Research Impact	4th Mission Impact	Market Plan Includes New Facilities/Services To Increase Training/Research Opportunities
(V22) (605) Loma Linda	No impact on training	Maintains or Has Plan to Transition	No PRC Designation	Increases Research Opportunities, Increases Training Opportunities

VISN 22 San Diego

The recommendations for modernization and realignment of VHA infrastructure submitted by the Secretary of the Department of Veterans Affairs to the Asset and Infrastructure Review (AIR) Commission are focused on allowing VA to provide accessible, timely, and high-quality health care for Veterans now and in the future. To inform the recommendations, VA conducted a Cost Benefit Analysis (CBA) that examines the cost-efficiency and benefits to Veterans of various courses of action (COAs) within each market. The CBA compares the costs and benefits associated with maintaining the current facilities, modernizing the current facilities, or strategically realigning and modernizing facilities in each market to inform the identification of a preferred COA.

The CBA aligns with requirements outlined in Section 1703C of Title 38, United States Code (U.S.C.), as added by Section 203 of the VA MISSION Act of 2018.

> *VA MISSION Act, Section 203(2)(F)*
>
> *"In making recommendations under this subsection, the Secretary shall consider…the extent and timing of potential costs and savings, including the number of years such costs or savings will be incurred, beginning with the date of completion of the proposed recommendation."*

This CBA summary document defines the COAs, provides a brief overview of the methodology, and outlines the results of the CBA and the associated sensitivity analysis.

Overview of COAs and Methodology

The Cost Benefit Analysis (CBA) reviews, analyzes, and compares the costs and benefits of three distinct courses of action (COA):

- maintaining VA's current facilities assuming no changes or additional modernization to current facilities, programs, and infrastructure (COA Name: Status Quo)
- modernizing the current facilities without strategically realigning facilities (COA Name: Modernization)
- strategically realigning and modernizing facilities (COA Name: VA Recommendation to the AIR Commission)

To evaluate these courses of action, VA examined the combined cost and benefits of each COA for each market. The CBA was 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 CBI equals the total life-cycle cost (PV) of each COA in PV dollars, divided by the Benefits Analysis score for that COA's non-financial benefits normalized to the billions place. The COA with the lowest CBI score is the preferred COA.

Summary of Results

The VA Recommendation COA is the leading COA analyzed in the VISN 22 San Diego Market due to its leading Cost Benefit Index (CBI) score. The CBI score for the VA Recommendation COA (2.03) is 26.0% lower than the Status Quo COA (2.75) and 15.9% lower than the Modernization COA (2.42).

The VA Recommendation COA is $1.7 B (6.9%) more expensive than the Status Quo COA and $165.6 M (0.6%) less expensive than the Modernization COA. While the VA Recommendation COA increases cost compared to the Status Quo COA and decreases costs compared to the Modernization COA, it also increases benefits as seen by a 13-point benefits score compared to 9 for the Status Quo COA and 11 for the Modernization COA.

The tables below detail the present values, benefit scores, and CBIs for each COA.

Table 27 – CBI Scores by COA

	Status Quo	Modernization	VA Recommendation
COA PV ($)	($24,742,213,171)	($26,616,745,574)	($26,451,112,008)
Benefit Analysis Score	9	11	13
CBI (Normalized in $Billions)	2.75	2.42	2.03
CBI % Change vs. Status Quo	N/A	-12.0%	-26.0%
CBI % Change vs. Modernization	N/A	N/A	-15.9%

Table 28 – Cost Analysis Cost Variance by COA

Cost Variance	Status Quo	Modernization	VA Recommendation
Capital Cost Variance vs. Status Quo	N/A	($1,874,532,403)	($1,708,898,837)
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($1,874,532,403)	($1,708,898,837)
Estimated Total Cost Variance vs. Modernization	N.A	N/A	$165,633,566

Note: Operational unit costs were provided at the parent facility level not at the facility level. Therefore, the analysis does not estimate the changes in operational costs stemming from new, expanded, or removed points of care (POC). The analysis only shows changes to operational costs when a service line is shifted, at the parent facility level, from VA care to non-VA care.

Table 29 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3
Access	2	2	2
Quality	3	3	3
Facilities and Sustainability	1	2	2
Mission	2	2	3
Total Benefit Score	**9**	**11**	**13**

VA Recommendation

The VA Recommendation for the VISN 22 San Diego Market COA is detailed below.

- Modernize and realign the San Diego VAMC by:
    - Establishing a strategic collaboration with Naval Hospital Camp Pendleton and Naval Medical Center San Diego to provide outpatient surgery and surgical specialty care
    - Modernizing the inpatient medical and surgical space at the San Diego VAMC
    - Modernizing the RRTP at the San Diego VAMC
    - Constructing a new CLC and SCI/D replacement building at the San Diego VAMC
- Modernize and realign outpatient facilities in the market by establishing a new MS CBOC in the vicinity of Poway, California

Cost Analysis

The Cost Analysis highlighted the estimated Present Value (PV) of each COA for the VISN 22 San Diego Market across a 30-year horizon. The cost of the VA Recommendation COA ($26.5 B) was higher than the Status Quo COA ($24.7 B) and lower than the Modernization COA ($26.6 B).

For the VISN 22 San Diego Market, the VA Recommendation COA is $1.7 B (6.9%) more expensive than the Status Quo COA and $165.6 M (0.6%) less expensive than the Modernization COA. The cost difference between the VA Recommendation COA and Status Quo COA can be attributed to new facilities, closing or modernizing existing facilities, and scaling capacity of existing facilities up or down to meet future Veteran in-house demand to accommodate changes in demand.

The table below outlines the costs associated with each of the COAs. For more detail refer to Appendix A – VISN 22 San Diego: Capital and Operational Costs Detail.

Table 30 – Total Cost Summary by COA

	Status Quo	Modernization	VA Recommendation
Total Costs (PV)	($24,742,213,171)	($26,616,745,574)	($26,451,112,008)
Capital Cost Variance vs. Status Quo	N/A	($1,874,532,403)	($1,708,898,837)
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Non-VA Care Operational Cost Variance	N/A	$0	$0
VA Care Operational Cost Variance	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	$0	($1,874,532,403)	($1,708,898,837)
Estimated Total Cost Variance vs. Modernization	N.A	N/A	$165,633,566

Benefit Analysis

This section describes the non-financial benefit analysis results for the VISN 22 San Diego Market across five domains: Demand and Supply, Access, Quality, Facilities and Sustainability, and Mission. The results indicate that the VA Recommendation COA provides the most benefit (greatest Total Benefit Score) in comparison to the Status Quo and Modernization COAs.

Table 31 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3
Access	2	2	2
Quality	3	3	3
Facilities and Sustainability	1	2	2
Mission	2	2	3
Total Benefit Score	**9**	**11**	**13**

The scoring and rationale within each domain are described in the following sections. The data underlying the analysis is provided in Appendix B – VISN 22 San Diego: Benefits Analysis Key Data. Additional information regarding the scoring methodology is provided in the CBA Methodology.

Demand and Supply

Within the Demand and Supply domain, the CBA considers how each COA impacts VA's ability to meet Veteran demand in the future. Each COA is assessed on two benefit components: (1) the ability to balance demand and supply; (2) the changes to facility placement or service offerings that improve VA's ability to meet future demand.

The table below shows the scores for VISN 22 San Diego for this domain.

Table 32 – Demand and Supply Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3

Status Quo: The COA received a score of 1 because at least one inpatient service line was over/under supplied, or more than 50% of specialties were inadequately supplied when compared to future Veteran in-house demand. Additionally, no changes to facilities or services were introduced that improve VA's ability to meet the future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, expansion of services).

Modernization: The COA received a score of 2 because, while Modernization right-sizes services to meet future Veteran in-house demand, the COA does not include changes to facilities or services that improve VA's ability to meet future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, addition of new services).

VA Recommendation: The COA received a score of 3 because it right-sizes services to meet future Veteran enrollee demand and includes changes to facilities or services that improve VA's ability to meet future Veteran enrollee demand based on guidelines established in the CBA methodology. These changes include the following:

- Establishes a new Poway MS CBOC to provide primary care, specialty care, and outpatient mental health services; there are 8,819 enrollees for which the proposed facility is the closest VA point of care within 60 minutes

Access

Within the Access domain, the CBA considers how each COA impacts Veteran access to care in the future. Each COA is assessed on the change in enrollee proximity to VA-provided primary care, specialty care, and outpatient mental health care.

The table below shows the CBA access scores for VISN 22 San Diego for this domain.

Table 33 – Access Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Access	2	2	2

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (inclusive of VA, Community Care Network providers, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future high-performing integrated delivery network (HPIDN).

Status Quo: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

Modernization: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

VA Recommendation: The COA received a score of 2 because access to VA-provided primary care was maintained within 1%, specialty care was maintained within 1%, and outpatient mental health care was maintained within 1%.

Quality

Within the Quality domain, the CBA considers how each COA impacts the quality of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the ability of the main patient care facilities to support modern healthcare; (2) the ability of demand to support clinical competency.

The table below shows the scores for VISN 22 San Diego for this domain.

Table 34 – Quality Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Quality	3	3	3

Status Quo: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Modernization: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning

guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

VA Recommendation: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Facilities and Sustainability

Within the Facilities and Sustainability domain, the CBA considers how each COA impacts the sustainability of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the useful life of the main patient care facilities; (2) changes that strengthen VA's ability to recruit and retain providers.

The table below shows the scores for VISN 22 San Diego for this domain.

Table 35 – Facilities and Sustainability Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Facilities and Sustainability	1	2	2

Note: The American Hospital Association estimates that a hospital's useful life, a measure which predicts the productive period of a typical capital asset before it becomes obsolete or needs replacement, is currently 40 years.

Status Quo: The COA received a score of 1 for two reasons. First, the COA includes at least one main patient care facility that exceeds its useful life as defined by the American Hospital Association, indicating it may be obsolete or need replacement. Second, the COA does not include changes that strengthen VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Modernization: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

VA Recommendation: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Mission

Within the Mission domain, the CBA considers how each COA impacts VA's ability to support its statutory missions of Education, Research, and Emergency Preparedness in the future. Each COA is assessed on three benefit components: (1) the impact on training programs; (2) the impact on research programs; (3) the impact on emergency preparedness.

A COA's overall score in the Mission domain is determined by the rounded average (unweighted) of its component (e.g., Education, Research, Emergency Preparedness) scores. The table below shows the scores for VISN 22 San Diego for this domain.

Table 36 – Mission Scoring Summary

Subdomain	Status Quo	Modernization	VA Recommendation
Education	2	2	3
Research	2	2	3
Emergency Preparedness	2	2	2
Overall Mission Score (Rounded Average)	**2**	**2**	**3**

Status Quo: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Modernization: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

VA Recommendation: The COA received a score of 3 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 3 because inpatient acute services remain VA-delivered and thus the COA maintains existing training programs. Additionally, the COA includes new (not replacement) infrastructure that creates new opportunities for training within the market.
- **Research:** The COA received a score of 3 because it maintains all research programs and builds new (not replacement) infrastructure to support additional research space.

- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Sensitivity Analysis

A sensitivity analyses study shows how various sources of uncertainty in a mathematical model contribute to the model's overall uncertainty. The market is considered sensitive to a scenario when the VA Recommendation is no longer the leading COA due to changes in benefit scores, VA capital costs, VA operational costs, or non-VA operational costs.

The table below outlines the sensitivity analysis scenarios completed.

Table 37 – Sensitivity Analysis Scenarios

Sensitivity Analysis Scenarios
Increase Benefit Scores for Status Quo and Modernization in increments of one from 1 to 3 points
Increase VA Capital Costs in 50% increments from 0% to 300%
Increase VA Operational Costs in 50% increments from 0% to 300%
Increase Non-VA Operational Costs in 50% increments from 0% to 300%

Sensitivity Analysis Results Summary

In the VISN 22 San Diego Market, one scenario changed the outcome of the CBA:

- Increasing the Modernization benefits score by three points

Sensitivity Analysis Full Results

The below tables show the results across all sensitivity analysis scenarios.

Table 38 – Sensitivity Analyses – Benefit Score Increase

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+0	2.75	2.42	2.03	VA Recommendation
+1	2.47	2.22	2.03	VA Recommendation
+2	2.25	2.05	2.03	VA Recommendation

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+3	2.06	1.90	2.03	Modernization

Table 39 – Sensitivity Analyses – VA Capital Cost Increase

VA Capital Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	2.75	2.42	2.03	VA Recommendation
50%	2.83	2.57	2.15	VA Recommendation
100%	2.91	2.72	2.28	VA Recommendation
150%	2.99	2.87	2.40	VA Recommendation
200%	3.06	3.02	2.52	VA Recommendation
250%	3.14	3.17	2.64	VA Recommendation
300%	3.22	3.32	2.76	VA Recommendation

Table 40 – Sensitivity Analyses – VA Operational Cost Increase

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	2.75	2.42	2.03	VA Recommendation
50%	3.71	3.21	2.70	VA Recommendation
100%	4.68	4.00	3.37	VA Recommendation

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
150%	5.64	4.79	4.04	VA Recommendation
200%	6.61	5.58	4.71	VA Recommendation
250%	7.57	6.37	5.37	VA Recommendation
300%	8.54	7.16	6.04	VA Recommendation

Table 41 – Sensitivity Analyses – Non-VA Operational Cost Increase

Non-VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	2.75	2.42	2.03	VA Recommendation
50%	3.08	2.69	2.26	VA Recommendation
100%	3.41	2.96	2.49	VA Recommendation
150%	3.74	3.23	2.72	VA Recommendation
200%	4.07	3.50	2.95	VA Recommendation
250%	4.41	3.78	3.18	VA Recommendation
300%	4.74	4.05	3.41	VA Recommendation

Appendix A – VISN 22 San Diego: Capital and Operational Costs Detail

Table 42 – Capital Costs by COA

	Status Quo	Modernization	VA Recommendation
VAMC Ideal Square Footage	-	1,927,300	1,998,265
Build New GSF	-	1,218,665	1,271,232
Renovate In Place GSF	-	101,036	101,493
Matched Convert To GSF	-	181,066	180,609
Demolition GSF	-	863,605	863,605
Total Build New Cost	$0	($1,370,177,761)	($1,424,350,242)
Total Renovate In Place Cost	$0	($38,536,302)	($38,606,004)
Total Matched Convert To Cost	$0	($90,756,974)	($89,935,729)
Total Demolition Cost	$0	($37,226,535)	($37,226,535)
Total Lease Build-Out Cost	$0	($71,727,405)	($80,544,741)
Total New Lease Cost	$0	($409,303,682)	($455,521,959)
Total Existing Lease Cost	($139,830,798)	($139,830,728)	($139,830,798)
NRM Costs for Owned Facilities	($921,203,392)	($224,998,006)	($233,282,698)
FCA Correction Cost	($285,506,405)	N/A	N/A
Estimated Base Modernization Cost	($1,346,540,595)	($2,382,557,393)	($2,499,298,706)
Additional Common/Lobby Space Needed (GSF)	-	426,533	444,931
Cost of Additional Common/Lobby Space	$0	($405,310,532)	($422,793,565)
Additional Parking Cost	$0	($59,841,603)	($63,092,579)

	Status Quo	Modernization	VA Recommendation
Potential Land Acquisition Cost	$0	($15,614,155)	($16,458,373)
Seismic Correction Cost	($64,820)	($20,377)	($20,378)
Non-Building FCA Correction Cost	($68,695,948)	($68,695,947)	($68,695,948)
Activation Costs	$0	($357,793,759)	($365,540,652)
Estimated Additional Costs for Modernization	($68,760,768)	($907,276,373)	($936,601,494)
Cost Adjustment: In-Progress Construction	N/A	N/A	$311,700,000
Cost Adjustment: In-Progress Lease	N/A	N/A	$0
Estimated Facilities Costs (PV)	($1,415,301,363)	($3,289,833,766)	($3,124,200,200)

Table 43 – Operational Costs by COA

	Status Quo	Modernization	VA Recommendation
VA Direct	($9,740,268,946)	($9,740,268,946)	($9,740,268,946)
Fixed Direct	($990,859,782)	($990,859,782)	($990,859,782)
VA Specific Direct	($564,896,331)	($564,896,331)	($564,896,331)
Indirect	($4,735,864,229)	($4,735,864,229)	($4,735,864,229)
VA Specific Indirect	($477,895,949)	($477,895,949)	($477,895,949)
Research and Education	($27,609,452)	($27,609,452)	($27,609,452)
VA Overhead	($825,657,097)	($825,657,097)	($825,657,097)
VA Care Operational Cost Total (PV)	($17,363,051,788)	($17,363,051,788)	($17,363,051,788)
CC Direct	($2,900,553,104)	($2,900,553,104)	($2,900,553,104)
Delivery and Operations	($137,187,535)	($137,187,535)	($137,187,535)

	Status Quo	Modernization	VA Recommendation
Care Coordination	($139,548,717)	($139,548,717)	($139,548,717)
CC Overhead	($167,554,715)	($167,554,715)	($167,554,715)
Admin PMPM	($2,619,015,949)	($2,619,015,949)	($2,619,015,949)
Non-VA Care Operational Cost Total (PV)	($5,963,860,020)	($5,963,860,020)	($5,963,860,020)
Estimated Operational Costs (PV)	($23,326,911,808)	($23,326,911,808)	($23,326,911,808)

Appendix B – VISN 22 San Diego: Benefits Analysis Key Data

Below are key data points used in the benefit analysis, summarized in the above Benefit Analysis section.

