U.S. DEPARTMENT OF VETERANS AFFAIRS

FY 2024 BUDGET SUBMISSION

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Budget Overview

Mission Statement

To fulfill President Lincoln's promise – "To care for him who shall have borne the battle, and for his widow, and his orphan" – the Department of Veterans Affairs (VA) is committed to providing Veterans and other eligible beneficiaries timely access to high-quality health services. VA's health care mission covers the continuum of care providing inpatient and outpatient services, including pharmacy, prosthetics and mental health care; long-term care in both institutional and non-institutional settings; and other health care programs, such as Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and Readjustment Counseling.

Budget Request

This budget request will ensure the Nation's Veterans receive high-quality health care and timely access to benefits and services. The 2024 Medical Care Budget separates VA Medical Care as a third category within the discretionary budget based on a recognition that VA Medical Care has grown much more rapidly than other discretionary spending over time, largely due to systemwide growth in health care costs. In 2024, the Budget reflects $128.1 billion in enacted advance appropriations for VA Medical Care programs, together with a proposed cancellation of $7.1 billion in unobligated balances, for a discretionary total of $121.0 billion in 2024. For 2025, the Budget requests $112.6 billion in discretionary advance appropriations for Medical Care.

This year, the Budget also reflects enactment of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act), which established the Cost of War Toxic Exposures Fund to ensure that there is sufficient funding available to cover costs associated with providing health care and benefits to Veterans exposed to environmental hazards. Consistent with the PACT Act, VA's Medical Care budget reflects $17.1 billion in 2024 and $21.5 billion in 2025 in the new Cost of War Toxic Exposures Fund (TEF).

When combining the requests for mandatory and discretionary appropriations across 2024 and 2025, this budget request fulfills the Administration's commitment to provide reliable and timely resources to support the delivery of accessible and high-quality medical services for Veterans. The 2024 Medical Care estimated total obligations level is $141.9 billion, afforded by the discretionary and mandatory appropriations requests combined with collections, reimbursements, transfers, proposed cancellations and net unobligated balances detailed later in this chapter.

Medical Care is composed of four appropriation categories:

Discretionary Appropriations

Dollars in Thousands ($000) Description	2024 Advance Approp. (AA)	2024 Revised Request (RR)	+/- 2024 AA 2024 RR	2025 Advance Approp. (AA)	+/- 2025 AA 2024 RR
Medical Services	$74,004,000	$74,004,000	$0	$71,000,000	($3,004,000)
Medical Community Care	$33,000,000	$33,000,000	$0	$20,382,000	($12,618,000)
Medical Support & Compliance	$12,300,000	$12,300,000	$0	$11,800,000	($500,000)
Medical Facilities	$8,800,000	$8,800,000	$0	$9,400,000	$600,000
Proposed Cancellation of Available Unobligated Balances:					
Medical Services		($4,933,113)			
Medical Community Care		($1,909,069)			
Medical Facilities		($250,515)			
Proposed Transfers Among Medical Care Accounts:					
From Medical Community Care (to Medical Facilities)		($3,919,081)			
From Medical Support & Compliance (to Medical Facilities).		($850,000)			
To Medical Facilities		$4,769,081			
Proposed Cancellation from Transferred Advance Appropriations		($4,769,081)			
Reappropriation of the Transferred Cancelled Funds					
In Medical Facilities with a 5-year Period of Availability		$4,769,081			
Discretionary Appropriation [Subtotal]	$128,104,000	$121,011,303	($7,092,697)	$112,582,000	($8,429,303)
Discretionary Accounts After Above Proposed Actions:					
Medical Services	*$74,004,000*	*$69,070,887*	*($4,933,113)*	*$71,000,000*	*$1,929,113*
Medical Community Care	*$33,000,000*	*$27,171,850*	*($5,828,150)*	*$20,382,000*	*($6,789,850)*
Medical Support & Compliance	*$12,300,000*	*$11,450,000*	*($850,000)*	*$11,800,000*	*$350,000*
Medical Facilities	*$8,800,000*	*$13,318,566*	*$4,518,566*	*$9,400,000*	*($3,918,566)*
Collections	$4,269,198	$4,269,198	$0	$4,362,307	$93,109
Discretionary Appropriations & Collections [Total]	$132,373,198	$125,280,501	($7,092,697)	$116,944,307	($8,336,194)

Mandatory Appropriations

Dollars in Thousands ($000) Description	2024 Advance Approp. (AA)	2024 Revised Request (RR)	+/- 2024 AA 2024 RR	2025 Advance Approp. (AA)	+/- 2025 AA 2024 RR
Cost of War Toxic Exposures Fund, request:					
Medical Services Category	$0	$9,525,428	$9,525,428	$10,336,542	$811,114
Medical Community Care Category	$0	$6,740,264	$6,740,264	$10,118,000	$3,377,736
Medical Support & Compliance Category	$0	$850,000	$850,000	$1,000,000	$150,000
Cost of War Toxic Exposures Fund [Subtotal]	$0	$17,115,692	$17,115,692	$21,454,542	$4,338,850
Medical Facilities (PACT Act, sec. 707)	$100,000	$100,000	$0	$200,000	$100,000
Mandatory Appropriation [Total]	$100,000	$17,215,692	$17,115,692	$21,654,542	$4,438,850

Appropriations and Collections After Above Proposals - All Funding Sources by Category

Dollars in Thousands ($000) Description	2024 Advance Approp. (AA)	2024 Revised Request (RR)	+/- 2024 AA 2024 RR	2025 Advance Approp. (AA)	+/- 2025 AA 2024 RR
Medical Services Category	$74,004,000	$78,596,315	$4,592,315	$81,336,542	$2,740,227
Medical Community Care Category	$33,000,000	$33,912,114	$912,114	$30,500,000	($3,412,114)
Medical Support & Compliance Category	$12,300,000	$12,300,000	$0	$12,800,000	$500,000
Medical Facilities Category	$8,900,000	$13,418,566	$4,518,566	$9,600,000	($3,818,566)
Appropriations [Subtotal]	$128,204,000	$138,226,995	$10,022,995	$134,236,542	($3,990,453)
Collections	$4,269,198	$4,269,198	$0	$4,362,307	$93,109
Appropriations & Collections [Grand Total]	$132,473,198	$142,496,193	$10,022,995	$138,598,849	($3,897,344)

Amounts in the table above are prior to transfers to the DoD-VA Health Care Sharing Incentive Fund and to the Joint DoD-VA Medical Facility Demonstration Fund.

Medical Services

- The request for discretionary appropriations, mandatory appropriations, and a proposed cancelation of unobligated balances provides a 2024 appropriations level of $78.6 billion. The 2024 Medical Services Category estimated total obligations level is $82.4 billion for clinical staff salaries, pharmacy, prosthetics, beneficiary travel and medical equipment, afforded by the appropriations request combined with collections, reimbursements, transfers, and unobligated end-of-year balances of $3.0 billion in discretionary and $1.3 billion in mandatory.

- The 2025 discretionary Advance Appropriation request of $71.0 billion and $10.3 billion in mandatory Advance Appropriations in the TEF, complemented by $4.3 billion in unobligated start-of-year balances and $3.4 billion of projected medical care collections, after transfers and reimbursements, will provide for an overall obligations level of $88.9 billion which is an increase of $6.5 billion over 2024.

Medical Services Category Obligations (Dollars in thousands)	2024 Revised Request	2025 Advance Approp.	+/- 2024-2025
Obligations by Category			
Medical Services Discretionary	$74,210,146	$77,260,286	$3,050,140
Medical Services Mandatory:			
Cost of War Toxic Exposures Fund	$8,187,428	$11,674,542	$3,487,114
VACAA, sec. 801	$5,678	$4,980	($698)
Medical Services Mandatory [Subtotal]	$8,193,106	$11,679,522	$3,486,416
Medical Services [Total]	$82,403,252	$88,939,808	$6,536,556

Medical Community Care

- The request for discretionary and mandatory appropriations, a proposed cancelation of unobligated balances, and transfers among Medical Care accounts provides a 2024 appropriations level of $33.9 billion. To realign funding among multiple sources, including the TEF, VA proposes to transfer $3.9 billion from the Medical Community Care 2024 Advance Appropriation to Medical Facilities. The 2024 Medical Community Category estimated total obligations level is $32.9 billion for non-VA provided medical claims and grants for state home nursing, domiciliary and adult day care services, afforded by the discretionary appropriation request combined with collections, reimbursements, transfers, proposed transfers and unobligated end of year balances of $2.8 billion in discretionary and $1.2 billion in mandatory.

- The 2025 discretionary Advance Appropriation request of $20.4 billion and $10.1 billion in mandatory Advance Appropriations in the TEF, complemented by $4.1 billion in unobligated start of year balances and $908 million of projected collections funds, after transfers, an overall obligation level of $35.4 billion which is an increase of $2.5 billion over 2024.

Medical Community Care Category Obligations (Dollars in thousands)	2024 Revised Request	2025 Advance Approp.	+/- 2024-2025
Obligations by Category			
Medical Community Care Discretionary	$27,082,317	$24,035,600	($3,046,717)
Medical Community Care Mandatory:			
Cost of War Toxic Exposures Fund	$5,510,910	$11,347,354	$5,836,444
Veterans Choice Fund	$272,550	$0	($272,550)
Medical Community Care Mandatory [Subtotal]	$5,783,460	$11,347,354	$5,563,894
Medical Community Care [Total]	$32,865,777	$35,382,954	$2,517,177

Medical Support and Compliance

- The request for discretionary and mandatory appropriations provides a 2024 appropriations level of $13.2 billion. To realign funding among multiple sources, including the TEF, VA proposes to transfer $850 million from the Medical Support and Compliance 2024 Advance Appropriation to Medical Facilities. The 2024 Medical Support and Compliance Category estimated total obligations level is $12.3 billion for regional and medical facility administrators, including leadership teams; community care claim processing and program management; human capital, contracting, financial and similar administrative support activities; and police officers, afforded by the appropriations requests combined with transfers, reimbursements, proposed cancellations and net unobligated balances.

- The 2025 discretionary Advance Appropriation request of $11.8 billion and $1.0 billion in mandatory Advance Appropriations in the TEF, after transfers and reimbursements, funds an overall obligation level of $12.8 billion which is an increase of $495 million over 2024.

Medical Support and Compliance Category Obligations (Dollars in thousands)	2024 Revised Request	2025 Advance Approp.	+/- 2024-2025
Obligations by Category			
Medical Support and Compliance Discretionary	$11,473,673	$11,821,986	$348,313
Medical Support and Compliance Mandatory:			
Cost of War Toxic Exposures Fund	$850,000	$1,000,000	$150,000
VACAA, sec. 801	$3,524	$256	($3,268)
Medical Support and Compliance Mandatory [Subtotal]	$853,524	$1,000,256	$146,732
Medical Support and Compliance [Total]	$12,327,197	$12,822,242	$495,045

Medical Facilities

- The request for discretionary appropriations, mandatory appropriations made available by Title VII of the PACT Act, a proposed cancellation of unobligated balances, and transfers among Medical Care accounts provides a 2024 appropriations level of $13.4 billion. To realign funding among multiple sources, including the Cost of War Toxic Exposures Fund, VA proposes to transfer $4.8 billion from Medical Community Care and Medical Support and Compliance 2024 advance appropriations to Medical Facilities for Non-Recurring Maintenance. The 2024 Medical Facilities Category estimated total obligations amount is

$14.3 billion for facility maintenance, leasing and energy, afforded by the appropriation request combined with transfers, reimbursements, and an unobligated mandatory balance of $1.4 billion.

- The 2025 discretionary Advance Appropriation request of $9.4 billion and $200 million mandatory previously appropriated by section 707 of PACT Act and complemented by $1.4 billion in unobligated start of year balances and after transfers and reimbursements funds an overall obligation level of $9.6 billion. This decrease of $4.7 billion is driven by the historic level of NRM investment in 2024.

Medical Facilities Category Obligations (Dollars in thousands)	2024 Revised Request	2025 Advance Approp.	+/- 2024-2025
Obligations by Category			
Medical Facilities Discretionary	$13,532,238	$9,360,384	($4,171,854)
Medical Facilities Mandatory:			
PACT Act, sec. 707	$786,724	$265,223	($521,501)
VACAA, sec. 801	$3,791	$0	($3,791)
Medical Facilities Mandatory [Subtotal]	$790,515	$265,223	($525,292)
Medical Facilities [Total]	$14,322,753	$9,625,607	($4,697,146)

Cost of War Toxic Exposures Fund Request Methodology

Consistent with the PACT Act, the 2024 budget proposes mandatory medical care funding in the TEF of $17.1 billion in 2024[1] and $21.5 billion in 2025. The PACT Act authorized the TEF to support incremental costs above 2021 for health care associated with environmental hazards and for any expenses incident to the delivery of health care and benefits associated with exposure to environmental hazards, as well as medical research relating to exposure to environmental hazards. Consistent with the law, the budget limits the TEF request to those increases only and excludes costs not associated with exposure to environmental hazards. The budget requests that all other funding needs be provided in the traditional discretionary appropriations to ensure that Veterans have the care and benefits they earned.

There are three elements that reflect the increased costs above the 2021 level that comprise the 2024 and 2025 medical care funding request for this account:

- **Baseline**. This represents the difference in health care costs from 2021 actuals for Veterans who would have been projected to receive VA Medical Care as result of exposure to environmental hazards during their military service prior to enactment of the PACT Act. The request uses the relative share of co-payment exempt care provided to a sample of Priority Group 6[2] veterans as a proxy for the proportion of health care that could reasonably

[1] In addition to the $17.1 billion for medical care, the 2024 budget proposes $3.2 billion of mandatory funding in the TEF for 2024 for non-medical care costs incident to the delivery of health care and benefits associated with exposure to environmental hazards and medical research relating to exposure to environmental hazards.

[2] Priority Group 6 Veterans are enrolled in both Priority Group 6 and in either Priority Group 7 or Priority Group 8, as applicable, pursuant to 38 CFR § 17.38(d)(3)(iii). For any care that VA cannot find to have resulted from a cause other than the service, testing, or activity that resulted in the exposure to environmental hazards, VA furnishes this

be associated with exposure to environmental hazards. This proxy was applied to the projected health care costs of Post-9/11 deployed and Gulf War deployed Veterans as well as Vietnam era Veterans based on their birthyear to determine the 2021 and outyear costs after discounting for lease costs (which are excluded by law).

- **Incremental**. This represents VA health care costs above what was projected to take place absent Titles I, III, and IV of the PACT Act, after applying the proxy adjustments described in the baseline methodology. The remaining incremental health care costs from these titles are funded by the discretionary appropriations.

- **Lost revenue**. This represents the projected lost revenue from decreases in 1st and 3rd party collections resulting from new service-connected health care as result of PACT Act.

The table below details the amounts of each element.

Cost of War Toxic Exposures Fund Request Methodology		
Description Dollars in Thousands ($000)	2024 Estimate	2025 Estimate
Cost of War Toxic Exposures Fund, request:		
Baseline Difference from 2021 Estimated Health Care Cost of Environmental Hazardous Exposure During Military Service	$14,726,000	$18,286,000
Estimated Eligible Portion of Incremental Health Care from Titles I, III, and IV of the PACT Act.....	$2,314,360	$3,104,857
Estimated Reduced 1st and 3rd Party Collections Resulting from PACT Act.....	$75,332	$63,685
Cost of War Toxic Exposures Fund Request [Total].....	$17,115,692	$21,454,542

Key VA Priorities

The VA is a diverse and inclusive organization welcoming all our Veterans, including women Veterans, Veterans of color and LGBTQ+ Veterans. In 2022, the Veterans Health Administration (VHA) provided more than 115 million clinical encounters, with VA serving over 6 million patients. This included roughly 40 million in-person appointments and more than 31 million tele-health and telephone appointments and approximately 38 million community care appointments. The 2024 request supports the following priorities foundational in every decision supporting VHA's long-term goals:

Hire Faster and More Competitively

Providing world class health care is only possible with an enterprise-wide team of the best and brightest in their respective fields. VA is investing in its people by dramatically increasing hiring, holding onboarding surge events to onboard staff more quickly, increasing the use of incentives for recruitment and retention, maximizing pay authorities and scheduling flexibilities, expanding scholarship opportunities, and providing more education loan repayment awards than ever before. And VA is implementing new hiring and retention authorities to grow and maintain a diverse, talented workforce with a shared mission to provide more care and more benefits to more Veterans.

In 2022, VHA nearly doubled the number of scholarships for clinical education offered to employees and increased the number of Education Debt Reduction Program (EDRP) awards to over 3,000. Additionally, the percentage of staff receiving recruitment, retention, and relocation incentives (3Rs) more than doubled from 5.9 to 12.2%. At rural facilities, the use of 3Rs increased

care without copayment liability pursuant to 38 U.S.C. § 1710(a)(2).

from 4.3 to 18.9%. And for some critical shortage occupations, such as housekeeping aides (10.5 to 35%) and food service workers (2.1 to 18.7%), the use of 3Rs increased even more dramatically. These incentives assisted with the reduction of loss rates for critical shortage occupations in those areas to address increased competition for health care and entry level staff. VA also conducted a nationwide onboarding surge event in November 2022 that resulted in onboarding more new staff in VHA in the first quarter of FY 2023 (12,900 staff) than first quarter onboarding in any previous year, 86.0% higher than the typical number onboarded in the first quarter.

Moving forward, VHA will improve its staffing effectiveness and hire more proactively, standardizing processes and improving data to increase onboard strength, particularly in key Veteran-facing professions. Active utilization of recently enacted pay authorities will empower VHA to attract, recruit and retain the best employees. Faster, more flexible onboarding processes will further reduce time-to-fill.

Connect Veterans to the Soonest and Best Care

Over the last two years, VA has delivered more care to more Veterans through both VA and community care providers than during any time in the Nation's history. Veterans completed more than 73 million outpatient appointments in VA and another 38 million community care outpatient appointments in calendar year 2022. While enrolled, Veterans continue to receive the majority of their outpatient care in VA. More than 3 million Veterans have completed at least one outpatient appointment with a community care provider since implementing the VA MISSION Act of 2018. As such, more than a third of all Veterans enrolled in VA health care have been eligible for and chosen to elect to receive at least one community care appointment at some point in the last five years.

Veterans today have more options for care than ever. VA has more than 1,100 medical centers and community-based outpatient clinics for Veterans to receive their care. VA offers care in-person, over the phone or through video appointments as clinically appropriate. VA's community care network has more than 1.3 million community care providers across all 50 States and U.S. Territories. Enrolled Veterans also have access to community urgent care, and all Veterans have access to emergent suicide care.

Veterans' trust levels for VA health care exceed 90% nationally, whether care is received in VA or through a community provider. Veterans believe VA health care is getting better, according to studies by the Veterans of Foreign Wars. More than 90% of Veterans surveyed say they would recommend VA care to other Veterans. VA is seeing more patients than ever before, and studies show VA compares favorably to the private sector for access as well as quality of care–exceeding private sector in many cases.

To build on these successes and continue world-class service for new Veterans and those new to VA, VHA is committed to providing Veterans with the soonest and best care, reducing wait times to see providers and prioritizing Veteran satisfaction metrics. VHA will improve its scheduling procedures, capturing Veterans' scheduling preferences for care from VA and community providers and implementing an optimized, standardized process to access telehealth, including telemental health. VA will improve efficiency at VA facilities by standardizing clinical practice management and referral coordination across the enterprise. Standardized bidirectional

communication between VHA and its contracted Third-Party Administrators about network adequacy and quality will improve timeliness and satisfaction with the community referral process.

Serve Veterans with Military Environmental Exposures

The PACT Act represents the largest expansion of Veterans' benefits in a generation. To ensure all eligible Veterans obtain the benefits and care they earned through their service, the Budget provides $82 million for the Health Outcomes and Military Exposures (HOME) Office, an 85% growth over 2022 and $68 million for Military Occupations and Environmental Exposures research. VHA will regularly screen enrolled Veterans for military-related toxic exposures and ensure clinicians are adequately informed to assess how such exposures affect Veterans' specific health concerns. VA will improve the Airborne Hazards and Open Burn Pit (AHOBP) registry and will track the VHA healthcare utilization of the PACT Act eligible cohort. To ensure these Veterans receive the highest quality care available, the Budget includes new medical research on the chronic health effects of conditions or substances encountered during military service with studies examining Agent Orange, dioxins, burn pits and other industrial chemicals expecting to yield improvements in the identification and treatment of medical conditions potentially associated with toxic exposures.

Accelerate VA's Journey to a High Reliability Organization

The healthcare high reliability organization (HRO) model is the managerial framework for transformational change. HROs focus on continuous improvement and enhancing the customer experience. VHA has identified its own path to high reliability to meet Veterans' unique needs. Starting in 2019, VHA began instilling HRO principles, tools and techniques at every level of the organization to address root causes, advance VA and VHA priorities and ultimately achieve our vision of providing exceptional, coordinated and connected care, anytime and anywhere for Veteran health and wellbeing. In 2024, VHA will accelerate its HRO efforts and move closer to its aim of becoming a "zero harm" organization that is constantly learning and applying those lessons toward improving Veteran care.

VA's HRO journey has already improved the organization and Veteran care. VHA's HRO cultural transformation efforts are positively impacting Patient Safety Event reporting, with more employees speaking up and reporting Close Call safety issues before they become events of harm. Since the launch of VHA's enterprise HRO implementation activities, both Patient Safety Culture and safety reporting measures have shown improvement across all three HRO Cohorts, encompassing all VA medical centers across VHA. The Patient Safety Culture Analysis demonstrated positive trends across all 16 questions in the Patient Safety Culture module of the All Employee Survey (AES), fiscal years 2019-2022.

In 2024 and beyond, VA will step up targets and monitoring against Zero Harm metrics. In becoming a more mature HRO, VA will promote more local medical center adoption of the four Foundational HRO Practices (Leader Rounding, Safety Huddles, Patient Safety Forums, and Visual Management Systems). VA will also ensure VHA Central Office organizations practice HRO activities and that VHA leaders actively foster a Just Culture.

Support Veterans' Whole Health, their Caregivers, and their Families

Whole Health is an approach to healthcare that empowers and equips Veterans, caregivers and employees to take charge of their health and well-being and to live their lives to the fullest. Transforming the VA into a Whole Health system of care has successfully launched and is receiving full support at both the national and local levels, including strong endorsement in a recent National Academy of Medicine report. Specifically, a system of care is being created that is Veteran-centric by aligning with Veterans' mission, aspiration and purpose. Research has shown that having a sense of purpose in life equates to a longer and better quality of life. The Whole Health approach has positive effects on several facets of care to include decreased opioid use in those Veterans with chronic pain, improvement in their experiences within the VA, and engagement in health care and self-care, which ultimately leads to improved overall health and well-being. The Whole Health approach is also demonstrating benefits for employees including decreased levels of burnout and increased resiliency.

In 2022, 16% of all Veterans receiving care through VA also received Whole Health services. This care was delivered to 1.1 million Veterans through nearly 4 million encounters that were both Whole Health specific and that integrated the Whole Health approach into routine clinical encounters. Tele-Whole Health encounters have grown to include 98,000 unique Veterans participating in 513,000 encounters in 2022, an increase of 39% unique patients and 33% of encounters over 2021. Robust formal evaluations continue to focus on outcomes for Veterans and employees, which includes a review of specific cost avoidance that is traceable to implementation of Whole Health Services (e.g., opioid use reduction, decrease in spinal procedures). The 2024 President's Budget for Whole Health includes $107.8 million. VA is fully committed to making the Whole Health approach an integral part of how we deliver care to Veterans and how we care for our employees.

In support of Whole Health, VA will adopt a public health approach to health equity, implementing targeted interventions to address health disparities and improve health outcomes for underserved Veteran groups defined by sex, sexual orientation, gender identity, race/ethnicity, urban/rural residence and social risk. VA will expand its Whole Health services, including new virtual, community and collaborative opportunities, as well as increase the number of Veterans who partake in them. In recognition of the ongoing strain on staff following the COVID-19 pandemic, VA will appoint facility-level Chief Well-Being Officers and employee Whole Health coordinators. The success of these employee-focused efforts will be assessed through questions about VA's "culture of well-being" on the annual All Employee Survey.

VA expanded its Program of Comprehensive Assistance for Family Caregivers (PCAFC) to eligible family members and Veterans of all eras on October 1, 2022 and has received over 44,300 applications as of February 8, 2023. Currently, there are over 45,500 Veterans participating in the PCAFC across the country, including territories. As of February 8, 2023, 98% of PCAFC applications are dispositioned in under 90 days.

The Budget recognizes the important role of these family caregivers in supporting the health and wellness of Veterans. The $2.4 billion included in this Budget supports staffing, stipend payments and many other services to help empower family caregivers of eligible Veterans. In addition, this funding allows for further improvements and enhancements, allowing VA to reach and support more caregivers than before.

VA is currently undertaking a broad programmatic review of the PCAFC to ensure it achieves intended outcomes for all applicants and participants. While this review is underway, VA has suspended all annual reassessments for participants of the PCAFC. VA will not discharge or decrease any support to PCAFC participants, and their Family Caregivers, based on reassessment, to include monthly stipends paid to Primary Family Caregivers, as the current eligibility criteria are examined.

As we look to the year ahead, VA seeks to build upon the Caregiver Support Program with an emphasis of the "Year of the Caregiver." The Year of the Caregiver is about ensuring caregivers know they belong to a community that cares. Through this theme, VA is not only adding to what it offers to caregivers but focusing on how it is offered and implementing and improving support and services for caregivers of Veterans, including mental health care and respite.

VA will extend the benefits of Whole Health to Veterans' caregivers as well. VA will revisit the eligibility criteria for its first-in-the-nation Caregivers Support Program and will begin offering specialized telemental health care to caregivers. A new Decedent Affairs Program will provide personalized, supportive experiences to Veterans and families through end of life and to survivors after the Veteran's death.

Prevent Veteran Suicide

VA has made suicide prevention a top clinical priority and is implementing a comprehensive public health approach to reach all Veterans. Funding for mental health, including suicide prevention, is $16.6 billion in 2024, up from $15.0 billion in 2023. The 2024 request further supports the Department's effort to address substance use disorders and invest in overdose prevention and treatment programs, including those in support of the Jason Simcakoski Memorial and Promise Act. Our commitment to a proactive, Veteran-centered Whole Health approach is integral to our mental health care efforts and includes online and telehealth access strategies. Whole Health can help Veterans reconnect with their mission and purpose in life as part of our comprehensive approach to reducing risk.

Suicide is a complex issue with no single cause. Maintaining the integrity of VA's mental health care system is vitally important, but it is not enough. We know some Veterans may not receive any health care services from VA, which highlights VA alone cannot end Veteran suicide. This requires a nationwide effort. To support this effort, the Budget specifies $559 million for suicide prevention outreach programs, on top of an estimated $2.5 billion in suicide-specific medical treatment, which includes a new $10.0 million program to further bolster these efforts under the authority of section 303 of Division V (Strong Veterans Act of 2022) of P.L. 117-328 (Consolidated Appropriations Act, 2023).

The Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) awarded $52.5 million to 80 community-based organizations in 43 states, the District of Columbia, and American Samoa in 2022. These organizations provide or coordinate the provision of suicide services for Veterans and their families. VA has provided technical assistance to grantees, who have begun providing suicide prevention services in January 2023. Twenty-one (21) grantees serve tribal lands including Navajo Nation, Cherokee Nation, Choctaw Nation, Alaskan Native tribes

and others. Funding decisions reflect VA's authority to prioritize the distribution of grants to rural communities, Tribal lands, Territories of the United States, medically underserved areas, areas with a high number or percentage of minority Veterans or women Veterans, and areas with a high number or percentage of calls to the Veterans Crisis Line. In alignment with VA's National Strategy for Preventing Veteran Suicide, this grant program assists in further implementing a public health approach that blends community-based prevention with evidence-based clinical strategies through community efforts. The 2024 Budget plans to award $55.6 million in grants in 2024.

The Veterans Comprehensive Preventions, Access to Care and Treatment Act of 2020 (hereafter referred to as the "COMPACT Act") (Public Law 116-214) created a new authorization in 38 U.S.C. 1720J for VA to provide healthcare services to all eligible Veterans in imminent suicide crisis at no cost in both VA and the community. This provision expands VA eligibility for care and is in full alignment with VA's National Strategy for Preventing Veteran Suicide. VA published the Interim Final Rule on January 17th, 2023, and immediately began providing this new benefit to eligible Veterans. VA continues to aggressively address critical cross-platform information technology enhancements to ensure that multiple administrative and clinical systems work seamlessly together to ensure timely and efficient care is provided to the Veteran at no cost. We are committed to ongoing education and training efforts within VA and in the community as we deploy this new, life-affirming benefit in our ongoing suicide prevention efforts.

Women Veterans carry an especially high burden of mental health conditions. These include gender-specific conditions associated with heightened suicide risk, such as premenstrual dysphoric disorder, postpartum depression and perimenopausal depression. Among women Veterans receiving VHA care, nearly 60% are diagnosed with at least one mental health condition; and many struggle with multiple mental health concerns, medical comorbidities and psychosocial challenges. VA has implemented numerous initiatives to ensure that VHA mental health providers have the skills and expertise to address women Veterans' unique and diverse treatment needs and suicide risks.

Among the risk factors for suicide, substance use disorder is strongly implicated. In addition, drug overdose fatalities inclusive of suicide have escalated dramatically. Therefore, the need for effective interventions to address substance use cannot be overstated. Supported by the President's Budget, VA is expanding evidence-based substance use disorder treatment and harm reduction initiatives consistent with the Biden-Harris Statement of Drug Policy Priorities.

Furthermore, VA's budget is continuing to support expansion of its Psychotropic Drug Safety Initiative to address the growing crisis of stimulant use overdose fatalities. This initiative is ensuring the safe and appropriate prescribing of stimulant medications as well as expanding Veterans' access to evidence-based treatments for stimulant use disorder including cognitive-behavioral therapy and contingency management.

President Biden's continued focus on the national mental health crisis recognizes that access to mental health care is challenged. VA continues to evaluate staffing needs and prioritizes mental health hiring and training. However, we recognize that hiring additional mental health staff in the VA will not resolve the growing demand. To address President Biden's vision to increase system

capacity, connect Veterans to care and create a full continuum of support for Veterans, VA is committed to being the nation's leader in ongoing research enhancing current mental health treatment, identifying new mental health interventions, and developing effective prevention and at-risk identification protocols. Ongoing congressional support for VA Mental Health Centers of Excellence (CoE), the Mental Illness Research, Education, and Clinical Centers (MIRECCs), and mental health research initiatives through the Health Services Research and Development Service (HSR&D) will be essential as VA continues to address access, mental health care, and suicide prevention.

Women's Health

Women make up 17.2% of today's Active-Duty military forces and 21.1% of National Guard and Reserves. VA continues to reach out to women Service members and Veterans, to encourage them to enroll and use the services they have earned. As a result, the number of women Veterans enrolling in VA health care is rapidly increasing. More women are choosing VA for their health care than ever before, with women accounting for over 30.0% of the increase in Veterans served over the past five years. Investments support comprehensive specialty medical and surgical services for women Veterans at a VA facility or through referrals to the community. The number of women Veterans using VA services has more than tripled since 2001, growing from 159,810 to 627,000 today. VA is committed to providing high quality, equitable care to women Veterans at all sites of care.

The Budget requests $257 million for women's health and childcare programs, a 66% increase over 2023. This increase supports $174 million for the Women's Health Innovation and Staffing Enhancement Initiative. VA is strategically enhancing services and access for women Veterans by hiring women's health personnel nationally to fill any gaps in capacity across all Veterans Integrated Service Networks. In 2023 VA is providing funding for a total of over 1,000 women's health personnel nationally: primary care providers, gynecologists, mental health providers and care coordinators. VA is also expanding childcare benefits beyond the current pilot sites as well as addressing clinical equipment needs such as those for mammography, exam tables designed for women with low mobility and breastfeeding privacy pods.

To support pregnant and postpartum Veterans, VA has developed a Maternity Care Coordination (MCC) program in all VA health care systems to ensure coordination of care both in VA and in the community. VA is expanding maternity care coordination to follow pregnant Veterans for one year postpartum, a particularly vulnerable time for families.

VA has also enhanced our capacity to provide lactation services to Veterans. VA has funded the training of lactation support providers and developed a lactation support toolkit and support community of practice to ensure Veterans have access to the assistance they need.

VA is focusing on enhancing care coordination for preventive care, such as breast and cervical cancer screening. VA is implementing the Dr. Kate Hendricks Thomas Supported Expanded Review for Veterans in Combat Environments (SERVICE) Act. VA is implementing the PACT Act by providing Toxic Exposure Screening for enrolled women Veterans. The Breast and Gynecologic Cancer System of Excellence is providing state of the art breast and gynecologic cancer care and care coordination across the system through VA's tele-oncology program.

The Budget supports all VA medical centers (VAMCs) across the United States having a full-time Women Veteran's Program Manager tasked with advocating for the health care needs of women Veterans. Mini-residencies in women's health with didactic and practicum components optimize women's health clinician proficiency.

Homelessness Programs

VA's longstanding support for Veterans who are homeless or at risk of homelessness is enhanced through a Whole Health lens. VA will ensure Veterans who are housed in VHA programs do not return to homelessness by implementing a case management model to mitigate risk factors. VHA will also leverage its existing programs through targeted outreach to reduce the number of unsheltered Veterans.

The 2024 Budget increases resources for Veterans' homelessness programs to $3.1 billion, with the goal of ensuring every Veteran has permanent, sustainable housing with access to high-quality health care and other supportive services to end and prevent future Veteran homelessness. This Budget includes funds to assist with the design and development of expanded services for aging and disabled Veterans, a growing need and area of focus for the Department of Housing and Urban Development (HUD)–VA Supportive Housing (VASH) program. In addition, funds will be used to provide a medical home model and population tailored approach to provide in-home primary care and wrap around services to Veterans actively enrolled in the HUD-VASH program, provide additional resources to increase outreach and community engagement efforts, as well as expansion of Veteran justice services, such as treatment courts and Veteran focused criminal justice initiatives. Funding will also support the VA Grant and Per Diem (GPD) program to adhere to recent modified statutory authority, that increases per diem rates to community partners actively supporting VA's effort to end Veteran homelessness.

Significant progress has been made to prevent and end Veteran homelessness. Since 2010, efforts by VA and its Federal partners have led to a more than 55% reduction in Veteran homelessness. On a single night in January 2022, there were 33,129 Veterans experiencing homelessness in the U.S. Since 2015, there were 83 communities and 3 States (Delaware, Connecticut and Virginia) that met the criteria and benchmarks established by the U.S. Interagency Council on Homelessness, VA and HUD, for achieving an effective end to Veteran homelessness. Additionally, in 2022, VA permanently housed more than 40,000 homeless Veterans, exceeding its permanent housing goal by more than 6%.

Supporting Cancer Moonshot and Advancements in Precision Oncology

VA is committed to promoting measurable progress toward President Biden's Cancer Moonshot initiative. The role of continuing scientific and medical advances in the ongoing rapid evolution of oncology clinical practice necessitates the close integration of research structures and frontline care delivery. The resulting oncology learning healthcare system facilitates agile implementation of new clinical practices in response to scientific discoveries and evolving knowledge. To that end, VHA's research and clinical oncology programs both collaborate with the National Cancer Institute (NCI) and other external partners to maximize Veterans' benefit from cutting edge improvements in oncology care (for example, by increasing Veterans' access to clinical trials).

The 2024 Budget includes $94 million to support 369 research projects to improve our ability to diagnose and treat cancers.

The vision of VA's Precision Oncology Initiative is that Veterans will have access to care as close to their homes as possible that is comparable to that available at the nation's leading cancer centers. VA's implementation of this vision is based on three clinical pillars: oncology clinical pathways that define preferred practice, molecular diagnostic services that facilitate access to testing and the requisite expertise to use the results and TeleOncology that delivers clinic care led by expert oncologists affiliated with National Cancer Institute-designated Cancer Centers to underserved areas.

Clinical trials are often part of standard clinical care for patients with cancer and are a second area of clinical-research integration in Precision Oncology. Together, these elements form a System of Excellence for the full spectrum of care for a particular cancer type. Systems of Excellence are established for Prostate/Genitourinary Cancers and Lung. In 2024, VA will expand on the Rare Cancers System of Excellence, add additional molecular testing capabilities, enhance the pathology and laboratory infrastructure, partner with the Department of Defense and others to improve cancer care through the White House Cancer Moonshot.

The Budget invests $29 million within VA's cancer research programs, together with $215.4 million within the VA Medical Care program, for precision oncology to provide access to the best possible cancer care for Veterans. Funds support research and programs that address cancer care, rare cancers and cancers in women, as well as genetic counseling and consultation that advance tele-oncology and precision oncology care. The 2024 investment for precision oncology represents a 28% increase over 2023.

Addressing an Aging Medical Infrastructure:

VA operates the largest integrated health care, benefits and cemeteries system in the Nation, with more than 1,700 hospitals, clinics and other health care facilities, a variety of benefits and service locations and 155 national cemeteries. The infrastructure portfolio consists of approximately 184 million owned and leased square feet—one of the largest in the Federal Government. While the median age of U.S. private sector hospitals is approximately 13 years, VA's portfolio has a median age of 58 years. A full 69% of VA hospitals are over the age of 50, and VA medical facilities, on average, are nearly six times the age of private sector facilities. Health care innovation is occurring at an exponential pace, and the comparative youth of private sector facilities is informed by these trends. The architects who designed and constructed many VA facilities in the decades following World War II could not have anticipated the requirements of today's medical technology and the key enabling role that infrastructure – and technological infrastructure - now plays in delivering safe and high-quality health care. Many of VA's facilities were not designed this way and this limits our agility and ability to meet the evolving health care needs of Veterans.

The transformation of VA health care to achieve a safer, sustainable, greener, person-centered national health care model requires that VA leverage innovations in medical technology and clinical procedures. As technology-enabled trends in U.S. medicine bring care close to individuals and communities, there is less demand for sprawling campuses and more emphasis on ambulatory facilities and virtual care. Many surgical, medical, and diagnostic procedures that once required a

hospital stay are now safely performed in the outpatient setting, and virtual health care delivery brings expertise to a patient's own home.

This evolving landscape requires VA to rebalance and recapitalize its infrastructure to optimize the mix of traditional inpatient hospitals with outpatient hospitals, multi-specialty community-based outpatient clinics, single specialty community-based outpatient clinics and virtual care. The 2024 request includes $5 billion for non-recurring maintenance projects to address infrastructure deficiencies and better equip VHA to deliver timely, quality care across the enterprise.

VA also is making progress in upgrading its facility infrastructure to correct deficient building systems, such as horizontal cabling and electrical upgrades, that will support modernized technologies such as the electronic health record, financial management, and supply chain management systems. This needed investment in facility infrastructure will allow timely and efficient future deployments of these modernized systems. The Budget includes an additional $750 million for non-recurring maintenance projects specifically associated with preparing facilities for the new Electronic Health Record rollout.

Methods Used to Formulate the Budget Request

VA uses three actuarial models to support formulation of the majority of the VA health care budget, to conduct strategic and capital planning and to assess the impact of potential policy changes in a dynamic health care environment. The three actuarial models are the VA Enrollee Health Care Projection Model (EHCPM), the Civilian Health and Medical Program Veterans Affairs (CHAMPVA) Model and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) Stipend Projection Model. Detailed information on the three actuarial models can be found in the Actuarial Model Projections chapter. Activities and programs that are not projected by these models are called "non-modeled" and change annually. In general, they include NRM, state-based long-term services and supports programs (LTSS), readjustment counseling, recently enacted programs, some components of CHAMPVA programs (spina bifida, foreign medical program and children of women Vietnam Veterans) and new initiatives.

VA's EHCPM is an actuarial model that supports the formulation of approximately 84% of VA's Medical Care request and has been extensively validated. The EHCPM projects enrollment, utilization and expenditures in more than100 categories of health care services for 20 years into the future.

PACT Act Projections

VA's EHCPM was used to project additional new enrollment and increased health care expenditures associated with the PACT Act. Historical, actuarial benchmarks related to Veteran behavior changes were implemented in the EHCPM along with VA leadership assumptions about further changes affecting new enrollment take-up due to outreach (in addition to the actuarial benchmarks). VA projected costs for Title I, which changes enrollment eligibility timelines, and Titles III and IV, which expand eligibility based on conditions presumed to be associated with hazardous exposures. VA accounted for interaction between Titles I, III, and IV, to remove "double-counting" impacts on the estimates. All other PACT Act-associated costs were evaluated separately. PACT Act affects VHA enrollment by expanding eligibility for selected Veterans and

by either introducing or increasing service-connected ratings for some Veterans, which increase the enrollment priority level for which the Veteran is eligible.

Not all Veterans who are eligible decide to enroll with VHA; this is primarily due to having other forms of health coverage (e.g., Medicare, Medicaid, TRICARE, employer plans, ACA). A little over 60% of all Veterans who are eligible to enroll (under any authority, not specific to PACT Act eligibility) have enrolled in VHA, while approximately 90% of Veterans with a service-connected disability have enrolled in VHA.

Population estimates of Veterans with the conditions identified in Titles III and IV are provided by the Veterans Benefits Administration (VBA). VBA's estimates of the benefit caseload are divided into those Veterans assumed to already be present in the VBA compensation rolls for separate conditions (On Rolls) and those who would be newly added as a result of the condition expansion (New to Rolls). For each of these two groups, VBA has also estimated the additional service-connected disability rating attributable to only the new conditions.

If a Veteran is already enrolled, then the priority level upgrade is anticipated to increase their reliance on VHA for health care over time; if they are not yet enrolled, then the change is expected to increase the chance that the Veteran decides to enroll. These behavior patterns are modeled using the actuarial benchmarks of Veterans with similar ages and priority levels, developed through a study of historical VHA enrollment and health care data. Due to a robust outreach campaign targeting the Veteran population potentially impacted by the PACT Act, VA leadership anticipates that these Veteran behavior changes will be significantly greater than the historical patterns, leading to a larger new enrollment impact than what is reflected in historical patterns.

The Title III & IV expenditure impact to VHA is anticipated to come from these two key drivers:

- New enrollment is expected to occur as previously non-enrolled Veterans become eligible for higher enrollment priorities due to the proposed legislation. While a significant portion of Veterans are already eligible for enrollment, adding the presumptive conditions would cause some Veterans to be eligible for enrollment under higher priorities, particularly service-connected priorities P1-3, and this tends to increase their enrollment rate. New VHA enrollment resulting from the policy is assumed to come wholly from the New to Rolls population. New enrollees under the proposed condition expansion are assumed to use VHA services at rates comparable to existing enrollees of similar age and enrollment priority who also have been diagnosed with the same condition(s). After modeling the long-term increase in market share (portion of eligible Veterans who are enrolled) resulting from PACT, VA leadership added an assumption that market share would grow further beyond these levels. This assumption is VA leadership's anticipated response to the robust outreach campaign leading to enrollment take-up above and beyond the historical behavior patterns.
- Increased reliance on VHA is expected among Veterans with the newly identified conditions who are currently enrolled or already projected to enroll with VHA under existing policies. In particular, existing enrollees with these conditions may receive a service-connected rating for the first time or an increase to a composite rating that was based on other conditions. Enrollees' priority levels are expected to increase into or within priorities 1-3, and their reliance on VHA for health care services is expected to grow as a

result. Historical data and actuarial analysis have shown that enrollees with higher service-connected ratings are more reliant on VA for health care (i.e., receiving increased amount of their total care from VA than from other sources of health care).

Additional Compensation and Pension (C&P) Exams conducted by VHA providers are also included in VA's estimates. VBA provided the estimates of the total expected C&P Exam caseload for each condition. Using the caseload assumptions for each year, the direct VHA costs for C&P Exams for each condition was estimated by multiplying the expected additional caseload by the average C&P Exam cost for enrollees in the same cohort.

Title I impacts were limited to the Post-9/11 combat era (P911) Veteran population as Gulf War I Veterans already have full eligibility in at least Priority 6. The enhanced eligibility window was shifted from 5 to 10 years and other enrollment barriers were lifted for all P911 Veterans on a phased schedule with respect to discharge date. Increased enrollment take-up rates and reliance shifts were modeled under these changes using a similar approach as for Titles III and IV.

VA also projected the loss of first- and third-party collections revenue due to priority transitions. Existing enrollees in a priority 7 or 8 status are assumed to have a total loss of first-party Inpatient/Outpatient collections. Enrollees transitioning to a priority 1 status are assumed to have an impact on First-party Pharmacy copayment. Further, VA incorporated an increase in revenue based on new enrollment and increased reliance. To estimate the potential increase in revenue from new enrollment and increased reliance, VHA applies an existing collections-to-expenditure ratio to the additional expenditure amount.

Key Drivers of Growth in Projected Resource Requirements

In projecting future Veteran demand for VA health care, the EHCPM accounts for the unique characteristics of the Veteran population and the VA health care system, as well as environmental factors that impact Veteran enrollment and use of VA health care services.

Historically, growth in expenditure requirements to provide care to enrolled Veterans was primarily driven by health care trends, the most significant of which is medical inflation. Health care trends are key drivers of annual cost increases for all health care providers – Medicare, Medicaid, commercial providers and the VA health care system. Health care trends increase VA's cost of care independent of any growth in enrollment or demographic mix changes. Enrollment dynamics contribute to a portion of the expenditure growth; however, their impact varies significantly by the type of health care service. An assumption that VA's level of management in providing health care will improve over time reduces the cost of providing care to enrollees.

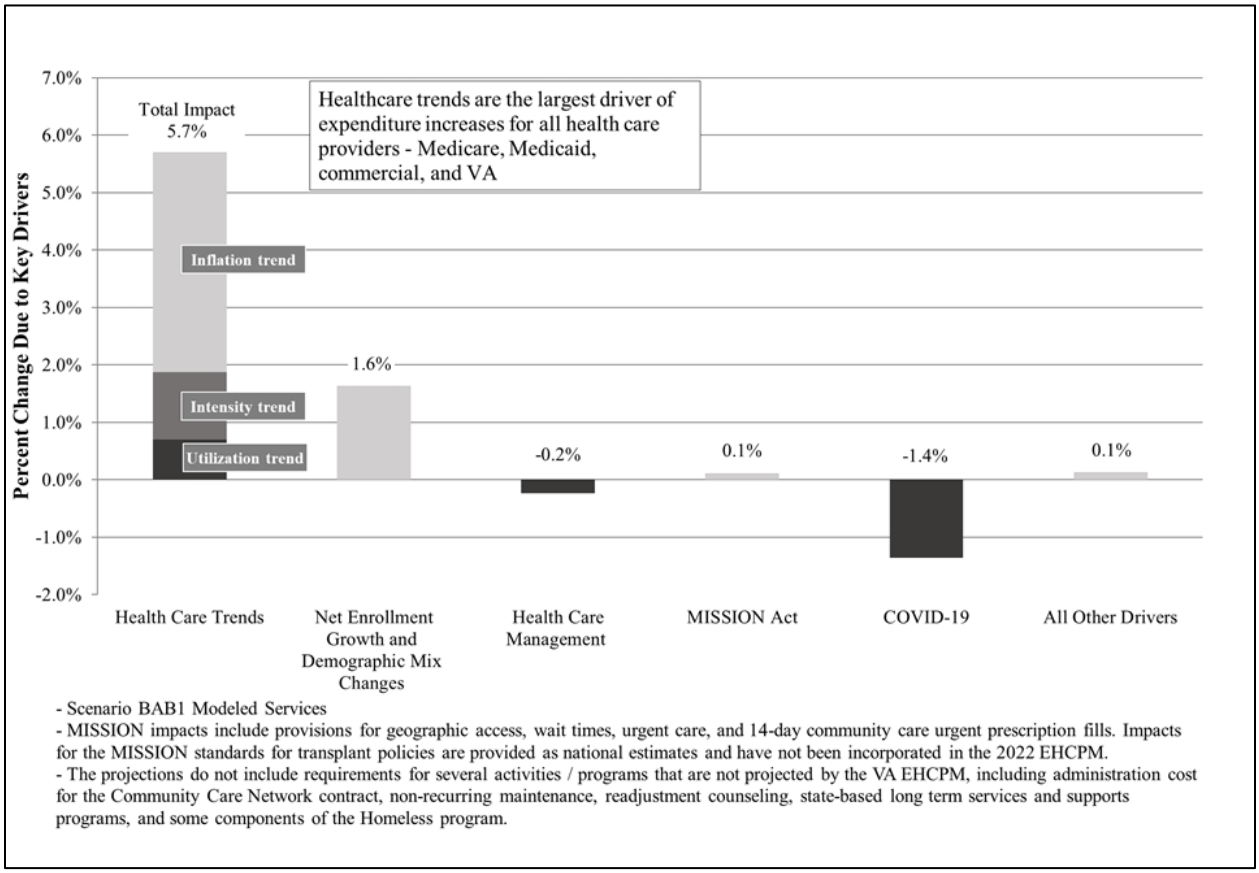
Since its implementation in June 2019, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act impacted the VA health care system by driving growth in the use of VA health care services. The 2022 EHCPM, which underpins the 2024 President's Budget, incorporated the actual experience and projected impact of the MISSION Act. Changes in eligibility to receive care in the community based on geographic access standards (also grandfathered Veterans Choice and Accountability (Choice) Act of 2014 enrollees), best medical interest provision, wait time standards, and urgent and emergency care benefits are also included.

The MISSION Act policies continue to drive increases in services available in both VA facilities and the community, particularly the use of outpatient primary and specialty care and inpatient care. The MISSION growth assumptions were increased and extended in the 2021 EHCPM to reflect higher than anticipated growth in community care workload in 2020 and 2021 and continue to remain elevated in the 2022 EHCPM.

The COVID-19 pandemic continued to have a significant impact on VA health care through 2021 and is expected to impact the amount of care provided over the next few years. During the pandemic, nationwide health care utilization saw a reduced amount of care provided in 2020 and 2021 as individuals chose to defer certain care. It was anticipated that less care was deferred in 2022 and that care previously deferred started to return in 2021 and will continue to do so through 2023.

Figure A quantifies the key drivers of the projected increase in expenditure requirements for 2024 for all modeled services. Health care trends, net enrollment growth and demographic mix changes, and health care management and their impact on the resources required to provide health care to enrolled Veterans are discussed in detail in the following sections.

Figure A. Key Drivers of Projected Expenditure Change, 2023 – 2024



- Scenario BAB1 Modeled Services
- MISSION impacts include provisions for geographic access, wait times, urgent care, and 14-day community care urgent prescription fills. Impacts for the MISSION standards for transplant policies are provided as national estimates and have not been incorporated in the 2022 EHCPM.
- The projections do not include requirements for several activities / programs that are not projected by the VA EHCPM, including administration cost for the Community Care Network contract, non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the Homeless program.

Medical Care Budgetary Resources

The following tables display:

- All Medical Care program appropriations by account, together with medical care collections
- Medical Care Obligations including all funding sources
- A summary of Medical Care Obligations by category and FTE

Table: Medical Care Appropriations by Account Category, Recurring Expenses Transformational Fund, and Medical Care Collections
(dollars in thousands)

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Appropriations							
Discretionary Appropriations 1/							
Medical Services (0160)	$58,697,219	$70,584,116	$70,584,116	$74,004,000	$71,000,000	$3,419,884	($3,004,000)
Medical Community Care (0140)	$23,217,244	$28,456,659	$28,456,659	$33,000,000	$20,382,000	$4,543,341	($12,618,000)
Medical Support & Compliance (0152)	$8,403,117	$11,073,409	$11,073,409	$12,300,000	$11,800,000	$1,226,591	($500,000)
Medical Facilities (0162)	$6,884,680	$8,633,816	$8,633,816	$8,800,000	$9,400,000	$166,184	$600,000
Proposed Cancellation of Available Unobligated Balances:							
Medical Services	$0	$0	$0	($4,933,113)	$0	($4,933,113)	$4,933,113
Medical Community Care	$0	$0	$0	($1,909,069)	$0	($1,909,069)	$1,909,069
Medical Facilities	$0	$0	$0	($250,515)	$0	($250,515)	$250,515
Discretionary Appropriations [Subtotal]	**$97,202,260**	**$118,748,000**	**$118,748,000**	**$121,011,303**	**$112,582,000**	**$2,263,303**	**($8,429,303)**
Recurring Expenses Transformational Fund (1124XN)	$0	$0	$75,000	$0	$0	($75,000)	$0
MCCF Collections 2/	$3,886,786	$3,909,801	$3,844,891	$4,269,198	$4,362,307	$424,307	$93,109
Discretionary Appropriations, Transformational Fund, and Collections [Total].	**$101,089,046**	**$122,657,801**	**$122,667,891**	**$125,280,501**	**$116,944,307**	**$2,612,610**	**($8,336,194)**
Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act) for Medical Care 3/							
Section 705:							
Medical Facilities (0162)	$275,205					$0	$0
Section 705 [Subtotal]	**$275,205**					**$0**	**$0**
Section 707:							
Medical Facilities (0162)	$0	$0	$1,880,000	$100,000	$200,000	($1,780,000)	$100,000
Section 707 [Subtotal]	**$0**	**$0**	**$1,880,000**	**$100,000**	**$200,000**	**($1,780,000)**	**$100,000**
Section 806							
Cost of War Toxic Exposures Fund for Medical Care (1126):							
Medical Services Category	$7,981						
Medical Support & Compliance Category	$26,143					$0	$0
Appropriated [Subtotal]	**$34,124**					**$0**	**$0**
PACT Act Mandatory Appropriations [Subtotal]	**$309,329**	**$0**	**$1,880,000**	**$100,000**	**$200,000**	**($1,780,000)**	**$100,000**
Cost of War Toxic Exposures Fund for Medical Care (1126):							
Medical Services Category	$0	$0	$3,822,377	$9,525,428	$10,336,542	$5,703,051	$811,114
Medical Community Care Category	$0	$0	$0	$6,740,264	$10,118,000	$6,740,264	$3,377,736
Medical Support & Compliance Category	$0	$0	$0	$850,000	$1,000,000	$850,000	$150,000
Appropriations [Subtotal]	**$0**	**$0**	**$3,822,377**	**$17,115,692**	**$21,454,542**	**$13,293,315**	**$4,338,850**
Mandatory Appropriations [Total]	**$309,329**	**$0**	**$5,702,377**	**$17,215,692**	**$21,654,542**	**$11,513,315**	**$4,438,850**
Discretionary and Mandatory Appropriations (Including Discretionary Collections and Transformational Fund) [Grand Total]	**$101,398,375**	**$122,657,801**	**$128,370,268**	**$142,496,193**	**$138,598,849**	**$14,125,925**	**($3,897,344)**

1/ Includes all rescissions and proposed cancellations but not transfers to the two joint Department of Defense (DoD)-VA health care accounts. Amounts are reflected before transfers among VA accounts. Please see the "Table: Funding Crosswalks 2022-2025" sections later in this chapter for proposed transfers among Medical Care discretionary accounts.

2/ Includes the portion of MCCF collections actually, or anticipated to be, transferred to the Joint DoD-VA Medical Facility Demonstration Fund, in support of the Captain James A. Lovell Federal Health Care Center (JALFHCC).

3/ Excludes all funding provided by the PACT Act and requested in the Cost of War Toxic Exposures Fund other than the four Medical Care categories. For more information on all VA accounts, please see Volume 1 and the Budget in Brief.

Table: Medical Care Obligations by Discretionary and Mandatory Accounts
(dollars in thousands)

		2023		2024	2025		
	2022 Actual	Budget Estimate	Current Estimate	Revised Request	Advance Approp.	+/- 2023-2024	+/- 2024-2025
Obligations 1/							
Discretionary Obligations:							
Regular Obligations:							
Medical Services (0160)	$61,255,782	$75,277,624	$71,757,434	$74,210,146	$77,260,286	$2,452,712	$3,050,140
Medical Community Care (0140)	$25,468,285	$29,196,966	$28,702,838	$27,082,317	$24,035,600	($1,620,521)	($3,046,717)
Medical Support & Compliance (0152)	$8,380,594	$11,306,234	$10,368,436	$11,473,673	$11,821,986	$1,105,237	$348,313
Medical Facilities (0162)	$6,884,293	$8,958,258	$9,165,595	$13,532,238	$9,360,384	$4,366,643	($4,171,854)
Recurring Expenses Transformational Fund (1124XN)	$0	$0	$75,000	$0	$0	($75,000)	$0
Regular Obligations [Subtotal]	**$101,988,954**	**$124,739,082**	**$120,069,303**	**$126,298,374**	**$122,478,256**	**$6,304,071**	**($3,820,118)**
Families First Coronavirus Response Act Obligations							
Medical Services (0160)	$973					$0	$0
Medical Community Care (0140)	$0					$0	$0
Families First Coronavirus Response Act Obligations [Subtotal]	**$973**					**$0**	**$0**
Discretionary Obligations [Subtotal]	**$101,989,927**	**$124,739,082**	**$120,069,303**	**$126,298,374**	**$122,478,256**	**$6,229,071**	**($3,820,118)**
Mandatory Obligations:							
Veterans Choice Act Section 801 2/							
Medical Services (0160)	$5,306	$3,980	$5,465	$5,678	$4,980	$213	($698)
Medical Support & Compliance (0152)	$3,293	$2,883	$3,392	$3,524	$256	$132	($3,268)
Medical Facilities (0162)	$8,699	$1,323	$7,093	$3,791	$0	($3,302)	($3,791)
Veterans Choice Act Section 801 [Subtotal]	**$17,298**	**$8,186**	**$15,950**	**$12,993**	**$5,236**	**($2,957)**	**($7,757)**
Veterans Choice Fund (0172) [Subtotal] 3/	**$20,764**	**$265,088**	**$0**	**$272,550**	**$0**	**$272,550**	**($272,550)**
American Rescue Plan Act Mandatory Obligations for Medical Care 4/							
Section 8002, the Veterans Medical Care and Health Fund (0173):							
Medical Services Category	$4,916,938	$696,300	$733,253			($733,253)	$0
Medical Community Care Category	$1,816,196	$2,098,805	$1,987,643			($1,987,643)	$0
Medical Support & Compliance Category	$476,128	$344,900	$502,305			($502,305)	$0
Medical Facilities Category	$1,800,902	$392,200	$772,056			($772,056)	$0
Veterans Medical Care and Health Fund [Subtotal]	**$9,010,164**	**$3,532,205**	**$3,995,257**			**($3,995,257)**	**$0**
Section 8007:							
Medical Services (0160)	$650,336	$0	$2,847			($2,847)	$0
Copayment Reimbursement (5287)	$4,737	$0	$16,861			($16,861)	$0
Medical Community Care (0140)	$81,433	$0	$176			($176)	$0
Section 8007 [Subtotal]	**$736,506**	**$0**	**$19,884**			**($19,884)**	**$0**
Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act) for Medical Care 5/							
Section 705:							
Medical Facilities (0162)	$0	$0	$0	$0	$0	$0	$0
Section 705 [Subtotal]	$0	$0	$0	$0	$0	**$0**	**$0**
Section 707:							
Medical Facilities (0162)	$0	$0	$50,281	$786,724	$265,223	$736,443	($521,501)
Section 707 [Subtotal]	**$0**	**$0**	**$50,281**	**$786,724**	**$265,223**	**$736,443**	**($521,501)**
Cost of War Toxic Exposures Fund for Medical Care (1126):							
Medical Services Category	$0	$0	$3,830,452	$8,187,428	$11,674,542	$4,356,976	$3,487,114
Medical Community Care Category	$0	$0	$0	$5,510,910	$11,347,354	$5,510,910	$5,836,444
Medical Support & Compliance Category	$0	$0	$26,049	$850,000	$1,000,000	$823,951	$150,000
Obligations [Subtotal]	**$0**	**$0**	**$3,856,501**	**$14,548,338**	**$24,021,896**	**$10,691,837**	**$9,473,558**
Mandatory Obligations [Subtotal]	**$9,784,732**	**$3,805,479**	**$7,937,873**	**$15,620,605**	**$24,292,355**	**$7,682,732**	**$8,671,750**
Discretionary and Mandatory Obligations [Total]	**$111,774,659**	**$128,544,561**	**$128,007,176**	**$141,918,979**	**$146,770,611**	**$13,911,803**	**$4,851,632**

[1/] Obligations after transfers, reimbursements, changes in unobligated balances and lapse.

[2/] OI&T and Minor Construction Section 801 mandatory obligations data are excluded from this table.

[3/] OI&T Section 802 Mandatory Obligations and FTE data are excluded from this table.

[4/] Excludes Medical and Prosthetics Research and OI&T portion of ARP Section 8002. Only ARP sections with Medical Care Category Obligations are included in this table. Obligations from ARP section 8004 on Grants for Construction of State Extended Care Facilities can be found in its chapter later in this volume. Obligations for ARP section 8008 are reported in the "Table: Funding Crosswalks 2022-2025" later in this chapter. Remaining information on VA ARP Act obligations can be found in Volume 1 and the Budget in Brief.

[5/] Excludes all obligations from funds provided by the PACT Act and from the request of Cost of War Toxic Exposures Funds other than the four Medical Care categories. For more information on all VA accounts, please see Volume 1 and the Budget in Brief.

Table: Discretionary and Mandatory Obligations and FTE by Account
(dollars in thousands)

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary and Mandatory Obligations by Category							
Medical Services	$66,829,335	$75,977,904	$76,329,451	$82,403,252	$88,939,808	$6,073,801	$6,536,556
Copayment Reimbursement	$4,737	$0	$16,861	$0	$0	($16,861)	$0
Community Care	$27,386,678	$31,560,859	$30,690,657	$32,865,777	$35,382,954	$2,175,120	$2,517,177
Medical Support & Compliance	$8,860,015	$11,654,017	$10,900,182	$12,327,197	$12,822,242	$1,427,015	$495,045
Medical Facilities	$8,693,894	$9,351,781	$9,995,025	$14,322,753	$9,625,607	$4,327,728	($4,697,146)
Obligations [Grand Total]	**$111,774,659**	**$128,544,561**	**$127,932,176**	**$141,918,979**	**$146,770,611**	**$13,986,803**	**$4,851,632**
Full-Time Equivalent (FTE) 1/							
Discretionary Funding							
Medical Services	257,853	282,781	277,558	293,544	306,013	15,986	12,469
Medical Support & Compliance	57,224	67,351	62,853	66,534	70,239	3,681	3,705
Medical Facilities	22,143	28,626	25,668	26,501	27,334	833	833
Discretionary Funding [Subtotal]	**337,220**	**378,758**	**366,079**	**386,579**	**403,586**	**20,500**	**17,007**
Mandatory Funding							
Veterans Medical Care and Health Fund - Medical Services 2/	11,126	0	3,517	0	0	(3,517)	0
Veterans Medical Care and Health Fund - Medical Support & Compliance 2/	1,223	0	0	0	0	0	0
Veterans Medical Care and Health Fund - Medical Facilities 2/	3,091	0	0	0	0	0	0
American Rescue Plan Act, sec. 8007 2/	2,522	0	0	0	0	0	0
Cost of War Toxic Exposures Fund - Medical Services	0	0	13	13	13	0	0
Veterans Choice Act, Sec. 801, FTE 3/	41	33	41	41	17	0	(24)
Veterans Choice Act, Sec. 802, FTE	0	0	0	0	0	0	0
Mandatory Funding [Subtotal]	**18,003**	**33**	**3,571**	**54**	**30**	**(3,517)**	**(24)**
FTE [Total]	**355,223**	**378,791**	**369,650**	**386,633**	**403,616**	**16,983**	**16,983**

1/ FTEs providing administrative support for the Veterans Community Care Program, including support for the Veterans Choice Program, are funded by the Medical Support and Compliance account.

2/ FTEs funded by ARP Act resources in 2022 and 2023 have been merged into their respective Medical Care Category discretionary appropriations in 2023 as remaining balances diminish.

3/ FTEs previously funded by Section 801 resources have been merged into and funded with Medical Services, Medical Support and Compliance and Medical Facilities discretionary appropriations. Only a small number of FTEs remain funded by Section 801, primarily to support the GME expansion in section 301.

Medical Care Obligations by Program

The following table displays obligations, the estimated resources by major category that VA projects to incur. For more information about each major category, please see the Medical Care chapter.

Table: Medical Care Total Obligations by Program

(Includes All Funding Sources)
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Health Care Services:							
Ambulatory Care	$53,847,276	$65,102,797	$62,340,341	$70,800,763	$71,125,162	$8,460,422	$324,399
Dental Care	$1,948,374	$2,291,788	$2,461,798	$2,573,291	$2,724,816	$111,493	$151,525
Inpatient Care	$21,489,091	$24,485,224	$25,066,857	$26,766,548	$28,294,437	$1,699,691	$1,527,889
Mental Health Care 1/	$13,017,739	$13,918,915	$14,983,333	$16,587,825	$17,681,247	$1,604,492	$1,093,422
Prosthetic and Sensory Aids Services	$3,722,046	$4,069,980	$4,147,810	$4,571,956	$5,025,363	$424,146	$453,407
Rehabilitation Care	$1,233,675	$1,258,933	$1,419,384	$1,491,565	$1,541,668	$72,181	$50,103
Health Care Services [Subtotal]	**$95,258,201**	**$111,127,637**	**$110,419,523**	**$122,791,948**	**$126,392,693**	**$12,372,425**	**$3,600,745**
Long-Term Services & Supports (LTSS):							
Institutional LTSS							
VA Community Living Centers (VA CLC)	$4,796,854	$4,942,654	$5,112,902	$5,292,497	$5,477,621	$179,595	$185,124
Community Nursing Home	$1,259,287	$1,550,526	$1,399,863	$1,529,213	$1,617,225	$129,350	$88,012
State Home Nursing	$1,239,773	$1,490,482	$1,352,486	$1,438,784	$1,522,235	$86,298	$83,451
State Home Domiciliary	$43,684	$49,095	$52,079	$55,402	$58,616	$3,323	$3,214
Institutional LTSS [Subtotal]	$7,339,598	$8,032,757	$7,917,330	$8,315,896	$8,675,697	$398,566	$359,801
Non-Institutional LTSS							
State Home Adult Day Care	$6,322	$1,286	$1,783	$1,892	$2,007	$109	$115
Other Non-Institutional LTSS	$3,919,930	$4,051,310	$4,262,901	$4,622,996	$4,899,328	$360,095	$276,332
Non-Institutional LTSS [Subtotal]	$3,926,252	$4,052,596	$4,264,684	$4,624,888	$4,901,335	$360,204	$276,447
LTSS [Subtotal]	**$11,265,850**	**$12,085,353**	**$12,182,014**	**$12,940,784**	**$13,577,032**	**$758,770**	**$636,248**
Other Health Care Programs:							
Camp Lejeune Families (P.L. 112-154)	$5,420	$3,808	$7,018	$7,597	$8,264	$579	$667
Caregivers 2/	$1,234,036	$1,846,210	$1,866,210	$2,422,410	$2,764,685	$556,200	$342,275
CHAMPVA & Other Dependent Prgs	$2,377,409	$2,164,071	$2,171,927	$2,335,332	$2,548,920	$163,405	$213,588
Homeless Program Grants 3/	$1,085,649	$977,441	$1,003,582	$1,067,265	$1,115,656	$63,683	$48,391
Readjustment Counseling	$307,541	$340,041	$340,041	$353,643	$363,361	$13,602	$9,718
Copayment Reimbursement	$4,737	$0	$16,861	$0	$0	($16,861)	$0
Other Health Care Programs [Subtotal]	**$5,014,792**	**$5,331,571**	**$5,405,639**	**$6,186,247**	**$6,800,886**	**$780,608**	**$614,639**
Obligations [Subtotal]	**$111,538,843**	**$128,544,561**	**$128,007,176**	**$141,918,979**	**$146,770,611**	**$13,911,803**	**$4,851,632**
Recoveries of prior year paid & unpaid obligations	$235,816						
Obligations [Total]	$111,774,659	$128,544,561	$128,007,176	$141,918,979	$146,770,611	$13,911,803	$4,851,632

Note: Dollars may not add due to rounding in this and subsequent charts.

1/ Mental Health Care includes costs for mental health treatment that take place both in settings that are primarily for mental health (for example, inpatient mental health) and settings that are not (for example, mental health treatment provided in a primary care clinic).

2/ Includes Stipend Costs, Respite Care, Mental Health Care, CHAMPVA benefits and Program Administration for the Caregivers Support Program.

3/ Includes projected grant costs for the Grant and Per Diem (GPD) and Supportive Services for Low Income Veterans (SSVF) programs.

The following table displays cross-cutting medical care activities that are non-additive and accounted for in the above Obligations by Program table. Further information can be found in the Medical Care chapter.

Table: Programs Included in Medical Care Obligations

(Includes All Funding Sources)
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Medical Care Programs: (Included Above)							
Activations	$342,239	$769,904	$769,904	$865,249	$623,359	$95,345	($241,890)
Blind Rehabilitation Treatment	$121,506	$126,900	$144,395	$168,746	$195,156	$24,351	$26,410
Epilepsy Center of Excellence 1/	$11,959	$19,086	$19,086	$23,585	$23,871	$4,499	$286
Education & Training	$2,593,928	$2,706,082	$2,838,744	$2,911,961	$3,090,477	$73,217	$178,516
Health Professionals Educational Assistance Program	$182,264	$248,033	$248,033	$303,356	$361,152	$55,323	$57,796
Indian Health Services	$34,770	$32,345	$36,752	$38,259	$39,789	$1,507	$1,530
Intensive Evaluation and Treatment Program Initiative	$6,324	$25,970	$25,970	$11,640	$15,304	($14,330)	$3,664
Intimate Partner Violence program	$19,432	$24,347	$24,347	$36,879	$40,118	$12,532	$3,239
Leases	$1,061,250	$1,500,000	$1,550,281	$2,305,729	$1,965,223	$755,448	($340,506)
Mental Health Topics:							
Opioid Prevention:							
Treatment Modalities	$418,850	$417,051	$442,726	$460,878	$479,312	$18,152	$18,434
Opioid Prevention Programs (Includes Jason's Law) 2/	$147,623	$245,754	$245,754	$254,478	$254,487	$8,724	$9
Substance Use Disorder Initiative	$44,064	$181,287	$183,287	$230,947	$239,647	$47,660	$8,700
Suicide Prevention:							
Medical Treatment	$2,671,116	$2,385,776	$2,848,404	$2,994,094	$3,140,875	$145,690	$146,781
Outreach Programs	$522,753	$496,598	$503,734	$558,794	$569,905	$55,060	$11,111
National Center for Posttraumatic Stress Disorder	$35,653	$40,000	$42,000	$42,000	$42,000	$0	$0
National Veterans Sports Program	$28,494	$27,229	$27,229	$30,414	$30,542	$3,185	$128
Non-Recurring Maintenance (Lands & Structure only) 3/	$2,830,339	$2,505,000	$3,017,000	$5,750,000	$995,000	$2,733,000	($4,755,000)
Precision Oncology Initiative	$92,746	$167,227	$167,227	$215,433	$223,133	$48,206	$7,700
Regional Readiness Centers 4/	$206,691	N/A	$204,661	$155,481	$155,476	($49,180)	($5)
Rural Health 1/	$308,178	$307,455	$337,455	$337,455	$337,455	$0	$0
Spinal Cord Injury Treatment	$728,636	$733,500	$773,428	$821,609	$873,543	$48,181	$51,934
Supply Chain Management	$86,820	$142,404	$142,404	$144,603	$148,866	$2,199	$4,263
Telehealth:							
Home & Clinic Based Telehealth	$4,311,216	$4,844,912	$4,580,140	$4,757,275	$5,110,477	$177,135	$353,202
Office of Connected Care Program	$261,520	$329,906	$329,776	$408,061	$439,920	$78,285	$31,859
Veterans Homelessness Programs	$2,808,320	$2,685,392	$2,870,559	$3,111,148	$3,267,927	$240,589	$156,779
Whole Health	$74,845	$75,851	$85,851	$107,848	$119,289	$21,997	$11,441

1/ 2022 actuals are represented by allocated amounts rather than obligations.

2/ The Office of Patient Advocacy's budget is no longer displayed in this row.

3/ See the Medical Facilities chapter for the 2021 actual that include supporting FTE and contract-related costs pertaining to Non-Recurring Maintenance, which are not included in this table.

4/ Regional Readiness Centers amount not previously displayed in the 2023 President's Budget.

Table: Veteran Population Obligations in Medical Care Obligations

(Includes All Funding Sources)
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
AIDS/HIV Program	$1,664,704	$1,619,700	$1,698,699	$1,818,782	$1,946,410	$120,083	$127,628
Health Outcomes Military Exposures (HOME):							
Gulf War Program	$6,081,978	$6,480,200	$7,130,227	$8,268,010	$9,476,239	$1,137,783	$1,208,229
OEF/OIF/OND/OIR	$12,118,965	$11,966,200	$13,872,121	$15,820,981	$17,926,342	$1,948,860	$2,105,361
Program Office	$44,350	$63,000	$104,692	$81,938	$93,141	($22,754)	$11,203
Traumatic Brain Injury and Polytrauma System of Care:							
OEF/OIF/OND/OIR	$301,587	$274,600	$326,221	$346,429	$368,729	$20,208	$22,300
All Veteran Care	$1,095,749	$1,034,200	$1,217,649	$1,329,518	$1,451,815	$111,869	$122,297
Women Veterans Health Care:							
Program Office & Initiative Budget	$89,180	$134,219	$155,131	$256,926	$306,073	$101,795	$49,147
Gender-Specific Care	$739,273	$766,900	$871,546	$1,022,170	$1,215,996	$150,624	$193,826
All Care	$9,657,762	$9,774,900	$11,101,448	$12,632,131	$14,213,871	$1,530,683	$1,581,740

Medical Care Collections Fund

VA estimates medical care collections of $4.3 billion in 2024 and $4.4 billion in 2025. Projected collections for 2023 through 2025 reflect the impact of the PACT Act implementation, recent collections trends, including the increased use of telehealth as a provision of care.

Medical Care Collections Fund[1,2]
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Medical Care Collections Fund:							
First Party Payments:							
1st Party Other Co-payments	$125,468	$154,132	$154,848	$133,239	$132,251	($21,609)	($988)
Community Care Collections 1st Party	$27,799	$20,018	$13,557	$23,515	$24,330	$9,958	$816
Long-Term Care Co-Payments	$1,163	$770	$791	$1,761	$1,720	$970	($41)
Pharmacy Co-payments	$327,439	$322,826	$331,314	$335,858	$341,244	$4,544	$5,386
First Party Payments [Subtotal]	**$481,869**	**$497,746**	**$500,510**	**$494,373**	**$499,545**	**($6,137)**	**$5,172**
Third Party Payments:							
3rd Party Insurance Collections	$2,463,691	$2,548,681	$2,382,874	$2,710,516	$2,775,340	$327,642	$64,823
3rd Party RX Insurance	$148,498	$151,965	$150,976	$173,176	$180,031	$22,200	$6,855
Community Care Collections 3rd Party	$753,371	$692,552	$770,531	$861,133	$877,390	$90,602	$16,258
Third Party Payments [Subtotal]	**$3,365,560**	**$3,393,198**	**$3,304,381**	**$3,744,825**	**$3,832,761**	**$440,444**	**$87,936**
Other MCCF:							
Comp. & Pension Living Expenses	$1,969	$810	$1,090	$1,506	$1,506	$416	$0
Comp. Work Therapy Collections	$32,511	$26,735	$35,974	$24,622	$24,622	($11,352)	$0
Enhanced-Use Revenue	$905	$562	$756	$672	$672	($84)	$0
Parking Fees	$3,972	$1,620	$2,180	$3,200	$3,200	$1,020	$0
Other MCCF [Subtotal]	**$39,357**	**$29,727**	**$40,000**	**$30,000**	**$30,000**	**($10,000)**	**$0**
Total Collections	**$3,886,786**	**$3,920,671**	**$3,844,891**	**$4,269,198**	**$4,362,307**	**$424,307**	**$93,108**
JALFHCC amount (included above)	$16,322	$15,641	$18,527	$20,444	$20,819	$1,917	$374

[1/] Estimates include collections actually or anticipated to be transferred to the Joint DoD-VA Medical Facility Demonstration Fund, in support of the JALFHCC.

[2/] Collections of $3.9 billion were received by VA in 2022. Due to a one month lag in timing from when the funds are received and transferred from the Medical Care Collections Fund, a total of $3.9 billion was transferred from the Medical Care Collections Fund to the receiving accounts, reflecting collections received from September 2020 through August 2020: $3.1 billion to Medical Services, $782.2 million to Medical Community Care and $16.3 million to the Joint DoD-VA Medical Demonstration Fund. The funds collected in September 2021 were transferred in 2022.

VA Staffing

The budget requests 386,633 FTE in 2024 and 403,616 FTE in 2025. The estimated staffing increase in 2024 allows VA to meet continued outpatient Relative Value Unit (RVU) growth for VA provided services, particularly due implementation of the PACT Act. The budget provides resources for provider growth, in a tightening provider labor market, as VA expands telehealth services and enhances suicide prevention and substance use disorder initiatives. Medical Support and Compliance staff growth is primarily driven by medical center support staff to facilitate business systems. Medical Facilities staff growth is primarily driven by the need for staff to support projects updating aging infrastructure and expanding clinical space to care for Veterans. In 2025, VA plans to realize FTE gains from 2024 onboarding in order to maintain timely access to care provided by VA facilities.

Table: Employment Summary (FTE)

Employment Summary (FTE)

Account	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**205 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Medical Services	260,375	282,781	277,558	293,544	306,013	15,986	12,469
Medical Community Care	0	0	0	0	0	0	0
Medical Support & Compliance	57,224	67,351	62,853	66,534	70,239	3,681	3,705
Medical Facilities	22,143	28,626	25,668	26,501	27,334	833	833
Total Discretionary Medical Care	339,742	378,758	366,079	386,579	403,586	20,500	17,007

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**205 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Veterans Medical Care and Health Fund - Medical Services 1/	11,126	0	3,517	0	0	(3,517)	0
Veterans Medical Care and Health Fund - Medical Support & Compliance 1/.	1,223	0	0	0	0	0	0
Veterans Medical Care and Health Fund - Medical Facilities 1/	3,091	0	0	0	0	0	0
Cost of War Toxic Exposures Fund - Medical Services 2/	0	0	13	13	13	0	0
Veterans Choice Act, Sec. 801, FTE 3/	41	33	41	41	17	0	(24)
Veterans Choice Act, Sec. 802, FTE 4/	0	0	0	0	0	0	0
Total Mandatory Medical Care	15,481	33	3,571	54	30	(3,517)	(24)

1/FTEs funded by ARP Act resources in 2022 have been merged into and funded with Medical Services and Medical Support and Compliance discretionary appropriations in 2023.
2/ Cost of War Toxic Exposures Fund Medical Services FTE reflect Veterans Experience Office PACT ACT implementation FTE funded via reimbursement by VHA.
3/ FTEs previously funded by Section 801 resources have been merged into and funded with Medical Services, Medical Support and Compliance, and Medical Facilities discretionary appropriations. Only a small number of FTEs remain funded by Section 801, primarily to support the GME expansion in section 301.
4/ FTEs providing administrative support for the Veterans Community Care Program, including support for the Veterans Choice Program, are funded by the Medical Support and Compliance account.

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**205 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Grand Total Medical Care FTE	**355,223**	**378,791**	**369,650**	**386,633**	**403,616**	**16,983**	**16,983**

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Estimate	+/- 2023-2024
Canteen Service	2,101	2,334	2,075	2,065	(10)
Medical & Prosthetic Research 4/	4,237	4,410	4,590	4,716	126
Veterans Medical Care and Health Fund - Research 1/	8	113	109	0	(109)
Cost of War Toxic Exposures Fund - Research	0	0	11	113	102
DOD-VA Health Care Sharing Fund - VA Civilian	31	29	34	34	0
DOD-VA Health Care Sharing Fund - DoD Personnel	55	68	63	55	(8)
James A. Lovell Federal Healthcare Center					
Civilian	2,285	2,324	2,440	2,490	50
DoD Uniformed Military	826	776	826	826	0
Joint DoD-VA Med. Fac. Demo. Fund Total	3,111	3,100	3,266	3,316	50

Table: FTE by Type, Medical Care

Account	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Physicians	22,005	24,450	23,888	25,452	26,544	1,564	1,092
Dentists	1,323	1,290	1,382	1,448	1,510	66	62
Registered Nurses	64,248	73,843	70,941	76,081	79,367	5,140	3,286
LP Nurse/LV Nurse/Nurse Assistant	26,451	30,260	28,163	29,769	31,033	1,606	1,264
Non-Physician Providers	17,970	18,589	18,833	19,772	20,616	939	844
Health Technicians/Allied Health	82,027	86,796	86,073	90,405	94,259	4,332	3,854
Wage Board/Purchase & Hire	24,436	30,959	27,860	28,883	29,888	1,023	1,005
All Other 1/	101,282	112,572	108,939	114,769	120,369	5,830	5,600
SubTotal	339,742	378,759	366,079	386,579	403,586	20,500	17,007
American Rescue Plan, FTE	15,440	0	3,517	0	0	(3,517)	0
Cost of War Toxic Exposures Fund - Medical Services	0	0	13	13	13		
Veterans Choice Act, Sec. 801, FTE	41	33	41	41	17	0	(24)
Veterans Choice Act, Sec. 802, FTE	0	0	0	0	0	0	0
Total	355,223	378,792	369,650	386,633	403,616	16,983	16,983

1/ All Other category includes personnel such as medical support assistance, administrative support clerks, administrative specialist, police, personnel management specialists, management and program analysts, medical records clerks/technicians, budget/fiscal, contract administrators, supply technicians, and other staff that are necessary for the effective operations of VHA medical facilities.

Table: FTE by Type, Medical Services

Account	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Physicians	21,287	23,617	23,103	24,621	25,667	1,518	1,046
Dentists	1,309	1,273	1,366	1,431	1,492	65	61
Registered Nurses	60,813	69,923	67,188	72,108	75,171	4,920	3,063
LP Nurse/LV Nurse/Nurse Assistant	26,449	30,201	28,162	29,768	31,032	1,606	1,264
Non-Physician Providers	17,669	18,239	18,510	19,430	20,255	920	825
Health Technicians/Allied Health	80,768	85,160	84,712	88,969	92,748	4,257	3,779
Wage Board/Purchase & Hire	5,369	6,043	5,601	5,868	6,117	267	249
All Other 1/	46,711	48,325	48,916	51,349	53,531	2,433	2,182
SubTotal	260,375	282,781	277,558	293,544	306,013	15,986	12,469
American Rescue Plan, FTE	11,126	0	3,517	0	0	(3,517)	0
Cost of War Toxic Exposures Fund - Medical Services	0	0	13	13	13		
Veterans Choice Act, Sec. 801, FTE	17	8	17	17	17	0	0
Total	271,518	282,789	281,105	293,574	306,043	12,469	12,469

1/ All Other FTE occupation types include Chaplains, medical support assistants, biomedical equipment support specialists, privacy officers, etc.

Table: FTE by Type, Medical Support and Compliance

Account	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Physicians	718	833	785	831	877	46	46
Dentists	14	17	16	17	18	1	1
Registered Nurses	3,433	3,920	3,753	3,973	4,196	220	223
LP Nurse/LV Nurse/Nurse Assistant	0	59	1	1	1	0	0
Non-Physician Providers	300	350	323	342	361	19	19
Health Technicians/Allied Health	1,109	1,446	1,196	1,266	1,336	70	70
Wage Board/Purchase & Hire	1,188	1,503	1,285	1,360	1,435	75	75
All Other 1/	50,462	59,223	55,494	58,744	62,015	3,250	3,271
SubTotal	57,224	67,351	62,853	66,534	70,239	3,681	3,705
American Rescue Plan, FTE	1,223	0	0	0	0	0	0
Veterans Choice Act, Sec. 801, FTE	24	24	24	24	0	0	(24)
Total	58,471	67,375	62,877	66,558	70,239	3,681	3,681

1/ All Other category includes: Administrative Support Clerk, Administrative Specialist, Police , Personnel Management Specialist, Management And Program Analyst, Medical Records Clerk/Technician, Budget/Fiscal, Contract Administrator, Supply Technician, Medical Support Assistance, and other staff that are necessary for the effective operations of VHA Medical Support & Compliance.

Table: FTE by Type, Medical Facilities

Account	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Physicians	0	0	0	0	0	0	0
Dentists	0	0	0	0	0	0	0
Registered Nurses	2	0	0	0	0	0	0
LP Nurse/LV Nurse/Nurse Assistant	2	0	0	0	0	0	0
Non-Physician Providers	1	0	0	0	0	0	0
Health Technicians/Allied Health	150	190	165	170	175	5	5
Wage Board/Purchase & Hire	17,879	23,413	20,974	21,655	22,336	681	681
All Other 1/	4,109	5,024	4,529	4,676	4,823	147	147
SubTotal	22,143	28,627	25,668	26,501	27,334	833	833
American Rescue Plan, FTE	3,091	0	0	0	0	0	0
Veterans Choice Act, Sec. 801, FTE	0	1	0	0	0	0	0
Total	25,234	28,628	25,668	26,501	27,334	833	833

1/All Other category includes maintenance controllers, engineers/architects, administrative support clerks, safety and occupational health specialists, fire protection and prevention staff, engineering technicians, hospitals housekeepers and managers, industrial hygienists, administrative specialists, and other staff that are necessary for the effective operations of VHA medical facilities.

Table: Employment Summary, FTE by Grade (Includes All Funding Sources)

	2022			
eneral Schedule Grade or Title 38	Medical Services Category	Medical Support & Compliance Category	Medical Facilities Category	Medical Care
Senior Executive Service	0	181	0	181
Title 38	104,598	4,896	8	109,502
15 or Higher	315	1,277	1	1,593
14	2,060	641	148	2,849
13	14,279	2,385	568	17,232
12	21,607	5,579	1,196	28,382
11	19,676	7,852	1,102	28,630
10	1,801	6,402	68	8,271
9	11,787	242	547	12,576
8	6,639	7,494	34	14,167
7	13,677	2,491	408	16,576
6	46,165	5,933	357	52,455
5	20,476	7,599	245	28,320
4	2,016	3,788	41	5,845
3	976	1,438	115	2,529
2	52	246	2	300
1	3	25	1	29
Wage Board	5,391	2	20,393	25,786
FTE Total	271,518	58,471	25,234	355,223

Table: FTE, 2022 Actual
(Includes All Funding Sources)

FTE, 2022 Actual (Includes All Funding Sources) Office of Personnel Management (OPM) Occupational Groups and Families	Medical Services Category	Medical Support & Compliance Category	Medical Facilities Category	Total Medical Care
0000 –Miscellaneous Occupations Group	809	5,777	800	7,386
0100 – Social Science, Psychology, And Welfare Group	29,998	563	2	30,563
0200 – Human Resources Management Group	1	7,106	0	7,107
0300 – General Administrative, Clerical, And Office Services Group	11,597	12,944	997	25,538
0500 – Accounting And Budget Group	364	5,841	52	6,257
0600 –Medical, Hospital, Dental, And Public Health Group	218,595	13,561	629	232,785
0800 – Engineering And Architecture Group	414	177	1,652	2,243
0900 – Legal And Kindred Group	257	1,124	1	1,382
1000 – Information And Arts Group	215	583	212	1,010
1100 – Business And Industry Group	1,033	3,521	47	4,601
1300 – Physical Sciences Group	34	58	29	121
1400 – Library And Archives Group	81	50	0	131
1600 – Equipment, Facilities, And Services Group	1,260	32	201	1,493
1700 – Education Group	804	948	30	1,782
2000 – Supply Group	336	3,982	52	4,370
2100 – Transportation Group	224	751	160	1,135
2600 – Electronic Equipment Installation And Maintenance Family	13	0	264	277
2800 – Electrical Installation And Maintenance Family	26	0	815	841
3500 – General Services And Support Work Family	18	6	10,576	10,600
4100 – Painting And Paperhanging Family	0	3	445	448
4200 – Plumbing And Pipefitting Family	0	0	654	654
4600 –Wood Work Family	3	0	502	505
4700 – General Maintenance And Operations Work Family	7	7	2,335	2,349
4800 – General Equipment Maintenance Family	39	11	137	187
5000 – Plant And Animal Work Family	1	0	251	252
5300 – Industrial Equipment Maintenance Family1	1	0	890	891
5400 – Industrial Equipment Operation Family	0	0	747	747
5700 – Transportation/Mobile Equipment Operation Family	93	274	1,646	2,013
6900 –Warehousing And Stock Handling Family	21	963	77	1,061
7300 – Laundry, Dry Cleaning, And Pressing Family	0	0	777	777
7400 – Food Preparation And Serving Family	5,073	0	3	5,076
OPM Occupational Groups and Families Not Covered Above1/	201	189	251	641
Grand Total	271,518	58,471	25,234	355,223

1/ includes Occupation Groups with Total Medical Care of less than 100

Veteran Patient Workload

VA administers its comprehensive medical benefits package through a patient enrollment system. The enrollment system is based on priority groups to ensure health care benefits are readily available to all enrolled Veterans. When these enrollees become patients who receive VA-provided care, VA's goal is to ensure these patients receive the finest quality health care, regardless of the treatment program or the location. Enrollment in the VA health care system provides Veterans with the assurance that comprehensive health care services will be available when and where they are needed during that enrollment period.

The budget expands health care services for our nation's Veterans while building an integrated system of care that both strengthens services within VA and improves VA and Veterans' relationships with community providers consistent with the MISSION Act. The 2024 request supports the treatment of 7.4 million patients, a 0.8% increase above 2023, and 139.7 million outpatient visits, an increase of 1.3% above 2023.

Table: Unique Patients

Unique Patients 1/

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Priority Levels							
1-6	5,291,413	5,423,798	5,357,801	**5,413,128**	**5,448,563**	55,327	35,435
7-8	1,005,417	1,067,737	982,781	**964,465**	**948,306**	(18,316)	(16,159)
Veterans [Subtotal]	6,296,830	6,491,535	6,340,582	**6,377,593**	**6,396,869**	37,011	19,276
Non-Veterans [Subtotal] 2/	951,616	855,860	978,661	**1,003,158**	**1,023,687**	24,497	20,529
Unique Patients [Total]	**7,248,446**	**7,347,395**	**7,319,243**	**7,380,751**	**7,420,556**	**61,508**	**39,805**

Unique Enrollees 3/4/

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Priority Levels							
1-6	7,208,621	7,466,987	7,279,203	**7,344,165**	**7,402,401**	64,962	58,236
7-8	1,871,513	1,747,328	1,783,285	**1,703,878**	**1,629,878**	(79,407)	(74,000)
Unique Enrollees [Total]	**9,080,134**	**9,214,315**	**9,062,488**	**9,048,043**	**9,032,280**	**(14,445)**	**(15,764)**

Users as a Percent of Enrollees

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Priority Levels							
1-6	73.4%	72.6%	73.6%	**73.7%**	**73.6%**	0.1%	-0.1%
7-8	53.7%	61.1%	55.1%	**56.6%**	**58.2%**	1.5%	1.6%
Unique Enrollees [Total]	**69.3%**	**70.5%**	**70.0%**	**70.5%**	**70.8%**	0.5%	0.3%

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA.

2/ Non-Veterans include active-duty military and reserve, spousal collateral, consultations and instruction, Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA) workload, reimbursable workload with affiliates, humanitarian care and employees receiving preventive occupational immunizations, such as Hepatitis A&B and flu vaccinations.

3/ Similar to unique patients, the count of unique enrollees represents the count of Veterans enrolled for Veteran's health care sometime during the course of the year, regardless of whether they received VA care as patients during that year.

4/ Projected enrollees are based on an underlying EHCPM scenario prior to the impact of PACT Act. PACT Act is expected to increase the enrollee level by approximately 170,000 through 2024 and affect even more patients as existing enrollees migrate to higher priority groups.

Table: Summary of Workloads for VA and Non-VA Facilities

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**205 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Outpatient Visits (000):							
Ambulatory Care:							
Staff	88,104	107,751	97,564	98,806	101,207	1,242	2,401
Community Care	36,889	39,079	38,877	39,392	40,249	515	857
Subtotal	124,993	146,830	136,441	138,198	141,456	1,757	3,258
Readjustment Counseling:							
Visits	1,369	1,553	1,421	1,499	1,582	78	83
Grand Total	126,362	148,383	137,862	139,697	143,038	1,835	3,341
Patients Treated:							
Inpatient Care	813,772	1,000,986	820,299	826,150	829,368	5,851	3,218
Rehabilitation Care	9,989	14,865	11,411	13,247	14,333	1,836	1,086
Mental Health Care Total	144,567	177,871	151,941	159,170	166,875	7,229	7,705
Acute Psychiatry	*59,730*	*85,031*	*57,871*	*56,152*	*54,724*	*(1,719)*	*(1,428)*
Community Care Hospital (Psych)	*59,185*	*52,490*	*66,411*	*74,530*	*82,759*	*8,119*	*8,229*
Residential Recovery Programs	*25,652*	*40,350*	*27,659*	*28,488*	*29,392*	*829*	*904*
Long-Term Care: Institutional	85,867	108,192	83,773	81,762	80,211	(2,011)	(1,551)
Subacute Care	1,244	958	1,244	1,223	1,225	(21)	2
Inpatient Facilities, Total	1,055,439	1,302,872	1,068,668	1,081,552	1,092,012	12,884	10,460
Average Daily Census:							
Inpatient Care	14,200	14,733	15,297	15,633	16,179	336	546
Rehabilitation Care	853	1,120	871	892	918	21	26
Mental Health Care Total	6,465	6,407	7,181	7,482	7,847	301	365
Acute Psychiatry	*1,676*	*1,986*	*1,609*	*1,571*	*1,553*	*(38)*	*(18)*
Community Care Hospital (Psych)	*1,506*	*1,382*	*1,686*	*1,894*	*2,105*	*208*	*211*
Residential Recovery Programs	*3,283*	*3,039*	*3,886*	*4,017*	*4,189*	*131*	*172*
Long-Term Care: Institutional	33,296	42,033	32,450	31,778	31,259	(672)	(519)
Subacute Care	42	31	41	41	41	0	0
Inpatient Facilities, Total	54,856	64,324	55,840	55,826	56,244	(14)	418
Length of Stay:							
Inpatient Care	6.4	5.4	6.8	6.9	7.1	0.1	0.2
Rehabilitation Care	31.2	27.5	27.9	24.6	23.4	(3.3)	(1.2)
Mental Health Care	16.3	13.1	17.3	17.2	17.2	(0.1)	0.0
Long-Term Care: Institutional	141.5	141.8	141.4	141.9	142.6	0.5	0.7
Subacute Care	12.3	11.8	12.0	12.2	12.2	0.2	0.0
Dental Procedures (000)	6,296	7,205	7,491	8,315	9,102	824	787
CHAMPVA/FMP/Spina Bifida:							
Unique Patients	482,122	463,773	497,235	511,745	525,461	14,510	13,716

Table: Global RVUs for VA and Non-VA Facilities

The following table provides the VA Enrollee Health Care Projection Model workload output used to support this budget submission categorized by health care setting. Global Relative Value Units (RVU) are defined in the narrative following this table. Note: Home-based LTSS care workload is in "All other workload" in this table; in the preceding table home-based LTSS visits are included in outpatient visits.

Global RVUs Projected by the VA Enrollee Health Care Projection Model

Description	2022 Projection	2023 Projection	2024 Projection	2025 Projection	+/- 2023-2024	+/- 2024-2025
VA System Delivered:						
Outpatient	330,346,566	391,058,722	391,890,379	408,220,568	831,657	16,330,189
Inpatient	154,267,802	159,917,346	161,143,695	163,894,546	1,226,349	2,750,851
All other workload	384,545,625	424,138,485	440,735,708	456,206,658	16,597,223	15,470,950
VA System Delivered [Subtotal]	869,159,993	975,114,553	993,769,782	1,028,321,772	18,655,229	34,551,990
Community Delivered:						
Outpatient	190,262,819	213,793,832	219,989,208	228,340,831	6,195,376	8,351,623
Inpatient	180,202,850	229,094,087	236,788,355	243,188,267	7,694,268	6,399,912
All other workload	101,217,912	109,410,401	114,285,942	117,657,222	4,875,541	3,371,280
Community Delivered [Subtotal]	471,683,581	552,298,320	571,063,505	589,186,320	18,765,185	18,122,815
Total VA Delivered:						
Outpatient	520,609,385	604,852,554	611,879,587	636,561,399	7,027,033	24,681,812
Inpatient	334,470,652	389,011,433	397,932,050	407,082,813	8,920,617	9,150,763
All other workload	485,763,537	533,548,886	555,021,650	573,863,880	21,472,764	18,842,230
Total Delivered [Subtotal]	**1,340,843,574**	**1,527,412,873**	**1,564,833,287**	**1,617,508,092**	**37,420,414**	**52,674,805**

The EHCPM Global RVUs were developed to address VA's unique modeling needs. For services paid under the Centers for Medicare and Medicaid Services (CMS) Resource-Based Relative Value Scale (RBRVS), the Global RVUs are equal to the CMS RBRVS RVUs.

The EHCPM Global RVUs build on the CMS RBRVS to cover services that are not assigned CMS RBRVS RVUs, including inpatient care, pharmacy, prosthetics and VA's special programs. In addition, the CMS RBRVS only assigns RVUs to the services billed by professional providers; RVUs are not assigned to services billed by facilities. The Global RVUs address this issue by assigning RVUs for these facility costs that are consistent with CMS's physician RVU schedule. Thus, the EHCPM Global RVUs cover all workload and expenditures associated with VA health care.

The EHCPM Global RVUs are a significant enhancement over the CMS RBRVS RVUs:

- Because the EHCPM Global RVUs assign RVUs for facility costs, EHCPM Global RVUs cover the total resource requirements for each health care service, not just the professional resource requirements covered by the CMS RBRVS. For some services such as surgeries, the professional resource requirements represented by the CMS RBRVS are only a small portion of the total resources required to provide the service.

- Because the EHCPM Global RVUs assign a consistent resource unit to all health care services, health care services of unequal intensity (e.g., immunizations and surgeries) can be aggregated and compared on an equivalent basis.
    - Aggregating health care services using expenditures introduces the effect of variations in unit cost that may exist for the same service from one locality, provider or care location to another.
    - In addition, for care VA purchases in the community, year-to-year comparisons of total expenditures can under- or over-state the volume of care purchased due to known changes in the level of Medicare allowable reimbursement in different contract mechanisms and over time.
- The Global RVUs facilitate an accurate comparison of workload between VA facility and community care and between different geographic areas (e.g., Community Care Network contract regions, VISNS, facilities).
    - The EHCPM Global RVUs reflect differences in workload mix and intensity but do not reflect cost differences between the care locations.
    - The EHCPM Global RVUs reflect the workload mix differences between care locations (i.e., 100 surgeries in the VA facility do not necessarily require the same resources as 100 surgeries in the community). Global RVUs account for these differences by assigning RVU values that represent the intensity of each surgery (e.g., a heart transplant will have a higher total Global RVU value than an appendectomy).

Types of Resource-Based Relative Value Scales

CMS RBRVS: The CMS RBRVS is a system of valuing physician services using RVUs. RVUs represent the amount of physician effort, risk and resources, provided or consumed, for one service relative to other services. The CMS RBRVS includes RVUs for the following resources:

- The work RVU is the portion of the professional service meant to reflect the workload done by the medical provider.
- The practice expense RVU is intended to capture the cost of maintaining a medical practice (e.g., leasing office space, employing administrative and medical support staff, purchasing supplies and equipment). The practice expense RVU can vary based on whether the service was performed in a physician's office or a medical facility.
- A third component is an RVU to represent malpractice insurance costs, however, these RVUs are not used in reporting RVUs for VA since these costs are not included in VA's appropriation.

Essential RBRVS: Essential RBRVS is a licensed product developed by Optum that builds on the CMS RBRVS by filling in many (not all) gaps in the CMS schedule. The CMS RBRVS does not include RVUs for many of the professional services reimbursed by Medicare under non-physician schedules (e.g., DME, Lab). The Essential RBRVS address this by assigning RVUs to many of these services using a process where analysts, medical coders and clinicians are consulted to determine an appropriate RVU value.

EHCPM Global RVUs: EHCPM Global RVUs are used to aggregate data across health care services, for use in reliance analyses, setting EHCPM adjustment tables, developing modeling expenditure targets, the Medicare Allowable Cost analysis and other ad hoc analyses. Beginning in the 2020 (Base Year 2019) EHCPM, EHCPM Global RVUs were integrated into the EHCPM. EHCPM Global RVUs are assigned to all services VA provides. As such, they represent the total resource requirements to provide VA health care.

- EHCPM Global RVUs build on CMS RBRVS and fills in most of the remaining gaps.
    - For services paid under CMS RBRVS, the Global RVUs are equal to the CMS RBRVS RVUs and are largely consistent with the Essential RBRVS RVUs.
    - For other medical services where CMS does not assign RVUS, the Global RVUs produce RVUs consistent with the CMS RBRVS RVUs.
    - Gaps are filled in using the Milliman Global RVUs, Milliman extended RVUs, and the VA Reasonable Charges schedule developed by the VHA Office of Community Care for use in billing, Health Service Category averages and the VA outpatient workload data file.
- Hospital RVUs – Outside of VA, health care costs associated with professional providers and hospital facilities are billed separately. The CMS and Essential RBRVS only assign RVUs to the services billed by professional providers; they are not assigned to services billed by facilities. The Global RVUs address this issue by developing RBRVS for hospitals that are consistent with the CMS RBRVS.

PACT Act, Titles I, III, IV Global RVUs Projected

Description	2023 Projection	2024 Projection	2025 Projection	+/- 2023-2024	+/- 2024-2025
Total Projected Global RVUs:					
Outpatient.....	7,884,527	15,405,150	20,168,527	7,520,624	4,763,377
Inpatient.....	5,586,764	11,012,666	14,030,172	5,425,902	3,017,506
All other workload	4,434,495	8,535,097	11,104,526	4,100,602	2,569,429
Total.....	**17,905,786**	**34,952,913**	**45,303,225**	**17,047,128**	**10,350,312**

Veteran Enrollment Priority Group Definitions

Veterans are enrolled in one of eight Priority Groups and/or sub-priority groups. The highest priority is Priority Group 1 and the lowest is Priority Group 8.

Priority Group 1

- Veterans with VA-rated service-connected disabilities 50% or more disabling
- Veterans determined by VA to be unemployable due to service-connected conditions, or
- Veterans awarded the Medal of Honor (MOH)

Priority Group 2

- Veterans with VA-rated service-connected disabilities 30% or 40% disabling

Priority Group 3

- Veterans who are Former Prisoners of War (POWs)
- Veterans awarded a Purple Heart medal
- Veterans discharged for a disability that was incurred or aggravated in the line of duty
- Veterans with VA-rated, service-connected disabilities 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, "benefits for individuals disabled by treatment or vocational rehabilitation"

Priority Group 4

- Veterans who are receiving aid and attendance or housebound benefits from VA
- Veterans who have been determined by VA to be catastrophically disabled

Priority Group 5

- Nonservice-connected Veterans and non-compensable, service-connected Veterans rated 0% disabled by VA, with annual income below the VA's and geographically adjusted income limits (based on resident zip code)
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid programs

Priority Group 6

- Compensable 0% service-connected Veterans
- Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki
- Project 112/SHAD participants
- Veterans who served in the Republic of Vietnam between January 9, 1962 and May 7, 1975
    - Effective August 10, 2022, the PACT Act expanded qualifying service locations for eligibility, based on Vietnam-era herbicide exposure and defined additional military service activities that qualify for eligibility based on radiation exposure (P.L. 117-168)
- Veterans of Persian Gulf War who served between August 2, 1990 and November 11, 1998
    - Once fully implemented, the PACT Act will expand VA health care eligibility to toxic-exposed Veterans who served during the Persian Gulf War era
- Effective 3/31/2023, World War II Veterans are eligible to enroll in Priority Group 6 under the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act (P.L. 117-328)
- Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987; or
- Veterans who are currently or newly enrolled in VA health care, and

- Veterans who served in a theater of combat operations after November 11, 1998, and
- Veterans who were discharged from active duty less than ten years ago

Priority Group 7

- Veterans with gross household income below the geographically-adjusted income limits (GMT) for their resident location and who agree to pay copays

Priority Group 8

- Veterans with gross household income above the VA and the geographically-adjusted income limits for their resident location and who agrees to pay copays
    - *Veterans eligible for enrollment:*
        - Non-compensable 0% service-connected and:
            - Sub-priority 8a: Enrolled as of January 16, 2003 and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status
            - Sub-priority 8b: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less
        - Nonservice-connected and:
            - Sub-priority 8c: Enrolled as of January 16, 2003 and who have remained enrolled since that date and/or placed in this sub priority due to changed eligibility status
            - Sub-priority 8d: Enrolled on or after June 15, 2009 whose income exceeds the current VA or geographic income limits by 10% or less
    - *Veterans not eligible for enrollment:*
        - Veterans not meeting the criteria above
            - Sub-priority 8e: Non-compensable 0% service-connected (eligible for care of their SC condition only)
            - Sub-priority 8g: Nonservice-connected

Non-Veteran Definitions

The majority of the individuals who receive medical attention from the VA health care system are individuals who have completed military service and are considered to hold Veteran status. However, a small number of patients who are treated within the VA health care system are not Veterans. This non-Veteran population consists of individuals such as VA employees, the widows and family of Veterans, or active military. Patient records indicate the non-Veteran status.

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), Foreign Medical Program (FMP), Spina Bifida Health Care Program (SB) and Children of Women Vietnam Veterans Health Care Benefits Program (CWVV)

For additional information on CHAMPVA, FMP, SB and CWVV, please see the Medical Community Care chapter.

Veterans' Health Administration (VHA) Facility Non-Veterans

Non-Veteran	Includes all non-Veterans who are seen only in a VA inpatient setting
Non-Veteran: Catastrophic Disability	Patient with catastrophic disability who is not a Veteran
Non-Veteran: CHAMPVA	A health care benefits program that provides coverage to the spouse or widow(er) and to the dependent children of a qualifying Veteran
Non-Veteran: Collaterals	Relatives, newborns and caregivers associated with Veterans
Non-Veteran: VA Employee	Employees of the VA
Non-Veteran: Other Federal	Patient with Federal employment
Non-Veteran: Allied Veteran	Allied beneficiaries are former members of the armed forces of nations allied with the United States in World Wars I and II
Non-Veteran: Humanitarian	Typically, emergency care to a non-Veteran patient
Non-Veteran: Sharing Agreement	Patient receiving care by way of a written Sharing agreement. Often times with the DoD
Non-Veteran: TRICARE/CHAMPUS	TRICARE is a program for Active-Duty personnel and certain other DoD beneficiaries

Table: Unique Patients [1/]

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Priority Levels							
Priority 1	2,785,827	2,823,222	2,922,581	**3,046,068**	**3,151,321**	123,487	105,253
Priority 2	461,559	477,761	456,195	**450,901**	**444,798**	(5,294)	(6,103)
Priority 3	792,685	825,168	797,945	**801,753**	**801,826**	3,808	73
Priority 4	132,160	133,757	124,441	**117,418**	**111,066**	(7,023)	(6,352)
Priority 5	892,601	921,895	834,536	**778,893**	**725,079**	(55,643)	(53,814)
Priority 6	226,581	241,995	222,103	**218,096**	**214,473**	(4,007)	(3,623)
Priority 7	234,087	248,892	242,542	**250,279**	**257,142**	7,737	6,863
Priority 8	771,330	818,845	740,240	**714,186**	**691,164**	(26,054)	(23,022)
Veterans [Subtotal]	6,296,830	6,491,535	6,340,582	**6,377,593**	**6,396,869**	37,011	19,276
Non-Veterans 2/							
CHAMPVA/SB/FMP/CW/CITI Non-Vets	451,682	459,716	467,847	**482,792**	**496,461**	14,945	13,669
N : Non-Veteran	4,399	3,206	4,419	**4,402**	**4,213**	(17)	(189)
N0: Non-Vet, Catastro Disab	42	46	45	**46**	**47**	1	1
N1: Non-Vet, CHAMPVA Ben	12,021	9,902	11,219	**10,743**	**10,440**	(476)	(303)
N2: Non-Vet, Collaterals	97,309	18,283	96,583	**95,652**	**95,073**	(931)	(579)
N3: Non-Vet, VA Employee	210,728	270,424	206,897	**200,733**	**193,174**	(6,164)	(7,559)
N4: Non-Vet, Other Federal	68,367	619	83,833	**99,983**	**114,519**	16,150	14,536
N5: Non-Vet, Allied Veterans	1,360	1,335	1,438	**1,513**	**1,574**	75	61
N6: Non-Vet, Humanitarian	34,814	30,902	35,168	**35,441**	**35,574**	273	133
N7: Non-Vet, Sharing Agreement	10,098	9,448	9,143	**8,467**	**7,897**	(676)	(570)
N9: Non-Vet, TRICARE/CHAMPUS	3,002	2,146	3,092	**3,225**	**3,373**	133	148
NF : FHC Active Duty 3/	57,794	49,833	58,977	**60,160**	**61,343**	1,183	1,183
Non-Veterans [Subtotal]	951,616	855,860	978,661	**1,003,158**	**1,023,687**	24,497	20,529
Unique Patients [Total]	**7,248,446**	**7,347,395**	**7,319,243**	**7,380,751**	**7,420,556**	61,508	39,805
OEF/OIF/OND/OIR (Incl. Above)	1,230,644	1,345,706	1,274,876	**1,313,399**	**1,347,696**	38,523	34,297

[1/] Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA.

[2/] Non-Veterans include active-duty military and reserve, spousal collateral, consultations, and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care and employees receiving preventive occupational immunizations, such as Hepatitis A&B and flu vaccinations.

[3/] Active-duty Non-Veterans at the Captain James A. Lovell Federal Health Care Center (JALFHCC).

Table: Unique Patients Under Age 65 [1/]

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Priority Levels							
Priority 1	1,732,153	1,760,426	1,845,439	**1,952,759**	**2,049,138**	107,320	96,379
Priority 2	248,929	261,877	243,978	**238,374**	**231,258**	(5,604)	(7,116)
Priority 3	346,005	369,636	343,513	**339,874**	**333,368**	(3,639)	(6,506)
Priority 4	25,778	26,565	21,634	**17,313**	**12,455**	(4,321)	(4,858)
Priority 5	342,667	359,063	301,024	**256,676**	**206,375**	(44,348)	(50,301)
Priority 6	70,972	74,151	68,271	**66,430**	**64,488**	(1,841)	(1,942)
Priority 7	97,003	106,108	101,376	**105,323**	**108,789**	3,947	3,466
Priority 8	274,069	309,723	269,931	**263,809**	**253,796**	(6,122)	(10,013)
Veterans [Subtotal]	3,137,576	3,267,549	3,195,166	**3,240,558**	**3,259,667**	45,392	19,109
Non-Veterans 2/							
CHAMPVA/SB/FMP/CW/CITI Non-Vets	430,319	436,811	445,783	**460,057**	**473,088**	14,274	13,031
N : Non-Veteran	3,806	2,578	3,807	**3,777**	**3,594**	(30)	(183)
N0: Non-Vet, Catastro Disab	40	43	43	**44**	**45**	1	1
N1: Non-Vet, CHAMPVA Ben	10,199	9,326	9,330	**8,801**	**8,468**	(529)	(333)
N2: Non-Vet, Collaterals	63,970	15,609	63,907	**63,058**	**62,957**	(849)	(101)
N3: Non-Vet, VA Employee	201,952	259,850	199,071	**193,581**	**186,317**	(5,490)	(7,264)
N4: Non-Vet, Other Federal	33,562	552	41,121	**51,878**	**62,172**	10,757	10,294
N5: Non-Vet, Allied Veterans	1,153	1,116	1,217	**1,314**	**1,377**	97	63
N6: Non-Vet, Humanitarian	27,713	27,201	28,043	**28,436**	**28,715**	393	279
N7: Non-Vet, Sharing Agreement	8,367	7,665	6,573	**4,854**	**2,297**	(1,719)	(2,557)
N9: Non-Vet, TRICARE/CHAMPUS	2,458	1,908	2,532	**2,635**	**2,767**	103	132
NF : FHC Active Duty 3/	57,794	49,833	58,977	**60,160**	**61,343**	1,183	1,183
Non-Veterans [Subtotal]	841,333	812,492	860,404	**878,595**	**893,140**	18,191	14,545
Unique Patients [Total]	**3,978,909**	**4,080,041**	**4,055,570**	**4,119,153**	**4,152,807**	63,583	33,654

[1/] Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA.

[2/] Non-Veterans include active-duty military and reserve, spousal collateral, consultations, and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care and employees receiving preventive occupational immunizations, such as Hepatitis A&B and flu vaccinations.

[3/] Active-duty Non-Veterans at the Captain James A. Lovell Federal Health Care Center (JALFHCC).

Table: Unique Patients Age 65 and Older [1/]

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Priority Levels							
Priority 1	1,053,674	1,062,796	1,077,142	**1,093,309**	**1,102,183**	16,167	8,874
Priority 2	212,630	215,884	212,217	**212,527**	**213,540**	310	1,013
Priority 3	446,680	455,532	454,432	**461,879**	**468,458**	7,447	6,579
Priority 4	106,382	107,192	102,807	**100,105**	**98,611**	(2,702)	(1,494)
Priority 5	549,934	562,832	533,512	**522,217**	**518,704**	(11,295)	(3,513)
Priority 6	155,609	167,844	153,832	**151,666**	**149,985**	(2,166)	(1,681)
Priority 7	137,084	142,784	141,166	**144,956**	**148,353**	3,790	3,397
Priority 8	497,261	509,122	470,309	**450,377**	**437,368**	(19,932)	(13,009)
Veterans [Subtotal]	3,159,254	3,223,986	3,145,417	**3,137,036**	**3,137,202**	(8,381)	166
Non-Veterans 2/							
CHAMPVA/SB/FMP/CW/CITI Non-Vets	21,363	22,905	22,064	**22,735**	**23,373**	671	638
N : Non-Veteran	593	628	612	**625**	**619**	13	(6)
N0: Non-Vet, Catastro Disab	2	3	2	**2**	**2**	0	0
N1: Non-Vet, CHAMPVA Ben	1,822	576	1,889	**1,942**	**1,972**	53	30
N2: Non-Vet, Collaterals	33,339	2,674	32,676	**32,594**	**32,116**	(82)	(478)
N3: Non-Vet, VA Employee	8,776	10,574	7,826	**7,152**	**6,857**	(674)	(295)
N4: Non-Vet, Other Federal	34,805	67	42,712	**48,105**	**52,347**	5,393	4,242
N5: Non-Vet, Allied Veterans	207	219	221	**199**	**197**	(22)	(2)
N6: Non-Vet, Humanitarian	7,101	3,701	7,125	**7,005**	**6,859**	(120)	(146)
N7: Non-Vet, Sharing Agreement	1,731	1,783	2,570	**3,613**	**5,600**	1,043	1,987
N9: Non-Vet, TRICARE/CHAMPUS	544	238	560	**590**	**606**	30	16
NF : FHC Active Duty 3/	0	0	0	**0**	**0**	0	0
Non-Veterans [Subtotal]	110,283	43,368	118,257	**124,562**	**130,548**	6,305	5,986
Unique Patients [Total]	**3,269,537**	**3,267,354**	**3,263,673**	**3,261,598**	**3,267,749**	(2,075)	6,151

[1/] Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA.

[2/] Non-Veterans include active-duty military and reserve, spousal collateral, consultations, and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care and employees receiving preventive occupational immunizations, such as Hepatitis A&B and flu vaccinations.

[3/] Active-duty Non-Veterans at the Captain James A. Lovell Federal Health Care Center (JALFHCC).

Table: Unique Obligations by Priority Group

Unique Patients 1/

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Priority Levels							
1-6	5,291,413	5,423,798	5,357,801	**5,413,128**	**5,448,563**	55,327	35,435
7-8	1,005,417	1,067,737	982,781	**964,465**	**948,306**	(18,316)	(16,159)
Veterans [Subtotal]	6,296,830	6,491,535	6,340,582	**6,377,593**	**6,396,869**	37,011	19,276
Non-Veterans 2/	951,616	855,860	978,661	**1,003,158**	**1,023,687**	24,497	20,529
Unique Patients [Total]	**7,248,446**	**7,347,395**	**7,319,243**	**7,380,751**	**7,420,556**	**61,508**	**39,805**

Obligations by Priority Group
Includes Veterans Choice Act
(dollars in thousands)

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Priority Levels							
1-6	$98,312,414	$106,475,924	$112,770,744	**$125,073,726**	**$129,266,755**	$12,302,981	$4,193,029
7-8	$10,379,666	$10,643,972	$11,959,528	**$13,347,767**	**$13,895,399**	$1,388,238	$547,632
Veterans [Subtotal]	$108,692,080	$117,119,896	$124,730,273	**$138,421,492**	**$143,162,154**	$13,691,219	$4,740,662
Non-Veterans 2/	$3,082,578	$2,602,011	$3,276,903	**$3,497,487**	**$3,608,457**	$220,584	$110,970
Obligations [Total]	**$111,774,659**	**$119,721,907**	**$128,007,176**	**$141,918,979**	**$146,770,611**	$13,911,803	$4,851,632

Obligations Per Unique Patient
(dollars)

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Priority Levels							
1-6	$18,580	$19,631	$21,048	**$23,106**	**$23,725**	$2,058	$619
7-8	$10,324	$9,969	$12,169	**$13,840**	**$14,653**	$1,671	$813
Veterans [Subtotal]	$17,261	$18,042	$19,672	**$21,704**	**$22,380**	$2,032	$676
Non-Veterans 2/	$3,239	$3,040	$3,348	**$3,486**	**$3,525**	$138	$39
Obligations Per Unique Patient [Total]	**$15,420**	**$16,294**	**$17,489**	**$19,228**	**$19,779**	**$1,739**	**$551**

1/ Unique patients are uniquely identified individuals treated by VA or whose treatment is paid for by VA.

2/ Non-Veterans include active-duty military and reserve, spousal collateral, consultations, and instruction, CHAMPVA workload, reimbursable workload with affiliates, humanitarian care and employees receiving preventive occupational immunizations, such as Hepatitis A&B and flu vaccinations.

Table: Obligations by Priority Group
2022-2025

	2022 Actual			2023 Current Estimate			2024 Current Estimate			2025 Current Estimate		
	Unique Patients	Obligations ($1,000)	Obligation per Person	Unique Patients	Obligations ($1,000)	Obligation per Person	Unique Patients	Obligations ($1,000)	Obligation per Person	Unique Patients	Obligations ($1,000)	Obligation per Person
Priority Groups												
Priority 1	2,785,827	$55,884,766	$20,060	2,922,581	$65,064,693	$22,263	3,046,068	$73,189,307	$24,027	3,151,321	$76,619,588	$24,313
Priority 2	461,559	$5,893,337	$12,768	456,195	$6,699,389	$14,685	450,901	$7,370,578	$16,346	444,798	$7,563,038	$17,003
Priority 3	792,685	$10,566,718	$13,330	797,945	$12,182,957	$15,268	801,753	$13,584,437	$16,943	801,826	$14,110,125	$17,597
Priority 4	132,160	$6,470,462	$48,959	124,441	$7,184,462	$57,734	117,418	$7,713,308	$65,691	111,066	$7,723,927	$69,544
Priority 5	892,601	$17,709,579	$19,840	834,536	$19,588,982	$23,473	778,893	$20,936,096	$26,879	725,079	$20,882,359	$28,800
Priority 6	226,581	$1,787,551	$7,889	222,103	$2,050,262	$9,231	218,096	$2,279,999	$10,454	214,473	$2,367,718	$11,040
P1-6 Subtotal	5,291,413	$98,312,414	$18,580	5,357,801	$112,770,744	$21,048	5,413,129	$125,073,726	$23,106	5,448,563	$129,266,755	$23,725
Priority 7	234,087	$2,904,871	$12,409	242,542	$3,426,546	$14,128	250,279	$3,910,279	$15,624	257,142	$4,156,006	$16,162
Priority 8	771,330	$7,474,795	$9,691	740,240	$8,532,983	$11,527	714,186	$9,437,488	$13,214	691,164	$9,739,393	$14,091
P7-8 Subtotal	1,005,417	$10,379,666	$10,324	982,782	$11,959,528	$12,169	964,465	$13,347,767	$13,840	948,306	$13,895,399	$14,653
Veterans [Subtotal]	6,296,830	$108,692,080	$17,261	6,340,582	$124,730,273	$19,672	6,377,593	$138,421,492	$21,704	6,396,869	$143,162,154	$22,380
Non-Veterans												
CHAMPVA/SB/FMP/CW Non-Vet (less CITI)	451,682	$2,383,302	$5,277	467,847	$2,526,300	$5,400	482,792	$2,677,878	$5,547	496,461	$2,706,173	$5,451
N: Non-Vet	4,399	$50,932	$11,578	4,419	$54,870	$12,417	4,402	$61,696	$14,015	4,213	$66,717	$15,836
N0: Non-Vet, Catastro Disab	42	$1,209	$28,781	45	$1,298	$28,834	46	$1,417	$30,800	47	$1,560	$33,185
N1: Non-Vet, CHAMPVA Ben	12,021	$98,345	$8,181	11,219	$99,563	$8,874	10,743	$103,268	$9,613	10,440	$108,995	$10,440
N2: Non-Vet, Collaterals	97,309	$128,453	$1,320	96,583	$137,881	$1,428	95,652	$151,557	$1,584	95,073	$167,844	$1,765
N3: Non-Vet, VA Employee	210,728	$210,685	$1,000	206,897	$226,149	$1,093	200,733	$246,940	$1,230	193,174	$271,949	$1,408
N4: Non-Vet, Other Federal	68,367	$21,791	$319	83,833	$26,491	$316	99,983	$32,042	$320	114,519	$39,618	$346
N5: Non-Vet, Allied Veterans	1,360	$18,931	$13,920	1,438	$20,321	$14,131	1,513	$23,189	$15,327	1,574	$25,427	$16,155
N6: Non-Vet, Humanitarian	34,814	$74,720	$2,146	35,168	$82,705	$2,352	35,441	$89,678	$2,530	35,574	$97,913	$2,752
N7: Non-Vet, Sharing Agreement	10,098	$73,026	$7,232	9,143	$78,486	$8,584	8,467	$83,992	$9,920	7,897	$94,226	$11,932
N9: Non-Vet, TRICARE/CHAMPUS	3,002	$21,185	$7,057	3,092	$22,839	$7,387	3,225	$25,830	$8,009	3,373	$28,035	$8,311
NF: FHC Active Duty 1/	57,794	$0	$0	58,977	$0	$0	60,160	$0	$0	61,343	$0	$0
Non-Veterans [Subtotal]	951,616	$3,082,578	$3,239	978,661	$3,276,903	$3,348	1,003,158	$3,497,487	$3,486	1,023,687	$3,608,457	$3,525
Total	**7,248,446**	**$111,774,659**	**$15,420**	**7,319,243**	**$128,007,176**	**$17,489**	**7,380,751**	**$141,918,979**	**$19,228**	**7,420,556**	**$146,770,611**	**$19,779**

[1/] Active-duty Non-Veterans at the Captain James A. Lovell Federal Health Care Center (JALFHCC) and funded by the DoD-VA Medical Facility Demonstration Fund Appropriation Transfers and excluded from the Medical Care obligation total.

Tables: Funding Crosswalks 2022-2025

The following crosswalk tables display the funding sources totaling obligations across all budget years.

2022 Actuals Dollars in Thousands ($000)	Discretionary				
Description	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162	Medical Care Total
APPROPRIATION					
Advance Appropriation	$58,897,219	$20,148,244	$8,403,117	$6,734,680	$94,183,260
Annual Appropriation Adjustment	$0	$3,269,000	$0	$0	$3,269,000
PL 117-103 § 253 (Infrastructure)	$0	$0	$0	$150,000	$150,000
Appropriation [Subtotal]	$58,897,219	$23,417,244	$8,403,117	$6,884,680	$97,602,260
RESCISSIONS (PL 117-103 § 255)	($200,000)	($200,000)	$0	$0	($400,000)
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
Unob. Bal. to VBA/GOE (PL 117-43 §151)	($89,000)	$0	$0	$0	($89,000)
Unob. Bal. to BVA (PL 117-43 §151)	($5,800)	$0	$0	$0	($5,800)
Unob. Bal. to OI&T (PL 117-43 §151)	($9,578)	$0	$0	$0	($9,578)
JALFHCC (0169)	($203,805)	($43,768)	($30,613)	($92,830)	($371,016)
Transfers To [Subtotal]	($323,183)	($43,768)	($30,613)	($92,830)	($490,394)
COLLECTIONS	$3,088,295	$782,169	$0	$0	$3,870,464
BUDGET AUTHORITY	$61,462,331	$23,955,645	$8,372,504	$6,791,850	$100,582,330
REIMBURSEMENTS	$127,577	$0	$57,424	$18,609	$203,610
UNOBLIGATED BALANCE (SOY)					
No-Year (Other)	$2,350,381	$439,288	$0	$18,489	$2,808,158
P.L. 115-141 § 255 (NRM)	$0	$0	$0	$115,406	$115,406
P.L. 115-244 § 248 (NRM)	$0	$0	$0	$336,087	$336,087
H1N1 No-Year (PL 111-32)	$7	$0	$111	$5	$123
2-Year	$837,241	$1,332,887	$149,880	$158,634	$2,478,642
2-Year (P.L. 116-136)	$0	$0	$0	$0	$0
3-Year (P.L. 116-127)	$200	$0	$0	$0	$200
4-Year Base Year 2019	$0	$10,532	$0	$0	$10,532
5-Year Base Year 2018	$0	$0	$0	$41,538	$41,538
Unobligated Balance (SOY) [Subtotal]	$3,187,829	$1,782,707	$149,991	$670,159	$5,790,686
UNOBLIGATED BALANCE (EOY)					
PL 117-103 § 253 (Infrastructure)	$0	$0	$0	($108,824)	($108,824)
No-Year (Other)	($3,130,737)	($155,299)	$0	($16,661)	($3,302,697)
P.L. 115-141 § 255 (NRM)	$0	$0	$0	($30,667)	($30,667)
P.L. 115-244 § 248 (NRM)	$0	$0	$0	($139,162)	($139,162)
H1N1 No-Year (PL 111-32)	($7)	$0	($111)	($5)	($123)
2-Year	($500,826)	($176,374)	($199,636)	($315,247)	($1,192,083)
3-Year (P.L. 116-127)	$0	$0	$0	$0	$0
4-Year Base Year 2019	$0	$0	$0	$0	$0
5-Year Base Year 2018	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($3,631,570)	($331,673)	($199,747)	($610,566)	($4,773,556)
LAPSE	($517)	($14,288)	($118)	($17,682)	($32,605)
OBLIGATIONS [Subtotal] NON-801/802	$61,145,650	$25,392,391	$8,380,054	$6,852,370	$101,770,465
PRIOR Year Recoveries	$111,105	$75,894	$540	$31,923	$219,462
OBLIGATIONS [Total] NON-801/802	$61,256,755	$25,468,285	$8,380,594	$6,884,293	$101,989,927
FTE NON-801	257,853	0	57,224	22,143	337,220

2022 Actuals
Dollars in Thousands ($000)

Veterans Access, Choice & Accountability Act of 2014, Section 801

	Mandatory								
						Information Technology			
Description	Medical Services 0160XA	Medical Support & Compl 0152XA	Medical Facilities 0162XA	Medical Care Total (continued)	Minor Cons. 0111XA	Dev. 0167XD	Sustain. 0167XO	Pay & Adm 0167XZ	Section 801 Grand Total
UNOBLIGATED BALANCE (SOY)									
No-Year	$21,338	$10,417	$16,095	$47,850	$1,978	$1,026	$0	$0	$50,854
UNOBLIGATED BALANCE (EOY)									
No-Year	($16,123)	($7,172)	($10,884)	($34,179)	($1,702)	($1,026)	$0	$0	($36,907)
OBLIGATIONS [Subtotal]	$5,215	$3,245	$5,211	$13,671	$276	$0	$0	$0	$13,947
PRIOR Year Recoveries	$91	$48	$3,488	$3,627	$2	$60	$0	$0	$3,689
OBLIGATIONS [Total]	$5,306	$3,293	$8,699	$17,298	$278	$60	$0	$0	$17,636
FTE	17	24	0	41	0	0	0	0	41

2022 Actuals
Dollars in Thousands ($000)

	Mandatory								Other Purposes				
	Medical Care Purposes								VMCHF		Grants for	Title 38	VHA ARP
	Veterans Medical Care and Health Fund					Medical		Medical		Information	Construction of	COVID	Sections
Description	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Services	Community Care	Copay Refunds	Care Total	Research	Technology OIT	State Extended Care Facilites	Leave 0131	Grand Total
UNOBLIGATED BALANCE (SOY)													
ARP Act § 8002	$9,020,413	$978,433	$2,572,958	$1,901,196	$0	$0	$0	$14,473,000	$1,772	$0	$0	$0	$14,474,772
ARP Act § 8004 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8004 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$395,596	$0	$395,596
ARP Act § 8007	$0	$0	$0	$0	$627,900	$72,100	$56,390	$756,390	$0	$0	$0	$0	$756,390
ARP Act § 8008	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$61,893	$61,893
Unobligated Balance (SOY) [Subtotal]	$9,020,413	$978,433	$2,572,958	$1,901,196	$627,900	$72,100	$56,390	$15,229,390	$1,772	$0	$395,596	$61,893	$15,688,651
REAPPORTIONMENT of § 8002													
ARP Act § 8002	($3,370,222)	$0	$0	$1,902,643	$0	$0	$0	($1,467,579)	$30,000	$1,437,579	$0	$0	$0
ARP Act § 8007	$0	$0	$0	$0	$25,283	$9,509	($34,792)	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)													
ARP Act § 8002 - 3 year	($733,253)	($502,305)	($772,056)	($1,987,643)	$0	$0	$0	($3,995,257)	($30,109)	($769,242)	$0	$0	($4,794,608)
ARP Act § 8004 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8004 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($938)	$0	($938)
ARP Act § 8007 - no year	$0	$0	$0	$0	($2,847)	($176)	($16,861)	($19,884)	$0	$0	$0	$0	($19,884)
ARP Act § 8008 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($733,253)	($502,305)	($772,056)	($1,987,643)	($2,847)	($176)	($16,861)	($4,015,141)	($30,109)	($769,242)	($938)	$0	($4,815,430)
PRIOR Year Recoveries	$0	$0	$0	$0	$0	$0	$0	$0	$315	$0	$2,558	$0	$2,873
LAPSE	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	($54,046)	($54,046)
OBLIGATIONS	$4,916,938	$476,128	$1,800,902	$1,816,196	$650,336	$81,433	$4,737	$9,746,670	$1,978	$668,337	$397,216	$7,847	$10,822,048
FTE ARP Act	11,126	1,223	3,091	0	2,522	0	0	17,962	3	0	0	0	17,965

2022 Actuals Dollars in Thousands ($000)	Mandatory							
	Medical Care Purposes						Other Purposes	VHA PACT Act Sections
	Cost of War Toxic Exposure Fund 1/						Cost of War TEF	Grand
Description	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Facilities	Medical Care Total	Research	Total
MANDATORY APPROPRIATION								
PACT Act § 705	$0	$0	$0	$0	$275,205	$275,205	$0	$275,205
PACT Act § 707	$0	$0	$0	$0	$0	$0	$0	$0
PACT Act § 806	$7,981	$26,143	$0	$0	$0	$34,124	$650	$34,774
Mandatory Appropriation [Subtotal]	$7,981	$26,143	$0	$0	$275,205	$309,329	$650	$309,979
REAPPORTIONMENT								
PACT Act § 705	$0	$0	$0	$0	$0	$0	$0	$0
PACT Act § 806	$0	$0	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)								
PACT Act § 705	$0	$0	$0	$0	($275,205)	($275,205)	$0	($275,205)
PACT Act § 707	$0	$0	$0	$0	$0	$0	$0	$0
PACT Act § 806	($7,981)	($26,143)	$0	$0	$0	($34,124)	($650)	($34,774)
Unobligated Balance (EOY) [Subtotal]	($7,981)	($26,143)	$0	$0	($275,205)	($309,329)	($650)	($309,979)
OBLIGATIONS	$0	$0	$0	$0	$0	$0	$0	$0
Mandatory FTE PACT Act	0	0	0	0	0	0	0	0

1/ The Cost of War Toxic Exposures Fund was established in section 805 of the PACT Act, and the column displays estimated allocations by category from the appropriation provided in section 806 of the PACT Act.

2022 Actuals Dollars in Thousands ($000) Veterans Access, Choice & Accountability Act of 2014, Section 802	Mandatory					Medical Care	Mandatory			Section 802
							Information Technology			
Description	Admin. 0172XA	Medical Care 0172XB	Emerg. Hepatitis C 0172XC	Emerg. Com. Care 0172XE	Med. Com Care (Mission) 0172XG	Total (continued)	Dev. 0172XD	Sustain. 0172XO	Pay & Adm 0172XZ	Grand Total
UNOBLIGATED BALANCE (SOY)										
No-Year	$42,748	$81,706	$0	$5,533	$150,395	$280,382	$144	$27	$0	$280,553
Unobligated Balance (SOY) [Subtotal]	$42,748	$81,706	$0	$5,533	$150,395	$280,382	$144	$27	$0	$280,553
TRANSFER OF UNOBLIGATED BALANCE										
Within the Veterans Choice Fund	($37,000)	$0	$0	($5,000)	$42,205	$205	($167)	($38)	$0	$0
UNOBLIGATED BALANCE (EOY)										
No-Year	($2,554)	($76,624)	$0	($772)	($192,600)	($272,550)	$0	$0	$0	($272,550)
Unobligated Balance (EOY) [Subtotal]	($2,554)	($76,624)	$0	($772)	($192,600)	($272,550)	$0	$0	$0	($272,550)
OBLIGATIONS [Subtotal]	$3,194	$5,082	$0	($239)	$0	$8,037	($23)	($11)	$0	$8,003
PRIOR YEAR RECOVERIES	$2	$12,477	$0	$248	$0	$12,727	$23	$11	$0	$12,761
OBLIGATIONS [Total]	$3,196	$17,559	$0	$9	$0	$20,764	$0	$0	$0	$20,764
FTE [Total]	0	0	0	0	0	0	0	0	0	0

Medical Care Obligations Regular	**$101,989,927**
Medical Care Obls., ARP	**$9,746,670**
Medical Care Obls., VACAA, Section 801	**$17,298**
Medical Care Obls., VACAA, Section 802	**$20,764**
Medical Care Obligations [Grand Total]	**$111,774,659**
Medical Care FTE, Regular	**339,742**
Medical Care FTE, ARP	**15,440**
Medical Care FTE, VACAA, Section 801	**41**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**355,223**

2023 Budget Estimate Dollars in Thousands ($000)	Discretionary				
Description	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162	Medical Care Total
APPROPRIATION					
Advance Appropriation	$70,323,116	$24,156,659	$9,673,409	$7,133,816	$111,287,000
Annual Appropriation Adjustment	$261,000	$4,300,000	$1,400,000	$1,500,000	$7,461,000
Appropriation [Subtotal]	$70,584,116	$28,456,659	$11,073,409	$8,633,816	$118,748,000
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000
JALFHCC (0169)	($190,377)	($50,768)	($30,613)	($50,297)	($322,055
Transfers To [Subtotal]	($205,377)	($50,768)	($30,613)	($50,297)	($337,055
TRANSFERS FROM (+)					
Transfers From [Subtotal]	$0	$0	$0	$0	$0
COLLECTIONS	$3,103,128	$791,075	$0	$0	$3,894,203
BUDGET AUTHORITY	$73,481,867	$29,196,966	$11,042,796	$8,583,519	$122,305,148
REIMBURSEMENTS	$132,760	$0	$63,438	$24,739	$220,937
UNOBLIGATED BALANCE (SOY)					
No-Year (Other)	$1,662,997	$0	$0	$0	$1,662,997
P.L. 115-141 § 255 (NRM)	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM)	$0	$0	$0	$0	$0
2-Year	$0	$0	$200,000	$350,000	$550,000
4-Year Base Year 2019	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$1,662,997	$0	$200,000	$350,000	$2,212,997
UNOBLIGATED BALANCE (EOY)					
No-Year (Other)	$0	$0	$0	$0	$0
P.L. 115-141 § 255 (NRM)	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM)	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0
4-Year Base Year 2019	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	$0
OBLIGATIONS [Total] NON-801/802	$75,277,624	$29,196,966	$11,306,234	$8,958,258	$124,739,082
FTE NON-801	282,781	0	67,351	28,626	378,758

2023 Budget Estimate Dollars in Thousands ($000)	Mandatory												
	Medical Care Purposes								Other Purposes				
	Veterans Medical Care and Health Fund				Medical								
Description	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Services	Community Care	Copay Refunds	Medical Care Total	Research	Information Technology OIT	Grants for Construction of State Extended Care Facilites	Title 38 COVID Leave 0131	VHA ARP Sections Grand Total
UNOBLIGATED BALANCE (SOY)													
ARP Act § 8002	$696,300	$344,900	$392,200	$2,098,805	$0	$0	$0	$3,532,205	$30,000	$630,057	$0	$0	$4,192,262
ARP Act § 8004 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8004 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8007	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8008	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$696,300	$344,900	$392,200	$2,098,805	$0	$0	$0	$3,532,205	$30,000	$630,057	$0	$0	$4,192,262
UNOBLIGATED BALANCE (EOY)													
ARP Act § 8002 - 3 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8004 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8004 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8007 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8008 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OBLIGATIONS	$696,300	$344,900	$392,200	$2,098,805	$0	$0	$0	$3,532,205	$30,000	$630,057	$0	$0	$4,192,262
FTE ARP Act	0	0	0	0	0	0	0	0	0	0	0	0	0

2023 Budget Estimate
Dollars in Thousands ($000)

Veterans Access, Choice & Accountability Act of 2014, Section 801

	Mandatory								
						Information Technology			
Description	Medical Services 0160XA	Medical Support & Compl 0152XA	Medical Facilities 0162XA	Medical Care Total (continued)	Minor Cons. 0111XA	Dev. 0167XD	Sustain. 0167XO	Pay & Adm 0167XZ	Section 801 Grand Total
UNOBLIGATED BALANCE (SOY)									
No-Year	$17,474	$7,618	$1,323	$26,415	$1,978	$1,026	$0	$0	$29,419
UNOBLIGATED BALANCE (EOY)									
No-Year	($13,494)	($4,735)	$0	($18,229)	($1,978)	($1,026)	$0	$0	($21,233)
OBLIGATIONS [Total]	$3,980	$2,883	$1,323	$8,186	$0	$0	$0	$0	$8,186
FTE	8	24	1	33	0	0	0	0	33

2023 Budget Estimate
Dollars in Thousands ($000)

Veterans Access, Choice & Accountability Act of 2014, Section 802

	Mandatory					Medical Care	Mandatory			Section 802
							Information Technology			
Description	Admin. 0172XA	Medical Care 0172XB	Emerg. Hepatitis C 0172XC	Emerg. Com. Care 0172XE	Med. Com are (Mission 0172XG	Total (continued)	Dev. 0172XD	Sustain. 0172XO	Pay & Adm 0172XZ	Grand Total
UNOBLIGATED BALANCE (SOY)										
No-Year	$0	$0	$0	$0	$265,088	$265,088	$0	$0	$0	$265,088
Unobligated Balance (SOY) [Subtotal]	$0	$0	$0	$0	$265,088	$265,088	$0	$0	$0	$265,088
UNOBLIGATED BALANCE (EOY)										
No-Year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OBLIGATIONS [Total]	$0	$0	$0	$0	$265,088	$265,088	$0	$0	$0	$265,088
FTE [Total]	0	0	0	0	0	0	0	0	0	0

Medical Care Obligations Regular	**$124,739,082**
Medical Care Obls., ARP	**$3,562,205**
Medical Care Obls., VACAA, Section 801	**$8,186**
Medical Care Obls., VACAA, Section 802	**$265,088**
Medical Care Obligations [Grand Total]	**$128,574,561**
Medical Care FTE, Regular	**378,758**
Medical Care FTE, ARP	**0**
Medical Care FTE, VACAA, Section 801	**33**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**378,791**

2023 Current Estimate Dollars in Thousands ($000)	Discretionary					
					Recurring Expenses	
Description	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162	Transformational Fund 1124	Medical Care Total
APPROPRIATION						
Advance Appropriation	$70,323,116	$24,156,659	$9,673,409	$7,133,816	$0	$111,287,000
Annual Appropriation Adjustment	$261,000	$4,300,000	$1,400,000	$1,500,000	$0	$7,461,000
Appropriation [Subtotal]	$70,584,116	$28,456,659	$11,073,409	$8,633,816	$0	$118,748,000
TRANSFERS TO (-)						
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	$0	($15,000)
Medical Community Care (0140)	($170,000)	$0	($930,000)	$0	$0	($1,100,000)
Medical Facilites (0162)	($270,000)	$0	$0	$0	$0	($270,000)
JALFHCC (0169)	($233,005)	($67,500)	($32,144)	($116,881)	$0	($449,530)
Transfers To [Subtotal]	($688,005)	($67,500)	($962,144)	($116,881)	$0	($1,834,530)
TRANSFERS FROM (+)						
Medical Services (0160)	$0	$170,000	$0	$270,000	$0	$440,000
Medical Support & Compliance (0152)	$0	$930,000	$0	$0	$0	$930,000
Transfers From [Subtotal]	$0	$1,100,000	$0	$270,000	$0	$1,370,000
Funds Made Available by P.L. 117-328 § 252	$0	$0	$0	$0	$75,000	$75,000
COLLECTIONS	$3,035,289	$791,075	$0	$0	$0	$3,826,364
BUDGET AUTHORITY	$72,931,400	$30,280,234	$10,111,265	$8,786,935	$75,000	$122,184,834
REIMBURSEMENTS	$127,577	$0	$57,424	$18,609	$0	$203,610
UNOBLIGATED BALANCE (SOY)						
PL 117-103 § 253 (Infrastructure)	$0	$0	$0	$108,824	$0	$108,824
No-Year (Other)	$3,130,737	$155,299	$0	$16,661	$0	$3,302,697
P.L. 115-141 § 255 (NRM)	$0	$0	$0	$30,667	$0	$30,667
P.L. 115-244 § 248 (NRM)	$0	$0	$0	$139,162	$0	$139,162
H1N1 No-Year (PL 111-32)	$7	$0	$111	$5	$0	$123
2-Year	$500,826	$176,374	$199,636	$315,247	$0	$1,192,083
Unobligated Balance (SOY) [Subtotal]	$3,631,570	$331,673	$199,747	$610,566	$0	$4,773,556
UNOBLIGATED BALANCE (EOY)						
PL 117-103 § 253 (Infrastructure)	$0	$0	$0	$0	$0	$0
No-Year (Other)	($3,433,113)	$0	$0	$0	$0	($3,433,113)
P.L. 115-141 § 255 (NRM)	$0	$0	$0	$0	$0	$0
P.L. 115-244 § 248 (NRM)	$0	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$0	$0	$0	$0	$0	$0
2-Year	($1,500,000)	($1,909,069)	$0	($250,515)	$0	($3,659,584)
Unobligated Balance (EOY) [Subtotal]	($4,933,113)	($1,909,069)	$0	($250,515)	$0	($7,092,697)
OBLIGATIONS [Total] NON-801/802	$71,757,434	$28,702,838	$10,368,436	$9,165,595	$75,000	$120,069,303
FTE NON-801	277,558	0	62,853	25,668	0	366,079

2023 Current Estimate Dollars in Thousands ($000)	Mandatory											
									Other Purposes			
	Medical Care Purposes											
	Veterans Medical Care and Health Fund				Medical						Grants for	VHA ARP
Description	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Services	Community Care	Copay Refunds	Medical Care Total	Research	Information Technology OIT	Construction of State Extended Care Facilites	Sections Grand Total
UNOBLIGATED BALANCE (SOY)												
ARP Act § 8002	$733,253	$502,305	$772,056	$1,987,643	$0	$0	$0	$3,995,257	$30,109	$769,242	$0	$4,794,608
ARP Act § 8004 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8004 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$938	$938
ARP Act § 8007	$0	$0	$0	$0	$2,847	$176	$16,861	$19,884	$0	$0	$0	$19,884
ARP Act § 8008	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$733,253	$502,305	$772,056	$1,987,643	$2,847	$176	$16,861	$4,015,141	$30,109	$769,242	$938	$4,815,430
UNOBLIGATED BALANCE (EOY)												
ARP Act § 8002 - 3 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8004 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8004 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8007 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP Act § 8008 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OBLIGATIONS	$733,253	$502,305	$772,056	$1,987,643	$2,847	$176	$16,861	$4,015,141	$30,109	$769,242	$938	$4,815,430
FTE ARP Act	3,517	0	0	0	0	0	0	3,517	0	0	0	3,517

2023 Current Estimate Dollars in Thousands ($000)	Mandatory							
	Medical Care Purposes						Other	VHA PACT
	Cost of War Toxic Exposure Fund					Medical	Purposes	Sections
Description	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Facilities	Care Total	TEF Research	Grand Total
MANDATORY APPROPRIATION								
PACT Act § 707	$0	$0	$0	$0	$1,880,000	$1,880,000	$0	$1,880,000
Annual Appropriation Adjustment	$3,822,377	$0	$0	$0	$0	$3,822,377	$1,830	$3,824,207
Mandatory Appropriation [Subtotal]	$3,822,377	$0	$0	$0	$1,880,000	$5,702,377	$1,830	$3,824,207
UNOBLIGATED BALANCE (SOY)								
PACT Act § 705	$0	$0	$0	$0	$275,205	$275,205	$0	$275,205
PACT Act § 707	$0	$0	$0	$0	$0	$0	$0	$0
PACT Act § 806	$7,981	$26,143	$0	$0	$0	$34,124	$650	$34,774
Unobligated Balance (EOY) [Subtotal]	$7,981	$26,143	$0	$0	$275,205	$309,329	$650	$309,979
REAPPORTIONMENT								
PACT Act § 705	$0	$0	$0	$0	$0	$0	$0	$0
PACT Act § 806	$94	($94)	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)								
PACT Act § 705	$0	$0	$0	$0	($275,205)	($275,205)	$0	($275,205)
PACT Act § 707	$0	$0	$0	$0	($1,829,719)	($1,829,719)	$0	($1,829,719)
PACT Act § 806	$0	$0	$0	$0	$0	$0	$0	$0
5-year (Base Year 2023)	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	($2,104,924)	($2,104,924)	$0	($2,104,924)
OBLIGATIONS	$3,830,452	$26,049	$0	$0	$50,281	$3,906,782	$2,480	$3,909,262
Mandatory FTE PACT Act	13	0	0	0	0	13	11	24

2023 Current Estimate
Dollars in Thousands ($000)

Veterans Access, Choice & Accountability Act of 2014, Section 801

Description	Medical Services 0160XA	Medical Support & Compl 0152XA	Medical Facilities 0162XA	Medical Care Total (continued)	Minor Cons. 0111XA	Information Technology Dev. 0167XD	Information Technology Sustain. 0167XO	Information Technology Pay & Adm 0167XZ	Section 801 Grand Total
	Mandatory								
UNOBLIGATED BALANCE (SOY)									
No-Year	$16,123	$7,172	$10,884	$34,179	$1,702	$1,026	$0	$0	$36,907
UNOBLIGATED BALANCE (EOY)									
No-Year	($10,658)	($3,780)	($3,791)	($18,229)	($1,702)	($1,026)	$0	$0	($20,957)
OBLIGATIONS [Total]	$5,465	$3,392	$7,093	$15,950	$0	$0	$0	$0	$15,950
FTE	17	24	0	41	0	0	0	0	41

2023 Current Estimate
Dollars in Thousands ($000)

Veterans Access, Choice & Accountability Act of 2014, Section 802

Description	Admin. 0172XA	Medical Care 0172XB	Emerg. Hepatitis C 0172XC	Emerg. Com. Care 0172XE	Med. Com are (Mission 0172XG	Medical Care Total (continued)	Information Technology Dev. 0172XD	Information Technology Sustain. 0172XO	Information Technology Pay & Adm 0172XZ	Section 802 Grand Total
	Mandatory						Mandatory			
UNOBLIGATED BALANCE (SOY)										
No-Year	$2,554	$76,624	$0	$772	$192,600	$272,550	$0	$0	$0	$272,550
Unobligated Balance (SOY) [Subtotal]	$2,554	$76,624	$0	$772	$192,600	$272,550	$0	$0	$0	$272,550
TRANSFER OF UNOBLIGATED BALANCE										
Within the Veterans Choice Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)										
No-Year	($2,554)	($76,624)	$0	($772)	($192,600)	($272,550)	$0	$0	$0	($272,550)
Unobligated Balance (EOY) [Subtotal]	($2,554)	($76,624)	$0	($772)	($192,600)	($272,550)	$0	$0	$0	($272,550)
OBLIGATIONS [Total]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTE [Total]	0	0	0	0	0	0	0	0	0	0

Medical Care Obligations Regular	**$120,069,303**
Medical Care Obls., ARP Act	**$4,015,141**
Medical Care Obls., PACT Act	**$3,906,782**
Medical Care Obls., VACAA, Section 801	**$15,950**
Medical Care Obls., VACAA, Section 802	**$0**
Medical Care Obligations [Grand Total]	**$128,007,176**
Medical Care FTE, Regular	**366,079**
Medical Care FTE, ARP	**3,517**
Medical Care FTE, PACT Act	**13**
Medical Care FTE, VACAA, Section 801	**41**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**369,650**

2024 Revised Request Dollars in Thousands ($000)	Discretionary				
Description	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162	Medical Care Total
APPROPRIATION					
Advance Appropriation	$74,004,000	$33,000,000	$12,300,000	$8,800,000	$128,104,000
Appropriation [Subtotal]	$74,004,000	$33,000,000	$12,300,000	$8,800,000	$128,104,000
Proposed Cancellation of Available Unobligated Balances	($4,933,113)	($1,909,069)	$0	($250,515)	($7,092,697)
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
Medical Facilities (0162)	$0	($3,919,081)	($850,000)	$0	($4,769,081)
JALFHCC (0169)	($263,141)	($70,000)	($33,751)	($55,452)	($422,344)
Transfers To [Subtotal]	($278,141)	($3,989,081)	($883,751)	($55,452)	($5,206,425)
TRANSFERS FROM (+)					
Medical Services (0160)				$0	$0
Medical Community Care (0140)				$3,919,081	$3,919,081
Medical Support & Compliance (0152)				$850,000	$850,000
Transfers From [Subtotal]	$0	$0	$0	$4,769,081	$4,769,081
Proposed Cancellation from Transferred Advance Appropriations				($4,769,081)	($4,769,081)
Reappropriation of the Transferred Cancelled Funds with a 5-Year Period of Availability				$4,769,081	$4,769,081
COLLECTIONS	$3,356,710	$892,044	$0	$0	$4,248,754
BUDGET AUTHORITY	$72,149,456	$27,993,894	$11,416,249	$13,263,114	$124,822,713
REIMBURSEMENTS	$127,577	$0	$57,424	$18,609	$203,610
UNOBLIGATED BALANCE (SOY)					
No-Year (Other)	$3,433,113	$0	$0	$0	$3,433,113
2-Year	$1,500,000	$1,909,069	$0	$250,515	$3,659,584
Unobligated Balance (SOY) [Subtotal]	$4,933,113	$1,909,069	$0	$250,515	$7,092,697
UNOBLIGATED BALANCE (EOY)					
No-Year (Other)	($2,000,000)	($820,646)	$0	$0	($2,820,646)
2-Year	($1,000,000)	($2,000,000)	$0	$0	($3,000,000)
Unobligated Balance (EOY) [Subtotal]	($3,000,000)	($2,820,646)	$0	$0	($5,820,646)
OBLIGATIONS [Total] NON-801/802	$74,210,146	$27,082,317	$11,473,673	$13,532,238	$126,298,374
FTE NON-801	293,544	0	66,534	26,501	386,579

2024 Revised Request Dollars in Thousands ($000)	Mandatory							
	Medical Care Purposes						Other Purposes	VHA PACT Sections
	Cost of War Toxic Exposure Fund							
Description	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Facilities	Medical Care Total	TEF Research	Grand Total
MANDATORY APPROPRIATION								
PACT Act § 707	$0	$0	$0	$0	$100,000	$100,000	$0	$100,000
Annual Appropriation Adjustment	$9,525,428	$850,000	$0	$6,740,264	$0	$17,115,692	$46,000	
Mandatory Appropriation [Subtotal]	$9,525,428	$850,000	$0	$6,740,264	$100,000	$17,215,692	$46,000	$100,000
UNOBLIGATED BALANCE (SOY)								
PACT Act § 705	$0	$0	$0	$0	$275,205	$275,205	$0	$275,205
PACT Act § 707	$0	$0	$0	$0	$1,829,719	$1,829,719	$0	$1,829,719
PACT Act § 806	$0	$0	$0	$0	$0	$0	$0	$0
5-year (Base Year 2023)	$0	$0	$0	$0	$0	$0		
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	$2,104,924	$2,104,924	$0	$2,104,924
REAPPORTIONMENT								
PACT Act § 806	$0	$0	$0	$0	$0	$0	$0	$0
5-year (Base Year 2023)	$0	$0	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)								
PACT Act § 705	$0	$0	$0	$0	($275,205)	($275,205)	$0	($275,205)
PACT Act § 707	$0	$0	$0	$0	($1,142,995)	($1,142,995)	$0	($1,142,995)
PACT Act § 806	$0	$0	$0	$0	$0	$0	$0	$0
5-year (Base Year 2023)	$0	$0	$0	$0	$0	$0	$0	
No-year (Base Year 2024)	($1,338,000)	$0	$0	($1,229,354)	$0	($2,567,354)	$0	
Unobligated Balance (EOY) [Subtotal]	($1,338,000)	$0	$0	($1,229,354)	($1,418,200)	($3,985,554)	$0	($1,418,200)
OBLIGATIONS	$8,187,428	$850,000	$0	$5,510,910	$786,724	$15,335,062	$46,000	$15,381,062
Mandatory FTE PACT Act	13	0	0	0	0	13	113	126

2024 Revised Request
Dollars in Thousands ($000)

Veterans Access, Choice & Accountability Act of 2014, Section 801

	Mandatory								
						Information Technology			
Description	Medical Services 0160XA	Medical Support & Compl 0152XA	Medical Facilities 0162XA	Medical Care Total (continued)	Minor Cons. 0111XA	Dev. 0167XD	Sustain. 0167XO	Pay & Adm 0167XZ	Section 801 Grand Total
UNOBLIGATED BALANCE (SOY)									
No-Year	$10,658	$3,780	$3,791	$18,229	$1,702	$1,026	$0	$0	$20,957
UNOBLIGATED BALANCE (EOY)									
No-Year	($4,980)	($256)	$0	($5,236)	($1,702)	($1,026)	$0	$0	($7,964)
OBLIGATIONS [Total]	$5,678	$3,524	$3,791	$12,993	$0	$0	$0	$0	$12,993
FTE	17	24	0	41	0	0	0	0	41

2024 Revised Request
Dollars in Thousands ($000)

Veterans Access, Choice & Accountability Act of 2014, Section 802

Description	Mandatory Admin. 0172XA	Medical Care 0172XB	Emerg. Hepatitis C 0172XC	Emerg. Com. Care 0172XE	Med. Com are (Mission 0172XG	Medical Care Total (continued)	Mandatory Information Technology Dev. 0172XD	Sustain. 0172XO	Pay & Adm 0172XZ	Section 802 Grand Total
UNOBLIGATED BALANCE (SOY)										
No-Year	$2,554	$76,624	$0	$772	$192,600	$272,550	$0	$0	$0	$272,550
Unobligated Balance (SOY) [Subtotal]	$2,554	$76,624	$0	$772	$192,600	$272,550	$0	$0	$0	$272,550
TRANSFER OF UNOBLIGATED BALANCE										
Within the Veterans Choice Fund	$0	($57,303)	$0	$0	$57,303	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)										
No-Year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OBLIGATIONS [Total]	$2,554	$19,321	$0	$772	$249,903	$272,550	$0	$0	$0	$272,550
FTE [Total]	0	0	0	0	0	0	0	0	0	0

Medical Care Obligations Regular	**$126,298,374**
Medical Care Obls., PACT Act	**$15,335,062**
Medical Care Obls., VACAA, Section 801	**$12,993**
Medical Care Obls., VACAA, Section 802	**$272,550**
Medical Care Obligations [Grand Total]	**$141,918,979**
Medical Care FTE, Regular	**386,579**
Medical Care FTE, ARP	**0**
Medical Care FTE, PACT Act	**13**
Medical Care FTE, VACAA, Section 801	**41**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**386,633**

2025 Advance Appropriation Dollars in Thousands ($000)	Discretionary				
Description	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162	Medical Care Total
APPROPRIATION					
Advance Appropriation	$71,000,000	$20,382,000	$11,800,000	$9,400,000	$112,582,000
Appropriation [Subtotal]	$71,000,000	$20,382,000	$11,800,000	$9,400,000	$112,582,000
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($287,884)	($75,000)	($35,438)	($58,225)	($456,547)
Transfers To [Subtotal]	($302,884)	($75,000)	($35,438)	($58,225)	($471,547)
TRANSFERS FROM (+)					
Transfers From [Subtotal]	$0	$0	$0	$0	$0
COLLECTIONS	$3,435,593	$907,954	$0	$0	$4,343,547
BUDGET AUTHORITY	$74,132,709	$21,214,954	$11,764,562	$9,341,775	$116,454,000
REIMBURSEMENTS	$127,577	$0	$57,424	$18,609	$203,610
UNOBLIGATED BALANCE (SOY)					
No-Year (Other)	$2,000,000	$820,646	$0	$0	$2,820,646
2-Year	$1,000,000	$2,000,000	$0	$0	$3,000,000
Unobligated Balance (SOY) [Subtotal]	$3,000,000	$2,820,646	$0	$0	$5,820,646
UNOBLIGATED BALANCE (EOY)					
No-Year (Other)	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	$0
OBLIGATIONS [Total] NON-801/802	$77,260,286	$24,035,600	$11,821,986	$9,360,384	$122,478,256
FTE NON-801	306,013	0	70,239	27,334	403,586

2025 Advance Appropriation Dollars in Thousands ($000)	Mandatory							
	Medical Care Purposes						Other Purposes	VHA PACT Sections
	Cost of War Toxic Exposure Fund					Medical Care	TEF	Grand
Description	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Facilities	Total	Research	Total
MANDATORY APPROPRIATION								
PACT Act § 707	$0	$0	$0	$0	$200,000	$200,000	$0	$200,000
Advance Appropriation	$10,336,542	$1,000,000	$0	$10,118,000	$0	$21,454,542	$0	
Mandatory Appropriation [Subtotal]	$10,336,542	$1,000,000	$0	$10,118,000	$200,000	$21,654,542	$0	$200,000
UNOBLIGATED BALANCE (SOY)								
PACT Act § 705	$0	$0	$0	$0	$275,205	$275,205	$0	$275,205
PACT Act § 707	$0	$0	$0	$0	$1,142,995	$1,142,995	$0	$1,142,995
PACT Act § 806	$0	$0	$0	$0	$0	$0	$0	$0
5-year (Base Year 2023)	$0	$0	$0	$0	$0	$0		
No-year (Base Year 2024)	$1,338,000	$0	$0	$1,229,354	$0	$2,567,354		
Unobligated Balance (EOY) [Subtotal]	$1,338,000	$0	$0	$1,229,354	$1,418,200	$3,985,554	$0	$1,418,200
UNOBLIGATED BALANCE (EOY)								
PACT Act § 705	$0	$0	$0	$0	($275,205)	($275,205)	$0	($275,205)
PACT Act § 707	$0	$0	$0	$0	($1,077,772)	($1,077,772)	$0	($1,077,772)
PACT Act § 806	$0	$0	$0	$0	$0	$0	$0	$0
5-year (Base Year 2023)	$0	$0	$0	$0	$0	$0		
No-year (Base Year 2024)	$0	$0	$0	$0	$0	$0		
No-year (Base Year 2025)	$0	$0	$0	$0	$0			
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	($1,352,977)	($1,352,977)	$0	($1,352,977)
OBLIGATIONS	$11,674,542	$1,000,000	$0	$11,347,354	$265,223	$24,287,119	$0	$24,287,119
Mandatory FTE PACT Act	13	0	0	0	0	13	0	13

2025 Advance Appropriation Dollars in Thousands ($000) Veterans Access, Choice & Accountability Act of 2014, Section 801	Mandatory								
						Information Technology			
Description	Medical Services 0160XA	Medical Support & Compl 0152XA	Medical Facilities 0162XA	Medical Care Total (continued)	Minor Cons. 0111XA	Dev. 0167XD	Sustain. 0167XO	Pay & Adm 0167XZ	Section 801 Grand Total
UNOBLIGATED BALANCE (SOY)									
No-Year	$4,980	$256	$0	$5,236	$1,702	$1,026	$0	$0	$7,964
UNOBLIGATED BALANCE (EOY)									
No-Year	$0	$0	$0	$0	($1,702)	($1,026)	$0	$0	($2,728)
OBLIGATIONS [Total]	$4,980	$256	$0	$5,236	$0	$0	$0	$0	$5,236
FTE	17	0	0	17	0	0	0	0	17

2025 Advance Appropriation
Dollars in Thousands ($000)

Veterans Access, Choice & Accountability Act of 2014, Section 802

Description	Mandatory Admin. 0172XA	Medical Care 0172XB	Emerg. Hepatitis C 0172XC	Emerg. Com. Care 0172XE	Med. Com are (Mission 0172XG	Medical Care Total (continued)	Mandatory Information Technology Dev. 0172XD	Sustain. 0172XO	Pay & Adm 0172XZ	Section 802 Grand Total
UNOBLIGATED BALANCE (SOY)										
No-Year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
TRANSFER OF UNOBLIGATED BALANCE										
Within the Veterans Choice Fund	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)										
No-Year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
OBLIGATIONS [Total]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
FTE [Total]	0	0	0	0	0	0	0	0	0	0

Medical Care Obligations Regular	**$122,478,256**
Medical Care Obls., PACT Act	**$24,287,119**
Medical Care Obls., VACAA, Section 801	**$5,236**
Medical Care Obls., VACAA, Section 802	**$0**
Medical Care Obligations [Grand Total]	**$146,770,611**
Medical Care FTE, Regular	**403,586**
Medical Care FTE, PACT Act	**13**
Medical Care FTE, VACAA, Section 801	**17**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**403,616**

American Rescue Plan Act, Section 8008: Employee Leave Fund

Section 8008 of the American Rescue Plan Act of 2021 (P.L. 117–2) provided $80.0 million to establish the Department of Veterans Affairs Emergency Employee Leave Fund. The law directed that the funds be available for payment to the Department for the use of paid leave by any employee appointed under chapter 74 of title 38, United States Code who is unable to work due to certain circumstances resulting from the COVID-19 pandemic. The authorization for the paid leave under Section 8008 is from the date of enactment of the Act, March 11, 2021, through September 30, 2021. The period of availability for Section 8008 funding is from the date of enactment of the Act, March 11, 2021, through September 20, 2022.

Tables: Obligations by Object Class by Medical Care Account

The tables that follow in the remainder of this chapter show Medical Care obligations by object class. Obligations include only Medical Care obligations and exclude VACAA section 801 actual and projected obligations for information technology and minor construction, as well as American Rescue Plan Act projected obligations for the Information Technology, Grants for Construction of State Extended Care Facilities, Medical and Prosthetics Research and all other non-VHA accounts. The 2022 and 2023 mandatory and grand total obligations to reimburse Veterans for copayments pursuant to section 8007 of the American Rescue Plan Act.

Funding from section 8002 of American Rescue Plan Act has been included in Medical Services, Medical Support and Compliance, Medical Facilities and Medical Community Care categories as projected to be allocated from the Veterans Medical Care and Health Fund. Funding from the Cost of War Toxic Exposures Fund has been included in Medical Services, Medical Support and Compliance, and Medical Community Care categories.

Obligations by Object - Medical Services Category (MS) Part 1 of 2
(dollars in thousands)

Description	Discretionary Appropriations Medical Services (Excluding FFCRA)				Discretionary Appropriations Families First Coronavirus Response Act (FFCRA)				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
10 Personnel Compensation and Benefits:												
Physicians	$7,865,947	$9,171,084	$10,383,253	$11,425,647	$0	$0	$0	$0	$4,054	$4,305	$4,472	$4,140
Dentists	$356,641	$383,800	$417,469	$448,682	$0	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$9,110,631	$11,474,718	$13,438,698	$15,023,963	$0	$0	$0	$0	$77	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$2,257,773	$2,647,962	$3,065,947	$3,474,508	$0	$0	$0	$0	$0	$0	$0	$0
Non-Physician Providers	$3,241,740	$3,712,150	$4,239,604	$4,734,653	$0	$0	$0	$0	$560	$577	$600	$559
Health Technicians/Allied Health	$9,598,679	$10,969,583	$12,535,721	$14,050,193	$0	$0	$0	$0	$46	$0	$0	$0
Wage Board/Purchase & Hire	$395,253	$445,256	$505,455	$564,012	$0	$0	$0	$0	$2	$0	$0	$0
All Other	$3,502,839	$4,155,697	$4,773,907	$5,316,878	$0	$0	$0	$0	$280	$288	$299	$281
Permanent Change of Station	$5,199	$5,305	$5,413	$5,523	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$267,388	$273,737	$279,716	$285,394	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$36,602,090	$43,239,292	$49,645,183	$55,329,453	$0	$0	$0	$0	$5,019	$5,170	$5,371	$4,980
21 Travel & Transportation of Persons:												
Employee	$29,632	$163,196	$269,928	$295,445	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$1,766,990	$2,261,747	$2,668,861	$3,069,190	$0	$0	$0	$0	$0	$0	$0	$0
Other	$34,405	$59,405	$84,405	$109,405	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,831,027	$2,484,348	$3,023,194	$3,474,040	$0	$0	$0	$0	$0	$0	$0	$0
22 Transportation of Things	$29,575	$32,266	$34,806	$37,346	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:												
Rental of Equipment	$273,887	$338,887	$403,887	$468,887	$0	$0	$0	$0	$0	$0	$0	$0
Communications	$405,935	$421,484	$432,635	$443,766	$0	$0	$0	$0	$0	$0	$0	$0
Utilities	$803	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$29,244	$30,911	$32,178	$33,465	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$709,869	$791,282	$868,700	$946,118	$0	$0	$0	$0	$0	$0	$0	$0
24 Printing & Reproduction:	$19,016	$25,517	$32,018	$38,519	$0	$0	$0	$0	$0	$0	$0	$0
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$6,185	$4,814	$1,098	$747	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$294,917	$228,207	$52,035	$35,397	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$354,501	$274,682	$62,632	$42,605	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$58,222	$45,059	$10,274	$6,989	$0	$0	$0	$0	$0	$0	$0	$0
Care in the Community Hospital Care	($87)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$303,024	$234,480	$53,465	$36,370	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$219,978	$170,219	$38,813	$26,402	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$17,846	$14,333	$3,268	$2,223	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$95,921	$88,965	$20,285	$13,799	$0	$0	$0	$0	$0	$0	$0	$0
House Staff Disbursing Agreement	$765,388	$592,206	$135,032	$91,856	$0	$0	$0	$0	($66)	$0	$0	$0
Scarce Medical Specialists	$267,978	$210,302	$47,952	$32,619	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$1,744,938	$1,359,234	$309,669	$210,861	$0	$0	$0	$0	($24)	$295	$307	$0
Administrative Contract Services	$1,502,284	$1,178,129	$268,647	$182,748	$0	$0	$0	$0	$9	$0	$0	$0
Training Contract Services	$95,580	$76,691	$17,487	$11,895	$0	$0	$0	$0	$5	$0	$0	$0
Caregiver Stipends	$910,670	$1,543,422	$1,982,190	$2,301,867	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$13,886	$17,718	$21,722	$24,295	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$6,651,231	$6,038,461	$3,024,569	$3,020,673	$0	$0	$0	$0	($76)	$295	$307	$0

Obligations by Object - Medical Services Category (MS) Part 1 of 2
(dollars in thousands)

Description	Discretionary Appropriations Medical Services (Excluding FFCRA)				Discretionary Appropriations Families First Coronavirus Response Act (FFCRA)				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
26 Supplies & Materials:												
Provisions	$127,541	$134,811	$140,338	$145,952	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$6,901,398	$8,255,247	$7,431,511	$7,314,276	$0	$0	$0	$0	$0	$0	$0	$0
Blood & Blood Products	$50,676	$60,617	$57,138	$56,237	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$1,918,862	$3,255,003	$1,988,861	$519,925	$200	$0	$0	$0	$5	$0	$0	$0
Operating Supplies	$274,913	$290,583	$302,497	$314,597	$0	$0	$0	$0	$45	$0	$0	$0
Maintenance & Repair Supplies	$40,300	$42,597	$44,343	$46,117	$0	$0	$0	$0	$23	$0	$0	$0
Other Supplies	$233,617	$246,933	$257,057	$267,339	$0	$0	$0	$0	$1	$0	$0	$0
Prosthetic Appliances	$3,164,510	$3,526,498	$3,887,110	$4,272,600	$0	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$31,469	$35,069	$38,655	$42,488	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$12,743,286	$15,847,358	$14,147,510	$12,979,531	$200	$0	$0	$0	$74	$0	$0	$0
31 Equipment	$1,795,908	$1,973,812	$2,054,739	$0	$0	$0	$0	$0	$198	$0	$0	$0
32 Lands & Structures:												
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$4,536	$4,794	$4,990	$5,190	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$4,536	$4,794	$4,990	$5,190	$0	$0	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:												
State Home	-$960	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$742,194	$1,301,608	$1,354,974	$1,409,175	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$2	$2	$2	$2	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$741,236	$1,301,610	$1,354,976	$1,409,177	$0	$0	$0	$0	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$17,676	$18,694	$19,461	$20,239	$0	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$61,145,450	$71,757,434	$74,210,146	$77,260,286	$200	$0	$0	$0	$5,215	$5,465	$5,678	$4,980
Prior Year Recoveries	$110,332	$0	$0	$0	$773	$0	$0	$0	$91	$0	$0	$0
Obligations [Total]	**$61,255,782**	**$71,757,434**	**$74,210,146**	**$77,260,286**	**$973**	**$0**	**$0**	**$0**	**$5,306**	**$5,465**	**$5,678**	**$4,980**

Obligations by Object - Medical Services Category (MS) Part 2 of 2
(dollars in thousands)

Description	Mandatory Appropriations American Resuce Plan Act, sec. 8002, 8007 FY 2022	FY 2023	FY 2024	FY 2025	Mandatory Appropriations Cost of War Toxic Exposures Fund FY 2022	FY 2023	FY 2024	FY 2025	Discretionary and Mandatory Grand Total Medical Services Category FY 2022	FY 2023	FY 2024	FY 2025
10 Personnel Compensation and Benefits:												
Physicians	$675,485	$181,487	$0	$0	$0	$0	$0	$0	$8,545,486	$9,356,876	$10,387,725	$11,429,787
Dentists	$3,495	$969	$0	$0	$0	$0	$0	$0	$360,136	$384,769	$417,469	$448,682
Registered Nurses	$1,455,316	$366,979	$0	$0	$0	$0	$0	$0	$10,566,024	$11,841,697	$13,438,698	$15,023,963
LP Nurse/LV Nurse/Nurse Assistant	$109,258	$27,375	$0	$0	$0	$0	$0	$0	$2,367,031	$2,675,337	$3,065,947	$3,474,508
Non-Physician Providers	$97,472	$26,871	$0	$0	$0	$0	$0	$0	$3,339,772	$3,739,598	$4,240,204	$4,735,212
Health Technicians/Allied Health	$238,371	$61,234	$0	$0	$0	$0	$0	$0	$9,837,096	$11,030,817	$12,535,721	$14,050,193
Wage Board/Purchase & Hire	$3,335	$836	$0	$0	$0	$0	$0	$0	$398,590	$446,092	$505,455	$564,012
All Other	$281,091	$67,088	$0	$0	$0	$1,476	$1,900	$2,000	$3,784,210	$4,224,549	$4,776,106	$5,319,159
Permanent Change of Station	$0	$0	$0	$0	$0	$0	$0	$0	$5,199	$5,305	$5,413	$5,523
Employee Compensation Pay	$1,309	$414	$0	$0	$0	$0	$0	$0	$268,697	$274,151	$279,716	$285,394
Subtotal	$2,865,132	$733,253	$0	$0	$0	$1,476	$1,900	$2,000	$39,472,241	$43,979,191	$49,652,454	$55,336,433
21 Travel & Transportation of Persons:												
Employee	$18,484	$0	$0	$0	$0	$0	$0	$0	$48,116	$163,196	$269,928	$295,445
Beneficiary	$95,993	$0	$0	$0	$0	$0	$0	$0	$1,862,983	$2,261,747	$2,668,861	$3,069,190
Other	$0	$0	$0	$0	$0	$0	$0	$0	$34,405	$59,405	$84,405	$109,405
Subtotal	$114,477	$0	$0	$0	$0	$0	$0	$0	$1,945,504	$2,484,348	$3,023,194	$3,474,040
22 Transportation of Things	$150	$0	$0	$0	$0	$0	$0	$0	$29,725	$32,266	$34,806	$37,346
23 Rent, Communications, and Utilities:												
Rental of Equipment	$1,126	$0	$0	$0	$0	$0	$0	$0	$275,013	$338,887	$403,887	$468,887
Communications	$206	$0	$0	$0	$0	$0	$0	$0	$406,141	$421,484	$432,635	$443,766
Utilities	$22	$0	$0	$0	$0	$0	$0	$0	$825	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$2,642	$0	$0	$0	$0	$0	$0	$0	$31,886	$30,911	$32,178	$33,465
Subtotal	$3,996	$0	$0	$0	$0	$0	$0	$0	$713,865	$791,282	$868,700	$946,118
24 Printing & Reproduction:	$0	$0	$0	$0	$0	$0	$0	$0	$19,016	$25,517	$32,018	$38,519
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$36	$0	$0	$0	$0	$2,662	$5,690	$5,817	$6,221	$7,476	$6,788	$6,564
Medical and Nursing Care in the Community	$0	$0	$0	$0	$0	$126,178	$269,764	$275,785	$294,917	$354,385	$321,799	$311,182
Repairs to Furniture/Equipment	$477	$0	$0	$0	$0	$151,875	$324,703	$331,950	$354,978	$426,557	$387,335	$374,555
Maintenance & Repair Contract Services	$9	$0	$0	$0	$0	$24,914	$53,265	$54,453	$58,231	$69,973	$63,539	$61,442
Care in the Community Hospital Care	$0	$0	$0	$0	$0	$0	$0	$0	($87)	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$129,647	$277,180	$283,366	$303,024	$364,127	$330,645	$319,736
Home Oxygen	$0	$0	$0	$0	$0	$94,116	$201,217	$205,708	$219,978	$264,335	$240,030	$232,110
Organ Procurement	$677	$0	$0	$0	$0	$7,925	$16,943	$17,321	$18,523	$22,258	$20,211	$19,544
Personal Services Contracts	$19,050	$0	$0	$0	$0	$49,190	$105,165	$107,513	$114,971	$138,155	$125,450	$121,312
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$327,438	$700,050	$715,674	$765,322	$919,644	$835,082	$807,530
Scarce Medical Specialists	$3,800	$0	$0	$0	$0	$116,278	$248,599	$254,147	$271,778	$326,580	$296,551	$286,766
Other Medical Contract Services	$12,030	$0	$0	$0	$0	$751,695	$1,607,022	$1,642,885	$1,756,944	$2,111,224	$1,916,998	$1,853,746
Administrative Contract Services	$20,317	$2,847	$0	$0	$0	$651,401	$1,392,751	$1,423,835	$1,522,610	$1,832,377	$1,661,398	$1,606,583
Training Contract Services	$3,524	$0	$0	$0	$0	$42,403	$90,656	$92,680	$99,109	$119,094	$108,143	$104,575
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0	$910,670	$1,543,422	$1,982,190	$2,301,867
CHAMPVA	$0	$0	$0	$0	$0	$0	$0	$0	$13,886	$17,718	$21,722	$24,295
Subtotal	$59,920	$2,847	$0	$0	$0	$2,475,722	$5,293,005	$5,411,134	$6,711,075	$8,517,325	$8,317,881	$8,431,807

Obligations by Object - Medical Services Category (MS) Part 2 of 2
(dollars in thousands)

Description	Mandatory Appropriations American Resuce Plan Act, sec. 8002, 8007				Mandatory Appropriations Cost of War Toxic Exposures Fund				Discretionary and Mandatory Grand Total Medical Services Category			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
26 Supplies & Materials:												
Provisions	$132	$0	$0	$0	$0	$0	$0	$0	$127,673	$134,811	$140,338	$145,952
Drugs & Medicines	$1,713,638	$0	$0	$0	$0	$1,353,254	$2,892,523	$4,124,480	$8,615,036	$9,608,501	$10,324,034	$11,438,756
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$50,676	$60,617	$57,138	$56,237
Medical/Dental Supplies	$220,135	$0	$0	$0	$0	$0	$0	$0	$2,139,202	$3,255,003	$1,988,861	$519,925
Operating Supplies	$26,131	$0	$0	$0	$0	$0	$0	$0	$301,089	$290,583	$302,497	$314,597
Maintenance & Repair Supplies	$13	$0	$0	$0	$0	$0	$0	$0	$40,336	$42,597	$44,343	$46,117
Other Supplies	$2,062	$0	$0	$0	$0	$0	$0	$0	$235,680	$246,933	$257,057	$267,339
Prosthetic Appliances	$34	$0	$0	$0	$0	$0	$0	$0	$3,164,544	$3,526,498	$3,887,110	$4,272,600
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$31,469	$35,069	$38,655	$42,488
Subtotal	$1,962,145	$0	$0	$0	$0	$1,353,254	$2,892,523	$4,124,480	$14,705,705	$17,200,612	$17,040,033	$17,104,011
31 Equipment	$71,265	$0	$0	$0	$0	$0	$0	$2,136,928	$1,867,371	$1,973,812	$2,054,739	$2,136,928
32 Lands & Structures:												
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$5	$0	$0	$0	$0	$0	$0	$0	$4,541	$4,794	$4,990	$5,190
Subtotal	$5	$0	$0	$0	$0	$0	$0	$0	$4,541	$4,794	$4,990	$5,190
41 Grants, Subsidies & Contributions:												
State Home	$0	$0	$0	$0	$0	$0	$0	$0	-$960	$0	$0	$0
Grants	$490,184	$0	$0	$0	$0	$0	$0	$0	$1,232,378	$1,301,608	$1,354,974	$1,409,175
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$2	$2	$2	$2
Subtotal	$490,184	$0	$0	$0	$0	$0	$0	$0	$1,231,420	$1,301,610	$1,354,976	$1,409,177
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$0	$0	$0	$0	$17,676	$18,694	$19,461	$20,239
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$5,567,274	$736,100	$0	$0	$0	$3,830,452	$8,187,428	$11,674,542	$66,718,139	$76,329,451	$82,403,252	$88,939,808
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0	$0	$111,196	$0	$0	$0
Obligations [Total]	**$5,567,274**	**$736,100**	**$0**	**$0**	**$0**	**$3,830,452**	**$8,187,428**	**$11,674,542**	**$66,829,335**	**$76,329,451**	**$82,403,252**	**$88,939,808**

Obligations by Object - Medical Support And Compliance Category (MSC) Part 1 of 2

(dollars in thousands)

Description	Discretionary Appropriations Medical Support And Compliance				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)				Mandatory Appropriations Veterans Medical Care and Health Fund			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
10 Personnel Compensation and Benefits:												
Physicians	$289,627	$334,885	$380,952	$428,572	$107	$0	$0	$0	$3,315	$0	$0	$0
Dentists	$5,381	$6,354	$7,235	$8,136	$0	$0	$0	$0	$244	$0	$0	$0
Registered Nurses	$592,843	$696,248	$803,838	$912,931	$467	$486	$511	$0	$10,178	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$6,717	$7,480	$8,417	$9,396	$26	$0	$0	$0	$28	$0	$0	$0
Non-Physician Providers	$58,961	$68,333	$78,992	$89,805	$62	$0	$0	$0	$82	$0	$0	$0
Health Technicians/Allied Health	$146,035	$169,805	$196,550	$223,819	$58	$0	$0	$0	$685	$0	$0	$0
Wage Board/Purchase & Hire	$89,967	$105,461	$122,068	$138,942	$0	$0	$0	$0	$1,003	$0	$0	$0
All Other	$5,292,211	$6,276,524	$7,214,429	$8,149,055	$1,581	$1,646	$1,729	$0	$133,872	$0	$0	$0
Permanent Change of Station	$10,281	$10,490	$10,703	$10,920	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$34,799	$38,361	$39,140	$39,935	$0	$0	$0	$0	$2,799	$0	$0	$0
Subtotal	$6,526,822	$7,713,941	$8,862,324	$10,011,511	$2,301	$2,132	$2,240	$0	$152,206	$0	$0	$0
21 Travel & Transportation of Persons:												
Employee	$29,621	$48,097	$66,437	$84,773	$10	$0	$0	$0	$199	$0	$0	$0
Beneficiary	$5	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$5,591	$5,973	$6,218	$6,467	$0	$0	$0	$0	$60	$0	$0	$0
Subtotal	$35,217	$54,070	$72,655	$91,240	$10	$0	$0	$0	$259	$0	$0	$0
22 Transportation of Things	$14,009	$15,084	$15,702	$16,330	$0	$0	$0	$0	$262	$0	$0	$0
23 Rent, Communications, and Utilities:												
Rental of Equipment	$68,365	$79,742	$87,047	$94,618	$0	$0	$0	$0	$1,902	$0	$0	$0
Communications	$66,331	$79,990	$88,475	$96,694	$0	$0	$0	$0	$1,894	$0	$0	$0
Utilities	$190	$0	$0	$0	$0	$0	$0	$0	$2	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$4,740	$0	$0	$0	$0	$0	$0	$0	$519	$0	$0	$0
Subtotal	$139,626	$159,732	$175,522	$191,312	$0	$0	$0	$0	$4,317	$0	$0	$0
24 Printing & Reproduction:	$36,340	$50,569	$64,796	$79,023	$0	$0	$0	$0	$1	$0	$0	$0
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$2,272	$2,402	$2,500	$2,600	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$4,476	$4,731	$4,925	$5,122	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$3,114	$3,291	$3,426	$3,563	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Care in the Community Hospital Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$305	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$11,313	$11,958	$12,448	$12,946	$0	$0	$0	$0	$0	$0	$0	$0
House Staff Disbursing Agreement	$149	$157	$163	$170	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$494	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$11,386	$12,035	$12,528	$13,029	$0	$0	$0	$0	$354	$0	$0	$0
Administrative Contract Services	$1,353,048	$1,957,397	$1,813,570	$1,084,229	-$1	$1,260	$1,284	$256	$287,827	$502,305	$0	$0
Training Contract Services	$63,450	$92,630	$96,428	$100,285	$248	$0	$0	$0	$3,937	$0	$0	$0
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,450,007	$2,084,601	$1,945,988	$1,221,944	$247	$1,260	$1,284	$256	$292,118	$502,305	$0	$0

Obligations by Object - Medical Support And Compliance Category (MSC) Part 1 of 2

(dollars in thousands)

Description	Discretionary Appropriations Medical Support And Compliance				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)				Mandatory Appropriations Veterans Medical Care and Health Fund			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
26 Supplies & Materials:												
Provisions	$2,769	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$11	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$1,344	$0	$0	$0	$56	$0	$0	$0	$7	$0	$0	$0
Operating Supplies	$41,456	$61,456	$63,976	$66,535	$442	$0	$0	$0	$1,135	$0	$0	$0
Maintenance & Repair Supplies	$661	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$64,089	$99,254	$106,746	$114,199	$23	$0	$0	$0	$417	$0	$0	$0
Prosthetic Appliances	$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$4	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$110,335	$160,710	$170,722	$180,734	$521	$0	$0	$0	$1,559	$0	$0	$0
31 Equipment	$51,838	$112,319	$147,840	$11,043	$166	$0	$0	$0	$24,794	$0	$0	$0
32 Lands & Structures:												
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$1,594	$1,685	$1,754	$1,824	$0	$0	$0	$0	$283	$0	$0	$0
Subtotal	$1,594	$1,685	$1,754	$1,824	$0	$0	$0	$0	$283	$0	$0	$0
41 Grants, Subsidies & Contributions:												
State Home	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$14,265	$15,725	$16,370	$17,025	$0	$0	$0	$0	$329	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$8,380,054	$10,368,436	$11,473,673	$11,821,986	$3,245	$3,392	$3,524	$256	$476,128	$502,305	$0	$0
Prior Year Recoveries	$540	$0	$0	$0	$48	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$8,380,594**	**$10,368,436**	**$11,473,673**	**$11,821,986**	**$3,293**	**$3,392**	**$3,524**	**$256**	**$476,128**	**$502,305**	**$0**	**$0**

Obligations by Object - Medical Support And Compliance Category (MSC) Part 2 of 2
(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund				Discretionary and Mandatory Grand Total Medical Support And Compliance Category			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
10 Personnel Compensation and Benefits:								
Physicians	$0	$0	$0	$0	$293,049	$334,885	$380,952	$428,572
Dentists	$0	$0	$0	$0	$5,625	$6,354	$7,235	$8,136
Registered Nurses	$0	$0	$0	$0	$603,488	$696,734	$804,349	$912,931
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$6,771	$7,480	$8,417	$9,396
Non-Physician Providers	$0	$0	$0	$0	$59,105	$68,333	$78,992	$89,805
Health Technicians/Allied Health	$0	$0	$0	$0	$146,778	$169,805	$196,550	$223,819
Wage Board/Purchase & Hire	$0	$0	$0	$0	$90,970	$105,461	$122,068	$138,942
All Other	$0	$0	$0	$0	$5,427,664	$6,278,170	$7,216,158	$8,149,055
Permanent Change of Station	$0	$0	$0	$0	$10,281	$10,490	$10,703	$10,920
Employee Compensation Pay	$0	$0	$0	$0	$37,598	$38,361	$39,140	$39,935
Subtotal	$0	$0	$0	$0	$6,681,329	$7,716,073	$8,864,564	$10,011,511
21 Travel & Transportation of Persons:								
Employee	$0	$0	$0	$0	$29,830	$48,097	$66,437	$84,773
Beneficiary	$0	$0	$0	$0	$5	$0	$0	$0
Other	$0	$0	$0	$0	$5,651	$5,973	$6,218	$6,467
Subtotal	$0	$0	$0	$0	$35,486	$54,070	$72,655	$91,240
22 Transportation of Things	$0	$0	$0	$0	$14,271	$15,084	$15,702	$16,330
23 Rent, Communications, and Utilities:								
Rental of Equipment	$0	$0	$0	$0	$70,267	$79,742	$87,047	$94,618
Communications	$0	$0	$0	$0	$68,225	$79,990	$88,475	$96,694
Utilities	$0	$0	$0	$0	$192	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$0	$0	$0	$0	$5,259	$0	$0	$0
Subtotal	$0	$0	$0	$0	$143,943	$159,732	$175,522	$191,312
24 Printing & Reproduction:	$0	$0	$0	$0	$36,341	$50,569	$64,796	$79,023
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$0	$0	$0	$0	$2,272	$2,402	$2,500	$2,600
Medical and Nursing Care in the Community	$0	$0	$0	$0	$4,476	$4,731	$4,925	$5,122
Repairs to Furniture/Equipment	$0	$0	$0	$0	$3,114	$3,291	$3,426	$3,563
Maintenance & Repair Contract Services	$0	$0	$0	$0	$0	$0	$0	$0
Care in the Community Hospital Care	$0	$0	$0	$0	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$305	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$0	$0	$0	$0	$11,313	$11,958	$12,448	$12,946
House Staff Disbursing Agreement	$0	$0	$0	$0	$149	$157	$163	$170
Scarce Medical Specialists	$0	$0	$0	$0	$494	$0	$0	$0
Other Medical Contract Services	$0	$0	$0	$0	$11,740	$12,035	$12,528	$13,029
Administrative Contract Services	$0	$26,049	$850,000	$1,000,000	$1,640,874	$2,487,011	$2,664,854	$2,084,485
Training Contract Services	$0	$0	$0	$0	$67,635	$92,630	$96,428	$100,285
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$26,049	$850,000	$1,000,000	$1,742,372	$2,614,215	$2,797,272	$2,222,200

Obligations by Object - Medical Support And Compliance Category (MSC) Part 2 of 2

(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund				Discretionary and Mandatory Grand Total Medical Support And Compliance Category			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
26 Supplies & Materials:								
Provisions	$0	$0	$0	$0	$2,769	$0	$0	$0
Drugs & Medicines	$0	$0	$0	$0	$11	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$0	$0	$0	$0	$1,407	$0	$0	$0
Operating Supplies	$0	$0	$0	$0	$43,033	$61,456	$63,976	$66,535
Maintenance & Repair Supplies	$0	$0	$0	$0	$661	$0	$0	$0
Other Supplies	$0	$0	$0	$0	$64,529	$99,254	$106,746	$114,199
Prosthetic Appliances	$0	$0	$0	$0	$1	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$4	$0	$0	$0
Subtotal	$0	$0	$0	$0	$112,415	$160,710	$170,722	$180,734
31 Equipment	$0	$0	$0	$0	$76,798	$112,319	$147,840	$11,043
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$1,877	$1,685	$1,754	$1,824
Subtotal	$0	$0	$0	$0	$1,877	$1,685	$1,754	$1,824
41 Grants, Subsidies & Contributions:								
State Home	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$1	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$1	$0	$0	$0
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$14,594	$15,725	$16,370	$17,025
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$26,049	$850,000	$1,000,000	$8,859,427	$10,900,182	$12,327,197	$12,822,242
Prior Year Recoveries	$0	$0	$0	$0	$588	$0	$0	$0
Obligations [Total]	**$0**	**$26,049**	**$850,000**	**$1,000,000**	**$8,860,015**	**$10,900,182**	**$12,327,197**	**$12,822,242**

Obligations by Object - Medical Facilities Category (MF) Part 1 of 2
(dollars in thousands)

Description	Discretionary Appropriations Medical Facilities				Discretionary Appropriations Recurring Expenses Transformational Funding				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
10 Personnel Compensation and Benefits:												
Physicians	$83	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Dentists	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$958	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$231	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Physician Providers	$109	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Technicians/Allied Health	$12,507	$14,950	$16,972	$19,009	$0	$0	$0	$0	$0	$0	$0	$0
Wage Board/Purchase & Hire	$1,429,621	$1,814,329	$2,047,845	$2,278,130	$0	$0	$0	$0	$37	$0	$0	$0
All Other	$499,635	$636,165	$721,507	$807,077	$0	$0	$0	$0	$0	$0	$0	$0
Permanent Change of Station	$735	$750	$765	$781	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$36,292	$37,489	$38,250	$39,026	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,980,171	$2,503,683	$2,825,339	$3,144,023	$0	$0	$0	$0	$37	$0	$0	$0
21 Travel & Transportation of Persons:												
Employee	$5,156	$5,450	$5,673	$5,900	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$3	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$49,915	$52,763	$54,926	$57,123	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$55,074	$58,213	$60,599	$63,023	$0	$0	$0	$0	$0	$0	$0	$0
22 Transportation of Things	$16,027	$16,941	$17,636	$18,341	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:												
Rental of Equipment	$14,941	$15,793	$16,441	$17,099	$0	$0	$0	$0	$1	$0	$0	$0
Communications	$43,883	$46,384	$48,286	$50,217	$0	$0	$0	$0	$0	$0	$0	$0
Utilities	$605,951	$688,173	$716,388	$745,044	$0	$0	$0	$0	$0	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$773,599	$1,185,375	$1,201,871	$1,428,680	$0	$0	$0	$0	$2	$6,575	$3,252	$0
Subtotal	$1,438,374	$1,935,725	$1,982,986	$2,241,040	$0	$0	$0	$0	$3	$6,575	$3,252	$0
24 Printing & Reproduction:	$63	$67	$70	$73	$0	$0	$0	$0	$0	$0	$0	$0
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$132	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$32	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$24,855	$18,107	$27,685	$28,792	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$313,661	$222,720	$346,724	$360,593	$0	$0	$0	$0	$170	$0	$0	$0
Care in the Community Hospital Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$2,332	$2,467	$2,568	$2,671	$0	$0	$0	$0	$0	$0	$0	$0
House Staff Disbursing Agreement	$19	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$21,441	$22,663	$23,592	$24,536	$0	$0	$0	$0	$0	$0	$0	$0
Administrative Contract Services	$624,139	$844,647	$1,428,668	$1,354,066	$0	$0	$0	$0	($122)	$518	$539	$0
Training Contract Services	$1,230	$1,308	$1,362	$1,416	$0	$0	$0	$0	$0	$0	$0	$0
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$987,841	$1,111,912	$1,830,599	$1,772,074	$0	$0	$0	$0	$48	$518	$539	$0

Obligations by Object - Medical Facilities Category (MF) Part 1 of 2
(dollars in thousands)

Description	Discretionary Appropriations Medical Facilities				Discretionary Appropriations Recurring Expenses Transformational Funding				Mandatory Appropriations Veterans Access, Choice, and Accountability Act (VACAA)			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
26 Supplies & Materials:												
Provisions	$96	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$427	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$2,584	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Operating Supplies	$165,184	$174,599	$181,758	$189,028	$0	$0	$0	$0	$117	$0	$0	$0
Maintenance & Repair Supplies	$194,689	$209,404	$217,990	$226,710	$0	$0	$0	$0	$185	$0	$0	$0
Other Supplies	$59,359	$62,742	$65,314	$67,927	$0	$0	$0	$0	$0	$0	$0	$0
Prosthetic Appliances	$12	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$422,351	$446,745	$465,062	$483,665	$0	$0	$0	$0	$302	$0	$0	$0
31 Equipment	$141,365	$149,963	$156,111	$162,355	$0	$0	$0	$0	$512	$0	$0	$0
32 Lands & Structures:												
Non-Recurring Maintenance	$1,480,758	$2,509,475	$5,750,000	$995,000	$0	$75,000	$0	$0	$99	$0	$0	$0
All Other Lands & Structures	$321,889	$423,932	$434,531	$471,113	$0	$0	$0	$0	$4,207	$0	$0	$0
Subtotal	$1,802,647	$2,933,407	$6,184,531	$1,466,113	$0	$75,000	$0	$0	$4,306	$0	$0	$0
41 Grants, Subsidies & Contributions:												
State Home	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$0	$0	$0	$0	$3	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$3	$0	$0	$0
42 - Insurance Claims and Indemnities	$8,457	$8,939	$9,305	$9,677	$0	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$6,852,370	$9,165,595	$13,532,238	$9,360,384	$0	$75,000	$0	$0	$5,211	$7,093	$3,791	$0
Prior Year Recoveries	$31,923	$0	$0	$0	$0	$0	$0	$0	$3,488	$0	$0	$0
Obligations [Total]	**$6,884,293**	**$9,165,595**	**$13,532,238**	**$9,360,384**	**$0**	**$75,000**	**$0**	**$0**	**$8,699**	**$7,093**	**$3,791**	**$0**

Obligations by Object - Medical Facilities Category (MF) Part 2 of 2

(dollars in thousands)

Description	Mandatory Appropriations Veterans Medical Care and Health Fund				Mandatory Appropriations PACT Act, sec. 707				Discretionary and Mandatory Grand Total Medical Facilities Category			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
10 Personnel Compensation and Benefits:												
Physicians	$0	$0	$0	$0	$0	$0	$0	$0	$83	$0	$0	$0
Dentists	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	-$410	$0	$0	$0	$0	$0	$0	$0	$548	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$0	$0	$0	$0	$231	$0	$0	$0
Non-Physician Providers	$0	$0	$0	$0	$0	$0	$0	$0	$109	$0	$0	$0
Health Technicians/Allied Health	$901	$0	$0	$0	$0	$0	$0	$0	$13,408	$14,950	$16,972	$19,009
Wage Board/Purchase & Hire	$202,815	$0	$0	$0	$0	$0	$0	$0	$1,632,473	$1,814,329	$2,047,845	$2,278,130
All Other	$70,120	$0	$0	$0	$0	$0	$0	$0	$569,755	$636,165	$721,507	$807,077
Permanent Change of Station	$0	$0	$0	$0	$0	$0	$0	$0	$735	$750	$765	$781
Employee Compensation Pay	$451	$0	$0	$0	$0	$0	$0	$0	$36,743	$37,489	$38,250	$39,026
Subtotal	$273,877	$0	$0	$0	$0	$0	$0	$0	$2,254,085	$2,503,683	$2,825,339	$3,144,023
21 Travel & Transportation of Persons:												
Employee	$1	$0	$0	$0	$0	$0	$0	$0	$5,157	$5,450	$5,673	$5,900
Beneficiary	$0	$0	$0	$0	$0	$0	$0	$0	$3	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0	$49,915	$52,763	$54,926	$57,123
Subtotal	$1	$0	$0	$0	$0	$0	$0	$0	$55,075	$58,213	$60,599	$63,023
22 Transportation of Things	$1	$0	$0	$0	$0	$0	$0	$0	$16,028	$16,941	$17,636	$18,341
23 Rent, Communications, and Utilities:												
Rental of Equipment	$34	$0	$0	$0	$0	$0	$0	$0	$14,976	$15,793	$16,441	$17,099
Communications	$0	$0	$0	$0	$0	$0	$0	$0	$43,883	$46,384	$48,286	$50,217
Utilities	$45,111	$0	$0	$0	$0	$0	$0	$0	$651,062	$688,173	$716,388	$745,044
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$85,875	$0	$0	$0	$0	$42,236	$660,848	$222,787	$859,476	$1,234,186	$1,865,971	$1,651,467
Subtotal	$131,020	$0	$0	$0	$0	$42,236	$660,848	$222,787	$1,569,397	$1,984,536	$2,647,086	$2,463,827
24 Printing & Reproduction:	$8	$0	$0	$0	$0	$0	$0	$0	$71	$67	$70	$73
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$0	$0	$0	$0	$0	$0	$0	$0	$132	$0	$0	$0
Medical and Nursing Care in the Community	$0	$0	$0	$0	$0	$0	$0	$0	$32	$0	$0	$0
Repairs to Furniture/Equipment	$306	$8,488	$0	$0	$0	$0	$0	$0	$25,161	$26,595	$27,685	$28,792
Maintenance & Repair Contract Services	$1,446	$110,348	$0	$0	$0	$0	$0	$0	$315,277	$333,068	$346,724	$360,593
Care in the Community Hospital Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$2	$0	$0	$0	$0	$0	$0	$0	$2,334	$2,467	$2,568	$2,671
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$0	$0	$0	$19	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$0	$0	$0	$0	$0	$0	$0	$0	$21,441	$22,663	$23,592	$24,536
Administrative Contract Services	$18,119	$220,695	$0	$0	$0	$0	$0	$0	$642,136	$1,065,860	$1,429,207	$1,354,066
Training Contract Services	$7	$0	$0	$0	$0	$0	$0	$0	$1,237	$1,308	$1,362	$1,416
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$19,880	$339,531	$0	$0	$0	$0	$0	$0	$1,007,769	$1,451,961	$1,831,138	$1,772,074

Obligations by Object - Medical Facilities Category (MF) Part 2 of 2
(dollars in thousands)

Description	Mandatory Appropriations Veterans Medical Care and Health Fund				Mandatory Appropriations PACT Act, sec. 707				Discretionary and Mandatory Grand Total Medical Facilities Category			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
26 Supplies & Materials:												
Provisions	$0	$0	$0	$0	$0	$0	$0	$0	$96	$0	$0	$0
Drugs & Medicines	$0	$0	$0	$0	$0	$0	$0	$0	$427	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$2,090	$0	$0	$0	$0	$0	$0	$0	$4,674	$0	$0	$0
Operating Supplies	$3,714	$0	$0	$0	$0	$0	$0	$0	$169,015	$174,599	$181,758	$189,028
Maintenance & Repair Supplies	$888	$0	$0	$0	$0	$0	$0	$0	$195,762	$209,404	$217,990	$226,710
Other Supplies	$122	$0	$0	$0	$0	$0	$0	$0	$59,481	$62,742	$65,314	$67,927
Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0	$12	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$6,814	$0	$0	$0	$0	$0	$0	$0	$429,467	$446,745	$465,062	$483,665
31 Equipment	$10,745	$0	$0	$0	$0				$152,622	$149,963	$156,111	$162,355
32 Lands & Structures:												
Non-Recurring Maintenance	$1,349,483	$432,525	$0	$0	$0	$0	$0	$0	$2,830,340	$3,017,000	$5,750,000	$995,000
All Other Lands & Structures	$9,073	$0	$0	$0	$0	$8,045	$125,876	$42,436	$335,169	$431,977	$560,407	$513,549
Subtotal	$1,358,556	$432,525	$0	$0	$0	$8,045	$125,876	$42,436	$3,165,509	$3,448,977	$6,310,407	$1,508,549
41 Grants, Subsidies & Contributions:												
State Home	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$0	$0	$0	$0	$3	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$3	$0	$0	$0
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$0	$0	$0	$0	$8,457	$8,939	$9,305	$9,677
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,800,902	$772,056	$0	$0	$0	$50,281	$786,724	$265,223	$8,658,483	$10,070,025	$14,322,753	$9,625,607
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0	$0	$35,411	$0	$0	$0
Obligations [Total]	**$1,800,902**	**$772,056**	**$0**	**$0**	**$0**	**$50,281**	**$786,724**	**$265,223**	**$8,693,894**	**$10,070,025**	**$14,322,753**	**$9,625,607**

Obligations by Object - Medical Community Care Category (MCC) - Part 1 of 2
(dollars in thousands)

Description	Discretionary Appropriations Medical Community Care				Mandatory Appropriations Veterans Choice Fund				Mandatory Appropriations American Resuce Plan Act, sec. 8002, 8007			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
10 Personnel Compensation and Benefits:												
Physicians	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Dentists	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Physician Providers	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Health Technicians/Allied Health	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Wage Board/Purchase & Hire	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
All Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Permanent Change of Station	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
21 Travel & Transportation of Persons:												
Employee	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$2,791	$2,950	$3,071	$3,194	$2	$0	$0	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$2,791	$2,950	$3,071	$3,194	$2	$0	$0	$0	$0	$0	$0	$0
22 Transportation of Things	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:												
Rental of Equipment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Communications	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Utilities	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
24 Printing & Reproduction:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$711,806	$1,041,713	$1,102,822	$1,158,811	-$153	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$8,453,162	$9,261,479	$10,023,476	$11,237,080	-$12,037	$0	$19,321	$0	$95,888	$176	$0	$0
Repairs to Furniture/Equipment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Care in the Community Hospital Care	$7,468,120	$9,270,632	$6,330,838	$1,518,473	-$229	$0	$250,675	$0	$1,782,077	$1,987,643	$0	$0
Community Nursing Homes	$1,156,173	$1,278,803	$1,395,426	$1,475,586	-$6	$0	$0	$0	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$19,595	$20,712	$21,561	$22,423	$0	$0	$0	$0	$146	$0	$0	$0
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$4,550,658	$4,810,046	$5,007,258	$5,207,548	$17,188	$0	$0	$0	$19,518	$0	$0	$0
Administrative Contract Services	$4,855	$8,590	$6,388	$9,300	$3,272	$0	$2,554	$0	$0	$0	$0	$0
Training Contract Services	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$1,627,772	$1,487,004	$1,594,743	$1,735,050	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$23,992,141	$27,178,979	$25,482,512	$22,364,271	$8,035	$0	$272,550	$0	$1,897,629	$1,987,819	$0	$0

Obligations by Object - Medical Community Care Category (MCC) - Part 1 of 2

(dollars in thousands)

	Discretionary Appropriations Medical Community Care				Mandatory Appropriations Veterans Choice Fund				Mandatory Appropriations American Resuce Plan Act, sec. 8002, 8007			
Description	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**	**FY 2022**	**FY 2023**	**FY 2024**	**FY 2025**
26 Supplies & Materials:												
Provisions	$107,079	$114,561	$100,656	$85,277	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	($3,265)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Operating Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$4,335	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prosthetic Appliances	$3,145	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$111,294	$114,561	$100,656	$85,277	$0	$0	$0	$0	$0	$0	$0	$0
31 Equipment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
32 Lands & Structures:												
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:												
State Home	$1,286,165	$1,406,348	$1,496,078	$1,582,858	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,286,165	$1,406,348	$1,496,078	$1,582,858	$0	$0	$0	$0	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$25,392,391	$28,702,838	$27,082,317	$24,035,600	$8,037	$0	$272,550	$0	$1,897,629	$1,987,819	$0	$0
Prior Year Recoveries	$75,894	$0	$0	$0	$12,727	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$25,468,285**	**$28,702,838**	**$27,082,317**	**$24,035,600**	**$20,764**	**$0**	**$272,550**	**$0**	**$1,897,629**	**$1,987,819**	**$0**	**$0**

Obligations by Object - Medical Community Care Category (MCC) - Part 2 of 2
(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund				Discretionary and Mandatory Grand Total Medical Community Care Category			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
10 Personnel Compensation and Benefits:								
Physicians	$0	$0	$0	$0	$0	$0	$0	$0
Dentists	$0	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$0	$0	$0	$0	$0	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$0	$0	$0	$0
Non-Physician Providers	$0	$0	$0	$0	$0	$0	$0	$0
Health Technicians/Allied Health	$0	$0	$0	$0	$0	$0	$0	$0
Wage Board/Purchase & Hire	$0	$0	$0	$0	$0	$0	$0	$0
All Other	$0	$0	$0	$0	$0	$0	$0	$0
Permanent Change of Station	$0	$0	$0	$0	$0	$0	$0	$0
Employee Compensation Pay	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
21 Travel & Transportation of Persons:								
Employee	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$0	$0	$0	$0	$2,793	$2,950	$3,071	$3,194
Other	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$2,793	$2,950	$3,071	$3,194
22 Transportation of Things	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:								
Rental of Equipment	$0	$0	$0	$0	$0	$0	$0	$0
Communications	$0	$0	$0	$0	$0	$0	$0	$0
Utilities	$0	$0	$0	$0	$0	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
24 Printing & Reproduction:	$0	$0	$0	$0	$0	$0	$0	$0
25 Other Contractual Services:								
Care in the Community Outpatient Dental Care	$0	$0	$0	$0	$711,653	$1,041,713	$1,102,822	$1,158,811
Medical and Nursing Care in the Community	$0	$0	$0	$0	$8,537,013	$9,261,655	$10,042,797	$11,237,080
Repairs to Furniture/Equipment	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	$0	$0	$0	$0	$0	$0	$0	$0
Care in the Community Hospital Care	$0	$0	$5,510,910	$11,347,354	$9,249,968	$11,258,275	$12,092,423	$12,865,827
Community Nursing Homes	$0	$0	$0	$0	$1,156,167	$1,278,803	$1,395,426	$1,475,586
Repairs to Prosthetic Appliances	$0	$0	$0	$0	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$0	$0	$0	$0	$19,741	$20,712	$21,561	$22,423
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0	$0	$0	$0	$0
Other Medical Contract Services	$0	$0	$0	$0	$4,587,364	$4,810,046	$5,007,258	$5,207,548
Administrative Contract Services	$0	$0	$0	$0	$8,127	$8,590	$8,942	$9,300
Training Contract Services	$0	$0	$0	$0	$0	$0	$0	$0
Caregiver Stipends	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0	$1,627,772	$1,487,004	$1,594,743	$1,735,050
Subtotal	$0	$0	$5,510,910	$11,347,354	$25,897,805	$29,166,798	$31,265,972	$33,711,625

Obligations by Object - Medical Community Care Category (MCC) - Part 2 of 2
(dollars in thousands)

Description	Mandatory Appropriations Cost of War Toxic Exposures Fund				Discretionary and Mandatory Grand Total Medical Community Care Category			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
26 Supplies & Materials:								
Provisions	$0	$0	$0	$0	$107,079	$114,561	$100,656	$85,277
Drugs & Medicines	$0	$0	$0	$0	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$0	$0	$0	$0	-$3,265	$0	$0	$0
Operating Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Supplies	$0	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$0	$0	$0	$0	$4,335	$0	$0	$0
Prosthetic Appliances	$0	$0	$0	$0	$3,145	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$111,294	$114,561	$100,656	$85,277
31 Equipment	$0	$0	$0	$0	$0	$0	$0	$0
32 Lands & Structures:								
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:								
State Home	$0	$0	$0	$0	$1,286,165	$1,406,348	$1,496,078	$1,582,858
Grants	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$1,286,165	$1,406,348	$1,496,078	$1,582,858
42 - Insurance Claims and Indemnities	$0	$0	$0	$0	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$5,510,910	$11,347,354	$27,298,057	$30,690,657	$32,865,777	$35,382,954
Prior Year Recoveries	$0	$0	$0	$0	$88,621	$0	$0	$0
Obligations [Total]	**$0**	**$0**	**$5,510,910**	**$11,347,354**	**$27,386,678**	**$30,690,657**	**$32,865,777**	**$35,382,954**

Obligations by Object - Discretionary & Mandatory Grand Total Medical Care
(dollars in thousands)

Description	Medical Care Total (Discretionary)				Medical Care Total (Mandatory)				Medical Care Grand Total (Discretionary & Mandatory)			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
10 Personnel Compensation and Benefits:												
Physicians	$8,155,657	$9,505,969	$10,764,205	$11,854,219	$682,961	$185,792	$4,472	$4,140	$8,838,618	$9,691,761	$10,768,677	$11,858,359
Dentists	$362,022	$390,154	$424,704	$456,818	$3,739	$969	$0	$0	$365,761	$391,123	$424,704	$456,818
Registered Nurses	$9,704,432	$12,170,966	$14,242,536	$15,936,894	$1,465,628	$367,465	$511	$0	$11,170,060	$12,538,431	$14,243,047	$15,936,894
LP Nurse/LV Nurse/Nurse Assistant	$2,264,721	$2,655,442	$3,074,364	$3,483,904	$109,312	$27,375	$0	$0	$2,374,033	$2,682,817	$3,074,364	$3,483,904
Non-Physician Providers	$3,300,810	$3,780,483	$4,318,596	$4,824,458	$98,176	$27,448	$600	$559	$3,398,986	$3,807,931	$4,319,196	$4,825,017
Health Technicians/Allied Health	$9,757,221	$11,154,338	$12,749,243	$14,293,021	$240,061	$61,234	$0	$0	$9,997,282	$11,215,572	$12,749,243	$14,293,021
Wage Board/Purchase & Hire	$1,914,841	$2,365,046	$2,675,368	$2,981,084	$207,192	$836	$0	$0	$2,122,033	$2,365,882	$2,675,368	$2,981,084
All Other	$9,294,685	$11,068,386	$12,709,843	$14,273,010	$486,944	$70,498	$3,928	$2,281	$9,781,629	$11,138,884	$12,713,771	$14,275,291
Permanent Change of Station	$16,215	$16,545	$16,881	$17,224	$0	$0	$0	$0	$16,215	$16,545	$16,881	$17,224
Employee Compensation Pay	$338,479	$349,587	$357,106	$364,355	$4,559	$414	$0	$0	$343,038	$350,001	$357,106	$364,355
Subtotal	$45,109,083	$53,456,916	$61,332,846	$68,484,987	$3,298,572	$742,031	$9,511	$6,980	$48,407,655	$54,198,947	$61,342,357	$68,491,967
21 Travel & Transportation of Persons:												
Employee	$64,409	$216,743	$342,038	$386,118	$18,694	$0	$0	$0	$83,103	$216,743	$342,038	$386,118
Beneficiary	$1,769,789	$2,264,697	$2,671,932	$3,072,384	$95,995	$0	$0	$0	$1,865,784	$2,264,697	$2,671,932	$3,072,384
Other	$89,911	$118,141	$145,549	$172,995	$60	$0	$0	$0	$89,971	$118,141	$145,549	$172,995
Subtotal	$1,924,109	$2,599,581	$3,159,519	$3,631,497	$114,749	$0	$0	$0	$2,038,858	$2,599,581	$3,159,519	$3,631,497
22 Transportation of Things	$59,611	$64,291	$68,144	$72,017	$413	$0	$0	$0	$60,024	$64,291	$68,144	$72,017
23 Rent, Communications, and Utilities:												
Rental of Equipment	$357,193	$434,422	$507,375	$580,604	$3,063	$0	$0	$0	$360,256	$434,422	$507,375	$580,604
Communications	$516,149	$547,858	$569,396	$590,677	$2,100	$0	$0	$0	$518,249	$547,858	$569,396	$590,677
Utilities	$606,944	$688,173	$716,388	$745,044	$45,135	$0	$0	$0	$652,079	$688,173	$716,388	$745,044
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$807,583	$1,216,286	$1,234,049	$1,462,145	$89,038	$48,811	$664,100	$222,787	$896,621	$1,265,097	$1,898,149	$1,684,932
Subtotal	$2,287,869	$2,886,739	$3,027,208	$3,378,470	$139,336	$48,811	$664,100	$222,787	$2,427,205	$2,935,550	$3,691,308	$3,601,257
24 Printing & Reproduction:	$55,419	$76,153	$96,884	$117,615	$9	$0	$0	$0	$55,428	$76,153	$96,884	$117,615
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$720,395	$1,048,929	$1,106,420	$1,162,158	-$117	$2,662	$5,690	$5,817	$720,278	$1,051,591	$1,112,110	$1,167,975
Medical and Nursing Care in the Community	$8,752,587	$9,494,417	$10,080,436	$11,277,599	$83,851	$126,354	$289,085	$275,785	$8,836,438	$9,620,771	$10,369,521	$11,553,384
Repairs to Furniture/Equipment	$382,470	$296,080	$93,743	$74,960	$783	$160,363	$324,703	$331,950	$383,253	$456,443	$418,446	$406,910
Maintenance & Repair Contract Services	$371,883	$267,779	$356,998	$367,582	$1,625	$135,262	$53,265	$54,453	$373,508	$403,041	$410,263	$422,035
Care in the Community Hospital Care	$7,468,033	$9,270,632	$6,330,838	$1,518,473	$1,781,848	$1,987,643	$5,761,585	$11,347,354	$9,249,881	$11,258,275	$12,092,423	$12,865,827
Community Nursing Homes	$1,156,173	$1,278,803	$1,395,426	$1,475,586	-$6	$0	$0	$0	$1,156,167	$1,278,803	$1,395,426	$1,475,586
Repairs to Prosthetic Appliances	$303,329	$234,480	$53,465	$36,370	$0	$129,647	$277,180	$283,366	$303,329	$364,127	$330,645	$319,736
Home Oxygen	$219,978	$170,219	$38,813	$26,402	$0	$94,116	$201,217	$205,708	$219,978	$264,335	$240,030	$232,110
Organ Procurement	$17,846	$14,333	$3,268	$2,223	$677	$7,925	$16,943	$17,321	$18,523	$22,258	$20,211	$19,544
Personal Services Contracts	$129,161	$124,102	$56,862	$51,839	$19,198	$49,190	$105,165	$107,513	$148,359	$173,292	$162,027	$159,352
House Staff Disbursing Agreement	$765,556	$592,363	$135,195	$92,026	-$66	$327,438	$700,050	$715,674	$765,490	$919,801	$835,245	$807,700
Scarce Medical Specialists	$268,472	$210,302	$47,952	$32,619	$3,800	$116,278	$248,599	$254,147	$272,272	$326,580	$296,551	$286,766
Other Medical Contract Services	$6,328,423	$6,203,978	$5,353,047	$5,455,974	$49,066	$751,990	$1,607,329	$1,642,885	$6,377,489	$6,955,968	$6,960,376	$7,098,859
Administrative Contract Services	$3,484,326	$3,988,763	$3,517,273	$2,630,343	$329,421	$1,405,075	$2,247,128	$2,424,091	$3,813,747	$5,393,838	$5,764,401	$5,054,434
Training Contract Services	$160,260	$170,629	$115,277	$113,596	$7,721	$42,403	$90,656	$92,680	$167,981	$213,032	$205,933	$206,276
Caregiver Stipends	$910,670	$1,543,422	$1,982,190	$2,301,867	$0	$0	$0	$0	$910,670	$1,543,422	$1,982,190	$2,301,867
CHAMPVA	$1,641,658	$1,504,722	$1,616,465	$1,759,345	$0	$0	$0	$0	$1,641,658	$1,504,722	$1,616,465	$1,759,345
Subtotal	$33,081,220	$36,413,953	$32,283,668	$28,378,962	$2,277,801	$5,336,346	$11,928,595	$17,758,744	$35,359,021	$41,750,299	$44,212,263	$46,137,706

Obligations by Object - Discretionary & Mandatory Grand Total Medical Care
(dollars in thousands)

Description	Medical Care Total (Discretionary)				Medical Care Total (Mandatory)				Medical Care Grand Total (Discretionary & Mandatory)			
	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025	FY 2022	FY 2023	FY 2024	FY 2025
26 Supplies & Materials:												
Provisions	$237,485	$249,372	$240,994	$231,229	$132	$0	$0	$0	$237,617	$249,372	$240,994	$231,229
Drugs & Medicines	$6,901,836	$8,255,247	$7,431,511	$7,314,276	$1,713,638	$1,353,254	$2,892,523	$4,124,480	$8,615,474	$9,608,501	$10,324,034	$11,438,756
Blood & Blood Products	$50,676	$60,617	$57,138	$56,237	$0	$0	$0	$0	$50,676	$60,617	$57,138	$56,237
Medical/Dental Supplies	$1,919,725	$3,255,003	$1,988,861	$519,925	$222,293	$0	$0	$0	$2,142,018	$3,255,003	$1,988,861	$519,925
Operating Supplies	$481,553	$526,638	$548,231	$570,160	$31,584	$0	$0	$0	$513,137	$526,638	$548,231	$570,160
Maintenance & Repair Supplies	$235,650	$252,001	$262,333	$272,827	$1,109	$0	$0	$0	$236,759	$252,001	$262,333	$272,827
Other Supplies	$361,400	$408,929	$429,117	$449,465	$2,625	$0	$0	$0	$364,025	$408,929	$429,117	$449,465
Prosthetic Appliances	$3,167,668	$3,526,498	$3,887,110	$4,272,600	$34	$0	$0	$0	$3,167,702	$3,526,498	$3,887,110	$4,272,600
Home Respiratory Therapy	$31,473	$35,069	$38,655	$42,488	$0	$0	$0	$0	$31,473	$35,069	$38,655	$42,488
Subtotal	$13,387,466	$16,569,374	$14,883,950	$13,729,207	$1,971,415	$1,353,254	$2,892,523	$4,124,480	$15,358,881	$17,922,628	$17,776,473	$17,853,687
31 Equipment	$1,989,111	$2,236,094	$2,358,690	$173,398	$107,680	$0	$0	$2,136,928	$2,096,791	$2,236,094	$2,358,690	$2,310,326
32 Lands & Structures:												
Non-Recurring Maintenance	$1,480,758	$2,584,475	$5,750,000	$995,000	$1,349,582	$432,525	$0	$0	$2,830,340	$3,017,000	$5,750,000	$995,000
All Other Lands & Structures	$328,019	$430,411	$441,275	$478,127	$13,568	$8,045	$125,876	$42,436	$341,587	$438,456	$567,151	$520,563
Subtotal	$1,808,777	$3,014,886	$6,191,275	$1,473,127	$1,363,150	$440,570	$125,876	$42,436	$3,171,927	$3,455,456	$6,317,151	$1,515,563
41 Grants, Subsidies & Contributions:												
State Home	$1,285,205	$1,406,348	$1,496,078	$1,582,858	$0	$0	$0	$0	$1,285,205	$1,406,348	$1,496,078	$1,582,858
Grants	$742,195	$1,301,608	$1,354,974	$1,409,175	$490,187	$0	$0	$0	$1,232,382	$1,301,608	$1,354,974	$1,409,175
Veteran Adoption Reimbursement	$2	$2	$2	$2	$0	$0	$0	$0	$2	$2	$2	$2
Subtotal	$2,027,402	$2,707,958	$2,851,054	$2,992,035	$490,187	$0	$0	$0	$2,517,589	$2,707,958	$2,851,054	$2,992,035
42 Insurance Claims and Indemnities	$40,398	$43,358	$45,136	$46,941	$329	$0	$0	$0	$40,727	$43,358	$45,136	$46,941
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$101,770,465	$120,069,303	$126,298,374	$122,478,256	$9,763,641	$7,921,012	$15,620,605	$24,292,355	$111,534,106	$127,990,315	$141,918,979	$146,770,611
Prior Year Recoveries	$219,462	$0	$0	$0	$16,354	$0	$0	$0	$235,816	$0	$0	$0
ARP Act 8007 Compayment Reimbursement	$0	$0	$0	$0	$4,737	$16,861	$0	$0	$4,737	$16,861	$0	$0
Obligations [Total]	**$101,989,927**	**$120,069,303**	**$126,298,374**	**$122,478,256**	**$9,784,732**	**$7,937,873**	**$15,620,605**	**$24,292,355**	**$111,774,659**	**$128,007,176**	**$141,918,979**	**$146,770,611**

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Medical Care

Medical Care Areas of Focus

This chapter outlines the major medical areas of focus, programs of interest and programs for select Veteran populations within the Veterans Health Administration (VHA) and the associated obligations by appropriation for each area or program. The following table displays the estimated obligations by major category that the Department of Veterans Affairs (VA) projects incur.

Table: Total Medical Care Obligations by Program
(Includes All Funding Sources)
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Health Care Services:							
Ambulatory Care	$53,847,276	$65,102,797	$62,340,341	$70,800,763	$71,125,162	$8,460,422	$324,399
Dental Care	$1,948,374	$2,291,788	$2,461,798	$2,573,291	$2,724,816	$111,493	$151,525
Inpatient Care	$21,489,091	$24,485,224	$25,066,857	$26,766,548	$28,294,437	$1,699,691	$1,527,889
Mental Health Care 1/	$13,017,739	$13,918,915	$14,983,333	$16,587,825	$17,681,247	$1,604,492	$1,093,422
Prosthetic and Sensory Aids Services	$3,722,046	$4,069,980	$4,147,810	$4,571,956	$5,025,363	$424,146	$453,407
Rehabilitation Care	$1,233,675	$1,258,933	$1,419,384	$1,491,565	$1,541,668	$72,181	$50,103
Health Care Services [Subtotal]	**$95,258,201**	**$111,127,637**	**$110,419,523**	**$122,791,948**	**$126,392,693**	**$12,372,425**	**$3,600,745**
Long-Term Services & Supports (LTSS):							
Institutional LTSS							
VA Community Living Centers (VA CLC)	$4,796,854	$4,942,654	$5,112,902	$5,292,497	$5,477,621	$179,595	$185,124
Community Nursing Home	$1,259,287	$1,550,526	$1,399,863	$1,529,213	$1,617,225	$129,350	$88,012
State Home Nursing	$1,239,773	$1,490,482	$1,352,486	$1,438,784	$1,522,235	$86,298	$83,451
State Home Domiciliary	$43,684	$49,095	$52,079	$55,402	$58,616	$3,323	$3,214
Institutional LTSS [Subtotal]	$7,339,598	$8,032,757	$7,917,330	$8,315,896	$8,675,697	$398,566	$359,801
Non-Institutional LTSS							
State Home Adult Day Care	$6,322	$1,286	$1,783	$1,892	$2,007	$109	$115
Other Non-Institutional LTSS	$3,919,930	$4,051,310	$4,262,901	$4,622,996	$4,899,328	$360,095	$276,332
Non-Institutional LTSS [Subtotal]	$3,926,252	$4,052,596	$4,264,684	$4,624,888	$4,901,335	$360,204	$276,447
LTSS [Subtotal]	**$11,265,850**	**$12,085,353**	**$12,182,014**	**$12,940,784**	**$13,577,032**	**$758,770**	**$636,248**
Other Health Care Programs:							
Camp Lejeune Families (P.L. 112-154)	$5,420	$3,808	$7,018	$7,597	$8,264	$579	$667
Caregivers 2/	$1,234,036	$1,846,210	$1,866,210	$2,422,410	$2,764,685	$556,200	$342,275
CHAMPVA & Other Dependent Prgs	$2,377,409	$2,164,071	$2,171,927	$2,335,332	$2,548,920	$163,405	$213,588
Homeless Program Grants 3/	$1,085,649	$977,441	$1,003,582	$1,067,265	$1,115,656	$63,683	$48,391
Readjustment Counseling	$307,541	$340,041	$340,041	$353,643	$363,361	$13,602	$9,718
Copayment Reimbursement 5/	$4,737	$0	$16,861	$0	$0	($16,861)	$0
Other Health Care Programs [Subtotal]	**$5,014,792**	**$5,331,571**	**$5,405,639**	**$6,186,247**	**$6,800,886**	**$780,608**	**$614,639**
Obligations [Subtotal]	**$111,538,843**	**$128,544,561**	**$128,007,176**	**$141,918,979**	**$146,770,611**	**$13,911,803**	**$4,851,632**
Recoveries of prior year paid & unpaid obligations	$235,816						
Obligations [Total]	$111,774,659	$128,544,561	$128,007,176	$141,918,979	$146,770,611	$13,911,803	$4,851,632

Note: Dollars may not add due to rounding in this and subsequent charts.

[1/] Mental health care includes costs for mental health treatment that take place both in settings that are primarily for mental health (for example, inpatient mental health) and settings that are not (for example, mental health treatment provided in a primary care clinic).

[2/] Includes stipend costs, respite care, mental health care, CHAMPVA benefits and program administration for the Caregivers Support Program.

[3/] Includes projected grant costs for the Grant and Per Diem (GPD) and Supportive Services for Low Income Veterans (SSVF) programs.

Table: Medical Care Obligations by Program (Included Above)
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Medical Care Programs: (Included Above)							
Activations	$342,239	$769,904	$769,904	$865,249	$623,359	$95,345	($241,890)
Blind Rehabilitation Treatment	$121,506	$126,900	$144,395	$168,746	$195,156	$24,351	$26,410
Epilepsy Center of Excellence 1/	$11,959	$19,086	$19,086	$23,585	$23,871	$4,499	$286
Education & Training	$2,593,928	$2,706,082	$2,838,744	$2,911,961	$3,090,477	$73,217	$178,516
Health Professionals Educational Assistance Program	$182,264	$248,033	$248,033	$303,356	$361,152	$55,323	$57,796
Indian Health Services	$34,770	$32,345	$36,752	$38,259	$39,789	$1,507	$1,530
Intensive Evaluation and Treatment Program Initiative	$6,324	$25,970	$25,970	$11,640	$15,304	($14,330)	$3,664
Intimate Partner Violence program	$19,432	$24,347	$24,347	$36,879	$40,118	$12,532	$3,239
Leases	$1,061,250	$1,500,000	$1,550,281	$2,305,729	$1,965,223	$755,448	($340,506)
Mental Health Topics:							
Opioid Prevention:							
Treatment Modalities	$418,850	$417,051	$442,726	$460,878	$479,312	$18,152	$18,434
Opioid Prevention Programs (Includes Jason's Law) 2/	$147,623	$245,754	$245,754	$254,478	$254,487	$8,724	$9
Substance Use Disorder Initiative	$44,064	$181,287	$183,287	$230,947	$239,647	$47,660	$8,700
Suicide Prevention:							
Medical Treatment	$2,671,116	$2,385,776	$2,848,404	$2,994,094	$3,140,875	$145,690	$146,781
Outreach Programs	$522,753	$496,598	$503,734	$558,794	$569,905	$55,060	$11,111
National Center for Posttraumatic Stress Disorder	$35,653	$40,000	$42,000	$42,000	$42,000	$0	$0
National Veterans Sports Program	$28,494	$27,229	$27,229	$30,414	$30,542	$3,185	$128
Non-Recurring Maintenance (Lands & Structure only) 3/	$2,830,339	$2,505,000	$3,017,000	$5,750,000	$995,000	$2,733,000	($4,755,000)
Precision Oncology Initiative	$92,746	$167,227	$167,227	$215,433	$223,133	$48,206	$7,700
Regional Readiness Centers 4/	$206,691	N/A	$204,661	$155,481	$155,476	($49,180)	($5)
Rural Health 1/	$308,178	$307,455	$337,455	$337,455	$337,455	$0	$0
Spinal Cord Injury Treatment	$728,636	$733,500	$773,428	$821,609	$873,543	$48,181	$51,934
Supply Chain Management	$86,820	$142,404	$142,404	$144,603	$148,866	$2,199	$4,263
Telehealth:							
Home & Clinic Based Telehealth	$4,311,216	$4,844,912	$4,580,140	$4,757,275	$5,110,477	$177,135	$353,202
Office of Connected Care Program	$261,520	$329,906	$329,776	$408,061	$439,920	$78,285	$31,859
Veterans Homelessness Programs	$2,808,320	$2,685,392	$2,870,559	$3,111,148	$3,267,927	$240,589	$156,779
Whole Health	$74,845	$75,851	$85,851	$107,848	$119,289	$21,997	$11,441

[1/] 2022 actuals are represented by allocated amounts rather than obligations.

[2/] The Office of Patient Advocacy's budget is no longer displayed in this row.

[3/] Please see the Medical Facilities chapter for the 2022 actual that includes supporting full time equivalent (FTE) employees and contract-related costs pertaining to non-recurring maintenance, which are not included in this table.

[4/] Regional readiness centers amount not previously displayed in the 2023 President's Budget.

Table: Programs for Select Veteran Populations
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
AIDS/HIV Program	$1,664,704	$1,619,700	$1,698,699	$1,818,782	$1,946,410	$120,083	$127,628
Health Outcomes Military Exposures (HOME):							
Gulf War Program	$6,081,978	$6,480,200	$7,130,227	$8,268,010	$9,476,239	$1,137,783	$1,208,229
OEF/OIF/OND/OIR	$12,118,965	$11,966,200	$13,872,121	$15,820,981	$17,926,342	$1,948,860	$2,105,361
Program Office	$44,350	$63,000	$104,692	$81,938	$93,141	($22,754)	$11,203
Traumatic Brain Injury and Polytrauma System of Care:							
OEF/OIF/OND/OIR	$301,587	$274,600	$326,221	$346,429	$368,729	$20,208	$22,300
All Veteran Care	$1,095,749	$1,034,200	$1,217,649	$1,329,518	$1,451,815	$111,869	$122,297
Women Veterans Health Care:							
Program Office & Initiative Budget	$89,180	$134,219	$155,131	$256,926	$306,073	$101,795	$49,147
Gender-Specific Care	$739,273	$766,900	$871,546	$1,022,170	$1,215,996	$150,624	$193,826
All Care	$9,657,762	$9,774,900	$11,101,448	$12,632,131	$14,213,871	$1,530,683	$1,581,740

The following tables provide the projected obligations for each activity by appropriation account. The abbreviations used in the funding tables are as follows:

- Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act (PACT Act) of 2022 (P.L. 117-168)
- American Rescue Plan (ARP) Act of 2022 (P.L. 117-2)
- Families First Coronavirus Response Act (FFCRA) (P.L. 116-127)
- Veterans Access, Choice and Accountability Act (VACAA) of 2014 (P.L. 113-146)

Ambulatory Care with Pharmacy

This health service category includes funding for ambulatory care in VA medical centers and community-based clinics, as well as ambulatory care provided in the community by non-VA providers.

Table: Ambulatory Care with Pharmacy

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA Obligations	$30,337,817	$41,089,652	$37,208,699	$39,008,217	$38,226,595	$1,799,518	($781,621)
Discretionary FFCRA Obligations	$200	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$30,338,017**	**$41,089,652**	**$37,208,699**	**$39,008,217**	**$38,226,595**	**$1,799,518**	**($781,621)**
Medical Community Care (0140):							
Discretionary Non-FFCRA Obligations	$10,423,789	$11,252,219	$10,761,092	$11,468,615	$12,653,291	$707,523	$1,184,676
Discretionary FFCRA Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$10,423,789**	**$11,252,219**	**$10,761,092**	**$11,468,615**	**$12,653,291**	**$707,523**	**$1,184,676**
Medical Support and Compliance (0152):							
Discretionary Obligations	$4,759,865	$5,831,080	$5,882,315	$6,513,105	$6,710,350	$630,790	$197,245
Discretionary Obligations [Subtotal]	**$4,759,865**	**$5,831,080**	**$5,882,315**	**$6,513,105**	**$6,710,350**	**$630,790**	**$197,245**
Medical Facilities Category:							
Discretionary Obligations (0162)	$3,506,566	$4,296,603	$4,758,865	$7,048,191	$4,857,988	$2,289,326	($2,190,203)
Recurring Expenses Transformational Fund (1124)	$0	$0	$75,000	$0	$0	($75,000)	$0
Discretionary Obligations [Subtotal]	**$3,506,566**	**$4,296,603**	**$4,833,865**	**$7,048,191**	**$4,857,988**	**$2,214,326**	**($2,190,203)**
Discretionary Total	**$49,028,238**	**$62,469,554**	**$58,685,971**	**$64,038,128**	**$62,448,224**	**$5,352,157**	**($1,589,903)**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$2,650,536	$5,665,408	$8,078,367	$3,014,872	$2,412,959
Veterans Medical Care and Health Fund (0173)	$3,442,977	$68,400	$456,001	$0	$0	($456,001)	$0
American Rescue Plan Act, Section 8007 (0160)	$394,305	$627,900	$2,847	$0	$0	($2,847)	$0
VACAA, Section 801 (0160)	$3,120	$3,980	$5,465	$5,678	$4,980	$213	($698)
Mandatory Obligations [Subtotal]	**$3,840,402**	**$700,280**	**$3,114,849**	**$5,671,086**	**$8,083,347**	**$2,556,237**	**$2,412,261**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$54,795	$969,609	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$79,870	$72,100	$176	$0	$0	($176)	$0
Veterans Choice Fund (0172)	-$4,907	$265,088	$0	$21,875	$0	$21,875	($21,875)
Mandatory Obligations [Subtotal]	**$129,758**	**$1,306,797**	**$176**	**$21,875**	**$0**	**$21,699**	**($21,875)**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$8,547	$278,896	$328,112	$270,349	$49,216
Veterans Medical Care and Health Fund (0173)	$154,518	$231,083	$163,014	$0	$0	($163,014)	$0
VACAA, Section 801 (0152)	$1,826	$2,883	$3,392	$3,524	$256	$132	($3,268)
Mandatory Obligations [Subtotal]	**$156,344**	**$233,966**	**$174,953**	**$282,420**	**$328,368**	**$107,467**	**$45,948**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$50,281	$786,724	$265,223	$736,443	($521,501)
Veterans Medical Care and Health Fund (0173)	$691,753	$392,200	$313,120	$0	$0	($313,120)	$0
VACAA, Section 801 (0162)	$782	$0	$991	$530	$0	($461)	($530)
Mandatory Obligations [Subtotal]	**$692,535**	**$392,200**	**$364,392**	**$787,254**	**$265,223**	**$422,862**	**($522,031)**
Mandatory Total	**$4,819,038**	**$2,633,243**	**$3,654,370**	**$6,762,635**	**$8,676,938**	**$3,108,265**	**$1,914,303**
Combined Discretionary and Mandatory by Category							
Medical Services	$34,178,419	$41,789,932	$40,323,548	**$44,679,303**	**$46,309,942**	$4,355,755	$1,630,640
Medical Community Care	$10,553,547	$12,559,016	$10,761,268	**$11,490,490**	**$12,653,291**	$729,222	$1,162,801
Medical Support and Compliance	$4,916,210	$6,065,046	$6,057,268	**$6,795,525**	**$7,038,718**	$738,257	$243,193
Medical Facilities	$4,199,101	$4,688,803	$5,198,257	**$7,835,445**	**$5,123,211**	$2,637,188	($2,712,234)
Obligations [Grand Total]	**$53,847,276**	**$65,102,797**	**$62,340,341**	**$70,800,763**	**$71,125,162**	**$8,460,422**	**$324,400**

Types of Services Provided / Method of Delivery

Primary Care
Patient Aligned Care (PAC) team is a customized patient-centered medical home model of care adopted and branded by VHA. PAC staff includes primary care (PC) providers (PCP) (physicians, advanced practice nurses and physician assistants), registered nurses (RN), clinical associates (licensed practical nurses (LPN), licensed vocational nurses (LVN), medical assistants, health technicians, intermediate care technicians and clerical associates. The extended PAC team staff includes, but is not limited to dieticians, clinical pharmacist technicians, primary care mental health integration, Primary Care Mental Health Integration (PCMHI) staff (psychologists, psychiatrists, licensed clinical social workers (LCSW), RNs) and case managers. The PAC model has remained the foundational model for team-based primary care and over the years has incorporated virtual primary care modalities (for example, synchronous telehealth into the home, clinic or non-VA site of care, secure messaging, telephone care, e-consults and so forth).

Nursing Services
Nurses play a vital role in PC delivery as part of the VHA multidisciplinary PAC team. Through in-person and virtual (video, secure messaging and telephone) encounters, RNs, LPNs and LVNs provide direct and indirect nursing care activities. Nurses engage patients and families in care coordination, enhance care transition (both within VA and with community care partners), manage complex chronic patient care plans and promote preventive care services to empower patient self-care.

Pharmacy Services
Clinical Pharmacist Practitioners (CPP) provide comprehensive medication management (CMM) as part of the PAC team working to increase Veteran access and quality of care. CPPs function under a scope of practice to provide CMM by initiating, modifying, or discontinuing medications to ensure optimal medication use for Veterans. As a key team member, CPPs collaborate with X-waivered providers to provide evidence-based treatment for opioid use disorder (OUD), provide screening, brief intervention, referral and/or treatment (SBIRT) for Veterans engaging in unhealthy alcohol use and assist with management with other chronic diseases such as hypertension, diabetes and lipid disorders.

Nutrition and Food Services
Nutrition and Food Service (NFS) develops and provides comprehensive evidence-based nutrition services through a modernized, Veteran-centric NFS program that empowers and engages a diverse workforce, educates future nutrition professionals and advances nutrition practice through research and continuous quality improvement. Most recently NFS has been focused on addressing food security within our Veteran population. In 2022, 7 million Veterans were screened. NFS provides group classes and individual sessions, via in-person appointments or virtual modalities. In the past year, NFS virtual appointments increased from 120,000 (2021) to 434,000 (2022), including 77 facilities offering healthy teaching kitchens programs virtually.

Emergency Medicine Services
Emergency Medicine (EM) provides acute, emergent and urgent care on-demand to over 2.5 million Veterans annually, through our 110 VHA emergency departments (ED) and 30 urgent care

centers (UCC). VHA Emergency and Urgent Care Medicine serves as a critical safety net for our Nation's Veterans, offering immediately accessible care with a focus on geriatric and mental health emergency care.

Podiatry
Podiatry includes medical and surgical foot and ankle care and the Prevention of Amputation in Veterans Everywhere (PAVE) program. This includes the amputation/ulcer database and the high-risk amputation pyramid cubes. The National Podiatry Program provides clinical guidance, policy and oversight and provided nearly 1.4 million in-person and over 16,000 CVT encounters in 2022.

Recent Trends
In 2022, VA continued to make the most of its legal and operational authority and business processes to integrate virtual care to Veterans at home.

- PC is leading implementation of PACT Act § 603, ensuring enrolled Veterans receive service-related toxic exposures screening (TES) at least every five years to connect them to benefits, promote research and establish exposures informed health care. The TES was launched November 8, 2022, with the goal of ultimately screening all 9.0 million enrolled Veterans. Phase 1 involved screening Veterans coming in for PC visits. By March 3, 2023, 2.2 million enrolled Veterans had been screened, 94% of TES have been performed in PC stop codes. Over 40% of those endorsed having at least one exposures concern while in the Military. The screening process was linked to providing information on exposures related health concerns, clinically evaluating and addressing any new symptoms related to the exposures, actively supporting the Veteran in submitting claims for presumptive conditions and adding the exposures concern to the Veteran's problem list in the electronic health record (EHR). The overall goal is to create a more exposures informed care model for all Veterans. We have now entered Phase 2, with broader implementation of TES screening into all clinical settings.
- 91% of VHA PC and MH providers have completed at least one synchronous telehealth visit using the VVC platform VA video connect encounter.
- More than 9.8 million video telehealth visits were conducted in 2022. Approximately 95% of these video visits (over 9.2 million) were completed with Veterans at home or some other non-VA location.
- Use of virtual care is also an industry standard and offers comparable outcomes, outstanding customer service for our Veterans and their caregivers who may experience difficulty or hardship with traveling to a facility. The opportunity to provide care virtually, when clinically appropriate, is also an effective tool to increase recruitment and retention of our scarce resources of PC and MH providers. Virtual care modalities enable clinics and medical centers to remain open as part of contingency planning during environmental or facility challenges.
- In September 2022, the fifth annual national Veterans in Pain: Pain Care, Opioid Safety and Substance Abuse Treatment (VIP POST) Conference was held virtually over three days. The conference brought together 1,071 attendees (clinicians and non-clinicians) from all disciplines, including the VISN and Facility Primary Care Pain Champions, to learn

about pain care transformation, opioid safety and substance use disorder/opioid use disorder (SUD/OUD) treatment.

- VA prescribers and their delegates are able to access state prescription drug monitoring programs (PDMP) through an innovative IT solution providing real-time direct access to state PDMPs in CPRS with an easily visible and actionable PDMP button. This has greatly influenced compliance with an essential element of opioid safety, permitting national visibility of most prescriptions for controlled substances in all but two states. This involved integrating a national gateway with each state, considering the variability of rules and regulations governing each state's PDMP. VHA mandates annual PDMP queries in addition to queries on new starts of controlled substances. Nationally, annual queries for all controlled substances through September 2022 were at 96.7% and at 85.1% for new starts.
- Providing collaborative PCMHI care to approximately 8.3% of Veterans enrolled at all primary care sites across 1.4 million encounters, which represents 104% of the encounter volume, compared to the year prior and demonstrates ongoing resilience of PAC team clinical functions.
- In 2022, all ambulatory clinical staff contributed to implementation of a streamlined suicide screening process, which resulted in 96% screening performance in the fourth quarter, 79% performance on subsequent same-day evaluation and consolidated tools and methods for sustained collaborative improvement in this area consistent with a high-performing learning health system.

Highlights of VA outpatient care, care coordination and management of chronic diseases include the following:

- VA health care demonstrated significantly better performance than commercial health maintenance organizations (HMO) and Medicaid HMOs for all 16 outpatient effectiveness measures and was significantly better for 14 measures, compared with Medicare HMOs (Price and others, 2018).
- VHA primary care clinics with the most patient centered medical home (PCMH) components had greater improvements in several chronic disease quality measures than the lowest PCMH clinics. In adjusted models containing 808 clinics, the 77 clinics with the most PAC components in place had significantly larger improvements in five of seven chronic disease intermediate outcome measures (for example, BP < 160/100 in diabetes), ranging from 1.3% to 5.2% of the patient population meeting measures and two of eight process measures (HbA1c measurement, LDL measurement in CAD) than the 69 clinics with the least PAC components. Clinics with moderate levels of PAC components showed few significantly larger improvements than the lowest PAC clinics (Rosland and others, 2017).
- Interdisciplinary primary care programs are associated with improved quality of care and reduced costs for high-utilization, high-cost patients. Key program elements include clinical pharmacists, social workers and mental health providers, comprehensive patient assessments and weekly interdisciplinary team meetings, which are found valuable to improving population management efforts of high-risk patients. VA sites across the

country are strengthening ties with extended team CPPs in managing hypertension and other chronic diseases.

- Virtual care tools for the field were created to help staff implement innovative practices. The VVC Primary Care Resource Guide is a document that acts to answer questions and offer best practice techniques. The Vlog, "Let's Talk Virtual Care," shares experiences from experts in the field of new technologies and practices throughout VA and beyond.
- Veterans with multiple chronic conditions (that is, multimorbidity), those seen in clinics with the greatest PCMH implementation compared to the least PCMH implementation had better chronic disease outcome measures (for 5 of 15 metrics), but as patients had more illnesses, this relationship was reduced (only 2 of 15), in adjusted models. This suggests more complex patients may have competing demands that interfere with chronic disease care (Schuttner and others, 2020).
- Veterans with multimorbidity seen in clinics with greater PCMH implementation reported a clinically significant, 2.0 (out of 100 points) higher physical health-related quality of life score, in adjusted models. This difference was greatest for patients at clinics with better performance for communication, continuity and shared decision-making (Schuttner and others, 2020).
- Veterans with comorbid mental and physical health conditions receiving care in PAC clinics with greater PCMH implementation had significantly lower rates of hospitalization. Specifically, Veterans receiving care in clinics with the greatest versus lowest quartile of implementation of team-based care had a 3.5% lower rate of hospitalization (Germack and others, 2021).
- Programs such as the Video Blood Pressure Visit (VBPV) program, a three-year Office of Rural Health (ORH) funded initiative, showed strong improvement in patient blood pressure outcomes for 2021-22. Efficacy analysis focused on monitoring change in BP readings from initial VBPV to follow up BP reading, with a specified time increment between the two events. An example of the improvement is seen in 25-35 days after a VBPV. A sample size of 4,253 patients saw a decrease is systolic pressures by 68.7% and a decrease in diastolic pressures by 60.7%. 60, 90 and 120 days demonstrated similar decreases.
- 2022 showed integration of the PAC CPP into measurement of Veteran experience. A total of 743 Veteran surveys were completed with a response rate of 20%. For primary care specifically, responses to the outpatient health care visit survey showed ease and simplicity was rated as a 4-5 response 94.6% of the time, quality 93.2%, employee helpfulness 96.1%, satisfaction 96.1% and confidence/trust 94.0% (McFarland and others, 2022).
- Healthy Teaching Kitchens (HTK) are hands-on or virtual demonstrations that teach Veterans and their caregivers how to prepare healthy dishes. Additionally, there is an HTK YouTube playlist for on-demand learning. VHA also has developed a national food insecurity screen that has screened over 10 million Veterans since October 2017. Over 68 VA facilities host food pantries that distribute to those in need.
- Close collaboration with Office of Mental Health and Suicide Prevention (OMHSP) to conduct aggressive suicide screening, risk mitigation and safety planning in emergency departments in our EDs and UCs.

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Dental Care

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$855,772	$802,383	$1,001,307	$924,469	$1,116,105	($76,838)	$191,636
Discretionary Obligations [Subtotal]	**$855,772**	**$802,383**	**$1,001,307**	**$924,469**	**$1,116,105**	**($76,838)**	**$191,636**
Medical Community Care (0140):							
Discretionary Obligations	$752,925	$1,118,905	$1,041,713	$1,102,822	$1,158,811	$61,109	$55,989
Discretionary Obligations [Subtotal]	**$752,925**	**$1,118,905**	**$1,041,713**	**$1,102,822**	**$1,158,811**	**$61,109**	**$55,989**
Medical Support and Compliance (0152):							
Discretionary Obligations	$155,696	$187,500	$192,600	$213,100	$219,600	$20,500	$6,500
Discretionary Obligations [Subtotal]	**$155,696**	**$187,500**	**$192,600**	**$213,100**	**$219,600**	**$20,500**	**$6,500**
Medical Facilities (0162):							
Discretionary Obligations	$170,174	$183,000	$225,500	$332,900	$230,300	$107,400	($102,600)
Discretionary Obligations [Subtotal]	**$170,174**	**$183,000**	**$225,500**	**$332,900**	**$230,300**	**$107,400**	**($102,600)**
Discretionary Total	**$1,934,567**	**$2,291,788**	**$2,461,120**	**$2,573,291**	**$2,724,816**	**$112,171**	**$151,525**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$12,116	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$593	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$77	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$12,786**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$643	$0	$678	$0	$0	($678)	$0
VACAA, Section 801 (0152)	$60	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$702**	**$0**	**$678**	**$0**	**$0**	**($678)**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$147	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$172	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$319**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$13,807**	**$0**	**$678**	**$0**	**$0**	**($678)**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$868,558	$802,383	$1,001,307	**$924,469**	**$1,116,105**	($76,838)	$191,636
Medical Community Care	$752,925	$1,118,905	$1,041,713	**$1,102,822**	**$1,158,811**	$61,109	$55,989
Medical Support and Compliance	$156,398	$187,500	$193,278	**$213,100**	**$219,600**	$19,822	$6,500
Medical Facilities	$170,492	$183,000	$225,500	**$332,900**	**$230,300**	$107,400	($102,600)
Obligations [Grand Total]	**$1,948,374**	**$2,291,788**	**$2,461,798**	**$2,573,291**	**$2,724,816**	**$111,493**	**$151,525**

Authority for Action

VA provides oral health services to eligible Veterans specified under U.S.C. §1710(c) and 1712. VA implements its statutory authority through regulations that establish the dental program, such as Title 38 CFR §17.160 – 17.166. The mission of VA dentistry is to Honor America's Veterans by contributing to their whole health through the provision of exceptional oral health care. Due to the high cost of dental care in the private sector, VA dentistry is highly visible. The statutory authority limits dental eligibility for comprehensive (routine) dental care to certain qualifying Veterans.

Population Covered
There are 9.0 million Veterans enrolled in VA health care. Approximately 1.5 million enrolled Veterans are eligible for comprehensive dental care. During 2022, VA dental services managed the care of 512,000 Veterans eligible for comprehensive dental care. An additional 102,000 were eligible and provided dental care due to medical necessity, totaling 607,000 Veterans (some Veterans eligible for limited care become eligible for comprehensive dental care during the year due to a change in their disability rating).

Types of Services Provided
The scope of dental care provided to Veterans varies based on eligibility. Services received by Veterans eligible for comprehensive dental care include examinations, hygiene services, dental radiology, restorative (fillings), endodontics (root canals), periodontal care, fixed, removable and oral maxillofacial prosthodontics (crowns, bridges, dentures and facial prosthetics for trauma or cancer patients), dental implants and oral surgery. Veterans eligible for focused care due to medical necessity receive treatment for the relief of pain, elimination of infection or improvement of speech or esthetics, which is generally limited to supportive periodontal therapy, endodontic therapy, restorative dentistry and oral surgical procedures.

Recent Trends
Veterans eligible for comprehensive dental care historically increased by approximately 8.5% annually during the last five years from 1.1 million to over 1.5 million and are growing at about 11,000 monthly. Over the previous five years, the number of dental treatment rooms increased by 4% per year. The total number of dental staff increased by 2.2%, led by dental hygienists up 17.5%, dental assistants up 2% and dentists up 3.7%. In 2022, the 233 VA dental clinics managed the care of 607,000 Veterans. 514,000 Veterans received dental care on-site in a VA clinic. 6.8 million procedures were completed during 2.1 million visits. The remaining 124,000 Veterans received dental care exclusively through community care.

Projections for the Future
Dental market share is defined as the number of Veterans provided care during the 2022 that are eligible for comprehensive dental care (512,000) divided by the number of Veterans eligible for comprehensive dental care (1.51 million). This gives a market share of 34%.

Most VA dental clinics operate at or near full capacity. It is expected that the increased number of Veterans eligible for dental care and those living outside the one-hour drive time requirements will lead to further increased community care dental costs as more Veterans utilize their dental entitlement to closer match access rates of the private sector, which is near 65%. The cost of community care per unique has historically been approximately 20% higher than that of in-house care. During the last five years, dental treatment rooms increased by 10% and dental staffing increased by 1.8% per year. The Office of Dentistry projects a target market share of 48% within five years. Given the historical annual growth rate of 8.5% for Veterans eligible for comprehensive dental care, the VA Office of Dentistry forecasts about 2.47 million Veterans will be eligible for comprehensive care by 2028. The number of unique Veterans forecasted to serve in 2028 is projected at 1.1 million for comprehensive dental care and 206,166 Veterans for focused care due to medical necessity, for a total of 1.5 million.

Studies by the American Dental Association[3] (ADA) and the Centers for Disease Control and Prevention[4] (CDC) show yearly dental service utilization up to 65% for those with third-party payor coverage in the U.S. population. These studies show there is significant potential for growth in VA dentistry.

Year	Unique Veterans Seen	Market Share
2017	493,900	50%
2018	512,790	47%
2019	541,291	45%
2020 (Pandemic)	462,823	36%
2021 (Pandemic)	464,603	34%
2022	514,385	34%
2023	623,917	38%
2024	710,798	40%
2025	807,940	42%
2026	916,461	44%
2027	1,037,593	46%
2028	1,172,696	48%

[3] Nasseh K, Vujicic M. Dental care utilization steady among working-age adults and children, up slightly among the elderly. Health Policy Institute Research Brief. American Dental Association. October 2016. Available from: http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_1016_1.pdf .

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Inpatient Care

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$8,589,309	$10,211,983	$9,341,501	$9,023,615	$9,441,341	($317,886)	$417,726
Discretionary Obligations [Subtotal]	**$8,589,309**	**$10,211,983**	**$9,341,501**	**$9,023,615**	**$9,441,341**	**($317,886)**	**$417,726**
Medical Community Care (0140):							
Discretionary Obligations	$6,995,724	$9,223,705	$9,270,632	$6,330,838	$1,518,473	($2,939,794)	($4,812,365)
Discretionary Obligations [Subtotal]	**$6,995,724**	**$9,223,705**	**$9,270,632**	**$6,330,838**	**$1,518,473**	**($2,939,794)**	**($4,812,365)**
Medical Support and Compliance (0152):							
Discretionary Obligations	$1,336,079	$2,234,700	$1,653,100	$1,829,300	$1,884,800	$176,200	$55,500
Discretionary Obligations [Subtotal]	**$1,336,079**	**$2,234,700**	**$1,653,100**	**$1,829,300**	**$1,884,800**	**$176,200**	**$55,500**
Medical Facilities (0162):							
Discretionary Obligations	$852,533	$1,642,600	$1,129,800	$1,668,100	$1,153,800	$538,300	($514,300)
Discretionary Obligations [Subtotal]	**$852,533**	**$1,642,600**	**$1,129,800**	**$1,668,100**	**$1,153,800**	**$538,300**	**($514,300)**
Discretionary Total	**$17,773,645**	**$23,312,988**	**$21,395,033**	**$18,851,853**	**$13,998,414**	**($2,543,180)**	**($4,853,439)**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$782,450	$1,672,454	$2,384,770	$890,004	$712,316
Veterans Medical Care and Health Fund (0173)	$986,375	$0	$277,252	$0	$0	($277,252)	$0
American Rescue Plan Act, Section 8007 (0160)	$150,857	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$862	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,138,094**	**$0**	**$1,059,702**	**$1,672,454**	**$2,384,770**	**$612,752**	**$712,316**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$5,510,910	$11,347,354	$5,510,910	$5,836,444
Veterans Medical Care and Health Fund (0173)	$1,585,235	$1,057,096	$1,987,643	$0	$0	($1,987,643)	$0
American Rescue Plan Act, Section 8007 (0140)	$1,355	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$11,537	$0	$0	$250,675	$0	$250,675	($250,675)
Mandatory Obligations [Subtotal]	**$1,598,127**	**$1,057,096**	**$1,987,643**	**$5,761,585**	**$11,347,354**	**$3,773,942**	**$5,585,769**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$14,689	$479,314	$563,899	$464,625	$84,585
Veterans Medical Care and Health Fund (0173)	$268,492	$113,817	$283,253	$0	$0	($283,253)	$0
VACAA, Section 801 (0152)	$612	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$269,104**	**$113,817**	**$297,942**	**$479,314**	**$563,899**	**$181,372**	**$84,585**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$708,547	$0	$324,026	$0	$0	($324,026)	$0
VACAA, Section 801 (0162)	$1,574	$1,323	$2,511	$1,342	$0	($1,169)	($1,342)
Mandatory Obligations [Subtotal]	**$710,121**	**$1,323**	**$326,537**	**$1,342**	**$0**	**($325,195)**	**($1,342)**
Mandatory Total	**$3,715,446**	**$1,172,236**	**$3,671,824**	**$7,914,695**	**$14,296,023**	**$4,242,871**	**$6,381,328**
Combined Discretionary and Mandatory by Category							
Medical Services	$9,727,403	$10,211,983	$10,401,203	**$10,696,069**	**$11,826,111**	$294,866	$1,130,042
Medical Community Care	$8,593,851	$10,280,801	$11,258,275	**$12,092,423**	**$12,865,827**	$834,148	$773,404
Medical Support and Compliance	$1,605,183	$2,348,517	$1,951,042	**$2,308,614**	**$2,448,699**	$357,572	$140,085
Medical Facilities	$1,562,654	$1,643,923	$1,456,337	**$1,669,442**	**$1,153,800**	$213,105	($515,642)
Obligations [Grand Total]	**$21,489,091**	**$24,485,224**	**$25,066,857**	**$26,766,548**	**$28,294,437**	**$1,699,691**	**$1,527,889**

Overview

Anesthesia

Anesthesia service provides sedation/anesthesia, homeostatic support, physiologic monitoring and pain management during surgical, therapeutic and diagnostic procedures for over 0.5 million surgical and invasive procedures each year, of which approximately 60% are operating room (OR) procedures and about 40% are non-OR procedures. Anesthesia service provides subject matter

expertise (SME) in the management of critical care surgical and non-surgical patients and oversight of surgical patients requiring interventional postoperative pain management.

Emergency Medicine
VHA emergency departments serve as the principal source of inpatient admissions to VHA medical centers, playing a critical role in the initial evaluation and stabilization of acutely ill and injured Veterans.

Hospital Medicine
Hospitalists provide direct inpatient care to our Nation's Veterans, including critical care in collaboration with pulmonary and critical care medicine clinicians. Hospitalists serve as the primary inpatient educators, supervising thousands of medical students and residents each year. The National Hospital Medicine (HM) Program supports the field through a network of 18 VISN Chief HM Consultants, direct guidance, policy development and ongoing advancement of the HM community of practice. Tele-hospital medicine has been implemented at a few sites and represents an area of growth and opportunity.

Tele-Critical Care
The National Tele-Critical Care Program (TeleCC) provides continuous 24/7/365 telemedicine access to critical care trained intensivists and nurses for all acutely ill Veterans in ICU's affiliated with the program. National TeleCC is comprised of a program office with two regional hubs. The east hub is based in Cincinnati, Ohio and the west hub is based in Minneapolis, Minnesota. The TeleCC Program currently has 10 sub-hubs that are located nationwide and are staffed by intensivists, APRNs, RNs, biomedical engineers and medical support assistants. The program serves 1,109 ICU beds in 74 hospitals throughout the VA.

Quality, Safety and Efficiency
VA's Inpatient Evaluation Center (IPEC) works closely with the Centers for Medicare and Medicaid Services (CMS) Center for Clinical Standards and Quality (CCSQ) to calculate standard measures of Veteran outcomes during a VA hospital stay. These outcomes include risk-adjusted 30-day mortality and readmission rates, rates of potentially preventable complications (patient safety indicators (PSI)) and health care associated infections (HAI).

By using the same methodology that CMS applies to hospitals, health systems and providers participating in Medicare, VA can directly compare its performance with the private sector and provide assurance to Veterans and the Nation about the value of VA care.

The comparisons listed in the table below are based on the most recent VA data sent to CMS for posting on their Hospital Compare website[5] and the most current published national non-VA benchmarks. Inpatient quality indicator (IQI) measures have been removed from this report.
The following overall trends are noted:

- After adjusting for patient characteristics, VA mortality is lower than the private sector for the three disease processes reported. Pneumonia was not reported due to COVID.

[5] www.medicare.gov/hospitalcompare

- Adverse events, as measured using patient safety indicators (PSI), are generally similar or lower, with one exception[6].
- Rates of health care associated infection are comparable to the private sector.

CMS data, including hospital-specific data, for VA and the private sector is available for public download[7], which allows other groups to conduct independent analyses of VA care. Three recent studies published in prominent medical journals confirm VA outcomes are superior to the private sector across a broad range of measures.[8,9,10]

Table: Quality Outcomes (Mortality and Readmission)

Quality Outcomes (Mortality and Readmission)	**VA[11] July 1, 2018 – June 30, 2020**	**CMS[12] July 1, 2018 – June 30, 2020**
Mortality	**Rate**	**Rate**
30-day risk standardized mortality rate - Congestive Heart Failure (CHF RSMR)	8.6	11.3
30-day risk standardized mortality rate - Pneumonia (Pneumonia RSMR)	NA	NA
30-day risk standardized mortality rate – Acute Myocardial Infarction (AMI RSMR)	11.7	12.4
30-day risk standardized mortality rate – Chronic Obstructive Pulmonary Disease (COPD RSMR)	7.6	8.4
Readmission	**Rate**	**Rate**
30-day risk standardized readmission rate - Congestive Heart Failure (CHF RSRR)	22.4	21.3
30-day risk standardized readmission rate - Pneumonia (Pneumonia RSRR)	NA	NA
30-day risk standardized readmission rate - Acute Myocardial Infarction (AMI RSRR)	16.2	15
30-day risk standardized readmission rate – Chronic Obstructive Pulmonary Disease (COPD RSRR)	20.9	19.8

[6] PSI 03 – Pressure Ulcer Rate – is higher, a difference attributable to the higher proportion of Veterans with spinal cord injury and related diseases that are served in VA hospitals, compared to non-VA hospitals. This difference is not accounted for in statistical adjustment.
[7] https://data.medicare.gov/
[8] Blay E, DeLancey, JO, Hewitt, DB. Initial public reporting of quality at Veterans Affairs vs Non–Veterans Affairs hospitals. *JAMA Internal Medicine.* 2017;177:882-5.
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[10] Weeks WB, West AN. Veterans Health Administration Hospitals outperform non-Veterans Health Administration hospitals in most health care markets. *Ann Intern Med* 2018; 11 December 2018 doi: 10.7326/M18-1540
[11] VA National Average Risk Standardized Rate calculated by CMS. July 1, 2018 – December 31, 2019, July 1, 2020 – June 30, 2021
[12] CMS National Observed Rate (Hospital Compare) July 1, 2018 – December 31, 2019, July 1, 2020 – June 30, 2021

Quality Outcomes (Mortality and Readmission)	VA[11] July 1, 2018 – June 30, 2020	CMS[12] July 1, 2018 – June 30, 2020
30-day risk standardized readmission rate - Hospital Wide Readmission (HWR)	17.4	15

Patient Safety Indicators (PSIs)	VA Risk Adjusted Rate per 1,000 Discharges from July 1, 2020 – June 30, 2022[13]	CMS Reported Nationwide Mean Smoothed Rate per 1,000 Discharges from July 1, 2017 – June 30, 2019[14]
Pressure Ulcer Rate (PSI 03)	1.09	0.57
Inpatient Surgical Deaths (PSI 04)	145.00	160.23
Collapsed lung due to medical treatment (PSI 06)	0.47	0.23
Postoperative Hip Fracture (PSI 08)	0.14	0.10
Perioperative Bleeding/Bruise (PSI 09)	2.22	2.53
Postoperative Kidney and Diabetic Complications (PSI 10)	0.90	1.43
Postoperative Respiratory Failure (PSI 11)	4.09	5.18
Perioperative Blood Clot/Embolism (PSI 12)	3.37	3.60
Postoperative Sepsis (PSI 13)	3.47	4.94
A wound that splits open after surgery on the abdomen or pelvis (PSI 14)	0.58	0.86
Accidental puncture or laceration from medical treatment (PSI 15)	1.20	1.22

Healthcare-Associated Infections (HAIs)	VA[15] (January – December 2021)	NHSN/CDC[16]
	Mean	Median SIR[17]
1. Central Line Associated Bloodstream Infection Rate (CLABSI) per 1,000-line days		
Acute Care	0.675	0.747
ICU	1.4	1.209

[13] Rates in this column calculated using International Classification of Diseases – 10th Edition (ICD-10) diagnoses and Centers for Medicare & Medicaid Services (CMS) v.11 software and are ***risk adjusted rates that include the impact of covid.***

[14] Data presented in this column are ***nationwide mean smoothed rates*** based on an analysis of discharge data from Medicare fee-for-service discharge data from 3,293 Inpatient Prospective Payment System hospitals from 7/1/2017 through 6/30/2019 and ***do not include the impact of covid***.

[15] 2021 SIR rate for calendar year averaged the 4 quarters

[16] National Healthcare Safety Network (NHSN) – Centers for Disease Control and Prevention (CDC). National and State Healthcare-Associated Infection Progress Report, NHNS 20212021 Current HAI Progress Report | HAI | CDC

[17] SIR: Standardized Infection Rate.

2. Catheter Associated Urinary Tract Infection (CAUTI) per 1,000 catheter days		
Acute Care	0.78	0.779
ICU	1.32	0.798
		NHSN[18]
3. Total Bloodstream (BSI) Infection rates per 100 patient months		
Outpatient Dialysis Treatment Center	0.65	0.64
4. Access-Related Bloodstream (ARB) Infection rates per 100 patient months		
Outpatient Dialysis Treatment Center	0.35	0.49
5. Total Bloodstream Standardized Infection Ratio (SIR)		
Outpatient Dialysis Treatment Center	0.82	1.0

Impact of COVID-19

As a result of the global COVID-19 pandemic, most VA facilities have seen wide fluctuation in the numbers of admitted patients, most notably during community surge events. In response, health care providers have volunteered to travel to sites in need to provide direct inpatient care. VA facilities have provided inpatient care to residents of state Veterans homes and to civilian patients through activation of VA's Fourth Mission. Within facilities, health care providers have moved from outpatient to inpatient positions, as needed, to meet clinical demands. The following table provides an overview of inpatient utilization and outcomes related to the pandemic. The numbers of Veterans hospitalized primarily for COVID-19 related illness has been decreasing over 3rd and 4th quarters of 2022.

[18] Nguyen DB, Shugart A, Lines C and others. National Healthcare Safety Network (NHSN) Dialysis Event Surveillance Report. *Clin J Am Soc Nephrol* 2017;12:1139-1146.

COVID-19 Summary**		
Feb 28 – Nov 15, 2022	Hospitalization for COVID-19	105,807
	ICU Admission*	40,963 (38.7%)
	Mechanical Ventilation	4,941 (12.1% of ICU Admissions*)
	In-Hospital Mortality	8,620 (8.1%)
	State Veterans Home Patients Hospitalized in VA	1865
	4th Mission Civilian Patients Hospitalized in VA	528
Subset Feb 28 – Nov 15, 2022[19]	Veterans Hospitalized for COVID-19	104,363
	Length of Stay, days (IQR)	11 (6-16)
	ICU Admission	40,406 (38.7%)
	In-Hospital Mortality	8,465 (8.1%)

*ICU beds at some facilities have been used for non-critically ill COVID-19 patients, for example, to provide adequate isolation precautions and availability of nursing staff.
**Please note that all statistics are for a patient's known lifetime first episode of COVID-19 and so this is an underestimate. For subsequent episodes, it becomes increasingly difficult to determine whether hospitalization is "with" or "for" COVID-19.

[19] Cates J, Lucero-Obusan C, Dahl RM and others. Risk for In-Hospital Complications Associated with COVID-19 and Influenza — Veterans Health Administration, United States, October 1, 2018–May 31, 2020. *MMWR Morb Mortal Wkly Rep* 2020;69:1528–1534. DOI: http://dx.doi.org/10.15585/mmwr.mm6942e3.

Mental Health

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$9,327,093	$10,248,343	$10,708,318	$11,103,529	$12,743,363	$395,211	$1,639,834
Discretionary Obligations [Subtotal]	**$9,327,093**	**$10,248,343**	**$10,708,318**	**$11,103,529**	**$12,743,363**	**$395,211**	**$1,639,834**
Medical Community Care (0140):							
Discretionary Obligations	$828,247	$775,972	$1,050,815	$1,112,740	$1,181,175	$61,925	$68,435
Discretionary Obligations [Subtotal]	**$828,247**	**$775,972**	**$1,050,815**	**$1,112,740**	**$1,181,175**	**$61,925**	**$68,435**
Medical Support and Compliance (0152):							
Discretionary Obligations	$1,058,625	$1,435,900	$1,309,800	$1,449,400	$1,493,400	$139,600	$44,000
Discretionary Obligations [Subtotal]	**$1,058,625**	**$1,435,900**	**$1,309,800**	**$1,449,400**	**$1,493,400**	**$139,600**	**$44,000**
Medical Facilities (0162):							
Discretionary Obligations	$1,317,526	$1,458,700	$1,746,000	$2,577,800	$1,783,100	$831,800	($794,700)
Discretionary Obligations [Subtotal]	**$1,317,526**	**$1,458,700**	**$1,746,000**	**$2,577,800**	**$1,783,100**	**$831,800**	**($794,700)**
Discretionary Total	**$12,531,491**	**$13,918,915**	**$14,814,933**	**$16,243,469**	**$17,201,038**	**$1,428,536**	**$957,569**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$143,476	$306,674	$437,290	$163,198	$130,616
Veterans Medical Care and Health Fund (0173)	$176,533	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$31,999	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$667	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$209,199**	**$0**	**$143,476**	**$306,674**	**$437,290**	**$163,198**	**$130,616**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$173,928	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$53	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$856	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$174,836**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$1,118	$36,481	$42,919	$35,363	$6,438
Veterans Medical Care and Health Fund (0173)	$20,434	$0	$21,558	$0	$0	($21,558)	$0
VACAA, Section 801 (0152)	$411	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$20,845**	**$0**	**$22,676**	**$36,481**	**$42,919**	**$13,805**	**$6,438**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$79,956	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$1,409	$0	$2,248	$1,201	$0	($1,047)	($1,201)
Mandatory Obligations [Subtotal]	**$81,366**	**$0**	**$2,248**	**$1,201**	**$0**	**($1,047)**	**($1,201)**
Mandatory Total	**$486,247**	**$0**	**$168,400**	**$344,356**	**$480,209**	**$175,956**	**$135,853**
Combined Discretionary and Mandatory by Category							
Medical Services	$9,536,292	$10,248,343	$10,851,794	**$11,410,203**	**$13,180,653**	$558,409	$1,770,450
Medical Community Care	$1,003,084	$775,972	$1,050,815	**$1,112,740**	**$1,181,175**	$61,925	$68,435
Medical Support and Compliance	$1,079,471	$1,435,900	$1,332,476	**$1,485,881**	**$1,536,319**	$153,405	$50,438
Medical Facilities	$1,398,892	$1,458,700	$1,748,248	**$2,579,001**	**$1,783,100**	$830,753	($795,901)
Obligations [Grand Total]	**$13,017,738**	**$13,918,915**	**$14,983,333**	**$16,587,825**	**$17,681,247**	**$1,604,492**	**$1,093,422**

Authority for Action

- 38 C.F.R. § 17.38 Medical Benefits Package
- 38 C.F.R § 17.98 Mental Health Services
- 38 U.S.C. §1712A, §1720H, §1720I
- P.L. 114-2, Clay Hunt Suicide Prevention for American Veterans Act
- Executive Order 13822, issued on January 9, 2018

The chart below displays different ways of categorizing obligations for VA mental health programs by treatment modality and by major characteristics of the program and also shows obligations for the Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND) population, as well as the average daily census and number of outpatient visits, as defined below:

Treatment Modality (Continuum of Care)

- VA Inpatient Hospital: VA inpatient bed based acute and long stay psychiatric care.
- Non-VA Inpatient Hospital: Purchased community inpatient bed based acute psychiatric care.
- Psychiatric Residential Rehabilitation Treatment: Staffed structured residential environment in the community providing some mental health services augmented by use of other VA outpatient services.
- VA Domiciliary Residential Rehabilitation Treatment: Staffed structured residential environment in a VA medical center (VAMC) providing some mental health services augmented by use of other VA outpatient services.
- VA Outpatient Clinic: The full range of VA mental health clinics, providing encounters with Psychiatrists, Psychologists, Social Workers, Nurses, Licensed Professional Mental Health Counselors, Marriage and Family Therapists and many other MH staff. The encounters may be individual, group or couples/family sessions. The issue may be general mental health or care with special emphasis on complex posttraumatic stress disorder (PTSD), substance use disorders, homelessness and other behavioral concerns.
- Non-VA Outpatient: General mental health service purchased from the community.

Suicide Prevention: Suicide prevention contains the Veteran Crisis Line, suicide coordinators and the cost of other national efforts to improve awareness of the risk of suicide and improve the care to those Veterans.

Suicide Prevention Treatment in Non-MH Setting: Suicide prevention is everyone's business, everyone has a role to play and suicide prevention services are available throughout the continuum of VA health care. These are services documented for patients at risk of suicide that do not take place in one of the previously described mental health treatment modalities. This will be care for patients at risk of suicide who present at the ER or may be managed in another setting like PC.

Major Characteristics of Program: The major characteristics in this section break out the care provided to Veterans with serious mentally illness (SMI) by sub-specialty such as PTSD, substance use and general mental health services. In addition, it shows the care associated with suicide prevention efforts and a default category which contains all the other mental health specialty care not provided to the SMI population, all community care mental health and all mental health provided in a non-mental health specialty setting, such as PC clinic.

Table: VA Mental Health Obligations by Treatment Modality and Major Characteristics

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Treatment Modality ($000):							
VA Inpatient Hospital	$2,018,810	$2,205,292	$2,258,871	$2,549,291	$2,659,378	$290,420	$110,087
Contract Inpatient Hospital	$1,083,768	$834,975	$1,000,538	$1,036,738	$1,089,690	$36,200	$52,952
Psychiatric and VA Dom Res. Rehab. Trmt	$951,108	$973,259	$1,009,951	$1,281,162	$1,299,756	$271,211	$18,594
VA Outpatient Clinics	$6,885,872	$7,868,910	$8,395,940	$9,197,509	$9,973,765	$801,569	$776,256
Non-VA Outpatient	$249,611	$197,710	$376,250	$417,287	$453,145	$41,037	$35,858
Subtotal Direct Mental Health	$11,189,169	$12,080,146	$13,041,550	$14,481,987	$15,475,734	$1,440,437	$993,747
Non-Add included above:							
Suicide Prevention Treatment in MH setting	*$1,579,764*	*$1,662,360*	$1,709,870	$1,816,787	$1,924,505	*$106,917*	*$107,718*
Suicide Prevention Outreach 1/:							
Suicide Prevention Direct Program, SP	$456,171	$431,857	$433,357	$485,532	$493,713	$52,175	$8,181
Suicide Prevention Coordinators, GP	$66,582	$64,741	$70,377	$73,262	$76,192	$2,885	$2,930
Subtotal Suicide Prevention Program Subtotal	$522,753	$496,598	$503,734	$558,794	$569,905	$55,060	$11,111
Suicide Prevention Treatment in Non MH Setting	$572,888	$639,616	$620,069	$658,842	$697,905	$38,773	$39,063
Contract Homeless	$192,812	$201,680	$196,307	$199,958	$204,091	$3,651	$4,133
VA - Mental Health in non MH Setting	$540,118	$500,874	$621,673	$688,244	$733,612	$66,571	$45,368
Total Mental Health	**$13,017,739**	**$13,918,914**	**$14,983,333**	**$16,587,825**	**$17,681,247**	$1,604,492	$1,093,422
Major Characteristics of Program ($000):							
SMI - PTSD	$354,871	$379,900	$402,503	$455,471	$514,878	$52,968	$59,407
SMI - Substance Abuse	$706,327	$697,700	$796,701	$892,230	$990,971	$95,529	$98,741
SMI - Other Than PTSD & SA	$6,158,550	$5,290,500	$6,757,179	$7,356,245	$7,955,491	$599,066	$599,246
Subtotal, SMI	$7,219,748	$6,368,100	$7,956,383	$8,703,946	$9,461,340	$747,563	$757,394
Suicide Prevention Outreach	$522,753	$496,598	$503,734	$558,794	$569,905	$55,060	$11,111
Other Mental Health (Non-SMI)	$5,275,238	$7,054,216	$6,523,216	$7,325,085	$7,650,002	$801,869	$324,917
Total Mental Health	**$13,017,739**	**$13,918,914**	**$14,983,333**	**$16,587,825**	**$17,681,247**	$1,604,492	$1,093,422
Included Above:							
OEF/OIF/OND POPULATION *ONLY*:							
SMI - PTSD	$172,073	$197,162	$203,622	$230,226	$249,911	$26,604	$19,685
SMI - Substance Abuse	$196,960	$215,518	$233,073	$263,524	$286,057	$30,451	$22,533
SMI - Other Than PTSD & SA	$1,494,869	$1,672,611	$1,768,955	$2,000,069	$2,171,084	$231,114	$171,015
Subtotal, SMI	$1,863,903	$2,085,291	$2,205,650	$2,493,819	$2,707,052	$288,169	$213,233
Other Mental Health (Non-SMI)	$959,798	$1,167,251	$1,135,778	$1,284,167	$1,393,969	$148,389	$109,802
Total OEF/OIF/OND	$2,823,700	$3,252,542	$3,341,428	$3,777,986	$4,101,021	$436,558	$323,035
Average Daily Census:							
Acute Psychiatry	1,676	1,986	1,609	1,571	1,553	1,951	(18)
Contract Hospital (Psych)	1,506	1,382	1,686	1,894	2,105	208	211
Psy Residential Rehab	3,283	3,039	3,886	4,017	4,189	131	172
Total	6,465	6,407	7,181	7,482	7,847	301	365
Outpatient Visits:							
VA Care - Mental Health	15,812,485	19,531,243	17,333,517	17,861,570	18,273,584	1,951	412,014
Non-VA Care - Mental Health	1,221,174	1,009,087	1,564,927	1,622,952	1,688,118	1,951	65,166
Not Included Above:							
VA - Mental Health in non MH Setting	1,789,291	1,777,352	2,059,464	2,279,999	2,430,293	220,535	150,294

1/ Suicide Prevention and Outreach program costs are depicted in these two rows. Please see the Suicide Prevention narrative later in this chapter for additional detail.

Population Covered

Mental health care at VA comprises an unparalleled system of comprehensive treatments and services to meet the needs of each Veteran and the family members involved in the Veteran's care. Veteran demand for VHA mental health care continues to grow, with approximately 1.86 million Veterans (29% of all VHA users) receiving mental health services in a VHA specialty mental health setting in 2022.

Across VA settings of care, more than 550,000 Veterans were seen in 2022 for a substance use disorder diagnosis. The proportions of VHA health service users who receive mental health treatment are highest among younger Veterans and decline with age. The proportions are also slightly higher for women as compared to men in older age groups with the gap declining in Veterans younger than age 35. Reflecting the size of the cohort of male Veterans over age 65, 61% of all users of VHA services in specialty mental health settings were men over age 50.

Type of Services Provided

Consistent with the Secretary's goal to innovate and deliver services more efficiently, the OMHSP now includes the Veterans Crisis Line (VCL) and the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) to accelerate VA's commitment to be there for Veterans, to prevent suicide, to promote recovery and to ensure access to high-quality mental health care across the entire spectrum of needs. OMHSP provides policy and implementation guidance and oversight and management of mental health and suicide prevention services. This alignment improves efficiency, deployment of resources toward priorities and communication and collaboration with VHA field operations. Additional information on VA's suicide prevention efforts and outreach is provided under Suicide Prevention narrative.

VA provides a comprehensive continuum of outpatient, residential and inpatient mental health services for the full range of mental health conditions. VA proactively screens for symptoms of depression, PTSD, problematic use of alcohol, experiences of military sexual trauma (MST) and suicide risk. VHA mental health services are based on a recovery-oriented model of care that offers rehabilitation to improve functioning, as well as treatment of symptoms. In this model, the Veteran and provider collaborate in developing the treatment plan to ensure that care is responsive to the individual Veteran's needs and that it promotes lifelong health and well-being. VHA mental health care rests on the principle that it is an essential component of overall health care and it requires the availability of a continuum of services, including self-help resources, telephone crisis intervention services, outpatient care, residential care (known as mental health residential rehabilitation treatment programs) and acute inpatient care. Program requirements for the full range of mental health services that VHA delivers are specified in VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics (the Uniform Mental Health Services Handbook), published in 2008 and amended in 2015.

VA's efforts to ensure access to high quality mental health care include the following:

- Availability of same-day mental health services at every VA health care facility.
- Robust use of technology such as tele-mental health resources, mobile apps and web-based self-help courses
- Integration of mental health care within PC, geriatric and specialty medical care programs and clinics.
- Leading the Nation in training mental health providers in evidence-based mental health treatments.
- VA's mental health centers of excellence conduct cutting edge research, provide education and implement clinical innovations across the VA system.

VA employs a mental health workforce of more than 20,000 psychiatrists, psychologists, social workers, nurses, counselors, therapists and peer specialists. Psychiatry and psychology have been identified by the Office of Personnel Management (OPM) as mission critical occupations that are difficult to fill in VA.

Recent Trends

- In 2019, the Mental Health Hiring Initiative completed hiring of over 1,000 additional mental health providers. VA is currently undertaking a Mental Health Hiring Sustainability Initiative (begun in 2019), which is providing targeted planning and human resources support for the facilities struggling the most with having adequate mental health staffing. In 2020, VA saw a net increase of 883 staff.
- The number of outpatient mental health encounters or treatment visits more than doubled between 2006 and 2022 (from 10.7 million to 21.8 million).
- Between 2006-22, the number of Veterans who received mental health care from the VHA grew by 85%. This rate of increase is more than three times the rate for VHA users overall. The proportion of Veterans served by VHA who receive mental health services has increased substantially. In 2006, 20% of VHA users received mental health services and in 2022, the figure was 29%.
- Since 2005, there has been a more than threefold increase in the number of women Veterans accessing VHA mental health services. In 2022, 223,000 women Veterans received VHA mental health care, representing approximately 42% of all women VHA patients.
- Introduction of peer specialists to the mental health workforce provides unique opportunities for engaging Veterans in care and supporting a Veteran-centric approach to mental health. Currently, there are 1,210 peer support staff members working in outpatient, inpatient and residential mental health services as well as homelessness programs. VA has also developed useful web and mobile tools to help connect Veterans and their families to mental health resources.
- VA has partnered with the VA Office of Patient Centered Care and Cultural Transformation to expand the VA's growing whole health orientation to mental health care. Like mental health recovery, whole health emphasizes biopsychosocial, spiritual holistic treatment that addresses what matters to the Veteran rather than maintaining a focus exclusively on symptom reduction.
- VHA is a recognized leader in evidence-based psychotherapy (EBP) training with 16 EBP training programs that address PTSD, depression, SUD, serious mental illness (SMI) and suicide prevention, as well as cross-cutting issues such as chronic pain, insomnia, motivation for treatment, relationship distress and problem-solving skills. VHA has trained over 16,500 clinicians in one or more of these EBPs.
- In 2017, VA began offering emergent mental health services to former Service members with other than honorable administrative discharges. In 2022, 4,692 Service members with an other than honorable discharge received mental health services.

- VA has used big data from its electronic medical record and predictive analytics to target clinical attention and outreach to Veterans estimated to be at highest risk of suicide and overdose.
- The Recovery Engagement and Coordination for Health - Veterans Enhanced Treatment (REACH VET) uses a statistical algorithm to identify patients at the highest risk of suicide in the next month. Once identified, a facility's REACH VET Coordinator identifies a clinician who knows the Veteran best. This clinician reviews the care the Veteran is receiving and reaches out to the Veteran. During this contact, clinical risk is assessed and collaborative discussions regarding care enhancement occur. Data suggests that in comparison to control groups, Veterans identified by REACH VET exhibited:
    - Increases in outpatient appointments
    - Decreases in percent of missed appointments
    - Greater initiation of suicide prevention safety plans
    - Decreases in inpatient mental health admissions
    - Reduced emergency department visit days
    - Reduced documented suicide attempts
- VA's Stratification Tool for Opioid Risk Mitigation (STORM) uses VHA administrative data and predictive modeling to help improve opioid safety by identifying patients at the highest risk for overdose or suicide-related events and assigning them a risk score. STORM is updated nightly and provides risk scores and risk mitigation strategies for patients with an active outpatient opioid prescription or who have an opioid use disorder. Since VA mandated case reviews for all Veterans identified as very high risk for overdose or suicide by STORM, a randomized program evaluation found a 22% reduction in all-cause mortality among patients targeted by this prevention program.
- The VA Opioid Overdose Education and Naloxone Distribution (OEND) program aims to decrease opioid-related overdose deaths among VHA patients by providing education on opioid overdose prevention, recognition of opioid overdose and training on the rescue response, including provision of naloxone. Since implementation of the OEND program in 2014, over 44,500 VHA prescribers, representing all VHA facilities, have prescribed naloxone and more than 837,200 naloxone prescriptions have been dispensed to over 394,300 Veterans (4th Quarter 2022). Further, as documented through spontaneous reporting of overdose reversal events as well as through a national note template, over 3,200 overdose reversals with naloxone have been reported, with an additional 146 reversals reported from naloxone in AED Cabinets and carried by VA Police.

Projections for the Future

- VA projects demand for services, not the number of patients consuming services. VA projects a 30% growth in inpatient and outpatient mental health care during the period from 2017-30 (an increase from 17.8 million to 25.4 million). In 2019, VA already provided 21.8 million outpatient mental health encounters or treatment visits. The projection for 2024, demonstrates continued high demand for mental health services. During the same

period, the inpatient-bed-days-of-care measurement is expected to be stable at about 3.4 million.

- Rapid growth in demand poses challenges for maintaining adequate mental health staffing to continue providing timely access to high quality, evidence-based mental health services. The Mental Health Hiring Initiative launched in 2017 successfully met the goal of increasing mental health providers by adding 1,045 additional net providers to the current workforce by December 2018. Since 2019 VA embarked on a Mental Health Hiring Sustainability Initiative to facilitate hiring and retention at facilities with severe shortages of mental health staff.
- Continue to increase Veterans' access to care through increased mental health staff hiring and ongoing expansion of telehealth services.
- Continue national outreach efforts to increase awareness of mental health services and resources, reduce negative perceptions about seeking mental health care and improve mental health literacy among Veterans, their families and friends.
- Proactively support transitioning Service members' mental health.
- Advance national implementation of measurement-based care (MBC) in mental health.
- Continue expansion of open access to care, ensuring access for urgent mental health care needs as well as sustained access to meet ongoing care needs.

Opioid Prevention, Treatment and Program

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2022-2023	+/- 2023-2024
Treatment Modality ($000):							
MH Inpatient	$114,678	$96,372	$121,214	$126,184	$131,231	$4,970	$5,047
MH Clinics	$117,206	$137,131	$123,887	$128,966	$134,125	$5,079	$5,159
MH Dom/RRT	$66,103	$68,608	$69,871	$72,736	$75,645	$2,865	$2,909
Methadone	$38,174	$42,187	$40,350	$42,004	$43,684	$1,654	$1,680
Other Inpatient	$12,001	$10,192	$12,686	$13,206	$13,734	$520	$528
Other OPC	$49,233	$41,040	$52,040	$54,174	$56,341	$2,134	$2,167
Subtotal Treatment	**$397,395**	$395,530	$420,048	$437,270	$454,760	$17,222	$17,490
Pharmacy	$21,455	$21,521	$22,678	$23,608	$24,552	$930	$944
Total Treatment	**$418,850**	**$417,051**	**$442,726**	**$460,878**	**$479,312**	**$18,152**	**$18,434**
Jason Simcakoski Memorial and Promise Act (*Jason's Law*) 1/ 2/ 3/:							
Pain and Opioid Management Services	$115,857	$207,197	$207,197	$215,712	$215,712	$8,515	$0
Pain and Opioid Management Administration	$3,399	$5,588	$5,588	$5,806	$5,806	$218	$0
Patient Centered Care Services	$25,270	$29,857	$29,857	$29,857	$29,857	$0	$0
Patient Centered Care Administration	$3,098	$3,112	$3,112	$3,112	$3,112	$0	$0
Program [Subtotal]	**$147,624**	**$245,754**	**$245,754**	**$254,487**	**$254,487**	**$8,733**	**$0**
Total Opioid Prevention, Treatment and Program Cost	**$566,474**	**$662,805**	**$688,480**	**$715,365**	**$733,799**	**$26,885**	**$18,434**

1/ Included in the Comprehensive Addiction and Recovery Act of 2016 (CARA)
2/ Patient Centered Care Services and Administration is included with the Whole Budget request shown later in the chapter.
3/ Office of Patient Advocacy's annual budget of $11.0 million is no longer reflected in this table

Authority for Action

- 38 U.S.C. § 1701,1730B, 7301(b), 5701(l), 7332.
- 38 C.F.R. § 1.483, 1.515, 17.419.
- Jason Simcakoski Memorial and Promise Act, P.L. 114-198 § 901-933

VA continues to pursue a comprehensive strategy that promotes safe opioid prescribing when indicated for effective pain management, treatment of Opioid Use Disorder (OUD) and prevention of opioid overdose. Through authorities established by the enactment of the Comprehensive Addiction and Recovery Act of 2016 (CARA) (P.L. 114 – 198), in Title IX, the Jason Simcakoski Memorial and Promise Act, otherwise known as Jason's Law, the Pain Management Program in Specialty Care Services (SCS), now Specialty Care Program Office (SCPO), expanded to form the Pain Management, Opioid Safety and Prescription Drug Monitoring Program (PMOP) in 2020. The 2024 budget request of $221.5 million, which is a 3.9% increase from 2023, will continue to provide targeted support for pain management and opioid safety programs primarily at the facility level, with national support, to ensure successful implementation and increase access to care across the enterprise, especially in rural areas.

Purpose

1. <u>Opioid Overdose Education and Naloxone Distribution (OEND):</u>

The VA Opioid Overdose Education and Naloxone Distribution (OEND) program aims to decrease opioid-related overdose deaths among VHA patients by providing education on opioid overdose prevention, recognition of opioid overdose and training on the rescue response, including the provision of naloxone. VA recommends offering OEND to Veterans prescribed or using opioids who are at increased risk for opioid overdose or whose provider deems it clinically indicated.

In September 2018, VA launched a Rapid Naloxone Initiative consisting of three elements:

- OEND to VA patients at-risk for opioid overdose,
- VA Police Naloxone and
- Automated External Defibrillator (AED) Cabinet Naloxone (Oliva and others, 2021).

VA's efforts include continuing to fund naloxone free to high-risk VHA patients (as is legislatively required by Jason's Law) and free to facilities (to reduce barriers to distribution), development and delivery of new educational and training materials (for academic detailing and field use) and providing support to the expansion of naloxone to first responders (VA Police) and in AED cabinets. VA issued a series of subsequent memos aimed at expanding OEND efforts to reach patients who use stimulants (given the high rates of stimulant overdose deaths involving opioids), require post-overdose reporting and improve post-overdose care through interdisciplinary risk reviews. A portion of the requested funding in 2024 will support the continued growth and replenishment of VA's OEND program.

VA is a national and international leader in naloxone distribution to health care patients (Oliva and others, 2017). OEND program 2022 achievements include:

- In 2018, VA dispensed a naloxone prescription for 1 in 6 patients on high-dose opioids (Oliva and others, 2021) compared to 1 in 69 patients in the private sector (Guy and others, 2019). By April 2021, 129 facilities equipped their VA Police with naloxone and 77 facilities deployed naloxone in AED cabinets. Across VA, this accounted for at least 1,095 AED cabinets and 3,552 VA Police Officers equipped with naloxone. The impact of these efforts is apparent across VHA, with an additional 146 reversals reported from AED cabinet and VA Police naloxone (10 and 136 reversals, respectively).
- Academic detailers (specially trained VA pharmacists) promoted OEND through individualized, evidence-based educational outreach visits and consultations for clinicians by clinicians, having completed more than 33,000 such visits with more than 23,000 health care professionals nationwide by 2022 Q4.
- VA Clinical Pharmacist Practitioners (CPP) provide outreach to Veterans through population health efforts to optimize OEND. The CPP focus is on ensuring that Veterans considered at high risk have naloxone on hand and are educated about overdose prevention and are offered other risk mitigation strategies to further reduce the risk of overdose. VA CPPs have prescribed 22% of all naloxone prescriptions accounting for over 48,500 released prescriptions to Veterans.
- Since implementing the OEND program in 2014, over 44,500 VHA prescribers, representing all VHA facilities, have prescribed naloxone and more than 837,200 naloxone prescriptions have been dispensed to over 394,300 Veterans (as of 2022 Q4).
- Through 2022 Q4, over 3,200 overdose reversals with naloxone have been documented through spontaneous reporting of overdose reversal events or the national note.
- On February 24, 2021, VHA released the memorandum Naloxone Distribution to Veterans Diagnosed with OUD, which aims to increase naloxone distribution among this high-risk population. Between 2021 Q1 and 2022 Q3 there was a 25% national increase in naloxone distribution among patients with OUD (increased from 38.7% to 63.7%, respectively).
- VA's Rapid Naloxone Initiative received the 2020 John M. Eisenberg National Level Innovation in Patient Safety and Quality Award. This prestigious award from The Joint Commission (TJC) and National Quality Forum recognizes those who have made significant and long-lasting contributions to improving patient safety and care health care quality.

2. <u>Opioid Stewardship:</u>

To support the implementation of Jason's Law, PMOP utilized funds to support current and newly established positions, including expansion of the Opioid Safety Initiative (OSI). Since 2021, PMOP has provided funding to support the hiring of PMOP Coordinators for each VA medical center and VISN. The PMOP Coordinator's role is critical to continue and expand opioid stewardship initiatives and for assessment of OSI effectiveness, addressing new and evolving evidence-based best practices and tracking trends in the opioid epidemic nationwide as mandated by The Joint Commission. This includes collaboration with Integrated Veteran Care (IVC) regarding opioid risk mitigation strategies for community care prescribers, mandated by the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 (P.L. 115-182) and Office of the Inspector General (OIG) recommendations. Additional

collaboration entails work with the Office of Information Technology (OIT) and Office of Electronic Health Record Modernization (OEHRM) to integrate a network of individual state, regional and Department of Defense (DoD) prescription drug monitoring programs (PDMPs) into VHA's electronic health record (EHR), as recommended in the National Drug Control Strategy of the Office of National Drug Control Policy (ONDCP). The 2024 budget will support facility and Veterans Integrated Service Network (VISN) pain and opioid safety leadership positions and will continue to expand and monitor the progress of the OSI.

Opioid safety activities achievements through 2022 include:

- PMOP expanded communication to the field by hosting monthly community of practice calls for behavioral pain management and for PMOP coordinators. There are currently over 350 VHA staff actively participating in these channels.
- PMOP has funded capstone projects for the VA Addiction Scholars Program.
- PMOP is working closely with the SUD Program in OMHSP to assist in addressing the requirements related to the GAO 2021 Drug Misuse High-Risk List (HRL) working towards outcomes for the Federal-wide efforts under the direction of ONDCP.
- PMOP is commencing several evaluative efforts including a PMOP Measures Initiative to explore measures and metrics that will be used to develop a core minimum measure set for reportable data across VA.
- Data efforts include expanding patient-reported outcomes using computerized adaptive technology, legacy measures and an evaluation of facility-level variations in pain specialty care services, including pain management teams (PMT) and pain clinics.
- PMOP supports funding of medication take back, mailing envelopes for Veterans, ensuring Veterans have a means of safely disposing of expired or unwanted prescription and over-the-counter drugs. The envelopes are free to Veterans and do not require postage.
- PMOP has collaborated with the VHA Support Service Center (VSSC) to create a database with an end user associated dashboard to track the hiring and onboarding of PMOP funded staff for PMOP's seven field hiring initiatives, including:
    - VA CPPs in collaboration with NPs or Physician Assistants to provide CARA-mandated medication management in PMTs (MMPMT),
    - Whole health coaches on PMTs (WHCPMT),
    - Psychologist and physical therapist duos in PMTs providing treatment under a newly created Active Management of Pain (AMP) Protocol,
    - Sustained funded VISN and facility-level PMOP coordinators, pain consultants, pain point of contacts (POC) and PAC plan pain champions,
    - PMT staffing to fill gaps and expand clinical pain care services, including high functioning PMTs at all facilities,
    - Clinical resource hub TelePain teams,
    - Mental health practitioner integration into pain and oncology clinics.

- PMOP has organized a workgroup of subject matter experts on the Enterprise Opioid Strategy Team (EOST) to develop and implement a multi-pronged strategy to address the seven recommendations outlined in the OIG's Comprehensive Healthcare Inspection Summary Report: Evaluation of Medication Management in Veterans Health Administration Facilities, Fiscal Year 2020 (VA OIG Report #21-01507-61) regarding long-term opioid therapy. PMOP has additionally commenced efforts to track relevant metrics enterprise-wide to ensure compliance with the recommendations.
- PMOP, in collaboration with the Clinical Pharmacy Practice Office (CPPO), developed and provided two virtual regional PMOP coordinator trainings to facilitate the implementation of comprehensive and coordinated opioid stewardship programs. The first session was held in April 2022 and the second session in June 2022. The curriculum focused on effective consultation and oversight regarding gaps in pain care delivery at facilities, safe pain care, leading change, resource management, health equity and addressing stigma.
- PMOP has initiated funding of a Sterile Syringe Program (SSP) to provide preventative and treatment services to Veterans who inject drugs and preventative services like vaccinations, naloxone to prevent overdose and pre-exposure prophylaxis (PrEP), a medication that prevents Human Immunodeficiency Virus (HIV).
- PMOP provides funding for 35 hours of accredited educational webinars annually through the VA Extension for Community Healthcare Outcomes (VA-ECHO) to address pertinent topics related to pain management and opioid safety.
- In 2018, MISSION Act established regulatory authority to assert federal supremacy for VA providers and authorized delegates to access the network of state and regional prescription drug monitoring programs (PDMP). Led by VHA's PMOP program, VA modernized the legacy Computerized Patient Record System (CPRS) by successfully deploying an integrated PDMP solution enterprise-wide in November 2020. The tool enables querying the network of PDMPs from within the Veteran's EHR, providing greater efficiency and satisfaction for providers while supporting the safe prescribing of controlled substances. In November 2022, the integrated PDMP solution for CPRS reached its two-year milestone. The tool now connects to 52 of the 54 individual state/regional/DoD PDMPs making it the largest existing network of PDMPs. Over 5 million queries have been executed through the tool to help guide treatment decisions. VA staff are now executing approximately 125,000 queries every two weeks using this tool.

3. TelePain (including prevention and treatment of Opioid Use Disorder):

In alignment with VHA's goal of delivering high-quality, accessible and integrated health care by strategically expanding virtual care, giving Veterans the choice to receive appropriate care at home and in the community, SCPO plans to expand VA access to specialty care through virtual modalities for Veterans, their family members and their caregivers. To that end, a portion of VA's 2023 and 2024 budget has been committed to increasing access to care via telehealth to ensure rural Veterans have access to the timely, quality care. Many aspects of complex chronic-pain care may be managed on a regular basis through these remote capabilities, decreasing the need for patients to travel to their closest clinic. The limited availability of pain specialty providers nationwide, especially in rural settings, has contributed to inadequate staffing of pain teams at

some VA facilities. Therefore, the 2024 budget request includes efforts to expand TelePain models at VISNs and facilities to provide multimodal pain care including pharmacological, behavioral, restorative and integrative pain care modalities and in particular provide oversight of opioid therapy including risk mitigation and OUD prevention and treatment with evidence-based approaches, in particular medication for OUD (MOUD). This budget request supports staffing both at the program and field levels, training, supplies, equipment and other tools needed to support the program. Initial funding will be provided to field sites to assist with hiring and staffing of the new activity. On-going national program office resources will be required to support the effort throughout the life of the program. Full time, centralized support of the program is essential.

Additionally, the ONDCP's National Drug Control Strategy (2022) and the ONDCP National Treatment Plan for Substance Use Disorder reflect the compelling need to provide access to evidence-based treatment modalities related to pain care and opioids for rural Veterans. VA is committed to addressing the unique challenges presented by a rural population that has been ravaged by the impacts of the opioid crisis.

Allocated funds expand capacity for TelePain efforts in the field, including:

- Clinical and staffing resources both at the program and field levels, including training, supplies, equipment and other tools needed to support the program.
- PMOP's creation of VHA's first TelePain Neuromodulation Program across the enterprise as part of the development of the Specialty Care Program Office-National Virtual Specialty Care Services Program (SCPO-VSCS) to include evidence-based interventions for pain management following appropriate biopsychosocial evaluation and determination of benefit.
- Implementing pain and opioid-related care using the existing tele-hub structure of the VISN-based clinical resource hubs with additional specialists in the areas of pharmacy as well as chronic-pain and opioid use disorder treatment, with access to medical, behavioral, restorative and integrative modalities added to each VISN hub site.
    - Implementation of such CRH TelePain teams in 2022. At the start of 2023, 12 of 18 VISNs will be participating. Further expansion is planned for 2024 and beyond to eventually reach Veterans in all VISNs.
- Expanding and complementing existing telehealth efforts by offering new care for complex pain and opioid safety that aligns with the VA goals for addressing the opioid epidemic and serves, in particular, Veterans living in rural communities.

4. <u>Pain Management Team (PMT)/Pain Clinic staffing:</u>

Jason's Law § 911(c) requires identification and designation of "a pain management team of health care professionals, which may include board certified pain medicine specialists, responsible for coordinating and overseeing pain management therapy at such facility for patients experiencing acute and chronic pain that is non-cancer related." VA's 2023 and 2024 pain management and opioid safety budget are being utilized to establish and sustain positions that support these Jason's Law-mandated interdisciplinary PMTs through field funding to staff a high functioning PMT at each VAMC. VAMCs have made great strides in establishing and beginning to staff and train the PMTs. Data gathered in the Spring of 2022 indicates 127 of 140 sites have a pain team, with staffing and represented disciplines varying greatly. Even at facilities reporting fully implemented

interdisciplinary PMTs, the volume of complex, high risk, chronic pain patients within VHA generally overwhelms capacity of these programs. This generates problematic pressure on other services, particularly primary care and limits Veteran access to evidence-based treatment modalities which requires additional staffing support of the PMTs created to address these complex cases. Further, PMTs will improve patient care outcomes by increasing provider utilization of pain specialty care services including e-consults and pain behavioral health. PMTs will empower the provider to manage patients experiencing complex chronic pain through education and outreach initiatives.

In 2023 and 2024, VISNs and facilities will be able to apply a portion of existing PMOP-supplied resources for hiring and retaining staff, training and education. VA's allocated budget is utilized to initiate and establish positions that support Jason's Law-mandated interdisciplinary PMTs through field funding to staff an active PMT at all sites.

- Since 2021, funds have been provided to be used for dedicated staffing at VISNs and facilities to ensure oversight, reporting and coordination of pain and opioid initiatives.
    - In addition to PMOP Coordinator positions (see Opioid Stewardship), funds have been used to support pain points of contact/consultants (0.25 FTE) and PC pain champions (0.25 FTE).
- Establishment and sustainment of PMTs to provide access to comprehensive specialty care.
    - Since March 2022, PMOP has supported four new initiatives with five-year seed funding to the field focused on staffing in pain clinics:
        - The Active Management of Pain (AMP) initiative delivers multimodal pain rehabilitation accessible in a pain clinic setting that maximizes resources in a small team setting.
        - The Medication Management in Pain Management Team's (MMPMT) initiative focuses on safe opioid prescribing in pain specialty care clinics and integrated access to medication for opioid use disorder (MOUD) through the integration of Clinical Pharmacist Practitioners (CPPs) and Nurse Practitioners/Physician Assistants to provide collaborative pain and opioid addiction medication management services.
        - The Whole Health Coaches in Pain Management Teams (WHCPMT) initiative seeks to staff pain clinics with Whole Health coaches to support the self-management pillar of the stepped care pain model.
        - The Mental Health Integration in Pain Clinics (MHIPC) initiative seeks to hire mental health providers to be integrated into pain clinics to provide mental health care and suicide prevention.
- PMOP field funding to support Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited Interdisciplinary Pain Rehabilitation Programs (IPRPs) in all VISNs.
- PMOP will begin evaluating best practices in care coordination to support future field funding initiatives underpinning and building upon PMTs in pain clinics.

- PMTs will complete a charter and establish a formal referral pathway for increasing the number of patients seen by PMTs.

5. Evidence:

Opioid Overdose Education and Naloxone Distribution: There are many studies to support the lifesaving potential of naloxone (Bird and others, 2016; McDonald & Strang, 2016; Walley and others, 2013; Wheeler and others, 2015). Within VA, an analysis of the impact of academic detailing on naloxone prescribing between October 2014 through September 2016 found a beneficial effect with the average number of naloxone prescriptions being seven times greater among providers with at least one OEND-specific academic detailing visit (Bounthavong and others, 2017).

Increasing naloxone availability is included in the ONDCP's Federal National Drug Control Strategy (NDCS) and is included in a Surgeon General Advisory from 2018 (available at: https://www.hhs.gov/surgeongeneral/priorities/opioids-and-addiction/naloxone-advisory/index.html).

Additional References:

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- Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic (Dec 2020), HAN Archive - 00438 | Health Alert Network (HAN) (cdc.gov). Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic (Dec 2020), HAN Archive - 00438 | Health Alert Network (HAN) (cdc.gov).

Opioid Stewardship: These efforts are supported by the following published articles:

- Sandbrink F, Oliva EM, McMullen TL, Aylor AR, Harvey MA, Christopher ML, Cunningham F, Minegishi T, Emmendorfer T, Perry JM (2020). Opioid Prescribing and Opioid Risk Mitigation Strategies in the Veterans Health Administration. J Gen Intern Med. 2020 Dec;35(Suppl 3):927-934
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- Seckel, E and others. Meeting the National Need for Expertise in Pain Management with Clinical Pharmacist Advanced Practice Providers. The Joint Commission Journal on Quality and Patient Safety 2019; 45:387–392

These efforts are supported by the best practices as outlined in**:**

- National Quality Partners Playbook: Opioid Stewardship (https://www.qualityforum.org/ National_Quality_Partners_Opioid_Stewardship_Action_Team.aspx)
- The Joint Commission. Joint Commission enhances pain assessment and management requirements for accredited hospitals. Jt Comm Perspect, 37 (2017 Jul 3-4), p. 1 TJC Pain Assessment and Management Requirements .

- VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) https://www.congress.gov/115/bills/s2372/BILLS-115s2372enr.pdf
- OIG Report No. 17-01846-316. Healthcare Inspection. Opioid Prescribing to High-Risk Veterans Receiving VA Purchased Care. July 31, 2017. https://www.va.gov/oig/pubs/VAOIG-17-01846-316.pdf

Additional References: Increase in Fatal Drug Overdoses Across the United States Driven by Synthetic Opioids Before and During the COVID-19 Pandemic (Dec 2020), HAN Archive - 00438 | Health Alert Network (HAN) (cdc.gov)

Telepain (including prevention and treatment of OUD)

These efforts are supported by the following published articles:

- Anne Roberts, Lorna Philip, Margaret Currie & Alasdair Mort (2015) Striking a balance between in-person care and the use of eHealth to support the older rural population with chronic pain, International Journal of Qualitative Studies on Health and Well-being, 10:1, DOI: 10.3402/qhw.v10.27536
- Carey EP and others. "Implementation of Telementoring for Pain Management in Veterans Health Administration: Spatial Analysis," Journal of Rehabilitation Research and Development 2016; 53(1):147-56.
- Nanda U, Luo J, Wonders Q, Pangarkar S. Telerehabilitation for Pain Management. Phys Med Rehabil Clin N Am. 2021 May;32(2):355-372.

These efforts are supported by the best practices as identified in**:**

- Final Report on Recommendations from the President's Commission on Combating Drug Addiction and the Opioid Crisis, https://www.whitehouse.gov/sites/whitehouse.gov/files/images/Final_Report_Draft_11-15-2017.pdf
- National Drug Control Strategy, A Report by the office of National Drug Control Policy, April 2022, https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf

Additional facts and information related to Telehealth and Rural Veterans:

- VA Fact Sheet regarding Telehealth functionality: https://connectedcare.va.gov/sites/default/files/OT_va-telehealth-factsheet-2019-01.pdf
- VA Fact Sheet regarding prevalence of health care needs for Veterans in rural areas: https://www.ruralhealth.va.gov/docs/ORH_Overview-InfoSheet_2018-508_FINAL.pdf
- VHA Office or Rural Health Fact Sheet: Clinical Resource Hubs. https://www.ruralhealth.va.gov/docs/VRHRC_FactSheet_102819_FINAL508.pdf
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Pain Management Teams and Pain Clinic Staffing: These efforts are supported by the following published articles:

- National Quality Forum (2021). Addressing Opioid-Related Outcomes Among Individuals With Co-occurring Behavioral Health Condition.
- Martin AM, Schmidt ZS, Murphy JL (2021). Chronic Pain: Behavioral Management. Practical Neurology.
- Becker W, Humphreys K, Matthias M (2020). Effective Management of Pain and Addiction: Strategies to Improve Opioid Safety. J Gen Intern Med. 2020 Dec; 35(3).
- Sandbrink F, What Is Special About Veterans in Pain Specialty Care?, Pain Medicine. 2017; 18(4): 623–625, https://doi.org/10.1093/pm/pnx054
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- Oquendo, M. and Volkow, N. Suicide: A Silent Contributor to Opioid-Overdose Deaths, N Engl J Med. 2018; 378:1567-1569. DOI: 10.1056/NEJMp18014.

These efforts are supported by the best practices as outlined in:

- The VA/DoD clinical practice guidelines (CPGs). The CPGs provide clear and comprehensive evidence-based recommendations incorporating current information and practices for practitioners throughout the DoD and VA Health Care systems. While based on evidence and the most current information and practices, a CPG is intended for use only as a tool to assist a clinician/health care professional and should not be used to replace clinical judgment.
    - VA/DoD Clinical Practice Guideline (CPG) for the Use of Opioids in the Management of Chronic Pain (2022).
    - VA/DoD Clinical Practice Guideline for Low Back Pain (2022)

- Centers for Disease Control (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain (2022). CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022 | MMWR The CDC clinical practice guidelines (CPGs) provide clear and comprehensive evidence-based recommendations incorporating current information and practices for practitioners throughout the United States. While based on evidence and the most current information and practices, a CPG is intended for use only as a tool to assist a clinician/health care professional and should not be used to replace clinical judgment.
- Pain Management Best Practices Inter-Agency Task Force.

  Report: https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf

  The Pain Management Best Practices Inter-Agency Task Force (Task Force) was convened by the U.S. Department of Health and Human Services in conjunction with the DoD and the VA with the Office of National Drug Control Policy to address acute and chronic pain in light of the ongoing opioid crisis. The Task Force mandate is to identify gaps, inconsistencies and updates and to make recommendations for best practices for managing acute and chronic pain. The 29-member Task Force included federal agency representatives as well as nonfederal experts and representatives from a broad group of stakeholders. The Task Force considered relevant medical and scientific literature and information provided by government and nongovernment experts in pain management, addiction and mental health as well as representatives from various disciplines.

Substance Use Disorder Program Initiative

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Services (0160):	$43,332	$179,681	$181,681	$228,220	$236,815	$46,539	$8,595
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$674	$1,606	$1,606	$2,727	$2,832	$1,121	$105
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$44,006**	**$181,287**	**$183,287**	**$230,947**	**$239,647**	**$47,660**	**$8,700**

Authority for Action

- 38 U.S.C. §1720A
- 38 C.F.R. §§ 1701, 17.38, 17.80
- VA/DoD Clinical Practice Guideline for Management of Substance Use Disorder (SUD) (2015). https://www.healthquality.va.gov/guidelines/MH/sud/

While the VA is a national leader in the prevention and treatment of SUD, gaps exist. In its 2019 National Survey on Drug Use and Health survey, the Substance Abuse Mental Health and Services Administration (SAMHSA) estimated less than 15% of Veterans with SUD receive treatment for their SUD. Among Veterans receiving care within the VHA, over 550,000 Veterans had a SUD diagnosis in 2022. To expand access to evidence-based SUD treatments, VHA is training and hiring clinicians to ensure there is SUD specialty expertise and evidence-based treatment options available not only within specialty SUD clinics, but also within general mental health and primary care mental health integration clinics. Over 345,000 Veterans with a SUD diagnosis (over 62%) received treatment for their SUD diagnosis within an outpatient mental health clinic. Less than

half of the Veterans treated in outpatient mental health clinics for SUD received that care within a designed subspecialty outpatient SUD clinic.

The OMHSP is responsible for national policy, management and oversight specific to substance use disorders within VHA. The scope of initiatives supported by or requiring engagement of OMHSP specific to SUD has increased substantially within recent years as have oversight and reporting requirements and include:

- Over 25 Internal and External Workgroups and Governance Councils
- Four Federal Workgroups responsive to the ONDCP supporting and informing policy development and implementation of the NDCS and the National Drug Control Assessment (NDCA). One Federal agency workgroup responsive to the Government Accountability Office (GAO) High Risk List drug misuse designation.
- Member - Interdepartmental SUD Coordinating Committee established under P.L. 115-271 §7022, *SUPPORT for Patients and Communities Act*
- Two Research Advisory Boards
- Multiple Conference/Education Planning Committees

Statutory or Congressional Requirements

- P.L. 115-271, *SUPPORT for Patients and Communities Act*
- P.L. 114 -98, title XI, Jason Simcakoski Memorial and Promise Act
- P.L. 115-182, VA Mission Act

Office of National Drug Control Policy Reporting Requirements

- National Drug Control Program Agency Budgets
- National Drug Control Assessment, National Drug Control Strategy, Performance Reporting System

Audit and Oversight Activities

- GAO review of SUD services and GAO High Risk List assigned to ONDCP: Opioid misuse
- VA Office of the Inspector General (OIG) review(s) of SUD services
- CTRs: Co-prescribing of Naloxone (2019); Substance Use Disorder Care (2020); Inpatient Substance Abuse Care (2019); Public-Private Partnerships (2020); and Substance Abuse Education (2022), Substance Use Disorder Programs (2023)

SUD treatment services are currently funded through existing appropriations. Additional resources are required to comply with the ONDCP's NDCS, NCDA, the NDCS Performance Reporting System (PRS) and congressional and statutory requirements. Funding is also closely aligned with the priorities outlined in "The Biden-Harris Administration's Statement of Drug Policy Priorities".

SUD commonly involves the use of multiple substances. The number of Veterans served within VHA with amphetamine (including methamphetamine), cannabis and alcohol use disorders is

rising. The number of Veterans with an amphetamine use disorder has increased by 57% since 2016 and the number with cannabis use disorder has increased by over 34%. Table 1 details the top five SUD diagnoses among Veterans served within VHA.

Table 1: Unique Veterans Served within VHA by Substance Use Diagnosis

Substance	2016	2017	2018	2019	2020[20]	2021	2022	% Change 2016 – 2022
Alcohol	363,763	388,933	393,531	416,590	397,986	405,850	411,615	11.6%
Cannabis	103,815	112,910	123,754	135,766	128,732	132,776	139,336	34.2%
Cocaine	69,524	70,407	72,258	73,272	66,419	61,754	61,127	(12.1%)
Opioid	66,851	69,142	71,471	71,327	68,773	67,548	67,198	1%
Amphetamine	25,549	30,085	37,290	43,720	39,889	38,852	40,185	57.3%

Overdose Deaths: Opioid and Stimulant Use Disorders

While there was a slight decline in the number of overdose deaths during 2018, review of overdose death data for 2019 and 2020 suggest a reversal of those trends with rising overdose rates. (https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm#dashboard). The CDC estimates that overdose fatalities during the pandemic increased by nearly 40%.

VHA has made significant progress with efforts targeted towards prevention of OUD and opioid overdose deaths.[21] Our most recent published data from 2019 suggest that the opioid crisis is evolving. Among Veterans receiving treatment within VHA, the rate of age-adjusted overdose mortality increased from 19.8 per 100,000 population in 2010 to 30.3 per 100,000 population in 2019 (Begley and others, 2022).[22] The increases in opioid overdoses were largely driven by non-methadone synthetic opioids (for example, fentanyl) and heroin overdoses but over the last few years there have also been an increasing number of stimulant-related overdose deaths, especially methamphetamine and cocaine. In 2019, data documents over 4,800 Veteran overdose deaths, over 3,100 related to opioids and over 2,000 related to stimulants (with overlap of both drug classes being involved in many of the overdose fatalities). This suggests the need to target future efforts more directly to address opioid use disorders and stimulant use disorders.

VHA is continuing to expand efforts to provide evidence-based pharmacotherapy for the treatment of OUD and in 2022 launched a stimulant safety initiative in part aimed at increasing the percentage of Veterans with stimulant use disorder who receive evidence-based contingency management or cognitive behavioral therapy.

[20] Data for 2020 were significantly impacted by changes in health care utilization due to the pandemic. Available data related to substance use during the pandemic would suggest that observed decreases are not reflective of changes in substance use or projected need for service.

[21] See Opioid Prevention, Treatment and Program budget for subset of treatment services specific to opioid use disorder. Historically, *Jason's Law* has targeted Opioid Safety Initiatives (OSI) specific to safe-opioid prescribing and prevention, integration of SUD services within Pain Management Teams and support for the Stratification Tool for Opioid Risk Mitigation (STORM).

[22] MR Begley, C Ravindran, T Peltzman, SW Morley, BM Stephens, LA and JF McCarthy, Veteran drug overdose mortality, 2010–2019, Drug and Alcohol Dependence, 2022-04-01, Volume 233.

National Drug Control Strategy - National Drug Control Assessment (NDCS/NDCA)

The Biden-Harris Administration's Drug Policy Priorities for Year One served as the basis for President Biden's inaugural NDCS available at https://www.whitehouse.gov/wp-content/uploads/2022/04/National-Drug-Control-2022Strategy.pdf), which builds upon the significant actions taken during the Administration's first year to reduce overdose deaths and improve the way this Nation approaches drug use and its harms. Specifically, this Strategy seeks to build the foundation for the Nation's work to reduce drug overdose deaths. This includes building a stronger SUD treatment infrastructure. Additional top priorities include expanding evidence-based harm reduction strategies to meet people where they are, preventing drug use from beginning, building a recovery-ready Nation and improving data systems and research that guide drug policy development. Implementation of the NDCS/NCDA within VA includes strategic engagement across multiple program offices (for example, Clinical Pharmacy Practice Office, Public Health, Primary Care, Community Care, Academic Affiliations and the Homeless Program Office) and requires collaboration with other Federal partners including the Department of Defense.

The 2024 SUD budget request includes initiatives supporting the NDCS/NDCA and PRS and are responsive to congressional expectations outlined in appropriations conference reports (for example, SUD services for women Veterans, access to residential treatment for SUD and use of technology to provide access to SUD services). Furthermore, the actions supported by the budget would directly address VA priorities of access and suicide prevention. VA also is developing informatics tools to help identify potentially undiagnosed patients with signs or risks related to substance use so that they can be proactively encouraged into care. This includes systems to identify lab tests or health care utilization patterns that might indicate drug use (for example, positive urine drug screens, infections that might be caused by injection drug use, heart failure diagnoses in younger patients) and natural language processing algorithms to identify mentions of substance use in free text clinical notes.

The 2024 SUD Budget outlined below closely aligns with The Biden-Harris Administration's Statement of Drug Policy Priorities, supports the NDCS and PRS and reflects VA's commitment to:

- expanding access to care, closing the treatment gap and responding to emerging drug threats
- enhancing employment opportunities for Veterans in recovery,
- supporting ongoing education and training to ensure Veterans continue to have access to state of the art, evidence-based treatment for substance use concerns and
- establishing a comprehensive strategy specific to harm reduction (initiated in 2022 but established as a formal area of focus for the 2024 budget request).

1. Access to Care

1.1. Stepped Care for SUD

Of the more than 550 thousand Veterans receiving SUD care within VHA during 2022, less than 25% received specialty SUD treatment with less than 4% receiving intensive SUD services. Current efforts to expand access to medications for OUD and alcohol use disorder (AUD) have had an impact, however, the historical focus on providing SUD services through specialty care has

limited the amount of growth that is possible with only 46% of Veterans diagnosed with OUD and close to 14% of Veterans with AUD receiving clinical practice guideline recommended medications during 2022.

Table 2: Number and Percent of Veterans Receiving Indicated Medications for Treatment of Opioid and Alcohol Use Disorder

Substance	2016	2017	2018	2019	2020	2021	2022
Alcohol Use	26,680 (7.0%)	31,905 (8.2%)	37,651 (9.45%)	42,305 (10.2%)	42,530 (10.8%)	45,038 (11%)	57,158 (13.7%)
Opioid Use	22,606 (34.1%)	24,069 (34.8%)	24,696 (34.9%)	26,415 (40.4%)	27,571 (44.4%)	27,358 (45.8%)	27,456 (46.3%)

To address evidence-based medication for opioid use disorder (M-OUD) treatment, VHA launched the Stepped Care for Opioid Use Disorder – Train the Trainer (SCOUTT) initiative in May 2018. Eighteen of our Phase One clinic-based teams comprised of staff from primary care, general mental health and pain management participated in the training. Between August 2018 and September 2022, the teams evidenced a 246% increase in the number of Veterans receiving buprenorphine for the treatment of OUD and a 209% increase in the number of providers with a Drug Enforcement Administration (DEA) X-waiver who are prescribing medication treatment for OUD with buprenorphine. Since the initiative launch, over 2,700 patients have been started on buprenorphine.

Provision of treatment for SUD in settings outside of specialty care is not fully captured in the current VAMC budgets. The SCOUTT initiative has demonstrated that M-OUD can be successfully provided outside of specialty care and that a stepped care approach to treatment provides opportunities to address the broader spectrum of SUD treatment needs. The SUD budget therefore requests support to expand and sustain access to SUD services outside of the specialty care setting, specifically targeting general mental health and primary care clinics[23]. There is also additional sustained support needed for Clinical Resource Hubs (CRH) in each VISN to address gaps in access to SUD services for Veterans who primarily receive care in Community Based Outpatient Clinics (CBOCs). The sustainment plan provides for at least two FTE per CRH, newly funded for 2022 with sustainment funds proposed through 2025, as well as staff targeted to VAMCs to support provision of SUD treatment within Behavioral Health Interdisciplinary Program (BHIP) teams or through Primary Care Mental Health Integration. The resources request would support:

- Sustainment funding for approximately 330 staff awarded in 2022 through 2025 to provide SUD services with capacity for each CRH to provide medications for OUD and AUD as well as SUD counseling.
- Partnered efforts with the SCOUTT team to implement and evaluate the stepped care model which expands SUD care beyond specialty care and into primary care (including women's health primary care), pain management and general mental health clinics.

[23] Expansion of SUD services within pain management settings is captured under Opioid Prevention, Treatment and Program budget narrative.

- Shifting pharmacy infrastructure efforts to focus on developing mobile methadone clinic capacity to treat Veterans with OUD in underserved and rural communities.
- VA Central Office infrastructure to support facilitated implementation, training and evaluation.
- In addition, to address transportation challenges, a common barrier to care and to address malnutrition, a negative consequence of SUD, the VA plans to support rideshare and food insecurity initiatives serving our most vulnerable Veterans as funding is available. The rideshare initiative would allow for critical, in-person appointments to treatment groups, intensive outpatient programs and other health services for patients with an SUD diagnosis. The food insecurity program would help improve nutrition among Veterans with SUD who do not have enough food to eat.

Metrics:

- SUD16% of Veterans with OUD receiving guideline indicated medication
- Percent of Veterans with AUD receiving guideline indicated medication
- Number of VA funded providers with DEA X-waiver
- Number of patients receiving Contingency Management

These efforts are responsive to the following recommendations and requirements:

- The Biden-Harris Administration's Statement of Drug Policy Priorities including increasing access to evidence-based care including medications for the treatment of OUD.
- ONDCP NDCS:
    - Substance Use Disorder Treatment, Principle 1: Improve Treatment Engagement by Meeting People Where They Are.
    - Substance Use Disorder Treatment, Principle 2: Improving Treatment Quality.
    - Substance Use Disorder Treatment, Principle 3: Supporting At-Risk Populations.
- ONDCP PRS:
    - The projected shortfall in the qualified workforce of behavioral health providers (including addiction professionals) funded by federal programs in the United States is reduced.
- 2019 Clay Hunt Independent Evaluation Report to Congress

1.2. Access to Residential Treatment and Post-stabilization Engagement

VHA provides two types of 24-hour care to Veterans with severe, complex, or acute substance use disorders. This includes inpatient withdrawal management and stabilization in numerous medical and general mental health units and provision of care in Mental Health Residential Rehabilitation Treatment Programs (MH RRTP), otherwise referred to as Domiciliary beds. Treatment provided within Specialty Domiciliary SUD programs is equivalent to standards specified by the American Society of Addiction Medicine Patient Placement Criteria, specifically Level 3.7, Medically Monitored Intensive Inpatient Services. At the end of 2022, 69 Domiciliary SUD programs were in operation with nearly 1,800 official operational beds focused specifically on intensive, medically monitored residential SUD treatment. ***NOTE:*** *At the end of 2022 there were 72 official*

Domiciliary SUD programs with three programs not currently operational. The average time between screening for residential treatment and admission to a SUD residential bed within VHA was 22 days during Q4 2022, significantly longer than current standards of care, but notably reduced from levels observed during Q1 2022 where the average time was 27 days. It is important to note the wait time does not include the time between referral and screening which in some cases may be a few weeks. The pandemic has had a significant and sustained impact on residential operations with waits for residential treatment increasing. The current increased waits for residential treatment in large part are related to reduction in capacity due to recurrent surges of the virus and staffing challenges.

Results from the 2021 MH RRTP Annual Program review identified deficiencies impacting access for Veterans needing SUD treatment. Areas of concern identified were inadequate resources to support regular admissions, staffing challenges, concerns related to COVID-19 mitigation and beds not being available. Historical concerns related to appropriateness of referrals and medical needs have also impacted access and often are related to the need for withdrawal management services. The residential treatment programs in VHA can provide medically monitored withdrawal management, comparable to ambulatory withdrawal management, which would facilitate more timely access to care and further address concerns with post-stabilization engagement in treatment. However, implementation of withdrawal management in the residential programs historically has been limited.

During 2019, each VISN completed a detailed market assessment for MH RRTP services as a subcomponent of a broader review of health care services. Review of information provided by facilities as part of that assessment identified that less than half of the VAMCs reported the ability to access residential admission for SUD treatment within seventy-two hours and only slightly more than 61% were able to access admission within thirty days. 12 of the 18 VISNs identified the need for additional SUD services that would require medical facilities funding. At the end of Q4 2022 there are thirteen Domiciliary SUD programs under development. These programs are critical to meeting requirements for reducing current wait times and providing admission within a few days of referral.

Beyond the specific need for expansion of bed-based services for SUD treatment congressional stakeholders have specifically identified a need for services for women. At the current time there are only two Domiciliary SUD programs that offer a dedicated track for women Veterans with an additional two programs under development following the 2022 SUD budget. The 2024 - 2025 SUD budget would build on planned 2022 efforts and provide the necessary funds to meet the national benchmarks established by the NDCS and the expectations of stakeholders. This will require:

- Sustained expansion of approximately 300 staff to increase access within existing Domiciliary SUD programs and SUD-Track programs within General Domiciliary to support admission within 48 hours including expansion of medically monitored withdrawal management. Hiring efforts began in 2022 with current funds requested to support sustainment while services are established. This includes funds to support the expansion of new Domiciliary SUD programs.
- National SUD program office infrastructure to support development of clinical informatic tools to facilitate referral and admission processes (for example, real-time report with bed

availability, number pending admission and projected waits). The 2022 SUD budget allowed for the development of informatic tools to support provision of medication for the treatment of SUD and prevention of overdose within the MH RRTPs, providing data that will allow for monitoring at the program level as well as a patient level report that will support real-time intervention and identification of Veterans that may benefit from medications for the treatment of alcohol use disorder or opioid use disorder as well as Veterans that may be appropriate for a naloxone prescription.

- Medical facility and activation funds to continue support for the expansion of Domiciliary SUD services initiated during 2022 and for the additional new programs now under development.

Metrics:

- Average time between screening and admission for residential SUD treatment
- Percent of Veterans accepted for residential admission who are not subsequently admitted
- Decreased utilization of high-cost services (that is, acute inpatient admission, emergency department) one-year post discharge

These efforts are responsive to the following recommendations and requirements:

- H. Rept. 117-81 recommending VA focus attention on further development of residential treatment programs for women Veterans and for the treatment of substance use disorder.
- ONDCP NDCS:
    - Substance Use Disorder Treatment, Principle 1: Improve Treatment Engagement by Meeting People Where They Are
    - Substance Use Disorder Treatment, Principle 2: Improving Treatment Quality
    - Substance Use Disorder Treatment, Principle 3: Supporting At-Risk Populations
    - Building a Recovery-Ready Nation, Principle 2: Make Recovery Possible for More Americans
- ONDCP PRS:
    - The projected shortfall in the qualified workforce of behavioral health providers (including addiction professionals) funded by federal programs in the United States is reduced.