Demand and Supply

Inpatient

Table 44 – Demand and Supply Key Data Points for Scoring – Inpatient (IP)

Service Line	100% of FY29 In-house Bed Need	120% of FY29 In-house Bed Need	Operating Beds	Supply Adequacy (within 100-120% of in-house demand)
IP CLC	39	47	43	Adequately Supplied
IP Med/Surg	82	99	114	Over Supplied
IP MH	40	48	38	Under Supplied

Note: Community Living Center (CLC); Medicine (Med); Surgery (Surg); Mental Health (MH)

Source: Enrollee Healthcare Projection Model Base Year 2019

Outpatient

Table 45 – Demand and Supply Key Data Points for Scoring – Outpatient (OP)

Physician Supply Adequacy	Count of Specialties	Percentage
Adequately Supplied	18	67%
Under Supplied	9	33%

Note: VA supply in the Status Quo COA is quantitatively evaluated based on the data above. It is assumed the Modernization COA scales the capacity of existing facilities up or down to meet future Veteran in-house demand. Similar to the Modernization COA, it is assumed the VA Recommendation COA scales the capacity of existing and proposed facilities up or down to meet future Veteran in-house demand. However, the VA Recommendation COA may account for factors that demand projections do not consider that may shift the future balance of in-house and community workload, such as:

- Areas with unmet Veteran demand that may warrant a net new point of care
- Low-census inpatient acute programs that may pose risks to quality and training programs, potentially warranting a shift to community providers
- Community capacity factors that may warrant changes to VA capacity

Source: Office of Productivity, Efficiency and Staffing 2019 Capacity Report

Table 46 – New Facility Demand Guidelines

Facility or Service	Guideline
Inpatient Acute VAMCs	Greater than or equal to 35,000 overlapping enrollees
Inpatient CLC	Greater than or equal to 21,000 overlapping enrollees
Health Care Center	Greater than or equal to 34,000 overlapping enrollees
MS CBOC	Greater than or equal to 4,300 non-overlapping enrollees
CBOC	Greater than or equal to 2,500 non-overlapping enrollees

Note: The above guidelines are used to determine whether a new (not replacement) point of care or service proposed in the VA recommendation had adequate demand.

Access

Table 47 – Access Key Data Points for Scoring

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of VA-provided OP Mental Health	97.8%	97.8%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of VA-provided OP Primary Care	97.8%	97.8%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of VA-provided OP Specialty Care	97.6%	97.6%	Maintained within 1%

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	99.4%	99.4%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.7%	99.7%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.9%	99.9%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Mental Health	97.8%	97.8%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Primary Care	97.8%	97.8%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of VA-provided OP Specialty Care	97.6%	97.6%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	99.4%	99.4%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.7%	99.7%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.9%	99.9%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Mental Health	97.8%	98.5%	Maintained within 1%

COA	Measure	Current	Future	Result
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Primary Care	97.8%	97.9%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of VA-provided OP Specialty Care	97.6%	98.0%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	99.4%	99.4%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.7%	99.7%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.9%	99.9%	Maintained within 1%

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (HPIDN) (inclusive of VA, Community Care Network, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future HPIDN. The table above shows the results for enrollee proximity to the full HPIDN as well as to VA-provided care in the market.

Source: Enrollee data from the FY19 Geocoded Enrollee File. Existing VA facility location data from VAST. Commercial provider location data from Definitive Healthcare.

Quality

Main Patient Care Facility Construction Date

Table 48 – Quality Key Data Points for Scoring – Age

Facility	Main Patient Care Facility Construction Date	Built Pre-1970?
(V22) (664) San Diego	1972	No

Source: Main patient care facility construction and renovation dates from CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Inpatient Acute Demand

Table 49 – Quality Key Data Points for Scoring – Inpatient Acute Demand

Facility	Service	Demand Guideline	Meets or Exceeds Guideline?	VA Recommendation
(V22) (664) San Diego	IP Med	20 ADC	Yes	Maintain
(V22) (664) San Diego	IP Surg	1,600 Cases	Yes	Maintain
(V22) (664) San Diego	IP MH	8 ADC	Yes	Maintain

Note: The Status Quo and Modernization COAs are assumed to maintain all current facilities and services. The VA Recommendation COA proposes maintaining, partnering, and divesting of services at each facility, shown in the last column titled “VA Recommendation”. To score a 3, the VA recommendation must partner or divest of all low-demand services.

Source: FY 2029 average daily census for inpatient services is based on Enrollee Healthcare Projection Model Base Year 2019. 2019 Total Surgical Cases is from the VA National Surgery Office.

Facilities and Sustainability

Table 50 – Facilities and Sustainability Key Data Points for Scoring

Facility	Main Patient Care Facility Construction Date	Most Recent Main Patient Care Facility Renovation Date	Exceeds Useful Life?
(V22) (664) San Diego	1972	N/A	Yes

Note: Exceeding useful life is defined as 1) When a main patient care facility was built before 1970 it has exceeded its useful life, even if it has undergone major renovation in the last 40 years. 2) When a main patient care facility was built after 1970 but is still more than 40 years old (built on or after 1971 and before 1989), it must have undergone major renovation within the last 40 years to not exceed its useful life. 3) When a main patient care facility was built in or after 1989, it has not exceeded its useful life.

Source: From CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Table 51 – Key Data Points for Scoring - Recruitment and Retention

Facility	Expands VA's Ability to Recruit/Retain?
N/A	N/A

Mission

Table 52 – Mission Key Data Points for Scoring

The Status Quo and Modernization COAs are assumed to have no impact on VA's statutory missions. The impact of the VA Recommendation on VA's statutory missions is shown in the table below:

Facility	Training Impact	Research Impact	4th Mission Impact	Market Plan Includes New Facilities/Services To Increase Training/Research Opportunities
(V22) (664) San Diego	No impact on training	Maintains or Has Plan to Transition	No PRC Designation	Increases Research Opportunities, Increases Training Opportunities

VISN 22 Greater Los Angeles

The recommendations for modernization and realignment of VHA infrastructure submitted by the Secretary of the Department of Veterans Affairs to the Asset and Infrastructure Review (AIR) Commission are focused on allowing VA to provide accessible, timely, and high-quality health care for Veterans now and in the future. To inform the recommendations, VA conducted a Cost Benefit Analysis (CBA) that examines the cost-efficiency and benefits to Veterans of various courses of action (COAs) within each market. The CBA compares the costs and benefits associated with maintaining the current facilities, modernizing the current facilities, or strategically realigning and modernizing facilities in each market to inform the identification of a preferred COA.

The CBA aligns with requirements outlined in Section 1703C of Title 38, United States Code (U.S.C.), as added by Section 203 of the VA MISSION Act of 2018.

> *VA MISSION Act, Section 203(2)(F)*
>
> *"In making recommendations under this subsection, the Secretary shall consider…the extent and timing of potential costs and savings, including the number of years such costs or savings will be incurred, beginning with the date of completion of the proposed recommendation."*

This CBA summary document defines the COAs, provides a brief overview of the methodology, and outlines the results of the CBA and the associated sensitivity analysis.

Overview of COAs and Methodology

The Cost Benefit Analysis (CBA) reviews, analyzes, and compares the costs and benefits of three distinct courses of action (COA):

- maintaining VA's current facilities assuming no changes or additional modernization to current facilities, programs, and infrastructure (COA Name: Status Quo)
- modernizing the current facilities without strategically realigning facilities (COA Name: Modernization)
- strategically realigning and modernizing facilities (COA Name: VA Recommendation to the AIR Commission)

To evaluate these courses of action, VA examined the combined cost and benefits of each COA for each market. The CBA was 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 CBI equals the total life-cycle cost (PV) of each COA in PV dollars, divided by the Benefits Analysis score for that COA's non-financial benefits normalized to the billions place. The COA with the lowest CBI score is the preferred COA.

Summary of Results

The VA Recommendation COA is the leading COA analyzed in the VISN 22 Greater Los Angeles Market due to its leading Cost Benefit Index (CBI) score. The CBI score for the VA Recommendation COA (3.67) is 39.6% lower than the Status Quo COA (6.07) and 18.4% lower than the Modernization COA (4.49).

The VA Recommendation COA is $881.4 M (1.8%) less expensive than the Status Quo COA and $1.7 B (3.5%) less expensive than the Modernization COA. While the VA Recommendation COA decreases cost compared to the Status Quo and Modernization COAs, it also increases benefits as seen by a 13-point benefits score compared to 8 for the Status Quo COA and 11 for the Modernization COA.

The tables below detail the present values, benefit scores, and CBIs for each COA.

Table 53 – CBI Scores by COA

	Status Quo	Modernization	VA Recommendation
COA PV ($)	($48,539,637,973)	($49,400,036,046)	($47,658,247,471)
Benefit Analysis Score	8	11	13
CBI (Normalized in $Billions)	6.07	4.49	3.67
CBI % Change vs. Status Quo	N/A	-26.0%	-39.6%
CBI % Change vs. Modernization	N/A	N/A	-18.4%

Table 54 – Cost Analysis Cost Variance by COA

Cost Variance	Status Quo	Modernization	VA Recommendation
Capital Cost Variance vs. Status Quo	N/A	($860,398,073)	$881,390,502
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($860,398,073)	$881,390,502
Estimated Total Cost Variance vs. Modernization	N/A	N/A	$1,741,788,575

Note: Operational unit costs were provided at the parent facility level not at the facility level. Therefore, the analysis does not estimate the changes in operational costs stemming from new, expanded, or removed points of care (POC). The analysis only shows changes to operational costs when a service line is shifted, at the parent facility level, from VA care to non-VA care.

Table 55 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3
Access	2	2	1
Quality	2	3	3
Facilities and Sustainability	1	2	3
Mission	2	2	3
Total Benefit Score	**8**	**11**	**13**

VA Recommendation

The VA Recommendation for the VISN 22 Greater Los Angeles Market COA is detailed below.

- Modernize and realign the Long Beach VAMC by:
  - Modernizing the CLC, blind rehabilitation, and SCI/D spaces at the Long Beach VAMC
  - Modernizing inpatient acute and mental health units at the Long Beach VAMC
- Modernize and realign the West Los Angeles VAMC by:
  - Modernizing the inpatient and outpatient space at the West Los Angeles VAMC
  - Modernizing the CLC at the West Los Angeles VAMC
- Modernize and realign outpatient facilities in the market by:
  - Relocating the Anaheim CBOC to a new site in the vicinity of Anaheim, California, and closing the Anaheim CBOC
  - Relocating the Santa Ana MS CBOC to a new site in the vicinity of Santa Ana, California, and closing the Santa Ana MS CBOC
  - Relocating the Gardena MS CBOC to a new site in the vicinity of Gardena, California, and closing the Gardena MS CBOC
  - Relocating all services to the proposed Los Angeles health care center (HCC) and closing the East Los Angeles CBOC
  - Relocating all services to the Santa Maria MS CBOC and the Oxnard MS CBOC and closing the Santa Barbara CBOC
  - Relocating all services to the proposed Santa Ana MS CBOC and closing the West Santa Ana OOS

Cost Analysis

The Cost Analysis highlighted the estimated Present Value (PV) of each COA for the VISN 22 Greater Los Angeles Market across a 30-year horizon. The cost of the VA Recommendation COA ($47.7 B) was lower than the Status Quo COA ($48.5 B) and the Modernization COA ($49.4 B).

For the VISN 22 Greater Los Angeles Market, the VA Recommendation COA is $881.4 M (1.8%) less expensive than the Status Quo COA and $1.7 B (3.5%) less expensive than the Modernization COA. The

cost difference between the VA Recommendation COA and Status Quo COA can be attributed to new facilities, closing or modernizing existing facilities, and scaling capacity of existing facilities up or down to meet future Veteran in-house demand to accommodate changes in demand.

The table below outlines the costs associated with each of the COAs. For more detail refer to Appendix A – VISN 22 Greater Los Angeles: Capital and Operational Costs Detail.

Table 56 – Total Cost Summary by COA

	Status Quo	Modernization	VA Recommendation
Total Costs (PV)	($48,539,637,973)	($49,400,036,046)	($47,658,247,471)
Capital Cost Variance vs. Status Quo	N/A	($860,398,073)	$881,390,502
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Non-VA Care Operational Cost Variance	N/A	$0	$0
VA Care Operational Cost Variance	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($860,398,073)	$881,390,502
Estimated Total Cost Variance vs. Modernization	N/A	N/A	$1,741,788,575

Benefit Analysis

This section describes the non-financial benefit analysis results for the VISN 22 Greater Los Angeles Market across five domains: Demand and Supply, Access, Quality, Facilities and Sustainability, and Mission. The results indicate that the VA Recommendation COA provides the most benefit (greatest Total Benefit Score) in comparison to the Status Quo and Modernization COAs.

Table 57 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3
Access	2	2	1
Quality	2	3	3

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Facilities and Sustainability	1	2	3
Mission	2	2	3
Total Benefit Score	**8**	**11**	**13**

The scoring and rationale within each domain are described in the following sections. The data underlying the analysis is provided in Appendix B – VISN 22 Greater Los Angeles: Benefits Analysis Key Data. Additional information regarding the scoring methodology is provided in the CBA Methodology.

Demand and Supply

Within the Demand and Supply domain, the CBA considers how each COA impacts VA's ability to meet Veteran demand in the future. Each COA is assessed on two benefit components: (1) the ability to balance demand and supply; (2) the changes to facility placement or service offerings that improve VA's ability to meet future demand.

The table below shows the scores for VISN 22 Greater Los Angeles for this domain.

Table 58 – Demand and Supply Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3

Status Quo: The COA received a score of 1 because at least one inpatient service line was over/under supplied, or more than 50% of specialties were inadequately supplied when compared to future Veteran in-house demand. Additionally, no changes to facilities or services were introduced that improve VA's ability to meet future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, expansion of services).

Modernization: The COA received a score of 2 because, while Modernization right-sizes services to meet future Veteran in-house demand, the COA does not include changes to facilities or services that improve VA's ability to meet future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, addition of new services).

VA Recommendation: The COA received a score of 3 because it right-sizes services to meet future Veteran enrollee demand and includes changes to facilities or services that improve VA's ability to meet future Veteran enrollee demand based on guidelines established in the CBA methodology. These changes include the following:

- Expands the Los Angeles MS CBOC to a HCC, adding outpatient surgery services
- Establishes the new Harbor UCLA Medical Center inpatient medicine and surgery partnership
- Establishes the new Cedars-Sinai Torrance Memorial Medical Center inpatient medicine and surgery partnership
- Establishes the new LAC+USC Medical Center inpatient medicine and surgery partnership

- Establishes the new UCLA Medical Center Santa Monica inpatient medicine and surgery partnership
- Establishes the new Ronald Reagan UCLA Medical Center inpatient medicine and surgery partnership
- Establishes the new USC Verdugo Hills Hospital inpatient medicine and surgery partnership
- Establishes the new Keck Hospital of USC inpatient medicine and surgery partnership
- Establishes the new Cedars-Sinai Medical Center inpatient medicine and surgery partnership
- Establishes the new Cedars-Sinai Marina Del Ray Hospital inpatient medicine and surgery partnership
- Establishes the new Olive View-UCLA Medical Center inpatient medicine and surgery partnership

Access

Within the Access domain, the CBA considers how each COA impacts Veteran access to care in the future. Each COA is assessed on the change in enrollee proximity to VA-provided primary care, specialty care, and outpatient mental health care.

The table below shows the CBA access scores for VISN 22 Greater Los Angeles for this domain.

Table 59 – Access Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Access	2	2	1

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (inclusive of VA, Community Care Network providers, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future high-performing integrated delivery network (HPIDN).

Status Quo: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

Modernization: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

VA Recommendation: The COA received a score of 1 because access to VA-provided primary care decreased 1% or more, specialty care was maintained within 1%, and outpatient mental health care decreased 1% or more.

Quality

Within the Quality domain, the CBA considers how each COA impacts the quality of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the ability of the main patient care facilities to support modern healthcare; (2) the ability of demand to support clinical competency.

The table below shows the scores for VISN 22 Greater Los Angeles for this domain.

Table 60 – Quality Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Quality	2	3	3

Status Quo: The COA received a score of 2 for two reasons. First, the COA includes main patient care facilities that were built prior to the emergence of modern healthcare design principles and specific standards to support modern medicine (e.g., floor-to-floor heights, corridor widths, columns spacing, and utility infrastructure requirements). Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Modernization: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

VA Recommendation: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery. The COA includes the following actions to ensure adequate demand across inpatient acute service lines throughout the market:

Facilities and Sustainability

Within the Facilities and Sustainability domain, the CBA considers how each COA impacts the sustainability of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the useful life of the main patient care facilities; (2) changes that strengthen VA's ability to recruit and retain providers.

The table below shows the scores for VISN 22 Greater Los Angeles for this domain.

Table 61 – Facilities and Sustainability Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Facilities and Sustainability	1	2	3

Note: The American Hospital Association estimates that a hospital's useful life, a measure which predicts the productive period of a typical capital asset before it becomes obsolete or needs replacement, is currently 40 years.

Status Quo: The COA received a score of 1 for two reasons. First, the COA includes at least one main patient care facility that exceeds its useful life as defined by the American Hospital Association, indicating it may be obsolete or need replacement. Second, the COA does not include changes that strengthen VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Modernization: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

VA Recommendation: The COA received a score of 3 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, in addition to modernized infrastructure which may attract providers, it also includes additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities). The COA includes the following actions to support VA's ability to recruit or retain providers:

- Establishes the new Harbor UCLA Medical Center inpatient medicine and surgery partnership
- Establishes the new Cedars-Sinai Torrance Memorial Medical Center inpatient medicine and surgery partnership
- Establishes the new LAC+USC Medical Center inpatient medicine and surgery partnership
- Establishes the new UCLA Medical Center Santa Monica inpatient medicine and surgery partnership
- Establishes the new Ronald Reagan UCLA Medical Center inpatient medicine and surgery partnership
- Establishes the new USC Verdugo Hills Hospital inpatient medicine and surgery partnership
- Establishes the new Keck Hospital of USC inpatient medicine and surgery partnership
- Establishes the new Cedars-Sinai Medical Center inpatient medicine and surgery partnership
- Establishes the new Cedars-Sinai Marina Del Ray Hospital inpatient medicine and surgery partnership
- Establishes the new Olive View-UCLA Medical Center inpatient medicine and surgery partnership

Mission

Within the Mission domain, the CBA considers how each COA impacts VA's ability to support its statutory missions of Education, Research, and Emergency Preparedness in the future. Each COA is assessed on three benefit components: (1) the impact on training programs; (2) the impact on research programs; (3) the impact on emergency preparedness.

A COA's overall score in the Mission domain is determined by the rounded average (unweighted) of its component (e.g., Education, Research, Emergency Preparedness) scores. The table below shows the scores for VISN 22 Greater Los Angeles for this domain.

Table 62 – Mission Scoring Summary

Subdomain	Status Quo	Modernization	VA Recommendation
Education	2	2	3
Research	2	2	3
Emergency Preparedness	2	2	2
Overall Mission Score (Rounded Average)	**2**	**2**	**3**

Status Quo: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Modernization: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

VA Recommendation: The COA received a score of 3 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 3 because inpatient acute services remain VA-delivered and thus the COA maintains existing training programs. Additionally, the COA includes new (not replacement) infrastructure that creates new opportunities for training within the market.
- **Research:** The COA received a score of 3 because it maintains all research programs and builds new (not replacement) infrastructure to support additional research space.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Sensitivity Analysis

A sensitivity analyses study shows how various sources of uncertainty in a mathematical model contribute to the model's overall uncertainty. The market is considered sensitive to a scenario when the VA Recommendation is no longer the leading COA due to changes in benefit scores, VA capital costs, VA operational costs, or non-VA operational costs.