1.3. Peer Support Services and Health Navigators – SUD Service Engagement

To close the treatment gap as required by the NDCS and NDCA and to provide a recovery environment as detailed in the Biden-Harris priorities, NCDS and PRS, services specific to Veteran engagement are required. The NDCS emphasizes that unmet needs for staffing harm reduction programs should primarily be addressed by recruiting and training new staff to serve such as peer support staff. In addition, the PRS identifies the need to expand peer-led recovery. VA supports peer recovery support services and continue peer outreach, engagement and intervention efforts. Since 2005, peer support staff have been working in the VA health care system. VHA Handbook 1160.01, Uniform Mental Health Services in VA medical centers and Clinics (2008) mandated the availability of peer support services for Veterans stating, "Peer support is one of the 10 fundamental components of recovery according to the National Consensus Statement on Mental Health Recovery" (p. 4) and "All Veterans with *SMI (Serious Mental Illness)* must have access to peer support services, either on-site or within the community" (p. 28). That same year, P.L. 110-387, *The Veterans' Mental Health and Other Care Improvements Act Of 2008* established the

requirement for the use of peer specialists and their qualifications in VHA. Through this legislation, peer specialists in VHA became defined as Veterans discharged under other than dishonorable conditions who are in recovery from a mental health and/or SUD and who are certified to provide peer support services.

Studies have found improvements in treatment engagement, treatment retention, reduction in symptoms of mental illness, improvements in abstinence from addictive substances and improvements on quality-of-life measures (Bassuk and others, 2016; Chinman and others, 2015; Druss and others, 2018; Fortuna and others, 2018; Ashford and others, 2019; McCarthy and others, 2019; Fortuna and others, 2020) for individuals who received peer support services as part of their mental health care services. Studies have found the following benefits for Veterans working with peer specialists in the VA health care system: increased hopefulness, increased treatment engagement, reduced isolation, reduced symptoms of mental illness, improved functioning and increased community integration (Chinman and others, 2015, Chinman and others, 2018, Gorman and others, 2018, Hernandez-Tejada and others, 2017, Hernandez-Tejada and others, 2021, McCarthy and others, 2019, Resnick and others, 2017, Shaw and others, 2020).

VHA has hired hundreds of Veterans as peer specialists and is now the single largest employer of peer specialists in the United States. The current 1,268 peer support staff work as part of interdisciplinary treatment teams throughout the VA health care system in inpatient and outpatient mental health and SUD programs, residential programs, Intensive Community Mental Health Recovery (ICMHR) services (formerly Mental Health Intensive Case Management (MHICM)), Psychosocial Rehabilitation and Recovery Centers (PRRC), vocational rehabilitation services, homeless programs, primary care PAC teams, Veterans Justice Program and the Veterans Crisis Line's Peer Support Outreach Center. Peer specialists are trained to effectively use their personal lived experience with recovery to inspire hope and serve as relatable role models of recovery for other Veterans. They work with Veterans to identify their personal strengths, needed resources and desirable skills that support their personal goals. Peer specialists use a host of recovery tools to help Veterans enhance healthy coping strategies and improve self-management skills over their health conditions. They assist Veterans with navigating the VA health care system and connecting to available VA and community resources. Peer specialists empower Veterans to learn and practice self-advocacy skills, reconnect with others and to find a sense of belonging and purpose both in VA and in their communities.

Homeless Population

Data on overdose deaths and current utilization rates of SUD services within VHA suggest a need to engage Veterans where they live. For Veterans who are homeless or at-risk for homelessness, this will require partnering with community providers. In addition to access to peer support services, the NDCS also requires VA to increase access to vulnerable populations such as the homeless. Substance use disorders disproportionately impact Veterans who are homeless. The COVID-19 health crisis has compounded those concerns given the risk both of exposure to the virus for those who use substances as well as the risk for emergent substance use concerns. VHA's existing infrastructure within the Homeless Program Office provides a foundation by which VHA can quickly direct resources to community providers with the intent of rapidly engaging or re-engaging Veterans with SUD services specific to their treatment needs.

The SUD budget directly addresses the requirements of The Biden-Harris Administration's Statement of Drug Policy Priorities and NDCS through the expansion of peer support services to SUD treatment services with a targeted focus on engagement in treatment using a stepped care approach. Peer specialists hired by facilities to work as members of the SUD treatment team prioritize treatment engagement for those Veterans presenting on inpatient units and in emergency departments with substance-related concerns. In addition, working in collaboration with the Homeless Program Office, the budget provides additional sustained support for SUD case managers to work with the Supportive Services for Veterans (SSVF) and VA Homeless Programs. The principal objective of the proposal is to link a VAMC SUD case manager to each SSVF grantee and VA Homeless Programs to coordinate MH and SUD care for VHA-eligible homeless Veterans, ensuring prompt access for this high-risk population. Once enrolled in SSVF or a VA Homeless Program, VHA-eligible Veterans identified as needing behavioral health services will be referred to a designated SUD case manager who will assist in providing an initial screening and then linking the Veteran to appropriate follow-up appointments. It is expected that SSVF grantees and VA Homeless Programs will review care coordination with the case manager during regularly scheduled case conferences.

Currently, there are 260 SSVF grantees serving communities through the country and US territories. SSVF served 105,170 Veterans and their family members in 2022, 72,297 of whom were Veterans. As approximately 85% of the Veterans served are VHA-eligible (68,000) and 60% of these Veterans will need assistance from a VA MH provider, potentially 41,000 Veterans would be linked to care.

Details of Peer Support Services – Health Navigators plan:

- Sustainment of approximately 275 peer specialists to work in SUD specialty care.
- National Program office support for training and certification of Peer Support Specialists consistent with current requirements. Monitoring of scope of SUD services provided by peer specialists with intention to identify strong practices that can be shared with current peer specialists working in other settings of care to meet the needs of Veterans with co-occurring SUD and mental health concerns.
- Partnered research to evaluate implementation of SUD specific peer support services.
- Sustainment of approximately 130 FTE SUD case managers to work directly with SSVF grantees and homeless program staff with the goal of engaging or re-engaging Veterans in SUD treatment.

Metrics:

- Number of Veterans with an SUD diagnosis served by SUD case managers hired for the special purpose funded SSVF initiative (new)
- Number of Veterans with a SUD diagnosis receiving Peer Support Services

These efforts are responsive to the following recommendations and requirements:

- ONDCP NDCS:
    - Substance Use Disorder Treatment, Principle 1: Improve Treatment Engagement by Meeting People Where They Are
    - Substance Use Disorder Treatment, Principle 2: Improving Treatment Quality
    - Substance Use Disorder Treatment, Principle 3: Supporting At-Risk Populations
    - Building a Recovery-Ready Nation, Principle 2: Make Recovery Possible for More Americans

1.4. Responding to Emerging Drug Threats

As previously noted, overdose deaths associated with stimulants including methamphetamine are increasing. Amphetamine use disorder diagnoses among those served in VHA increased 52% from 2016 through 2021. Contingency Management (CM) is the most evidence-based treatment for stimulant (including amphetamines) and cannabis use disorders and has been shown to be cost effective, however, implementation often is limited by challenges in funding incentives for the program as well as the availability of point of care toxicology testing important to CM's treatment approach. VHA's Centers for Excellence in Substance Addiction Treatment and Education (CESATEs) implemented a CM program in 2011. CM is a core component of VA's efforts to respond to the emerging threat posed by methamphetamine.

The SUD budget will provide the necessary funding to sustain existing implementation of CM and expand availability such that abstinence-based CM specific to stimulant use disorder is available at every VA medical center.

The ability to respond to emerging drug threats requires timely access to data on substance use and overdose. The VA OIG report, *Illicit Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center (September 12, 2018),* required VHA to develop and implement a monitoring program to identify regional trends of drug abuse for facilities. Further policy recommendations from the September 2019 SOTA, recommended that VHA treat overdose in a manner like that of suicide, requiring completion of the Suicidal Behavior and Overdose Report (SBOR) for all overdoses, regardless of assessed intent and for non-lethal overdoses requiring post-overdose follow-up and review. The previously described expansion of services targeted to engagement and expansion of stepped care for SUD support post-overdose follow-up and review. The VHA infrastructure identified for monitoring and development of clinical informatic tools have already been developed to be responsive to this requirement.

Metrics:

- Number of facilities offering abstinence-based CM for stimulant use disorder
- Percent of Veterans with stimulant use disorder receiving guideline indicated evidence-based treatment (New)
- Number of Veterans with stimulant use disorder diagnosis receiving CM
- Percent of urine drug samples that are negative for the target substance in CM

These efforts are supported by VA- DoD Clinical Practice Guidelines (CPG) for the Management of Substance Use Disorders and recommendations outlined in SAMHSA. Treatment of Stimulant Use Disorders. SAMHSA Publication No. PEP20-06-01-001 Rockville, MD: National Mental Health and Substance Use Policy Laboratory. Substance Abuse and Mental Health Services Administration, 2020.

These efforts are responsive to the following recommendations and requirements:

- *Fentanyl Use and Urine Drug Screening Practices in a Domiciliary Residential Rehabilitation Treatment Program at the Bath VA Medical Center (September 12, 2018),* Office of the Inspector General
- HSR&D State of the Art Conference, *Effective Management of Pain and Addiction*, Policy Recommendation, OUD Sub-group
- ONDCP NDCS:
    - Substance Use Disorder Treatment, Principle 1: Improve Treatment Engagement by Meeting People Where They Are
- Substance Use Disorder Treatment, Principle 2: Improving Treatment Quality.

1.5. Use of Technology

Individuals experiencing SUDs often face barriers to care such as lack of access to transportation necessary to access services. The NDCS outlines the importance of mobile technologies and mobile units to support access to SUD treatment. The CESATEs and the Office of Connected Care (OCC) are working to develop a mobile app to support treatment among Veterans with SUD.

National implementation of mobile technologies for the treatment of SUD will require support to train providers and facilitate implementation, provide technical assistance and support for use of existing mobile app solutions. The SUD budget therefore seeks a phased development and deployment of mobile apps to support treatment of SUD. Initial development has begun and we anticipate implementation will begin in late 2023 with continued expansion in 2024 and sustainment in 2025 and beyond. The budget would align resources within the CESATEs responsible for guiding the development and deployment of the mobile app. The budget also seeks support for research to evaluate an SUD mobile application within VHA.

Metrics:

- Percent of Veterans utilizing mobile app solutions (*New*)
- Outcome metrics as defined by the mobile app solution selected (*New*)

These efforts are responsive to the following recommendations and requirements:

- ONDCP NDCS:
    - Substance Use Disorder Treatment, Principle 1: Improve Treatment Engagement by Meeting People Where They Are
    - Substance Use Disorder Treatment, Principle 2: Improving Treatment Quality
    - Substance Use Disorder Treatment, Principle 3: Supporting At-Risk Populations.

2. Enhancement of Employment Opportunities for Veterans in Recovery

During 2022, 57% of Veterans newly enrolled in VHA Vocational services had a SUD diagnosis. However, research has shown that Veterans are frequently not assessed for, or if assessed, not referred to vocational services suggesting the number of Veterans in need of vocational support may be higher. The NDCS emphasizes the need for VA to explore opportunities to support expanded access to employment for those in recovery. VA Supported employment (SE) is currently available to Veterans diagnosed with a Serious Mental Illness. Expansion is being phased in over 2022 and 2023 with sustainment needed in 2024 and 2025 to hire additional staff at VA medical centers to provide the necessary vocational supports as well as support for implementation to include mechanisms for monitoring fidelity to the SE model of care. Review of the literature suggests the SE has the potential to significantly improve employment outcomes for those Veterans experiencing SUD concerns, particularly those Veterans with other co-occurring conditions (Lones and others, 2017; Rosenheck & Mares, 2007; Mueser and others, 2011). Considering the current pandemic and impact on unemployment rates nationally, the budget seeks to increase access to SE services for Veterans diagnosed with a SUD with support for over 45 FTE during 2022 (targeted to a subset of VMCs) with anticipated expansion during 2023 to support at least 156 total new staff. The SUD 2024 budget proposes sustainment through 2025.

Metrics:

- Number of Veterans served
- Number of Veterans securing competitive employment

These efforts are responsive to the following recommendations and requirements:

- ONDCP NDCS:
    - Building a Recovery-Ready Nation, Principle 3: Eliminate Barriers and Increase Opportunities, including expanding employment opportunities and promoting Recovery-Ready Workplace policies.

3. Education, Training and Consultation

3.1. <u>Evidence-Based Treatment for SUD</u>

Improving Veteran outcomes by providing evidence-based psychotherapy (EBP) is the primary focus of this effort. The budget seeks to bring together experts in clinical training, program development, SUD, program evaluation, quality assurance and quality improvement and implementation specialists. This will be a collaborative effort between the CESATEs and EBP subject matter experts in OMHSP. The intent of this effort is to ensure Veterans have ready access to evidence-based psychotherapies for SUD to include therapies recommended by the current clinical practice guidelines. At this time four EBPs for SUD have been implemented or partially implemented in VHA: Cognitive-Behavioral Therapy for SUD (CBT-SUD), Motivational Enhancement Therapy (MET) and Motivational Interviewing (MI). *(NOTE: This list does not include contingency management which is considered an evidence-based practice, but not a psychotherapy).* Implementation of MI and has been limited. At the current time the EBPs that have been deployed do not address the full scope of recommended treatments defined by the VA/DoD Clinical Practice Guidelines for the Management of SUD. In addition, these current EBPs can only be delivered by licensed providers and via individual psychotherapy. Further, most of the care within VHA is provided in group settings particularly in intensive outpatient and residential

settings. The SUD budget is addressing this treatment and training gap through the development, expansion and implementation of evidence-based services that began in 2022. For example:

- Cognitive Behavioral Therapy (CBT) for SUD
- CBT SUD group format
- Motivational Enhancement Therapy
- Motivational Interviewing

The SUD budget will provide the resources necessary for the development of clinical treatment protocols aligned with evidence-based clinical practice guidelines, the development of treatment manuals needed to standardize and facilitate national dissemination of the evidence-based treatments, comprehensive curriculum needed to train providers to competently deliver the therapies and the resources needed to continuously validate that the provider training programs reliably equip providers to deliver the most likely effective interventions in the manner intended and validation that providing the interventions as intended reliably produces expected patient outcomes. All activities will occur within a framework of continuous quality improvement focusing on training outcomes, numbers of Veterans reached and Veteran outcomes. A current capability to locate previously trained providers will allow for targeted dissemination and implementation based on gaps in needed evidence-based psychotherapy competencies.

Metrics:

- Number of providers trained
- Number of Veterans receiving guideline indicated treatment
- Outcomes as measured by the Brief Addiction Monitor

These efforts are responsive to the following recommendations / requirements:

- ONDCP NDCS:
  - Substance Use Disorder Treatment, Principle 1: Improve Treatment Engagement by Meeting People Where They Are
  - Substance Use Disorder Treatment, Principle 2: Improving Treatment Quality.

3.2. Expanding the Addictions Workforce

The NDCS defines a current gap in the number of trained addiction treatment professionals. VHA is a leader in training health care professionals, including those working in SUD treatment settings. The VA Office of Academic Affiliations (OAA) currently provides support for the Interdisciplinary Advanced Addiction Professional Fellowship Coordinating Center. The Coordinating Center currently provides support for seven Advanced Addiction Fellowship sites with the capacity for a maximum of 28 trainees. The SUD budget continues to align support for the Coordinating Center within OMHSP to build on the foundation already established by OAA. The alignment sustains the infrastructure necessary to increase the number of Advance Addiction Fellowship sites and to better coordinate the work between the Advanced Fellowships and the current Associated Health Education training activities. Further, Synergies gained by aligning within OMHSP and in coordination with the CESATEs is enhancing existing efforts to address training for current staff and trainees across multiple disciplines.

Metrics:

- Number of staff providing SUD services within VHA
- Number of DEA X-waiver providers

This effort is responsive to the following recommendations / requirements:

- ONDCP NDCS:
  - Substance Use Disorder Treatment, Principle 1: Improve Treatment Engagement by Meeting People Where They Are
  - Substance Use Disorder Treatment, Principle 2: Improving Treatment Quality
  - Substance Use Disorder Treatment, Principle 3: Supporting At-Risk Populations
  - Building a Recovery-Ready Nation, Principle 2: Make Recovery Possible for More Americans
- ONDCP PRS:
  - Treatment efforts are increased in the United States. The projected shortfall in the qualified workforce of behavioral health providers (including addiction professionals) funded by federal programs in the US is reduced.

3.3. Addressing Stigma and Shifting the Culture

The recent HSR&D SOTA Conference, *Effective Management of Pain and Addiction*, policy recommendations specifically highlighted stigma, both Veteran and provider, as the most significant barrier to accessing SUD treatment and specifically to accessing guideline indicated treatment. Rates of compliance and relapse between SUD and other chronic medical conditions such as diabetes are similar. It is not uncommon for individuals to be administratively discharged from treatment due to a relapse, return to substance use, or for medications for OUD to be discontinued because of use of another substance versus modifying treatment to introduce another guideline indicated treatment. Changing the culture and ensuring that providers have the information they need to provide appropriate SUD treatment will require resources to support consultation, education and training. To help mitigate stigma, VA strongly encourages all staff who serve Veterans with SUD to use Veteran-centric, science-based language that de-stigmatizes SUD and encourages Veterans' engagement and collaboration in their treatment.

In addition, OMHSP in collaboration with the National Tele-mental Health Center has deployed a two-part national consultation resource – responding to provider questions via email to AskTheExpert-SUD@va.gov and direct, ancillary patient assessment and care via the National SUD Consultation program. Triaging of consults for this service is managed largely by the National Tele-mental Health Center with subject matter expertise provided by CESATE staff and representatives from various program offices. Since its launch at the end of March 2020, consultation requests are submitted routinely. In 2022, the AskTheExpert e-mail received incoming consultations from 219 unique clinicians. Recommendations from the OUD Workgroup from the SOTA included the establishment of a National SUD Consultation program comparable to the National Center for Posttraumatic Stress Disorder (NC-PTSD) Consultation Program as well as similar resources for Military Sexual Trauma and Suicide Risk Management. In addition, consultation plays an important role in directly addressing stigma and improving access to care.

The SUD budget would sustain the formal establishment of a National SUD Consultation resource with dedicated resources to sustain operations. The plan leverages expertise currently available within the CESATES and aligns subject matter experts with the CESATEs within OMHSP through collaboration with the National-Telemental Health Center. The level of resources needed for sustainment identified in the 2024 budget request are consistent with recommendations from experts at the NC-PTSD. In 2022, there were 109 consults placed to the NTMHC-SUD program, a larger than 75% increase from 2021.

Beyond the establishment of a formal National SUD Consultation Program, support would be provided for:

- Field-based training consistent with initiatives outlined
- Decision support tools designed to facilitate access to SUD treatment in Level 1 clinics

Metrics:

- Number of consultation requests
- Additional metrics will be defined annually specific to trainings completed

These efforts are responsive to the following recommendations and requirements:

- The Biden-Harris Administration's Statement of Drug Policy Priorities including expanding access to evidence-based treatment, advancing the recovery-ready workplace and expanding the addiction workforce
- HSR&D State of the Art Conference, *Effective Management of Pain and Addiction*, Policy Recommendation, OUD Sub-group
- ONDCP NDCS:
    - Substance Use Disorder Treatment, Principle 1: Improve Treatment Engagement by Meeting People Where They Are
    - Substance Use Disorder Treatment, Principle 2: Improving Treatment Quality
    - Substance Use Disorder Treatment, Principle 3: Supporting At-Risk Populations
- ONDCP PRS:
    - Treatment efforts are increased in the United States. The projected shortfall in the qualified workforce of behavioral health providers (including addiction professionals) funded by federal programs in the US is reduced

Establishing a Coordinated Harm Reduction Approach in VA

Purpose

As the largest civilian health care system in the United States, the VHA is uniquely positioned to implement enterprise-wide harm reduction strategies aimed at reducing negative consequences associated with drug use among people who use drugs (PWUD), particularly people who inject drugs (PWID). Harm reduction includes syringe services programs (SSPs), HIV Pre-Exposure Prophylaxis (PrEP), low barrier buprenorphine treatment for opioid use disorder, testing and linkage to care for bloodborne infectious diseases such as HIV and viral hepatitis, opioid overdose education and naloxone distribution (OEND) and wound care among other initiatives. Harm

reduction strategies are critically important for addressing both the overdose and HIV epidemics. The Biden-Harris Administration's 2022 National Drug Control Strategy includes and emphasizes the importance of harm reduction in general and SSPs in particular.

VHA is promoting harm reduction strategies across the system, including development of SSPs. SSPs provide injection equipment supplies to PWUD, lowering the risk of exposure to HIV and viral hepatitis. Other SSP services include access to tools to prevent and reduce overdoses, such as fentanyl test strips and substance use disorder treatment including low threshold buprenorphine treatment. However, VHA health care facilities currently do not have a dedicated lead to plan and coordinate harm reduction initiatives, leading to critical gaps in executing harm reduction strategies. For example, the absence of a dedicated facility-level harm reduction lead creates a major obstacle to coordinating buprenorphine treatment, especially with respect to initiation. Having dedicated individuals will help programs to successfully implement and coordinate these services the purpose of which includes supporting Veteran engagement in SUD treatment.

In addition to these dedicated individuals, VHA Central Office-level program management and administrative support will be essential for activities such as coordinated acquisition and distribution of standardized sterile injection equipment supplies for SSPs, purchase fentanyl test strips, design and execution of a communications and education campaign for Veterans and VHA providers and program evaluation.

Harm reduction leads would leverage VA's infrastructure and data systems to support harm reduction efforts (for example, utilize dashboards to track populations and interventions); oversee implementation of broad systems level solutions (for example, clinical reminders); support establishment of an SSP and other harm reduction activities; coordinate with mental health and substance use disorder programs to improve treatment; support establishment of low barrier buprenorphine treatment for opioid use disorder and efforts to ensure maintenance of patients on buprenorphine; and manage HIV PrEP medications. These efforts will involve close collaborations with substance use and infectious disease clinics. Partnerships with Pharmacy Benefits Management Services will also be critical, especially with Academic Detailing Services (ADS) and the Clinical Pharmacy Practice Office. The support of ADS will ensure knowledge translation services along with addressing local barriers for accessing the array of harm reduction services.

The US Department of Health and Human Services launched its Ending the HIV Epidemic (EHE): A Plan for America in February 2019 with the goal of reducing newly diagnosed HIV infections by 50% by 2025 and 90% by 2030. The EHE campaign centers around identifying patients with undiagnosed HIV infection and linking them to care, as well as identifying uninfected individuals at high risk for HIV infection and offering them PrEP. VHA is a key agency participating in this campaign, however, its ability to execute the EHE strategy is hampered by facility-level variability in delivering harm reduction services. Establishing a dedicated harm reduction position at all VHA facilities would greatly advance VHA's campaign to end new HIV infections among Veterans in care.

These efforts are responsive to the following recommendations and requirements:

- The Biden-Harris Administration's Statement of Drug Policy Priorities including expanding access to evidence-based treatment, advancing the recovery-ready workplace and expanding the addiction workforce

- ONDCP NDCS:
    - Harm Reduction, Principle 1: Integrating Harm Reduction into the U.S. Substance Use Disorder System of Care Is Necessary to Save Lives and Increase Access to Treatment including but not limited to facilitating low barrier buprenorphine initiation through harm reduction services.
    - Harm Reduction, Principle 2: Collaboration on Harm Reduction with Public Safety Agencies, including reducing fatal overdoses through data-driven efforts to get naloxone to where it is most urgently needed.
    - Substance Use Disorder Treatment, Principle 1: Improve Treatment Engagement by Meeting People Where They Are.
    - Substance Use Disorder Treatment, Principle 2: Improving Treatment Quality.
    - Substance Use Disorder Treatment, Principle 3: Supporting At-Risk Populations.
- ONDCP PRS:
    - The number of drug overdose deaths is reduced.
    - The number of counties with high overdose death rates which have at least one Syringe Service Program (SSP) is increased.
    - The percentage of SSPs that offer some type of drug safety checking support service, including, but not limited to Fentanyl Test Strips, is increased.
    - Treatment admissions for the populations most at risk of overdose death is increased.

Evidence: SSPs provide comprehensive, integrated care for some of VHA's most vulnerable Veterans. They are a key component of the national Ending the HIV Epidemic Initiative being implemented in VA and across many federal agencies. Further, the Biden-Harris Administration's Statement of Drug Policy Priorities for Year One includes mandates for federal agencies to remove barriers to federal funding for SSPs, integrate and build linkages between funding streams to support SSPs and identifying state laws that limit access to SSPs, naloxone and other services. The 2022 National Drug Control Strategy also sets national targets to increase the number of SSPs nation-wide.

Since being introduced in the 1980s as community-based harm reduction programs, SSPs have been recognized as one of the most successful and cost-effective public health interventions ever devised. An enormous body of robust published peer-reviewed biomedical research has demonstrated that SSPs are associated with an estimated 50% reduction in HIV and HCV incidence. HCV transmission is reduced by over two-thirds among PWID who received services from SSPs that include access to OUD treatment compared to those who did not receive such services. In addition, new participants in SSPs are five times more likely to enter drug treatment than PWID who do not use SSPs, while PWID who use an SSP regularly are almost three times more likely to report a decrease in injection frequency than PWID who do not use SSPs. SSPs also play a key role in preventing overdose deaths by training PWID to rapidly recognize and reverse opioid overdoses. Specifically, many SSPs provide clients and community members with overdose rescue kit, along with and education on correctly identifying an overdose, rescue response and administering naloxone, a medication used to reverse overdose.

Failure to adequately fund the EHE campaign in VHA will result in failure to prevent new HIV infections among Veterans in care. An HIV diagnosis carries negative physical and mental burdens for Veterans in VHA care and represents an enormous financial obligation for VHA, resulting in annual VHA expenditures of over $1 billion. Achieving the EHE goal of decreasing new HIV infections in VHA by 90% by 2030 would allow significant long-term cost avoidance. Of note, PrEP has high efficacy and cost-effectiveness in preventing HIV infection, given lifetime HIV treatment costs. The CDC's most recent published estimate of lifetime HIV treatment costs was $380,000 per patient in 2010 dollars. The number needed to treat is 25 PrEP patients to prevent one HIV infection. HIV infection also has associated monetary and non-monetary impacts on the health of Veterans and Veteran family members in terms of increased comorbidities of the immunocompromised.

One of the key elements of the recently released National Drug Control Strategy is to "Facilitate low barrier buprenorphine induction through harm reduction organizations." Since a key goal of this proposal is to support harm reduction efforts within VHA, integrating low barrier buprenorphine induction into these efforts and appropriately resourcing it is critical. There is overwhelming evidence that buprenorphine for opioid use disorder is both effective (decreased mortality) and cost-effective, hence its prominent inclusion throughout the National Drug Control Strategy. Similarly, the National Drug Control Strategy specifically targets efforts to "Address obstacles to the expansion of drug checking, syringe service programs and buprenorphine induction at harm reduction programs." In addition to requesting funding to support a rigorous evaluation of our proposed efforts, we have already gathered information on obstacles to implementing SSPs and drug checking using fentanyl test strips from early VHA adopters. Their feedback underscored delays and barriers with provision of these harm reduction interventions given the need to assemble kits locally (for example, work with logistics, pharmacy and so forth) and informed our request for funding for national SSP and fentanyl test strip kits.

Program Elements: National support for harm reduction efforts will include dedicated FTE in the OMHSP and HIV, Hepatitis and Related Conditions (HHRC) Program in the Specialty Care Program Office. These administrators will provide educational opportunities for the facility coordinators building on the success of the SSP Affinity Group, national OEND efforts (for example, accredited national community of practice call resources to support implementation) and expanding to provide technical assistance on harm reduction more broadly, including collaboration with Academic Detailing Service. The national leads will produce national communications and education for Veterans including printed resources, coordinate a contract for supply items and coordinate dashboard and metric efforts. In addition, there will be a partnership with VA research in the second year to evaluate harm reduction quality improvement efforts.

Implementation Plan: Establish program management leads for harm reduction in the OMHSP and HIV, Hepatitis and Related Conditions (HHRC) Program in the Specialty Care Program Office. These program managers will work collaboratively with relevant VHA Central Office program offices to develop policy and national tools (annual survey, dashboard, note template, data tracking) as well as provide education including addressing stigma and technical assistance to the field via a bimonthly call series. The national leads will work with ADS to provide additional education to providers throughout VA.

VHA facilities will establish a role for one FTE clinician to establish a harm reduction program locally. This will include SSP development and/or fentanyl test strip distribution if not in an area where prohibited, using dashboards to identify opportunities, outreach to Veterans about HIV PrEP, supporting implementation of low barrier buprenorphine initiation, infectious disease testing, working with local colleagues to improve sexual and drug use history, and taking and linkage to appropriate harm reduction services. Facilities will establish .5 FTE for a prescribing provider, linked to SUD specialty care, to initiate buprenorphine treatment. This FTE will work closely with the harm reduction lead to facilitate maintenance for patients.

Nationally, VA will contract for SSP supplies including fentanyl test strips based on past contracting efforts. We will establish national communications products via contract. This will be coordinated by the national administrative lead. Finally, we will work with VA researchers to evaluate the program using a partnered quality improvement approach.

Suicide Prevention

		2023		2024	2025		
Description	2022 Actual	Budget Estimate	Current Estimate	Revised Request	Advance Approp.	+/- 2023-2024	+/- 2024-2025
Treatment Modality ($000):							
Suicide Diagnosis	$1,408,559	$1,532,736	$1,681,371	$1,786,506	$1,892,429	$105,135	$105,923
MH care in the Emergency Room	$145,024	$184,279	$228,824	$243,132	$257,548	$14,308	$14,416
Reach Veteran in Crisis	$1,883	$2,197	$2,197	$2,334	$2,473	$137	$139
Suicide Safety Plan	$264,975	$194,880	$286,798	$304,731	$322,799	$17,933	$18,068
High Risk of Suicide	$328,987	$384,474	$356,082	$378,348	$400,780	$22,266	$22,432
MH Suicide Prevention PACT	$3,225	$3,410	$3,491	$3,709	$3,929	$218	$220
COMPACT Act 1/		$83,800					
Total Treatment	**$2,152,652**	**$2,385,776**	**$2,329,939**	**$2,475,629**	**$2,622,410**	**$159,997**	**$146,781**
Suicide Prevention Outreach Program:							
Veterans Crisis Line	$169,716	$255,968	$255,968	$300,500	$306,683	$44,532	$6,183
National Suicide Prevention Strategy Implementation	$193,498	$45,606	$45,606	$46,819	$48,792	$1,213	$1,973
Demonstration Projects	$6,993	$4,821	$4,821	$7,674	$7,703	$2,853	$29
Suicide Prevention 2.0 Initiative	$41,790	$63,590	$65,090	$58,213	$58,907	($6,877)	$694
PREVENTS	$29,547	$0	$0	$0	$0	$0	$0
VA Governors Challenge Program	$0	$0	$0	$10,000	$10,000	$10,000	$0
Centers of Excellence (includes MIRECC and SMITREC)	$9,854	$5,365	$5,365	$5,993	$6,059	$628	$66
Local Facility and Community Outreach Activities	$591	$750	$750	$750	$750	$0	$0
Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program	$4,182	$55,757	$55,757	$55,583	$54,819	($174)	($764)
Specific Purpose [Subtotal]	**$456,171**	**$431,857**	**$433,357**	**$485,532**	**$493,713**	$52,175	$8,181
Suicide Prevention Coordinators and Teams	$66,582	$64,741	$70,377	$73,262	$76,192	$2,885	$2,930
Total Suicide Prevention Outreach Program	**$522,753**	**$496,598**	**$503,734**	**$558,794**	**$569,905**	**$55,060**	**$11,111**

1/COMPACT Act obligations are now factored in the actuals and projected costs above. The Budget Estimate column reflected the additional cost of the Act prior to implementation.

Authority for Action

- P.L. 116-171, *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*
- P.L. 114-2, *Clay Hunt Suicide Prevention for American Veterans Act*

- 38 U.S.C. §1720F authorizes the comprehensive program for suicide prevention among Veterans.
- P.L. 110-110, *Joshua Omvig Veterans Suicide Prevention Act*
- *Exec. Order No. 13822, 3 C.F.R. 1513 (2018)*
- P.L. 114-247, *No Veterans Crisis Line Call Should Go Unanswered Act*
- *Exec. Order No. 13861, 84 FR 8585 (2019)*

Veterans Crisis Line (VCL)

Purpose

Serves as the operational budget for VCL, which provides 24-hours per day, 7-days per week and 365-days per year suicide prevention and crisis intervention services. VCL connects Veterans in crisis and their families and friends with qualified, caring VA responders through a confidential toll-free hotline, online chat or text. VCL's 2024 budget will support increased staffing levels to support and sustain VCL mission with implementation of 988 as the new three-digit number of the National Suicide Prevention Lifeline. The transition to 988 was completed and activated nation-wide on July 16, 2022.

Implementation

988 – Press 1 was officially activated nation-wide on July 16, 2022. VA is proud to support the new Veterans Crisis Line number (Dial 988 then Press 1) alongside such partners as the Federal Communications Commission, the Substance Abuse and Mental Health Services Administration and the National Suicide Prevention Lifeline. 988 expansion addresses the need clarity in times of crisis, both for Veterans and non-Veterans alike. ln 2021, VCL received approval and supplemental funding to increase its Full Time Employees (FTEE). To ensure timely call engagement given significant call volume increases, the VCL is continuing aggressive hiring, training and onboarding through 2023 and is projecting full staffing (2,568 FTEE) to be in place in 2024.

National Suicide Prevention Strategy:

Purpose

Serves as the core operational budget for the National Suicide Prevention Program (SPP) within the OMHSP. As the highest clinical priority within the Department of Veterans Affairs (VA), VA's suicide prevention efforts are guided by the National Strategy for Preventing Veteran Suicide, a long-term plan published in 2018 that provides a framework for identifying priorities, organizing efforts and focusing national attention and community resources to prevent suicide among Veterans while adopting a comprehensive public health approach with an emphasis on comprehensive, community-based engagement and ongoing clinical and crisis interventions.

The National Suicide Prevention Strategy core operational budget supports the Suicide Prevention Program, which retained the same program FTE (66) in 2021-22. In coming years, the program projects the need for further expansion of local and network clinical suicide prevention efforts, primarily under the "Suicide Prevention 2.0 Initiatives.

The core budget also supports several contracts including those that focus on our communications and paid media efforts that aim to raise awareness about suicide prevention and educate Veterans, their families and communities about the suicide prevention resources available to them. Contracts

also support work for the *Clay Hunt Suicide Prevention for American Veterans Act* (P. L. 114-2), community engagement and awareness materials that include the VCL phone number and gun lock acquisitions – an important element of lethal means safety for suicide prevention and part of the National Strategy. The budget also supports requirements of the *Joshua Omvig Veterans Suicide Prevention Act* (P.L. 110-110), *Veterans COMPACT Act of 2020* (P.L. 116-214 § 201) and *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* (P.L. 116-171 § 506).

When successful, the work directed and supported by the National Suicide Prevention Program within OMHSP will see a decline in Veteran suicide, will see more Veterans engaged in care and will see local community and state coalitions better informed and better equipped to support Veterans in their communities and states.

Evidence
Modeled after the 2012 National Strategy for Suicide Prevention — a joint effort between the Office of the U.S. Surgeon General and the Action Alliance for Suicide Prevention — and a complement to the Department of Defense Strategy for Suicide Prevention, the White House strategy for Reducing Military and Veteran Suicide, the National Strategy for Preventing Veteran Suicide encompasses four interconnected directional components:

- Healthy and Empowered Veterans, Families and Communities
- Clinical and Community Preventive Services
- Treatment, Recovery and Support Services
- Surveillance, Research and Evaluation

The 14 goals and 43 objectives included in the National Strategy for Preventing Veteran Suicide are meant to work together in a synergistic way to promote wellness, increase protective factors, reduce suicide risk and facilitate effective mental health treatment and recovery through a public health approach.

Furthermore, guidance from the CDC offers four key components of the public health approach, which uses science to address multiple risk factors for suicide and prevent suicidal thoughts and behaviors from occurring. These components are:

- **Population Approach:** Public health uses a population approach to improve health on a large scale. A population approach means focusing on prevention approaches that impact groups or populations of people, as opposed to treatment of individuals.
- **Primary Prevention:** Public health focuses on preventing suicidal behavior before it occurs and addresses a broad range of risk and protective factors.
- **Commitment to Science:** Public health uses science to increase our understanding of suicide prevention in order to develop new and better solutions.
- **Multidisciplinary Strategies:** Public health advocates for multidisciplinary collaboration, bringing together many different perspectives to engineer solutions for diverse communities.

With suicide prevention as the top clinical priority for VA, the National Strategy offers guidance to VA personnel and stakeholders — including other federal agencies, state and local governments, health care systems and community organizations — so that as a Nation, we can reduce suicide rates among Veterans. The overall goal of the Suicide Prevention Program is to reduce Veteran suicide rates. In doing so, this will serve as a model for the Nation in how to best address suicide as a national public health issue

Implementation
Supports VA national FTE and contracts, all of which supports the work of the additional Suicide Prevention Program components that operate at the VISN and facility level as well as VA's SPP Now Initiative (Now plan).

Beginning in 2023, this line item will also include the incorporation of any necessary sustainment efforts related to Executive Order (EO) 13861, signed on March 5, 2019, the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS). As of June 2022, PREVENTS will have completed the requirements of EO 13861. Ongoing efforts from PREVENTS will move into sustainment in alignment with the overarching National Strategy for Preventing Veteran Suicide (2018), the White House National Military and Veteran Suicide Prevention Strategy (2021) and will include ongoing increased focus on lethal means safety effort, public health campaigns and community-based prevention strategies, with ongoing program evaluation and research to expand implementation of practices in collaboration with other Federal agencies as part of the Administration's efforts at the national level. These areas are covered in other topics within this narrative. The PREVENTS Office staff will continue to move forward these efforts in a streamlined manner with the Suicide Prevention Program efforts underway.

SPP's Now Plan aims to initiate quick deployment of interventions which are deemed essential for the successful engagement of Veterans at high risk for suicide within one year's time. The five areas of focus are lethal means safety, suicide prevention in at-risk medical populations, outreach and understanding prior and non-VHA users, Suicide Prevention Program enhancements and media campaigns.

Demonstration Projects
Purpose
Supports the funding of innovative and promising practices intended to address risk factors and/or enhance known protective factors of suicide.

The development and dissemination of promising practices and innovative strategies and interventions are an important component of VA's suicide prevention work. Funding is provided to national centers and facility-based initiatives to support efforts focused on crucial areas such as rural Veterans, American Indian and Alaskan Native Veterans, suicide risk screening and caring communications efforts and the exploration of digital interventions addressing anxiety and depressive disorders. These efforts are working to fill identified needs in support of the National Strategy for Preventing Veteran Suicide.

Evidence
Some examples of past and current funded demonstration projects include:

- **National Center for Veteran Financial Empowerment (NCVFE)**: Financial strain has been demonstrated in multiple studies to be significantly associated with increased risk of suicidal ideation and suicide attempts. Financial wellness of Veterans should be addressed upstream to reduce risk of future suicide risk as well as in the context of financial crises linked to acute suicide risk among Veterans. Efforts are needed to coordinate financial education, tools and resources across multiple VA mental health services and Veteran populations. The goal of the NCVFE is to increase knowledge of Veterans' financial wellness as a core component of promoting recovery and offering Veterans protection from suicidal behaviors. The NCVFE will communicate information to Veterans at risk of suicide about education, tools and resources to successfully navigate challenges to financial wellness and thereby reduce risk of suicide. In 2022, program development, implementation and evaluation began.
- **Understanding Suicide Risk and Enhancing Suicide Prevention among Asian American and Pacific Islander Veterans (AAPI):** This project aims to understand characteristics of AAPI Veterans who died by suicide and look at differences between AAPI and non-AAPI Veterans who die by suicide. The project will assess demographic and military service characteristics, social determinants of health, suicide methods, VA health care utilization and circumstances surrounding death. This information and analysis will identify suicide prevention needs, barriers and critical next steps for enhancing suicide prevention care to reduce suicide among AAPI Veterans. VA is developing an AAPI Veteran Engagement Group to inform this project and an analysis of suicide death data to better understand risk and barriers unique to these Veterans. A geospatial analysis has been conducted, resulting in this publication: Spark, T. L., Kreisel, C., Brenner, L. A., Hoffmire, C. A., & Monteith, L. L. (2022). Putting it on a map: Geographic visualization to inform suicide prevention in Asian, Native Hawaiian and Pacific Islander Veterans. Asian Journal of Psychiatry, 73, 103125.
- **Improving Safe Firearm Storage in Veterans**: The goal of this project is to conduct a feasibility and acceptability pilot of a novel firearm safety storage and mental health crisis planning intervention. Reducing access to lethal means, including firearms, is one of few universal suicide prevention strategies supported by evidence. Securing household firearms (that is, unloaded, locked, with ammunition stored separately) is one method for reducing access and has been associated with reduced suicide rates in civilian populations (Grossman and others, 2005; Shenassa and others, 2003). Reciprocally, unsafe firearm storage practices are associated with increases in suicide death, among both active-duty military populations and civilians (Anestis and others, 2017; Dempsey and others, 2019; Kung and others, 2003; Miller and others, 2012; Shenassa and others, 2003). Collectively, safe storage and reducing access during at-risk periods are potential strategies to reduce suicide risk, yet there are limited broad-scale interventions to date. This pilot will aim to engage Veterans and their identified Concerned Significant Other (CSO) in conversations about safe firearm storage, how the CSO can identify warning signs for mental health symptoms or suicide risk and how the Veteran and CSO can create a collaborative safe storage plan.

Implementation

Demonstration projects are typically funded for 1-3 years with quarterly and annual review and the resubmission of a project budget for each year. These projects demonstrate measurable impacts for Veterans, providing further evidence and support for wider dissemination of the effort and intervention. It is the intent of the National Suicide Prevention Program to take these successful

demonstration projects and find pathways to enhance and spread them to ensure the greatest impact for our Veterans, as evidenced by some of the highlighted examples above.

Suicide Prevention 2.0 Initiative (SP 2.0 Initiative)

Purpose

In January 2019, Suicide Prevention 2.0 (SP 2.0), a population-based, public health model, was approved by the Executive in Charge of VHA. To reach Veterans both inside and outside VA care, SP 2.0 is moving suicide prevention beyond a one-size-fits-all model to a blended model combining community prevention strategies and evidence-based clinical strategies that will empower action at the national, regional and local levels.

To accomplish its goal of reducing suicide among all 20 million U.S. Veterans, a comprehensive approach to suicide prevention that blends community-based prevention and clinically based interventions is needed. This comprehensive approach is organized across three domains: universal, which encompasses all Veterans; selective, which targets those at an increased risk of suicide; and indicated, which is a smaller segment of those at a high risk. SP 2.0 combines community-based prevention and clinically based intervention strategies within every VA health care system across these three domains of universal, selective and indicated, over a three-year period.

As Figure 1 below highlights, the Community-Based Interventions for Suicide Prevention (CBI-SP) model aims to reach Veterans through multiple touchpoints. CBI-SP implementation will occur through 2022 in a phased roll-out across VHA. CBI-SP initiatives include the Governor's Challenge, Together with Veterans and Community Engagement and Partnership for Suicide Prevention. Community Engagement and Partnership for Suicide Prevention involves a comprehensive strategy to hire and train qualified Community Engagement and Partnerships Coordinators (CEPC) and Community-Based Interventions Program Managers (PM), who will collaborate at the community, regional and state levels, to support community coalition building for evidence-informed suicide prevention interventions specific to each locality's Veteran population. This model strengthens VA's focus on high-risk individuals in health care settings while embracing cross-agency collaborations and community partnerships.

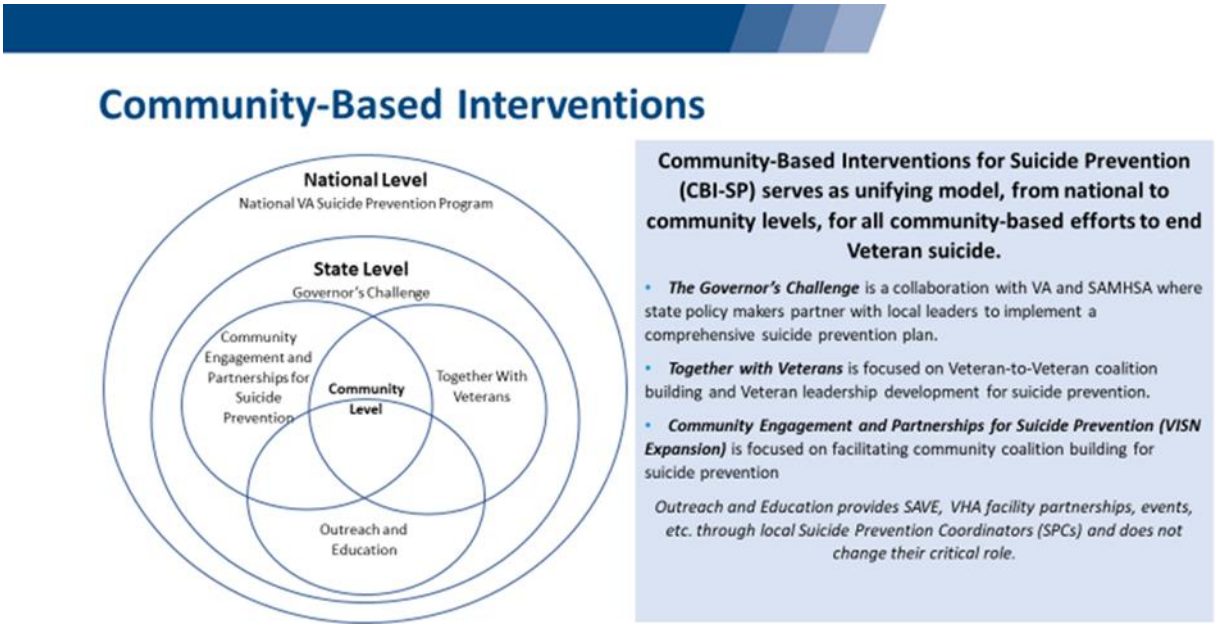

Figure 1: SP 2.0 – Community-Based Prevention

For the clinically based strategy of SP 2.0, SPP's Clinical Telehealth Program in partnership with VA's Clinical Resource Hubs (CRH), has begun implementation of evidenced-based interventions for suicide prevention via telehealth. As indicated in the in the 2019 VA/DoD Clinical Practice Guideline (CPG) on the Assessment and Management of Patients at Risk for Suicide the focus has been on the roll out of:

1) Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), which was initially piloted under SPP's "Demonstration Projects" line item
2) Problem-Solving Therapy for Suicide Prevention (PST-SP)
3) Dialectical Behavior Therapy (DBT), conducted in a small pilot beginning in late 2021
4) Safety Planning Initiative (SPI)

SP 2.0 Clinical Telehealth interventions target Veterans with a history of suicidal self-directed violence.

Evidence
This initiative is informed by the evidence supporting suicide prevention interventions and public health approaches. The Center for Disease Control, the Substance Abuse and Mental Health Services and the National Action Alliance for Suicide have all moved toward a public health approach to suicide prevention. The model works to incorporate reaching both Veterans in the community as well as those we currently serve in the VA with innovative community-based prevention strategies combined with strategies with known outcomes for reducing suicide and suicide attempts based upon the recently updated VA-DoD CPGs.

Implementation of SP 2.0 is focused on developing both clinical and community-based approaches to reducing Veteran suicide. These strategies are evidence-based and address gaps in existing VA

suicide prevention programs, which have been primarily focused on internal strategies to reach Veterans within our system.

As mentioned above, the public health approach to suicide prevention can be organized into universal, selective, or indicated prevention strategies. Universal prevention strategies are grounded in the premise of broadly addressing factors that could put all persons at-risk for suicide, are set in locations and sites the public would visit and do not discriminate based on individual risk level by targeting the whole community. Selective prevention strategies are grounded in the premise of interventions among persons at in a subgroup at higher risk for suicidal behaviors, are set in most physical and health treatment locations. Indicated prevention strategies are grounded in the premise of creating access to highly specialized evidenced based care, are set mental health treatment locations and are meant to capture those identified as being at high risk for suicidal behaviors. The public health model moves across both community prevention and clinical intervention strategies to reach the entire population of those in the universal (all Veterans), selective (some Veterans at elevated risk for suicide) and indicated (few Veterans at highest risk for suicide) areas.

Furthermore, partnerships promoted by health care organizations with communities have been shown to improve patient outcomes (Clyne and others, 2012). Implementing research-informed communication efforts designed to prevent Veteran suicide by changing knowledge, attitudes and behaviors is critical. The U.S. Air Force implemented a public health, universal approach which significantly lowered suicide rates through comprehensive organizational changes including communication efforts (Knox and others, 2010). This model also included gatekeeper training which has been shown to reduce suicidal ideation and deaths by suicide while positively affecting the knowledge, skills and attitudes of trainees through improving communication (Isaac and others, 2009).

Community efforts promoting responsible media reporting of Veteran suicide, accurate portrayals of Veteran suicide and mental illnesses in the entertainment industry and the safety of online content related to Veteran suicide is also crucial. The Werther Effect (the negative consequences of media's portrayal of suicide) has been well established and implementing recommendations for improvement for media reporting are key to reducing this effect (Ortiz & Khin, 2018; Sisask & Varnik, 2012), as responsible media reporting can have a protective effect (Papageno Effect) (Sisask & Varnik, 2012). Safe messaging is an important part of community outreach strategies.

Further, lethal means safety education is a critical area within community-based prevention strategies. An education campaign targeting firearm retailers led to increased use of materials promoting firearm safety and its association with suicide with retailers accepting that they have a role in preventing suicide (Vriniotis and others, 2015). Goals to delay gun access during periods of immediate risk for suicide were shown to be feasible to implement and effective (Walters and others, 2012) and reducing immediate access to lethal means access has been shown to be most effective when implemented alongside other suicide prevention strategies (Sarchiapone and others, 2011). All these noted elements are informing and being incorporated into the roll out of SP 2.0.

Implementation

SP 2.0 started in the fourth quarter of 2020 with the phased implementation continuing through 2023 and moving to sustainment in 2023 and 2024. In the fourth quarter of 2020, for the

community component of SP 2.0, four VISNs, identified as early adopters, began implementation of SP 2.0 community-based intervention strategies. In 2021, five additional VISNs were selected to start in the second quarter and the remaining nine VISNs started in the second quarter of 2022.

This phased approach for SP 2.0 allows for us to adapt our approach based on lessons learned over time and to improve innovative community strategies and engagement, which will allow for the selection of specific unique intervention and prevention strategies for local context, the promotion of testing of assumptions and workload over time and the opportunity to study what works to promote suicide prevention strategies for all Americans.

For the clinical component of SP 2.0, the program has focused on building the infrastructure and capacity for the nationwide implementation of evidenced-based suicide prevention treatments for Veterans with a history of suicidal self-directed violence through OMHSP's partnership with VISN CRHs.

SP 2.0 Clinical Telehealth is in its final stage of phased implementation roll out. The program has hired over 100 psychotherapists (at least one psychotherapist in each of the 18 VISNs) and 100% of therapists are trained in at least one of the four evidence-based protocols. SP2.0 Clinical Telehealth is currently accessible in 99% of the Health Care Systems across the country with a goal of reaching 100% of the HCS by the end of 2022.

Sustainment plans include training trainers and consultants within the CRH system to ensure the continued capacity of trained therapists.

The National Suicide Prevention Program has dedicated staff and resources to design and implement program monitoring and evaluation protocols for SP 2.0. Program evaluation and implementation science experts have designed measurement protocols that will allow for the assessment of process measures, short- and long-term outcomes over time, most frequently in an interrupted time series framework, for each of the components of SP 2.0. Unique elements of SP 2.0 utilizing both community prevention and clinical intervention strategies will be studied including such variables as:

- Increased awareness and utilization of suicide prevention resources for Veterans
- Lowered stigma and increased willingness to seek care
- Increased availability of suicide prevention-specific evidence based clinical treatments for Veterans at risk
- Increased state and community coalitions
- Increased policies and programs being implemented in the six key priority areas by local communities
- Increase collaboration between communities and VA facilities to support Veterans in need
- Decrease in Veteran suicide attempts and behaviors and Veteran suicides

Across the spectrum of SP 2.0, the National Suicide Prevention Program anticipates supporting approximately 420 FTE in 2024.

Recent Trends

The National Suicide Prevention Program is currently working with its partners to continue to support Governor's Challenge teams and community-based coalitions. Despite limitations on travel and face-to-face engagement, Community Engagement and Partnership Coordinators have been able to establish new community coalitions. Together with Veterans continues to be implemented in existing communities and several graduated sites are operating independently. For Governor's Challenge, 49 states and 5 territories (including Guam, Puerto Rico, US Virgin Islands, American Samoa and Northern Mariana Islands) in the Governor's Challenge remain engaged with technical assistance around implementation of action plans. All but one state (OR) has accepted an invitation to participate in the Governor's Challenge. By the end of the phased roll out in 2023, the *CBI-SP* will have expanded to all 18 VISNs and all 50 states will have been invited to participate in the Governor's Challenge. In 2024, VA is launching a new $10 million program to further bolster Veteran suicide prevention efforts through VA's Governor's Challenge Program under the authorities, including providing technical assistance and support for implementation of state and tribal Veteran suicide prevention proposals, provided under P.L. 117-328, Strong Veterans Act, section 303 (Consolidated Appropriations Act, 2023). Community Engagement and Partnership Coordinators are facilitating more than 700 community coalitions working towards ending Veteran suicide, including adding over 300 new coalitions in 2022. By the end of 2023, we will have a national network of local, state and national community-based Veteran suicide prevention efforts.

For the clinical side of SP 2.0, the development and implementation of delivery of identified EBPs via telehealth is timely and will help to ensure that Veterans with a history of suicidal self-directed violence in need of care receive it.

Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program

Purpose
Supports implementation of P.L. 116-171 §201, *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 201*9, signed in to law on October 17, 2020. The new Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP) will enable VA to provide resources toward community-based suicide prevention efforts to meet the needs of Veterans and their families through outreach, suicide prevention services and connection to VA and community resources.

In alignment with VA's National Strategy for Preventing Veteran Suicide (2018), this grant program will assist in further implementing a public health approach that blends community-based prevention with evidence-based clinical strategies through community efforts.

Evidence
Many Veterans who die by suicide have not received care from VA prior to their deaths. Specifically, 11 of the 17 Veterans who die daily by suicide have not been within VHA care for 2 years or more (Department of Veterans Affairs, 2020). VA recognizes the critical importance communities play in ending suicide. Community-based and public health suicide prevention have been shown to effectively reduce suicide rates in diverse communities (Hegerl and others, 2006). This grant program will strengthen local community capacity to conduct outreach to Veterans and families, provide them with suicide prevention services and connect them to resources within the community and VA to prevent Veteran suicide. Effective community-based suicide prevention includes both health promotion and "upstream" strategies, as well as efforts to improve the delivery of clinical and crisis services throughout the community and across partners (Caine, 2013; Lai and others, 2019; Oyama and others, 2005).

Implementation
Congress has authorized $174 million to be appropriated to carry out the SSG Fox SPGP, a three-year community-based grant program that will provide resources to community organizations serving certain Veterans and their families across the country. Organizations can apply for grants worth up to $750,000 and may apply to renew awards from year to year throughout the length of the program. Grants will be awarded to organizations that provide or coordinate the provision of suicide prevention services for eligible individuals at risk of suicide and their families that qualify, including:

- Baseline mental health screening for risk and outreach to identify those at risk of suicide
- Education on suicide risk and prevention to families and communities
- Provision of clinical services for emergency treatment
- Case management and Peer Support services
- VA benefits assistance for eligible individuals and their families
- Assistance with obtaining and coordinating other benefits provided by the federal government, a state or local government, or an eligible entity
- Assistance with emergent needs relating to health care services, daily living services, personal financial planning and counseling, transportation services, temporary income support services,

fiduciary and representative payee services, legal services to assist the eligible individual with issues that may contribute to the risk of suicide and childcare

- Nontraditional and innovative approaches and treatment practices
- Other services necessary for improving the mental health status and well-being and reducing the suicide risk of eligible individuals and their families as VA determines appropriate

In 2022, critical program infrastructure and regulation were established to ensure successful implementation of the grants program. Following priorities set forth in section 201 of the *John Scott Hannon Veterans Mental Health Improvement Ac*t, on September 19, 2022, VA announced $52.5 million in SSG Fox SPGP service awards to 80 grantees in 43 states, the District of Columbia and American Samoa for 2022-23. Twenty-one grantees in 2023 cover tribal lands including the following tribes: Navajo Nation, Cherokee Nation, Choctaw Nation and Alaska Natives. Full list of grantees is available at https://www.mentalhealth.va.gov/ssgfox-grants/.

Additionally, VA is working on establishing a robust program evaluation design to measure short, mid-term and long-term effectiveness of the program and identify best practices after the study.

Centers of Excellence (includes MIRECC and SMITREC):

Purpose
Funds the ongoing and sustained operational support that VHA Centers of Excellence and Program Evaluation Centers provide in supporting the National Suicide Prevention Program. VA has two nationally recognized research centers that work in collaboration with other federal, academic and community partners and with each other to advance the science and strategy related to suicide prevention.

- *Center of Excellence for Suicide Prevention:* The mission of the Center of Excellence for Suicide Prevention (CoE-SP) is to prevent morbidity and mortality from suicidal behaviors among all Veterans using a public health approach. In pursuing its mission, the CoE-SP is guided by four overarching goals that systematically drive CoE-SP activities and align with objectives outlined in the National Strategy: 1) surveillance to define the problem, 2) identification of risk/protective factors, 3) development/testing of novel interventions and 4) implementation of evidence-informed strategies. Consistent with these objectives, the CoE-SP manages VA's Behavioral Health Autopsy Program (BHAP) on behalf of OMHSP's Suicide Prevention Program. BHAP is designed to enhance suicide prevention efforts by systematically collecting information from all Veteran suicide deaths reported to VHA clinicians and Suicide Prevention Coordinators (SPCs). Informed by psychological autopsy methodologies, BHAP is a multifaceted quality improvement program that consists of standardized chart reviews, interviews with bereaved family members and targeted interviews with SPCs across the nation. BHAP team members combine information collected from these three sources to better understand the characteristics and contexts of Veteran suicide and in so doing, enhance the care and services provided to Veterans.
- *Rocky Mountain Mental Illness Research, Education and Clinical Center (RM MIRECC):* The mission of the RM MIRECC for Suicide Prevention is to study suicide with the goal of reducing suicidal ideation and behaviors in the Veteran population. Towards this end, the work

of the RM MIRECC is focused on promising clinical interventions, as well as the cognitive and neurobiological underpinnings of suicidal thoughts and behaviors that may lead to innovative prevention strategies. In alignment with the National Strategy, members of the RM MIRECC are working to promote Veteran wellness, provide training to clinician and community providers and promote suicide prevention activities, education and research. This includes developing and evaluating innovative assessment strategies, as well as upstream and downstream interventions.

In addition to these Centers, program evaluation centers such as the Serious Mental Illness Treatment Center (SMITREC) and the Program Evaluation Resource Center (PERC) within OMHSP support suicide prevention by evaluating a variety of initiatives and ongoing programs to determine utilization and improve effectiveness in both mental health services and suicide prevention efforts.

Some specific examples of ongoing operational support include:

- **Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment** (REACH VET): Officially launched in 2017, REACH VET uses a predictive model to identify Veterans who may benefit from enhanced care. The RM MIRECC Team supports implementation of this national suicide prevention program, which includes providing clinical and technical support via the REACH VET support email group or over the phone to program coordinators and providers, monthly technical assistance calls, developing and disseminating clinical tools and resources and providing ongoing education about the program to the field. The RM MIRECC team also helps expand the use of predictive analytics for suicide risk through education about the CRISTAL and SPPRITE dashboards. Additionally, RM MIRECC offers enhanced focused support to sites who are underperforming based on national performance metrics.
- **Safety Planning in the Emergency Department** (SPED): SPED is a suicide prevention intervention required for implementation in VHA. This intervention is based on a study by Stanley and colleagues (2018) that found that Veterans identified to be at risk who received the safety planning intervention plus follow-up phone calls until they were engaged in care had 45% less suicidal behaviors in the six months following the emergency department visit, as compared to a control group. The RM MIRECC team provides implementation support to SPED Champions nationwide, which includes providing technical assistance on weekly national calls and via an email support group. The RM MIRECC team also supports the development and dissemination of SPED metrics and supports underperforming sites
- **VA Suicide Risk Management (VA SRM) Consultation Program**: Developed and led by the RM MIRECC team, the SRM Consultation Program offers consultation to any clinician (in VA or the community) working with Veterans at risk for suicide and is founded in the Therapeutic Risk Management of the Suicidal Patient model. Recommendations made are also consistent with the VA/DoD Clinical Practice Guideline (CPG), making SRM a vehicle for dissemination of the CPG.
- **Suicide Risk Identification Strategy (Risk ID)**: Required via VHA Memorandum as of 2019, Risk ID is the largest population-based suicide risk screening and evaluation strategy employed by any United States health care system. The RM MIRECC team continues to support national

implementation and evaluation of the Risk ID requirements. Support provided includes maintaining a SharePoint site, providing technical assistance via national phone calls and email, development of a community of practice among Risk ID Champions, facilitating the design of training materials and revising and tracking performance metrics

- **VA's Behavioral Health Autopsy Program** (BHAP): BHAP is designed to enhance suicide prevention efforts by systematically collecting information for all Veteran suicide deaths reported to VHA clinicians and Suicide Prevention Coordinators (SPCs). BHAP is a multifaceted quality improvement program that consists of standardized chart reviews, interviews with bereaved family members and targeted interviews with SPCs across the nation. BHAP combines information collected from these three sources (that is, chart reviews, family members and SPCs) to better understand the characteristics and contexts of Veteran suicide and in so doing, enhance the care and services provided to Veterans.

Evidence
Supports the already established efforts that have demonstrated impact on National Suicide Prevention Programming and the ability to engage with Veterans identified as at risk for suicide while also providing information from the unfortunate occurrences of Veteran suicide. The highlighted examples have had a demonstrable impact on highlighting Veteran risk factors (BHAP) and addressing these risk factors and providing additional support and care (REACH VET, SPED).

REACH VET: The percent of Veterans targeted through predictive modeling algorithms (REACH VET) within the VHA system continues to remain at 99%-100% across the four required metrics (coordinator accepted, provider accepted, care evaluation and outreach attempted) and 89% for successful outreach.

In the fourth quarter (Q4) of 2022, national performance exceeded metrics goals.

Metric	2022 Q4 Performance	Benchmark Target
Coordinator Accepted	100%	95%
Provider Accepted	99%	95%
Care Evaluation	99%	95%
Outreach Attempted	99%	95%
Successful Outreach*	89%	80%

*Veterans who are flagged as High Risk for Suicide who have also screened (or tested) positive for COVID-19

Findings from the McCarthy and others, (2021)[24] evaluation of the REACH VET program indicates REACH VET patients have increased outpatient appointments, decreased percent of missed appointments, greater initiation of suicide prevention safety plans, decreased inpatient mental health admissions, reduced Emergency Department visit days and reduced documented suicide attempts.

[24] McCarthy JF, Cooper SA, Dent KR and others. Evaluation of the Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment Suicide Risk Modeling Clinical Program in the Veterans Health Administration. *JAMA Netw Open.* 2021;4(10):e2129900. doi:10.1001/jamanetworkopen.2021.29900

SPED: As of September 30, 2022, VA increased implementation of SPED to 93% of eligible Veterans in the ED/UCC received engagement to complete Safety Planning (baseline of 66%). The effectiveness of SPED, as noted above, was described in the Stanley and colleagues (2018) article. The original study was conducted in VHA Emergency Departments and showed a 45% reduction in suicidal behavior. As of the fourth quarter of 2022, 76% of SPED-eligible Veterans reached completed plans (baseline of 65%).

VA SRM: Caring for Veterans at risk for suicide can be emotionally challenging. Providers can serve Veterans better when they have access to the right resources and tools and feel confident in their treatment decisions to mitigate Veterans' risk for suicide. Silva and others, 2016, conducted a survey of mental health providers (not specific to VA) regarding their training in this area. Their findings illustrate the unfortunate irony in the vital importance of suicide risk management versus the relative lack of training generally received and confidence in skills across mental health providers. "Strikingly, most behavioral health care staff across the overall sample reported having received no training in suicide prevention or risk assessment…This lack of training is particularly concerning among staff with greater clinical contact, especially in primary care contexts...The staff most in need of training …may not receive adequate (if any) training."[25] These issues are of vital concern to both VA and non-VA systems of care who are treating Veterans, a population that is at higher risk for suicide than non-Veteran populations. SRM addresses this need by providing resources, training and consultation to any provider serving Veterans at risk for suicide.

The need for SRM is further evidenced by the utilization and growth of the program over time. In 2014-2017, SRM completed under 100 consults each year with VA providers. Since that time, our completed consult volume has grown each year, with over 100 consults in the second quarter of 2022 alone. In 2022 RM MIRECC continues with the #NeverWorryAlone marketing campaign, including 21 presentations highlighting SRM and continued community outreach efforts by building targeted partnerships with community agencies that primarily serve Veterans (for example, Cohen Veterans Network). RM MIRECC also continues the monthly SRM Lecture Series, which offers free Continuing Education credit for both VA and non-VA community providers and partners. In the second quarter of 2022, RM MIRECC averaged 128 attendees per lecture (range of 72-209).

Risk ID: Implementation of Risk ID is currently being measured in the ED/UCC setting as well as ambulatory (that is, outpatient care). As of the fourth quarter of 2022, 93% of Veterans who had a positive suicide risk screen in these settings had a timely Comprehensive Suicide Risk Evaluation (CSRE).

A new annual screening requirement in ambulatory care was implemented at the beginning of the second quarter of 2021.

[25] Silva C, Smith AR, Dodd DR, Covington DW, Joiner TE. Suicide-Related Knowledge and Confidence Among Behavioral Health Care Staff in Seven States. *Psychiatr Serv.* 2016;67(11):1240-1245. doi:10.1176/appi.ps.201500271

Among Veterans in ambulatory care, a positive C-SSRS screen was found to be associated with significantly increased mental health care follow-up and engagement, particularly for those who had not received any mental health care in the previous year (Bahraini and others, 2021). These findings suggest that C-SSRS screening helps identify Veterans at high risk of suicide and connect them with appropriate services.

BHAP: Psychological autopsies, provide a systematic surveillance tool to better understand the psychological and contextual circumstances preceding suicide. Although distal risk factors for suicide may be obtained using a variety of methods, the behavioral autopsy remains the only validated approach to explicate the psychological and contextual circumstances that occur near to suicide (that is, proximal risk factors; Conner and others, 2011).

Since 2012 when BHAP data collection began, there have been more than 9,690 BHAP chart reviews completed (approximately 1,000 per year). To date, since the BHAP Family Interview Program began in 2014, there have been more than 820 family interviews completed (approximately 100 per year). Since 2015, more than 500 SPC interviews have been completed (approximately 65 per year). In 2020, BHAP data were used to explore the implementation of suicide prevention efforts among Veterans who died by suicide, with and without the use of a firearm and to identify factors that differentiated Veteran suicide decedents to help inform suicide prevention efforts (Ammerman & Reger, 2020).

Detailed findings from BHAP data are compiled on an annual basis to provide leadership and the field with actions to further suicide prevention activities. Additionally, in 2020, separate focused analyses were conducted to inform suicide prevention efforts in medical populations at high-risk for suicide such as Veterans with Traumatic Brain Injuries (TBIs).

Implementation

REACH VET: Although the REACH VET national adherence metrics are quite strong, RM MIRECC aims to reduce facility- and VISN-level variation and is aiming for facilities to hit 100% outreach of their identified REACH VET Veterans. RM MIRECC provided ongoing implementation support through technical assistance, monthly coordinator calls (~100 attendees each month), dissemination and interpretation of metrics and development of materials. REACH VET Coordinators have anecdotally shared that leadership support has been one the strongest facilitators of this program. Most common implementation barriers (for example, provider buy-in) have been addressed in previous years. One outstanding barrier is regarding the current REACH VET note templates. Based on feedback from the field, updates have been made to both the REACH VET COORDINATOR and REACH VET PROVIDER national note template. Changes include, adding clickable "tips" throughout the template to assist users filling it out and overall structure of the note templates. Examples of structure changes include more options to accurately capture specific scenarios (for example, if Veteran is in residential or inpatient care, incarcerated and so forth). Additionally, the language of the templates has been changed to make it clear each step is required of the program not an option. These changes will decrease user workload related to manual edits they previously had to make the template and improve tracking capabilities. Based on this feedback, updates to the national templates are in development. All training materials will be updated to accompany release of the updated templates. This will include an updated training in TMS.

In addition to improving quantitative metrics related to REACH VET, RM MIRECC is designing a robust program evaluation to learn more about how providers utilize the information provided to them by REACH VET and Veterans' experiences with REACH VET. Information gained from the program evaluation will be used to inform the development of future trainings and tools for the field.

SPED: RM MIRECC continues developing metrics related to SPED implementation and uses these data to engage with high performing sites to learn best practices, which are then shared on weekly technical assistance calls. These data are also used to offer tailored technical assistance to underperforming facilities to collaboratively problem-solve around barriers to implementation. Common barriers among underperforming facilities include a lack of dedicated mental health staff in their ED or UCC, challenges with completing tasks during nights and weekends, challenges associated with training rotating staff such as residents and inadequate monitoring of information available on the SPED dashboard. Additionally, RM MIRECC continues developing training resources to ensure that the SPED intervention is delivered in a high-quality manner. RM MIRECC has also updated a national template to facilitate the development of additional SPED metrics and to improve documentation of SPED efforts.

SRM: RM MIRECC is working with a marketing team to improve the dissemination of SRM to both VA and community providers via the #NeverWorryAlone marketing campaign. Examples of these efforts include: the re-designed website; the monthly SMR Lecture Series (offering free continuing education units for both VA and non-VA community providers and partners); the SRM Quarterly Newsletter; LinkedIn and Google search targeted advertising; and community partnerships. Within VA, SRM is regularly included in trainings and presentations. Additionally, OMHSP leadership regularly recommends use of the program when indicated. Ongoing program evaluation efforts allow the team to continually adjust to changing needs of consultees.

Risk ID: During the first quarter of 2021, VHA released VHA Memorandum 2021-11-13, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*. The memo related to Risk ID, changing the strategy from a three-step process to a two-step process. It also announced a new annual screening requirement for all Veterans receiving VHA care. The VA Risk ID TMS trainings have been attended by a total of 63,681 VHA staff since 2018. The RM MIRECC team provides ongoing implementation support via weekly technical assistance calls (average weekly attendance in the second quarter of 2022 =167) and email support (1,044 emails). Guidance documents for the field have been updated per new requirements in opioid treatment programs and are located on the SharePoint site: https://dvagov.sharepoint.com/sites/ECH/srsa/. In partnership with SPP, monthly Risk ID metrics are sent to VISN CMHOs and additional support is provided to underperforming sites.

BHAP: CoE will continue its work on BHAP, which includes but is not limited to:

- *Program Management and Oversight* (for example, BHAP team members work closely with SPCs in the field to ensure timely completion of chart reviews)
- *Interview Coordination* (for example, CoE-SP trained interviewers conduct structured interviews with bereaved family members and Suicide Prevention Coordinators)
- *Data Management and Collection* (for example, BHAP programmers develop and manage

BHAP collection tools and revise them as needed)

- *Data Analyses and Reporting* (for example, BHAP team members analyze and report on findings through annual field reports, invited briefings, leadership requests and national conference presentations for key stakeholders [for example, OMHSP, Mental Health & VISN leadership, VA providers and local SPCs])

Furthermore, driven by quality improvement principles, the BHAP team will continue its ongoing training efforts with SPCs and clinical interviewers to streamline BHAP processes and enhance data quality.

Prosthetic and Sensory Aids Services

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$3,722,046	$4,069,980	$4,147,810	$4,571,956	$5,025,363	$424,146	$453,407
Discretionary Obligations [Subtotal]	**$3,722,046**	**$4,069,980**	**$4,147,810**	**$4,571,956**	**$5,025,363**	**$424,146**	**$453,407**
Medical Community Care (0140):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$3,722,046**	**$4,069,980**	**$4,147,810**	**$4,571,956**	**$5,025,363**	**$424,146**	**$453,407**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$3,722,046	$4,069,980	$4,147,810	**$4,571,956**	**$5,025,363**	$424,146	$453,407
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$3,722,046**	**$4,069,980**	**$4,147,810**	**$4,571,956**	**$5,025,363**	**$424,146**	**$453,407**

Authority for Action

Public Laws and U.S. Code authorizing VA to provide prosthetic and sensory aids and other medical devices, items and services include 38 C.F.R. 17.150, § 1701(6)(F) and 1710.

New prosthetics regulations, Prosthetic and Rehabilitation Items and Services, 38 C.F.R. 17.3200-3250 were published December 2020 to clarify Veteran eligibility and provide comprehensive regulatory authority to standardize types and quality of prosthetic items/services, update business processes and replace expired policies.

Additional statutes and regulations associated with prosthetic items and services are listed in the below chart:

Item or Service	Statute	Regulation(s)
Clothing allowance	38 U.S.C. 1162	38 C.F.R. 3.810
Service and guide dog benefits	38 U.S.C. 1714(b) and (c)	38 C.F.R. 17.148
Sensori-neural aids	38 U.S.C. 1707(b)	38 C.F.R. 17.149
Equipment for blind Veterans	38 U.S.C. 1714(b)	38 C.F.R. 17.154
Automobile adaptive equipment	38 U.S.C. 3901 et seq.	38 C.F.R. 17.155 - 17.159
Home improvements and structural alterations	38 U.S.C. 1717(a)(2)	38 C.F.R. 17.3100 - 17.3130

Note: *Clothing Allowance and Automobile Adaptive Equipment programs are funded from Veterans Benefits Administration (VBA) appropriations.*

Populations Covered

Prosthetic and Sensory Aids Services (PSAS) are critical services provided to the Nation's Veterans. Services provided include prosthetic and orthotic devices, sensory aids, medical equipment and support services for Veterans. PSAS serves Veterans with needs related to: amputation, spinal cord injury/disorders, polytrauma and traumatic brain injury, hearing and vision, podiatric care, cardio-pulmonary disease, speech and swallowing deficits, geriatric impairments, neurologic dysfunction, muscular dysfunction, women's health, orthopedic care, diabetes and metabolic disease, peripheral vascular disease, cerebral vascular diseases and other medical disorders.

In 2022, VA obligated $3.6 billion dollars to provide nearly 22 million devices and items to more than 3.4 million Veterans, over 50% of all Veterans treated by the VHA.

Types of Services Provided

PSAS delivers medically prescribed prosthetic and sensory aids, medical devices, assistive aids, repairs and services to eligible Veterans. This enables them to achieve their highest level of function and maximize their independence.

The term "prosthetic device" refers to any device that supports or replaces loss of a body part or function including a full range of equipment and services for Veterans. This includes, but is not limited to artificial limbs, orthopedic footwear, orthopedic braces and supports, eyeglasses, hearing aids, speech communication aids, cosmetic restorations, breast prostheses, wigs, home oxygen, items that improve accessibility and mobility (for example, ramps, vehicle modifications, wheelchairs and mobility aids) and devices surgically placed in the Veteran (for example, implants, stents, joint replacements and pacemakers). PSAS is responsible for provision of these items from prescription through procurement, delivery, training, replacement and when necessary, repair.

Recent Trends

- Since 2017, PSAS obligations have increased by 16% from $3.1 billion dollars to $3.6 billion dollars obligated in 2022. This is due to increased Veteran utilization of PSAS. Additionally, VHA data analysis processes were streamlined to improve tracking and

analysis of trending and emerging PSAS items and services and better coordinate budget projection between VHA program offices for clinical policies and services, policy analysis and forecasting and budget.

- Since 2017, the number of unique Veterans served by PSAS has increased from 3.4 to 3.5 million Veterans in 2022 and the number of devices/items provided by PSAS has steadily increased from 21 to nearly 22 million.
- PSAS continued supporting Community Care and implementation of the MISSION Act for Veterans receiving durable medical equipment (DME) and medical devices in the community by updating contract modification language for DME medical devices for Community Care Network (CCN) Contracts and through development of process flows, operational procedure guides, trainings and consult templates to streamline communication between community providers and VA staff.
- Since 2017, PSAS has increased national acquisition strategies by utilizing historical spend data and employing clinical requirements analysis to identify vendors best positioned to meet agency needs, awarding over 118 national contracts to multiple vendors to sustain technological advances in the commercial industry and ensure a sustained quality level of service to Veterans.

Projections for the Future

- The PSAS budget is projected to continue to increase as more Veterans are enrolled in the VHA, the Veteran population ages and requires more prosthetic devices and services and as advanced technology is introduced to the market.
- Expand standardized note templates and event capture system procedure codes to support virtual care initiatives, increase Veteran's access to PSAS items and services and improve care coordination and communication across clinical service lines.
- PSAS continues to collaborate with internal and external partners to support VA modernization efforts in the areas of the electronic health record, supply chain and finance/budget/procurement.
    - PSAS is working with clinical partners to design clinical ordering templates for the vast majority of PSAS devices and services. The ordering templates will standardize ordering workflows and provide a mechanism to ensure that prosthetic requests from clinicians include the comprehensive information for PSAS to fulfil the request and eliminate unnecessary delays.
    - PSAS continues to work within the Office of Electronic Health Record Modernization Supply Chain Council framework to process map current business processes that will inform business process reengineering initiatives that build upon critical needs and enhance workflow efficiencies. PSAS is developing business requirements to inform the next generation of PSAS operational systems that will integrate PSAS processes with the department's modernization initiatives to maximize customer satisfaction and activate internal controls for greater accountability.

- PSAS manages a large specific purpose budget requiring a level of system integration with patient level activity to continue using data to manage and inform policy, improve Veteran services and provide pathways to patient level accounting for costing and third-party billing.

- In 2022, PSAS was authorized to procure items and services designed specifically for prevention and monitoring purposes. This is an emerging category of devices that coincide with advancing technology and capacity to provide prevention and monitoring services outside of the traditional clinical setting.
- PSAS has developed templates, trainings and operational guides for prosthetic items of national implementation of CCN contracts to support provision of the increasing number of prosthetic items to Veterans receiving care in the community.
- New Automobile Adaptive Equipment regulations (proposed rule published in the Federal Register, Document Number: 2020-04564) would provide a schedule for Automobiles and Other Conveyances to calculate the amount of the monetary allowance for adaptive equipment based on industry standards and VA experience administering this program. ***Note:*** *This program is funded through VBA's appropriations.*
    - Link to proposed rulemaking- https://www.federalregister.gov/documents/2020/03/12/2020-04564/adaptive-equipment-allowance
- Procurement and issuance procedures for prosthetic items will be improved to reduce clinical administrative burden, increase Veteran access to prosthetic items and improve the Veteran experience by:
    - Improving inventory management practices by streamlining data system reporting and responsibilities with Supply Chain Partners for increased efficiencies.
    - Exploring prosthetic commodities to use the Denver Logistics Center to automate the ordering, shipping, of prosthetic consumable items by permitting flexibility to deliver items direct shipment to a Veteran's residence.
    - Standardizing negotiated pricing for additional prosthetic commodities utilizing national acquisition strategies to streamline distribution, re-ordering and direct shipment to a Veteran's residence.
    - Establishing a national acquisition mechanism for Veterans to receive expedited repairs to wheeled mobility devices.
    - Improving clinical efficiency and access to prosthetic supplies by streamlining procurement of implant-related critical essential items.

Prosthetics Workload

2022 Prosthetic and Sensory Aids Service Category		
Commodity Type	**Unique Patients**	**Work Actions**
Wheeled Mobility	161,975	694,627
Artificial Limbs	34,528	190,547
Respiratory	791,734	6,081,450
Orthotic Items	839,287	1,687,529
Sensori-Neural Aids	1,974,427	5,110,751
Dialysis	4,016	7,087
Implants	159,603	427,403
HISA	11,109	12,917
Restorations	6,193	9,798
Medical Equipment	1,864,721	5,401,845
Other	1,067,142	2,010,928
Grand Total	**3,455,854**	**21,634,882**

Rehabilitative Care

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$855,390	$914,733	$997,172	$901,310	$1,011,374	($95,862)	$110,064
Discretionary Obligations [Subtotal]	**$855,390**	**$914,733**	**$997,172**	**$901,310**	**$1,011,374**	**($95,862)**	**$110,064**
Medical Community Care (0140):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$128,535	$169,600	$159,000	$175,900	$181,200	$16,900	$5,300
Discretionary Obligations [Subtotal]	**$128,535**	**$169,600**	**$159,000**	**$175,900**	**$181,200**	**$16,900**	**$5,300**
Medical Facilities (0162):							
Discretionary Obligations	$167,333	$174,600	$221,800	$327,500	$226,500	$105,700	($101,000)
Discretionary Obligations [Subtotal]	**$167,333**	**$174,600**	**$221,800**	**$327,500**	**$226,500**	**$105,700**	**($101,000)**
Discretionary Total	**$1,151,259**	**$1,258,933**	**$1,377,972**	**$1,404,710**	**$1,419,074**	**$26,738**	**$14,364**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$38,284	$81,830	$116,682	$43,546	$34,852
Veterans Medical Care and Health Fund (0173)	$45,141	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$10,501	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$81	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$55,723**	**$0**	**$38,284**	**$81,830**	**$116,682**	**$43,546**	**$34,852**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$154	$5,025	$5,912	$4,871	$887
Veterans Medical Care and Health Fund (0173)	$2,819	$0	$2,974	$0	$0	($2,974)	$0
VACAA, Section 801 (0152)	$50	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$2,869**	**$0**	**$3,128**	**$5,025**	**$5,912**	**$1,897**	**$887**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$23,631	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$193	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$23,824**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$82,416**	**$0**	**$41,412**	**$86,855**	**$122,594**	**$45,443**	**$35,739**
Combined Discretionary and Mandatory by Category							
Medical Services	$911,113	$914,733	$1,035,456	**$983,140**	**$1,128,056**	($52,316)	$144,916
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$131,405	$169,600	$162,128	**$180,925**	**$187,112**	$18,797	$6,187
Medical Facilities	$191,157	$174,600	$221,800	**$327,500**	**$226,500**	$105,700	($101,000)
Obligations [Grand Total]	**$1,233,675**	**$1,258,933**	**$1,419,384**	**$1,491,565**	**$1,541,668**	**$72,181**	**$50,103**

Blind Rehabilitation Service (BRS) Continuum of Care (CoC) is a seamless service integration ensuring Veterans and Service Members with a visual impairment receive the finest medical and rehabilitative care. The mission of BRS is to assist eligible blind and visually impaired Veterans and Service members in developing the skills needed for personal independence and successful reintegration into the community and family environment. Rehabilitation in BRS is patient-centered and interdisciplinary, developing and deploying integrated plans of care that address the Veterans' needs and goals to guide service delivery. Family members, included as members of the

team, are provided with education and training that allows them to understand visual impairment and provide support for goal achievement.

Blind Rehabilitation Service

$ in 1,000s		Total Obligations	Total Patients
Description	2022 Act.	$121,506	12,935
	2023 BE	$126,900	17,426
	2023 CE	$144,395	14,021
	2024 RR	$168,746	14,924
	2025 AA	$195,156	15,702
+/-	2023-2024	$24,351	903
	2024-2025	$26,410	778
+/-	2023-2024	16.9%	6.4%
	2024-2025	15.7%	5.2%

Authority for Action

Public Laws and U.S. Code governing rehabilitation provided by Blind Rehabilitation Service include:

- *Public Law 104-262, Section 104:* Requires the VA to maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled Veterans, including those with spinal cord dysfunction, amputations, blindness and mental illness, within distinct programs dedicated to the specialized treatment of those Veterans.
- *Public Law 109–461, Section 207:* Establishes 35 new Blind Rehabilitation Outpatient Specialist positions.
- *Public Law 111–163, section 7501:* Establishes a scholarship program leading to a degree or certificate in visual impairment or orientation and mobility rehabilitation.
- *Public Law 114–223, Section 250:* Changes to beneficiary travel funding for Veterans who receive care in rehabilitation centers and clinics provided through special disabilities rehabilitation program of the Department.

Population Covered

BRS CoC is a seamless service integration ensuring Veterans and Service Members with a visual impairment receive the finest medical and rehabilitative care. The mission of BRS is to assist eligible blind and visually impaired Veterans and Service members in developing the skills needed for personal independence and successful reintegration into the community and family environment. Rehabilitation in BRS is patient-centered and interdisciplinary, developing and

deploying integrated plans of care that address the Veterans' needs and goals to guide service delivery. Family members, included as members of the team, are provided with education and training that allows them to understand visual impairment and provide support for goal achievement.

Types of Services Provided

Blind Rehabilitation Services offers cascading levels of care coordination to all Veterans with visual impairment enrolled in the BRS CoC. BRS life-time care coordination provides structured systems support to complement the blind and visual impairment rehabilitation care offered in BRS.

Each Veteran receives a coordinated and integrated interdisciplinary plan of care with therapeutic instruction provided in the least restrictive environment available. BRS addresses the Veteran's whole well-being, particularly through the provision of skill area therapeutic instruction, prosthetic usage, adjustment counseling, health and wellness care, family/caregiver training and specialty programs

BRS programs provide a model of care that extends from the Veteran's home to the local VA care site, regional low vision clinics and lodger and inpatient training programs. Blind Rehabilitation Outpatient Specialists (BROS) who provide care at VA medical facilities and in Veterans' homes. BROS are assigned at Polytrauma Centers and other sites of care to support the care of Servicemembers and Veterans whose injuries and disorders include vision loss.

Across all VISNs, BRS provides rehabilitation care through the following programs and services:

- 163 Visual Impairment Service Team Coordinators
- 100 Blind Rehabilitation Outpatient Specialists
- 13 Inpatient Blind Rehabilitation Centers
- 21 Intermediate Low Vision Clinics
- 22 Advanced Low Vision Clinics
- 9 Visual Impairment Services Outpatient Rehabilitation (VISOR) programs

Recent Trends

<u>Increasing Access to Care</u>
In 2021 Q1, BRS expanded the provision of lifetime case management to all Veterans with a visual impairment, to include both those who are diagnosed as legally blind, as well as those Veterans diagnosed with low vision or other visual impairment. This result increased the number of Veterans with visual impairment who are on rosters tracked by VISNs from 47,278 in 2021 to 64,750 Veterans nation-wide by the end of 2022. BRS is not well duplicated in the private sector, leading to high reliance on VA and limited community options. There is a lack of consistency enterprise-wide within VA related to how Community Care is being deployed and used for BRS programs. Currently, non-VA community vendors are not recognized as authorized OCC vendors due to not being CMS billable providers. Per the Delegation of Authority Medical Services List, only Licensed Independent Practitioners (LIP) can enter consults and be the clinical reviewer for OCC

requests. BRS is not included in national data reports for OCC consults in VSSC (Non-VA Care Cube), hampering BRS National Program Office's ability to monitor this area of clinical activity.

Shift in Demographics of Population Served

Trends in visual impairment and blindness among Veterans continue to demonstrate increases in incidence of age-related macular degeneration and diabetic retinopathy among aging Veterans. These conditions are increasingly treatable if detected early with intravitreal anti-vascular endothelial growth factor (VEGF) injections, delaying the onset of severe visual impairment. Older patients with visual impairment are also more likely to experience increased co-morbidities. The combination of vision impairment coupled with other significant health conditions often substantially compromises Veteran performance of activities and social participation. BRS providers educate and collaborate with other VA and non-VA services to implement a whole health approach. With the increase of older patients with co-morbidities it is essential for BRS providers to understand the implications of all medical conditions and incorporate strategies into treatment planning.

Veteran Geographical Relocation

Shifts have occurred in the demographics of Veterans with visual impairments, with varying rates of growth or decline by VISN. BRS comprises a wide range of inpatient and outpatient programs and services to Veterans with visual impairments. The level of services available are dependent on the location, resources available and space/co-location requirements for Veterans requiring blind and low vision services. This service is not well duplicated in the private sector, leading to high reliance on VA and limited community options. The distribution and utilization of inpatient and outpatient blind rehabilitation services needs to be optimized to maximize access to care for Veterans.

Workforce Management

Development of a new monitoring system for workload productivity of BRS clinical disciplines permits a more detailed and current analysis of staffing distribution and workload of providers, as well the ability to pinpoint other opportunities for improvement that may exist in a local VA facility.

Professional Development

Within the blind rehabilitation field, there is increased competition for certified specialists that can manage rapidly evolving technology and address the needs of a shift in the demographic of persons served. VA is currently experiencing a shortage of providers in the continuum of care with certifications as Certified Low Vision Therapist (CLVT) and Computer Assistive Technology Instructor Specialist (CATIS). VA professional qualification standards require that BRS providers must hold an active certification or license in one of the following disciplines to practice at full performance level: CLVT, CATIS, Certified Orientation & Mobility (COMS), or Certified Vision Rehabilitation Teaching (CVRT). VA implemented the Visual Impairment Orientation and Mobility Professionals Scholarship Program (VIOMPSP) to develop young professionals entering the field. Since the implementation of VIOMPSP in 2015, BRS has provided 39 graduate training scholarships to help provide a much-needed supply of future professionals available to enter the specialty of Blind Rehabilitation.

Emerging Technology

VA BRS are more comprehensive than services provided in the civilian community. Since the release of smartphones and tablets, computer access training programs have become one of the primary referrals for blind rehabilitation. The increasing use of portable electronic hand-held magnification devices will continue to replace earlier desktop and bulky magnification systems previously used by severely visually impaired Veterans. The current renewal of a national VA contract for such devices clearly recognizes this trend and has positioned VA to effectively meet this growing trend and demand for our Veteran population. Similarly, other "smart" devices in the home environment that provide access to immediate information and communication to the outside world (for example, Alexa, Amazon Echo and so forth) represent another growing area of assistive technology that is anticipated to become widely adopted among our patient population.

Tele-Rehabilitation

VA BRS professionals' involvement in Tele-rehabilitation is an emerging practice area and requires VHA practitioners to stay abreast of current technology, utilize evidence and optimize continued education opportunities to obtain and maintain competency in using telehealth to deliver services. Of all BRS providers, 93% captured at least one telehealth encounters and 77% captured at least five encounters in 2022.

Pandemic COVID-19 Response

In close partnership with VHA national and local leadership and all field-based programs providing BRS rehabilitation training, BRS initiated immediate mitigation strategies to ensure the safety and well-being of all Veterans and staff within BRS. These efforts included expansion of virtual care and treatment modalities within BRS to maximize access to services while minimizing risks. In 2022, all 13 blind rehabilitation centers resumed inpatient admissions at a reduced capacity to ensure the safety of Veterans and staff. In addition, outpatient clinics have resumed face-to-face appointments, home visits and some have resumed Hoptel short term lodging programs.

Projections for the Future

Addressing the shift in demographics of population served

While still a small percentage of the overall Veteran population, female Veterans who will need to receive BRS will continue to grow as the overall number of female Veterans receiving care with VHA increases in the coming years. VA must ensure appropriate planning and programmatic posture to best meet the needs of this growing female Veteran population, particularly in our residential inpatient Blind Rehab Centers.

Veterans experiencing a visual impairment need to be referred for low-vision care. Per VHA Directive 1121(2), Low Vision care is provided within every VHA Eye Clinic or referred to the appropriate clinic. Of the 162 VA facilities approximately 93 can provide low vision optometric evaluation care. Due to a lack of access to low vision optometry at every medical center, there is no consistent functional assessment in routine eye exam and referral pathway to blind and vision rehabilitation.

Workload Productivity

BRS will continue to monitor and maximize clinician productivity and programmatic efficiency within this specialized discipline to enhance and expedite Veteran access to BRS care, services and treatment. The productivity metric benchmarks of all BRS providers will fall into the Inner-Quartile Range (25th-75th percentile), with an expectation of 50th percentile or higher.

Veteran Geographical Relocation

The VA Market Areas Health System Optimization (MAHSO) effort completed an initial assessment of VA markets, facilities and service lines to produce recommendations for the design of high-performing integrated delivery networks. BRS was identified as a service line requiring a set of national planning guidelines and thresholds that would be applicable for use in current and future planning efforts. In 2021, BRS National Program Office collaborated with MAHSO to develop the Blind Rehabilitation National Planning Strategies which provides guidance on how Blind Rehabilitation programs can respond to varied market demands and trends while optimizing VA resources in a Veteran-centric framework. These guidelines and thresholds can be applied to the development of a Blind and Vision Rehabilitation Clinical Resource Hub to ensure that planning is matched to Veteran demand. The planning priorities for BRS are to align VA resources with current and future Veteran geographical distribution, improve timely access to care, address increased demand for outpatient services, services for women Veterans and telehealth.

Workforce Development

Over the next five years, BRS plans to partner with various universities to provide staff with the skills, tools and resources to excel in their area of care and empower them to honor their potential. Specifically, BRS will focus on low vision therapy courses and assistive technology workshops that will result in a provider's ability to obtain professional certification. Enhancing workforce development by engaging in best practices, expanding opportunities for continuing education, will also assist with succession planning, staff retention and overall job satisfaction for the benefit of all stakeholders. A workgroup has been established through Workforce Management to review and revise the BRS Qualification Standards for BRS and BROS. These efforts are being made to address the needs of a changing field and workforce.

Emerging Technology

The rapid proliferation, adoption and reliance on accessible technology among our Veteran population, particularly involving smart-phones, smart-tablets and other similar portable devices that promote independence, autonomy and mobility will continue to grow dramatically. Another burgeoning area of emerging technology that will impact this Veteran population is the growth in head-mounted electronic magnification and optical enhancement devices that will provide exciting new modalities for Veterans managing visual impairment. The implications of this emerging technological innovation includes the increasing need to incorporate this training utilizing these platforms across virtually facets of BRS (inpatient and outpatient), as well as across all disciplines and modalities of training areas within BRS teams. VA BRS is determining appropriate avenues to augment and enrich therapy options through virtual and augmented reality to Veterans and VA staff. Potential applications of the immersive technology include fall risk assessments, meditation and pain management.

Tele-Rehabilitation

The expected benefits of Blind Telerehabilitation includes increased clinical capacity, resulting in improved access to BRS closer to the Veterans' home and better continuity of care. Seamless access to care across the health care continuum has proven to decrease hospitalizations, emergency room encounters and pharmacy costs, as well as improve access to other specialty medical services.

Adoption of Alternative Modalities for Rehabilitation and Care

An increase in the utilization of tele-rehabilitation as a viable platform and alternative for face-to-face clinical care has been demonstrated in past years and represents an exciting new mechanism to improve timeliness and access to BRS programs. BRS Continuum of Care response to COVID-19 incorporated alternative modalities for rehabilitation and care as a best practice. A strategic initiative is to develop and deploy a Blind and Visual Impairment Rehabilitation Clinical Resource Hub focusing on the provision of care coordination, treatment and rehabilitation using a virtual modality of service delivery. This will expand access to care for Veterans with visual impairments by providing virtual treatment to any Veteran or Service member within the system, regardless of residential location. The model includes clinical and administrative support similar to an inpatient Blind Rehabilitation Center.

External Review and Accreditation

External review is a key function of the quality assurance program to ensure compliance and improvement consistent with industry standards and community health care delivery. BRS National Program Office is developing resources to assist programs that are challenged with preparing for CARF accreditation and Joint Commission readiness.

Spinal Cord Injuries and Disorders

$ in 1,000s		Total Obligations	Total Patients
Description	2022 Act.	$728,636	12,816
	2023 BE	$733,500	14,155
	2023 CE	$773,428	12,620
	2024 RR	$821,609	12,435
	2025 AA	$873,543	12,261
+/-	2023-2024	$48,181	-185
	2024-2025	$51,934	-174
+/-	2023-2024	6.2%	-1.5%
	2024-2025	6.3%	-1.4%

The mission of the VA Spinal Cord Injuries and Disorders (SCI/D) System of Care is to support and maintain the health, independence, quality of life and productivity of Veterans with SCI/D throughout their lives. The program is supported by The Veterans' Health Care Eligibility Reform Act of 1996 and VHA Directive 1176 ("Spinal Cord Injuries and Disorders System of Care", September 30, 2019).

Populations Covered
The SCI/D System of Care provides lifelong care for all enrolled Veterans who have spinal cord injuries and disorders. Active Duty Service Members are also provided care as established by Memoranda of Agreement between VA and the Department of Defense, most recently under "Memorandum of Agreement between the Department of Veterans Affairs (VA) and the DoD for Medical Treatment Provided to Active Duty Service Members (ADSM) with Spinal Cord Injury, Traumatic Brain Injury, Blindness, or Polytraumatic Injuries" and "Memorandum of Understanding between Veteran Affairs (VA) and DoD For Interagency Complex Care Coordination Requirements for Service Members and Veterans of 29 July 2014."

Types of Services Provided
The VA SCI/D System of Care is organizationally designed as a "hub-and-spokes" model in which 25 regional SCI/D Centers (hubs) provide comprehensive primary and specialty care and primary care services are delivered at VA medical centers that do not have SCI/D Centers (spokes) by SCI/D Patient Aligned Care Teams (PACT). The comprehensive care provided at SCI/D Centers spans all relevant clinical settings including inpatient, outpatient, home and telehealth care.

The SCI/D System of Care provides the full continuum of services, including acute rehabilitation, sustaining medical/surgical treatment, primary and preventive care including annual evaluations, provisions for prosthetics and durable medical equipment and unique SCI/D care such as ventilator management, home-based care, telehealth, respite care, long term care and end-of-life care. Several inter-connected SCI/D programs and activities coordinate and extend care including SCI/D telehealth, SCI/D home care and other non-institutional care programs. There are also dedicated institutional SCI/D long-term care units at six SCI/D Centers.

The SCI/D Centers are staffed by interdisciplinary teams of highly trained SCI/D health care clinicians. These teams include physicians, physician assistants, nurse practitioners, nurses, physical, occupational, recreation and kinesio-therapists, psychologists, social workers, pharmacists, dietitians and vocational counselors.

Recent Trends

- *Bowel & Bladder Program*
  The SCI/D National Program Office, Office of Community Care and Payment Operations Management Office work in collaboration for Veterans to receive care and timely payment for their providers through the Bowel and Bladder Program using individuals or agencies. The offices are updating processes because of the Mission Act, change in billing systems and consolidation of payment centers. As processes are updated, there has been work in developing a standard invoice form and factsheets related to the program which are in the final stages of completion. Regarding payments, the standardization and consolidation of the process has combined fourteen VISNs in 2022. The SCI/D National Program Office has further improved communication with field staff by creating a report mechanism to request guidance related to Bowel and Bladder Program issues as well as reoccurring virtual office hours. The SCI/D intranet site will be updated with the latest information as it become available.

- *SCI/D Data Operations*
  The SCI/D Registry & Outcomes Modernization Initiative continues to be an important priority for the SCI/D National Program Office. The SCI/D National Program Office continues its strong partnership with the Veterans Service Support Center (VSSC) in the sustainment of the VSSC SCI/D Registry which identifies Veterans with spinal cord injuries and disorders. The SCI/D Registry and Outcomes Think Tank was retired during 2022 after meeting the original targets of SCI/D Registry development. A new think tank, the SCI/D Data Operations Think Tank, is on track to form in 2023 with the principal charge of providing the SCI/D System of Care with data information that is valid, valuable and leads to real-time positive impact for Veterans with SCI/D. In the effort to improve data use and access within the field, the SCI/D National Program Office has developed data reports that address Veteran access to specialty care, specialty care utilization, mammography screening and special population trends. These reports are supported with monthly open office hours with the SCI/D National Program Office data analyst as well as the SCI/D Management of Information and Outcomes (MIO) Coordinators community of practice. Additionally, 2022 efforts included the development of a consolidated SCI/D Registry resource that standardizes historical SCI/D data from multiple sources into a single structured dataset which is anticipated for use by both research and operational partners.

- *SCI/D Research*
  The SCI/D National Program Office is in its fifth year of a partnered HSR&D-funded program evaluation project focused on SCI/D Annual Exam (AE) utilization and implementing the Functional Mobility Assessment (FMA) tool. Direct operational impacts have included quantitative associations with how Veterans with SCI/D choose AE services; completion of a Veteran survey of qualitative AE experiences communicated to the field with recommendations for actionable steps; and expanding FMA use to two more SCI/D Centers. The SCI/D National Program Office partnered with the United States SCI Model Systems (SCIMS) to obtain Paralyzed Veterans of America (PVA) Research Foundation funding for a post-doctoral fellow to complete a two-year evaluation titled, "Advance traumatic spinal cord injury research through data harmonization, curation and integrative data analysis: Spinal Cord Injury Model Systems and Veterans Health Administration Spinal Cord Injury (January 1, 2023 through December 31, 2024). The SCI/D National Program Office provided a co-investigator representative for a newly funded HSR&D program evaluation project titled, "Disruption of health services: The impact of COVID-19 on Veterans with SCI/D" (Award notification: October 18, 2022). The national program office is also providing co-investigator and mentor support for a VISN 7 funded Research Development Award, titled, "Predicting fracture risk in spinal cord injury" (October 2, 2022 through September 30, 2024). Additional early-career support and mentorship is being provided by the SCI/D National Program Office for clinician-researchers focused on stroke risk and whole health utilization in the Veteran SCI/D population. The SCI/D National Program Office led the authorship team on a recent publication in Archives of Rehabilitation Research and Clinical Translation titled, "Modernization of a large spinal cord injury and disorders registry: The Veterans Health Administration experience." A manuscript titled "Utilization of Whole Health Services Among Veterans with Spinal Cord Injuries and Disorders (SCI/D): Early Insights from the VA SCI/D System of Care" has been revised and submitted to the *Journal of Spinal Cord Medicine.*

Manuscripts in progress include: "United States Department of Veterans Affairs Spinal Cord Injuries & Disorders (SCI/D) Registry: 1994 to 2022" and "United States Veterans' Utilization of Spinal Cord Injuries and Disorders Annual Evaluation Services." The SCI/D National Program Office strategic plan includes a 3–5-year focus on further enhancing within and outside VHA partnerships to obtain evidence to support quick, direct, positive operational impacts for Veterans with SCI/D, further SCI/D knowledge and develop the next generation of SCI/D clinicians, leaders and researchers.

Projections for the Future

- *Oracle Cerner Electronic Health Record*
  The transition to the Oracle Cerner electronic health record (EHR) system will continue over the next several years. The SCI/D National Program Office and System of Care continue a close partnership with VA EHRM-IO and Oracle Cerner, in the development of SCI/D-specific documentation, workflows, interdisciplinary team instruments and Veteran outcomes measures. Focus areas for SCI/D Oracle Cerner documentation include each of the major care settings, including inpatient, outpatient, SCI/D home care, SCI/D telehealth and SCI/D Long Term Care, ensuring documentation follows the Veteran's lifespan throughout the SCI/D System of Care. There are also SCI/D unique challenges that are addressed in Oracle Cerner powerforms, quick orders and algorithms, including autonomic dysreflexia, neurogenic bladder and bowel, catastrophic disability and the SCI Pressure Ulcer Monitoring Tool (PUMT). The SCI/D National Program Office continues to provide communication, education and informatic support to SCI/D Hub and Spoke teams as facilities transition, with national data reports.

- *Making Advances in Mammography and Medical Options for Veterans (MAMMO) Act, P.L. 117-135 § 105- Mammography Accessibility for Paralyzed and Disabled Veterans*
  The SCI/D National Program Office is working in partnership with the Office of Diagnostics, Healthcare Environment and Facilities Programs, Construction and Facilities Management, Women's Health, Amputation Care and Integrated Veterans Care to lead planning and implementation of Section 105 of *Making Advances in Mammography and Medical Options for Veterans (MAMMO) Act* (P.L. 117-135), which addresses mammography accessibility for Veterans with SCI/D and other physical disabilities. With the intent to enhance breast cancer screening rates among Women Veterans with SCI/D or amputation, the SCI/D National Program Office and collaborating offices are addressing accessibility definitions, standards and measures, developing and executing an accessibility study, creating a screening dashboard and evaluating community care accessibility.

Long-Term Services & Supports (LTSS) and State Home Programs

The following twenty-two tables display obligations, workload and appropriation details in the following order:

- Obligations by Program and overall Average Daily Census and Per Diem
- Institutional Programs:
  - Average Daily Census by Long and Short Stay
  - Patients Treated by Long and Short Stay
  - Obligations by Long and Short Stay
  - Per Diem by Long and Short Stay
- Non-Institutional Obligations and Clinic Stops/Procedures
- Obligations by Appropriation for the following VA System Provided
  - VA Community Living Centers
  - Community Residential Care
  - Home Telehealth
  - Home-Based Primary Care
  - Spinal Cord Injury and Disability Home Care
  - VA Adult Day Health Care
- Obligations by Appropriation for the following Non-VA Providers
  - Community Nursing Home
  - State Home Nursing
  - State Home Domiciliary
  - State Home Adult Day Health Care
  - Community Adult Day Health Care
  - Home Hospice Care
  - Home Respite Care
  - Homemaker/Home Health Aide Programs
  - Purchased Skilled Care
- 2022 Unique Patients using Non-Institutional Long-Term Supportive Services by Fund

Obligations by Program and Overall Average Daily Census and Per Diem

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Obligations ($000)							
Institutional							
Community Nursing Home	$1,259,287	$1,550,526	$1,399,863	$1,529,213	$1,617,225	$129,350	$88,012
State Home Domiciliary	$43,684	$49,095	$52,079	$55,402	$58,616	$3,323	$3,214
State Home Nursing	$1,239,773	$1,490,482	$1,352,486	$1,438,784	$1,522,235	$86,298	$83,451
VA Community Living Centers	$4,796,854	$4,942,654	$5,112,902	$5,292,497	$5,477,621	$179,595	$185,124
Institutional Obligations [Total]	**$7,339,599**	**$8,032,757**	**$7,917,330**	**$8,315,896**	**$8,675,697**	$398,566	$359,801
Non-Institutional							
Community Adult Day Health Care	$219,254	$220,338	$228,324	$238,510	$246,594	$10,186	$8,084
Community Residential Care	$99,414	$86,238	$104,007	$105,825	$106,283	$1,818	$458
Home Hospice Care	$21,521	$35,158	$22,099	$22,739	$23,290	$640	$551
Home Respite Care	$127,454	$96,900	$136,104	$145,324	$153,523	$9,220	$8,199
Home Telehealth	$360,651	$345,103	$377,714	$395,102	$407,206	$17,388	$12,104
Home-Based Primary Care	$1,164,049	$1,221,183	$1,303,643	$1,467,179	$1,591,185	$163,536	$124,006
Homemaker/Home Health Aide Prgs.	$1,573,605	$1,432,533	$1,716,143	$1,856,733	$1,964,148	$140,590	$107,415
Purchased Skilled Home Care	$335,592	$599,848	$350,694	$366,350	$381,089	$15,656	$14,739
Spinal Cord Injury & Disability Home Care	$15,746	$12,184	$16,275	$16,853	$17,312	$578	$459
State Home Adult Day Health Care	$6,322	$1,286	$1,783	$1,892	$2,007	$109	$115
VA Adult Day Health Care	$2,645	$1,825	$7,898	$8,381	$8,698	$483	$317
Non-Institutional Obligations [Total]	$3,926,252	$4,052,596	$4,264,684	$4,624,888	$4,901,335	$360,204	$276,447
Long-Term Services & Supports Obligations [Total]	**$11,265,851**	**$12,085,353**	**$12,182,014**	**$12,940,784**	**$13,577,032**	**$758,770**	**$636,248**
Institutional Average Daily Census							
Community Nursing Home	9,805	12,205	9,819	9,907	9,972	88	66
State Home Domiciliary	2,280	2,691	2,204	2,175	2,162	(29)	(13)
State Home Nursing	14,754	19,235	14,123	13,514	12,992	(609)	(522)
VA Community Living Centers	6,457	7,902	6,304	6,182	6,132	(122)	(50)
Institutional Average Daily Census [Total]	33,296	42,033	32,450	31,779	31,259	(671)	(520)
Institutional Per Diem							
Community Nursing Home	$351.87	$348.07	$390.60	$421.75	$444.31	$31.15	$22.56
State Home Domiciliary	$52.49	$49.98	$64.74	$69.58	$74.27	$4.84	$4.69
State Home Nursing	$230.22	$212.29	$262.36	$290.88	$321.00	$28.52	$30.12
VA Community Living Centers	$2,035.32	$1,713.70	$2,222.12	$2,339.12	$2,447.33	$117.00	$108.21
Institutional Per Diem [Total]	$603.93	$523.58	$668.46	$714.98	$760.39	$46.52	$45.41

Average Daily Census

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Nursing Home Average Daily Census, Long & Short Stay							
Community Nursing Home							
Long Stay	7,951	9,882	7,963	8,034	8,087	71	53
Short Stay	1,854	2,322	1,856	1,873	1,885	17	12
Community Nursing Home Stays [Total]	9,805	12,205	9,819	9,907	9,972	88	66
State Home Nursing							
Long Stay	14,292	18,451	13,681	13,092	12,586	(590)	(506)
Short Stay	462	784	442	423	406	(19)	(16)
State Nursing Home Stays [Total]	14,754	19,235	14,123	13,514	12,992	(609)	(522)
VA Community Living Centers							
Long Stay	5,227	6,332	5,103	5,005	4,964	(99)	(40)
Short Stay	1,230	1,569	1,200	1,177	1,168	(23)	(10)
VA Community Living Centers Stays [Total]	6,457	7,902	6,304	6,182	6,132	(122)	(50)
All Nursing Home Average Daily Census, Long & Short Stay [Grand Total]	31,016	39,342	30,246	29,603	29,097	(643)	(507)
Nursing Home Average Daily Census by Age							
Community Nursing Home							
< 65	976	1,279	977	986	993	9	7
65 to 84	6,911	8,503	6,921	6,983	7,029	62	46
> 84	1,918	2,423	1,920	1,938	1,950	17	13
Community Nursing Home Stays [Total]	9,805	12,205	9,819	9,907	9,972	88	66
State Home Nursing							
<65	661	925	632	605	582	(27)	(23)
65 to 84	8,740	10,937	8,367	8,007	7,697	(361)	(309)
> 84	5,353	7,373	5,124	4,903	4,713	(221)	(189)
State Home Nursing Stays [Total]	14,754	19,235	14,123	13,514	12,992	(609)	(522)
VA Community Living Centers							
< 65	810	1,043	791	775	769	(15)	(6)
65 to 84	4,541	5,463	4,433	4,347	4,312	(86)	(35)
> 84	1,106	1,396	1,080	1,059	1,051	(21)	(9)
VA Community Living Centers Stays [Total]	6,457	7,902	6,304	6,182	6,132	(122)	(50)
All Nursing Home Average Daily Census by Age [Grand Total]	31,016	39,342	30,246	29,603	29,097	(643)	(507)
Nursing Home Average Daily Census by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	8,053	10,094	8,064	8,137	8,190	72	54
Non-Service Connected	1,053	1,265	1,055	1,064	1,071	9	7
Service-Connected	699	845	700	706	711	6	5
Community Nursing Home Stays [Total]	9,805	12,205	9,819	9,907	9,972	88	66
State Home Nursing							
Priority 1A	4,624	5,541	4,426	4,235	4,072	(191)	(164)
Non-Service Connected	7,635	10,399	7,309	6,994	6,723	(315)	(270)
Service-Connected	2,495	3,295	2,389	2,286	2,197	(103)	(88)
State Home Nursing Stays [Total]	14,754	19,235	14,123	13,514	12,992	(609)	(522)
VA Community Living Centers							
Priority 1A	3,864	4,736	3,772	3,699	3,670	(73)	(30)
Non-Service Connected	1,703	2,104	1,662	1,630	1,617	(32)	(13)
Service-Connected	890	1,062	869	853	846	(17)	(7)
VA Community Living Centers Stays [Total]	6,457	7,902	6,304	6,182	6,132	(122)	(50)
All Nursing Home Stays by Priority 1A, SC & Non-SC [Total]	31,016	39,342	30,246	29,603	29,097	(643)	(507)

Patients Treated

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Patients Treated by Long & Short Stay							
Community Nursing Home							
Long Stay	11,751	13,145	11,725	11,516	11,246	(209)	(270)
Short Stay	24,207	27,369	24,153	23,723	23,167	(431)	(556)
Community Nursing Home Patients Trtd., [Total]	35,958	40,514	35,878	35,239	34,413	(640)	(826)
State Home Nursing							
Long Stay	17,733	21,477	17,103	16,678	16,518	(425)	(160)
Short Stay	3,728	6,004	3,595	3,506	3,472	(89)	(34)
State Home Nursing Patients Trtd., [Total]	21,461	27,482	20,698	20,184	19,990	(515)	(194)
VA Community Living Centers							
Long Stay	7,198	12,068	6,876	6,648	6,502	(228)	(146)
Short Stay	18,018	31,296	17,211	16,641	16,275	(570)	(366)
VA Community Living Centers Patients Trtd., [Total]	25,216	43,364	24,086	23,289	22,776	(798)	(512)
Grand Total Patients Treated by Long & Short Stay	82,635	111,360	80,663	78,711	77,179	(1,952)	(1,532)
Patients Treated by Age							
Community Nursing Home							
< 65	3,718	4,583	3,710	3,644	3,558	(66)	(85)
65 to 84	24,112	26,791	24,059	23,630	23,076	(429)	(554)
> 84	8,128	9,140	8,110	7,965	7,779	(145)	(187)
Community Nursing Home Stays [Total]	35,958	40,514	35,878	35,239	34,413	(640)	(826)
State Home Nursing							
< 65	879	1,187	848	827	819	(21)	(8)
65 to 84	12,465	15,376	12,022	11,723	11,611	(299)	(112)
> 84	8,117	10,919	7,829	7,634	7,561	(195)	(73)
State Home Nursing Stays [Total]	21,461	27,482	20,698	20,184	19,990	(515)	(194)
VA Community Living Centers							
< 65	3,730	6,642	3,563	3,445	3,369	(118)	(76)
65 to 84	16,935	29,009	16,176	15,641	15,297	(536)	(344)
> 84	4,551	7,713	4,347	4,203	4,111	(144)	(92)
VA Community Living Centers Stays [Total]	25,216	43,364	24,086	23,289	22,776	(798)	(512)
All Patients Treated by Age [Grand Total]	82,635	111,360	80,663	78,711	77,179	(1,952)	(1,532)
Patients Treated by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	23,250	26,244	23,199	22,785	22,251	(414)	(534)
Non-Service Connected	8,393	9,357	8,374	8,225	8,032	(149)	(193)
Service-Connected	4,315	4,913	4,305	4,229	4,130	(77)	(99)
Community Nursing Home Stays [Total]	35,958	40,514	35,878	35,239	34,413	(640)	(826)
State Home Nursing							
Priority 1A	6,618	7,790	6,382	6,224	6,164	(159)	(60)
Non-Service Connected	11,122	14,903	10,728	10,461	10,360	(267)	(100)
Service-Connected	3,721	4,789	3,588	3,499	3,466	(89)	(34)
State Home Nursing Stays [Total]	21,461	27,482	20,698	20,184	19,990	(515)	(194)
VA Community Living Centers							
Priority 1A	10,468	17,636	9,999	9,668	9,455	(331)	(213)
Non-Service Connected	9,728	17,483	9,292	8,984	8,787	(308)	(198)
Service-Connected	5,020	8,245	4,795	4,636	4,534	(159)	(102)
VA Community Living Centers Stays [Total]	25,216	43,364	24,086	23,289	22,776	(798)	(512)
All Patients Treated by Priority 1A, SC & Non-SC [Total]	82,635	111,360	80,663	78,711	77,179	(1,952)	(1,532)

Length of Stay

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Length of Stay by Long & Short Stay							
Community Nursing Home							
Long Stay	247.0	274.4	247.9	255.3	262.5	7.4	7.2
Short Stay	28.0	31.0	28.1	28.9	29.7	0.8	0.8
Community Nursing Home Length of Stay	99.5	110.0	99.9	102.9	105.8	3.0	2.9
State Home Nursing							
Long Stay	294.2	313.6	292.0	287.3	278.1	(4.7)	(9.2)
Short Stay	45.2	47.7	44.9	44.1	42.7	(0.8)	(1.4)
State Home Nursing Length of Stay	250.9	255.5	249.1	245.1	237.2	(4.0)	(7.9)
VA Community Living Centers							
Long Stay	265.1	191.5	270.9	275.5	278.7	4.6	3.2
Short Stay	24.9	18.3	25.5	25.9	26.2	0.4	0.3
VA Community Living Centers Length of Stay	93.5	66.5	95.5	97.2	98.3	1.7	1.1
Grand Total Length of Stay by Long & Short Stay	137.0	128.9	136.9	137.7	137.6	0.8	(0.1)
Length of Stay by Age							
Community Nursing Home							
< 65	95.8	101.9	96.1	99.0	101.8	2.9	2.8
65 to 84	104.6	115.8	105.0	108.2	111.2	3.2	3.0
> 84	86.1	96.7	86.4	89.0	91.5	2.6	2.5
Community Nursing Home Length of Stay [Total]	99.5	110.0	99.9	102.9	105.8	3.0	2.9
State Home Nursing							
< 65	274.5	284.4	272.3	267.9	259.3	(4.4)	(8.6)
65 to 84	255.9	259.6	254.0	250.0	242.0	(4.0)	(8.0)
> 84	240.7	246.5	238.9	235.1	227.5	(3.8)	(7.6)
State Home Nursing Length of Stay [Total]	250.9	255.5	249.1	245.1	237.2	(4.0)	(7.9)
VA Community Living Centers							
< 65	79.3	57.3	81.0	82.4	83.3	1.4	0.9
65 to 84	97.9	68.7	100.0	101.7	102.9	1.7	1.2
> 84	88.7	66.1	90.7	92.2	93.3	1.5	1.1
VA Community Living Centers Length of Stay [Total]	93.5	66.5	95.5	97.2	98.3	1.7	1.1
Grand Total Length of Stay by Age	137.0	128.9	136.9	137.7	137.6	0.8	(0.1)
Length of Stay by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	126.4	140.4	126.9	130.7	134.4	3.8	3.7
Non-Service Connected	45.8	49.3	46.0	47.4	48.7	1.4	1.3
Service-Connected	59.1	62.8	59.3	61.1	62.8	1.8	1.7
Community Nursing Home Length of Stay [Total]	99.5	110.0	99.9	102.9	105.8	3.0	2.9
State Home Nursing							
Priority 1A	255.0	259.6	253.1	249.1	241.1	(4.0)	(8.0)
Non-Service Connected	250.6	254.7	248.7	244.7	236.9	(4.0)	(7.8)
Service-Connected	244.7	251.1	243.0	239.1	231.4	(3.9)	(7.7)
State Home Nursing Length of Stay [Total]	250.9	255.5	249.1	245.1	237.2	(4.0)	(7.9)
VA Community Living Centers							
Priority 1A	134.7	98.0	137.7	140.1	141.7	2.4	1.6
Non-Service Connected	63.9	43.9	65.3	66.4	67.2	1.1	0.8
Service-Connected	64.7	47.0	66.2	67.3	68.1	1.1	0.8
VA Community Living Centers Length of Stay [Total]	93.5	66.5	95.5	97.2	98.3	1.7	1.1
Grand Total Length of Stay by Priority 1A, SC & Non-SC [Total]	137.0	128.9	136.9	137.7	137.6	0.8	(0.1)

Obligations

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Obligations by Long & Short Stay							
Community Nursing Home							
Long Stay	$1,016,762	$1,246,767	$1,133,811	$1,242,263	$1,316,808	$108,452	$74,545
Short Stay	$242,525	$303,759	$266,052	$286,950	$300,417	$20,898	$13,467
Community Nursing Home Patients Trtd., [Total]	$1,259,287	$1,550,526	$1,399,863	$1,529,213	$1,617,225	$129,350	$88,012
State Home Nursing							
Long Stay	$1,189,646	$1,436,568	$1,301,445	$1,386,740	$1,483,675	$85,295	$96,935
Short Stay	$50,127	$53,914	$51,041	$52,044	$38,560	$1,003	($13,484)
State Home Nursing Patients Trtd., [Total]	$1,239,773	$1,490,482	$1,352,486	$1,438,784	$1,522,235	$86,298	$83,451
VA Community Living Centers							
Long Stay	$3,779,176	$3,830,475	$4,090,907	$4,309,194	$4,524,432	$218,287	$215,238
Short Stay	$1,017,678	$1,112,179	$1,021,995	$983,303	$953,189	($38,692)	($30,114)
VA Community Living Centers Patients Trtd., [Total]	$4,796,854	$4,942,654	$5,112,902	$5,292,497	$5,477,621	$179,595	$185,124
Grand Total Obligations by Long & Short Stay [Total]	$7,295,915	$7,983,662	$7,865,251	$8,260,494	$8,617,081	$395,243	$356,587
Obligations by Age							
Community Nursing Home							
< 65	$139,833	$179,277	$155,442	$169,806	$179,578	$14,364	$9,772
65 to 84	$886,289	$1,081,587	$985,227	$1,076,263	$1,138,207	$91,036	$61,944
> 84	$233,165	$289,622	$259,194	$283,144	$299,440	$23,950	$16,296
Community Nursing Home Obligations [Total]	$1,259,287	$1,550,526	$1,399,863	$1,529,213	$1,617,225	$129,350	$88,012
State Home Nursing							
< 65	$58,148	$72,919	$63,435	$67,482	$71,396	$4,047	$3,914
65 to 84	$743,612	$855,078	$811,216	$862,978	$913,032	$51,762	$50,054
> 84	$438,013	$562,485	$477,835	$508,324	$537,807	$30,489	$29,483
State Home Nursing Obligations [Total]	$1,239,773	$1,490,482	$1,352,486	$1,438,784	$1,522,235	$86,298	$83,451
VA Community Living Centers							
< 65	$611,640	$670,503	$651,939	$670,503	$694,596	$18,564	$24,093
65 to 84	$3,332,968	$3,503,837	$3,552,565	$3,853,680	$3,989,205	$301,115	$135,525
> 84	$852,246	$768,314	$908,398	$768,314	$793,820	($140,084)	$25,506
VA Community Living Centers Obligations [Total]	$4,796,854	$4,942,654	$5,112,902	$5,292,497	$5,477,621	$179,595	$185,124
Grand Total Obligations by Age	$7,295,915	$7,983,662	$7,865,251	$8,260,494	$8,617,081	$395,243	$356,587
Obligations by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	$1,043,857	$1,291,053	$1,160,384	$1,267,606	$1,340,562	$107,222	$72,956
Non-Service Connected*	$128,804	$155,129	$143,183	$156,413	$165,415	$13,230	$9,002
Service-Connected*	$86,626	$104,344	$96,296	$105,194	$111,248	$8,898	$6,054
Community Nursing Home Obligations [Total]	$1,259,287	$1,550,526	$1,399,863	$1,529,213	$1,617,225	$129,350	$88,012
State Home Nursing							
Priority 1A	$432,351	$459,565	$471,658	$501,753	$530,855	$30,095	$29,102
Non-Service Connected*	$602,691	$779,026	$657,484	$699,436	$740,004	$41,952	$40,568
Service-Connected*	$204,731	$251,891	$223,344	$237,595	$251,376	$14,251	$13,781
State Home Nursing Obligations [Total]	$1,239,773	$1,490,482	$1,352,486	$1,438,784	$1,522,235	$86,298	$83,451
VA Community Living Centers							
Priority 1A	$2,757,790	$2,842,026	$2,939,491	$3,042,743	$3,149,174	$103,252	$106,431
Non-Service Connected*	$1,348,051	$1,403,714	$1,436,870	$1,487,341	$1,539,366	$50,471	$52,025
Service-Connected*	$691,013	$696,914	$736,541	$762,413	$789,081	$25,872	$26,668
VA Community Living Centers Obligations [Total]	$4,796,854	$4,942,654	$5,112,902	$5,292,497	$5,477,621	$179,595	$185,124
Obligations by Priority 1A, SC & Non-SC [Total]	$7,295,915	$7,983,662	$7,865,251	$8,260,494	$8,617,081	$395,243	$356,587

Per Diems

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Per Diems by Long & Short Stay							
Community Nursing Home							
Long Stay	$350.34	$345.65	$390.12	$422.48	$446.11	$32.36	$23.63
Short Stay	$358.44	$358.33	$392.67	$418.61	$436.57	$25.94	$17.96
Community Nursing Home Patients Trtd., [Total]	$351.87	$348.07	$390.60	$421.75	$444.31	$31.15	$22.56
State Home Nursing							
Long Stay	$228.04	$213.31	$260.62	$289.41	$322.97	$28.79	$33.56
Short Stay	$297.52	$188.43	$316.48	$336.31	$259.90	$19.83	($76.41)
State Home Nursing Patients Trtd., [Total]	$230.22	$212.29	$262.36	$290.88	$321.00	$28.52	$30.12
VA Community Living Centers							
Long Stay	$1,980.85	$1,657.37	$2,196.16	$2,352.52	$2,496.95	$156.36	$144.43
Short Stay	$2,267.58	$1,941.47	$2,332.47	$2,282.16	$2,236.38	($50.31)	($45.78)
VA Community Living Centers Patients Trtd., [Total]	$2,035.32	$1,713.70	$2,222.12	$2,339.12	$2,447.33	$117.00	$108.21
Overall Per Diem by Long & Short Stay	$644.47	$555.98	$712.45	$762.40	$811.38	$49.95	$48.98
Per Diem by Age							
Community Nursing Home							
< 65	$392.52	$384.03	$435.79	$470.54	$495.70	$34.75	$25.16
65 to 84	$351.34	$348.50	$390.00	$421.10	$443.62	$31.10	$22.52
> 84	$333.10	$327.53	$369.78	$399.26	$420.62	$29.48	$21.36
Community Nursing Home Overall Per Diem	$351.87	$348.07	$390.60	$421.75	$444.31	$31.15	$22.56
State Home Nursing							
< 65	$241.01	$215.98	$274.80	$304.71	$336.32	$29.91	$31.61
65 to 84	$233.10	$214.20	$265.62	$294.49	$324.98	$28.87	$30.49
> 84	$224.18	$209.01	$255.51	$283.28	$312.61	$27.77	$29.33
State Home Nursing Overall Per Diem	$230.22	$212.30	$262.36	$290.88	$321.00	$28.52	$30.12
VA Community Living Centers							
< 65	$2,068.80	$1,761.26	$2,258.75	$2,362.40	$2,473.96	$103.65	$111.56
65 to 84	$2,010.88	$1,757.19	$2,195.51	$2,421.93	$2,534.43	$226.42	$112.50
> 84	$2,111.14	$1,507.86	$2,304.53	$1,982.15	$2,070.28	($322.38)	$88.13
VA Community Living Centers Overall Per Diem	$2,035.32	$1,713.68	$2,222.12	$2,339.12	$2,447.33	$117.00	$108.21
Overall Per Diem by Age	$644.47	$555.98	$712.45	$762.40	$811.38	$49.95	$48.98
Per Diem by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	$355.13	$350.42	$394.23	$425.66	$448.43	$31.43	$22.77
Non-Service Connected*	$335.13	$335.98	$371.94	$401.60	$423.08	$29.66	$21.48
Service-Connected*	$339.53	$338.31	$376.96	$407.02	$428.79	$30.06	$21.77
Community Nursing Home Overall Per Diem	$351.87	$348.07	$390.60	$421.75	$444.31	$31.15	$22.56
State Home Nursing							
Priority 1A	$256.17	$227.23	$291.95	$323.69	$357.20	$31.74	$33.51
Non-Service Connected*	$216.27	$205.24	$246.46	$273.25	$301.55	$26.79	$28.30
Service-Connected*	$224.81	$209.44	$256.18	$284.03	$313.43	$27.85	$29.40
State Home Nursing Overall Per Diem	$230.22	$212.30	$262.36	$290.88	$321.00	$28.52	$30.12
VA Community Living Centers							
Priority 1A	$1,955.38	$1,644.08	$2,134.82	$2,247.23	$2,351.19	$112.41	$103.96
Non-Service Connected*	$2,168.70	$1,827.85	$2,368.44	$2,493.14	$2,608.47	$124.70	$115.33
Service-Connected*	$2,127.17	$1,797.88	$2,321.18	$2,443.40	$2,556.43	$122.22	$113.03
VA Community Living Centers Overall Per Diem	$2,035.32	$1,713.68	$2,222.12	$2,339.12	$2,447.33	$117.00	$108.21
Overall Per Diem for Priority 1A, SC & Non-SC	$644.47	$555.98	$712.45	$762.40	$811.38	$49.95	$48.98

Non-Institutional Obligations and Clinic Stops/Procedures

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2022-2023	+/- 2023-2024
Non-Institutional Obligations ($000)							
Community Adult Day Health Care	$219,254	$220,338	$228,324	$238,510	$246,594	$10,186	$8,084
Community Residential Care	$99,414	$86,238	$104,007	$105,825	$106,283	$1,818	$458
Home Hospice Care	$21,521	$35,158	$22,099	$22,739	$23,290	$640	$551
Home Respite Care	$127,454	$96,900	$136,104	$145,324	$153,523	$9,220	$8,199
Home Telehealth	$360,651	$345,103	$377,714	$395,102	$407,206	$17,388	$12,104
Home-Based Primary Care	$1,164,049	$1,221,183	$1,303,643	$1,467,179	$1,591,185	$163,536	$124,006
Homemaker/Home Health Aide Prgs.	$1,573,605	$1,432,533	$1,716,143	$1,856,733	$1,964,148	$140,590	$107,415
Purchased Skilled Home Care	$335,592	$599,848	$350,694	$366,350	$381,089	$15,656	$14,739
Spinal Cord Injury & Disability Home Care	$15,746	$12,184	$16,275	$16,853	$17,312	$578	$459
State Home Adult Day Health Care	$6,322	$1,286	$1,783	$1,892	$2,007	$109	$115
VA Adult Day Health Care	$2,645	$1,825	$7,898	$8,381	$8,698	$483	$317
Non-Institutional Obligations [Total]	**$3,926,252**	**$4,052,596**	**$4,264,684**	**$4,624,888**	**$4,901,335**	**$360,204**	**$276,447**
Non-Institutional Clinic Stops/Procedures							
Community Adult Day Health Care	451,198	222,463	531,563	652,111	772,136	120,548	120,025
Community Residential Care	39,938	60,724	41,548	43,963	46,297	2,415	2,334
Home Hospice Care	460,876	616,786	526,711	551,888	567,380	25,177	15,492
Home Respite Care	25,926	24,751	30,851	35,375	39,939	4,524	4,564
Home Telehealth 1/	709,554	730,124	680,943	672,356	668,456	(8,587)	(3,900)
Home-Based Primary Care	1,289,913	1,719,793	1,345,263	1,406,740	1,467,604	61,477	60,864
Homemaker/Home Health Aide Prgs.	13,054,076	12,472,715	14,443,467	15,440,095	16,257,035	996,628	816,940
Purchased Skilled Home Care	50,886	109,590	37,578	32,384	29,686	(5,194)	(2,698)
Spinal Cord Injury Home Care	17,903	18,246	19,302	21,401	23,430	2,099	2,029
State Adult Day Health Care	9,592	9,010	10,587	11,574	12,562	987	988
VA Adult Day Health Care	7,548	3,000	9,686	12,893	15,993	3,207	3,100
Non-Institutional Clinic Stops/Procedures [Total]	**16,117,410**	**15,987,202**	**17,677,499**	**18,880,780**	**19,900,518**	**1,203,281**	**1,019,738**
Non-Institutional Cost Per Clinic Stops/Procedures							
Community Adult Day Health Care	$485.94	$990.45	$429.53	$365.75	$319.37	($63.78)	($46.38)
Community Residential Care	$2,489.20	$1,420.16	$2,503.30	$2,407.14	$2,295.68	($96.16)	($111.46)
Home Hospice Care	$46.70	$57.00	$41.96	$41.20	$41.05	($0.76)	($0.15)
Home Respite Care	$4,916.08	$3,914.99	$4,411.66	$4,108.10	$3,843.94	($303.56)	($264.16)
Home Telehealth	$508.28	$472.66	$554.69	$587.64	$609.17	$32.95	$21.53
Home-Based Primary Care	$902.42	$710.08	$969.06	$1,042.96	$1,084.21	$73.90	$41.25
Homemaker/Home Health Aide Prgs.	$120.55	$114.85	$118.82	$120.25	$120.82	$1.43	$0.57
Purchased Skilled Home Care	$6,594.98	$5,473.57	$9,332.43	$11,312.69	$12,837.33	$1,980.26	$1,524.64
Spinal Cord Injury Home Care	$879.52	$667.76	$843.18	$787.49	$738.88	($55.69)	($48.61)
State Adult Day Health Care	$2.62	$0.57	$0.67	$0.65	$0.64	($0.02)	($0.01)
VA Adult Day Health Care	$350.47	$608.33	$815.40	$650.04	$543.86	($165.36)	($106.18)
Non-Institutional Cost Per Clinic Stops/Procedures	**$243.60**	**$253.49**	**$241.25**	**$244.95**	**$246.29**	**$3.70**	**$1.34**

VA Community Living Centers Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$3,104,394	$3,250,754	$3,361,863	$3,022,616	$3,324,222	($339,247)	$301,606
Discretionary Obligations [Subtotal]	**$3,104,394**	**$3,250,754**	**$3,361,863**	**$3,022,616**	**$3,324,222**	**($339,247)**	**$301,606**
Medical Community Care (0140):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$543,302	$799,500	$672,200	$743,900	$766,500	$71,700	$22,600
Discretionary Obligations [Subtotal]	**$543,302**	**$799,500**	**$672,200**	**$743,900**	**$766,500**	**$71,700**	**$22,600**
Medical Facilities (0162):							
Discretionary Obligations	$539,858	$892,400	$715,400	$1,056,200	$730,600	$340,800	($325,600)
Discretionary Obligations [Subtotal]	**$539,858**	**$892,400**	**$715,400**	**$1,056,200**	**$730,600**	**$340,800**	**($325,600)**
Discretionary Total	**$4,187,555**	**$4,942,654**	**$4,749,463**	**$4,822,716**	**$4,821,322**	**$73,253**	**($1,394)**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$195,924	$418,779	$597,141	$222,855	$178,362
Veterans Medical Care and Health Fund (0173)	$227,696	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$57,065	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$300	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$285,061**	**$0**	**$195,924**	**$418,779**	**$597,141**	**$222,855**	**$178,362**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$1,541	$50,284	$59,158	$48,743	$8,874
Veterans Medical Care and Health Fund (0173)	$28,172	$0	$29,721	$0	$0	($29,721)	$0
VACAA, Section 801 (0152)	$218	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$28,389**	**$0**	**$31,262**	**$50,284**	**$59,158**	**$19,022**	**$8,874**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$295,007	$0	$134,910	$0	$0	($134,910)	$0
VACAA, Section 801 (0162)	$842	$0	$1,343	$718	$0	($625)	($718)
Mandatory Obligations [Subtotal]	**$295,849**	**$0**	**$136,253**	**$718**	**$0**	**($135,535)**	**($718)**
Mandatory Total	**$609,299**	**$0**	**$363,439**	**$469,781**	**$656,299**	**$106,342**	**$186,518**
Combined Discretionary and Mandatory by Category							
Medical Services	$3,389,455	$3,250,754	$3,557,787	**$3,441,395**	**$3,921,363**	($116,392)	$479,968
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$571,692	$799,500	$703,462	**$794,184**	**$825,658**	$90,722	$31,474
Medical Facilities	$835,707	$892,400	$851,653	**$1,056,918**	**$730,600**	$205,265	($326,318)
Obligations [Grand Total]	**$4,796,854**	**$4,942,654**	**$5,112,902**	**$5,292,497**	**$5,477,621**	**$179,595**	**$185,124**

Community Residential Care Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$75,537	$60,438	$74,007	$65,925	$74,183	($8,082)	$8,258
Discretionary Obligations [Subtotal]	**$75,537**	**$60,438**	**$74,007**	**$65,925**	**$74,183**	**($8,082)**	**$8,258**
Medical Community Care (0140):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$9,646	$12,500	$11,900	$13,200	$13,600	$1,300	$400
Discretionary Obligations [Subtotal]	**$9,646**	**$12,500**	**$11,900**	**$13,200**	**$13,600**	**$1,300**	**$400**
Medical Facilities (0162):							
Discretionary Obligations	$13,658	$13,300	$18,100	$26,700	$18,500	$8,600	($8,200)
Discretionary Obligations [Subtotal]	**$13,658**	**$13,300**	**$18,100**	**$26,700**	**$18,500**	**$8,600**	**($8,200)**
Discretionary Total	**$98,842**	**$86,238**	**$104,007**	**$105,825**	**$106,283**	**$1,818**	**$458**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$548	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$7	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$554**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$4	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$4**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$14	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$14**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$572**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$76,092	$60,438	$74,007	**$65,925**	**$74,183**	($8,082)	$8,258
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$9,650	$12,500	$11,900	**$13,200**	**$13,600**	$1,300	$400
Medical Facilities	$13,672	$13,300	$18,100	**$26,700**	**$18,500**	$8,600	($8,200)
Obligations [Grand Total]	**$99,414**	**$86,238**	**$104,007**	**$105,825**	**$106,283**	**$1,818**	**$458**

Home Telehealth Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$249,922	$219,003	$237,314	$209,102	$257,106	($28,212)	$48,004
Discretionary Obligations [Subtotal]	**$249,922**	**$219,003**	**$237,314**	**$209,102**	**$257,106**	**($28,212)**	**$48,004**
Medical Community Care (0140):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$46,366	$62,400	$57,400	$63,500	$65,400	$6,100	$1,900
Discretionary Obligations [Subtotal]	**$46,366**	**$62,400**	**$57,400**	**$63,500**	**$65,400**	**$6,100**	**$1,900**
Medical Facilities (0162):							
Discretionary Obligations	$62,630	$63,700	$83,000	$122,500	$84,700	$39,500	($37,800)
Discretionary Obligations [Subtotal]	**$62,630**	**$63,700**	**$83,000**	**$122,500**	**$84,700**	**$39,500**	**($37,800)**
Discretionary Total	**$358,918**	**$345,103**	**$377,714**	**$395,102**	**$407,206**	**$17,388**	**$12,104**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$1,440	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$189	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$23	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,652**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$18	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$18**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$63	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$63**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$1,733**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$251,574	$219,003	$237,314	**$209,102**	**$257,106**	($28,212)	$48,004
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$46,384	$62,400	$57,400	**$63,500**	**$65,400**	$6,100	$1,900
Medical Facilities	$62,693	$63,700	$83,000	**$122,500**	**$84,700**	$39,500	($37,800)
Obligations [Grand Total]	**$360,651**	**$345,103**	**$377,714**	**$395,102**	**$407,206**	**$17,388**	**$12,104**

Home Based Primary Care Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$854,183	$885,583	$925,054	$951,996	$1,147,893	$26,942	$195,897
Discretionary Obligations [Subtotal]	**$854,183**	**$885,583**	**$925,054**	**$951,996**	**$1,147,893**	**$26,942**	**$195,897**
Medical Community Care (0140):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$120,701	$169,600	$149,300	$165,200	$170,200	$15,900	$5,000
Discretionary Obligations [Subtotal]	**$120,701**	**$169,600**	**$149,300**	**$165,200**	**$170,200**	**$15,900**	**$5,000**
Medical Facilities (0162):							
Discretionary Obligations	$157,218	$166,000	$208,400	$307,700	$212,800	$99,300	($94,900)
Discretionary Obligations [Subtotal]	**$157,218**	**$166,000**	**$208,400**	**$307,700**	**$212,800**	**$99,300**	**($94,900)**
Discretionary Total	**$1,132,102**	**$1,221,183**	**$1,282,754**	**$1,424,896**	**$1,530,893**	**$142,142**	**$105,997**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$19,782	$42,283	$60,292	$22,501	$18,009
Veterans Medical Care and Health Fund (0173)	$23,932	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$4,819	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$78	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$28,829**	**$0**	**$19,782**	**$42,283**	**$60,292**	**$22,501**	**$18,009**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$1,050	$0	$1,107	$0	$0	($1,107)	$0
VACAA, Section 801 (0152)	$46	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,096**	**$0**	**$1,107**	**$0**	**$0**	**($1,107)**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$1,861	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$160	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$2,022**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$31,947**	**$0**	**$20,889**	**$42,283**	**$60,292**	**$21,394**	**$18,009**
Combined Discretionary and Mandatory by Category							
Medical Services	$883,012	$885,583	$944,836	**$994,279**	**$1,208,185**	$49,443	$213,906
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$121,798	$169,600	$150,407	**$165,200**	**$170,200**	$14,793	$5,000
Medical Facilities	$159,240	$166,000	$208,400	**$307,700**	**$212,800**	$99,300	($94,900)
Obligations [Grand Total]	**$1,164,049**	**$1,221,183**	**$1,303,643**	**$1,467,179**	**$1,591,185**	**$163,536**	**$124,006**

Spinal Cord Injury and Disability Home Care Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$12,077	$9,384	$11,675	$10,753	$12,312	($922)	$1,559
Discretionary Obligations [Subtotal]	**$12,077**	**$9,384**	**$11,675**	**$10,753**	**$12,312**	**($922)**	**$1,559**
Medical Community Care (0140):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$1,522	$1,500	$1,900	$2,100	$2,200	$200	$100
Discretionary Obligations [Subtotal]	**$1,522**	**$1,500**	**$1,900**	**$2,100**	**$2,200**	**$200**	**$100**
Medical Facilities (0162):							
Discretionary Obligations	$2,044	$1,300	$2,700	$4,000	$2,800	$1,300	($1,200)
Discretionary Obligations [Subtotal]	**$2,044**	**$1,300**	**$2,700**	**$4,000**	**$2,800**	**$1,300**	**($1,200)**
Discretionary Total	**$15,643**	**$12,184**	**$16,275**	**$16,853**	**$17,312**	**$578**	**$459**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$99	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$1	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$100**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$1	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$2	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$2**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$103**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$12,177	$9,384	$11,675	**$10,753**	**$12,312**	($922)	$1,559
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$1,523	$1,500	$1,900	**$2,100**	**$2,200**	$200	$100
Medical Facilities	$2,046	$1,300	$2,700	**$4,000**	**$2,800**	$1,300	($1,200)
Obligations [Grand Total]	**$15,746**	**$12,184**	**$16,275**	**$16,853**	**$17,312**	**$578**	**$459**

VA Adult Day Home Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$2,074	$1,225	$7,198	$7,581	$7,998	$383	$417
Discretionary Obligations [Subtotal]	**$2,074**	**$1,225**	**$7,198**	**$7,581**	**$7,998**	**$383**	**$417**
Medical Community Care (0140):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$311	$300	$400	$400	$400	$0	$0
Discretionary Obligations [Subtotal]	**$311**	**$300**	**$400**	**$400**	**$400**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Obligations	$259	$300	$300	$400	$300	$100	($100)
Discretionary Obligations [Subtotal]	**$259**	**$300**	**$300**	**$400**	**$300**	**$100**	**($100)**
Discretionary Total	**$2,644**	**$1,825**	**$7,898**	**$8,381**	**$8,698**	**$483**	**$317**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$2,074	$1,225	$7,198	**$7,581**	**$7,998**	$383	$417
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$311	$300	$400	**$400**	**$400**	$0	$0
Medical Facilities	$259	$300	$300	**$400**	**$300**	$100	($100)
Obligations [Grand Total]	**$2,644**	**$1,825**	**$7,898**	**$8,381**	**$8,698**	**$483**	**$317**

Community Nursing Home Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$44,267	$27,556	$44,060	$47,787	$54,039	$3,727	$6,252
Discretionary Obligations [Subtotal]	**$44,267**	**$27,556**	**$44,060**	**$47,787**	**$54,039**	**$3,727**	**$6,252**
Medical Community Care (0140):							
Discretionary Obligations	$1,150,651	$1,443,170	$1,278,803	$1,395,426	$1,475,586	$116,623	$80,160
Discretionary Obligations [Subtotal]	**$1,150,651**	**$1,443,170**	**$1,278,803**	**$1,395,426**	**$1,475,586**	**$116,623**	**$80,160**
Medical Support and Compliance (0152):							
Discretionary Obligations	$60,615	$76,300	$75,000	$83,000	$85,500	$8,000	$2,500
Discretionary Obligations [Subtotal]	**$60,615**	**$76,300**	**$75,000**	**$83,000**	**$85,500**	**$8,000**	**$2,500**
Medical Facilities (0162):							
Discretionary Obligations	$1,516	$3,500	$2,000	$3,000	$2,100	$1,000	($900)
Discretionary Obligations [Subtotal]	**$1,516**	**$3,500**	**$2,000**	**$3,000**	**$2,100**	**$1,000**	**($900)**
Discretionary Total	**$1,257,049**	**$1,550,526**	**$1,399,863**	**$1,529,213**	**$1,617,225**	**$129,350**	**$88,012**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$2,238	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$2,238**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$2,238**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$44,267	$27,556	$44,060	**$47,787**	**$54,039**	$3,727	$6,252
Medical Community Care	$1,152,889	$1,443,170	$1,278,803	**$1,395,426**	**$1,475,586**	$116,623	$80,160
Medical Support and Compliance	$60,615	$76,300	$75,000	**$83,000**	**$85,500**	$8,000	$2,500
Medical Facilities	$1,516	$3,500	$2,000	**$3,000**	**$2,100**	$1,000	($900)
Obligations [Grand Total]	**$1,259,287**	**$1,550,526**	**$1,399,863**	**$1,529,213**	**$1,617,225**	**$129,350**	**$88,012**

State Nursing Home Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Obligations	$1,239,773	$1,490,482	$1,352,486	$1,438,784	$1,522,235	$86,298	$83,451
Discretionary Obligations [Subtotal]	**$1,239,773**	**$1,490,482**	**$1,352,486**	**$1,438,784**	**$1,522,235**	**$86,298**	**$83,451**
Medical Support and Compliance (0152):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$1,239,773**	**$1,490,482**	**$1,352,486**	**$1,438,784**	**$1,522,235**	**$86,298**	**$83,451**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$1,239,773	$1,490,482	$1,352,486	**$1,438,784**	**$1,522,235**	$86,298	$83,451
Medical Support and Compliance	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$1,239,773**	**$1,490,482**	**$1,352,486**	**$1,438,784**	**$1,522,235**	**$86,298**	**$83,451**

State Home Domiciliary

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Obligations	$43,684	$49,095	$52,079	$55,402	$58,616	$3,323	$3,214
Discretionary Obligations [Subtotal]	**$43,684**	**$49,095**	**$52,079**	**$55,402**	**$58,616**	**$3,323**	**$3,214**
Medical Support and Compliance (0152):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$43,684**	**$49,095**	**$52,079**	**$55,402**	**$58,616**	**$3,323**	**$3,214**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$43,684	$49,095	$52,079	**$55,402**	**$58,616**	$3,323	$3,214
Medical Support and Compliance	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$43,684**	**$49,095**	**$52,079**	**$55,402**	**$58,616**	**$3,323**	**$3,214**

State Home Adult Day Health Care Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$3,601	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$3,601**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Obligations	$2,721	$1,286	$1,783	$1,892	$2,007	$109	$115
Discretionary Obligations [Subtotal]	**$2,721**	**$1,286**	**$1,783**	**$1,892**	**$2,007**	**$109**	**$115**
Medical Support and Compliance (0152):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$6,322**	**$1,286**	**$1,783**	**$1,892**	**$2,007**	**$109**	**$115**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$3,601	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$2,721	$1,286	$1,783	**$1,892**	**$2,007**	$109	$115
Medical Support and Compliance	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$6,322**	**$1,286**	**$1,783**	**$1,892**	**$2,007**	**$109**	**$115**

Community Adult Day Health Care Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$5,366	$6,430	$2,888	$1,876	$2,144	($1,012)	$268
Discretionary Obligations [Subtotal]	**$5,366**	**$6,430**	**$2,888**	**$1,876**	**$2,144**	**($1,012)**	**$268**
Medical Community Care (0140):							
Discretionary Obligations	$197,688	$203,308	$205,436	$214,434	$221,650	$8,998	$7,216
Discretionary Obligations [Subtotal]	**$197,688**	**$203,308**	**$205,436**	**$214,434**	**$221,650**	**$8,998**	**$7,216**
Medical Support and Compliance (0152):							
Discretionary Obligations	$15,939	$10,200	$19,700	$21,800	$22,500	$2,100	$700
Discretionary Obligations [Subtotal]	**$15,939**	**$10,200**	**$19,700**	**$21,800**	**$22,500**	**$2,100**	**$700**
Medical Facilities (0162):							
Discretionary Obligations	$261	$400	$300	$400	$300	$100	($100)
Discretionary Obligations [Subtotal]	**$261**	**$400**	**$300**	**$400**	**$300**	**$100**	**($100)**
Discretionary Total	**$219,254**	**$220,338**	**$228,324**	**$238,510**	**$246,594**	**$10,186**	**$8,084**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$5,366	$6,430	$2,888	**$1,876**	**$2,144**	($1,012)	$268
Medical Community Care	$197,688	$203,308	$205,436	**$214,434**	**$221,650**	$8,998	$7,216
Medical Support and Compliance	$15,939	$10,200	$19,700	**$21,800**	**$22,500**	$2,100	$700
Medical Facilities	$261	$400	$300	**$400**	**$300**	$100	($100)
Obligations [Grand Total]	**$219,254**	**$220,338**	**$228,324**	**$238,510**	**$246,594**	**$10,186**	**$8,084**

Home Hospice Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$9,954	$5,343	$10,111	$10,344	$10,626	$233	$282
Discretionary Obligations [Subtotal]	**$9,954**	**$5,343**	**$10,111**	**$10,344**	**$10,626**	**$233**	**$282**
Medical Community Care (0140):							
Discretionary Obligations	$10,625	$27,915	$10,888	$11,195	$11,464	$307	$269
Discretionary Obligations [Subtotal]	**$10,625**	**$27,915**	**$10,888**	**$11,195**	**$11,464**	**$307**	**$269**
Medical Support and Compliance (0152):							
Discretionary Obligations	$916	$1,800	$1,100	$1,200	$1,200	$100	$0
Discretionary Obligations [Subtotal]	**$916**	**$1,800**	**$1,100**	**$1,200**	**$1,200**	**$100**	**$0**
Medical Facilities (0162):							
Discretionary Obligations	$26	$100	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$26**	**$100**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$21,521**	**$35,158**	**$22,099**	**$22,739**	**$23,290**	**$640**	**$551**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$9,954	$5,343	$10,111	**$10,344**	**$10,626**	$233	$282
Medical Community Care	$10,625	$27,915	$10,888	**$11,195**	**$11,464**	$307	$269
Medical Support and Compliance	$916	$1,800	$1,100	**$1,200**	**$1,200**	$100	$0
Medical Facilities	$26	$100	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$21,521**	**$35,158**	**$22,099**	**$22,739**	**$23,290**	**$640**	**$551**

Home Respite Care Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$0	$0	$6,401	$6,942	$7,368	$541	$426
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$6,401**	**$6,942**	**$7,368**	**$541**	**$426**
Medical Community Care (0140):							
Discretionary Obligations	$121,695	$96,900	$129,703	$138,382	$146,155	$8,679	$7,773
Discretionary Obligations [Subtotal]	**$121,695**	**$96,900**	**$129,703**	**$138,382**	**$146,155**	**$8,679**	**$7,773**
Medical Support and Compliance (0152):							
Discretionary Obligations	$5,739	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$5,739**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$127,434**	**$96,900**	**$136,104**	**$145,324**	**$153,523**	**$9,220**	**$8,199**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$20	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$20**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$20**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$6,401	**$6,942**	**$7,368**	$541	$426
Medical Community Care	$121,715	$96,900	$129,703	**$138,382**	**$146,155**	$8,679	$7,773
Medical Support and Compliance	$5,739	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$127,454**	**$96,900**	**$136,104**	**$145,324**	**$153,523**	**$9,220**	**$8,199**

Homemaker/Home Health Aide Programs Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$50,025	$28,641	$46,450	$48,090	$55,563	$1,640	$7,473
Discretionary Obligations [Subtotal]	**$50,025**	**$28,641**	**$46,450**	**$48,090**	**$55,563**	**$1,640**	**$7,473**
Medical Community Care (0140):							
Discretionary Obligations	$1,449,411	$1,331,692	$1,578,593	$1,706,943	$1,804,985	$128,350	$98,042
Discretionary Obligations [Subtotal]	**$1,449,411**	**$1,331,692**	**$1,578,593**	**$1,706,943**	**$1,804,985**	**$128,350**	**$98,042**
Medical Support and Compliance (0152):							
Discretionary Obligations	$71,575	$69,000	$88,600	$98,000	$101,000	$9,400	$3,000
Discretionary Obligations [Subtotal]	**$71,575**	**$69,000**	**$88,600**	**$98,000**	**$101,000**	**$9,400**	**$3,000**
Medical Facilities (0162):							
Discretionary Obligations	$1,885	$3,200	$2,500	$3,700	$2,600	$1,200	($1,100)
Discretionary Obligations [Subtotal]	**$1,885**	**$3,200**	**$2,500**	**$3,700**	**$2,600**	**$1,200**	**($1,100)**
Discretionary Total	**$1,572,896**	**$1,432,533**	**$1,716,143**	**$1,856,733**	**$1,964,148**	**$140,590**	**$107,415**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$15	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$6	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$21**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$155	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$532	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$687**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$708**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$50,046	$28,641	$46,450	**$48,090**	**$55,563**	$1,640	$7,473
Medical Community Care	$1,450,098	$1,331,692	$1,578,593	**$1,706,943**	**$1,804,985**	$128,350	$98,042
Medical Support and Compliance	$71,575	$69,000	$88,600	**$98,000**	**$101,000**	$9,400	$3,000
Medical Facilities	$1,885	$3,200	$2,500	**$3,700**	**$2,600**	$1,200	($1,100)
Obligations [Grand Total]	**$1,573,604**	**$1,432,533**	**$1,716,143**	**$1,856,733**	**$1,964,148**	**$140,590**	**$107,415**

Purchased Skilled Home Care Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$29,815	$19,163	$28,227	$28,163	$29,807	($64)	$1,644
Discretionary Obligations [Subtotal]	**$29,815**	**$19,163**	**$28,227**	**$28,163**	**$29,807**	**($64)**	**$1,644**
Medical Community Care (0140):							
Discretionary Obligations	$287,075	$546,285	$299,367	$312,487	$324,982	$13,120	$12,495
Discretionary Obligations [Subtotal]	**$287,075**	**$546,285**	**$299,367**	**$312,487**	**$324,982**	**$13,120**	**$12,495**
Medical Support and Compliance (0152):							
Discretionary Obligations	$18,235	$33,000	$22,600	$25,000	$25,800	$2,400	$800
Discretionary Obligations [Subtotal]	**$18,235**	**$33,000**	**$22,600**	**$25,000**	**$25,800**	**$2,400**	**$800**
Medical Facilities (0162):							
Discretionary Obligations	$400	$1,400	$500	$700	$500	$200	($200)
Discretionary Obligations [Subtotal]	**$400**	**$1,400**	**$500**	**$700**	**$500**	**$200**	**($200)**
Discretionary Total	**$335,525**	**$599,848**	**$350,694**	**$366,350**	**$381,089**	**$15,656**	**$14,739**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$66	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$1	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$67**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$67**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$29,882	$19,163	$28,227	**$28,163**	**$29,807**	($64)	$1,644
Medical Community Care	$287,075	$546,285	$299,367	**$312,487**	**$324,982**	$13,120	$12,495
Medical Support and Compliance	$18,235	$33,000	$22,600	**$25,000**	**$25,800**	$2,400	$800
Medical Facilities	$400	$1,400	$500	**$700**	**$500**	$200	($200)
Obligations [Grand Total]	**$335,592**	**$599,848**	**$350,694**	**$366,350**	**$381,089**	**$15,656**	**$14,739**

2022 Unique Patients using Non-Institutional Long-Term Supportive Services by Fund

FY 2022 Unique Patients using Non Instutional Long Term Supportive Services by Fund						
LTCC Category	Medical Services (0160)	Medical Support & Compliance (0152)	Medical Facilities (0162)	Joint Demonstration Fund (0169)	Medical Community Care (0140)	Veterans Choice Program (0172)
VA Adult Day Health Care	270	270	270	0	0	0
Community Adult Day	5,567	5,567	5,567	23	5,545	0
Home-Based Primary	87,168	87,168	87,168	170	0	0
Home Respite Care	25,926	25,926	25,926	86	25,840	0
Purchased Skilled Care	50,886	50,886	50,886	135	50,883	0
Hospice Care	82,359	82,359	82,359	449	52,390	0
Homemaker/Home Health Aide	156,243	156,243	156,243	653	155,597	0
SCI Home Care	2,075	2,075	2,075	0	0	0
Community Residential	4,202	4,202	4,202	0	0	0
Home Telehealth	167,402	167,402	167,402	702	0	0
State Adult Day Health Care	0	125	0	0	125	0

Notes:

Medical Services (0160) funds the provision of these services in VA facilities, while MCC (0140) fund the purchase of these services from community providers; All accounts are involved with the primarily purchased care programs due to care coordination requirements.

LTSS Programs

Authority for Action

- LTSS programs
  - 38 U.S.C. Chapter 17, 1710, 1710A, 1710B, 1720, 1720B, 1720C
  - 38 C.F.R. § 17.38, 38 C.F.R. § 17.4000 et seq.

Population Covered

VA's health care system provides enrolled Veterans with a broad spectrum of LTSS, which include geriatric outpatient programs, facility-based services, home and community-based services and end-of-life services. Clinical indicators and Veteran conditions help health care professionals determine whether the service is needed to promote, preserve, or restore the health of the individual in accordance with generally accepted standards of medical practice. Specific eligibility and admission criteria are unique to each of three venues of facility-based services – VA Community Living Centers (CLCs), Community Nursing Homes (CNHs), State Veterans Homes (SVHs) – as well as the array of home and community-based services (HCBS). VA is legislatively mandated by the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) to provide nursing home care for enrolled Veterans in need of nursing home care for a service-connected disability, as well as enrolled Veterans in need of nursing home care who has a single or combined service-connected disability rating of 70% or greater. This includes Veterans with a single disability rated 60% but who have total disability ratings based on individual unemployability.

In 2022, the LTSS programs managed by the Office of Geriatrics and Extended Care (GEC) served 496,939 Veterans. The Veteran population served with these programs are all ages, with 73% 65 or older and 20% 85 or older. About a third (33%) of all Veterans who used VA LTSS lived in rural areas, which is comparable to the percent of total Veterans who live in rural areas and use VA. Upon further breakdown by Priority Group for Veterans who use VA LTSS, Priority Group 1 Veterans make up about 43% and Priority Group 1A Veterans make up to 20%.

Types of Services Provided
Long-term services and supports include facility-based programs and HCBS. There are six facility-based GEC programs: VA CLCs; CNHs; SVHs (nursing homes and domiciliaries); Inpatient Hospice; Inpatient Respite; and Brain Injury – Residential Rehabilitation. Some HCBS programs focus on Veterans' skilled care needs that are VA-provided (Home-Based Primary Care, Adult Day Health Care), purchased through community providers (Skilled Home Health Care, Home Hospice, Home Infusion, Program of All-Inclusive Care for the Elderly) and provided through State Veterans Homes (Adult Day Health Care). Four purchased HCBS programs focus on Veterans' personal care service needs: Homemaker/Home Health Aide, Veteran Directed Care, Home Respite Care and Community Adult Day Health Care. There are two HCBS programs that provide supportive housing: Community Residential Care and Medical Foster Home.

Recent Trends
GEC honored Veterans' preferences to receive care at home by providing access to home and community-based services throughout the COVID-19 Pandemic, serving 411,887 Veterans in 2022 – a 19.4% increase over 2021. The increase reflected changes in care patterns and a return to more in home visits coming out of the pandemic. GeriPACT experienced a 6.3% decrease in unique Veterans between 2020 and 2021. In 2022, the number of unique Veteran encounters trended back up by 11.8% but remained 14.4% below pre-pandemic levels. At the beginning of 2022, 87 facilities had GeriPACT programs, compared to only 82 facilities at the end of 2022. Geriatric Evaluation Programs have also experienced a decline in unique Veteran encounters between pre and post-pandemic restriction periods of 16.8% (2019 compared to 2022).

There were 163,634 Veterans who received personal care services in 2022, a 9.8% increase over 2021. Homemaker/Home Health Aide services continued to represent the main offering for Veterans, growing 7.0% to 149,009. Veteran Directed Care (VDC), an innovative personal care program allowing Veterans more flexibility, grew to 6,301 Veterans in 2022, a 24.7% increase over 2021. 2022 was the first year of VDC's planned expansion to all VAMCs and all U.S. territories over the next five years, part of VA's enhancement of home and community based services.

<u>Home Based Primary Care</u>
Home Based Primary Care (HBPC) continues to see an increase in overall contacts and interventions from the previous years. The use of home telehealth in more than 55% of Veterans enrolled in HBPC continues to provide a strong avenue to support HBPC clinical care. HBPC programs use GIS software to improve organizational efficiencies within programs. HBPC maintains an 82% vaccination rate among this frail population with access limitations. National support for HBPC expansion has been provided through special funding for additional teams. This five year expansion effort is expected to boost HBPC growth in support of population data and growing demand for HBPC level of care in targeted geographic locations.

HBPC is an extensively researched evidenced based program of comprehensive home care with demonstrated outcomes to cost effectively support the goal of Veterans aging in place. A recent study demonstrated that VAs HBPC program supported Veterans' end of life desires, surpassing population benchmarks. In the years studied, VA-HBPC Veterans who died at home and rates of

home death with hospice increased and were higher than both benchmarks (VA patients without HBPC and Medicare non-Veterans).[26]

Community Living Centers

VA owns and operates a total of 134 CLCs nationwide in all states except Alaska, Rhode Island, Utah and Vermont. The CLCs provide a dynamic array of health and rehabilitative services in a person-centered environment designed to meet the individual needs of Veteran residents. CLCs are home to Veterans who require short stays before going home, as well as those who require longer or permanent stays. Short-stay services provided in the CLC include respite care, rehabilitation, restorative care, continuing care, mental health recovery, geriatric evaluation and management and skilled nursing care. Long-stay services include continuing care and mental health recovery. CLCs are also home to several special populations of Veterans, including those with spinal-cord injury and disorders, dementia and those who choose hospice and palliative care. CLCs have embraced cultural transformation, creating therapeutic environments that function as real homes and where daily activities are scheduled around the Veteran's preferences. Staff aim to provide the CLC residents a Veteran-centric approach and help them attain and maintain their optimal functional abilities.

VA continues to update information on quality in the CLC program, using the same metrics as the Centers for Medicare and Medicaid Services (CMS) use for Care Compare. During 2022 Qtr. 1 thru Qtr. 3, CLC maintained the number of overall one star rated CLCs at zero with the exception of one CLC receiving an overall 1-star during quarter 4. As of 2023, VA was able to bring the CLCs with an overall one star rated CLCs back to zero. Results on the community nursing homes that VA contracts with are also posted on VA's public facing website.

The COVID-19 pandemic identified the elevated risks to highly vulnerable nursing home residents globally. At the onset of the COVID-19 pandemic, VA Office of GEC immediately activated infection prevention and control safeguards geared to prevent entry of SARS-CoV-2 virus into the CLCs, prompt identification of cases and minimize spread. VA remains committed to implementing strong strategies to mitigate the risk of SARS-CoV-2 transmission within the CLCs. These strategies include:

- Screening residents and staff for symptoms consistent with COVID-19,
- Promoting consistent staffing
- Testing approaches of CLC residents and staff
- Vaccination of CLC residents and staff
- Expansion of safe visitation in line with Centers for Medicare and Medicaid (CMS) and Center for Disease Control (CDC).

[26] Intrator, et.al. Benchmarking Site of Death and Hospice Use: A Case Study of Veterans Cared by Department of Veterans Affairs Home-Based Primary Care. Med Care 2020;58: 805–814

VA Office of GEC is committed to ensure the CLC programs and services assist Veterans to achieve the highest practicable level of well-being and function. In recognition of the elevated risks and impact that COVID-19 poses on the highly vulnerable CLC residents, VA Office of GEC continues to actively monitor COVID-19 activity and adjust guidance with the evolving COVID-19 information and the recommendations by CMS and CDC.

There are 162 recognized SVHs with 155 recognized SVH Nursing Homes programs, 49 recognized Domiciliary Care programs and three ADHC programs, with an average daily census of over 17,500 Veterans, 1,560 Veteran Spouses and/or Gold Star Parents.

Projections for the Future

VHA must meet many challenges to fulfill its mission, including meeting the demands of a rapidly-aging patient population regardless of the Veteran's capacity – whether healthy and stable, in decline, or at the end of life.