The table below outlines the sensitivity analysis scenarios completed.

Table 63 – Sensitivity Analysis Scenarios

Sensitivity Analysis Scenarios
Increase Benefit Scores for Status Quo and Modernization in increments of one from 1 to 3 points
Increase VA Capital Costs in 50% increments from 0% to 300%
Increase VA Operational Costs in 50% increments from 0% to 300%
Increase Non-VA Operational Costs in 50% increments from 0% to 300%

Sensitivity Analysis Results Summary

In the VISN 22 Greater Los Angeles Market, one scenario changed the outcome of the CBA:

- Increasing the Modernization benefits score by three points

Sensitivity Analysis Full Results

The below tables show the results across all sensitivity analysis scenarios.

Table 64 – Sensitivity Analyses – Benefit Score Increase

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+0	6.07	4.49	3.67	VA Recommendation
+1	5.39	4.12	3.67	VA Recommendation
+2	4.85	3.80	3.67	VA Recommendation
+3	4.41	3.53	3.67	Modernization

Table 65 – Sensitivity Analyses – VA Capital Cost Increase

VA Capital Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	6.07	4.49	3.67	VA Recommendation
50%	6.39	4.76	3.83	VA Recommendation
100%	6.71	5.04	3.99	VA Recommendation
150%	7.03	5.31	4.16	VA Recommendation
200%	7.35	5.58	4.32	VA Recommendation
250%	7.67	5.85	4.48	VA Recommendation
300%	7.99	6.13	4.65	VA Recommendation

Table 66 – Sensitivity Analyses – VA Operational Cost Increase

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	6.07	4.49	3.67	VA Recommendation
50%	8.32	6.13	5.05	VA Recommendation
100%	10.57	7.76	6.44	VA Recommendation
150%	12.82	9.40	7.82	VA Recommendation
200%	15.07	11.04	9.20	VA Recommendation
250%	17.32	12.67	10.59	VA Recommendation

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
300%	19.57	14.31	11.97	VA Recommendation

Table 67 – Sensitivity Analyses – Non-VA Operational Cost Increase

Non-VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	6.07	4.49	3.67	VA Recommendation
50%	6.53	4.83	3.95	VA Recommendation
100%	6.99	5.16	4.24	VA Recommendation
150%	7.46	5.50	4.52	VA Recommendation
200%	7.92	5.84	4.80	VA Recommendation
250%	8.38	6.17	5.09	VA Recommendation
300%	8.84	6.51	5.37	VA Recommendation

Appendix A – VISN 22 Greater Los Angeles: Capital and Operational Costs Detail

Table 68 – Capital Costs by COA

	Status Quo	Modernization	VA Recommendation
VAMC Ideal Square Footage	-	5,132,172	5,117,218
Build New GSF	-	2,077,866	2,066,789
Renovate In Place GSF	-	1,208,302	1,179,265
Matched Convert To GSF	-	1,118,751	1,147,788
Demolition GSF	-	2,343,671	2,343,671
Total Build New Cost	$0	($2,387,394,176)	($2,374,223,744)
Total Renovate In Place Cost	$0	($482,735,792)	($470,401,008)
Total Matched Convert To Cost	$0	($547,518,280)	($564,538,629)
Total Demolition Cost	$0	($101,819,567)	($101,819,567)
Total Lease Build-Out Cost	$0	($50,159,998)	($61,996,741)
Total New Lease Cost	$0	($229,002,821)	($268,433,306)
Total Existing Lease Cost	($69,682,421)	($69,682,334)	($62,934,608)
NRM Costs for Owned Facilities	($3,599,804,641)	($599,143,174)	($597,397,411)
FCA Correction Cost	($1,204,317,772)	N/A	N/A
Estimated Base Modernization Cost	($4,873,804,833)	($4,467,456,142)	($4,501,745,013)
Additional Common/Lobby Space Needed (GSF)	-	727,253	723,376
Cost of Additional Common/Lobby Space	$0	($693,327,463)	($689,529,650)
Additional Parking Cost	$0	($48,184,844)	($49,307,908)

	Status Quo	Modernization	VA Recommendation
Potential Land Acquisition Cost	$0	($10,380,432)	($9,927,939)
Seismic Correction Cost	($179,473,014)	($74,995,756)	($74,995,757)
Non-Building FCA Correction Cost	($85,647,485)	($85,647,484)	($85,647,485)
Activation Costs	$0	($619,331,284)	($613,681,077)
Estimated Additional Costs for Modernization	($265,120,499)	($1,531,867,263)	($1,523,089,816)
Cost Adjustment: In-Progress Construction	N/A	N/A	$1,767,300,000
Cost Adjustment: In-Progress Lease	N/A	N/A	$0
Estimated Facilities Costs (PV)	($5,138,925,332)	($5,999,323,405)	($4,257,534,830)

Table 69 – Operational Costs by COA

	Status Quo	Modernization	VA Recommendation
VA Direct	($19,676,406,040)	($19,676,406,040)	($19,676,406,040)
Fixed Direct	($2,431,807,098)	($2,431,807,098)	($2,431,807,098)
VA Specific Direct	($1,232,931,787)	($1,232,931,787)	($1,232,931,787)
Indirect	($9,461,532,044)	($9,461,532,044)	($9,461,532,044)
VA Specific Indirect	($1,411,344,093)	($1,411,344,093)	($1,411,344,093)
Research and Education	($106,836,515)	($106,836,515)	($106,836,515)
VA Overhead	($1,678,782,728)	($1,678,782,728)	($1,678,782,728)
VA Care Operational Cost Total (PV)	($35,999,640,305)	($35,999,640,305)	($35,999,640,305)
CC Direct	($4,282,347,461)	($4,282,347,461)	($4,282,347,461)
Delivery and Operations	($180,024,544)	($180,024,544)	($180,024,544)

	Status Quo	Modernization	VA Recommendation
Care Coordination	($157,458,295)	($157,458,295)	($157,458,295)
CC Overhead	($230,362,198)	($230,362,198)	($230,362,198)
Admin PMPM	($2,550,879,837)	($2,550,879,837)	($2,550,879,837)
Non-VA Care Operational Cost Total (PV)	($7,401,072,336)	($7,401,072,336)	($7,401,072,336)
Estimated Operational Costs (PV)	($43,400,712,642)	($43,400,712,642)	($43,400,712,642)

Appendix B – VISN 22 Greater Los Angeles: Benefits Analysis Key Data

Below are key data points used in the benefit analysis, summarized in the above Benefit Analysis section.

Demand and Supply

Inpatient

Table 70 – Demand and Supply Key Data Points for Scoring – Inpatient (IP)

Service Line	100% of FY29 In-house Bed Need	120% of FY29 In-house Bed Need	Operating Beds	Supply Adequacy (within 100-120% of in-house demand)
IP CLC	288	345	348	Over Supplied
IP Med/Surg	177	213	248	Over Supplied
IP MH	81	97	82	Adequately Supplied

Note: Community Living Center (CLC); Medicine (Med); Surgery (Surg); Mental Health (MH)

Source: Enrollee Healthcare Projection Model Base Year 2019

Outpatient

Table 71 – Demand and Supply Key Data Points for Scoring – Outpatient (OP)

Physician Supply Adequacy	Count of Specialties	Percentage
Adequately Supplied	10	37%
Under Supplied	17	63%

Note: VA supply in the Status Quo COA is quantitatively evaluated based on the data above. It is assumed the Modernization COA scales the capacity of existing facilities up or down to meet future Veteran in-house demand. Similar to the Modernization COA, it is assumed the VA Recommendation COA scales the capacity of existing and proposed facilities up or down to meet future Veteran in-house demand. However, the VA Recommendation COA may account for factors that demand projections do not consider that may shift the future balance of in-house and community workload, such as:

- Areas with unmet Veteran demand that may warrant a net new point of care
- Low-census inpatient acute programs that may pose risks to quality and training programs, potentially warranting a shift to community providers
- Community capacity factors that may warrant changes to VA capacity

Source: Office of Productivity, Efficiency and Staffing 2019 Capacity Report

Table 72 – New Facility Demand Guidelines

Facility or Service	Guideline
Inpatient Acute VAMCs	Greater than or equal to 35,000 overlapping enrollees
Inpatient CLC	Greater than or equal to 21,000 overlapping enrollees
Health Care Center	Greater than or equal to 34,000 overlapping enrollees
MS CBOC	Greater than or equal to 4,300 non-overlapping enrollees
CBOC	Greater than or equal to 2,500 non-overlapping enrollees

Note: The above guidelines are used to determine whether a new (not replacement) point of care or service proposed in the VA recommendation had adequate demand.

Access

Table 73 – Access Key Data Points for Scoring

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of VA-provided OP Mental Health	94.6%	94.6%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of VA-provided OP Primary Care	94.6%	94.6%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of VA-provided OP Specialty Care	97.1%	97.1%	Maintained within 1%

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	99.4%	99.4%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.8%	99.8%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	100.0%	100.0%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Mental Health	94.6%	94.6%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Primary Care	94.6%	94.6%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of VA-provided OP Specialty Care	97.1%	97.1%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	99.4%	99.4%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.8%	99.8%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	100.0%	100.0%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Mental Health	94.6%	93.5%	Decreased 1% or more

COA	Measure	Current	Future	Result
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Primary Care	94.6%	93.5%	Decreased 1% or more
VA Recommendation	% of enrollees within 60 minutes of VA-provided OP Specialty Care	97.1%	97.2%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	99.4%	99.4%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.8%	99.8%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	100.0%	100.0%	Maintained within 1%

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (HPIDN) (inclusive of VA, Community Care Network, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future HPIDN. The table above shows the results for enrollee proximity to the full HPIDN as well as to VA-provided care in the market.

Source: Enrollee data from the FY19 Geocoded Enrollee File. Existing VA facility location data from VAST. Commercial provider location data from Definitive Healthcare.

Quality

Main Patient Care Facility Construction Date

Table 74 – Quality Key Data Points for Scoring – Age

Facility	Main Patient Care Facility Construction Date	Built Pre-1970?
(V22) (600) Long Beach	1967	Yes
(V22) (691) West Los Angeles	1976	No
(V22) (691A4) Sepulveda	1996	No

Source: Main patient care facility construction and renovation dates from CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Inpatient Acute Demand

Table 75 – Quality Key Data Points for Scoring – Inpatient Acute Demand

Facility	Service	Demand Guideline	Meets or Exceeds Guideline?	VA Recommendation
(V22) (600) Long Beach	IP Med	20 ADC	Yes	Maintain
(V22) (600) Long Beach	IP Surg	1,600 Cases	Yes	Maintain
(V22) (600) Long Beach	IP MH	8 ADC	Yes	Maintain
(V22) (691) West Los Angeles	IP Med	20 ADC	Yes	Maintain
(V22) (691) West Los Angeles	IP Surg	1,600 Cases	Yes	Maintain
(V22) (691) West Los Angeles	IP MH	8 ADC	Yes	Maintain

Note: The Status Quo and Modernization COAs are assumed to maintain all current facilities and services. The VA Recommendation COA proposes maintaining, partnering, and divesting of services at each facility, shown in the last column titled “VA Recommendation”. To score a 3, the VA recommendation must partner or divest of all low-demand services.

Source: FY 2029 average daily census for inpatient services is based on Enrollee Healthcare Projection Model Base Year 2019. 2019 Total Surgical Cases is from the VA National Surgery Office.

Facilities and Sustainability

Table 76 – Facilities and Sustainability Key Data Points for Scoring

Facility	Main Patient Care Facility Construction Date	Most Recent Main Patient Care Facility Renovation Date	Exceeds Useful Life?
(V22) (600) Long Beach	1967	1996	Yes
(V22) (691) West Los Angeles	1976	N/A	Yes
(V22) (691A4) Sepulveda	1996	N/A	No

Note: Exceeding useful life is defined as 1) When a main patient care facility was built before 1970 it has exceeded its useful life, even if it has undergone major renovation in the last 40 years. 2) When a main patient care facility was built after 1970 but is still more than 40 years old (built on or after 1971 and before 1989), it must have

undergone major renovation within the last 40 years to not exceed its useful life. 3) When a main patient care facility was built in or after 1989, it has not exceeded its useful life.

Source: From CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Table 77 – Key Data Points for Scoring - Recruitment and Retention

Facility	Expands VA's Ability to Recruit/Retain?
Harbor UCLA Medical Center IP Partnership	Yes
Cedars-Sinai Torrance Memorial Medical Center IP Partnership	Yes
LAC+USC Medical Center IP Partnership	Yes
UCLA Medical Center Santa Monica IP Partnership	Yes
Ronald Reagan UCLA Medical Center IP Partnership	Yes
USC Verdugo Hills Hospital IP Partnership	Yes
Keck Hospital of USC IP Partnership	Yes
Cedars-Sinai Medical Center IP Partnership	Yes
Cedars-Sinai Marina Del Ray Hospital IP Partnership	Yes
Olive View-UCLA Medical Center IP Partnership	Yes

Mission

Table 78 – Mission Key Data Points for Scoring

The Status Quo and Modernization COAs are assumed to have no impact on VA's statutory missions. The impact of the VA Recommendation on VA's statutory missions is shown in the table below:

Facility	Training Impact	Research Impact	4th Mission Impact	Market Plan Includes New Facilities/Services To Increase Training/Research Opportunities
(V22) (600) Long Beach	No impact on training	Maintains or Has Plan to Transition	Maintains PRC-designation	Increases Research Opportunities, Increases Training Opportunities

Facility	Training Impact	Research Impact	4th Mission Impact	Market Plan Includes New Facilities/Services To Increase Training/Research Opportunities
(V22) (691) West Los Angeles	No impact on training	Maintains or Has Plan to Transition	No PRC Designation	Increases Research Opportunities, Increases Training Opportunities

VISN 22 Albuquerque

The recommendations for modernization and realignment of VHA infrastructure submitted by the Secretary of the Department of Veterans Affairs to the Asset and Infrastructure Review (AIR) Commission are focused on allowing VA to provide accessible, timely, and high-quality health care for Veterans now and in the future. To inform the recommendations, VA conducted a Cost Benefit Analysis (CBA) that examines the cost-efficiency and benefits to Veterans of various courses of action (COAs) within each market. The CBA compares the costs and benefits associated with maintaining the current facilities, modernizing the current facilities, or strategically realigning and modernizing facilities in each market to inform the identification of a preferred COA.

The CBA aligns with requirements outlined in Section 1703C of Title 38, United States Code (U.S.C.), as added by Section 203 of the VA MISSION Act of 2018.

> *VA MISSION Act, Section 203(2)(F)*
>
> *"In making recommendations under this subsection, the Secretary shall consider…the extent and timing of potential costs and savings, including the number of years such costs or savings will be incurred, beginning with the date of completion of the proposed recommendation."*

This CBA summary document defines the COAs, provides a brief overview of the methodology, and outlines the results of the CBA and the associated sensitivity analysis.

Overview of COAs and Methodology

The Cost Benefit Analysis (CBA) reviews, analyzes, and compares the costs and benefits of three distinct courses of action (COA):

- maintaining VA's current facilities assuming no changes or additional modernization to current facilities, programs, and infrastructure (COA Name: Status Quo)
- modernizing the current facilities without strategically realigning facilities (COA Name: Modernization)
- strategically realigning and modernizing facilities (COA Name: VA Recommendation to the AIR Commission)

To evaluate these courses of action, VA examined the combined cost and benefits of each COA for each market. The CBA was 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 CBI equals the total life-cycle cost (PV) of each COA in PV dollars, divided by the Benefits Analysis score for that COA's non-financial benefits normalized to the billions place. The COA with the lowest CBI score is the preferred COA.

Summary of Results

The VA Recommendation COA is the leading COA analyzed in the VISN 22 Albuquerque Market due to its leading Cost Benefit Index (CBI) score. The CBI score for the VA Recommendation COA (1.19) is 29.1% lower than the Status Quo COA (1.68) and 14.7% lower than the Modernization COA (1.39).

The VA Recommendation COA is $367.8 M (2.4%) more expensive than the Status Quo COA and $128.3 M (0.8%) more expensive than the Modernization COA. While the VA Recommendation COA increases cost compared to the Status Quo and Modernization COAs, it also increases benefits as seen by a 13-point benefits score compared to 9 for the Status Quo COA and 11 for the Modernization COA.

The tables below detail the present values, benefit scores, and CBIs for each COA.

Table 79 – CBI Scores by COA

	Status Quo	Modernization	VA Recommendation
COA PV ($)	($15,079,510,039)	($15,319,048,032)	($15,447,351,758)
Benefit Analysis Score	9	11	13
CBI (Normalized in $Billions)	1.68	1.39	1.19
CBI % Change vs. Status Quo	N/A	-16.9%	-29.1%
CBI % Change vs. Modernization	N/A	N/A	-14.7%

Table 80 – Cost Analysis Cost Variance by COA

Cost Variance	Status Quo	Modernization	VA Recommendation
Capital Cost Variance vs. Status Quo	N/A	($239,537,993)	($367,841,719)
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($239,537,993)	($367,841,719)
Estimated Total Cost Variance vs. Modernization	N/A	N/A	($128,303,726)

Note: Operational unit costs were provided at the parent facility level not at the facility level. Therefore, the analysis does not estimate the changes in operational costs stemming from new, expanded, or removed points of care (POC). The analysis only shows changes to operational costs when a service line is shifted, at the parent facility level, from VA care to non-VA care.

Table 81 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3
Access	2	2	1
Quality	3	3	3
Facilities and Sustainability	1	2	3
Mission	2	2	3
Total Benefit Score	**9**	**11**	**13**

VA Recommendation

The VA Recommendation for the VISN 22 Albuquerque Market COA is detailed below.

- Modernize and realign the Albuquerque VAMC by:
  - Relocating and expanding CLC services at the Albuquerque VAMC
  - Modernizing the inpatient medical and surgical units and the RRTP at the Albuquerque VAMC
  - Modernizing the SCI/D units at the Albuquerque VAMC
  - Modernizing the dental clinic at the Albuquerque VAMC
  - Modernizing the women's health clinic at the Albuquerque VAMC
- Modernize and realign outpatient facilities in the market by:
  - Relocating the Northwest Metro New Mexico CBOC to a new site in the vicinity of Albuquerque, New Mexico, and closing the Northwest Metro New Mexico CBOC
  - Establishing a strategic collaboration with the Indian Health Service (IHS) to provide primary care and outpatient mental health services and closing the Gallup CBOC
  - Relocating all services at the Las Vegas, New Mexico, CBOC and closing the Las Vegas, New Mexico CBOC
  - Relocating all services at the Raton OOS and closing the Raton OOS
  - Relocating all services at the Espanola OOS and closing the Espanola OOS

Cost Analysis

The Cost Analysis highlighted the estimated Present Value (PV) of each COA for the VISN 22 Albuquerque Market across a 30-year horizon. The cost of the VA Recommendation COA ($15.4 B) was higher than the Status Quo COA ($15.1 B) and the Modernization COA ($15.3 B).

For the VISN 22 Albuquerque Market, the VA Recommendation COA is $367.8 M (2.4%) more expensive than the Status Quo COA and $128.3 M (0.8%) more expensive than the Modernization COA. The cost difference between the VA Recommendation COA and Status Quo COA can be attributed to new facilities, closing or modernizing existing facilities, and scaling capacity of existing facilities up or down to meet future Veteran in-house demand to accommodate changes in demand.

The table below outlines the costs associated with each of the COAs. For more detail refer to Appendix A – VISN 22 Albuquerque: Capital and Operational Costs Detail.

Table 82 – Total Cost Summary by COA

	Status Quo	Modernization	VA Recommendation
Total Costs (PV)	($15,079,510,039)	($15,319,048,032)	($15,447,351,758)
Capital Cost Variance vs. Status Quo	N/A	($239,537,993)	($367,841,719)
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Non-VA Care Operational Cost Variance	N/A	$0	$0
VA Care Operational Cost Variance	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($239,537,993)	($367,841,719)
Estimated Total Cost Variance vs. Modernization	N/A	N/A	($128,303,726)

Benefit Analysis

This section describes the non-financial benefit analysis results for the VISN 22 Albuquerque Market across five domains: Demand and Supply, Access, Quality, Facilities and Sustainability, and Mission. The results indicate that the VA Recommendation COA provides the most benefit (greatest Total Benefit Score) in comparison to the Status Quo and Modernization COAs.

Table 83 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3
Access	2	2	1
Quality	3	3	3
Facilities and Sustainability	1	2	3
Mission	2	2	3

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Total Benefit Score	**9**	**11**	**13**

The scoring and rationale within each domain are described in the following sections. The data underlying the analysis is provided in Appendix B – VISN 22 Albuquerque: Benefits Analysis Key Data. Additional information regarding the scoring methodology is provided in the CBA Methodology.

Demand and Supply

Within the Demand and Supply domain, the CBA considers how each COA impacts VA's ability to meet Veteran demand in the future. Each COA is assessed on two benefit components: (1) the ability to balance demand and supply; (2) the changes to facility placement or service offerings that improve VA's ability to meet future demand.

The table below shows the scores for VISN 22 Albuquerque for this domain.

Table 84 – Demand and Supply Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3

Status Quo: The COA received a score of 1 because at least one inpatient service line was over/under supplied, or more than 50% of specialties were inadequately supplied when compared to future Veteran in-house demand. Additionally, no changes to facilities or services were introduced that improve VA's ability to meet the future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, expansion of services).

Modernization: The COA received a score of 2 because, while Modernization right-sizes services to meet future Veteran in-house demand, the COA does not include changes to facilities or services that improve VA's ability to meet future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, addition of new services).

VA Recommendation: The COA received a score of 3 because it right-sizes services to meet future Veteran enrollee demand and includes changes to facilities or services that improve VA's ability to meet future Veteran enrollee demand based on guidelines established in the CBA methodology. These changes include the following:

- Establishes a new Northwest Metro New Mexico MS CBOC to provide primary care, specialty care, and outpatient mental health services; there are 13,035 enrollees for which the proposed facility is the closest VA point of care within 60 minutes
- Establishes the new Gallup primary care and outpatient mental health partnership

Access

Within the Access domain, the CBA considers how each COA impacts Veteran access to care in the future. Each COA is assessed on the change in enrollee proximity to VA-provided primary care, specialty care, and outpatient mental health care.

The table below shows the CBA access scores for VISN 22 Albuquerque for this domain.

Table 85 – Access Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Access	2	2	1

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (inclusive of VA, Community Care Network providers, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future high-performing integrated delivery network (HPIDN).

Status Quo: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

Modernization: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

VA Recommendation: The COA received a score of 1 because access to VA-provided primary care decreased 1% or more, specialty care increased 1% or more, and outpatient mental health care decreased 1% or more.

Quality

Within the Quality domain, the CBA considers how each COA impacts the quality of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the ability of the main patient care facilities to support modern healthcare; (2) the ability of demand to support clinical competency.

The table below shows the scores for VISN 22 Albuquerque for this domain.

Table 86 – Quality Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Quality	3	3	3

Status Quo: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Modernization: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning

guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

VA Recommendation: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Facilities and Sustainability

Within the Facilities and Sustainability domain, the CBA considers how each COA impacts the sustainability of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the useful life of the main patient care facilities; (2) changes that strengthen VA's ability to recruit and retain providers.

The table below shows the scores for VISN 22 Albuquerque for this domain.

Table 87 – Facilities and Sustainability Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Facilities and Sustainability	1	2	3

Note: The American Hospital Association estimates that a hospital's useful life, a measure which predicts the productive period of a typical capital asset before it becomes obsolete or needs replacement, is currently 40 years.

Status Quo: The COA received a score of 1 for two reasons. First, the COA includes at least one main patient care facility that exceeds its useful life as defined by the American Hospital Association, indicating it may be obsolete or need replacement. Second, the COA does not include changes that strengthen VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Modernization: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

VA Recommendation: The COA received a score of 3 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, in addition to modernized infrastructure which may attract providers, it also includes additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded

partnerships between VA and academic affiliates, other Federal facilities, or community facilities). The COA includes the following action to support VA's ability to recruit or retain providers:

- Establishes the new Gallup primary care and outpatient mental health partnership

Mission

Within the Mission domain, the CBA considers how each COA impacts VA's ability to support its statutory missions of Education, Research, and Emergency Preparedness in the future. Each COA is assessed on three benefit components: (1) the impact on training programs; (2) the impact on research programs; (3) the impact on emergency preparedness.

A COA's overall score in the Mission domain is determined by the rounded average (unweighted) of its component (e.g., Education, Research, Emergency Preparedness) scores. The table below shows the scores for VISN 22 Albuquerque for this domain.

Table 88 – Mission Scoring Summary

Subdomain	Status Quo	Modernization	VA Recommendation
Education	2	2	3
Research	2	2	3
Emergency Preparedness	2	2	2
Overall Mission Score (Rounded Average)	**2**	**2**	**3**

Status Quo: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Modernization: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

VA Recommendation: The COA received a score of 3 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 3 because inpatient acute services remain VA-delivered and thus the COA maintains existing training programs. Additionally, the COA includes new (not replacement) infrastructure that creates new opportunities for training within the market.
- **Research:** The COA received a score of 3 because it maintains all research programs and builds new (not replacement) infrastructure to support additional research space.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Sensitivity Analysis

A sensitivity analyses study shows how various sources of uncertainty in a mathematical model contribute to the model's overall uncertainty. The market is considered sensitive to a scenario when the VA Recommendation is no longer the leading COA due to changes in benefit scores, VA capital costs, VA operational costs, or non-VA operational costs.

The table below outlines the sensitivity analysis scenarios completed.

Table 89 – Sensitivity Analysis Scenarios

Sensitivity Analysis Scenarios
Increase Benefit Scores for Status Quo and Modernization in increments of one from 1 to 3 points
Increase VA Capital Costs in 50% increments from 0% to 300%
Increase VA Operational Costs in 50% increments from 0% to 300%
Increase Non-VA Operational Costs in 50% increments from 0% to 300%

Sensitivity Analysis Results Summary

In the VISN 22 Albuquerque Market, two scenarios changed the outcome of the CBA:

- Increasing the Modernization benefits score by two points
- Increasing the Modernization benefits score by three points

Sensitivity Analysis Full Results

The below tables show the results across all sensitivity analysis scenarios.

Table 90 – Sensitivity Analyses – Benefit Score Increase

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+0	1.68	1.39	1.19	VA Recommendation

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+1	1.51	1.28	1.19	VA Recommendation
+2	1.37	1.18	1.19	Modernization
+3	1.26	1.09	1.19	Modernization

Table 91 – Sensitivity Analyses – VA Capital Cost Increase

VA Capital Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	1.68	1.39	1.19	VA Recommendation
50%	1.74	1.45	1.25	VA Recommendation
100%	1.80	1.52	1.30	VA Recommendation
150%	1.86	1.58	1.36	VA Recommendation
200%	1.92	1.64	1.42	VA Recommendation
250%	1.98	1.70	1.47	VA Recommendation
300%	2.05	1.76	1.53	VA Recommendation

Table 92 – Sensitivity Analyses – VA Operational Cost Increase

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	1.68	1.39	1.19	VA Recommendation

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
50%	2.19	1.81	1.55	VA Recommendation
100%	2.71	2.24	1.90	VA Recommendation
150%	3.22	2.66	2.26	VA Recommendation
200%	3.74	3.08	2.62	VA Recommendation
250%	4.26	3.50	2.97	VA Recommendation
300%	4.77	3.93	3.33	VA Recommendation

Table 93 – Sensitivity Analyses – Non-VA Operational Cost Increase

Non-VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	1.68	1.39	1.19	VA Recommendation
50%	1.94	1.61	1.37	VA Recommendation
100%	2.20	1.82	1.55	VA Recommendation
150%	2.46	2.03	1.73	VA Recommendation
200%	2.71	2.24	1.91	VA Recommendation
250%	2.97	2.46	2.09	VA Recommendation
300%	3.23	2.67	2.27	VA Recommendation

Appendix A – VISN 22 Albuquerque: Capital and Operational Costs Detail

Table 94 – Capital Costs by COA

	Status Quo	Modernization	VA Recommendation
VAMC Ideal Square Footage	-	1,450,978	1,559,884
Build New GSF	-	447,341	528,012
Renovate In Place GSF	-	474,169	471,727
Matched Convert To GSF	-	372,899	375,341
Demolition GSF	-	260,304	260,304
Total Build New Cost	$0	($413,877,210)	($487,886,944)
Total Renovate In Place Cost	$0	($150,056,380)	($148,574,066)
Total Matched Convert To Cost	$0	($150,544,500)	($151,346,149)
Total Demolition Cost	$0	($8,895,658)	($8,895,658)
Total Lease Build-Out Cost	$0	($20,646,959)	($25,410,519)
Total New Lease Cost	$0	($72,214,948)	($88,927,346)
Total Existing Lease Cost	($23,631,398)	($23,631,320)	($11,279,917)
NRM Costs for Owned Facilities	($862,845,804)	($169,391,002)	($182,104,955)
FCA Correction Cost	($187,980,851)	N/A	N/A
Estimated Base Modernization Cost	($1,074,458,054)	($1,009,257,977)	($1,104,425,554)
Additional Common/Lobby Space Needed (GSF)	-	156,569	184,804
Cost of Additional Common/Lobby Space	$0	($117,951,087)	($139,221,734)
Additional Parking Cost	$0	($8,519,315)	($12,577,470)

	Status Quo	Modernization	VA Recommendation
Potential Land Acquisition Cost	$0	($2,301,598)	($3,351,427)
Seismic Correction Cost	($12,892,532)	($7,124,544)	($7,124,545)
Non-Building FCA Correction Cost	($24,829,271)	($24,829,270)	($24,829,271)
Activation Costs	$0	($181,734,058)	($188,491,575)
Estimated Additional Costs for Modernization	($37,721,802)	($342,459,872)	($375,596,020)
Cost Adjustment: In-Progress Construction	N/A	N/A	$0
Cost Adjustment: In-Progress Lease	N/A	N/A	$0
Estimated Facilities Costs (PV)	($1,112,179,856)	($1,351,717,849)	($1,480,021,575)

Table 95 – Operational Costs by COA

	Status Quo	Modernization	VA Recommendation
VA Direct	($5,215,169,452)	($5,215,169,452)	($5,215,169,452)
Fixed Direct	($871,876,494)	($871,876,494)	($871,876,494)
VA Specific Direct	($246,927,697)	($246,927,697)	($246,927,697)
Indirect	($2,175,788,199)	($2,175,788,199)	($2,175,788,199)
VA Specific Indirect	($331,966,489)	($331,966,489)	($331,966,489)
Research and Education	($702,263)	($702,263)	($702,263)
VA Overhead	($447,724,624)	($447,724,624)	($447,724,624)
VA Care Operational Cost Total (PV)	($9,290,155,218)	($9,290,155,218)	($9,290,155,218)
CC Direct	($2,512,369,493)	($2,512,369,493)	($2,512,369,493)
Delivery and Operations	($115,950,691)	($115,950,691)	($115,950,691)

	Status Quo	Modernization	VA Recommendation
Care Coordination	($123,028,497)	($123,028,497)	($123,028,497)
CC Overhead	($148,068,494)	($148,068,494)	($148,068,494)
Admin PMPM	($1,777,757,791)	($1,777,757,791)	($1,777,757,791)
Non-VA Care Operational Cost Total (PV)	($4,677,174,966)	($4,677,174,966)	($4,677,174,966)
Estimated Operational Costs (PV)	($13,967,330,184)	($13,967,330,184)	($13,967,330,184)

Appendix B – VISN 22 Albuquerque: Benefits Analysis Key Data

Below are key data points used in the benefit analysis, summarized in the above Benefit Analysis section.

Demand and Supply

Inpatient

Table 96 – Demand and Supply Key Data Points for Scoring – Inpatient (IP)

Service Line	100% of FY29 In-house Bed Need	120% of FY29 In-house Bed Need	Operating Beds	Supply Adequacy (within 100-120% of in-house demand)
IP CLC	16	19	43	Over Supplied
IP Med/Surg	63	75	103	Over Supplied
IP MH	23	27	40	Over Supplied

Note: Community Living Center (CLC); Medicine (Med); Surgery (Surg); Mental Health (MH)

Source: Enrollee Healthcare Projection Model Base Year 2019

Outpatient

Table 97 – Demand and Supply Key Data Points for Scoring – Outpatient (OP)

Physician Supply Adequacy	Count of Specialties	Percentage
Adequately Supplied	12	44%
Under Supplied	15	56%

Note: VA supply in the Status Quo COA is quantitatively evaluated based on the data above. It is assumed the Modernization COA scales the capacity of existing facilities up or down to meet future Veteran in-house demand. Similar to the Modernization COA, it is assumed the VA Recommendation COA scales the capacity of existing and proposed facilities up or down to meet future Veteran in-house demand. However, the VA Recommendation COA may account for factors that demand projections do not consider that may shift the future balance of in-house and community workload, such as:

- Areas with unmet Veteran demand that may warrant a net new point of care
- Low-census inpatient acute programs that may pose risks to quality and training programs, potentially warranting a shift to community providers
- Community capacity factors that may warrant changes to VA capacity

Source: Office of Productivity, Efficiency and Staffing 2019 Capacity Report

Table 98 – New Facility Demand Guidelines

Facility or Service	Guideline
Inpatient Acute VAMCs	Greater than or equal to 35,000 overlapping enrollees
Inpatient CLC	Greater than or equal to 21,000 overlapping enrollees
Health Care Center	Greater than or equal to 34,000 overlapping enrollees
MS CBOC	Greater than or equal to 4,300 non-overlapping enrollees
CBOC	Greater than or equal to 2,500 non-overlapping enrollees

Note: The above guidelines are used to determine whether a new (not replacement) point of care or service proposed in the VA recommendation had adequate demand.

Access

Table 99 – Access Key Data Points for Scoring

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of VA-provided OP Mental Health	74.0%	74.0%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of VA-provided OP Primary Care	77.3%	77.3%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of VA-provided OP Specialty Care	57.6%	57.6%	Maintained within 1%

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	94.6%	94.6%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	94.7%	94.7%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.0%	99.0%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Mental Health	74.0%	74.0%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Primary Care	77.3%	77.3%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of VA-provided OP Specialty Care	57.6%	57.6%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	94.6%	94.6%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	94.7%	94.7%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.0%	99.0%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Mental Health	74.0%	72.7%	Decreased 1% or more

COA	Measure	Current	Future	Result
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Primary Care	77.3%	72.7%	Decreased 1% or more
VA Recommendation	% of enrollees within 60 minutes of VA-provided OP Specialty Care	57.6%	58.6%	Increased 1% or more
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	94.6%	94.6%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	94.7%	95.6%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.0%	99.0%	Maintained within 1%

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (HPIDN) (inclusive of VA, Community Care Network, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future HPIDN. The table above shows the results for enrollee proximity to the full HPIDN as well as to VA-provided care in the market.

Source: Enrollee data from the FY19 Geocoded Enrollee File. Existing VA facility location data from VAST. Commercial provider location data from Definitive Healthcare.

Quality

Main Patient Care Facility Construction Date

Table 100 – Quality Key Data Points for Scoring – Age

Facility	Main Patient Care Facility Construction Date	Built Pre-1970?
(V22) (501) Albuquerque	1986	No

Source: Main patient care facility construction and renovation dates from CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Inpatient Acute Demand

Table 101 – Quality Key Data Points for Scoring – Inpatient Acute Demand

Facility	Service	Demand Guideline	Meets or Exceeds Guideline?	VA Recommendation
(V22) (501) Albuquerque	IP Med	20 ADC	Yes	Maintain
(V22) (501) Albuquerque	IP Surg	1,600 Cases	Yes	Maintain
(V22) (501) Albuquerque	IP MH	8 ADC	Yes	Maintain

Note: The Status Quo and Modernization COAs are assumed to maintain all current facilities and services. The VA Recommendation COA proposes maintaining, partnering, and divesting of services at each facility, shown in the last column titled “VA Recommendation”. To score a 3, the VA recommendation must partner or divest of all low-demand services.

Source: FY 2029 average daily census for inpatient services is based on Enrollee Healthcare Projection Model Base Year 2019. 2019 Total Surgical Cases is from the VA National Surgery Office.

Facilities and Sustainability

Table 102 – Facilities and Sustainability Key Data Points for Scoring

Facility	Main Patient Care Facility Construction Date	Most Recent Main Patient Care Facility Renovation Date	Exceeds Useful Life?
(V22) (501) Albuquerque	1986	N/A	Yes

Note: Exceeding useful life is defined as 1) When a main patient care facility was built before 1970 it has exceeded its useful life, even if it has undergone major renovation in the last 40 years. 2) When a main patient care facility was built after 1970 but is still more than 40 years old (built on or after 1971 and before 1989), it must have undergone major renovation within the last 40 years to not exceed its useful life. 3) When a main patient care facility was built in or after 1989, it has not exceeded its useful life.