Roughly 90% of aging adults would prefer to remain at home for care versus admission to a care facility. However, VA allocated nearly 65% of its GEC program spending on institutional care in 2022, with overall spending totaling 10% of VHA's overall budget. VA projects demand for long-term care will continue to increase, creating an enterprise-wide need to expand home and community-based services, which will honor Veterans' preferences and allow Veterans to age successfully at home and in their communities.

In response to these challenges, GEC created a transformational GEC strategic plan to redesign its care delivery model, expand services and give Veterans the choice to receive care in their home and community. GECs way forward centers on the standup of six overarching strategies: Expand Home and Community-Based Services, Modernize Systems for Healthy Aging, Modernize and Improve Facility-Based Care, Improve Access with Technology, Increase Geriatric Expertise, Develop Data Definitions and Processes to meet the growing demand of the aging Veteran population.

State Home Programs

Authority for Action

The State Home Per Diem (SHPD) Program is a grant program providing federal assistance to VA-recognized State Veteran Home (SVH) facilities through the provision of a percentage of the cost of construction and paying a per diem payment for care provided to eligible Veterans in SVH. Admissions to SVHs are limited to eligible Veterans and certain categories of Veteran-related family members to include spouses and Gold Star Parents.

Under the State Home Per Diem Program, states may provide care in a SVH for eligible Veterans in need of care in three different levels of care: Nursing Home Care (NHC), Domiciliary (DOM) and Adult Day Health Care (ADHC). Only facilities recognized by the Under Secretary for Health (USH), under 38 C.F.R. §51.30 for NHC and 38 C.F.R. §52.30 for ADHC, or DOM programs recognized by the Secretary of Veterans Affairs, as set forth in 38 C.F.R. §51, are SVHs and will receive per diem payments in accordance with 38 U.S.C. 1741-1745.

Population Covered

In 2022, there were 162 SVHs, 155 recognized NHs, 49 recognized DOMs and 3 ADHCs. with an average daily census (average daily number of patients) of over 17,500 Veterans and approximately 1,560 Veteran spouses and gold star parents.

Type of Services Provided

SHPD will continue to support eligible Veterans with a basic rate for NHC, ADHC and DOM; and the prevailing rate for eligible Veterans that are in the SVH for NHC and ADHC and are in need of care for a VA adjudicated service-connected disability or have a singular or combined rating of 70% or more based on one or more service-connected disabilities or a rating of total disability based on individual unemployability.

Recent Trends

The 2024 Budget reflects a year-over-year 3% increase in the average daily census (ADC) as well as a 3% year-over-year increase in per diem rates beginning in 2022 to account for the historical rise in occupancy as well as the increase in occupancy we have been realizing in 2022.

Per diem trends are influenced by the amount of new SVH construction and the number of Veterans that are admitted. Per diem expenditures have significantly decreased over the past 2 years due to closing new admissions to prevent COVID-19 as opposed to the yearly increase within the five years prior. In 2021, VA received $500 million from the American Rescue Plan (ARP) Act to offset the decrease so that VA may update and construct new SVHs. As a result, VA anticipates that 12 new SVHs will open in 2023 and 2024. Additionally, the Megabus Act, P.L. 116-315 § 3007 relaxed domiciliary admission criteria that will be published in late 2023. This will result in an increase in the number of approved domiciliary admissions. State home occupancy is again increasing, albeit very slowly. We expect to observe a rise in occupancy to coincide with the opening of 12 new state home facilities by 2024.

Camp Lejeune Family Member Program (CLFMP)

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$346	$0	$700	$725	$703	$25	($22)
Discretionary Obligations [Subtotal]	**$346**	**$0**	**$700**	**$725**	**$703**	**$25**	**($22)**
Medical Community Care (0140):							
Discretionary Obligations	$2,221	$3,808	$3,319	$3,718	$4,312	$399	$594
Discretionary Obligations [Subtotal]	**$2,221**	**$3,808**	**$3,319**	**$3,718**	**$4,312**	**$399**	**$594**
Medical Support and Compliance (0152):							
Discretionary Obligations	$2,853	$0	$2,999	$3,154	$3,249	$155	$95
Discretionary Obligations [Subtotal]	**$2,853**	**$0**	**$2,999**	**$3,154**	**$3,249**	**$155**	**$95**
Medical Facilities (0162):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$5,420**	**$3,808**	**$7,018**	**$7,597**	**$8,264**	**$579**	**$667**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$346	$0	$700	**$725**	**$703**	$25	($22)
Medical Community Care	$2,221	$3,808	$3,319	**$3,718**	**$4,312**	$399	$594
Medical Support and Compliance	$2,853	$0	$2,999	**$3,154**	**$3,249**	$155	$95
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$5,420**	**$3,808**	**$7,018**	**$7,597**	**$8,264**	**$579**	**$667**

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154) extended eligibility for VA hospital care and medical services to certain Veterans who were stationed at Camp Lejeune, North Carolina, for at least 30 days between 1953 and 1987. Additional details can be found in the Medical Community Care chapter.

CHAMPVA (Excluding Caregivers) Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$471,266	$365,844	$484,705	$524,735	$574,226	$40,030	$49,490
Discretionary Obligations [Subtotal]	**$471,266**	**$365,844**	**$484,705**	**$524,735**	**$574,226**	**$40,030**	**$49,490**
Medical Community Care (0140):							
Discretionary Obligations	$1,742,086	$1,527,504	$1,487,004	$1,594,743	$1,735,050	$107,739	$140,307
Discretionary Obligations [Subtotal]	**$1,742,086**	**$1,527,504**	**$1,487,004**	**$1,594,743**	**$1,735,050**	**$107,739**	**$140,307**
Medical Support and Compliance (0152):							
Discretionary Obligations	$19,955	$157,303	$21,093	$21,958	$22,836	$865	$878
Discretionary Obligations [Subtotal]	**$19,955**	**$157,303**	**$21,093**	**$21,958**	**$22,836**	**$865**	**$878**
Medical Facilities (0162):							
Discretionary Obligations	$0	$8,700	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$8,700**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$2,233,307**	**$2,059,351**	**$1,992,802**	**$2,141,436**	**$2,332,112**	**$148,634**	**$190,675**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$471,266	$365,844	$484,705	**$524,735**	**$574,226**	$40,030	$49,490
Medical Community Care	$1,742,086	$1,527,504	$1,487,004	**$1,594,743**	**$1,735,050**	$107,739	$140,307
Medical Support and Compliance	$19,955	$157,303	$21,093	**$21,958**	**$22,836**	$865	$878
Medical Facilities	$0	$8,700	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$2,233,307**	**$2,059,351**	**$1,992,802**	**$2,141,436**	**$2,332,112**	**$148,634**	**$190,675**

Foreign Medical Programs Obligations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$2	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$2**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Obligations	$85,218	$50,026	$93,815	$106,883	$127,191	$13,068	$20,308
Discretionary Obligations [Subtotal]	**$85,218**	**$50,026**	**$93,815**	**$106,883**	**$127,191**	**$13,068**	**$20,308**
Medical Support and Compliance (0152):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$85,220**	**$50,026**	**$93,815**	**$106,883**	**$127,191**	**$13,068**	**$20,308**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$2	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$85,218	$50,026	$93,815	**$106,883**	**$127,191**	$13,068	$20,308
Medical Support and Compliance	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$85,220**	**$50,026**	**$93,815**	**$106,883**	**$127,191**	**$13,068**	**$20,308**

Spina Bifida Program Obligations

Spinia Bifida Program
(dollars in thousands)

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$25	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$25**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Obligations	$58,852	$54,486	$85,110	$86,813	$89,417	$1,703	$2,604
Discretionary Obligations [Subtotal]	**$58,852**	**$54,486**	**$85,110**	**$86,813**	**$89,417**	**$1,703**	**$2,604**
Medical Support and Compliance (0152):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$58,877**	**$54,486**	**$85,110**	**$86,813**	**$89,417**	**$1,703**	**$2,604**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$25	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$58,852	$54,486	$85,110	**$86,813**	**$89,417**	$1,703	$2,604
Medical Support and Compliance	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$58,877**	**$54,486**	**$85,110**	**$86,813**	**$89,417**	**$1,703**	**$2,604**

Children of Women Vietnam Vets Obligations

(dollars in thousands)

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Obligations	$5	$208	$200	$200	$200	$0	$0
Discretionary Obligations [Subtotal]	**$5**	**$208**	**$200**	**$200**	**$200**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$5**	**$208**	**$200**	**$200**	**$200**	**$0**	**$0**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$5	$208	$200	**$200**	**$200**	$0	$0
Medical Support and Compliance	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$5**	**$208**	**$200**	**$200**	**$200**	**$0**	**$0**

VA is currently providing health care benefit administration for the beneficiaries of the following programs: CHAMPVA, Foreign Medical Programs, Spina Bifida Program and Children of Women Vietnam Veterans. This includes reimbursement for Inpatient, Outpatient, Durable Medical, Pharmacy, travel and limited dental. Covered medical claims are reimbursed to the provider or the beneficiary directly. Additional details can be found in the Medical Community Care chapter.

Caregiver Support Program

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$1,220,189	$1,811,210	$1,831,210	$2,385,880	$2,726,731	$554,670	$340,851
Discretionary Obligations [Subtotal]	**$1,220,189**	**$1,811,210**	**$1,831,210**	**$2,385,880**	**$2,726,731**	**$554,670**	**$340,851**
Medical Community Care (0140):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$13,847	$35,000	$35,000	$36,530	$37,954	$1,530	$1,424
Discretionary Obligations [Subtotal]	**$13,847**	**$35,000**	**$35,000**	**$36,530**	**$37,954**	**$1,530**	**$1,424**
Medical Facilities (0162):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$1,234,036**	**$1,846,210**	**$1,866,210**	**$2,422,410**	**$2,764,685**	**$556,200**	**$342,275**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$1,220,189	$1,811,210	$1,831,210	**$2,385,880**	**$2,726,731**	$554,670	$340,851
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$13,847	$35,000	$35,000	**$36,530**	**$37,954**	$1,530	$1,424
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$1,234,036**	**$1,846,210**	**$1,866,210**	**$2,422,410**	**$2,764,685**	**$556,200**	**$342,275**

[1/] The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act and the column displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change in response to workload demand requirements throughout 2022 and 2023.

Authority for Action

- Program of Comprehensive Assistance for Family Caregivers (PCAFC) and Program of General Caregiver Support Services are authorized by 38 U.S.C. §1720G.
- P.L. 111-163, *The Caregiver and Veterans Omnibus Health Services Act of 2010, Title 1,* established a National Caregiver Support Program and additional services and supports for Family Caregivers of eligible post 9/11 era Veterans seriously injured in the line of duty under the PCAFC.
- P.L. 115-182 §161, *VA MISSION Act of 2018,* expands Family Caregiver Program over two-year period to include eligible pre-9/11 era Veterans seriously injured in the line of duty under the PCAFC.
- P.L. 115-232 §601, Title IV, *Purple Heart and Disabled Veterans Equal Access Act of 2018,* permitted a Caregiver or family caregiver use of commissary, stores and MWR facilities on the same basis as a member of the armed forces entitled to retired or retainer pay.
- P.L. 117-4, *Strengthening and Amplifying Vaccination Efforts to Locally Immunize All Veterans and Every Spouse Act (SAVE LIVES Act)* authorized VA to furnish COVID-19 vaccine to covered individuals, to include family caregivers of Veterans participating in PCAFC, during the COVID-19 public health emergency.

Increasing Support to Families and Caregivers

Purpose

The VA MISSION Act of 2018 required expansion of PCAFC in a phased approach. The first phase, which commenced on October 1, 2020, expanded PCAFC to eligible Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975 (among other criteria) and their Family Caregivers. During this first phase of PCAFC expansion (October 1, 2020 – September 30, 2022), VA received more than 184,000 PCAFC applications and added 21,700 additional Veterans and Primary Family Caregivers to PCAFC. The second phase of the PCAFC expansion commenced on October 1, 2022, which expanded PCAFC to eligible Veterans who incurred or aggravated a serious injury in the line of duty during any time (among other criteria) and their Family Caregivers. During the first two months of this expansion, an estimated 26,800 PCAFC applications were received by VA.

Beyond expanding PCAFC, VA is re-examining its approach to evaluating applications. Feedback from numerous stakeholders and results of recent reassessments of legacy applicants, legacy participants and their Family Caregivers highlighted concerns that current regulatory criteria may be too restrictive and may be excluding certain Veterans with moderate and severe needs and their Family Caregivers, that PCAFC is intended to support. In June 2022, this commitment was expanded to include post-expansion PCAFC participants. On September 21, 2022, VA amended its regulations through an interim final rule, to extend eligibility for legacy applicants, legacy participants and their Family Caregivers and the applicable benefits afforded to such Family Caregivers, by three additional years (87 F.R. 57602).

In addition to rulemaking to expand PCAFC and pursue other changes impacting Program eligibility, CSP continues to experience the impact of two significant court rulings.

On April 19, 2021, the United States Court of Appeals for Veterans Claims (Court), in the case of *Jeremy Beaudette & Maya Beaudette v. Denis McDonough, Secretary of Veterans Affairs*, ruled in favor of petitioners seeking review by the Board of Veterans' Appeals (Board) of decisions under VA's PCAFC. This ruling determined, among other matters, that all PCAFC decisions are appealable to the Board of Veterans' Appeals. As a result, CSP has sought to notify all individuals who received a PCAFC decision between May 2011 – September 27, 2021, of the right to appeal to the Board. Additionally, beginning September 28, 2021, VA Form 10-305, *Your Rights to Seek Further Review of Program of Comprehensive Assistance for Family Caregivers (PCAFC) Decisions* is included in all decision notices. This form describes the expanded decision review and appeal options available to individuals who disagree, in whole or in part, with a PCAFC decision. Such options include the right to file a Supplemental Claim, Higher-Level Review, or Appeal to the Board of Veterans' Appeals. In addition, the Veterans Health Administration (VHA) Clinical Review process (also referred to as the VHA Clinical Appeals process) remains available in tandem with other VHA review options.

On March 25, 2022, the United States Court of Appeals for the Federal Circuit struck down VA's definition of "need for supervision, protection, or instruction" in 38 C.F.R. § 71.15. Veteran Warriors, Inc. v. Sec'y of Veterans Affs., 29 F.4th 1320, 1342-43 (Fed. Cir. 2022). The Court found VA's definition to be inconsistent with the statutory provisions in 38 U.S.C. 1720G(a)(2)(C)(ii) and (iii) on which the definition was based. As a result, VA is legally required to apply 38 U.S.C. 1720G(a)(2)(C)(ii) and (iii) in place of "need for supervision, protection, or instruction" where that term is used in 38 C.F.R. Part 71 when making any PCAFC determination under the PCAFC regulations that became effective on October 1, 2020, for any cases or claims initiated on or after March 25, 2022, or any cases or claims for which VA has not issued the last notice of a decision it intends to issue. This includes but is not limited to any evaluation of the legacy cohort for which final notice had not been provided.

Implementation Plan
CSP has implemented processes and procedures to carry out expanded PCAFC programming, stood up a new workstream to conduct and effectuate decisions resulting from expanded PCAFC review and appeal options, including Board appeals and incorporate statutory criteria as required by the *Veteran Warriors* decision, when evaluating eligibility for PCAFC. Funding is needed to support stipend and health care benefits for disenrolled participants or denied applicants that may have pursued a decision review and subsequently been awarded retroactive benefits. Additional funding is also needed to support the extension of legacy applicants, legacy participants and their Family Caregivers and those who have been projected to be discharged from the program.

Family Coordinator

Purpose
In 2021, Department of Veterans Affairs (VA) Secretary Denis McDonough approved the implementation of a Family Coordinator Program within the VHA based on President Biden's American Families Plan. The program is intended to serve Veterans and their families by providing connections to services for the entire family unit via information, education and available resources

that enhance the resiliency, health and well-being of Veteran families (Strengthening America's Military Families).

Family Coordinators will have subject matter expertise in family systems and will have knowledge and experience in the provision of resources and interventions that VA has the authority to provide to Veterans, families and caregivers.

Family Coordinators will have the ability to refer to internal and external resources and develop community level partnerships to best address the unique and varied needs of these families. Partnerships and collaborations that support the mission of the Family Coordinator Program will also be explored and initiated with national organizations as appropriate.

Evidence
In 2015, at least 6.4 million Veterans had at least one minor child in their household (Source: U.S. Veterans Eligibility Trends and Statistics, 2015 Prepared by the National Center for Veterans Analysis and Statistics). Of the 9.2 million Veterans enrolled in VA, it is anticipated that many Veterans are currently providing or will provide care for a minor child, older adult, or other vulnerable person and will benefit from intervention and support from the Family Coordinator Program.

Given the sheer number of Veterans caring for children, interventions focused on providing family education and support are essential to Veteran wellness, as family resiliency is a protective factor for Veterans. Additionally, families lose critical support following the transition out of the military. This leads to a decrease in vital social connections and services. Surveys conducted by Blue Star Families found that 41% of Veterans reported reintegration to family as "difficult" or "very difficult" [27]and 48% of Veterans reported strain in family relations since transitioning out of the military[28]. Family support is critical during the period following military discharge and transition to VA services.

Social Determinants of Health (SDOH), as defined by the Centers for Disease Control (CDC), are the conditions in the places where people live, learn, work and play that affect a wide range of health and quality of life risks and outcomes. This program will allow Veterans and their family members to receive services that proactively support the SDOH, including education, skills training, resource linkage to food, housing, transportation and the digital divide. Using an upstream approach to assessment, the Family Coordinators will provide early interventions that will improve overall outcomes for health and well-being in the family unit.

Implementation Plan
A National Program Manager and two Health System Specialists are needed in the national program office to develop the implementation plan of this new program, roll-out of Family Coordinators across the enterprise and conduct program evaluation.

[27] Linsner, R.K., Maury, R.V., (2021, April). Research Brief: The Impacts and Opportunities of Military Life for Military Children. Syracuse, NY: Institute for Veterans and Military Families, Syracuse University.
[28] The Military-Civilian Gap. War and Sacrifice in the Post-9/11 Era. Pew Research Center Social and Demographic Trends.

The Family Coordinator Program will be implemented as a pilot program in 2024, placing one Family Coordinator in ten medical centers across the enterprise. Beginning in 2025-26, the program is planned to expand to 170 VA medical centers across VHA. Expansion of the program enables VA to provide these services and broaden the scope of resources to address the critical needs of the Veteran community.

Family Coordinators at VAMCs will:

- assess the needs of the families of Veterans using evidence-based strategies
- build positive relationships with such families
- refer Veterans to other resources (including local, State and Federal) that support Veterans and their families
- develop and maintain a list of supportive services offered by the VAMC and supportive services offered at reduced or no cost by non-VA providers located in the VAMC's catchment area
- develop and maintain online a list of family resources that would be made available for all enrolled Veterans in the catchment area of the medical center.

Costs

The 2024 budget request includes $17.8 million for the costs associated with developing and implementing a pilot program as well as hiring FTE to provide national oversight and clinical support locally.

Readjustment Counseling

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$242,852	$279,635	$277,182	$287,270	$295,568	$10,088	$8,298
Discretionary Obligations [Subtotal]	**$242,852**	**$279,635**	**$277,182**	**$287,270**	**$295,568**	**$10,088**	**$8,298**
Medical Community Care (0140):							
Discretionary Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Obligations	$6,207	$11,951	$12,429	$13,926	$14,297	$1,497	$371
Discretionary Obligations [Subtotal]	**$6,207**	**$11,951**	**$12,429**	**$13,926**	**$14,297**	**$1,497**	**$371**
Medical Facilities (0162):							
Discretionary Obligations	$58,482	$48,455	$50,430	$52,447	$53,496	$2,017	$1,049
Discretionary Obligations [Subtotal]	**$58,482**	**$48,455**	**$50,430**	**$52,447**	**$53,496**	**$2,017**	**$1,049**
Discretionary Total	**$307,541**	**$340,041**	**$340,041**	**$353,643**	**$363,361**	**$13,602**	**$9,718**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$242,852	$279,635	$277,182	**$287,270**	**$295,568**	$10,088	$8,298
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$6,207	$11,951	$12,429	**$13,926**	**$14,297**	$1,497	$371
Medical Facilities	$58,482	$48,455	$50,430	**$52,447**	**$53,496**	$2,017	$1,049
Obligations [Grand Total]	**$307,541**	**$340,041**	**$340,041**	**$353,643**	**$363,361**	**$13,602**	**$9,718**

Authority for Action: 38 U.S.C. § 7309.

Recent Legislation

P.L. 116-315, *The Johnny Isakson and David P. Roe, M.D. Veterans' Health Care and Benefits Improvement Act of 2020,* Section 5104: expands and makes permanent reintegration and readjustment services offered to women Veterans by providing counseling services individually or in a group retreat setting. Veterans also have the option of receiving counseling with family

members or in group retreat settings where all the participants are women. In addition, Veterans may receive financial counseling and information regarding employment and other community resources. In 2022-25, the maximum number of individuals who receive integration and readjustment services cannot exceed 1,200 individuals. In addition, the legislation creates a two-year pilot program to assess the feasibility and advisability of providing childcare assistance to qualified Veterans during the period that such Veterans receive readjustment counseling and related health care services at a Vet Center (*P.L. 116-315 § 5107(b)).* For purposes of the pilot program, the term "qualified Veteran" would mean a Veteran who is the primary caretaker of a child or children and either (1) receives regular readjustment counseling and related mental health services from VA; or (2) is in need of regular readjustment counseling and related mental health services from VA and but for lack of childcare services, would receive such counseling and services from VA. The pilot program would be required in at least three Readjustment Counseling Service Regions.

P.L. 116-171, ***Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019,*** **Section 502**: Required VA to establish a scholarship program for RCS along with the Specialty Education Loan Repayment Program and to begin awarding scholarships within one year of enactment. The initial cohort will begin in 2023. Estimated cost of program will be approximately $301,200 the first year, assuming five new scholarships will be awarded each year until the first-year cohort graduates and stasis is achieved. Second-year costs is estimated to be $590,000, third year is estimated to be $898,000 and fourth year is estimated to be $1.3 million and so forth, until first cohort graduates and a standing number of scholarships are achieved.

P.L. 116-176, ***Vet Center Eligibility Expansion Act***: The Act amends Section 1712A of title 38, U.S.C, to expand eligibility for Vet Center services to any individual who is a Veteran or Service member of the Armed Forces, who actively served in response to a national emergency or major disaster declared by the President; or in the National Guard of a State under orders of the chief executive of that State in response to a disaster or civil disorder in the state; or to any Coast Guard member who participated in a drug interdiction, no matter the location. RCS implemented this new eligibility in May 2021 and anticipates that the demand for services related to this newly eligible population will expand as more service organizations and eligible individuals learn about these changes to eligibility.

P.L. 116-283, ***The William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (NDAA)*** allows that VA, in consultation with the Secretary of Defense, may extend Readjustment Counseling Service (RCS) Vet Center eligibility to any member of the reserve components of the Armed Forces who has a behavioral health condition or psychological trauma. This legislation became effective January 1, 2022.

RCS implemented this new eligibility in January 2022 and anticipates that the demand for services related to this newly eligible population will expand as more service organizations and eligible individuals learn about these changes to eligibility. Additionally, RCS continues to work through the process to formally update regulation to include both new eligibilities under this law P.L. 116-176, *Vet Center Eligibility Expansion Act*.

Population Covered: RCS clients include Veterans (92%) and active-duty Service members (8%), along with their families, who experience challenges from deployment, combat or other military-related trauma. Approximately 83% of clients are male and 17% female. The average age of RCS client is 52 and 63% are currently younger than 60 years.

Over 31% of clients have served or are serving in recent combat theaters or areas of hostility such as Iraq or Afghanistan, with an additional 8% having served in Desert Storm/ Desert Shield. The second largest group of clients served are Vietnam Veterans, representing 25% of those receiving Vet Center Services. Another 13% have served in other areas of Combat or Hostility (not otherwise specified), 11% of those who come to RCS for services have experienced military sexual trauma and approximately 1% of clients are provided services for bereavement care.

RCS client population is diverse. By self-report, 66% of clients are Caucasian, 22% African American and 15% Hispanic. Approximately 2% are Asian Americans, 1.4% Pacific Islander/Hawaiian and 2% Alaskan Native or Native American. RCS provides services to individuals who have both honorable (83%) and problematic (17%) discharges.

Types of Services Provided: RCS consists of 300 Vet Centers, 83 Mobile Vet Centers, 996 Community Access Points (CAPS) and 26 Vet Center Outstations. Vet Centers across the country provide a broad range of counseling, outreach and referral services to eligible Veterans, active-duty Service members and their families, to include individuals with problematic discharges. Vet Centers provide guidance to Veterans, Service members and their families through various challenges that often occur after individuals return from deployment or exposures to other traumatic situations. Services for eligible individuals include individual, group, marriage and family counseling for challenges such as the symptoms associated with Post-traumatic stress disorder (PTSD), substance-abuse, suicidal or homicidal ideations and socio-economic issues. Vet Centers also provide connection to other services and benefits available through VA. Vet Center services are provided to family members of Veterans and Service members for military-related issues when it is found to aid in the readjustment of those that have served. This includes bereavement counseling for families who experience an active-duty death. All services are at no cost and are strictly confidential.

To strengthen readjustment counseling capacity across the country, RCS has aggressively pursued ongoing strategies to increase access to Vet Centers and all other VA services to all eligible Veterans, Service members and their families.

Please see the Medical Support and Compliance chapter for more information on the administration of this program.

Recent Trends: Outreach staff hours have increased 2% from 2021 to 2022. From 2021 to 2022, RCS has seen the total number of unique clients seen for counseling services remain stable. During the same period of 2021 to 2022, crisis interventions continue within RCS with a 12.2% decrease in acute counseling interventions suggesting that the acuity of those seen in Vet Centers has decreased slightly.

From 2021 to 2022, RCS demonstrated growth in the percentage of clients who identify as female. In 2021, less than 16% of all RCS visits were provided for female clients. In 2022 this number increased to 17% of the overall client visits.

RCS is continuing to see a change in its two largest service era populations. As Vietnam Veterans are decreasing in numbers, their utilization of counseling services is also decreasing (decrease of 18% in visits from 2020 to 2021). During this same time frame, the number of unique individuals who served recently in Iraq and Afghanistan coming to RCS for services decreased by 0.38%, however the visits provided has increased by 4%. (Note: Counselor selection options for eligibility were modified in 2021 to account for new eligibilities.)

While Vet Centers are the main service delivery sites, nearly 23% of visits are provided at Outstations, CAPs, MVCs and other locations away from primary Vet Centers. These alternate locations allow RCS to meet the needs of Veterans and to provide greater access to services. In addition, hours of operation are adjusted to meet the needs of Veterans and to make access to RCS services convenient.

Recognizing the need for counseling among National Guard and Reservists who are met with the challenges of deployment, RCS is actively reaching out to National Guard and reserve component leaders to promote the availability of services to eligible Service members.

In 2022:

- RCS has provided 1.4 million counseling visits for 119,517 unique Veterans, Service members and families.
- Among the 1.4 million visits, there were 29,823 family visits, 33,367 couple visits, 446,868 group visits and 859,325 individual visits.
- The modalities of the 1.4 million visits include 478,744 phone visits, 294,753 telehealth visits and 595,885 in-person visits.
- Visits during Non-Traditional Hours totaled 111,923. (Defined as before 8:00 a.m., after 4:30 p.m. and weekends.)
- Vet Center staff provided services in over 996 CAPs and 26 Outstations. 5% of all visits were provided in these distant locations.
- RCS has invested 187,830 direct staff hours hosting and/or participating in 30,722 Outreach Events. Resulting in 164,155 outreach contacts.
- RCS staff in the Vet Center Call Center took 152,701 live telephone calls from Veterans, members of the Armed Forces, families and community stakeholders. RCS has actively engaged with VA and Community Partners to support to emergency needs for Veterans, Service members and their families at their time of need. RCS has provided outreach and counseling support following natural disasters (wildfires, tornadoes and floods), mass shootings and VA facility closures. RCS also supported a unique mission in collaboration with the US Customs and Border Protection at the Eagle Pass, Texas border crossing. In 2022, RCS provided services (outreach and/or counseling) to 660 Veterans, 178 Service Members and 281

family members. Additionally, 967 civilians were referred to appropriate community agencies for additional resources and support.

- RCS supported 52 deployment efforts, including 49 Emergency Responses, 3 VAMC support missions.
- RCS partnered with the US Customs and Border Protection to support both Veteran and non-Veteran agents who were experiencing increased stressors related to trauma situations at the border crossing in Eagle Pass, Texas. In 2022, RCS provided 17 outreach briefings to CBP agents, which has resulted in 31 counseling contacts to date (25 eligible Veterans contacted).
- RCS Managed 300 leases with total obligations for the leased spaces in excess of $58 million dollars. Thirty-three new lease contracts were awarded including 13 relocations, 14 renewals and five expansions.

Projections for the Future: Based on the figures provided above and the recently enacted legislation, RCS anticipates continued growth in demand for services. RCS will be refining client and utilization projections in the upcoming year taking into consideration the legislation to expand eligibility for mental health and behavioral health care to former members of the National Guard and Reserves. In addition, a process of determining the locations of Vet Centers will be refined to address potential shifts in population demand.

In 2024 and beyond RCS will:

- Continue to increase capacity to meet demand related to expanded eligibility for Vet Center services resulting from P.L. 116-176, *Vet Center Eligibility Expansion Act* and P.L. 116-283, *The William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (NDAA).*
- Continue the retreats for eligible Vet Center cohorts into 2024 and beyond and continue implementation of the two-year pilot child-care assistance program to assess the feasibility and advisability of providing childcare assistance to qualified Veterans during the period that such Veterans receive readjustment counseling and related health care services at a Vet Center (*P.L. 116-315 Sections 5104 and 5107 (b).*
- Develop and implement new processes to proactively identify and engage eligible Service members separating from the military to enhance outreach efforts and connection to readjustment counseling services.
- Assess levels of awareness and existing barriers to care among eligible individuals and create strategic marketing and advertising plans, including paid and organic marketing, to ensure awareness and increase utilization of Vet Center services.
- Continue to assess infrastructure needs to increase capacity and access.
- Continue efforts to expand and relocate Vet Centers that are inadequate for current staffing needs, authorized staff growth and optimal service delivery to eligible individuals and their families as well as address infrastructure deficiencies.
- Seek the approval for the movement of CAPs to Outstations.
- Expand Tele-Mental Health Services (Vet Center to eligible individual’s home, Vet Center to VA Medical Center when higher level care is required).

- Provide employees with training opportunities to ensure successful knowledge transfer and leadership development.
- Replace aging Mobile Vet Centers.
- Continue to modernize the Mobile Vet Center Fleet, improve infrastructure by adding to the number of Vet Centers and/or relocations in 2024 to include, but not limited to, 2 additional Vet Centers and 45 projected lease awards.

To prepare for implementation of eligibility expansion related to new legislation, RCS held planning and collaboration meetings with the Department of Defense (DoD), internal RCS staff and other VA and community stakeholders. Through these interactions, RCS determined that there are strong favorable views on these eligibility expansions and encountered no opposition from these stakeholders in the process. Additionally, through these collaborative sessions it was determined that baseline data does not currently exist that would clearly delineate the number of new unique individuals that would potentially be eligible for Vet Center services. These new eligibility categories are not tracked by DoD separate from other existing Vet Center eligibility categories and there is potential for significant overlap with existing eligibilities for Vet Center services. RCS has identified this as a significant barrier to accurate forecasting of demand and planning for future services. Use of this raw data would result in gross overestimation of the potential population of newly eligible individuals.

To mitigate this barrier and forecast initial demand, RCS applied planning factors based upon average percentage of Service members who seek behavioral health services and applied this to a phased increase of individuals seen as the new eligibilities become more well known. Additionally, to ensure proper resource allocation, RCS is collecting specific Vet Center service utilization data on these new eligibility demographics and will continue to evaluate respective capacity to meet trends in service demand. Furthermore, RCS has started to utilize new service projection model data to help improve forecasting of demand and subsequent resources required to meet that demand, in future budget cycles. RCS is also utilizing direct customer feedback data from the RCS Vet Centers V-Signals surveys implemented in July 2021 to measure satisfaction with services, outcomes and access to services specific to demographics for these newly eligible individuals to evaluate success of service expansion implementation.

RCS has existing capacity to meet initial trends in demand for services for newly eligible reserve component individuals related to recent eligibility expansions in Public Laws 116-176 and 116-283, however, additional budgetary allocations are required to fully support the anticipated program growth. As these new eligibilities are further socialized and become more widely recognized by DoD and community partners, RCS anticipates the need for subsequent growth in staffing and physical infrastructure to provide adequate service levels in direct correlation to the increase in eligible individuals referred for services.

With the newly enacted legislation, RCS expects continued growth and expansion of services. To meet this demand, RCS will continue to assess the need for additional staff to increase Vet Center services and support the multi-year planned expansions and/or relocations of Vet Centers nationwide in high-demand and rural areas.

RCS has continued efforts to expand and relocate Vet Centers that were inadequate for current staffing needs, authorized staff growth and optimal service delivery to eligible individuals and their families as well as address infrastructure deficiencies. RCS continues to improve access to readjustment counseling in communities distant from existing Vet Center services through increasing the number of Vet Centers (projected increase of five), Outstations (projected increase of five) and CAPS in Rural and Highly Rural Areas.

In consideration of continued expansion initiatives, RCS considered potential alternatives in providing Vet Center services to rural communities and newly eligible populations. Contract for fee services were considered, however, availability of contract providers, oversight and staff resource burdens associated with management of contracts and associated contract costs have shown this option to be unfeasible. Additionally, customer feedback indicates a strong preference for Veterans, Active Duty Service members and their families to receive services through organic Vet Center resources and not contract providers. Finally, in relation to recently enacted legislation, statutory language is specific to Vet Center services to be provided and lays out the types of services and eligibilities that are required as result of this legislation.

RCS plans to budget at a minimum $13 million annually in support of Vet Center relocations and/or expansions. The Procurement Acquisition Lead Times (PALT) for procuring a new space is two to three years. Many variables can impact the procurement awards, such as viable spaces that meet our space criteria, a successful solicitation for offers, safety, security, geographic location and environmental impacts. Leasing and construction cost vary nationwide. There are several factors that go into determining commercial building construction cost estimates including labor rates and productivity, material prices and the competitive conditions of the marketplace within a geographic region. With the recent nationwide supply chain challenges, RCS has seen a significant increase in construction cost, with relocations and build-outs averaging $850,000. A competitive marketplace coupled with the increase in cost and materials are just a few challenges RCS has encountered during the solicitation process for new space.

The RCS budget request for 2024-25 allows for the sustainment and strengthening of services to Veterans, Service members and their families due to projected growth, infrastructure requirements and the recently enacted legislation. With the requested budget, RCS can deliver quality services to Veterans today, address a previous backlog and future RCS capital improvements and more capably address the growing future demand combat Veterans have for RCS services.

RCS Workload

Readjustment Counseling Workload
(in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Advance Approp.	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Visits.....	1,369	1,553	1,423	1,583	**1,501**	**1,584**	78	83
Uniques*.....	109	359	113	379	**119**	**126**	6	7

*Data validation identified challenges in unique client counts for outreach contacts resulting in a change in methodology in 2022 to focus visit and unique client counts strictly to counseling services delivered.

Activations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Services (0160):	$212,167	$591,526	$591,526	$563,619	$411,634	($27,907)	($151,985)
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$22,746	$132,193	$132,193	$140,596	$94,115	$8,403	($46,481)
Medical Facilities (0162):	$15,585	$46,185	$46,185	$161,034	$117,610	$114,849	($43,424)
Obligations [Grand Total]	**$250,498**	**$769,904**	**$769,904**	**$865,249**	**$623,359**	**$95,345**	**($241,890)**
Mandatory Obligations							
Veterans Medical Care and Health Fund:							
Medical Services (0173MS):	$77,211	$0	$0	$0	$0	$0	$0
Medical Community Care (0173CC):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0173SC):	$7,081	$0	$0	$0	$0	$0	$0
Medical Facilities (0173MF):	$7,448	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$91,740**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary and Mandatory Obligations							
Medical Services (0160):	$289,378	$591,526	$591,526	$563,619	$411,634	($27,907)	($151,985)
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$29,827	$132,193	$132,193	$140,596	$94,115	$8,403	($46,481)
Medical Facilities (0162):	$23,033	$46,185	$46,185	$161,034	$117,610	$114,849	($43,424)
Obligations [Grand Total]	**$342,238**	**$769,904**	**$769,904**	**$865,249**	**$623,359**	**$95,345**	**($241,890)**

For details on VHA Activations, please see the Medical Services Chapter.

Epilepsy Centers of Excellence: Telehealth and Tele EEG Expansion

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Services (0160):	$11,959	$19,086	$19,086	$19,983	$20,218	$897	$235
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$0	$0	$0	$3,602	$3,653	$3,602	$51
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$11,959**	**$19,086**	**$19,086**	**$23,585**	**$23,871**	**$4,499**	**$286**

Purpose

The Epilepsy Centers of Excellence (ECoE) were established to improve the health and well-being of Veterans with epilepsy and other seizure disorders through integration of clinical care, outreach, research and education. The ECoE network comprises four regional centers and 17 VA Hospitals that provide comprehensive epilepsy care for Veterans with seizure disorders, including those with post traumatic epilepsy due to traumatic brain injury. To reach the over 404,000 Veterans with definite/probable epilepsy and seizures receiving care in VA (2020), there is an acute need to expand access to specialized epilepsy care. Access to electroencephalograms (EEGs), the gold standard test for diagnosing and treating epilepsy, is insufficient at many VA Hospitals and medical centers resulting in expensive community transfers. EEG studies sent to the community are often interpreted by general neurologists who lack the subspecialty expertise that VA has amassed within ECoE. Further expanding the current ECoE telehealth and Tele-EEG programs will extend the expertise of VA epileptologists to ensure that Veterans nationwide receive equitable care.

Evidence:
There is a crucial need for this program. Many Veterans live in rural areas, far from VA Hospitals that provide specialized epilepsy care. Community neurology care is limited in these areas and subspecialty epilepsy care is virtually non-existent. As a result, numerous Veterans with epileptic and non-epileptic seizures remain undiagnosed or misdiagnosed. Lack of timely correct diagnosis leads to treatment delays, unnecessary morbidity and increased costs due to frequent emergency department visits and hospital admissions. Seizures dramatically impair Veteran quality of life. Those with inadequately treated seizures often cannot drive or work. Consequently, the suicide rate in Veterans with seizures is double that of other Veterans—an already high-risk population (reference link).

As a compound effect to rural need, there is a shortage of Epileptologists nationally that maintain the qualifications to read and interpret Tele-EEG reports. The ECoE telehealth and Tele-EEG Program provides the framework to regional and local VHA hospitals that cannot recruit or retain this critical position by remotely reading, interpreting and reporting the findings back to the patient's home station as well as providing expert Epileptologists to consult and refer for follow-up consultation via telehealth infrastructure.

ECoE can deploy epilepsy care to remote areas via telehealth. Tele-EEG networks allow EEGs to be performed in remote VA hospitals or clinics and interpreted by a remote epilepsy subspecialist. Despite rapid expansion during the COVID-19 pandemic, access and connectivity to epilepsy specialists remains insufficient to meet needs of Veterans with seizures. This leads to increased community care referrals and discontinuity in VA Epilepsy Care. Community care costs for EEG services was $7 million dollars in 2019 (pre-COVID). The expansion and optimization of telehealth and Tele-EEG networks proposed here will expedite diagnosis, reduce Veteran wait times and travel distances and decrease reliance on community care referrals. Thus, this proposal will reduce inequities in epilepsy care across VA. The alternative to this expansion is the status quo, where Veterans who live in urban areas with epilepsy expertise have access to state-of-the-art diagnosis and treatment whereas rural Veterans may not be diagnosed correctly if at all.

Implementation Plan:
Program implementation is feasible as demonstrated by a pilot program beginning in 2011 involving several ECoE sites comprising three Tele-EEG hubs (Boston, Portland and Durham) and the recently added Madison and Gainesville Hubs in 2021-22 that evolved to support 20 remote connections with active planning for many new connections. This current network supports only store-and-forward EEG used for outpatient and some inpatient evaluations. The continuous (real-time synchronous) Tele-EEG monitoring proposed above to support VA critical care is also feasible, requiring only additional staffing and connections. This will integrate with current Tele-Critical Care Program. One barrier is the challenge to recruit and retain EEG technologists, particularly in rural areas, which would be addressed by creating new retention/signing bonuses, developing VA- based training programs and contracting with EEG vendors for the technologist service component while retaining the professional component (EEG interpretation by VA epileptologists) within VA.

Effectiveness of the program expansion will be evaluated by the following metrics:

- Increases in the proportion of Veterans with a seizure disorder/epilepsy seen by an VA epilepsy specialist.
- Decreases in the proportion of Veterans transferred from a VA medical facility or emergency department for urgent EEG or continuous EEG monitoring.
- Year to year increase in Tele-EEG workload performed by ECoE (resulting in increase in access to care and increase in bookable slots at local sites).
- Reduction in ratio of community care referrals to VA Epilepsy Referrals at supported sites.

The proposed expanded epilepsy Telehealth and Tele-EEG program will include:

- National Tele-EEG and Epilepsy Director and three Clinical Directors (0.5 FTE): 1) Tele-EEG East and West and 2) Tele-Epilepsy Clinical Director. Six hubs will have 1.5 FTEE for Clinical Hub Directors (epileptologists).
- Development of a Tele-Epilepsy team to complete virtual seizure evaluations nationwide. This team will consist of: 3.0 FTEE physicians, 2.0 FTEE RNs, an Administrative Officer (GS-12) and one Telehealth Care Technician (GS-8) for administrative support (shared with Tele-EEG).
- Tele-EEG expansion plan in two phases:
    - 2023-24: Expansion of Store and Forward Network and administrative infrastructure
    - 2024-25: Development of Synchronous Tele-EEG network supporting Epilepsy Monitoring Units (EMUs) in 2024 then ICU/Critical Care in 2025
- Development of a Reader Pool of epileptologists to interpret outpatient EEGs, as well as continuous EEGs to support critical care provided in VA intensive care units and EDs. A portion of this pool will come from existing ECoE staff epileptologists. To provide 24/7/365 continuous EEG services, a minimum of 6 FTEE additional epileptologist FTE are required by 2024 and 11 FTE by 2025 to support critical care EEG.
- EEG administrative and technical infrastructure to support the expansion of both programs consisting of: a National Program Administrator, Quality Management/Compliance Registered Nurse, Data Analyst, Group Practice Manager, Credentialling support, National Administrative Officer, 2 Regional Administrative Officers, 2 National Lead EEG Technologists, 2 FTE Monitor Pool/Education Lead technologists), 6 hub EEG technologists, a minimum of 5 additional Monitor Pool technologists FTEs are required by 2024 and a total of 10 FTE by 2025 to support critical care EEG and regional biomed support (1.5 FTE total) and national biomed leads (2 FTE). A business plan for OI&T funding and support has been submitted and approved in 2021 to support effort.
- Development and maintenance of Tele-EEG servers or virtual storage for new Hubs and provision of EEG equipment for new connections.
- Creation of National EEG Repository and Synchronous Tele-EEG network by 2024.
- Creation of national contracts with three home-based EEG vendors to complement VA Tele-EEG. These vendors provide service in areas remote from all Tele-EEG connections, or in sites lacking EEG technologists. Contracts will specialize in EEG interpretation by VA epileptologists. Additional funds are requested to expand the use of other EEG technologies

including Rapid EEG and Skull Cap technology, which are currently undergoing pilots in the ECoEs.

- Site visits to bring up new sites (one traveler to eight sites per year).
- Two planning meetings per year with VA stakeholders including the VA Office of Connected Care, Tele-Critical Care Program Office and Tele-Neurology Program. Outside consultants with network management and telehealth expertise will be included as needed.

The 2024 budget request reflects the cost to maintain operation of the existing ECoE and to further expand Store and Forward EEG and offer 24/7 Tele-EEG support for all VA sites and support synchronous Tele-EEG by 2024.

Education and Training

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):	$2,407,711	$2,511,533	$2,635,542	$2,707,115	$2,881,065	$71,573	$173,950
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$73,237	$79,626	$80,312	$80,825	$85,300	$513	$4,475
Medical Facilities (0162):	$102,532	$110,971	$111,932	$112,632	$118,876	$700	$6,244
Discretionary Total	**$2,583,480**	**$2,702,130**	**$2,827,786**	**$2,900,572**	**$3,085,241**	**$72,786**	**$184,669**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$5,215	$2,448	$5,465	$5,678	$4,980	$213	($698)
Mandatory Obligations [Subtotal]	**$5,215**	**$2,448**	**$5,465**	**$5,678**	**$4,980**	**$213**	**($698)**
Medical Community Care Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8004 (0140)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$3,245	$1,504	$3,392	$3,524	$256	$132	($3,268)
Mandatory Obligations [Subtotal]	**$3,245**	**$1,504**	**$3,392**	**$3,524**	**$256**	**$132**	**($3,268)**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$1,988	$0	$2,101	$2,187	$0	$86	($2,187)
Mandatory Obligations [Subtotal]	**$1,988**	**$0**	**$2,101**	**$2,187**	**$0**	**$86**	**($2,187)**
Mandatory Total	**$10,448**	**$3,952**	**$10,958**	**$11,389**	**$5,236**	**$431**	**($6,153)**
Combined Discretionary and Mandatory by Category							
Medical Services	$2,412,926	$2,513,981	$2,641,007	$2,712,793	$2,886,045	$71,786	$173,252
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$76,482	$81,130	$83,704	$84,349	$85,556	$645	$1,207
Medical Facilities	$104,520	$110,971	$114,033	$114,819	$118,876	$786	$4,057
Obligations [Grand Total]	**$2,593,928**	**$2,706,082**	**$2,838,744**	**$2,911,961**	**$3,090,477**	**$73,217**	**$178,516**

Graduate Medical Education (GME) Trainees

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):	$770,163	$862,532	$862,532	$892,721	$937,357	$30,189	$44,636
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$770,163**	**$862,532**	**$862,532**	**$892,721**	**$937,357**	**$30,189**	**$44,636**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$5,215	$2,448	$5,465	$5,678	$4,980	$213	($698)
Mandatory Obligations [Subtotal]	**$5,215**	**$2,448**	**$5,465**	**$5,678**	**$4,980**	**$213**	**($698)**
Medical Community Care Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8004 (0140)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$3,245	$1,504	$3,392	$3,524	$256	$132	($3,268)
Mandatory Obligations [Subtotal]	**$3,245**	**$1,504**	**$3,392**	**$3,524**	**$256**	**$132**	**($3,268)**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$1,988	$0	$2,101	$2,187	$0	$86	($2,187)
Mandatory Obligations [Subtotal]	**$1,988**	**$0**	**$2,101**	**$2,187**	**$0**	**$86**	**($2,187)**
Mandatory Total	**$10,448**	**$3,952**	**$10,958**	**$11,389**	**$5,236**	**$431**	**($6,153)**
Combined Discretionary and Mandatory by Category							
Medical Services	$775,378	$864,980	$867,997	$898,399	$942,337	$30,402	$43,938
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$3,245	$1,504	$3,392	$3,524	$256	$132	($3,268)
Medical Facilities	$1,988	$0	$2,101	$2,187	$0	$86	($2,187)
Obligations [Grand Total]	**$780,611**	**$866,484**	**$873,490**	**$904,110**	**$942,593**	**$30,620**	**$38,483**

Education and Training Non-GME Trainees

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):	$246,049	$253,939	$253,939	$285,827	$330,402	$31,888	$44,575
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$0	$361	$361	$374	$389	$13	$15
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$246,049**	**$254,300**	**$254,300**	**$286,201**	**$330,791**	**$31,901**	**$44,590**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8004 (0140)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$246,049	$253,939	$253,939	$285,827	$330,402	$31,888	$44,575
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$0	$361	$361	$374	$389	$13	$15
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$246,049**	**$254,300**	**$254,300**	**$286,201**	**$330,791**	**$31,901**	**$44,590**

Education and Training Support

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):	$1,391,499	$1,395,062	$1,519,071	$1,528,567	$1,613,306	$9,496	$84,739
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$73,237	$79,265	$79,951	$80,451	$84,911	$500	$4,460
Medical Facilities (0162):	$102,532	$110,971	$111,932	$112,632	$118,876	$700	$6,244
Discretionary Total	**$1,567,268**	**$1,585,298**	**$1,710,954**	**$1,721,650**	**$1,817,093**	**$10,696**	**$95,443**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8004 (0140)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$1,391,499	$1,395,062	$1,519,071	$1,528,567	$1,613,306	$9,496	$84,739
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$73,237	$79,265	$79,951	$80,451	$84,911	$500	$4,460
Medical Facilities	$102,532	$110,971	$111,932	$112,632	$118,876	$700	$6,244
Obligations [Grand Total]	**$1,567,268**	**$1,585,298**	**$1,710,954**	**$1,721,650**	**$1,817,093**	**$10,696**	**$95,443**

Authority for Action

As one of four statutory missions, VA, through the Office of Academic Affiliations (OAA), conducts the largest education and training platform for Health Professions Trainees (HPTs) in the Nation "to assist in providing an adequate supply of health personnel to the Nation" (38 United States Code [U.S.C.], section 7302). In accordance with this mission "to educate for VA and for the Nation", VA's health professions education (HPE) mission is accomplished in partnership with affiliated U.S. academic institutions.

In addition, Public Law 113-146, *Veterans Access, Choice and Accountability Act of 2014* (VACAA), Section 301(b)(2) of the Act, charges VA to "increase the number of Graduate Medical Education (GME) residency positions at medical facilities of the Department by up to 1,500 positions," over a five-year period beginning one year after the enactment of the VACAA. Subsequently, P.L. 114-315, *Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016*, extended the period for the increase in GME residency positions from 5 to 10 years (expiring August

7, 2024). Additionally, P.L. 115-182, *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018* (VA MISSION), Section 403 of the Act, charges VA to develop and implement a pilot program to establish GME programs and positions at covered facilities in underserved areas. P.L. 116-159 extended the authority of Section 403 from August 7, 2024, to August 7, 2031.

VA Staff Impacted
Over 113,000 HPTs participated in over 7,000 training programs offered through partnerships between 150 VA medical facilities and over 1,400 academic institutions. Ninety-nine percent of medical schools are affiliated with VA, including 153 of the Nation's 155 Liaison Committee on Medical Education (LCME)-accredited allopathic schools and all 37 Commission on Osteopathic College Accreditation (COCA)-accredited osteopathic medical schools in the US. In addition to physicians, over 60 other clinical disciplines are represented in VA's training programs. Over 15,000 HPTs in VA come from Minority Serving Institutions, such as Hispanic Serving Institutions (HSIs) and Historically Black Colleges and Universities (HBCUs). GME HPTs account for approximately 78% of the clinical HPT budget, non-GME HPTs account for the remainder. Non-GME HPTs include all other health professions such as nursing, podiatry, optometry, psychology and pharmacy. OAA creates and maintains policy oversight of the HPE mission in VA and offers guidance and consultation to field facilities, Veterans Integrated Service Networks and other VA constituencies. OAA is the primary source for HPT data in VA and acts as the main liaison to external stakeholders such as professional and member organizations, specialty societies and accrediting bodies for HPE.

Type of Services Provided
HPTs contribute substantially to VA's mission to deliver cost-effective, high-quality patient care for Veterans. VA HPE programs play a leading role in creating the health care workforce for VA and the Nation. For example, over 72% of VA podiatrists and psychologists, over 81% of VA optometrists and over 64% of VA physicians participated in VA training programs prior to employment. When HPTs are queried about the impact of their recent training experiences in VA, their willingness to work for VA increases by 18% as compared to before participating in VA training. Therefore, VA's involvement in HPE is an effective mechanism to support VA's patient care mission.

Data shows that registered nurses and nurse practitioners continue to be ranked as Mission-Critical Occupations. In response, OAA has implemented multiple innovative nursing education training programs aimed to address VHA and national RN and NP workforce shortages, such as a robust expansion of RN and NP residency programs, with more than 20,000 nursing HPTs completed their clinical training at VA facilities.

Recent Trends
VA's HPE mission continues to add value for VA. HPE is a cost-effective mechanism for creating a workforce pipeline to fill critical VA and national workforce needs. VA has augmented the health care workforce in rural and under-served communities and at small and low complexity VA medical centers through establishment or expansion of existing HPE programs. Recent legislation affecting the HPE mission in VA include the following:

- **VACAA:** VACAA allowed VA to increase the number of GME physician residency positions by up to 1,500 over a ten-year period, with an emphasis on primary care, mental

health and other specialties that the Secretary deemed appropriate. Thus far, 1,491 positions have been awarded through this initiative, with two thirds of awarded positions in primary care (internal medicine, family medicine and geriatrics) and mental health (addiction medicine, general psychiatry and psychiatric sub-specialties). VA plans to implement the nine remaining VACAA positions in 2023.

- **MISSION:** The VA MISSION Act contained numerous provisions to augment recruitment of HPTs into the VA workforce. Section 304 is a scholarship program (in progress) for Veteran students enrolled in selected medical schools. With the understanding that physicians tend to stay and practice in the area they last trained, Section 403 aims to increase GME programs in high priority rural locations (Indian and tribal, Indian Health Service and underserved VA facilities). Section 403 provides new authorities for the payment of resident stipends and benefits and reimburses startup costs for new residency programs. The MISSION Act recognizes that in rural areas, the density of Veteran patients alone may not be enough to establish new residency programs, therefore, Section 403 also authorizes VA to expand its ability to pay for resident time beyond delivering Veteran care. VA expects that a request for proposals (RFP) will be disseminated after publication of the MISSION Act Section 403 Final Rule.

Projections for the Future

VA is a sought-after partner for HPE programs, due to its size, national scope and breadth of training opportunities. Veterans are a unique patient population and HPTs value their experiences working with Veterans. VA is the second largest federal payor of GME (second to the Center for Medicare and Medicaid Services) and is a major funder of residency programs across a variety of health professions.

VA expects continued growth in HPE, due to accreditation of new professions as well as the continued addition of new levels of training (for example, new residency programs for both nurse practitioners and physician assistants). Furthermore, OAA has conducted extensive outreach to minority serving institutions and expects continued growth in the number of partnerships with these institutions.

VA is the largest employer of nursing personnel in the country, with more than 112,000 registered nurses. The VA Office of Workforce Management and Consulting (WMC) projection models indicate that VA will need to annually hire approximately 14,260 additional nursing personnel across all education levels for a total of roughly 77,500 new hires over the next five years to fulfill a critical mission of caring for our Nation's Veterans. OAA nurse residency programs serve as critical components of the VA nursing workforce pipeline, facilitating VA's recruitment and retention goals. OAA, in collaboration with WMC and the Office of Nursing Services, devised a VHA Nurse Residency Expansion plan with the goal of increasing 2023 Nurse Residency allocations by an additional 110 RN residency and 30 NP residency positions.

Approved Graduate Medical Education and Dental Positions

Academic Year	Year	Category	Filled Positions
2017 – 2018	2018	Actual	11,043
2018 – 2019	2019	Actual	11,247
2019 – 2020	2020	Actual	11,444
2020 – 2021	2021	Actual	11,454
2021 – 2022	2022	Actual	11,698
2022 – 2023	2023	Estimate	11,844
2023 - 2024	2024	Estimate	11,938
2024 - 2025	2025	Estimate	12,066

Health Care Professionals Educational Assistance Program

		2023		2024	2025		
Description (Dollars in thousands)	2022 Actual	Budget Estimate	Current Estimate	**Revised Request**	**Advance Approp.**	**+/- 2022-2023**	**+/- 2023-2024**
Obligations [Total]	**$182,263**	**$248,033**	**$249,894**	**$303,356**	**$361,152**	**$53,462**	**$57,796**
Education Debt Reduction Program (EDRP)	$120,222	$160,000	$160,000	$190,000	$230,000	$30,000	$40,000
Specialty Education Debt Reduction Program (SELRP)	$2,560	$12,000	$12,000	$12,000	$12,000	$0	$0
Employee Incentive Scholarship Program (EISP)	$3,677	$3,600	$3,600	$7,470	$10,324	$3,870	$2,854
VA National Education for Employees Program (VANEEP)	$16,446	$13,900	$13,900	$19,395	$30,387	$5,495	$10,992
Nat'l Nursing Education Initiative (NNEI)	$12,565	$18,460	$18,460	$19,707	$22,201	$1,247	$2,494
Health Professional Scholarship Program (HPSP)	$26,545	$39,848	$39,848	$49,700	$51,000	$9,852	$1,300
Visual Impairment Education Assistance Program (VIOMPSP)	$0	$225	$225	$225	$225	$0	$0
Administration 1/	$248	N/A	$1,861	$4,859	$5,015	$2,998	$156

1/ Administration costs not previously shown.

Education Debt Reduction Program

Purpose

The Education Debt Reduction Program (EDRP) serves as a critical recruitment and retention tool used by the VA, VHA medical centers to recruit and retain its most difficult-to-fill direct patient care clinical positions. As a multi-year program that reimburses participant education loan payments up to $40,000 per year–for up to five years–for an overall total of $200,000 per participant. EDRP is a principal incentive that allows VHA to remain competitive with the private sector, proving successful in both recruiting and retaining health care providers.

Evidence:

Since program inception, EDRP has been used to recruit and retain over 23,000 individuals providing patient care to Veterans. A record 3,038 new EDRP awards have been approved for the 2022 application cycle. Registered Nurses (including Advanced Practice Nurses) received the most EDRP awards in 2022 followed by Psychologists and Physicians. The EDRP remains a strong recruiting tool for VHA and is used to help meet the immediate need to fill hard-to-recruit patient care providers in nationally scarce specialties.

Implementation Plan:
EDRP will be used by medical centers to recruit and retain approximately 3,000 additional health care professionals annually in hard-to-fill patient care positions, while continuing to retain current program participants for the remainder of their service periods, which typically lasts five years.

Costs:
EDRP participants can receive up to $200,000 over five years at $40,000 annually. Average award amounts have increased along with program demand to meet VHA recruitment and retention health care provider needs. New EDRP awards averaged $77,000 in 2018 prior to the increase in EDRP award provided by the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act. In comparison, EDRP awards for new participants averaged near $96,000 for 2022.

EDRP will reimburse over 7,700 total participants in 2023 and is projecting nearly 11,000 participants in 2024 at a total reimbursement cost of $190 million and 13,000 participants in 2025 at a total of $230 million in EDRP reimbursement payments. The increase in participants will require additional operational staff to fully execute the program to recruit and retain providers for VHA's hardest to fill patient care positions. As requested in the 2023 budget submission, EDRP requires nine additional staff beginning in 2023 at a cost of $1.2 million and an additional six staff in 2024 for a total of $2.2 million annually. The personnel and infrastructure redesign of the EDRP application and reimbursement processes will result in improved service delivery that will support program demand, maximize utilization by more strategically targeting areas of greatest need while significantly reducing the collateral duties currently burdening over-extended human resources staff also serving in a shortage occupation.

Specialty Education Loan Repayment Program

Purpose
The Specialty Education Loan Repayment Program (SELRP) was authorized by Section 303 of the MISSION Act of 2018 as a loan repayment program specifically targeted to attract recent medical school graduates for VA service in exchange for a total of $160,000 (at $40,000 per year) in education loan repayment. The program will establish a pipeline of specialized providers to meet VHA's future staffing needs by offering loan repayment to medical school graduates with at least two years remaining in their residency programs, thereby allowing VHA to compete with the private sector for new graduates.

Evidence
SELRP is a new program mandated by the MISSION Act in 2018 and deployed in April 2021. According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of up to 122,000 physicians by 2032, including a critical need for specialists to treat an aging population that will increasingly live with chronic disease. The VHA currently competes against lucrative private sector offers to physicians during their residency training. It is imperative that VHA use financial incentive programs like the SELRP to secure early employment commitments from physicians completing training programs. The VHA currently anticipates system wide recruitment challenges for physicians with specialized training in Primary Care, Geriatrics, Emergency Medicine, Gastroenterology and Psychiatry, all of which are among the

Nation's most scarce specialties. The SELRP will target medical students and residents training in these specialties to establish a pipeline of specialists to address the projected needs.

Implementation Plan
SELRP was deployed in April 2021 with an initial cohort of 10 participants. In 2022, the SELRP awarded 35 loan repayments to residency students specializing in Family Practice, Psychiatry, Internal Medicine, Anesthesiology, Urology and Emergency Medicine. From the inception of the SELRP in 2021 through September 30, 2022, VA has awarded 45 total awards to participants. Each SELRP recipient agrees to a service obligation period at a VA medical facility which helps alleviate health care workforce shortages. Upon award, recipients sign a minimum 2-year service obligation as well as a mobility agreement. Future benefits are gained in reduced recruitment costs as SELRP recipients will have obligated service agreements to fulfill.

Costs:
The 2023 budget of $12.0 million will cover the reimbursement costs for 300 SELRP participants at a rate of $40,000 each. The program will continue to expand each year, offering loan repayment for 100 new participants annually for a cost of $12.0 million in 2024.

Employee Incentive Scholarship Program (EISP) /VA National Education for Employees Program (VANEEP)/ National Nursing Education Initiative (NNEI):

Purpose
Title 38 United States Code, Chapter 76, established the Employee Incentive Scholarship Program (EISP). EISP authorizes VA to award scholarships to employees pursuing academic degrees in clinical occupations where recruitment and retention of qualified personnel may be challenging. The academic curricula covered under this program includes education and training programs in fields leading to appointments or retention in clinical occupations. EISP awards cover tuition and related expenses such as registration, fees and books in return for a one to three-year service obligation following graduation and licensure or certification. The VA National Education for Employees Program (VANEEP) and the National Nursing Education Initiative (NNEI) are initiatives within EISP. Under VANEEP, VA facilities allow certain scholarship participants to accelerate their degree completion by attending school full time. VANEEP provides educational funding and replacement salary to the facility to cover critical staffing needs during the participant's absence. The NNEI program is limited to funding Registered Nurses (RN) pursuing associate, baccalaureate and other advanced degrees.

Evidence
As the Nation's largest integrated health care delivery system, VA nursing workforce challenges mirror those of the health care industry. The EISP, NNEI and VANEEP help alleviate the health care workforce shortages in VA by requiring scholarship recipients to complete a one to three-year service obligation at a VA medical facility. As of September 30, 2022, VA has awarded 24,182 scholarships to EISP, NNEI and VANEEP participants since the program started in 2000. During 2022, VA administered 4,470 scholarships for continuing employees and approved 1,205 new awards to EISP, NNEI and VANEEP participants.

The NNEI program is a key resource for retention of employees in the registered nursing occupation. Rugs and others, (2021)[29] conducted an evaluation of NNEI and identified predictors of degree completion for 10,043 participants in 162 VHA facilities from 2000-12. At least 86.7% of NNEI participants completed the academic degree requirement. Of those who completed their degree, 97% completed the service obligation. For this cohort, 89% of individuals who completed their service obligation were still employed by VHA two years later. Consistent with the statutory intent, NNEI helps alleviate the health care workforce shortages as well as helps VA build a highly qualified nursing workforce capable of supplying the best care to Veterans.

Implementation Plan
In alignment with VA's Human Infrastructure Plan, VA will expand scholarship programs in critical areas of need as defined by the VA and VHA strategic workforce plans and the VA Office of Inspector General (OIG) determination of VHA's occupational staffing shortages. This added funding would allow WMC to expand the health care workforce pipeline and increase the number of awards with a focus on mental health, long-term care and rural settings. Additionally, as we continue to partner with Minority Serving Institutions (MSIs) the added funding would help with building a workforce that reflects the diversity of the Veteran population.

Increased funding for the Employee Incentive Scholarship Program (EISP), National Nursing Education Initiative (NNEI) and VA National Education for Employees Program (VANEEP) will provide increased opportunities to retain employees in clinical occupations with a service obligation commitment at a VA facility. Also, priority consideration will be given to those employees entering or staying in the mental health setting, long-term care setting, or at a rural health facility. The expansion of the employee scholarship programs will require additional program support at VA facilities and the national program office. WMC is requesting added funding to provide additional scholarship awards to frontline employees and to pay the added salary and benefit costs of facility and program office staff administering the employee scholarship programs.

In 2023, VHA will award a minimum of 960 new employee scholarship awards and projects awarding a minimum of 1500 new employee scholarship awards in 2024. This is in addition to managing and funding the EISP, VANEEP and NNEI awards for continuing participants. Failure to secure funding to continue the work of the EISP, VANEEP and NNEI programs would have an adverse impact on VHA's ability to sustain the increased new and continuing awards supported by the national program office and would also limit future expansion of critical nursing workforce initiatives. If the future budgets are not adjusted, EISP, NNEI and VANEEP would continue to provide educational assistance at current levels.

Costs
EISP, VANEEP and NNEI awards are based on the average total of educational assistance awarded to all occupations. The current average annual costs per participant for each of the programs (that is, EISP at $9,171, VANEEP at $43,947 and NNEI at $8,819) are based on historical disbursements to employees. The increase in medical compliance and support would sustain the infrastructure necessary to increase the number of new awards, continuing awards, developing and

[29] Rugs D, Nedd N, Quast T, Wang X, Hyacinthe M, Hall KS, Powell-Cope G. An evaluation of the Veterans Health Administration National Nursing Education Initiative. *Nurse Outlook. 2021 Mar-Apr;69*(2):193-201

deploying training and education to over 336 field-based coordinators, enhancing academic partnerships and conducting daily management and operations of the Scholarship Clinical Education Program (SCEP) Application systems. For 2023, WMC included a request for the addition of one national program office staff to support NNEI program growth. For 2024, WMC included a request for the addition of four national program office staff to support the added growth for EISP, NNEI and VANEEP. The added national program office position is calculated at the GS-09 Training Technician (2022 Rest of US Salary Pay Scale). Salary increases use 3.4% OMB economic assumption and benefits at 34%.

Expansion of employee scholarship programs will require additional resources at VA field facilities that manage the employee scholarship programs. The added administrative costs would support the salary of VA staff who administer the scholarship programs at the facility level. The addition of a 0.5 FTE GS-09 Training Technician at the facility level will provide resources to standardize administration of the programs, including consistent implementation of financial responsibilities and retention strategies and provide streamlined avenues to establish a robust health care workforce pipeline. Currently, facility scholarship coordinators administer the scholarship programs in addition to other primary duties and core functions. Based on annual customer surveys, the facility coordinators have expressed dissatisfaction with the multiple collateral duties. Additionally, a Government Accountability Office (GAO-15-794) review of VHA nurse recruitment and retention initiatives determined several medical centers faced challenges, such as lack of sufficient administrative support, in offering national programs. The ability to pay the salary and benefit costs of administrative support would allow facilities to implement and expand strategic education programs for their workforce.

Health Professional Scholarship Program (HPSP)

Purpose
HPSP allows VA to award scholarships to applicants pursuing degrees or training in health care disciplines for which recruitment and retention of qualified personnel are difficult. The HPSP prioritizes applicants training in a clinical occupation commensurate with the largest staffing shortages in the VA. The increased funding for the HPSP would expand the pipeline of qualified candidates to fill critical health care workforce shortage areas since the applicants awarded the scholarship must fulfill a service obligation at a VA medical facility.

Evidence
From the inception of the HPSP in 2016, VA has awarded scholarships to participants in the following occupational disciplines: Physicians, Physician Assistants, Nurses, Nurse Practitioners, Pharmacists, Physical Therapists, Diagnostic Radiological Technicians, Social Workers, Clinical Psychologist and Medical Technologists. In 2018, Title III of the MISSION Act was passed with the intent to create a pipeline of medical doctors to fill vacancies and increase access to care for Veterans.

Section 301 of the VA MISSION Act requires that not less than 50 scholarships be awarded each year to individuals who are accepted for enrollment, or, are enrolled in a program of education or training leading to employment as a physician or dentist until such date as the Secretary determines that the staffing shortage of physicians and dentists in the Department is less than 500.

In 2022, the HPSP expanded to include Social Workers and Clinical Psychologist. As of September 30, 2022, 303 medical students have been awarded scholarships. From the inception of the HPSP in 2016 through September 30, 2022, VA has awarded 1,110 total scholarships to HPSP participants. Each HPSP recipient agrees to a service obligation period at a VA medical facility which helps alleviate health care workforce shortages. Upon award of the scholarship, recipients sign a minimum 2-year service obligation as well as a mobility agreement. Since the inception of HPSP in 2016, VA placed over 325 clinicians - in multiple disciplines - across the Nation. Additionally, HPSP enables students to gain academic credentials without additional burden of student loan debt. Future benefits are gained in reduced recruitment costs as scholarship recipients will have obligated service agreements to fulfill.

Implementation Plan
In 2023 and 2024, HPSP will award a minimum of 75 new awards annually while managing and funding the continuing HPSP awards for active participants. This program will provide a pipeline of providers once medical school and the required residency training are completed.

In 2023, HPSP will expand Nurse selection to a minimum of 300 from its current rate of 50 per year. In 2024, the minimum nursing selection rate will increase to 400 annually. In addition, VA HPSP will expand offering to Marriage Counselors and Family Counselors in 2023.

Costs: HPSP costs are based on the average annual individual award amount of $67,000, which includes tuition charges, miscellaneous expenses and a monthly stipend. The average annual awards are based on historical payments to schools and students. Scholarship amounts include a 3.3% annual average increase for each out-year of the program. These percentage increases are based on average rate of growth of percentage increase published by The College Board.

A cost analysis was completed. The $39.8 million request for 2023 and the $49.7 million request for 2024 (Mission Act HPSP) would sustain the medical student portion of HPSP as required by the VA MISSION Act of 2018 and allow for the nursing selection expansion. This amount allows for 75 new awards annually as well as funding for continuing awards from previous years for medical students, the selection of an additional 300 nurses annually and supports awards for other critical specialties.

Visual Impairment Education Assistance Program (VIOMPSP)

Purpose
The purpose of VIOMPSP is to increase the supply of qualified blind rehabilitation specialists for VA and the Nation. VA competes with private sector organizations and other governmental agencies for scarce health care staff. VIOMPSP authorizes VA to provide for the payment of scholarship participant's tuition and allowable fees. Educational assistance, such as that afforded under VIOMPSP, is an excellent recruitment tool that can help VA in meeting its current and projected workforce needs for Blind Rehabilitation Specialists and Blind Rehabilitation Outpatient Specialists for which recruitment and retention is difficult. VIOMPSP will help VA meet its need for qualified health care staff by obligating scholarship recipients to complete a service obligation at a VHA health care facility after graduation and licensure or certification.

Evidence
From the inception of the VIOMPSP in 2015 through August 22, 2022, VA has awarded 30 scholarships to VIOMPSP focusing on orientation and mobility, living skills and low vision.

Implementation Plan
The VIOMPSP provides financial assistance to individuals pursuing a program of study leading to a degree or certificate in visual impairment or orientation and mobility. For VIOMPSP, each scholarship recipient receives tuition (up to $15,000) for each year of a degree program (not to exceed a total of $45,000). As of August 22, 2022, VA has awarded 30 scholarships to VIOMPSP participants since the program started in 2015.

Indian Health Service (IHS)/Tribal Health Programs (THP) / Urban Indian Organizations (ITU) Reimbursement Agreements Program

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Services (0160):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$34,770	$30,000	$36,752	$38,259	$39,789	$1,507	$1,530
Medical Support and Compliance (0152):	$0	$0	$0	$0	$0	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$34,770**	**$30,000**	**$36,752**	**$38,259**	**$39,789**	**$1,507**	**$1,530**

Under the authority of 25 U.S.C. § 1645(c) and 38 U.S.C. § 8153, the VA established a national interagency sharing/ reimbursement agreement with the Department of Health and Human Services/Indian Health Service (HHS/IHS) in 2012 to reimburse IHS for the provision of Direct Care Services to eligible American Indian (AI)/Alaska Native (AN) Veterans. The National Reimbursement Agreement paved the way for VA to enter into individual agreements with Tribal Health Programs (THPs) to reimburse THPs for Direct Care Services provided to eligible AI/AN Veterans. Additional details can be found in the Medical Community Care chapter.

Intensive Evaluation and Treatment Program (IETP) for Veterans and Service Members with Traumatic Brain Injury (TBI) and Polytrauma

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Services (0160):	$5,224	$11,776	$11,776	$11,194	$14,664	($582)	$3,470
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$29	$149	$149	$446	$640	$297	$194
Medical Facilities (0162):	$1,069	$14,045	$14,045	$0	$0	($14,045)	$0
Obligations [Grand Total]	**$6,322**	**$25,970**	**$25,970**	**$11,640**	**$15,304**	**($14,330)**	**$3,664**

Purpose

The IETP for TBI and polytrauma is a highly successful rehabilitation program initially developed at the Tampa Polytrauma Rehabilitation Center (PRC) as the Post-Deployment Rehabilitation and Evaluation Program (PREP) initiative. The expansion of this program from one to five PRC locations approved by VHA will address increasing demand for IETP services in maintaining the military readiness of Service members, treating Veterans with chronic TBI-related symptoms, fulfilling requirements for TBI-related research mandated by Congress and advancing the overall support for Veterans and Service members.

The IETP provides specialized integrated rehabilitation care for Veterans and Service members with a complex history of multiple TBIs, numerous body injuries, post-traumatic stress disorder and emotional dysregulation. This population has been historically underserved due to bias towards diagnosis-based medical care. Service members are eligible for VA care as per the "Memorandum of Agreement between VA and DoD for Medical Treatment Provided to Active

Duty Service Members with Spinal Cord Injury, TBI, Blindness, or Polytraumatic Injuries (TRICARE Operations Manual 6010.56-M).
The IETP is the only program of this kind in the country, integrating medical, rehabilitation, mental health and whole health resources to develop an intensive and comprehensive recovery plan tailored to the needs of the individuals served. Care is provided in an inpatient bed unit environment. The IETP employs teams of licensed, credentialed rehabilitation professionals including physiatry, nursing, physical therapy, occupational therapy, speech-language pathology, social work, neuropsychology, psychology and recreation therapy. The IETP has access to a broad range of specialists who participate in interdisciplinary assessment and treatment planning to address disorders of sleep, vision, pain, vestibular system, musculoskeletal problems system, cognitive difficulties and other problems, as indicated.

Evidence
The expansion of IETP as a critical step to modernize VA care and support DoD to maintain force readiness was determined by a strategic review of the PRCs by the Deloitte Consulting LLP team, with oversight from the VHA Office of Healthcare Transformation. The reviewers conducted over 35 interviews with more than 100 stakeholders across both VA and DoD to gather information, conduct analysis of data and develop a set of recommendations for the VHA Executive in Charge.

The success of Tampa's IETP delivering rehabilitation care to Special Operation Forces personnel led to a growing demand for these services and a wait list of pending admissions. Based on input from the U.S. Special Operations Command, the experience of the Tampa IETP and the TBI prevalence among Service members and Veterans, the review team determined that demand for IETP services exceeds existing capacity and recommended expanding IETP capacity at four additional PRCs by a total of 24 additional inpatient beds. Initial implementation of the IETP at the Tampa site in 2020 focused on program development and obtaining participant feedback on the clinical experience to assist in developing a core data set. Data shows that 89% of participants in the Tampa IETP rate their cognitive abilities as improved at the completion of the program and 92% of participants report similar improvements in their physical skills. In 2020, 80% of participants rated their physical, cognitive and emotional functioning as improved and ranked their overall satisfaction with services received at 9.5 on a 10-point scale. Tampa IETP is accredited by the Commission on Accreditation of Rehabilitation Facilities for brain injury specialty programming under the medical rehabilitation standards.

Funding reductions from the Defense and Veterans Brain Injury Center in 2020 have hampered the translation of IETP and PRC outcomes and research contributions into improved clinical care for Veterans and Service members with TBI. To mitigate this reduction in resources, the strategic review team recommended the addition of a Knowledge Translation (KT) specialist at each of the PRCs. These KT staff will collaborate with the Physical Medicine and Rehabilitation (PMR) Program Office to form a virtual KT Center focused on enhancing outcome data collection and analysis and translating the findings into actionable clinical enhancements. KT positions will be clinical positions focused on quality improvement efforts and standardizing TBI clinical care delivery.

Recent Trends
The IETP expansion started in 2021 with increased volume of services at the Palo Alto, Richmond, San Antonio and Tampa locations. Programs focused on meeting the demand for care by offering flexible outpatient and virtual admissions. The volume of admissions to IETP grew to 170 patients in 2021 compared to 52 patients in 2020. Participant feedback on the clinical experience at all locations showed outstanding satisfaction with services.

Future Trends

IETP expansion plans for 2022 include:

- A standardized and objective core data set has been developed with data collection to begin in 2022. The data set includes standardized tools to measure changes in physical and mental health function, societal participation, satisfaction with life and satisfaction with services.
- Increase bed capacity by eight beds overall.
- Hiring additional clinical staff to support increased bed capacity.
- Begin buildout operations at Minneapolis and San Antonio.
- Collaborate with the *Partnered Evaluation Initiative* group under VHA QUERI program to determine parameters for the evaluation the IETP model of care.

Implementation Plan
The 2023 budget request is to supplement clinical positions and augment facility renovation needed to support expanded IETP clinical programming. In 2023, 46% of the budget request is for medical services. In 2024, 100% of the budget is allocated to medical services. The proposed staffing model is based on the proven success of the Tampa IETP model. Of the 47.3 number of proposed total staff, 41.3 (87.3%) are clinical and 6 (12.7%) are administrative support. FTE necessary to meet the expansion include physicians, nurses, psychologists, neuropsychologists, physical therapists, occupational therapists, speech-language pathologists, social workers, recreation therapists and creative art and music therapists.

<u>2023</u>

- Expand IETP to a total of 34 bed capacity at Tampa, Palo Alto, San Antonio and Richmond. The 2023 budget: $11.9 million for medical services and $14.0 million for facility buildout/renovation.
- Continue facility buildout/renovation at Minneapolis and San Antonio to allow bed unit expansions at these sites.
- Finalize treatment protocols for Mental Health, Vestibular Rehab and Sleep Assessment/Treatment.
- Analyze outcome data collected and initiate performance improvement measures, as appropriate.
- Train new staff in protocol implementation and data collection via virtual and F2F events.

2024

- Complete facility buildout/renovation at Minneapolis and San Antonio to allow bed unit expansions by additional eight beds to a total of 42 beds at the 5 PRCs. 2024 budget: $12.5 million for medical services.
- Analyze outcome data of IETP to refine treatment protocols and revise clinical programming to maximize impact and duration of intervention.
- Travel and training for the development of a fidelity of practice monitoring method.

Intimate Partner Violence Assistance Program (IPVAP)

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Services (0160):	$19,417	$23,837	$23,837	$35,696	$38,906	$11,859	$3,210
Medical Community Care (0140):	$0	$0	$0			$0	$0
Medical Support and Compliance (0152):	$14	$510	$510	$1,183	$1,212	$673	$29
Medical Facilities (0162):	$0	$0	$0			$0	$0
Obligations [Grand Total]	**$19,431**	**$24,347**	**$24,347**	**$36,879**	**$40,118**	**$12,532**	**$3,239**

Authority for Action

VHA's Intimate Partner Violence Assistance Program (IPVAP) was launched in January 2014, in response to recommendations provided in the *VHA Plan for Implementation of the Domestic Violence/Intimate Partner Violence Assistance Program* (2013). Congress included an initial $17.0 million for VA's Intimate Partner Violence (IPV) Program in both P.L. 115-141, *Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2018* and P.L. 115-244, *Energy and Water, Legislative Branch and Military Construction and Veterans Affairs Appropriation Act, 2019*. VHA Directive 1198, Intimate Partner Violence Assistance Program was published in January 2019, requiring every VA medical facility to implement and maintain an Intimate Partner Violence Assistance Program to ensure that Veterans, their intimate partners and employees impacted by IPV (experiencing or using) have access to services including education, resources, assessment, intervention and/or referrals to VA or community agencies as deemed appropriate and clinically indicated. As the largest health care system in the Nation, VA is committed to developing and delivering quality programming and services to address this national health epidemic.

Intimate Partner Violence (defined as physical, verbal, emotional, psychological, stalking and sexual abuse) is a national health epidemic with far-reaching bio-psycho-social consequences. IPV impacts individuals from all racial, ethnic, religious and socioeconomic backgrounds and is a significant health concern among Veteran populations - including their partners and caregivers. It is significantly correlated with increased risks for other public health issues including suicide and homicide, homelessness and substance abuse.

VA's IPVAP has made tremendous strides toward national program implementation including the expansion of vital services for Veterans, their partners, caregivers and VA staff impacted by IPV. This expansion includes implementation of screening, assessment and various modalities of safety

planning and intervention to promote safety and healthy relationships. To date, the program achieved national IPVAP coverage, with an identified IPVAP Coordinator covering all VA medical facilities. IPVAP funding is distributed from the National IPVAP to VA medical facilities in support of IPVAP staffing and program implementation.

Purpose
The purpose of this funding is to support the continuation of the Intimate Partner Violence Assistance Program (IPVAP) across the enterprise to provide vital services for Veterans, their partners and VA staff impacted by intimate partner violence per *VHA Directive 1198, Intimate Partner Violence Assistance Program*. This policy requires that every facility designate and support an IPVAP Coordinator to oversee the implementation and operations of a comprehensive array of programs and services to mitigate risk of intimate partner violence (IPV), known to be highly associated with suicide, homicide, homelessness, substance use and other forms of sexual trauma including human trafficking.

In addition, continued funding is requested to support the completion of a congressionally mandated 2-year pilot program led by the IPVAP in support of P.L. 116-315, the Johnny Isakson and David P. Roe, M.D. Veterans Healthcare and Benefits Improvement Act of 2020. The 2-year pilot was launched on October 1, 2021, and will conclude on September 30, 2023, in accordance with the legislative requirement. The program will have 180 additional days following the close of the pilot phase to draft and submit the findings and recommendations in a Congressionally Mandated Report (CMR) due by March 30, 2025.

This funding will:

1) Support existing approved IPVAP Coordinator positions at each VA Medical Facility allowing for attrition and turnover of existing staff and to support step increases and potential cost of living adjustments for the salaries of existing staff.

2) Allow for program growth by requesting increase of FTEE at large facilities who demonstrate need by an estimated 10 FTEE for 2024 and by 15 additional FTEE in 2025 to allow for the expansion of IPVAP clinical and supportive programming.

3) Continue to support existing national program office staff and operations.

4). Support existing approved field-based staff at the 10 pilot sites as well as the program manager through the duration of the pilot project.

Evidence
As many as one in three women and one in four men experience significant intimate partner violence, including sexual violence, in their lifetimes. Some studies[303132] indicate that Veterans and their families may have unique risks that may increase this prevalence and is associated with greater risk of suicide, homicide, homelessness, substance use and physical and mental injuries. Recognizing the need to address relationship health and safety and related issues for Veterans to support overall health and well-being, VHA launched the IPVAP in January 2014, with broadscale implementation beginning in 2018 when funding was approved. It was originally funded at $17 million as part of P.L. 115-141, *Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2018* and P.L.115-244, *Energy and Water, Legislative Branch and Military Construction and Veterans Affairs Appropriation Act, 2019.*

Implementation Plan
The IPVAP has been implemented nationally and continues to strengthen and expand services in response to need.

The national office increased staff in 2022 and plans to maintain IPVAP and Megabus pilot program based on current staffing. The national office will continue support of facility-based IPVAP operation and growth by funding a minimum of 1.0 FTEE IPVAP Coordinator at every VA medical center while planning for program expansion to meet increased needs of with an expectation to add 10 new positions in 2024.

In addition, the national office will continue to support the Megabus 5304 national program manager. This position will extend through the term of the appointment to assist in the completion of the pilot project including the drafting of the CMR and subsequent actions. The term is expected to end at the end of the 2025 cycle.

National Center for Posttraumatic Stress Disorder (NCPTSD)

		2023		**2024**	**2025**		
Description (dollars in thousands)	2022 Actual	Budget Estimate	Current Estimate	**Revised Request**	**Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Services (0160):	$29,764	$13,001	$15,001	$15,001	$15,001	$0	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$9,564	$26,999	$26,999	$26,999	$26,999	$0	$0
Medical Facilities (0162):	$158	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$39,486**	**$40,000**	**$42,000**	**$42,000**	**$42,000**	**$0**	**$0**

[30] National Center for Injury Prevention and Control, Division of Violence Prevention (https://www.cdc.gov/injury/)
[31] The National Center on Family Homelessness. (2013). Preventing Violence in Veteran and Military Families: A Guide to Understanding a Promising Community-Based Intervention. Needham, MA: The National Center on Family Homelessness.
[32] Marshall AD, Panuzio J, Taft CT. Intimate partner violence among military Veterans and active duty servicemen. Clin Psychol Rev. 2005 Nov;25(7):862-76. doi: 10.1016/j.cpr.2005.05.009. PMID: 16006025.

Authority for Action
NCPTSD, a multisite Center of Excellence in the OMHSP, was created in 1989 in response to a Congressional mandate (P.L. 98-528, 98 Stat. 2686, 1984) to address the needs of Veterans with PTSD. In 2014, National Center for PTSD (NCPTSD) received funding that had two goals: to establish a PTSD brain bank to facilitate PTSD research and to enhance access for rural Veterans by providing PTSD treatment consultation to community providers.

Population Covered
The NCPTSD mission is to advance the clinical care and social welfare of America's Veterans through research, education and training, but without direct responsibility for patient care. NCPTSD also was mandated to serve as a resource center for information about PTSD research and education for VA and other Federal and non-Federal organizations. NCPTSD currently consists of six divisions located at VA facilities, with headquarters in White River Junction, VT. Other division locations include Boston, Massachusetts, West Haven, Connecticut, Palo Alto, California and Honolulu, Hawaii. NCPTSD is an integral component of the OMHSP.

Type of Services Provided
NCPTSD aims to translate basic research findings into clinically relevant techniques and to study how best to implement evidence-based practices into care. Each of NCPTSD's divisions has an area of specialization towards this aim, with the PTSD Consultation and Mentoring programs providing pathways for dissemination. Besides its own staff, NCPTSD has built strong collaborative relationships with institutions and agencies from VA, other branches of government, the health care community and academia. NCPTSD brings current research and clinical knowledge from the field to Veterans, their families, the public, clinicians, military leaders and others via an award-winning website (https://www.ptsd.va.gov), publications, online resources, as well as nationwide trainings.

Recent Trends

Research Support:

- From 2018-22, the Center had an average of 142 competitively awarded research grants and produced an average of 319 peer-reviewed publications per year. In 2022, NCPTSD investigators led 131 funded studies (totaling $230.8 million), 16 studies were pending as of November 2022 and investigators had 571 publications.
- Established VA's National Posttraumatic Stress Disorder Brain Bank (PTSD Brain Bank) in 2014 as the first and only brain bank devoted exclusively to PTSD. The PTSD Brain Bank is a consortium of five VA Medical Centers and the Uniformed Services University of Health Sciences. The PTSD Brain Bank studies postmortem brain tissue to characterize gene expression associated with stress, PTSD and suicide, which may lead to biological markers that could be used to diagnose and monitor treatment response. At the end of 2022, the Brain Bank had acquired 333 frozen hemispheres (roughly divided in thirds from donors with PTSD, donors with major depression and controls without depression or PTSD) and 333 fixed hemispheres, 207 individuals have enrolled in our antemortem donor program. To date, 18 peer-reviewed publications have been published using brain bank data. We continue to collaborate scientifically with the Lieber Institute for Brain Development and other academic partners.

- Continued co-leading the Consortium to Alleviate PTSD (CAP), a multi-year $42 million award funded by the VA and Defense, at the University of Texas and NCPTSD. The CAP focuses on novel clinical trials and identification of biomarkers for PTSD. As of 2022, all 11 CAP projects are completed, four of these have published their findings and the remainder are finishing data analyses.
- Participated in the Million Veteran Program. Published the first evidence of genetic vulnerability to one of the hallmark symptoms of PTSD — re-experiencing traumatic events. Other biomarker studies are examining biological predictors of response to medication and device-based treatments for PTSD.
- Conducted multiple studies of treatment efficacy, efficiency and engagement of established and novel treatments for PTSD. Research has led to VA national rollouts of evidence-based psychotherapies. Recently completed data collection for a study that will be helpful for determining which psychotherapy is optimal for which patients and launched another large study that will identify optimal medications for sleep problems in Veterans with PTSD.
- Developed and validated the field's most frequently used questionnaires and structured diagnostic interviews to assess PTSD according to the revised diagnostic criteria in the 5th edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. Continued research on effective screening for military sexual trauma and intimate partner violence.
- Participated in large-scale studies of the implementation of evidence-based treatments for PTSD. Investigated barriers to implementation in outpatient and residential PTSD treatment programs. Continued a large multi-site study aimed at increasing the use of Prolonged Exposure for PTSD, one of the most effective treatments for PTSD within the military health system. Continued two multi-site trials testing modeling tools that enable clinic teams to run simulations of their workflow and decide how to best allocate their staff so more Veterans receive evidence-based treatment.
- Continued data collection, analysis and publication on several longitudinal studies that assess the course of PTSD over time in cohorts of Veterans, furthering understanding of the prevalence, severity and genetics of PTSD in Veterans, including:
    - Continued data analyses for the Project VALOR (Veterans After-Discharge Longitudinal Registry), collecting data on a large cohort of combat exposed OEF/OIF/OND men and women Veterans to examine trajectories of PTSD symptomatology and diagnosis, the nature and extent of MST, including the contribution of MST to PTSD symptoms and diagnosis and associations of PTSD, mTBI, major depressive disorder (MDD) and treatment utilization in relation to changes in suicidal behaviors. Recently collected DNA samples from the sample that will be analyzed to examine genome-wide associations.
    - Continued data collection for LIGHT, the Longitudinal Investigation of Gender, Health and Trauma study, which focuses on the impact of community violence on Veteran mental, physical and reproductive health. Questions related to COVID-19 exposure were collected 2020-23 to understand the impact of COVID-19 on male and female V
    - Veterans from different ethnic and racial groups.

- Continued data collection for the National Health and Resilience in Veterans Study (NHRVS), which explores the prevalence and correlates of successful aging and psychological resilience in a large, contemporary and nationally representative Veteran sample. NHRVS data collection waves since late 2020 have included measures of COVID-19 exposure and mental health responses.
- Data analysis and publication continues on Neuropsychological and Mental Outcomes of Operation Iraqi Freedom: A Longitudinal Cohort Study, designed to examine the impact of Iraq combat-zone deployment on neuropsychological outcomes, including neurobehavioral and emotional functioning

- Expanded portfolio focused on PTSD and suicide. Identified biomarker of PTSD-related suicidal ideation. Awarded funding for a study of predictors of suicidal ideation among Veterans during the post-deployment transition period. Launched a study of whether PTSD treatment during inpatient hospitalization reduces risk of suicide for Service members and Veterans with significant PTSD symptoms. Awarded funding to use the Military Suicide Research Consortium Common Data Elements to examine transdiagnostic phenotypes associated with self-injurious thoughts and behaviors (SITBIs) among military personnel. Recently awarded funding to evaluate the efficacy of a novel treatment to reduce the incidence and severity of SITBs in psychiatrically hospitalized active-duty military Service members and adult military beneficiaries. NCPTSD researchers have recently partnered with the ARMY STARRS team to examine predictors of SITBIs among Service members transitioning to civilian life.
- Continued to expand the PTSD Trials Standardized Data Repository (PTSD-Repository), a database that brings together data from nearly 400 published studies on a wide range of treatments and is updated annually to capture new research. In 2021, the Repository was updated to include studies focused on PTSD and comorbid substance use, a reference guide for users was added and a data story centered around risk of bias in PTSD research was launched. In 2022 the site began including standardized effect sizes and added a data story on medications. Publicly available and free to use, the PTSD-Repository helps researchers, clinicians, Veterans and family members better understand the treatment literature.

Provider Support:

- Responded to over 2,100 requests in the PTSD Consultation Program in 2021, about 22% of which were from non-VA providers who were treating Veterans. The program offers a monthly continuing education webinar on the topics that providers often ask about in consultation. Recorded webinars are available as online courses with free continuing education credits. With a continued focus on supporting providers in rural areas, the program trained over 100 non-VA providers in military culture and the assessment of PTSD and suicide risk. Plans are underway to train over 200 non-VA providers in 2022 and to continue these trainings in 2023.
- Promoted best practices for PTSD Specialty Care within VHA through the PTSD Mentoring Program. Initiated in 2008, the program provides administrative guidance to ensure best management and clinical practices. The PTSD Mentoring Program continued toward the goal of improving VA PTSD specialty care with an enhanced focus on helping PTSD specialty programs align with OMHSP-supported principles of care. Program activities in 2022 focused on continuation and expansion of implementation support provided to the PTSD specialty programs with focus on continuing to improve EBP "Reach" and measurement-based care

(MBC). At the conclusion of 2022, 31 sites demonstrated increases in EBP reach (≥ 5%) and 22 sites demonstrated improvements in MBC implementation (≥ 10%). Of the 116 facilities with PCTs, 67 were high EBP reach, with only 15 sites at low EBP reach for the full year.

- Developed an advanced training simulation that uses artificial intelligence, real-time and summary feedback and responsive virtual human technology (RVHT) to allow learners to practice the administration and scoring of the Clinician Administered PTSD Scale for DSM-5 (CAPS-5). The course was launched in TMS and TRAIN in March 2020 and in 2021 and 2022 additional virtual patients were added to enhance and extend the training.
- Utilized the Tech into Care (TIC) initiative, which evolved out of the Practice-Based Implementation (PBI) Network, to facilitate implementation of mental health technology into care across VA. Monthly continuing education lectures continue to be offered, uniting clinicians, researchers and other staff from inside and outside of VA to leverage technology and improve uptake of innovative best practices and evidence-based interventions for Veterans. TIC released three new online courses and an informational podcast and continued to create a wide variety of materials, including app demo videos, handouts and promotional items, to increase the ease with which professionals can integrate mobile apps into Veterans' care. As measured by a congressionally funded quality improvement project, the 1,110 VA staff trained through this initiative reached more than 50,000 Veterans across the care continuum in 2020-21. To capitalize on interest in the project from new sites, the team is piloting Tech into Care+, an online, self-guided implementation tool to help VA health care systems integrate mental health apps into care with minimal support from implementation facilitators.
- Continued its Office of Rural Health-supported implementation facilitation at six VA medical centers across the country. By looking at contextual factors present in each site, Implementation facilitation helps sites expand the use of PTSD care that aligns with the VA/DoD Clinical Practice Guideline. One of the sites, originally a low adopter of evidence-based treatment (EBT), emerged as a national leader in EBT reach by the end of 2021.
- Utilized the Practice-Based Implementation (PBI) Network, a robust program that unites clinicians, researchers and other practitioners from inside and outside of VA to leverage technology and improve uptake of innovative best practices and evidence-based interventions for Veterans. Under the auspices of its Tech into Care initiative, the PBI Network offered monthly CE lectures, created an online course and released app demo videos to continue to integrate mobile apps into Veterans' care. As measured by a congressionally funded program evaluation project, the 1,110 VA staff trained through this initiative reached more than 17,000 Veterans across the care continuum in 2020.
- Continued to supported VA's efforts to implement measurement-based care (MBC). Collaborated with OMHSP to provide subject matter expertise to the field while implementing the new requirement for MBC within all PTSD specialty programs. Efforts also included developing the data reporting mechanism and distribution of program MBC data throughout implementation efforts in 2021. Worked closely with OMHSP to develop initial thresholds, based on 2021 data, to identify both high and low implementing sites for MBC. Efforts in 2022 will include providing direct consultation and support to low implementing sites and continuing to offer data feedback quarterly to the field.

- Continued to develop and disseminate online trainings that offer free continuing education credits to VA and community providers. This year, a new model of course development was introduced in which presentations from the live PTSD Consultation Program Lecture Series are rapidly made available as enduring continuing education courses. In addition, the final course in the Clinician-Administered PTSD Scale for *DSM-5* training curriculum was released. It uses state-of-the-art responsive virtual patient technology to teach the administration of the gold-standard PTSD assessment measure.
- In 2021, finalized redesign of the Community Provider Toolkit. The revamped site was developed using a human-centered design approach that integrates the perspectives of key stakeholder groups. A new podcast series for providers, "Caring for Those Who Have Served," was completed and launched in the fall of 2021/winter 2022. Episodes are currently on most streaming platforms (for example, Spotify, iHeart). The podcast content aligns with that of the Community Provider Toolkit.

Support of Veterans, family members and the general public*:*

- Continued to lead VA efforts each June for PTSD Awareness Month, including the establishment in 2021 of the Step Up for PTSD Awareness Virtual Walk. More than 30,000 people across the country participated and in the first year and more than 50,000 are registered for 2022. Also in 2022, the Center launched PTSD Screening Day (June 27) to encourage Veterans and other people who have experienced trauma to get screened and talk with their providers about treatment if they need it. In 2022, there were over 6.3 billion estimated PTSD Awareness Month interactions.
- Released 19 mobile apps, including self-help apps like COVID Coach and apps to support evidence-based treatments for PTSD, including Cognitive Processing Therapy, Prolonged Exposure Therapy and Cognitive Behavioral Therapy for Insomnia. These products have been downloaded over five million times across the U.S. In collaboration with the Office of Connected Care and the Veterans Crisis Line, the apps team built a safety planning module to be incorporated into NCPTSD's mobile apps. Beyond MST, designed to help survivors of military sexual trauma manage distress and improve quality of life, was completed in 2020. Developing tools for assessing how users engage with app components to make ongoing refinements and improve users' experience.
- Developed and updated the first online PTSD Treatment Decision Aid to correspond to the 2017 VA/DoD Clinical Practice Guideline for PTSD. This interactive tool assists patients in learning about treatments for PTSD and can play a key role in shared decision-making.
- Produced AboutFace, a public awareness campaign to motivate Veterans to seek treatment. Includes videos of Veterans, family members and expert clinicians. In 2021 we launched a new feature on MST and began development of one on PTSD and race. Also, this year, AboutFace began an ambitious redesign effort to provide a guided experience for the Veterans, family members and providers who access it.
- Created new educational products for family members including infographics, animated whiteboard videos and traditional brochures. Spanish translations of many of these materials increase their reach. Recent highlights include an interactive version of the Primary Care PTSD Screen and "explainer" videos for Written Exposure Therapy and Cognitive-Behavioral Conjoint Therapy.

- Developed online self-help programs such as PTSD Coach Online to help Veterans cope with symptoms like anger, sadness, anxiety and trouble sleeping, webSTAIR to help with problems with mood and relationships and VetChange to help Veterans cut down on their drinking and manage their PTSD symptoms.

Projections for the Future

- Continue to investigate the neurobiology of PTSD to better address its identification, prevention and treatment. An example of this work includes expanding the VA's National PTSD Brain Bank through strategic partnerships with groups that include potential donors, such as Veteran registries, Servicemember registries and medical examiners' offices.
- Continue to develop and test novel treatments for PTSD. Examples of this work include the continued development of psychotherapeutic interventions associated with increased patient engagement, studies of psychological and pharmacological enhancers of psychotherapy effectiveness and ongoing collaboration with VA's Office of Research and Development to develop more effective medications for PTSD.
    - Continue to expand our research portfolio to better understand the neurobiology, epidemiology, prevention and treatment of suicide risk in individuals with PTSD.
    - Continue to study the implementation of evidence-based treatments for PTSD. Continue to increase awareness, recognition and understanding of PTSD and decrease barriers to seeking help.
    - Continue to promote the dissemination of evidence-based care for Veterans and other trauma survivors through the PTSD Consultation and Mentoring Programs, in-person trainings and educational products.
    - Expand reach by more effectively targeting Veterans with PTSD who need care during the post-deployment transition period and Veterans who are not engaged in care at VA.
    - Continued a Center-wide Diversity, Equity and Inclusion workgroups to explore how we may expand our work studying the intersection of race and trauma, racial disparities in access to care and differential outcomes in PTSD treatment.

National Veterans Sports Program

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Direct Programs (Medical Services):							
VA National Rehabilitation Adaptive Sports and Therapeutic Arts Events	$6,334	$2,750	$2,750	$3,000	$3,000	$250	$0
Veteran Monthly Assistance Allowance for Disabled Veterans Training Paralympic & Olympic Sports Program	$0	$2,000	$2,000	$2,000	$2,000	$0	$0
Grants for Adaptive Sports Programs for Disabled Veterans & Disabled Members of the Armed Forces Program	$16,502	$14,500	$14,500	$14,500	$14,500	$0	$0
Equine Therapy Grants for Adaptive Sports Programs	$0	$1,500	$1,500	$1,500	$1,500	$0	$0
Program Administration (Medical Support & Compliance)	$5,658	$6,479	$6,479	$9,414	$9,542	$2,935	$128
Grand Total	**$28,494**	**$27,229**	**$27,229**	**$30,414**	**$30,542**	**$3,185**	**$128**

Authority for Action

- 38 U.S.C. § 322 establishes the Office of National Veterans Sports Programs and Special Events
  - 38 U.S.C. § 322(d) authorizes a monthly assistance allowance for Veterans with a disability training or competing in Paralympic or Olympic sports
  - Regulation for the monthly assistance allowance 38 CFR Part 76

- 38 U.S.C. § 521A authorizes the adaptive sports programs for disabled Veterans and members of the Armed Forces
  - Regulation for the Adaptive Sports Grant Program is listed in 38 CFR Part 77

Populations Covered

Primarily includes Veterans with spinal cord injuries, amputations, traumatic brain injuries, visual impairments, multiple sclerosis, stroke, post-traumatic stress disorder, other neurological and mental health conditions. In addition, VA staff is offered training in adaptive sports and therapeutic arts through hands-on experience and in-person training and online modules for continuing education credits.

Type of Services Provided

Veteran Monthly Assistance Allowance for Disabled Veterans Training in Paralympic and Olympic Sports Program

This provides a monthly stipend to emerging and elite Veteran athletes with disabilities who are actively training in a Paralympic or Olympic sport. Eligibility includes meeting the standard established by the sport governing body or being selected as a member of the National or Olympic Team in a qualifying sport.

Grants for Adaptive Sports Programs for Disabled Veterans and Disabled Members of the Armed Forces Program

Grants are awarded to qualifying organizations to plan, develop, manage and implement adaptive sports programs, provider training and other opportunities for 13,000+ Veterans and members of the Armed Forces. With the use of these grants, VA is helping community organizations encourage a healthy and active lifestyle through sports and equine therapy. Activities include Paralympic sports, equine activities and many modern options of adaptive sports.

VA Adaptive Sports and Therapeutic Arts Rehabilitation Events

VA provides opportunities for thousands of Veterans to improve their independence, self-confidence and quality of life through adaptive sports and therapeutic arts programs in accordance with 38 U.S.C. § 322 and 521A. The programs complement VA's rehabilitation system of care and encourage Veterans with disabilities to stretch beyond perceived limitations. In service of this mission, VA directs seven national rehabilitation events delivering direct patient care to Veterans eligible for VA health care. VA also provides the largest coordinated therapeutic arts program for Veterans.

Essential support from Veteran Service Organizations, corporate sponsors, individual donors and community partners helps build the foundation for the seven events which allows VA to extend its care beyond the clinical setting.

Held in cities across the Nation, the events train hundreds of VA rehabilitation providers across more than 100 VA medical centers annually.

- ***National Veterans Wheelchair Games***
  With 20+ competitions and Paralympic sports, the National Veterans Wheelchair Games inspires and empowers Veterans around the globe to persevere through daily challenges. VA and Paralyzed Veterans of America present the annual event which serves Veterans with spinal cord injuries, multiple sclerosis, limb loss, stroke and other neurological disorders. It is the largest annual wheelchair sports rehabilitation event in the United States for Veterans with disabilities and was founded in 1981.

- ***National Veterans Golden Age Games***
  The National Veterans Golden Age Games offers Veterans ages 55 and older a chance to compete in sports and learn new skills through exhibitions. Through its "Fitness for Life" motto, it demonstrates the value that sports, wellness and fitness provide to encourage senior Veterans to stay active. The National Veterans Golden Age Games is held annually and is a qualifying event for the National Senior Games.

- ***National Disabled Veterans Winter Sports Clinic***
  Since 1987, the National Disabled Veterans Winter Sports Clinic has helped Veterans with disabilities overcome obstacles and challenge perceived limitations. Headlined with adaptive skiing and snowboarding, the clinic serves Veterans with traumatic brain injuries, spinal cord injuries, limb loss, visual impairments and neurological conditions. VA and DAV (Disabled American Veterans) present the clinic yearly.

- ***National Veterans Creative Arts Festival***
  The National Veterans Creative Arts Festival is a culmination of creative arts competitions held at VA facilities across the country. The festival showcases Veteran artistry and the therapeutic benefits of art, music, dance, drama and creative writing. VA and the American Legion Auxiliary present the yearly festival which features a stage performance, writing exhibition and gallery-style showcase of artwork.

- ***National Disabled Veterans Golf Clinic***
  The National Disabled Veterans Golf Clinic provides access to a rehabilitative golf program and a range of adaptive recreational opportunities for Veterans with visual impairments, spinal cord injuries, traumatic brain injuries, limb-loss and other disabilities. The clinic helps Veterans strengthen confidence and enjoy the freedom of being on the course. It is presented annually by VA and DAV (Disabled American Veterans).

- ***National Veterans Summer Sports Clinic***
  Founded in 2008, the National Veterans Summer Sports Clinic introduces newly injured Veterans to adaptive summer sports such as surfing, sailing, kayaking, cycling and adaptive fitness. With its hands-on instruction, the clinic complements therapy Veterans receive at VA rehabilitation programs, offering an opportunity to discover new ways to gain motivation, improve independence and achieve a healthier lifestyle. It is held annually in San Diego.

- ***Sports4Vets Throwdown***
  A new program created during the height of the COVID-19 pandemic, Sports4Vets Throwdown keeps Veterans active mentally and physically. The Sports4Vets Throwdown is a three week-long virtual adaptive fitness event empowering Veterans of all ability levels and ages to live healthier lives though fitness. Through this event, Veterans embrace a virtual community support system and receive expert instruction from top fitness instructors. These adaptive fitness movements help Veterans work on maintenance or regain functional capacity.

Recent Trends

During the pandemic, the national rehab events pivoted to at home or hybrid versions as did many of the VA adaptive sports grant recipients. For 2021 and 2022 events, Veteran participation also increased by providing both an in-person and at-home/virtual option to participate. While Veteran participation decreased in 2022 compared to 2021 for the virtual components of the in-person national rehabilitation events, Veteran registration doubled for the completely virtual Sports4Vets Throwdown. To reach more Veterans, VA enhanced services by utilizing multiple delivery models. Small group instruction and large-scale competitions were achieved through both true at home and programing in collaboration with support from VA medical center rehabilitation providers nationally. VA's modernization efforts and ability to leverage technology continues to show success in new methods of care delivery for VA adaptive sports and therapeutic arts.

All seven national rehabilitation events continue to note an increase in women Veterans. Women Veterans comprised over 20% of the participants at the national rehabilitation events in 2021 and 2022. Increased outreach and marketing efforts to reflect the diverse population has been effective. Outreach efforts to women Veterans included focus groups, forums and other engagements tailored to gain feedback on program improvement and then implementing recommendations into the Veteran experience that is offered. Outreach efforts also included round tables and one-to-one meetings with Veteran Service Organizations to elevate awareness of the programs and garner feedback from women Veterans.

Interest in non-traditional sports continues to grow and the National Veterans Sports Programs and Special Events has added adaptive fitness (CrossFit) to 50% of its portfolio. These growth areas are well suited for national efforts that leverage virtual platforms and regional VA support along with collaborations with industry partners.

The adaptive sports grant program awarded nearly $16 million through a total of 108 grants to community based adaptive sports providers in 2022. These record totals reflect a year after year trend which has allowed more Veterans to participate in adaptive sports activities. In addition, adaptive sports grantees have offered programming to Veterans in all 50 states, the District of Columbia and Puerto Rico.

Projections for the Future
Over the next few years, the trends outlined above will continue. NVSPSE expects continued increases in participation in non-traditional sports in complement to the traditional sports at the national rehabilitation events. The non-traditional sports reach to underserved populations of Veterans including those with the most complex physical disabilities and those who may not previously sought VA for health care needs. The demand specifically for therapeutic arts programming will continue its consistent participatory growth in the National Veterans Creative Arts Competition and National Veterans Creative Arts Festival. Increased funding to accommodate the need for additional services and opportunities provided through the seven national rehabilitation events for Veterans with disabilities is necessary to maintain modest growth trajectory.

Program Budget Justification:

Purpose
The NVSPSE's mission is to incorporate adaptive sports and creative arts in the lifelong rehabilitation plan of Veterans with disabilities. This service leads the Nation in formalized adaptive sports medicine as a practice specialty and coordinates the growing therapeutic arts programs for Veterans. These programs encourage Veterans to lead and improve their independence, quality of life and well-being.

Evidence
The NVSPSE program serves thousands of Veterans and trains hundreds of VA rehabilitation providers across more than 135 VA medical centers annually. Veterans' satisfaction with remote options has sustained with growth in the past year by 50% the completely virtual rehabilitation event. VA's modernization efforts and ability to leverage technology have shown success in this new method of care delivery and outcomes for VA adaptive sports and therapeutic arts.

Implementation Plan
The NVSPSE will be furthering outreach opportunities to meet the challenge by Veterans to provide them with virtual opportunities to engage in familiar and new avocations and lifestyle changes. In person events have resumed in redesigned models due to the global pandemic to keep all participants safe. NVSPSE shall provide further opportunities for Veterans' experiential learning and life enhancement.

Non-Recurring Maintenance (NRM)

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations - All Other	$1,228,408	$2,443,698	$2,339,646	$5,750,000	$995,000	$3,410,354	($4,755,000)
Discretionary P.L. 115-141 sec. 255	$84,739	$0	$30,667	$0	$0	($30,667)	$0
Discretionary P.L. 115-244 sec. 248	$196,925	$61,302	$139,162	$0	$0	($139,162)	$0
Discretionary RETF Obligations 1/	$0	$0	$75,000	$0	$0	($75,000)	$0
Discretionary Obligations [Subtotal]	**$1,510,072**	**$2,505,000**	**$2,584,475**	**$5,750,000**	**$995,000**	**$3,165,525**	**($4,755,000)**
Veterans Medical Care and Health Fund	$1,353,001	$0	$432,525	$0	$0	($432,525)	$0
VACAA, sec. 801	($129)	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,352,872**	**$0**	**$432,525**	**$0**	**$0**	**($432,525)**	**$0**
Obligations [Total]	**$2,862,944**	**$2,505,000**	**$3,017,000**	**$5,750,000**	**$995,000**	**$2,733,000**	**($4,755,000)**
Non-Add (Included Above)							
Discretionary Obligations - Base NRM	$1,510,072	$2,000,000	$2,079,475	$5,000,000	$700,000	$2,920,525	($4,300,000)
Mandatory Obligations - Base NRM	$597,650	$0	$0	$0	$0	$0	$0
Discretionary Obligations - EHRM NRM	$0	$505,000	$505,000	$750,000	$295,000	$245,000	($455,000)
Mandatory Obligations - EHRM NRM	$755,222	$0	$432,525	$0	$0	($432,525)	$0
Base NRM/EHRM NRM Obligations [Subtotal]	**$2,862,944**	**$2,505,000**	**$3,017,000**	**$5,750,000**	**$995,000**	**$2,733,000**	**($4,755,000)**

Note: The 2020 NRM actual in the above table includes additional object classes than what is displayed in the Budget Overview chapter's Obligations by Object table, such as Personnel Compensation and benefits, Other Contractual Services, Supplies and Materials and Equipment.

Non-Recurring Maintenance (NRM) funds projects to make additions, alterations and modifications to land, buildings, other structures, nonstructural improvements of land and fixed equipment. NRM can also occur when the equipment is acquired under contract and becomes permanently attached to or part of the building or structure. NRM is utilized to maintain and modernize existing campus facilities, buildings and building systems, replace existing building system components and provide for adequate future functional building system capacity. NRM can also be used for environmental remediation and abatement and building demolition. This is accomplished without constructing any new building square footage for functional program space.

Please see the Medical Facilities chapter in Volume II and various chapters in Volume IV for additional information.

Precision Oncology

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Services (0160):	$85,708	$145,109	$145,109	$195,747	$202,447	$50,638	$6,700
Medical Support and Compliance (0152):	$6,768	$13,519	$13,519	$19,087	$20,087	$5,568	$1,000
Medical Facilities (0162):	$0	$8,599	$8,599	$599	$599	($8,000)	$0
Pharmacogenomics (Non-add; included in above)		$15,610	$15,610	$35,616	$35,616	$20,006	$0
Obligations [Total]	**$92,476**	**$167,227**	**$167,227**	**$215,433**	**$223,133**	**$48,206**	**$7,700**

Precision Oncology and Cancer Research

(dollars in thousands)

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**
Appropriation				
Medical Care - Precision Oncology Only	$92,476	$167,227	$167,227	$215,433
NRM - Precision Oncology Only (non-add, included above)		*$8,000*	*$8,000*	*$0*
Medical and Prosthetic Research - All Cancers		$81,295	$81,295	$93,822
Medical and Prosthetic Research - Precision Oncology Only (non-add, included above)		*$22,550*	*$22,550*	*$33,251*
Obligations [Total] 1/	**$92,476**	**$248,522**	**$248,522**	**$309,255**

1/Excludes OI&T

Purpose

As the largest integrated provider of cancer care in the United States, VA is committed to providing access to the best possible cancer care. The vision of the Precision Oncology Initiative is that Veterans will have access to care as close to their homes as possible that is comparable to that available at the Nation's leading cancer centers. VA's implementation is based on three clinical pillars: oncology clinical pathways that define preferred practice, molecular diagnostic services that facilitate access to testing and the requisite expertise to use the results and TeleOncology that delivers clinic care led by expert oncologists affiliated with National Cancer Institute-designated Cancer Centers to underserved areas. The ongoing rapid evolution of oncology clinical practice driven by continuing scientific and medical advances necessitates the close integration of research structures and clinical services to form an oncology learning health care system, the dual goals are to facilitate agile implementation of new clinical practices in response to new scientific discoveries and to develop new knowledge from clinical practice. Clinical trials are often part of standard clinical care for patients with cancer and are a second area of clinical-research integration in Precision Oncology. Together, these elements form a System of Excellence for the full spectrum of care for a particular cancer type. Systems of Excellence are established for Prostate/Genitourinary Cancers and Lung. In 2023, VA addressed molecular diagnostics (tumor testing, germline testing and required enhancement of genetic counseling and pharmacogenomics), to include the creation of the Cancer Genetics Service and the establishment of the Breast and

Gynecologic Cancers System of Excellence, began development of the Rare Cancers System of Excellence and enhanced and modernized Radiation Oncology services. In 2024, VA will expand on the Rare Cancers System of Excellence, add additional molecular testing capabilities, enhance the pathology and laboratory infrastructure, partner with the Department of Defense and others to improve cancer care and cancer navigation through the White House Cancer Moonshot.

In 2010, there were approximately 50,000 new cancer cases reported in VA, a 16.9% increase from 2007.[33] Of those cases, 97% were men and 3% were women.[37] The three most frequently occurring cancers within VA were prostate (29%), lung/bronchus (18%) and colon/rectum (8%), with lung cancer being the deadliest [37] The top three most frequently occurring cancers in the VA are the same as those observed among U.S. men.[37] Women Veterans differed slightly with breast cancer being the most frequently occurring at 30%, while the second and third were the same, lung/bronchus (15%) and colon/rectum (7%).[37]

VA continues to expand molecular diagnostics in Precision Oncology through the National Precision Oncology Program (NPOP), addressing all three of its strategic goals. In addition to providing cutting-edge clinical tumor DNA sequencing, the program also provides germline testing for patients with cancer to guide treatment decisions and address the in-depth knowledge gained regarding patient risks of developing cancer. NPOP, targeting the most frequently diagnosed and deadly cancers within the VA, provides access to standardized tumor testing for both metastatic lung and prostate cancers for nearly every VA oncology practice site. The program also provides an expert consultation service to assist with interpretation of complex test results and a system-wide Molecular Oncology Tumor Board. Germline testing for metastatic prostate cancer is currently available at all sites but we continue to improve timeliness and utilization of the service. In 2023, NPOP expanded to include testing for a broader range of cancer types, including rare cancers. Systematic implementation of molecular testing via clinical pathways within the electronic health record system is planned to ensure broad adoption. To enable a true learning health care system, gathering data from VA's precision oncology efforts and the use of this data for clinical decision support is a part of NPOP's 2023 efforts and will improve in 2024. To optimize resources, leverage common technologies and enhance cancer research and discovery, VA will continue to collaborate with other agencies such as the Department of Defense (DoD) and the National Cancer Institute under an existing collaboration named APOLLO (Applied Proteogenomics Organizational Learning and Outcomes) with a planned expansion of VA sites that can submit biospecimens to APOLLO biorepositories in 2023 and 2024. VA is partnering with cabinet level agencies on the Cancer Moonshot 2.0. Through the moonshot we will address disparities in cancer care, increase access to clinical trials, improve lung cancer screening and create greater awareness and access to cancer screening.

VA is expanding the use of TeleOncology, which facilitates cutting-edge cancer care to Veterans anywhere, reducing geographic disparities. The United States and by default the VA, are facing a

[33] Leah L. Zullig, PhD, MPH, Kellie J. Sims, PhD, MS, Rebecca McNeil, PhD, Christina D. Williams, PhD, George L. Jackson, PhD, MHA, Dawn Provenzale, MD, MHS, Michael J. Kelley, MD, Cancer Incidence Among Patients of the U.S. Veterans Affairs Health Care System: 2010 Update, *Military Medicine*, Volume 182, Issue 7, July-August 2017, Pages e1883–e1891, https://doi.org/10.7205/MILMED-D-16-00371

shortage in oncologists, geneticists and genetic counselors.[34] The American Society of Clinical Oncology (ASCO) anticipates a shortage of approximately 2,250 oncologists by 2025. Attracting top oncologists and research talent remains a priority for VA. Again, VA is uniquely positioned to achieve this goal through its ability to offer incentives such as: partnerships with National Cancer Institute (NCI) designated cancer centers, partnerships with academic affiliates, research opportunities and working within the largest Telehealth program in the country. Oncologists working with the TeleOncology service participate in research and innovation through these partnerships, bringing state of the art care opportunities within the VA Veterans. The TeleOncology service provides expertise across the spectrum of oncology care in addition to those areas already covered by Precision Oncology such as use of immunotherapy, chemotherapy, genetic counseling, virtual tumor boards, decentralized clinical trials, survivorship and palliative care. Through participation in the National TeleOncology service, Veterans receive sub-specialized oncology care. Care is provided in disease site specific teamlets that consist of a sub-specialized oncologist and an oncology certified team consisting of an advanced practice provider, registered nurse and clinical pharmacy practitioner. In 2023 and 2024 the team will expand to include a social worker and dietitian, additional tumor boards will be developed, decentralized clinical trial access will expand and breast and gynecologic care will be enhanced and its care coordination will be standardized.

Evidence

TeleOncology: According to ASCO's 2020 State of the Oncology Workforce in America, only 11.6% of oncologists practice in a rural area and 4 in 10 Americans living in rural areas with cancer report there are no cancer specialists near their home.[35] With 2.7 million rural Veterans enrolled in VA and an additional 2 million rural Veterans not currently enrolled, VA must position itself to address the potential access needs for rural cancer care, ensuring that rural Veterans receive the same state of the art care as their urban counterparts.[36] VA is addressing this through expansion of its TeleOncology services. In 2020, VA paid more than $1.2 billion in Community Care services for oncology care and is projected to meet or exceed this amount in 2021.[37] This care includes hematology/oncology and chemotherapy/infusion services but excludes surgical oncology, radiation and benign hematology. A 2020 study using the Centers for Medicare and Medicaid Services new quality measure OP-35, to reduce potentially avoidable hospital admissions and emergency department visits among patients receiving outpatient chemotherapy found that patients receiving chemotherapy in the VA are significantly less likely to have potentially avoidable hospitalizations than patients receiving chemotherapy through Medicare outside of the

[34] Maren T. Scheuner, MD, MPH, corresponding author Kenute Myrie, PhD, Jane Peredo, ScM, Lori Hoffman-Hogg, MS, RN, CNS, AOCN, Margaret Lundquist, DNP, MPH, ACNP-C, Stephanie L. Guerra, PhD and Douglas Ball, MD. Integrating Germline Genetics Into Precision Oncology Practice in the Veterans Health Administration: Challenges and Opportunities. Fed Pract. 2020 Aug; 37(Suppl 4): S82–S88

[35] https://www.asco.org/research-data/reports-studies/state-cancer-care-america

[36] RURAL VETERANS - Office of Rural Health (va.gov)

[37] https://app.powerbigov.us/groups/me/apps/91fcf820-44be-44d4-b539-742d91e503ba/reports/fdeef2ea-e1ad-4447-a9a3-c9ce0ff16dc7/ReportSection4b0de5008c02a89cb725

VA.[38] VA believes the quality of care is better in the VA because of the sub-specialized care utilizing TeleOncology and the standardized care coordination of oncology care with other VA-provided and community provided care.

Molecular Diagnostics and Rare Cancers: Rare cancers have been defined by the Rare Tumor Initiative at the National Institute of Health's National Cancer Institute as those affecting fewer than 200,000 total people in the US or less than 40,000 annually. There are hundreds of different types of rare and less common cancers and when combined, they have a devastating impact. There are approximately 8,000 new cases of rare cancers in VA per year which account for 16% of all VA cancers. This number is expected to grow as precision oncology is fundamentally changing how cancers have conventionally been defined. Cancers considered common are emerging as a collection of multiple rare subtypes that share the same tissue of origin but distinct pathophysiology that can directly impact prognosis and treatment efficacy.[39] As we learn more about the genomics of each cancer, it has become evident that every rare cancer subtype has unique characteristics that often require individualized treatments. Advanced genomic testing is also revealing that molecular features in certain rare cancers may be treated with drugs for more common cancers. Therefore, it is becoming evident that in order to better categorize cancer types for treatment decisions and to determine patient eligibility for clinical trials, molecular diagnostics will continue to play an increasingly important role in oncology clinical practice.

Breast and Gynecologic Cancers: In 2010, female Veterans represented 3% of the total cancer diagnoses in VA, with breast cancer being the most frequently diagnosed, accounting for 30% of their diagnoses. Consistent with both overall VA and U.S. men, the second and third most frequently occurring cancer for women Veterans are cancers of the lung/bronchus (15%) and colon/rectum (7%).[40] Gynecologic System of Excellence will develop a framework for Veterans with breast and gynecologic cancers to receive state of the art, guideline-adherent care, whether in the VA system or at outside institutions. In 2022, VA developed a dashboard that tracks Veterans with these cancers across their care journey, regardless of where they receive care. It will also include defining guideline-adherent quality care and care coordination between VA and community care, identifying necessary system components for care coordination. In 2023, VA is building the infrastructure to support oversight of end-to-end care in the system, linkages to research and clinical trials. In 2023, VA is conducting virtual breast and gynecologic national tumor boards.

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[38] Gidwani-Marszowski R, Faricy-Anderson K, Asch SM, Illarmo S, Ananth L, Patel MI. Potentially avoidable hospitalizations after chemotherapy: Differences across medicare and the Veterans Health Administration. *Cancer*. 2020;126(14):3297-3302. doi:10.1002/cncr.32896

[39] *Nature* **579**, S10-S11 (2020), *doi:* https://doi.org/10.1038/d41586-020-00845-4

[40] Leah L. Zullig, PhD, MPH, Kellie J. Sims, PhD, MS, Rebecca McNeil, PhD, Christina D. Williams, PhD, George L. Jackson, PhD, MHA, Dawn Provenzale, MD, MHS, Michael J. Kelley, MD, Cancer Incidence Among Patients of the U.S. Veterans Affairs Health Care System: 2010 Update, *Military Medicine*, Volume 182, Issue 7, July-August 2017, Pages e1883–e1891, https://doi.org/10.7205/MILMED-D-16-00371

Implementation Plan

TeleOncology & Breast and Gynecologic Cancer System of Excellence: VA was awarded a grant for $4.5 million in 2020 by the Bristol Meyer Squibb Foundation to develop infrastructure for a TeleOncology program to reduce rural disparities in cancer treatment. VA implemented TeleOncology in 12 locations across the country by the end of 2021. VA also provided interim coverage to support four additional sites and plans expanded to 29 sites in calendar year (CY) 2022 and midway through 2023 VA supports 31 sites with the goal of reaching 100 sites by the end of calendar year 2025. Through the TeleOncology service, the VA will build clinical and research teams in partnership with NCI designated cancer centers and Nation-leading academic affiliates to address breast, gynecologic and rare cancers in 2023. These multidisciplinary teams will provide expert sub-specialized oncology services as well as care coordination across the cancer care continuum, from diagnosis to survivorship or palliative care. They will focus on ensuring quality evidence-based care is received regardless of location. This innovative cancer care coordination model will be the first of its kind for these subsets of cancer within the VA. VA will also expand national expert consultation services through e-consultation with TeleOncology sub-specialists and virtual tumor boards.

Germline genetic testing is becoming increasingly important for patients with cancer not only to assess whether they and their families have increased risk for developing cancer but also for informing how best to treat patients. TeleOncology will increase the availability of genetic testing along with educating the oncology provider workforce in this practice. The VA clinical genetics workforce needs to expand to keep pace with increasing demand, which will be accelerated by the precision oncology programs for prostate and lung cancers and the VA TeleOncology initiative. In the US there are 10 to 15 genetics professionals per 1 million residents.[41] TeleOncology will create the infrastructure and communications plan to support oncology related genetic testing in 2022. In 2023, TeleOncology will expand the genetic testing service to include training for field oncologists.

Clinical Pathways: VA will expand upon current clinical pathways to provide the best-in-class and system-wide standardized Oncology care. Clinical pathways formally standardize oncology practice in a multi-disciplinary fashion. The clinical pathways provide decision-support to the clinical care team through technology embedded within both electronic health records systems (CPRS and Cerner). This technology also allows precision monitoring of care to facilitate systematic, real-time assessment of care in coordination with national experts. Clinical pathways customized by VA were developed and deployed for lung and prostate cancer in 2021. In 2022, VA completed pathways for kidney, head and neck and salivary gland cancers and began developing breast, hematologic malignancies and gastro-intestinal clinical pathways. To date, 12 cancer pathways have been developed. In 2023, clinical pathways were completed for bladder, breast, esophageal, plasma cell disorders and follicular lymphoma cancers. Pathways are publicly available at https://www.cancer.va.gov.

Molecular Diagnostics and Rare Cancers: To expand molecular diagnostics under NPOP, VA will pursue additional acquisitions to cover testing for a broad range of cancer types including rare

[41] Hoskovec JM, Bennett RL, Carey ME and others. Projecting the supply and demand for certified genetic counselors: a workforce study. J Genet Couns. 2018;27(1):16-20.

cancers in 2023. This would occur through a systematic expansion, cancer type by cancer type. For monitoring of drug response and resistance, emerging liquid biopsy methods that require repeat testing of patients during their treatment will be required. This will lead to the need for new testing partners offering best in class tests to cover additional sample types, cancer types, different stages of the disease and diverse molecular testing applications including diagnosis, risk prediction, prognosis and treatment monitoring.

Funding: VA is requesting an additional $48.2 million above the 2023 request for 2024. Building on 2023 efforts, the funding request enables VA to expand pharmacogenomics, improve clinical cancer genetics services, complete the lung cancer screening network, improve clinical pharmacy provider support, increase new and unique infusion efforts, ensure access to high quality sub-specialized TeleOncology care, improve colorectal cancer screening, enhance cancer patient navigation and to increase molecular testing and survivorship programs in 2024. The 2024 funding increases the number of radiotherapy sites by two and increases the number of pharmacogenomic pharmacists from 56 in 2023 to 128 by the end of 2024. Additionally, PGx testing increases by 10,000 Veterans annually with the goal of reaching 30,000, annually, by the end of 2025. Rare cancers, breast and gynecologic and prostate and lung precision oncology networks are all sustained in the 2024 budget.

TeleOncology will partner with VA's National Teleradiology Program for central collection and review of VA and non-VA imaging by the oncology care teams and expert radiologists in 2023 and 2024.

Finally, the complex data generated by Precision Oncology requires advanced informatics systems both to maximize the clinical utility of the data and to facilitate knowledge generation that can improve future care of Veterans. It is critical to ensure the learnings from a molecular test do not end with the single patient and can be used to inform the care of the next patient particularly for rare cancers where the number of patients may be small. In September 2020, the VA awarded a contract to assess the informatics needs to support precision oncology. This work highlighted the complexity of this data and the need for a larger effort around defining informatics requirements with more specialized partners than originally anticipated. The use of technologies such as machine learning, natural language processing and advanced analytics will be needed within a precision oncology data platform to unveil unprecedented insights for clinical care and research. In addition to its complexity, much of the data generated requires significant storage space and analysis for example Binary Alignment Map (BAM) files. These files represent unique needs due to its size and multidimensionality. Therefore, the VA will use a portion of these funds to fulfill these data needs either through partnership(s) or by building the capability within the VA system. A significant portion of the funding required for developing the data systems will have to come from the OIT appropriation.

COVID-19 Impact: A study conducted May 29, 2020, found a high rate of mortality in patients who have both COVID-19 and cancer. A second similar study also found high COVID-19 mortality rates among cancer patients. "The two studies are the largest to date to examine how cancer patients, who are often older, immunocompromised and have high levels of contact with the health care system, are affected by SARS-CoV-2, the virus that causes COVID-19. Initial

reports have suggested cancer patients, especially those receiving treatment, are at increased risk from the disease."[42]

TeleOncology utilizes several virtual modalities which endeavor to ensure both high quality care and the safest delivery method for the patient's individual treatment plan. Telehealth can be used to avoid dangerous exposure to health care systems where COVID-19 may be more prevalent.

Pharmacogenomics

Purpose

Pharmacogenomics (PGx) is a proactive, medication optimization strategy that can reduce adverse drug events (ADEs), improve treatment outcomes and/or reduce costs. Every Veteran prescribed selected, high-risk medications should have PGx used to inform their prescription therapy. Similarly, selected patients at high-risk for ADEs or who would be at risk for poor outcomes due to therapeutic failure should also undergo PGx to inform their prescriptions. The VA National Pharmacogenomics Program (NPP) was created in 2023 and provides a coordinated approach to pharmacogenomics services for all Veterans across the VA. In addition to providing clinical leadership, a NPP establishes evidence-based criteria for appropriate PGx testing within the VA, create the data infrastructure needed to identify the Veterans eligible for such testing; build the capability to provide PGx testing to the up to 30,000 patients annually in whom PGx is considered a high-impact and high-value intervention for the following conditions: mental health, chronic pain, cancer, cardiovascular, infectious disease, auto-immune and neurological disorders; educate and train the workforce of providers, including pharmacists, on the appropriate ordering, interpretation and application of PGx in clinical practice; monitor Veterans' prescriptions, medication outcomes and health care utilization over time; establish metrics to ensure that high-quality pharmacogenomics care is being delivered; ensure that all VA facilities have the capability for providers to order clinically appropriate pharmacogenomics tests for their patients; and incorporate software to provide clinical decision support systems into the VistA and Cerner electronic health records.

Evidence

Nearly one out of two Veterans is currently prescribed a medication that is potentially impacted by their genetics.[43] The Food and Drug Administration (FDA) has evaluated the evidence supporting dozens of medications impacted by PGx and concluded that there are many where there is "sufficient scientific evidence to suggest that subgroups of patients with certain genetic variants…are likely to have altered drug metabolism and in certain cases, differential therapeutic effects, including differences in risks of adverse events."[44] The Clinical Pharmacogenomics Implementation Consortium (CPIC) is a National Institutes of Health supported organization that

[42] https://www.cidrap.umn.edu/news-perspective/2020/05/studies-highlight-covid-19-impact-cancer-patients#:~:text=Two%20studies%20published%20yesterday %20in,and%20found%20that%2013%25%20died.

[43] Projected Prevalence of Actionable Pharmacogenetic Variants and Level A Drugs Prescribed Among US Veterans Health Administration. Pharmacy Users Catherine Chanfreau-Coffinier, PhD; Leland E. Hull, MD, MPH; Julie A. Lynch, RN, PhD,Scott L. DuVall, PhD; Scott M. Damrauer, MD; Francesca E. Cunningham, PharmD; Benjamin F. Voight, PhD; Michael E. Matheny, MD, MPH; David W. Oslin, MD; Michael S. Icardi, MD; Sony Tuteja, PharmD JAMA Netw Open. 2019;2(6):e195345

[44] https://www.fda.gov/medical-devices/precision-medicine/table-pharmacogenetic-associations

provides comprehensive evidenced based recommendations on how best to manage patients with selected genetic variants prescribed certain medications with the goal of preventing ADEs or therapeutic outcomes.[45] To date there are 26 medication classes where CPIC and/or FDA has concluded that there is moderate to strong evidence that modifying prescription therapy based on a patients PGx test results is likely to improve medication outcomes. CPIC guidelines are used by many US medical centers implementing PGx including VA (see below) and many are also endorsed by the American Society of Health System Pharmacists.[46] A comprehensive review of the evidence used to support PGx testing is provided by CPIC and varies depending on the medication of interest. For many medications there are randomized controlled

[45] https://cpicpgx.org/

[46] https://www.ashp.org/Pharmacy-Practice/Policy-Positions-and-Guidelines/Browse-by-Document-Type/Endorsed-Documents?loginreturnUrl=SSOCheckOnly

trials[47;48;49;50;51;52;53;54;55;56] demonstrating that use of PGx testing can improve medication outcomes and/or can prevent adverse drug reactions. For other medications, the use of PGx is, supported by non-randomized trials[57], retrospective studies[58,59], or extrapolation from the known

[47] Coenen MJH, de Jong DJ, van Marrewijk CJ and others. Identification of patients with variants in tpmt and dose reduction reduces hematologic events during thiopurine treatment of inflammatory bowel disease. *Gastroenterology*. 2015;149(4):907-917.e7. doi:10.1053/j.gastro.2015.06.002

[48] Smith DM, Weitzel KW, Elsey AR and others. CYP2D6-guided opioid therapy improves pain control in CYP2D6 intermediate and poor metabolizers: a pragmatic clinical trial. *Genet Med*. 2019;21(8):1842-1850. doi:10.1038/s41436-018-0431-8

[49] Greden JF, Parikh SV, Rothschild AJ and others. Impact of pharmacogenomics on clinical outcomes in major depressive disorder in the GUIDED trial: A large, patient- and rater-blinded, randomized, controlled study. *Journal of Psychiatric Research*. 2019;111:59-67. doi:10.1016/j.jpsychires.2019.01.003

[50] Effect of Genotype-Guided Oral P2Y12 Inhibitor Selection vs Conventional Clopidogrel Therapy on Ischemic Outcomes After Percutaneous Coronary Intervention: The TAILOR-PCI Randomized Clinical Trial Naveen L Pereira, Michael E Farkouh, Derek So, Ryan Lennon, Nancy Geller, Verghese Mathew, Malcolm Bell, Jang-Ho Bae, Myung Ho Jeong, Ivan Chavez 9, Paul Gordon, J Dawn Abbott, Charles Cagin, Linnea Baudhuin, Yi-Ping Fu, Shaun G Goodman, Ahmed Hasan, Erin Iturriaga, Amir Lerman, Mandeep Sidhu, Jean-Francois Tanguay, Liewei Wang, Richard Weinshilboum, Robert Welsh, Yves Rosenberg, Kent Bailey, Charanjit Rihal JAMA. 2020 Aug 25;324(8):761-771

[51] A Genotype-Guided Strategy for Oral P2Y12 Inhibitors in Primary PCI Daniel M.F. Claassens, M.D., Gerrit J.A. Vos, M.D., Thomas O. Bergmeijer, M.D., Renicus S. Hermanides, M.D., Ph.D., Arnoud W.J. van 't Hof, M.D., Ph.D., Pim van der Harst, M.D., Ph.D., Emanuele Barbato, M.D., Ph.D., Carmine Morisco, M.D., Ph.D., Richard M. Tjon Joe Gin, M.D., Folkert W. Asselbergs, M.D., Ph.D., Arend Mosterd, M.D., Ph.D., Jean-Paul R. Herrman, M.D., Ph.D. and others. N Engl J Med 2019; 381:1621-1631

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[53] A Randomized Trial of Genotype-Guided Dosing of Warfarin. Munir Pirmohamed, Ph.D., F.R.C.P., Girvan Burnside, Ph.D., Niclas Eriksson, Ph.D. andrea L. Jorgensen, Ph.D., Cheng Hock Toh, M.D., Toby Nicholson, F.R.C.Path., Patrick Kesteven, M.D., Christina Christersson, M.D., Ph.D., Bengt Wahlström, M.D., Christina Stafberg, M.D., J. Eunice Zhang, Ph.D., Julian B. Leathart, M.Phil. and others, for the EU-PACT Group* N Engl J Med 2013; 369:2294-2303

[54] Effect of Genotype-Guided Warfarin Dosing on Clinical Events and Anticoagulation Control Among Patients Undergoing Hip or Knee Arthroplasty The GIFT Randomized Clinical Trial Brian F. Gage, MD, MSc; Anne R. Bass, MD; Hannah Lin, BA; Scott C. Woller, MD; Scott M. Stevens, MD; Noor Al-Hammadi, MBChB, MPH; Juan Li, MPH; Tomás Rodríguez Jr, MS; J. Philip Miller, AB; Gwendolyn A. McMillin, PhD; Robert C. Pendleton, MD; Amir K. Jaffer, MD, MBA; Cristi R. King, BS; Brandi DeVore Whipple, BS; Rhonda Porche-Sorbet, MS; Lynnae Napoli, BS; Kerri Merritt, BA; Anna M. Thompson, BA; Gina Hyun, MD; Jeffrey L. Anderson, MD; Wesley Hollomon, MD, MBA; Robert L. Barrack, MD; Ryan M. Nunley, MD; Gerard Moskowitz, PhD; Victor Dávila-Román, MD; Charles S. Eby, MD *JAMA*. 2017;318(12):1115-1124

[55] Effect of Pharmacogenomic Testing for Drug-Gene Interactions on Medication Selection and Remission of Symptoms in Major Depressive Disorder: The PRIME Care Randomized Clinical Trial - PubMed (nih.gov)

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[57] Hicks JK, Quilitz RE, Komrokji RS and others. Prospective cyp2c19-guided voriconazole prophylaxis in patients with neutropenic acute myeloid leukemia reduces the incidence of subtherapeutic antifungal plasma concentrations. *Clin Pharmacol Ther*. 2020;107(3):563-570. doi:10.1002/cpt.1641

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pharmacology and drug mechanisms of action.[60] In summary, pharmacogenomic testing is an evidenced-based practice that can prevent adverse drug effects and improve therapeutic outcomes to some of the most prescribed medications to Veterans.

Implementation Plan

In 2019, the VA launched the Pharmacogenomics testing for Veterans (PHASER) program, a partnership between VHA and Sanford Health (Sioux Falls, SD), which is brought panel based PGx testing for up to 250,000 Veterans at approximately 60 VA facilities nationwide through a $50 million donation provided to VA by Sanford Health. Through the PHASER program, Veterans have access to PGx testing as part of their regular health care for the duration of this 5-year program which is slated to end in December 2024. By June 2023, PGx testing will be available to 57 VA health care systems (up from 27 in 2022) through PHASER with an additional 11 slated for 2024. The PHASER program provides education and training for health care providers, including pharmacists to learn how to integrate PGx into their practice. In addition, PHASER is implementing a series of clinical decision support systems (CDSS) in the VistA electronic health record. These CDSS assist providers so that they are aware of the availability of PGx test results, their interpretation and action to mitigate the impact of gene-drug interactions through dose modification or an alternative medication. The PHASER program has gained significant experience and knowledge regarding the barriers to effective implementation of pharmacogenomics with the VA. While a significant advance, the PHASER program is time-limited (as it is externally funded, it is a temporary program) and of limited scope in terms of the number of medications impacted and the number of facilities where it is offered. The newly formed VA National Pharmacogenomics Program (NPP) aims to not only sustain the implementation efforts of the PHASER program beyond its original funding, but also expand implementation nationwide so that all eligible Veterans have access to appropriate, evidenced-based PGx testing, continue to educate clinicians and pharmacists on the use of PGx, hire and train new, local, clinical pharmacists with expertise in pharmacogenomics that are expected to be needed to help interpret and manage Veterans who have undergone PGx testing and begin to transition PGx testing currently offered through Sanford Health to a vendor selected by VA and/or performed internal to VA. In 2023, we expect to provide PGx testing to approximately 18,000 (mostly tested through the partnership with Sanford Health). In 2024, we will fund approximately 20,000 Veterans to receive PGx testing. In 2025, we expect this number to increase to 30,000 and all testing will be performed by VA labs or a VA vendor testing contract.

Radiation Oncology

VA has 130 sites that provide medical oncology but only 41 sites have radiation oncology facilities available. Upon last review 45,000 dually enrolled Veterans receive radiotherapy annually and 15,000 Veterans receive radiotherapy in-house at 40 sites in the VA. The 2023 funding will fund new equipment for one site to provide radiation oncology services to Veterans. The remaining funding will be provided to support equipment replacement which is intended to modernize existing infrastructure.

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[60] Zhao F, Wang J, Yang Y and others. Effect of CYP2C19 genetic polymorphisms on the efficacy of proton pump inhibitor-based triple therapy for Helicobacter pylori eradication: a meta-analysis. *Helicobacter.* 2008;13(6):532-541. doi:10.1111/j.1523-5378.2008.00643.

VA radiotherapy quality is superior in-house compared to community care based on a direct comparison of quality metrics reviewed in VHA in 2017 and what could be found in a community provided sample.[61] Also, on-site VA Radiation Oncology ensures an expert opinion and referral for proton therapy when in the best medical interests of the patient. Four sites will be identified for the provision of new Radiation Oncology services by 2025. This accounts for two in 2024 and two in 2025 with minor construction support. New Orleans was identified as the initial site. Equipment will be purchased in 2023 for New Orleans which is planned to be the model for future sites.

Rural Health

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Services (0160):	$281,429	$275,688	$305,688	$305,688	$305,688	$0	$0
Medical Community Care (0140):	$0	$0				$0	$0
Medical Support and Compliance (0152):	$16,200	$19,459	$19,459	$19,459	$19,459	$0	$0
Medical Facilities (0162):	$10,549	$12,308	$12,308	$12,308	$12,308	$0	$0
Obligations [Grand Total]	**$308,178**	**$307,455**	**$337,455**	**$337,455**	**$337,455**	**$0**	**$0**

Purpose

To enable the sustainment of programs, including but not limited to full sustainment funding for the VHA Clinical Resource Hubs, Rural Patient Tablet Program and Tele-Critical Care Initiative. These programs directly support the accomplishment of the congressionally mandated functions of the Office of Rural Heath (ORH) (38 U.S.C. § 7308).

In addition to these programs, ORH's five Veterans Rural Health Resource Centers, in Portland, Oregon, Salt Lake City, Utah, Iowa City, Iowa, Gainesville, Florida and White River Junction, Vermont are assigned (38 U.S.C. § 7308) identify, formulate and develop practices and improve understanding of challenges in order to enhance the delivery of health care to Veterans living in rural areas.

[61] Katsoulakis E, Kapoor R, Park J, Chapman C, Solanki A, Puckett L and others. VA-Radiation Oncology Quality Surveillance Program: Enhancing Quality Measure Data Capture, Measuring Quality Benchmarks and Ensuring Long Term Sustainability of Quality Improvements in Community Care. Arch Cancer Biol Ther. 2020; 1(2): 25-30.

Evidence
In 2022, the Office of Rural Health increased Rural Health Initiative contributions to the programs named above as well as to funding far reaching new programs in rural workforce training, education and continuing mental/behavioral health programs focused on rural Veterans. ORH has worked with VHA clinical and non-clinical offices to create more than 50 mature Enterprise-Wide Initiatives (EWIs) that reach Veterans at more than 99% of all VHA sites that serve rural Veterans. The development of new programs will continue through 2023 and beyond. Historically, ORH receives approximately $50 million annually in requests for funding new EWIs from other VHA program offices that go unfulfilled due to lack of available funding.

The 2023 Rural Health Initiative budget supports innovative programs in the rural space across the following clinical and vital non-clinical access program areas:

- Primary Care
- Specialty Care
- Mental Health
- Clinical Resource Hubs
- Workforce Training and Education
- Care Coordination
- Transportation

Overall, in 2022, these programs touched the lives of more than 1.3 million Veterans at 700 rural serving sites across VHA. VA expects to see a significant expansion of many of these programs in 2023 and 2024 as new sites are added and new rural access innovations are created.

Implementation Plan
ORH is currently engaged with partners across VHA program offices to accurately project 2024 programming needs with the expectation that the 2024 budget request will fund third year sustainment and expansion efforts of thriving innovations. ORH is also working towards the creation of long-term funding streams for the rural portion of vital initiatives such as Tele-Critical Care, Clinical Resource Hubs (CRHs) and the Rural Veteran Tablet programs. ORH has nearly $10 million in projected new EWIs in 2023 and 2024. Each ORH-funded initiative is required to have a strong implementation plan and quantitative evaluation that is overseen by VHA Central Office program offices, ORH and the ORH Center for the Evaluation of Enterprise-Wide Initiatives (CEEWI).

In 2022, ORH and Specialty Care Services (SCS) continued a five-year funding agreement to support rural Tele-Critical Care expansion. This National Tele-Critical Care Program provided critical care to 56,800 acutely ill Veterans in 69 facilities throughout the country with 636,037 video activations.

CRHs are rural-serving telehealth hubs in all 18 VISNs across the country for primary care, mental health, specialty care, rehabilitation and extended care and surgery services. In 2023 and 2024, ORH is continuing support for a significant expansion in tele-specialty care services within the CRHs, broadening access to cardiology, pulmonology, urology, dermatology, sleep medicine, endocrinology and other specialty care services that are increasingly more difficult to access in rural areas of the United States, even from community partners. As the COVID-19 pandemic has

demonstrated, these hubs supply the flexibility necessary to rapidly respond to changing health care demands and to satisfy rural access requirements outlined in the MISSION Act.

All 18 VISNs CRHs offer primary care and mental health services to support access to care for underserved Veteran populations. This care is delivered primarily via telehealth modalities and includes robust team-based care with nursing and clinical pharmacist practitioners. Additionally, many CRHs provide access to numerous specialty care, surgery and rehabilitation and extended care services. CRHs that received initial funding for the funding cycle 2021-2023 will have many services moving into sustainment funding phase. This allows further expansion and growth of CRH based services based on Veteran population needs in 2024 and 2025.

- Since inception in 2018, CRHs provided over 1.9M encounters with Veterans.
- 1,570 dedicated FTE provide clinical care and administrative support across all 18 CRHs.
- 1,146 spoke sites are being served by CRH clinicians today.

During the COVID-19 pandemic, CRHs assisted in coverage of the Clinical Contact Centers, inpatient services and emergency departments throughout the enterprise.

The Rural Patient Tablet Program provides computer tablets to rural Veterans for delivery of telehealth care into their homes via secure internet connection.

- In 2022, 36,861 Veterans were shipped an iPad. Of these Veterans, 25,148 (68.2%) had 266,771 Virtual Video Connect (VVC) visits.
- Six months after receiving a tablet, there was an increase in Veterans reporting more convenient care (from 67% to 80%), 28% fewer missed appointments or no shows in mental health and an increase in VA's mental health continuity of care measure (from 31.6% to 40.2%).

ORH expects this trend to continue and is creating a long-term funding stream to acquire tablets for rural Veterans over the next several years to ensure that every rural Veteran that needs a tablet will have one.

In the area of rural workforce training and compensation, ORH collaborated with the VA Office of Academic Affiliations (OAA) to develop the Rural Interprofessional Faculty Development Initiative program designed to attract providers and improve retention by developing teaching and training skills for rural clinician/educators. In 2022, the program trained 298 clinicians at 73 rural sites.

ORH's five Veterans Rural Health Resource Centers (VRHRCs) continue to fulfill their congressionally mandated mission to conduct research, innovate new rural access programs and disseminate them system wide. In 2023, these resource centers will establish additional new Rural Promising Practices, bringing the total number of Rural Promising Practices in system-wide mentored implementation to at least 9. The VRHRC promising practices range from training programs like Rural Clergy Training and Geriatric Scholars, to clinical programs such as In-home Cardiac Rehabilitation, HIV virtual teams and Rural Implementation of Comprehensive Telehealth-Based Diabetes Care. These promising rural practices are operating at more than 100 sites across VHA. In 2024, ORH is collaborating with Office of Connected Care, VISN 19, VA

Diffusion of Excellence, Quality Enhancement Research Initiative (QUERI) and Health Services Research and Development (HSR&D) Center of Innovation to Accelerate Discovery and Practice Transformation (ADAPT) to significantly expand our Rural Promising Practices program in the areas of rural diabetes care and pulmonary rehabilitation.

The ORH VRHRCs strong innovation programs focus on addressing gaps in rural Veterans' access to care and services and reach into program areas focused on health challenges rural women Veterans face in accessing the health care they have earned. These programs include the Post Natal, Web Based Care (Mom Mood Booster) initiative that reached out to 8,500 Veteran mothers and ultimately provided care strategies to over 350 participants. This important rural-focused effort complements the ORH-funded EWI that conducts clinical skills training focused on women Veterans' care. In 2022, this training program conducted 12 courses of instruction for providers who care for rural women Veterans that resulted in training over 280 clinicians at 78 different sites across the country.

In addition, some VRHRC programs focus on American Indian/Alaska Native (AI/AN) rural Veterans, including ORH's Rural Native Veteran Health Care Navigation program. ORH anticipates first pilots of this program in 2023 and expansion through 2024. The goal of this innovative program is to reach rural AI/AN Veterans to ensure their access to VHA health care. Congress has acknowledged the contributions and impact of the ORH VRHRCs in past reports and in response ORH will continue expanding their excellent programs in the areas of research, innovation and system-wide dissemination of best practices, through 2024 and beyond.

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Supply Chain Management

Medical Care Appropriation Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Inventory Management and Access	$52,557	$101,938	$101,938	$104,996	$108,146	$3,058	$3,150
Medical Surgical Prime Vendor (MSPV) 2.0	$14,233	$13,756	$13,756	$28,337	$29,187	$14,581	$850
Defense Logistics Agency (DLA) Source Support for MSPV	$14,233	$13,756	$13,756	$0	$0	($13,756)	$0
Supply Chain Master Catalog	$5,475	$5,175	$5,175	$5,175	$5,333	$0	$158
Point of Use	$322	$5,184	$5,184	$3,500	$3,605	($1,684)	$105
Clinical Decision Strategic Sourcing	$0	$2,595	$2,595	$2,595	$2,595	$0	$0
Grand Total	$86,820	$142,404	$142,404	$144,603	$148,866	$2,199	$4,263

Inventory Management and Access

(dollars in thousands)

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	+/- 2023-2024
Medical Support and Compliance Category					
Discretionary Medical Support and Compliance (0152):	$4,128	$101,938	$101,938	$104,996	$3,058
Mandatory Veterans Medical Care and Health Fund (0173) 1/	$48,429	$0	$0	$0	$0
MSC subtotal	$52,557	$101,938	$101,938	$104,996	$3,058
OIT Category					
Discretionary OI&T	$40,171	$141,412	$141,412	$136,257	-$5,155
Mandatory ARP Act, Section 8003	$23,895	$0	$0	$0	$0
OIT subtotal	$64,066	$141,412	$141,412	$136,257	-$5,155
Grand Total	$116,623	$243,350	$243,350	$241,253	-$2,097

The VA's fourth Strategic Goal is to transform business operations by modernizing systems and focusing resources more efficiently to be competitive and to provide world-class customer service to Veterans and VA employees. One focus area within this goal is Business Transformation, specifically to modernize VA's supply chain. Effective supply chain management is a major differentiator between high- and low-quality health care systems and directly influences Veteran access to care. VA's supply chain modernization priorities include deploying multiple systems and improvements to improve enterprise management and oversight of materiel to provide better support for care delivery in the field.

Inventory Management and Access

VA is replacing its 50-year-old legacy inventory management system and standalone systems for its support. With a modern inventory management system, VA would acquire the capability to support all health care logistics and support service lines of business, in a fully integrated environment, including end-to-end supply chain management inclusive of inventory management, distribution and transportation management, catalog research and purchase decision support; biomedical equipment management and maintenance; property and equipment accountability management; facility and environmental management for building service equipment and work orders; assemblage management; business analytics; and total asset visibility.

VA's COVID-19 response efforts highlighted the deficiencies with the existing, 50-year-old legacy inventory system, especially the lack of enterprise visibility of personal protective equipment. Standardization of VHA business practices across the enterprise consistent with federal and commercial best business practices will enable VA to build a lean supply chain that provides timely access to meaningful data focused on improved patient and financial outcomes.

Currently VA is assessing potential to systems for feasibility and compatibility with the other system transformations underway.

Medical/Surgical Prime Vendor (MSPV)

MSPV-Next Generation (NG) is a collection of contract vehicles that enable the VA to streamline supply chain management for an array of Medical, Surgical, Dental, Lab and Environmental Medical Supplies (EMS). The program achieves long term savings for VA medical centers by combining a "just in time" logistics approach with strategic sourcing and volume buying for Med-Surg supply needs. Item prices, prior to the application of the distribution fee, are published on the MSPV website.

VHA facilities transitioned to MSPV-NG Bridge contracts on April 1, 2020, to prevent a gap in MSPV program coverage between expiration of the MSPV-NG contracts and implementation of the next MSPV contract vehicle. The Strategic Acquisition Center (SAC) worked in collaboration with VHA Logistics to extend the MSPV-NG Bridge contracts for eight months -- from April 1, 2021 to December 1, 2021 -- ensuring continuity of care as the next PV contract vehicle is developed and solicited.

Defense Logistics Agency Electronic Catalog (DLA e-Cat)

VA is seeking to access to DLA contracts and suppliers to ensure VA facilities have continuous, efficient and cost-effective access to quality medical supplies. VA and DLA signed an Interagency Agreement (IAA) for VAMCs to leverage DLA's best-in-class medical logistics capabilities. The intent is for VAMCs to receive DLA-sourced materiel through the Electronic Catalog (ECAT) Prime Vendor Web Ordering (PVWO) until the supply chain is modernized throughout VA.

Expanding this partnership has several benefits. VA will: be able to deliver products faster and more consistently; expand the breadth and depth of medical materiel available to better support Veterans; increase opportunities for small businesses with the Federal Government; reduce operating costs; and address documented challenges the VA program has encountered. Achieving these goals will continuously improve upon VA's medical services and support 9.3 million+ Veteran beneficiaries.

Clinically Driven Strategic Sourcing (CDSS)

CDSS is a commercial health care best practice that incorporates physicians and clinicians into the product sourcing process to achieve tangible results including cost reduction, improved clinical outcomes and patient safety, standardized medical-surgical products and customer satisfaction. CDSS facilitates collaboration between clinicians and logisticians throughout the value analysis and standardization process. Further, CDSS drives purchase order volume toward clinically based best-value contracts to increase VHA cost-avoidance.

CDSS supports VA's supply chain transformation and VHA's commitment to becoming a High Reliability Organization. Internal and external reports -- including the Commission on Care Assessment J, Government Accountability Office (GAO) 18-34 and the Logistics Satisfaction and Time Resource Survey -- highlighted procedural and structural challenges in VA's supply chain processes that increased patient care risks and clinician dissatisfaction, while decreasing cost avoidance opportunities.

Using CDSS helps reduce clinically equivalent medical supply variation used across VHA. Reducing variation decreases the time required to train clinicians on proper product use and promotes product knowledge continuity. VA clinicians benefit by having more time for patient care, which improves patient outcomes.

VA continues its strategic partnership with DoD supporting VA's obligation to ensure we provide optimum care and benefits to Veterans. VA is engaging with the clinically driven Medical Materiel Enterprise Standardization Office to understand their collaborative clinical process for medical materiel standardization, determine applicability to VA processes and develop a strategy for integration and enterprise implementation to further strengthen the CDSS program.

Supply Chain Master Catalog (SCMC)

VA's SCMC will provide VA users with visibility of all VA medical commodities, prosthetic devices (to include durable medical equipment), expendable and non-expendable equipment and non-clinical products. The SCMC is a fully searchable, online catalog available via a web interface offered to VA as a Software Service solution through the Microsoft Azure Government cloud host.

The VA SCMC harmonizes contract information from VA and other approved Federal contract offices. It is a critical element in improving product oversight, visibility and establishing enterprise best practices. Further, the SCMC is essential to providing the standard product information necessary for electronic health record (Cerner) and financial (Momentum) systems.

VA lacks standardized enterprise business rules for its cataloging efforts, which results in inconsistencies including incomplete records, duplicate records, stock-level discrepancies, incorrect dollar values, conversion factor errors and missing mandatory sources. Multiple contract systems operate across the VA and VHA that do not share product or sourcing data. These multiple siloed systems contribute to the lack of data standardization, inconsistent ordering practices and redundant contracts for identical products. For these reasons the SCMC is a critical element in product oversight, visibility and establishing enterprise best practices.

Point of Use (POU)

The POU program seeks to standardize the supply POU system at the enterprise level across medical centers while maintaining local efficiencies already realized. POUs automatically inventory, manage and store expendable medical supplies in the vicinity of patient care. POUs ensure proper supplies are available at the proper time for patient procedures. POUs optimize inventory with usage data trend analysis, on-hand inventory cost reduction and increased clinical staff focus on patient care and patient safety. The program aims to centrally standardize POU procurement, sustainment, vendor support, cybersecurity support, training and the POU implementation efforts with supply chain modernization and EHRM at the enterprise level.

VA's use of POU will enable VA the ability to become more efficient and provide a higher level of patient care.

Telehealth

Description	2022 Actual	2023 Budget Estimate 1/	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Treatment Modality ($000):							
Home Telehealth	$413,775	N/A	$433,351	$453,302	$467,189	$19,951	$13,887
Clinic Based Telehealth	$3,897,441	N/A	$4,580,140	$4,757,275	$5,110,477	177,135	353,202
Total Treatment	**$4,311,216**	**$4,844,912**	**$4,580,140**	**$4,757,275**	**$5,110,477**	**177,135**	**353,202**
Connected Care Program Funding: Sustainment and Expansion							
Medical Services	$236,825	N/A	$291,414	$366,446	$396,945	75,032	30,499
Medical Support & Compliance	$24,695	N/A	$38,362	$41,615	$42,975	3,253	1,360
Sustainment and Expansion Total	**$261,520**	**$329,906**	**$329,776**	**$408,061**	**$439,920**	**78,285**	**31,859**

1/Amounts not previously displayed.

Authority for Action

P.L. 115-182, *VA MISSION Act of 2018* and the *National Defense Authorization Act for Fiscal Year 2021*, authorize the practice of telehealth by VA health care professionals across the country, irrespective of the location of the provider or the Veteran. This allows for the expansion of the Telehealth/Connected Care Services program with the goal to increase Veteran access to health care.

The Office of Connected Care – Telehealth/Connected Care Services

The Office of Connected Care and its' Telehealth/Connected Care Services, has the mission to deliver high-quality, Veteran-centered care, optimize individual and population health, advance health care that is personalized and proactive and enhance the health care experience through virtual modalities of care.

Home and Community Based Services

Purpose - Supports sustainment and expansion of synchronous, asynchronous and remote patient monitoring services in the home or home communities inclusive of VA Video Connect, the Veteran tablet initiative, Remote Patient Monitoring/Home Telehealth Program's equipment and services and ATLAS (Accessing Telehealth Through Local Area Stations) pilot.

Clinic Based Services

Purpose - Supports expansion of clinical resource hubs for primary care, mental health and specialty care; expansion of targeted initiatives such at TeleDermatology, TeleEye Care and TeleSleep medicine; and expansion of the national expert consultation services.

Hospital and Emergency Services

Purpose - Supports expansion of inpatient and emergency room telehealth programs including TeleStroke Care and TeleCritical Care. It also includes the telehealth emergency management initiative.

Program Foundations
Purpose - Supports the staffing, training, application development and remediation, national equipment maintenance and refresh, provider and Veteran facing help desk support, communications and research needed to support and expand Connected Care services.

COVID-19 Impact
VA has leveraged telehealth to maintain the safe delivery of high-quality outpatient VA services in the context of pandemic-related social distancing guidelines. As a result, Telehealth has experienced a surge in adoption since early in 2020 which continued into 2021.

In 2022, VA provided Veterans more than 9.2 million video telehealth visits to their home or other offsite location, representing an increase of greater than over 3,100% compared to 2019. Overall, when considering all its telehealth modalities, VA provided more than 2.3 million Veterans with over 11 million telehealth episodes of care in 2022. The number of Veterans utilizing telehealth in 2022 grew by 157% when compared with 2019.

VA's connected care capabilities have become a vital part of VA's health care system. VA will continue to build on its success and leadership as a provider of digitally enabled care. By continuing its connected care innovation, VA will further enhance the human connections that are at the heart of health care and help more Veterans turn to VA as their health care system of choice. VA is also accelerating a transformation of health care that will provide Veterans more quality options going into the future.

Program Budget Justification:

Purpose
The Office of Connected Care budget request increases in 2023 over 2022 to account for the sustainment of services expanded during the pandemic and the lack of CARES Act and ARP funding available to Connected Care starting in 2023. The increase is noted in the Home and Community Based Services Category of the budget request for Connected Care.

Evidence
Video-to-home telehealth utilization increased over thirty-fold in 2022, compared to 2019 due to the pandemic and resulting need to deliver safe, quality, engaging care while adhering to social distancing. The VA's pivot to virtual care drove growth of the connected tablets program to support Veterans impacted by the digital divide. Further, the VA continues to provide telehealth technology (that is, web cameras) to health care professionals to ensure they are capable of delivering services through telehealth. In addition, VA is expanding its capabilities to deliver comprehensive service to Veterans by increasing availability of peripheral technologies (that is, digital stethoscopes) that can be provided to Veterans for use as part of their video visits from home.

In addition, the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* authorizes VA to establish a grant program to develop telehealth access points (ATLAS) in the community. Connected Care's 2024 budget for Home and Community Based Services also includes the funding needed to support the law's intended purpose.

Implementation Plan
The combination of ongoing expansion of video-to-home services, enhanced video-to-home telehealth capabilities and the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* are the basis for the budget increase.

Costs
VA is requesting an increase in Connected Care funding from $330 million in 2023 to $408 million in 2024 and $440 million in 2025. The combination of ongoing expansion of video-to-home services, enhanced video-to-home telehealth capabilities and the need to sustain previous expansion efforts funded with the support of CARES Act and ARP funding are the basis for the budget increase.