Source: From CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Table 103 – Key Data Points for Scoring - Recruitment and Retention

Facility	Expands VA's Ability to Recruit/Retain?
(V22) (501XX) Gallup OP Partnership	Yes

Mission

Table 104 – Mission Key Data Points for Scoring

The Status Quo and Modernization COAs are assumed to have no impact on VA's statutory missions. The impact of the VA Recommendation on VA's statutory missions is shown in the table below:

Facility	Training Impact	Research Impact	4th Mission Impact	Market Plan Includes New Facilities/Services To Increase Training/Research Opportunities
(V22) (501) Albuquerque	No impact on training	Maintains or Has Plan to Transition	No PRC Designation	Increases Training Opportunities; Increases Research Opportunities

VISN 22 Tucson

The recommendations for modernization and realignment of VHA infrastructure submitted by the Secretary of the Department of Veterans Affairs to the Asset and Infrastructure Review (AIR) Commission are focused on allowing VA to provide accessible, timely, and high-quality health care for Veterans now and in the future. To inform the recommendations, VA conducted a Cost Benefit Analysis (CBA) that examines the cost-efficiency and benefits to Veterans of various courses of action (COAs) within each market. The CBA compares the costs and benefits associated with maintaining the current facilities, modernizing the current facilities, or strategically realigning and modernizing facilities in each market to inform the identification of a preferred COA.

The CBA aligns with requirements outlined in Section 1703C of Title 38, United States Code (U.S.C.), as added by Section 203 of the VA MISSION Act of 2018.

> *VA MISSION Act, Section 203(2)(F)*
>
> *"In making recommendations under this subsection, the Secretary shall consider…the extent and timing of potential costs and savings, including the number of years such costs or savings will be incurred, beginning with the date of completion of the proposed recommendation."*

This CBA summary document defines the COAs, provides a brief overview of the methodology, and outlines the results of the CBA and the associated sensitivity analysis.

Overview of COAs and Methodology

The Cost Benefit Analysis (CBA) reviews, analyzes, and compares the costs and benefits of three distinct courses of action (COA):

- maintaining VA's current facilities assuming no changes or additional modernization to current facilities, programs, and infrastructure (COA Name: Status Quo)
- modernizing the current facilities without strategically realigning facilities (COA Name: Modernization)
- strategically realigning and modernizing facilities (COA Name: VA Recommendation to the AIR Commission)

To evaluate these courses of action, VA examined the combined cost and benefits of each COA for each market. The CBA was 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 CBI equals the total life-cycle cost (PV) of each COA in PV dollars, divided by the Benefits Analysis score for that COA's non-financial benefits normalized to the billions place. The COA with the lowest CBI score is the preferred COA.

Summary of Results

The VA Recommendation COA is the leading COA analyzed in the VISN 22 Tucson Market due to its leading Cost Benefit Index (CBI) score. The CBI score for the VA Recommendation COA (1.587) is 20.6% lower than the Status Quo COA (2.00) and 0.1% lower than the Modernization COA (1.588).

The VA Recommendation COA is $1.5 B (9.1%) more expensive than the Status Quo COA and $10.4 M (0.1%) less expensive than the Modernization COA. While the VA Recommendation COA increases cost compared to the Status Quo COA and decreases costs compared to the Modernization COA, it also increases benefits; the VA Recommendation (11 points) outscored the Status Quo COA (8 points) and tied the Modernization COA (11 points).

The tables below detail the present values, benefit scores, and CBIs for each COA.

Table 105 – CBI Scores by COA

	Status Quo	Modernization	VA Recommendation
COA PV ($)	($15,994,635,859)	($17,465,657,028)	($17,455,296,393)
Benefit Analysis Score	8	11	11
CBI (Normalized in $Billions)	2.00	1.588	1.587
CBI % Change vs. Status Quo	N/A	-20.58%	-20.6%
CBI % Change vs. Modernization	N/A	N/A	-0.1%

Table 106 – Cost Analysis Cost Variance by COA

Cost Variance	Status Quo	Modernization	VA Recommendation
Capital Cost Variance vs. Status Quo	N/A	($1,471,021,169)	($1,460,660,534)
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($1,471,021,169)	($1,460,660,534)
Estimated Total Cost Variance vs. Modernization	N/A	N/A	$10,360,635

Note: Operational unit costs were provided at the parent facility level not at the facility level. Therefore, the analysis does not estimate the changes in operational costs stemming from new, expanded, or removed points of care (POC). The analysis only shows changes to operational costs when a service line is shifted, at the parent facility level, from VA care to non-VA care.

Table 107 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	2
Access	2	2	2
Quality	2	3	3
Facilities and Sustainability	1	2	2
Mission	2	2	2
Total Benefit Score	**8**	**11**	**11**

VA Recommendation

The VA Recommendation for the VISN 22 Tucson Market COA is detailed below.

- Modernize and realign the Tucson VAMC by:
    - Modernizing the inpatient medical and surgical space at the Tucson VAMC
    - Modernizing the CLC and RRTP at the Tucson VAMC
- Modernize and realign outpatient facilities in the market by:
    - Relocating the Yuma MS CBOC to a new site in the vicinity of Yuma, Arizona, and closing the Yuma MS CBOC
    - Relocating the Casa Grande MS CBOC to a new site in the vicinity of Casa Grande, Arizona, and closing the Casa Grande MS CBOC
    - Relocating the Sierra Vista MS CBOC to a new site in the vicinity of Sierra Vista, Arizona, and closing the Sierra Vista MS CBOC
    - Relocating the Southeast Tucson MS CBOC to a new site in the vicinity of southeast Tucson, Arizona, and closing the Southeast Tucson MS CBOC
    - Relocating all services to the Sierra Vista MS CBOC and closing the Cochise County OOS

Cost Analysis

The Cost Analysis highlighted the estimated Present Value (PV) of each COA for the VISN 22 Tucson Market across a 30-year horizon. The cost of the VA Recommendation COA ($17.46 B) was higher than the Status Quo COA ($16.0 B) and lower than the Modernization COA ($17.47 B).

For the VISN 22 Tucson Market, the VA Recommendation COA is $1.5 B (9.1%) more expensive than the Status Quo COA and $10.4 M (0.1%) less expensive than the Modernization COA. The cost difference between the VA Recommendation COA and Status Quo COA can be attributed to new facilities, closing or modernizing existing facilities, and scaling capacity of existing facilities up or down to meet future Veteran in-house demand to accommodate changes in demand.

The table below outlines the costs associated with each of the COAs. For more detail refer to Appendix A – VISN 22 Tucson: Capital and Operational Costs Detail.

Table 108 – Total Cost Summary by COA

	Status Quo	Modernization	VA Recommendation
Total Costs (PV)	($15,994,635,859)	($17,465,657,028)	($17,455,296,393)
Capital Cost Variance vs. Status Quo	N/A	($1,471,021,169)	($1,460,660,534)
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Non-VA Care Operational Cost Variance	N/A	$0	$0
VA Care Operational Cost Variance	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($1,471,021,169)	($1,460,660,534)
Estimated Total Cost Variance vs. Modernization	N/A	N/A	$10,360,635

Benefit Analysis

This section describes the non-financial benefit analysis results for the VISN 22 Tucson Market across five domains: Demand and Supply, Access, Quality, Facilities and Sustainability, and Mission. The results indicate that the VA Recommendation COA and Modernization COA provide the most benefit (greatest Total Benefit Score) in comparison to the Status Quo COA.

Table 109 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	2
Access	2	2	2
Quality	2	3	3
Facilities and Sustainability	1	2	2

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Mission	2	2	2
Total Benefit Score	**8**	**11**	**11**

The scoring and rationale within each domain are described in the following sections. The data underlying the analysis is provided in Appendix B – VISN 22 Tucson: Benefits Analysis Key Data. Additional information regarding the scoring methodology is provided in the CBA Methodology.

Demand and Supply

Within the Demand and Supply domain, the CBA considers how each COA impacts VA's ability to meet Veteran demand in the future. Each COA is assessed on two benefit components: (1) the ability to balance demand and supply; (2) the changes to facility placement or service offerings that improve VA's ability to meet future demand.

The table below shows the scores for VISN 22 Tucson for this domain.

Table 110 – Demand and Supply Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	2

Status Quo: The COA received a score of 1 because at least one inpatient service line was over/under supplied, or more than 50% of specialties were inadequately supplied when compared to future Veteran in-house demand. Additionally, no changes to facilities or services were introduced that improve VA's ability to meet future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, expansion of services).

Modernization: The COA received a score of 2 because, while Modernization right-sizes services to meet future Veteran in-house demand, the COA does not include changes to facilities or services that improve VA's ability to meet future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, addition of new services).

VA Recommendation: The COA received a score of 2 because, while the COA right-sizes services to meet future Veteran in-house demand, the COA does not include changes to facilities or services that improve VA's ability to meet future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, expansion of services).

Access

Within the Access domain, the CBA considers how each COA impacts Veteran access to care in the future. Each COA is assessed on the change in enrollee proximity to VA-provided primary care, specialty care, and outpatient mental health care.

The table below shows the CBA access scores for VISN 22 Tucson for this domain.

Table 111 – Access Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Access	2	2	2

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (inclusive of VA, Community Care Network providers, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future high-performing integrated delivery network (HPIDN).

Status Quo: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

Modernization: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

VA Recommendation: The COA received a score of 2 because access to VA-provided primary care was maintained within 1%, specialty care was maintained within 1%, and outpatient mental health care was maintained within 1%.

Quality

Within the Quality domain, the CBA considers how each COA impacts the quality of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the ability of the main patient care facilities to support modern healthcare; (2) the ability of demand to support clinical competency.

The table below shows the scores for VISN 22 Tucson for this domain.

Table 112 – Quality Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Quality	2	3	3

Status Quo: The COA received a score of 2 for two reasons. First, the COA includes main patient care facilities that were built prior to the emergence of modern healthcare design principles and specific standards to support modern medicine (e.g., floor-to-floor heights, corridor widths, columns spacing, and utility infrastructure requirements). Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA’s planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Modernization: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning

guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

VA Recommendation: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Facilities and Sustainability

Within the Facilities and Sustainability domain, the CBA considers how each COA impacts the sustainability of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the useful life of the main patient care facilities; (2) changes that strengthen VA's ability to recruit and retain providers.

The table below shows the scores for VISN 22 Tucson for this domain.

Table 113 – Facilities and Sustainability Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Facilities and Sustainability	1	2	2

Note: The American Hospital Association estimates that a hospital's useful life, a measure which predicts the productive period of a typical capital asset before it becomes obsolete or needs replacement, is currently 40 years.

Status Quo: The COA received a score of 1 for two reasons. First, the COA includes at least one main patient care facility that exceeds its useful life as defined by the American Hospital Association, indicating it may be obsolete or need replacement. Second, the COA does not include changes that strengthen VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Modernization: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

VA Recommendation: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or

expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Mission

Within the Mission domain, the CBA considers how each COA impacts VA's ability to support its statutory missions of Education, Research, and Emergency Preparedness in the future. Each COA is assessed on three benefit components: (1) the impact on training programs; (2) the impact on research programs; (3) the impact on emergency preparedness.

A COA's overall score in the Mission domain is determined by the rounded average (unweighted) of its component (e.g., Education, Research, Emergency Preparedness) scores. The table below shows the scores for VISN 22 Tucson for this domain.

Table 114 – Mission Scoring Summary

Subdomain	Status Quo	Modernization	VA Recommendation
Education	2	2	2
Research	2	2	2
Emergency Preparedness	2	2	2
Overall Mission Score (Rounded Average)	**2**	**2**	**2**

Status Quo: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Modernization: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

VA Recommendation: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because inpatient acute services remain VA-delivered and thus the COA maintains existing training programs.

- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Sensitivity Analysis

A sensitivity analyses study shows how various sources of uncertainty in a mathematical model contribute to the model's overall uncertainty. The market is considered sensitive to a scenario when the VA Recommendation is no longer the leading COA due to changes in benefit scores, VA capital costs, VA operational costs, or non-VA operational costs.

The table below outlines the sensitivity analysis scenarios completed.

Table 115 – Sensitivity Analysis Scenarios

Sensitivity Analysis Scenarios
Increase Benefit Scores for Status Quo and Modernization in increments of one from 1 to 3 points
Increase VA Capital Costs in 50% increments from 0% to 300%
Increase VA Operational Costs in 50% increments from 0% to 300%
Increase Non-VA Operational Costs in 50% increments from 0% to 300%

Sensitivity Analysis Results Summary

In the VISN 22 Tucson Market, three scenarios changed the outcome of the CBA:

- Increasing the Modernization benefits score by one point
- Increasing the Modernization benefits score by two points
- Increasing the Modernization benefits score by three points

Sensitivity Analysis Full Results

The below tables show the results across all sensitivity analysis scenarios.

Table 116 – Sensitivity Analyses – Benefit Score Increase

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+0	2.00	1.59	1.59	VA Recommendation
+1	1.78	1.46	1.59	Modernization

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+2	1.60	1.34	1.59	Modernization
+3	1.45	1.25	1.59	Modernization

Table 117 – Sensitivity Analyses – VA Capital Cost Increase

VA Capital Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	2.00	1.59	1.59	VA Recommendation
50%	2.02	1.67	1.66	VA Recommendation
100%	2.03	1.74	1.74	VA Recommendation
150%	2.05	1.82	1.82	VA Recommendation
200%	2.06	1.90	1.90	VA Recommendation
250%	2.08	1.98	1.98	VA Recommendation
300%	2.10	2.06	2.05	VA Recommendation

Table 118 – Sensitivity Analyses – VA Operational Cost Increase

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	2.00	1.59	1.59	VA Recommendation
50%	2.72	2.11	2.11	VA Recommendation

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
100%	3.45	2.64	2.64	VA Recommendation
150%	4.17	3.17	3.17	VA Recommendation
200%	4.89	3.69	3.69	VA Recommendation
250%	5.62	4.22	4.22	VA Recommendation
300%	6.34	4.74	4.74	VA Recommendation

Table 119 – Sensitivity Analyses – Non-VA Operational Cost Increase

Non-VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	2.00	1.59	1.59	VA Recommendation
50%	2.26	1.78	1.78	VA Recommendation
100%	2.52	1.97	1.97	VA Recommendation
150%	2.78	2.16	2.15	VA Recommendation
200%	3.04	2.34	2.34	VA Recommendation
250%	3.30	2.53	2.53	VA Recommendation
300%	3.56	2.72	2.72	VA Recommendation

Appendix A – VISN 22 Tucson: Capital and Operational Costs Detail

Table 120 – Capital Costs by COA

	Status Quo	Modernization	VA Recommendation
VAMC Ideal Square Footage	-	1,602,480	1,593,356
Build New GSF	-	725,892	719,133
Renovate In Place GSF	-	337,014	338,728
Matched Convert To GSF	-	285,512	283,798
Demolition GSF	-	455,115	455,115
Total Build New Cost	$0	($654,628,137)	($648,632,369)
Total Renovate In Place Cost	$0	($56,683,440)	($57,273,948)
Total Matched Convert To Cost	$0	($103,149,332)	($102,519,657)
Total Demolition Cost	$0	($15,199,668)	($15,199,668)
Total Lease Build-Out Cost	$0	($42,762,667)	($42,762,667)
Total New Lease Cost	$0	($152,712,175)	($152,712,175)
Total Existing Lease Cost	($32,942,464)	($32,942,464)	($32,942,464)
NRM Costs for Owned Facilities	($174,756,624)	($187,077,724)	($186,012,488)
FCA Correction Cost	($42,251,178)	N/A	N/A
Estimated Base Modernization Cost	($249,950,266)	($1,245,155,605)	($1,238,055,435)
Additional Common/Lobby Space Needed (GSF)	-	254,062	251,697
Cost of Additional Common/Lobby Space	$0	($187,047,124)	($185,305,471)
Additional Parking Cost	$0	($13,793,724)	($13,445,675)

	Status Quo	Modernization	VA Recommendation
Potential Land Acquisition Cost	$0	($3,640,163)	($3,548,186)
Seismic Correction Cost	($443,669)	($350,282)	($350,282)
Non-Building FCA Correction Cost	($4,895,970)	($4,895,970)	($4,895,970)
Activation Costs	$0	($271,428,206)	($270,349,419)
Estimated Additional Costs for Modernization	($5,339,639)	($481,155,469)	($477,895,004)
Cost Adjustment: In-Progress Construction	N/A	N/A	$0
Cost Adjustment: In-Progress Lease	N/A	N/A	$0
Estimated Facilities Costs (PV)	($255,289,904)	($1,726,311,073)	($1,715,950,439)

Table 121 – Operational Costs by COA

	Status Quo	Modernization	VA Recommendation
VA Direct	($6,613,068,905)	($6,613,068,905)	($6,613,068,905)
Fixed Direct	($757,766,405)	($757,766,405)	($757,766,405)
VA Specific Direct	($299,955,786)	($299,955,786)	($299,955,786)
Indirect	($2,938,161,807)	($2,938,161,807)	($2,938,161,807)
VA Specific Indirect	($417,092,694)	($417,092,694)	($417,092,694)
Research and Education	($1,417,429)	($1,417,429)	($1,417,429)
VA Overhead	($547,682,236)	($547,682,236)	($547,682,236)
VA Care Operational Cost Total (PV)	($11,575,145,261)	($11,575,145,261)	($11,575,145,261)
CC Direct	($2,034,300,654)	($2,034,300,654)	($2,034,300,654)
Delivery and Operations	($97,377,646)	($97,377,646)	($97,377,646)

	Status Quo	Modernization	VA Recommendation
Care Coordination	($103,764,200)	($103,764,200)	($103,764,200)
CC Overhead	($123,851,878)	($123,851,878)	($123,851,878)
Admin PMPM	($1,804,906,315)	($1,804,906,315)	($1,804,906,315)
Non-VA Care Operational Cost Total (PV)	($4,164,200,693)	($4,164,200,693)	($4,164,200,693)
Estimated Operational Costs (PV)	($15,739,345,955)	($15,739,345,955)	($15,739,345,955)

Appendix B – VISN 22 Tucson: Benefits Analysis Key Data

Below are key data points used in the benefit analysis, summarized in the above Benefit Analysis section.