Veterans Homelessness Programs

Description (Dollars in thousands)	2022 Actual	2023 Budget Estimate 2/	2023 Current Estimate	2024 Revised Request	2025 Advance Appropriation	+/- 2022-2023	+/- 2023-2024
Homeless Veterans Treatment Costs	**$9,182,465**	**$9,145,900**	**$9,348,899**	**$9,522,772**	**$9,719,596**	$173,873	$196,824
Programs to Assist Homeless Veterans							
Permanent Housing Supportive Services							
HUD-VASH Case Management:							
HUD-VASH Case Management Base (I) 1/	*$470,462*	*$557,921*	*$557,921*	*$617,618*	*$661,535*	$59,697	$43,917
HUD-VASH Case Management ARP Act (I) 3/	*$0*	*$0*	*$0*	*$0*	*$0*	$0	$0
HUD-VASH Case Management [Subtotal]:	**$470,462**	**$557,921**	**$557,921**	**$617,618**	**$661,535**	$59,697	$43,917
HUD-VASH (S)	$378,780	$381,354	$400,371	$416,786	$433,457	$16,415	$16,671
Perm. Housing Supp. Services [Subtotal]	**$849,242**	**$939,275**	**$958,292**	**$1,034,404**	**$1,094,992**	$76,112	$60,588
Transitional Housing							
Grant & Per Diem:							
Grant & Per Diem Base (I) 1/	*$253,021*	*$240,423*	*$240,423*	*$264,465*	*$276,841*	$24,042	$12,376
Grant & Per Diem ARP Act 3/ (I)	*$64,670*	*$0*	*$0*	*$0*	*$0*	$0	$0
Grant & Per Diem [Subtotal]:	**$317,691**	**$240,423**	**$240,423**	**$264,465**	**$276,841**	$24,042	$12,376
Grant & Per Diem Liaisons (I)	$37,801	$35,945	$35,945	$41,696	$42,947	$5,751	$1,251
Other (S)	$18,872	$8,722	$19,664	$20,490	$21,351	$826	$861
Health Care for Homeless Vets:							
Health Care for Homeless Base (I)	*$180,132*	*$229,484*	*$229,484*	*$268,457*	*$278,927*	$38,973	$10,470
Health Care for Homeless ARP Act 3/ (I)	*$12,351*	*$0*	*$0*	*$0*	*$0*	$0	$0
Health Care for Homeless Vets [Subtotal]:	**$192,483**	**$229,484**	**$229,484**	**$268,457**	**$278,927**	**$38,973**	**$10,470**
Transitional Housing [Subtotal]	**$566,847**	**$514,574**	**$525,516**	**$595,108**	**$620,066**	$69,592	$24,958
Prevention Services							
Supportive Svcs Low Income Vets & Families:							
Supportive Svcs Low Income Vets & Families Base (I)	*$420,138*	*$730,436*	*$740,436*	*$774,744*	*$788,673*	$34,308	$13,929
Supportive Svcs Low Income Vets & Families ARP Act 3/ (I)	*$371,076*	*$0*	*$0*	*$0*	*$0*	$0	$0
Supportive Svcs Low Income Vets & Families [Subtotal]:	**$791,214**	**$730,436**	**$740,436**	**$774,744**	**$788,673**	$34,308	$13,929
National Call Center for Homeless Veterans (I)	$8,371	$8,044	$8,044	$10,892	$11,317	$2,848	$425
Justice Outreach Homeless Prevention Base (I)	$53,675	$56,983	$56,983	$64,723	$74,787	$7,740	$10,064
Legal Services for Veterans (I) 1/	$0	$12,992	$12,992	$28,056	$48,056	$15,064	$20,000
Justice Outreach Homeless Prevention ARP Act (I) 3/	$0	$0	$0	$0	$0	$0	$0
Justice Outreach Homeless Prevention (S)	$15,619	$11,419	$16,275	$16,942	$17,620	$667	$678
Prevention Services [Subtotal]	**$868,878**	**$819,874**	**$834,730**	**$895,357**	**$940,453**	$60,627	$45,096
Treatment							
Domiciliary Care for Homeless Vets (S)	$219,876	$206,514	$232,409	$241,938	$251,615	$9,529	$9,678
Homeless Patient Aligned Care Teams (I)	$8,311	$12,000	$12,000	$15,468	$16,071	$3,468	$603
Homeless Patient Aligned Care Teams ARP(I) 3/	$6,261	$0	$0	$0	$0	$0	$0
Telephone Homeless Chronically Mental Ill (S)	$78,007	$95,304	$81,284	$84,616	$88,001	$3,333	$3,385
Treatment [Subtotal]	**$312,456**	**$313,818**	**$325,693**	**$342,022**	**$355,687**	$16,329	$13,665
Employment/Job Training							
Homeless Veterans Community Employment Prg (I)	$17,075	$19,800	$19,800	$20,572	$21,374	$772	$802
Homeless Veterans Community Employment ARP (I)	$0	$0	$0	$0	$0	$0	$0
Homeless. Ther. Empl., CWT & CWT/TR (S)	$182,574	$64,506	$192,980	$200,893	$208,928	$7,912	$8,036
Employment/Job Training [Subtotal]	**$199,649**	**$84,306**	**$212,780**	**$221,465**	**$230,302**	$8,684	$8,838
Administrative							
Supportive Svces Low Income Vets & Families Adm.	$8,833	$9,731	$9,731	$11,045	$11,476	$1,314	$431
National Homeless Registry	$2,415	$3,817	$3,817	$5,166	$5,352	$1,349	$186
National Homeless Registry ARP 3/	$0	$0	$0	$0	$0	$0	$0
National Center on Homelessness among Veterans	$0	$0	$0	$6,581	$9,598	$6,581	$3,017
Administrative [Subtotal]	**$11,249**	**$13,548**	**$13,548**	**$22,792**	**$26,426**	$9,244	$3,634
Obligations [Total]	**$2,808,320**	**$2,685,395**	**$2,870,559**	**$3,111,148**	**$3,267,927**	$240,589	$156,779
ARP Act 1/ [Total included above]	*$435,745*	*$0*	*$0*	*$0*	*$0*	$0	$0
Breakout by Specific & General Purpose							
(I) Initiative Specific Purpose	$1,914,592	$1,917,576	$1,927,576	$2,129,483	$2,246,954	$195,326	$114,454
(S) Sustainment General Purpose	$893,728	$767,819	$942,983	$981,665	$1,020,973	$38,682	$39,308
Obligations [Total]	**$2,808,320**	**$2,685,395**	**$2,870,559**	**$3,111,148**	**$3,267,927**	$240,589	$156,779

VA's goal is a systematic end to Veteran homelessness, which means ensuring communities across the country:

- Have identified all Veterans experiencing homelessness,
- Can provide shelter immediately to any Veteran experiencing unsheltered homelessness who wants shelter,
- Provide service-intensive transitional housing in limited instances,
- Have capacity to assist Veterans to swiftly move into permanent housing and
- Have resources, plans and system capacity in place should any Veteran become homeless or be at risk of homelessness in the future.

Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH):

Purpose

HUD-VASH is a collaborative program between the U.S. Department of Housing and Urban Development (HUD) and VA which provides eligible homeless Veterans a Housing Choice Voucher (HCV) from HUD paired with case management and supportive services from VA. These services are targeted to assist HUD-VASH Veterans in obtaining and sustaining permanent housing while recovering from physical and mental health problems, substance use disorders and functional concerns contributing to or resulting from homelessness. HUD-VASH is authorized by 38 U.S.C § 2003(b) which requires VA to ensure that sufficient case management is provided to HUD-VASH participants.

Evidence

HUD-VASH subscribes to the principles of the Housing First model of care. Housing First is an evidence-based practice model which has demonstrated that rapidly moving individuals into housing and wrapping supportive services around them as needed, assists homeless individuals in exiting from homelessness and maintaining housing stability. HUD-VASH program goals include assisting homeless Veterans and their families in achieving housing stability while promoting maximum recovery and independence in the community. HUD-VASH targets Veterans with the greatest needs, ensuring that the most vulnerable Veterans are moved into housing as quickly as possible.

HUD-VASH Voucher Utilization as of September 30, 2022:

- Vouchers Allocated: 107,556
- Vouchers Under Lease: 80,501
- Vouchers Issued to Veterans Seeking Housing: 6,057
- Vouchers Reserved for Veterans: 1,547

HUD-VASH Measures of Success:

- Voucher Utilization Rate: Target 92% (Utilization as of September 30, 2022: 79%)
- HUD-VASH Case Manager Positions Filled: Target 90% (Positions filled as of September 30, 2022: 83%)

Implementation Plan
HUD awards HUD-VASH vouchers based on geographic need to public housing authorities (PHAs) who self-identify to HUD their interest in receiving an allocation. HUD announced its 2021 allocation of 2,050 new vouchers in December 2021 and anticipates additional awards of up to 8,500 vouchers will be made available with its 2022 funding. Additionally, HUD's Office of Native American Programs (ONAP) announced expansion grants for the Tribal HUD-VASH Demonstration Program in 2021 and 2022. In total, three new tribes were awarded Tribal HUD-VASH grants and five tribes were awarded expansion grant funding.

Upon HUD's publication of new HUD-VASH voucher awards and Tribal HUD-VASH grants, VA funds will be distributed to the VA medical centers (VAMCs) partnering with the local PHAs or Tribally Designated Housing Authorities (TDHEs). These funds will be used to provide VA or VA-contracted case management services to HUD-VASH Veterans. The 2024 total funding level of $617.6 million is projected to support approximately 115,000 HUD-VASH rental subsidies anticipated to be available in 2024.

Recent Trends
More than 107,000 HUD-VASH vouchers and Tribal HUD-VASH Demonstration Program rental subsidies are currently administered by HUD. VA's HUD-VASH budget supports the FTE and contract staff who provide case management and supportive services to Veterans in receipt of these subsidies. HUD-VASH currently funds more than 4,300 VA FTE nationally, in addition to approximately $40 million in contract services. The proposed 2024 budget would fund these existing staff and contractors as well as additional staff and services congruent with the recent expansion of the Tribal HUD-VASH Demonstration Program, the anticipated award of new HUD-VASH vouchers in 2023 and additional HUD-VASH voucher awards in 2024. Medical Support and Compliance funds are also included to support a technical assistance contract to assist with the design and development of expanded services for aging and disabled Veterans, who account for more than 60% of the current HUD-VASH population. The proposed 2024 budget also includes funds to support the increased costs associated with compliance with Section 4207 of the *William M (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021* (P.L. 116-283).

Grant & Per Diem (GPD):

Purpose
VA's GPD Program is a permanently authorized program (P.L. 109-461) to provide transitional housing and supportive services for homeless Veterans. The purpose is to promote the development and provision of supportive housing and services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels or income and obtain greater self-determination. The program currently supports approximately 12,000 transitional housing beds nationwide. Grantee awards entitled them to receive per diem payments from VA to offset the operational costs associated with serving these Veterans. Per diem rates are statutorily tied to the State Home for domiciliary care and increase annually with inflation. VA assumes a 3% inflation factor in future years to support anticipated increases in the State Home per diem rate and accounts for an increase in the maximum per diem rate from 100% to 115% of the State Home rate for domiciliary care, effective after the end of the public health emergency due to COVID-19, per P.L. 116-315. Of note, the 2022 per diem rate increased by nearly 5% from 2021, which is more than

the usual approximately 2% annual increase. Therefore, VAs projected per diem increase is estimated at 3% for 2024.

Evidence
The GPD Program has effectively served as a resource for communities to assist homeless Veterans with transitioning out of homelessness since it was first authorized in 1994. GPD fosters a partnership between VA and community-based agencies to create transitional housing resources for homeless Veterans nationwide. GPD-funded projects offer communities a way to help homeless Veterans with housing and services while assisting VAMCs by augmenting or supplementing care. Although the GPD funding request is not to support a new initiative, these funds will allow VA to continue to support this much-needed housing resource. The increase in funding will support costs associated with projected inflation of per diem and new provisions for minor dependents associated with the implementation of P.L. 116-315, which the Department is statutorily required to provide.

GPD's impact in 2022 included:

- VA's largest transitional housing program with approximately 12,300 beds nationwide.
- Over 18,000 Veterans entered GPD transitional housing.
- Nearly 24,000 homeless Veterans were served by GPD transitional housing grants.
- Over 10,000 homeless Veterans exited GPD transitional housing to permanent housing.
- GPD transitional housing grants continued from 2021:
    - **Per Diem Only grants** are used to provide transitional housing beds and operate service centers for Veterans experiencing homelessness. These grants provide funding in the form of per diem payments to reimburse grantees for the cost of care provided to Veterans during the award period. A total of 357 grants to organizations were awarded to provide approximately 11,500 beds and 17 service centers totaling approximately $246 million.
    - **Transition in Place grants** provide funding to community agencies that place Veterans experiencing homelessness in transitional housing while providing them with supportive services. These services are designed to help Veterans become more stable and independent with the ultimate goal of Veterans assuming full responsibility for the lease or other housing agreement. When that goal has been achieved, the transitional residence becomes the Veteran's permanent residence and supportive services come to an end. A total of 42 grants to organizations were awarded to provide 678 beds totaling about $55 million.
- VA awarded three different types of grants from new Notices of Funding Opportunity.
    - **Case Management grant**: VA offered approximately $30 million for two-year renewal funding. This is an opportunity for existing grantees providing housing retention services to former homeless Veterans and Veterans at risk for homelessness. A total of 121 grants to organizations were awarded to support almost 155 case managers, totaling about $28 million over two years.
    - **Special Need**: VA offered a minimum of $15 million for a three-year grant to provide funding to organizations to help Veterans with special needs who are experiencing

homelessness, including women, individuals with chronic mental illnesses and Veterans who care for minor dependents. A total of 26 grants to organizations were awarded for 217 beds totaling about $24 million over three years.

- **Capital grant**: VA offered two funding opportunities to current Per Diem Only transitional housing grant recipients. The grant would be used to reduce shared living spaces within transitional housing by creating private bedrooms and private bathrooms for homeless Veterans. In total, VA awarded over 90 capital grants totaling approximately $128 million to improve approximately 2,000 beds over the next 18 to 24 months.

Implementation Plan

With the grants, GPD has approximately 12,300 transitional housing beds in 2022, which will sustain existing capacity. Performance standards are established and tracked for all GPD grants. GPD liaisons review progress toward meeting these targets with all grantees at least quarterly. The total funding level of $306.1 million for 2024 and $319.8 million for 2025 is projected to support 12,300 transitional housing beds and 17 independent services centers.

- GPD funding is primarily used to support grants and per diem payments for approximately 600 active grants nationwide. A 10% increase has been added to help support inflation costs and the recently modified statutory authority under P.L. 116-315 that increased per diem from 100% of the State Home rate to 115%. This change impacts approximately 11,500 of the 12,300 transitional housing.
- Additionally, P.L. 116-315 also expanded the statutory authority to pay per diem for minor dependents.
- Funding level will support sustainment of approximately 12,300 per diem beds, as well as the continuation of Case Management and Transition In Place grants. Per diem is statutorily tied to the State Home domiciliary rate and increases annually.
- Due to the expansion in the number and types of grants that the GPD Program is responsible to oversee, an additional $1 million in MS&C appropriated funding is needed to ensure essential fiscal and programmatic oversight activities occur. The MS&C funding covers program office salaries and an SLA for fiscal oversight and monitoring for all grant projects.
- GPD Liaison FTEs are located at VAMCs nationwide and responsible for the oversight, monitoring and ensuring grant compliance for all active GPD grants.

Health Care for Homeless Veterans (HCHV):

Purpose

The HCHV program has effectively provided outreach services to the Nation's most vulnerable Veterans and has served as a resource for communities to assist homeless Veterans with transitioning out of homelessness since it was first authorized in 1987. The central goal of all HCHV programs is to reduce homelessness among Veterans by engaging and connecting homeless Veterans with health care and other needed services. HCHV programs provide outreach, case management and HCHV Contract Residential Services (CRS) programs ensuring that homeless Veterans, especially those who are chronically homeless (many with serious mental health diagnoses and/or substance use disorders) can engage with VA and community partners that

provide quality housing and services that meet the needs of these special populations. The HCHV Program is authorized by 38 U.S.C. §2031 and 38 CFR Part 63.

Evidence
Through September 2022, HCHV program staff provided outreach services to 21,566 Veterans, case management to over 8,810 Veterans and served more than 38,321 through Stand Downs. The HCHV Program also supports 3,858 operational CRS emergency transitional housing beds with 4,060 Veterans exiting the CRS programs into permanent housing October 2021 through September 2022. The age of homeless Veterans exiting the CRS transitional housing into permanent housing was 54% through September 2022. This percentage of Veterans exiting into permanent housing has increased each consecutive year from 48% in 2017, to 51% in 2018, 54% in 2019 and then 56% in 2020 (there was a slight dip to 52% in 2021 due to COVID-related challenges). It is expected that 15,000 Veterans will need outreach services in 2023 and 16,000 Veterans in 2024.

Implementation Plan
Each VA medical center across the country implements the HCHV program at the field level and ensures continuity of services each year. HCHV staff are in place at each medical center to provide outreach services to those Veterans experiencing literal street homelessness. Performance standards are established and tracked for all HCHV CRS Programs. CRS liaisons review progress toward meeting these targets with all grantees at least quarterly. The 2024 funding level of $264.5 million is projected to support HCHV outreach staff and CRS liaisons, more than 3,900 HCHV CRS beds, which offer residential treatment for Veterans experiencing homelessness; 86 Coordinated Entry Specialists who work with local Continuums of Care to identify and coordinate services for homeless Veterans in their communities; Stand Down support for VAMCs and 32 Community Resource and Referral Centers (CRRCs) which are a collaborative effort of VA, the community, service providers and agency partners which provide an open door, one-stop hub for homeless Veterans, providing a central location to engage homeless Veterans in VA and community services.

In addition to the above, the VA is exploring development of a new shelter-like level of care within its homeless services continuum called Safe Haven Shelter Services (SHSS). SHSS provides vulnerable unsheltered homeless Veterans with low barrier to entry safe haven shelter services, with access to health care, case management, peer support, meal services, a clean environment and temporary housing assistance in a designated area on VAMC campuses. SHSS is based on an innovative practice initiated by the VA Greater Los Angeles Healthcare System (VAGLAHS) on its West LA campus called Care Treatment and Rehabilitative Services (CTRS). Created under authority provided by section 4201 of P.L. 116-315, CTRS was designed initially as a safe and healthy shelter alternative for homeless Veterans residing in an encampment outside the medical center. CTRS participants are provided a private tiny shelter and access to VA medical and behavioral health care services, three daily meals, clean water, soap, bathrooms, showers and weekly laundry services during their program participation. The West LA Campus site currently has 141 tiny shelters for Veterans, including ADA-accessible accommodations for those with impaired mobility. Based on the success of CTRS in Los Angeles, the continuing high numbers of unsheltered homeless Veterans nationally and the need for low barrier safe haven settings that can provide 24-hour, weekly immediate access to shelter and services for Veterans. VA is launching a

pilot effort to develop at least three new SHSS projects nationally. Using GLA's CTRS as a reference, VA estimates that each new SHSS project could cost up to $10 million to develop and operate in its first year. In subsequent years, VA estimates ongoing annual operational costs of approximately $4 million per project. Thus, VA requests a total of $30 million for the first year of this pilot project. It should be noted that these estimates assume a project of 50 tiny shelter units on a one-acre lot. Actual costs could vary widely, depending on the actual number of housing units at each site, type of housing used, whether it requires new construction or significant remodeling as opposed to a move-in ready structure, whether donated or purchased by VA and so forth.

Supportive Services for Low Income Veterans & Families (SSVF):

Purpose
SSVF is a critical initiative designed to help reach the Administration's goal of ending homelessness among Veterans. The SSVF program was authorized by P.L. 110-387, *Veterans' Mental Health and Other Care Improvements Act of* 2008 and provides supportive services to very low-income Veteran families that are currently in or transitioning to permanent housing. SSVF is designed to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis. Funds are granted to private non-profit organizations and consumer cooperatives that will assist very low-income Veteran families by providing a range of supportive services designed to promote housing stability.

Evidence
During the 10 years of operation, SSVF has exited more than 80% of Veterans and their families to permanent housing. SSVF's success has significantly contributed to decreasing the number of homeless Veterans since 2010. Annual reports published since the inception of the SSVF program continue to demonstrate the efficiency and effectiveness of the SSVF program (reports and additional research is available at https://www.va.gov/homeless/ssvf/research-library). For example, research conducted by the National Center on Homelessness Among Veterans found that for those Veterans exiting SSVF and placed in permanent housing, only 6% to 13% of families and 7% to 15% of individuals re-enter the homeless system one year after discharge from SSVF. As a point of comparison, these return rates were comparable to the 7% to 10% of Veterans in poverty who are estimated to experience homelessness on an annual basis according to the best available data from 2012 through 2019. This is a particularly important finding as it is well-established that those who have previously been homeless are at higher risk of future homelessness. SSVF's ability to maintain these strong outcomes depends on training and support for its grantees coupled with a robust oversight program.

- In 2022, SSVF helped 102,306 individuals, with 71,386 Veterans assisted and 17% or 17,588 of those enrolled represented dependent children.
    - Of the Veterans assisted, 9,960, or 14% were female (compared to 8-9% of the homeless Veteran population)
    - 72% of those discharged from the SSVF program obtained permanent housing

SSVF innovations and services supported by the 2024 budget:

- The housing affordability crisis has been exacerbated by the epidemic. On January 30, 2022, The Washington Post reported, "Rents are up more than 30% in some cities, forcing millions

to find another place to live." To help close the housing affordability gap that has grown significantly due to the pandemic, 2022 funding included $350 million to nationally expand Shallow Subsidies. Shallow Subsidies provide two years of continuous rental assistance (traditional SSVF rental assistance provides only 10 to 12 months of rental assistance in a two-year period) for Veteran families who do not need intensive clinical supports and are struggling to meet growing housing costs burdens.

- SSVF has introduced new incentives in an effort to recruit landlords and increase the stock of available housing. These incentives, offering the equivalent of 2-months' rent, were introduced in a June 24, 2022, Notice of Funding Availability (NOFA) targeting high-need communities. These incentives are critical to mitigating the risks landlords accept when leasing to Veterans who often have poor credit histories or criminal justice involvement. This NOFA was largely funded through ARP and resulted in $137 million in non-recurring 4-year awards. SSVF also expanded eligibility so that Veteran families with incomes up to 80% of the area median income (AMI) could now be served. This step was critically important for disabled Veterans with high levels of service-connected benefits who had incomes exceeding the 50% AMI income cap previously used for SSVF eligibility. On October 27, 2022, SSVF issued another NOFA that expanded this resource nationally for 2024, based on the President's Proposed Budget.
- A hotel or motel emergency housing option can be a critical engagement tool for those unsheltered homeless unwilling to go into traditional shelter or emergency housing options available through the community or VA. SSVF's hotel/motel option will continue to be utilized post-COVID as a critical engagement option for this population. A current example of this value is the recent success moving Veterans out of encampments near the Greater Los Angeles VAMC and into permanent housing.
    - As of July 30, 2022, SSVF grantees maintain 1,383 Veterans in hotels or motels.
- Upgraded health care supports, such as the health care navigators now offered by all SSVF grantees, help homeless and at-risk Veteran families access critically needed health and mental health resources. Initially supported with CARES funding, this initiative is now sustained with $20 million in ARP funding.
    - Creating attractive new emergency housing alternatives engaged more seriously ill Veterans. Between 2019 (pre-pandemic) and 2020, SSVF participants with substance use disorders increased from 46 to 59%, major depressive disorders increased from 35 to 56% and cardiovascular disease increased from 50 to 61%. Hotels and motels offer safer, less restrictive and more private accommodations than traditional shelters or other program-based temporary housing.
- SSVF has distributed $24 million in ARP funds to support direct access to legal services for those enrolled in SSVF. The eviction moratorium demonstrated the importance of policy and legal remedies in preventing homelessness.

Base grant awards of $418 million in support for 2022 grantees were provided to non-profit organizations in all 50 states, Puerto Rico, the District of Columbia, Guam and the Virgin Islands. This does not include supplemental funding for special initiatives related to VA's COVID-19 response.

Implementation Plan
VA publishes the SSVF NOFA in the Federal Register, typically at the end of the calendar year. Awards are made to community-based, non-profit organizations who are responsible for delivering SSVF services. Currently, Veteran families throughout the country can access SSVF services becuase grantees are located in all 50 states, the District of Columbia, Puerto Rico, Guam and the Virgin Islands. The 2024 budget proposes a funding level of $774 million to support the SSVF program.

A NOFA was published in the Federal Register, on October 27, 2022, to announce the availability of SSVF grant funding for 2024. The availability of 2025 grant funding would be announced through a NOFO published in the first quarter of 2024.

National Call Center for Homeless Veterans (NCCHV):

Purpose
In alignment with the President's definition of our country's most sacred obligation of caring for Veterans and their families and in support of Secretary McDonough's pledge "to be a fierce, staunch advocate to Veterans" and "focus on working to eliminate Veterans' homelessness,"[62] Member Services NCCHV program plans to improve homeless support services by improving quality, expanding communication modalities and closing the gap from Active Duty to post-service life as a Veteran.

Our quality improvement effort will provide NCCHV leadership the ability to quickly identify, understand and resolve problems within the contact and proactively implement changes for future interactions with Veterans. This will help NCCHV become a more Highly Reliable Organization by not only rectifying intermittent and systemic problems but also objectively identifying improvement opportunities for Veteran Access.

Adding text capability to the current phone and chat modalities will enhance the Veteran experience and allow NCCHV to be more responsive to younger and tech-savvy Veterans who are more willing to correspond via text, while saving money for those with limited cell plan minutes or calling card resources.

NCCHV is currently partnering with the Homeless Program Office, Veterans Benefits Administration (VBA) and Department of Defense (DoD) in a Transitioning Service Member Resource Connection (TSMRC) pilot, which provides information, resources and tools to Service Members and their families to help prepare for the move from military to civilian life and NCCHV to assist Service Members at risk for homelessness upon separation from the military. Creating a mechanism for a warm handoff with NCCHV contact prior to leaving active-duty service will ensure at-risk Service Members are actively managed and connected with the appropriate VA Homeless Veteran's representative. Follow-up reviews will ensure each Veteran has adequate housing prior to their first night on the street.

[62] Secretary McDonough, March 2021, End Homelessness Virtual Conference, Washington, DC

Evidence
Commission on Accreditation of Rehabilitation Facilities and International Customer Management Institute Accreditation depends on the establishment and utilization of a quality monitoring program. A Quality Monitoring Pilot conducted in 2019 showed an 8% increase in productivity for NCCHV due to coaching and monitoring to ensure Social Service Representatives were using the correct processes. Text messaging is currently used by the Veterans Crisis Line (VCL) as one of three effective modalities high-risk Veterans use to contact a VA representative to assist them with their needs. Currently NCCHV takes over 50,000 chats per year, text messaging will provide another avenue of contact. Approximately 18,000 separating Service Members per year without Post Transition Housing Plans are projected to receive an inbound phone call. Each new Veteran served would receive at a minimum one (1) referral and one (1) follow-up review.

Implementation Plan
NCCHV would rely on Health Resource Center's current Quality Monitoring Team to implement a plan specific to NCCHV. NCCHV can duplicate an already established text messaging process utilized by the VCL. NCCHV will continue collaborating with VBA, Homeless Program Office and DoD to expand the TSMRC pilot from five DoD installations to a nationwide rollout by 2024. The 2024 funding level of $10.9 million will support NCCHV's Quality Monitoring Pilot to mirror VCL's already-established text messaging process and its coordination efforts with the TSMRC to better assist Service Members who are at risk for homelessness upon separation from the military.

Veterans Justice Outreach Homeless Prevention (VJO):

Purpose
The VJO program facilitates access to VA health care and other services for Veterans who are involved with the criminal justice system and therefore face heightened risks of homelessness, suicide and other negative outcomes. Congress has recognized the value of this program by mandating the expansion of VJO field staff by 50 FTE in 2019, through P.L. 115-240, *Veterans Treatment Court Improvement Act of 2018*. This request provides for the continued growth and sustainment of the program, in keeping with Congress's demonstrated intent.

Evidence
The demand for VJO services is expected to continue growing through 2024. As communities become increasingly aware of the presence of Veterans in their criminal justice system and of resources available for addressing their needs, more and more of these communities adopt and develop program models such as Veterans Treatment Courts and/or Veteran-specific housing units in local jails. The number of VTCs and other Veteran-focused courts is now more than 600 and the number of Veteran-specific housing units in local jails is now over 100 and rising. In order to facilitate Veterans' access to VA services at the earliest possible point after contact with the criminal justice system, these programs require assistance from VJO Specialists, whose time and capacity are finite.

As noted above, communities across the country continue to launch new Veteran-specific criminal justice programs – such as Veterans Treatment Courts and Veteran-specific jail housing units – and in some cases to expand the capacity of such programs that already exist. The sustained growth in demand for VJO services is evidenced by VAMCs' continued requests for additional VJO FTE

to serve justice-involved Veterans in the communities they serve. The 2022 increase in the VJO budget allowed VAMCs to add 27.5 new FTE, including the first peer specialist positions dedicated to working with justice-involved Veterans (11 FTE), which should satisfy a significant amount of the demand for new VJO capacity. The more modest projected increase in 2023 will mean that facilities will have a significant demand for additional VJO capacity in 2024.

VJO Specialists serve a Veteran population with significant and often complex clinical needs and recent evidence demonstrates a high level of effectiveness at linking these Veterans to responsive services. In 2021, 95% of Veterans served by VJO Specialists went on to access face-to-face VHA services. Of these Veterans:

- 75% were diagnosed with one or more mental health disorders and 92% of those with such diagnoses entered VHA mental health treatment.

56% were diagnosed with one or more substance use disorders and 66% of those with such diagnoses entered VHA substance use disorder treatment.

Implementation Plan
The additional funds requested for 2024 would support VAMCs' hiring of additional VJO Specialists and Peer Specialists (approximately 50 FTE) to develop and/or expand partnerships with local criminal justice agencies to facilitate justice-involved Veterans' access to needed VA treatment at the earliest possible point. The award and hiring processes would follow a model that has been in place for ten years. These positions are awarded on a needs-driven basis, in response to VA facilities' demonstrations to the VJO program office of current and projected demand for VJO services in the communities they serve. After receiving notification of a new award, each receiving VAMC fills its allocated position and reports on its status to VHACO via the Homeless Staffing Database operated by the Veterans Support Service Center. Facilities are given 90 days to fill newly awarded positions, after which the award is subject to withdrawal.

The use of specific-purpose funding from VHACO has been critical to the growth of the VJO program to date and will remain so. Because VJO Specialists must spend significant time in collaborative planning with criminal justice partners, as well as traveling to distant outreach locations, their clinical workload is often lower than that of staff in VAMC-based programs. VAMC's have generally requested additional funding from VHACO to sustain locally funded positions over time.

The 2024 estimated funding level of $64.7 million is projected to support outreach and linkage to VA services for justice-involved Veterans by approximately 470 VJO staff. The 2025 funding level of $74.8 million will facilitate an expansion of the VJO workforce to approximately 545 staff. This expanded VJO workforce will be able to respond to the continued growth of Veteran-focused interventions in local criminal justice systems, including by providing direct support to more than the 623 VTCs in which they currently serve Veterans.

Legal Services for Veterans (LSV):

Purpose
This is a new program within the Homeless Programs Office, focused on facilitating Veterans' access to legal services, including for civil legal matters such as landlord/tenant disputes and child

support arrears that can present barriers to housing stability. In addition to providing training, technical assistance and partnership-development support with legal service providers for VHA, the LSV program will administer two streams of grant funding to support the provision of legal services to Veterans by eligible non-VA entities.

Evidence
These new grant programs are mandated by section 4202 of the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020* (P.L. 116-315) and section 548 of the *William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021* (P.L. 116-283).

Implementation Plan
Section 4202 of P.L. 116-315 requires VA to award grants to eligible entities for the provision of legal services to Veterans who are homeless or at risk of homelessness. Following consultation with Veteran Service Organizations and legal service providers, VA developed regulations governing this new grant program, which were published as an Interim Final Rule on June 1, 2022. VA published a Notice of Funding Opportunity in October 2022 and will award the first round of grants in 2023.

Section 548 of P.L. 116-283 requires VA to establish a pilot grant program within one year to assess the feasibility and advisability of awarding grants to external entities for the provision of legal services to individuals who served in the Armed Forces, regardless of the conditions of their discharge or release. Subsection (b) also requires VA to ensure at least one grant is issued in each state under the pilot program. Legal services funded by these grants must be provided at locations other than VA facilities. VA's authority to award grants under this pilot program runs for five years from the date of the program's establishment.

After consulting with external groups that currently provide legal assistance to Veterans and former Service members for issues identified in the statute (discharge upgrades, benefits assistance and others), VA is developing regulations under which it will be able to award grants to eligible entities. As required by section 548(b), these grants will be awarded through a competitive process that ensures consideration of applicants' experience, financial capacity and other specified qualifications.

The 2024 budget request will support the salary for the coordinator of these two new grant programs. The amount requested for 2024 includes these salary costs, as well as $15 million for the grant program authorized by sec. 548 of P.L. 116-283, to support the award of an estimated 100 grants to legal service providers, in amounts of up to $150,000 each. An additional $11 million of the amount requested for 2024 will support up to 75 grants under section 4202 of P.L. 116-315, also of up to $150,000 each. Grants in this amount would cover annual salary and benefit costs for approximately one attorney position, depending on experience and locality (National Association for Law Placement, 2018), as well as data collection, reporting and other administrative costs associated with the grant. The amount requested for 2025 includes an additional $20 million to support expansion of either or both new grant programs, if justified by successful performance.

Homeless Patient Aligned Care Team (HPACT):

Purpose

The HPACT program is a multi-disciplinary, population-tailored medical home designed around the unique needs and distinct challenges homeless Veterans face both accessing and engaging in health care. Interdisciplinary teams of doctors, nurses, case managers and other health professionals respond to the ongoing and evolving medical, social, mental health and substance abuse needs of homeless Veterans entering the VA system. The program serves as a conduit for treatment engagement and involvement in VA Homeless Programs and clinical services and support through a "no wrong door" policy. The HPACT program provides and coordinates health care that Veterans may need to help accelerate placement into permanent housing and prevent a return to homelessness. HPACT is authorized to provide health care to eligible Veterans under Title 38 U.S.C. 7302(b), Title 38 CFR Section 17.38.

Evidence

In 2012, the HPACT program began with a total of 32 pilot sites. There are 86 HPACT teams and providers operating at 56 VAMCs, CBOCs and CRRCs across the country. HPACTs are located in every VISN with over 192 FTE staff serving over 22,000 Veterans annually. Collectively, Veterans enrolled in HPACT show a 19% reduction in emergency department visits and a 35% reduction in inpatient hospitalizations. Veterans in HPACTs were housed in permanent housing 81 days faster than those not enrolled in a HPACT. In addition, HPACT Veterans are more likely to report positive patient care experiences related to access, communication, provider ratings and comprehensiveness of care than those enrolled in standard primary care. The benefits of HPACT and potential expansion is the program's ability to address multiple medical and social needs of Veterans in one setting. This is accomplished by incorporating five core elements that distinguish HPACT from traditional primary care models:

1. Reducing barriers to care by providing open-access, walk-in care in addition to community outreach to engage those Veterans disconnected from VA services.
2. One-stop, wrap-around services that are integrated and coordinated and include mental health, homeless programs and primary care staff that are co-located to create a continuum of care and an integrated care team. Most HPACTs also provide food and clothing assistance, hygiene items, showers and laundry facilities and other services on-site to meet the full spectrum of Veteran needs.
3. Engaging Veterans in intensive case management that is coordinated with community agencies, partners and other VA services for continuous care with more seamless transitions.
4. Providing high-quality, evidence-based and culturally sensitive care that is validated through research evaluation and achieved through the provision of ongoing homeless education for HPACT staff.
5. Being performance-based and accountable with real-time data and predictive analytics to assist teams in targeting Veterans most in-need, provide on-going technical assistance and personalized feedback to teams and inform field-based performance.

Implementation Plan
HPACT last issued funding for the start-up of new teams or expansion of existing teams in 2017 and recently received funding to provide an opportunity for the launch of up to eight new teams in 2023. The 2024 budget request is to support the growth and increased need of the HPACT program to include a new pilot initiative that brings the HPACT program model directly to HUD-VASH Veterans. This HUD-VASH/HPACT pilot utilizes the HPACT medical home model and population tailored approach to provide in-home primary care services to Veterans actively enrolled in the HUD-VASH program. Providing medical care, mental health and wrap around services that are coordinated and integrated for enrolled HUD-VASH Veterans increases housing stability by helping to keep these Veterans in their homes as they age and reduces emergency department visits and inpatient admissions. Initial pilot sites will be prioritized based on total HUD-VASH voucher allocation overall and a focus on high need areas. Specific purpose funding is an integral part of the growth, expansion and sustainment of the HPACT program and needed to launch this pilot. Therefore, a $3 million increase is requested for 2024 to cover the pilot program for HUD-VASH/HPACT team staffing at five VA medical center sites. This includes the following positions for team composition based on the HPACT model: provider (MD/DO, NP, PA), RN care manager, LPN/LVN and MSA. The case manager (SW) role will be fulfilled by the Veteran's current HUD-VASH case manager and mental health services to be fulfilled by close collaboration with all homeless services, mental health and use of other resources such as telehealth. With almost 14% of current HUD-VASH enrolled Veterans having no assigned primary care provider and many with high acuity medical needs as 60% are over the age of 60, this pilot program will create an opportunity for HUD-VASH Veterans to have direct access to in-home HPACT services. Increased access and engagement with health-related resources will help to improve housing retention for HUD-VASH Veterans while ultimately increasing voucher utilization and contribute to the goal of ending Veteran homelessness.

Homeless Veterans Community Employment Services (HVCES):

Purpose

HVCES provides employment services and resources to Veterans participating in VHA homeless programs to increase access to permanent housing and improve housing stability. This is accomplished both through the provision of direct services and by providing a bridge to employment opportunities and resources in the local community. To help improve employment outcomes for homeless Veterans, VA continues to support the Vocational Development Specialists who are embedded in homeless program teams and serve as Employment Specialists and Community Employment Coordinators (CEC). HVCES staff ensure that a range of employment services are accessible to Veterans who have experienced homelessness, including chronically homeless Veterans and complement existing medical center-based employment services. Homeless Veteran Community Employment Services (HVCES) is authorized by 38 U.S. Code §2031 and §2033.

Evidence
In 2022, approximately 5,600 Veterans exited homeless residential programs with competitive employment (that is, GPD, Low-Demand Supportive Housing (LDSH) and Healthcare for Homeless Veterans–Contract Residential Services (HCHV-CERS). Employment rates for Veterans housed through HUD-VASH were over 52% exceeding the national target of 47%.

During 2022, there were 13,171 newly documented, unique instances of employment for Veterans engaged in or who exited from VA Homeless Programs or Services. Although staff have returned to face-to-face visits with Veterans, virtual platforms are well utilized in the provision of employment services and provide increased flexibility for Veterans and greater opportunities to reach those who are not in close proximity to a VA medical center.

Implementation Plan
HVCES received increased funding in 2023 to better serve the increased numbers of Veterans in HUD-VASH case management (the largest VHA homeless program) which rose from 66,287 in 2014 to 88,489 in 2020. While not all Veterans served by VHA Homeless Programs may be interested in employment, it is critical to provide employment assistance to all Veterans who are able to return to work. The requested funds support the Vocational Development Specialists who provide direct employment services to homeless Veterans and develop employment opportunities and community partnerships to broaden available resources. In 2024, the collaboration between VHA homeless programs and Department of Labor (DOL) programs such as, but not limited to, Veterans' Employment and Training Services (VETS), Homeless Veterans Reintegration Program (HVRP) and Senior Community Services Employment Program (SCSEP) will continue to be a focus on both national and local levels including joint trainings for staff and highlighting the impact of this partnership on employment for Veterans who have experienced homelessness. The 2023 funding level of $19.8 million supports 200 FTE at the GS-11 level. An additional $772,000 is requested in 2024 to allow for promotion of up to 10 staff across sites to function as leads or supervisors based on local needs. Opportunities for advancement increase overall staff satisfaction and help to retain high producing and experienced staff who can provide support and training to the field. In addition, this increase would fund two additional FTE which have been specifically requested by sites to increase the reach of their services across local catchment areas, including rural locations.

National Homeless Registry:

Purpose
The National Homeless Registry is a comprehensive repository of Veterans who have been identified as homeless or at risk for homelessness any time since October 1, 2005 and their associated housing, employment, clinical, administrative and benefit information. It is designed as both a robust repository and data management tool that provides longitudinal information designed to monitor VA's progress in achieving the goal of ending Veteran homelessness. The Homeless Registry incorporates information from Homeless Operations, Management and Evaluation (HOMES), a data collection tool used by front-line homeless coordinators to manage their outreach, assessment, referral and case management work, as well as VHA health care records, VBA benefits and claims, homeless program specific evaluation data and community partner data related to services provided to homeless Veterans and those at risk for homelessness. The Homeless Registry also contains geographic, programmatic and Veteran-specific information related to housing stability, treatment engagement and VA benefit enrollment.

Evidence
To actualize the goal to advance the VA's mission to end Veterans' homelessness, a consolidated repository of Veteran data was created. In 2010, funding for the Registry Budget was secured to

address this gap. The creation of this registry of Veteran data has become the foundation for guiding program development and formatting research to enhance services for Veterans. Knowledge gained from these efforts augment the original registry content and adds to its ongoing development.

The National Homeless Registry supports Homeless Program Initiatives related to the expansion of ongoing efforts to support VA's mission to end Veteran homelessness, specifically related to (1) increasing access to telehealth services for Veterans engaged in homeless programs; (2) productivity and workload capture compliance and standards; (3) EHRM Medical Record transition to Cerner, (4) OSCVA calendar year 2022 permanent housing placement goal; (5) centralized technical assistance for VISN and VAMCs around homeless program policy and compliance efforts; (6) identification of service gaps and proactive engagement to reduce gaps; (7) Homeless Program performance measurement and program evaluation efforts; (8) Federal Partner, community and VA data sharing initiatives; (9) national identification and dissemination of innovative practices; (10) tracking and reporting mechanisms for homeless programs to support increased utilization, service provision and resource allocation; (11) national support to ensure prioritization of required clinical staffing levels for VA Homeless Programs and (12) centralized COVID-19 response.

Implementation Plan
Maintenance and addition to the Registry is an ongoing process. The Registry Budget supports the development and maintenance of a comprehensive repository of Veterans who have been identified as homeless or at risk for homelessness any time since October 1, 2005 and their associated housing status, employment, clinical, administrative and benefit information. It is designed as both a robust repository and data management tool that provides longitudinal information intended to monitor VA's progress in achieving the goal of ending Veteran homelessness.

The requested increase of $1.2 million in MSC funding supports FTE and travel for the following:

- The Homeless Operations, Management and Evaluation (HOMES) 2.0 development, management, technical assistance and sustainment. HOMES is a data collection platform used by front-line homeless coordinators to manage and document outreach, assessment, referral and engagement in homeless program services. Data are used to support budgetary, evaluative, performance measurement and policy decisions, in addition to supporting VAMC homeless program operations. Previously, partner offices dedicated over ten FTE to this work, however, these offices have rescinded support. Sustainment of HOMES is critical to homeless program operations and workload must be assumed by HPO going forward, therefore, FTE is critical.
- Homeless Program Telehealth Initiative was initiated in 2021 and FTE are needed to sustain the expansion of telehealth to homeless Veterans, to include procurement and logistical management of telehealth equipment, technical assistance and ongoing coordination with partner clinical offices.
- VHA migration to the new Oracle Cerner EHR, specifically technical assistance, clinical consultative support with Cerner and data migration efforts.

- Expansion of homeless program reporting capabilities, to include VAMC level and leadership dashboards to support national initiatives, data sharing with community providers and national/VISN/VAMC level insights to support program operations and service provision.

The National Center on Homelessness among Veterans (The Center):

Purpose
The Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016 (P.L. 114–315) codified the National Center on Homelessness among Veterans (the Center). The Center promotes recovery-oriented care for Veterans who are homeless or at risk for homelessness. The Center conducts and supports research, assesses the effectiveness of programs, identifies and disseminates best practices and integrates these practices into polices, programs and services for homeless or at-risk of homelessness Veteran populations and serves as a resource center for all research and training activities carried out by the Department and by other Federal and non-Federal entities with respect to Veteran homelessness. The Center operates within an integrated organizational model and is comprised of the following cores:

- Model Development & Implementation Core
- Policy/Program Integration Core
- Education & Dissemination Core
- Research & Methodology Core

Evidence
The Center works with its operational partners within VHA Homeless Programs and other stakeholders, such as community organizations, other VHA program offices, government agencies and academic affiliates, to identify key areas of research and program-process evaluations, educational needs and program integration opportunities. As a result, the Center has developed and piloted numerous housing models and interventions for Veterans at risk of homelessness and who have experienced homelessness. These programs are now VHA Homeless Programs' foundational services, including Homeless Patient Aligned Care Teams, Supportive Services for Veteran Families, Housing First, CRRCs, Low Demand Grant and Per Diem and the National Homeless Registry. Annually, the Center generates numerous peer-reviewed publications, trainings and on-line resources for thousands of VA and non-VA providers on issues related to homelessness and provides grants to the Center affiliated researchers to assist in expanding the Center's research capabilities.

Implementation Plan
Plans are on the way to expand the Center's research program in 2024 by developing and evaluating new interventions (targeting housing instability, health needs and social determinants of health) in partnership with other VA program offices and universities. Additional expansion opportunities include exploring the development of programs for vulnerable Veterans at risk for homelessness and the deployment of evidence-based practice training, such as Critical Time Intervention (CTI) based models for CRRC and HCHV outreach staff, predictive analytics and dashboards to identify Veterans at-risk of evictions and negative exits from homeless programs,

data-driven enhancements of virtual care services including services offered by the National Call Center for Homeless Veterans and development of financial literacy and money management resources for Veterans.

The National Center on Homelessness among Veterans (the Center) is seeking an increase in its MS&C funding to perform more research, program evaluation, education, model development and technical assistance to meet its public law mandates and support VA's priority mission of ending and preventing homelessness among Veterans.

- **Research/Program Evaluation:** An additional $2.6 million is being requested for 2024 and an additional $3.6 million in 2025 to expand the Center's Homeless Veterans-Research Engagement Panel (HV-REP), expand the Center's Research Fellowship Program, supplement an ongoing national data collection effort on low-income Veterans at risk for homelessness who are and are not accessing VA services, create a national homeless clinical trials network and refine and expand a primary homeless, unemployment and suicide prevention program for transitioning Servicemembers.
- **Education/Model Development/Technical Assistance:** An additional $950 thousand is being requested for 2024 and an additional $2.5 million for 2025 to develop and augment a public-facing online resource center that is viable, current and interactive; replicate a promising trauma-informed practice aimed at engaging and providing services to vulnerable Veterans who are chronically homeless or at risk of homelessness with serious mental illness and physical illness diagnoses and develop best practices to reach Veterans experiencing homelessness and at risk of experiencing homelessness who are not enrolled in VA homeless programs or VA health care.

Whole Health

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations 1/							
Medical Services (0160):	$66,764	$66,508	$66,508	$87,074	$97,937	$20,566	$10,863
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$8,080	$9,343	$9,343	$18,924	$19,502	$9,581	$578
Medical Facilities (0162):	$0	$0	$0	$1,850	$1,850	$1,850	$0
Obligations [Grand Total]	**$74,844**	**$75,851**	**$75,851**	**$107,848**	**$119,289**	**$31,997**	**$11,441**

[1/]Whole Health budget includes the entire $33.0 million in obligations requested for Patient Centered Care Services and Administration supporting P.L. 114-198 §933 (part of *Jason's Law*). This amount is also included in the Opioid Prevention, Treatment and Program budget shown earlier in the chapter.

Authority for Action

The activities of the office are governed by the following public laws and Executive Orders:

- Public Law 114-198 §933, *Comprehensive Addiction and Recovery Act of 2016*, signed into law July 22, 2016. Efforts are underway across VHA addressing the requirements of Comprehensive Addiction and Recovery Act (CARA), Public Law (P.L.) 114-198, Sections 932 and 933, which directed planning for and expansion of Complementary and Integrative Health services. The Whole Health System creates the health care approach that optimizes the benefits of complementary and integrative health services and selfcare.
- Executive Order 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life*, issued January 2018. It requires the Departments of Defense, Veterans Affairs and Homeland Security, through the Assistant to the President for Domestic Policy, to develop "a joint plan that describes concrete actions to provide, to the extent consistent with the law, seamless access to mental health treatment and suicide prevention resources for transitioned uniformed services members in the year following discharge, separation, or retirement."
- Executive Order 14058, Transforming Federal Customer Experience and Service Delivery to Rebuild Trust in Government. Specifically, the President's Management Agenda includes navigating transition to civilian life.

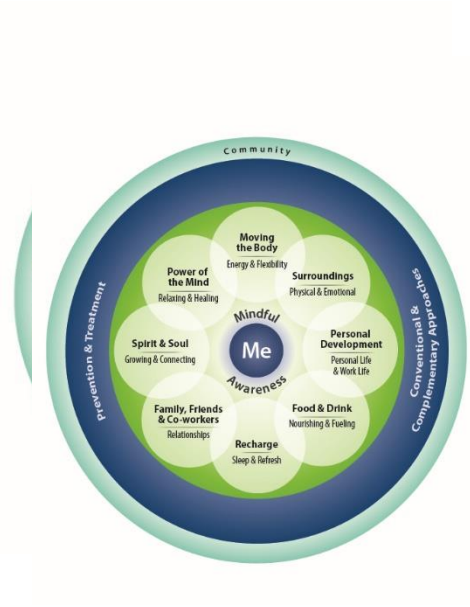
Populations Covered

All Veterans regardless of eligibility status are encouraged to participate in the Whole Health approach to care. Whole Health concepts are introduced in the Military Health System via in-person contact through the Transition Assistance Program (TAP). The materials include an overview of Whole Health and steps for engaging in the approach at local VA facilities or through on-line resources. All Veterans and the public have access to Whole Health web-based tools and resources: https://www.va.gov/wholehealth/. VA medical sites are encouraged to develop outreach mechanisms for both enrolled and unenrolled Veterans to encourage participation. The Whole Health system is also designed to be used by employees, both to engage employees in the system of care for Veterans as well as to positively impact the lives of the VA workforce. Research shows that personal experience with health interventions makes it more likely that a provider will share those interventions with their patients and increase the likelihood that the interventions will be

effective.[63] [64] Employee Whole Health is essential to health and resiliency and represents a proactive model of well-being that is protective against stressors and challenges employees face daily. Employee Whole Health will create an environment that encourages VA staff to adopt healthy behaviors that promote well-being, reduce the incidence of preventable illness and injury, staff turnover and burnout. Likewise, Employee Whole Health fosters a culture of engagement, which increases productivity and job satisfaction resulting in the best care for Veterans. VHA has created support tools for employees, especially during and following the coronavirus pandemic, to support well-being and resiliency, both of which are critical for a high-reliability organization (https:/www.va.gov/WHOLEHEALTH/professional-resources/EWH-resources .asp). Employees who reported involvement with Whole Health also reported their facility as a "best place to work," lower voluntary turnover, lower burnout and greater motivation.

Types of Services Provided

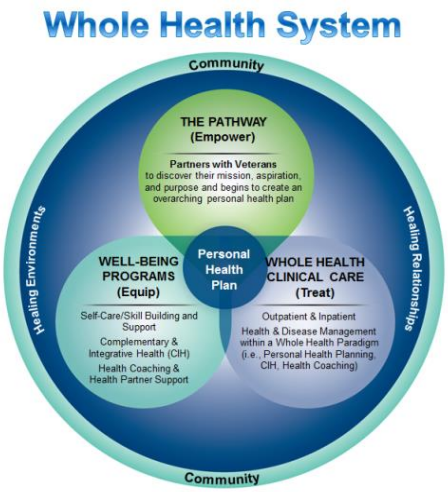
The Whole Health System centers around supporting the Veteran to improve their overall health and well-being. It integrates peer-led personalized health planning, use of Whole Health Coaches and well-being classes, with both allopathic (conventional medicine) and complementary and health approaches (for example, stress reduction, yoga, tai chi, mindfulness, nutrition, acupuncture and health coaching) that focus on Veterans' goals and priorities.



The Whole Health approach partners with Veterans to improve their whole health and is especially important for Veterans with complex conditions, such as chronic pain and mental health issues. The Whole Health approach also improves access by using trained Whole Health coaches and trained peer facilitators, which reduces the burden on primary care. The goals of the Whole Health approach focus on understanding the patient's life mission, aspiration or purpose (that is, what matters most to the Veteran versus what is the matter with the Veteran). Completion of the Personal Health Inventory that addresses the Whole Health Components of proactive health and well-being (first graphic), results in a Personalized Health Plan. The Personal Health Plan is owned by the Veteran and serves as an integrator among the components of the Whole Health System, keeping all members of the Veteran's team informed (second graphic).

[63] Witt, Martins, Willich, Schützler. 2012. "Can I help you? Physicians' Expectations as Predictor for Treatment outcome". *European Journal of Pain.*

[64] Frank, Dresner, Shani, Vinker. 2013. "The Association Between Physicians' and Patients' Preventive Health Practices. *Canadian Medical Association Journal.*



This model is based on the experience of over 200 innovation projects, followed by a total of 25 Whole Health Design sites in 2016-18. In addition to a detailed implementation guide, the Flagship facilities received education and training, resources and tools and onsite support. The next 37 facilities began Whole Health implementation in July 2019 and received similar resources and support. All other sites not formally designated as Flagship sites or next wave sites have engaged in consultative services to begin implementation of the Whole Health approach.

A detailed evaluation plan was developed for the flagship sites by the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) in collaboration with VHA's Health Services Research and Development Service's (HSR&D) Quality Enhancement Research Initiative (QUERI) to achieve the objective of the CARA/Whole Health System evaluation effort. The results of the current pilot justify making this program permanent and available across the entire VA health care system. At the 18 pilot sites, Veteran-participants dealing with chronic pain or mental health issues are experiencing a reduction in symptoms and a reduced need for long-term opioid therapy. Early data on the impact of Whole Health suggests that it can lead to a decrease in overall outpatient costs as well as to a more rapid decrease in opioid utilization than is being seen in the overall VHA patient population. Veterans at the 18 Flagship facilities are also experiencing an improvement in their sense of well-being. Results seen in the CARA-mandated pilot sites concluded that system-wide expansion of the Whole Health initiative can help to avoid or mitigate the recognized dangers of opioid overuse, while still clinically managing the chronic pain of our patients and improve overall well-being and other clinical outcomes. In addition, the VA can provide a model of health care delivery that will transform American health care.

Recent Trends

Nationally, there is a growing trend toward more patient-centered, value-based health care with a focus on well-being as opposed to purely disease management. Though leaders in health care including the Institute for Healthcare Improvement and the National Academy of Medicine are spearheading this trend, the Whole Health approach in VA is seen nationally as a cutting-edge example of how to implement this new focus.[65] The Whole Health System is the cornerstone of the VA strategy to implement this shift. As a result, 96% of VA medical centers offer Introduction to Whole Health sessions in person or through telehealth modalities with 69,879 over 73,500 participants through 2022 Quarter 3. In addition, 9% of these have resulted in request for referrals to Mental Health.

As Veterans, family members and caregivers begin to engage in the Whole Health approach at VA facilities. Interest in accessing aspects of the Whole Health approach in the community has also grown. VA facilities, through a national memorandum of understanding with the YMCA, have the

[65] Jonas, Schoomaker, Marzolf. 2019. "Finding the Cause of the Crises: Opioids, Pain, Suicide, Obesity and Other "Epidemics". *NEJM Catalyst.*

opportunity to partner to offer Introduction to Whole Health, Taking Charge of My Life and Health and some complementary and integrative health modalities (for example, yoga, tai chi) at local YMCA facilities. The VA Caregiver Support Program is also incorporating opportunities for caregivers to participate in coaching sessions using the Whole Health approach.

In August 2019, the VHA Governance Board approved continued support of Whole Health implementation at the 18 Flagship facilities. Additionally, they supported consistent levels of funding for implementation for the next wave of whole health sites (37 across all VISNs) and implementation of a strong infrastructure in each VISN to include a Network Sponsor and/or Whole Health Clinical Director.

The integration of Whole Health approaches into Mental Health and Primary Care clinics is mandated in the Executive Decision Memo (EDM) on Engaging Veterans in Lifelong Health, Well-being and Resilience. This was approved by the VHA Governance Board in March 2020. Launch of this initiative was delayed by the COVID-19 pandemic yet remains a priority for VHA and resumed at full speed in March 2021. The "2021 Transform Healthcare Delivery: Whole Health" Integrated Project Team (IPT) focuses on Veterans at increased risk for suicide in Mental Health and Primary Care clinics by helping Veterans reconnect with their mission and purpose in life as part of the comprehensive approach to reducing risk. The Whole Health IPT reports to the Healthcare Delivery Council of the VHA Governance Board via the Whole Health Advisory Committee. A "Transforming Healthcare Delivery: Whole Health Integration with Primary Care and Mental Health" virtual conference was held in June 2021 with 2,800 participants. The conference provided tools and resources necessary for the Whole Health clinical care transformation. A second virtual conference was held in November 2022 for the 36 phase-two facilities that will expand Whole Health integration in Mental Health and Primary Care beyond the 18 Whole Health Flagship sites.

In February 2020, the first stage of an evaluation of the outcomes of the Whole Health Flagship effort was completed by a team from IP. The report (https://www.va.gov/WHOLEHEALTH/docs/EPCC_WHSevaluation_FinalReport_508.pdf) was the basis of the Congressional progress report mandated in the CARA legislation, which was submitted to congress March 31, 2020. Even relatively early in the course of the Whole Health deployment at the flagships, this evaluation indicates positive results, including:

- 31% of Veterans with chronic pain at the flagships engaged in some Whole Health services.
- There was a threefold reduction in opioid use among Veterans with chronic pain who used Whole Health services compared to those who did not. Opioid use among comprehensive Whole Health users decreased 38% compared with only an 11% decrease among those with no Whole Health use.
- Compared to Veterans who did not use Whole Health services, Veterans who used Whole Health services reported:
  - Greater improvements in perceptions of the care received as being more patient centered
  - Greater improvements in engagement in health care and self-care

- Greater improvements in engagement in life indicating improvements in mission, aspiration and purpose
- Greater improvements in perceived stress indicating improvements in overall well-being

In early 2022, VHA's HSR&D published "From patient outcomes to system change: Evaluating the impact of VHA's implementation of the Whole Health System of Care".

Continuing analysis of Veteran outcomes shows significant improvement in Veteran satisfaction, engagement with care, pain, stress and quality of physical and mental health in those using Whole Health. In addition, users of Whole Health with back pain showed a reduction of 20-40% in downstream invasive spine procedures. Finally, Veterans with a mental health diagnosis who began using Whole Health had a 2.3 times probability of being engaged in evidence-based psychotherapies 12 months later as those not using Whole Health.

During the first two quarters of 2022, there have been 448,204 Whole Health encounters in VHA bringing the total number of Veterans reached by Whole Health to 390,715 (about 8% of active Veterans). To reach an annual goal of 10% of Veterans receiving Whole Health at the intensive level (5 Whole Health encounters) the projected cost is an average of approximately $2 million per facility. This includes the provision of Whole Health services to Veterans as well as support for Employee Whole Health Coordinator positions and Whole Health Program Manager and Clinical Director positions.

Continued Expansion of Whole Health in the telehealth environment at individual (for example, development of a Personal Health Plan and coaching) and group levels (for example, yoga, mindfulness training and healthy eating instruction). Telehealth technology has enabled VA to expand complementary and integrative health services to Veterans when in-person care is not available, or when geographic, accessibility, transportation or other barriers exist. Since the beginning of the pandemic and with the temporary closure of non-urgent, in-person services, more VAMCs are offering complementary and integrative health and Whole Health approaches via telehealth. Tele-Whole Health has grown to include 55,483 unique Veterans through March 2022. This growth highlights continued Veteran demand for Whole Health and complementary and integrative health services and emphasizes the feasibility for both providers delivering and Veterans receiving telehealth services. Continued growth in the delivery of Whole Health and complementary and integrative health services via telehealth is expected as health care continues to be shaped by the pandemic. Collaboration with VHA program offices to offer virtual well-being resources to VA staff to support them through the pandemic will also continue. Through March 2022 there have been a total of 119,062-page views. In response to COVID-19, VHA launched the #LiveWholeHealth self-care blog series for Veterans. Self-care experiential videos include meditation, yoga, breathwork, movement, healthy cooking and more are posted weekly to VA social media that Veterans, family, caregivers and staff can access on demand. The #LiveWholeHealth self-care blog series includes 124 VAntage Point blog posts with embedded self-care videos and roughly 9.3 million total social media reaches between April 2020 and March 2022.

Projections for the Future

Several focus areas for the advancement of the Whole Health System are underway:

- Expansion of Employee Whole Health Coordinators and programs to additional sites. Pilot program to evaluate the effectiveness of Chief Well-Being Officers.
- Partnering with the Homeless Veterans Program Office as well as other initiatives aimed at addressing how the Whole Health approach can help identify and address systemic racism and the social determinants of health (education, employment, food security, housing, spiritual support and transportation), all of which can have significant negative impacts on Veterans' physical and mental health.
- Assessing Circumstances & Offering Resources for Needs (ACORN) is a collaborative initiative that aims to: systematically screen Veterans for social needs within 10 domains; provide clinical teams with real-time information about Veterans' unmet needs; and offer Veterans relevant resources and referrals to VA and community services. Opportunities are being identified to use ACORN in Whole Health settings like the Taking Charge of My Life and Health course and Whole Health Coaching.
- The integration of Whole Health principles with the Military Health System. Specifically, the documentation of a Personal Health Plan for every transitioning Service member in Cerner's One Plan platform in the new electronic health record will facilitate self-empowerment, self-healing and self-care as well as continuity during this critical transition.
- In collaboration with the Department of Defense Consortium for Health and Military Performance, a Total Force Fitness and Whole Health Summit was sponsored in March 2022 to promote a shared mission of optimizing the health and well-being of Service Members and Veterans across their lifecycles. One specific outcome of this is the exploration of a Joint Incentive Fund proposal to advance Whole Health for Active Duty Transitioning Service Members.
- Expansion of partnerships with Veterans Service Organizations to assist in spreading the word about Whole Health services.
- Assess the effectiveness of the Whole Health Self-Assessment Tool and the Whole Health System Designation Framework to further evaluate the system-wide transformation to a Whole Health System of Care. The Whole Health System Designation Framework outlines milestone accomplishments sites can achieve toward Whole Health transformation as they progress through four phases of implementation: Preparation, Foundational, Developmental and Full. The Designation Framework describes key accomplishments across each phase and is organized around seven domains of focus: Governance, Operations, Pathway, Well-Being, Clinical Care, Employee Whole Health and Community Partnerships.
- VHA is leading the Nation in transforming health care from a disease-based system of care to one that is centered on health and well-being by focusing on what matters to the individual.

Programs for Select Veteran Populations

This section provides narrative descriptions of selected programs that serve certain Veteran populations.[66] The obligations shown in each table below reflect the cost of total health care services provided to each designated Veteran population.[67] However, some programs overlap and therefore cannot be added together to determine the overall funding amount. For example, the cost of health care services provided to a female Gulf War Veteran would appear in both the Gulf War and Women Veterans Health Care funding lines.

AIDS / HIV Program

Description (*dollars in thousands*)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary & Mandatory Obligations by Category:							
Medical Services	$1,260,854	$1,260,100	$1,286,256	$136,060	$1,473,067	($1,150,196)	$1,337,007
Medical Community Care	$169,923	$142,000	$173,689	$186,275	$199,654	$12,586	$13,379
Medical Support and Compliance	$124,522	$120,500	$127,071	$1,376,819	$145,616	$1,249,748	($1,231,203)
Medical Facilities	$109,405	$97,100	$111,683	$119,628	$128,073	$7,945	$8,445
Obligations [Total]	$1,664,704	$1,619,700	$1,698,699	$1,818,782	$1,946,410	$120,083	$127,628

Authority for Action

The Veterans Health Administration's (VHA) National Human Immunodeficiency Virus (HIV) Program is governed by Title 38 United States Code (U.S.C.) 7301(b), 7332 and 1703, Title 38 Code of Federal Regulations (C.F.R.) 17.38 and VHA Directive 1304. The Program falls under the jurisdiction of VHA's HIV, Hepatitis and Related Conditions Programs Office (HHRC), within the Specialty Care Program Office (SCPO). HHRC is responsible for providing primary guidance and advice to the Under Secretary for Health on policy and services related to HIV infection. Using population-based approaches, HHRC leads the coordination of activities within VHA for HIV prevention and for diagnosis, care and treatment of Veterans living with HIV (VLHIV).

VLHIV suffer from high rates of medical and psychiatric co-morbidities, including mental health and substance use disorders, cardiovascular disease, renal dysfunction and metabolic disorders. VHA's National HIV Program ensures that these Veterans receive the highest quality comprehensive clinical care: testing, diagnosis, timely linkage to care and treatment of co-morbidities, Additionally, the office strives to reduce health disparities and promote evidence-based HIV preventive services.

VHA's HIV prevention efforts are based on recommendations by the CDC and approval by the FDA of drugs found to be safe and effective for HIV Pre-exposure Prophylaxis (PrEP). In 2014, VHA's Pharmacy Benefits Management Service (PBM) added PrEP to its Criteria for Use for a fixed-dose combination of emtricitabine/tenofovir that was already on the VA National Formulary

[66] The sources of the clinical and utilization data used to identify the sub-populations are the Inpatient discharge file, the Outpatient encounter file and Purchased Care payment file. The cost of the relevant patients and the services associated with each of the sub-populations is based on the Managerial Cost Accounting (MCA) system. The MCA system assigns costs to all VHA inpatient and outpatient encounters. In the budget submission, the MCA costs are augmented with the payments for community care services and adjusted to reflect obligations.

[67] Obligations exclude the Captain James A. Lovell Federal Health Care Center (JALFHCC) fund (0169).

(VANF) for treatment of HIV. VA continues to promote the broader use of PrEP across the VHA system by addressing local and systemic barriers to increased uptake, as well as working to make condoms universally available to all Veterans in VA care.

Population Covered
VHA policy requires that all Veterans be offered HIV testing at least once in their lifetime as part of routine health care, with testing offered at least annually to those who have on-going risk of exposure. Multiple published studies have shown that individuals who are aware of their infection are less likely to transmit HIV to others and are more likely to modify behaviors likely to transmit HIV, decreasing the number of new HIV infections in the community.

During calendar year 2021, 3.7 million Veterans in VHA care had no documentation of ever having received an HIV test or having received a diagnosis of HIV. VA continues to increase the cumulative number of Veterans in VHA care who have received HIV testing each year, with a cumulative percentage of about 48% of all Veterans in VHA care having been tested for HIV as of December 31, 2021. Of those who tested positive and were alive for at least 90 days after their HIV diagnosis, 75% were linked to care within 30 days of their diagnosis. Since 2016, rates of linkage to care within 30 days have ranged from 74-87%, while rates of linkage to care within 90 days have consistently been close to or at 100%.

VA is the single largest provider of HIV care in the U.S., with 31,712 VLHIV in VA care in 2022. VLHIV receiving care in VA in 2022 had a median age of 60.3 years (range, 20 y – 98 y), 96.1% were men. Regarding race, 43.4% were reported as Black or African American and 38.7% as White. Regarding ethnicity, 7.1% were reported as Hispanic or Latino. Regarding rurality, 14.1% lived in rural, highly rural, or insular island areas. With regard to period of service, 36.6% were classified as serving in the Persian Gulf War era, 25.9% in the Vietnam War era and 25.9% in the post-Vietnam War era.

Of all VLHIV in VA care in 2022, 85% had a prescription filled for an antiretroviral drug during that year. Of all VLHIV in VA care in 2021, 72% were virally suppressed, while of those who had a viral load test in that year, 92% were virally suppressed.

As of June 30, 2022, 4,838 HIV-negative Veterans in VA care were receiving PrEP, an increase of 494 (11.7%) compared to December 31, 2020, but a decrease of 221 (4.4%) compared to December 31, 2021. Because of the transition to the Cerner EHR at the Mann-Grandstaff VA Medical Center in Spokane, WA, this number does not include HIV-negative Veterans in care at that facility.

Services Provided
VA has aligned its HIV care and prevention services with the White House's National HIV/Acquired Immunodeficiency Syndrome (AIDS) Strategy (NHAS). The first NHAS was released in July 2010, with four major goals: Reducing New HIV Infections; Increasing Access to Care and Improving Health Outcomes for People Living with HIV; Reducing HIV-Related Disparities and Health Inequities; and Achieving a More Coordinated National Response to the HIV Epidemic. The NHAS was revised and updated in December 2015, with addition of measurable indicators reflecting all steps in the HIV Care Continuum: diagnosis; active linkage to

and retention in care; initiation of antiretroviral therapy (ART); and viral suppression, meaning no detectable virus present in the blood. The third iteration of the NHAS is currently undergoing final review and clearance by participating Federal agencies.

As one of the Federal agencies participating in formulating and implementing the NHAS, the VA utilizes the HIV Care Continuum model to assess gaps in care and for population health-based management of HIV services at the individual facility level. VA provides comprehensive HIV prevention and clinical care across the health care system from prevention of HIV to diagnosis, linkage to care, management and treatment. All medications approved by FDA for ART are available on the VANF, as is comprehensive care management for co-morbid mental health and medical comorbidities. All VA medical centers and outpatient clinics offer HIV testing, with timely linkage to HIV-specific care for patients with newly diagnosed infection.

All VHA facilities have access to benchmark data across the VHA system at the national, VISN and facility levels on annual HIV testing rates and performance on the HIV Care Continuum. Other clinical and population health decision support resources include dashboards for population health management of VLHIV in VA care to monitor linkage to and retention in care, utilization of antiviral therapy and rates of viral suppression, point-of-care electronic clinical reminders for HIV testing and for PrEP and dashboards designed to increase PrEP uptake, particularly among Veterans identified as being at increased risk from STI screening results.

HHRC offers training and educational programs throughout the year to VHA HIV providers and holds monthly teleconferences for all HIV providers in the VHA system to discuss current issues. Under VHA policy, all VHA facilities have an HIV Lead Clinician, who acts as both a point of contact with HHRC and as a local champion for initiatives to improve access to and quality of HIV care and prevention services.

Recent Trends

Table 1 shows recent trends in HIV diagnosis and care metrics within VHA.

Table 1. HIV diagnosis and care metrics, 2018 - 2022

	2018	2019	2020[4]	2021[4]	2022[4]
% of Veterans in VA care ever tested for HIV[1]	43.1%[3]	43.5%[3]	46.9%[3]	47.5%[3]	Data not available
% of Veterans with new HIV diagnosis linked to care within 30 days[1]	84.6%	83.1%	77.9%	74.8%	Data not available
% of VLHIV in VA care on ART[2]	85.5%	85.8%	86.2%	84.8%	Data not available
% viral suppression among VLHIV in VA care[2]					
All VLHIV	73.5%	75.5%	72.7%	71.6%	Data not available
All VLHIV with VL obtained	90.6%	92.5%	92.7%	91.1%	Data not available

[1] Data source: HHRC Data and Analysis Group

[2] Data source: VSSC HIV Clinical Data Cube
[3] Data measured over calendar year
[4] Mann-Grandstaff VAMC data

Projections for the Future

Based on the trends over the last four years, VA projects the following:

a. HIV testing rates in VHA have increased over the last few years but have plateaued when compared to the rate of increase a decade ago. Despite the effects of COVID-19 on VHA operations, VHA's HIV testing rate and the absolute number of Veterans ever tested did increase. VA is working to increase HIV testing rates in 2023 through targeted outreach to sites with low testing rates; implementing strategies to increase rates of screening for sexually transmitted infections; and promotion of testing among Veterans in care at increased risk for HIV infection. VA projects a 1% to 3% annual increase in cumulative HIV testing rates over the next 3-5 years.

b. Despite year-to-year variability in rates of linkage to care within 30 days, linkage to care within 90 days has consistently reached levels of 95-100%. Most HIV care in VHA occurs in infectious disease clinics. During 2020 and 2021, VHA ambulatory care shifted to virtual encounters for routine outpatient care because of the COVID-19 pandemic, with face-to-face encounters limited to high priority clinical situations. Although such situations included linkage to care of patients newly diagnosed with HIV, the pandemic likely led to a decrease in linkage to care rates. VA expects to reverse this trend and increase linkage to care rates for newly diagnosed Veterans over the next two to three years.

c. Since 2017, the proportion of Veterans with HIV in VA care receiving ART has remained stable or increased. the small decrease in 2021 is likely due to the effects of the COVID-19 pandemic on VHA operations. VA's internal goal is to have ART prescribed to 90% of VLHIV in care by 2030. Strategies to accomplish this include broadening deployment of HIV telehealth clinics in VHA, as well as improving rates of linkage to and retention in care.

d. HIV prevention continues to be a major focus for VHA. Although barriers to PrEP uptake have slowed the increase in the number of HIV-negative Veterans receiving preventive medication, VA is moving aggressively to implement and execute an integrated set of strategies aimed at dramatically reducing new HIV infections among Veterans in care. In addition to PrEP, these include standing up syringe service programs at individual VA medical centers and increasing access to STI screening. Both will enhance VA's ability to offer PrEP and other preventive measures to Veterans at increased risk of HIV infection, particularly harm-reduction interventions benefiting injecting drug users.

AIDS / HIV Workload

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Advance Approp.	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Unique Patients								
AIDS/HIV	32,474	32,928	32,790	33,271	**33,103**	**33,404**	313	301

Health Outcomes Military Exposures (HOME)

(formerly Post Deployment Health Services (PDHS))

HOME: Gulf War Program

Description (*dollars in thousands*)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary & Mandatory Obligations by Category:							
Medical Services	$3,827,800	$4,271,100	$4,486,321	$785,122	$5,959,755	($3,701,199)	$5,174,633
Medical Community Care	$974,698	$861,400	$1,143,684	$1,327,195	$1,522,123	$183,511	$194,928
Medical Support and Compliance	$577,526	$635,300	$677,071	$5,200,954	$899,864	$4,523,883	($4,301,090)
Medical Facilities	$701,954	$712,400	$823,151	$954,739	$1,094,497	$131,588	$139,758
Obligations [Total]	$6,081,978	$6,480,200	$7,130,227	$8,268,010	$9,476,239	$1,137,783	$1,208,229

HOME: Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND)/Operation Inherent Resolve (OIR) Program

Description (*dollars in thousands*)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary & Mandatory Obligations by Category:							
Medical Services	$7,749,925	$7,977,500	$8,869,085	$1,382,430	$11,455,882	($7,486,655)	$10,073,452
Medical Community Care	$2,214,159	$1,900,400	$2,537,798	$2,898,577	$3,288,176	$360,779	$389,599
Medical Support and Compliance	$1,059,601	$1,074,600	$1,212,527	$10,112,499	$1,565,987	$8,899,972	($8,546,512)
Medical Facilities	$1,095,280	$1,013,700	$1,252,711	$1,427,475	$1,616,297	$174,764	$188,822
Obligations [Total]	$12,118,965	$11,966,200	$13,872,121	$15,820,981	$17,926,342	$1,948,860	$2,105,361

HOME Program Office Budget

(dollars in thousands)

Description (*dollars in thousands*)	2022 Actual	2023 Budget Estimate 1/	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary & Mandatory Obligations:							
Base Programs:							
Post Deployment Health (Burn Pits)	$7,500	N/A	$7,684	$10,000	$10,000	$2,316	$0
National CTRS Study War Related Illness	$9,184	N/A	$10,739	$11,312	$11,770	$573	$458
All Other Base Programs	$12,666	N/A	$13,077	$19,689	$20,142	$6,612	$453
Base Programs [Subtotal]	$29,350	N/A	$31,500	$41,001	$41,912	$9,501	$911
Expansions:							
Veterans Exposure Team	$586	N/A	$15,000	$15,000	$17,000	$0	$2,000
Airborne Hazards Cancer Surveillance	$0	N/A	$1,000	$1,500	$1,500	$500	$0
Airborne Hazards Review of NASEM conditions	$2,600	N/A	$1,000	$2,500	$2,500	$1,500	$0
Airborne Hazards Burn Pit COE	$5,063	N/A	$4,000	$4,000	$4,000	$0	$0
All Other Expansions	$6,751		$10,500	$11,000	$11,000	$500	$0
All other expansions [Subtotal]	$15,000	N/A	$31,500	$34,000	$36,000	$2,500	$2,000
PACT Act Implementation:							
Titles II and III	$0	N/A	$11,280	$1,563	$1,610	($9,717)	$47
Title V	$0	N/A	$16,381	$1,060	$1,092	($15,321)	$32
Title VI	$0	N/A	$4,538	$3,911	$6,912	($627)	$3,001
Title VIII	$0	N/A	$9,493	$403	$5,615	($9,090)	$5,212
PACT Act [Subtotal]	$0	N/A	$41,692	$6,937	$15,229	($34,755)	$8,292
HOME [Total]	**$44,350**	**$63,000**	**$104,692**	**$81,938**	**$93,141**	**($22,754)**	**$11,203**

1/Amounts not previously displayed.

Authority for Action

The activities of the office are governed by the following public laws, Federal Registry and Presidential, VA/VHA initiatives. Environmental exposures are of great interest to Congress.

HOME is in a unique position with respect to the PACT Act in that much of this new law deals with military environmental exposures, described in legislation as "toxic exposures," which is the work that HOME was established to do. The 2023 requests for new positions related to PACT Act overlapped with the previously increased interest in military environmental exposures from the White House, Congress, Veterans Service Organizations, media and the public. Given this interest, HOME was already expanding prior to passage of the PACT Act to support the more than 19 million Veterans who may have intense interest in military environmental exposures. Support in the 2024 and 2025 budgets are required to sustain this expansion.

Exposures to contaminants and environmental hazards during military service poses a major health concern for Veterans of all generations and cohorts. There are gaps and delays in the scientific evidence demonstrating conclusive links between known exposures and health impacts, leaving many Veterans without access to VA benefits and high-quality treatment to address significant health conditions. As a result, HOME has restructured, to expand VET-HOME FTE.

To clarify the context of the increased budget requests, the additional authority for action beyond the PACT Act is included below. This is in addition to the following PACT Act sections for which HOME has direct responsibility: 202, 302, 502-510, 604, 801, 802 and 808, with assistance to Primary Care on section 603.

A single piece of legislation addressing military exposures can last for a generation. One main example is legislation surrounding Agent Orange. As interest with the exposures of Vietnam Veterans (to include the PACT Act with new presumptions for this cohort) and other Veteran

cohorts continues, the work carries over into subsequent years with new legislation and ongoing requirements. HOME is planning for a long-term capacity to be able to adequately respond to the demands and expectations of the groups mentioned above and most of all, to serve Veterans.

Public Laws

- P.L. 91-441: directed the Department of Defense to contract with the National Academy of Sciences to conduct a comprehensive study of dangers of herbicides and the defoliation program in Vietnam. In 1978, VA began the Agent Orange Registry.
- P.L. 99-576, *Veterans' Benefits Improvement and Health Care Authorization Act of 1986*: Established the Ionizing Radiation Registry (IRR), including physical examination, medical history and baseline laboratory tests.
- P.L. 100-321, *Radiation-Exposed Veterans Compensation Act of 1988*: Authorized a list of "presumptive" diseases that qualify Veterans involved in "radiation risk activities" for compensation.
- P.L. 100-322, *Veterans Benefits and Services Act of 1988*: Specifies requirements to provide medical services, domiciliary care and nursing home care to Veterans. Provides for the confidentiality of medical records that identify persons with acquired immune deficiency syndrome (AIDS), except in specifically described circumstances and prohibits discrimination in admission to VA facilities for treatment of Veterans infected with AIDS. Also includes a number of administrative, personnel and reporting requirements.
- P.L. 102-4, *Agent Orange Act of 1991*: Requires VA to obtain independent scientific review of the available scientific evidence regarding associations between diseases and exposures to dioxin and other chemical compounds in herbicides.
- P.L. 105-277, *Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999*: Requires VA to determine, based on IOM reports, whether particular illnesses warrant a presumption of service connection and to set compensation regulations establishing such a connection for each illness.
- P.L. 105-368, *Veterans Programs Enhancement Act of 1998*: Directed VA to establish an advisory committee to help review research on the medical problems of Gulf War Veterans and submit an annual report to Congress on the results of research on the health consequences of military service in the Gulf War.
- P.L. 107-103, *Veterans Education and Benefits Expansion Act of 2001:* Expanded the definition of service-connected "qualifying chronic disability" to include "a medically unexplained chronic multi-symptom illness."
- P.L. 108-170, *Veterans Health Care, Capital Asset and Business Improvement Act of 2003*: Provided priority enrollment (Category 6) for Veterans who participated in Project 112/SHAD, allowing them to be eligible for VA health care at no cost for any illness possibly related chemical warfare agent testing.
- P.L. 108-183, *Veterans Benefits Act of o 2003*: Required VA and DoD to establish The Veterans' Advisory Board on Dose Reconstruction to audit dose reconstructions and VA claims decisions for service connection of radiogenic diseases.

- P.L. 109-417, *Pandemic and All-Hazards Preparedness Act of 2006*: requires VA to work in coordination with HHS, DHS and DoD on a national response plan for influenza.

Presidential directive

- Homeland Security Presidential Directive 10 (HSPD-10) Biodefense for the 21st Century: provides a comprehensive framework for the Nation's biodefense.

Registries

- **Agent Orange Registry:** P.L. 102-4, 38 U.S.C. §527, 38 U.S.C. §1116, P.L. 102-585 §703 and P.L. 100-687
- **Ionizing Radiation Registry:** 38 U.S.C. §527, 38 U.S.C. §1116, P.L. 102-585 §703 and P. L. 100-687
- **Depleted Uranium Registry:** 38 U.S.C. §7301(b), P.L. 102-585 §703(b) (2)
- **Gulf War Registry:** P.L. 102-585, P.L. 103-446, 38 U.S.C. §1117
- **Airborne Hazards and Open Burn Pits Registry:** 38 U.S.C. §527, P.L. 112-260 §201; and P.L 102-585 (1992), Step 3: Clari Organizational Mission and Vision

Types of Services Provided

Health Outcomes Military Exposures (HOME) assesses the impact of deployment/military environmental exposures on Veterans and develops related policy, research, education and health care strategies. The Epidemiology Service manages several surveillance programs on specific military-combat exposures and conducts original research to understand the effects of military service and deployment on Veterans' health. The affected Veteran populations include:

- Agent Orange (AO) Veterans: Vietnam, Korean Demilitarized Zone (DMZ) at certain times and certain Thai bases and certain occupational series, certain C-123 crews and some Blue Water Navy Veterans stationed within 12 nautical miles of the coast of Vietnam; approximately 3.1 million Veterans served in Vietnam and are presumed to have Agent Orange exposures
- Atomic Veterans exposed to ionizing radiation (above and some below-ground tests)
- Scientific literature reviews for determination of presumptions as directed by the Military Environmental Exposure Sub-Committee (MEESC), subordinate to the VA Operations Board (VAOB) and the VE Executive Board (VAEB)
- Gulf War Veterans: served in the Gulf during Operation Desert Shield, Operation Desert Storm; approximately 650,000 Veterans served during Desert Storm/Desert Shield: early Gulf War. This includes Veterans exposed to Depleted Uranium and possible toxins in embedded fragments.
- Airborne Hazard Open Burn Pit Veterans: served in Afghanistan, Djibouti, Syria and Uzbekistan during the Persian Gulf War, from September 19, 2001, to the present, **or** The Southwest Asia theater of operations from August 2, 1990, to the present

- Garrison-related environmental health concerns, such as Camp Lejeune and aqueous fire-fighting foam (AFFF) exposures in garrison water supplies (PFAS)
- Karshi-Khanabad (K2) Veterans– possibly exposed to various hazards, fuels, DU, asbestos, lead and so forth at a former Soviet airbase in Uzbekistan from 2001-05.
- Reviews of other emerging issues such as exposures to anomalous health events, directed energy, prophylactic medications, rare cancers, respiratory illness, fuels, fire-fighting foams (PFAS - Perfluoroalkyl and polyfluoroalkyl substances), directed energy (anomalous health incidents) and vaccines and concerns for intergenerational and gender issues.

Vietnam War

HOME continues to review the health of Veterans who may have been exposed to Agent Orange. This now includes the health of Blue Water Navy Veterans, not in Vietnam but within 12 miles of the coast. Additional presumptions added in 2021 were bladder cancer, hypothyroidism and Parkinson's-like conditions.

Gulf War

The Gulf War Veteran program provides special clinical and diagnostic evaluations for combat Veterans with difficult-to-diagnose illnesses and research on these health issues. VA works to meet the special medical needs of Gulf War Veterans. VA conducts surveys of Gulf War Veterans to determine if they have any adverse health effects related to their deployment and develops effective outreach and educational tools for Gulf War Veterans. Research includes collaborations with DoD and uses Millennium Cohort Study and DoD-VA longitudinal data to create a longitudinal exposures and health record and examine temporal changes in the burden of disease among Gulf War and Gulf Era Veterans.

OEF/OIF/OND/OIR

VA provides medical care to military personnel who served in OEF/OIF/OND/OIR. Veterans deployed to combat zones are entitled to five years of eligibility for VA health care services following separation, even if they are not otherwise eligible to enroll in VA. VA's outreach ensures that returning Service members receive full information about VA benefits and services. Each medical center and benefits office has a point of contact assigned to work with returning OEF/OIF/OND/OIR Veterans who represent 18% of the overall VA patients served. Care includes Airborne Hazards Open Burn Pit Registry exams and Karshi-Khanabad (K2), where Service members were possibly exposed to various hazards: fuels, DU, asbestos, lead and so forth at a former Soviet airbase in Uzbekistan from 2001-05.

War Related Illness and Injury Study Center (WRIISC)

(New Jersey, District of Columbia, California): The WRIISC is a Congressionally mandated VA program devoted to the post-deployment health concerns of Veterans. Overseen by the Health Outcomes Military Exposures, the three WRIISC sites are located within VA medical centers in Washington, DC, East Orange, New Jersey and Palo Alto, California. These centers serve as a resource providing clinical evaluation, research, education and risk communication for Veterans, their families, health care providers and others. In addition, the WRIISC provides specialized

evaluations for Veterans with difficult to diagnose deployment-related health concerns utilizing a multidisciplinary team with an evidence-based approach.

Airborne Hazards Open Burn Pits Center of Excellence (AHBPCE)

Four primary areas of responsibility: 1) Conduct clinical and translational research focusing on a range of health conditions including respiratory concerns and unexplained shortness of breath (dyspnea), 2) Develop and deliver new educational content and best practices for health care providers, Veterans and other stakeholders, 3) Deliver specialized clinical care and consultation to Veterans with airborne hazard exposures concerns and 4) Monitor enterprise clinical response through analysis of the VA Airborne Hazards and Open Burn Pit Registry (AHOBPR).

Veterans Exposure Team-Health Outcomes Military Exposures (VET-HOME)

The VET HOME call center will connect Veterans with a cadre of 40 dedicated Environmental Health (EH) Subject Matter Experts geographically distributed across the country, thereby increasing access, improving quality of care and yielding a better return on investment when compared to the current suboptimal model for evaluating military environmental exposures.

Recent Trends

- Congress, Veterans, Veterans special interest groups and social media have had a great influence on highlighting emerging concerns related to environmental exposures among Veterans. HOME monitors, conducts and interprets these positions and the scientific research. Select areas of emphasis among these sources include:
    - Karshi-Khanabad (K2)
    - Intergenerational effects, such as VA care of Camp Lejeune family member health concerns.
    - Burn pit and airborne hazard exposures
    - PFAS - Perfluoroalkyl and polyfluoroalkyl substances such fire-fighting foams and Teflon found at many military bases.
    - Anomalous Health Incidents/Directed Energy
    - Fuels exposures
    - Cancer
    - Veteran Mortality
- Registry Enhancement
- Increased interest in Garrison exposures, such as exposures seen at Camp Lejeune (water), Ft. Benning (lead paint in housing) and Ft. McClellan (industrial off-post contamination)
- Increased interest in the creation of self-reported registries for purposes of documenting what Veterans experienced and when the experienced it. This would be used in combination with objective medical data and authoritative sources of deployment information to help VA medical, benefits and research teams triangulate insights into environmental exposures and potential health outcomes.

- VA and DoD are currently working on the Individual Longitudinal Exposures Record (ILER), which will compliment registries by providing a validated exposures record for each Service member with location, time, date and exposures monitoring noted where the military captured that information. This record will not be able to provide information on historic events if the data does not currently exist within DOD systems.

Projections for the Future

Steady growth in concern for military environmental and garrison exposures. Increasing use of VA services for Environmental Health (EH) exposures. This involves increasing the support for front-line clinicians to ensure military exposures are recognized and addressed using evidence-based, Veteran-centric care. In support of front-line clinicians is necessary to improve Veterans' and clinicians' perception that the VA prioritizes addressing exposures concerns–patients assess the quality of their care in terms of interactions with individual clinicians. The HOME RISE will be an innovative method to implement system-wide health care strategies to address known barriers to addressing exposures will assist in reducing delays in care and services provided to the Veteran.

Expansion of the Individual Longitudinal Exposures Record (ILER) with DoD will be a key addition to the Electronic Health Record. This will allow a Veteran's records to reflect specific time, place and exposures based on authoritative records which will minimize the need for creation and maintenance of multiple self-reported registries for identifying those exposed and improve care and benefits determinations for Veterans.

Operationalization of the WRIISC-WOMEN (located in California) will respond to the ongoing need to address women Veterans' toxic exposures health concerns and educate the VA and community providers of sex-based differences of medical conditions associated with military deployment and toxic exposures.

Operationalization of the WRIISC-CETC (Complex Exposure Threats Center) will establish a rapid response consultation or evaluation and study the full scope of complex exposures with unknown pathology. This group will target health effects related to military environmental exposures able to synthesize existing knowledge and epidemiological data including other external exposures measures within the environment and biometrics. This information will be paired with markers that describe biological effects resulting from cumulative exposures in those affected by these complex injuries.

HOME Workload

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Advance Approp.	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Unique Patients								
Gulf War	455,158	485,742	463,224	503,496	**470,423**	**476,483**	7,199	6,060
OEF/OIF/OND/OIR	1,230,644	1,345,706	1,274,876	1,421,800	**1,313,399**	**1,347,696**	38,523	34,297

Traumatic Brain Injury (TBI) and Polytrauma System of Care (PSC)

*TBI: OEF/OIF/OND/OIR**

Description (*dollars in thousands*)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary & Mandatory Obligations by Category:							
Medical Services	$203,864	$191,000	$220,644	$35,956	$249,559	($184,688)	$213,603
Medical Community Care	$25,855	$21,700	$27,758	$29,350	$31,082	$1,592	$1,732
Medical Support and Compliance	$31,262	$28,600	$33,841	$234,368	$38,286	$200,527	($196,082)
Medical Facilities	$40,606	$33,300	$43,978	$46,755	$49,802	$2,777	$3,047
Obligations [Total]	$301,587	$274,600	$326,221	$346,429	$368,729	$20,208	$22,300

*TBI: All Veteran Care***

Description (*dollars in thousands*)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary & Mandatory Obligations by Category:							
Medical Services	$674,857	$645,600	$750,436	$131,487	$896,032	($618,949)	$764,545
Medical Community Care	$175,720	$165,900	$194,488	$211,440	$230,012	$16,952	$18,572
Medical Support and Compliance	$108,227	$103,500	$120,345	$819,997	$143,660	$699,652	($676,337)
Medical Facilities	$136,945	$119,200	$152,380	$166,594	$182,111	$14,214	$15,517
Obligations [Total]	$1,095,749	$1,034,200	$1,217,649	$1,329,518	$1,451,815	$111,869	$122,297

*Included in TBI-All Veteran Care. VA estimates the 10-year cost (2022-2031) to be $2.8 billion for TBI-OEF/OIF/OND/OIR Veteran Care.

**VA estimates the 10-year cost (2022-2031) to be $9.9 billion for TBI-All Veteran Care.

As required by P.L. 110-161, *Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008,* the 10-year cost is reported in compliance with Senate Report 110-85, page 7: "The Committee therefore directs the VA to include in its budget calculations not only the current health care needs of all Veterans but also the long-range projected health care needs of OEF/OIF Veterans, particularly those suffering from Post-Traumatic Stress Disorder and Traumatic Brain Injury."

Authority for Action

Public laws and the United States Code governing rehabilitation provided by the Polytrauma System of Care include:

- P.L. 104-262, *Veterans' Health Care Eligibility Reform Act of 1996,* Section 104: Requires the Department of Veterans Affairs (VA) to maintain its capacity to provide for the specialized treatment and rehabilitative needs of disabled Veterans, including those with spinal cord dysfunction, amputations, blindness and mental illness, within distinct programs dedicated to the specialized treatment of those Veterans.
- P.L. 108-447, *Consolidated Appropriations Act, 2005*: Directs VA to ensure that Veterans with loss of limb and other very severe and lasting injuries have access to the best of both modern medicine and integrative holistic therapies for rehabilitation.
- P.L. 110-181, *National Defense Authorization Act for Fiscal Year 2008,* Section 1704(d): Directs VA to collaborate with the TBI rehabilitation research community, grantees of the National Institute of Disability and Rehabilitation Research of the Department of

Education, the Defense and Veterans Brain Injury Center and other Governmental entities engaged in TBI rehabilitation.

Title 38 United States Code:

- *§1710C* – TBI: plans for rehabilitation and reintegration into the community
- *§1710D* – TBI: Comprehensive program for long-term rehabilitation
- *§1710E* – TBI: use of non-Department facilities for rehabilitation
- *§7327* – Centers for research, education and clinical activities on complex multi-trauma
- *§8111* – Sharing of DVA and DoD health care resources
- *§8153* – Sharing of health-care resources

Type of Services Provided

VHA's PSC provides a full range of rehabilitation services for eligible Veterans and Active Duty Servicemembers covered by Defense Health Agency Great Lakes or TRICARE authorization, who sustained polytrauma and TBI. This includes persons with:

- TBI (whether military-related deployment related or not),
- Blast and non-blast related traumatic injuries including but not limited to amputations, musculoskeletal injuries and open wounds,
- Other acquired brain injuries including, but not limited to, stroke, brain tumors, infection, poisoning, hypoxia, ischemia, encephalopathy, or substance abuse, as appropriate for specific cases,
- Physical, cognitive, emotional and behavioral impairments related to the brain injury or
- Impairments that are clinically and functionally significant and lead to activity and participation restrictions.

PSC programs are organized into a four-tier system that ensures access to the appropriate level of specialized rehabilitation care at 110 medical centers across VA. Medical rehabilitation services in PSC address the goals of recovery and community re-integration of Veterans with TBI and polytrauma including:

- Mandatory TBI Screening of all Veterans of Post-9/11 combat operations. Veterans with positive screens are referred for comprehensive evaluations by specialty providers.
- Veterans with TBI requiring rehabilitation receive an Individualized Rehabilitation and Community Reintegration (IRCR) Plan of Care documenting the physical, cognitive, mental health and vocational problems that affect the Veteran’s successful community re-integration and the plan for addressing those problems. The functional status of Veterans with an IRCR Plan of Care is measured using a validated tool that allows VA providers to track changes and to provide appropriate interventions at the right time.
- The interdisciplinary teams providing services in PSC comprise specialists from physiatrists, nursing, psychology, social work, physical therapy, occupational therapy,

speech-language pathology, recreational therapy and other disciplines, as appropriate for the individual needs of the patient.

- Since 2010, the five Polytrauma Rehabilitation Centers (PRCs) have collaborated with Department of Health and Human Services' (HHS) TBI Model System Program sponsored by the National Institute on Disability, Independent Living and Rehabilitation Research. This enables VA to benchmark outcomes against those facilities that are the gold standard for private sector rehabilitation, for which VA has demonstrated outcomes that are similar or better than the community standard.
- VA continues to demonstrate patient outcomes that are similar or better than the community standard as measured by functional improvement, discharge rates and length of stay in inpatient care. These outcomes reflect the outstanding rehabilitative care, prosthetic services, benefits and adaptive modifications to the home and automobile that help Veterans with severe disabilities overcome obstacles to achieving personal independence, positive life adjustment and opportunities in meaningful areas of life.
- PSC collaborates with specialists in the DoD, HHS, academia and private sector to develop and deploy consensus positions and guidance on best practices such as the *VA-DoD Clinical Practice Guidelines for the Management of Mild TBI.* The Guidelines have been widely disseminated to VA rehabilitation providers through educational and training opportunities and reinforced through information technology solutions in the computerized medical record.

Recent Trends

VHA has seen a steady increase in demand for TBI related services since 2009, the year when this data became available. The area of specific growth has been services for management of long-term effects of TBI. The Polytrauma Specific Purpose Funding provides supplementary support for the interdisciplinary teams that ensure access to TBI expertise throughout the health care system and maintain readiness for potential surge in demand.

VHA is at the forefront of trends in rehabilitation care with the development of clinical services including:

- Assistive Technology Labs now in operation at 27 PSC locations to provide assessment, training, prescriptions and consultations for devices and equipment that optimize Veteran's independence and support their community participation goals.
- The Emerging Consciousness Programs at the five PRCs are unique in their dedication to improving the lives of Veterans and Service members with severe injuries and their caregivers.
- The five PRCs have implemented Intensive Evaluation and Treatment Programs to provide intensive programming for Veterans and Servicemembers with a history of multiple mild traumatic brain injuries and complex co-morbidities whose needs can't be met in traditional outpatient settings.
- PSC was the first clinical service that deployed a nationwide Telehealth System dedicated to improving access to specialized rehabilitation and care coordination. Since then, the utilization of telehealth technologies has increased exponentially, particularly in the area

of in-home health. In 2022, 54.5% of patients treated in polytrauma clinic stop codes had telehealth encounters, consistent with 55.3% in 2021.

- PSC developed a framework for managing the long-term effects of TBI in response to recent research findings about the potential devastating consequences of such events. Collaboration with the Chronic Effects of Neurotrauma Consortium enabled VA to perform multi-center research protocols in collaboration with DoD, academic centers and non-profit organizations.

Projections for the Future

VHA's focus for the future is to maintain capacity for specialized TBI rehabilitation while allowing sufficient flexibility in the system to respond to potential uptakes in demand for services. Among the trends for the future:

- Expanding access to TBI expertise through telehealth with the goal that all Veterans receiving care in PSC are offered the option of utilizing telehealth services.
- Strengthening collaboration with community partners to provide effective and efficient options for services for Veterans.
- Enhancing long-term rehabilitation surveillance and services for Veterans with TBI-related chronic disabilities.
- Collaborating with the Long-Term Impact of Military-related Brain Injury Consortium, a government, academic and non-profit consortium, conducting research in the long-term impact of military related brain injury, in order to advance identification treatment and prevention of brain injuries.

Headache Centers of Excellence (HCoE)

Purpose

In 2018, P.L. 115-141, *Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2018*, directed VA to create a Headache Centers of Excellence (HCoE) national program to treat the pain and comorbidities common among Veterans with chronic and refractory headache associated with traumatic brain injury (TBI), chronic migraine and other disabling headache diseases. A total of 19 HCoE sites, including 7 HCoE Hub sites and 12 HCoE consortium sites, have been established with each Veterans Integrated Service Network (VISN) having at least one HCoE. HCoEs provide access to team-based care and evidence-based therapies for headache, including pharmacotherapies, injections and infusions and non-pharmacological options such as cognitive behavioral therapy, physical and rehabilitation modalities and neuro-modulatory devices. The HCoE program has developed interdisciplinary staffing models for headache centers, provided educational initiatives to clinicians, Veterans and families and has conducted clinical epidemiological work to understand impact of headache on Veterans and the health care system. In 2022, P.L. 117-103, *Joint Explanatory Statement – Division J* accompanying P.L. 117-103 (*Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2022*), directed VA to expand the HCoE program to at least 28 sites, ensure the successful recruitment and retention of health care providers with specialty training in headache medicine and to report on whether an association exists between open burn pit exposures and headaches.

Expansion of the HCoE program will enhance access to interdisciplinary headache care. Data analytic capacities developed by the HCoE will monitor and evaluate headache care, both within HCoEs and VA facilities without a HCoE.

Evidence
Between 2008-21, VA provided over 10 million clinical encounters for headache care to more than 1.7 million Veterans. Approximately 25% of Veterans receiving headache care within VHA served in military campaigns during the Post-9/11 Global War on Terror, resulting in a notable increase in headache care utilization. In 2016, 322,000 Veterans received at least one visit for headache care. in 2021, over 421,000 Veterans received headache care, representing a more than 30% increase in the use of VHA medical care for headache management. The link between headache and TBI, especially mild TBI is well established, with 90% of Veterans experiencing headache after a TBI and 50% continuing to have headaches more than a year after injury. Data from the VA Airborne Hazards and Open Burn Pit Registry (AHOBR) reports that 22% of Veterans who were exposed to and had duties which involved open burn pits have reported developing severe headaches-migraine, compared to 12% of Veterans with no open burn pit exposures. While considering the current state of headache care within VHA, in 2021:

- More than 20% of Veterans with a headache diagnosis accessed VHA Emergency Department services for headache pain treatment.
- Less than 25% of Veterans receiving headache care saw a provider with headache medicine specialty training.
- About 66% of Veterans receiving headache care were provided the most generic headache diagnosis–"headache not otherwise specified (NOS)."
- Data from the AHOBR indicates a higher rate of self-reported severe headaches-migraine among those with greater degree of open burn pit exposures, however, there have been scientific studies to validate this potential association (including those reviewed within the *Long-Term Health Consequences of Exposures to Burn Pits in Iraq and Afghanistan* 2011 report by the Institute of Medicine).
- The number of United Council for Neurological Subspecialty Headache Medicine-certified providers within the HCoEs increased from 1 to 12 since 2018.

Since 2018, the HCoE program has developed and implemented staffing models for interdisciplinary headache care and for headache centers more broadly. These programs have effectively improved headache-related quality of life for Veterans, however access to headache medicine providers and teams within VHA is still very limited. Expansion of HCoE sites would be superior to alternatives of Veterans getting inadequate headache care within VHA or increased utilization of Care in the Community for headache management.

Success of the HCoE expansion and headache care within VHA would include:

- Increase in the number of HCoEs to 28 sites and the number of United Council for Neurologic Subspecialties **(**UCNS)-headache medicine certified providers to 30 within the HCoE program.
- Within three years of a new HCoE being brought online, demonstration of:
    - Reduction in Care in the Community Cost attributable to headache care by 30% in

each VA medical center (VAMC) with an HCoE

- Delivery of virtual headache care to at least three VAMCs which do not have a HCoE within the same VISN
- Decrease in the facility-level percentage of Veterans diagnosed with headache NOS by 20%
- Availability of cognitive behavioral therapy (CBT) delivered via telehealth modalities (for example, VA Video Connect, interactive voice response [IVR] at 100% of HCoEs)
- Neuromodulation (that is, devices) for headache management available at 100% of HCoEs

Implementation Plan
The HCoE program would expand through enhanced staffing of all existing sites to provide comprehensive, interdisciplinary headache clinical care and adding nine new HCoE sites. HCoE sites would realign in a Hub (a VAMC with an HCoE) and Spoke (a VAMC without an HCoE) model for headache care to facilitate referrals of Veterans with complex headache to an HCoE. All Hub sites (28 in total) would develop a spoke linkage to VAMCs within their VISN to provide virtual care and create referral pathways to these centers. The greatest density of Veterans living with headache disease are found within VISNs which are paradoxically underrepresented within the HCoE program and new sites would be added from:

- VISN 22 (neither Arizona nor New Mexico have a HCoE)
- VISN 16 (Houston, Texas is the only HCoE located in this VISN)
- VISN 17 (San Antonio, Texas is the only HCoE in this VISN)
- VISN 8 (Tampa, Florida, has a HCoE; Puerto Rico does not have a HCoE)
- VISN 7 (Columbia, South Carolina and Birmingham, Alabama both have a HCoE; however, Georgia does not have a HCoE)
- VISN 6 (Richmond, Virginia has a HCoE; North Carolina does not have a HCoE)
- VISN10 (Cleveland, Ohio has a HCoE; neither Indiana nor Michigan has a HCoE)

Clinical care is currently being delivered in the field but staffing models for higher level headache care have not previously existed in VHA until recently. The HCoE expansion initiative is ready to implement on day one due to the development of HCoE Staffing models and dedicated national program funding. The national program funding is expected to be ongoing to support the regional nature of care provided by an HCoE site, however some of the FTE costs are supported by the host medical facility demonstrating the shared responsibility of this initiative. Success of the HCoE will be measured based on number of encounters, unique patients seen, patients seen within 14-days, percentage change in facility-level headache NOS diagnoses given and use of Emergency Department for headache care and reduction in Care in the Community for headache.

The requested budget of $21.4 million in 2024 will support the expansion of the HCoE program from 19 to 28 sites based on implementation of an interdisciplinary HCoE Staffing Model.

TBI Workload

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Advance Approp.	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Unique Patients								
TBI-OEF/OIF/OND/OIR 1/	61,577	60,722	65,289	61,365	**67,926**	**70,554**	2,637	2,628
TBI-All Veteran Care	121,356	119,928	129,158	121,330	**134,925**	**140,592**	5,767	5,667

1/ Included in TBI-All Veteran Care.

Women Veterans Health Care

Women Veterans Health: Gender-Specific Care [1/]

Description (*dollars in thousands*)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary & Mandatory Obligations by Category:							
Medical Services	$393,236	$433,600	$462,954	$90,486	$644,117	($372,468)	$553,631
Medical Community Care	$216,389	$206,700	$255,681	$300,671	$358,370	$44,990	$57,699
Medical Support and Compliance	$65,442	$68,200	$77,153	$542,088	$107,647	$464,935	($434,441)
Medical Facilities	$64,206	$58,400	$75,758	$88,925	$105,862	$13,167	$16,937
Obligations [Total]	$739,273	$766,900	$871,546	$1,022,170	$1,215,996	$150,624	$193,826

[1/] Included in Women Veterans Health-All Care.

Women Veterans Health: All Care

Description (*dollars in thousands*)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary & Mandatory Obligations by Category:							
Medical Services	$6,063,006	$6,409,000	$6,970,464	$1,080,545	$8,927,546	($5,889,919)	$7,847,001
Medical Community Care	$1,944,270	$1,732,400	$2,233,271	$2,539,331	$2,855,275	$306,060	$315,944
Medical Support and Compliance	$825,991	$855,900	$949,537	$7,932,843	$1,215,939	$6,983,306	($6,716,904)
Medical Facilities	$824,495	$777,600	$948,176	$1,079,412	$1,215,111	$131,236	$135,699
Obligations [Total]	$9,657,762	$9,774,900	$11,101,448	$12,632,131	$14,213,871	$1,530,683	$1,581,740

Program Office Budget
(dollars in thousands)

Description (*dollars in thousands*)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary & Mandatory Obligations:							
Women's Health Innovation and Staffing Enhancement Initiative	$73,859	$129,836	$114,000	$174,192	$205,238	$60,192	$31,046
Child Care 1/	$908	N/A	$24,192	$23,286	$39,709	($906)	$16,423
Implementation of PACT Act and MAMMO Act	$0	$0	$0	$32,121	$33,085	$32,121	$964
Office of Women's Health Program 1/	$14,413	N/A	$16,939	$27,327	$28,041	$10,388	$714
Implementation of Deborah Sampson Act	Included above	$4,383	Included above	Included above	Included above		
Obligations [Total]	$89,180	$134,219	$155,131	$256,926	$306,073	**$101,795**	**$49,147**

1/Details not displayed in the 2023 President's Budget

Authority for Action

P.L. 102-585, Veterans Health Care Act of 1992, enacted November 4, 1992, authorized the Department of Veterans Affairs (VA) to provide gender-specific services, such as Pap tests, breast examinations, mammography and general reproductive health care to eligible women Veterans. It also provided the initial authorization (which was later made permanent and expanded in scope) to provide women Veterans with counseling for sexual trauma experienced while on active duty.

P.L. 114-223, Continuing Appropriations and Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2017, authorized VA to offer in-vitro fertilization (IVF) and P.L. 115-141, Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017, removed the expiration date for IVF services and the time limits on cryopreservation of embryos and gametes.

P.L. 116-315, *Johnny Isakson and David P. Roe M.D., Veterans Health Care and Benefits Improvement Act of 2020*, establishes an Office of Women's Health and provides greater opportunities for women Veterans to enhance their overall well-being by getting direct care and services related to fertility, expansion of newborn care, childcare, sexual assault and trauma and homelessness.

- §3005 - Continuation of Women's Health Transition Training program of Department of Veterans Affairs.
- §3006 - Authority for Secretary of Veterans Affairs to furnish medically necessary transportation for newborn children of certain women veterans.
- §4203 - Gap analysis of Department of Veterans Affairs programs that provide assistance to women veterans who are homeless.
- Title V, *Deborah Sampson Act of 2020,* §5101 - §5402 – This comprehensive legislation will help enhance and improve VA program and health services for women Veterans, as well as address issues such as health care access, harassment and sexual assault, eligibility for military sexual trauma related care and gender-specific prosthetics.
- §5101 To provide a central office for monitoring and encouraging the activities of the Veterans Health Administration with respect to the provision, evaluation and improvement of health care services provided to women Veterans ''(5) To oversee distribution of resources and information related to health programming for women Veterans under this title.

P.L. 116-171, *Hannon Mental Health Improvement Act,* Title VI – This legislation will help improve care and services for Women Veterans.

- §601 - Expansion of capabilities of Women Veterans Call Center to include text messaging.
- §602 - Requirement for Department of Veterans Affairs internet website to provide information on services available to women Veterans.

P.L. 116-214, *COMPACT Act,* Title III – This legislation will help improve care and services for Women Veterans.

- §301 – Gap analysis of Department of Veterans Affairs programs that aid women Veterans who are homeless.
- §302 – Report on locations where women Veterans are using health care from Department of Veterans Affairs.

P.L. 116-283 §764, *National Defense Authorization Act for Fiscal Year 2021:* Inclusion Of Members of Reserve Components in Mental Health Programs of Department Of Veterans Affairs.

P.L. 116-79 *Protecting Moms Who Served Act* – This legislation will help improve maternity care coordination and provide training to community maternity care providers about the unique needs of Veterans.

P.L. 117-135 *Making Advances in Mammography and Medical Options for Veterans Act* (MAMMO) Act is legislation to help improve mammography services furnished by the VA.

P.L. 117-133 - *Dr. Kate Hendricks Thomas Supporting Expanded Review for Veterans in Combat Environments Act* (SERVICE Act) will help improve mammography screening to certain Veterans, based on their period and place of active service.

P.L. 117-168 - *Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics* (PACT Act) expands VA health care and benefits for Veterans exposed to burn pits and other toxic substances.

PACT/MAMMO/SERVICE Acts Implementation and Care Coordination
VA is focusing on enhancing care coordination for preventive care, such as breast and cervical cancer screening. VA is implementing the Dr. Kate Hendricks Thomas Supported Expanded Review for Veterans in Combat Environments (SERVICE) Act. Beginning in March 2023, VA will be providing SERVICE Act breast cancer risk assessments, including toxic exposures risk assessments, to SERVICE Act eligible Veterans with referral for mammography as clinically indicated. In 2023, VA is projecting that there will be an additional 52,000 breast cancer risk assessments across all sites. Breast and cervical cancer screening programs require meticulous tracking to ensure that all eligible Veterans receive appropriate screening, results of screening tests and follow-up care is arranged as needed. VA policy requires each facility to have a process for tracking results and timely follow-up for breast and cervical cancer screening. VA policy also requires that facilities have personnel assigned to breast and cervical cancer care coordination. Through specific purpose medical services funds, the Office of Women's Health will support hiring of an additional 160 advanced nurse practitioners (one for each VA medical center) to oversee Breast Cancer Risk Assessment Clinics. To ensure accuracy, timeliness and reliability, VA tracks the provision of breast and cervical cancer screening and the availability of breast and cervical cancer care coordinators across the system. In 2022, 89% of sites had a full- or part-time Breast Cancer Screening Coordinator and 77% of sites had a full- or part-time Cervical Cancer Screening Coordinator.

Population Covered
In 2022, approximately 39% of women Veteran VHA patients were 18-44 years old, 43% were 45-64 years old and 19% were 65+ years old. Within these age groups, gender-specific care was provided to 37%, 46% and 17% of patients, respectively. As of 2022, 87% of women overall were assigned to specially trained or experienced designated women's health primary care providers (WH-PCP), which has been shown to enhance satisfaction and quality of care.

Type of Services Provided
VA provides high-quality comprehensive care that includes basic preventive care, acute care and chronic disease management, reproductive health care (such as maternity and gynecology care) and treatment for all gender-specific conditions and disorders, as well as mental health care.

VA provides comprehensive specialty medical and surgical services for women Veterans either on site or through care in the community. In addition, VA is providing infertility counseling and treatment and assistive reproductive technology, in-vitro fertilization services through Integrated Veteran Care and Office of Community Care.

Recent Trends
The number of women Veterans enrolling in VA health care is increasing, placing new demands on VA's health care system. Women make up 17.2% of today's active-duty military forces and 21.1% of National Guard and Reserves. Based on the upward trend of women in all service branches, the expected number of women Veterans using VA health care is and will continue to rise. More women are choosing VA for their health care than ever before, with women accounting for over 30% of the increase in Veterans enrolled over the past five years. The number of women Veterans using VA services has more than tripled since 2001, growing from 159,810 to 627,000 today. This increase may reflect, in part, successful efforts to enroll women Veterans in VHA at military discharge, through the Women's Health Transition Training Program, as well as increasing awareness of and availability of specific services for women throughout VHA. The rapid demographic shift highlights the need to ensure ample capacity for clinical services for women in their childbearing years, including reproductive health services.

VA has enhanced provision of care to women Veterans by focusing on the goal of developing designated Women's Health Primary Care Providers (WH-PCP) at every site where women access VA. To ensure we meet the needs for the increasing numbers of women Veterans, the VHA is rapidly increasing access to trained designated Women's Health Providers through large-scale educational initiatives and has now trained over 10,000 clinicians since 2008. Educational efforts include hosting national mini-residency programs at training conferences each year, local mini-residency programs and the newest training at rural sites. In 2017, the Office of Women's Health engaged in a partnership with the Office of Rural Health to adapt the mini-residency into a mobile training program targeted for rural providers and nurses. As a result of this effort, the VA has trained over 1,000 rural clinicians to enhance rural women Veterans' VA experience. VA has at least two WH-PCPs at all of VA's health care systems and 92% of CBOCs have a WH-PCP in place. VA is in the process of training additional providers to ensure that every woman Veteran has the opportunity to receive her primary care from a WH-PCP. Despite all of these initiatives, due to growth of the population, turnover and attrition of providers, VA continues to have an ongoing need to train approximately 800 primary care providers per year to become WH-PCPs. In addition, VA has focused training with primary care providers to target musculoskeletal conditions in women, one of the top conditions affecting women Veterans.

In addition to expanding the primary care workforce, VA has recognized the importance of developing the gynecology workforce. Academic affiliations with Departments of Obstetrics and Gynecology have increased. Additionally, VA is developing training for VA gynecologists and building a community of practice to enhance their ability to provide services. VA has also

developed training for Emergency Medicine providers to ensure up-to-date skills in caring for women Veterans. For services not provided in the VA, such as maternity care, VA has hired maternity care coordinators to facilitate transition between VA and the Community during pregnancy.

VA is proud of providing high-quality health care for women Veterans. VA is on the forefront of information technology for women's health and has redesigned its electronic medical record to track breast and reproductive health care. Quality measures show that women Veterans are more likely to receive breast cancer and cervical cancer screening than women in private sector health care. VA also tracks quality by gender and, unlike other health care systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention and chronic disease management.

In 2014, VA established a hotline specific for women Veterans. The Women Veteran Call Center (WVCC) makes outgoing calls to women Veterans to provide information about VA services and resources and responds to incoming calls from women Veterans their families and caregivers. The call center implemented a chat feature in May 2016 and text option in 2019 to increase access for women Veterans. During 2022, the WVCC received 16,648 inbound calls, 2,502 inbound chats and made 75,947 successful outbound calls (spoke with Veteran or left a voice message) and mailed 4,835 informational packets. In addition, the WVCC emailed 5,891 informational packets and received 973 inbound texts.

Projections for the Future

Women comprise 17.2% of today's active-duty military forces and 21.1% of National Guard and Reserves. Women are now the fastest growing cohort within the Veteran community. The need for increased services will continue for the foreseen future as data from the AIR Commission MAHSO evaluation confirms a 32% increase in women using VA in the next five years.

Based on the upward trend of women in all service branches, the decision to allow women in combat roles and the increased number of women choosing VA for health care, the expected number of women Veterans using VA health care will continue to rise rapidly. The complexity of medical and mental health conditions of returning troops is likely to increase and cost associated with their care will grow accordingly.

Women Veterans Workload

		2023		2024	**2024**	**2025**		
	2022	Budget	Current	Advance	**Revised**	**Advance**	+/-	+/-
Description	Actual	Estimate	Estimate	Approp.	**Request**	**Approp.**	2023-2024	2024-2025
Unique Patients								
Women Veterans Health-Gender-Specific Care 1/.....	355,877	380,836	370,189	402,302	**384,426**	**400,513**	14,237	16,087
Women Veterans Health-All Care.....	626,935	658,618	652,889	686,562	**679,323**	**705,616**	26,434	26,293

1/ Included in Women Veterans Total Unique Patients.

Gender-Specific Care 2/

	2022 Actual		2023 Estimate		2024 Estimate		2025 Estimate	
Category of Care	VA Care	Community Care	VA Care	Community Care	VA Care	Community Care	VA Care	Community Care
Cancer and Screening 3/	58.2%	41.8%	57.7%	42.3%	57.6%	42.4%	58.0%	42.0%
Genitourinary Care	70.7%	29.3%	70.6%	29.4%	70.3%	29.7%	70.4%	29.6%
Osteoporosis	86.6%	13.4%	86.0%	14.0%	86.5%	13.5%	86.7%	13.3%
Pregnancy and Postpartum	11.5%	88.5%	10.9%	89.1%	8.6%	91.4%	7.6%	92.4%
Womans Clinic	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%	100.0%	0.0%

[2/] Gender-Specific Care is included in Women Veterans Health-All Care. The above Women Veterans data reflects the percentages of cost for VA and Community care by gender-specific categories.

[3/] Includes breast and cervical cancer screenings.

Veterans Childcare Program

Purpose
Implement requirement from P.L. 116-315, §5107a Programs on Assistance for Childcare for Certain Veterans

Evidence
Section 5107a requires each VA medical center (VAMC) to provide a method of childcare assistance to qualified Veterans no later than January 2026.

Need
Quality Enhancement Research Initiative (QUERI) surveyed 2,000 VHA enrolled Veterans with dependent children and also facilitated Veteran focus groups. The data concludes that 75% of surveyed Veterans experienced a barrier to finding childcare when they needed to attend a VA medical appointment. About 42% reported that they missed or canceled a VA medical appointment due to childcare failure including the inability to attain childcare services. Veterans who were able to attain childcare services to attend a VA medical appointment reported paying an average of $60 per episode.

The Veterans Experience Office (VEO) VSignals survey data from over 300,00 enrolled Veterans during the period of February to December 2022, suggests that 4% of Veterans have at least one child in need of childcare when they attend a VA medical appointment. According to 2022 enrollment data, this accounts for 353,000 Veterans.

Both QUERI and VSignals data indicate that roughly 49% of Veterans prefer a reimbursement option, 41% prefer VA to provide onsite childcare and 10% prefer a non-VA operated offsite childcare option. VHA currently operates one Veteran childcare program in VA Puget Sound Health Care System's American Lake Medical Center location. This pilot site has been operating since 2012 under a special legislative pilot and cares for an average of 3,000 Veteran dependents per year. Currently, there are no other existing VA resources to assist Veterans in need of childcare.

Feasibility
This legislated initiative is in line with VA's 2022-2028 Strategic Plan as it relates to access to care. The COVID-19 pandemic brought to light the extent of childcare deficits across the country. There are virtually no existing options for short term drop-in childcare services in communities.

VA's original four pilot sites have proven the ability to operate safely. The addition of the Veterans Childcare Assistance Program Office (VCAP) will further strengthen safety and operational protocols through national level standardization and support.

Drop-in childcare in health care settings exist in non-VA health care systems. University of Utah Health (UUH) operates onsite drop-in childcare with the intent of removing barriers to care and broadening its patient base. The demand for drop-in childcare resulted in the need for program expansion. It's average patient drive time extended from a 15-minute average to nearly 30 minutes. Patients were willing to drive further to benefit from its childcare program. In many cases, this meant patients would forgo receiving care closer to home because of UUH's childcare services.

Implementation of a reimbursement model is pending VA Secretary approval. Operationally, the program has a high likelihood of success as it will essentially mirror the Veterans Transportation Program's (VTP) Beneficially Travel model of reimbursement.

Effectiveness
Data from QUERI's research suggests that as many as 42% of enrolled Veterans with dependent children have missed or canceled a VA medical appointment due to childcare failure. It is likely that access to childcare assistance will improve outpatient no-show rates, improve access and improve provider productivity. Furthermore, availability of childcare services will improve the patient experience resulting in an improved customer service response.

Veterans who attained childcare during VA medical appointments reported paying an average of $60 per childcare episode. This financial factor further compounds barriers to health care. Financial factors unquestionably impact special Veteran populations facing economic hardship.

Pilot site utilization data reports roughly a fifty-fifty split in utilization by populations who identify as male and female. However, when examining the same data, female Veterans used Veteran childcare in a significantly greater per capita proportion. Statistically, Veteran childcare programs will impact more women Veterans. VA childcare programs have the potential to positively impact special populations including underserved and marginalized communities, which is an objective VA's 2022-2028 Strategic Plan.

Program success will be measured through continuous Veteran feedback including but not limited to assessment of barriers to care and patient experience. Operational success will be measured through impact of facility performance metrics including but not limited to improvement of no-show rates, canceled appointments, enrollment and increase in active users among childcare service utilizers.

Implementation Plan
Efforts are underway to establish 10 onsite drop-in childcare centers in 2023, 20 sites in 2024 and 28 sites in 2025. The initial build out cost is estimated at $500,000 per site.

On-site childcare services will be provided via contract by a non-VA entity at an estimated $250,000 per year per site. Ten sites are anticipated to be operational in 2023, 20 sites in 2024 and 28 additional sites in 2025 requiring.

An increase in program office core FTE will be required to operate this national program. A total of six core FTE will be required in 2024. VCAP will provide 1 FTE per site with an active drop-in childcare program for local program oversight. The FTE subsidy to the field at 1 FTE per site with onsite childcare will total 58. An additional 10 core FTE will be required to facilitate a childcare reimbursement operation.[1] The total request for 2024 and 2025 is 36 and 74 FTE, respectively.

To meet full implementation by January 2026, the program will require a short menu of options for each VAMC. These options include onsite drop-in childcare services and a reimbursement model for sites with unique challenges.

The average number of unique Veterans per VA Health Care System is 56,234. VCAP prioritized onsite childcare delivery for sites with above average enrollment. This totals 58 VAMC's and 4.9 million Veterans with an anticipated impact to 199,225 enrolled Veterans. Based on pilot site data, onsite childcare to 58 VAMC's may result in 174,000 childcare encounters per year. A reimbursement model will further amplify this number depending on the approved reimbursement model type.

Women's Health Innovation and Staffing Enhancement (WHISE) Initiative

Purpose
To address the growing number of women Veterans who are eligible for health care, VA is strategically improving services and access for women Veterans. The WHISE Initiative, by providing funds to the VA medical centers, will enhance women's health programs through hiring of new staff and purchasing equipment specific for women's health care. The funding will support these new women's health positions for three years out, building the core staff required to answer the influx of women Veterans.

Evidence

Primary Care:
VA has continued to enhance the quality of care for women Veterans by requiring that women are offered assignment to designated Women's Health Primary Care Providers (WH-PCP). These providers offer general primary care and gender-specific primary care in the context of a longitudinal patient-provider relationship. VA research has shown that women Veterans assigned to designated WH-PCPs have higher satisfaction and quality of care than women assigned to other providers. In addition, the Barriers to Care Survey of over 8,000 women Veterans completed in 2015 found that women assigned to women's health providers were more satisfied overall with their care, comfort and safety in VA facilities.

Gynecology:
A significant number of Veterans use maternity services. In 2022, 39% of women Veterans using VA were of childbearing age (between age 18 and 44). VA is building a gynecologic workforce equipped to meet the unique needs of the Veterans we serve. VA holds National Gynecology Conferences biannually to provide training on the specific gynecologic needs of Veterans. VA has also built an enterprise-wide gynecology community of practice as a vehicle for VA gynecologists to share best practices and clinical expertise. VA is proud to offer high-quality comprehensive gynecologic services, including complex gynecology care such as gynecologic surgery and treatment of gynecologic cancers to Veterans. At the end of 2022, 83% of VA health care systems had a gynecology provider onsite and 69,000 women Veterans utilized VA Gynecology Care.

Maternity Care Coordination:
To support pregnant Veterans, VA offers maternity care coordination. Every VA medical center (100% of sites) has a full- or part-time Maternity Care Coordinator (MCC) that cares for pregnant Veterans through every stage of pregnancy. MCCs help pregnant Veterans navigate health care services both inside and outside of VA, connect to community resources, cope with pregnancy loss, connect to needed care after delivery and answer questions about billing. Once a pregnancy is diagnosed, the MCC contacts and educates the Veteran on maternity benefits and the process for maternity care throughout the pregnancy. The MCC answers Veterans' questions and remains in communication with pregnant Veterans throughout their pregnancy and postpartum care.
P.L. 116-79 *Protecting Moms Who Served Act* requires VA to implement maternity care coordination for Veterans. Maternity care coordination is critical not just during pregnancy, but also during the postpartum period, which is a particularly vulnerable time for Veterans and their families. Therefore, VA is expanding maternity care coordination services to cover Veterans for 12 months after their pregnancy ends, thereby doubling the workload of current MCCs. As a result of these efforts, Women's Health anticipates an additional 185 MCCs across the enterprise will be needed to provide critical maternity care coordination services during pregnancy and the full 12 months postpartum.

Women's Health Program:
Additionally, to provide local leadership for the Women's Health Program, sites are required by policy to have a full-time Women Veteran Program Manager (WVPM) without collateral duties and a Women's Health Medical Director who is the clinical leader for the Women's Health Program at the facility. In 2022, 137 sites had a full- or part-time WVPM. In addition, 135 sites had a Women's Health Medical Director.

Mental Health:
The number of women Veterans accessing VA mental health care has nearly doubled over the past decade. Today nearly 60% of women Veterans who use VA have been diagnosed with at least one mental health condition and many struggle with multiple, clinically complex conditions, such as trauma, mood and eating disorders.
VA's mental health programming for women Veterans is guided by the principles of gender-sensitive care. Gender-sensitive care is informed by known differences in how men and women experience emotional problems and treatment thereby recognizing the importance of offering choice, flexibility and options for care. To ensure that VA mental health providers have the skills

and expertise to meet women Veterans' unique and diverse treatment needs and preferences, the OMHSP has developed innovative clinical trainings and initiatives to strengthen mental health services for the growing population of women Veterans, such as a Reproductive Mental Health Consultation Program and a national infrastructure of Women's Mental Health Champions at each VA medical center.

Performance Goal and Evaluation
Office of Women's Health maintains quality of care and access by gender and these measures will be tracked nationally and assessed quarterly for improvement. Additionally, women's health satisfaction and trust with VA will be continually measured. Women's Health will continue close collaboration with researchers through QUERI, as well as the VHA Office of Research and other projects to monitor success of the program. Ongoing tracking of non-VA care, use and quality measures will be conducted.

Implementation Plan Women's Health Innovation and Staffing Enhancement (WHISE)
Women's Health Innovation and Staffing Enhancement: Due to significant deficits in women's health personnel, including primary care providers, gynecologists, mental health providers, care coordinators and others, in 2021, VA launched the Women's Health Innovation and Staffing Enhancements (WHISE) program. WHISE provides an opportunity for sites to apply for specific purpose funding for women's health personnel or programs such as pelvic floor physical therapy or lactation support, to mitigate local gaps in availability of women's health personnel.

Between 2021 and 2023, $259 million was distributed to the field across all 18 Veteran Integrated Service Networks in support of over 1000 positions, programs, mammography and specialty equipment for women Veterans with limited mobility. As women's health field positions are being filled, there is an inherent need for support staff to assist medical professionals in providing care. While the majority of the funds for this initiative are intended to hire medical professionals using medical services dollars, the 2024 and 2025 budget seeks some of the funds in Medical Support and Compliance to be able to offer assistance to the field in administrative positions. In 2024 and 2025, Women's Health will continue to support the encumbered positions, evaluate and support additional positions and request for equipment specific for the care of women Veterans.

Office of Women's Health will continue to support the encumbered positions for a total of three years and will collaborate with VISNs for additional staffing requests to care for women Veterans in 2024 and 2025. Medical services funds will be distributed from specific-purpose funding to facilities based on priority of newly emerging needs in staffing, equipment and supplies. In addition, Medical Support and Compliance funds will be used to increase the position of VISN Lead WVPM from 0.5 FTE to 1.0 FTE as well as administrative support (GS-9) across VISNs and facilities.

Women Veterans Peer Support Initiatives

Purpose

There is a critical need to expand VHA peer support programming that is tailored to meet the needs and interests of women Veterans who use VHA's mental health services. Efforts to do so are underway and include two key strategies:

- Develop and disseminate broad educational efforts to ensure that all VA peer specialists have adequate foundational knowledge in women Veterans' mental health to effectively provide peer support services to women Veterans, regardless of the peer specialist's own gender or lived experience.
- Identify and pilot promising gender-specific peer specialist strategies and protocols, specifically tailored to enhance VA peer support programming for women Veterans.

Evidence

- **Women's Mental Health Peer Specialist Virtual Training Initiatives:** In 2021, OMHSP offered the first VA training series of its kind for peer specialists (of all genders) who work with women Veterans. The training topics included conditions and life experiences that affect women Veterans (for example, reproductive mental health, interpersonal traumas, gender-linked stressors) and strategies for working with women Veterans (for example, facilitating mixed-gender and women-only support groups, how to relate to women Veterans when you don't have the same lived experience). The full series included eight one-hour sessions which were designed and co-led by women's mental health subject matter experts and male and female peer specialists. Each session was attended by approximately 200 participants and 89% agreed or strongly agreed that the content was useful to their practice and professional development. In 2022, to shape future efforts to grow and support peer support services for women Veterans in a data-informed way, a national quantitative and qualitative needs assessment was conducted in 2022. The development, implementation and interpretation of this needs assessment was conducted in partnership with the VISN 5 Mental Illness Research Education and Clinical Center (MIRECC).

  In 2023, OMHSP will host a national virtual conference for peer specialists and peer support supervisors, centered on the theme of women's mental health. The curriculum is guided by the aforementioned 2022 national women's mental health, peer support needs assessment and will include women-specific themes throughout all sessions.

- **WoVeN in VA:** WoVeN in VA is an adaption of community-based Women Veterans Network (WoVeN) peer-led support groups. WoVeN support groups are designed to enhance wellness and build social connections among women Veterans while exploring shared challenges, priorities and goals, including life transitions, balance, stress relief, connections, trust and esteem. In 2021, VA trained an initial cohort of women-identified peer specialists to co-lead WoVeN in VA groups. Evaluation results of this pilot were extremely positive. The majority of women Veterans who participated in WoVeN in VA groups indicated high satisfaction with the group and reported feeling less isolated, more empowered and having increased self-esteem as a result of group participation. In

qualitative interviews, some participants also noted that the experience had a positive impact on their view of and engagement in VA mental health services.

To facilitate broader implementation and sustainability, a single group leader version will be piloted in 2023. In 2023-2024, efforts will continue to focus on scaling up dissemination by implementing a train-the-trainer model. A detailed program evaluation to learn more about women Veterans' experiences participating in WoVeN in VA groups is in progress.

- **Identify and Adapt New Gender-Specific Peer Specialist Interventions for VHA Implementation:** Two additional gender-specific, peer-led interventions are being adapted for VA implementation in partnership with their developers. Initial piloting and dissemination will begin in 2023.
    - The first, called *Confident and Courageous*, is a recovery-oriented, peer specialist-led support group for women Veterans. The lead developer was VA's 2022 Peer Specialist of the Year. In *Confident and Courageous*, women Veterans work together to create group activities that reflect their strengths, skills and interests, to promote self-care, care of others, community engagement, advocacy and meaningful connections and experiences. It complements the time-limited, highly structured *WoVeN in VA* support group by creating an enduring forum to grow local communities of women Veterans.
    - The second, called *Beyond MST Together*, is a brief, one-on-one, peer specialist-led intervention. *Beyond MST Together* leverages the recently launched *Beyond MST* VA mobile app and is designed to encourage psychosocial recovery from experiences of military sexual trauma (MST).
    - Unlike *WoVeN in VA*, both *Confident and Courageous* and *Beyond MST Together* are not session-by-session protocolized intervention. Initial piloting and dissemination will not require extensive training of peer specialist facilitators. However, both are new resources. As such, modifications based on user feedback are anticipated. The 2023 pilot of both interventions will focus on gathering feedback from peer specialist facilitators (for example, usability, satisfaction, barriers to uptake and implementation) that will inform potential modifications and future dissemination efforts. Assuming successful 2023 pilots, broad dissemination of both interventions in 2024 and 2025 is anticipated, with ongoing evaluation and support (for example, training, consultation, community of practice) for peer specialist end-users.

Implementation Plan
The key activities to continue expanding VHA peer support programming for women Veterans include:

- Ongoing development, dissemination and evaluation of broad educational efforts to all VA peer specialists and peer specialist supervisors.
- Ongoing piloting, national implementation and evaluation of gender-specific peer specialist strategies and protocols.
- Develop a national infrastructure to support community of practice for peer specialists who work with women Veterans.

- Design, implementation and evaluation of new initiatives, informed by 2022 national needs assessment results.

These efforts align with Section 5206 of P.L. 116-315, the *Deborah Sampson of 2020*, which directs VA to develop and implement a staffing improvement plan for women peer specialists.

Appropriation Language

Medical Services

For necessary expenses for furnishing, as authorized by law, inpatient and outpatient care and treatment to beneficiaries of the Department of Veterans Affairs and veterans described in section 1705(a) of title 38, United States Code, including care and treatment in facilities not under the jurisdiction of the Department, and including medical supplies and equipment, bioengineering services, food services, and salaries and expenses of healthcare employees hired under title 38, United States Code, assistance and support services for caregivers as authorized by section 1720G of title 38, United States Code, loan repayments authorized by section 604 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111–163; 124 Stat. 1174; 38 U.S.C. 7681 note), monthly assistance allowances authorized by section 322(d) of title 38, United States Code, grants authorized by section 521A of title 38, United States Code, and administrative expenses necessary to carry out sections 322(d) and 521A of title 38, United States Code, and hospital care and medical services authorized by section 1787 of title 38, United States Code; [$261,000,000, which shall be in addition to funds previously appropriated under this heading that became available on October 1, 2022; and, in addition, $74,004,000,000]*$71,000,000,000*, plus reimbursements, *which* shall become available on October 1, [2023] *2024*, and shall remain available until September 30, [2024] *2025*: *Provided*, That, of the amount made available on October 1, [2023] *2024*, under this heading, $2,000,000,000 shall remain available until September 30, [2025] *2026*: *Provided further*, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall establish a priority for the provision of medical treatment for veterans who have service-connected disabilities, lower income, or have special needs: Provided further, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs shall give priority funding for the provision of basic medical benefits to veterans in enrollment priority groups 1 through 6: *Provided further*, That, notwithstanding any other provision of law, the Secretary of Veterans Affairs may authorize the dispensing of prescription drugs from Veterans Health Administration facilities to enrolled veterans with privately written prescriptions based on requirements established by the Secretary: Provided further, That the implementation of the program described in the previous proviso shall incur no additional cost to the Department of Veterans Affairs: *Provided further*, That the Secretary of Veterans Affairs shall ensure that sufficient amounts appropriated under this heading for medical supplies and equipment are available for the acquisition of prosthetics designed specifically for female veterans: *Provided further*, That nothing in section 2044(e)(1) of title 38, United States Code, may be construed as limiting amounts that may be made available under this heading for fiscal years [2023] *2024* and [2024] *2025* in this or prior Acts. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2023.)*

Contingent upon the enactment of legislation establishing a Department of Veterans Affairs Public Health Service Joint Scholarship Program in chapter 76 of title 38, United States Code, the Secretary of Veterans Affairs may carry out such program from within amounts appropriated under this heading, including amounts previously appropriated under this heading that became available on October 1, 2023.

In addition, contingent upon the enactment of authorizing legislation, the Secretary of Veterans Affairs may reimburse qualifying veterans for certain adoption expenses from within amounts appropriated under this heading, including amounts previously appropriated under this heading that became available on October 1, 2023.

Medical Community Care

For necessary expenses for furnishing health care to individuals pursuant to chapter 17 of title 38, United States Code, at non-Department facilities, [$4,300,000,000, which shall be in addition to funds previously appropriated under this heading that became available on October 1, 2022; and, in addition, $33,000,000,000]*$20,382,000,000*, plus reimbursements, *which* shall become available on October 1, [2023] *2024*, and shall remain available until September 30, [2024] *2025*: *Provided*, That, of the amount made available on October 1, [2023] *2024*, under this heading, $2,000,000,000 shall remain available until September 30, [2025] *2026*. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2023.)*

Medical Support and Compliance

For necessary expenses in the administration of the medical, hospital, nursing home, domiciliary, construction, supply, and research activities, as authorized by law; administrative expenses in support of capital policy activities; and administrative and legal expenses of the Department for collecting and recovering amounts owed the Department as authorized under chapter 17 of title 38, United States Code, and the Federal Medical Care Recovery Act (42 U.S.C. 2651 et seq.), [$1,400,000,000, which shall be in addition to funds previously appropriated under this heading that became available on October 1, 2022; and, in addition, $12,300,000,000]*$11,800,000,000*, plus reimbursements, *which* shall become available on October 1, [2023] *2024*, and shall remain available until September 30, [2024] *2025*: *Provided*, That, of the amount made available on October 1, [2023] *2024*, under this heading, $350,000,000 shall remain available until September 30, [2025] *2026*. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2023.)*

Medical Facilities

For necessary expenses for the maintenance and operation of hospitals, nursing homes, domiciliary facilities, and other necessary facilities of the Veterans Health Administration; for administrative expenses in support of planning, design, project management, real property acquisition and disposition, construction, and renovation of any facility under the jurisdiction or for the use of the Department; for oversight, engineering, and architectural activities not charged to project costs; for repairing, altering, improving, or providing facilities in the several hospitals and homes under the jurisdiction of the Department, not otherwise provided for, either by contract or by the hire of temporary employees and purchase of materials; for leases of facilities; and for laundry services; [$1,500,000,000, which shall be in addition to funds previously appropriated under this heading

that became available on October 1, 2022; and, in addition, $8,800,000,000]*$9,400,000,000*, plus reimbursements, *which* shall become available on October 1, [2023] *2024*, and shall remain available until September 30, [2024] *2025*: *Provided*, That, of the amount made available on October 1, [2023] *2024*, under this heading, $500,000,000 shall remain available until September 30, [2025] *2026*. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2023.)*

2022 Appropriation Transfers and Supplemental Appropriations

This section provides details on past year transfers, supplemental appropriations, rescissions and annual appropriation adjustments reflected on the funding crosswalk tables and budget authority tables.

Explanation of Honoring our PACT Act of 2022

On August 10, 2022, President Biden signed into law the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (Public Law 117-168) ("PACT Act"). The PACT Act expanded and extended eligibility for VA health care for Veterans with toxic exposures and Veterans of the Vietnam, Gulf War, and post-911 eras.

The PACT Act provided mandatory appropriations in section 705 and section 806, as follows:

- Section 705 appropriated $922,000,000 in fiscal year 2022 for the Department's enhanced-use lease program to be available until expended. The Department allocated **$275,000,000** of this funding to the Medical Facilities account.
- Section 806 appropriated $500 million in fiscal year 2022 for the Cost of War Toxic Exposures Fund, to remain available until September 30, 2024, in addition to amounts otherwise available. Of the $500 million, the Department allocated **$34,000,000** to the Medical Care program, as follows:
    - **$7,981,000 Addition to the Medical Services Funding Category**.
    - **$26,143,000 Addition to the Medical Support and Compliance Funding Category.**

Annual Appropriation Adjustment in 2022

- **$3,269,000,000 Addition to the Medical Community Care Appropriation.** This reflects an addition to the funds previously appropriated in the Advance Appropriation under Medical Community Care that became available on October 1, 2021. The authority for the addition to the Medical Community Care Appropriation is provided in the Consolidated Appropriation Act, 2022, (Public Law 117-103), Division J, Title II, signed on March 15, 2022.

- **$150,000,000 Addition to the Medical Facilities Appropriation.** This reflects an additional amount for the Medical Facilities account, to remain available until expended, from unobligated balances previously available in the Recurring Expenses Transformation Fund established in the Consolidated Appropriations Act, 2016, Public Law 114-113, Division J, Title II, Section 243. The authority for the addition to the Medical Facilities Appropriation is provided in the Consolidated Appropriation Act, 2022, (Public Law 117-103), Division J, Title II, Section 253, signed on March 15, 2022.

Explanation of Rescissions in 2022

- **$200,000,000 Rescission to the Medical Services Appropriation.** This reflects a rescission of $200,000,000 from unobligated balances available from prior appropriations Acts. The authority for the rescission is provided in the Consolidated Appropriation Act, 2022, (Public Law 117-103), Division J, Title II, Section 255, signed on March 15, 2022.

- **$200,000,000 Rescission to the Medical Community Care Appropriation.** This reflects a rescission of $200,000,000 from unobligated balances available from prior appropriations Acts. The authority for the rescission is provided in the Consolidated Appropriation Act, 2022, (Public Law 117-103), Division J, Title II, Section 255, signed on March 15, 2022.

Explanation of Transfers in 2022

- **$15,000,000 Transfer to the DoD–VA Health Care Sharing Incentive Fund (JIF) from Medical Services Appropriation.** Title 38, section 8111(d)(2), states that, "To facilitate the incentive program, there is established in the Treasury a fund to be known as the "DoD–VA Health Care Sharing Incentive Fund." Each Secretary shall annually contribute to the fund a minimum of $15,000,000 from the funds appropriated to that Secretary's Department. Such funds shall remain available until expended and shall be available for any purpose authorized by this section." The authority for this0 transfer is provided in the Consolidated Appropriation Act, 2022, (Public Law 117-103), Division J, Title II, Section 222, signed on March 15, 2022.

- **$314,847,000 Transfer to Joint DoD–VA Medical Facility Demonstration Fund**. This reflects a transfer to the Joint DoD–VA Medical Facility Demonstration Fund from Medical Services ($203,805,000), Medical Community Care ($43,768,000), Medical Support and Compliance ($30,613,000), and Medical Facilities ($92,830,000). The authority for this transfer is provided in the Consolidated Appropriation Act, 2022, (Public Law 117-103), Division J, Title II, Section 219, signed on March 15, 2022. The Demonstration Fund supports the continuing operations of the Captain James A. Lovell Federal Health Care Center (JALFHCC), in North Chicago, which began operations on December 20, 2010.

- **$89,000,000 Transfer to General Operating Expenses, Veterans Benefits Administration**. This reflects a transfer to the General Operating Expenses, Veterans Benefits Administration from unobligated Medical Services balances ($89,000,000) made available under the Continuing Appropriations Act, 2022, (Public Law 117-43), Division A, Section 151, signed on September 30, 2021, for personnel costs and other expenses to implement the interim final rule entitled "Presumptive Service Connection for Respiratory Conditions Due to Exposure to Particulate Matter," published on August 5, 2021 (86 FR 42724), and any revisions to such rule.

- **$5,800,000 Transfer to Departmental Administration, Board of Veterans Appeals**. This reflects a transfer to the Departmental Administration, Board of Veterans Appeals from unobligated Medical Services balances ($5,800,000) made available under the Continuing Appropriations Act, 2022, (Public Law 117-43), Division A, Section 151, signed on September 30, 2021, for personnel costs and other expenses to implement the interim final rule entitled

"Presumptive Service Connection for Respiratory Conditions Due to Exposure to Particulate Matter," published on August 5, 2021 (86 FR 42724), and any revisions to such rule.

- **$9,578,000 Transfer to Departmental Administration, Information Technology Systems**. This reflects a transfer to the Departmental Administration, Information Technology Systems from unobligated Medical Services balances ($9,578,000) made available under the Further Consolidated Appropriation Act 2020, Division F, Title II (Public Law 116-94) or the American Rescue Plan, Title VIII, Section 8002 (Public Law 117-2). The authority for this transfer is provided in the Continuing Appropriations Act, 2022, (Public Law 117-43), Division A, Section 151, signed on September 30, 2021, for personnel costs and other expenses to implement the interim final rule entitled "Presumptive Service Connection for Respiratory Conditions Due to Exposure to Particulate Matter," published on August 5, 2021 (86 FR 42724), and any revisions to such rule.

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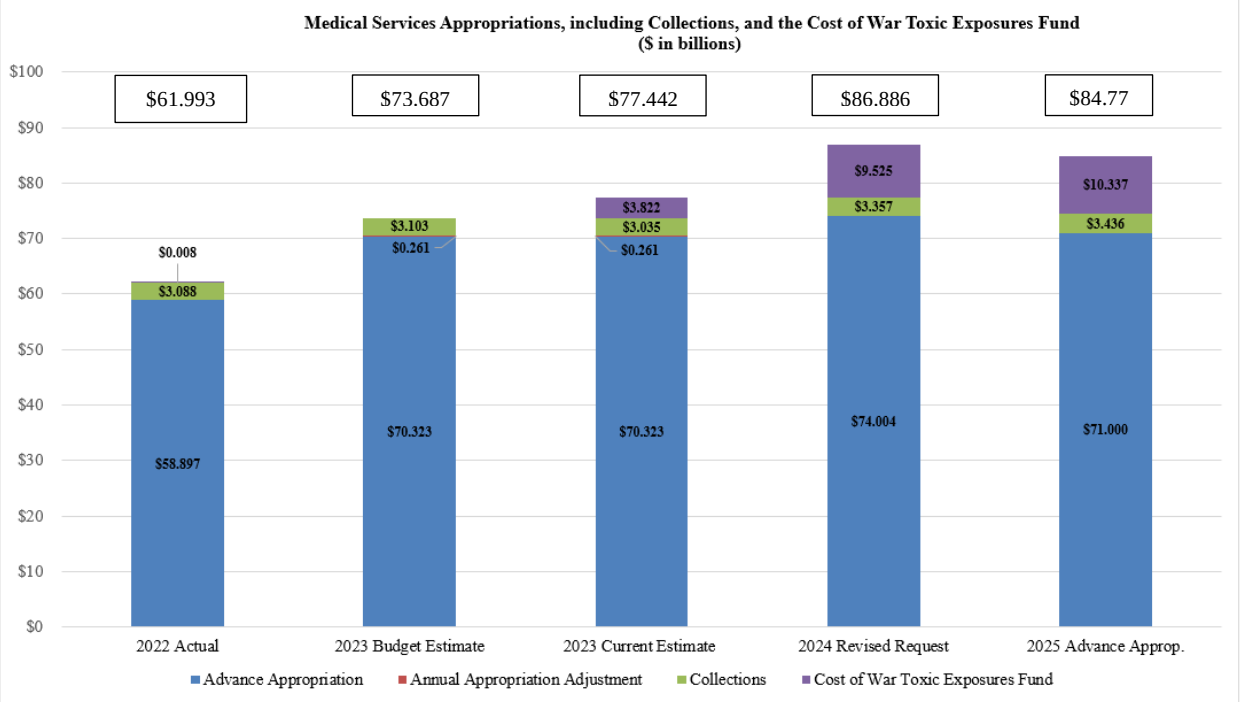
Medical Services Category

Chart: Medical Services Appropriations and Collections



1/The table displays appropriations prior to proposed cancelations and transfers discussed later in this chapter

Table: Medical Services Discretionary Funding Crosswalk 2022-2025

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Appropriation Medical Services (0160)							
Advance Appropriation Medical Services (0160)	$58,897,219	$70,323,116	$70,323,116	$74,004,000	$71,000,000	$3,680,884	($3,004,000)
Annual Appropriation Adjustment Medical Services (0160)	$0	$261,000	$261,000	$0	$0	($261,000)	$0
Appropriations Request Subtotal	**$58,897,219**	**$70,584,116**	**$70,584,116**	**$74,004,000**	**$71,000,000**	**$3,419,884**	**($3,004,000)**
Rescission (P.L. 117-103 § 255)	($200,000)	$0	$0	$0	$0	$0	$0
Proposed Cancellation of Available Unobligated Balances	$0	$0	$0	($4,933,113)	$0	($4,933,113)	$4,933,113
Net Appropriation	**$58,697,219**	**$70,584,116**	**$70,584,116**	**$69,070,887**	**$71,000,000**	**($1,513,229)**	**$1,929,113**
Tranfers To:							
North Chicago Demo. Fund (0169) from Medical Services (0160)	($203,805)	($190,377)	($233,005)	($263,141)	($287,884)	($30,136)	($24,743)
DoD-VA Hlth Care Sharing Incentive Fund (0165) from Medical Services (016	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)	$0	$0
Medical Community Care (0140)	$0	$0	($170,000)	$0	$0	$170,000	$0
Medical Facilites (0162)	$0	$0	($270,000)	$0	$0	$270,000	$0
Unob. Bal. to VBA/GOE (PL 117-43 §151)	($89,000)	$0	$0	$0	$0	$0	$0
Unob. Bal. to BVA (PL 117-43 §151)	($5,800)	$0	$0	$0	$0	$0	$0
Unob. Bal. to OI&T (PL 117-43 §151)	($9,578)	$0	$0	$0	$0	$0	$0
Transfers To [Subtotal]	($323,183)	($205,377)	($688,005)	($278,141)	($302,884)	$409,864	($24,743)
Collections:							
Transfer from Medical Care Collections Fund (5287)	$3,088,295	$3,103,128	$3,035,289	$3,356,710	$3,435,593	$321,421	$78,883
Collections [Subtotal]	$3,088,295	$3,103,128	$3,035,289	$3,356,710	$3,435,593	$321,421	$78,883
Discretionary Budget Authority Total	$61,462,331	$73,481,867	$72,931,400	$72,149,456	$74,132,709	($781,944)	$1,983,253
Reimbursements Medical Services (0160)	$127,577	$132,760	$127,577	$127,577	$127,577	$0	$0
Unobligated Balance (SOY):							
No-Year Medical Services (0160)	$2,350,381	$1,662,997	$3,130,737	$3,433,113	$2,000,000	$302,376	($1,433,113)
H1N1 No-Year (PL 111-32)	$7	$0	$7	$0	$0	($7)	$0
2-Year (Medical Services)	$837,241	$0	$500,826	$1,500,000	$1,000,000	$999,174	($500,000)
3-Year (P.L. 116-127)	$200	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$3,187,829	$1,662,997	$3,631,570	$4,933,113	$3,000,000	$1,301,543	($1,933,113)
Unobligated Balance (EOY):							
No-Year Medical Services (0160)	($3,130,737)	$0	($3,433,113)	($2,000,000)	$0	$1,433,113	$2,000,000
H1N1 No-Year (PL 111-32)	($7)	$0	$0	$0	$0	$0	$0
2-Year (Medical Services)	($500,826)	$0	($1,500,000)	($1,000,000)	$0	$500,000	$1,000,000
3-Year (P.L. 116-127)	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($3,631,570)	$0	($4,933,113)	($3,000,000)	$0	$1,933,113	$3,000,000
Lapse Medical Services (0160)	($517)	$0	$0	$0	$0	$0	$0
Subtotal	$61,145,650	$75,277,624	$71,757,434	$74,210,146	$77,260,286	$2,452,712	$3,050,140
Prior Year Recoveries	$111,105	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0160) [Subtotal]	**$61,256,755**	**$75,277,624**	**$71,757,434**	**$74,210,146**	**$77,260,286**	**$2,452,712**	**$3,050,140**

Table: Medical Services Mandatory Funding Crosswalk 2022-2025

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Veterans Medical Care and Health Fund (0173MS)							
Unobligated Balance (SOY)	$9,020,413	$696,300	$733,253	$0	$0	($733,253)	$0
Reapportionment of Unobligated Balances	($3,370,222)	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)	($733,253)	$0	$0	$0	$0	$0	$0
Obligations, ARP Act Section 8002 (0173MS) [Total]	$4,916,938	$696,300	$733,253	$0	$0	($733,253)	$0
ARP Act, sec. 8007 (0160XP)							
Unobligated Balance (SOY)	$627,900	$0	$2,847	$0	$0	($2,847)	$0
Adjustment to SOY Balance	$25,283	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)	($2,847)	$0	$0	$0	$0	$0	$0
Obligations, ARP Act, sec. 8007 (0160XP) [Total]	$650,336	$0	$2,847	$0	$0	($2,847)	$0
American Rescue Plan Act Obligations [Subtotal]	**$5,567,274**	**$696,300**	**$736,100**	**$0**	**$0**	**($736,100)**	**$0**
Cost of War Toxic Exposures Fund							
Mandatory Appropriation	$7,981	$0	$3,822,377	$9,525,428	$10,336,542	$5,703,051	$811,114
Unobligated Balance (SOY)	$0	$0	$7,981	$0	$1,338,000	($7,981)	$1,338,000
Reapportionment of Unobligated Balances	$0	$0	$94	$0	$0		
Unobligated Balance (EOY)	($7,981)	$0	$0	($1,338,000)	$0	($1,338,000)	$1,338,000
Obligations, TEF [Total]	**$0**	**$0**	**$3,830,452**	**$8,187,428**	**$11,674,542**	**$4,356,976**	**$3,487,114**
VACAA, sec. 801 (0160XA)							
Unobligated Balance (SOY):	$21,338	$17,474	$16,123	$10,658	$4,980	($5,465)	($5,678)
Unobligated Balance (EOY):	($16,123)	($13,494)	($10,658)	($4,980)	$0	$5,678	$4,980
Subtotal	$5,215	$3,980	$5,465	$5,678	$4,980	$213	($698)
Prior Year Recoveries	$91	$0	$0	$0	$0	$0	$0
Obligations (0160XA) [Total]	**$5,306**	**$3,980**	**$5,465**	**$5,678**	**$4,980**	**$213**	**($698)**
Mandatory Budget Authority [Subtotal]	$7,981	$0	$3,822,377	$9,525,428	$10,336,542	$5,703,051	$811,114
Mandatory Obligations [Subtotal]	**$5,572,580**	**$700,280**	**$4,572,017**	**$8,193,106**	**$11,679,522**	**$3,621,089**	**$3,486,416**

Table: Medical Services All Funding Sources Crosswalk 2022-2025

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Budget Authority [Grand Total]	$61,470,312	$73,481,867	$76,753,777	$81,674,884	$84,469,251	$4,921,107	$2,794,367
Obligations [Grand Total]	**$66,829,335**	**$75,977,904**	**$76,329,451**	**$82,403,252**	**$88,939,808**	**$6,073,801**	**$6,536,556**
FTE							
Medical Services (0160)	260,375	282,781	277,558	293,544	306,013	15,986	12,469
Veterans Medical Care and Health Fund (0173MS)	11,126	0	3,517	0	0	(3,517)	0
Cost of War Toxic Exposures Fund (1126MS) 1/	0	0	13	13	13	0	0
VACAA, sec. 801 (0160XA)	17	8	17	17	17	0	0
FTE [Total]	271,518	282,789	281,105	293,574	306,043	12,469	12,469

1/ Cost of War Toxic Exposures Fund FTE reflect Veterans Experience Office PACT ACT implementation FTE funded via reimbursement by VHA

Summary of 2024 Revised Request

The 2024 Budget request reflects the discretionary 2024 advance appropriation request of $74.0 billion and a proposed cancellation of $4.9 billion in unobligated balances in 2024 to realign resources among accounts. When combined with a mandatory appropriation request of $9.5 billion

from the Cost of War Toxic Exposures Fund and a collections projection of $3.4 billion, total Budget Authority is expected to be $81.7 billion in the Medical Services Category. When combined with unobligated start of year balances, reimbursements, and transfers to other accounts, the total amount of resources to be obligated in the Medical Services Category in 2024 is $82.4 billion and $88.9 billion in 2025, as detailed in the tables below.

Table: Medical Services Discretionary Obligations by Program

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Health Care Services:							
Health Care Services without Families First Act (FF)	$53,687,427	$67,337,074	$63,404,807	$65,533,096	$67,564,141	$2,128,289	$2,031,046
Health Care Services - Families First Act	$200	$0	$0	$0	$0	$0	$0
Health Care Services [Total]	**$53,687,627**	**$67,337,074**	**$63,404,807**	**$65,533,096**	**$67,564,141**	**$2,128,289**	**$2,031,046**
Non-Add included above and below:							
Activations	*$212,167*	*$591,526*	*$591,526*	*$563,619*	*$411,634*	*($27,907)*	*($151,985)*
Beneficiary Travel	*$1,766,990*	*$1,488,378*	*$2,261,747*	*$2,668,861*	*$3,069,190*	*$407,114*	*$400,329*
Medical Contracts	*$6,651,083*	*$12,013,847*	*$6,038,747*	*$3,024,877*	*$3,020,675*	*($3,013,870)*	*($4,202)*
Medical Equipment	*$1,787,879*	*$2,514,904*	*$1,973,812*	*$2,054,739*	*$0*	*$80,927*	*($2,054,739)*
Medical Staffing	*$36,602,090*	*$42,237,314*	*$43,239,292*	*$49,645,183*	*$55,329,453*	*$6,405,890*	*$5,684,270*
Pharmacy	*$7,632,512*	*$10,653,033*	*$9,129,787*	*$8,605,862*	*$8,470,101*	*($523,925)*	*($135,761)*
Prosthetics	*$3,722,046*	*$4,069,980*	*$4,147,810*	*$4,571,956*	*$5,025,363*	*$424,146*	*$453,407*
VA Long-Term Services and Supports [Total]	**$4,441,215**	**$4,513,520**	**$4,755,248**	**$4,411,175**	**$4,983,261**	**($344,073)**	**$572,086**
Other Health Care Programs VA Care:							
CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers	$471,293	$365,844	$484,705	$524,735	$574,226	$40,030	$49,490
Caregivers (Including CHAMPVA)	$1,220,189	$1,811,210	$1,831,210	$2,385,880	$2,726,731	$554,670	$340,851
Camp Lejeune - Family	$346	$0	$700	$725	$703	$25	($22)
Homeless Grants	$1,082,127	$970,341	$1,003,582	$1,067,265	$1,115,656	$63,683	$48,391
Readjustment Counseling	$242,852	$279,635	$277,182	$287,270	$295,568	$10,088	$8,298
Other Health Care Programs without FF Act and CARES Act [Total]	$3,016,808	$3,427,030	$3,597,379	$4,265,875	$4,712,884	$668,496	$447,008
Obligations without Families First Act and CARES Act [Subtotal]	$61,145,450	$75,277,624	$71,757,434	$74,210,146	$77,260,286	$2,452,712	$3,050,140
Obligations - Families First Act and CARES Act Only [Subtotal]	$200	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$61,145,650**	**$75,277,624**	**$71,757,434**	**$74,210,146**	**$77,260,286**	**$2,452,712**	**$3,050,140**
VA Prior-Year Recoveries	$111,105	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	$61,256,755	$75,277,624	$71,757,434	$74,210,146	$77,260,286	$2,452,712	$3,050,140

Table: Medical Services Mandatory Obligations by Program

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Health Care Services:							
Health Care Services - Veterans Medical Care and Health Fund	$4,663,142	$696,300	$733,253	$0	$0	($733,253)	$0
Health Care Services - Cost of War Toxic Exposures Fund	$0	$0	$3,614,746	$7,726,366	$11,017,109	$4,111,620	$3,290,743
Health Care Services - American Rescue Plan Act, sec. 8007	$588,255	$0	$2,847	$0	$0	($2,847)	$0
Health Care Services - VACAA Section 801	$4,807	$3,980	$5,465	$5,678	$4,980	$213	($698)
Health Care Services [Total]	**$5,256,204**	**$700,280**	**$4,356,311**	**$7,732,044**	**$11,022,089**	**$3,375,733**	**$3,290,045**
Non-Add included above and below:							
Activations	*$77,211*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Beneficiary Travel	*$114,475*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Medical Contracts	*$59,848*	*$696,590*	*$2,478,864*	*$5,293,312*	*$5,411,134*	*$2,814,447*	*$117,822*
Medical Equipment	*$203*	*$0*	*$0*	*$0*	*$2,136,928*	*$0*	*$2,136,928*
Medical Staffing	*$2,870,148*	*$3,690*	*$739,899*	*$7,271*	*$6,980*	*($732,627)*	*($291)*
Pharmacy	*$1,967,709*	*$0*	*$1,353,254*	*$2,892,523*	*$4,124,480*	*$1,539,269*	*$1,231,957*
Prosthetics	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Long-Term Services and Supports VA Care:							
LTSS - Veterans Medical Care and Health Fund	$253,796	$0	$0	$0	$0	$0	$0
LTSS - Cost of War Toxic Exposures Fund	$0	$0	$215,706	$461,062	$657,433	$245,356	$196,371
LTSS - American Rescue Plan Act, sec. 8007	$62,081	$0	$0	$0	$0	$0	$0
LTSS - VACAA, sec. 801	$408	$0	$0	$0	$0	$0	$0
VA Long-Term Services and Supports [Total]	**$316,285**	**$0**	**$215,706**	**$461,062**	**$657,433**	**$245,356**	**$196,371**
Other Health Care Programs VA Care							
CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers	$0	$0	$0	$0	$0	$0	$0
Caregivers (Including CHAMPVA)	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune - Family	$0	$0	$0	$0	$0	$0	$0
Homeless Grants	$0	$0	$0	$0	$0	$0	$0
Readjustment Counseling	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs - [Total]	$0	$0	$0	$0	$0	$0	$0
Obligations - Veterans Medical Care and Health Fund [Subtotal] 2/	$4,916,938	$696,300	$733,253	$0	$0	($733,253)	$0
Obligations - Cost of War Toxic Exposures Fund	$0	$0	$3,830,452	$8,187,428	$11,674,542		
Obligations - American Rescue Plan Act, sec. 8007 [Subtotal]	$650,336	$0	$2,847	$0	$0	($2,847)	$0
Obligations - VACAA Section 801 [Subtotal]	$5,215	$3,980	$5,465	$5,678	$4,980	$213	($698)
Obligations [Total]	**$5,572,489**	**$700,280**	**$4,572,017**	**$8,193,106**	**$11,679,522**	**$3,621,089**	**$3,486,416**
VA Prior-Year Recoveries	$91	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	$5,572,580	$700,280	$4,572,017	$8,193,106	$11,679,522	$3,621,089	$3,486,416

Table: Medical Services Total Obligations by Program

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Health Care Services:							
Health Care Services [Total]	$58,943,831	$68,037,354	$67,761,118	$73,265,140	$78,586,230	$5,504,022	$5,321,091
Non-Add included above and below:							
Activations	*$289,378*	*$591,526*	*$591,526*	*$563,619*	*$411,634*	*($27,907)*	*($151,985)*
Beneficiary Travel	*$1,881,465*	*$1,488,378*	*$2,261,747*	*$2,668,861*	*$3,069,190*	*$407,114*	*$400,329*
Medical Contracts	*$6,710,931*	*$12,710,437*	*$8,517,611*	*$8,318,189*	*$8,431,809*	*($199,423)*	*$113,620*
Medical Equipment	*$1,788,082*	*$2,514,904*	*$1,973,812*	*$2,054,739*	*$2,136,928*	*$80,927*	*$82,189*
Medical Staffing	*$39,472,238*	*$42,241,004*	*$43,979,191*	*$49,652,454*	*$55,336,433*	*$5,673,263*	*$5,683,979*
Pharmacy	*$9,600,221*	*$10,653,033*	*$10,483,041*	*$11,498,385*	*$12,594,581*	*$1,015,344*	*$1,096,196*
Prosthetics	*$3,722,046*	*$4,069,980*	*$4,147,810*	*$4,571,956*	*$5,025,363*	*$424,146*	*$453,407*
Long-Term Services and Supports VA Care:							
VA Long-Term Services and Supports [Total]	$4,757,500	$4,513,520	$4,970,954	$4,872,237	$5,640,694	($98,717)	$768,457
Other Health Care Programs VA Care:							
CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers	$471,293	$365,844	$484,705	$524,735	$574,226	$40,030	$49,490
Caregivers (Including CHAMPVA)	$1,220,189	$1,811,210	$1,831,210	$2,385,880	$2,726,731	$554,670	$340,851
Camp Lejeune - Family	$346	$0	$700	$725	$703	$25	($22)
Homeless Grants	$1,082,127	$970,341	$1,003,582	$1,067,265	$1,115,656	$63,683	$48,391
Readjustment Counseling	$242,852	$279,635	$277,182	$287,270	$295,568	$10,088	$8,298
Other Health Care Programs [Total]	$3,016,808	$3,427,030	$3,597,379	$4,265,875	$4,712,884	$668,496	$447,008
Obligations [Subtotal]	**$66,718,139**	**$75,977,904**	**$76,329,451**	**$82,403,252**	**$88,939,808**	**$6,073,801**	**$6,536,556**
VA Prior-Year Recoveries	$111,196	$0	$0	$0	$0	$0	$0
Total Obligations	$66,829,335	$75,977,904	$76,329,451	$82,403,252	$88,939,808	$6,073,801	$6,536,556

In 2024, total obligations are projected to increase by $6.1 billion above the 2023 current estimate in the following areas:

- **Health Care Services (+$5.5 billion).** Ongoing health care services are projected to increase due to revised actuarial trends based on the most recent data, which accounts for the latest demographic and healthcare trends, and modes of care delivery. For 2024, these updates include the impact of the increased projected health care delivery associated with the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022. The budget request includes the following impacts to account for the projected increase in health care services:

    - **Medical Staffing (+$5.7 billion).** Medical Services full-time equivalents (FTE) are projected to increase by 12,469 (4.4% above the 2023 current estimate level), allowing VA to accelerate growth in projected appointments at VA facilities. The increase includes support for precision oncology, suicide prevention, mental health and opioid abuse prevention initiatives and increased caregiver support staff.

    - **Medical Contracts (-$199.4 million).** Medical Services contracts are projected to decrease in their direct support of VA Medical Centers (VAMCs) in meeting their health care workload demand as FTE increase. This resource level will assist VAMCs' work to achieve the right balance between care provided through VA and care provided in the community to ensure Veterans have timely access to the highest quality health care services.

- **Pharmacy (+$1.0 billion).** Estimates are increased to reflect the latest actuarial and programmatic trends, which include growing outpatient prescription demand and price inflation.

- **Prosthetics (+$424.1 million).** Estimates are based on the latest programmatic trends.

- **Medical Equipment (+$80.9 million).** This adjustment reflects a return to recent historical levels of annual equipment purchases, following the significant increase in 2022 for high tech equipment purchases that will be paid for using ARP funds.

- **Long-Term Services and Support (-$98.7 million).** Estimates are projected to decrease due to latest demographic trends and modes of care delivery.

- **Other Health Care Programs (+$668.5 million).** VA-provided health service programs not projected by the Enrollee Health Care Projection Model (EHCPM) are expected to yield a net increase of $668.5 million, driven largely by Caregiver program costs associated with the MISSION Act expanded eligibility.

Summary of the 2025 Advance Appropriation Request

The Medical Services discretionary advance appropriations request is $71.0 billion, an increase of $1.9 billion from the 2024 revised discretionary request funding level, with an additional request of $10.3 billion in mandatory funding from the Cost of War Toxic Exposures Fund. When combining appropriations with unobligated balances, collections, and reimbursements VA projects to obligate $88.9 billion in 2025. The 2025 request ensures continuity of Veterans' health care services and sustains VA's increased capacity for care following the pandemic. In 2025, total obligations are projected to be $6.5 billion more than total obligations in 2024. The 2025 request continues to enhance VA's capacity for care and for successful implementation of the PACT Act.

In 2025, total obligations are projected to increase by $6.5 billion from the 2024 revised request level in the following areas:

- **Health Care Services (+$5.3 billion).** Significant drivers of this change include the following:

    - **Medical Staffing (+$5.7 billion).** Medical Services FTE are projected to increase by 12,469 over the 2024 level, and this increase accounts for Federal Employee Retirement System (FERS) adjustments, wage increases and change in experience levels of the recently onboarded staff.

    - **Medical Contracts (+$113.6 million).** Medical Services contracts are projected to increase by $114 million from the projected 2024 level. The total amount requested reflects recent actual year trends in contract service growth.

- **Pharmacy (+$1.1 billion).** Estimates are increased to reflect the latest actuarial and programmatic trends which include growing outpatient prescription demand and price inflation.

- **Prosthetics (+$453.4 million).** Estimates are based on the latest programmatic trends.

- **Medical Equipment (+$82.1 million).** This increase sustains the recent average annual cost of equipment and inflation.

- **Activations (-$151.9 million).** This adjustment reflects funding required for VA to begin the fiscal year. The overall activations need of the agency will be reassessed during the 2024 budget cycle.

- **Long-Term Services and Supports (+$768.5 million).** Estimates reflect the latest programmatic trends and modes of care delivery.

- **Other Health Care programs (+$447.0 million).** The increase is largely driven by the expanding Caregiver Program, which includes the remaining cohort of eligible Veterans for the Program of Comprehensive Assistance for Family Caregivers (PCAFC).

Medical Services Program Funding Requirements

VA is committed to providing the best access to care for Veterans. To deliver the full care spectrum as defined in VA's medical benefits package, VA will allocate resources based on the following principles:

- Enable VA to provide access to high-quality care for Veterans, whether in VA facilities, through community partners or using telehealth modalities, while accounting for Veterans' preferences and clinical needs, changing demands for care and resource limitations;
- Promote operational efficiency and simplicity, while supporting VA's clinical care, education and research missions; and
- Allow facilities to meet the changing needs of Veterans in a flexible way.

VA continues to execute a multi-pronged strategy in 2024 that will target resources to improve Veterans' access to timely, high-quality care through targeted hiring, improved care coordination and continued telehealth enhancements. These efforts will reduce the number of appointments that VA must refer to community care and enable VA to deliver in-house more efficiently and with higher quality and greater coordination.

- Improved Care Coordination: Through this initiative, Veterans will have more access to a greater variety of care options than ever before. Enhanced care coordination services, staffed in many cases by nurses and social workers in coordination with specialty care teams led by physicians, will help Veterans navigate their options and choose the most clinically-appropriate, convenient path to best meet their healthcare needs.

- Targeted Hiring: VA will use targeted hiring initiatives to ensure Veterans have timely access to high-quality primary and mental health throughout our infrastructure. The Budget will also support full staffing for VA's Patient Aligned Care Teams, which make VA a leader in providing robust quality primary care and preventing costly future interventions.

- Telehealth Enhancements: Many Veterans prefer the convenience, timeliness and efficiency of telehealth appointments, particularly after their more widespread use during the pandemic. VA will continue to augment its clinical resource telehealth hubs with additional Primary Care, Mental Health and Clinical Pharmacy Specialists who deliver care via VA Video Connect appointments. In addition, VA will expand the development of Specialty Care telehealth hubs, providing services such as cardiology, neurology, dermatology and inpatient intensive care unit (ICU) and stroke programs.

- Improve Veterans' Access to Same-Day Mental Health Care: Veterans are at higher risk for mental health and substance use challenges than the general population. Increasing their access to quality mental health care is the first step to closing this disparity. VA will reduce barriers to mental health access by fully implementing its Primary Care Mental Health Integration and Behavioral Health Interdisciplinary Program, which connects Veterans to same-day mental health care and improves the integration of these services into primary care settings.

HR Modernization

The 2024 budget is focused on investing in VA's workforce and attracting and retaining new talent by leveraging investments and improvements in VA's human capital infrastructure. The budget supports VA's efforts to: increase opportunities to advance at VA through leadership development programs; expediting the hiring process by simplifying the application requirements; investing in employee well-being through programs such as the VHA Reduce Burnout and Optimize Organizational Thriving (REBOOT) task force; investing in scholarship programs to offer educational opportunities to even more employees; and continuing to focus on keeping employee and visitor safety at the forefront.

Providing Seamless and Coordinated Access to Care for Veterans

Veterans are getting more care through VA than ever from VA staff who completed more than 88 million Veteran visits in 2022.

Even as Veterans receive care in-person, many clinical needs of our Veterans will continue to be delivered virtually. The 2024 Budget supports the continued build out of enterprise-wide technology infrastructure that is enabling VA to provide 24/7 access to virtual care from regional clinical contact centers. This access is supplemental to care offered through our VA medical centers and Community Based Outpatient Clinics and for those eligible through VA's robust community care network. The Office of Integrated Veteran Care (IVC) oversees the design and implementation of an integrated access and care coordination model for VA and community care. IVC will assure that Veterans are at the center of their own care, so they are the ultimate decision-makers on where and how to receive care. IVC also seeks to achieve the right balance of care

provided in VA and the community and to ensure timely access to the highest quality health care services.

The 2024 request supports meeting the workload demand as result of the PACT Act in 2024 by increasing staff and resources to ensure VA provides timely primary care, specialty care and care coordination with community providers.

The following tables provide additional detail on eight distinct activities of the Medical Services account: Activations, Medical Equipment, Medical Services Staffing, Long-Term Services Supports and Programs, Other Health Care Programs VA Care, Beneficiary Travel, Pharmacy and Prosthetics.

Activations 1/

		2023		**2024**	**2025**		
	2022	Budget	Current	**Revised**	**Advance**	+/-	+/-
Description (dollars in thousands)	Actual	Estimate	Estimate	**Request**	**Approp.**	2023-2024	2024-2025
Discretionary Obligations	$212,167	$591,526	$591,526	$563,619	$411,634	($27,907)	($151,985)
Mandatory Obligations	$77,211	$0	$0	$0	$0	$0	$0
Medical Services Obligations [Grand Total]	**$212,167**	**$591,526**	**$591,526**	**$563,619**	**$411,634**	**($27,907)**	**($151,985)**

1/ This table displays obligations for the Medical Services account only. See the Medical Care chapter for detail on all accounts that support the Activations program. In general, the Medical Services account provides for medical staffing and equipment, while the other budget accounts provide for administrative support, physical space and facility maintenance.

Facility activations provide non-recurring (equipment and supplies) and recurring (additional personnel) costs associated with the activation of completed construction of new or replacement medical care facilities. Resources include assumed rates for medical equipment and furniture reuse based on the facility type (renovation, replacement or new). VA's activation plans are sensitive to delays in construction schedules and lease awards. VA has recently taken steps to identify and more closely monitor the activations of new facilities and leases to assure that projects stay on schedule, which will promote better synchronization of budgetary resources with program needs.

Medical Equipment 1/

		2023		**2024**	**2025**		
	2022	Budget	Current	**Revised**	**Advance**	+/-	+/-
Description (dollars in thousands)	Actual	Estimate	Estimate	**Request**	**Approp.**	2023-2024	2024-2025
Discretionary Obligations	$1,787,879	$2,514,904	$1,973,812	$2,054,739	$2,136,928	$80,927	$82,189
Mandatory Obligations (including VMCHF)	$203	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$1,788,082**	**$2,514,904**	**$1,973,812**	**$2,054,739**	**$2,136,928**	**$80,927**	**$82,189**

1/ This table only displays obligations for medical equipment; for total obligations on all types of equipment, including non-medical, please see the Obligations by Object table at end of the Budget Overview chapter.

The medical equipment used across VHA is the same equipment used in United States (U.S.) commercial healthcare. Medical Services equipment includes capitalized equipment such as diagnostic imaging equipment, radiation oncology equipment, surgical systems and intensive care monitoring systems, with a purchase price of $1 million or more; and non-capitalized equipment, such as biomedical devices, dentistry equipment, laboratory analyzers, hospital beds, scientific instruments and appliances, measuring and weighing instruments, surgical equipment and instruments and accessories that cost less than $1 million. Medical Services equipment includes

clinical systems used in medical/surgical subspecialties for diagnostic interpretation, treatment planning, decision support and results reporting. Current medical equipment holdings across VHA have a value of approximately $10 billion.

The Assistant Under Secretary for Health for Support (AUSH-S) is responsible for national policies, standards and guidance related to medical equipment management and safety. AUSH-S provides leadership, consultation and expertise in technology configuration management and VHA medical equipment and clinical systems deployment, commissioning and technical sustainment and refresh. The Healthcare Technology Management Office manages this program on behalf of the AUSH-S and is accountable for program execution and oversight through coordination with Biomedical Engineering field operations managers.

VHA business process and systems re-engineering initiatives enhance clinical capabilities, patient safety, access to care and medical technology cybersecurity.

Medical Services funding in 2024 and 2025 will continue to address medical equipment replacement deferred for replacement during the pandemic. Modernizing VHA's medical equipment, while improving its safety and cybersecurity, requires deliberate systems engineering and extensive collaboration across VA lines of business and VHA clinical programs.

Plans for New and Replacement Equipment

The lifecycle replacement model applied to existing VHA medical equipment drives medical equipment and health technology refresh. The model incorporates equipment lifespans based on equipment clinical utility, evolving clinical functionality and technical supportability. Equipment lifecycle management also facilitates medical technology strategic sourcing. For planning and forecasting purposes, the medical equipment portfolio is grouped by its clinical function, volume and cost into High Criticality medical equipment, High Volume medical equipment, High Cost Diagnostic Imaging equipment, Low Cost Imaging equipment, High Cost Non-Imaging equipment, Sterile Processing equipment, Pathology/Laboratory equipment, Clinical Systems and General Biomedical equipment. VHA uses its lifecycle replacement model to identify medical equipment due for replacement for each equipment grouping by VISN and fiscal year.

Additionally, VA will upgrade or replace medical equipment and clinical systems to comply with the Oracle Cerner EHR interface requirements to correspond with medical center implementations and ensure medical device interoperability that align with clinical requirements.

Impact of VA Medical Equipment on Medical Care and Staff Productivity

Medical equipment is a foundational element of Veteran healthcare. Some examples of lifesaving equipment include linear accelerators to provide radiation treatment for cancer; computerized tomography scanners that provide imaging to screen for lung cancer; physiologic monitoring systems that display patient vital signs in real time; anesthesia delivery systems that induce and maintain anesthesia in surgical patients; and laboratory analyzers that determine blood glucose measurements.

VA continues to deploy new medical equipment at all medical centers in response to the most critical and time-sensitive needs. Modernized medical equipment expands Veterans' access to

care, provides clinical functionality that meets or exceeds community standards, enhances patient safety and mitigates information security risks.

Medical equipment directly contributes to improving the Veteran experience by providing state-of-the art equipment in the VA healthcare environment. Medical equipment refresh supports VA's overarching modernization efforts by improving VHA's capabilities to provide high reliability healthcare to Veterans. Medical equipment plays a vital role in focusing VA resources more efficiently by enhancing and supporting the clinical staff through human factors design, training on technology use and systems integration. Medical equipment directly contributes to improving the service timeliness by ensuring VAMCs have the technology essential to provide medical care to Veterans.

Medical Services Staffing 1/

		2023		**2024**	**2025**		
	2022	Budget	Current	**Revised**	**Advance**	+/-	+/-
Description (dollars in thousands)	Actual	Estimate	Estimate	**Request**	**Approp.**	2023-2024	2024-2025
Discretionary Obligations	$36,602,090	$42,237,314	$43,239,292	$49,645,183	$55,329,453	$6,405,890	$5,684,270
Mandatory Obligations - VACAA, sec. 801	$5,019	$3,690	$5,170	$5,371	$4,980	$202	($391)
Mandatory Obligations - ARP Act, sec. 8007	$545,644	$0	$0	$0	$0		
Mandatory Obligations - Cost of War Toxic Exposures Fund	$0	$0	$1,476	$1,900	$2,000	$424	$100
Mandatory Obligations - VMCHF	$2,319,485	$0	$733,253	$0	$0	($733,253)	$0
Obligations [Grand Total]	**$39,472,238**	**$42,241,004**	**$43,979,191**	**$49,652,454**	**$55,336,433**	**$5,673,263**	**$5,683,979**

1/ For additional FTE details, please see the Employment Summary tables and the Obligations by Object table at the end of the Budget Overview chapter.

Medical Services FTE represents the largest share of VHA obligations by object class. They include:

- Physicians;
- Dentists;
- Registered Nurses;
- Licensed Practical Nurses (LPNs)/Licensed Vocational Nurses (LVNs)/ Nurse Assistants;
- Non-physician providers, such as podiatrists, physician assistants, psychologists, nurse practitioners, chiropractors and optometrists;
- Health Technicians/Allied Health, such as respiratory therapists, physical therapists, dietitians, social workers, radiology technologists, pharmacists, audiologist and speech pathologists, nuclear medicine technologists and laboratory aids and workers;
- Wage Board/Purchase & Hire; and
- All Other.

As part of VA's multi-pronged initiative in 2024 and 2025 to improve Veterans' access to timely, high-quality care, and to meet Veterans' health care needs following enactment of the PACT Act, VA will increase VA hiring. Medical Services will have 293,574 FTE in 2024, an increase of 12,469 FTE over the 2023 current estimate. This FTE level sustains and builds on VA's capacity to provide care, given an anticipated growth in reliance on VA for care, and to meet the demand for PACT Act-induced. The 2025 FTE level realizes the gains from onboarding staff throughout 2024, enabling VA to further meet Veteran demand for VA-provided services.

FTE by Type
Medical Services

Account	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary FTE							
Physicians	21,063	23,617	23,103	24,621	25,667	1,518	1,046
Dentists	1,309	1,273	1,366	1,431	1,492	65	61
Registered Nurses	59,371	69,923	67,188	72,108	75,171	4,920	3,063
LP Nurse/LV Nurse/Nurse Assistant	26,247	30,201	28,162	29,768	31,032	1,606	1,264
Non-Physician Providers	17,604	18,239	18,510	19,430	20,255	920	825
Health Technicians/Allied Health	80,484	85,160	84,712	88,969	92,748	4,257	3,779
Wage Board/Purchase & Hire	5,352	6,043	5,601	5,868	6,117	267	249
All Other	46,424	48,325	48,916	51,349	53,531	2,433	2,182
Discretionary Medical Service FTE [Subtotal]	**257,854**	**282,781**	**277,558**	**293,544**	**306,013**	**15,986**	**12,469**
Medical Services ARP Act, sec. 8007 FTE							
Mandatory FTE							
Physicians	224	0	0	0	0	0	0
Dentists	0	0	0	0	0	0	0
Registered Nurses	1,442	0	0	0	0	0	0
LP Nurse/LV Nurse/Nurse Assistant	202	0	0	0	0	0	0
Non-Physician Providers	65	0	0	0	0	0	0
Health Technicians/Allied Health	284	0	0	0	0	0	0
Wage Board/Purchase & Hire	17	0	0	0	0	0	0
All Other	287	0	0	0	0	0	0
ARP Act, sec. 8007 FTE [Subtotal]	**2,521**	**0**	**0**	**0**	**0**	**0**	**0**
Veterans Medical Care and Health Fund							
Mandatory FTE							
Physicians	1,493	0	472	0	0	(472)	0
Dentists	14	0	4	0	0	(4)	0
Registered Nurses	5,873	0	1,857	0	0	(1,857)	0
LP Nurse/LV Nurse/Nurse Assistant	1,081	0	342	0	0	(342)	0
Non-Physician Providers	302	0	95	0	0	(95)	0
Health Technicians/Allied Health	1,511	0	478	0	0	(478)	0
Wage Board/Purchase & Hire	58	0	18	0	0	(18)	0
All Other	794	0	251	0	0	(251)	0
VMCHF FTE [Subtotal]	**11,126**	**0**	**3,517**	**0**	**0**	**(3,517)**	**0**
Cost of War Toxic Exposures Fund							
Mandatory FTE							
All Other	0	0	13	13	13	0	0
American Families Plan FTE [Subtotal]	**0**	**0**	**13**	**13**	**13**	**0**	**0**
Veterans Choice Act (P.L. 113-146)							
Section 801							
Mandatory FTE							
Physicians	11	6	11	11	11	0	0
Non-Physician Providers	2	1	2	2	2	0	0
All Other	4	1	4	4	4	0	0
Veterans Choice Act FTE [Subtotal]	**17**	**8**	**17**	**17**	**17**	**0**	**0**
Total Medical Services FTE							
Physicians	22,791	23,623	23,586	24,632	25,678	1,046	1,046
Dentists	1,323	1,273	1,370	1,431	1,492	61	61
Registered Nurses	66,686	69,923	69,045	72,108	75,171	3,063	3,063
LP Nurse/LV Nurse/Nurse Assistant	27,530	30,201	28,504	29,768	31,032	1,264	1,264
Non-Physician Providers	17,973	18,240	18,607	19,432	20,257	825	825
Health Technicians/Allied Health	82,279	85,160	85,190	88,969	92,748	3,779	3,779
Wage Board/Purchase & Hire	5,427	6,043	5,619	5,868	6,117	249	249
All Other	47,509	48,326	49,184	51,366	53,548	2,182	2,182
Medical Services FTE [Grand Total[	**271,518**	**282,789**	**281,105**	**293,574**	**306,043**	**12,469**	**12,469**

VA's Medical Provider Recruitment & Retention Practices

As the Nation's largest integrated health care delivery system, VHA workforce challenges mirror those of the health care industry. VHA remains fully engaged in a competitive clinical recruitment market and, therefore, faces similar challenges as our private sector counterparts. Some factors include: the growing national shortage and availability of experienced, quality candidates who possess the competencies required for the position; the salaries typically paid by private industry for similar positions; employment trends and labor-market factors that may affect the ability to recruit candidates; and other supporting factors, such as rural/highly rural locations that may be considered less desirable.

VHA is the largest administration within VA, and in 2022 accounted for 370,954 FTE of the total 416,430 FTE (89.1%). VHA's annual turnover rate for full-time and part-time employees has typically averaged 9.3% but has increased to 10.0% as of 2022. VHA turnover compares favorably with the healthcare industry turnover rate of 27.0-45.0%[68], including those occupations identified as mission critical[69]. In addition, VHA hired 48,524 new employees in 2022, the highest number of new external hires in a given year, and 5,000 more than in 2021. This resulted in a net increase of 8,428 employees and a 2.3% annual growth rate from 2021 to 2022, compared to the 5-year average annual growth rate of 3.0%.

Over the last five years (2018-2022), VHA grew by 52,500 additional health care providers and support staff, the majority of which (60.5%) was in clinical occupations. Of the clinical growth, 70.8% occurred in top clinical staffing shortage occupations. VHA typically hires approximately 2,700 physicians and 8,000 or more registered nurses annually to replace losses and grow the workforce to meet access standards and provide the best possible care to Veterans. In 2022, VHA hired a record 9,051 registered nurses.

VA has a multi-year action plan to address the root causes of dissatisfaction for primary care physicians, psychiatrists, and psychologists. Ongoing analysis includes a review of support staff ratios, workload, promotion potential and compensation. In addition, VA conducted a detailed compensation analysis of all physician specialties and updated its pay tables to ensure VA remains competitive with the private sector.

Critical resources used in VA to improve recruitment and retention include: increased maximum physician salaries; implementation of Stay in VA Touchpoints to strengthen employee engagement and retention through regularly scheduled supervisory-staff conversations; targeted use of recruitment, relocation, and retention (3Rs) incentives; total rewards brochures/flyers to demonstrate the total rewards of a career in VA; full utilization of the Education Debt Reduction Program (EDRP), Health Profession Scholarship Program (HPSP) and Specialty Education Loan Repayment Programs (SELRP), respectively; targeted nationwide recruitment advertising and marketing; virtual Trainee Recruitment Events to connect, match and place highly trained VA Health Professions Trainees in facilities with appropriate positions; expansion of scholarship programs; the DoD/VA Transitioning Military Program (TMP) to recruit transitioning service

[68] BLS (Bureau of Labor Statistics) JOLTS (Job Openings and Labor Turnover Survey), https://www.bls.gov/jlt/

[69] The annual "National Health Care Retention and RN Staffing Report" published by NSI Nursing Solutions Inc. in March 2021 identified turnover rates for nurses and other health professionals. VHA's turnover rate for registered nurses, physician assistants, pharmacists, physical therapists, and occupational therapists was lower than the industry average reported for these occupations.

members in health care specialties; and exhibiting regularly at key healthcare conferences and job fairs.

In 2022, VHA invested over $312 million from the Offices of Community Care and Rural Health, into expanding its existing "hub" model for telehealth clinical resource sharing with 18 Clinical Resource Hubs (CRH), each of which will provide primary care, mental health, and specialty care services using telehealth across their VISN, with the capability of extending their services across the country, if needed. In addition, reducing time to hire remains a top priority for HR modernization in 2023. Continuation and expansion of these efforts will ensure that VA achieves its projected growth in 2024.

VA Long-Term Services and Supports Programs 1/

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Services (0160) Institutional							
VA Community Living Centers (VA CLC)	$3,104,394	$3,250,754	$3,361,863	$3,022,616	$3,324,222	($339,247)	$301,606
Medical Services (0160) Non-Institutional							
Community Residential Care	$75,537	$60,438	$3,361,863	$3,022,616	$3,324,222	($339,247)	$301,606
Home Telehealth	$249,922	$219,003	$74,007	$65,925	$74,183	($8,082)	$8,258
Home-Based Primary Care	$854,183	$885,583	$237,314	$209,102	$257,106	($28,212)	$48,004
Spinal Cord Injury & Disability Home Care	$12,077	$9,384	$925,054	$951,996	$1,147,893	$26,942	$195,897
VA Adult Day Health Care	$2,074	$1,225	$11,675	$10,753	$12,312	($922)	$1,559
Non-Institutional [Subtotal]	**$1,193,793**	**$1,175,633**	**$7,198**	**$7,581**	**$7,998**	**$383**	**$417**
Care Coordination for Community Care LTSS programs	$143,027	$87,133	$138,137	$143,202	$159,547	$5,065	$16,345
Discretionary Obligations [Subtotal]	**$4,441,214**	**$4,513,520**	**$3,507,198**	**$3,173,399**	**$3,491,767**	**($333,799)**	**$318,368**
Mandatory Obligations (includes VACAA, ARP Act, and PACT Act)							
Medical Services Category Institutional							
VA Community Living Centers (VA CLC)	$285,061	$0	$195,924	$418,779	$597,141	$222,855	$178,362
Medical Services Category Non-Institutional							
Community Residential Care	$555	$0	$0	$0	$0	$0	$0
Home Telehealth	$162,923	$0	$0	$0	$0	$0	$0
Home-Based Primary Care	$28,829	$0	$19,782	$42,283	$60,292	$22,501	$18,009
Spinal Cord Injury & Disability Home Care	$100	$0	$0	$0	$0	$0	$0
VA Adult Day Health Care	$0	$0	$0	$0	$0	$0	$0
Non-Institutional [Subtotal]	**$192,407**	**$0**	**$19,782**	**$42,283**	**$60,292**	**$22,501**	**$18,009**
Care Coordination for Community Care LTSS programs	$88	$783	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$477,556**	**$783**	**$215,706**	**$461,062**	**$657,433**	**$245,356**	**$196,371**
Discretionary and Mandatory Obligations							
Medical Services Category Institutional							
VA Community Living Centers (VA CLC)	$3,389,455	$3,250,754	$3,557,787	$3,441,395	$3,921,363	($116,392)	$479,968
Medical Services Category Non-Institutional							
Community Residential Care	$76,092	$60,438	$3,361,863	$3,022,616	$3,324,222	($339,247)	$301,606
Home Telehealth	$412,845	$219,003	$74,007	$65,925	$74,183	($8,082)	$8,258
Home-Based Primary Care	$883,012	$885,583	$257,096	$251,385	$317,398	($5,711)	$66,013
Spinal Cord Injury & Disability Home Care	$12,177	$9,384	$925,054	$951,996	$1,147,893	$26,942	$195,897
VA Adult Day Health Care	$2,074	$1,225	$11,675	$10,753	$12,312	($922)	$1,559
Non-Institutional [Subtotal]	**$1,386,200**	**$1,175,633**	**$4,629,695**	**$4,302,675**	**$4,876,008**	**($327,020)**	**$573,333**
Care Coordination for Community Care LTSS programs	$143,115	$87,916	$138,137	$143,202	$159,547	$5,065	$16,345
Obligations [Grand Total]	**$4,918,770**	**$4,514,303**	**$8,325,619**	**$7,887,272**	**$8,956,918**	**($438,347)**	**$1,069,646**

1/ This table only displays obligations for Medical Services for VA-provided LTSS; for total obligations across all appropriations please see the Medical Care chapter.

The Medical Services portions of the VA-provided Long-Term Services and Supports programs include VA Community Living Centers, Community Residential Care, VA Adult Day Care, Home-Based Primary Care, Spinal Cord Injury Home Care and Home Telehealth. Please see the Medical Care chapter for more information about these programs.

Other Health Care Programs VA Care

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary							
CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers	$471,293	$365,844	$484,705	$524,735	$574,226	$40,030	$49,490
Caregivers (Including CHAMPVA)	$1,220,189	$1,811,210	$1,831,210	$2,385,880	$2,726,731	$554,670	$340,851
Camp Lejeune - Family	$346	$0	$700	$725	$703	$25	($22)
Homeless Grants	$1,082,127	$970,341	$1,003,582	$1,067,265	$1,115,656	$63,683	$48,391
Readjustment Counseling	$242,852	$279,635	$277,182	$287,270	$295,568	$10,088	$8,298
Discretionary Obligations [Subtotal]	$3,016,808	$3,427,030	$3,597,379	$4,265,875	$4,712,884	$668,496	$447,008
Obligations [Total]	**$3,016,808**	**$3,427,030**	**$3,597,379**	**$4,265,875**	**$4,712,884**	**$668,496**	**$447,008**

1/ This table only displays obligations for Medical Services; for total obligations across all appropriations please see the Medical Care chapter.

Medical Services costs associated with the CHAMPVA program remaining in the Medical Services appropriation include implementing the CHAMPVA In-house Treatment Initiative (CITI) as well as Pharmacy costs associated with the CHAMPVA program. CITI is a voluntary program that allows treatment of beneficiaries of CHAMPVA at VAMCs that have elected to participate in the initiative. Additionally, costs for Caregivers' stipend payments, including the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act expansion, and the Medical Services costs for the Readjustment Counseling program remain in the Medical Services appropriation. Please see the Medical Community Care chapter for more information about these programs.

Medical Services Support for VA- and Community-Provided Care

Beneficiary Travel 1/

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$1,766,990	$1,488,378	$2,261,747	$2,668,861	$3,069,190	$407,114	$400,329
Mandatory Obligations	$114,475	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$1,881,465**	**$1,488,378**	**$2,261,747**	**$2,668,861**	**$3,069,190**	**$407,114**	**$400,329**

1/ This table displays obligations only in Medical Services. A breakout of the $1.9 billion in total 2022 obligations for the Beneficiary Travel program can be found in the Medical Care Chapter, Obligations by Object table.

Beneficiary Travel by Type
(dollars in thousands)

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Beneficiary Travel-Mileage	$317,112	$356,027	$404,943	$477,119	$562,159	$72,176	$85,040
Beneficiary Travel-Special Mode	$1,480,762	$1,088,915	$1,773,662	$2,093,781	$2,391,610	$320,119	$297,829
All Other Beneficiary Travel	$65,109	$43,436	$83,142	$97,961	$115,421	$14,819	$17,460
Beneficiary Travel Total	**$1,862,983**	**$1,488,378**	**$2,261,747**	**$2,668,861**	**$3,069,190**	**$407,114**	**$400,329**

Description of the Program

VA administers a Beneficiary Travel (BT) Program to help alleviate the costs of travel to medical appointments for eligible Veterans. Travel benefit eligibility for Veterans is based on either the characteristics of the Veteran, the type of medical appointment or a combination of the two. Others who are not Veterans, including family members or those accompanying Veterans to appointments, may also be eligible for the benefit, based on qualifying criteria. Travel costs are reimbursed to beneficiaries, usually after a deductible. Costs covered by the program include a per-mile rate for travel in private vehicles; "special mode" (e.g., ambulance) travel in certain circumstances; and in some cases, airfare, meals and lodging.

Title 38 U.S.C, § 111, "Payments or allowances for beneficiary travel," as regulated in 38 C.F.R. §§ 70.1 – 70.50, authorizes VA to provide or reimburse to certain eligible Veterans and other beneficiaries for:

- Mileage (currently $0.415), or when medically indicated, special mode (ambulance, wheelchair van, etc.) transport and common carrier (plane, train, bus, taxi, light rail, etc.) transport;
- The actual cost of bridge tolls, road and tunnel tolls, parking and authorized luggage fees when supported by a receipt; and
- The actual cost, in limited circumstances, of meals, lodging or both, not to exceed 50% of the local Federal employee rate.

Eligibility is based upon receipt of VA disability compensation service connection and/or low income (VA pension thresholds) or special administrative authority. The current BT regulations only provide authorization for BT within the States, Territories and possessions of the United States, the District of Columbia and the Commonwealth of Puerto Rico.

Pharmacy 1/

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
DISCRETIONARY							
Medical Services (0160):							
Discretionary Obligations	$7,632,512	$10,303,084	$9,129,784	$8,605,862	$8,470,101	($523,922)	($135,761)
Discretionary Obligations [Subtotal]	**$7,632,512**	**$10,303,084**	**$9,129,784**	**$8,605,862**	**$8,470,101**	**($523,922)**	**($135,761)**
Medical Community Care (0140):							
Discretionary Obligations	$105,143	$407,505	$114,561	$100,656	$85,277	($13,905)	($15,379)
Discretionary Obligations [Subtotal]	**$105,143**	**$407,505**	**$114,561**	**$100,656**	**$85,277**	**($13,905)**	**($15,379)**
Medical Support and Compliance (0152):							
Discretionary Obligations	$568,251	$712,900	$703,100	$778,000	$801,600	$74,900	$23,600
Discretionary Obligations [Subtotal]	**$568,251**	**$712,900**	**$703,100**	**$778,000**	**$801,600**	**$74,900**	**$23,600**
Medical Facilities (0162):							
Discretionary Obligations	$152,533	$195,700	$202,100	$298,400	$206,400	$96,300	($92,000)
Discretionary Obligations [Subtotal]	**$152,533**	**$195,700**	**$202,100**	**$298,400**	**$206,400**	**$96,300**	**($92,000)**
Discretionary Total	**$8,458,439**	**$11,619,189**	**$10,149,545**	**$9,782,918**	**$9,563,378**	**($366,627)**	**($219,540)**
MANDATORY							
Medical Services Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$1,353,254	$2,892,523	$4,124,480	$1,539,269	$1,231,957
Veterans Medical Care and Health Fund (0173)	$1,899,587	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0160)	$67,267	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$855	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,967,709**	**$0**	**$1,353,254**	**$2,892,523**	**$4,124,480**	**$1,539,269**	**$1,231,957**
Medical Community Care Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund (0172)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$924	$0	$975	$0	$0	($975)	$0
VACAA, Section 801 (0152)	$217	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,141**	**$0**	**$975**	**$0**	**$0**	**($975)**	**$0**
Medical Facilities Category							
Cost of War Toxic Exposures Fund (1126)	$0	$0	$0	$0	$0	$0	$0
Heath Robinson PACT Act Section 707	$0	$0	$0	$0	$0	$0	$0
Veterans Medical Care and Health Fund (0173)	$7,056	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$161	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$7,217**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Mandatory Total	**$1,976,067**	**$0**	**$1,354,229**	**$2,892,523**	**$4,124,480**	**$1,538,294**	**$1,231,957**
Combined Discretionary and Mandatory by Category							
Medical Services	$9,600,221	$10,303,084	$10,483,038	**$11,498,385**	**$12,594,581**	$1,015,347	$1,096,196
Medical Community Care	$105,143	$407,505	$114,561	**$100,656**	**$85,277**	($13,905)	($15,379)
Medical Support and Compliance	$569,392	$712,900	$704,075	**$778,000**	**$801,600**	$73,925	$23,600
Medical Facilities	$159,750	$195,700	$202,100	**$298,400**	**$206,400**	$96,300	($92,000)
Obligations [Grand Total]	**$10,434,506**	**$11,619,189**	**$11,503,774**	**$12,675,441**	**$13,687,858**	**$1,171,667**	**$1,012,417**

[1/] This table displays all obligations in the Pharmacy program, not just Medical Services obligations, as total funding for this program is not displayed in any other chapter.

Pharmacy Program Data

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Number of 30-Day RXs (Millions).....	306	313	311	314	317	3	3

VA's use of medication therapies is a fundamental underpinning of how VA delivers health care today. VA's primary focus is on diagnosis and treatment in an ambulatory environment and home environment basis with institutional care as the modality of last resort.

Key Pharmacy Benefits Management Service (PBM) Functions:

National Formulary- The VA National Formulary (VANF) is the sole drug formulary in use in VA. The VANF contains national standardization items within selected therapeutic categories and ensures uniform availability of drug therapies across the nation. Drugs not listed on the VANF are available on a Prior Authorization (PA) basis. The VANF is an evidence-based process that places a premium on drug safety and effectiveness and has been judged as clinically and economically sound by multiple external reviewing organizations.

Consolidated Mail Outpatient Pharmacies (CMOP)- VA automated and consolidated its prescription fulfillment processes for Veteran outpatients. Prescriptions are filled and mailed to the Veteran's home. CMOPs significantly improve customer service, reduce the potential for errors and improve efficiency by filling large volumes of prescriptions faster with continually improving technologies that require less staff than would be needed at individual VA medical centers. VA currently operates seven facilities across the nation and fills approximately 80% of all outpatient prescriptions via the CMOP system.

VA Adverse Drug Event Reporting System (VA ADERS) / VA Center for Medication Safety (VAMedSAFE)- VAMedSAFE conducts passive surveillance (VA ADERS), active medication safety surveillance (integrated databases) and national medication safety Medication Use Evaluations and Risk Reduction efforts for certain classes of medication and vaccines. The staff works collaboratively with the Food and Drug Administration (FDA) on surveillance with an emphasis on the safe use of medications and vaccines in the Veteran population.

VA Mobile Pharmacies- VA mobile pharmacies provide acute and chronic medications to Veterans and potentially other Americans affected by a natural disaster. VA's four mobile pharmacies are capable of connecting via satellite to a CMOP, which can then dispense prescriptions for delivery to a central location within the disaster zone.

Pharmacy Clinical Informatics and Re-engineering- VA Pharmacy Informatics and Re-engineering program provides business owner oversight of pharmacy development activities to improve and transform health care through information technology. The primary initiative is to support the Oracle Cerner EHR replacement system and to innovate the Pharmacy VistA system component of VA's EHR, which will continue to be in use at VA Medical Centers for many years during the transitional period. VA's Pharmacy Product System/National Drug File Project (PPS/NDF) is the largest open-source drug file in the United States. The Drug File contains over

128,000 medications and product terms, and the system contains medication information that is provided to patients. Development plans are in progress for adding pharmacogenomic (drug/gene) warnings to the Medication Order Check Healthcare Application (MOCHA) suite of order checks which currently includes drug interaction, therapeutic duplication, and dosage warnings.

Clinical Pharmacy Program Office- The CPPO team is committed to the mission of integrating and optimizing VA clinical pharmacy practice across primary, specialty and acute care settings to improve access and provide evidence-based, cost-effective, safe, and high-quality care focused on Veteran experience and outcomes. Leveraging Clinical Pharmacist Practitioners (CPP) as advanced practice providers to deliver comprehensive medication management services as part of the collaborative team-based model is critical to expanding access to care for Veterans. CPPO works to develop and deploy strategies to empower the pharmacy workforce to adapt to changing needs of Veterans and VHA as part of a high reliability organization and ensure all Veterans have access to CPP services. Strategies include expanded program office partnerships to increase the number of CPPs delivering care for rural and urban Veterans with a focus on health equity along with a multi-layered approach for training, development and driving innovation through clinical boot camps, group coaching, and mentorship for the clinical pharmacy workforce. CPPO has developed robust and comprehensive data collection tools, including productivity and impact metrics that illustrate both the performance and quality of clinical pharmacy practice in VHA. In 2022, CPP workforce growth continued with 5,466 CPPs accounting for 53.0% of the pharmacist workforce. These CPPs completed over 6.1 million patient care visits for more than 1.5 million Veterans across the continuum of care.

Pharmacy Residency Program Office- The Pharmacy Residency Program Office's (PRPO) mission is to train post-doctoral pharmacists for the VA and the profession, and, over the past 20 years, the program office has trained over 13,000 pharmacists in post-graduate years (PGY) 1 and 2 and fellowships. VA is the largest post-doctoral training program in the nation, with over 350 programs nationally, and has become the residencies-of-choice for the profession. The PRPO has won national recognition for its training programs through the American Society of Health-System Pharmacists (ASHP) Board of Excellence Award which recognizes strong influential programs nationwide. PRPO is the first program office to have an accredited virtual residency program which is part of the CRH. There are plans to expand virtual training to increase clinicians with residency training in highly specialized areas such as Neurology and Informatics. This will enable VA to have the highly trained clinical pharmacist specialists required to serve Veterans with the latest therapies and research.

Academic Detailing- Academic Detailing Services (ADS): An evidence-based knowledge-translation service provided to front-line clinical and associated staff. ADS addresses many clinical topics including, but not limited to, the Opioid Safety Initiative, Suicide Prevention, Opioid Use Disorder, Alcohol Use Disorder, Tobacco Use Disorder, Chronic Obstructive Pulmonary Disease, Heart Failure, and Diabetes. Academic detailing knowledge-translation services include distillation of updated VA-DOD Clinical Practice Guidelines and the latest clinical literature into practical actions front-line clinical teams can put into immediate practice.

Academic Detailers, primarily a subgroup of clinical pharmacists, provide this service in small group or one-on-one settings to ensure the specific needs of the clinical staff are individualized

and supportive implementation services are delivered. AD programs are organized at the VISN and have avenues to report and address systemwide barriers with leadership. Since 2019 implementation, Academic Detailers have conducted approximately 25,000 educational outreach visits annually and worked with over 14,000 unique clinical staff with a workforce of under 70 FTE. Most of these visits were focused on addressing the opioid epidemic and optimizing access to evidence-based treatments for Veterans across many chronic conditions. Despite that effort many clinical practice sites remained untouched, including 139 rural divisions with no educational outreach visits in 2022.

Patient Medication Information Management and Medication Reconciliation Initiative Office- Collaborates with program offices, the field and partner federal healthcare organizations to ensure patients and their caregivers have safe, effective, team-based, patient-driven medication reconciliation as part of a larger goal to partner with patients and their medications.

Meds by Mail Program- The PBM Meds by Mail (MbM) Program provides comprehensive outpatient mail pharmacy services and call center support to qualifying beneficiaries of VHA's Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA), including the CHAMPVA In-house Treatment Initiative (CITI) and Spina Bifida / Children of Women Vietnam Veterans (CWVV) programs. All prescriptions processed by MbM are filled by VA's CMOP and mailed directly to the beneficiary at no cost.

Virtual Pharmacy Service Program- The PBM Virtual Pharmacy Service (VPS) Program provides outpatient pharmacy support to VAMC pharmacies to process unverified prescriptions waiting for pharmacist review. Participating VAMC pharmacies (19) have an average outpatient prescription processing time of fewer than two days. The VPS program is staffed by pharmacists located at the MbM serving centers in Dublin, Georgia and Cheyenne, Wyoming.

Pharmacy Compliance- This program develops policy, guidance and central educational resources to support compliance with external entities' standards and federal regulations at VA medical facility pharmacies. This program collaborates with external entities such as the Drug Enforcement Agency (DEA), FDA, United States Pharmacopoeia (USP) and The Joint Commission to ensure policy and guidance are consistent with pharmacy practice regulations and standards. Initiatives include providing Veterans free medication take back services through mail-back envelopes and on-site receptacles compliant with DEA regulations, developing pharmacy efficiency initiatives to promote an evidence-based and cost effective uniform pharmacy benefit to meet the medical needs of our nation's Veterans, developing educational resources consistent with USP standards for patient specific sterile compounding programs and guidance for handling hazardous drugs at VA medical facilities.

Population Covered - Overall, reliance on prescription drugs for the enrolled Veteran population was 63.0% in 2021.

Prescription drug reliance was projected to increase by approximately 0.5% additively in 2021 due to the 14-day Rx Urgent/Emergent adjustment before stabilizing in 2022 and later.

Recent Trends - Drug ingredient cost per outpatient prescription, the total cost of outpatient prescription drug ingredients and the total number of outpatient prescriptions filled all trended upward from 2020 to 2021 by 5.3%, 6.2% and 0.9%, respectively. Over this period, the number of Veterans receiving outpatient prescriptions is essentially flat, trending upward slightly by only 0.03%. Projected outpatient prescription workload through 2024 is largely driven by utilization trend, demographic changes, and net enrollment growth.

Projected Trends - The impact of the underlying prescription drug utilization trend assumptions from 2021 to 2024 is approximately 4.6% (1.5% annually).

Demographic Changes - Prescription utilization tends to increase with age, though the increases seen in VHA utilization drops sharply after age 65 as enrollees become less reliant on VHA health care. Enrollees in Priorities 1a, 1b, 4 and 5 tend to have the highest utilization, while enrollees in Priorities 6 - 8 tend to have the lowest utilization. The enrollee population is projected to become older on average and to transition to higher enrollment priority levels over time. These demographic shifts will move more enrollees to ages and priorities with a higher prescription drug demand. The total workload impact from 2021 to 2024 due to these and other demographic changes is approximately 11.7%.

Net Enrollment Growth – While prescription drug utilization is projected to increase on a per enrollee basis due to the changes above, total prescription drug utilization also varies with the size of the projected enrollee population. The total enrollee population is projected to decrease from 2021 to 2024 due in part to additional deaths related to COVID-19, and also lower enrollment rates than projected in prior models. The impact of net changes in enrollment is decreasing total prescription drug utilization by approximately 6.0% from 2021 to 2024.

Prosthetics 1/

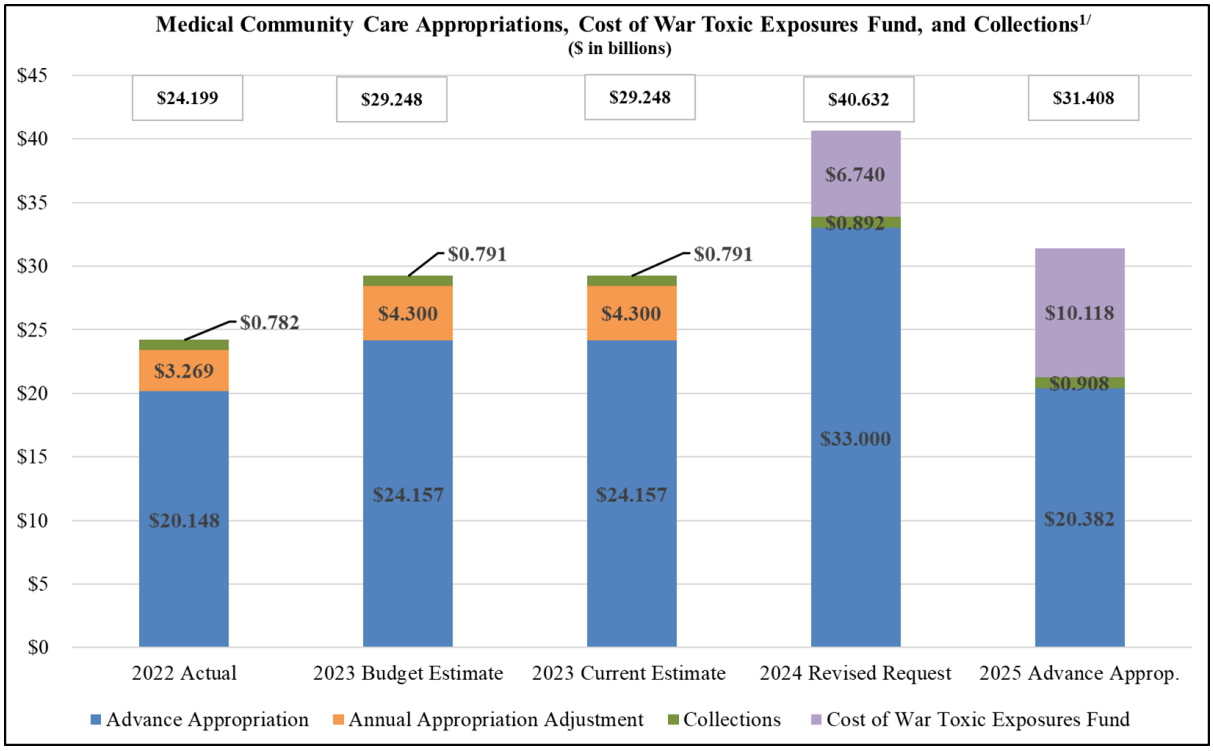
		2023		**2024**	**2025**		
	2022	Budget	Current	**Revised**	**Advance**	+/-	+/-
Description (dollars in thousands)	Actual	Estimate	Estimate	**Request**	**Approp.**	2023-2024	2024-2025
Discretionary Obligations	$3,722,046	$4,069,980	$4,147,810	$4,571,956	$5,025,363	$424,146	$453,407
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$3,722,046**	**$4,069,980**	**$4,147,810**	**$4,571,956**	**$5,025,363**	**$424,146**	**$453,407**

1/ With the exception of the 2023 Budget Estimate column, this table displays obligations for the Medical Services account, only. See the Medical Care chapter for detail on all accounts that support the Prosthetics program.

Nearly all prosthetics obligations will be in the Medical Services appropriation. Services provided include prosthetic and orthotic devices, sensory aids, medical equipment and support services for Veterans. PSAS serves Veterans with needs related to: amputation, spinal cord injury/disorders, polytrauma and traumatic brain injury, hearing and vision, podiatric care, cardio-pulmonary disease, speech and swallowing deficits, geriatric impairments, neurologic dysfunction, muscular dysfunction, women's health, orthopedic care, diabetes/metabolic disease, peripheral vascular disease, cerebral vascular diseases and other medical disorders. For more information, please see the Medical Care chapter.

Medical Community Care Category

Chart: Medical Community Care Appropriations and Collections



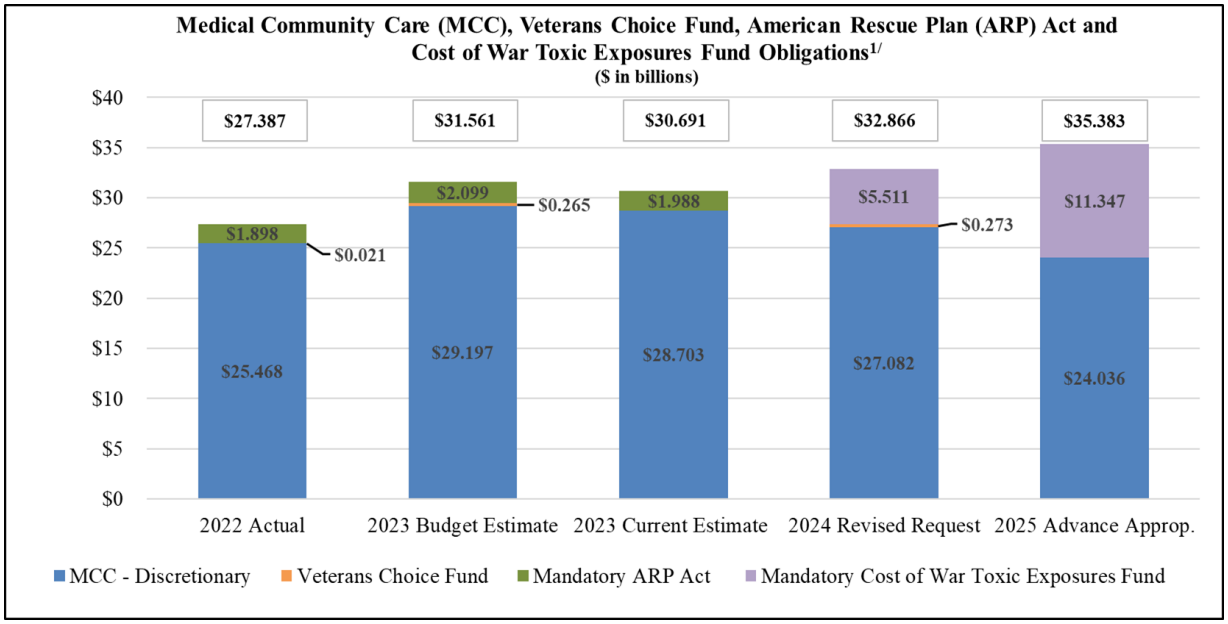
1/ This table reflects appropriations prior to proposed cancellations and transfers

Providing Veterans with timely access to high quality health care is absolutely essential whether through a Department of Veterans Affairs (VA) facility or community provider. It is clear that community care is a key part of how the Department cares for the Nation's Veterans. VA will continue to use a combination of care at VA facilities and in the community to meet the needs of Veterans. With the Veteran at the center of their own care, VA will work to achieve the right balance between care provided in the community and care provided through VA to ensure Veterans have timely access to the highest quality health care services.

The Budget reflects the following discretionary appropriation funding: 2024 advance appropriation request of $33.0 billion and 2025 advance appropriation request of $20.4 billion. In 2024, to realign funding among the four Medical Care accounts, the Budget reflects a transfer of $3.9 billion from Medical Community Care to Medical Facilities and a proposed cancellation of $1.9 billion in unobligated balances. VA is requesting $6.7 billion in 2024 and $10.1 billion in

2025 in mandatory funding from the Cost of War Toxic Exposures Fund, as authorized in the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act), to supplement discretionary Medical Community Care resources to fund revised estimates of community care costs based on 2022 actuals and updated actuarial projections. When combined with unobligated start of year balances, reimbursements, and transfers to other accounts, the total amount of resources to be obligated in the Medical Community Care Category is $32.9 billion in 2024 and $35.4 billion in 2025, as detailed in the table below.

Chart: Medical Community Care Obligations



1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the chart displays the estimated allocation for the Medical Community Care category. Final funding allocations among account-level categories may change in response to workload demand requirements throughout 2023.

Tables: Community Care Funding Crosswalks 2022-2025

(dollars in thousands)

The following four tables show funding crosswalks for 2022 through 2025 for the VA community care program, separately by funding sources as follows:

- Medical Community Care (MCC), discretionary funding
- Veterans Choice Fund (VCF), mandatory funding for Medical Care only
- American Rescue Plan Act, mandatory funding
- Cost of War Toxic Exposures Fund, mandatory funding
- Grand total: MCC, VCF, American Rescue Plan Act and Cost of War Toxic Exposures Fund

Table: Medical Community Care (0140) Discretionary Funding Crosswalk 2022-2025

(dollars in thousands)

		2023		2024	2025		
Description	2022 Actual	Budget Estimate	Current Estimate	Revised Request	Advance Approp.	+/- 2023-2024	+/- 2024-2025
Appropriation Medical Community Care (0140)							
Advance Appropriation Medical Community Care (0140)	$20,148,244	$24,156,659	$24,156,659	$33,000,000	20,382,000	$8,843,341	($12,618,000)
Annual Appropriation Adjustment Medical Community Care (0140)	$3,269,000	$4,300,000	$4,300,000	$0	$0	($4,300,000)	$0
Appropriations Request Subtotal	$23,417,244	$28,456,659	$28,456,659	$33,000,000	$20,382,000	$4,543,341	($12,618,000)
Proposed Cancellation of Available Unobligated Balances	$0	$0	$0	($1,909,069)	$0	($1,909,069)	$1,909,069
Recissions (PL 117-103 § 255)	($200,000)	$0	$0	$0	$0	$0	$0
Tranfers To:							
Medical Facilities (0162)	$0	$0	$0	($3,919,081)	$0	($3,919,081)	$3,919,081
North Chicago Demo. Fund (0169) from Medical Community Care (0140)	($43,768)	($50,768)	($67,500)	($70,000)	($75,000)	($2,500)	($5,000)
Transfers To [Subtotal]	($43,768)	($50,768)	($67,500)	($3,989,081)	($75,000)	($3,921,581)	$3,914,081
Transfers From:							
Medical Services (0160)	$0	$0	$170,000	$0	$0	($170,000)	$0
Medical Support & Compliance (0152)	$0	$0	$930,000	$0	$0	($930,000)	$0
Transfers From [Subtotal]	$0	$0	$1,100,000	$0	$0	($1,100,000)	$0
Collections:							
MCCF Transfer to Medical Community Care (0140)	$782,169	$791,075	$791,075	$892,044	$907,954	$100,969	$15,910
Collections [Subtotal]	$782,169	$791,075	$791,075	$892,044	$907,954	$100,969	$15,910
Budget Authority Total	**$23,955,645**	**$29,196,966**	**$30,280,234**	**$27,993,894**	**$21,214,954**	**($2,286,340)**	**($6,778,940)**
Unobligated Balance (SOY):							
No-Year Medical Community Care (0140)	$439,288	$0	$155,299	$0	$820,646	($155,299)	$820,646
2-Year	$1,332,887	$0	$176,374	$1,909,069	$2,000,000	$1,732,695	$90,931
4-Year Base Year 2019	$10,532	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$1,782,707	$0	$331,673	$1,909,069	$2,820,646	$1,577,396	$911,577
Unobligated Balance (EOY):							
No-Year Medical Community Care (0140)	($155,299)	$0	$0	($820,646)	$0	($820,646)	$820,646
2-Year	($176,374)	$0	($1,909,069)	($2,000,000)	$0	($90,931)	$2,000,000
Unobligated Balance (EOY) [Subtotal]	($331,673)	$0	($1,909,069)	($2,820,646)	$0	($911,577)	$2,820,646
Lapse	($14,288)	$0	$0	$0	$0	$0	$0
Subtotal	$25,392,391	$29,196,966	$28,702,838	$27,082,317	$24,035,600	($1,620,521)	($3,046,717)
Prior Year Recoveries	$75,894	$0	$0	$0	$0	$0	$0
Obligations (0140) [Total]	**$25,468,285**	**$29,196,966**	**$28,702,838**	**$27,082,317**	**$24,035,600**	**($1,620,521)**	**($3,046,717)**

Table: Veterans Choice Fund (0172) Medical Care Only Crosswalk 2022-2025

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Unobligated Balance (SOY):							
No-Year	$280,382	$265,088	$272,550	$272,550	$0	$0	($272,550)
Unobligated Balance (SOY) [Subtotal]	$280,382	$265,088	$272,550	$272,550	$0	$0	($272,550)
Transfer of Unboligated Balance							
Within the Veterans Choice Fund	$205	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY):							
No-Year	($272,550)	$0	($272,550)	$0	$0	$272,550	$0
Unobligated Balance (EOY) [Subtotal]	($272,550)	$0	($272,550)	$0	$0	$272,550	$0
Subtotal	$8,037	$265,088	$0	$272,550	$0	$272,550	($272,550)
Prior Year Recoveries	$12,727	$0	$0	$0	$0	$0	$0
Obligations (0172) 1/ [Total]	**$20,764**	**$265,088**	**$0**	**$272,550**	**$0**	**$272,550**	**($272,550)**

1/ Excludes OI&T Obligations

Table: Medical Community Care, American Rescue Plan Act Crosswalk 2022-2025

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
UNOBLIGATED BALANCE (SOY)							
ARP Act § 8002	$1,901,196	$2,098,805	$1,987,643	$0	$0	($1,987,643)	$0
ARP Act § 8007	$72,100	$0	$176	$0	$0	($176)	$0
Unobligated Balance (SOY) [Subtotal]	**$1,973,296**	**$2,098,805**	**$1,987,819**	**$0**	**$0**	**($1,987,819)**	**$0**
REAPPORTIONMENT of § 8002							
ARP Act § 8002	$1,902,643	$0	$0	$0	$0	$0	$0
ADJUSTMENT to SOY BALANCE of § 8007							
ARP Act § 8007	$9,509	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)							
ARP Act § 8002 - 3 year	($1,987,643)	$0	$0	$0	$0	$0	$0
ARP Act § 8007 - no year	($176)	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	**($1,987,819)**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
LAPSE	$0	$0	$0	$0	$0	$0	$0
OBLIGATIONS	**$1,897,629**	**$2,098,805**	**$1,987,819**	**$0**	**$0**	**($1,987,819)**	**$0**

Table: Medical Community Care, Cost of War Toxic Exposures Fund Crosswalk 2022-2025

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
MANDATORY APPROPRIATION							
Annual Appropriation Adjustment	$0	$0	$0	$6,740,264	$10,118,000	$6,740,264	$3,377,736
Mandatory Appropriation [Subtotal]	**$0**	**$0**	**$0**	**$6,740,264**	**$10,118,000**	**$6,740,264**	**$3,377,736**
UNOBLIGATED BALANCE (SOY)							
No-year (Base Year 2024)	$0	$0	$0	$0	$1,229,354	$0	$1,229,354
Unobligated Balance (SOY) [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$1,229,354**	**$0**	**$1,229,354**
UNOBLIGATED BALANCE (EOY)							
No-year (Base Year 2024)	$0	$0	$0	($1,229,354)	$0	($1,229,354)	$1,229,354
Unobligated Balance (EOY) [Subtotal]	**$0**	**$0**	**$0**	**($1,229,354)**	**$0**	**($1,229,354)**	**$1,229,354**
OBLIGATIONS	**$0**	**$0**	**$0**	**$5,510,910**	**$11,347,354**	**$5,510,910**	**$5,836,444**

Table: Medical Community Care, Veterans Choice Fund (Medical Care Only), American Rescue Plan Act, Cost of War Toxic Exposures Fund Crosswalk 2022-2025

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations							
Medical Community Care (0140)	$25,468,285	$29,196,966	$28,702,838	$27,082,317	$24,035,600	($1,620,521)	($3,046,717)
Discretionary Obligations [Total]	**$25,468,285**	**$29,196,966**	**$28,702,838**	**$27,082,317**	**$24,035,600**	**($1,620,521)**	**($3,046,717)**
Mandatory Obligations							
Veterans Choice Act (P.L. 113-146)							
Veterans Choice Fund, Medical Care							
Administration (0172XA)	$3,194	$0	$0	$2,554	$0	$2,554	($2,554)
Medical Care (0172XB)	$5,082	$0	$0	$19,321	$0	$19,321	($19,321)
Emergency Hepatitis C (0172XC)	$0	$0	$0	$0	$0	$0	$0
Emergency Community Care (0172XE)	($239)	$0	$0	$772	$0	$772	($772)
Medical Community Care (0172XG)	$0	$265,088	$0	$249,903	$0	$249,903	($249,903)
Veterans Choice Fund Prior-Year Recoveries	$12,727	$0	$0	$0	$0	$0	$0
Veterans Choice Fund [Subtotal]	**$20,764**	**$265,088**	**$0**	**$272,550**	**$0**	**$272,550**	**($272,550)**
American Rescue Plan (ARP) Act							
Veterans Medical Care and Health Fund							
Community Care (Section 8002) 1/	$1,816,196	$2,098,805	$1,987,643	$0	$0	($1,987,643)	$0
Section 8007 - Medical Community Care	$81,433	$0	$176	$0	$0	($176)	$0
American Rescue Plan [Subtotal]	**$1,897,629**	**$2,098,805**	**$1,987,819**	**$0**	**$0**	**($176)**	**$0**
PACT Act							
Cost of War Toxic Exposures Fund	$0	$0	$0	$5,510,910	$11,347,354	$5,510,910	$5,836,444
PACT [Subtotal]	$0	$0	$0	$5,510,910	$11,347,354	$5,510,910	$5,836,444
Mandatory Obligations [Total]	**$1,918,393**	**$2,363,893**	**$1,987,819**	**$5,783,460**	**$11,347,354**	**$3,795,641**	**$5,563,894**
Obligations [Grand Total]	**$27,386,678**	**$31,560,859**	**$30,690,657**	**$32,865,777**	**$35,382,954**	**$2,175,120**	**$2,517,177**

Tables: Community Care Obligations by Program

(dollars in thousands)

The following six tables show community care obligations by program, separately by funding sources as follows:

- Medical Community Care (MCC)
- American Rescue Plan Act (ARP)
- Cost of War Toxic Exposures Fund
- Veterans Choice Fund (VCF)
- Grand total: MCC, ARP Act, Cost of War Toxic Exposures Fund, and VCF

Medical Community Care Obligations by Program

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Health Care Services MISSION Act Affected:							
Ambulatory Care	$10,318,646	$10,844,714	$10,646,531	$11,367,959	$12,568,014	$721,428	$1,200,055
Dental Care	$752,925	$1,118,905	$1,041,713	$1,102,822	$1,158,811	$61,109	$55,989
Inpatient Care	$6,995,724	$9,223,705	$9,270,632	$6,330,838	$1,518,473	($2,939,794)	($4,812,365)
Mental Health Care	$828,247	$775,972	$1,050,815	$1,112,740	$1,181,175	$61,925	$68,435
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$105,143	$407,505	$114,561	$100,656	$85,277	($13,905)	($15,379)
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$19,000,685	$22,370,801	$22,124,252	$20,015,015	$16,511,750	($2,109,237)	($3,503,265)
Long-Term Services and Supports Community Care:							
Community Nursing Home	$1,150,651	$1,443,170	$1,278,803	$1,395,426	$1,475,586	$116,623	$80,160
Community Non-Institutional Care	$2,066,496	$2,206,100	$2,223,987	$2,383,441	$2,509,236	$159,454	$125,795
State Nursing Home	$1,239,773	$1,490,482	$1,352,486	$1,438,784	$1,522,235	$86,298	$83,451
State Home Domiciliary	$43,684	$49,095	$52,079	$55,402	$58,616	$3,323	$3,214
State Home Adult Day Care	$2,721	$1,286	$1,783	$1,892	$2,007	$109	$115
Community Long-Term Services and Supports [Total]	$4,503,325	$5,190,133	$4,909,138	$5,274,945	$5,567,680	$365,807	$292,735
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,886,160	$1,632,224	$1,666,129	$1,788,639	$1,951,858	$122,510	$163,219
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$2,221	$3,808	$3,319	$3,718	$4,312	$399	$594
Other Health Care Programs community care [Total]	$1,888,381	$1,636,032	$1,669,448	$1,792,357	$1,956,170	$122,909	$163,813
Obligations [Subtotal]	**$25,392,391**	**$29,196,966**	**$28,702,838**	**$27,082,317**	**$24,035,600**	**($1,620,521)**	**($3,046,717)**
VA Prior-Year Recoveries	$75,894	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$25,468,285**	**$29,196,966**	**$28,702,838**	**$27,082,317**	**$24,035,600**	**($1,620,521)**	**($3,046,717)**

ARP Act Obligations by Program
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Health Care Services MISSION Act Affected:							
Ambulatory Care	$134,665	$1,041,709	$176	$0	$0	($176)	$0
Dental Care	$0	$0	$0	$0	$0	$0	$0
Inpatient Care	$1,586,590	$1,057,096	$1,987,643	$0	$0	($1,987,643)	$0
Mental Health Care	$173,981	$0	$0	$0	$0	$0	$0
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$0	$0	$0	$0	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$1,895,236	$2,098,805	$1,987,819	$0	$0	($1,987,819)	$0
Long-Term Services and Supports Community Care:							
Community Nursing Home	$2,238	$0	$0	$0	$0	$0	$0
Community Non-Institutional Care	$0	$0	$0	$0	$0	$0	$0
State Nursing Home	$155	$0	$0	$0	$0	$0	$0
State Home Domiciliary	$0	$0	$0	$0	$0	$0	$0
State Home Adult Day Care	$0	$0	$0	$0	$0	$0	$0
Community Long-Term Services and Supports [Total]	$2,393	$0	$0	$0	$0	$0	$0
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$0	$0	$0	$0	$0	$0	$0
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs community care [Total]	$0	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	**$1,897,629**	**$2,098,805**	**$1,987,819**	**$0**	**$0**	**($1,987,819)**	**$0**
VA Prior-Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$1,897,629**	**$2,098,805**	**$1,987,819**	**$0**	**$0**	**($1,987,819)**	**$0**

Cost of War Toxic Exposures Fund (TEF) Obligations by Program
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Health Care Services MISSION Act Affected:							
Ambulatory Care	$0	$0	$0	$0	$0	$0	$0
Dental Care	$0	$0	$0	$0	$0	$0	$0
Inpatient Care	$0	$0	$0	$5,510,910	$11,347,354	$5,510,910	$5,836,444
Mental Health Care	$0	$0	$0	$0	$0	$0	$0
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$0	$0	$0	$0	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$0	$0	$0	$5,510,910	$11,347,354	$5,510,910	$5,836,444
Long-Term Services and Supports Community Care:							
Community Nursing Home	$0	$0	$0	$0	$0	$0	$0
Community Non-Institutional Care	$0	$0	$0	$0	$0	$0	$0
State Nursing Home	$0	$0	$0	$0	$0	$0	$0
State Home Domiciliary	$0	$0	$0	$0	$0	$0	$0
State Home Adult Day Care	$0	$0	$0	$0	$0	$0	$0
Community Long-Term Services and Supports [Total]	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$0	$0	$0	$0	$0	$0	$0
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs community care [Total]	$0	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	**$0**	**$0**	**$0**	**$5,510,910**	**$11,347,354**	**$5,510,910**	**$5,836,444**
VA Prior-Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Total Obligations	**$0**	**$0**	**$0**	**$5,510,910**	**$11,347,354**	**$5,510,910**	**$5,836,444**

Veterans Choice Fund Obligations by Program
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Health Care Services MISSION Act Affected:							
Ambulatory Care	($4,908)	$265,088	$0	$21,875	$0	$21,875	($21,875)
Dental Care	$0	$0	$0	$0	$0	$0	$0
Inpatient Care	$11,537	$0	$0	$250,675	$0	$250,675	($250,675)
Mental Health Care	$856	$0	$0	$0	$0	$0	$0
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$0	$0	$0	$0	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$7,485	$265,088	$0	$272,550	$0	$272,550	($272,550)
Long-Term Services and Supports Community Care:							
Community Nursing Home	$0	$0	$0	$0	$0	$0	$0
Community Non-Institutional Care	$552	$0	$0	$0	$0	$0	$0
State Nursing Home	$0	$0	$0	$0	$0	$0	$0
State Home Domiciliary	$0	$0	$0	$0	$0	$0	$0
State Home Adult Day Care	$0	$0	$0	$0	$0	$0	$0
Community Long-Term Services and Supports [Total]	$552	$0	$0	$0	$0	$0	$0
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$0	$0	$0	$0	$0	$0	$0
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs community care [Total]	$0	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	**$8,037**	**$265,088**	**$0**	**$272,550**	**$0**	**$272,550**	**($272,550)**
VA Prior-Year Recoveries	$12,727	$0	$0	$0	$0	$0	$0
Total Obligations	**$20,764**	**$265,088**	**$0**	**$272,550**	**$0**	**$272,550**	**($272,550)**

Medical Community Care, VCF, ARP Act and Cost of War Toxic Exposures Fund Act Obligations by Program
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Health Care Services MISSION Act Affected:							
Ambulatory Care	$10,448,403	$12,151,511	$10,646,707	$11,389,834	$12,568,014	$743,127	$1,178,180
Dental Care	$752,925	$1,118,905	$1,041,713	$1,102,822	$1,158,811	$61,109	$55,989
Inpatient Care	$8,593,851	$10,280,801	$11,258,275	$12,092,423	$12,865,827	$834,148	$773,404
Mental Health Care	$1,003,084	$775,972	$1,050,815	$1,112,740	$1,181,175	$61,925	$68,435
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$105,143	$407,505	$114,561	$100,656	$85,277	($13,905)	($15,379)
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$20,903,406	$24,734,694	$24,112,071	$25,798,475	$27,859,104	$1,686,404	$2,060,629
Long-Term Services and Supports Community Care:							
Community Nursing Home	$1,152,889	$1,443,170	$1,278,803	$1,395,426	$1,475,586	$116,623	$80,160
Community Non-Institutional Care	$2,067,048	$2,206,100	$2,223,987	$2,383,441	$2,509,236	$159,454	$125,795
State Nursing Home	$1,239,928	$1,490,482	$1,352,486	$1,438,784	$1,522,235	$86,298	$83,451
State Home Domiciliary	$43,684	$49,095	$52,079	$55,402	$58,616	$3,323	$3,214
State Home Adult Day Care	$2,721	$1,286	$1,783	$1,892	$2,007	$109	$115
Community Long-Term Services and Supports [Total]	$4,506,270	$5,190,133	$4,909,138	$5,274,945	$5,567,680	$365,807	$292,735
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,886,160	$1,632,224	$1,666,129	$1,788,639	$1,951,858	$122,510	$163,219
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$2,221	$3,808	$3,319	$3,718	$4,312	$399	$594
Other Health Care Programs community care [Total]	$1,888,381	$1,636,032	$1,669,448	$1,792,357	$1,956,170	$122,909	$163,813
Obligations [Subtotal]	**$27,298,057**	**$31,560,859**	**$30,690,657**	**$32,865,777**	**$35,382,954**	**$2,175,120**	**$2,517,177**
VA Prior-Year Recoveries	$88,621	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	$27,386,678	$31,560,859	$30,690,657	$32,865,777	$35,382,954	$2,175,120	$2,517,177
Obligations [Total]	**$27,386,678**	**$31,560,859**	**$30,690,657**	**$32,865,777**	**$35,382,954**	**$2,175,120**	**$2,517,177**

In 2024, total obligations are projected to increase by $2.2 billion above the 2023 current estimate in the following areas:

- **Health Care Services (+$1.7 billion).** Estimates are projected to increase due to revised actuarial trends based on the most recent data, which accounts for the latest demographic trends and modes of care delivery. In addition, the MISSION Act policies continue to drive increases in services available in both VA facilities and the community, particularly the use of outpatient primary, specialty and inpatient care. The costs driven by the PACT Act are reflected in community care by the historical allocation of care between VA facility-provided care and community-provided care.

- **Long-Term Services and Support (+$365.8 million).** Estimates are projected to increase due to the latest demographic trends and modes of care delivery. The enrollment dynamics that have a very significant impact on long-term services and support are priority level transitions and the aging of the enrollee population.

- **Other Health Care Programs (+$122.9 million).** VA-provided health service programs not projected by the Enrollee Health Care Projection Model (EHCPM) are expected to yield a net increase of $122.5 million, driven largely by Civilian Health and Medical Program (CHAMPVA) program costs.

Summary of the 2025 Advance Appropriation Request

The Medical Community Care discretionary 2025 advance appropriations request is $20.4 billion. The 2025 advance appropriations request from the Cost of War Toxic Exposures Fund for community care is $10.1 billion, which in conjunction with the discretionary advance appropriation ensures continuity of Veterans' health care services and sustain VA's increased capacity for care following the pandemic and implementation of the PACT Act.

In 2025, total obligations are projected to increase by $2.5 billion from the 2024 revised request total obligations estimate in the following areas:

- **Health Care Services (+$2.1 billion).** Estimates are projected to increase following general healthcare trends and because of the PACT Act.

- **Long-Term Services and Support (+$292.7 million).** Estimates are projected to increase due latest demographic trends and modes of care delivery.

- **Other Health Care Programs (+$163.8 million).** VA-provided health service programs not projected by the EHCPM are expected to yield a net increase of $163.2 million, driven largely by CHAMPVA program costs.

Medical Community Care Description

Veterans may be eligible to receive care from a community provider when VA cannot provide the care needed. This care is provided on behalf of and paid for by VA. Community care is available to Veterans based on certain conditions and eligibility requirements, and in consideration of a Veteran's specific needs and circumstances. In general, community care must be first authorized by VA before a Veteran can receive care from a community provider.

VA also provides health care to Veterans' family members and dependents through programs like CHAMPVA. Care for Veterans' family members and dependents is provided based on specific eligibility requirements, which vary by program. Additional information regarding these health care programs can be found in the "Medical Community Care Programs" section below.

In addition to funding payments for health care services to non-VA providers, the MCC category funds clinical service delivery requirements for community care. This includes care coordination and referrals, eligibility verification and enrollment. Resources are also used to establish care network requirements such as developing contracts that serve as vehicles for VA to purchase care for Veterans from community providers as well as develop and maintain IT functions. MCC also funds short-term prescription medications for a 14-day or fewer supply filled at a non-VA pharmacy.

Some obligations related to VA's provision of community care are funded through the Medical Support and Compliance and Information Technology accounts. These accounts fund administrative expenses such as claims processing performed by the Third-Party Administrator (TPA) and the Veterans Health Administration (VHA) and software required to meet system requirements.

Medical Community Care Programs for Veterans' Family Members and Dependents

Camp Lejeune Family Member Program (CLFMP)

Authority for Action

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154)

Population Covered

The Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012 (P.L. 112-154) extended eligibility for VA hospital care and medical services to certain Veterans who were stationed at Camp Lejeune, North Carolina, for at least 30 days between 1957 and 1987. Family members of such Veterans who resided, or were in utero, at Camp Lejeune for at least 30 days during that period are eligible for reimbursement of hospital care and medical services for 15 specified illnesses and conditions; and VA is the payer of last resort. Hospital care and medical services may only be furnished to family members to the extent and in the amount provided in

advance in appropriations Acts for such purpose. In addition, VA may only provide reimbursement for such hospital care and medical services provided to a family member after all other claims and remedies against third parties for such care and services have been exhausted. The Consolidated and Further Continuing Appropriations Act of 2015 (P.L. 113-235), signed on December 16, 2014, changed the Camp Lejeune exposure period from beginning January 1, 1957 to beginning August 1, 1953.

VA began providing care to Camp Lejeune Veterans on August 6, 2012, the day the initial law was enacted, and published regulations supporting implementation of this statutory requirement on September 11, 2013. VA began enrolling and reimbursing family members for medical care related to treatment of the Camp Lejeune conditions on October 24, 2014, 30 days after the family member interim final rule was published in the Federal Register and became effective. Qualified family members with at least 30 days of Camp Lejeune residency from 1957-1987 may receive reimbursement for treatment received up to two years prior to the date on their eligibility determination. For family members with at least 30 days of Camp Lejeune residency from August 1, 1953 – December 31, 1956, VA may only provide claims reimbursement for covered treatment received on or after December 16, 2014. VA may not reimburse family members for Camp Lejeune related care prior to March 26, 2013, the date when Congress provided funding to CLFMP.

Type of Services Provided

VA Office of Community Care currently provides reimbursement for medical care received by family members related to approved treatment of the Camp Lejeune conditions. CLFMP also represents the VA at the Agency for Toxic Substance Disease Registry (ATSDR) Community Assistance Panel (CAP) quarterly meetings. Camp Lejeune clinicians provide subject-matter expertise to the War Related Illness and Injury Study Center (WRIISC). CLFMP conducts training to ensure VA employees involved in operation and administration of the Camp Lejeune Family Member Program are fully educated on the eligibility, enrollment and claims processes, systems, and procedures, including coordinating with physicians to conduct clinical analysis on the determination of individual applicant eligibility for CLFMP. VA continues to use numerous communication channels to reach out to these key stakeholders, including websites, social media, handouts, stakeholder briefings, call centers, newsletters, and traditional media. Briefings and information papers have been provided to members of the Camp Lejeune Community Action Panel, concerned Veterans and their family members, Veterans Service Organizations, congressional staff, and the media.

Recent Trends

From October 2021 to October 2022, new administrative eligibility determinations increased by 48% and new clinical eligibility determinations increased by 4%. One hundred sixty (160) administrative eligibility determinations were made in 2021 and 309 were made in 2022. Seventy (70) clinical eligibility determinations were made in 2021 and 73 were made in 2022. Administrative eligibility determinations show the family member was a dependent to an eligible Veteran during the covered timeframe and resided (including in-utero) on Camp Lejeune for at least 30 days between August 1, 1953 and December 31, 1987. Clinical eligibility determinations show the family member is administratively eligible AND has one or more of the 15 qualifying health conditions. At of the end of 2022, there are 2,977 administratively eligible family members

and 931 clinically eligible family members that receive medical reimbursement for one or more of the 15 approved conditions. The program continues to communicate with family members and their concerns.

Projections for the Future

VA will continue to promptly reimburse family members for care related to the 15 conditions. Future goals include expanding outreach efforts to continue to educate Veterans and family members about CLFMP. The expectation is that CLFMP will experience small growth based on historical program data and the recent implementation of the PACT Act.

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and Other Dependent Programs

VA provides healthcare benefit administration for the beneficiaries of the following programs: CHAMPVA, Foreign Medical Programs, Spina Bifida Program and Children of Women Vietnam Veterans. This includes reimbursement for Inpatient, Outpatient, Durable Medical, Pharmacy, travel and limited dental. Covered medical claims are reimbursed to the provider or the beneficiary directly.

Authority for Action

- Title 38 U.S.C. § 1781, Medical care for survivors and dependents of certain Veterans
- Title 38 U.S.C. § 1802, Spina bifida conditions covered
- Title 38 U.S.C. § 1803, Health care
- Title 38 U.S.C. § 1821, Benefits for children of certain Korea service veterans born with spina bifida
- Title 38 U.S.C. § 1822, Benefits for children of certain Thailand service veterans born with spina bifida
- Title 38 U.S.C. § 1811, Definitions
- Title 38 U.S.C. § 1812, Covered birth defects
- Title 38 U.S.C. § 1813, Health care
- Title 38 U.S.C. § 1724, Hospital care, medical services, and nursing home care abroad
- Title 38 U.S.C. § 5104C, Options following decision by agency of original jurisdiction
- Title 38 U.S.C. § 1724, Hospital care, medical services, and nursing home care abroad

Population Covered

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA): The Veterans Health Care Expansion Act of 1973, Public Law 93-82, authorized VA to provide a health benefits program that shares the cost of medical supplies and services with eligible beneficiaries. The Veterans' Survivor Benefits Improvements Act of 2001, Public Law 107-14, extended CHAMPVA benefits, as a secondary payer to Medicare, to CHAMPVA beneficiaries over age 65.

To be eligible for CHAMPVA benefits, the beneficiary must be the spouse or child of a Veteran who has a total and permanent service-connected disability, or the widowed spouse or child of a Veteran who: (a) died as a result of a service-connected disability; (b) had a total, permanent disability resulting from a service-connected condition at the time of death; or (c) died on active duty and in all cases the family member is not eligible for medical benefits under the Department of Defense (DoD) TRICARE Program. CHAMPVA by law is a secondary payer to other health insurance plans to include Medicare. CHAMPVA assumes primary payer status for Medicaid, Indian Health Service and State Victims of Crime Compensation Programs.

The Veterans Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163, section 102, further expanded CHAMPVA to include primary family caregivers of certain seriously injured Veterans. Eligible primary family caregivers are authorized to receive health care benefits through the existing CHAMPVA Program when the primary family caregiver is not eligible for any other health care coverage (including TRICARE, Medicare and Medicaid).

***Foreign Medical Program (FMP)*:** The Foreign Medical Program is a health care benefits program for United States Veterans with VA-rated, service-connected conditions that are residing or traveling abroad, including the Philippines as of October 1, 2017. Under FMP, VA assumes payment responsibility for certain necessary medical services associated with the treatment of Veterans' service-connected conditions, with certain exclusions. The FMP program does not pay for Compensation and Pension exams or travel.

***Spina Bifida Health Care Program*:** Under the Departments of Veterans Affairs and Housing and Urban Development, and Independent Agencies Appropriations Act of 1997, Public Law 104-204, section 421, VA administers the Spina Bifida Health Care Benefits Program for birth children of Vietnam Veterans diagnosed with spina bifida (excluding spina bifida occulta). Additionally, the Veterans Benefit Act of 2003, Public Law 108-183, section 102, authorized birth children with spina bifida of certain Veterans who served in Korea to be eligible for care under this program. Prior to October 10, 2008, the program provided reimbursement only for medical services associated with spina bifida; however, under the Veterans' Mental Health and Other Care Improvements Act of 2008, Public Law 110-387, the program provides reimbursement for comprehensive medical care. The Blue Water Navy Vietnam Veterans Act of 2019, Public Law 116-23, Section 1116B, authorizes birth children of certain Veterans who served in Thailand to be eligible for care under this program.

***Children of Women Vietnam Veterans Health Care Benefits Program (CWVV)*:** Under the Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106-419, section 401, VA administers the CWVV Program for children with certain birth defects born to women Vietnam Veterans. CWVV Program provides reimbursement only for covered birth defects.

Recent Trends

The number of enrolled beneficiaries in CHAMPVA has increased by 5.0% on an annual basis from 2015 to 2022, and the number of unique users of CHAMPVA has increased by 5.1% annually. In 2022, CHAMPVA served 445,397 unique beneficiaries of which 2,630 are eligible based on participation in the Program of Comprehensive Assistance for Family Caregivers (PCAFC). This represents an annual increase of 11,488 beneficiaries. The CHAMPVA program

expects to continue to see about a 5.0% increase in unique users in the upcoming years based on historical trends. Projections for unique users in 2023 are 456,564 and for 2024 projections are 485,609. The recent enactment of the PACT Act has not yet had a significant impact on CHAMPVA enrollees/unique users.

The number of unique users of the Foreign Medical Program increased from 4,929 in 2021 to 5,500 in 2022. This represents a 10.3% increase. The FMP program expects to see a 10.0% increase in unique users in the upcoming year based on historical trends and the recission of COVID travel restrictions.

The Spina Bifida Health Care program saw a decrease in unique users submitting claims from 871 in 2021 to 850 in 2022. This represents a 2.3% decrease. The total population of Spina Bifida beneficiaries had 29 deaths occur in 2021 and 24 in 2022. The program expects to see a 3.0% decrease in unique users in the upcoming year due to recent decedent trends. The recent passing of the PACT Act has not had a significant impact on new Spina Bifida enrollees.

The number of unique users in the CWVV program went from 2 in 2021 down to 1 in 2022. Projected beneficiary enrollments for CWVV should remain at this level for the next year.

CHAMPVA Consolidated Mail Outpatient Pharmacy (CMOP)

The cost of CHAMPVA prescriptions fulfilled through VA's CMOP have been increasing each year and is projected to grow by 8.3% in 2024 and 9.4% in 2025. This portion of the program is funded by the Medical Services category

Indian Health Service / Tribal Health Programs / Urban Indian Organizations (ITU) Reimbursement Agreements Program

Authority for Action

In 2012, under the authority of 25 U.S.C. §1645(c) and 38 U.S.C §8153, VA established a national interagency sharing/reimbursement agreement with the Department of Health and Human Services/Indian Health Service (HHS/IHS) to reimburse IHS for the provision of direct care services to eligible American Indian (AI)/Alaska Native (AN) Veterans. The National Reimbursement Agreement paved the way for VA to enter into individual agreements with Tribal Health Programs (THPs) to reimburse THPs for Direct Care Services provided to eligible AI/AN Veterans. In January 2022, VA expanded the program to include Urban Indian Organizations (UIO), as authorized in Division FF, Title XI, Western Water and Indian Affairs, section 1113 of P.L. 116-260, Consolidated Appropriations Act, 2021. Under these Agreements, VA reimburses for direct care services provided by IHS, THP, and UIOs to eligible AI/AN Veterans that are included in the Medical Benefits Package under Title 38 Code of Federal Regulations (CFR) Section 17.38.

VA continues to establish individual agreements with THP and UIOs to increase health care options for all eligible AI/AN Veterans facilitating access to culturally sensitive care, VA tribal collaboration, and resource-sharing between VA and IHS/THP/UIOs. Due to the highly rural

nature of Alaska, agreements with Alaska THPs also cover non-Native Veterans with preauthorization.

In 2023, VA will continue working with stakeholders to adopt new agreements which include VA reimbursement to IHS and THPs for eligible purchased/referred care (PRC) provided to eligible AI/AN Veterans, as authorized in P.L. 116-311, the Proper and Reimbursed Care for Native Veterans Act.

Population Covered

The population covered under the IHS/THP/UIO reimbursement agreements are eligible AI/AN Veterans and non-Native Veterans (Alaska only). Eligible AI/AN Veterans may choose to use their tribal benefit and obtain IHS/THP/UIO care without VA preauthorization, while non-Native Veterans in Alaska can use the Agreements with pre-authorization. Many of the AI/AN Veterans and non-Native Veterans in Alaska reside in highly rural areas where VA has limited presence. Thus, these reimbursement agreements provide better access to care closer to home.

Type of Services Provided

Direct Care Services are provided at IHS or THP facilities under the 38 CFR § 17.38, Medical Benefits Package. Examples of these services are basic and preventive care, outpatient, inpatient, ambulatory surgical services, prescription drugs, etc. These services are provided at IHS/THP /UIO hospitals, clinics, or facilities. Purchased/referred care services are provided away from an IHS or THP facility but paid for by the IHS/THP facility.

Recent Trends

The 2022 actual obligations were $35.0 million in MCC funds.

In 2023, obligations are projected to be $36.8 million. In general, this funding supports an estimated 74 IHS sites under the VA-IHS National Reimbursement Agreement and 119 agreements with THPs, and 3 agreements with a UIO currently enrolled. VA anticipates providing reimbursement to more than 6,800 unique Veterans and processing over 72,000 medical claims per year. The increased funding level in 2023 supports the expansion of VA reimbursement to include greater numbers of UIOs as well as to reimburse IHS/THPs for eligible purchased/referred care.

In 2024 obligations are projected to be $ 38.3 million. In general, this funding supports an estimated 74 IHS sites under the VA-IHS National Reimbursement Agreement and 119 agreements with THPs, and 3 agreements with a UIO currently enrolled. VA anticipates providing reimbursement to more than 6,800 unique Veterans and processing over 73,000 medical claims per year. The increased funding level in 2024 supports the expansion of VA reimbursement to include greater numbers of UIOs as well as to reimburse IHS/THPs for eligible purchased/referred care.

Administrative Costs Justification

The Medical Community Care Programs includes funding for necessary costs incurred to operate the program, including several contracting and administration fees. VA's Community Care

Network (CCN) contract operates in Regions 1-6, with limited exceptions. Notably, Region 6 operates under the Region 4 contract, which maintains its own negotiated rates. Additionally, when a provider is not available under CCN, VA continues its practice to utilize Veterans Care Agreements (VCA) to procure services.

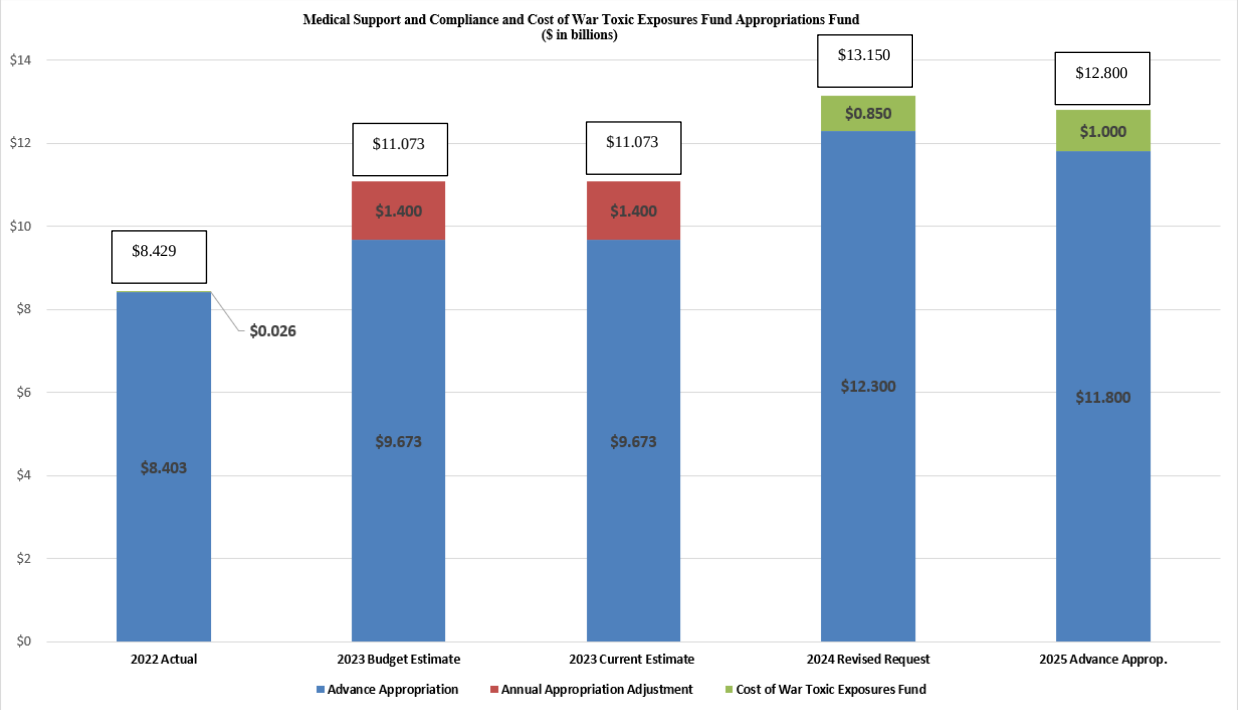
Community Care Network (CCN)

The request for the Medical Community Care account includes the administrative cost associated with the CCN contract. The 2024 projected obligation of $960.0 million will be paid to a Third-Party Administrator (TPA) and cover regions 1 – 6. Administrative costs associated with the CCN contract include:

- Per Member Per Month (PMPM) administrative fees which is the negotiated contract rate multiplied by the number of active Veterans receiving monthly care.
- Recurring costs associated with contract modifications such as but not limited to urgent care call center (actual per month, or fixed rate per call), reprocessing fees (per claim) and other adjustments as needed.
- New contract modifications are one-time monetary adjustments added through the issuance of a new task order.
- Incentive/disincentives based on TPA performance.
- Optional tasks not included in the original contract or additional modifications.

Medical Support and Compliance Category

Chart: Medical Support and Compliance Appropriations 1/



1/The table displays appropriation prior to transfers.

Update to the 2024 Advance Appropriations Request

The Department of Veterans Affairs (VA) is requesting an additional $850 million from the mandatory Cost of War Toxic Exposures Fund account for the Medical Support and Compliance (MSC) category above the enacted 2024 discretionary advance appropriation of $12.3 billion in the MSC discretionary account. VA is proposing to transfer $850 million of the 2024 MSC advance appropriation to the Medical Facilities appropriation to realign resources among accounts. When combined with unobligated start-of-year balances, reimbursements and transfers to other accounts, the total amount of resources to be obligated in 2024 in the MSC category is $12.3 billion.

The 2024 MSC budget funds regional and medical facility administrators, including leadership teams, provides for community care claims processing and program management; supports VA medical centers (VAMC) transition to a new financial management system; provides additional administrative support in areas such as acquisition and finance; demonstrates VA's continued

commitment to the modernization of its supply chain and support systems throughout the Nation; and further invests in its personnel management workforce enterprise-wide.

2024 Funding and 2025 Advance Appropriations Request

The MSC appropriation finances the supporting structures that underlie the Veterans Health Administration's (VHA) ability to deliver high-quality health care services to our Veterans. Approximately 61% of the 2024 total funding for this appropriation category is designated for VAMCs and Veteran Integrated Service Networks (VISN) direct allocations. The remaining 39% of the funding is designated for VHA Central Office (VHACO) programs to support their staff as well as to allocate to VAMCs for specific tasks. This funding ensures:

- leadership teams are in place to govern,
- appropriate oversight to safeguard quality of care for our Veterans is available,
- essential security services are provided,
- needed supplies and medications are ordered,
- health care provider vacancies are filled and
- financial services and oversight are provided, required medical equipment is procured and patient encounters are appropriately recorded.

The following tables display the discretionary, mandatory and combined sources of funds.

Table: MSC Crosswalk

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Appropriation Medical Support & Compliance (0152)							
Advance Appropriation	$8,403,117	$9,673,409	$9,673,409	$12,300,000	$11,800,000	$2,626,591	($500,000)
Annual Appropriation Adjustment	$0	$1,400,000	$1,400,000	$0	$0	($1,400,000)	$0
Net Appropriation	**$8,403,117**	**$11,073,409**	**$11,073,409**	**$12,300,000**	**$11,800,000**	**$1,226,591**	**($500,000)**
Tranfers To							
Medical Community Care (0140)	$0	$0	($930,000)	$0	$0	$930,000	$0
Medical Facilities (0162)	$0	$0	$0	($850,000)	$0	($850,000)	$850,000
JALFHCC (0169)	($30,613)	($30,613)	($32,144)	($33,751)	($35,438)	($1,607)	($1,687)
Transfers To [Subtotal]	($30,613)	($30,613)	($962,144)	($883,751)	($35,438)	$78,393	$848,313
Discretionary Budget Authority [Total]	$8,372,504	$11,042,796	$10,111,265	$11,416,249	$11,764,562	$1,304,984	$348,313
Reimbursements	$57,424	$63,438	$57,424	$57,424	$57,424	$0	$0
Unobligated Balance (SOY)							
No-Year	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$111	$0	$111	$0	$0	($111)	$0
2-Year	$149,880	$200,000	$199,636	$0	$0	($199,636)	$0
2-Year (P.L. 116-136)	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$149,991	$200,000	$199,747	$0	$0	($199,747)	$0
Unobligated Balance (EOY)							
No-Year	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	($111)	$0	$0	$0	$0	$0	$0
2-Year (Other)	($199,636)	$0	$0	$0	$0	$0	$0
2-Year (P.L. 116-136)	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($199,747)	$0	$0	$0	$0	$0	$0
Lapse	($118)	$0	$0	$0	$0	$0	$0
Subtotal	$8,380,054	$11,306,234	$10,368,436	$11,473,673	$11,821,986	$1,105,237	$348,313
Prior Year Recoveries	$540	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0152) [Total]	**$8,380,594**	**$11,306,234**	**$10,368,436**	**$11,473,673**	**$11,821,986**	**$1,105,237**	**$348,313**
Cost of War Toxic Exposures Fund (1126)							
Appropriation	$26,143	$0	$0	$850,000	$1,000,000	$850,000	$150,000
Reapportionment	$0	$0	($94)	$0	$0	$94	$0
Unobligated Balance (SOY)	$0	$0	$26,143	$0	$0	($26,143)	$0
Unobligated Balance (EOY)	($26,143)	$0	$0	$0	$0	$0	$0
Obligations (1126) [Total]	**$0**	**$0**	**$26,049**	**$850,000**	**$1,000,000**	**$823,951**	**$150,000**
Veterans Medical Care and Health Fund (0173SC)							
Unobligated Balance (SOY)	$978,433	$344,900	$502,305	$0	$0	($502,305)	$0
Unobligated Balance (EOY)	($502,305)	$0	$0	$0	$0	$0	$0
Obligations (0173SC) [Total]	**$476,128**	**$344,900**	**$502,305**	**$0**	**$0**	**($502,305)**	**$0**
VACAA, sec. 801 (0152XA)							
Unobligated Balance (SOY)	$10,417	$7,618	$7,172	$3,780	$256	($3,392)	($3,524)
Unobligated Balance (EOY)	($7,172)	($4,735)	($3,780)	($256)	$0	$3,524	$256
Subtotal	$3,245	$2,883	$3,392	$3,524	$256	$132	($3,268)
Prior Year Recoveries	$48	$0	$0	$0	$0	$0	$0
Obligations (0152XA) [Total]	**$3,293**	**$2,883**	**$3,392**	**$3,524**	**$256**	**$132**	**($3,268)**
Mandatory Budget Authority [Total]	$26,143	$0	$0	$850,000	$1,000,000	$850,000	$150,000
Mandatory Obligations [Total]	**$479,421**	**$347,783**	**$531,746**	**$853,524**	**$1,000,256**	**$321,778**	**$146,732**
Budget Authority [Grand Total]	$8,398,647	$11,042,796	$10,111,265	$12,266,249	$12,764,562	$2,154,984	$498,313
Obligations [Grand Total]	**$8,860,015**	**$11,654,017**	**$10,900,182**	**$12,327,197**	**$12,822,242**	**$1,427,015**	**$495,045**
FTE							
Medical Support & Compliance (0152)	57,224	67,351	62,853	66,534	70,239	3,681	3,705
Veterans Medical Care and Health Fund (0173SC)	1,223	0	0	0	0	0	0
VACAA, Section 801 (0152XA) 1/	24	24	24	24	0	0	(24)
FTE [Total]	**58,471**	**67,375**	**62,877**	**66,558**	**70,239**	**3,681**	**3,681**

The funding levels shown below include the program's total discretionary budget authority, mandatory budget authority plus reimbursements as well as the budget authority available due to unobligated start-of-year balances. The programmatic funding levels are shown with both funding sources combined to allow for a comprehensive picture of the program's operations.

Program Resources

- $12.3 billion in 2024
- $12.8 billion in 2025

To provide better visibility into the spending under this appropriation, additional detail on obligations by the following categories are reflected in the following charts.

Table: Summary of Obligations by Functional Area

Medical Support and Compliance Obligations by Activity - Discretionary Funds

(dollars in thousands)

Description:	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Annual Appropriations							
VISN & Medical Center Based:							
VAMC	$4,532,847	$6,105,292	$4,964,129	$5,488,977	$5,696,294	$524,848	$207,317
VISN	$1,075,368	$952,236	$1,182,159	$1,230,628	$1,258,932	$48,469	$28,304
VHA Central Office Based:							
Clinical Services	$107,067	$274,067	$274,067	$302,073	$309,021	$28,006	$6,948
Patient Care Services	$148,859	$316,939	$290,890	$350,995	$359,068	$60,105	$8,073
Discovery, Education and Affiliate Networks	$64,987	$124,443	$123,934	$175,849	$183,243	$51,915	$7,394
Operations	$159,694	$255,917	$255,917	$269,123	$275,312	$13,206	$6,189
Integrated Veterans Care	$516,552	$1,089,501	$482,890	$512,952	$524,750	$30,062	$11,798
Quality and Patient Safety	$159,377	$205,955	$175,955	$209,000	$213,807	$33,045	$4,807
Support Services	$392,815	$688,777	$688,777	$765,103	$782,700	$76,326	$17,597
Human Capital Management	$247,675	$340,791	$340,791	$437,442	$447,503	$96,651	$10,061
Health Informatics	$137,007	$179,057	$179,057	$213,742	$218,658	$34,685	$4,916
All Other Support and Program Offices	$837,806	$773,259	$1,409,870	$1,517,789	$1,552,698	$107,919	$34,909
Central Office Based Obligations [Subtotal]	$2,771,839	$4,248,706	$4,222,148	$4,754,068	$4,866,760	$531,920	$112,692
Prior Year Recoveries	$540	$0	$0	$0	$0	$0	$0
MSC Obligations - Discretionary Funds [Total]	**$8,380,594**	**$11,306,234**	**$10,368,436**	**$11,473,673**	**$11,821,986**	**$1,105,237**	**$348,313**

Medical Support and Compliance Obligations by Activity - Mandatory Funds
(dollars in thousands)

Description:	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Cost of War Toxic Exposures Fund (TEF)							
VAMC	$0	$0	$0	$850,000	$1,000,000	$850,000	$150,000
VISN	$0	$0	$0	$0	$0	$0	$0
Clinical Services	$0	$0	$0	$0	$0	$0	$0
Patient Care Services	$0	$0	$26,049	$0	$0	($26,049)	$0
Discovery, Education and Affiliate Networks	$0	$0	$0	$0	$0	$0	$0
Operations	$0	$0	$0	$0	$0	$0	$0
Integrated Veterans Care	$0	$0	$0	$0	$0	$0	$0
Quality and Patient Safety	$0	$0	$0	$0	$0	$0	$0
Support Services	$0	$0	$0	$0	$0	$0	$0
Human Capital Management	$0	$0	$0	$0	$0	$0	$0
Health Informatics	$0	$0	$0	$0	$0	$0	$0
All Other Support and Program Offices	$0	$0	$0	$0	$0	$0	$0
TEF Obligations [Subtotal]	**$0**	**$0**	**$26,049**	**$850,000**	**$1,000,000**	**$823,951**	**$150,000**
Veterans Medical Care and Health Fund							
VAMC	$154,547	$344,900	$502,305	$0	$0	($502,305)	$0
VISN	$43,042	$0	$0	$0	$0	$0	$0
Clinical Services	$700	$0	$0	$0	$0	$0	$0
Support Services	$132,720	$0	$0	$0	$0	$0	$0
All Other Support and Program Offices	$145,119	$0	$0	$0	$0	$0	$0
VMCHF Obligations [Subtotal]	**$476,128**	**$344,900**	**$502,305**	**$0**	**$0**	**($502,305)**	**$0**
			$502,305				
VACAA, sec. 801							
VAMC	$3,245	$0	$0	$0	$0	$0	$0
Discovery, Education and Affiliate Networks	$0	$2,883	$3,392	$3,524	$256	$132	($3,268)
VACAA, sec. 801 Obligations [Subtotal]	**$3,245**	**$2,883**	**$3,392**	**$3,524**	**$256**	**$132**	**($3,268)**
Prior Year Recoveries	$48	$0	$0	$0	$0	$0	$0
MSC Obligations - Mandatory Funds [Total]	**$479,421**	**$347,783**	**$531,746**	**$853,524**	**$1,000,256**	**($502,173)**	**($3,268)**

Medical Support and Compliance Obligations by Activity - Total
(dollars in thousands)

Description:	2022 Actual	2023 President's Budget	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
VISN & Medical Center Based:							
VAMC	$4,690,639	$6,450,192	$5,466,434	$6,338,977	$6,696,294	$872,543	$357,317
VISN	$1,118,410	$952,236	$1,182,159	$1,230,628	$1,258,932	$48,469	$28,304
				added pact act in places			
VHA Central Office Based:							
Clinical Services	$107,767	$274,067	$274,067	$302,073	$309,021	$28,006	$6,948
Patient Care Services	$148,859	$316,939	$316,939	$350,995	$359,068	$34,056	$8,073
Discovery, Education and Affiliate Networks	$64,987	$127,326	$127,326	$179,373	$183,499	$52,047	$4,126
Operations	$159,694	$255,917	$255,917	$269,123	$275,312	$13,206	$6,189
Integrated Veterans Care 1/	$516,552	$1,089,501	$482,890	$512,952	$524,750	$30,062	$11,798
Quality and Patient Safety	$159,377	$205,955	$175,955	$209,000	$213,807	$33,045	$4,807
Support Services	$525,535	$688,777	$688,777	$765,103	$782,700	$76,326	$17,597
Human Capital Management	$247,675	$340,791	$340,791	$437,442	$447,503	$96,651	$10,061
Health Informatics	$137,007	$179,057	$179,057	$213,742	$218,658	$34,685	$4,916
All Other Support and Program Offices	$982,925	$773,259	$1,409,870	$1,517,789	$1,552,698	$107,919	$34,909
Central Office Based Obligations [Subtotal]	**$3,050,378**	**$4,251,589**	**$4,251,589**	**$4,757,592**	**$4,867,016**	**$506,003**	**$109,424**
Prior Year Recoveries	$588	$0	$0	$0	$0	$0	$0
MSC Obligations [Total]	**$8,860,015**	**$11,654,017**	**$10,900,182**	**$12,327,197**	**$12,822,242**	**$1,427,015**	**$495,045**

1/VHA reorganized the Office of Community Care (OCC) in 2022. As part of this reorganization, full-time equivalent (FTE) employees were moved from the Office of Integrated Veteran Care (IVC) to the Office of VHA Finance within the All-Other Support and Program Offices line item.

MSC Program Office Narratives

The MSC activity supports care provided at VA medical facilities and through community providers. The following twelve narratives describe VHA's main support office functions.

VAMC and VISN Based Activities

The obligations shown in the tables below reflect discretionary and mandatory budget authority plus reimbursements.

VAMCs

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$4,532,847	$6,105,292	$4,964,129	$5,488,977	$5,696,294	$524,848	$207,317
Mandatory Obligations	$157,792	$344,900	$502,305	$850,000	$1,000,000	$347,695	$150,000
Obligations [Total]	$4,690,639	$6,450,192	$5,466,434	$6,338,977	$6,696,294	$872,543	$357,317

VAMC Program Description

Funding in this account for VAMC-based activities supports the management, operation, oversight, security and administration of the VA's health care system. This includes VAMC leadership teams (Director, Chief of Staff, Chief Medical Officer and Chief Nurse), VAMC support functions (quality of care oversight, security services, legal services, billing and coding activities, acquisition, procurement and logistics activities), human resource (HR) management, logistics and supply chain management and financial management. Of the many functions required to operate VHA facilities, one essential function is revenue generation. This begins at the VAMCs and clinics with the verification of insurance and the coding of inpatient and outpatient encounters. The increase in obligation projections for 2023-25 are directly related to inflationary and programmatic growth for implementing initiatives such as those relating to the increases in acquisition, financial and other administrative staff in support of a new Electronic Health Record (EHR), transition to a new logistical and support system, a new financial management system and further investment in personnel management workforce.

VISNs

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$1,075,368	$952,236	$1,182,159	$1,230,628	$1,258,932	$48,469	$28,304
Mandatory Obligations	$43,042	$0	$0	$0	$0	$0	$0
Obligations [Total]	$1,118,410	$952,236	$1,182,159	$1,230,628	$1,258,932	$48,469	$28,304

VISN Program Description

These funds provide the necessary resources for the VISN offices that provide regional support, management and oversight to the VAMCs, clinics and other field activities within their regions. This includes but is not limited to network leadership teams (Network Director, Deputy Network Director, Chief Financial Officer, Chief Medical Officer and Chief Information Officer) and clinical and administrative functional leads, that are centrally located to provide leadership to those

programs within each VISN. Each VISN office is responsible for coordinating the delivery of health care to Veterans by leveraging and integrating operations at all VA health care facilities within the VISN. The increase in obligation projections for 2023-25 are directly related to inflationary and programmatic growth for implementing initiatives.

VHACO Based Activities

Clinical Services
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$107,067	$274,067	$274,067	$302,073	$309,021	$28,006	$6,948
Mandatory Obligations	$700	$0	$0	$0	$0	$0	$0
Obligations [Total]	$107,767	$274,067	$274,067	$302,073	$309,021	$28,006	$6,948

Program Description

The Office of the Assistant Under Secretary for Health for Clinical Services and the Chief Medical Officer (AUSH/CS) provides leadership for the many VHA clinical programs and their necessary coordination with clinical and administrative leadership within the VISNs, integrated clinical community committees and service-based communities of practice. The Office of the AUSH/CS strives to provide Veterans and their families with high-quality, integrated and standardized clinical services that serve as the benchmark for health care excellence and value.

Dentistry

The Office of Dentistry utilizes MSC funds for salary support comprising of the Assistant Under Secretary for Health for Dentistry, the Deputy Dental Program Director and staff assigned under the directorates of Dental Operations, Dental Informatics and Analytics, Dental Laboratory Operations, Homeless Veterans Dental Program, Dental Education, Dental Research, Oral Health Quality Group and Dental Administration.

Diagnostics

Diagnostic Services uses MSC funds to fund staff payroll, travel, contract services at VHACO and field-based medical support staff. The funds are used to establish national policy and provide clinical operational oversight and enforcement functions. Additionally, these funds are used for national contracts providing services for accreditation, inspections, licenses to operate, proficiency assessments, education and training, agreements, program analytics and data management and reporting. The MSC funds are used to promote Veteran access to services, safety initiatives, quality improvement and communication for clinical standards of practice.

Homeless

The VHA Homeless Programs Office manages an annual MSC budget of over $27.1 million, which supports 93 total FTE and over $9.0 million in contractual services. Of the 93 FTE, 57 FTE provide direct support to seven Homeless Programs Initiatives:

- Housing and Urban Development (HUD) – VA Supported Housing: a collaborative program between HUD and VA where eligible homeless Veterans receive a Housing

Choice rental voucher from HUD paired with VA provided case management and supportive services.

- Health Care for Homeless Veterans: provides contract residential services, outreach and case management to Veterans who are homeless or at-risk of homelessness.
- Veterans Justice Outreach: aims to prevent homelessness and avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans.
- Homeless Veterans Community Employment Services: assists Veterans with accessing employment opportunities to support their housing needs, improve the quality of their lives and assist in their community reintegration efforts.
- Grant and Per Diem (GPD): awards grants to community-based agencies to create transitional housing programs and offer per diem payment to GPD funded organizations.
- Supportive Services for Veteran and Families: provides supportive services to homeless and at-risk Veteran families.
- Veterans National Homeless Registry: maintains a comprehensive repository of Veterans who have been identified as homeless or at-risk for homelessness.
- Homeless Patient Aligned Care Teams: provides multidisciplinary, population tailored medical homes designed around the unique needs and distinct challenges homeless Veterans face, both accessing and engaging in health care.

The remaining 36 FTE constitute Homeless Programs Central Office leadership and administrative staff in addition to leadership and support staff for other Homeless Program administrative offices. Please see the Veterans Homeless Programs narrative in the Medical Care chapter for more information.

Mental Health and Suicide Prevention

The Office of Mental Health and Suicide Prevention (MHSP) employs national and international subject matter experts to provide oversight and deploy national guidance in VA medical facilities throughout the country, enabling VHA to provide a full continuum of Veteran centered, high-quality outpatient, residential and inpatient mental health services and suicide prevention programming. VA's top clinical priority is preventing Veteran suicide. MHSP has operationalized the VA National Strategy to Prevent Veteran Suicide in Suicide Prevention NOW and Suicide Prevention 2.0, short- and long-term efforts combining community prevention and clinical intervention strategies as part of a public health approach.

MHSP's Program Evaluation Centers track, analyze and report on hundreds of data points, which are used to create dashboards and tools to facilitate evidence-based decision making at the provider and facility levels and promote more effective, cost efficient and Veteran centered care. In addition, MHSP manages some of the Department's largest outreach campaigns, such as #BeThere, Make the Connection, AboutFace and other public facing resources. MHSP's National Center for Posttraumatic Stress Disorder (PTSD), VA's Center of Excellence in research and education on PTSD, developed the COVID Coach Application and other tools for dealing with stressors. Please see the MHSP sections in the Medical Care chapter for more information.

Primary Care and Disability and Medical Assessment

The National Primary Care Office provides national oversight and monitoring of primary care delivery and develops policies and programs to direct clinical operations and research and educational program activities. The office facilitates the delivery of quality oriented, efficient, timely, safe and effective primary care within VHA facilities.

The Office of Disability and Medical Assessment is also aligned under the National Primary Care Office, whereby it provides executive leadership to VHA's disability programs worldwide, including both the traditional Compensation and Pension (CP) and the Integrated Disability Evaluation System Programs. These responsibilities include securing and executing funding, quality performance improvement, clinician certification and training, providing analytics support and development of national CP policy.

Specialty Care

Specialty Care Services uses MSC funds to fund VHACO and field-based medical administrative staff that support field-based clinical operations and policy work. The support is salary, travel and all-other for national contracts that are administrative in nature, such as licensing agreements, inspections, program analyses work and the collection, review and reporting of data. The national programs' assigned work is not for clinical care but involves clinical administrative staff and clinical operations.

Spinal Cord Injuries and Disorders

The Spinal Cord Injuries and Disorders (SCI/D) National Program Office utilizes MSC funding to support salary expenses, travel, education and conferences for staff and printing expenses. In addition to the above, the MSC funding also supports contracts for Long-Term Care Institute surveys, Universal Stakeholder Participation and Experience Questionnaire customer satisfaction surveys, Data Programmer and SCI/D Nurse Staffing Analysis.

Surgery

The National Surgery Office (NSO) uses the annual budgeted MSC funds to ensure and support the optimal delivery of surgical services to promote, preserve and restore the health of the Veteran in accordance with generally accepted standards of medical practice through an established quality improvement program and monitoring of surgical quality improvement activities at the national, regional and local level. The NSO establishes and maintains VHA surgical policy related to the delivery of surgical and transplant services by VHA Surgical Programs. The NSO also provides stewardship for surgical data for research purposes and oversight of funds for the delivery of transplant and related services.

Patient Care Services

Patient Care Services

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$148,859	$316,939	$290,890	$350,995	$359,068	$60,105	$8,073
Mandatory Obligations	$0	$0	$26,049	$0	$0	($26,049)	$0
Obligations [Total]	$148,859	$316,939	$316,939	$350,995	$359,068	$34,056	$8,073

Program Description

The Office of Patient Care Services (PCS) leads VHA in delivering the highest quality Veteran centric care, supporting health and wellbeing through leveraging technology and providing clinical services across the continuum of care. The Assistant Under Secretary for Health for PCS (AUSHPCS) also serves as the Chief Nursing Officer (CNO). The CNO is the Senior Advisor to the Under Secretary for Health and to key VHA and Department officials on all matters relating to VA nursing and the delivery of PCS. The CNO collaborates inter-professionally to enhance and support evidence-based professional practice, workforce research and education and the VA nursing workforce to strengthen leadership and teamwork to provide quality patient driven care for the Nation's Veterans. PCS is comprised of the following health care services and programs:

Office of Nursing Services

The Office of Nursing Services (ONS) serves as the primary consultant to the AUSHPCS/CNO on all matters relating to nursing and the delivery of patient care. ONS is responsible for the planning and formulation of national policies and activities that impact all nursing staff in the delivery of health care within the VA. ONS collaborates inter-professionally to enhance and support evidence-based professional practice, workforce research, education and the VA nursing workforce to strengthen leadership and teamwork to provide quality patient driven care for the Nation's Veterans. ONS utilizes MSC funds to support and fund salaries, travel and training for the implementation of the VHA Nursing Workforce Strategic Plan.

Caregiver Support Program

The Caregiver Support Program (CSP) mission is to promote the health and wellbeing of family caregivers, who care for our Nation's Veterans, through education, resources, support and services. Please see the CSP section in the Medical Care chapter for more information.

Care Management and Social Work Services

Care Management and Social Work Services (CMSW) leads the development and implementation of clinical person centric interventions, military transitions and programming that emphasize health, wellness and social determinants of health for all Veterans, Service members, their families, caregivers and survivors. As the Nation's largest employer and training organization for social workers, CMSW is an innovator in social work professional practice, advocator for equal access to care and resources and promoter for social justice. This is achieved through the coordination of care, services and benefits afforded to Veterans by VA programs and collaboration with community partners. Services include transition assistance, assessment, crisis intervention, high

risk screening, discharge planning, case management, advocacy, education, supportive counseling, psychotherapy, resource referrals and resource acquisition.

CMSW develops policy and provides oversight of five national programs (National Social Work Program, VA Fisher House and Family Hospitality Program, Intimate Partner Violence Assistance Program, Post-9/11 Military2VA Case Management Program and VA Liaisons Program) and several initiatives aligned to the service. CMSW also provides clinical practice oversight to over 17,400 facility-based Master's prepared social workers in the delivery of holistic care. MSC funds are used for program office salaries, travel and contracts which support CMSW clinical programming, supportive services and other Veteran centric initiatives.

Chaplain Services

MSC funds are utilized for necessary expenses (personnel, travel and transportation of persons, printing and reproduction and other contractual services) in the provision of oversight and management of the National Chaplain Services as well as the planning and directing of a spiritual and pastoral care program consistent with the overall mission of health care delivery in VHA.

Connected Care

The Office of Connected Care focuses on delivering health information technology (IT) solutions that increase Veterans' access to care and support Veterans' participation in their own health care. Connected Care works collaboratively to standardize and promote the use of virtual and digital health products and their interfaces and development tools. This includes driving the growth and adoption of technologies that help Veterans communicate with their VA care teams and coordinate, track and manage their health care. These technology and health solutions are delivered through Connected Care Programs including VA Telehealth Services, My HealtheVet and VA Mobile and Virtual Health Resource Centers. MSC funds are used to support and fund salaries, travel, training and services for the implementation of Connected Care's Strategic Plan. Additionally, MSC funds are used to support the field to meet strategic plan standards.

Geriatrics and Extended Care

This program provides national guidance on the long-term services and support for geriatric Veterans and those requiring extended care. This includes facility-based programs, home and community-based and purchased care programs and data analytics, quality improvement and research support. Geriatrics and Extended Care (GEC) manages the Community Living Center and State Veterans Homes (SVH) Surveys, SVH Per Diem and Construction Grant Programs, Community Nursing Homes and Purchased Long-term Services and Support, Medical Foster Homes and Home-Based Primary Care. GEC also provides support for the Veteran Community Partnerships, Geriatric Research and Education Centers, Palliative and Hospice Care and other aging initiatives. MSC funds are used for program office salaries and contracts to support these quality surveys and other Veteran centric programs.

Patient Centered Care and Cultural Transformation

The office utilizes MSC funds to support the development and sustainment of whole health in VHA. The majority of the office's MSC funds are spent on salaries, travel and training for staff who support the strategic direction and implementation of whole health in VHA. These staff work

in Whole Health Education, Complementary and Integrative Health, Whole Health Research and Evaluation, Whole Health Communications and Strategic Partnership Employee Whole Health and Whole Health System Development.

Pharmacy Benefits Management Services

Pharmacy Benefits Management Services utilizes MSC funds for several programs decentralized throughout the country to provide organizational and clinical leadership to VHA pharmacies, as well as support to other health care providers to facilitate the highest quality care to Veterans by ensuring safe, effective and medically necessary management of medications. This is accomplished by creating a practice environment that fosters education, professional development, progressive practice initiatives and innovative technologies to ensure consistent, accurate and reliable medication distribution and information systems.

Physician Assistant Services

The Director of Physician Assistant (PA) Services advises the VA senior management of all matters relating to the employment and effective utilization of the 2,700 PAs in VHA. Responsibilities include: policy development, consultation on the PA role in various settings and capacities, recruitment strategies, credentialing requirements and ongoing educational needs, Congressional inquiries, constituent and external organization, coordination and collaboration with external Federal and state regulatory agencies and local and national organizations, succession planning, monitoring trending data, academic preparation for qualified professionals and current community practice patterns.

Population Health

Population Health aims to transform VA into a system that assists Veterans and their families to achieve their health goals through primary prevention and accessible, evidence-based, equitable and high value Veteran centric interactions. The office has oversight for the following programs:

- Office of Rural Health,
- Health Outcomes Military Exposures Office,
- Office of Health Equity: identifies disparities experienced by different groups of Veterans, develops quality improvement tools to help VA facilities reduce disparities through the Equity Guided Improvement Strategy and partners with stakeholders to share equity knowledge and best practices,
- Lesbian, Gay, Bisexual, Transgender, Queer and Other Identities Health Program: oversees policy, training, education, consultation and implementation of best clinical practices to reduce health disparities in sexual and gender minority Veterans,
- National Center for Health Promotion and Disease Prevention: provides programs, resources, training and guidance to promote health promotion, disease prevention and health education for Veterans through resources such as the Veterans Health Library,
- National Public Health Program Office: leads public health activities, surveillance and investigations for high consequence infections through the VA National Public Health Reference and has oversight for the policy for VHA's All Hazards Emergency Cache Program
- Health Solutions: deploys and refines electronic medical record solutions to monitor and optimize health care delivery.

Rehabilitation and Prosthetic Services

Rehabilitation and Prosthetic Services oversees program and policy development for medical rehabilitation services for VHA, coordinating the provision of the full continuum of medical rehabilitative and prosthetic services to promote the health, independence and quality of life for Veterans with disabilities. This office administers program and policy development for 8 national programs with 11 different rehabilitation disciplines: Physical Medicine and Rehabilitation, Blind Rehabilitation, Chiropractic Care, Audiology and Speech Pathology, Recreation and Creative Arts Therapy, Orthotic, Prosthetic and Pedorthic Clinical Services, Prosthetics and Sensory Aids and the National Veterans Sports Program and Special Events. Specialized programs administered by this office include the Polytrauma/Traumatic Brain Injury System of Care, Amputation System of Care, Driver Rehabilitation Training and Advanced Technology Labs. The office aligns clinical expertise, clinical and practice guidance and specialized procurement resources to provide comprehensive rehabilitation, prosthetic and orthotic services across the VHA health care system in the most economical and timely manner.

Office of Sterile Processing

The Office of Sterile Processing (OSP) is dedicated to the success of Sterile Processing Services across VHA, serving as leaders and consultative experts regarding the use of reusable medical devices, through collaboration with VA and external partners. OSP provides critical guidance, oversight, education and support to VHA sterile processing staff across the Nation.

Discovery, Education and Affiliate Networks

Discovery, Education and Affiliate Networks

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$64,987	$124,443	$123,934	$175,849	$183,243	$51,915	$7,394
Mandatory Obligations	$0	$2,883	$3,392	$3,524	$256	$132	($3,268)
Obligations [Total]	$64,987	$127,326	$127,326	$179,373	$183,499	$52,047	$4,126

Program Description

The Office of Discovery, Education and Affiliate Networks (DEAN) ensures that Veterans have access to the most innovative health care solutions by promoting medical research initiatives, training health care professions and developing community partnerships. DEAN is responsible for managing education and training programs for health profession students and residents to enhance the quality of care provided to Veteran patients as required by 38 U.S.C. § 7302; applying basic, translational, clinical, health services and rehabilitative research to apply scientific knowledge to develop effective care solutions for Veterans; and providing innovative project management of the design, evaluation and diffusion of new processes that facilitate health care innovations in the field to better serve Veterans. This year's increase is largely driven by realigning some of the administrative functions and funding them centrally with MSC as well as expanding administrative capacity to implement the programs below.

Academic Affiliations

As one of four statutory missions of VA, the Office of Academic Affiliations (OAA) utilizes its MSC funding to support the statutory mission of health professions education (HPE) as outlined in 38 U.SC. § 7302. OAA's effective execution of MSC funding in support of this mission contributes substantially to VA's ability to deliver cost-effective, high-quality patient care for Veterans and has a major impact on the health care workforce in VA. OAA's MSC funding supports OAA staff salaries and travel, funding for mission critical conferences and committees (for example: National Academic Affiliations Council, National Designated Education Officer Conference and Request for Proposal Review Committees), funding for National Coordinating Centers for VA-based advanced fellowships and fees and payments for accreditation of VA-based HPE Programs.

National Center for Health Care Advancement and Partnerships

The National Center for Health Care Advancement and Partnerships, Office of Community Engagement (OCE) utilizes its MSC funding to accomplish VHA's mission to honor America's Veterans by cultivating public private partnerships and exploring emerging therapies when other treatments have not been successful. This MSC funding supports salaries, travel and training for staff in addition to supporting a communications contract. This contract provides strategic support to OCE and includes a quarterly newsletter, more than 75 feature articles, more than 25 programmatic short documents (press releases, outreach materials, fact sheets, white papers, brochures, flyers and toolkits), campaigns, social media and web support and an annual report.

Office of Health Care Innovation and Learning

The Office of Health Care Innovation and Learning (HIL) brings together VHA Innovation Ecosystem, the Simulation Learning, Evaluation, Assessment and Research Network (SimLEARN) and the Center for Care and Payment Innovation. Through these core programs, HIL advances VHA health care delivery and service by:

- fostering the discovery and spread of grassroots and strategic innovative solutions, practices and products across VA,
- promoting competencies in innovation and simulation,
- combining clinical simulation and training to further enhance the utilization and uptake of emerging health care technology in clinical practice,
- developing innovative approaches to testing payment and service delivery models and
- advancing the use of clinical training and simulation to further VHA's mission of becoming a high reliability organization (HRO).

Research and Development

The Office of Research and Development supports the Research mission by utilizing its MSC funding for salary support and sustainment of the Medicare Data Merge initiative at the Edward Hines Jr. VAMC located in Hines, Illinois. The VA Information Resource Center at Hines serves as the data custodian for Centers for Medicare and Medicaid Services (CMS) and United States Renal Data System (USRDS) data for VA research use. The project warehouses and provides data from CMS and USRDS to VA researchers. In addition, the project serves the VA research community by providing education and assistance to VA researchers using these data and conducting research on Veterans' use of Medicare and Medicaid services.

SimLEARN

The SimLEARN Office utilizes its MSC funding for salaries, travel, training for staff in addition to several contracts in support of the Simulation Training Program. These include the Video Simulation Management System operations support, Human Ultrasound Models, Training Modules for Emergency Nursing, Virtual Interview Skills Training System and Fundamentals of Critical Care Support courseware license.

Operations

Operations
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$159,694	$255,917	$255,917	$269,123	$275,312	$13,206	$6,189
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$159,694	$255,917	$255,917	$269,123	$275,312	$13,206	$6,189

Program Description

The Office of the Assistant Under Secretary for Health for Operations (AUSHO) is responsible for overseeing the delivery of health care services. The Office of the AUSHO provides oversight for 18 VISNs, 172 VAMCs and over 1,000 outpatient sites of care. The following program offices make up the Office of the AUSHO: Office of Emergency Management (OEM), Center for Development and Civic Engagement (CDCE), the Health Care Operations Center and Member Services (MS).

Center for Development and Civic Engagement

CDCE's MSC funding is used to facilitate the strategic integration of volunteers, donations and community partners for the purpose of enhancing care and benefits for America's Veterans.

Office of Emergency Management

Funding supports the VHA enterprise through the integration of Emergency Management Programs, functions and supporting activities to prevent, protect, mitigate, respond and recover from all hazards. OEM provides support in the form of personnel, finances, materials and processes during these five overlapping phases of internal and external disasters and military contingencies.

Health Care Operations Center

These funds support the centralized management and support of operations across the VHA enterprise. This includes daily operational support to and management of the VISNs, routine monitoring and analytics of operational, quality and productivity metrics and implementation of enterprise-wide initiatives. The Health Care Operations Center provides rapid, near real time information and analyses to support senior leader decision making, problem solving and improve VHA's ability to provide Veterans timely access to the highest quality care.

Member Services

MS's mission is to facilitate access to health care, benefits and support services for Veterans and their families. MS is comprised of four national programs:

- Health Eligibility Center: enrolls eligible Veterans who apply for VA health care in addition to providing other enrollment and related services,
- Health Resource Center: assists Veterans in understanding and obtaining benefits,
- Veterans Transportation Program – helps alleviate the costs of travel to medical appointments for eligible Veterans and
- Pharmacy Services: assists Veterans with management of prescription issues and copayments through the Pharmacy Customer Care and Clinical Pharmacy Resources efforts, respectively.

Allocation from the MSC appropriation is used to fund multiple Veteran facing initiatives within these national programs as well as supporting administrative offices and staff.

Integrated Veteran Care

Integrated Veteran Care

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate 1/	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$516,552	$1,089,501	$482,890	$512,952	$524,750	$30,062	$11,798
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$516,552	$1,089,501	$482,890	$512,952	$524,750	$30,062	$11,798

Program Description

IVC was established in 2022 by the VHA Under Secretary for Health. IVC will create a more seamless and coordinated experience for any Veteran who accesses the VHA system, within VHA or in the community. IVC will position VHA for better coordination and resource alignment, while also offering streamlined and simplified access processes for the field and for Veterans.

IVC is a matrixed organization structure that allows for increased collaboration across functional areas. Four organizational functions will coordinate across IVC to create seamless, integrated Veteran access to care.

Integrated Access

Integrated Access (IA) guides VHA processes, roles and practices to provide Veterans with access to timely, appropriate, quality health care, whether within the direct care system, virtual care system or in the community. IA examines all parts of integrated delivery systems to identify opportunities to reduce variation, remove waste and manage constraints. IA continually drives improvements in access to outpatient care via strong practices, innovation, policy, training, technology, data analysis and collaboration with the field that ultimately results in an optimized Veteran access experience. IA focuses on optimization, integrated care management and alternative care modalities.

Integrated Field Operations

Integrated Field Operations (IFO) collaborates with VAMCs, VISNs, regional and national program office leadership to address challenges and opportunities for optimizing Veterans' access to health care within the direct care system and in the community. IFO focuses on field support, technology, innovation, training and development.

Integrated External Networks

Integrated External Networks (IEN) leads, develops and administers community care contracts and networks for purchased care for Veterans and their beneficiaries. IEN is responsible for providing oversight and management to the community care network of providers, consultation with stakeholders, problem resolution using data driven analysis and coordination of innovative strategies and technologies for performance and quality improvement of community care Veteran health care programs. IEN focuses on network development, adequacy, contract management and performance, as well as customer support and stakeholder relations. IEN also provides education, outreach and customer support to providers and Veterans and manages and oversees the Veteran Family Members Program for beneficiary health care access.

Integrated Informatics and Analytics

Integrated Informatics and Analytics (IIA) provides the tools and support for VHA and IVC leadership to make data driven decisions on access investments or partnerships as appropriate for the market. IIA focuses on data validity, stewardship, governance and data tools and systems.

Quality and Patient Safety

Quality and Patient Safety

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$159,377	$205,955	$175,955	$209,000	$213,807	$33,045	$4,807
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$159,377	$205,955	$175,955	$209,000	$213,807	$33,045	$4,807

Program Description

The Office of Quality and Patient Safety provides oversight, expertise and support to advance the highest standards of care, innovation, responsible stewardship and ethical practice within the VA health care system.

National Center for Patient Safety

The National Center for Patient Safety (NCPS) establishes policy and provides oversight for the VHA National Patient Safety Program, including the development of guidance and measurement to mitigate Veteran harm and the fostering of a just and safe culture. Furthermore, NCPS is responsible for maintaining a database for patient safety events and root cause analysis reports, curriculum delivery for two post graduate patient safety educational programs, promoting the VHA HRO Journey to Zero Harm through clinical team and just culture training, oversight and administration of the Patient Safety Centers of Inquiry to advance patient safety science, evaluation of health care solutions, technology and innovations from a patient safety and value-based

perspective and oversight of the VHA Alerts and Recall Program for Medical Products, Drugs and Food. The Offices of Product Effectiveness and Utilization Management report directly to NCPS.

Analytics and Performance Integration

The Office of Analytics and Performance Integration's (API) mission delivers innovative and authoritative performance measurement, analytic and reporting tools and capabilities throughout VHA to enhance the value and quality of care for Veterans. API utilizes its MSC funding for staff salaries, travel and education to enable the entire VHA health system use data to drive high value and Veteran centric care through areas such as but not limited to:

- The Center for Strategic Analytic Reporting: develops the Strategic Analytics for Improvement and Learning report to measure, evaluate and benchmark quality and efficiency at VA medical facilities, in addition to utilizing data from the CMS for comparisons to the private sector,
- The Inpatient Evaluation Center: produces innovative products focused on tracking and improving the outcomes of hospitalized Veterans and
- The Office of Productivity, Efficiency and Staffing: is dedicated to enhancing VHA health care effectiveness using standard industry practices and external practice benchmarks for monitoring and improving clinical productivity and effectiveness.

Additionally, API supports legislative requirements such as the Survey of Health Care Experiences of Patients to measure patient experiences in the VA and the External Peer Review Program contract to operate a system of external review of identified medical records in alignment with external comparators in order to assess the quality of VHA inpatient and outpatient care.

Quality Management

The Office of Quality Management (OQM) supports the ongoing assessment and improvement of health care outcomes and health care delivery processes. OQM program offices help ensure VHA is hiring the right providers, identifying evidence-based practices, screening for deviations from standards of care and keeping facilities in a continuous state of readiness and compliance with industry standards. In addition, OQM provides education, training and competency build for quality professionals across the VHA to further enhance data knowledge and use, leadership skills and quality competencies. OQM programs working to achieve these goals include External Accreditation Services and Programs, Systems Redesign and Improvement, the Center for Improvement Coordination, Evidenced-Based Practice Program, Medical Staff Affairs, Clinical Risk Management and the Office of Medical Legal Affairs.

Support Services

Support Services
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$392,815	$688,777	$688,777	$765,103	$782,700	$76,326	$17,597
Mandatory Obligations	$132,720	$0	$0	$0	$0	$0	$0
Obligations [Total]	$525,535	$688,777	$688,777	$765,103	$782,700	$76,326	$17,597

Program Description

The Office of the Assistant Under Secretary for Health for Support provides facilities, engineering, equipment, occupational safety and health, procurement and logistics support services, expertise and program oversight to enable effective and efficient medical facility operations, clinical services and patient care services.

As part of its continued commitment to the modernization of its supply chain and support systems, the 2024 budget further allows VA to recruit for and hire a workforce of skilled VHA supply chain, health care technology and facilities management staff. VHA will increase health care logistics staff capacity at each VAMC to ease and facilitate the transition to a new integrated logistics and medical support services system enterprise-wide. Moreover, this increases capacity will also ensure that health care logistics support in our VAMCs fully supports the needs of Veterans and staff nationwide, in addition to furthering VA's commitment to its fourth Strategic Goal to transform business operations by modernizing systems and focusing resources more efficiently to be competitive and to provide world class customer service to Veterans and VA employees.

In accordance with VA's investment in its workforce and focus on employee education, the 2024 President's Budget allows VHA to establish and operate the Health Care Environment and Facilities Training Center of Excellence. A National Academies Study of the VA Health Care Engineering Workforce identified a significant need for detailed and sequential provision of technical skills training, inclusive of a structured path for critical succession planning to guarantee the continuity of a skilled and effective workforce. The Health Care Environment and Facilities Training Center of Excellence will provide competency enhancement for essential staff, including engineers, engineering trades, safety specialists, industrial hygienists, environmental protection, environmental services and other health environment of care related professionals.

Health Care Environment and Facilities Programs

Health Care Environment and Facilities Programs uses MSC funds to provide oversight in the areas of capital asset management, health care engineering, environmental management and occupational safety and health across the VHA enterprise in support of medical facility infrastructure. Each of these specialty areas works together to ensure operational compliance with codes, standards, regulations, statutes and executive orders. MSC funds directly support the salaries and training requirements of VISN level Green Environmental Management Systems Program Managers and Energy Engineers.

Acquisitions, Technology and Logistics

The Acquisitions, Technology and Logistics Office is the new office resulting from the merging on the offices formerly known as Procurement and Logistics and Health Care Technology Management. This office uses MSC funds to recruit and retain the best qualified acquisition workforce to provide support to all of VHA in purchasing high-quality, cost-effective health care products and services for all facilities, provide world class logistics and acquisition services to VHA's integrated health care system and medical facilities and develops, implements and oversees policies and processes compliant with all applicable laws and regulations. Additionally, this office uses MSC funds to employ biomedical engineers and other support staff to provide oversight to Biomedical Engineering Programs across VHA field operations regarding the commissioning,

technical sustainment and systematic technical refresh of medical equipment used across VHA. Please see the Medical Equipment section in the Medical Services chapter for more information.

Veterans Canteen Service

Since 1946 Veterans Canteen Service (VCS) has been serving America's Veterans, caregivers, family members, visitors and volunteers as the commercial retail, café and coffee shop service across 200 VAMCs and facilities as a self-sustaining entity with one mission: providing comfort and wellbeing. VCS is an integral part of the VA community, driven to be efficient, innovative and customer focused, giving back to Veterans with support for rehabilitation events, homelessness programs, suicide prevention and emergency support during natural disasters. VCS does not use MSC funds. Please see the VCS Revolving Fund section in the Revolving and Trust Activities chapter for more information.

VA Logistics Redesign

VA's supply chain modernization priorities include deploying multiple systems and improvements to improve enterprise management and oversight of materiel to provide better support for care delivery in the field. Please see the Supply Chain Management section in the Medical Care chapter for more information.

Human Capital Management

Human Capital Management

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$247,675	$340,791	$340,791	$437,442	$447,503	$96,651	$10,061
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$247,675	$340,791	$340,791	$437,442	$447,503	$96,651	$10,061

Program Description

The Office of Human Capital Management (HCM) is committed to achieving individual and organizational high performance for VHA workforce to serve our Nation's Veterans. HCM supports the human capital needs of VHA employees and health professions trainees. HCM provides guidance, information and consultation to VHACO components, VHA health care facilities, VISNs and external entities such as health professional organizations, Congress and other Federal agencies. HCM oversees VHA's succession and workforce planning, identifies and monitors talent needs and trends within the organization and links succession planning and business strategies, presenting VHA with the opportunity to reach long-term goals and achieve human capital objectives. To drive change and the long-term development of people and culture to address future challenges as VA continues its modernization transformation, HCM conducts a Departmentwide assessment of organizational health annually providing data analytics and action planning consultation to ensure results are used to improve the workplace. HCM consists of the following program offices: Institute for Learning, Education and Development (ILEAD), formerly Employee Education System (EES) and Health Care Leadership Talent Institute, National Center for Organization Development (NCOD) and Workforce Management and Consulting (WMC). MSC funds support additional HCM functions including administrative, financial and logistical oversight for all VHA headquarters program offices and staff.

The 2024 budget further invests in VHA HR due to its vital role in delivering on our mission and enabling implementation of workforce enhancements. A 2016 Government Accountability Office report, Management Attention is Needed to Address System, Long-standing Human Capital Challenges, indicated VHA is facing key human capital challenges that hamper its ability to effectively serve Veterans. As a result of these findings, VHA began a transformation in 2018 to shift decentralized field HR operations to VISN HR shared services and supported by a VHACO HR Center of Expertise. In a large integrated health care system like VHA, shared services can flex and scale to support local health care delivery needs and identify meaningful performance improvement opportunities to help organizations achieve strategic goals. With the consolidation of HR being completed, there is now increased focus on standardizing and optimizing operations prioritized by customer needs and agency expectations.

VHA will create HR staffing models, which will ensure human capital resources are adequately and appropriately allocated. These staffing models will focus on productivity and efficiency metrics, which will draw upon existing production measures and outcomes to determine optimal HR staffing levels for each functional area of HR. A data system audit is underway and, once completed, this staffing model is expected to have a profound impact on time to hire and therefore address a significant concern among HR's customers.

VHA is piloting customer focused HR interfaces that provide employees real time access to benefits and other information, as well as providing self-service options to submit HR requests, changes and finds resources to assist with HR related requests. To further improve customer service, VHA will continue expanding options for HR to respond to customer inquiries and issues that require assistance, with the ultimate goal of further enabling leadership at all levels and HR professionals hire and onboard medical professionals and support staff in a timely manner. Funding for the operational and logistical capabilities, in addition to staffing, will be needed once metrics and results from the pilot are complete.

To further assist VAMCs and VISNs in their hiring capabilities, VHA is updating and realigning its position categorization structure to enable VAMCs and VISNs to better define and track their staffing requirements in addition to enabling predictive staffing power on the part of VAMCs and VISNs. Additionally, it will simultaneously allow for the flow of staffing requirements to the enterprise level, facilitating national recruitment efforts and driving more accurate workforce planning and analysis outcomes. Moreover, VHA is expanding the Physician/Provider Recruiter role by adding this specialty to local infrastructure to recruit hard to find physicians and advanced practice providers in the Nation's most scarce specialties. Additionally, in order to supplement and support our expanded specialized recruitment function, VHA is investing in expanding its national recruitment and sourcing capabilities to build and leverage what would become the Nation's largest database of practicing physicians and advanced practice providers that would be provided to VAMCs for immediate consideration and appointment at our hospitals and outpatient clinics. These actions allow VA to expand the health care workforce pipeline with continued focus on mental health, long-term care and rural communities. These expanded capabilities provide VHA a market advantage by generating large actionable and diverse talent pools of candidates for current and future needs, thus solidifying our readiness to meet emerging clinical workforce demands.

VHA's Talent Team includes a combination of new and existing highly talented individuals with strong leadership skills and a working knowledge of HR policy and operational practices with the goal of helping facilitate and validate custom technical and behavioral assessments-based on job analysis workshop results. Furthermore, rapid process improvement and standardization teams have been established and are working to enhance HR operational processes such as but not limited to onboarding, creation of national standard protocols and expansion of training for hiring managers and their designees. Additionally, baseline service delivery performance data is being collected to prepare for monitoring improvement efforts, as trends in service delivery performance coupled with customer satisfaction at all stages within the employee journey enable refined targets for operational improvements. Growth of these teams would enable a shorter design period by analysis of multiple HR processes at once, resulting in faster time to implement for identified improvements and allow for dedicated resources to monitor and analyze service delivery performance.

As part of its effort to integrate HR IT systems, VHA is partnering with the Office of Personnel Management to improve interoperability, facilitate data exchange, eliminate duplicate and out of sync information and enhance workflows and training. An acquisition strategy and timeline for implementation will be pursued once preparations are in place. Additionally, HCM plays a critical role in training VHA employees for implementation of VA's Electronic Health Records Management (EHRM) rollout through a long-term enterprise infrastructure, including development, sustainment and oversight of training requirements.

VHA's high volume accelerated training program, HR Specialist Training and Accelerated Readiness (STAR), provides centralized training and introduction to HR operations in a standardized one-year curriculum. At the end of the training period, trainees are placed in servicing HR specialist position. Launched in 2023, HR STAR will reach the initial program target of 1,000 trainees per year in 2024. VHA will assess the effectiveness and impact of HR STAR, procure training space for learning labs, workshops and other simulations to ensure experiential learning and development for HR professionals is ongoing at all levels, not just the foundational level.

Institute for Learning, Education and Development

ILEAD, merged from EES and Health Care Talent Leadership Institute in 2023, provides employee learning, education, and development opportunities and solutions to VHA's workforce. The ILEAD transformation goal is to create a learning community of practice through continuous engagement, provide training solutions and services that empower the advancement of VHA's high performing workforce and enable VHA learners to deliver exceptional care to Veterans.

ILEAD partners with VA, VHA program offices, VISNs and medical facilities to provide quality workforce education and training to improve outcomes in Veteran clinical care, health care operations and administration. VHA employees rely upon ILEAD for high-quality, impactful education and training support. ILEAD continues to serve as a managing partner for the Federal Health Care Training Partnership, consisting of agencies (including the Department of Defense) that collaborate and share continuing medical education training programs among partner organizations with a clinical and public health training mission. ILEAD shares, at no cost to the learner, continuing medical education/continuing education in the health professions training programs on the VHA Training Finder Real Time Affiliate Integrated Network (TRAIN). A

service of Public Health Foundation, TRAIN operates through collaborative partnerships with state and Federal agencies, local and national organizations and educational institutions. MSC funds support overhead costs associated with maintaining the program and administrative support costs for training, travel, equipment and supplies.

ILEAD is responsible for linking talent planning and talent development processes and programs into a single system characterized by informed, structured, ongoing and deliberate processes to identify, develop and leverage the leadership talents of the VHA workforce. The result is a cadre of ready, willing, diverse and capable leaders to step into VHA's most demanding roles. ILEAD promotes and manages leadership programs and developmental opportunities that maximize the acquisition of leadership and health care leadership competencies through growth activities that are 70% experiential (for example, activities, details, assignments and committees), 20% exposure (for example, coaching, mentoring and shadowing) and 10% traditional didactic training. ILEAD oversees VHA leadership succession planning, identifies and monitors talent needs and trends within the organization and links succession planning and business strategies to present VHA with the opportunity to reach long-term goals and achieve human capital objectives.

National Center for Organization Development

NCOD collaborates with leaders throughout VA enabling them to create a highly engaged workforce to increase the long-term growth and performance of the VA. NCOD administers, analyzes and presents results of the annual All Employee Survey to leaders and assists with action planning across VA. NCOD conducts consultative engagements designed to support services/workgroups by working with individual leaders virtually and/or in person. NCOD provides services designed to strengthen executive leadership teams to better overcome challenges and grow their organizations together. NCOD offers 360° assessments as well as executive coaching to current and developing leaders within the organization and conducts the VA Internal Coach Training Program to build a broader cadre of skilled, qualified coaches who support highly valued, impactful leadership coaching and who become eligible for the International Coaching Federation credential.

NCOD reaches out to leaders at sites considered at-risk related to employee engagement, offering foundation approaches aimed at improving the work environment for employees. NCOD oversees VA Voices, which is designed to engage employees and promote collaboration to achieve the shared mission of serving Veterans. The aim is twofold: to engage employees and to create an organizational climate that sustains engagement over time. NCOD has developed several programs, services and resources focused on engagement to support leaders in creating a workplace where employees want to work and Veterans want to receive care. MSC funds support additional NCOD functions including oversight and coordination of travel for the VA Voices Program, assisted logistical support and facilitation of the VHA Governance Board and direct support of enterprise-wide VA All Employee Survey administration and related consultative services.

Workforce Management and Consulting

WMC provides VHA-wide leadership for workforce operations and administration management through strategic human capital planning, senior executive recruitment, performance and advisory services, labor management and labor relations and training and career development. WMC

ensures the recruitment and retention of a highly skilled, motivated and effective workforce and provides advice and assistance to VHA leadership on HR issues. WMC provides full-service HR operations for VA employees (including VHACO, specific VA staff office organizations and VA's Office of Information and Technology (OIT)) and serves as the delegated examining unit for all VHA. WMC also provides personnel security and credentialing oversight to VISNs and VAMCs through issuance of policy, technical guidance and consultative services focused on establishing consistency in suitability and credentialing related practices. MSC funds support essential HR staff salaries, human capital recruitment and retention programs such as employee scholarship programs and critical HR contracts and services supporting VHA employees nationwide.

Health Informatics

Health Informatics

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$137,007	$179,057	$179,057	$213,742	$218,658	$34,685	$4,916
Mandatory Obligations	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$137,007	$179,057	$179,057	$213,742	$218,658	$34,685	$4,916

Program Description

Office of Health Informatics (OHI) oversees the collection, exchange and use of EHR data, optimizes the current EHR to promote evidence-based decision making and patient centered care and delivers health IT solutions that increase Veteran access to care and supports participation in their health care by:

- ensuring that health care information systems are implemented in a manner that meets the requirements of VHA users, including EHRM,
- enhancing heath information exchanges with Federal and private partners,
- providing national policy and guidance to health informatics, Freedom of Information Act (FOIA), privacy, health information management, records management and library personnel nationwide,
- facilitating sound decision making for development, acquisition and maintenance of health IT investments through business requirements, IT strategy and priorities and investment analysis,
- developing, delivering and implementing virtual and digital technologies that help Veterans communicate with their VA care teams and coordinate, track and manage their health care and
- partnering with VHA programs and VA's OIT to deploy enterprise applications and databases to support strategic goals and objectives for VHA.

Program Support Operations

Program Support Operations, manages the business functions for OHI, providing guidance and support in such areas as planning and strategy, budget, HR and contracting.

Clinical Informatics and Data Management Office

Clinical Informatics and Data Management Office's (CIDMO) mission is to advance the enterprise standards of care and experience for Veterans and clinical staff through information and process

management. CIDMO partners with program offices, the OIT and the field to derive clinical value from technologies and improve the user experience. The office accomplishes this work though application of technical expertise including process engineering, human factors engineering, terminology, knowledge representation, system design and computer science-based analytical methods. CIDMO products usually have four components: reengineered clinical processes, encoded clinical logic, new or configured software and change management. CIDMO provides products for use in direct patient care. The rest of its work is focused on the safe operation and use of IT, developing and piloting foundational methods of information management including national standards, providing technical consultations to other offices, improving the management and competencies of the informatics workforce, coordinating high return collaborations with other Federal agencies and health care systems and cooperatively managing applications and technical platforms such as those for data, clinical decision support and interoperability. Nearly all CIDMO activities are designed to support EHRM with dual benefit to Veterans Health Information Systems and Technology Architecture sites.

Health Information Governance

Health Information Governance (HIG) represents VA on national and international health care policy initiatives regarding Veterans' data. HIG serves as VHAs subject matter and policy expert regarding privacy, health care security and data contained in Veterans' EHR and in national data systems. The office provides compliance monitoring, management of national data systems and knowledge-based library services. The office develops and implements policy and regulations in accordance with FOIA, Privacy Act, title 38, United States Code confidentiality statutes and Health Insurance Portability and Accountability Act privacy rule. HIG provides national guidance, policy and training to VHA field-based professionals on health information management, library, privacy, FOIA, records management, identity management and health care security topics.

Strategic Investment Management

Strategic Investment Management (SIM) was established to support the business' health IT needs by facilitating business transformation, informing change management efforts and providing the information that leaders need to make sound decisions. SIM adds value by informing decision making and driving business transformation. SIM is composed of three organizational services:

- Business Architecture Services: bridges the gap between VHA capabilities and stakeholders by establishing a common language to describe the business of health care delivery. Additionally, this service identifies, classifies and models health business strategies, functions, processes and information to allow executives and portfolio managers to make better and more informed decisions regarding health care transformation and IT solution development, acquisition and configuration.
- Investment Governance Services: provides oversight of budget planning activities relative to VHA IT needs, coordinates IT governance functions within VHA and provides VHA liaison to VA-wide IT governance.
- Requirements Development and Management Services: collaborates with VHA program offices, VHA field staff, subject matter experts and stakeholders to gather, document, analyze, validate and communicate requirements supporting clinical and business needs which drives traceability towards an enterprise standard. This ensures VHA's IT needs are documented in a manner that is crucial to improving existing IT systems and in the acquisition of new technology.

Office of Nursing Informatics

Office of Nursing Informatics (ONI) supports nurses throughout the care continuum to link science, technology and the use of EHR, tools and processes to improve health. ONI ensures providers can access knowledge that reflects the best evidence of care practices to help lead to the desired outcomes in care delivery and operational performance. ONI measures outcomes based on what nurses caring for Veterans are experiencing and what solutions mean to Veterans.

All-Other Support and Program Offices

All-Other Support and Program Offices

(dollars in thousands)

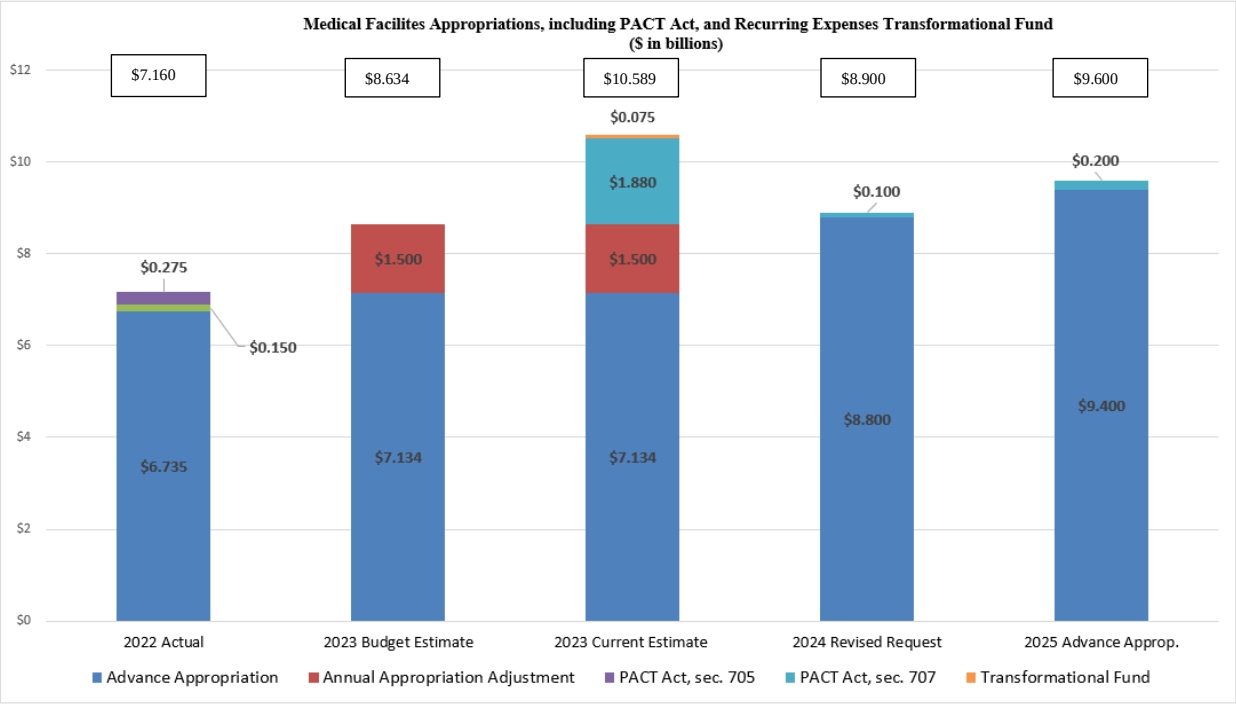
Description	2022 Actual	2023 Budget Estimate 1/	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations	$837,806	$773,259	$1,409,870	$1,517,789	$1,552,698	$107,919	$34,909
Mandatory Obligations	$145,119	$0	$0	$0	$0	$0	$0
Obligations [Total]	$982,925	$773,259	$1,409,870	$1,517,789	$1,552,698	$107,919	$34,909

Program Description

The VHA program offices in this line include Patient Advocacy, Readjustment Counseling, Women's Health, Health Care Transformation, Finance, Strategy, Oversight, Risk and Ethics, Chief of Staff, Office of the Deputy Under Secretary for Health and Office of the Under Secretary for Health.

Section G: Medical Facilities Category

Chart: Medical Facilities Appropriations [1/]



1/The table displays appropriations prior to proposed cancellations and transfers discussed later in this chapter and, in 2023, includes resources available from the Recurring Expenses Transformational Fund.

The following tables display the discretionary, mandatory, and combined sources of funds for the Medical Facilities category.

Table: Medical Facilities Discretionary Crosswalk, 2022-2025

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Appropriation Medical Facilities (0162)							
Advance Appropriation	$6,734,680	$7,133,816	$7,133,816	$8,800,000	$9,400,000	$1,666,184	$600,000
Annual Appropriation Adjustment	$0	$1,500,000	$1,500,000	$0	$0	($1,500,000)	$0
PL 117-103 § 253 (Infrastructure)	$150,000	$0	$0	$0	$0	$0	$0
Appropriations Request [Subtotal]	$6,884,680	$8,633,816	$8,633,816	$8,800,000	$9,400,000	$166,184	$600,000
Proposed Cancellation of Available Unobligated Balances	$0	$0	$0	($250,515)	$0	($250,515)	$250,515
Net Appropriation	**$6,884,680**	**$8,633,816**	**$8,633,816**	**$8,549,485**	**$9,400,000**	**($84,331)**	**$850,515**
Tranfers To							
JALFHCC (0169)	($92,830)	($50,297)	($116,881)	($55,452)	($58,225)	$61,429	($2,773)
Transfers To [Subtotal]	($92,830)	($50,297)	($116,881)	($55,452)	($58,225)	$61,429	($2,773)
Tranfers From							
Medical Services (0160)	$0	$0	$270,000	$0	$0	($270,000)	$0
Medical Community Care (0140)	$0	$0	$0	$3,919,081	$0	$3,919,081	($3,919,081)
Medical Support & Compliance (0152)	$0	$0	$0	$850,000	$0	$850,000	($850,000)
Transfers From [Subtotal]	$0	$0	$270,000	$4,769,081	$0	$4,499,081	($4,769,081)
Proposed Cancellation from Transferred Advance Appropriations	$0	$0	$0	($4,769,081)	$0	($4,769,081)	$4,769,081
Reappropriation of the Transferred Cancelled Funds with a 5-Year Period of Availability	$0	$0	$0	$4,769,081	$0	$4,769,081	($4,769,081)
Budget Authority [Total]	$6,791,850	$8,583,519	$8,786,935	$13,263,114	$9,341,775	$4,476,179	($3,921,339)
Reimbursements	$18,609	$24,739	$18,609	$18,609	$18,609	$0	$0
Unobligated Balance (SOY)							
PL 117-103 § 253 (Infrastructure)	$0	$0	$108,824	$0	$0	($108,824)	$0
No-Year	$18,489	$0	$16,661	$0	$0	($16,661)	$0
P.L. 115-141 sec 255 (NRM)	$115,406	$0	$30,667	$0	$0	($30,667)	$0
P.L. 115-244 sec 248 (NRM)	$336,087	$0	$139,162	$0	$0	($139,162)	$0
H1N1 No-Year (PL 111-32)	$5	$0	$5	$0	$0	($5)	$0
2-Year	$158,634	$350,000	$315,247	$250,515	$0	($64,732)	($250,515)
5-Year Base Year 2018 - P.L. 116-20 (Disaster Relief)	$41,538	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$670,159	$350,000	$610,566	$250,515	$0	($360,051)	($250,515)
Unobligated Balance (EOY)							
PL 117-103 § 253 (Infrastructure)	($108,824)	$0	$0	$0	$0	$0	$0
No-Year (Other)	($16,661)	$0	$0	$0	$0	$0	$0
P.L. 115-141 sec 255 (NRM)	($30,667)	$0	$0	$0	$0	$0	$0
P.L. 115-244 sec 248 (NRM)	($139,162)	$0	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	($5)	$0	$0	$0	$0	$0	$0
2-Year	($315,247)	$0	($250,515)	$0	$0	$250,515	$0
5-Year Base Year 2018 - P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($610,566)	$0	($250,515)	$0	$0	$250,515	$0
Lapse	($17,682)	$0	$0	$0	$0	$0	$0
Subtotal	$6,852,370	$8,958,258	$9,165,595	$13,532,238	$9,360,384	$4,366,643	($4,171,854)
Prior Year Recoveries	$31,923	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0162) [Total]	**$6,884,293**	**$8,958,258**	**$9,165,595**	**$13,532,238**	**$9,360,384**	**$4,366,643**	**($4,171,854)**
Recurring Expenses Transformational Fund (1124XN)							
Discretionary Appropriations	$0	$0	$75,000	$0	$0	($75,000)	$0
						$0	$0
Unobligated Balance (SOY)	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY)	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations RETF (1124XN) [Total]	**$0**	**$0**	**$75,000**	**$0**	**$0**	**($75,000)**	**$0**
Discretionary Budget Authority	$6,791,850	$8,583,519	$8,861,935	$13,263,114	$9,341,775	$4,401,179	($3,921,339)
Discretionary Obligations [Total]	**$6,884,293**	**$8,958,258**	**$9,240,595**	**$13,532,238**	**$9,360,384**	**$4,291,643**	**($4,171,854)**

Table: Medical Facilities Mandatory Crosswalk, 2022-2025

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
PACT Act, sec. 705 (0162XU)							
Mandatory Appropriations	$275,205	$0	$0	$0	$0	$0	$0
						$0	$0
Unobligated Balance (SOY)	$0	$0	$275,205	$275,205	$275,205	$0	$0
Unobligated Balance (EOY)	($275,205)	$0	($275,205)	($275,205)	($275,205)	$0	$0
Obligations PACT Act, sec. 705 (0162XU) [Total]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
PACT Act, sec. 707 (0162XL)							
Mandatory Appropriations	$0	$0	$1,880,000	$100,000	$200,000	($1,780,000)	$100,000
						$0	$0
Unobligated Balance (SOY)	$0	$0	$0	$1,829,719	$1,142,995	$1,829,719	($686,724)
Unobligated Balance (EOY)	$0	$0	($1,829,719)	($1,142,995)	($1,077,772)	$686,724	$65,223
Obligations PACT Act, sec. 707 (0162XL) [Total]	**$0**	**$0**	**$50,281**	**$786,724**	**$265,223**	**$736,443**	**($521,501)**
Veterans Medical Care and Health Fund (0173MF)							
Unobligated Balance (SOY)	$2,572,958	$392,200	$772,056	$0	$0	($772,056)	$0
Unobligated Balance (EOY)	($772,056)	$0	$0	$0	$0	$0	$0
Obligations (0173MF) [Total]	**$1,800,902**	**$392,200**	**$772,056**	**$0**	**$0**	**($772,056)**	**$0**
VACAA, sec. 801 (0162XA)							
Unobligated Balance (SOY)	$16,095	$1,323	$10,884	$3,791	$0	($7,093)	($3,791)
Unobligated Balance (EOY)	($10,884)	$0	($3,791)	$0	$0	$3,791	$0
Subtotal	$5,211	$1,323	$7,093	$3,791	$0	($3,302)	($3,791)
Prior Year Recoveries	$3,488	$0	$0	$0	$0	$0	$0
Obligations (0162XA) [Total]	**$8,699**	**$1,323**	**$7,093**	**$3,791**	**$0**	**($3,302)**	**($3,791)**
Mandatory Budget Authority	$275,205	$0	$1,880,000	$100,000	$200,000	($1,780,000)	$100,000
Mandatory Obligations [Total]	**$1,809,601**	**$393,523**	**$829,430**	**$790,515**	**$265,223**	**($38,915)**	**($525,292)**

Table: Medical Facilities Discretionary & Mandatory Total and FTE, 2022-2025

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Discretionary and Mandatory Budget Authority [Grand Total]	$7,067,055	$8,583,519	$10,741,935	$13,363,114	$9,541,775	$2,621,179	($3,821,339)
Discretionary and Mandatory Obligations [Grand Total]	**$8,693,894**	**$9,351,781**	**$10,070,025**	**$14,322,753**	**$9,625,607**	**$4,252,728**	**($4,697,146)**
FTE							
Medical Facilities (0162)	22,143	28,626	25,668	26,501	27,334	833	833
Veterans Medical Care and Health Fund (0173MF)	3,091	0	0	0	0	0	0
VACAA, Section 801 (0162XA)	0	1	0	0	0	0	0
FTE [Total]	**25,234**	**28,627**	**25,668**	**26,501**	**27,334**	**833**	**833**

Summary of 2024 Revised Request

The discretionary Medical Facilities Budget reflects a 2024 advance appropriation of $8.8 billion and a proposes a $4.8 billion cancellation from advance appropriations transferred from Medical Community Care and Medical Support and Compliance to Medical Facilities, with a corresponding reappropriation of the same amount ($4.8 billion) with a five-year period of availability to provide for increased investment in the Non-Recurring Maintenance (NRM) program.

Mandatory appropriations were provided in Title VII of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act):

- Section 705 appropriated $922.0 million in fiscal year 2022 for the Department's enhanced-use lease program to be available until expended. The Department allocated $275.2 million of this funding to the Medical Facilities account.

- Section 707 appropriated $5.5 billion in fiscal years 2023-2031 of which $1.9 billion was made available in 2023, $100 million in 2024, and $200 million in 2025, $400 million in 2026, $450 million in 2027, $600 million in 2028, $610 million in 2029, $620 million in 2030, and $650 million in 2031. These funds are available until expended for major medical facility leases authorized by section 702.

When these resources are combined with available transfers, reimbursements and other net unobligated balances, Medical Facilities will meet the projected 2024 obligation level of $14.3 billion, as detailed in the tables below.