Demand and Supply

Inpatient

Table 122 – Demand and Supply Key Data Points for Scoring – Inpatient (IP)

Service Line	100% of FY29 In-house Bed Need	120% of FY29 In-house Bed Need	Operating Beds	Supply Adequacy (within 100-120% of in-house demand)
IP CLC	57	69	92	Over Supplied
IP Med/Surg	74	89	120	Over Supplied
IP MH	21	25	31	Over Supplied

Note: Community Living Center (CLC); Medicine (Med); Surgery (Surg); Mental Health (MH)

Source: Enrollee Healthcare Projection Model Base Year 2019

Outpatient

Table 123 – Demand and Supply Key Data Points for Scoring – Outpatient (OP)

Physician Supply Adequacy	Count of Specialties	Percentage
Adequately Supplied	13	48%
Under Supplied	14	52%

Note: VA supply in the Status Quo COA is quantitatively evaluated based on the data above. It is assumed the Modernization COA scales the capacity of existing facilities up or down to meet future Veteran in-house demand. Similar to the Modernization COA, it is assumed the VA Recommendation COA scales the capacity of existing and proposed facilities up or down to meet future Veteran in-house demand. However, the VA Recommendation COA may account for factors that demand projections do not consider that may shift the future balance of in-house and community workload, such as:

- Areas with unmet Veteran demand that may warrant a net new point of care
- Low-census inpatient acute programs that may pose risks to quality and training programs, potentially warranting a shift to community providers
- Community capacity factors that may warrant changes to VA capacity

Source: Office of Productivity, Efficiency and Staffing 2019 Capacity Report

Table 124 – New Facility Demand Guidelines

Facility or Service	Guideline
Inpatient Acute VAMCs	Greater than or equal to 35,000 overlapping enrollees
Inpatient CLC	Greater than or equal to 21,000 overlapping enrollees
Health Care Center	Greater than or equal to 34,000 overlapping enrollees
MS CBOC	Greater than or equal to 4,300 non-overlapping enrollees
CBOC	Greater than or equal to 2,500 non-overlapping enrollees

Note: The above guidelines are used to determine whether a new (not replacement) point of care or service proposed in the VA recommendation had adequate demand.

Access

Table 125 – Access Key Data Points for Scoring

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of VA-provided OP Mental Health	91.9%	91.9%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of VA-provided OP Primary Care	92.7%	92.7%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of VA-provided OP Specialty Care	96.0%	96.0%	Maintained within 1%

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	96.8%	96.8%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.2%	99.2%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.8%	99.8%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Mental Health	91.9%	91.9%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Primary Care	92.7%	92.7%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of VA-provided OP Specialty Care	96.0%	96.0%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	96.8%	96.8%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.2%	99.2%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.8%	99.8%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Mental Health	91.9%	91.9%	Maintained within 1%

COA	Measure	Current	Future	Result
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Primary Care	92.7%	92.7%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of VA-provided OP Specialty Care	96.0%	96.0%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	96.8%	96.8%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	99.2%	99.3%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.8%	99.8%	Maintained within 1%

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (HPIDN) (inclusive of VA, Community Care Network, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future HPIDN. The table above shows the results for enrollee proximity to the full HPIDN as well as to VA-provided care in the market.

Source: Enrollee data from the FY19 Geocoded Enrollee File. Existing VA facility location data from VAST. Commercial provider location data from Definitive Healthcare.

Quality

Main Patient Care Facility Construction Date

Table 126 – Quality Key Data Points for Scoring – Age

Facility	Main Patient Care Facility Construction Date	Built Pre-1970?
(V22) (678) Tucson	1928	Yes

Source: Main patient care facility construction and renovation dates from CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Inpatient Acute Demand

Table 127 – Quality Key Data Points for Scoring – Inpatient Acute Demand

Facility	Service	Demand Guideline	Meets or Exceeds Guideline?	VA Recommendation
(V22) (678) Tucson	IP Med	20 ADC	Yes	Maintain
(V22) (678) Tucson	IP Surg	1,600 Cases	Yes	Maintain
(V22) (678) Tucson	IP MH	8 ADC	Yes	Maintain

Note: The Status Quo and Modernization COAs are assumed to maintain all current facilities and services. The VA Recommendation COA proposes maintaining, partnering, and divesting of services at each facility, shown in the last column titled “VA Recommendation”. To score a 3, the VA recommendation must partner or divest of all low-demand services.

Source: FY 2029 average daily census for inpatient services is based on Enrollee Healthcare Projection Model Base Year 2019. 2019 Total Surgical Cases is from the VA National Surgery Office.

Facilities and Sustainability

Table 128 – Facilities and Sustainability Key Data Points for Scoring

Facility	Main Patient Care Facility Construction Date	Most Recent Main Patient Care Facility Renovation Date	Exceeds Useful Life?
(V22) (678) Tucson	1928	1962	Yes

Note: Exceeding useful life is defined as 1) When a main patient care facility was built before 1970 it has exceeded its useful life, even if it has undergone major renovation in the last 40 years. 2) When a main patient care facility was built after 1970 but is still more than 40 years old (built on or after 1971 and before 1989), it must have undergone major renovation within the last 40 years to not exceed its useful life. 3) When a main patient care facility was built in or after 1989, it has not exceeded its useful life.

Source: From CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Table 129 – Key Data Points for Scoring - Recruitment and Retention

Facility	Expands VA's Ability to Recruit/Retain?
N/A	N/A

Mission

Table 130 – Mission Key Data Points for Scoring

The Status Quo and Modernization COAs are assumed to have no impact on VA’s statutory missions. The impact of the VA Recommendation on VA’s statutory missions is shown in the table below:

Facility	Training Impact	Research Impact	4th Mission Impact	Market Plan Includes New Facilities/Services To Increase Training/Research Opportunities
(V22) (678) Tucson	No impact on training	Maintains or Has Plan to Transition	Maintains PRC-designation	Does Not Increase Training/Research Opportunities

VISN 22 Prescott

The recommendations for modernization and realignment of VHA infrastructure submitted by the Secretary of the Department of Veterans Affairs to the Asset and Infrastructure Review (AIR) Commission are focused on allowing VA to provide accessible, timely, and high-quality health care for Veterans now and in the future. To inform the recommendations, VA conducted a Cost Benefit Analysis (CBA) that examines the cost-efficiency and benefits to Veterans of various courses of action (COAs) within each market. The CBA compares the costs and benefits associated with maintaining the current facilities, modernizing the current facilities, or strategically realigning and modernizing facilities in each market to inform the identification of a preferred COA.

The CBA aligns with requirements outlined in Section 1703C of Title 38, United States Code (U.S.C.), as added by Section 203 of the VA MISSION Act of 2018.

> *VA MISSION Act, Section 203(2)(F)*
>
> *"In making recommendations under this subsection, the Secretary shall consider…the extent and timing of potential costs and savings, including the number of years such costs or savings will be incurred, beginning with the date of completion of the proposed recommendation."*

This CBA summary document defines the COAs, provides a brief overview of the methodology, and outlines the results of the CBA and the associated sensitivity analysis.

Overview of COAs and Methodology

The Cost Benefit Analysis (CBA) reviews, analyzes, and compares the costs and benefits of three distinct courses of action (COA):

- maintaining VA's current facilities assuming no changes or additional modernization to current facilities, programs, and infrastructure (COA Name: Status Quo)
- modernizing the current facilities without strategically realigning facilities (COA Name: Modernization)
- strategically realigning and modernizing facilities (COA Name: VA Recommendation to the AIR Commission)

To evaluate these courses of action, VA examined the combined cost and benefits of each COA for each market. The CBA was 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 CBI equals the total life-cycle cost (PV) of each COA in PV dollars, divided by the Benefits Analysis score for that COA's non-financial benefits normalized to the billions place. The COA with the lowest CBI score is the preferred COA.

Summary of Results

The VA Recommendation COA is the leading COA analyzed in the VISN 22 Prescott Market due to its leading Cost Benefit Index (CBI) score. The CBI score for the VA Recommendation COA (0.73) is 31.9% lower than the Status Quo COA (1.06) and 6.4% lower than the Modernization COA (0.77).

The VA Recommendation COA is $523.4 M (7.0%) more expensive than the Status Quo COA and $227.5 M (2.9%) more expensive than the Modernization COA. While the VA Recommendation COA increases cost compared to the Status Quo and Modernization COAs, it also increases benefits as seen by a 11-point benefits score compared to 7 for the Status Quo COA and 10 for the Modernization COA.

The tables below detail the present values, benefit scores, and CBIs for each COA.

Table 131 – CBI Scores by COA

	Status Quo	Modernization	VA Recommendation
COA PV ($)	($7,452,938,466)	($7,748,881,886)	($7,976,341,140)
Benefit Analysis Score	7	10	11
CBI (Normalized in $Billions)	1.06	0.77	0.73
CBI % Change vs. Status Quo	N/A	-27.2%	-31.9%
CBI % Change vs. Modernization	N/A	N/A	-6.4%

Table 132 – Cost Analysis Cost Variance by COA

Cost Variance	Status Quo	Modernization	VA Recommendation
Capital Cost Variance vs. Status Quo	N/A	($295,943,420)	($523,402,674)
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($295,943,420)	($523,402,674)
Estimated Total Cost Variance vs. Modernization	N/A	N/A	($227,459,254)

Note: Operational unit costs were provided at the parent facility level not at the facility level. Therefore, the analysis does not estimate the changes in operational costs stemming from new, expanded, or removed points of care (POC). The analysis only shows changes to operational costs when a service line is shifted, at the parent facility level, from VA care to non-VA care.

Table 133 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	2
Access	2	2	3
Quality	1	2	2
Facilities and Sustainability	1	2	2
Mission	2	2	2
Total Benefit Score	**7**	**10**	**11**

VA Recommendation

The VA Recommendation for the VISN 22 Prescott Market COA is detailed below.

- Modernize and realign outpatient facilities in the market by relocating the Flagstaff CBOC to a new site in the vicinity of Flagstaff, Arizona, and closing the Flagstaff CBOC

Cost Analysis

The Cost Analysis highlighted the estimated Present Value (PV) of each COA for the VISN 22 Prescott Market across a 30-year horizon. The cost of the VA Recommendation COA ($8.0 B) was higher than the Status Quo COA ($7.5 B) and the Modernization COA ($7.7 B).

For the VISN 22 Prescott Market, the VA Recommendation COA is $523.4 M (7.0%) more expensive than the Status Quo COA and $227.5 M (2.9%) more expensive than the Modernization COA. The cost difference between the VA Recommendation COA and Status Quo COA can be attributed to new facilities, closing or modernizing existing facilities, and scaling capacity of existing facilities up or down to meet future Veteran in-house demand to accommodate changes in demand.

The table below outlines the costs associated with each of the COAs. For more detail refer to Appendix A – VISN 22 Prescott: Capital and Operational Costs Detail.

Table 134 – Total Cost Summary by COA

	Status Quo	Modernization	VA Recommendation
Total Costs (PV)	($7,452,938,466)	($7,748,881,886)	($7,976,341,140)
Capital Cost Variance vs. Status Quo	N/A	($295,943,420)	($523,402,674)
Operational Cost Variance vs. Status Quo	N/A	$0	$0

	Status Quo	Modernization	VA Recommendation
Non-VA Care Operational Cost Variance	N/A	$0	$0
VA Care Operational Cost Variance	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($295,943,420)	($523,402,674)
Estimated Total Cost Variance vs. Modernization	N/A	N/A	($227,459,254)

Benefit Analysis

This section describes the non-financial benefit analysis results for the VISN 22 Prescott Market across five domains: Demand and Supply, Access, Quality, Facilities and Sustainability, and Mission. The results indicate that the VA Recommendation COA provides the most benefit (greatest Total Benefit Score) in comparison to the Status Quo and Modernization COAs.

Table 135 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	2
Access	2	2	3
Quality	1	2	2
Facilities and Sustainability	1	2	2
Mission	2	2	2
Total Benefit Score	**7**	**10**	**11**

The scoring and rationale within each domain are described in the following sections. The data underlying the analysis is provided in Appendix B – VISN 22 Prescott: Benefits Analysis Key Data. Additional information regarding the scoring methodology is provided in the CBA Methodology.

Demand and Supply

Within the Demand and Supply domain, the CBA considers how each COA impacts VA's ability to meet Veteran demand in the future. Each COA is assessed on two benefit components: (1) the ability to

balance demand and supply; (2) the changes to facility placement or service offerings that improve VA's ability to meet future demand.

The table below shows the scores for VISN 22 Prescott for this domain.

Table 136 – Demand and Supply Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	2

Status Quo: The COA received a score of 1 because at least one inpatient service line was over/under supplied, or more than 50% of specialties were inadequately supplied when compared to future Veteran in-house demand. Additionally, no changes to facilities or services were introduced that improve VA's ability to meet the future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, addition of new services).

Modernization: The COA received a score of 2 because, while Modernization right-sizes services to meet future Veteran in-house demand, the COA does not include changes to facilities or services that improve VA's ability to meet future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, addition of new services).

VA Recommendation: The COA received a score of 2 because, while the COA right-sizes services to meet future Veteran in-house demand, the COA does not include changes to facilities or services that improve VA's ability to meet future Veteran demand (e.g., relocation or establishment of facilities in areas with greater Veteran demand, expansion of services).

Access

Within the Access domain, the CBA considers how each COA impacts Veteran access to care in the future. Each COA is assessed on the change in enrollee proximity to VA-provided primary care, specialty care, and outpatient mental health care.

The table below shows the CBA access scores for VISN 22 Prescott for this domain.

Table 137 – Access Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Access	2	2	3

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (inclusive of VA, Community Care Network providers, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future high-performing integrated delivery network (HPIDN).

Status Quo: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

Modernization: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

VA Recommendation: The COA received a score of 3 because access to VA-provided primary care was maintained within 1%, specialty care increased 1% or more, and outpatient mental health care was maintained within 1%.

Quality

Within the Quality domain, the CBA considers how each COA impacts the quality of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the ability of the main patient care facilities to support modern healthcare; (2) the ability of demand to support clinical competency.

The table below shows the scores for VISN 22 Prescott for this domain.

Table 138 – Quality Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Quality	1	2	2

Status Quo: The COA received a score of 1 for two reasons. First, the COA includes main patient care facilities that were built prior to the emergence of modern healthcare design principles and specific standards to support modern medicine (e.g., floor-to-floor heights, corridor widths, columns spacing, and utility infrastructure requirements). Second, the COA includes facilities with projected future demand below VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Modernization: The COA received a score of 2 for two reasons. First, the COA replaces aged infrastructure with modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand below VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

VA Recommendation: The COA received a score of 2 for two reasons. First, the COA replaces aged infrastructure with modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand below VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Facilities and Sustainability

Within the Facilities and Sustainability domain, the CBA considers how each COA impacts the sustainability of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the useful life of the main patient care facilities; (2) changes that strengthen VA's ability to recruit and retain providers.

The table below shows the scores for VISN 22 Prescott for this domain.

Table 139 – Facilities and Sustainability Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Facilities and Sustainability	1	2	2

Note: The American Hospital Association estimates that a hospital's useful life, a measure which predicts the productive period of a typical capital asset before it becomes obsolete or needs replacement, is currently 40 years.

Status Quo: The COA received a score of 1 for two reasons. First, the COA includes at least one main patient care facility that exceeds its useful life as defined by the American Hospital Association, indicating it may be obsolete or need replacement. Second, the COA does not include changes that strengthen VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Modernization: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

VA Recommendation: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Mission

Within the Mission domain, the CBA considers how each COA impacts VA's ability to support its statutory missions of Education, Research, and Emergency Preparedness in the future. Each COA is assessed on three benefit components: (1) the impact on training programs; (2) the impact on research programs; (3) the impact on emergency preparedness.

A COA's overall score in the Mission domain is determined by the rounded average (unweighted) of its component (e.g., Education, Research, Emergency Preparedness) scores. The table below shows the scores for VISN 22 Prescott for this domain.

Table 140 – Mission Scoring Summary

Subdomain	Status Quo	Modernization	VA Recommendation
Education	2	2	2

Subdomain	Status Quo	Modernization	VA Recommendation
Research	2	2	2
Emergency Preparedness	2	2	2
Overall Mission Score (Rounded Average)	**2**	**2**	**2**

Status Quo: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Modernization: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

VA Recommendation: The COA received a score of 3 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because inpatient acute services remain VA-delivered and thus the COA maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Sensitivity Analysis

A sensitivity analyses study shows how various sources of uncertainty in a mathematical model contribute to the model's overall uncertainty. The market is considered sensitive to a scenario when the VA Recommendation is no longer the leading COA due to changes in benefit scores, VA capital costs, VA operational costs, or non-VA operational costs.

The table below outlines the sensitivity analysis scenarios completed.

Table 141 – Sensitivity Analysis Scenarios

Sensitivity Analysis Scenarios
Increase Benefit Scores for Status Quo and Modernization in increments of one from 1 to 3 points
Increase VA Capital Costs in 50% increments from 0% to 300%
Increase VA Operational Costs in 50% increments from 0% to 300%
Increase Non-VA Operational Costs in 50% increments from 0% to 300%

Sensitivity Analysis Results Summary

In the VISN 22 Prescott Market, three scenarios changed the outcome of the CBA:

- Increasing the Modernization benefits score by one point
- Increasing the Modernization benefits score by two points
- Increasing the Modernization benefits score by three points

Sensitivity Analysis Full Results

The below tables show the results across all sensitivity analysis scenarios.