Table: Discretionary Obligations by Program

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Program (0162)							
Engineering & Environmental Management	$801,181	$919,548	$827,650	$1,245,577	$1,395,577	$417,927	$150,000
Engineering Service	$996,085	$1,227,419	$1,189,964	$1,444,823	$1,611,472	$254,859	$166,649
Ground Maintenance & Fire Protection	$132,579	$138,910	$156,858	$178,197	$182,296	$21,339	$4,099
Leases	$971,803	$1,498,840	$1,493,425	$1,515,753	$1,700,000	$22,328	$184,247
Non-Recurring Maintenance	$1,510,072	$2,505,000	$2,509,475	$5,750,000	$995,000	$3,240,525	($4,755,000)
Base NRM	*$1,510,072*	*$2,000,000*	*$2,004,475*	*$5,000,000*	*$700,000*	*$2,995,525*	*($4,300,000)*
EHRM NRM	*$0*	*$505,000*	*$505,000*	*$750,000*	*$295,000*	*$245,000*	*($455,000)*
Operating Equipment Maintenance & Repair	$351,902	$398,495	$441,454	$503,971	$515,562	$62,517	$11,591
Other Facilities Operation Support	$45,813	$122,660	$65,481	$73,802	$75,499	$8,321	$1,697
Plant Operation	$890,157	$970,901	$1,115,862	$1,274,587	$1,303,903	$158,725	$29,316
Recurring Maintenance & Repair	$710,058	$698,290	$837,273	$945,454	$967,199	$108,181	$21,745
Textile Care Processing & Maintenance	$223,395	$234,051	$260,572	$294,247	$301,015	$33,675	$6,768
Transportation	$219,325	$244,144	$267,581	$305,827	$312,861	$38,246	$7,034
Obligations Before Prior Year Recoveries (0162)	$6,852,370	$8,958,258	$9,165,595	$13,532,238	$9,360,384	$4,366,643	($4,171,854)
Prior Year Recoveries	$31,923	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$6,884,293**	**$8,958,258**	**$9,165,595**	**$13,532,238**	**$9,360,384**	**$4,366,643**	**($4,171,854)**
Discretionary Program (0162) - Recurring Expenses Transformational Fund							
Non-Recurring Maintenance (Base)	$0	$0	$75,000	$0	$0	($75,000)	$0
RETF Obligations Before Prior Year Recoveries [Subtotal]	**$0**	**$0**	**$75,000**	**$0**	**$0**	**($75,000)**	**$0**
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$0**	**$0**	**$75,000**	**$0**	**$0**	**($75,000)**	**$0**
Discretionary Obligations [Total] (0162)	**$6,884,293**	**$8,958,258**	**$9,240,595**	**$13,532,238**	**$9,360,384**	**$4,291,643**	**($4,171,854)**

Table: Medical Facilities Mandatory Obligations by Program

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Mandatory Program (0162) - PACT Act, Sec 705							
Leases	$0	$0	$0	$0	$0	$0	$0
Obligations PACT Act, sec. 705	$0	$0	$0	$0	$0	$0	$0
Mandatory Program (0162) - PACT Act, Sec 707							
Leases	$0	$0	$50,281	$786,724	$265,223	$736,443	($521,501)
Obligations PACT Act, sec. 707	$0	$0	$50,281	$786,724	$265,223	$736,443	($521,501)
Mandatory Program (0173MF) - Veterans Medical Care and Health Fund							
Engineering & Environmental Management	$86,525	$317,200	$264,531	$0	$0	($264,531)	$0
Engineering Service	$135,963	$75,000	$75,000	$0	$0	($75,000)	$0
Ground Maintenance & Fire Protection	$3,010	$0	$0	$0	$0	$0	$0
Leases	$85,380	$0	$0	$0	$0	$0	$0
Non-Recurring Maintenance	$1,353,001	$0	$432,525	$0	$0	($432,525)	$0
Base NRM	*$597,479*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
EHRM NRM	*$755,522*	*$0*	*$432,525*	*$0*	*$0*	*($432,525)*	*$0*
Operating Equipment Maintenance & Repair	$26,129	$0	$0	$0	$0	$0	$0
Other Facilities Operation Support	$11,590	$0	$0	$0	$0	$0	$0
Plant Operation	$64,384	$0	$0	$0	$0	$0	$0
Recurring Maintenance & Repair	$21,550	$0	$0	$0	$0	$0	$0
Textile Care Processing & Maintenance	$4,066	$0	$0	$0	$0	$0	$0
Transportation	$9,304	$0	$0	$0	$0	$0	$0
Obligations Veterans Medical Care and Health Fund	$1,800,902	$392,200	$772,056	$0	$0	($772,056)	$0
Mandatory Program (0162) -VACAA Sec. 801							
Engineering & Environmental Management	$490	$163	$518	$539	$0	$21	($539)
Engineering Service	$0	$0	$0	$0	$0	$0	$0
Ground Maintenance & Fire Protection	$0	$0	$0	$0	$0	$0	$0
Leases	$4,067	$1,160	$6,575	$3,252	$0	($3,323)	($3,252)
Non-Recurring Maintenance	($129)	$0	$0	$0	$0	$0	$0
Base NRM	*($129)*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
EHRM NRM	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Operating Equipment Maintenance & Repair	$0	$0	$0	$0	$0	$0	$0
Other Facilities Operation Support	$46	$0	$0	$0	$0	$0	$0
Plant Operation	$0	$0	$0	$0	$0	$0	$0
Recurring Maintenance & Repair	$397	$0	$0	$0	$0	$0	$0
Textile Care Processing & Maintenance	$340	$0	$0	$0	$0	$0	$0
Transportation	$0	$0	$0	$0	$0	$0	$0
Obligations Before Prior Year Recoveries [Subtotal]	**$5,211**	**$1,323**	**$7,093**	**$3,791**	**$0**	**($3,302)**	**($3,791)**
Prior Year Recoveries	$3,488	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$8,699**	**$1,323**	**$7,093**	**$3,791**	**$0**	**($3,302)**	**($3,791)**
Mandatory Obligations [Total] (0162)	**$1,809,601**	**$393,523**	**$779,149**	**$3,791**	**$0**	**($775,358)**	**($3,791)**

Table: Medical Facilities Total Obligations by Program
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Program:							
Engineering & Environmental Management	$888,196	$1,236,911	$1,092,699	$1,246,116	$1,395,577	$153,417	$149,461
Engineering Service	$1,132,048	$1,302,419	$1,264,964	$1,444,823	$1,611,472	$179,859	$166,649
Ground Maintenance & Fire Protection	$135,589	$138,910	$156,858	$178,197	$182,296	$21,339	$4,099
Leases	$1,061,250	$1,500,000	$1,550,281	$2,305,729	$1,965,223	$755,448	($340,506)
Non-Recurring Maintenance 1/	$2,862,944	$2,505,000	$3,017,000	$5,750,000	$995,000	$2,733,000	($4,755,000)
Base NRM	*$2,107,722*	*$2,000,000*	*$2,079,475*	*$5,000,000*	*$700,000*	*$2,920,525*	*($4,300,000)*
EHRM NRM	*$755,222*	*$505,000*	*$937,525*	*$750,000*	*$295,000*	*($187,525)*	*($455,000)*
Operating Equipment Maintenance & Repair	$378,031	$398,495	$441,454	$503,971	$515,562	$62,517	$11,591
Other Facilities Operation Support	$57,449	$122,660	$65,481	$73,802	$75,499	$8,321	$1,697
Plant Operation	$954,541	$970,901	$1,115,862	$1,274,587	$1,303,903	$158,725	$29,316
Recurring Maintenance & Repair	$732,005	$698,290	$837,273	$945,454	$967,199	$108,181	$21,745
Textile Care Processing & Maintenance	$227,801	$234,051	$260,572	$294,247	$301,015	$33,675	$6,768
Transportation	$228,629	$244,144	$267,581	$305,827	$312,861	$38,246	$7,034
Obligations Before Prior Year Recoveries (0162)	$8,658,483	$9,351,781	$10,070,025	$14,322,753	$9,625,607	$4,252,728	($4,697,146)
Prior Year Recoveries	$35,411	$0	$0	$0	$0	$0	$0
Obligations Total After Prior Year Recoveries (0162)	**$8,693,894**	**$9,351,781**	**$10,070,025**	**$14,322,753**	**$9,625,607**	$4,252,728	($4,697,146)

1/ The 2022 NRM actual in the above table includes additional object classes than what is displayed in the Budget Overview chapter's Obligations by Object table, such as Personnel Compensation and benefits, Other Contractual Services, Supplies & Materials and Equipment.

In 2024, total obligations are projected to increase by $4.3 billion above the 2023 current estimate in the following areas:

- **Non-Recurring Maintenance (+$2.7 billion)**. Non-Recurring Maintenance is projected to increase by a historic $2.7 billion to partially address the capital infrastructure needs of medical care facilities.
- **Leases (+$755.4 million).** Leases are projected to increase, largely influenced by the major leases authorized by section 702 of the PACT Act.
- **Engineering Services (+$179.9 million)**. Engineering Services is projected to increase by to expand oversight and management of engineering environmental management services.
- **Plant Operations (+$158.7 million)**. Plant Operations are projected to increase for utility costs.
- **Engineering and Environmental Management (+$153.4 million)**. Engineering and Environmental Management is projected to increase to expand project management.
- **All Other Increases (+$272.3 million)**. This amount covers the projected increased cost of textile care processing, transportation, maintenance and repairs.

Summary of the 2025 Advance Appropriation Request

The Medical Facilities discretionary advance appropriations request is $9.4 billion, an increase of $600 million from the 2024 revised discretionary request. The 2025 request ensures continuity of

Veterans' health care services. In 2025, total obligations are projected to decrease by $4.7 billion from the 2024 revised request level in the following areas:

- **Leases (-$340.5 million)**. Leases are projected to decrease largely because of the projected Sec. 707 spend plan which goes from $786.7 million in 2024 to $265.2 million in 2025. Space needs will be reassessed as part of the 2025 President's Budget.
- **Non-Recurring Maintenance (-$4.8 billion)**. NRM is projected to decrease after the historic obligation level to update existing VA system space in 2024. NRM needs will be reassessed as part of the 2025 President's Budget.
- **All Other Increases (+$443.4 million).** This amount covers the projected increased cost of engineering, operations, textile care processing, transportation, maintenance and repairs.

Medical Facilities Program Funding Requirements

The Medical Facilities appropriation supports the operation and maintenance of VA hospitals, CBOCs, community living centers, domiciliary facilities, Vet Centers and the health care corporate offices. The appropriation also supports the administrative expenses of planning, designing and executing construction or renovation projects at these facilities. VHA operates a portfolio of approximately 5,640 owned buildings with a total of 152.4 million square feet of space on 16,057 acres of land. The portfolio also includes 1,722 leases with a total of 21.9 million square feet of space. A detailed explanation of the types and numbers of VHA health care facilities can be found in the Medical Facilities by Type chapter.

The staff and associated funding supported by this appropriation are responsible for: keeping the VA hospitals and clinics climate controlled; maintaining a clean and germ- and pest- free environment; sanitizing and washing hospital linens, surgical scrubs and clinical coats; cleaning and sterilizing the medical equipment; keeping the hospital signage clear and current; maintaining the trucks, buses and cars in good operating condition; ensuring the parking lots and walk ways are sanded and free of snow and ice; cutting the grass; keeping the boiler plants and air conditioning units operating effectively; and undertaking certain repairs and alterations to the buildings to keep them in good condition.

Construction of new or replacement facilities are paid for under the Major Construction or Minor Construction appropriations. See Volume 4 for additional detail.

When VA's discretionary appropriation, mandatory appropriation, and cancellation and transfer requests are combined with available reimbursements and other net unobligated balances, Medical Facilities will meet the projected 2024 obligation level of $14.3 billion, as detailed in the tables below.

Each section below details the operations of each of the account's 11 programs.

Engineering and Environmental Management Services

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations [Subtotal]	**$801,181**	**$919,548**	**$827,650**	**$1,245,577**	**$1,395,577**	**$417,927**	**$150,000**
Veterans Medical Care and Health Fund	$86,525	$317,200	$264,531	$0	$0	($264,531)	$0
VACAA, sec. 801	$490	$163	$518	$539	$0	$21	($539)
Mandatory Obligations [Subtotal]	**$87,015**	**$317,363**	**$265,049**	**$539**	**$0**	**($264,510)**	**($539)**
Obligations [Total]	**$888,196**	**$1,236,911**	**$1,092,699**	**$1,246,116**	**$1,395,577**	**$153,417**	**$149,461**

Engineering and Environmental Management Services are associated with personal services and other costs associated with the oversight and management of engineering activities; fire and safety engineering activities; project engineers, resident engineers, drafters, technicians, construction inspectors and clerical employees and all supplies and materials needed for preparation of specifications and drawings and contractual service cost for recurring projects; fleet, green and energy managers for related studies and activities.

Engineering Service

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations [Subtotal]	**$996,085**	**$1,227,419**	**$1,189,964**	**$1,444,823**	**$1,611,472**	**$254,859**	**$166,649**
Veterans Medical Care and Health Fund	$135,963	$75,000	$75,000	$0	$0	($75,000)	$0
VACAA, sec. 801	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$135,963**	**$75,000**	**$75,000**	**$0**	**$0**	**($75,000)**	**$0**
Obligations [Total]	**$1,132,048**	**$1,302,419**	**$1,264,964**	**$1,444,823**	**$1,611,472**	**$179,859**	**$166,649**

Engineering Service is associated with personal services and other costs associated with the oversight and management of environmental management activities, including the recycling operations; pest management operations; polytrauma equipment upgrades; bed services and patients' assistance programs; removal and transportation of all waste materials.

Grounds Maintenance and Fire Protection

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations [Subtotal]	**$132,579**	**$138,910**	**$156,858**	**$178,197**	**$182,296**	**$21,339**	**$4,099**
Veterans Medical Care and Health Fund	$3,010	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$3,010**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$135,589**	**$138,910**	**$156,858**	**$178,197**	**$182,296**	**$21,339**	**$4,099**

Grounds Maintenance and Fire Protection costs are associated with the maintenance of roads, walks, parking areas and lawn management, as well as personal services and other costs associated with fire truck operation, supplies and materials.

Leases

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations [Subtotal]	**$971,803**	**$1,498,840**	**$1,493,425**	**$1,515,753**	**$1,700,000**	**$22,328**	**$184,247**
Veterans Medical Care and Health Fund	$85,380	$0	$0	$0	$0	$0	$0
PACT Act, sec. 705	$0	$0	$0	$0	$0	$0	$0
PACT Act, sec. 707	$0	$0	$50,281	$786,724	$265,223	$736,443	($521,501)
VACAA, sec. 801	$4,067	$1,160	$6,575	$3,252	$0	($3,323)	($3,252)
Mandatory Obligations [Subtotal]	**$89,447**	**$1,160**	**$56,856**	**$789,976**	**$265,223**	**$733,120**	**($524,753)**
Obligations [Total]	**$1,061,250**	**$1,500,000**	**$1,550,281**	**$2,305,729**	**$1,965,223**	**$755,448**	**($340,506)**

Leases can have many functions, including clinical space for CBOCs; administrative workspace for Veterans' support; research; and warehouses for storage of supplies and equipment, all in direct or indirect support of the operational needs of the local medical center. Leases complement the portfolio of VA-owned medical facilities and provide additional flexibility in providing services to Veterans in the right place and at the right time.

The 2024 request seeks Congressional Committee approval for ten major leases. The new VA's Strategic Capital Investment Planning (SCIP) major lease request consists of two new leases and eight replacement leases in 2024. See Volume 4 for additional detail.

VA uses both in-house Lease Contracting Officers and the General Services Administration (GSA) to procure medical facility space and administrative space for VA use. When VA procures the lease, it is through a delegation that is granted on a lease-by-lease basis by GSA. These leases are critical to meeting Veterans' needs by allowing VA to operate clinics or other necessary services close to Veteran populations while maintaining flexibility, so these points of service can be relocated or resized on a regular basis due to shifting demographic trends.

Non-Recurring Maintenance (NRM)

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations - All Other	$1,228,408	$2,443,698	$2,339,646	$5,750,000	$995,000	$3,410,354	($4,755,000)
Discretionary P.L. 115-141 sec. 255	$84,739	$0	$30,667	$0	$0	($30,667)	$0
Discretionary P.L. 115-244 sec. 248	$196,925	$61,302	$139,162	$0	$0	($139,162)	$0
Discretionary RETF Obligations 1/	$0	$0	$75,000	$0	$0	($75,000)	$0
Discretionary Obligations [Subtotal]	**$1,510,072**	**$2,505,000**	**$2,584,475**	**$5,750,000**	**$995,000**	**$3,165,525**	**-$4,755,000**
Veterans Medical Care and Health Fund	$1,353,001	$0	$432,525	$0	$0	($432,525)	$0
VACAA, sec. 801	($129)	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,352,872**	**$0**	**$432,525**	**$0**	**$0**	**($432,525)**	**$0**
Obligations [Total]	**$2,862,944**	**$2,505,000**	**$3,017,000**	**$5,750,000**	**$995,000**	**$2,733,000**	**($4,755,000)**
Non-Add (Included Above)							
Discretionary Obligations - Base NRM	$1,510,072	$2,000,000	$2,079,475	$5,000,000	$700,000	$2,920,525	($4,300,000)
Mandatory Obligations - Base NRM	$597,650	$0	$0	$0	$0	$0	$0
Discretionary Obligations - EHRM NRM	$0	$505,000	$505,000	$750,000	$295,000	$245,000	($455,000)
Mandatory Obligations - EHRM NRM	$755,222	$0	$432,525	$0	$0	($432,525)	$0
Base NRM/EHRM NRM Obligations [Subtotal]	**$2,862,944**	**$2,505,000**	**$3,017,000**	**$5,750,000**	**$995,000**	**$2,733,000**	**($4,755,000)**

Note: The 2022 NRM actual in the above table includes additional object classes than what is displayed in the Budget Overview chapter's Obligations by Object table, such as Personnel Compensation and benefits, Other Contractual Services, Supplies & Materials and Equipment.

1/ P.L. 117-328, the Consolidated Appropriations Act, 2023 made $75 million in the Recurring Expenses Transformational Fund (RETF) available for NRM.

Non-recurring maintenance program funds additions, alterations and modifications to land, buildings, other structures, nonstructural improvements of land and fixed equipment (when the equipment is acquired under contract and becomes permanently attached to or part of the building or structure) to maintain and modernize existing campus facilities, buildings and building systems; replace existing building system components; provide for adequate future functional building system capacity without constructing any new building square footage for functional program space; and/or provide for environmental remediation and abatement and building demolition.

VHA uses the NRM program as its primary means of addressing its most pressing infrastructure needs as identified by Facility Condition Assessments. These assessments are performed at each facility every three years and highlight a building's most pressing and mission critical repair and maintenance needs. VHA specifically supports research and development infrastructure projects by ensuring that the Office of Research and Development is involved in the identification of gaps to support the SCIP process. This inclusion ensures a research focus for mitigation within a ten-year window of identified research infrastructure deficiencies.

VHA projects obligations of $750 million in Electronic Health Record Modernization (EHRM) related NRM in 2024, an increase of $245 million from the 2023 President's Budget request of $505 million and in alignment with the current EHRM implementation schedule. The 2022 Non-Recurring Maintenance actual related to EHRM was $755 million.

NRM projects are broken into three categories, as discussed and defined below.

Sustainment projects:

NRM sustainment projects involve the provision of resources that will convert functional space to a different program function within existing buildings or spaces, without adding any new space. Each sustainment project must be equal to, or less than, the amount outlined in title 38, United States Code, section 8104 (currently $20 million). The total project cost includes all amounts and expenditures associated with design, impact, contingency, and construction costs.

Infrastructure Modernization projects:

NRM infrastructure modernization projects involve the provision of resources to repair, modernize, replace, renovate and provide for new "building systems," and do not convert functional space to a different program function. Such projects have no project cost limitation; however, any work to be done beyond the underlying building system must be ancillary to the overall total project cost (not exceed 25% of the total project cost). The overall total project cost includes all amounts and expenditures associated with design, impact, contingency and construction costs. The 2024 and 2025 Advance Appropriations request supports continued implementation of EHRM with $750 million in 2024 and $295 million in 2025 for NRM projects that will support infrastructure modifications at VA facilities that are necessary prerequisites to the completion of the Initial Operating Capacity phase and broader nationwide rollout.

The types of "building systems" permitted for NRM infrastructure projects consist of the following: building thermal and moisture protection; doors and windows; interior finishes only directly related with building system work; conveyance and transport systems; fire suppression; plumbing; heating, ventilation and air conditioning; electrical systems; communication systems; safety and security systems; utility systems, boiler plants, chiller plants, water filtration and treatment plants, cogeneration plants, central energy plants, elevator towers, connecting corridors and stairwells.

Clinical Specific Initiative Projects:

Clinical Specific Initiative (CSI) projects are emergent projects that cannot be planned due to dynamic health care environments. Associated funding for these projects is distributed to the VISNs at the beginning of each year, to obligate towards existing clinical building space and address workload gaps, or support access within the following VHA high-profile categories:

- Women's Health
- Mental Health
- High-Cost/High Tech Medical Equipment Site Prep/Installations
- Reduce the Footprint Reduction (includes building demolition or conversion of under-utilized space to clinical functions)

- Donated Building Site Preparation (e.g., Fisher House) when constructed on VHA land
- Other Emergent Need Categories may be added to CSI program based on direction from the Under Secretary for Health.

*For CSI projects, only high-cost/high-tech medical equipment site prep/installation projects may involve the construction of new program functional building space.

Operating Equipment Maintenance and Repair

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations [Subtotal]	**$351,902**	**$398,495**	**$441,454**	**$503,971**	**$515,562**	**$62,517**	**$11,591**
Veterans Medical Care and Health Fund	$26,129	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$26,129**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$378,031**	**$398,495**	**$441,454**	**$503,971**	**$515,562**	**$62,517**	**$11,591**

Operating Equipment Maintenance and Repair costs are associated with maintenance and repair of all non-expendable operating equipment, furniture, and fixtures, when performed by maintenance personnel or procured on a contractual basis, including rental equipment.

Other Facilities Operation Support

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations [Subtotal]	**$45,813**	**$122,660**	**$65,481**	**$73,802**	**$75,499**	**$8,321**	**$1,697**
Veterans Medical Care and Health Fund	$11,590	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$46	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$11,636**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$57,449**	**$122,660**	**$65,481**	**$73,802**	**$75,499**	**$8,321**	**$1,697**

This function includes other costs associated with inpatient and outpatient providers and miscellaneous benefits and services.

Plant Operations

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations [Subtotal]	**$890,157**	**$970,901**	**$1,115,862**	**$1,274,587**	**$1,303,903**	**$158,725**	**$29,316**
Veterans Medical Care and Health Fund	$64,384	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$64,384**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$954,541**	**$970,901**	**$1,115,862**	**$1,274,587**	**$1,303,903**	**$158,725**	**$29,316**

Plant Operations support all the basic functions of the hospitals and medical clinics. Examples of these activities include the purchase of utilities, such as water, electricity, steam, gas and sewage; general operations supervision; and operation of emergency electrical power systems, elevators, renewable energy; and all plant operations.

Recurring Maintenance and Repair

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations [Subtotal]	**$710,058**	**$698,290**	**$837,273**	**$945,454**	**$967,199**	**$108,181**	**$21,745**
Veterans Medical Care and Health Fund	$21,550	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$397	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$21,947**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$732,005**	**$698,290**	**$837,273**	**$945,454**	**$967,199**	**$108,181**	**$21,745**

Recurring Maintenance and Repair services encompass all projects where the minor improvement is below $25,000, such as maintenance service contracts and routine repair of facilities and the upkeep of land. Examples include painting interior and exterior walls, the repair of water leaks in pipes and roofs and the replacement of light bulbs, carpet, ceiling and floor tiles.

Textile Care Processing and Management

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations [Subtotal]	**$223,395**	**$234,051**	**$260,572**	**$294,247**	**$301,015**	**$33,675**	**$6,768**
Veterans Medical Care and Health Fund	$4,066	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$340	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$4,406**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$227,801**	**$234,051**	**$260,572**	**$294,247**	**$301,015**	**$33,675**	**$6,768**

Textile Care Processing and Management include the receipt, washing, drying, dry cleaning, folding and the return of textiles such as bed linens, surgical towels and nursing uniforms. Processing also involves the activities concerning maintenance and repair of textile processing equipment. Textile management activities include the procurement, inventory, delivery, issuance, repair and marking of various types of textiles contained within the facility.

Transportation Services

Description (dollars in thousands)	2022 Actual	2023 Budget Estimate	2023 Current Estimate	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Discretionary Obligations [Subtotal]	**$219,325**	**$244,144**	**$267,581**	**$305,827**	**$312,861**	**$38,246**	**$7,034**
Veterans Medical Care and Health Fund	$9,304	$0	$0	$0	$0	$0	$0
VACAA, sec. 801	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$9,304**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$228,629**	**$244,144**	**$267,581**	**$305,827**	**$312,861**	**$38,246**	**$7,034**

Transportation Services include the costs to operate facilities' motor vehicles, including the purchase and operation of VA vans and buses, facility maintenance vehicles and the clinical motor vehicle pool operations.

Actuarial Model Projections

Models Used to Inform the Budget Request

The Department of Veterans Affairs (VA) uses three actuarial models to support formulation of the majority of the VA health care budget, to conduct strategic and capital planning, and to assess the impact of potential policies and changes in a dynamic health care environment. The three actuarial models are the VA Enrollee Health Care Projection Model (EHCPM), the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) Model, and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) Model.

Activities and programs that are not projected by any of these three models are called "non-modeled" and can change from year to year. In general, they include non-recurring maintenance (NRM), community care network contract administration, state-based long-term services and supports programs (LTSS), readjustment counseling, recently enacted programs, some components of CHAMPVA programs (Camp Lejeune family member program, spina bifida, foreign medical program, children of women Vietnam Veterans), and some components for the PCAFC program (caregiver travel, VA oversight, administrative salaries, and contracts).

VA Enrollee Health Care Projection Model

The VA EHCPM supports approximately 84% of the VA medical care budget. The EHCPM, which was first developed in 1998, is a sophisticated health care demand projection model that uses actuarial methods and approaches to project Veteran demand for VA health care. These approaches are consistent with the actuarial methods employed by the Nation's insurers and public providers, such as Medicare and Medicaid.

The EHCPM projects enrollment, utilization, and expenditures for the enrolled Veteran population in more than 140 categories of health care services 20 years into the future. The EHCPM consists of three main components.

- **Enrollment.** VA uses the EHCPM to project how many Veterans will be enrolled in VA health care each year and their age, gender, priority level, and geographic location.

- **Utilization.** VA uses the EHCPM to project the total health care services needed by those enrollees and then estimates the portion of that care that those enrollees will demand from VA (known as "reliance").

- **Expenditures.** Total health care expenditures are developed by multiplying the expected VA utilization by the anticipated cost per service.

The projections are supported by extensive research and analyses of the Veteran enrollee population and the drivers of demand for VA health care. VA program, field, and research staff provide expertise on program strategies and initiatives, the unique needs of the enrollee population, and the VA health care system.

The 2022 EHCPM (Base Year 2021), was used to build the 2024 and 2025 Medical Care budget request. Typically, the EHCPM is tied to the previous fiscal year's actual enrollment, utilization, and expenditures. However, 2020 and 2021 were impacted heavily by the COVID-19 pandemic and utilization, enrollment and expenditure patterns that existed in those years are not expected to remain in the long-term. Because of this, many EHCPM modeling assumptions were developed using data through 2019, rather than updated to use 2020 and 2021 experience. The temporary COVID impacts were modeled on top of this pre-COVID basis and adjusted in the projections as the effects of the pandemic are assumed to subside. Other persistent changes that emerged during 2020 and 2021 were also layered on the pre-COVID projection basis, though these remain past the assumed pandemic timeline. See additional details in the section "Impact of the 2022 EHCPM Update."

The expenditure basis used to build the EHCPM projections includes the Medical Services, Medical Community Care, Medical Support & Compliance, and Medical Facilities appropriations, but excludes non-recurring maintenance. The projections include all care provided in VA facilities (direct care) or paid for by VA (community care).

Key Drivers of Growth in Projected Resource Requirements

In projecting future Veteran demand for VA health care, the EHCPM accounts for the unique characteristics of the Veteran population and the VA health care system, as well as environmental factors that impact Veteran enrollment and use of VA health care services.

Historically, growth in expenditure requirements to provide care to enrolled Veterans was primarily driven by health care trends, the most significant of which is medical inflation. Health care trends are key drivers of annual cost increases for all health care providers – Medicare, Medicaid, commercial providers, and the VA health care system. Health care trends increase VA's cost of care independent of any growth in enrollment or demographic mix changes. Enrollment dynamics contribute to a portion of the expenditure growth; however, their impact varies significantly by the type of health care service. An assumption that VA's level of management in providing health care will improve over time reduces the cost of providing care to enrollees.

Since its implementation in June 2019, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act impacted the VA health care system by driving growth in the use of VA health care services. The 2022 EHCPM incorporated the actual experience and projected impact of the MISSION Act, including changes to eligibility to receive care in the community based on geographic access standards (including grandfathered Veterans Choice and Accountability (Choice) Act of 2014 enrollees), best medical interest provision, wait time standards, and urgent and emergency care benefits.

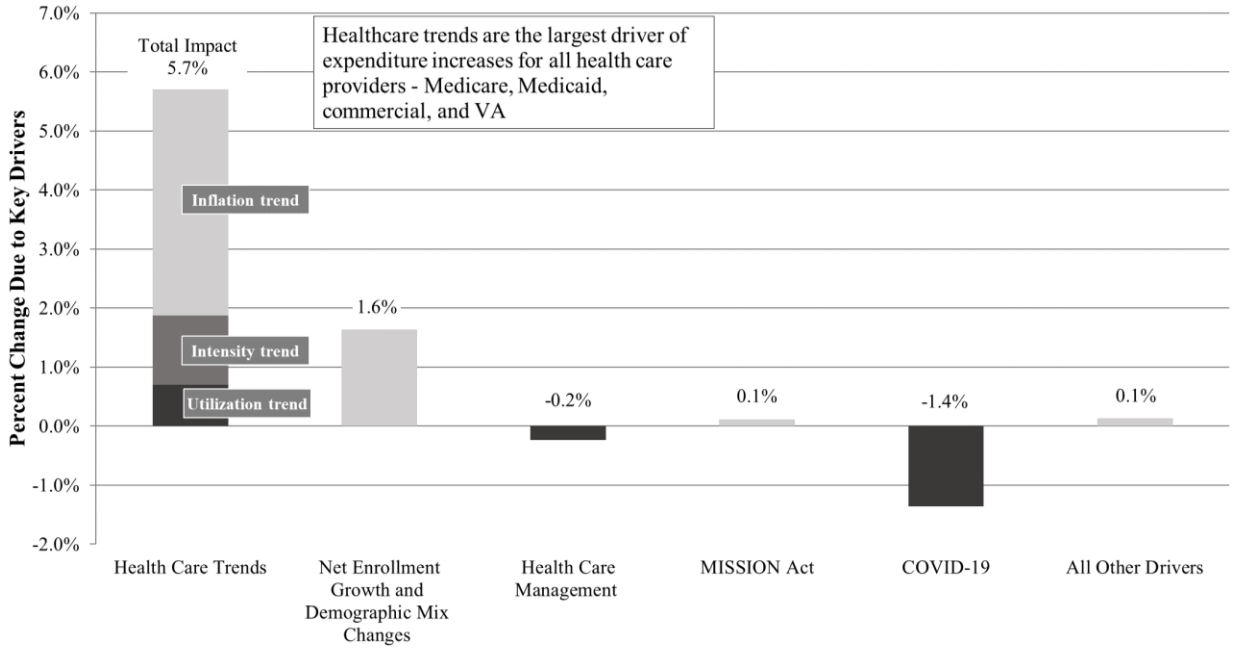
The MISSION Act policies continue to drive increases in services available in both VA facilities and the community, particularly the use of outpatient primary and specialty care and inpatient care. The MISSION growth assumptions were increased and extended in the 2021 EHCPM to reflect

higher than anticipated growth in community care workload in 2020 and 2021, and continue to remain elevated in the 2022 EHCPM.

The COVID-19 pandemic continued to have a significant impact on VA health care through 2021. During the pandemic, nationwide health care utilization saw a reduced amount of care provided in 2020 and 2021 as individuals chose to defer certain care. It was anticipated that less care was deferred in 2022 and that care previously deferred started to return in 2021, and will continue to do so through 2023.

Figure A quantifies the key drivers of the projected increase in expenditure requirements for 2024 for all modeled services. Health care trends, net enrollment growth and demographic mix changes, and health care management and their impact on the resources required to provide health care to enrolled Veterans are discussed in detail in the following sections. MISSION Act and COVID-19 are discussed throughout the chapter.

Figure A. Key Drivers of Projected Expenditure Change, 2023 – 2024



- Scenario BAB1 Modeled Services
- MISSION impacts include provisions for geographic access, wait times, urgent care, and 14-day community care urgent prescription fills. Impacts for the MISSION standards for transplant policies are provided as national estimates and have not been incorporated in the 2022 EHCPM.
- The projections do not include requirements for several activities / programs that are not projected by the VA EHCPM, including administration cost for the Community Care Network contract, non-recurring maintenance, readjustment counseling, state-based long term services and supports programs, and some components of the Homeless program.

Health Care Trends

Health care trends represent a significant driver of growth in the cost of health care in the United States and in the VA health care system. Health care trends (inflation, utilization, and intensity) represent anticipated changes in health care utilization and cost due to advances in technology, including new diagnostics, drugs, and treatments, as well as price inflation. Health care trends increase VA's projected expenditure requirements independent of any enrollment growth or demographic mix changes. The health care trends incorporated into the EHCPM are informed by

federal policy and anticipated trends in Medicare, together with VA-specific trends for pharmacy and prosthetics, and private sector trends for community care.

Inflation is comprised of personnel and non-personnel components. Inflation on VA's personnel costs is determined by federal wage policy, including wage increases and freezes. VA's projected inflation for pharmacy and prosthetics products reflects VA's well managed purchasing programs for these products. VA's expected inflation on supplies, utilities, etc., is based on projected Consumer Price Index - Urban (CPI-U) and Producer Price Index (PPI) inflation trends for these items.

Utilization and intensity (cost) trends increase health care costs due to changes in health care practice and new technology. VA's costs are driven by these trends similar to other health care insurers and providers because Veterans expect access to these advances in the VA health care system. Utilization trends reflect expected changes in utilization of services due to changes in health care practice, such as updates to the clinical guidelines for preventive screenings. Intensity trends reflect changes in costs for services as technology advances; for example, the newer high-cost PCSK9 inhibitor drugs offer an alternative cholesterol management option for patients who do not respond well to less expensive conventional statin treatments, which increases VA's prescription drug costs.

VA's utilization and intensity trends for Medicare-covered medical services are informed by anticipated Medicare utilization and intensity trends, as projected by the Center for Medicare & Medicaid Services' Office of the Actuary. They have been adjusted downward for efficiencies in the VA health care system as compared to Medicare's primarily fee-for-service environment. VA's pharmacy and prosthetics trends are set by VA workgroups to reflect VA's unique practice patterns for these services.

Net Enrollment Growth and Demographic Mix Changes

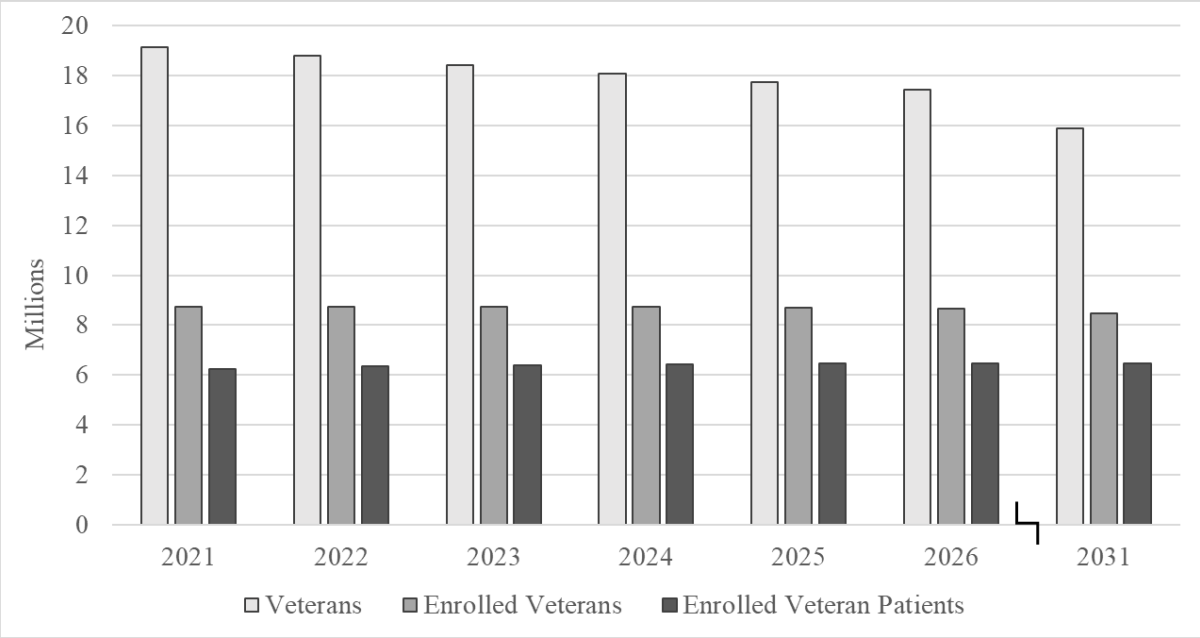
Veteran demand for VA health care is influenced by the following demographic characteristics of the Veteran population and environmental factors. Many of these factors are dynamic and are expected to change over time. Some can be anticipated (e.g., changing demographics) and some cannot (e.g., future economic downturns, pandemics, future military conflicts).

- Growth of the Post-9/11 Era Combat Veteran and female enrolled population.
- Enrollee age, gender, mortality, income, travel distance to VA facilities, and geographic migration patterns.
- Increases in prevalence of service-connected conditions and changes in enrollee income levels. These are associated with transitions between enrollment priorities.
- Health care utilization patterns of Post-9/11 Era Combat Veteran, female, disabled, new enrollees, and other enrollee cohorts with unique utilization patterns for particular services.
- Economic conditions, including changes in local unemployment rates and home values (as a proxy for asset values) over time.
- Policies, presidential executive orders, regulations, and new legislation, such as the

elimination of net worth from the VA Means Test, automatic income verification through tax records, expanding eligibility for Blue Water Navy Veterans, and MISSION Act.

Using current assumptions, the 2022 EHCPM has projected Veteran enrollment in VHA to decrease slightly from 2021 to 2031, even though the Veteran population is declining more quickly (Figure B).

Figure B. National Veterans, Enrollees, and Patients, 2021 -2031



Starting in 2020, unique enrollment has decreased with each year, and is expected to continue to decrease slightly each year. The overall Veteran population is expected to continue to decrease over time. High enrollment rates for Post-9/11 Era Combat Veterans and Gulf War Veterans are largely causing the decrease in enrollment to be less extreme than the decrease in the overall Veteran population. Enrollment is projected to continue to decline slightly as the impact of mortality in the enrollee population continues to outweigh new enrollment. As described below, costs for VA health care are dependent not just on the number of enrollees but on the demographics of the enrolled Veteran population.

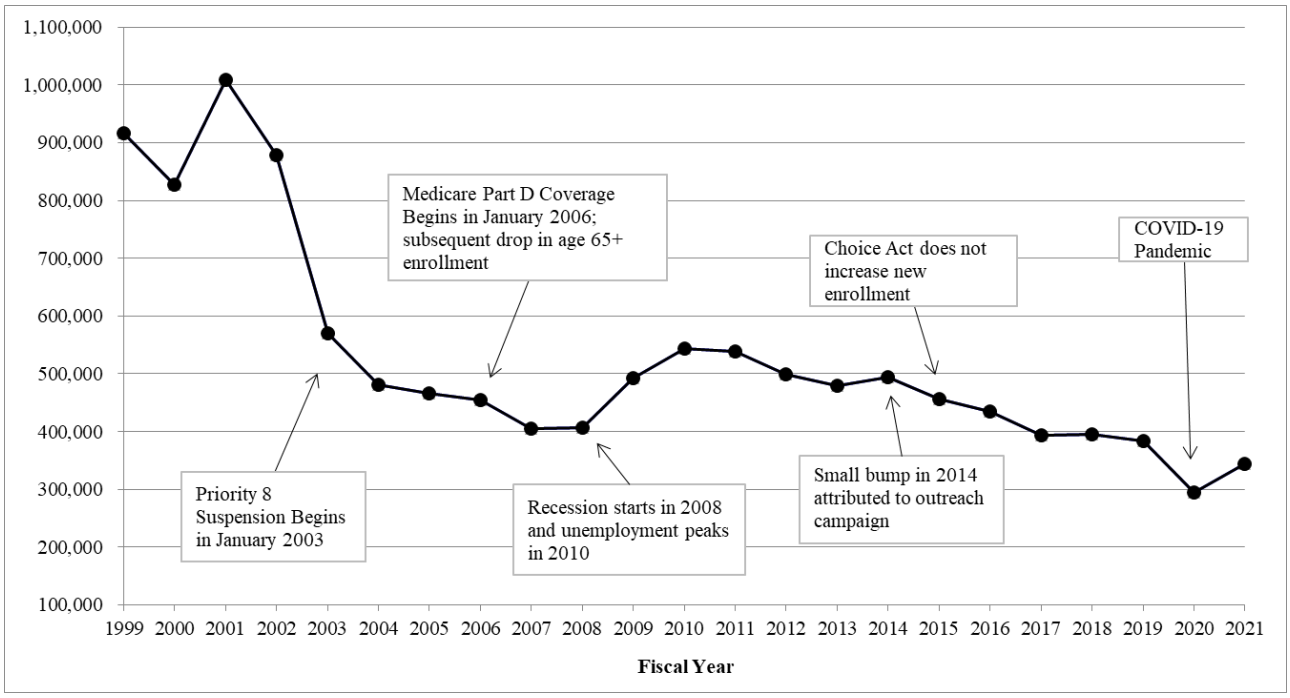
Veteran enrollment in VA is dynamic and responds to all of the demographic factors discussed above. Changes in the broader environment also impact Veterans' decisions to enroll. The lower new enrollment in 2007 and 2008 seen in Figure C was partially driven by the availability of the new Medicare drug benefit (Part D). The chart also shows the growth in new enrollment as a result of the 2008 economic recession and the decline in new enrollment as the economy recovered. The slight uptick in 2014 was driven by VHA enrollment outreach efforts related to the Affordable Care Act. Of note, it is sometimes difficult to ascertain causal impacts due to the multiple factors changing over any given time period.

As can be seen in Figure C, the new enrollment declined between 2015 and 2017. Thus, even in the Veterans Choice Act environment, greater than expected new enrollment was not the driver of the growth in enrollee use of VA health care. This growth was the result of current enrollees increasing

their reliance on VA versus their other health care options (Medicare, Medicaid, commercial insurance, etc.). See the section on Enrollee Reliance in this chapter for details.

The rate of new enrollment decreased significantly during the initial response to COVID-19 in 2020 and remained suppressed to varying degrees through 2021. However, rates for new enrollment are expected to increase and surpass pre-COVID-19 levels as pent-up demand for enrollment is fulfilled over time, returning to closer-to-normal levels by 2026.

Figure C. New Enrollment Over Time

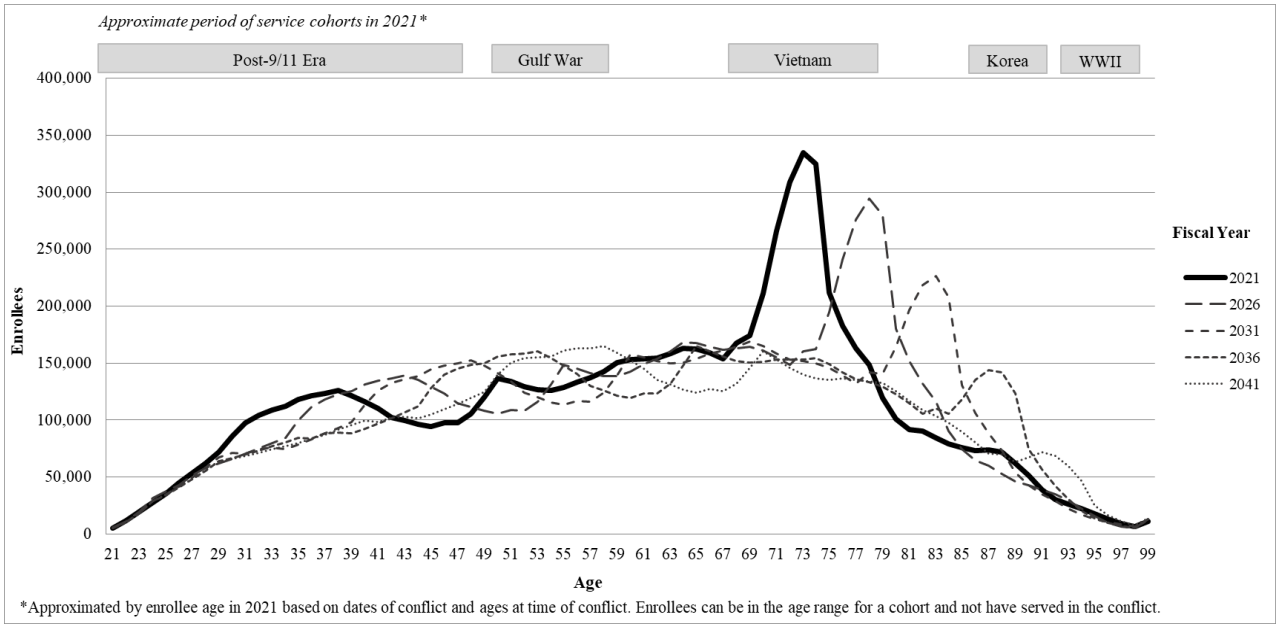


Net enrollment growth (new enrollment minus deaths) is not a significant driver of increases in annual expenditure requirements for VA health care. Enrollees who are dying are generally sicker and need more VA health care than new enrollees, so even modest increases in the number of enrollees can end up being budget neutral over the near term. However, the cost of caring for enrollees can change due to other demographic factors (e.g., priority transitions) and changes in the broader environment (e.g., economic recession).

Within the enrollee population, two dynamic demographic trends are impacting the projected future cost of VA health care more than other demographic factors: the aging of the Vietnam Era enrollee population and the increasing number of enrollees being adjudicated for service-connected disabilities, which increases the number of enrollees in Priorities 1, 2, and 3. These demographic trends combine in the Vietnam Era enrollee population with particular implications for demand for LTSS.

Figure D shows actual enrollment in 2021 and projected enrollment by age and highlights the relative size of the Vietnam Era enrollee cohort compared to other period-of-service cohorts.

Figure D. Enrollment by Age

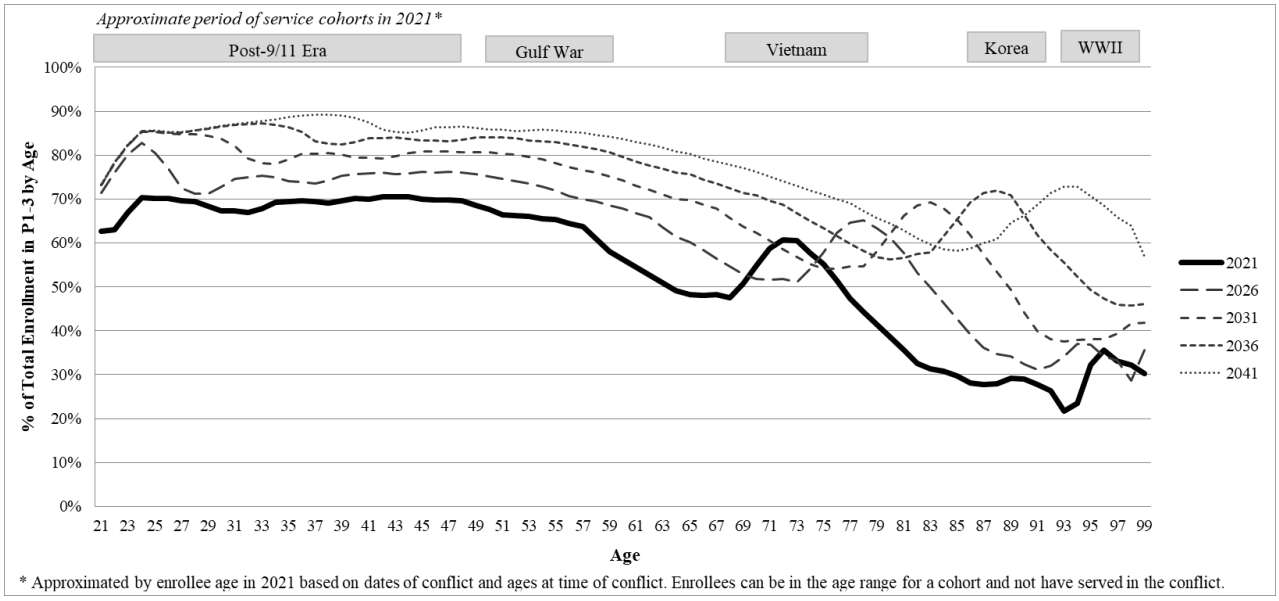


Aging has less of an impact on expenditures than might be expected because reliance on VA for health care decreases beginning at age 65 as enrollees become eligible for Medicare coverage (see section on Enrollee Reliance below). Although the large Vietnam Era enrollee cohort that has mostly become Medicare eligible magnifies this effect, enrollees who have become Medicare eligible more recently have shown a slightly lower decline in reliance than older enrollees. Aging is driving growth in LTSS, and other services generally not covered by private insurance or Medicare (e.g., hearing aids).

Veterans are enrolled in one of eight priority groups and/or sub-priority groups. The highest priority is Priority Group 1 and the lowest is Priority Group 8. See the "Veterans Enrollment Priority Group Definitions" section of the Budget Overview Chapter for more information. An enrollee's enrollment priority is dynamic. In recent experience, approximately 27% of new enrollees transitioned to a new priority level within three years of enrolling. Enrollees transition between Priorities 5, 7, and 8 due to changes in income. Enrollees also transition into Priorities 1,2, and 3 as a result of adjudication for service-connected disabilities by the Veterans Benefits Administration (VBA). The number of enrollees being adjudicated for service-connected disabilities has escalated in recent years. This is largely a result of the scope and definitions of service-connected conditions broadening over time and the improved capture of service-connected conditions at the time of military separation. These enrollees are expected to increase their reliance on VA health care, resulting in an increase in VA medical care costs.

Figure E shows the significant projected growth in service-connected status for Post-9/11 Era Combat Veteran, Gulf War, and Vietnam enrollee populations over the next 20 years. As a result of the increasing numbers of enrollees moving into Priorities 1-3, projected enrollment is declining in Priorities 5, 7, and 8.

Figure E. Percent of Enrollees in Priority 1-3, by Age



As a result of the previously mentioned trend of enrollees being adjudicated to higher service-connected priorities, as of 2021, 7% of enrollees had transitioned into Priority 1a (70% or higher service-connected disability) over the previous three years, compared with 4% as of 2011. The Priority 1a population is projected to continue to grow by 18% between 2021 and 2024 and by 53% between 2021 and 2031.

Aging and the changes in the Priority 1a population are significant drivers of projected expenditure increases for LTSS. VA is mandated by law to provide continuing care nursing home services to Priority 1a enrollees. Additionally, World War II and Korean War era enrollees are in the age bands (greater than age 85) that are the highest users of LTSS and are driving the recent and near-term annual growth in LTSS expenditure requirements, and Vietnam Era Veterans will be an increasing driver of LTSS expenditures, with most having aged beyond age 75 by 2026.

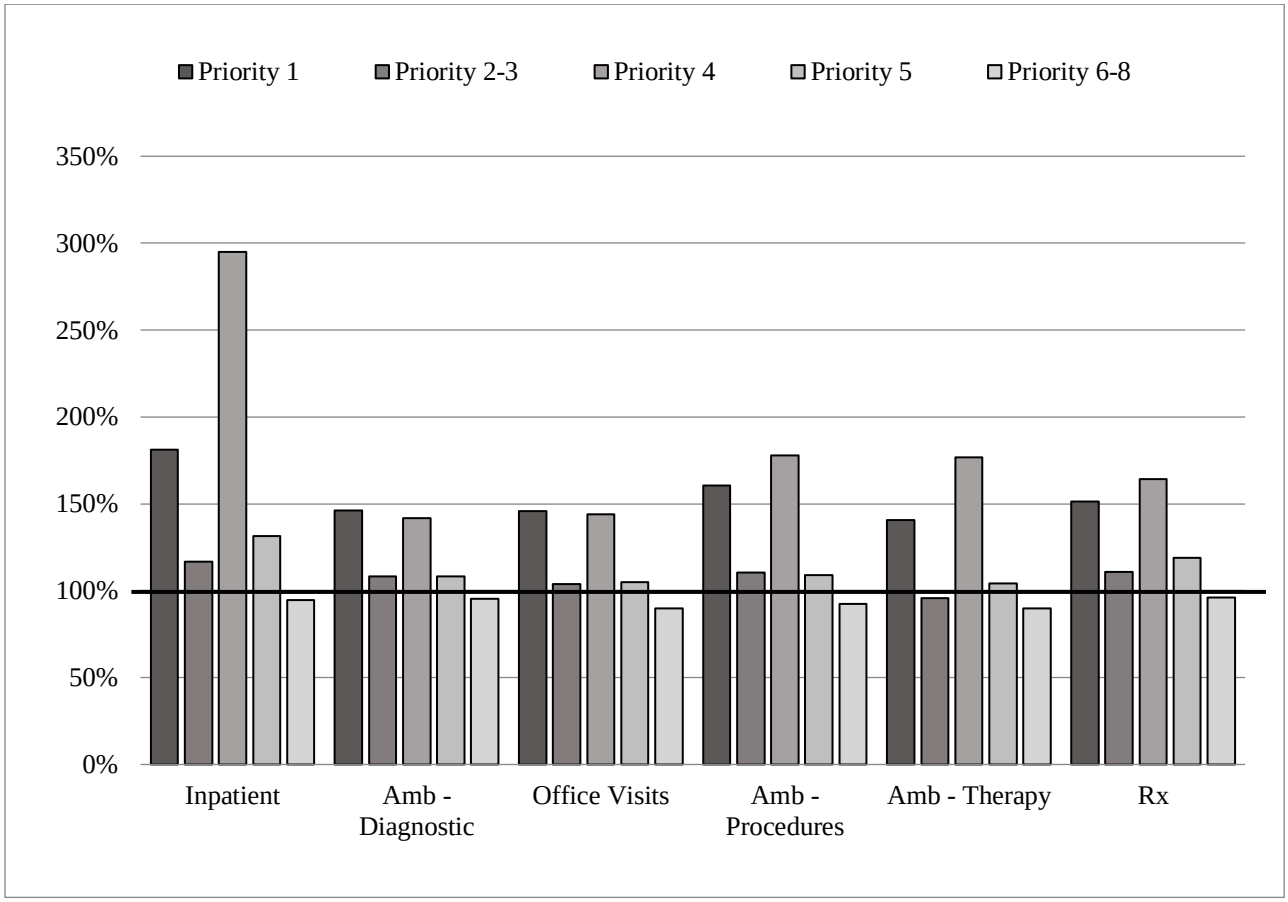
Enrollee Morbidity

The VA enrollee population consists largely of older males, which is typically the segment of the population with the highest health care costs. Even after accounting for the age and gender mix of the enrollee population, the VA enrollee population is significantly more morbid (sicker) than the general population in the U.S., and this higher morbidity further increases VA's cost of providing care.

Using a diagnosis-based methodology, the average morbidity of the VA enrollee population is estimated to be approximately 31% higher than that of the general U.S. population. This analysis is corroborated by the 2021 VA Survey of Veteran Enrollees' Health and Use of Health Care which shows that 26% of enrollees rated their health as "fair" or "poor" compared to other people their age. Only 14% of the U.S. adult population responded similarly in Centers for Disease Control's (CDC) National Center for Health Statistics' 2021 National Health Interview Survey. Similarly, 38% of enrollees rated their health as "excellent" or "very good" compared to approximately 59% of the U.S. population in the CDC survey.

Morbidity varies significantly by priority level and health care service. For example, the morbidity of Priority 4 (catastrophically disabled) enrollees results in inpatient care costs that are nearly three times that of the general U.S. population, even after accounting for the age and gender differences in the populations. Figure F shows the relative morbidity of enrollees by priority compared to the general population for several large categories of health care services. In the figure, 100% reflects the cost of health care based on the morbidity of the general U.S. population.

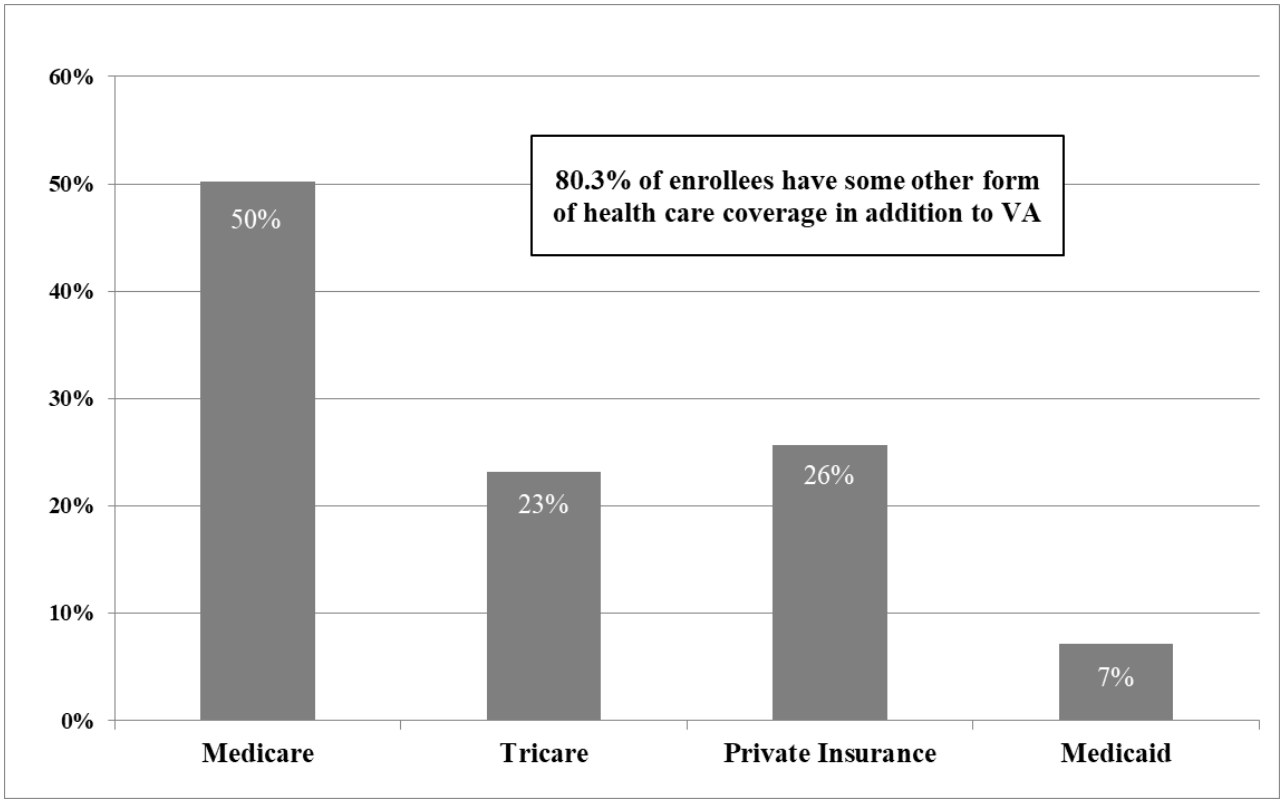
Figure F. Relative Morbidity of Veteran Enrollees vs. General Population



Enrollee Reliance on VA Health Care

Reliance refers to the portion of an enrollee's total health care needs that VA will provide either at VA facilities or purchase in the community. A unique aspect of the enrolled Veteran population is that enrollees have many options for health care coverage in addition to VA: Medicare, Medicaid, TRICARE, Indian Health Service, and private insurance. According to the VHA Survey of Enrollees, in 2021 approximately 80% of enrollees had one or more other sources of public or private health care coverage in addition to VA (Figure G).

Figure G. Enrollee Insurance Coverage



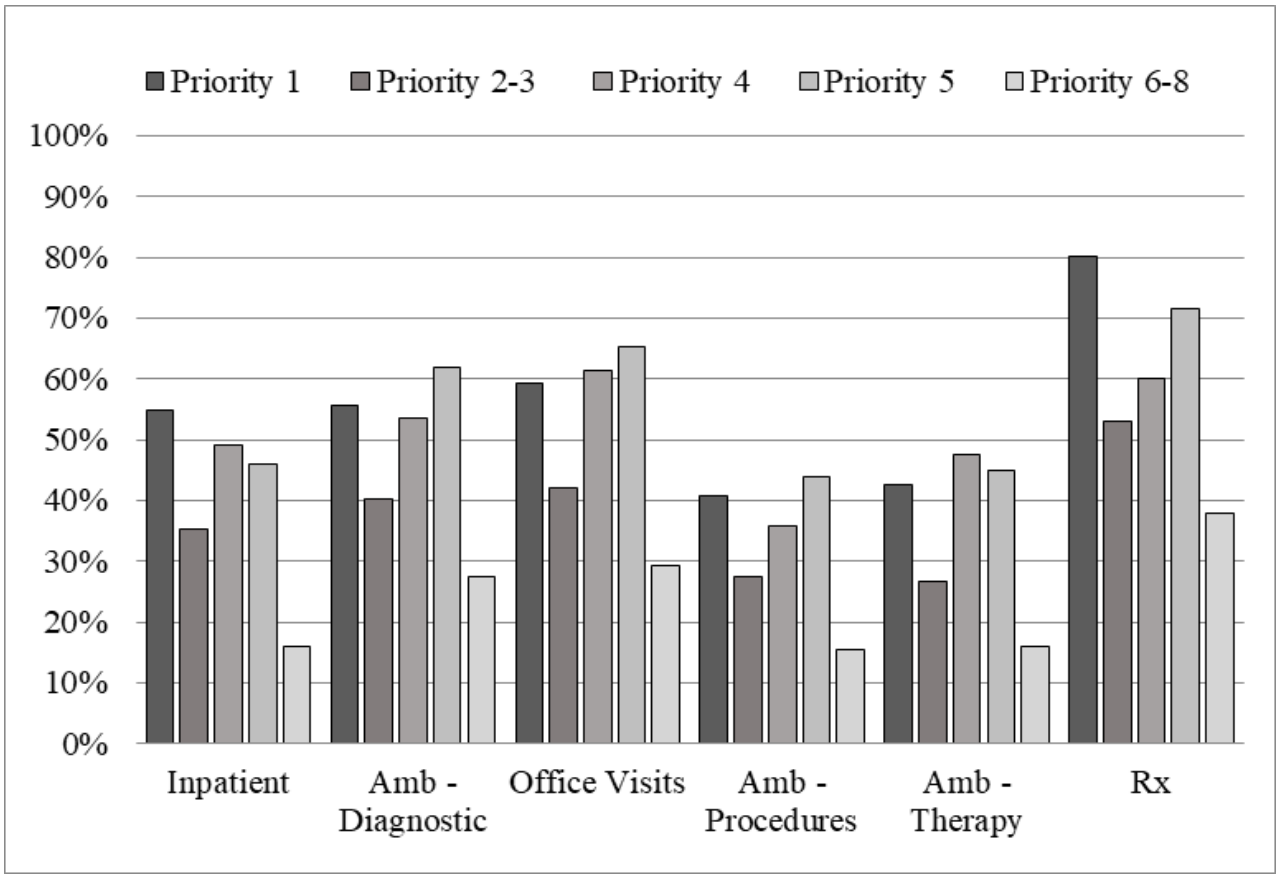
As a result, most enrollees do not use VA as their sole source of health care. On average, enrollees rely on VA for only 44% of their health care needs (excluding LTSS). This represented $92 billion in 2021. If the Veterans enrolled in 2021 had chosen to receive all of their health care in VA (100% reliance), this would have required an additional $122 billion for a total of $214 billion in 2021.

Like Veteran enrollment and demographics, enrollee reliance on VA health care is dynamic. Changes in enrollee reliance occur as a result of many factors: enrollee movement into service-connected priorities; changing economic conditions; VA's efforts to provide Veterans access to the services they need (e.g., mental health and homeless initiatives); VA's efforts to enhance its practice of health care; the opening of new or expanded facilities; the cost sharing associated with services (e.g., dialysis) in the private sector compared to VA.

In the past few years, the Veterans Choice Act and MISSION Act have significantly expanded enrollee access to care in the community paid for by VA, thus increasing their overall reliance on VA health care. VA expects this impact to continue as enrollees continue to get more of their care through VA versus their other health care options. Additionally, enrollees have exhibited a "generational shift" in their reliance on VA, slowly increasing reliance on VA over time for both VA direct care and community care. For example, enrollees aged 65-69 in 2021 had, on average, higher reliance than enrollees aged 65-69 in 2017. Similar community care growth is attributed to the generational shift as well. VA expects this impact to continue as younger (and more reliant) enrollees age and older (and less reliant) enrollees leave VA.

Figure H shows reliance by priority for several large categories of health care services. For example, Priority 4 enrollees get approximately 49% of the inpatient care they need in VA.

Figure H. Reliance of Veteran Enrollees



Enrollee Cohorts

Within the enrollee population, several cohorts of enrollees exhibit unique health care utilization patterns that reflect their morbidity and/or reliance on VA health care. These include Post-9/11 Era Combat Veteran, enrollees Pre, post-Vietnam Era, Vietnam Era, World War II Era, and female enrollees.

- Post-9/11 Era Combat Veteran enrollees have different utilization rates than non-Post-9/11 Era Combat Veteran enrollees of the same age for many services. For some services, the difference is attributable to the higher utilization rates typically experienced by new enrollees, and therefore, is not expected to persist over time. Post-9/11 Era Combat Veterans represented 22% of the enrollee population in 2021 and are expected to grow to 27% in 2031.
- Enrollees who used VA prior to the Eligibility Reform Act of 1996 (enrollees Pre) differ from those who enrolled after (enrollees Post). Enrollees Pre are both sicker and more reliant on VA for health care and therefore, have higher utilization rates. These higher utilization rates are observed even after accounting for the higher average age of the enrollees Pre. Enrollees Pre represented only 13% of enrollees in 2021 but accounted for 26% of modeled expenditures. Since there are no new enrollees Pre, this group is declining over time due to mortality; enrollees Pre are projected to decline to 8% of the population by 2031, but still

account for 16% of expenditures.

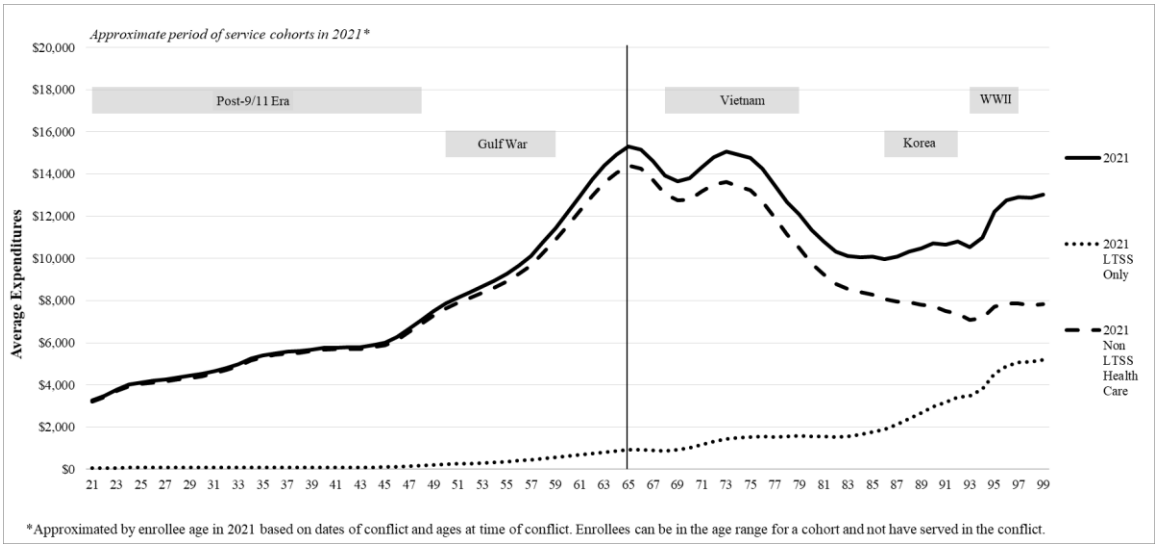
- Enrollees who served immediately after Vietnam have the highest health care utilization relative to other enrollees when they were at the same age. These enrollees exhibit higher than expected needs for many mental health and substance abuse services. This cohort represents about 18% of the enrollee population in 2021.
- Younger Vietnam Era enrollees represent a cohort that has largely aged into Medicare eligibility with a corresponding drop in reliance on VA health care. As they age and transition into Priority 1a, Vietnam Era enrollees are expected to be significant users of LTSS. Vietnam Era enrollees represent 29% of the enrollee population in 2021.
- World War II Era enrollees are high utilizers of LTSS, since those services are typically provided to older enrollees. This cohort represents about 1% of overall enrollment in 2021.
- Women are one of the fastest growing enrollee cohorts. Women comprised close to 10% of the enrollee population in 2021 and are expected to grow to 13% by 2031. Women tend to use more health care than men at younger ages and fewer services than men at older ages. Female enrollees also use a different mix of services than the historically male-dominated enrollee population. For example, women are more likely to use physical therapy and preventive services, but less likely to use dermatological services.

Expenditure Requirements by Enrollee Age

As discussed, many demographic and environmental factors influence Veteran demand for VA health care and the resources required to provide that care. Some of these factors increase VA's resource requirements and some decrease VA's resource requirements. Figure I shows the net impact of all the factors on expenditures.

In Figure I, the actual 2021 expenditures by age highlight the impact of key factors influencing the cost per enrollee. For the under age 65 enrollee population, the figure shows the impact of the increase in the need for health care services as enrollees age. It also highlights how the impact of aging is mitigated by a decline in reliance on VA health care beginning at age 65 when enrollees typically become eligible for Medicare. Enrollees who have become Medicare eligible more recently have shown a slightly lower decline in reliance than older enrollees. Expenditures per enrollee increase again beginning at age 70, attributed to the higher proportion of Priority 1 enrollees among the Vietnam era period of service. The impact of providing LTSS to enrollees (services that are generally not covered by Medicare) on expenditures by age is also illustrated.

Figure I. Average Expenditures per Enrollee by Age



Health Care Management and Dynamics of the VA Health Care System

The VA health care system is continually evolving due to VA's efforts to enhance its practice of health care, provide Veterans access to the services they need, and improve its level of health care management.

The EHCPM includes assumptions for initiatives to increase capacity for mental health, homeless services, and LTSS. These initiatives are discussed in the service-specific sections.

The EHCPM also includes assumptions that VA's level of management in providing health care will improve over time and reduce the cost of providing care to enrollees. The majority of these efficiencies result from improvements in VA's level of management in inpatient care. The future improvements are expected to result from a wide range of activities that collectively improve VA's level of management, including:

- Improved coordination of care as a result of Patient Aligned Care Teams (PACT), expansion of home telehealth services, and other disease management activities that result in reductions in hospitalizations for ambulatory care sensitive conditions
- A focus on creating alternative services, such as intensive outpatient mental health programs, support services, and alternative locations of care
- VHA's well-established inpatient system redesign initiative
- Admission appropriateness and continued stay reviews through the National Utilization Management Initiative

Assumptions for improvement in VA's level of health care management may increase or decrease ambulatory utilization projections depending on the service. Generally, well-managed organizations provide more preventative services and fewer diagnostic services. Improvements in management may also reduce the projected growth in utilization for inpatient acute bed days and admissions.

Expenditure Requirements by Service Category

The following sections discuss the non-MISSION Act key drivers of increases in expenditure requirements for categories of health care services in a non-COVID-19 environment. The MISSION Act policies are driving increases in services available in both VA facilities and the community, particularly the use of outpatient primary and specialty care and inpatient care.

Ambulatory Primary and Specialty Care

Ambulatory care projections are developed forthe full range of services provided under a typical private sector health plan (e.g., office visits, radiology, pathology, surgeries) as well as specialized services offered by VA (e.g., nutritional counseling, hearing aid services, recreational therapy). These services are broadly classified into Diagnostics, Evaluation and Management Services (includes primary care and specialty care office visits), Professional Services and Procedures, and Therapies.

Expenditures required to provide ambulatory care services to enrolled Veterans are expected to grow in both 2024 and 2025. The projected increase in ambulatory care expenditures is largely due to the impact of health care trends. VA's cost of providing ambulatory services is expected to increase due to inflation and changes in health care practice that increase the cost per service (intensity trends). Further, utilization of ambulatory care is expected to grow due to changes in health care practice independent of any changes in enrollee demographics. For example, utilization of ambulatory surgery and the cost per service of ambulatory surgeries is expected to increase as more complex surgeries are provided in the ambulatory environment.

Changes in enrollee demographics are also driving increases in annual expenditure

Modeled Ambulatory Primary and Specialty Care

Diagnostics

- Cardiovascular
- Colonoscopy
- Dermatology Services and Diagnostic Exams
- Hearing and Speech Exams
- Miscellaneous Medical Services and Diagnostics
- Non-Invasive Vascular Studies
- Ophthalmology Services and Diagnostic Exams
- Pathology
- Pulmonology Services, Diagnostic Exams, and Ventilator Management
- Radiology – CT
- Radiology – General
- Radiology – MRI
- Radiology – Mammography Diagnostic
- Radiology – Mammography Screening
- Radiology – Nuclear Medicine
- Radiology – PET and PET/CT
- Radiology – Radiation Oncology
- Radiology – Ultrasound
- Vision Exams

Evaluation and Management Services

- Office Visits, including Physical Exams, Urgent Care Visits, and Telephone Care Visits
- Compensation & Pension Exams (only those provided in VA facilities)
- Outpatient Medication Therapy Management
- Case Management – Rehabilitation

Professional Services and Procedures

- Ambulance
- Ambulatory Surgery - Ambulatory Surgery Center Setting
- Ambulatory Surgery - Office Setting
- Ambulatory Surgery - Outpatient Setting
- Emergency Room Visits
- Eye Glasses Services
- Hearing Aid Services
- Prosthetics and Orthotics Services

requirements for ambulatory care. The growth in the Priority 1-3 population has a positive impact. Aging is driving an increase in annual expenditure requirements. However, the impact of aging can vary by service. For example, use of hearing aid services increases significantly with age, while use of maternity services decreases significantly with age.

Modeled Ambulatory Primary and Specialty Care (cont'd)

Therapies

- Allergy Testing and Immunotherapy
- Chiropractic
- Dialysis and Related Services
- Nephrology – End Stage Renal Disease Services
- Immunizations
- Office Administered Drugs
- Physical Therapy, Occupational Therapy, and Speech and Language Pathology

Changes in enrollee reliance are increasing VA'sexpenditure requirements for providing dialysis services. Enrollee reliance on VA for dialysis and related services increased from 29% in 2011 to an estimated 47% in 2021 and is expected to continue to increase through 2028. This increase in reliance is due in part to lower cost sharing in VA compared to Medicare.

Pharmacy – Outpatient Prescriptions

Pharmacy workload projections are developed for prescription drugs that are typically coveredunder a private sector health plan, as well as pharmacy items that are not, but that are coveredby VA, such as over-the-counter (OTC) medication and supplies.

Modeled Pharmacy

Outpatient Prescriptions

- Prescription Drugs
- Over-the-Counter Medication
- Prescription Related Supplies

Expenditures required to provide pharmacy services to enrolled Veterans are expected to increase significantly in 2024 and 2025, driven primarily by inflation. VA's well-managed pharmacy benefit management program and contracting practices do moderate inflation's impact, but price increases are still contributing substantially to VA's cost of providing prescription drugs. The prescription drug pipeline is monitored regularly, and potential impacts of emerging treatments are assessed in collaboration with the VA Pharmacy Benefits Management (PBM) Services. This information is considered when setting the trend assumptions for prescription drugs.

Inpatient Acute Care

Inpatient projections are developed for acute bed days of care for medicine, surgery, and maternity. In order to support workforce planning, the EHCPM also projects utilization for inpatient encounters that occur during inpatient stays. The inpatient encounters projected by the EHCPM include diagnostics, therapies, professional services, and procedures provided in an inpatient environment. The cost of all inpatient encounters is included in the cost of acute bed days of care.

Modeled Inpatient Acute Care

Inpatient Acute
- Medical
- Surgical
- Maternity Deliveries
- Maternity Non-Deliveries

Inpatient Encounters

- Cardiovascular
- Case Management - Rehabilitation Therapists
- Colonoscopy
- Dermatology Services and Diagnostic Exams
- Dialysis and Related Services
- Emergency and Observation – Facility Component
- Emergency and Observation – Professional Component
- Eye Glasses Services
- Hearing Aid Services
- Hearing and Speech Exams
- Inpatient Evaluation & Management (E&M) Services - Non- Mental Health
- Maternity
- Medication Therapy Management
- Miscellaneous Medical Services and Diagnostics
- Nephrology – End Stage Renal Disease Services
- Non-Invasive Vascular Studies
- Nutritional Counseling
- Office Administered Drugs
- Ophthalmology Services and Diagnostic Exams
- Pathology
- Prosthetic and Orthotic Services
- PT/OT/SLP
- Pulmonology Svcs, Diag Exams, Ventilator Mgmt
- Radiology – CT
- Radiology – General
- Radiology – MRI
- Radiology – Mammography (All)
- Radiology – Nuclear Medicine
- Radiology – PET and PET/CT
- Radiology – Radiation Oncology
- Radiology – Ultrasound
- Recreational Therapy

Expenditures required to provide inpatient acute services to enrolled Veterans are expected to grow in both 2024 and 2025. The projected increase in expenditures is largely due to the impact of health care trends. VA's cost of providing acute inpatient services is expected to increase due to inflation and changes in health care practice that increases the cost of services (intensity trends). For example, as more surgeries are performed in an ambulatory environment, the average cost per service of the remaining inpatient surgeries, which are more complex, is expected to increase.

Although expenditures are increasing, utilization is stable with growth dampened due to several factors:

- Aging and priority transitions are increasing utilization projections but are largely offset by a negative impact of net enrollment growth (new enrollment minus deaths). Net enrollment growth is reducing inpatient utilization because the enrollees who are dying are generally sicker than new enrollees.

- Improvements in VA's level of management in inpatient care reduces utilization by improving management processes (e.g., early discharge planning), reducing hospitalizations for ambulatory care sensitive conditions and readmissions through care coordination, disease management, expansion of home telehealth services, etc., and the continuing transition of care from an inpatient to outpatient environment.

VA's cost of providing inpatient maternity care is increasing due to high-cost trend for maternity services in the private sector (most maternity care is purchased).

Mental Health Care

Mental health projections are developed for a continuum of mental health services, including general outpatient mental health, evidence-based psychotherapies, intensive outpatient programs, residential rehabilitation treatment, and inpatient mental health care (the cost of mental health inpatient encounters includes diagnostics, therapies, professional services, and procedures provided in the inpatient environment). These services treat a variety of common mental healthconditions as well as conditions requiring more specialized and/or intensive interventions including the most severe and persisting mental health conditions.

Expenditures required to provide mental health services to enrolled Veterans are expected to grow in both 2024 and 2025. The projected increase in expenditures is due to the impact of health care trends, primarily inflation, on the cost per service, and VA's initiatives to expand access to mental health care through increased substance use disorder staffing. The growth in expenditure requirements slows after 2024 as the impact of the access initiatives are expected to be limited and utilization changes are primarily based on the demographics of the enrollee population.

Modeled Mental Health Care

Mental Health Inpatient

- Inpatient Acute Mental Health
- Inpatient Acute Mental Health and Substance Use Disorder Extended Stays
- Inpatient Acute Substance Use Disorder
- Inpatient Mental Health Residential Rehabilitation
- Inpatient Compensated Work Therapy/Transitional Residence (CWT/TR)
- Inpatient Sustained Treatment and Rehabilitation (STAR)

Mental Health Inpatient Professional Services

- Mental Health
- Mental Health Inpatient E&M Services
- Psychotherapy
- Substance Use Disorder
- Psychosocial Rehabilitation and Recovery Centers
- Intensive Community Mental Health Recovery Services
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Inpatient Encounters
- Homeless

Mental Health Outpatient

- Outpatient Mental Health
- Psychotherapy
- Outpatient Substance Use Disorder
- Mental Health Office Visits
- Psychosocial Rehabilitation and Recovery Centers
- Intensive Community Mental Health Recovery Services (ICMHR)
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Outpatient and Residential Stay
- Homeless

Utilization of mental health services is expectedto grow (independent of any change due to enrollment dynamics) due to VA's initiatives to increase capacity. For example, Mental Health Residential Rehabilitation is projected to grow 4% through 2024 due to these access initiatives. Also recognizing the need for additional care to treat increasing nationwide substance use disorders, including care to combat the opioid crisis, the 2022 EHCPM includes a multi-year positive trend in utilization (included as utilization trend, not specifically a program change) related to an initiative to increase mental health staffing. The overall effect is an 8% increase in utilization by 2024. Enrollment dynamics are driving growth in mental health services for certain segments of the enrollee population.

- The continued growth of the Post-9/11 Era Combat Veteran enrollee population (9% from 2021 to 2024) and their high proportion of service-connected status (almost 76% of these enrollees are projected to be in service-connected Priorities 1-3 by 2024) are driving increases in utilization for this population. From 2021 to 2024, the utilization of Mental Health services by this populationis expected to increase by 81% for inpatient services and increase by 62% for ambulatory. This growth varies by service.

- In addition, post-Vietnam Era enrollees use a significant amount of inpatient mental health and substance abuse services.

However, the aging of the non-Post-9/11 Era Combat Veteran enrollee population is mitigating the projected growth in utilization of mental health services because use of mental health services declines at older ages. For example, utilization of many mental health services peaks around 60 then drops off dramatically by age 65.

Rehabilitative Care

Projections are developed for two special rehabilitative care inpatient services provided byVA: Blind Rehabilitation, and Spinal Cord Injury/ Disorders (SCI/D) services. These services promote the health, independence, quality of life, and productivity of individuals.

Modeled Inpatient Rehabilitative Care

- Blind Rehabilitation Services
- Spinal Cord Injury and Disorders

VA operates 13 Blind Rehabilitation Centers, which provide 4-6 weeks of inpatient adjustment-to-blindness training to help blinded Veterans achieve a realistic level of independence. VA operates 25 Spinal Cord Injury Centers. These provide expertise in treating new and longstanding spinal cord injuries and disorders and provide rehabilitation, medical care, prosthetics, and training in skills needed to live and work with SCI/D and maintain quality of life.

Expenditures required to provide Rehabilitative Care to enrolled Veterans are expected to grow in both 2024 and 2025. The projected increase in expenditures is largely due to the impact of inflation on the cost per bed day for rehabilitative care.

Priority transitions are also driving increases in expenditure requirements for these services. Aging is driving growth in utilization for Blind Rehabilitation inpatient services, as diagnoses of vision problems increase with age.

SCI/D utilization rates are highest for enrollees aged 60 – 80, and that population is projected to decrease as a portion of the total enrolled population within the next few years. This, in combination with enrollment growth at younger ages, means the overall SCI/D utilization rate is expected to fall in each projection year.

Prosthetics

VA provides a full range of medically prescribed medical equipment and products to enrolled Veterans.VA is the largest and most comprehensive provider of prosthetic devices and sensory aids in the country. Although the term "prosthetic device" may suggest images of artificial limbs, it actually refers to any device that supports or replaces a body part or function.

These include devices worn by the Veteran, such as an artificial limb or hearing aid; those that improve accessibility, such as wheelchairs, ramps, and vehicle modifications; and implants surgically placed in the Veteran, such as hips and pacemakers. The relative cost of these devices varies dramatically, e.g., basic medical supplies cost very little while sophisticated implant and artificial limbs are much more expensive.

Modeled Prosthetics

- Glasses/Contacts
- Hearing Aids
- Surgical Implants
- Cardiothoracic Surgical Implants
- Medical Equipment & Supplies (e.g. diabetic socks, blood pressure monitors, dressing aids)
- Home Telehealth Devices
- Oxygen
- Respiratory Equipment
- Wheeled Mobility Devices
- Orthotics
- Artificial Limbs
- Blind Aids (e.g. magnifiers, talking products, training computer software)
- VA Specialized Products and Services (e.g., environmental modifications (ramps), services for service dogs)

The requirements to provide prosthetic services to enrolled Veterans are expected to grow in both 2024 and 2025. The projected increase in expenditures is primarily due to health care trends.

The cost of prosthetic devices generally grows each year due to inflation and changes in health care practice. Extensive development and use of national committed-use contracts, as well as regional and local contracts, are expected to mitigate the expected inflation trends for prosthetics to some extent. These contracts provide quality assurance through active participation of clinicians and subject matter experts in developing requirements of the devices and the ability to obtain the best value for VA. As discussed in the Impact of the 2022 EHCPM Update section, inflation has increased significantly in the wake of the pandemic and has been a leading driver of the increased costs across all modeled prosthetic categories in 2021. The cost of prosthetic devices such as glasses, blind aids, oxygen, orthotics, and wheeled mobility devices is also expected to increase due to advancements in technology (intensity trends).

Changes in health care practice may also drive growth in prosthetics utilization independent of any changes in enrollee demographics. With the increased use of technologies in all aspects of health care, more clinical specialties are using advanced prosthetic technology and devices to treat patients. Clinicians are better informed about the availability of technologies and are becoming more comfortable with prescribing these devices to treat and assist patients with specific conditions.

As a result, VA has observed an increase in the number of purchase orders, work actions, and associated prosthetic devices that are prescribed and provided per unique patient. In recent years,

VA has seen the portfolio of prosthetic devices expand and the types of available and prescribed devices diversity. For example, wireless communication devices and other devices compatible with hearing aids are being prescribed and provided in conjunction with hearing aids with wireless capabilities. The increased diversity of prosthetic devices coupled with technological advances is driving material increases in utilization of prosthetic devices.

The increasing number of enrollees being adjudicated for service-connected disabilities is also driving increases in prosthetics utilization. As enrollees transition from non-service-connected priorities into Priorities 1-3, they are expected to reflect the significantly higher utilization rates of enrollees in Priorities 1-3, particularly for blind aids, artificial limbs, wheeled mobility devices, and VA specialized products and services.

Overall aging has a large impact on prosthetic services but does vary by service. For example, the use of hearing aids (which are not covered by private insurance or Medicare) increases significantly with age, while utilization of surgical implants shows minor increases as enrollees elect to use Medicare for surgical procedures. Aging is driving material increases in utilization of hearing aids, blind aids, wheeled mobility devices, VA specialized products and services, and oxygen.

The continued growth of the Post-9/11 Era Combat Veteran enrollee population (9% from 2021 to 2024), their aging, and their increase in service-connected conditions (and the resulting transition into service-connected Priorities 1-3) is driving significant growth in utilization for prosthetics services for this population. Since almost this entire population is not yet eligible for Medicare (with the associated decline in reliance on VA), aging is driving increases in this population's use of prosthetics, particularly for oxygen, glasses/contacts, cardiothoracic surgical implants, and hearing aids.

Long-Term Services and Supports

LTSS include the full range of services providedto help Veterans with functional limitations and chronic health conditions in non-acute settings. These services are provided through facility-based care or via home and community-based services (HCBS).

Facility-based care is provided in VA Community Living Centers (CLC), Community Nursing Homes (CNH), and State Veterans Homes for durations of both short-stay (90 days or less) and long-stay (more than 90 days). HCBS are provided through both VA and via purchased care. State Veterans Homes provide both facility-based care and HCBS but are not projected by the EHCPM.

Modeled Long-Term Services and Supports

Facility Based Services

- VA Community Living Centers, long-stay (>90 days)
- VA Community Living Centers, short-stay
- Community Nursing Homes, long-stay
- Community Nursing Homes, short-stay

Home and Community Based Services

- VA Adult Day Health Care
- Community Adult Day Health Care
- Home Based Primary Care
- Home Respite Care
- Purchased Skilled Home Care
- Home Hospice Care
- Homemaker/ Home Health Aide Programs
- Spinal Cord Injury & Disorders Home Care
- Community Residential Care
- Home Telehealth

Expenditures required to provide LTSS to enrolled Veterans are expected to increase in both 2024 and 2025. The projected growth for expenditures is primarily the impact of inflation and two enrollment dynamics that have a very significant impact on LTSS in both facility and HCBS settings: priority transitions and the aging of the enrollee population. This growth is tempered by the impact of net new enrollment (new enrollees minus deaths). This net effect tends to reduce LTSS utilization because death rates are higher for older enrollees with relatively high utilization of LTSS, while new enrollment is primarily younger enrollees who tend to not yet need these services.

Enrollees transitioning into service-connected priorities are driving significant growth in utilization for facility-based LTSS as well as HCBS. In particular, the growth in Priority 1a enrollees (70% service-connected or more) is driving significant growth for long-stay facility-based LTSS. VA is legislatively mandated by the Veterans Millennium Health Care and Benefits Act (P.L. 106-117) to provide continuing facility-based care for enrolled Veterans who have a 70% or greater service-connected disability, as well as those who need such care for a service-connected disability, or who have a rating of total disability based on individual un-employability.

The aging of the enrollee population is also having a significant impact on expenditures and utilization. Unlike other modeled services, reliance on certain LTSS does not decline after Medicare eligibility, due to limited Medicare coverage for long-stay facility-based services and HCBS. Currently World War II and Korea era enrollees are in the age bands that are the highest users of LTSS. Vietnam era Veterans will be an increasing driver of LTSS, with most having aged beyond 75 by 2026. CLC short-stay, which is used primarily for post-acute care and hospice care, is less impacted by aging than the other facility-based care categories.

Projected utilization for LTSS reflects programmatic changes in delivery of these services. Reflecting similar shifts in the health care system at large, VA is focusing efforts to provide care in the most appropriate setting for enrollees. This change includes deliberate shifts to CLC short-stay care for those who are in an inpatient setting and are not ready to be discharged to home, but no longer need acute care. It also includes VA's initiative to provide care through HCBS rather than in facility-based LTSS when appropriate. These efforts are driving some growth for short-stay facility-based care and HCBS but are mitigating expected growth for long-stay facility-based care.

Dental

Projections are developed for three categories of dental care services based on the intensity and complexity of the service. By law, VA provides dental care to enrollees based on special eligibility criteria, which are different than eligibility criteria for other VA medical care benefits. Providing preventive and basic dental services to enrollees aligns with VA's

Modeled Dental Care

- Preventive and Basic Dental Services
- Minor Restorative Dental Services
- Major Restorative Dental Services

mission to provide enhanced preventive oral health services for eligible dental patients to maximize their health outcomes in the health care setting of their choice.

Expenditures required to provide dental services to enrolled Veterans are expected to grow in both 2024 and 2025. The projected increase is primarily due to the transition of enrollees into higher priority groups and inflation.

Impact of 2022 EHCPM Update

Health care is very dynamic. Further, the EHCPM projections supporting the VA budget are developed based on data that are three years removed from the beginning of the budget year (four years for the Advance Appropriation). During this time, new policies, legislation, regulations, and external factors, such as pandemics, can occur and change the projected demand for VA health care. Therefore, each year the EHCPM is updated to reflect the most recent data and emerging experience.

The 2022 EHCPM was used to build the 2024 and 2025 VHA Medical Care budget requests. The EHCPM was updated to 2020 and 2021 experience, but only some EHCPM assumptions were updated based on 2020 and 2021 data. Typically, the EHCPM is updated annually to reflect emerging information on the enrollee population and their utilization of VHA health care. These analyses are generally tied to the most recent fiscal years of data and establish assumptions that are based on this recent information, which then persist throughout the full EHCPM projection period. However, due to the significant impact of the COVID-19 pandemic on the 2020 and 2021 utilization and enrollment patterns, which are not expected to remain in the long-term, many modeling assumptions in the 2022 EHCPM were developed using data through 2019, rather than updated to use 2020 and 2021 experience.

Inflation has increased significantly in the wake of the pandemic. For the 2022 EHCPM, the non-personnel inflation trend derives from the 2021 Medicare Trustee's Report. Normally, a 20-year historical average trend would be used to project inflation from 2021 to 2025; however, 2021 and 2022 are based on a more recent CMS Market Basket forecast to recognize the near-term inflation experience. Similarly, pharmacy cost trends take into account expected increases in the Consumer Price Index for All Urban Consumers which, due to contracting provisions, has a direct impact on the acquisition cost of many brand name and specialty drugs.

Historically, the most significant factors changing the EHCPM's projections have been external and could not have been anticipated in advance, such as the impacts of the COVID-19 pandemic, the MISSION Act, the civilian wage freeze policy, American Reinvestment and Recovery Act (ARRA) funding, and the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (PACT Act). The impact of the PACT Act is not included in the 2022 EHCPM, but estimates have been provided outside of the model. Please see the section entitled "Uncertainty Associated with Actuarial Projections in the VA Enrollee Health Care Projection Model" later in this chapter for more information on the impact of COVID-19 on the VA health care system as well as on sources of risk inherent in modeling.

Table: 2024 Revised Estimate and 2025 Advance Appropriation EHCPM Model & Non-Model Obligations

All Funding Sources
(dollars in thousands)

Description	2024 Revised Estimate			2025 Advance Appropriation		
	EHCPM	Non-EHCPM	Total	EHCPM	Non-EHCPM	Total
Health Care Services	$108,266,524	$14,525,424	$122,791,948	$115,195,281	$11,197,412	$126,392,693
Long-Term Care	$11,354,132	$1,586,652	$12,940,784	$11,838,428	$1,738,604	$13,577,032
Non-Add Included in Above Rows:						
Non-Recurring Maintenance	*$0*	*$5,750,000*	*$5,750,000*	*$0*	*$995,000*	*$995,000*
Titles 1, 3, 4, of PACT Act	*$0*	*$2,785,835*	*$2,785,835*	*$0*	*$3,737,369*	*$3,737,369*
PACT Act Leases:						
Section 705	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Section 707	*$0*	*$786,724*	*$786,724*	*$0*	*$265,223*	*$265,223*
Remaining PACT Act Implementation	*$0*	*$1,001,256*	*$1,001,256*	*$0*	*$1,014,179*	*$1,014,179*
State Home Programs	*$0*	*$1,496,078*	*$1,496,078*	*$0*	*$1,582,858*	*$1,582,858*
Other Health Care Programs:						
Camp Lejeune Families (P.L. 112-154)	$0	$7,597	$7,597	$0	$8,264	$8,264
Caregivers (Including CHAMPVA)	$0	$2,422,410	$2,422,410	$0	$2,764,685	$2,764,685
CHAMPVA & Other Dependent Prgs	$0	$2,335,332	$2,335,332	$0	$2,548,920	$2,548,920
Homeless Program Grants	$0	$1,067,265	$1,067,265	$0	$1,115,656	$1,115,656
Readjustment Counseling	$0	$353,643	$353,643	$0	$363,361	$363,361
Obligations [Grand Total]	$119,620,656	$22,298,323	$141,918,979	$127,033,709	$19,736,902	$146,770,611

Civilian Health and Medical Program Model

The Civilian Health and Medical Program Veterans Affairs (CHAMPVA) Model, which was adopted in 2010, projects the cost of providing medical coverage to the spouse or widow(er) and to the children of a Veteran, also referred to as a sponsor, who is rated permanently and totally disabled due to a service-connected disability, or was rated permanently and totally disabled due to a service-connected condition at the time of death, or died of service-connected disability, or died on active duty and the dependents are not otherwise eligible for Department of Defense TRICARE benefits. In 2021, CHAMPVA covered 557,933 beneficiaries. The number of beneficiaries is expected to rise to approximately 672,000 in 2024 and 713,000 in 2025.

The 2022 CHAMPVA Model was developed using the data from 2012 to 2021, publicly available research, and input from a development team (including subject matter experts from VHA and VHA's CHAMPVA program). The CHAMPVA Model consists of two major components: the enrollment model and the claims cost model. The enrollment model projects the number of beneficiaries enrolled in CHAMPVA, and the claims cost model projects expenditures for providing care to beneficiaries.

The enrollment model projects the number of CHAMPVA sponsors and beneficiaries. For each fiscal year, sponsors are projected and then the beneficiaries of those sponsors are projected. Within a given fiscal year, sponsors are projected at an individual level, with modeled individual beneficiaries linked to each sponsor. Three categories of beneficiaries are projected: spouses, children, and helpless children. Beneficiaries eligible for CHAMPVA as a primary caregiver enrolled in the Program of Comprehensive Assistance for Family Caregivers (PCAFC) (i.e., who are not also an eligible spouse or child of a sponsor) are not modeled in the CHAMPVA projection model. Starting with the 2020 Model, such caregivers have been projected as part of the

PCAFC Model. The Veteran population basis underlying the enrollment assumptions and projections is primarily based on VetPop 2018.

The claims cost model is driven by several factors including: enrollment counts produced from the enrollment model, assumed annual claim cost trends, age/gender cost relativity factors, and the actual (historical) CHAMPVA paid claims data. The projected beneficiaries from the enrollment model are then linked to the claims cost model to generate expenditures. These projections also include assumptions for the impact of COVID-19 on deferred care and returning care during 2022 through 2024, as well as the impact of the RIN 2900-AP02/WP2010-004 (CHAMPVA Modernization of Regulation) on expenditures.

The Program of Comprehensive Assistance for Family Caregivers Model

Historically, the Program of Comprehensive Assistance for Family Caregivers (PCAFC) has provided comprehensive assistance to caregivers of certain Veterans and Service members who were seriously injured during service on or after September 11, 2001. For enrolled Veterans, their primary caregivers are eligible for a monthly stipend payment, health care expense reimbursement through the CHAMPVA program (if they have no other health insurance), education and training, mental health care services, respite care services, travel, lodging and per diem expenses in order to attend required caregiver training and to travel to and from the Veteran's medical appointments. Following the program changes required by the MISSION Act, eligibility requirements were updated to include, over a two-year period, eligible Veterans that were seriously injured prior to September 11, 2001. Additional information regarding the PCAFC program can be found in the Caregiver Support Program section of the 2024 budget submission.

The PCAFC Model was first developed in 2015 and has been updated each year since then. The PCAFC Model includes projections for unique Veteran sponsor counts, unique primary caregiver counts, stipend payment costs, CHAMPVA benefit costs, mental health benefit costs, and respite care benefit costs. The stipend cost projections make up the majority of total PCAFC costs. The CHAMPVA benefit cost projection in the PCAFC is limited to primary caregivers who qualify for CHAMPVA purely through their involvement in the PCAFC; CHAMPVA beneficiaries who qualify for CHAMPVA by being eligible spouses or children of a Veteran are projected as part of the CHAMPVA Model. The PCAFC Model does not include other PCAFC program expenses such as training, travel, lodging, and per diem.

Projections are developed using a combination of historical program experience, projected enrollment pattern assumptions, stipend payment and cost trends, projected health care cost trends, projected payment tier/level enrollment distribution, and assumptions regarding policy decisions to implement the MISSION Act.

PCAFC costs are largely driven by projected enrollment into the PCAFC program. From PCAFC inception in May 2011 through 2016, there was a steady increase in the number of caregivers enrolled in the PCAFC program. From 2017 to 2021, the program saw a reduced number of total Veteran sponsors and caregivers. However, due to program expansion to include Vietnam service era Veterans and Pre-Vietnam service era Veterans beginning October 1, 2020, and Post-Vietnam service era Veterans beginning October 1, 2022, the number of caregivers has begun growing and is expected to continue growing.

Uncertainty Associated with Actuarial Projections in the VA Enrollee Health Care Projection Model

VA develops the VA EHCPM, an actuarial projection of enrollment, utilization, and expenditures, to support its budget submission and long-term strategic planning. A critical function is to assess the sources and magnitude of overall uncertainty associated with actuarial projections and to communicate that information to stakeholders. This report fulfills part of this communication to stakeholders and describes the activities that comprise VA's assessment of uncertainty associated with the actuarial projections.

This report identifies sources of risk and describes the degree of uncertainty that they add to the actuarial projections in general and specifically for the projections supporting the 2024 VA health care budget (Budget Scenario).

This communication of risk is intended to inform stakeholders of sources of uncertainty, describe how they may affect the assumptions which drive the actuarial projections, and discuss their potential magnitude. The risk assessment includes sensitivity testing for enrollee reliance and enrollment to demonstrate the potential variability of the projections over the short term and long term. This report discusses ways VA manages uncertainty in the actuarial projections, but it does not address approaches to manage operational risk to the Department.

Framework for Assessing Actuarial Projection Uncertainty

The complex nature of health care is a challenge in all types of health coverage and must be addressed by all payers and providers alike. Utilization and expenditures are impacted by many different factors and are sensitive to the interaction between them. In addition, there is substantial random variation in health care needs over time. As a result, modeling health care utilization and expenditures is inherently challenging. The vast majority of payers and providers use actuarial methods to model health care by accounting for the key drivers and to understand and communicate uncertainty in projections. The EHCPM is structured in a manner consistent with tools used by other health care payors and providers, and it has been adapted to meet the specific needs of VA stakeholders.

One of the most important functions of an actuarial model is to describe how factors influence utilization and expenditures over time, in order to gain a deeper understanding and to communicate it to users. The EHCPM provides this cohesive and critical framework for evaluating and communicating results and the key drivers of those results. There is significant inherent uncertainty and there is risk of emerging experience differing from projections. Understanding the key drivers enables greater insight into the sources of risk and how they contribute to uncertainty.

The EHCPM produces projections of enrollment, utilization, and expenditures based on numerous model assumptions about how the future will be the same or different from past experience. There is uncertainty about how actual emerging experience will compare with these assumptions. A framework for assessing actuarial projection uncertainty involves identifying, analyzing, and responding to underlying risks, consistent with Principal 7 of the Government Accountability Office's "Standards for internal control in the federal government" (see Appendix A).

The EHCPM is a projection model, which is based on a set of assumptions that affect the projection output over time. Because the assumptions are specified for each scenario, the projection output is a single estimate, usually referred to as the "best estimate." This type of model is referred to as a deterministic model. By contrast, a stochastic model uses assumptions that are sampled randomly from preset distributions, resulting in projection outputs that land in a random distribution. The decision to make the EHCPM a deterministic model, wherein each scenario results in a single "best estimate," is driven by practical purposes, including having the ability to explain the contribution of each assumption to the budget projection. In this approach, the projection output does not state the expected variability around the "best estimate." Instead, variability is communicated to stakeholders using alternate "what if" scenarios, sensitivity testing where practical, and through a qualitative discussion of the risks that contribute to uncertainty.

Many of the sources of risk that create uncertainty in the projections cannot be statistically measured in the first place. For example, there is uncertainty about future combat operations and deployment levels, which can have a material impact on long term enrollment levels and morbidity. Yet, VA cannot ascribe a probability to these future events. This is another reason why the EHCPM is not a stochastic model that produces a statistical range of projection results. Instead, variation is presented using scenarios that vary based on changing selected assumptions. This approach allows stakeholders to understand how the projection changes when underlying assumptions are changed and to understand the magnitude of their impact.

Within the EHCPM, a sudden event can occur that can have a large impact on enrollment, utilization, or expenditures. In addition, there are ongoing factors that can differ from expectations, and these changes can also have a large impact on the projections. These sources create a risk that the model assumptions will not unfold as expected, thereby increasing uncertainty in the projection outputs. For example, the uncertainty about future combat operations and deployments creates uncertainty in the EHCPM's enrollment and utilization projections primarily by affecting two key model assumptions: the size of the future Veteran population and the health status of newly separating Veterans.

Identification of Risks Causing Projection Uncertainty

Sources of risk manifest in uncertainty about projection model output by affecting assumptions that are the key drivers of enrollment, utilization, and expenditure change over time. For example, an economic downturn is an event that can lead to higher enrollment and greater enrollee reliance. Consequently, the potential for an economic recession can manifest in greater uncertainty about future enrollment and utilization levels. The underlying sources of risk which affect the EHCPM's assumptions and projection outputs are outlined below.

Identified Sources of Risk, Affected EHCPM Assumptions and Projection Outputs

Sources of Risk	Assumptions	Projection Output
• Acts of nature*	• Cost per service	• Enrollment
• Combat and deployments	• Community care reimbursement schedule	• Expenditures
• Demand allocation between VA facilities and community care*	• Enrollee mortality	• Utilization
	• Enrollment rates	
• Enrollee and Veterans preferences*	• Geographic migration	
• Enrollment policy	• Health care management	
• Health care practice*	• Inflation	
• Health status	• Intensity trends	
• Inflation*	• Morbidity	
• Legislative, regulatory and judicial policy*	• Priority transitions	
	• Reliance	
• Management policies and initiatives	• Utilization differences across demographic groups	
• Non-VA health care coverage	• Utilization trends	

*Indicates a source of risk with the highest impact for the Budget Scenario.

Role of Reliance in Risk and Uncertainty in the Model

VA estimates that 80% of enrollees have some type of public or private health care coverage other than VA. Enrollees with multiple sources of coverage can choose to use their VA or non-VA coverage for each health care service. Reliance is defined as the portion of enrollees' total health care needs expected from the VA health care system, including both VA direct care and community care paid by VA, versus other health care options. For example, if an enrollee received 10 office visits in a year, 4 from VA and 6 through Medicare, that enrollee would be considered 40% (= 4 / 10) reliant on VA for office visits.

Note that reliance is not the percentage of enrollees that receive health care from VA. Most enrollees who use VA health care are only partially reliant; that is, they use VA for some of their care but rely on other health care sources such as Medicare or private health insurance for their remaining care.

Prior to COVID-19 during 2019, average reliance was approximately 38% across all enrollees for their health care needs (excluding LTSS). The large portion of enrollee care that is not currently funded by VA creates a significant model risk since events that may cause only small increases in reliance can generate significant additional expenditures. A 1% unexpected increase in reliance levels (i.e., additive increase, or 100 points) is estimated to cause the EHCPM's budget projection to increase by around 2%, or $2 billion, over a pre-COVID-19 baseline.

Characterizing the Degree of Uncertainty

There are different ways to categorize sources of risk in terms of the type of uncertainty each brings into the model.

- Likelihood – Some events are very rare, and others occur more frequently. For example, a major overhaul to health care law is relatively rare, whereas unexpected changes in the inflation rate are nearly guaranteed, regular occurrences (though the magnitude and direction of the unexpected change are not known in advance).

- Magnitude – Notwithstanding the likelihood of an event occurring, the magnitude of the event is very important. For example, a pandemic is a rare, but high impact event.

- Single vs. Recurring Impact – Some events will create a one-time upward or downward shift in an assumption or the model projections (e.g., opening a new facility). Other sources of risk will lead to recurring changes in cost, therefore bending the expenditure curve upward or downward (e.g., expansion of enrollment eligibility).

- Time Horizon - The EHCPM projections serve two primary purposes:

    - First, there is the 3-4-year projection to support the budget submission and the advance appropriation.

    - Second, there is a longer-term projection over 20 years to support strategic planning at the market level.

- Sources of risks that lead to uncertainty in the projections will affect these time horizons differently and so are prioritized differently depending on the time horizon being used. For example, uncertainty around a trend assumption, such as inflation or mortality rates, can have a relatively small impact on the three-year budget projection but will compound into a much larger impact over a 10-20-year strategic planning timeline. Conversely, events, such as an economic downturn, can have a relatively large impact over the short-term but then revert to "normal" conditions and thereby have less impact over a strategic planning timeline.

A particular source of risk can influence the uncertainty about several model assumptions and to varying degrees. Similarly, each model assumption is uncertain due to the underlying influence of several sources of risk. Generally, utilization trends and reliance levels create a greater uncertainty in the model projections than other key drivers such as enrollment rates, which only have a marginal impact on total enrollment in any given period. The list below is sorted in approximate order of impact over the budget horizon.

Affected EHCPM Assumptions by Level of Uncertainty

Assumptions	Contributes most to which projection output
Reliance	Utilization
Utilization trends	Utilization
Inflation	Expenditures
Intensity trends	Expenditures
Morbidity	Utilization
Utilization differences across demographic groups	Utilization
Health care management	Utilization
Priority transitions	Enrollment
Enrollment rates	Enrollment
Cost per service	Expenditures
Community care reimbursement schedule	Expenditures
Enrollee mortality	Enrollment
Geographic migration	Enrollment

Approaches to Assess and Reduce Modeling Uncertainty

There are several important activities that are undertaken prior to developing the projections, which are focused on collecting historical data and identifying sources of risk that have led to model uncertainty in the past.

Baselining the Model

VA gathers data from multiple sources, such as workload information from different facilities and information stored in multiple databases. Each year, the EHCPM is updated to reflect historical enrollment, utilization, and expenditure information. Historical information over several years is used to estimate important model assumptions, such as utilization trends by service category, enrollment rates and reliance. The EHCPM is calibrated so that it projects the enrollment, utilization and expenditures that actually occurred during the model's base year. For example, the base year of the 2022 EHCPM was 2021. This process is referred to as "baselining," and is an important step toward reducing model uncertainty.

One of the challenges in baselining is to obtain accurate and comprehensive data through the base year. VA works extensively to collate data from within the department and to organize it in a timely manner. Great care is taken to evaluate the completeness and accuracy of each data source. This is accomplished by reconciling data to other sources, testing it for both internal consistency and the validity of data entries, and through discussions with key subject matter experts.

Integrating Data Sources from Outside VA

VA also obtains important data from outside of the Department to help understand the base year. A Medicare data match is available to assist in the review of overall health care utilization for Veterans ages 65 and over. This is a valuable information in understanding a more complete picture of medical conditions, overall utilization, and reliance on VA health care for many enrollees ages 65 and over. There is no corresponding data set for Veterans under age 65, since health care data is fragmented across numerous private sector and government programs. As a result, modeling for Veterans under 65 years of age is primarily based on the VA health care and supplemented by VA's annual Survey of Enrollees, which provides self-reported responses on enrollee reliance. Through this process, VA arrives at an effective means of assessing overall utilization and reliance for enrollees under age 65.

Other outside data sources include date of death files from the Social Security Administration (SSA) and the VA/Department of Defense Identity Repository (VADIR) data. Since many Veteran enrollees may die outside of VA facilities and there is no direct requirement for their families or physicians to report this to VA, it is important to supplement dates of death that are reported within VA with information from outside sources, including SSA. This allows for a more up to date and accurate count of current enrollees. The VADIR data includes military discharge dates along with information about active-duty theaters of deployment, and this data is used to identify post-9/11 combat Veterans, other deployment cohorts, and to track time since separation.

Reducing the Impact of Reporting Lag

Most data sources have at least some degree of reporting lag. Enrollee deaths are not all immediately reported to VA and, therefore, there is a lag in complete reporting of enrollee deaths. For community care, VA, like other payers, experiences a gap between the provision of the service and the date of payment. This is an unavoidable feature of some data sources. Where the impact is expected to be material, adjustments are made to arrive at a more complete model of the base period experience. A primary benefit of making adjustments for reporting lag is that more recent, relevant data can be used to develop model assumptions. By contrast, waiting an extended period of time for a data source to be free of reporting lag can make it less relevant for identifying emerging trends.

As time passes, the information on prior periods develops and a more complete picture is formed. This development pattern is evaluated for older periods so that the impact of reporting lag can be modeled and applied to the most recent base year information.

The Medicare data match is usually about two years old by the time it is available for analysis, so additional review on trends is performed to better estimate key assumptions such as morbidity and

reliance during the base year. *Note: Currently, the data match is only available through 2019. Therefore, direct measurements of enrollee reliance remain on a pre-COVID-19, 2019 basis.*

Other Steps to Reduce Uncertainty

Some events or processes give rise to uncertainty that cannot be reduced through deeper analysis alone; for example, it is not possible to predict natural disasters or new military conflicts. Other risks that create uncertainty are more accurately measured by accessing better sources of data and gathering data that is more representative of the base year experience. Sometimes, sources of uncertainty, such as a new law, can be anticipated before their impacts show up in actual experience data, prompting model assumptions to be initially established and refined over time.

As an example, the model historically assumed that reliance for a given enrollee demographic profile was stable over time. As additional longitudinal data emerged, VA identified changes in enrollee reliance due to a "generational shift": enrollees in younger generations are more reliant than those in older generations. Using this data, VA developed and refined assumptions to more accurately project reliance changes over time due to the generational shift and reduce model uncertainty.

The first step in assessing projection uncertainty is to identify the underlying sources of risk. Actuarial, clinical, policy, and operational expertise are continually consulted to identify new sources of risk and reassess the importance of previously known sources.

The second step is to analyze each source of risk and evaluate its significance. A source of risk is considered significant if it can have a material impact on the accuracy of model projections. Often in these situations, alternative projection scenarios are presented along with a discussion of key causes of uncertainty (e.g., sensitivity testing).

The third step is to take appropriate action in response to the risk analysis. If a source of risk is contributing significant uncertainty, then it warrants deeper analysis, more data investigations, and other efforts to arrive at a better estimate of the model assumptions involved. As part of this work, the level of uncertainty is communicated with stakeholders along with the best estimate.

An important part of this framework involves monitoring emerging experience and comparing it to prior projections. When material deviations are found, they are analyzed so that the underlying cause can be identified. Through this process, new sources of risk can be identified as being material and relevant to the projection uncertainty. This activity is accomplished in several ways:

- Monthly monitoring of enrollment – Identifies changing trends and potential data quality issues. Relevant experts within VA are consulted depending on the issue being discussed. Material deviations in emerging experience can be communicated with leadership and changes in enrollment projection methodology are considered.
- Comprehensive annual analysis of prior year enrollment relative to projections – Establishes a new starting point for the enrollment projections and creates a new data set for evaluating projection assumptions. Key model assumptions are tested against the new data and changes are made where appropriate. These include monitoring separate drivers of enrollment change on a monthly basis, such as new enrollment, mortality, and transitions

in priority level. As a result, material deviations from the projected enrollment trajectory can be isolated to the specific assumption that is causing the deviation to occur. This assumption can then be investigated in more detail using the most appropriate data and in collaboration with subject matter experts within VA.

- Comprehensive annual analysis of prior year utilization and expenditures – Establishes a new starting point for the utilization and expenditure projections and creates a new data set for evaluating projection assumptions and differences in utilization patterns across demographic categories. Key model assumptions are tested against the new data and changes are made where appropriate. Utilization and expenditure projections are affected by a multitude of assumptions. Through this review, material deviations from projections can be isolated to the specific assumption that is causing the deviation to occur. This assumption can then be investigated in more detail using the most appropriate data and in collaboration with subject matter experts within VA.
- Ad hoc interim utilization review – Identifies material deviations at the service category level on a periodic basis. These deviations are investigated, and stakeholders are alerted to the new observations. Oftentimes, the interim results are not sufficiently conclusive to warrant an immediate change in the projections but are incorporated into later model scenarios as appropriate.
- Consultation with work groups of subject matter experts on major model components (e.g., mental health, women's health, pharmacy, health care economics) – Evaluates differences between historical experience and prior projections and updates methodology where appropriate. Emerging developments in care delivery and other information are collated to develop a new estimate of future trends. Emerging sources of risks are discussed (e.g., unknown outcomes of new blockbuster drugs, proposed legislation, impact of changing economic forecasts) in order to better understand uncertainty in the projections.

There are several important examples for assessing uncertainty, which inform the approach that is taken with the EHCPM. These include government and private industry examples for risk analysis:

- Comptroller General of the United States published standards for internal control for the Federal Government
- National Association of Insurance Commissioners Risk Based Capital Plan and Own Risk and Solvency Assessment Summary Report
- State Medicaid Agencies
- Actuarial Standards Board of the American Academy of Actuaries Actuarial Standards of Practice

For detailed information on VA's approach to using these examples in the development of the EHCPM, please see Appendix A.

Approaches to Address Evolving Events and Policies

Many risks are difficult to predict and occur suddenly, such as combat deployments, pandemics, and economic recessions. In addition, new policy directions can be considered by leadership or influenced by judicial decisions, such as the MISSION Act.

Depending on the timing of the event, the projections supporting the VA health care budget may not include estimates of the impact of the event or policy direction. However, as the event or policy unfolds, estimates are developed that provide high-level impacts to inform budgeting for these costs. These high-level estimates allow for flexibility when the policy is in flux or when detailed information is not available to support integration into the EHCPM. These estimates are revised as new information and/or analyses are available.

The EHCPM scenario documentation identifies policies that are included in the scenario, provided as a high-level estimate, or not modeled.

Assessment of EHCPM Projection Uncertainty from the Perspective of Underlying Sources of Risk

All sources of risk are discussed below, including their impact on key model assumptions and potentially different impacts by projection time horizon. Sources of risk are listed in approximate order of the anticipated magnitude of their impact in the Budget Scenario. Sources of risk which have a specific impact to the scenario supporting the budget outside of the general impact on model assumptions will have an additional subsection labeled "Budget Scenario."

Acts of Nature

Acts of nature (e.g., hurricanes, tornadoes, wildfires, pandemics) affecting parts of or the entire nation are difficult to predict and can arrive suddenly, as was the case with Hurricane Katrina in 2005 and with the COVID-19 pandemic in 2020.

Assumptions most affected

Morbidity, mortality, reliance, enrollment rates, utilization trend, cost per service, community care reimbursement schedule:

- An act of nature is an unpredictable episode that can dramatically increase mortality and morbidity among vulnerable segments of the enrollee population until the disaster is contained.
- Uncertainty comes in part from the inability to predict the start of and severity of the act of nature. It also comes from unpredictable differences in how society responds.

Time horizon

Short-term and long-term:

- The impact of acts of nature is modeled primarily within a 3-4-year period, anticipating a return to normal over longer time horizons. In the case of COVID-19, it is likely that there will be permanent changes to health care delivery as well, such as a faster and more widespread adoption of telemedicine, but those outcomes are much less certain.

Budget Scenario

While the impact of the COVID-19 pandemic on health care utilization has lessened since its peak in spring 2020, it is continuing to add significant uncertainty to the model projections. A portion of this deferred care will ultimately return at a future date rather than cancelled outright, and there is great uncertainty about how these two drivers will play out. If an unexpectedly larger portion of deferred care from 2020 and 2021 returns in 2022 and 2023, in addition to normal levels of care in those years, then there will be an unexpectedly higher strain on VA direct care and community care capacity at that time.

The Budget Scenario estimates the net impact of deferred and returning care will result in a $1.6 billion increase in expenditures in 2022 (relative to 2021), and a $7.4 billion increase in 2023, based on current deferred and returning care assumptions.

An additional area of uncertainty is related to unit cost impacts during the pandemic. For VA direct care, the reduction in health care utilization due to COVID deferrals did not lead to proportional reductions in expenditures due to VA's fixed cost structure, e.g., staff salaries and facility maintenance costs. Therefore, the average cost per service at VA facilities has increased considerably during the pandemic, though it is expected to decline as care approaches pre-pandemic levels. Community care unit costs are not subject to this same dynamic, as community care reimbursement is on a fee for service basis. However, there are community care unit cost impacts related to changes in Medicare reimbursement during the pandemic, though like the VA direct care impacts, it is assumed that these changes are temporary and will be removed over time.

Yet another area of uncertainty is the degree to which post-pandemic health care utilization returns to the pre-pandemic projected trajectory. Scenario BAB1 assumes deferrals and returns are essentially done by the end of 2024 and that health care utilization in 2024 and later years is largely at the same level as what would be expected had the COVID-19 pandemic never occurred. If instead there is a long-term reduction in health care demand, either due to a nationwide shift in healthcare utilization patterns or a shift in enrollee reliance to use more non-VA care, then this could have material impacts on VHA expenditures. For example, if demand for VHA care is permanently suppressed and utilization levels return to only 95% of pre-pandemic projections, then this could reduce the expenditures by $5.7 billion in 2024 and by $6.1 billion in 2025. These impacts assume fixed costs for VA direct care are reduced from the levels need to support the pre-pandemic projected trajectory, so that the full 5% reduction in VA facility expenditures is realized.

The pandemic could also affect enrollee health status and mortality and health care practice patterns. See the Health Status and Health Care Practice sections for discussion.

Economic Conditions

Economic conditions influence individual behavior primarily due to changes in employment (which in turn affect availability of non-VA health coverage) and a sense of financial security. These influences affect Veterans' propensity to enroll in VA and to use VA to satisfy their health care needs. It is difficult to predict future economic conditions, including the incidence and depth of recessions. Even when a recession has begun, it is difficult to forecast the recovery with precision.

Assumptions most affected

Reliance, enrollment rates, priority transitions:

- Most enrollees have other forms of health insurance, including employer-sponsored health coverage and individually purchased coverage. When unemployment increases, enrollees may lose other forms of insurance and begin to rely more on VA for their care. Conversely, as employment increases, enrollees may reduce their reliance as they become eligible for employer-sponsored coverage.
- There is significant uncertainty around how much reliance may change. A primary reason for this uncertainty is that reliance changes during previous recessions may not repeat in future recessions. For example, the Affordable Care Act introduced significant new safety nets for health coverage among unemployed and lower income individuals beginning in 2014. This safety net was not available during the economic downturn in 2008/2009. Therefore, there is more uncertainty about whether the potential reliance changes during a new economic downturn may be dampened.
- Enrollment rates may also increase as more Veterans decide to come to VA for the first time due to financial insecurity or lack of other health coverage options. Finally, priority transitions between income-based priority levels (i.e., priority 5, 7, 8) may occur with major changes in employment and income.

Time horizon

Short-term:

- Most economic forecasts that include a downturn revert to typical economic conditions over time. For example, during the Great Recession, the economic forecasts included a gradual recovery of unemployment over several years. Reliance is the most material assumption that moves during an economic downturn, and it is expected to revert back to pre-recessionary levels as the recovery develops. Therefore, the long-term projections are less affected by current economic downturns and recoveries.
- The greatest uncertainty is over the short-term. In the early months and years of an economic downturn, the future path of the downturn and recovery is usually the most variable, and so these are the times where uncertainty is greatest. The four recessions that began in 1981, 1990, 2001, and 2008, respectively, took on average 22 months (ranging from 16 to 27) to reach their peak unemployment levels prior to gradual recovery lasting 19 to 71 months in order to reach pre-recession levels. These prior precedents illustrate the variability of paths an economic downturn and recovery can take, and they are also not necessarily representative of the current economic downturn. Hence, the uncertainty is greatest especially in the first year or two after a recession begins.

Budget Scenario

The scenario supporting this request uses the Office of Management and Budget November 2021 economic projections to assume that the unemployment rates will decline from 7% in 2020 to 3% in 2023, then increase slightly to 4% in 2024. This primary economic forecast is supplemented by the Bureau of Labor Statistics forecasted Civilian Non-institutional Population and the Milliman COVID-19 Advanced Population Shift (CAPS) model. This model projects expected changes in

the mix of other health insurance (OHI) coverage due to the OMB economic forecast. The Milliman CAPS model is calibrated to the VHA enrollee population.

There is greater uncertainty about modeling the impact since starting assumptions are based on enrollee behavior changes during the downturn and recovery of the previous recession. There is a risk that enrollees today will respond differently. The factors driving the recession differ, sources of health care coverage have changed, and Federal stimulus and other measures have been much more significant than during the previous recession. All of these factors could change how enrollee reliance changes in the current environment.

With the unemployment rate decline happening so recently, there is much greater uncertainty about the path of recovery going forward. VA expects that forecasts of unemployment will be revised with greater changes than the previous forecasts, which were during a relatively stable and positive environment for employment.

Legislative, Regulatory, and Judicial Policies

It is difficult to anticipate the decisions of current and future congresses, courts and administrations, and they can have a substantial impact on expenditures. Also, there can be sweeping legislative changes or many small legislative or regulatory changes happening simultaneously leading to a large impact on VA's health care system.

Assumptions most affected

All changes to legislative, regulatory, and judicial policies over time have the potential to impact VA enrollment, utilization, and expenditures. Here is a list of examples:

- Medicare Modernization Act of 2003 – Among other Medicare reforms, this act expanded prescription drug coverage to seniors, thereby increasing the attractiveness of Medicare benefits. This created uncertainty about how seniors would change their use of VA over time. Ultimately, the rates of new enrollment into VA began to fall and reliance on VA pharmacy benefits change due to seniors having more options outside of VA.
- Affordable Care Act (ACA) of 2010 – Expanded guaranteed policy issuance (including for pre-existing conditions) and subsidized health care primarily for individuals under the age of 65 who are not otherwise eligible for Medicaid. Initially, the law included a mandate for individuals to obtain coverage. This created uncertainty about whether more Veterans would enroll with VA to satisfy the mandate. It also created uncertainty about whether Veterans would choose ACA coverage instead of VA in the future.
- Choice Act of 2014 and MISSION Act of 2018 – Among other reforms, these acts expanded access to community care. This introduced more uncertainty about how community care utilization and expenditures would trend over time. While the Choice Act did not significantly increase enrollment, it did create more demand on the system for the eligible groups of enrollees. Community care growth has continued since the implementation of the MISSION Act, though the full impact of the MISSION Act is still uncertain.
- Honoring our PACT Act of 2022 (PACT Act) – This act became Public Law No 117-168 in August of 2022, expanding benefits for Veterans exposed to certain toxins in the course of their military service, with a focus on Gulf War era Veterans as well new groups of Vietnam Veterans who were exposed to Agent Orange. Over the long-term, this law is expected to increase the number of enrollees, patients, and overall expenditures of VA. There remains significant uncertainty about the full impact of PACT Act due to the absence of significant emerging experience on eligibility changes, enrollment rate changes, reliance shifts, and other impacts. These drivers of enrollment, utilization, and expenditures will be impacted by several factors, including but not limited to VBA caseload levels, the timing of adjudication and program implementation, the kind of outreach from VHA to Veterans, and the response among Veterans to the PACT Act. Over time, by evaluating emerging experience, the uncertainty and variability will diminish.

Time horizon

Short-term and long-term

- Unlike other sources of risk, historical experience is not always an effective guide to projecting the course of future legislative or regulatory changes. The short-term uncertainty is that emerging experience will be different than projected. Uncertainty is greater over the long term, as the divergence between the two compounds over a longer period of time.

Budget Scenario

- Includes estimated impacts for a number of MISSION Act provisions, including the enhanced drive time access, best medical interest provisions, and wait time benefit. While these provisions went into effect in June 2019, enrollee behavior is still evolving over time in response.
- The emerging experience from 2020 and 2021 shows a larger than initially expected increase in community care workload and costs. This follows 2019 which also had a larger than expected increase. This can be traced to an acceleration in growth beginning in June 2019 as the act became effective. The emerging 2020 and 2021 experience has also been significantly impacted by changes in claim processing speed and COVID-19 deferring or eliminating care. These impacts have obfuscated MISSION's impact on community care utilization growth. Based on currently available data, VA cannot definitively determine whether the higher-than-expected growth so far is an indication that the MISSION Act is increasing enrollee reliance more quickly than anticipated, that the MISSION Act will have a larger ultimate impact on enrollee reliance, or that another force unrelated to MISSION is having a role in changing enrollee behavior. This adds to the overall model uncertainty.
- Enrollee reliance has been projected to increase over time due to MISSION as the program implementation and enrollee behavior matures. Projected reliance growth is then expected to slow as it reaches an assumed steady state by 2023 and then level off. Based on the analysis supporting the budget scenario, emerging experience (paid through September 2021) suggests that community care claims are continuing to increase in 2021, though the growth rate is tapering. There is a significant uncertainty as to how long enrollee reliance will continue to increase before reaching a steady state, producing a risk around 2022 and later projections.

Health Care Practice

Advancements in medical technology and pharmaceuticals occur regularly, though the timing of these inventions is difficult to predict. Examples include the widespread introduction of magnetic resonance imaging over the past two decades, advancements in prosthetics for lost limbs, and the discovery of more effective Hepatitis C treatments in the mid-2010s.

Assumptions most affected

Utilization trends, intensity trends, morbidity, mortality:

- The introduction of new treatments and devices can change the trend in utilization levels by introducing treatments for the first time or changing the price and effectiveness of existing treatments. Often, these advancements may be focused on a very specific service category (e.g., prosthetics). Changes in cost will affect the cost per service (e.g., a more intense, higher cost service) as well. Uncertainty around the timing and impact of these advancements translates into uncertainty about these model assumptions.
- Improvements in health care, especially life-saving treatments, tend to reduce mortality rates over time, improve overall health (morbidity) and extend lifespans. The EHCPM

specifically includes mortality improvement assumptions and uncertainty about the pace of future changes in mortality compounds over the long-term.

- The utilization and intensity trend assumptions incorporated into the model will, barring any specific information, account for average trend movements over time. These trends cannot anticipate rare and/or exceptional events.

Time horizon

Short-term and long-term:

- Due to the gradual nature of most innovations, whether it be changing practice patterns or the gradual adoption of new medical technologies, the uncertainty about their effects compounds more significantly over the long-term.
- However, short-term breakthroughs, especially the introduction of new and expensive pharmaceuticals, contribute to uncertainty over the shorter-term budget horizon. For example, the introduction of genotype-specific Hepatitis C drugs (e.g. Harvoni, Viekira, Daklinza) beginning in 2014, which had an initial price approaching $100,000 per patient, came to market quickly and within the time frame of the three-year budget projection.

Budget Scenario

COVID-19, in addition to the extensive disruptions to short-term care due to deferral of care and treatment of COVID patients, may also affect underlying health care practice trends. For example, resources directed toward the development of the vaccine may be affecting the speed with which other drugs come to market, the increase in video telehealth care could be sustained, or the significant disruption in regular care patterns could affect future treatment protocols. These possibilities, among others, cause a higher than usual level of uncertainty in emerging health care patterns. The Budget Scenario assumes some long-term changes in health care practice in addition to higher vaccination rates. For LTSS, many adult day health care centers (ADHC) closed during the initial lockdowns in 2020 and 2021, and many of them went on to permanently close. Based on these developments, the Budget Scenario reflects lower long-term utilization as a result of the reduced supply of ADHCs. Finally, the trajectory of telehealth services provided by VA was increased further to account for additional projected mental health evaluation & management provided via telehealth. VA continues to evaluate emerging experience and available information to assess whether long-term changes in health care practice for other services is developing and measurable, and the assumptions will be revised as appropriate.

Demand Allocation between VA Direct Care and Community Care

The EHCPM projects enrollees' total enrollee demand for VA health care. Then, the total projected demand is allocated to VA direct care and community care based on eligibility criteria for community care (e.g., MISSION Act) and operational guidelines.

Assumptions most affected

Reliance, cost per service:

- The projected resource requirements for VA direct care and community care represent a division of the total enrollee demand projected by the EHCPM. Therefore, both care locations need to be funded at the projected expenditure levels to meet the total projected enrollee demand for VA health care. For example, if VA direct care is not funded at the projected level, VA would need to purchase this care in the community, which would increase the projected resource requirements for community care.

- In addition, the EHCPM projects significant growth for ambulatory care services in both VA facilities and in community care. If VA is not able to expand capacity in VA facilities to meet this growth due to resource constraints or the lack of available providers and/or space, this projected increase in services will need to be met in the community, which would increase the projected resource requirements for community care. Under the MISSION Act, if VA cannot provide care in VA facilities in a timely manner, enrollees are eligible to receive care in the community.

  Likewise, if VA's community care network cannot expand to meet the projected growth in demand, VA may not be able to meet all of enrollees' projected demand. This would suppress enrollees' preferred reliance on VA health care.

  Mismatches in resource availability or the inability to increase capacity in VA facilities or the community care network to meet the projected service growth could disrupt timely access to care for enrollees.

  Also, because these two locations of care require different funding streams and operational support, there is risk associated with the allocation of care between locations, and not just the total amount of care provided by VA.

Time Horizon

Short-term:

- The allocation of the total projected health care demand between VA direct care and community care allows VA to budget and plan to meet enrollees total demand for VA health care. The short-term uncertainty is that emerging experience will be different than the allocation of care, causing operational disruption.

Budget Scenario

Assumes the projected future growth in services follows the historical split between VA direct care and community care except for the reliance growth due to the expanded eligibility criteria for community care under the MISSION Act. The pandemic has disrupted care patterns for almost all providers and enrollees. As that care resumes, there is an elevated risk of emerging care patterns differing from the historical pattern, particularly if VA direct care re-opens at a different pace than community care.

Enrollee and Veteran Preferences

Eligible Veterans have a choice to enroll with VA and, once enrolled, can choose how much of their health care to get through VA instead of through their other coverage. Because most Veterans have these choices, their individual preferences will influence the result.

Assumptions most affected

Enrollment rates, reliance:

- Enrollment with VA is free (i.e., there is no monthly premium like there is in Medicare and private insurance); yet not all eligible Veterans choose to enroll with VA. As a result, there can be large swings in new enrollment over time, affected by a wide variety of external factors and the individual preferences of Veterans (see Figure C). It should be noted, however, that new enrollment represents a small part of total enrollment. If approximately 400,000 new enrollees join in a year, it represents about 4.4% of the 9 million unique Veterans enrolled in that year. An unexpected increase of +4,000 new enrollees (i.e., 1% of the annual new enrollment) would only increase the total enrollment by 0.04% and budget requirements may increase by even less if the additional enrollees are younger and have fewer health care needs.

  Similarly, those enrolled with VA may not get all of their care through VA. Indeed, enrollee reliance has been trending up gradually over the past few years. There is considerable room for increases in reliance if Veteran preferences were to change dramatically, and this could have a large impact on utilization and expenditures.

Average Reliance for All Enrollees Across All Services (Excluding LTSS)

	2016	2017	2018	2019
Estimated Aggregate Reliance	35.6%	36.0%	37.0%	38.2%

Average expenditures per enrollee tend to increase with age, but the impact of reduced reliance on VA among older Veterans tends to outweigh this trend. Reliance has typically decreased over time for enrollees aging past 65 and as they gravitate toward Medicare coverage. This process is a direct expression of enrollee preference as new coverage options become available, and there is significant uncertainty around the pace of this change as well as whether younger enrollees will follow the same pattern after they reach age 65. If enrollee preferences begin to change more quickly than projected, then it can have a very large impact on the required budget.
VA has emphasized telehealth, increased accessibility to women Veterans, a focus on mental health issues specific to Veterans, and pursued other innovations in its health care delivery. These efforts can translate into gradual preference shifts over time, resulting in longer-term shifts in enrollment rates and reliance.

Time horizon

Short-term and long-term:

- Events, like acts of nature or economic downturns, could affect Veteran preferences for VA compared to other health care systems over a short period of time. Longer-term trends in preferences may be identified directionally but are difficult to predict. Due to the significant slack in demand for new enrollment and reliance, even small changes in how these preferences trend over time can compound substantially over a long-term horizon.

Budget Scenario

The pandemic is causing a reduction in enrollment rates since enrollment often coincides with the need for health care services. While enrollment rates are likely to return to historical levels, it is less certain whether there will be a surge in enrollment as care deferral ends and enrollees begin to seek care.

Health care utilization patterns are subject to significant inertia. That is, health care users will tend to continue using the same care providers over time, even if changes in circumstances would suggest that choice is no longer optimal. The significant disruption of care that occurred during the COVID-19 pandemic may cause more enrollees to re-evaluate their care patterns. This could lead to increases or decreases in reliance, and changes to the demand for VA direct care vs. community care.

Enrollment policy

VA has discretion over many aspects of enrollment eligibility. For example, VA can decide to expand enrollment to previously suspended income levels.[70]

Assumptions most affected

Enrollment rates, priority transitions:

- Changes in eligibility are likely to increase rates of new enrollment, especially if a large group of previously ineligible Veterans becomes newly eligible. Not all eligible Veterans choose to enroll because most have other health coverage options through Medicare, Medicaid, employer-sponsored coverage, TRICARE, individual health insurance, and others. Therefore, there is uncertainty about how these Veterans will respond to changes in eligibility. The take-up rate usually cannot be directly observed in historical data, and so the initial assumptions are likely to be revised substantially in subsequent model updates.
- VA removed the net worth test from the VA Means Test (VMT) in 2015 and also streamlined the annual means test requirement for enrollees beginning in mid-2014. This change caused shifts in priority levels, which took several years to adjust to the new policy. Most changes involved enrollees getting a priority upgrade, which may have induced some additional reliance on VA for care. For a change like this, uncertainty mostly comes from the change in categorization by priority rather than an underlying change in morbidity, a

[70] New enrollment is suspended for Veterans with household incomes above the VA Means Test (VMT) and more than 10% greater than the Geographic Means Test (GMT), provided they do not meet other eligibility criteria, such as a service-connected disability rating.

technical change that increases the uncertainty around modeling future assumptions by priority using historical data that is categorized differently.

Time horizon

Short-term and long-term:

- There is uncertainty in the short-term due to Veteran responses to policy changes, and this can compound more substantially over the long-term horizon.

Health Status

Acute illnesses among enrollees may require substantial care by VA, and ongoing treatment for chronic medical conditions account for a significant part of VA direct care and community care workload. However, due to the approximately 9 million Veterans currently enrolled, of which approximately 6 million are patients during the year, the uncertainty about the workload required for individuals is spread and diversified across a very large population. The impact of an individual enrollee's medical condition is even diversified across the patients of a particular VA facility.

If, however, there are systematic changes in the prevalence and severity of medical conditions across a large portion of the enrollee population, then this diversification may become less effective at reducing potential volatility in the overall demand for health care services.

Assumptions most affected

Morbidity, utilization trends, utilization differences across demographic groups:

- Systematic changes across large groups of enrollees will impact morbidity levels for specific service categories at the market and national level. For example, increases in opioid addiction raise uncertainty about how to model long term substance abuse disorder morbidity. These types of systematic changes in disease prevalence tend to be gradual and may be detected through ongoing monitoring of workload and through consultation with VHA program offices.

Time horizon

Short-term and long-term:

- Due to the diversification of risks across a large enrollee population, short-term uncertainty arises more from systematic and sudden changes across a broad portion of the population, such as a pandemic. Uncertainty is greater over the long-term, as emerging trends in disease prevalence compound over a longer period of time.

Budget Scenario

The long-term health status impacts of the pandemic are not fully known. Emerging literature, including VA research, demonstrates an increase in demand for health care following recovery from COVID-19, particularly care related to cardiovascular disease and mental health conditions. However, a number of factors could cause changes in health status in the broader enrollee population:

- Mental health strain caused by the pandemic and resulting quarantine.

- Complications caused by the deferral of care. This includes both the deferral of treatments and the deferral of preventive care services, which could lead to missed or delayed identification of health care conditions.

- While most patients contracting the virus appear to have recovered fully, there is uncertainty about the potential for emerging complications.

The Budget Scenario does not include any adjustments to reflect these factors. VA continues to consult with subject matter experts, reviewing literature and analyzing emerging data and will incorporate adjustments to the model as appropriate.

Inflation

The cost of goods and services tends to increase over time, and the rate of inflation is difficult to forecast over both short and long periods. For example, the consumer price index for all urban consumers (CPI-U) increased 9% on a 12 month basis as of May 2022, which is about 6% higher than typical projections made as recently as January 2020[71]. VA's operational expenses are impacted by changes in the cost of supplies, equipment, software, buildings and maintenance. They are also impacted by federal wage and benefits policy, which drives the cost of medical and administrative staff for care provided in VA facilities.

[71] Congressional Budget Office's (CBO's) January 2020 "The Budget and Economic Outlook from 2020 to 2030", Table 2-1, indicated a projected annual CPI-U increases of 2.6% during 2021 and 2022. On June 10, 2022, the Bureau of Labor Statistics reported that the CPI-U increased by 8.6% over the prior 12 months ending May 2022.https://www.cbo.gov/publication/56073

Assumptions most affected

Inflation, cost per service, community care reimbursement rates:

- The inflation assumption reflects the cost of providing specific services, including payments for care purchased in the community, and the consumption of specific supplies and pharmaceuticals at VA facilities. In addition, staff salaries, investments in medical equipment, infrastructure costs, and other overhead expenses are allocated across all services provided during the year. Therefore, the cost of a specific medical service is modeled as a combination of direct and indirect costs in order to link utilization levels with overall VA budget expenditures.
- Staff salaries and benefit levels, including required retirement contributions, are a significant part of VA's expenditures that are determined by circumstances outside the Department. Assumptions are set regarding the trajectory of wage schedules and benefit levels for staff, though the actual amounts are uncertain.
- Community care claim costs are directly linked to the amounts paid to community providers for each service according to negotiated fee schedules. Those schedules are in turn often tied to Medicare fee-for-service payment rates which are impacted by inflation.

Time horizon

Short-term and long-term:

- Divergence of actual inflation trends over the EHCPM's assumptions will have a small impact over the short-term, but they may compound substantially over time. This risk is higher than normal at the current time due to the recent increase in inflation.
- While the fee schedules for community care may be set over a short period of time, over the long-term it is more difficult to anticipate the reimbursement levels that will be negotiated in the future. Similarly, uncertainty around inflation in both variable and fixed expenses will compound over time for services at VA facilities.
- Salaries are a significant component of VA facilities cost per service and change based on federal wage policy, which is generally set just prior to the impacted calendar year. In the short-term, differences between the actual wage increase/freeze and the assumptions in the EHCPM are addressed in the budget submission.

Budget Scenario

The CPI based forecast for VA's operational expenses was updated from using a twenty-year average inflation forecast (appropriate for the stable inflation environment preceding this year) to reflect a rise in inflation based on the recent CPI outcomes. This adjustment was applied to the near-term fiscal year forecasts before reverting back to a stable inflation rate for the long term.

Management Policies and Initiatives

VA leadership exercises some discretion in how health care benefits are provided through program policies and initiatives; as leadership changes, so can the top priorities of the organization. Changes in management approach and policy can impact many aspects of how care is delivered. VA may pursue new ways to improve the provision of care, but it may be difficult to predict what specific initiatives will be implemented and how they might affect future capacity for budget, capital and strategic planning purposes.

Assumptions most affected

- Enrollment rates, health care management, cost per service, priority transitions, reliance, utilization trends.
- Changes in management policies and initiatives range from broad, sweeping transformations of the health care system through leadership priorities to detailed decisions by program offices that promote patient centered care. Examples of policies and initiatives that have impacted the EHCPM include:
    - ***Programmatic adjustments for LTSS*** – VA is required to meet the LTSS needs of Veterans by providing facility-based care for enrollees with service-connected disabilities of 70% or greater as well as for those in need of such care due to service-connected conditions. Resources permitting, VA also must provide such care for enrollees who do not meet these criteria. VA is also required to provide home and community-based services to all enrollees as needed. Each year, the Office of Geriatrics and Extended Care provides policy assumptions to shift projected utilization to align with their initiative of keeping enrollees out of long-term facility-based care for as long as is feasible.
    - ***Mental health and homeless staff hiring initiatives*** – VA places a high priority on ensuring that all enrolled Veterans have access to needed mental health services. VA also offers a wide array of special programs and initiatives specifically designed to help homeless Veterans live as self-sufficiently and independently as possible. Staffing for these programs, and subsequently projected utilization, can be dependent on temporary special purpose funds targeted for hiring mental health providers or availability of Housing and Urban Development-VA Supportive Housing vouchers. Each year, the Office of Mental Health and Suicide Prevention and the Homeless Program Office provide guidance on the presence of internal and external drivers impacting staffing so that appropriate adjustments can be made to projected utilization.
    - ***Inpatient System Redesign*** – VA seeks to continuously improve its level of inpatient care management through initiatives such as the Flow Improvement Inpatient Initiative, full implementation of utilization management review programs, and improvements in disease management and care coordination through the Patient Aligned Care Team initiative. The EHCPM incorporates assumptions about VA's current efficiency level and the impact of system redesign on its future level. These assumptions are incorporated into the EHCPM to project utilization. Any expected savings from increased efficiency are reported as clinical efficiencies in the budget impact analysis.

Time horizon

Long-term:

- The expectation is that changes in the organization will occur gradually. In the long-term, there is uncertainty about their efficacy.

Non-VA Health Care Coverage

Veterans have access to other forms of health care, including through Medicare, Medicaid, employer-sponsored coverage, TRICARE, and individual health insurance. As the availability and affordability of external health care coverage changes, it can materially impact the choices available to a Veteran. For example, the ACA significantly expanded coverage options for individuals beginning in 2014 by regulating and subsidizing individual coverage and funding expanded eligibility for Medicaid coverage in many states. Even for those with coverage, gradual increases in cost sharing over time may cause enrollees to shift more care to VA, thereby increasing reliance.

Medicare coverage is available to most seniors ages 65 and over and many disabled individuals under 65. Medicaid coverage is also available to lower income Veterans. Federal statute and regulation determines eligibility and benefits for Medicare coverage throughout the country whereas both the Federal government and each state's own Medicaid program determines eligibility and benefits of each state's Medicaid coverage. ACA affects the availability of health care through individual and employer-sponsored coverage. It is difficult to predict long-term changes to these programs.

Assumptions most affected

Reliance, enrollment rates, community care reimbursement schedule:

- The availability, affordability, and scope of health insurance options outside of VA will affect both the likelihood that individual Veterans enroll with VA and once enrolled, may impact the portion of care and scope of services for which they rely on VA.
- Other sources of health insurance will affect a Veteran's behavior in different ways as they age or as their life situation changes. The loss of health coverage from the Department of Defense upon separating from the military is a key motivator for new Veterans to enroll with VA. If a Veteran has not yet enrolled with VA, they may reconsider it at key points in their life, such as after the loss of a job, when nearing retirement, or after losing health coverage from a spouse. Even when already enrolled, their reliance may change over time as they move from employer-sponsored coverage to Medicare, for example.
- Program changes may increase the benefit richness or generosity of Medicare and Medicaid. This can cause some enrollees to have less reliance for services. If a state expands Medicaid eligibility to higher income levels, then there could be a new portion of enrollees in that state who decide to get more of their care through Medicaid or who move over to Medicaid for the first time. Similarly, if subsidies for individual coverage under

ACA are expanded, then these options will be more attractive when Veterans are deciding whether to get their care at VA.

- Projections of changes in reliance are hampered by incomplete data on enrollees' non-VA care, specifically, the lack of a comprehensive source to capture claims for enrollees under age 65.
- Community providers often derive a significant part of their income from serving Medicare and Medicaid beneficiaries, and so changes to the fee schedules under those programs can make providers more or less willing to participate in VA's community care contracts. Private insurance coverage, offered through ACA marketplaces or sponsored by employers, often reimburses providers more than they get from Medicare and Medicaid. There could be more pressure from community providers to be reimbursed by VA at higher levels if they think Medicare, Medicaid and private insurance reimbursement levels are insufficient. Conversely, contractions in the scope of coverage by other health care coverages may reduce their workload and make them more willing to provide care purchased by VA. This increases uncertainty about future cost per service levels for community care.
- Much of the VA Community Care Network contract references Medicare reimbursement rates, so changes to Medicare's fee schedules will also directly affect community care reimbursement.

Time horizon

Short-term and long-term:

- There is uncertainty in the short-term due to Veteran responses to changes in their health care coverage, and this can compound more substantially over the long-term horizon. Enrollment in other sources of coverage tends to be "sticky" in the sense that individuals tend to stay with their current health coverage and health care providers.
- Short-term changes in other sources of health insurance, such as during an economic downturn, can introduce uncertainty about reliance levels over the short-term budget horizon. For example, when a Veteran loses their job or insurance from an employer, they may consider a variety of options, including COBRA coverage, subsidized insurance through ACA marketplaces, or Medicaid, in addition to VA. If their period of unemployment is short, then they may go back to employer-sponsored coverage without ever considering VA health care.
- Longer-term, there is much more uncertainty about insurance markets and public programs. Programs can become more or less attractive over time, and gradual changes can compound over many years as Veteran decisions on where to get their care begin to change on an individual basis.

Combat and deployments

Military conflicts are difficult to predict. Yet, they can have a dramatic impact on the number of Service members, the timing of their separations from the military, the nature of medical conditions related to military service, and the long-term relationship between former Service members and government agencies. In each conflict era, newly separating Service members

initially represent a small and young cohort of the enrolled Veteran population. Over time, they may grow to be a more substantial portion of the population. Historical data from Veterans of earlier conflicts may be a guide but is not a perfect template for predicting the behaviors and health care needs of more recent Veterans.

Extended combat deployments can lead to greater morbidity and higher prevalence of service-connection disability which can lead greater health care needs after discharge. Furthermore, each period of combat gives rise to different types of disability due to the changing nature of warfare, changes in survivability of injuries, and other factors.

Assumptions most affected

Enrollment rates, morbidity, reliance:

- Recently separated Post-9/11 combat Veterans have much different health care needs and enrollment rates than Veterans of the earlier Gulf War era. Similarly, Vietnam era Veterans (representing about 29% of current enrollees) have different health care needs than WWII Veterans (currently representing about 1% of enrollees), even after adjusting for the passage of time and aging. For example, exposure to Agent Orange during the Vietnam War has led to a unique mix of medical conditions over the lifetime of those combat Veterans, requiring VA to develop a presumptive service-connected disability authority. In addition, battlefield injuries among surviving Veterans are different, causing morbidity differences by service category to differ. There are other generational differences that show up in various model assumptions, including enrollment rates and reliance.
- Women Veterans currently represent about 10% of enrollees, a share that continues to increase and which is projected to reach 13% by 2031. Women Veterans historically have enrolled at a lower rate than their male counterparts. However, women combat Veterans have enrolled at, or in some cases above, the level of their male counterparts. This development underscores the importance of monitoring emerging experience for evidence of large changes of assumptions such as this. There is relatively little historical data about the health care needs of women Veterans at older ages and VA does not expect those patterns to be predictive of the newer generation of women Veterans, especially those with combat theater experience. Therefore, the longer-term projection of women Veterans with combat experience is subject to greater uncertainty and must be monitored closely.

Time horizon

Long-term:

- It takes longer than the short-term budget horizon for active-duty Service members to separate and grow into a significant portion of the Veteran population. The uncertainty about how various demographic cohorts will behave as they age takes many years to unfold and increases the uncertainty over longer time horizons.

APPENDIX A: Government and Private Industry Examples for Risk Analysis

Standards for internal control in the Federal Government

The Comptroller General of the United States publishes standards for internal control for Federal Government agencies[72]. A key principle of risk assessment is *Principle 7 - Identify, analyze, and respond to risks.*

The Department of Veterans Affairs (VA) follows this principal of risk assessment when developing actuarial projections and communicating projection uncertainty to stakeholders. Risks are identified and their link to important projection drivers are modeled. Through the annual model update process, these risks are analyzed using historical data and actuarial models. Finally, through ongoing monitoring of emerging experience, changes in these risks and their impact on utilization and expenditure is measured and corrective actions taken where appropriate.

Examples from private health insurer regulation

The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. NAIC creates guidance and model laws that many states adopt when regulating health insurance companies in their jurisdictions. Projection risk assessment is a significant component of two key guidelines:

- Risk based capital (RBC)[73,74]
- Own Risk and Solvency Assessment (ORSA)[75]

Risk monitoring in the RBC Plan

The primary objective of RBC is to quantitatively measure solvency risk for a health insurance company and to establish minimum levels of required capital and surplus. While these capital and surplus requirements do not apply to VA in the same way due to the backing of the Federal government, RBC requirements set an important example for how to assess and manage risk. When a health insurer's capital and surplus level falls below a particular minimum level, they must prepare an RBC Plan for their regulator. The RBC Plan includes several components, but one in particular is a listing and discussion of key assumptions impacting the insurer's projections and the sensitivity of those projections to the assumptions. The purpose of this exercise is to demonstrate to the regulator that that company is aware of the risks to which it is exposed.

VA's approach to monitoring actuarial projection uncertainty is consistent with this industry precedent. When a material difference between actual and projected utilization and expenditures is identified, the conditions leading to that difference are investigated. Key model assumptions that

[72] Standards for internal control in the Federal Government, Government Accountability Office, September 2014, https://www.gao.gov/assets/670/665712.pdf
[73] RBC Overview: https://content.naic.org/cipr_topics/topic_riskbased_capital.htm
[74] RBC Model Act: https://content.naic.org/sites/default/files/inline-files/MDL-312.pdf
[75] ORSA Guidance Manual: https://www.naic.org/documents/prod_serv_fin_recievership_ORSA-2014.pdf

led to the difference are identified and adjusted, as appropriate. Other corrective action, including but not limited to operational and funding changes are considered.

Risk assessment in the ORSA Summary Report

Most health insurers must prepare an annual summary report documenting their assessment of risks. The primary goal of this assessment is for each insurer to identify, assess, monitor, prioritize, and internally report on the material and relevant risks to the business. Included in this report is an assessment of risks on both a quantitative and qualitative basis and under both normal and stressed environments. The assessment considers a range of potential outcomes.

VA's approach to assessing actuarial projection uncertainty is consistent with this industry example. Where appropriate in communications of specific model assumptions, the sensitivity of final projections to these assumption inputs is discussed. Overall uncertainty of the EHCPM across all assumptions and risks is discussed in this report. Moreover, selected scenarios representing illustrative stress environments are discussed on a qualitative and quantitative basis.

State Medicaid Agencies

Medicaid programs are managed at the state level, including budget development, though there is federal oversight by Centers for Medicare & Medicaid Services (CMS) due to the significant federal match of state budget projections. CMS requires states to systematically think through the assumptions that can influence their Medicaid program costs. State Medicaid Agencies provide CMS with documentation of all the major risks affecting budget development using a consistent framework.

Managed care budgets are developed in accordance with generally accepted actuarial principals, such as actuarial standard of practice (ASOP) No 49 *Medicaid Managed Care Capitation Rate Development and Certification*, and they are documented to CMS using a rate development guide[76]. In the guide, each assumption is discussed in terms of its development, its source of uncertainty, and its impact on the projection results. Through this process, the State Medicaid Agency takes stock of the most important sources of uncertainty in the projections.

VA's approach is similar in taking a systematic approach to evaluating assumptions and risks each time it does a scenario.

[76] https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html

Actuarial Standards of Practice

Actuaries performing work relating to projecting health care utilization and expenditures are subject to ASOP promulgated by the Actuarial Standards Board of the American Academy of Actuaries. Among these are:

- *ASOP No. 5 Incurred Health and Disability Claims*
- *ASOP No. 12 Risk Classification*
- *ASOP No. 23 Data Quality*
- *ASOP No. 25 Credibility Procedures*
- *ASOP No. 41 Actuarial Communications*

These standards guide the analysis methodology and communications of actuaries that develop the VA Enrollee Health Care Projection Model. These standards also apply to the assessment and communication of uncertainty in the projections. In particular, the actuaries consider which cautions regarding possible uncertainty or risk in any results are disclosed in communications to stakeholders.

The EHCPM report sections include these communications on a topical basis for each major assumption in the EHCPM. Reports describing specific analyses or projection scenarios will include a discussion of key areas of uncertainty in the projections, including uncertainty about future trends as well as uncertainty about historical data quality and applicability.

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Medical Facilities by Type

As of September 30, 2022, the Veterans Health Administration (VHA) operates a portfolio of approximately 5,640 owned buildings with a total of 152.4 million square feet of space on 16,057 acres of land. The portfolio also includes 1,722 leases with a total of 21.9 million square feet of space.

The table below provides a more granular level of detail based on the services provided and is consistent with the current classification methodology. A description of each of category of facility, along with an explanation of any changes in the number of installations, is provided after the table. Tables containing the names and locations of each installation within each facility category are located at the end of the chapter.

Medical Care
Number of Installations

Description	2022 Actual 1/	2023 Budget Estimate	2023 Current Estimate	2024 Advance Approp.	2024 Revised Request	2025 Advance Approp.	+/- 2023-2024	+/- 2024-2025
Veterans Integrated Service Networks (VISN)	**18**	**18**	**18**	**18**	**18**	**18**	0	0
VA Medical Centers (VAMC), Total	**172**	**171**	**172**	**171**	**172**	**172**	0	0
Included in VA Medical Centers, Total:								
VA Hospitals	145	145	145	145	145	145	0	0
Community Living Centers (CLC)	135	135	135	135	135	135	0	0
Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)	120	124	124	129	127	129	3	2
VAMC-Based Outpatient Care Sites	172	171	172	171	172	172	0	0
Health Care Centers (HCC)	**12**	**12**	**12**	**12**	**12**	**12**	0	0
Community-Based Outpatient Clinics (CBOC)	**702**	**740**	**703**	**740**	**704**	**704**	1	0
Multi-Specialty CBOC	289	204	289	204	289	289	0	0
Primary Care CBOC	413	536	414	536	415	415	1	0
Other Outpatient Services (OOS) Sites, Total	**415**	**377**	**415**	**377**	**415**	**415**	0	0
Included in OOS Sites, Total:								
Dialysis Centers	70	73	70	73	70	70	0	0
Community Resource and Referral Centers (CRRC)	32	32	33	32	33	33	0	0
Vet Centers	**300**	**300**	**300**	**300**	**300**	**300**	0	0
Mobile Vet Centers	**83**	**83**	**83**	**83**	**83**	**83**	0	0
Vet Center Outstations	**23**	**22**	**23**	**22**	**23**	**23**	0	0

1/ Reflects historical data as of September 30, 2022.

Annual Changes in Medical Care Installations

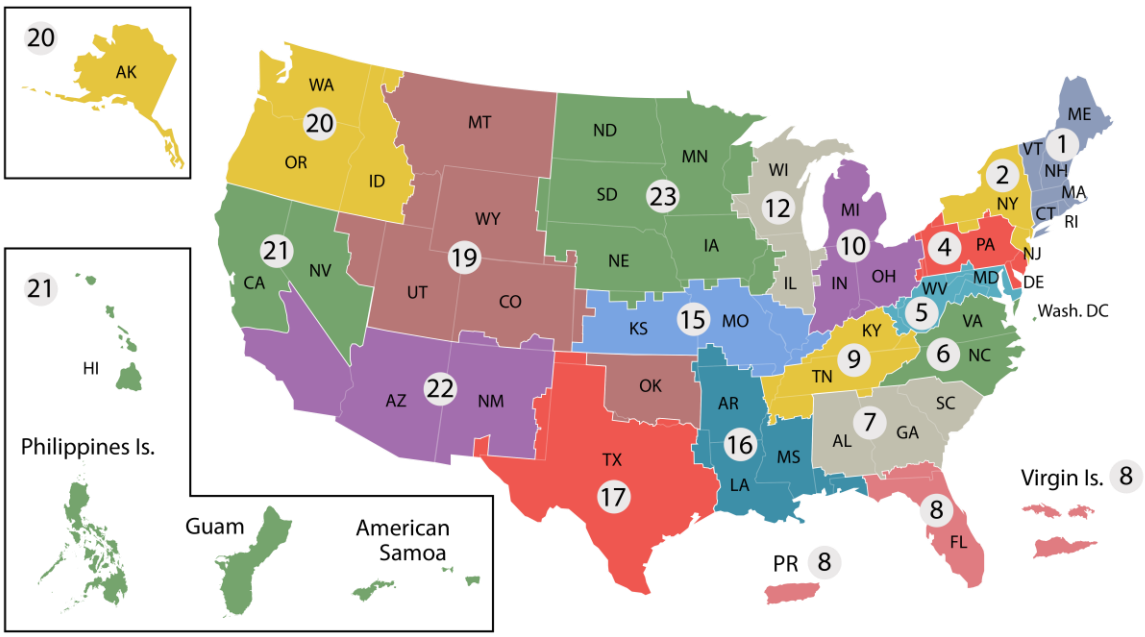
Veterans Integrated Service Networks (VISN)

In the late 1990s, VHA was geographically separated into 21 areas known as Veterans Integrated Service Networks (VISNs) and was further modified in October 2015 in compliance with the VA Memorandum on VISN Realignment. As a result of the VISN realignment, VHA currently has five districts and 18 VISNs.

VA Districts by VISN

District	District Name	VISN
1	North Atlantic	1,2,4,5,6
2	Southeast	7,8,9
3	Midwest	10,12,15,23
4	Continental	16,17,19
5	Pacific	20,21,22

Map with 18 VISNs:



VA Medical Centers (VAMC)

VAMCs are facilities that provide two or more categories of care (inpatient, outpatient, residential rehabilitation, or institutional extended care).

VA Hospitals
A VA Hospital provides both inpatient acute care and outpatient care and may also provide residential rehabilitation care and/or institutional extended care.

VAMC changes in 2022
In 2022, 1 VAMC site has been activated (+1 VAMC):

- +1 VAMC: VISN 10 Detroit VAMC (Valor Center), Detroit, MI (553A4)

Of the 172 VAMCs, 145 were classified as VA Hospitals in 2022. To meet the criteria of a VA Hospital, a facility must report over 500 inpatient acute bed days of care. The other 27 VAMCs provided a mix of other bed-care services, such as CLCs and/or residential rehabilitation care, thus meeting the VAMC criteria.

Please refer to the section titled "FY 2022 VA Medical Centers and Hospitals" for the complete list of VA Medical Centers and Hospitals in 2022.

Community Living Centers (CLC)
CLCs provide institutional extended care services and may be part of a VA Hospital (e.g., a wing), or a free-standing structure.

CLC changes in 2022
Based on workload data, 1 CLC site has been activated, resulting in a net increase from 134 to 135 (+1 CLC):

- +1 CLC: VISN 23 Papillion VA Community Living Center, Papillion, NE (6369AA)

Please refer to the section titled "FY 2022 Community Living Centers (CLC)" for the complete list of CLCs in 2022.

Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)
MH RRTPs provide rehabilitative care in a residential setting. Like a CLC, it may be part of a VA Hospital or a free-standing structure.

MH RRTP changes in 2022
Based on workload data, 4 sites of care have been activated and 1 site deactivated, resulting in a net increase from 117 to 120 (+3 MH RRTP):

- +1 Domiciliary Substance Use Disorder (DOM SUD): VISN 19 VA Western Colorado Healthcare System, Grand Junction, CO (575)
- +1 MH RRTP, VISN 1 VA Connecticut Healthcare System, West Haven, CT (689)
- +1 Compensated Work-Therapy/Transitional Residence (CWT-TR), VISN 12 LaCrosse VA Stand-Alone Residential Care Site, LaCrosse, WI (676PA)
- +1 CWT-TR, VISN 23 VA Black Hills Healthcare System, Black Hills, SD (568)
- - 1 MH RRTP, VISN 10 VA Cincinnati Healthcare, Cincinnati, OH (539)

Please refer to the section titled "FY 2022 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)" for the complete list of MH RRTPs in 2022.

MH RRTP changes in 2023

In 2023, 4 sites of care are projected to be activated, resulting in a net increase from 120 to 124 (+4 MH RRTP):

- +1 Domiciliary Care for Homeless Veterans, Houston, TX
- +1 DOM SUD, Alexandria, LA
- +1 DOM SUD, Amarillo, TX
- +1 Domiciliary Post-Traumatic Stress Disorder (DOM PTSD), Denver, CO

MH RRTP changes in 2024

In 2024, MH RRTPs are projected to increase from 124 to 127 (+3 MH RRTP):

- +1 General Domiciliary, San Juan, PR
- +1 DOM SUD, Oklahoma City, OK
- +1 DOM SUD, Poplar Bluff, MO

MH RRTP changes in 2025

In 2025, MH RRTPs are projected to increase from 127 to 129 (+2 MH RRTP):

- +1 MH RRTP, New Orleans, LA
- +1 DOM SUD, Togus, ME

VAMC-Based Outpatient Care Sites

A VAMC-Based Outpatient Care site is a VAMC that provides outpatient care. By definition, all VA Hospitals provide outpatient care, but some free-standing CLCs and/or MH RRTPs also provide outpatient care and are therefore included in this classification.

Outpatient Classification Criteria

Outpatient Medical Facilities	Primary Care Encounters 1/	Mental Health Encounters 1/	Specialty Care Encounters 1/	Ambulatory Surgery Services 2/
Health Care Center (HCC)	Greater than 500	Greater than 500	Greater than 500 in any 2 or more Specialties	Yes
Multi-Specialty CBOC	Greater than 500	Greater than 500	Greater than 500 in any 2 or more Specialties	None
Primary Care CBOC	Greater than 500	Greater than 500	Greater than 500 in any 1 Specialty	None
Primary Care CBOC	Greater than 500	Greater than 500	500 or less in 1 or more Specialties	None
Other Outpatient Service Site (OOS)	Greater than 500	Less than 500	Greater than 0	None
Other Outpatient Service Site (OOS)	Less than or equal to 500	Greater than 500	None	None
Other Outpatient Service Site (OOS)	Less than or equal to 500	Greater than 500	Greater than 0	None
Other Outpatient Service Site (OOS)	Less than or equal to 500	Less than or equal to 500	Greater than 0	None
Other Outpatient Service Site (OOS)	None	Less than or equal to 500	None	None

1/ Source: VSSC Outpatient Encounters data
2/ Source: Surgery and Clinical Inventory data (Ambulatory Surgery Center, Ambulatory Surgery Services and / or Moderate Sedation)

There are four outpatient classifications: (1) Health Care Center (HCC); (2) Multi-Specialty Community Based Outpatient Clinic (MS CBOC); (3) Primary Care Community Based Outpatient Clinic (PC CBOC); and (4) Other Outpatient Services site (OOS).