Table 142 – Sensitivity Analyses – Benefit Score Increase

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+0	1.06	0.77	0.73	VA Recommendation
+1	0.93	0.70	0.73	Modernization
+2	0.83	0.65	0.73	Modernization
+3	0.75	0.60	0.73	Modernization

Table 143 – Sensitivity Analyses – VA Capital Cost Increase

VA Capital Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	1.06	0.77	0.73	VA Recommendation
50%	1.08	0.80	0.76	VA Recommendation
100%	1.10	0.83	0.80	VA Recommendation
150%	1.12	0.86	0.83	VA Recommendation
200%	1.14	0.89	0.87	VA Recommendation
250%	1.16	0.92	0.91	VA Recommendation
300%	1.18	0.95	0.94	VA Recommendation

Table 144 – Sensitivity Analyses – VA Operational Cost Increase

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	1.06	0.77	0.73	VA Recommendation
50%	1.30	0.94	0.88	VA Recommendation
100%	1.54	1.11	1.03	VA Recommendation
150%	1.78	1.27	1.18	VA Recommendation
200%	2.01	1.44	1.33	VA Recommendation
250%	2.25	1.60	1.48	VA Recommendation

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
300%	2.49	1.77	1.63	VA Recommendation

Table 145 – Sensitivity Analyses – Non-VA Operational Cost Increase

Non-VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	1.06	0.77	0.73	VA Recommendation
50%	1.34	0.97	0.90	VA Recommendation
100%	1.62	1.16	1.08	VA Recommendation
150%	1.89	1.35	1.25	VA Recommendation
200%	2.17	1.55	1.43	VA Recommendation
250%	2.44	1.74	1.60	VA Recommendation
300%	2.72	1.93	1.78	VA Recommendation

Appendix A – VISN 22 Prescott: Capital and Operational Costs Detail

Table 146 – Capital Costs by COA

	Status Quo	Modernization	VA Recommendation
VAMC Ideal Square Footage	-	564,236	741,495
Build New GSF	-	201,709	333,012
Renovate In Place GSF	-	154,516	146,779
Matched Convert To GSF	-	137,413	145,150
Demolition GSF	-	305,852	305,852
Total Build New Cost	$0	($181,366,072)	($296,352,882)
Total Renovate. In Place Cost	$0	($25,327,525)	($23,761,091)
Total Matched Convert To Cost	$0	($50,177,988)	($53,651,594)
Total Demolition Cost	$0	($10,452,219)	($10,452,219)
Total Lease Build-Out Cost	$0	($16,718,218)	($18,326,222)
Total New Lease Cost	$0	($64,387,450)	($70,589,687)
Total Existing Lease Cost	($24,355,866)	($24,355,778)	($13,731,877)
NRM Costs for Owned Facilities	($189,466,563)	($65,870,402)	($86,564,086)
FCA Correction Cost	($44,388,173)	N/A	N/A
Estimated Base Modernization Cost	($258,210,602)	($438,655,651)	($573,429,658)
Additional Common/Lobby Space Needed (GSF)	-	70,598	116,554
Cost of Additional Common/Lobby Space	$0	($53,184,921)	($87,805,785)
Additional Parking Cost	$0	($5,677,411)	($48,974,840)

	Status Quo	Modernization	VA Recommendation
Potential Land Acquisition Cost	$0	$0	$0
Seismic Correction Cost	($6,877,441)	($2,429,072)	($2,429,072)
Non-Building FCA Correction Cost	($13,675,273)	($13,675,273)	($13,675,273)
Activation Costs	$0	($61,084,408)	($75,851,362)
Estimated Additional Costs for Modernization	($20,552,714)	($136,051,085)	($228,736,332)
Cost Adjustment: In-Progress Construction	N/A	N/A	$0
Cost Adjustment: In-Progress Lease	N/A	N/A	$0
Estimated Facilities Costs (PV)	($278,763,316)	($574,706,736)	($802,165,990)

Table 147 – Operational Costs by COA

	Status Quo	Modernization	VA Recommendation
VA Direct	($1,666,936,041)	($1,666,936,041)	($1,666,936,041)
Fixed Direct	($280,262,584)	($280,262,584)	($280,262,584)
VA Specific Direct	($42,612,298)	($42,612,298)	($42,612,298)
Indirect	($954,876,269)	($954,876,269)	($954,876,269)
VA Specific Indirect	($195,606,012)	($195,606,012)	($195,606,012)
Research and Education	($261,401)	($261,401)	($261,401)
VA Overhead	($176,937,263)	($176,937,263)	($176,937,263)
VA Care Operational Cost Total (PV)	($3,317,491,867)	($3,317,491,867)	($3,317,491,867)
CC Direct	($2,582,811,054)	($2,582,811,054)	($2,582,811,054)
Delivery and Operations	($116,960,033)	($116,960,033)	($116,960,033)

	Status Quo	Modernization	VA Recommendation
Care Coordination	($129,144,170)	($129,144,170)	($129,144,170)
CC Overhead	($151,076,897)	($151,076,897)	($151,076,897)
Admin PMPM	($876,691,129)	($876,691,129)	($876,691,129)
Non-VA Care Operational Cost Total (PV)	($3,856,683,283)	($3,856,683,283)	($3,856,683,283)
Estimated Operational Costs (PV)	($7,174,175,150)	($7,174,175,150)	($7,174,175,150)

Appendix B – VISN 22 Prescott: Benefits Analysis Key Data

Below are key data points used in the benefit analysis, summarized in the above Benefit Analysis section.

Demand and Supply

Inpatient

Table 148 – Demand and Supply Key Data Points for Scoring – Inpatient (IP)

Service Line	100% of FY29 In-house Bed Need	120% of FY29 In-house Bed Need	Operating Beds	Supply Adequacy (within 100-120% of in-house demand)
IP CLC	36	43	85	Over Supplied
IP Med/Surg	14	17	21	Over Supplied
IP MH	6	7	0	Under Supplied

Note: Community Living Center (CLC); Medicine (Med); Surgery (Surg); Mental Health (MH)

Source: Enrollee Healthcare Projection Model Base Year 2019

Outpatient

Table 149 – Demand and Supply Key Data Points for Scoring – Outpatient (OP)

Physician Supply Adequacy	Count of Specialties	Percentage
Under Supplied	27	100%

Note: VA supply in the Status Quo COA is quantitatively evaluated based on the data above. It is assumed the Modernization COA scales the capacity of existing facilities up or down to meet future Veteran in-house demand. Similar to the Modernization COA, it is assumed the VA Recommendation COA scales the capacity of existing and

proposed facilities up or down to meet future Veteran in-house demand. However, the VA Recommendation COA may account for factors that demand projections do not consider that may shift the future balance of in-house and community workload, such as:

- Areas with unmet Veteran demand that may warrant a net new point of care
- Low-census inpatient acute programs that may pose risks to quality and training programs, potentially warranting a shift to community providers
- Community capacity factors that may warrant changes to VA capacity

Source: Office of Productivity, Efficiency and Staffing 2019 Capacity Report

Table 150 – New Facility Demand Guidelines

Facility or Service	Guideline
Inpatient Acute VAMCs	Greater than or equal to 35,000 overlapping enrollees
Inpatient CLC	Greater than or equal to 21,000 overlapping enrollees
Health Care Center	Greater than or equal to 34,000 overlapping enrollees
MS CBOC	Greater than or equal to 4,300 non-overlapping enrollees
CBOC	Greater than or equal to 2,500 non-overlapping enrollees

Note: The above guidelines are used to determine whether a new (not replacement) point of care or service proposed in the VA recommendation had adequate demand.

Access

Table 151 – Access Key Data Points for Scoring

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of VA-provided OP Mental Health	78.3%	78.3%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of VA-provided OP Primary Care	82.5%	82.5%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of VA-provided OP Specialty Care	64.0%	64.0%	Maintained within 1%

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	87.3%	87.3%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	95.9%	95.9%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	97.5%	97.5%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Mental Health	78.3%	78.3%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Primary Care	82.5%	82.5%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of VA-provided OP Specialty Care	64.0%	64.0%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	87.3%	87.3%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	95.9%	95.9%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	97.5%	97.5%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Mental Health	78.3%	78.3%	Maintained within 1%

COA	Measure	Current	Future	Result
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Primary Care	82.5%	82.5%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of VA-provided OP Specialty Care	64.0%	65.3%	Increased 1% or more
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	87.3%	87.3%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	95.9%	96.0%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	97.5%	98.6%	Increased 1% or more

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (HPIDN) (inclusive of VA, Community Care Network, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future HPIDN. The table above shows the results for enrollee proximity to the full HPIDN as well as to VA-provided care in the market.

Source: Enrollee data from the FY19 Geocoded Enrollee File. Existing VA facility location data from VAST. Commercial provider location data from Definitive Healthcare.

Quality

Main Patient Care Facility Construction Date

Table 152 – Quality Key Data Points for Scoring – Age

Facility	Main Patient Care Facility Construction Date	Built Pre-1970?
(V22) (649) Prescott	1937	Yes

Source: Main patient care facility construction and renovation dates from CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Inpatient Acute Demand

Table 153 – Quality Key Data Points for Scoring – Inpatient Acute Demand

Facility	Service	Demand Guideline	Meets or Exceeds Guideline?	VA Recommendation
(V22) (649) Prescott	IP Med	20 ADC	No	Maintain
(V22) (649) Prescott	IP Surg	1,600 Cases	No Service	N/A
(V22) (649) Prescott	IP MH	8 ADC	No Service	N/A

Note: The Status Quo and Modernization COAs are assumed to maintain all current facilities and services. The VA Recommendation COA proposes maintaining, partnering, and divesting of services at each facility, shown in the last column titled “VA Recommendation”. To score a 3, the VA recommendation must partner or divest of all low-demand services.

Source: FY 2029 average daily census for inpatient services is based on Enrollee Healthcare Projection Model Base Year 2019. 2019 Total Surgical Cases is from the VA National Surgery Office.

Facilities and Sustainability

Table 154 – Facilities and Sustainability Key Data Points for Scoring

Facility	Main Patient Care Facility Construction Date	Most Recent Main Patient Care Facility Renovation Date	Exceeds Useful Life?
(V22) (649) Prescott	1937	2010	Yes

Note: Exceeding useful life is defined as 1) When a main patient care facility was built before 1970 it has exceeded its useful life, even if it has undergone major renovation in the last 40 years. 2) When a main patient care facility was built after 1970 but is still more than 40 years old (built on or after 1971 and before 1989), it must have undergone major renovation within the last 40 years to not exceed its useful life. 3) When a main patient care facility was built in or after 1989, it has not exceeded its useful life.

Source: From CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Table 155 – Key Data Points for Scoring - Recruitment and Retention

Facility	Expands VA's Ability to Recruit/Retain?
N/A	N/A

Mission

Table 156 – Mission Key Data Points for Scoring

The Status Quo and Modernization COAs are assumed to have no impact on VA's statutory missions. The impact of the VA Recommendation on VA's statutory missions is shown in the table below:

Facility	Training Impact	Research Impact	4th Mission Impact	Market Plan Includes New Facilities/Services To Increase Training/Research Opportunities
(V22) (649) Prescott	No impact on training	No Research Program	No PRC Designation	Does Not Increase Training/Research Opportunities

VISN 22 Phoenix

The recommendations for modernization and realignment of VHA infrastructure submitted by the Secretary of the Department of Veterans Affairs to the Asset and Infrastructure Review (AIR) Commission are focused on allowing VA to provide accessible, timely, and high-quality health care for Veterans now and in the future. To inform the recommendations, VA conducted a Cost Benefit Analysis (CBA) that examines the cost-efficiency and benefits to Veterans of various courses of action (COAs) within each market. The CBA compares the costs and benefits associated with maintaining the current facilities, modernizing the current facilities, or strategically realigning and modernizing facilities in each market to inform the identification of a preferred COA.

The CBA aligns with requirements outlined in Section 1703C of Title 38, United States Code (U.S.C.), as added by Section 203 of the VA MISSION Act of 2018.

> *VA MISSION Act, Section 203(2)(F)*
>
> *"In making recommendations under this subsection, the Secretary shall consider…the extent and timing of potential costs and savings, including the number of years such costs or savings will be incurred, beginning with the date of completion of the proposed recommendation."*

This CBA summary document defines the COAs, provides a brief overview of the methodology, and outlines the results of the CBA and the associated sensitivity analysis.

Overview of COAs and Methodology

The Cost Benefit Analysis (CBA) reviews, analyzes, and compares the costs and benefits of three distinct courses of action (COA):

- maintaining VA's current facilities assuming no changes or additional modernization to current facilities, programs, and infrastructure (COA Name: Status Quo)
- modernizing the current facilities without strategically realigning facilities (COA Name: Modernization)
- strategically realigning and modernizing facilities (COA Name: VA Recommendation to the AIR Commission)

To evaluate these courses of action, VA examined the combined cost and benefits of each COA for each market. The CBA was 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 CBI equals the total life-cycle cost (PV) of each COA in PV dollars, divided by the Benefits Analysis score for that COA's non-financial benefits normalized to the billions place. The COA with the lowest CBI score is the preferred COA.

Summary of Results

The VA Recommendation COA is the leading COA analyzed in the VISN 22 Phoenix Market due to its leading Cost Benefit Index (CBI) score. The CBI score for the VA Recommendation COA (2.34) is 29.3% lower than the Status Quo COA (3.32) and 8.8% lower than the Modernization COA (2.57).

The VA Recommendation COA is $3.9 B (14.8%) more expensive than the Status Quo COA and $2.2 B (7.7%) more expensive than the Modernization COA. While the VA Recommendation COA increases cost compared to the Status Quo and Modernization COAs, it also increases benefits as seen by a 13-point benefits score compared to 8 for the Status Quo COA and 11 for the Modernization COA.

The tables below detail the present values, benefit scores, and CBIs for each COA.

Table 157 – CBI Scores by COA

	Status Quo	Modernization	VA Recommendation
COA PV ($)	($26,524,115,439)	($28,273,009,324)	($30,456,792,492)
Benefit Analysis Score	8	11	13
CBI (Normalized in $Billions)	3.32	2.57	2.34
CBI % Change vs. Status Quo	N/A	-22.5%	-29.3%
CBI % Change vs. Modernization	N/A	N/A	-8.8%

Table 158 – Cost Analysis Cost Variance by COA

Cost Variance	Status Quo	Modernization	VA Recommendation
Capital Cost Variance	N/A	($1,748,893,885)	($3,932,677,053)
Operational Cost Variance	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($1,748,893,885)	($3,932,677,053)
Estimated Total Cost Variance vs. Modernization	N/A	N/A	($2,183,783,168)

Note: Operational unit costs were provided at the parent facility level not at the facility level. Therefore, the analysis does not estimate the changes in operational costs stemming from new, expanded, or removed points of care (POC). The analysis only shows changes to operational costs when a service line is shifted, at the parent facility level, from VA care to non-VA care.

Table 159 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3
Access	2	2	2
Quality	2	3	3
Facilities and Sustainability	1	2	2
Mission	2	2	3
Total Benefit Score	**8**	**11**	**13**

VA Recommendation

The VA Recommendation for the VISN 22 Phoenix Market COA is detailed below.

- Modernize and realign the Phoenix VAMC by:
    - Constructing a replacement VAMC with inpatient medical and surgical, inpatient mental health, emergency department, outpatient specialty care, outpatient surgical, and women's health services in the vicinity of Phoenix, Arizona
    - Relocating CLC and RRTP services provided at the Phoenix VAMC to future VA facilities and discontinuing these services at the Phoenix VAMC
    - Closing the Phoenix VAMC
- Constructing a new VAMC with CLC and RRTP services in the vicinity of Anthem, Arizona
- Modernize and realign outpatient facilities in the market by:
    - Relocating the Northeast-Phoenix CBOC to a new site in the vicinity of Phoenix, Arizona, and closing the Northeast-Phoenix CBOC
    - Relocating the Northwest Surprise CBOC to a new site in the vicinity of Surprise, Arizona, and closing the Northwest Surprise CBOC
    - Relocating all services at the 32nd St MS CBOC and closing the Phoenix Midtown CBOC
    - Relocating all services at the Globe CBOC and closing the Globe CBOC

Cost Analysis

The Cost Analysis highlighted the estimated Present Value (PV) of each COA for the VISN 22 Phoenix Market across a 30-year horizon. The cost of the VA Recommendation COA ($30.5 B) was higher than the Status Quo COA ($26.5 B) and the Modernization COA ($28.3 B).

For the VISN 22 Phoenix Market, the VA Recommendation COA is $3.9 B (14.8%) more expensive than the Status Quo COA and $2.2 B (7.7%) more expensive than the Modernization COA. The cost difference between the VA Recommendation COA and Status Quo COA can be attributed to new facilities, closing

or modernizing existing facilities, and scaling capacity of existing facilities up or down to meet future Veteran in-house demand to accommodate changes in demand.

The table below outlines the costs associated with each of the COAs. For more detail refer to Appendix A – VISN 22 Phoenix: Capital and Operational Costs Detail.

Table 160 – Total Cost Summary by COA

	Status Quo	Modernization	VA Recommendation
Total Costs (PV)	($26,524,115,439)	($28,273,009,324)	($30,456,792,492)
Capital Cost Variance vs. Status Quo	N/A	($1,748,893,885)	($3,932,677,053)
Operational Cost Variance vs. Status Quo	N/A	$0	$0
Non-VA Care Operational Cost Variance	N/A	$0	$0
VA Care Operational Cost Variance	N/A	$0	$0
Estimated Total Cost Variance vs. Status Quo	N/A	($1,748,893,885)	($3,932,677,053)
Estimated Total Cost Variance vs. Modernization	N/A	N/A	($2,183,783,168)

Benefit Analysis

This section describes the non-financial benefit analysis results for the VISN 22 Phoenix Market across five domains: Demand and Supply, Access, Quality, Facilities and Sustainability, and Mission. The results indicate that the VA Recommendation COA provides the most benefit (greatest Total Benefit Score) in comparison to the Status Quo and Modernization COAs.

Table 161 – Benefit Analysis Scores by COA

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3
Access	2	2	2
Quality	2	3	3

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Facilities and Sustainability	1	2	2
Mission	2	2	3
Total Benefit Score	**8**	**11**	**13**

The scoring and rationale within each domain are described in the following sections. The data underlying the analysis is provided in Appendix B – VISN 22 Phoenix: Benefits Analysis Key Data. Additional information regarding the scoring methodology is provided in the CBA Methodology.

Demand and Supply

Within the Demand and Supply domain, the CBA considers how each COA impacts VA's ability to meet Veteran demand in the future. Each COA is assessed on two benefit components: (1) the ability to balance demand and supply; (2) the changes to facility placement or service offerings that improve VA's ability to meet future demand.

The table below shows the scores for VISN 22 Phoenix for this domain.

Table 162 – Demand and Supply Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Demand and Supply	1	2	3

Status Quo: The COA received a score of 1 because at least one inpatient service line was over/under supplied, or more than 50% of specialties were inadequately supplied when compared to future Veteran in-house demand. Additionally, no changes to facilities or services were introduced that improve VA's ability to meet the future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, expansion of services).

Modernization: The COA received a score of 2 because, while Modernization right-sizes services to meet future Veteran in-house demand, the COA does not include changes to facilities or services that improve VA's ability to meet the future Veteran enrollee population (e.g., relocation or establishment of facilities in areas with greater Veteran demand, addition of new services).

VA Recommendation: The COA received a score of 3 because it right-sizes services to meet future Veteran enrollee demand and includes changes to facilities or services that improve VA's ability to meet future Veteran enrollee demand based on guidelines established in the CBA methodology. These changes include the following:

- Establishes a new Anthem VAMC to provide inpatient community living center and inpatient residential rehabilitative services; 102,907 enrollees live within 60 minutes of the proposed facility
- Expands the Southeast Gilbert MS CBOC to a HCC, adding outpatient surgery services
- Expands the Northwest Surprise CBOC to a MS CBOC, adding outpatient specialty care services

Access

Within the Access domain, the CBA considers how each COA impacts Veteran access to care in the future. Each COA is assessed on the change in enrollee proximity to VA-provided primary care, specialty care, and outpatient mental health care.

The table below shows the CBA access scores for VISN 22 Phoenix for this domain.

Table 163 – Access Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Access	2	2	2

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (inclusive of VA, Community Care Network providers, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future high-performing integrated delivery network (HPIDN).

Status Quo: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

Modernization: The COA received a score of 2 because access is maintained within 1% for VA-provided primary care, specialty care, and outpatient mental health care.

VA Recommendation: The COA received a score of 2 because access to VA-provided primary care was maintained within 1%, specialty care was maintained within 1%, and outpatient mental health care was maintained within 1%.

Quality

Within the Quality domain, the CBA considers how each COA impacts the quality of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the ability of the main patient care facilities to support modern healthcare; (2) the ability of demand to support clinical competency.

The table below shows the scores for VISN 22 Phoenix for this domain.

Table 164 – Quality Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Quality	2	3	3

Status Quo: The COA received a score of 2 for two reasons. First, the COA includes main patient care facilities that were built prior to the emergence of modern healthcare design principles and specific standards to support modern medicine (e.g., floor-to-floor heights, corridor widths, columns spacing, and utility infrastructure requirements). Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA’s planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Modernization: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

VA Recommendation: The COA received a score of 3 for two reasons. First, the COA contains only modern facilities that meet modern health care design standards. Modern facilities support current standards of care (e.g., PACT-enabled environment in the outpatient setting, single patient rooms in the inpatient setting) and utilization of technologies. They can also improve the experience for both Veterans and staff. Second, the COA includes facilities with projected future demand at or above VA planning guidelines for maintaining programs. VA's planning guidelines reflect that sufficient volume and diversity of cases are required for all members of the care team to maintain proficiency and quality care delivery.

Facilities and Sustainability

Within the Facilities and Sustainability domain, the CBA considers how each COA impacts the sustainability of Veteran care in the future. Each COA is assessed based on two benefit components: (1) the useful life of the main patient care facilities; (2) changes that strengthen VA's ability to recruit and retain providers.

The table below shows the scores for VISN 22 Phoenix for this domain.

Table 165 – Facilities and Sustainability Scoring Summary

Key Benefit Domain	Status Quo	Modernization	VA Recommendation
Facilities and Sustainability	1	2	2

Note: The American Hospital Association estimates that a hospital's useful life, a measure which predicts the productive period of a typical capital asset before it becomes obsolete or needs replacement, is currently 40 years.

Status Quo: The COA received a score of 1 for two reasons. First, the COA includes at least one main patient care facility that exceeds its useful life as defined by the American Hospital Association, indicating it may be obsolete or need replacement. Second, the COA does not include changes that strengthen VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Modernization: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

VA Recommendation: The COA received a score of 2 for two reasons. First, the COA replaces all main patient care facilities that have exceeded their useful life with modern facilities that can be sustained over the coming years. Second, while the COA includes modernized infrastructure, which may attract providers, it does not include additional changes to support VA's ability to recruit or retain providers (e.g., relocation of VA facilities closer to health care hubs based on Hospital Referral Regions; new or expanded partnerships between VA and academic affiliates, other Federal facilities, or community facilities).

Mission

Within the Mission domain, the CBA considers how each COA impacts VA's ability to support its statutory missions of Education, Research, and Emergency Preparedness in the future. Each COA is assessed on three benefit components: (1) the impact on training programs; (2) the impact on research programs; (3) the impact on emergency preparedness.

A COA's overall score in the Mission domain is determined by the rounded average (unweighted) of its component (e.g., Education, Research, Emergency Preparedness) scores. The table below shows the scores for VISN 22 Phoenix for this domain.

Table 166 – Mission Scoring Summary

Subdomain	Status Quo	Modernization	VA Recommendation
Education	2	2	3
Research	2	2	3
Emergency Preparedness	2	2	2
Overall Mission Score (Rounded Average)	**2**	**2**	**3**

Status Quo: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Modernization: The COA received a score of 2 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 2 because it does not impact inpatient acute service lines and thus maintains existing training programs.
- **Research:** The COA received a score of 2 because all existing facilities with research programs are maintained.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

VA Recommendation: The COA received a score of 3 (rounded average of scores across Education, Research, and Emergency Preparedness).

- **Education:** The COA received a score of 3 because inpatient acute services remain VA-delivered and thus the COA maintains existing training programs. Additionally, the COA includes new (not replacement) infrastructure that creates new opportunities for training within the market.
- **Research:** The COA received a score of 3 because it maintains all research programs and builds new (not replacement) infrastructure to support additional research space.
- **Emergency Preparedness:** The COA received a score of 2 because it maintains the current count of Primary Receiving Center-designated VAMCs in the market.

Sensitivity Analysis

A sensitivity analyses study shows how various sources of uncertainty in a mathematical model contribute to the model's overall uncertainty. The market is considered sensitive to a scenario when the VA Recommendation is no longer the leading COA due to changes in benefit scores, VA capital costs, VA operational costs, or non-VA operational costs.

The table below outlines the sensitivity analysis scenarios completed.

Table 167 – Sensitivity Analysis Scenarios

Sensitivity Analysis Scenarios
Increase Benefit Scores for Status Quo and Modernization in increments of one from 1 to 3 points
Increase VA Capital Costs in 50% increments from 0% to 300%
Increase VA Operational Costs in 50% increments from 0% to 300%
Increase Non-VA Operational Costs in 50% increments from 0% to 300%

Sensitivity Analysis Results Summary

In the VISN 22 Phoenix Market, five scenarios changed the outcome of the CBA:

- Increasing the Modernization benefits score by two points
- Increasing the Modernization benefits score by three points
- Increasing the VA Capital Cost by 200%; Modernization becomes the preferred COA
- Increasing the VA Capital Cost by 250%; Modernization becomes the preferred COA
- Increasing the VA Capital Cost by 300%; Modernization becomes the preferred COA

Sensitivity Analysis Full Results

The below tables show the results across all sensitivity analysis scenarios.

Table 168 – Sensitivity Analyses – Benefit Score Increase

Status Quo and Modernization Benefit Score Change	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
+0	3.32	2.57	2.34	VA Recommendation
+1	2.95	2.36	2.34	VA Recommendation
+2	2.65	2.17	2.34	Modernization
+3	2.41	2.02	2.34	Modernization

Table 169 – Sensitivity Analyses – VA Capital Cost Increase

VA Capital Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	3.32	2.57	2.34	VA Recommendation
50%	3.38	2.70	2.53	VA Recommendation
100%	3.44	2.82	2.72	VA Recommendation
150%	3.50	2.95	2.91	VA Recommendation
200%	3.57	3.07	3.10	Modernization
250%	3.63	3.20	3.29	Modernization
300%	3.69	3.32	3.48	Modernization

Table 170 – Sensitivity Analyses – VA Operational Cost Increase

VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	3.32	2.57	2.34	VA Recommendation
50%	4.30	3.29	2.95	VA Recommendation
100%	5.28	4.00	3.55	VA Recommendation
150%	6.27	4.72	4.16	VA Recommendation
200%	7.25	5.43	4.77	VA Recommendation
250%	8.24	6.15	5.37	VA Recommendation
300%	9.22	6.87	5.98	VA Recommendation

Table 171 – Sensitivity Analyses – Non-VA Operational Cost Increase

Non-VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
0%	3.32	2.57	2.34	VA Recommendation
50%	3.93	3.01	2.72	VA Recommendation
100%	4.54	3.46	3.09	VA Recommendation
150%	5.15	3.90	3.47	VA Recommendation
200%	5.76	4.35	3.85	VA Recommendation
250%	6.37	4.79	4.22	VA Recommendation

Non-VA Operational Cost Increase %	Status Quo CBI	Modernization CBI	VA Recommendation CBI	Leader (lowest CBI)
300%	6.98	5.23	4.60	VA Recommendation

Appendix A – VISN 22 Phoenix: Capital and Operational Costs Detail

Table 172 – Capital Costs by COA

	Status Quo	Modernization	VA Recommendation
VAMC Ideal Square Footage	-	1,950,556	2,685,779
Build New GSF	-	1,195,489	1,989,466
Renovate In Place GSF	-	158,569	-
Matched Convert To GSF	-	178,077	-
Demolition GSF	-	600,393	-
Total Build New Cost	$0	($1,047,433,945)	($1,648,661,110)
Total Renovate In Place Cost	$0	($46,043,185)	$0
Total Matched Convert To Cost	$0	($67,922,436)	$0
Total Demolition Cost	$0	($20,517,891)	$0
Total Lease Build-Out Cost	$0	($90,321,923)	($90,863,111)
Total New Lease Cost	$0	($395,837,329)	($397,592,525)
Total Existing Lease Cost	($103,433,909)	($103,433,837)	($62,861,660)
NRM Costs for Owned Facilities	($718,284,593)	($227,713,019)	($1,031,829,459)
FCA Correction Cost	($152,741,372)	N/A	N/A
Estimated Base Modernization Cost	($974,459,874)	($1,999,223,565)	($3,231,807,866)
Additional Common/Lobby Space Needed (GSF)	-	418,421	696,313
Cost of Additional Common/Lobby Space	$0	($315,216,417)	($524,565,551)
Additional Parking Cost	$0	($46,542,262)	($578,235,727)

	Status Quo	Modernization	VA Recommendation
Potential Land Acquisition Cost	$0	($12,145,863)	($184,159)
Seismic Correction Cost	($20,345,201)	($5,389,103)	($20,345,201)
Non-Building FCA Correction Cost	($7,950,168)	($7,950,167)	($160,691,540)
Activation Costs	$0	($365,181,751)	($419,602,253)
Estimated Additional Costs for Modernization	($28,295,369)	($752,425,563)	($1,703,624,430)
Cost Adjustment: In-Progress Construction	N/A	N/A	$0
Cost Adjustment: In-Progress Lease	N/A	N/A	$0
Estimated Facilities Costs (PV)	($1,002,755,243)	($2,751,649,128)	($4,935,432,296)

Table 173 – Operational Costs by COA

	Status Quo	Modernization	VA Recommendation
VA Direct	($9,596,879,726)	($9,596,879,726)	($9,596,879,726)
Fixed Direct	($753,492,169)	($753,492,169)	($753,492,169)
VA Specific Direct	($351,907,517)	($351,907,517)	($351,907,517)
Indirect	($3,743,730,902)	($3,743,730,902)	($3,743,730,902)
VA Specific Indirect	($559,595,248)	($559,595,248)	($559,595,248)
Research and Education	($310,674)	($310,674)	($310,674)
VA Overhead	($745,575,651)	($745,575,651)	($745,575,651)
VA Care Operational Cost Total (PV)	($15,751,491,888)	($15,751,491,888)	($15,751,491,888)
CC Direct	($6,019,475,090)	($6,019,475,090)	($6,019,475,090)
Delivery and Operations	($260,286,224)	($260,286,224)	($260,286,224)

	Status Quo	Modernization	VA Recommendation
Care Coordination	($268,103,879)	($268,103,879)	($268,103,879)
CC Overhead	($336,069,792)	($336,069,792)	($336,069,792)
Admin PMPM	($2,885,933,324)	($2,885,933,324)	($2,885,933,324)
Non-VA Care Operational Cost Total (PV)	($9,769,868,308)	($9,769,868,308)	($9,769,868,308)
Estimated Operational Costs (PV)	($25,521,360,196)	($25,521,360,196)	($25,521,360,196)

Appendix B – VISN 22 Phoenix: Benefits Analysis Key Data

Below are key data points used in the benefit analysis, summarized in the above Benefit Analysis section.

Demand and Supply

Inpatient

Table 174 – Demand and Supply Key Data Points for Scoring – Inpatient (IP)

Service Line	100% of FY29 In-house Bed Need	120% of FY29 In-house Bed Need	Operating Beds	Supply Adequacy (within 100-120% of in-house demand)
IP CLC	66	80	46	Under Supplied
IP Med/Surg	89	106	117	Over Supplied
IP MH	37	44	48	Over Supplied

Note: Community Living Center (CLC); Medicine (Med); Surgery (Surg); Mental Health (MH)

Source: Enrollee Healthcare Projection Model Base Year 2019

Outpatient

Table 175 – Demand and Supply Key Data Points for Scoring – Outpatient (OP)

Physician Supply Adequacy	Count of Specialties	Percentage
Adequately Supplied	9	33%
Under Supplied	18	67%

Note: VA supply in the Status Quo COA is quantitatively evaluated based on the data above. It is assumed the Modernization COA scales the capacity of existing facilities up or down to meet future Veteran in-house demand. Similar to the Modernization COA, it is assumed the VA Recommendation COA scales the capacity of existing and proposed facilities up or down to meet future Veteran in-house demand. However, the VA Recommendation COA may account for factors that demand projections do not consider that may shift the future balance of in-house and community workload, such as:

- Areas with unmet Veteran demand that may warrant a net new point of care
- Low-census inpatient acute programs that may pose risks to quality and training programs, potentially warranting a shift to community providers
- Community capacity factors that may warrant changes to VA capacity

Source: Office of Productivity, Efficiency and Staffing 2019 Capacity Report

Table 176 – New Facility Demand Guidelines

Facility or Service	Guideline
Inpatient Acute VAMCs	Greater than or equal to 35,000 overlapping enrollees
Inpatient CLC	Greater than or equal to 21,000 overlapping enrollees
Health Care Center	Greater than or equal to 34,000 overlapping enrollees
MS CBOC	Greater than or equal to 4,300 non-overlapping enrollees
CBOC	Greater than or equal to 2,500 non-overlapping enrollees

Note: The above guidelines are used to determine whether a new (not replacement) point of care or service proposed in the VA recommendation had adequate demand.

Access

Table 177 – Access Key Data Points for Scoring

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of VA-provided OP Mental Health	90.1%	90.1%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of VA-provided OP Primary Care	92.8%	92.8%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of VA-provided OP Specialty Care	93.4%	93.4%	Maintained within 1%

COA	Measure	Current	Future	Result
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	97.4%	97.4%	Maintained within 1%
Status Quo	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	98.2%	98.2%	Maintained within 1%
Status Quo	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.3%	99.3%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Mental Health	90.1%	90.1%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of VA-provided OP Primary Care	92.8%	92.8%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of VA-provided OP Specialty Care	93.4%	93.4%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	97.4%	97.4%	Maintained within 1%
Modernization	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	98.2%	98.2%	Maintained within 1%
Modernization	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.3%	99.3%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Mental Health	90.1%	89.5%	Maintained within 1%

COA	Measure	Current	Future	Result
VA Recommendation	% of enrollees within 30 minutes of VA-provided OP Primary Care	92.8%	92.2%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of VA-provided OP Specialty Care	93.4%	93.6%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Mental Health	97.4%	97.3%	Maintained within 1%
VA Recommendation	% of enrollees within 30 minutes of HPIDN-provided OP Primary Care	98.2%	98.2%	Maintained within 1%
VA Recommendation	% of enrollees within 60 minutes of HPIDN-provided OP Specialty Care	99.3%	99.7%	Maintained within 1%

Note: the CBA Access domain score is based on enrollee proximity to VA-provided care only rather than the full high-performing integrated delivery network (HPIDN) (inclusive of VA, Community Care Network, and non-Community Care Network providers meeting quality criteria). While a COA may have a reduced access score within the CBA, the Section 203 Criteria analysis shows that the VA Recommendation COA maintains or improves access to all service lines in the future HPIDN. The table above shows the results for enrollee proximity to the full HPIDN as well as to VA-provided care in the market.

Source: Enrollee data from the FY19 Geocoded Enrollee File. Existing VA facility location data from VAST. Commercial provider location data from Definitive Healthcare.

Quality

Main Patient Care Facility Construction Date

Table 178 – Quality Key Data Points for Scoring – Age

Facility	Main Patient Care Facility Construction Date	Built Pre-1970?
(V22) (644) Phoenix	1952	Yes

Source: Main patient care facility construction and renovation dates from CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Inpatient Acute Demand

Table 179 – Quality Key Data Points for Scoring – Inpatient Acute Demand

Facility	Service	Demand Guideline	Meets or Exceeds Guideline?	VA Recommendation
(V22) (644) Phoenix	IP Med	20 ADC	Yes	Replace/Relocate
(V22) (644) Phoenix	IP Surg	1,600 Cases	Yes	Replace/Relocate
(V22) (644) Phoenix	IP MH	8 ADC	Yes	Replace/Relocate

Note: The Status Quo and Modernization COAs are assumed to maintain all current facilities and services. The VA Recommendation COA proposes maintaining, partnering, and divesting of services at each facility, shown in the last column titled "VA Recommendation". To score a 3, the VA recommendation must partner or divest of all low-demand services.

Source: FY 2029 average daily census for inpatient services is based on Enrollee Healthcare Projection Model Base Year 2019. 2019 Total Surgical Cases is from the VA National Surgery Office.

Facilities and Sustainability

Table 180 – Facilities and Sustainability Key Data Points for Scoring

Facility	Main Patient Care Facility Construction Date	Most Recent Main Patient Care Facility Renovation Date	Exceeds Useful Life?
(V22) (644) Phoenix	1952	1999	Yes

Note: Exceeding useful life is defined as 1) When a main patient care facility was built before 1970 it has exceeded its useful life, even if it has undergone major renovation in the last 40 years. 2) When a main patient care facility was built after 1970 but is still more than 40 years old (built on or after 1971 and before 1989), it must have undergone major renovation within the last 40 years to not exceed its useful life. 3) When a main patient care facility was built in or after 1989, it has not exceeded its useful life.

Source: From CAI Buildings and FCA Condition Gaps Reports 9-14-2020

Table 181 – Key Data Points for Scoring - Recruitment and Retention

Facility	Expands VA's Ability to Recruit/Retain?
N/A	N/A

Mission

Table 182 – Mission Key Data Points for Scoring

The Status Quo and Modernization COAs are assumed to have no impact on VA's statutory missions. The impact of the VA Recommendation on VA's statutory missions is shown in the table below:

Facility	Training Impact	Research Impact	4th Mission Impact	Market Plan Includes New Facilities/Services To Increase Training/Research Opportunities
(V22) (644) Phoenix	No impact on training	Maintains or Has Plan to Transition	No PRC Designation	Increases Research Opportunities, Increases Training Opportunities