Outpatient medical facilities are classified based on workload (encounters) by the following services: Primary Care, Mental Health, Specialty Care, and Ambulatory Surgery. Please refer to the "Outpatient Classification Criteria" table below for complete detail.

Health Care Centers (HCC)
HCCs are VA-owned, VA-leased, or contract clinics operated 5 days per week that provide primary care, mental health care, on-site specialty services, and perform ambulatory surgery and/or invasive procedures which may require moderate sedation or general anesthesia.

HCC changes in 2022
In 2022, 1 new site of care has been activated and 1 HCC has been reclassified into MS CBOC, resulting in a total of 12 HCC sites:

- +1 HCC: VISN 17 North West San Antonio VA Clinic, San Antonio, TX (671GS)
- -1 HCC: VISN 8 Viera VA Clinic, Viera, FL (675GA)

Please refer to the section titled "FY 2022 Health Care Centers (HCC)" for the complete list of HCCs in 2022.

Multi-Specialty Community Based Outpatient Clinics (MS CBOC)
MS CBOCs (formerly known as CBOCs) are VA-owned, VA-leased, mobile, or contract clinics that offer both primary and mental health care and two or more specialty services physically on site. Access to additional specialty services may be offered by referral or telehealth. These clinics may offer support services, such as pharmacy, laboratory, and x-ray. The clinic may be operational from 1 to 7 days per week. These clinics are permitted to provide invasive procedures with local anesthesia or minimal sedation, but not with moderate sedation or general anesthesia (see VHA Directive 2006-023). The establishment of a new MS CBOC can only be approved by the Secretary, with Congressional notification consistent with 38 U.S.C. 8119(b) (2), (3), and (4).

MS CBOC changes in 2022
In 2022, 8 MS CBOC has been activated, 1 HCC, 3 OOS sites and 82 PC CBOCs have been reclassified into MS CBOC (+94 MS CBOC); 1 MS CBOC has been deactivated, 5 MS CBOCs have been reclassified into OOS, and 3 MS CBOCs have been reclassified into PC CBOC (-9 MS CBOC), resulting in a net increase from 204 to 289 (+85 MS CBOC).

Activations (+8 MS CBOC):

- +1 MS CBOC: VISN 7 Cobb County VA Clinic, Marietta, GA (508GQ)
- +1 MS CBOC: VISN 7 Pike County VA Clinic, Zebulon, GA (508GS)
- +1 MS CBOC: VISN 17 Tyler Centennial VA Clinic, Tyler, TX (549GN)
- +1 MS CBOC: VISN 19 Northern Colorado VA Clinic, Loveland, CO (442GE)
- +1 MS CBOC: VISN 19 North Oklahoma City VA Clinic, Oklahoma City, OK (635GL)
- +1 MS CBOC: VISN 21 Stockton VA Clinic, French Camp, CA (612QE)
- +1 MS CBOC: VISN 22 Phoenix 32nd Street VA Clinic, Phoenix, AZ (644GI)
- +1 MS CBOC: VISN 23 South Des Moines VA Clinic, Des Moines, IA (636GZ)

HCC reclassified into MS CBOCs (+1 MS CBOC):

- +1 MS CBOC: VISN 8 Viera VA Clinic, Viera, FL (675GA)

OOS sites reclassified into MS CBOCs (+3 MS CBOC):

- +1 MS CBOC: VISN 10 Bloomington VA Clinic, Bloomington, IN (583GB)
- +1 MS CBOC: VISN 17 Garland VA Clinic, Garland, TX (549A5)
- +1 MS CBOC: VISN 19 Yukon VA Clinic, Yukon, OK (635GJ)

PC CBOCs reclassified into MS CBOCs (+82 MS CBOC):

- +1 MS CBOC: VISN 1 Littleton VA Clinic, Littleton, NH (405HC)
- +1 MS CBOC: VISN 1 New Bedford VA Clinic, New Bedford, MA (650GA)
- +1 MS CBOC: VISN 1 Hyannis VA Clinic, Hyannis, MA (650GB)
- +1 MS CBOC: VISN 2 Hackensack VA Clinic, Hackensack, NJ (561GD)
- +1 MS CBOC: VISN 2 Staten Island Community VA Clinic, Staten Island, NY (630GB)
- +1 MS CBOC: VISN 2 East Meadow VA Clinic, East Meadow, NY (632GA)
- +1 MS CBOC: VISN 2 Port Jervis VA Clinic, Port Jervis, NY (620GE)
- +1 MS CBOC: VISN 4 Huntingdon County VA Clinic, Mapleton, PA (503GD)
- +1 MS CBOC: VISN 4 Indiana County VA Clinic, Indiana, PA (503GE)
- +1 MS CBOC: VISN 5 Fort Belvoir VA Clinic, Fort Belvoir, VA (688GA)
- +1 MS CBOC: VISN 5 Charlotte Hall VA Clinic, Charlotte Hall, MD (688GD)
- +1 MS CBOC: VISN 6 Raleigh VA Clinic, Raleigh, NC (558GB)
- +1 MS CBOC: VISN 6 Morehead City VA Clinic, Morehead City, NC (558GC)
- +1 MS CBOC: VISN 6 Raleigh III VA Clinic, Raleigh, NC (558GG)
- +1 MS CBOC: VISN 6 Chesapeake VA Clinic, Chesapeake, VA (590GD)
- +1 MS CBOC: VISN 6 Henrico County VA Clinic, Richmond, VA (652GC)
- +1 MS CBOC: VISN 7 Myrtle Beach VA Clinic, Myrtle Beach, SC (534GB)
- +1 MS CBOC: VISN 7 Florence VA Clinic, Florence, SC (544GB)
- +1 MS CBOC: VISN 7 Oakwood VA Clinic, Flowery Branch, GA (508GE)
- +1 MS CBOC: VISN 7 West Cobb County VA Clinic, Marietta, GA (508GF)
- +1 MS CBOC: VISN 7 Stockbridge VA Clinic, Stockbridge, GA (508GG)
- +1 MS CBOC: VISN 7 Lawrenceville VA Clinic, Lawrenceville, GA (508GH)
- +1 MS CBOC: VISN 7 Blairsville VA Clinic, Blairsville, GA (508GJ)
- +1 MS CBOC: VISN 7 Rome VA Clinic, Rome, GA (508GL)
- +1 MS CBOC: VISN 7 Northeast Cobb County, Marietta, GA (508GO)
- +1 MS CBOC: VISN 7 Athens VA Clinic, Athens, GA (509GA)
- +1 MS CBOC: VISN 7 Beaufort VA Clinic, Beaufort, SC (534GC)
- +1 MS CBOC: VISN 7 Hinesville VA Clinic, Hinesville, GA (534GE)
- +1 MS CBOC: VISN 8 Sarasota VA Clinic, Sarasota, FL (516GA)
- +1 MS CBOC: VISN 8 North Pinellas VA Clinic, Clearwater, FL (516GC)
- +1 MS CBOC: VISN 8 Key West VA Clinic, Key West, FL (546GB)
- +1 MS CBOC: VISN 8 Fort Pierce VA Clinic, Fort Pierce, FL (548GA)
- +1 MS CBOC: VISN 8 Ocala VA Clinic, Ocala, FL (573GD)
- +1 MS CBOC: VISN 8 Port Charlotte VA Clinic, Port Charlotte, FL (516GE)
- +1 MS CBOC: VISN 8 Naples VA Clinic, Naples, FL (516GF)
- +1 MS CBOC: VISN 8 Delray Beach VA Clinic, Delray Beach, FL (548GB)
- +1 MS CBOC: VISN 8 Stuart VA Clinic, Stuart, FL (548GC)
- +1 MS CBOC: VISN 8 Tavares VA Clinic, Tavares, FL (675GE)
- +1 MS CBOC: VISN 8 Sebring VA Clinic, Sebring, FL (516GH)
- +1 MS CBOC: VISN 9 New Albany VA Clinic, New Albany, IN (603GB)

- +1 MS CBOC: VISN 9 Tupelo VA Clinic, Tupelo, MS (614GA)
- +1 MS CBOC: VISN 9 Jackson VA Clinic, Jackson, TN (614GG)
- +1 MS CBOC: VISN 9 International Plaza VA Clinic, Nashville, TN (626GO)
- +1 MS CBOC: VISN 10 Marietta VA Clinic, Marietta, OH (538GC)
- +1 MS CBOC: VISN 10 Martinsville VA Clinic, Martinsville, IN (583GC)
- +1 MS CBOC: VISN 10 Grove City VA Clinic, Grove City, OH (757GB)
- +1 MS CBOC: VISN 12 Kankakee County VA Clinic, Bourbonnais, IL (578GC)
- +1 MS CBOC: VISN 12 Aurora VA Clinic, North Aurora, IL (578GD)
- +1 MS CBOC: VISN 12 Hoffman Estates VA Clinic, Hoffman Estates, IL (578GE)
- +1 MS CBOC: VISN 12 LaSalle VA Clinic, Peru, IL (578GF)
- +1 MS CBOC: VISN 12 Springfield VA Clinic, Springfield, IL (550GD)
- +1 MS CBOC: VISN 15 St. Louis County VA Clinic, Florissant, MO (657GB)
- +1 MS CBOC: VISN 15 St. Charles County VA Clinic, O'Fallon, MO (657GD)
- +1 MS CBOC: VISN 15 Marshfield VA Clinic, Marshfield, MO (589JD)
- +1 MS CBOC: VISN 15 Sikeston VA Clinic, Sikeston, MO (657GV)
- +1 MS CBOC: VISN 16 Fort Smith VA Clinic, Fort Smith, AR (564GB)
- +1 MS CBOC: VISN 16 Mountain Home VA Clinic, Mountain Home, AR (598GA)
- +1 MS CBOC: VISN 16 Douglas Fournet Department of Veterans Affairs Clinic, Lake Charles, LA (502GE)
- +1 MS CBOC: VISN 16 Fort Polk VA Clinic, Leesville, LA (502GF)
- +1 MS CBOC: VISN 16 Eglin Air Force Base VA Clinic, Eglin Air Force Base, FL (520GC)
- +1 MS CBOC: VISN 16 Pine Bluff VA Clinic, Pine Bluff, AR (598GE)
- +1 MS CBOC: VISN 16 Searcy VA Clinic, Searcy, AR (598GF)
- +1 MS CBOC: VISN 16 Russellville VA Clinic, Russellville, AR (598GH)
- +1 MS CBOC: VISN 16 Joplin VA Clinic, Joplin, MO (564GF)
- +1 MS CBOC: VISN 17 Corpus Christi VA Clinic, Corpus Christi, TX (740GC)
- +1 MS CBOC: VISN 17 North Central Federal VA Clinic, San Antonio, TX (671GO)
- +1 MS CBOC: VISN 17 Balcones Heights VA Clinic, San Antonio, TX (671GP)
- +1 MS CBOC: VISN 19 Wichita Falls VA Clinic, Wichita Falls, TX (635GB)
- +1 MS CBOC: VISN 19 Ogden VA Clinic, South Ogden, UT (660GB)
- +1 MS CBOC: VISN 20 Silverdale VA Clinic, Silverdale, WA (663GB)
- +1 MS CBOC: VISN 21 Mare Island VA Clinic, Mare Island, CA (612GE)
- +1 MS CBOC: VISN 21 Southeast Las Vegas VA Clinic, Henderson, NV (593GE)
- +1 MS CBOC: VISN 22 Murrieta VA Clinic, Murrieta, CA (605GB)
- +1 MS CBOC: VISN 22 Palm Desert VA Clinic, Palm Desert, CA (605GC)
- +1 MS CBOC: VISN 22 Northwest VA Clinic, Surprise, AZ (644GA)
- +1 MS CBOC: VISN 22 Antelope Valley VA Clinic, Lancaster, CA (691GG)
- +1 MS CBOC: VISN 23 Chippewa Valley VA Clinic, Chippewa Falls, WI (618GE)
- +1 MS CBOC: VISN 23 Sioux City VA Clinic, Dakota Dunes, SD (438GC)
- +1 MS CBOC: VISN 23 Maplewood VA Clinic, Maplewood, MN (618GD)
- +1 MS CBOC: VISN 23 Rochester VA Clinic, Rochester, MN (618GG)
- +1 MS CBOC: VISN 23 Shakopee VA Clinic, Shakopee, MN (618GJ)
- +1 MS CBOC: VISN 23 Holdrege VA Clinic, Holdrege, NE (636GQ)

Deactivations (-1 MS CBOC):

- -1 MS CBOC: VISN 21 Oakland VA Clinic, Oakland, CA (612BY)

MS CBOCs reclassified into OOS sites (-5 MS CBOC):

- -1 MS CBOC: VISN 15 Lenexa VA Clinic, Lenexa, KS (589JG)
- -1 MS CBOC: VISN 21 Clearlake VA Clinic, Clearlake, CA (662GG)
- -1 MS CBOC: VISN 21 Oakland VA Clinic, Oakland, CA (662GH)
- -1 MS CBOC: VISN 22 Sorrento Valley VA Clinic, San Diego, CA (664GF)
- -1 MS CBOC: VISN 23 Sterling VA Clinic, Sterling, IL (636GT)

MS CBOCs reclassified into PC CBOCs (-3 MS CBOC):

- -1 MS CBOC: VISN 1 Lewiston VA Clinic, Lewiston, ME (402GE)
- -1 MS CBOC: VISN 10 Navy Corpsman Steve Andrews Department of Veterans Affairs Health Care Clinic, Gaylord, MI (655GA)
- -1 MS CBOC: VISN 10 Clare VA Clinic, Clare, MI (655GE)

Please refer to the section titled "FY 2022 Multi-Specialty Community Based Clinics (MS CBOC)" for the complete list of MS CBOCs in 2022.

Primary Care Clinics (PC CBOC)

PC CBOCs are VA-owned, VA-leased, mobile, or contract clinics that offer both medical (physically on site) and mental health care (either physically on site or by telehealth) and may offer support services such as pharmacy, laboratory, and x-ray. The clinics may be operational one to seven days per week. Access to specialty care is not provided on site but may be available through referral or telehealth. PC CBOCs often provide home-based primary care (HBPC) and home telehealth to the populations they serve to meet the primary care and mental health needs of Veterans who have difficulty accessing clinic-based care. These clinics have access to a higher level of care within a VHA network of care. Primary care in VA includes both medical and mental health care services, as they are inseparable in providing personalized, proactive, patient-centered health care. The establishment of a new PC CBOC can only be approved by the Secretary of Veterans Affairs, with Congressional notification consistent with 38 U.S.C. 8119(b) (2), (3), (4).

PC CBOC changes in 2022

In 2022, 10 PC CBOCs have been activated, 3 MS CBOCs and 27 OOS sites have been reclassified into PC CBOCs (+40 PC CBOC); 3 PC CBOCs have been deactivated, 82 PC CBOCs have been reclassified into MS CBOCs, and 65 PC CBOCs have been reclassified into OOS sites (-150 PC CBOC), resulting in a net decrease from 523 to 413 (-110 PC CBOC).

Activations (+10 PC CBOC):

- +1 PC CBOC: VISN 9 Morristown East VA Clinic, Morristown, TN (621GP)
- +1 PC CBOC: VISN 10 Canton VA Clinic, Canton, MI (506GD)
- +1 PC CBOC: VISN 10 Howell VA Clinic, Howell, MI (506GE)
- +1 PC CBOC: VISN 17 Walzem VA Clinic, San Antonio, TX (671GT)
- +1 PC CBOC: VISN 19 Shawnee VA Clinic, Shawnee, KS (635GK)
- +1 PC CBOC: VISN 19 Butte VA Clinic, Butte, MT (436GO)
- +1 PC CBOC: VISN 20 Everett VA Clinic, Everett, WA (663GK)
- +1 PC CBOC: VISN 22 North Loma Linda VA Clinic, Loma Linda, CA (605GF)

- +1 PC CBOC: VISN 22 Ventura VA Clinic, Ventura VA Clinic (691GQ)
- +1 PC CBOC: VISN 22 Mesa VA Clinic, Mesa, AZ (644GJ)

MS CBOCs reclassified into PC CBOCs (+3 PC CBOC):

- +1 PC CBOC: VISN 1 Lewiston VA Clinic, Lewiston, ME (402GE)
- +1 PC CBOC: VISN 10 Navy Corpsman Steve Andrews Department of Veterans Affairs Health Care Clinic, Gaylord, MI (655GA)
- +1 PC CBOC: VISN 10 Clare VA Clinic, Clare, MI (655GE)

OOS sites reclassified into PC CBOCs (+27 PC CBOC):

- +1 PC CBOC: VISN 1 Framingham VA Clinic, Framingham, MA (523GA)
- +1 PC CBOC: VISN 2 Paterson VA Clinic, Paterson, NJ (561GJ)
- +1 PC CBOC: VISN 6 Clayton-East Raleigh VA Clinic, Clayton, NC (558GH)
- +1 PC CBOC: VISN 6 Portsmouth VA Clinic, Portsmouth, VA (590GE)
- +1 PC CBOC: VISN 7 Pickens County VA Clinic, Jasper, GA (508GM)
- +1 PC CBOC: VISN 7 North Charleston VA Clinic, North Charleston, SC (534GF)
- +1 PC CBOC: VISN 8 Zephyrhills VA Clinic, Zephyrhills, FL (673GF)
- +1 PC CBOC: VISN 8 Middleburg VA Clinic, Middleburg, FL (573GO)
- +1 PC CBOC: VISN 9 Morehead VA Clinic, Morehead, KY (596GB)
- +1 PC CBOC: VISN 9 Athens VA Clinic, Athens, TN (626GN)
- +1 PC CBOC: VISN 9 Mountain City VA Clinic, Mountain City, TN (621GO)
- +1 PC CBOC: VISN 10 Vine Street VA Clinic, Cincinnati, OH (539QC)
- +1 PC CBOC: VISN 10 Cleveland VA Clinic-Euclid, Cleveland, OH (541QB)
- +1 PC CBOC: VISN 15 Paola VA Clinic, Paola, KS (589GC)
- +1 PC CBOC: VISN 15 Pocahontas VA Clinic, Pocahontas, AR (657GW)
- +1 PC CBOC: VISN 15 Manchester Avenue VA Clinic, St. Louis, MO (657GY)
- +1 PC CBOC: VISN 17 Greenville VA Clinic, Greenville, TX (549GH)
- +1 PC CBOC: VISN 17 North Bexar VA Clinic, San Antonio, TX (671GR)
- +1 PC CBOC: VISN 17 El Paso Westside VA Clinic, El Paso, TX (756GC)
- +1 PC CBOC: VISN 19 North May VA Clinic, Oklahoma City, OK (635QA)
- +1 PC CBOC: VISN 19 Norman VA Clinic, Norman, OK (635GI)
- +1 PC CBOC: VISN 20 La Grande VA Clinic, La Grande, OR (687GC)
- +1 PC CBOC: VISN 21 Capitol Hill VA Clinic, Reno, NV (654QB)
- +1 PC CBOC: VISN 22 Gardena VA Clinic, Gardena, CA (600GF)
- +1 PC CBOC: VISN 22 San Gabriel Valley VA Clinic, Arcadia, CA (691GP)
- +1 PC CBOC: VISN 23 Williston VA Clinic, Williston, ND (437GF)
- +1 PC CBOC: VISN 23 North Fargo VA Clinic, Fargo, ND (437QA)

Deactivations (-3 PC CBOC):

- -1 PC CBOC: VISN 1 Saco VA Clinic, Saco, ME (402GD)
- -1 PC CBOC: VISN 10 Goshen VA Clinic, Goshen, IN (610GC)
- -1 PC CBOC: VISN 20 South Sound VA Clinic, Chehalis, WA (663GD)

PC CBOCs reclassified into OOS sites (-65 PC CBOC):

- -1 PC CBOC: VISN 1 Rumford VA Clinic, Lewiston, ME (402GC)
- -1 PC CBOC: VISN 1 Haverhill VA Clinic, Haverhill, MA (518GB)
- -1 PC CBOC: VISN 1 Hyannis VA Clinic, Hyannis, MA (650GB)
- -1 PC CBOC: VISN 1 Stamford VA Clinic, Stamford, CT (689GB)

- -1 PC CBOC: VISN 1 Errera VA Clinic, West Haven, CT (689QA)
- -1 PC CBOC: VISN 2 Glens Falls VA Clinic, Glens Falls, NY (528GT)
- -1 PC CBOC: VISN 2 Niagara Falls VA Clinic, Niagara Falls, NY (528GD)
- -1 PC CBOC: VISN 2 Rochester Clinton Crossings VA Clinic, Rochester, NY (528GE)
- -1 PC CBOC: VISN 2 Hamilton VA Clinic, Hamilton, NJ (561GA)
- -1 PC CBOC: VISN 2 Harlem VA Clinic, New York, NY (630GA)
- -1 PC CBOC: VISN 2 Riverhead VA Clinic, Riverhead, NY (632HB)
- -1 PC CBOC: VISN 2 Lockport VA Clinic, Lockport, NY (528GK)
- -1 PC CBOC: VISN 2 Piscataway VA Clinic, Piscataway, NJ (561GF)
- -1 PC CBOC: VISN 2 Carmel VA Clinic, Carmel, NY (620GB)
- -1 PC CBOC: VISN 2 Goshen VA Clinic, Goshen, NY (620GD)
- -1 PC CBOC: VISN 2 Saranac Lake VA Clinic, Saranac Lake, NY (528QK)
- -1 PC CBOC: VISN 5 Braxton County VA Clinic, Gassaway, WV (540GC)
- -1 PC CBOC: VISN 6 Tazewell VA Clinic, Tazewell, VA (658GA)
- -1 PC CBOC: VISN 6 Emporia VA Clinic, Emporia, VA (652GF)
- -1 PC CBOC: VISN 7 Ray Hendrix Department Of Veterans Affairs Clinic, Statesboro, GA (509QA)
- -1 PC CBOC: VISN 7 Selma VA Clinic, Selma, AL (679GA)
- -1 PC CBOC: VISN 7 Robins VA Clinic, Warner Robins, GA (557GG)
- -1 PC CBOC: VISN 7 Columbus Downtown VA Clinic, Columbus, GA (619GG)
- -1 PC CBOC: VISN 8 Boca Raton VA Clinic, Boca Raton, FL (548GD)
- -1 PC CBOC: VISN 8 Okeechobee VA Clinic, Okeechobee, FL (548GF)
- -1 PC CBOC: VISN 8 Miami Flagler VA Clinic, Miami, FL (546GA)
- -1 PC CBOC: VISN 9 Carrollton VA Clinic, Carrollton, KY (603GH)
- -1 PC CBOC: VISN 10 Adrian VA Clinic, Adrian, MI (506GF)
- -1 PC CBOC: VISN 10 Defiance VA Clinic, Defiance, OH (610GE)
- -1 PC CBOC: VISN 12 Gladstone VA Clinic, Gladstone, MI (585GG)
- -1 PC CBOC: VISN 12 Lakeside VA Clinic, Chicago, IL (537GD)
- -1 PC CBOC: VISN 12 Janesville VA Clinic, Janesville, WI (607GC)
- -1 PC CBOC: VISN 12 Beaver Dam VA Clinic, Beaver Dam, WI (607GE)
- -1 PC CBOC: VISN 15 Belton VA Clinic, Belton, MO (589GB)
- -1 PC CBOC: VISN 15 Nevada VA Clinic, Nevada, MO (589GD)
- -1 PC CBOC: VISN 15 St. Clair County VA Clinic, Shiloh, IL (657GA)
- -1 PC CBOC: VISN 16 Natchez VA Clinic, Natchez, MS (586GE)
- -1 PC CBOC: VISN 16 Little Rock VA Clinic, Little Rock, AR (598QA)
- -1 PC CBOC: VISN 16 Kingwood VA Clinic, Humble, TX (580GK)
- -1 PC CBOC: VISN 17 Palestine VA Clinic, Palestine, TX (674GA)
- -1 PC CBOC: VISN 19 Ada VA Clinic, Ada, OK (635GD)
- -1 PC CBOC: VISN 19 Rock Springs VA Clinic, Rock Springs, WY (666GF)
- -1 PC CBOC: VISN 19 Union Boulevard VA Clinic, Colorado Springs, CO (554GK)
- -1 PC CBOC: VISN 20 Brookings VA Clinic, Brookings, OR (653GB)
- -1 PC CBOC: VISN 20 Loren R. Kaufman VA Clinic, The Dalles, OR (648GJ)
- -1 PC CBOC: VISN 20 North Olympic Peninsula VA Clinic, Port Angeles, WA (663GE)
- -1 PC CBOC: VISN 20 Grants Pass VA Clinic, Grants Pass, OR (692GB)

- -1 PC CBOC: VISN 20 Edmonds VA Clinic, Edmonds, WA (663GH)
- -1 PC CBOC: VISN 20 Olympia VA Clinic, Olympia, WA (663GI)
- -1 PC CBOC: VISN 20 Puyallup VA Clinic, Puyallup, WA (663GJ)
- -1 PC CBOC: VISN 20 East Front Avenue VA Clinic, Spokane, WA (668GC)
- -1 PC CBOC: VISN 21 Windward VA Clinic, Kaneohe, HI (459QC)
- -1 PC CBOC: VISN 21 Oakhurst VA Clinic, Oakhurst, CA (570GC)
- -1 PC CBOC: VISN 21 Master Chief Petty Officer Jesse Dean VA Clinic, Laughlin, NV (593GH)
- -1 PC CBOC: VISN 21 Reno East VA Clinic, Reno, NV (654GE)
- -1 PC CBOC: VISN 22 Farmington VA Clinic, Farmington, NM (501GB)
- -1 PC CBOC: VISN 22 Cabrillo VA Clinic, Long Beach, CA (600GC)
- -1 PC CBOC: VISN 22 Imperial Valley VA Clinic, El Centro, CA (664GA)
- -1 PC CBOC: VISN 22 Safford VA Clinic, Safford, AZ (678GD)
- -1 PC CBOC: VISN 22 Durango VA Clinic, Durango, CO (501GJ)
- -1 PC CBOC: VISN 22 Northwest Metro VA Clinic, Rio Rancho, NM (501GM)
- -1 PC CBOC: VISN 23 Jamestown VA Clinic, Jamestown, ND (437GK)
- -1 PC CBOC: VISN 23 Rice Lake VA Clinic, Rice Lake, WI (618GM)
- -1 PC CBOC: VISN 23 Montevideo VA Clinic, Montevideo, MN (656GB)
- -1 PC CBOC: VISN 23 Burlington VA Clinic, Burlington, IA (636GY)

PC CBOCs reclassified into MS CBOCs (-82 PC CBOC):

- -1 PC CBOC: VISN 1 Littleton VA Clinic, Littleton, NH (405HC)
- -1 PC CBOC: VISN 1 New Bedford VA Clinic, New Bedford, MA (650GA)
- -1 PC CBOC: VISN 1 Hyannis VA Clinic, Hyannis, MA (650GB)
- -1 PC CBOC: VISN 2 Hackensack VA Clinic, Hackensack, NJ (561GD)
- -1 PC CBOC: VISN 2 Staten Island Community VA Clinic, Staten Island, NY (630GB)
- -1 PC CBOC: VISN 2 East Meadow VA Clinic, East Meadow, NY (632GA)
- -1 PC CBOC: VISN 2 Port Jervis VA Clinic, Port Jervis, NY (620GE)
- -1 PC CBOC: VISN 4 Huntingdon County VA Clinic, Mapleton, PA (503GD)
- -1 PC CBOC: VISN 4 Indiana County VA Clinic, Indiana, PA (503GE)
- -1 PC CBOC: VISN 5 Fort Belvoir VA Clinic, Fort Belvoir, VA (688GA)
- -1 PC CBOC: VISN 5 Charlotte Hall VA Clinic, Charlotte Hall, MD (688GD)
- -1 PC CBOC: VISN 6 Raleigh VA Clinic, Raleigh, NC (558GB)
- -1 PC CBOC: VISN 6 Morehead City VA Clinic, Morehead City, NC (558GC)
- -1 PC CBOC: VISN 6 Raleigh III VA Clinic, Raleigh, NC (558GG)
- -1 PC CBOC: VISN 6 Chesapeake VA Clinic, Chesapeake, VA (590GD)
- -1 PC CBOC: VISN 6 Henrico County VA Clinic, Richmond, VA (652GC)
- -1 PC CBOC: VISN 7 Myrtle Beach VA Clinic, Myrtle Beach, SC (534GB)
- -1 PC CBOC: VISN 7 Florence VA Clinic, Florence, SC (544GB)
- -1 PC CBOC: VISN 7 Oakwood VA Clinic, Flowery Branch, GA (508GE)
- -1 PC CBOC: VISN 7 West Cobb County VA Clinic, Marietta, GA (508GF)
- -1 PC CBOC: VISN 7 Stockbridge VA Clinic, Stockbridge, GA (508GG)
- -1 PC CBOC: VISN 7 Lawrenceville VA Clinic, Lawrenceville, GA (508GH)
- -1 PC CBOC: VISN 7 Blairsville VA Clinic, Blairsville, GA (508GJ)
- -1 PC CBOC: VISN 7 Rome VA Clinic, Rome, GA (508GL)

- -1 PC CBOC: VISN 7 Northeast Cobb County, Marietta, GA (508GO)
- -1 PC CBOC: VISN 7 Athens VA Clinic, Athens, GA (509GA)
- -1 PC CBOC: VISN 7 Beaufort VA Clinic, Beaufort, SC (534GC)
- -1 PC CBOC: VISN 7 Hinesville VA Clinic, Hinesville, GA (534GE)
- -1 PC CBOC: VISN 8 Sarasota VA Clinic, Sarasota, FL (516GA)
- -1 PC CBOC: VISN 8 North Pinellas VA Clinic, Clearwater, FL (516GC)
- -1 PC CBOC: VISN 8 Key West VA Clinic, Key West, FL (546GB)
- -1 PC CBOC: VISN 8 Fort Pierce VA Clinic, Fort Pierce, FL (548GA)
- -1 PC CBOC: VISN 8 Ocala VA Clinic, Ocala, FL (573GD)
- -1 PC CBOC: VISN 8 Port Charlotte VA Clinic, Port Charlotte, FL (516GE)
- -1 PC CBOC: VISN 8 Naples VA Clinic, Naples, FL (516GF)
- -1 PC CBOC: VISN 8 Delray Beach VA Clinic, Delray Beach, FL (548GB)
- -1 PC CBOC: VISN 8 Stuart VA Clinic, Stuart, FL (548GC)
- -1 PC CBOC: VISN 8 Tavares VA Clinic, Tavares, FL (675GE)
- -1 PC CBOC: VISN 8 Sebring VA Clinic, Sebring, FL (516GH)
- -1 PC CBOC: VISN 9 New Albany VA Clinic, New Albany, IN (603GB)
- -1 PC CBOC: VISN 9 Tupelo VA Clinic, Tupelo, MS (614GA)
- -1 PC CBOC: VISN 9 Jackson VA Clinic, Jackson, TN (614GG)
- -1 PC CBOC: VISN 9 International Plaza VA Clinic, Nashville, TN (626GO)
- -1 PC CBOC: VISN 10 Marietta VA Clinic, Marietta, OH (538GC)
- -1 PC CBOC: VISN 10 Martinsville VA Clinic, Martinsville, IN (583GC)
- -1 PC CBOC: VISN 10 Grove City VA Clinic, Grove City, OH (757GB)
- -1 PC CBOC: VISN 12 Kankakee County VA Clinic, Bourbonnais, IL (578GC)
- -1 PC CBOC: VISN 12 Aurora VA Clinic, North Aurora, IL (578GD)
- -1 PC CBOC: VISN 12 Hoffman Estates VA Clinic, Hoffman Estates, IL (578GE)
- -1 PC CBOC: VISN 12 LaSalle VA Clinic, Peru, IL (578GF)
- -1 PC CBOC: VISN 12 Springfield VA Clinic, Springfield, IL (550GD)
- -1 PC CBOC: VISN 15 St. Louis County VA Clinic, Florissant, MO (657GB)
- -1 PC CBOC: VISN 15 St. Charles County VA Clinic, O'Fallon, MO (657GD)
- -1 PC CBOC: VISN 15 Marshfield VA Clinic, Marshfield, MO (589JD)
- -1 PC CBOC: VISN 15 Sikeston VA Clinic, Sikeston, MO (657GV)
- -1 PC CBOC: VISN 16 Fort Smith VA Clinic, Fort Smith, AR (564GB)
- -1 PC CBOC: VISN 16 Mountain Home VA Clinic, Mountain Home, AR (598GA)
- -1 PC CBOC: VISN 16 Douglas Fournet Department of Veterans Affairs Clinic, Lake Charles, LA (502GE)
- -1 PC CBOC: VISN 16 Fort Polk VA Clinic, Leesville, LA (502GF)
- -1 PC CBOC: VISN 16 Eglin Air Force Base VA Clinic, Eglin Air Force Base, FL (520GC)
- -1 PC CBOC: VISN 16 Pine Bluff VA Clinic, Pine Bluff, AR (598GE)
- -1 PC CBOC: VISN 16 Searcy VA Clinic, Searcy, AR (598GF)
- -1 PC CBOC: VISN 16 Russellville VA Clinic, Russellville, AR (598GH)
- -1 PC CBOC: VISN 16 Joplin VA Clinic, Joplin, MO (564GF)
- -1 PC CBOC: VISN 17 Corpus Christi VA Clinic, Corpus Christi, TX (740GC)
- -1 PC CBOC: VISN 17 North Central Federal VA Clinic, San Antonio, TX (671GO)
- -1 PC CBOC: VISN 17 Balcones Heights VA Clinic, San Antonio, TX (671GP)

- -1 PC CBOC: VISN 19 Wichita Falls VA Clinic, Wichita Falls, TX (635GB)
- -1 PC CBOC: VISN 19 Ogden VA Clinic, South Ogden, UT (660GB)
- -1 PC CBOC: VISN 20 Silverdale VA Clinic, Silverdale, WA (663GB)
- -1 PC CBOC: VISN 21 Mare Island VA Clinic, Mare Island, CA (612GE)
- -1 PC CBOC: VISN 21 Southeast Las Vegas VA Clinic, Henderson, NV (593GE)
- -1 PC CBOC: VISN 22 Murrieta VA Clinic, Murrieta, CA (605GB)
- -1 PC CBOC: VISN 22 Palm Desert VA Clinic, Palm Desert, CA (605GC)
- -1 PC CBOC: VISN 22 Northwest VA Clinic, Surprise, AZ (644GA)
- -1 PC CBOC: VISN 22 Antelope Valley VA Clinic, Lancaster, CA (691GG)
- -1 PC CBOC: VISN 23 Chippewa Valley VA Clinic, Chippewa Falls, WI (618GE)
- -1 PC CBOC: VISN 23 Sioux City VA Clinic, Dakota Dunes, SD (438GC)
- -1 PC CBOC: VISN 23 Maplewood VA Clinic, Maplewood, MN (618GD)
- -1 PC CBOC: VISN 23 Rochester VA Clinic, Rochester, MN (618GG)
- -1 PC CBOC: VISN 23 Shakopee VA Clinic, Shakopee, MN (618GJ)
- -1 PC CBOC: VISN 23 Holdrege VA Clinic, Holdrege, NE (636GQ)

Please refer to the section titled "FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)" for the complete list of PC CBOCs in 2022.

PC CBOC changes in 2023

In 2023, PC CBOCs are projected to increase from 413 to 414 (+1 PC CBOC):

- +1 PC CBOC: VISN 19 Rogers County PC CBOC, Rogers County, OK

PC CBOC changes in 2024

In 2024, PC CBOCs are projected to increase from 414 to 415 (+1 PC CBOC):

- +1 PC CBOC: VISN 10 Medina County PC CBOC, Medina County, OH

Other Outpatient Services (OOS) Sites

OOS sites are sites in which Veterans receive services that do not generate VHA encounter workload, or do not meet minimum workload criteria to be classified as a CBOC or HCC. Many of the services provided at these sites are contacts made by VA or VHA personnel to provide information, social services, homelessness outreach services, activities to increase Veteran awareness of benefits and services, and support services, such as those provided in Vet Centers. Other services could be more clinical in nature, which can be provided to remote areas through a Telehealth clinic or other arrangement. If any other services are provided in this venue (external to a VA clinic or facility), they must be associated with, attached to, and coordinated by a health care delivery site located in a clinic or facility.

OOS site changes in 2022

In 2022, 14 OOS sites have been activated, 5 MS CBOCs and 65 PC CBOCs have been reclassified into OOS (+84 OOS); 15 OOS sites have been deactivated, 3 OOS sites have been reclassified into MS CBOCs, and 27 OOS sites have been reclassified into PC CBOCs (-45 OOS), resulting in a net increase from 376 to 415 (+39 OOS).

Activations (+14 OOS):

- +1 OOS: VISN 7 Birmingham East VA Clinic, Irondale, AL (521QB)
- +1 OOS: VISN 8 Orlando 2 VA Mobile Clinic, Orlando, FL (675QH)
- +1 OOS: VISN 9 Vansant VA Clinic, Vansant, VA (621QC)
- +1 OOS: VISN 9 Knox West VA Clinic, Knoxville, TN (621QG)
- +1 OOS: VISN 16 Jackson 2 VA Mobile Clinic, Jackson, MS (586QD)
- +1 OOS: VISN 16 Houston 2 VA Mobile Clinic, Houston, TX (580QC)
- +1 OOS: VISN 16 New Orleans South VA Mobile Clinic, New Orleans, LA (629QB)
- +1 OOS: VISN 16 Gulf Coast West VA Mobile Medical Unit-Clinic, Biloxi, MS (520QB)
- +1 OOS: VISN 16 Houston 3 VA Mobile Clinic, Houston, TX (580QD)
- +1 OOS: VISN 19 Evans VA Clinic, Fort Carson, CO (554QD)
- +1 OOS: VISN 19 Garden of the Gods VA Clinic, Colorado Springs, CO (554QF)
- +1 OOS: VISN 19 Academy VA Clinic, U.S. Air Force Academy, CO (554QE)
- +1 OOS: VISN 21 North Santa Rosa VA Clinic, Santa Rosa, CA (662QB)
- +1 OOS: VISN 23 Macomb VA Clinic, Macomb, IL (636GD)

MS CBOCs reclassified into OOS sites (+5 OOS):

- +1 OOS: VISN 15 Lenexa VA Clinic, Lenexa, KS (589JG)
- +1 OOS: VISN 21 Clearlake VA Clinic, Clearlake, CA (662GG)
- +1 OOS: VISN 21 Oakland VA Clinic, Oakland, CA (662GH)
- +1 OOS: VISN 22 Sorrento Valley VA Clinic, San Diego, CA (664GF)
- +1 OOS: VISN 23 Sterling VA Clinic, Sterling, IL (636GT)

PC CBOCs reclassified into OOS sites (+65 OOS):

- +1 OOS: VISN 1 Rumford VA Clinic, Lewiston, ME (402GC)
- +1 OOS: VISN 1 Haverhill VA Clinic, Haverhill, MA (518GB)
- +1 OOS: VISN 1 Hyannis VA Clinic, Hyannis, MA (650GB)
- +1 OOS: VISN 1 Stamford VA Clinic, Stamford, CT (689GB)
- +1 OOS: VISN 1 Errera VA Clinic, West Haven, CT (689QA)
- +1 OOS: VISN 2 Glens Falls VA Clinic, Glens Falls, NY (528GT)
- +1 OOS: VISN 2 Niagara Falls VA Clinic, Niagara Falls, NY (528GD)
- +1 OOS: VISN 2 Rochester Clinton Crossings VA Clinic, Rochester, NY (528GE)
- +1 OOS: VISN 2 Hamilton VA Clinic, Hamilton, NJ (561GA)
- +1 OOS: VISN 2 Harlem VA Clinic, New York, NY (630GA)
- +1 OOS: VISN 2 Riverhead VA Clinic, Riverhead, NY (632HB)
- +1 OOS: VISN 2 Lockport VA Clinic, Lockport, NY (528GK)
- +1 OOS: VISN 2 Piscataway VA Clinic, Piscataway, NJ (561GF)
- +1 OOS: VISN 2 Carmel VA Clinic, Carmel, NY (620GB)
- +1 OOS: VISN 2 Goshen VA Clinic, Goshen, NY (620GD)
- +1 OOS: VISN 2 Saranac Lake VA Clinic, Saranac Lake, NY (528QK)
- +1 OOS: VISN 5 Braxton County VA Clinic, Gassaway, WV (540GC)
- +1 OOS: VISN 6 Tazewell VA Clinic, Tazewell, VA (658GA)
- +1 OOS: VISN 6 Emporia VA Clinic, Emporia, VA (652GF)
- +1 OOS: VISN 7 Ray Hendrix Department Of Veterans Affairs Clinic, Statesboro, GA (509QA)
- +1 OOS: VISN 7 Selma VA Clinic, Selma, AL (679GA)

- +1 OOS: VISN 7 Robins VA Clinic, Warner Robins, GA (557GG)
- +1 OOS: VISN 7 Columbus Downtown VA Clinic, Columbus, GA (619GG)
- +1 OOS: VISN 8 Boca Raton VA Clinic, Boca Raton, FL (548GD)
- +1 OOS: VISN 8 Okeechobee VA Clinic, Okeechobee, FL (548GF)
- +1 OOS: VISN 8 Miami Flagler VA Clinic, Miami, FL (546GA)
- +1 OOS: VISN 9 Carrollton VA Clinic, Carrollton, KY (603GH)
- +1 OOS: VISN 10 Adrian VA Clinic, Adrian, MI (506GF)
- +1 OOS: VISN 10 Defiance VA Clinic, Defiance, OH (610GE)
- +1 OOS: VISN 12 Gladstone VA Clinic, Gladstone, MI (585GG)
- +1 OOS: VISN 12 Lakeside VA Clinic, Chicago, IL (537GD)
- +1 OOS: VISN 12 Janesville VA Clinic, Janesville, WI (607GC)
- +1 OOS: VISN 12 Beaver Dam VA Clinic, Beaver Dam, WI (607GE)
- +1 OOS: VISN 15 Belton VA Clinic, Belton, MO (589GB)
- +1 OOS: VISN 15 Nevada VA Clinic, Nevada, MO (589GD)
- +1 OOS: VISN 15 St. Clair County VA Clinic, Shiloh, IL (657GA)
- +1 OOS: VISN 16 Natchez VA Clinic, Natchez, MS (586GE)
- +1 OOS: VISN 16 Little Rock VA Clinic, Little Rock, AR (598QA)
- +1 OOS: VISN 16 Kingwood VA Clinic, Humble, TX (580GK)
- +1 OOS: VISN 17 Palestine VA Clinic, Palestine, TX (674GA)
- +1 OOS: VISN 19 Ada VA Clinic, Ada, OK (635GD)
- +1 OOS: VISN 19 Rock Springs VA Clinic, Rock Springs, WY (666GF)
- +1 OOS: VISN 19 Union Boulevard VA Clinic, Colorado Springs, CO (554GK)
- +1 OOS: VISN 20 Brookings VA Clinic, Brookings, OR (653GB)
- +1 OOS: VISN 20 Loren R. Kaufman VA Clinic, The Dalles, OR (648GJ)
- +1 OOS: VISN 20 North Olympic Peninsula VA Clinic, Port Angeles, WA (663GE)
- +1 OOS: VISN 20 Grants Pass VA Clinic, Grants Pass, OR (692GB)
- +1 OOS: VISN 20 Edmonds VA Clinic, Edmonds, WA (663GH)
- +1 OOS: VISN 20 Olympia VA Clinic, Olympia, WA (663GI)
- +1 OOS: VISN 20 Puyallup VA Clinic, Puyallup, WA (663GJ)
- +1 OOS: VISN 20 East Front Avenue VA Clinic, Spokane, WA (668GC)
- +1 OOS: VISN 21 Windward VA Clinic, Kaneohe, HI (459QC)
- +1 OOS: VISN 21 Oakhurst VA Clinic, Oakhurst, CA (570GC)
- +1 OOS: VISN 21 Master Chief Petty Officer Jesse Dean VA Clinic, Laughlin, NV (593GH)
- +1 OOS: VISN 21 Reno East VA Clinic, Reno, NV (654GE)
- +1 OOS: VISN 22 Farmington VA Clinic, Farmington, NM (501GB)
- +1 OOS: VISN 22 Cabrillo VA Clinic, Long Beach, CA (600GC)
- +1 OOS: VISN 22 Imperial Valley VA Clinic, El Centro, CA (664GA)
- +1 OOS: VISN 22 Safford VA Clinic, Safford, AZ (678GD)
- +1 OOS: VISN 22 Durango VA Clinic, Durango, CO (501GJ)
- +1 OOS: VISN 22 Northwest Metro VA Clinic, Rio Rancho, NM (501GM)
- +1 OOS: VISN 23 Jamestown VA Clinic, Jamestown, ND (437GK)
- +1 OOS: VISN 23 Rice Lake VA Clinic, Rice Lake, WI (618GM)
- +1 OOS: VISN 23 Montevideo VA Clinic, Montevideo, MN (656GB)

- +1 OOS: VISN 23 Burlington VA Clinic, Burlington, IA (636GY)

Deactivations (-15 OOS):

- -1 OOS: VISN 1 Bingham VA Mobile Clinic, Bingham, ME (402HL)
- -1 OOS: VISN 1 Lake Avenue VA Clinic, Worcester, MA (631QB)
- -1 OOS: VISN 2 Newark VA Clinic, Newark, NJ (561BY)
- -1 OOS: VISN 7 Tuscaloosa VA Mobile Clinic, Tuscaloosa, AL (679HK)
- -1 OOS: VISN 8 Jacksonville Navy VA Medical Center, Jacksonville, FL (573A5)
- -1 OOS: VISN 8 Crossroads VA Clinic, Winter Park, FL (675QD)
- -1 OOS: VISN 8 Gainesville Sixteenth Street VA Clinic, Gainesville, FL (573QA)
- -1 OOS: VISN 10 Montgomery County 3 VA Mobile Clinic, Dayton, OH (552QC)
- -1 OOS: VISN 10 Crane VA Clinic, Crane, IN (583QF)
- -1 OOS: VISN 10 Vigo County VA Clinic, Terre Haute, IN (583QC)
- -1 OOS: VISN 12 Tomah VA Mobile Clinic, Tomah WI (676QA)
- -1 OOS: VISN 15 South Parklane VA Clinic, Wichita, KS (589QC)
- -1 OOS: VISN 19 Anaconda VA Clinic, Anaconda, MT (436GA)
- -1 OOS: VISN 19 Sterling VA Clinic, Sterling, CO (442QE)
- -1 OOS: VISN 21 Twenty First Street VA Clinic, Oakland, CA (612QB)

OOS sites reclassified into MS CBOCs (-3 OOS):

- -1 OOS: VISN 10 Bloomington VA Clinic, Bloomington, IN (583GB)
- -1 OOS: VISN 17 Garland VA Clinic, Garland, TX (549A5)
- -1 OOS: VISN 19 Yukon VA Clinic, Yukon, OK (635GJ)

OOS sites reclassified into PC CBOCs (-27 OOS):

- -1 OOS: VISN 1 Framingham VA Clinic, Framingham, MA (523GA)
- -1 OOS: VISN 2 Paterson VA Clinic, Paterson, NJ (561GJ)
- -1 OOS: VISN 6 Clayton-East Raleigh VA Clinic, Clayton, NC (558GH)
- -1 OOS: VISN 6 Portsmouth VA Clinic, Portsmouth, VA (590GE)
- -1 OOS: VISN 7 Pickens County VA Clinic, Jasper, GA (508GM)
- -1 OOS: VISN 7 North Charleston VA Clinic, North Charleston, SC (534GF)
- -1 OOS: VISN 8 Zephyrhills VA Clinic, Zephyrhills, FL (673GF)
- -1 OOS: VISN 8 Middleburg VA Clinic, Middleburg, FL (573GO)
- -1 OOS: VISN 9 Morehead VA Clinic, Morehead, KY (596GB)
- -1 OOS: VISN 9 Athens VA Clinic, Athens, TN (626GN)
- -1 OOS: VISN 9 Mountain City VA Clinic, Mountain City, TN (621GO)
- -1 OOS: VISN 10 Vine Street VA Clinic, Cincinnati, OH (539QC)
- -1 OOS: VISN 10 Cleveland VA Clinic-Euclid, Cleveland, OH (541QB)
- -1 OOS: VISN 15 Paola VA Clinic, Paola, KS (589GC)
- -1 OOS: VISN 15 Pocahontas VA Clinic, Pocahontas, AR (657GW)
- -1 OOS: VISN 15 Manchester Avenue VA Clinic, St. Louis, MO (657GY)
- -1 OOS: VISN 17 Greenville VA Clinic, Greenville, TX (549GH)
- -1 OOS: VISN 17 North Bexar VA Clinic, San Antonio, TX (671GR)
- -1 OOS: VISN 17 El Paso Westside VA Clinic, El Paso, TX (756GC)
- -1 OOS: VISN 19 North May VA Clinic, Oklahoma City, OK (635QA)
- -1 OOS: VISN 19 Norman VA Clinic, Norman, OK (635GI)
- -1 OOS: VISN 20 La Grande VA Clinic, La Grande, OR (687GC)

- -1 OOS: VISN 21 Capitol Hill VA Clinic, Reno, NV (654QB)
- -1 OOS: VISN 22 Gardena VA Clinic, Gardena, CA (600GF)
- -1 OOS: VISN 22 San Gabriel Valley VA Clinic, Arcadia, CA (691GP)
- -1 OOS: VISN 23 Williston VA Clinic, Williston, ND (437GF)
- -1 OOS: VISN 23 North Fargo VA Clinic, Fargo, ND (437QA)

Please refer to the section titled "FY 2022 Other Outpatient Services (OOS) Sites" for the complete list of OOS sites in 2022.

Included among the OOS sites are Dialysis Centers and Community Resource and Referral Centers (CRRC).

Dialysis Centers are highly specialized programs which provide facilities for the treatment of patients with irreversible renal insufficiencies. Treatment procedures require professional supervision by staff experienced in renal pathophysiology. The services may include self-dialysis training for Peritoneal Dialysis, in addition to on-site assisted dialysis (i.e., Hemodialysis). The Dialysis Centers administer both single-patient and multi-patient Hemodialysis systems.

Dialysis Center changes in 2022
Based on workload data, 3 Dialysis Center sites have been deactivated, resulting in a net decrease from 73 to 70 (-3 Dialysis Center):

- -1 Dialysis Center: VISN 8 Bay Pines VA Healthcare System, Bay Pines, FL
- -1 Dialysis Center: VISN 16 G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS
- -1 Dialysis Center: VISN 19 VA Salt Lake City Healthcare System, Salt Lake City, UT

Please refer to the section titled, "FY 2022 Outpatient Dialysis Centers" for the complete list of Dialysis Centers in 2022.

CRRCs provide Veterans who are homeless and at risk of homelessness with one-stop access to community-based, multiagency services to promote permanent housing, health and mental health care, career development and access to VA and non-VA benefits.

As of September 30, 2022, there were 32 active CRRC facilities. For the complete list, please refer to the section titled "FY 2022 Community Resource and Referral Centers (CRRC)."

CRRC changes in 2023
In 2023, the number of CRRC facilities is projected to increase from 32 to 33 (+1 CRRC):

- +1 CRRC: VISN 16 Overton Brooks VA Medical Center, Shreveport, LA

Additional Services in the Community

Vet Centers (VC)
A Vet Center is a community-based counseling facility under the direct supervision of the Readjustment Counseling Service (RCS), within the Department of Veterans Affairs. Vet Centers provide professional readjustment counseling, community education, outreach to special

populations, brokering of services with community agencies, and access to links between the Veteran and VA.

Mobile Vet Centers (MVC)
A Mobile Vet Center is a community-based counseling mobile unit under the direct supervision of the Readjustment Counseling Service (RCS), within the Department of Veterans Affairs. Mobile Vet Centers are like Vet Centers, and may provide an array of services such as professional readjustment counseling, community education, and outreach to special populations, brokering of services with community agencies, and access to links between the Veteran and VA.

Vet Center Outstations (VC Outstations)
A Vet Center Outstation is a community-based counseling facility located in a community that does not meet the requirements for a full Vet Center. A Vet Center Outstation provides readjustment counseling services full-time (i.e., 40 hours/week), and is created when the established demand for readjustment counseling within a community justifies the delivery of services on a full-time basis. Vet Center Outstation staff are supervised by a designated local Vet Center Director and are under the overall authority of the Readjustment Counseling Service (RCS), within the Department of Veterans Affairs.

In 2022, there were 300 Vet Centers and 83 Mobile Vet Centers. 5 Vet Center Outstations have been activated (+5 VC Outstation) and 1 facility closed (-1 VC Outstation), resulting in a net increase from 19 to 23 (+4 VC Outstation):

- +1 VC Outstation: VISN 5 Leesburg Outstation, Leesburg, VA
- +1 VC Outstation: VISN 21 Solano County Outstation, Fairfield, CA
- +1 VC Outstation: VISN 21 Mariana Islands Outstation, Saipan, MP
- +1 VC Outstation: VISN 22 Sierra Vista Outstation, Sierra Vista, AZ
- +1 VC Outstation: VISN 23 St. Cloud Outstation, St. Cloud, MN
- -1 VC Outstation: VISN 10 McCafferty Outstation, Cleveland, OH

For the complete list, please refer to the section titled “FY 2022 Vet Centers, Mobile Vet Centers and Vet Center Outstations.”

FY 2022 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	FY 2022 Hospital (Yes / No)
1	402	Togus VA Medical Center	VA Medical Center (VAMC)	Yes
1	405	White River Junction VA Medical Center	VA Medical Center (VAMC)	Yes
1	518	Edith Nourse Rogers Memorial Veterans' Hospital	VA Medical Center (VAMC)	Yes
1	523	Jamaica Plain VA Medical Center	VA Medical Center (VAMC)	No
1	523A4	West Roxbury VA Medical Center	VA Medical Center (VAMC)	Yes
1	523A5	Brockton VA Medical Center	VA Medical Center (VAMC)	Yes
1	608	Manchester VA Medical Center	VA Medical Center (VAMC)	No
1	631	Edward P. Boland Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
1	650	Providence VA Medical Center	VA Medical Center (VAMC)	Yes
1	689	West Haven VA Medical Center	VA Medical Center (VAMC)	Yes
2	526	James J. Peters Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
2	528	Buffalo VA Medical Center	VA Medical Center (VAMC)	Yes
2	528A4	Batavia VA Medical Center	VA Medical Center (VAMC)	No
2	528A5	Canandaigua VA Medical Center	VA Medical Center (VAMC)	No
2	528A6	Bath VA Medical Center	VA Medical Center (VAMC)	Yes
2	528A7	Syracuse VA Medical Center	VA Medical Center (VAMC)	Yes
2	528A8	Samuel S. Stratton Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
2	561	East Orange VA Medical Center	VA Medical Center (VAMC)	Yes
2	561A4	Lyons VA Medical Center	VA Medical Center (VAMC)	Yes
2	620	Franklin Delano Roosevelt Hospital	VA Medical Center (VAMC)	Yes
2	620A4	Castle Point VA Medical Center	VA Medical Center (VAMC)	Yes
2	630	Manhattan VA Medical Center	VA Medical Center (VAMC)	Yes
2	630A4	Brooklyn VA Medical Center	VA Medical Center (VAMC)	Yes
2	630A5	St. Albans VA Medical Center	VA Medical Center (VAMC)	No
2	632	Northport VA Medical Center	VA Medical Center (VAMC)	Yes
4	460	Wilmington VA Medical Center	VA Medical Center (VAMC)	Yes
4	503	James E. Van Zandt Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
4	529A4	Butler VA Medical Center	VA Medical Center (VAMC)	No
4	542	Coatesville VA Medical Center	VA Medical Center (VAMC)	Yes
4	562	Erie VA Medical Center	VA Medical Center (VAMC)	No
4	595	Lebanon VA Medical Center	VA Medical Center (VAMC)	Yes
4	642	Corporal Michael J. Crescenz Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
4	646	Pittsburgh VA Medical Center-University Drive	VA Medical Center (VAMC)	Yes
4	646A4	H. John Heinz III Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	No
4	693	Wilkes-Barre VA Medical Center	VA Medical Center (VAMC)	Yes
5	512	Baltimore VA Medical Center	VA Medical Center (VAMC)	Yes
5	512A5	Perry Point VA Medical Center	VA Medical Center (VAMC)	No
5	512GD	Loch Raven VA Medical Center	VA Medical Center (VAMC)	No
5	517	Beckley VA Medical Center	VA Medical Center (VAMC)	Yes
5	540	Louis A. Johnson Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
5	581	Huntington / Hershel "Woody" Williams VA Medical Center	VA Medical Center (VAMC)	Yes
5	613	Martinsburg VA Medical Center	VA Medical Center (VAMC)	Yes
5	688	Washington VA Medical Center	VA Medical Center (VAMC)	Yes

FY 2022 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	FY 2022 Hospital (Yes / No)
6	558	Durham VA Medical Center	VA Medical Center (VAMC)	Yes
6	565	Fayetteville VA Medical Center	VA Medical Center (VAMC)	Yes
6	590	Hampton VA Medical Center	VA Medical Center (VAMC)	Yes
6	637	Charles George Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
6	652	Hunter Holmes McGuire Hospital	VA Medical Center (VAMC)	Yes
6	658	Salem VA Medical Center	VA Medical Center (VAMC)	Yes
6	659	W.G. (Bill) Hefner Salisbury Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
7	508	Atlanta VA Medical Center	VA Medical Center (VAMC)	Yes
7	508GA	Fort McPherson VA Clinic	VA Medical Center (VAMC)	No
7	508GK	Trinka Davis Veterans Village	VA Medical Center (VAMC)	No
7	509	Charlie Norwood Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
7	509A0	Augusta VA Medical Center-Uptown	VA Medical Center (VAMC)	Yes
7	521	Birmingham VA Medical Center	VA Medical Center (VAMC)	Yes
7	534	Ralph H. Johnson Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
7	544	Wm. Jennings Bryan Dorn Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
7	557	Carl Vinson Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
7	619	Central Alabama VA Medical Center-Montgomery	VA Medical Center (VAMC)	Yes
7	619A4	Central Alabama VA Medical Center-Tuskegee	VA Medical Center (VAMC)	Yes
7	679	Tuscaloosa VA Medical Center	VA Medical Center (VAMC)	Yes
8	516	C.W. Bill Young Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
8	546	Bruce W. Carter Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
8	548	West Palm Beach VA Medical Center	VA Medical Center (VAMC)	Yes
8	573	Malcom Randall Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
8	573A4	Lake City VA Medical Center	VA Medical Center (VAMC)	Yes
8	672	San Juan VA Medical Center	VA Medical Center (VAMC)	Yes
8	673	James A. Haley Veterans' Hospital	VA Medical Center (VAMC)	Yes
8	675	Orlando VA Medical Center	VA Medical Center (VAMC)	Yes
8	675GG	Lake Baldwin VA Clinic	VA Medical Center (VAMC)	No
9	596	Lexington VA Medical Center (Franklin R. Sousley Campus)	VA Medical Center (VAMC)	No
9	596A4	Lexington VA Medical Center (Troy Bowling Campus)	VA Medical Center (VAMC)	Yes
9	603	Robley Rex Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
9	614	Memphis VA Medical Center	VA Medical Center (VAMC)	Yes
9	621	James H. Quillen Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
9	626	Nashville VA Medical Center	VA Medical Center (VAMC)	Yes
9	626A4	Alvin C. York Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
10	506	Ann Arbor VA Medical Center	VA Medical Center (VAMC)	Yes
10	515	Battle Creek VA Medical Center	VA Medical Center (VAMC)	Yes
10	538	Chillicothe VA Medical Center	VA Medical Center (VAMC)	Yes
10	539	Cincinnati VA Medical Center	VA Medical Center (VAMC)	Yes
10	541	Louis Stokes Cleveland Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
10	552	Dayton VA Medical Center	VA Medical Center (VAMC)	Yes
10	553	John D. Dingell Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
10	553A4	Detroit VA Medical Center (Valor Center)	VA Medical Center (VAMC)	No
10	583	Richard L. Roudebush Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
10	610	Marion VA Medical Center	VA Medical Center (VAMC)	Yes
10	610A4	Fort Wayne VA Medical Center	VA Medical Center (VAMC)	Yes

FY 2022 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	FY 2022 Hospital (Yes / No)
10	655	Aleda E. Lutz Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
12	537	Jesse Brown Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
12	550	Danville VA Medical Center	VA Medical Center (VAMC)	Yes
12	556	Captain James A. Lovell Federal Health Care Center	VA Medical Center (VAMC)	Yes
12	578	Edward Hines Junior Hospital	VA Medical Center (VAMC)	Yes
12	585	Oscar G. Johnson Department of Veterans Affairs Medical Facility	VA Medical Center (VAMC)	Yes
12	607	William S. Middleton Memorial Veterans' Hospital	VA Medical Center (VAMC)	Yes
12	676	Tomah VA Medical Center	VA Medical Center (VAMC)	Yes
12	695	Clement J. Zablocki Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
15	589	Kansas City VA Medical Center	VA Medical Center (VAMC)	Yes
15	589A4	Harry S. Truman Memorial Veterans' Hospital	VA Medical Center (VAMC)	Yes
15	589A5	Colmery-O'Neil Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
15	589A6	Dwight D. Eisenhower Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
15	589A7	Robert J. Dole Department of Veterans Affairs Medical and Regional Office Center	VA Medical Center (VAMC)	Yes
15	657	John Cochran Veterans Hospital	VA Medical Center (VAMC)	Yes
15	657A0	St. Louis VA Medical Center-Jefferson Barracks	VA Medical Center (VAMC)	Yes
15	657A4	John J. Pershing Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
15	657A5	Marion VA Medical Center	VA Medical Center (VAMC)	Yes
16	502	Alexandria VA Medical Center	VA Medical Center (VAMC)	Yes
16	520	Biloxi VA Medical Center	VA Medical Center (VAMC)	Yes
16	564	Fayetteville VA Medical Center	VA Medical Center (VAMC)	Yes
16	580	Michael E. DeBakey Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
16	586	G.V. (Sonny) Montgomery Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
16	598	John L. McClellan Memorial Veterans' Hospital	VA Medical Center (VAMC)	Yes
16	598A0	Eugene J. Towbin Healthcare Center	VA Medical Center (VAMC)	Yes
16	629	New Orleans VA Medical Center	VA Medical Center (VAMC)	Yes
16	667	Overton Brooks Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
17	504	Thomas E. Creek Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
17	519	George H. O'Brien, Jr., Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	No
17	549	Dallas VA Medical Center	VA Medical Center (VAMC)	Yes
17	549A4	Sam Rayburn Memorial Veterans Center	VA Medical Center (VAMC)	No
17	671	Audie L. Murphy Memorial Veterans' Hospital	VA Medical Center (VAMC)	Yes
17	671A4	Kerrville VA Medical Center	VA Medical Center (VAMC)	No
17	674	Olin E. Teague Veterans' Center	VA Medical Center (VAMC)	Yes
17	674A4	Doris Miller Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
19	436	Fort Harrison VA Medical Center	VA Medical Center (VAMC)	Yes
19	436A4	Miles City VA Medical Center	VA Medical Center (VAMC)	No
19	442	Cheyenne VA Medical Center	VA Medical Center (VAMC)	Yes
19	554	Rocky Mountain Regional VA Medical Center	VA Medical Center (VAMC)	Yes
19	575	Grand Junction VA Medical Center	VA Medical Center (VAMC)	Yes
19	623	Jack C. Montgomery Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
19	635	Oklahoma City VA Medical Center	VA Medical Center (VAMC)	Yes
19	660	George E. Wahlen Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
19	666	Sheridan VA Medical Center	VA Medical Center (VAMC)	Yes
20	463	Anchorage VA Medical Center	VA Medical Center (VAMC)	No

FY 2022 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	FY 2022 Hospital (Yes / No)
20	531	Boise VA Medical Center	VA Medical Center (VAMC)	Yes
20	648	Portland VA Medical Center	VA Medical Center (VAMC)	Yes
20	648A4	Portland VA Medical Center-Vancouver	VA Medical Center (VAMC)	No
20	653	Roseburg VA Medical Center	VA Medical Center (VAMC)	Yes
20	663	Seattle VA Medical Center	VA Medical Center (VAMC)	Yes
20	663A4	American Lake VA Medical Center	VA Medical Center (VAMC)	Yes
20	668	Mann-Grandstaff Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
20	687	Jonathan M. Wainwright Memorial VA Medical Center	VA Medical Center (VAMC)	No
20	692	White City VA Medical Center	VA Medical Center (VAMC)	No
21	459	Spark M. Matsunaga Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
21	570	Fresno VA Medical Center	VA Medical Center (VAMC)	Yes
21	593	North Las Vegas VA Medical Center	VA Medical Center (VAMC)	Yes
21	612A4	Sacramento VA Medical Center	VA Medical Center (VAMC)	Yes
21	612GF	Martinez VA Medical Center	VA Medical Center (VAMC)	No
21	640	Palo Alto VA Medical Center	VA Medical Center (VAMC)	Yes
21	640A0	Palo Alto VA Medical Center-Menlo Park	VA Medical Center (VAMC)	Yes
21	640A4	Palo Alto VA Medical Center-Livermore	VA Medical Center (VAMC)	No
21	654	Ioannis A. Lougaris Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
21	662	San Francisco VA Medical Center	VA Medical Center (VAMC)	Yes
22	501	Raymond G. Murphy Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
22	600	Long Beach (Tibor Rubin) VA Medical Center	VA Medical Center (VAMC)	Yes
22	605	Jerry L. Pettis Memorial Veterans' Hospital	VA Medical Center (VAMC)	Yes
22	644	Carl T. Hayden Veterans' Administration Medical Center	VA Medical Center (VAMC)	Yes
22	649	Bob Stump Department of Veterans Affairs Medical Center	VA Medical Center (VAMC)	Yes
22	664	San Diego VA Medical Center	VA Medical Center (VAMC)	Yes
22	678	Tucson VA Medical Center	VA Medical Center (VAMC)	Yes
22	691	West Los Angeles VA Medical Center	VA Medical Center (VAMC)	Yes
22	691A4	Sepulveda VA Medical Center	VA Medical Center (VAMC)	No
23	437	Fargo VA Medical Center	VA Medical Center (VAMC)	Yes
23	438	Royal C. Johnson Veterans' Memorial Hospital	VA Medical Center (VAMC)	Yes
23	568	Fort Meade VA Medical Center	VA Medical Center (VAMC)	Yes
23	568A4	Hot Springs VA Medical Center	VA Medical Center (VAMC)	Yes
23	618	Minneapolis VA Medical Center	VA Medical Center (VAMC)	Yes
23	636	Omaha VA Medical Center	VA Medical Center (VAMC)	Yes
23	636A4	Grand Island VA Medical Center	VA Medical Center (VAMC)	No
23	636A6	Des Moines VA Medical Center	VA Medical Center (VAMC)	Yes
23	636A8	Iowa City VA Medical Center	VA Medical Center (VAMC)	Yes
23	656	St. Cloud VA Medical Center	VA Medical Center (VAMC)	Yes

FY 2022 Community Living Centers (CLC)

CLC Program Count	VISN	Station Number	Official Name
1	1	402	Maine VA
2	1	518	Edith Nourse Rogers VA
3	1	523A5	Boston VA-Brockton
4	1	608	Manchester VA
5	1	631	Central Western Massachusetts VA-Leeds
6	1	689	Connecticut VA-West Haven
7	2	528	Western New York VA-Buffalo
8	2	528A4	Western New York VA-Batavia
9	2	528A5	Canandaigua VA
10	2	528A6	Bath VA
11	2	528A7	Syracuse VA
12	2	528A8	Samuel S. Stratton VA
13	2	526	James J. Peters VA
14	2	561A4	New Jersey VA-Lyons
15	2	620	Franklin Delano Roosevelt VA - Montrose
16	2	620A4	Hudson Valley VA-Castle Point
17	2	630A5	New York Harbor VA-St. Albans
18	2	632	Northport VA
19	4	460	Wilmington VA
20	4	503	James E. Van Zandt VA
21	4	529	Butler VA
22	4	542	Coatesville VA
23	4	562	Erie VA
24	4	595	Lebanon VA
25	4	642	Philadelphia VA
26	4	646A4	Pittsburgh VA-H.J. Heinz VA
27	4	693	Wilkes-Barre VA
28	5	540	Louis A. Johnson VA
29	5	512	Maryland VA-Baltimore
30	5	512A5	Maryland VA-Perry Point
31	5	613	Martinsburg VA
32	5	688	Washington VA
33	5	517	Beckley VA
34	6	558	Durham VA
35	6	565	Fayetteville VA
36	6	590	Hampton VA
37	6	637	Charles George VA
38	6	652	Hunter Holmes McGuire VA
39	6	658	Salem VA
40	6	659	W.G. (Bill) Hefner VA

FY 2022 Community Living Centers (CLC)

CLC Program Count	VISN	Station Number	Official Name
41	7	508	Atlanta VA
42	7	508GK	Trinka Davis Veterans Village Clinic
43	7	509A0	Augusta VA-Uptown
44	7	534	Ralph H. Johnson VA
45	7	544	William Jennings Bryan Dorn VA
46	7	557	Carl Vinson VA
47	7	619A4	Central Alabama VA-Tuskegee
48	7	679	Tuscaloosa VA
49	8	516	C.W. Bill Young VA
50	8	546	Miami VA
51	8	548	West Palm Beach VA
52	8	573	Malcom Randall VA
53	8	573A4	North Florida-South Georgia VA-Lake City
54	8	672	Caribbean VA-San Juan
55	8	673	James A. Haley VA
56	8	675	Orlando VA
57	9	596	Lexington VA-Leestown
58	9	621	James H. Quillen VA
59	9	626A4	Alvin C. York VA
60	10	538	Chillicothe VA
61	10	539	Cincinnati VA
62	10	541	Louis Stokes VA
63	10	552	Dayton VA
64	10	506	Ann Arbor VA
65	10	515	Battle Creek VA
66	10	553	John D. Dingell VA
67	10	610	Northern Indiana VA-Marion
68	10	655	Aleda E. Lutz VA
69	12	550	Illiana VA-Danville
70	12	537	Jesse Brown VA
71	12	556	Captain James A. Lovell VA
72	12	578	Edward Hines Jr. VA
73	12	585	Oscar G. Johnson VA
74	12	607	William S. Middleton VA
75	12	676	Tomah VA
76	12	695	Clement J. Zablocki VA
77	15	589A4	Harry S. Truman VA
78	15	589A5	Eastern Kansas VA-Colmery-O'Neil
79	15	589A6	Eastern Kansas VA-Dwight D. Eisenhower
80	15	589A7	Robert J. Dole VA
81	15	657A0	St. Louis VA-Jefferson Barracks
82	15	657A4	John J. Pershing VA
83	15	657A5	Marion VA

FY 2022 Community Living Centers (CLC)

CLC Program Count	VISN	Station Number	Official Name
84	16	502	Alexandria VA
85	16	520	Gulf Coast VA-Biloxi
86	16	580	Michael E. DeBakey VA
87	16	586	G. V. (Sonny) Montgomery VA
88	16	598A0	Central Arkansas VA-Eugene J. Tobin
89	16	629	New Orleans VA
90	17	549	North Texas VA-Dallas
91	17	549A4	North Texas VA-Sam Rayburn
92	17	671	South Texas VA-Audie L. Murphy
93	17	671A4	South Texas VA-Kerrville
94	17	674	Central Texas VA-Olin E. Teague
95	17	674A4	Central Texas VA-Waco
96	17	504	Thomas E. Creek VA
97	17	519	West Texas VA-George H. O'Brien, Jr.
98	19	635	Oklahoma City VA
99	19	436GJ	Miles City VA Clinic
100	19	442	Cheyenne VA
101	19	554A4	Eastern Colorado VA-Pueblo
102	19	575	Grand Junction VA
103	19	666	Sheridan VA
104	20	531	Boise VA
105	20	648A4	Portland VA-Vancouver
106	20	653	Roseburg VA
107	20	663	Puget Sound VA-Seattle
108	20	663A4	Puget Sound VA-American Lake
109	20	668	Mann-Grandstaff VA
110	21	459	Pacific Islands VA-Spark M. Matsunaga
111	21	570	Central California VA-Fresno
112	21	612	Northern California VA-East Bay (Martinez)
113	21	640	Palo Alto VA
114	21	640A0	Palo Alto VA-Menlo Park
115	21	640A4	Palo Alto VA-Livermore
116	21	654	Sierra Nevada VA-Ioannis A. Lougaris
117	21	662	San Francisco VA
118	22	501	New Mexico VA-Raymond G. Murphy
119	22	644	Carl T. Hayden VA
120	22	649	Northern Arizona VA-Prescott
121	22	678	Southern Arizona VA-Tucson
122	22	600	Long Beach VA
123	22	605	Loma Linda VA
124	22	664	San Diego VA
125	22	691	Greater Los Angeles VA-West Los Angeles
126	22	691A4	Sepulveda VA Clinic

FY 2022 Community Living Centers (CLC)

CLC Program Count	VISN	Station Number	Official Name
127	23	437	Fargo VA
128	23	438	Sioux Falls VA
129	23	568	Black Hills VA-Fort Meade
130	23	568A4	Black Hills VA-Hot Springs
131	23	618	Minneapolis VA
132	23	636A4	Grand Island VA Clinic
133	23	636A6	Central Iowa VA-Des Moines
134	23	6369AA	Papillion VA Community Living Center
135	23	656	St. Cloud VA

FY 2022 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

MH RRTP Program Count	VISN	Station Number	Official Name	Classification	Type of Service
1	1	405	White River Junction VA	VA Medical Center (VAMC)	Domiciliary Program
2	1	518	Edith Nourse Rogers VA- Bedford	VA Medical Center (VAMC)	Dom & CWT/TR Program
3	1	523	Boston VA-Jamaica Plain	VA Medical Center (VAMC)	Dom & CWT/TR Program
4	1	523A5	Boston VA-Brockton	VA Medical Center (VAMC)	Dom & CWT/TR Program
5	1	631	Central Western Massachusetts VA-Leeds (Northampton)	VA Medical Center (VAMC)	CWT/TR Program
6	1	689BW	Connecticut VA - West Haven - Maple Street	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
7	1	689BX	Connecticut VA - West Haven - Norton Street	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
8	2	528	Western New York VA-Buffalo	VA Medical Center (VAMC)	Domiciliary Program
9	2	528A4	Western New York VA-Batavia	VA Medical Center (VAMC)	Domiciliary Program
10	2	528A5	Canandaigua VA	VA Medical Center (VAMC)	Domiciliary Program
11	2	528A6	Bath VA	VA Medical Center (VAMC)	Domiciliary Program
12	2	528A8	Samuel S. Stratton VA- Albany	VA Medical Center (VAMC)	Domiciliary Program
13	2	561	New Jersey VA-East Orange	VA Medical Center (VAMC)	Domiciliary Program
14	2	561A4	New Jersey VA-Lyons	VA Medical Center (VAMC)	Domiciliary Program
15	2	620	Franklin Delano Roosevelt VA (Montrose)	VA Medical Center (VAMC)	Domiciliary Program
16	2	630A4	New York Harbor VA-Brooklyn Division	VA Medical Center (VAMC)	Domiciliary Program
17	2	632	Northport VA	VA Medical Center (VAMC)	Domiciliary Program
18	4	529	Butler VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
19	4	542	Coatesville VA	VA Medical Center (VAMC)	Domiciliary Program
20	4	595	Lebanon VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
21	4	642BU	Philadelphia VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
22	4	646A4	Pittsburgh VA-H.J. Heinz VA	VA Medical Center (VAMC)	Domiciliary Program & CWT/TR
23	4	562	Erie VA	VA Medical Center (VAMC)	Domiciliary Program
24	4	693	Wilkes-Barre VA	VA Medical Center (VAMC)	Domiciliary Program
25	5	512A5	Maryland VA-Perry Point	VA Medical Center (VAMC)	Dom & CWT/TR Program
26	5	540	Louis A. Johnson VA (Clarksburg)	VA Medical Center (VAMC)	Domiciliary Program
27	5	581	Huntington, West VA	VA Medical Center (VAMC)	Domiciliary Program
28	5	613	Martinsburg VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
29	6	590	Hampton VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
30	6	637	Charles George VA (Asheville)	VA Medical Center (VAMC)	Domiciliary Program
31	6	652	Hunter Holmes McGuire VA (Richmond)	VA Medical Center (VAMC)	Domiciliary Program
32	6	658	Salem VA	VA Medical Center (VAMC)	Domiciliary Program
33	6	659	W.G. (Bill) Hefner VA (Salisbury)	VA Medical Center (VAMC)	Dom & CWT/TR Program
34	7	508	Atlanta VA - Decatur	VA Medical Center (VAMC)	CWT/TR Program
35	7	508GA	Atlanta VA - Fort McPherson	VA Medical Center (VAMC)	Domiciliary Program
36	7	509A0	Augusta VA-Uptown	VA Medical Center (VAMC)	Domiciliary Program
37	7	521	Birmingham VA	VA Medical Center (VAMC)	CWT/TR Program
38	7	557	Carl Vinson VA (Dublin)	VA Medical Center (VAMC)	Domiciliary Program
39	7	619A4	Central Alabama VA-Tuskegee	VA Medical Center (VAMC)	Dom & CWT/TR Program
40	7	679	Tuscaloosa VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
41	8	516	C.W. Bill Young VA (Bay Pines)	VA Medical Center (VAMC)	Domiciliary Program
42	8	546	Bruce W. Carter VAMC (Miami)	VA Medical Center (VAMC)	Domiciliary Program
43	8	548	West Palm Beach	VA Medical Center (VAMC)	Domiciliary Program
44	8	573A4	North Florida-South Georgia VA-Lake City	VA Medical Center (VAMC)	Domiciliary Program
45	8	573BU	Gainesville VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
46	8	673BV	Tampa VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
47	8	675GG	Orlando VA (Lake Baldwin)	VA Medical Center (VAMC)	Domiciliary Program
48	8	675	Orlando VA (Lake Nona)	VA Medical Center (VAMC)	Domiciliary Program
49	9	596	Lexington VA-Leestown	VA Medical Center (VAMC)	Domiciliary Program
50	9	603	Robley Rex VA (Louisville)	VA Medical Center (VAMC)	Domiciliary Program
51	9	614	Memphis VA	VA Medical Center (VAMC)	Domiciliary Program
52	9	621	James H. Quillen VA (Mountain Home)	VA Medical Center (VAMC)	Domiciliary Program
53	9	626A4	Alvin C. York VA (Murfreesboro)	VA Medical Center (VAMC)	Domiciliary Program
54	10	538	Chillicothe VA	VA Medical Center (VAMC)	Domiciliary Program
55	10	539A4	Cincinnati VA-Fort Thomas	VA Medical Center (VAMC)	Domiciliary Program
56	10	541	Louis Stokes VA (Cleveland - Wade Park Division)	VA Medical Center (VAMC)	Dom & CWT/TR Program
57	10	552	Dayton VA	VA Medical Center (VAMC)	Domiciliary Program
58	10	515	Battle Creek VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
59	10	553BU	Detroit VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
60	10	583BU	Indianapolis VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only

FY 2022 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

MH RRTP Program Count	VISN	Station Number	Official Name	Classification	Type of Service
61	10	610	Northern Indiana VA (Marion)	VA Medical Center (VAMC)	Domiciliary Program
62	12	537	Jesse Brown VA (Chicago)	VA Medical Center (VAMC)	Domiciliary Program
63	12	550	Illiana VA-Danville	VA Medical Center (VAMC)	Dom & CWT/TR Program
64	12	556	Captain James A. Lovell VA (North Chicago)	VA Medical Center (VAMC)	Dom & CWT/TR Program
65	12	578	Edward Hines Jr. VA	VA Medical Center (VAMC)	Domiciliary Program
66	12	607	William S. Middleton VA (Madison)	VA Medical Center (VAMC)	CWT/TR Program
67	12	676	Tomah VA	VA Medical Center (VAMC)	Domiciliary Program
68	12	676PA	LaCrosse VA	Residential Care Site (MH RRTP/DRRTP)	Stand Alone CWT/TR Program
69	12	695	Clement J. Zablocki VA (Milwaukee)	VA Medical Center (VAMC)	Dom & CWT/TR Program
70	15	589	Kansas City VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
71	15	589A4	Harry S. Truman VA (Columbia MO)	VA Medical Center (VAMC)	Dom & CWT/TR Program
72	15	589A5	Eastern Kansas VA - Topeka Division	VA Medical Center (VAMC)	Dom & CWT/TR Program
73	15	589A6	Eastern Kansas VA - Leavenworth Division	VA Medical Center (VAMC)	Domiciliary Program
74	15	657A0	St. Louis VA-Jefferson Barracks	VA Medical Center (VAMC)	Domiciliary Program
75	15	657A5	Marion IL VA	VA Medical Center (VAMC)	Domiciliary Program
76	15	589A7	Wichita VA	VA Medical Center (VAMC)	Domiciliary Program
77	16	520	Gulf Coast VA-Biloxi	VA Medical Center (VAMC)	Domiciliary Program
78	16	564	Veterans HCS of the Ozarks - Fayetteville	VA Medical Center (VAMC)	Domiciliary Program
79	16	586BU	Jackson VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
80	16	598A0	Central Arkansas VA-Eugene J. Tobin (N.Little Rock)	VA Medical Center (VAMC)	Dom & CWT/TR Program
81	17	549	North Texas VA-Dallas	VA Medical Center (VAMC)	Dom & CWT/TR Program
82	17	549A4	North Texas VA-Sam Rayburn (Bonham)	VA Medical Center (VAMC)	Dom & CWT/TR Program
83	17	671	South Texas VA-Audie L. Murphy (San Antonio)	VA Medical Center (VAMC)	Domiciliary Program
84	17	674	Central Texas VA-Olin E. Teague (Temple)	VA Medical Center (VAMC)	Dom & CWT/TR Program
85	17	674A4	Central Texas VA-Waco	VA Medical Center (VAMC)	Domiciliary Program
86	17	519	West Texas VA-George H. O'Brien, Jr. (Big Spring)	VA Medical Center (VAMC)	Domiciliary Program
87	19	436	Montana VA-Fort Harrison	VA Medical Center (VAMC)	Domiciliary Program
88	19	442	Cheyenne VA	VA Medical Center (VAMC)	Domiciliary Program
89	19	554BU	Valor Point VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
90	19	660	George E. Wahlen VA (Salt Lake)	VA Medical Center (VAMC)	Domiciliary Program
91	19	635	Oklahoma City VA	VA Medical Center (VAMC)	CWT/TR Program
92	19	666	Sheridan VA	VA Medical Center (VAMC)	Domiciliary Program
93	19	575	VA Western Colorado Healthcare System	VA Medical Center (VAMC)	Domiciliary Program
94	20	463	Alaska VA-Anchorage	VA Medical Center (VAMC)	Dom & CWT/TR Program
95	20	531	Boise VA	VA Medical Center (VAMC)	Domiciliary Program
96	20	648A4	Portland VA-Vancouver	VA Medical Center (VAMC)	Domiciliary Program
97	20	653	Roseburg VA	VA Medical Center (VAMC)	Domiciliary Program
98	20	663A4	Puget Sound VA-American Lake	VA Medical Center (VAMC)	Dom & CWT/TR Program
99	20	687	Jonathan M. Wainwright VA (Walla Walla)	VA Medical Center (VAMC)	Domiciliary Program
100	20	692	Southern Oregon VA-White City	VA Medical Center (VAMC)	Domiciliary Program
101	21	459	Pacific Islands VA-Spark M. Matsunaga	VA Medical Center (VAMC)	Domiciliary Program
102	21	593	Southern Nevada (Las Vegas)	VA Medical Center (VAMC)	Domiciliary Program
103	21	640A0	Palo Alto VA-Menlo Park	VA Medical Center (VAMC)	Dom & CWT/TR Program
104	21	640BV	Palo Alto VA	VA Medical Center (VAMC)	Domiciliary Program
105	21	662	San Francisco VA	VA Medical Center (VAMC)	CWT/TR Program
106	22	664	San Diego VA	VA Medical Center (VAMC)	Domiciliary Program
107	22	664BV	San Diego VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary Only
108	22	501	New Mexico VA-Raymond G. Murphy (Albuquerque)	VA Medical Center (VAMC)	Dom & CWT/TR Program
109	22	644	Carl T. Hayden VA (Phoenix)	VA Medical Center (VAMC)	Domiciliary Program
110	22	649	Northern Arizona VA-Prescott	VA Medical Center (VAMC)	Domiciliary Program
111	22	678	Southern Arizona VA-Tucson	VA Medical Center (VAMC)	Domiciliary Program
112	22	691	Greater Los Angeles VA-West Los Angeles	VA Medical Center (VAMC)	Domiciliary Program
113	23	568A4	Black Hills VA-Hot Springs	VA Medical Center (VAMC)	Dom & CWT/TR Program
114	23	568PB	Black Hills VA-Sturgis VA CWT-TR	Residential Care Site (CWT/TR)	Stand Alone CWT/TR Program
115	23	568PC	Black Hills VA - Pine Ridge CWT-TR	Residential Care Site (CWT/TR)	Stand Alone CWT/TR Program
116	23	568PD	Black Hills VA - Rapid City CWT-TR	Residential Care Site (CWT/TR)	Stand Alone CWT/TR Program
117	23	636	Nebraska-Western Iowa VA-Omaha	VA Medical Center (VAMC)	Domiciliary Program
118	23	636A4	Grand Island VA Clinic	VA Medical Center (VAMC)	Dom & CWT/TR Program
119	23	636A6	Central Iowa VA-Des Moines	VA Medical Center (VAMC)	Domiciliary Program
120	23	656	St. Cloud VA	VA Medical Center (VAMC)	Domiciliary Program

FY 2022 Health Care Centers (HCC)

HCC Count	VISN	Station Number	Station Name & Location
1	6	565GL	Cumberland County VA Clinic, Fayetteville, NC
2	6	659BY	Kernersville VA Clinic, Kernersville, NC
3	6	659BZ	South Charlotte VA Clinic, Charlotte, NC
4	8	516BZ	Lee County VA Clinic, Cape Coral, FL
5	10	757	Chalmers P. Wylie Veterans Outpatient Clinic, Columbus, OH
6	12	695GD	Milo C. Huempfner VA Outpatient Clinic, Green Bay, WI
7	15	657GJ	Evansville VA Clinic, Evansville, IN
8	17	671GS	North West San Antonio VA Clinic, San Antonio, TX
9	17	740	Harlingen VA Clinic, Harlingen, TX
10	17	756	El Paso VA Clinic, El Paso, TX
11	19	436GH	Billings VA Clinic, Billings, MT
12	20	653BY	Eugene VA Clinic, Eugene, OR

FY 2022 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
1	1	402HB	Bangor VA Clinic	Bangor
2	1	405HA	Burlington Lakeside VA Clinic	Burlington Lakeside
3	1	405HC	Littleton VA Clinic	Littleton, New Hampshire
4	1	523BY	Lowell VA Clinic	Lowell
5	1	631BY	Springfield VA Clinic	Springfield, Massachusetts
6	1	650GA	New Bedford VA Clinic	New Bedford
7	1	650GB	Hyannis VA Clinic	Hyannis
8	1	689A4	Newington VA Clinic	Newington
9	2	528GM	Donald J. Mitchell VA Outpatient Clinic	Rome, New York
10	2	528GN	Binghamton VA Clinic	Binghamton
11	2	528QC	Rochester Calkins VA Clinic	Rochester Calkins
12	2	561BZ	James J. Howard Veterans' Outpatient Clinic	Brick
13	2	561GD	Hackensack VA Clinic	Hackensack, New Jersey
14	2	620GA	New City VA Clinic	New City
15	2	620GE	Port Jervis VA Clinic	Port Jervis
16	2	630GB	Staten Island Community VA Clinic	Staten Island
17	2	632GA	East Meadow VA Clinic	East Meadow
18	4	460HG	Cumberland County VA Clinic	Cumberland County, New Jersey
19	4	503GA	Johnstown VA Clinic	Johnstown, Pensilvanya
20	4	503GB	DuBois VA Clinic	DuBois
21	4	503GC	State College VA Clinic	State College
22	4	503GD	Huntingdon County VA Clinic	Mapleton Depot
23	4	503GE	Indiana County VA Clinic	Indiana
24	4	529	Abie Abraham VA Clinic	Butler
25	4	595GA	Cumberland County VA Clinic	Cumberland County Pennsylvania
26	4	595GC	Lancaster County VA Clinic	Lancaster County
27	4	595GE	York VA Clinic	York
28	4	642GA	Burlington County VA Clinic	Burlington County
29	4	642GC	Victor J. Saracini VA Outpatient Clinic	Horsham
30	4	642GD	Gloucester County VA Clinic	Gloucester County
31	4	646GA	Belmont County VA Clinic	Belmont County
32	4	646GC	Beaver County VA Clinic	Beaver County
33	4	646GD	Washington County VA Clinic	Washington County
34	4	646GE	Fayette County VA Clinic	Fayette County
35	4	693B4	Allentown VA Clinic	Allentown
36	5	512GA	Cambridge VA Clinic	Cambridge, Maryland
37	5	512GC	Glen Burnie VA Clinic	Glen Burnie
38	5	512GG	Fort Meade VA Clinic	Fort Meade
39	5	581GB	Charleston VA Clinic	Charleston, West Virginia
40	5	613GA	Cumberland VA Clinic	Cumberland, Maryland
41	5	613GG	Fort Detrick VA Clinic	Fort Detrick
42	5	688GA	Fort Belvoir VA Clinic	Fort Belvoir
43	5	688GD	Charlotte Hall VA Clinic	Charlotte Hall

FY 2022 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
44	6	558GA	Greenville VA Clinic	Greenville, North Carolina
45	6	558GB	Raleigh VA Clinic	Raleigh
46	6	558GC	Morehead City VA Clinic	Morehead City
47	6	558GG	Raleigh III VA Clinic	Raleigh III
48	6	565GC	Wilmington VA Clinic	Wilmington
49	6	590GD	Chesapeake VA Clinic	Chesapeake, Virginia
50	6	637GC	Hickory VA Clinic	Hickory, North Carolina
51	6	652GC	Henrico County VA Clinic	Richmond, Virginia
52	6	652GE	Charlottesville VA Clinic	Charlottesville, Virginnia
53	6	659GA	North Charlotte VA Clinic	North Charlotte, North Carolina
54	7	508GE	Oakwood VA Clinic	Flowery Branch, Georgia
55	7	508GF	West Cobb County VA Clinic	West Cobb County, Marietta
56	7	508GG	Stockbridge VA Clinic	Stockbridge
57	7	508GH	Lawrenceville VA Clinic	Lawrenceville
58	7	508GJ	Blairsville VA Clinic	Blairsville
59	7	508GL	Rome VA Clinic	Rome, Georgia
60	7	508GO	Northeast Cobb County VA Clinic	Northeast Cobb County, Marietta
61	7	508GQ	Cobb County VA Clinic	Cobb County, Marietta
62	7	508GS	Pike County VA Clinic	Pike County, Zebulon
63	7	508QF	Atlanta VA Clinic	Atlanta North Arcadia Avenue
64	7	509GA	Athens VA Clinic	Athens
65	7	521GA	Huntsville VA Clinic	Huntsville
66	7	521GJ	Birmingham VA Clinic	Birmingham 7th Avenue South
67	7	534BY	Savannah VA Clinic	Savannah
68	7	534GB	Myrtle Beach VA Clinic	Myrtle Beach, South Carolina
69	7	534GC	Beaufort VA Clinic	Beaufort
70	7	534GD	Goose Creek VA Clinic	Goose Creek
71	7	534GE	Hinesville VA Clinic	Hinesville
72	7	534QA	Market Commons VA Clinic	Market Commons
73	7	544BZ	Greenville VA Clinic	Greenville
74	7	544GB	Florence VA Clinic	Florence
75	7	544GD	Anderson VA Clinic	Anderson
76	7	557GA	Macon VA Clinic	Macon
77	7	557GB	Albany VA Clinic	Albany, Georgia
78	7	557GE	Brunswick VA Clinic	Brunswick
79	7	619GA	Columbus VA Clinic	Columbus, Georgia
80	7	619GD	Wiregrass VA Clinic	Wiregrass
81	7	619GF	Central Alabama Montgomery VA Clinic	Central Alabama Montgomery
82	8	516GA	Sarasota VA Clinic	Sarasota, Florida
83	8	516GC	North Pinellas VA Clinic	North Pinellas
84	8	516GD	Bradenton VA Clinic	Bradenton
85	8	516GE	Port Charlotte VA Clinic	Port Charlotte
86	8	516GF	Naples VA Clinic	Naples
87	8	516GH	Sebring VA Clinic	Sebring

FY 2022 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
88	8	546BZ	William "Bill" Kling VA Outpatient Clinic	Sunrise
89	8	546GB	Key West VA Clinic	Key West
90	8	546GC	Homestead VA Clinic	Homestead
91	8	548GA	Fort Pierce VA Clinic	Fort Pierce
92	8	548GB	Delray Beach VA Clinic	Delray Beach
93	8	548GC	Stuart VA Clinic	Stuart
94	8	573BY	Jacksonville 1 VA Clinic	Jacksonville
95	8	573GD	Ocala VA Clinic	Ocala
96	8	573GE	Saint Augustine VA Clinic	Saint Augustine
97	8	573GF	Sergeant Ernest I. "Boots" Thomas VA Clinic	Tallahassee
98	8	573GI	The Villages VA Clinic	The Villages
99	8	573QJ	Jacksonville 2 VA Clinic	Jacksonville 2
100	8	672B0	Eurípides Rubio VA Outpatient Clinic	Ponce
101	8	672BZ	Mayaguez VA Clinic	Mayaguez
102	8	673BZ	New Port Richey VA Clinic	New Port Richey
103	8	673GC	Brooksville VA Clinic	Brooksville
104	8	673GG	South Hillsborough VA Clinic	South Hillsborough
105	8	673QJ	Hidden River VA Clinic	Hidden River
106	8	675GA	Viera VA Clinic	Viera
107	8	675GB	William V. Chappell, Jr. Veterans' Outpatient Clinic	Daytona Beach
108	8	675GE	Tavares VA Clinic	Tavares
109	9	596GA	Somerset VA Clinic	Somerset
110	9	603GB	New Albany VA Clinic	New Albany, Indiana
111	9	614GA	Tupelo VA Clinic	Tupelo, Mississippi
112	9	614GF	Nonconnah Boulevard VA Clinic	Nonconnah Boulevard
113	9	614GG	Jackson VA Clinic	Jackson
114	9	621BY	William C. Tallent VA Outpatient Clinic	Knoxville, Tennessee
115	9	626GE	Clarksville VA Clinic	Clarksville
116	9	626GF	Chattanooga VA Clinic	Chattanooga
117	9	626GO	International Plaza VA Clinic	Nashville, Tennessee
118	10	506GA	Toledo VA Clinic	Toledo
119	10	515BY	Wyoming VA Clinic	Wyoming
120	10	538GC	Marietta VA Clinic	Marietta, Ohio
121	10	539GB	Clermont County VA Clinic	Clermont County
122	10	539GC	Dearborn VA Clinic	Dearborn
123	10	539GD	Florence VA Clinic	Florence, Kentucky
124	10	539GE	Hamilton VA Clinic	Hamilton, Ohio
125	10	541BY	Canton VA Clinic	Canton
126	10	541BZ	Youngstown VA Clinic	Youngstown
127	10	541GB	Lorain VA Clinic	Lorain
128	10	541GD	David F. Winder VA Community Based Outpatient Clinic	Mansfield
129	10	541GF	Lake County VA Clinic	Lake County
130	10	541GG	Akron VA Clinic	Akron
131	10	541GL	Parma VA Clinic	Parma

FY 2022 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
132	10	552GA	Middletown VA Clinic	Middletown, Ohio
133	10	552GB	Lima VA Clinic	Lima
134	10	552GC	Richmond VA Clinic	Richmond, Indiana
135	10	552GD	Springfield VA Clinic	Springfield, Ohio
136	10	583GB	Bloomington VA Clinic	Bloomington, Indiana
137	10	583GC	Martinsville VA Clinic	Martinsville
138	10	583GD	Indianapolis West VA Clinic	Indianapolis West
139	10	583GF	Wakeman VA Clinic	Wakeman
140	10	583GG	Shelbyville VA Clinic	Shelbyville
141	10	610BY	St. Joseph County VA Clinic	St. Joseph County
142	10	655GB	Colonel Demas T. Craw VA Clinic	Traverse City
143	10	757GB	Grove City VA Clinic	Grove City
144	10	757GD	Daniel L. Kinnard VA Clinic	Newark, Ohio
145	12	537BY	Adam Benjamin Jr., Veterans' Administration Outpatient Clinic	Crown Point, Indiana
146	12	550BY	Bob Michel Department of Veterans Affairs Outpatient Clinic	Peoria, Illinois
147	12	550GA	Decatur VA Clinic	Decatur
148	12	550GD	Springfield VA Clinic	Springfield, Ohio
149	12	578GA	Joliet VA Clinic	Joliet
150	12	578GC	Kankakee County VA Clinic	Bourbonnais
151	12	578GD	Aurora VA Clinic	North Aurora
152	12	578GE	Hoffman Estates VA Clinic	Hoffman Estates
153	12	578GF	LaSalle VA Clinic	LaSalle
154	12	607HA	Rockford VA Clinic	Rockford
155	12	676GD	Wisconsin Rapids VA Clinic	Wisconsin Rapids
156	12	695BY	John H. Bradley Department of Veterans Affairs Outpatient Clinic	Appleton
157	15	589G1	Warrensburg VA Clinic	Warrensburg, Missouri
158	15	589G8	Jefferson City VA Clinic	Jefferson City
159	15	589JD	Marshfield VA Clinic	Marshfield
160	15	657GB	St. Louis County VA Clinic	Saint Louis
161	15	657GD	St. Charles County VA Clinic	Saint Charles
162	15	657GV	Sikeston VA Clinic	Sikeston
163	16	502GB	Lafayette VA Clinic	Lafayette, Louisiana
164	16	502GE	Douglas Fournet Department of Veterans Affairs Clinic	Lake Charles
165	16	502GF	Fort Polk VA Clinic	Leesville
166	16	520BZ	Pensacola VA Clinic	Pensacola, Florida
167	16	520GA	Mobile VA Clinic	Mobile, Alabama
168	16	520GC	Eglin Air Force Base VA Clinic	Eglin Air Force Base, Florida
169	16	564BY	Gene Taylor Veterans' Outpatient Clinic	Springfield, Missouri
170	16	564GB	Fort Smith VA Clinic	Fort Smith
171	16	564GC	Branson VA Clinic	Branson
172	16	564GF	Joplin VA Clinic	Joplin
173	16	580BY	Beaumont VA Clinic	Beaumont
174	16	580BZ	Charles Wilson Department of Veterans Affairs Outpatient Clinic	Lufkin
175	16	580GD	Conroe VA Clinic	Conroe

FY 2022 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
176	16	580GE	Katy VA Clinic	Katy
177	16	580GG	Richmond VA Clinic	Richmond, Texas
178	16	580GH	Tomball VA Clinic	Tomball
179	16	580GJ	Texas City VA Clinic	Texas City
180	16	598GA	Mountain Home VA Clinic	Mountain Home, Arkansas
181	16	598GC	Hot Springs VA Clinic	Hot Springs
182	16	598GE	Pine Bluff VA Clinic	Pine Bluff
183	16	598GF	Searcy VA Clinic	Searcy
184	16	598GG	Conway VA Clinic	Conway
185	16	598GH	Russellville VA Clinic	Russellville
186	16	629BY	Baton Rouge VA Clinic	Baton Rouge
187	16	629GB	Hammond VA Clinic	Hammond
188	16	629GC	Slidell VA Clinic	Slidell
189	16	667GA	Texarkana VA Clinic	Texarkana
190	16	667GB	Monroe VA Clinic	Monroe
191	16	667GC	Longview VA Clinic	Longview
192	17	504BY	Lubbock VA Clinic	Lubbock, Texas
193	17	519HC	Abilene VA Clinic	Abilene
194	17	549A5	Garland VA Medical Center	Garland
195	17	549BY	Fort Worth VA Clinic	Fort Worth
196	17	549GN	Tyler Centennial VA Clinic	Tyler, Texas
197	17	549QC	Tyler Broadway VA Clinic	Tyler Broadway
198	17	671BY	Frank M. Tejeda Department of Veterans Affairs Outpatient Clinic	San Antonio Eckert Road
199	17	671GO	North Central Federal VA Clinic	North Central Federal
200	17	671GP	Balcones Heights VA Clinic	Balcones Heights
201	17	674BY	Austin VA Clinic	Austin
202	17	740GA	Harlingen VA Clinic-Treasure Hills	Harlingen Treasure Hills
203	17	740GB	McAllen VA Clinic	McAllen
204	17	740GC	Corpus Christi VA Clinic	Corpus Christi
205	17	740GH	South Enterprize VA Clinic	South Enterprize
206	17	756GB	El Paso Eastside VA Clinic	El Paso Eastside
207	19	436GC	David J. Thatcher VA Clinic	Missoula
208	19	436GF	Kalispell VA Clinic	Kalispell
209	19	442GC	Fort Collins VA Clinic	Fort Collins
210	19	442GD	Loveland VA Clinic	Loveland
211	19	442GE	Northern Colorado VA Clinic	Cheyenne
212	19	554GC	Golden VA Clinic	Golden
213	19	554GD	PFC James Dunn VA Clinic	Pueblo, Colorado
214	19	554GE	PFC Floyd K. Lindstrom Department of Veterans Affairs Clinic	Colorado Springs
215	19	623BY	Ernest Childers Department of Veterans Affairs Outpatient Clinic	Tulsa
216	19	635GA	Lawton VA Clinic	Lawton
217	19	635GB	Wichita Falls VA Clinic	Wichita Falls
218	19	635GJ	Yukon VA Clinic	Yukon
219	19	635GL	North Oklahoma City VA Clinic	North Oklahoma City

FY 2022 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
220	19	635QB	South Oklahoma City VA Clinic	South Oklahoma City
221	19	660GB	Ogden VA Clinic	Ogden, Utah
222	20	531GG	Caldwell VA Clinic	Caldwell
223	20	648GA	Bend VA Clinic	Bend
224	20	648GB	Salem VA Clinic	Salem, Oregon
225	20	648GF	Hillsboro VA Clinic	Hillsboro
226	20	663GB	Silverdale VA Clinic	Silverdale
227	20	663GC	Mount Vernon VA Clinic	Mount Vernon, Washington
228	20	668GA	Wenatchee VA Clinic	Wenatchee
229	20	668GB	Coeur d 'Alene VA Clinic	Coeur d 'Alene
230	21	570GA	Merced VA Clinic	Merced, California
231	21	593GE	Southeast Las Vegas VA Clinic	Henderson, Nevada
232	21	612B4	Redding VA Clinic	Redding, California
233	21	612GD	Fairfield VA Clinic	Fairfield
234	21	612GE	Mare Island VA Clinic	Mare Island
235	21	612GG	Chico VA Clinic	Chico
236	21	612GH	McClellan VA Clinic	McClellan Park
237	21	612QE	Stockton VA Clinic	Stockton
238	21	640BY	San Jose VA Clinic	San Jose
239	21	640HA	Stockton VA Clinic	Stockton
240	21	640HB	Modesto VA Clinic	Modesto
241	21	640HC	Major General William H. Gourley VA-DoD Outpatient Clinic	Monterey
242	21	662GA	Santa Rosa VA Clinic	Santa Rosa
243	21	662GC	Eureka VA Clinic	Eureka
244	21	662GD	Ukiah VA Clinic	Ukiah
245	21	662GE	San Bruno VA Clinic	San Bruno
246	22	600GB	Santa Ana VA Clinic	Santa Ana
247	22	605BZ	Loma Linda VA Clinic	Loma Linda Redlands
248	22	605GB	Murrieta VA Clinic	Murrieta
249	22	605GC	Palm Desert VA Clinic	Palm Desert
250	22	644BY	Southeast VA Clinic	Southeast Gilbert
251	22	644GA	Northwest VA Clinic	Surprise, Arizona
252	22	644GI	Phoenix 32nd Street VA Clinic	Phoenix
253	22	664BY	Mission Valley VA Clinic	Mission Valley
254	22	664GB	Oceanside VA Clinic	Oceanside
255	22	664GC	Chula Vista VA Clinic	Chula Vista
256	22	678GA	Sierra Vista VA Clinic	Sierra Vista
257	22	678GB	Yuma VA Clinic	Yuma
258	22	678GC	Casa Grande VA Clinic	Casa Grande
259	22	678GF	Northwest Tucson VA Clinic	Northwest Tucson
260	22	678GG	Southeast Tucson VA Clinic	Southeast Tucson
261	22	691GD	Bakersfield VA Clinic	Bakersfield
262	22	691GE	Los Angeles VA Clinic	Los Angeles
263	22	691GG	Antelope Valley VA Clinic	Antelope Valley

FY 2022 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
264	22	691GL	Santa Maria VA Clinic	Santa Maria
265	22	691GM	Oxnard VA Clinic	Oxnard
266	23	438GC	Sioux City VA Clinic	Sioux City
267	23	438GD	Aberdeen VA Clinic	Aberdeen
268	23	568GA	Rapid City VA Clinic	Rapid City
269	23	618BY	Twin Ports VA Clinic	Twin Ports
270	23	618GD	Maplewood VA Clinic	Maplewood
271	23	618GE	Chippewa Valley VA Clinic	Chippewa Falls
272	23	618GG	Rochester VA Clinic	Rochester
273	23	618GI	Northwest Metro VA Clinic	Northwest Metro Minnesota
274	23	618GJ	Shakopee VA Clinic	Shakopee
275	23	636A5	Lincoln VA Clinic	Lincoln, Nebraska
276	23	636GA	Norfolk VA Clinic	Norfolk
277	23	636GB	North Platte VA Clinic	North Platte
278	23	636GC	Mason City VA Clinic	Mason City
279	23	636GD	Marshalltown VA Clinic	Marshalltown
280	23	636GF	Quad Cities VA Clinic	Quad Cities
281	23	636GG	Quincy VA Clinic	Quincy, Illinois
282	23	636GJ	Dubuque VA Clinic	Dubuque, Iowa
283	23	636GM	Carroll VA Clinic	Carroll
284	23	636GQ	Holdrege VA Clinic	Holdrege, Nebraska
285	23	636GR	Knoxville VA Clinic	Knoxville, Iowa
286	23	636GS	Ottumwa VA Clinic	Ottumwa
287	23	636GU	Decorah VA Clinic	Decorah
288	23	636GZ	South Des Moines VA Clinic	Des Moines, Iowa
289	23	656GA	Brainerd VA Clinic	Brainerd

FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
1	1	402GA	Caribou VA Clinic	Caribou
2	1	402GE	Lewiston VA Clinic	Lewiston, Maine
3	1	402HC	Portland VA Clinic	Portland, Maine
4	1	405GA	Bennington VA Clinic	Bennington
5	1	405GC	Brattleboro VA Clinic	Brattleboro
6	1	405HE	Keene VA Clinic	Keene
7	1	405HF	Rutland VA Clinic	Rutland
8	1	405QB	Newport VA Clinic	Newport, Vermont
9	1	518GA	Lynn VA Clinic	Lynn
10	1	523BZ	Causeway VA Clinic	Causeway
11	1	523GA	Framingham VA Clinic	Framingham
12	1	608GA	Portsmouth VA Clinic	Portsmouth, New Hampshire
13	1	608GC	Somersworth VA Clinic	Somersworth
14	1	608HA	Tilton VA Clinic	Tilton
15	1	631GC	Pittsfield VA Clinic	Pittsfield
16	1	631GD	Greenfield VA Clinic	Greenfield
17	1	631GF	Fitchburg VA Clinic	Fitchburg
18	1	650GD	Middletown VA Clinic	Middletown, Rhode Island
19	1	689GA	Waterbury VA Clinic	Waterbury
20	1	689GC	Willimantic VA Clinic	Willimantic
21	1	689GD	Winsted VA Clinic	Winsted
22	1	689GE	Danbury VA Clinic	Danbury
23	1	689HC	John J. McGuirk Department of Veterans Affairs Outpatient Clinic	New London
24	2	526GA	White Plains VA Clinic	White Plains
25	2	526GB	Yonkers VA Clinic	Yonkers
26	2	528G3	Bainbridge VA Clinic	Bainbridge
27	2	528G4	Elmira VA Clinic	Elmira
28	2	528G5	Auburn VA Clinic	Auburn
29	2	528G8	Wellsville VA Clinic	Wellsville
30	2	528G9	Tompkins County VA Clinic	Tompkins County
31	2	528GB	Jamestown VA Clinic	Jamestown, New York
32	2	528GC	Dunkirk VA Clinic	Dunkirk
33	2	528GL	Potsdam VA Clinic	Potsdam
34	2	528GO	Watertown VA Clinic	Watertown, New York
35	2	528GP	Oswego VA Clinic	Oswego
36	2	528GQ	West Seneca VA Clinic	West Seneca
37	2	528GR	Olean VA Clinic	Olean
38	2	528GV	Plattsburgh VA Clinic	Plattsburgh
39	2	528GZ	Kingston VA Clinic	Kingston
40	2	561GE	Jersey City VA Clinic	Jersey City

FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
41	2	561GI	Tinton Falls VA Clinic	Tinton Falls
42	2	561GJ	Paterson VA Clinic	Paterson
43	2	632HA	Valley Stream VA Clinic	Valley Stream
44	2	632HC	Bay Shore VA Clinic	Bay Shore
45	2	632HD	Patchogue VA Clinic	Patchogue
46	4	460GA	Sussex County VA Clinic	Sussex County
47	4	460GC	Kent County VA Clinic	Kent County
48	4	460GD	Cape May County VA Clinic	Cape May County
49	4	460HE	Atlantic County VA Clinic	Atlantic County
50	4	529GA	Michael A. Marzano Department of Veterans Affairs Outpatient Clinic	Hermitage
51	4	529GB	Lawrence County VA Clinic	Lawrence County
52	4	529GC	Armstrong County VA Clinic	Armstrong County
53	4	529GF	Cranberry Township VA Clinic	Cranberry Township
54	4	542GA	Delaware County VA Clinic	Delaware County
55	4	542GE	West Norriton VA Clinic	West Norriton
56	4	562GA	Crawford County VA Clinic	Crawford County
57	4	562GB	Ashtabula County VA Clinic	Ashtabula County
58	4	562GD	Venango County VA Clinic	Venango County
59	4	562GE	Warren County VA Clinic	Warren County
60	4	595GD	Berks County VA Clinic	Berks County
61	4	595GF	Schuylkill County VA Clinic	Schuylkill County
62	4	642GF	Camden VA Clinic	Camden
63	4	642GH	West Philadelphia VA Clinic	West Philadelphia
64	4	646GB	Westmoreland County VA Clinic	Westmoreland County
65	4	693GA	Sayre VA Clinic	Sayre
66	4	693GB	Williamsport VA Clinic	Williamsport
67	5	512GE	Pocomoke City VA Clinic	Pocomoke City
68	5	512GF	Eastern Baltimore County VA Clinic	Eastern Baltimore County
69	5	517GB	Greenbrier County VA Clinic	Greenbrier County
70	5	517QA	Princeton VA Clinic	Princeton
71	5	540GB	Wood County VA Clinic	Wood County
72	5	540GD	Monongalia County VA Clinic	Monongalia County
73	5	581GA	Prestonsburg VA Clinic	Prestonsburg
74	5	613GB	Hagerstown VA Clinic	Hagerstown
75	5	613GC	Stephens City VA Clinic	Stephens City
76	5	613GE	Petersburg VA Clinic	Petersburg
77	5	613GF	Harrisonburg VA Clinic	Harrisonburg
78	5	688GE	Southern Prince George's County VA Clinic	Southern Prince George's County
79	5	688GF	Montgomery County VA Clinic	Montgomery County, Maryland
80	5	688GG	Lexington Park VA Clinic	Lexington Park

FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
81	6	558GH	Clayton-East Raleigh VA Clinic	Clayton-East Raleigh
82	6	565GA	Jacksonville VA Clinic	Jacksonville, North Carolina
83	6	565GD	Hamlet VA Clinic	Hamlet
84	6	565GE	Robeson County VA Clinic	Robeson County
85	6	565GF	Goldsboro VA Clinic	Goldsboro
86	6	565GG	Lee County VA Clinic	Lee County, North Carolina
87	6	565GH	Brunswick County VA Clinic	Brunswick County
88	6	590GB	Virginia Beach VA Clinic	Virginia Beach
89	6	590GC	Albemarle VA Clinic	Albemarle
90	6	590GE	Portsmouth VA Clinic	Portsmouth, Virginia
91	6	637GA	Franklin VA Clinic	Franklin, North Carolina
92	6	637GB	Rutherford County VA Clinic	Rutherford County
93	6	652GA	Fredericksburg VA Clinic	Fredericksburg
94	6	652GB	Fredericksburg 2 VA Clinic	Fredericksburg 2
95	6	652GI	Massaponax VA Clinic	Massaponax
96	6	658GB	Danville VA Clinic	Danville, Virginia
97	6	658GC	Lynchburg VA Clinic	Lynchburg
98	6	658GD	Staunton VA Clinic	Staunton
99	6	658GE	Wytheville VA Clinic	Wytheville
100	7	508GI	Newnan VA Clinic	Newnan
101	7	508GM	Pickens County VA Clinic	Pickens County
102	7	508GN	Covington VA Clinic	Covington, Georgia
103	7	508QE	Gwinnett County VA Clinic	Gwinnett County
104	7	509GB	Aiken VA Clinic	Aiken
105	7	521GC	Florence VA Clinic	Florence, Alabama
106	7	521GD	Rainbow City VA Clinic	Rainbow City
107	7	521GE	Oxford VA Clinic	Oxford
108	7	521GF	Jasper VA Clinic	Jasper
109	7	521GG	Bessemer VA Clinic	Bessemer
110	7	521GH	Childersburg VA Clinic	Childersburg
111	7	521GI	Guntersville VA Clinic	Guntersville
112	7	534GF	North Charleston VA Clinic	North Charleston
113	7	544GC	Rock Hill VA Clinic	Rock Hill
114	7	544GE	Orangeburg VA Clinic	Orangeburg
115	7	544GF	Sumter VA Clinic	Sumter
116	7	544GG	Spartanburg VA Clinic	Spartanburg
117	7	557GC	Milledgeville VA Clinic	Milledgeville
118	7	557GF	Tifton VA Clinic	Tifton
119	7	557HA	Perry VA Clinic	Perry, Georgia
120	7	619GE	Monroe County VA Clinic	Monroe County, Alabama

FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
121	7	619QA	Dothan 2 VA Clinic	Dothan 2
122	7	619QB	Fort Benning VA Clinic	Fort Benning
123	8	516GB	St. Petersburg VA Clinic	St. Petersburg
124	8	546GD	Pembroke Pines VA Clinic	Pembroke Pines
125	8	546GF	Hollywood VA Clinic	Hollywood
126	8	546GH	Deerfield Beach VA Clinic	Deerfield Beach
127	8	548GE	Vero Beach VA Clinic	Vero Beach
128	8	573GA	Valdosta VA Clinic	Valdosta
129	8	573GJ	St. Marys VA Clinic	St. Marys
130	8	573GK	Marianna VA Clinic	Marianna
131	8	573GL	Palatka VA Clinic	Palatka
132	8	573GM	Waycross VA Clinic	Waycross
133	8	573GO	Middleburg VA Clinic	Middleburg
134	8	573QG	Jacksonville Southpoint VA Clinic	Jacksonville Southpoint
135	8	672GC	Arecibo VA Clinic	Arecibo
136	8	672GD	Ceiba VA Clinic	Ceiba
137	8	672GE	Guayama VA Clinic	Guayama
138	8	673GF	Zephyrhills VA Clinic	Zephyrhills
139	8	673GH	Lecanto VA Clinic	Lecanto
140	8	675GC	Kissimmee VA Clinic	Kissimmee
141	8	675GD	Deltona VA Clinic	Deltona
142	8	675GF	Clermont VA Clinic	Clermont
143	9	596GB	Morehead VA Clinic	Morehead
144	9	596GC	Hazard VA Clinic	Hazard
145	9	596GD	Berea VA Clinic	Berea
146	9	603GA	Fort Knox VA Clinic	Fort Knox
147	9	603GC	Greenwood VA Clinic	Greenwood
148	9	603GD	Stonybrook VA Clinic	Stonybrook
149	9	603GE	Newburg VA Clinic	Newburg
150	9	603GF	Grayson County VA Clinic	Grayson County
151	9	603GG	Scott County VA Clinic	Scott County
152	9	614GB	Jonesboro VA Clinic	Jonesboro
153	9	614GC	Holly Springs VA Clinic	Holly Springs
154	9	614GD	Savannah VA Clinic	Savannah, Tennessee
155	9	614GE	Covington VA Clinic	Covington, Tennessee
156	9	614GI	Dyersburg VA Clinic	Dyersburg
157	9	614GN	Helena VA Clinic	Helena, Arkansas
158	9	621GC	Norton VA Clinic	Norton
159	9	621GG	Morristown VA Clinic	Morristown, Tennessee
160	9	621GI	Dannie A. Carr Veterans Outpatient Clinic	Sevierville

FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
161	9	621GJ	Bristol VA Clinic	Bristol
162	9	621GK	Campbell County VA Clinic	Campbell County
163	9	621GO	Mountain City VA Clinic	Mountain City
164	9	621GP	Morristown East VA Clinic	Morristown East
165	9	626GC	Bowling Green VA Clinic	Bowling Green
166	9	626GH	Cookeville VA Clinic	Cookeville
167	9	626GJ	Hopkinsville VA Clinic	Hopkinsville
168	9	626GK	McMinnville VA Clinic	McMinnville
169	9	626GL	Roane County VA Clinic	Roane County
170	9	626GM	Columbia VA Clinic	Columbia
171	9	626GN	Athens VA Clinic	Athens, Tennessee
172	9	626GP	Gallatin VA Clinic	Gallatin
173	9	626QA	Albion Street VA Clinic	Albion Street
174	9	626QB	Charlotte Avenue VA Clinic	Charlotte Avenue
175	10	506GB	Flint VA Clinic	Flint
176	10	506GC	Jackson VA Clinic	Jackson, Michigan
177	10	506GD	Canton VA Clinic	Canton, Michigan
178	10	506GE	Howell VA Clinic	Howell
179	10	515GA	Muskegon VA Clinic	Muskegon
180	10	515GB	Lansing VA Clinic	Lansing
181	10	515GC	Benton Harbor VA Clinic	Benton Harbor
182	10	538GA	Athens VA Clinic	Athens, Ohio
183	10	538GB	Portsmouth VA Clinic	Portsmouth, Ohio
184	10	538GD	Lancaster VA Clinic	Lancaster
185	10	538GE	Cambridge VA Clinic	Cambridge, Ohio
186	10	538GF	Wilmington VA Clinic	Wilmington, Ohio
187	10	539GA	Bellevue VA Clinic	Bellevue, Kentucky
188	10	539GF	Georgetown VA Clinic	Georgetown
189	10	539QC	Vine Street VA Clinic	Vine Street
190	10	541GC	Sandusky VA Clinic	Sandusky
191	10	541GH	East Liverpool VA Clinic	East Liverpool
192	10	541GI	Warren VA Clinic	Warren
193	10	541GJ	New Philadelphia VA Clinic	New Philadelphia
194	10	541GK	Ravenna VA Clinic	Ravenna
195	10	541QB	Cleveland VA Clinic-Euclid	Cleveland Euclid Avenue
196	10	553GA	Yale VA Clinic	Yale
197	10	553GB	Pontiac VA Clinic	Pontiac
198	10	583GE	Lafayette VA Clinic	Lafayette, Indiana
199	10	610GB	Muncie VA Clinic	Muncie
200	10	610GD	Hoosier VA Clinic	Hoosier

FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
201	10	655GA	Navy Corpsman Steve Andrews Department of Veterans Affairs Health Care Clinic	Gaylord
202	10	655GC	Oscoda VA Clinic	Oscoda
203	10	655GD	Lieutenant Colonel Clement C. Van Wagoner Department of Veterans Affairs Clinic	Alpena
204	10	655GE	Clare VA Clinic	Clare
205	10	655GF	Bad Axe VA Clinic	Bad Axe
206	10	655GG	Cadillac VA Clinic	Cadillac
207	10	655GH	Cheboygan County VA Clinic	Cheboygan County
208	10	655GI	Grayling VA Clinic	Grayling
209	10	757GA	Zanesville VA Clinic	Zanesville
210	10	757GC	Marion VA Clinic	Marion, Ohio
211	12	537GA	Chicago Heights VA Clinic	Chicago Heights
212	12	537HA	Auburn Gresham VA Clinic	Auburn Gresham
213	12	550GF	Mattoon VA Clinic	Mattoon
214	12	550GG	Bloomington VA Clinic	Bloomington, Illinois
215	12	556GA	Evanston VA Clinic	Evanston, Illinois
216	12	556GC	McHenry VA Clinic	McHenry
217	12	556GD	Kenosha VA Clinic	Kenosha
218	12	578GG	Oak Lawn VA Clinic	Oak Lawn
219	12	585GA	Hancock VA Clinic	Hancock
220	12	585GB	Rhinelander VA Clinic	Rhinelander
221	12	585GC	Menominee VA Clinic	Menominee
222	12	585GD	Ironwood VA Clinic	Ironwood
223	12	585GF	Manistique VA Clinic	Manistique
224	12	585HA	Marquette VA Clinic	Marquette
225	12	585HB	Sault Saint Marie VA Clinic	Sault Saint Marie
226	12	607GG	Madison West VA Clinic	Madison West
227	12	676GA	Wausau VA Clinic	Wausau
228	12	676GC	La Crosse VA Clinic	La Crosse
229	12	676GE	Clark County VA Clinic	Clark County
230	12	695GA	Union Grove VA Clinic	Union Grove
231	12	695GC	Cleveland VA Clinic	Cleveland, Wisconsin
232	15	589G4	Hays VA Clinic	Hays
233	15	589G5	Parsons VA Clinic	Parsons
234	15	589G7	Hutchinson VA Clinic	Hutchinson
235	15	589GC	Paola VA Clinic	Paola
236	15	589GF	Waynesville VA Clinic	Waynesville
237	15	589GH	Camdenton VA Clinic	Camdenton
238	15	589GI	St. Joseph VA Clinic	St. Joseph
239	15	589GJ	Kansas City Kansas VA Clinic	Kansas City Kansas
240	15	589GR	Lieutenant General Richard J. Seitz Community-Based Outpatient Clinic	Junction City
241	15	589GU	Lawrence VA Clinic	Lawrence
242	15	589GV	Fort Scott VA Clinic	Fort Scott
243	15	589GW	Salina VA Clinic	Salina
244	15	589GX	Mexico VA Clinic	Mexico
245	15	589GY	St. James VA Clinic	St. James, Missouri

FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
246	15	589JA	Sedalia VA Clinic	Sedalia
247	15	589JB	Excelsior Springs VA Clinic	Excelsior Springs
248	15	589JE	Platte City VA Clinic	Platte City
249	15	589JF	Honor VA Clinic	Honor
250	15	657GF	West Plains VA Clinic	West Plains
251	15	657GG	Paragould VA Clinic	Paragould
252	15	657GH	Cape Girardeau VA Clinic	Cape Girardeau
253	15	657GI	Farmington VA Clinic	Farmington, Missouri
254	15	657GK	Mount Vernon VA Clinic	Mount Vernon, Illinois
255	15	657GL	Paducah VA Clinic	Paducah
256	15	657GM	Effingham VA Clinic	Effingham
257	15	657GP	Owensboro VA Clinic	Owensboro
258	15	657GQ	Vincennes VA Clinic	Vincennes
259	15	657GR	Mayfield VA Clinic	Mayfield
260	15	657GT	Carbondale VA Clinic	Carbondale
261	15	657GU	Harrisburg VA Clinic	Harrisburg
262	15	657GW	Pocahontas VA Clinic	Pocahontas
263	15	657GX	Washington Avenue VA Clinic	Washington Avenue
264	15	657GY	Manchester Avenue VA Clinic	Manchester Avenue
265	15	657QA	Olive Street VA Clinic	Olive Street
266	15	657QD	Heartland Street VA Clinic	Heartland Street
267	16	502GA	Jennings VA Clinic	Jennings
268	16	502GG	Natchitoches VA Clinic	Natchitoches
269	16	520GB	Panama City Beach VA Clinic	Panama City Beach, Florida
270	16	564GD	Ozark VA Clinic	Ozark
271	16	564GE	Jay VA Clinic	Jay
272	16	580GC	Galveston County VA Clinic	Galveston County
273	16	580GF	Lake Jackson VA Clinic	Lake Jackson
274	16	586GA	Kosciusko VA Clinic	Kosciusko
275	16	586GB	Meridian VA Clinic	Meridian
276	16	586GC	Greenville VA Clinic	Greenville, Mississippi
277	16	586GD	Hattiesburg VA Clinic	Hattiesburg
278	16	586GF	Columbus VA Clinic	Columbus, Mississippi
279	16	598GB	El Dorado VA Clinic	El Dorado
280	16	598GD	Mena VA Clinic	Mena
281	16	629GA	Houma VA Clinic	Houma
282	16	629GD	St. John VA Clinic	St. John
283	16	629GE	Franklin VA Clinic	Franklin, Louisiana
284	16	629GF	Bogalusa VA Clinic	Bogalusa
285	17	504BZ	Clovis VA Clinic	Clovis
286	17	519GA	Wilson and Young Medal of Honor VA Clinic	Permian Basin
287	17	519GB	Hobbs VA Clinic	Hobbs
288	17	519HF	San Angelo VA Clinic	San Angelo
289	17	549GD	Denton VA Clinic	Denton
290	17	549GH	Greenville VA Clinic	Greenville, Texas

FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
291	17	549GJ	Sherman VA Clinic	Sherman
292	17	549GL	Plano VA Clinic	Plano
293	17	549GM	Grand Prairie VA Clinic	Grand Prairie
294	17	671GB	Victoria VA Clinic	Victoria
295	17	671GF	South Bexar County VA Clinic	South Bexar County
296	17	671GK	San Antonio VA Clinic	San Antonio Fredericksburg Road
297	17	671GQ	Shavano Park VA Clinic	Shavano Park
298	17	671GR	North Bexar VA Clinic	North Bexar
299	17	671GT	Walzem VA Clinic	Walzem
300	17	674GB	Brownwood VA Clinic	Brownwood
301	17	674GC	Bryan VA Clinic	Bryan
302	17	674GD	Cedar Park VA Clinic	Cedar Park
303	17	674GF	Temple VA Clinic	Temple South General Bruce Drive
304	17	674HB	LaGrange VA Clinic	LaGrange
305	17	740GD	Laredo VA Clinic	Laredo
306	17	756GA	Las Cruces VA Clinic	Las Cruces
307	17	756GC	El Paso Westside VA Clinic	El Paso Westside
308	19	436GB	Great Falls VA Clinic	Great Falls
309	19	436GD	Travis W. Atkins Department of Veterans Affairs Clinic	Bozeman
310	19	436GK	Glendive VA Clinic	Glendive
311	19	436GO	Butte VA Clinic	Butte
312	19	436HC	Merril Lundman Department of Veterans Affairs Outpatient Clinic	Havre
313	19	554GB	Aurora VA Clinic	Aurora, Colorado
314	19	554GF	Alamosa VA Clinic	Alamosa
315	19	554GG	La Junta VA Clinic	La Junta
316	19	575QA	Glenwood Springs VA Clinic	Glenwood Springs
317	19	623GA	McAlester VA Clinic	McAlester
318	19	623GB	Vinita VA Clinic	Vinita
319	19	623GC	McCurtain County VA Clinic	McCurtain County
320	19	635GE	Stillwater VA Clinic	Stillwater
321	19	635GF	Altus VA Clinic	Altus
322	19	635GI	Norman VA Clinic	Norman
323	19	635GK	Shawnee VA Clinic	Shawnee
324	19	635HB	Ardmore VA Clinic	Ardmore
325	19	635QA	North May VA Clinic	North May
326	19	660GA	Pocatello VA Clinic	Pocatello
327	19	660GE	Orem VA Clinic	Orem
328	19	660GG	St. George VA Clinic	St. George
329	19	660GJ	South Jordan VA Clinic	South Jordan
330	19	660QA	Idaho Falls VA Clinic	Idaho Falls
331	19	666GB	Casper VA Clinic	Casper
332	19	666GC	Riverton VA Clinic	Riverton
333	20	463GA	Fairbanks VA Clinic	Fairbanks
334	20	463GB	Soldotna VA Clinic	Soldotna
335	20	463GC	Mat-Su VA Clinic	Mat-Su

FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
336	20	531GE	Twin Falls VA Clinic	Twin Falls
337	20	648GE	Fairview VA Clinic	Fairview
338	20	648GG	West Linn VA Clinic	West Linn
339	20	648GI	Portland VA Clinic	Portland 1st Avenue
340	20	653GA	North Bend VA Clinic	North Bend
341	20	663GK	Everett VA Clinic	Everett
342	20	687GA	Richland VA Clinic	Richland
343	20	687GB	Lewiston VA Clinic	Lewiston, Idaho
344	20	687GC	La Grande VA Clinic	La Grande
345	20	687HA	Yakima VA Clinic	Yakima
346	20	692GA	Klamath Falls VA Clinic	Klamath Falls
347	21	459GA	Maui VA Clinic	Maui
348	21	459GB	Hilo VA Clinic	Hilo
349	21	459GC	Kailua-Kona VA Clinic	Kailua-Kona
350	21	459GD	Lihue VA Clinic	Lihue
351	21	459GE	Guam VA Clinic	Guam
352	21	459GF	Faleomavaega Eni Fa'aua'a Hunkin VA Clinic	American Samoa
353	21	459GG	Leeward Oahu VA Clinic	Leeward Oahu
354	21	570GB	Tulare VA Clinic	Tulare
355	21	593GC	Pahrump VA Clinic	Pahrump
356	21	593GD	Northwest Las Vegas VA Clinic	Northwest Las Vegas
357	21	593GF	Southwest Las Vegas VA Clinic	Southwest Las Vegas
358	21	593GG	Northeast Las Vegas VA Clinic	Northeast Las Vegas
359	21	612GI	Yuba City VA Clinic	Yuba City
360	21	612GK	Sierra Foothills VA Clinic	Sierra Foothills
361	21	640GA	Capitola VA Clinic	Capitola
362	21	640GB	Sonora VA Clinic	Sonora
363	21	640GC	Fremont VA Clinic	Fremont
364	21	654QB	Capitol Hill VA Clinic	Capitol Hill
365	21	662GF	San Francisco VA Clinic	San Francisco Downtown
366	22	501GA	Artesia VA Clinic	Artesia
367	22	501GK	Santa Fe VA Clinic	Santa Fe
368	22	600GA	Placentia VA Clinic	Placentia
369	22	600GD	Santa Fe Springs VA Clinic	Santa Fe Springs
370	22	600GE	Laguna Hills VA Clinic	Laguna Hills
371	22	600GF	Gardena VA Clinic	Gardena
372	22	605GA	Victorville VA Clinic	Victorville
373	22	605GD	Corona VA Clinic	Corona
374	22	605GE	Rancho Cucamonga VA Clinic	Rancho Cucamonga
375	22	605GF	North Loma Linda VA Clinic	North Loma Linda
376	22	644GB	Show Low VA Clinic	Show Low
377	22	644GC	Southwest VA Clinic	Southwest Phoenix
378	22	644GE	Thunderbird VA Clinic	Thunderbird
379	22	644GG	Northeast Phoenix VA Clinic	Northeast Phoenix
380	22	644GH	Phoenix Midtown VA Clinic	Phoenix Midtown

FY 2022 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
381	22	644GJ	Mesa VA Clinic	Mesa
382	22	649GA	Kingman VA Clinic	Kingman
383	22	649GB	Flagstaff VA Clinic	Flagstaff
384	22	649GC	Lake Havasu City VA Clinic	Lake Havasu City
385	22	649GD	Anthem VA Clinic	Anthem
386	22	649GE	Cottonwood VA Clinic	Cottonwood
387	22	664GD	Escondido VA Clinic	Escondido
388	22	691GB	Santa Barbara VA Clinic	Santa Barbara
389	22	691GF	East Los Angeles VA Clinic	East Los Angeles
390	22	691GK	San Luis Obispo VA Clinic	San Luis Obispo
391	22	691GP	San Gabriel Valley VA Clinic	San Gabriel Valley
392	22	691GQ	Ventura VA Clinic	Ventura
393	23	437GB	Bismarck VA Clinic	Bismarck
394	23	437GC	Fergus Falls VA Clinic	Fergus Falls
395	23	437GD	Minot VA Clinic	Minot
396	23	437GE	Bemidji VA Clinic	Bemidji
397	23	437GF	Williston VA Clinic	Williston
398	23	437GI	Grand Forks VA Clinic	Grand Forks
399	23	437QA	North Fargo VA Clinic	North Fargo
400	23	438GA	Spirit Lake VA Clinic	Spirit Lake
401	23	438GF	Watertown VA Clinic	Watertown, South Dakota
402	23	568HH	Scottsbluff VA Clinic	Scottsbluff
403	23	618GB	Hibbing VA Clinic	Hibbing
404	23	618GK	Albert Lea VA Clinic	Albert Lea
405	23	618GL	Minneapolis VA Clinic	Minneapolis Harmon Place
406	23	618GN	Lyle C. Pearson Community Based Outpatient Clinic	Mankato
407	23	636GH	Waterloo VA Clinic	Waterloo
408	23	636GI	Lane A. Evans VA Community Based Outpatient Clinic	Galesburg
409	23	636GL	Bellevue VA Clinic	Bellevue, Nebraska
410	23	636GN	Cedar Rapids VA Clinic	Cedar Rapids
411	23	636GP	Shenandoah VA Clinic	Shenandoah
412	23	636GW	Coralville VA Clinic	Coralville
413	23	656GC	Max J. Beilke Department of Veterans Affairs Outpatient Clinic	Alexandria, Minnesota

FY 2022 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
1	1	402GB	Calais VA Clinic	Calais
2	1	402GC	Rumford VA Clinic	Rumford
3	1	402GF	Lincoln VA Clinic	Lincoln, Maine
4	1	402QA	Fort Kent VA Clinic	Fort Kent
5	1	402QB	Houlton VA Clinic	Houlton
6	1	518GB	Haverhill VA Clinic	Haverhill
7	1	518GE	Gloucester VA Clinic	Gloucester
8	1	523GC	Quincy VA Clinic	Quincy, Massachusetts
9	1	523GD	Plymouth VA Clinic	Plymouth
10	1	608GD	Conway VA Clinic	Conway, New Hampshire
11	1	631GE	Worcester VA Clinic	Worcester
12	1	631QA	Plantation Street VA Clinic	Plantation Street
13	1	650QA	Eagle Square VA Clinic	Eagle Square
14	1	650QB	Eagle Street VA Clinic	Eagle Street
15	1	689GB	Stamford VA Clinic	Stamford
16	1	689GF	Orange VA Clinic	Orange
17	1	689QA	Errera VA Clinic	Errera
18	2	526GD	Thomas P. Noonan Jr. Department of Veterans Affairs Outpatient Clinic	Sunnyside
19	2	526QA	Bronx VA Mobile Clinic	Bronx Mobile
20	2	528G2	Westport VA Clinic	Westport
21	2	528G6	Fonda VA Clinic	Fonda
22	2	528G7	Catskill VA Clinic	Catskill
23	2	528GD	Niagara Falls VA Clinic	Niagara Falls
24	2	528GE	Rochester Clinton Crossings VA Clinic	Rochester Clinton Crossings
25	2	528GK	Lockport VA Clinic	Lockport
26	2	528GT	Glens Falls VA Clinic	Glens Falls
27	2	528GW	Schenectady VA Clinic	Schenectady
28	2	528GY	Clifton Park VA Clinic	Clifton Park
29	2	528QA	Buffalo VA Clinic	Buffalo Main Street
30	2	528QB	Packard VA Clinic	Packard
31	2	528QE	Coudersport VA Clinic	Coudersport
32	2	528QF	Wellsboro VA Clinic	Wellsboro
33	2	528QG	Erie West VA Clinic	Erie West
34	2	528QH	South Salina VA Clinic	South Salina
35	2	528QI	Erie East VA Clinic	Erie East
36	2	528QK	Saranac Lake VA Clinic	Saranac Lake
37	2	528QN	Watertown 2 VA Clinic	Watertown 2
38	2	561GA	Hamilton VA Clinic	Hamilton, New Jersey
39	2	561GF	Piscataway VA Clinic	Piscataway
40	2	561GH	Morristown VA Clinic	Morristown, New Jersey
41	2	561GK	Sussex VA Clinic	Sussex
42	2	620GB	Carmel VA Clinic	Carmel

FY 2022 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
43	2	620GD	Goshen VA Clinic	Goshen
44	2	620GF	Monticello VA Clinic	Monticello
45	2	620GG	Poughkeepsie VA Clinic	Poughkeepsie
46	2	620GH	Eastern Dutchess VA Clinic	Eastern Dutchess
47	2	630GA	Harlem VA Clinic	Harlem
48	2	630QA	New York Harbor 1 VA Mobile Clinic	New York Harbor 1 Mobile
49	2	630QB	New York Harbor 2 VA Mobile Clinic	New York Harbor 2 Mobile
50	2	632HB	Riverhead VA Clinic	Riverhead
51	2	632QA	Northport 1 VA Mobile Clinic	Northport 1 Mobile
52	2	632QB	Northport 2 VA Mobile Clinic	Northport 2 Mobile
53	4	460HK	Wilmington VA Mobile Clinic	Wilmington Mobile
54	4	529GD	Clarion County VA Clinic	Clarion County
55	4	562GC	McKean County VA Clinic	McKean County
56	4	595QA	Fort Indiantown Gap VA Clinic	Annville
57	4	642QA	Chestnut Street VA Clinic	Chestnut Street
58	4	642QB	Fourth Street VA Clinic	Fourth Street
59	4	693GC	Tobyhanna VA Clinic	Tobyhanna
60	4	693GF	Columbia County VA Clinic	Columbia County
61	4	693GG	Northampton County VA Clinic	Northampton County
62	4	693QA	Wayne County VA Clinic	Wayne County
63	5	512QA	Baltimore VA Clinic	Baltimore West Fayette Street
64	5	517HK	Beckley VA Mobile Clinic	Beckley Mobile
65	5	540GA	Tucker County VA Clinic	Tucker County
66	5	540GC	Braxton County VA Clinic	Braxton County
67	5	540HK	Clarksburg VA Mobile Clinic	Clarksburg Mobile
68	5	581GG	Gallipolis VA Clinic	Gallipolis
69	5	581GH	Lenore VA Clinic	Lenore
70	5	581QA	Huntington Ninth Street VA Clinic	Huntington Ninth Street
71	5	581QB	Huntington VA Mobile Clinic	Huntington Mobile
72	5	613GD	Franklin VA Clinic	Franklin, West Virginia
73	5	688GB	Southeast Washington VA Clinic	Southeast Washington
74	5	688QA	Franklin Street VA Clinic	Franklin Street
75	6	558GD	Durham County VA Clinic	Durham County
76	6	558GE	Hillandale Road VA Clinic	Hillandale Road
77	6	558GF	Wake County VA Clinic	Wake County
78	6	558QA	Brier Creek VA Clinic	Brier Creek
79	6	565GJ	Jacksonville 2 VA Clinic	Jacksonville, North Carolina 2
80	6	565GM	Jacksonville 3 VA Clinic	Jacksonville 3
81	6	565GN	Jacksonville 4 VA Clinic	Jacksonville 4
82	6	565QA	Robeson Street VA Clinic	Robeson Street
83	6	565QB	Fayetteville VA Mobile Clinic	Fayetteville Mobile
84	6	565QC	Fayetteville 2 VA Mobile Clinic	Fayetteville 2 Mobile

FY 2022 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
85	6	565QD	Raeford Road VA Clinic	Raeford Road
86	6	565QE	Womack VA Clinic	Womack
87	6	590QA	Hampton VA Mobile Clinic	Hampton 1 Mobile
88	6	590QB	Hampton City County VA Mobile Clinic	Hampton City County Mobile
89	6	652GF	Emporia VA Clinic	Emporia
90	6	652GG	Richmond 1 VA Mobile Clinic	Richmond 1 Mobile
91	6	652GH	Hunter Holmes McGuire 2 VA Mobile Clinic	Richmond 2 Mobile
92	6	658GA	Tazewell VA Clinic	Tazewell
93	7	508GP	South Cobb County VA Clinic	South Cobb County
94	7	508QC	Henderson Mill VA Clinic	Henderson Mill
95	7	508QH	South Fulton County VA Clinic	South Fulton County
96	7	508QI	North DeKalb County VA Clinic	North DeKalb County
97	7	508QJ	North Fulton County VA Clinic	North Fulton County
98	7	509QA	Ray Hendrix Department Of Veterans Affairs Clinic	Statesboro
99	7	521QB	Birmingham East VA Clinic	Birmingham East
100	7	534QB	Trident 2 VA Clinic	Trident 2
101	7	534QC	Charleston VA Clinic	Charleston City Hall Lane
102	7	544HK	Columbia VA Mobile Clinic	Columbia Mobile
103	7	557GG	Robins VA Clinic	Robins
104	7	619GG	Columbus Downtown VA Clinic	Columbus Downtown
105	7	679GA	Selma VA Clinic	Selma
106	8	546GA	Miami Flagler VA Clinic	Miami Flagler
107	8	546GE	Key Largo VA Clinic	Key Largo
108	8	548GD	Boca Raton VA Clinic	Boca Raton
109	8	548GF	Okeechobee VA Clinic	Okeechobee
110	8	548QA	Port Saint Lucie VA Clinic	Port Saint Lucie
111	8	573GN	Perry VA Clinic	Perry, Florida
112	8	573QB	Gainesville Ninety Eighth Street VA Clinic	Gainesville 2-98th Street
113	8	573QC	Gainesville Sixty Fourth Street 1 VA Clinic	Gainesville 3-64th Street (C)
114	8	573QD	Gainesville Sixty Fourth Street 2 VA Clinic	Gainesville 4-64th Street (O)
115	8	573QE	Gainesville Sixty Fourth Street 3 VA Clinic	Gainesville 5-64th Street (D)
116	8	573QF	Gainesville Twenty Third Avenue VA Clinic	Gainesville 6-23rd Avenue
117	8	573QH	Ocala West VA Clinic	Ocala West
118	8	573QK	Lake City VA Clinic	Lake City Commerce Drive
119	8	672GA	Saint Croix VA Clinic	Saint Croix
120	8	672GB	Saint Thomas VA Clinic	Saint Thomas
121	8	672QA	Comerio VA Clinic	Comerio
122	8	672QB	Utuado VA Clinic	Utuado
123	8	672QC	Vieques VA Clinic	Vieques
124	8	673GB	Lakeland VA Clinic	Lakeland
125	8	673QA	Forty Sixth Street North VA Clinic	Forty Sixth Street North
126	8	673QB	Forty Sixth Street South VA Clinic	Forty Sixth Street South

FY 2022 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
127	8	673QC	West Lakeland VA Clinic	West Lakeland
128	8	673QD	Deer Park VA Clinic	Deer Park
129	8	673QE	New Port Richey South VA Clinic	New Port Richey South
130	8	673QF	Winners Circle VA Clinic	Winners Circle
131	8	673QG	Little Road VA Clinic	Little Road
132	8	673QH	Bruce B. Downs Boulevard VA Clinic	Bruce B. Downs Boulevard
133	8	673QI	Medical View Lane VA Clinic	Medical View Lane
134	8	673QK	Tampa 1 VA Mobile Clinic	Tampa 1 Mobile
135	8	673QL	Tampa 2 VA Mobile Clinic	Tampa 2 Mobile
136	8	675QB	Port Orange VA Clinic	Port Orange
137	8	675QC	Westside Pavilion VA Clinic	Westside Pavilion
138	8	675QE	Orlando 1 VA Mobile Clinic	Orlando 1 Mobile
139	8	675QG	Palm Bay VA Clinic	Palm Bay
140	8	675QH	Orlando 2 VA Mobile Clinic	Orlando 2 Mobile
141	9	603GH	Carrollton VA Clinic	Carrollton, Kentucky
142	9	614QA	Union Avenue VA Clinic	Union Avenue
143	9	621GA	Rogersville VA Clinic	Rogersville
144	9	621QA	Jonesville VA Clinic	Jonesville
145	9	621QB	Marion VA Clinic	Marion, Virginia
146	9	621QC	Vansant VA Clinic	Vansant
147	9	621QD	Knox County VA Clinic	Knox County
148	9	621QE	Downtown West VA Clinic	Downtown West
149	9	621QF	Johnson City VA Clinic	Johnson City
150	9	621QG	Knox West VA Clinic	Knox West
151	9	626GA	Dover VA Clinic	Dover
152	9	626GG	Tullahoma VA Clinic	Tullahoma
153	9	626QC	Pointe Centre VA Clinic	Pointe Centre
154	9	626QD	Glenis Drive VA Clinic	Glenis Drive
155	9	626QE	Glenis Drive 2 VA Clinic	Glenis Drive 2
156	9	626QF	Dalton Drive VA Clinic	Dalton Drive
157	10	506GF	Adrian VA Clinic	Adrian
158	10	506QA	Packard Road VA Clinic	Ann Arbor Packard Road
159	10	506QB	Green Road VA Clinic	Green Road
160	10	515QB	Century Avenue VA Clinic	Century Avenue
161	10	538QA	Chillicothe VA Mobile Clinic	Chillicothe Mobile
162	10	539QA	Cincinnati VA Mobile Clinic	Cincinnati Mobile
163	10	539QB	Highland Avenue VA Clinic	Highland Avenue
164	10	539QD	Norwood VA Clinic	Norwood
165	10	541GM	Cleveland VA Clinic-Superior	Cleveland Superior Avenue
166	10	541QA	Summit County VA Clinic	Summit County
167	10	541QC	Cleveland 1 VA Mobile Clinic	Cleveland 1 Mobile
168	10	541QE	Cleveland East Boulevard 3 VA Mobile Clinic	Cleveland East Boulevard 3 Mobile

FY 2022 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
169	10	541QF	Cuyahoga County 4 VA Mobile Clinic	Cuyahoga County 4 Mobile
170	10	552GF	Wright-Patterson VA Clinic	Wright-Patterson
171	10	553QA	Piquette Street VA Clinic	Piquette Street
172	10	583GA	Terre Haute VA Clinic	Terre Haute
173	10	583QA	Monroe County VA Clinic	Monroe County, Indiana
174	10	583QB	Indianapolis VA Clinic	Indianapolis Meridian Street
175	10	583QD	Indianapolis YMCA VA Clinic	Indianapolis YMCA
176	10	583QE	Cold Spring Road VA Clinic	Cold Spring Road
177	10	610GE	Defiance VA Clinic	Defiance
178	10	610QA	Fort Wayne VA Clinic	Fort Wayne East State Boulevard
179	10	610QB	Columbia Place VA Clinic	Columbia Place
180	10	655QA	Saginaw VA Clinic	Saginaw Barnard Road
181	10	655QC	Saginaw North VA Clinic	Saginaw North
182	10	757QA	Columbus 1 VA Mobile Clinic	Columbus 1 Mobile
183	10	757QB	North James Road 2 VA Mobile Clinic	North James Road 2 Mobile
184	10	757QC	Columbus VA Clinic	Columbus Airport Drive
185	12	537GD	Lakeside VA Clinic	Lakeside
186	12	537QA	Chicago VA Clinic	Chicago South California Avenue
187	12	585GG	Gladstone VA Clinic	Gladstone
188	12	607GC	Janesville VA Clinic	Janesville
189	12	607GD	Baraboo VA Clinic	Baraboo
190	12	607GE	Beaver Dam VA Clinic	Beaver Dam
191	12	607GF	Freeport VA Clinic	Freeport
192	12	695QA	Milwaukee VA Clinic	Milwaukee MLK Drive
193	15	589G2	Dodge City VA Clinic	Dodge City
194	15	589GB	Belton VA Clinic	Belton
195	15	589GD	Nevada VA Clinic	Nevada
196	15	589GE	Kirksville VA Clinic	Kirksville
197	15	589GM	Chanute VA Clinic	Chanute
198	15	589GP	Garnett VA Clinic	Garnett
199	15	589GZ	Cameron VA Clinic	Cameron
200	15	589HK	Kansas City VA Mobile Clinic	Kansas City Mobile
201	15	589JC	Shawnee VA Clinic	Shawnee
202	15	589JG	Lenexa VA Clinic	Lenexa
203	15	589QA	Overland Park VA Clinic	Overland Park
204	15	589QB	Sedgwick County VA Clinic	Sedgwick County
205	15	589QD	Wichita VA Mobile Clinic	Wichita Mobile
206	15	657GA	St. Clair County VA Clinic	St. Clair County
207	15	657GO	Madisonville VA Clinic	Madisonville
208	15	657GS	Franklin County VA Clinic	Franklin County
209	15	657QB	Jefferson Avenue VA Clinic	Jefferson Avenue
210	15	657QE	Scott Air Force Base VA Clinic	Scott Air Force Base

FY 2022 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
211	16	502QB	Lafayette Campus B VA Clinic	Lafayette Campus B
212	16	520QA	Panama City Beach West VA Clinic	Panama City Beach West
213	16	520QB	Gulf Coast West VA Mobile Medical Unit-Clinic	Gulf Coast West MMU
214	16	564GA	Harrison VA Clinic	Harrison
215	16	564QA	Township VA Clinic	Township
216	16	564QB	Sunbridge VA Clinic	Sunbridge
217	16	580GK	Kingwood VA Clinic	Kingwood
218	16	580GL	Sugar Land VA Clinic	Sugar Land
219	16	580QB	Houston VA Mobile Clinic	Houston Mobile
220	16	580QC	Houston 2 VA Mobile Clinic	Houston 2 Mobile
221	16	580QD	Houston 3 VA Mobile Clinic	Houston 3 Mobile
222	16	586GE	Natchez VA Clinic	Natchez
223	16	586GG	McComb VA Clinic	McComb
224	16	586QA	Jackson VA Mobile Clinic	Jackson Mobile
225	16	586QB	Dogwood View Parkway VA Clinic	Dogwood View Parkway
226	16	586QD	Jackson 2 VA Mobile Clinic	Jackson 2 Mobile
227	16	598QA	Little Rock VA Clinic	Little Rock Main Street
228	16	598QB	Little Rock VA Mobile Clinic	Little Rock Mobile
229	16	629QA	Baton Rouge South VA Clinic	Baton Rouge South
230	16	629QB	New Orleans South VA Mobile Clinic	New Orleans South Mobile
231	16	667QA	Knight Street VA Clinic	Knight Street
232	17	504GA	Childress VA Clinic	Childress
233	17	504HB	Dalhart VA Clinic	Dalhart
234	17	519GD	Fort Stockton VA Clinic	Fort Stockton
235	17	549GE	Decatur VA Clinic	Decatur, Texas
236	17	549GF	Granbury VA Clinic	Granbury
237	17	549GK	Polk Street VA Clinic	Polk Street
238	17	549HK	North Texas VA Mobile Clinic	North Texas Mobile
239	17	549QA	Dallas VA Clinic	Dallas South Lancaster Road
240	17	549QB	Fort Worth New York VA Clinic	Fort Worth New York
241	17	671GL	New Braunfels VA Clinic	New Braunfels
242	17	671GN	Seguin VA Clinic	Seguin
243	17	671QA	South Texas VA Mobile Clinic	South Texas Mobile
244	17	671QB	Data Point VA Clinic	Data Point
245	17	671QC	Christus Santa Rosa VA Clinic	Christus Santa Rosa San Antonio
246	17	674GA	Palestine VA Clinic	Palestine
247	17	740GI	Old Brownsville VA Clinic	Old Brownsville
248	17	740GJ	North Tenth Street VA Clinic	North Tenth Street
249	17	740QA	Texas Valley Coastal Bend VA Mobile Clinic	Texas Valley Coastal Bend Mobile
250	17	756GD	El Paso Northeast VA Clinic	El Paso Northeast
251	17	756QA	El Paso South Central VA Clinic	El Paso South Central
252	17	756QB	El Paso Central VA Clinic	El Paso Central

FY 2022 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
253	19	436GI	Glasgow VA Clinic	Glasgow
254	19	436GL	Cut Bank VA Clinic	Cut Bank
255	19	436GM	Lewistown VA Clinic	Lewistown
256	19	436GN	Dr. Joseph Medicine Crow VA Clinic	Billings Spring Creek Lane
257	19	436QA	Hamilton VA Clinic	Hamilton, Montana
258	19	436QB	Plentywood VA Clinic	Plentywood
259	19	436QC	Helena VA Clinic	Helena, Montana
260	19	436QD	Browning VA Clinic	Browning
261	19	436QE	Miles City VA Clinic	MIles City
262	19	442GB	Sidney VA Clinic	Sidney
263	19	442HK	Wheatland VA Mobile Clinic	Wheatland Mobile
264	19	442QA	Rawlins VA Clinic	Rawlins
265	19	442QB	Torrington VA Mobile Clinic	Torrington Mobile
266	19	442QD	Laramie VA Mobile Clinic	Laramie Mobile
267	19	442QF	Cheyenne VA Mobile Clinic	Cheyenne Mobile
268	19	554GH	Lamar VA Clinic	Lamar
269	19	554GI	Burlington VA Clinic	Burlington, Colorado
270	19	554GK	Union Boulevard VA Clinic	Union Boulevard
271	19	554QA	York Street VA Clinic	York Street
272	19	554QB	Jewell VA Clinic	Jewell
273	19	554QC	Salida VA Clinic	Salida
274	19	554QD	Evans VA Clinic	Evans
275	19	554QE	Academy VA Clinic	Academy
276	19	554QF	Garden of the Gods VA Clinic	Garden of the Gods
277	19	575GA	Montrose VA Clinic	Montrose, Colorado
278	19	575GB	Major William Edward Adams Department of Veterans Affairs Clinic	Craig
279	19	575QB	Moab VA Clinic	Moab
280	19	575QC	Grand Junction VA Mobile Clinic	Grand Junction Mobile
281	19	575QD	Grand Junction 28 Road VA Clinic	Grand Junction 28 Road
282	19	575QE	Western Colorado VA Mobile Clinic	Western Colorado Mobile
283	19	623QA	Muskogee East VA Clinic	Muskogee East
284	19	623QB	Tulsa Eleventh Street VA Clinic	Tulsa Eleventh Street
285	19	623QC	Yale Avenue VA Clinic	Yale Avenue
286	19	635GC	Blackwell VA Clinic	Blackwell
287	19	635GD	Ada VA Clinic	Ada
288	19	635GG	Enid VA Clinic	Enid
289	19	635GH	Clinton VA Clinic	Clinton
290	19	635PA	Friendship House VA Compensated Work Therapy/Transitional Residence	Friendship House CWT/TR
291	19	635QC	Fourteenth Street VA Clinic	Fourteenth Street
292	19	635QD	Lawton North VA Clinic	Lawton North
293	19	635QE	Tinker VA Clinic	Tinker
294	19	660GD	Roosevelt VA Clinic	Roosevelt

FY 2022 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
295	19	660GK	Elko VA Clinic	Elko
296	19	660QB	Price VA Clinic	Price
297	19	660QD	Cache Valley VA Clinic	Cache Valley
298	19	666GD	Cody VA Clinic	Cody
299	19	666GE	Gillette VA Clinic	Gillette
300	19	666GF	Rock Springs VA Clinic	Rock Springs
301	19	666QA	Afton VA Clinic	Afton
302	19	666QB	Evanston VA Clinic	Evanston, Wyoming
303	19	666QC	Worland VA Clinic	Worland
304	20	463GD	Homer VA Clinic	Homer
305	20	463GE	Juneau VA Clinic	Juneau
306	20	463QA	Elmendorf-Richardson VA Clinic	Elmendorf-Richardson
307	20	531GH	Eastern Oregon VA Clinic	Eastern Oregon
308	20	531GI	Mountain Home VA Clinic	Mountain Home, Idaho
309	20	531GJ	Salmon VA Clinic	Salmon
310	20	648GD	North Coast VA Clinic	North Coast
311	20	648GH	Newport VA Clinic	Newport, Oregon
312	20	648GJ	Loren R. Kaufman VA Clinic	The Dalles
313	20	648GK	Lincoln City VA Clinic	Lincoln City
314	20	653GB	Brookings VA Clinic	Brookings
315	20	653QA	Downtown Eugene VA Clinic	Downtown Eugene
316	20	663GE	North Olympic Peninsula VA Clinic	North Olympic Peninsula
317	20	663GH	Edmonds VA Clinic	Edmonds
318	20	663GI	Olympia VA Clinic	Olympia
319	20	663GJ	Puyallup VA Clinic	Puyallup
320	20	663HK	Puget Sound VA Mobile Clinic	Puget Sound Mobile
321	20	663QA	Renton VA Clinic	Renton
322	20	663QB	South Lucile Street VA Clinic	South Lucile Street
323	20	668GC	East Front Avenue VA Clinic	East Front Avenue
324	20	668HK	Spokane VA Mobile Clinic	Spokane Mobile
325	20	668QB	Libby VA Clinic	Libby
326	20	668QD	Sandpoint VA Clinic	Sandpoint
327	20	668QE	Spokane VA Clinic	Spokane 2nd Avenue
328	20	687QB	Morrow County VA Clinic	Morrow County
329	20	687QC	Wallowa County VA Clinic	Wallowa County
330	20	692GB	Grants Pass VA Clinic	Grants Pass
331	21	358	Manila VA Clinic	Manila
332	21	459GH	Saipan VA Clinic	Saipan
333	21	459QA	Lanai VA Clinic	Lanai
334	21	459QB	Molokai VA Clinic	Molokai
335	21	459QC	Windward VA Clinic	Windward
336	21	570GC	Oakhurst VA Clinic	Oakhurst

FY 2022 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
337	21	593GH	Master Chief Petty Officer Jesse Dean VA Clinic	Laughlin
338	21	593QC	West Cheyenne VA Clinic	West Cheyenne
339	21	612GJ	Yreka VA Clinic	Yreka
340	21	612QC	Cypress Avenue VA Clinic	Cypress Avenue
341	21	612QD	Howe Road VA Clinic	Howe Road
342	21	640QA	Palo Alto 1 VA Mobile Clinic	Palo Alto 1 Mobile
343	21	640QB	Palo Alto 2 VA Mobile Clinic	Palo Alto 2 Mobile
344	21	654GB	Carson Valley VA Clinic	Carson Valley
345	21	654GC	Lahontan Valley VA Clinic	Lahontan Valley
346	21	654GD	Diamond View VA Clinic	Diamond View
347	21	654GE	Reno East VA Clinic	Reno East
348	21	654GF	North Reno VA Clinic	North Reno
349	21	654QA	Kietzke VA Clinic	Kietzke
350	21	654QC	Winnemucca VA Clinic	Winnemucca
351	21	654QD	Virginia Street VA Clinic	Virginia Street
352	21	662GG	Clearlake VA Clinic	Clearlake
353	21	662GH	Oakland VA Clinic	Oakland
354	21	662QA	Twenty First Street VA Clinic	Twenty First Street
355	21	662QB	North Santa Rosa VA Clinic	North Santa Rosa
356	22	501G2	Las Vegas VA Clinic	Las Vegas
357	22	501GB	Farmington VA Clinic	Farmington, New Mexico
358	22	501GC	Silver City VA Clinic	Silver City
359	22	501GD	Gallup VA Clinic	Gallup
360	22	501GE	Espanola VA Clinic	Espanola
361	22	501GH	Truth or Consequences VA Clinic	Truth or Consequences
362	22	501GI	Alamogordo VA Clinic	Alamogordo
363	22	501GJ	Durango VA Clinic	Durango
364	22	501GM	Northwest Metro VA Clinic	Northwest Metro New Mexico
365	22	501GN	Taos VA Clinic	Taos
366	22	501HB	Raton VA Clinic	Raton
367	22	600GC	Cabrillo VA Clinic	Cabrillo
368	22	600QA	West Santa Ana VA Clinic	West Santa Ana
369	22	605QA	Blythe VA Clinic	Blythe
370	22	644GD	Payson VA Clinic	Payson
371	22	644GF	Globe VA Clinic	Globe
372	22	644QA	Phoenix VA Clinic	Phoenix East Thomas Road
373	22	644QB	Phoenix VA Mobile Clinic	Phoenix Mobile
374	22	649QA	Chinle VA Clinic	Chinle
375	22	649QB	Holbrook VA Clinic	Holbrook
376	22	649QD	Page VA Clinic	Page
377	22	649QF	Tuba City VA Clinic	Tuba City
378	22	649QG	Polacca VA Clinic	Polacca

FY 2022 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)
379	22	649QH	Kayenta VA Clinic	Kayenta
380	22	664GA	Imperial Valley VA Clinic	Imperial Valley
381	22	664GF	Sorrento Valley VA Clinic	Sorrento Valley
382	22	664QA	Rio VA Clinic	Rio
383	22	678GD	Safford VA Clinic	Safford
384	22	678GE	Green Valley VA Clinic	Green Valley
385	22	678QA	Cochise County VA Clinic	Cochise County
386	22	678QB	Pinal County VA Clinic	Pinal County
387	23	437GA	Grafton VA Clinic	Grafton
388	23	437GJ	Dickinson VA Clinic	Dickinson
389	23	437GK	Jamestown VA Clinic	Jamestown, North Dakota
390	23	437GL	Devils Lake VA Clinic	Devils Lake
391	23	438GE	Wagner VA Clinic	Wagner
392	23	568GB	Pierre VA Clinic	Pierre
393	23	568HA	Newcastle VA Clinic	Newcastle
394	23	568HB	Gordon VA Clinic	Gordon
395	23	568HF	Pine Ridge VA Clinic	Pine Ridge
396	23	568HK	Cheyenne River VA Clinic	Cheyenne River
397	23	568HP	Winner VA Clinic	Winner
398	23	618GA	St. James VA Clinic	St. James, Minnesota
399	23	618GH	Hayward VA Clinic	Hayward
400	23	618GM	Rice Lake VA Clinic	Rice Lake
401	23	618QA	Fort Snelling VA Clinic	Fort Snelling
402	23	618QB	Ely VA Clinic	Ely
403	23	636GK	Fort Dodge VA Clinic	Fort Dodge
404	23	636GT	Sterling VA Clinic	Sterling, Illinois
405	23	636GX	Fort Dodge North VA Clinic	Fort Dodge North
406	23	636GY	Burlington VA Clinic	Burlington
407	23	636QA	Omaha VA Clinic	Omaha Dorcas Street
408	23	636QB	Des Moines VA Clinic	Des Moines Center Street
409	23	636QC	Linn County VA Clinic	Linn County
410	23	636QD	Macomb VA Clinic	Macomb
411	23	636QG	Iowa City VA Mobile Clinic	Iowa City Mobile
412	23	636QH	Des Moines VA Mobile Clinic	Des Moines Mobile
413	23	636QI	Davenport VA Clinic	Davenport
414	23	636QJ	Iowa City VA Clinic	Iowa City South Clinton Street
415	23	656GB	Montevideo VA Clinic	Montevideo

FY 2022 Outpatient Dialysis Centers

Dialysis Center Count	Station Number	Station Name	City	State
1	523	VA Boston HCS	Boston	MA
2	650	Providence VA Med Center	Providence	RI
3	689	VA Connecticut HCS	West Haven	CT
4	526	James J. Peters VA Med Center	Bronx	NY
5	528	Albany Stratton VA Med Center	Albany	NY
6	528	VA Western NY HCS	Buffalo	NY
7	561	VA New Jersey HCS	East Orange	NJ
8	630	VA NY Harbor HCS - Brooklyn	Brooklyn	NY
9	630	VA NY Harbor HCS - Manhattan	New York	NY
10	632	Northport VA Med Center	Northport	NY
11	460	Wilmington VA Med Center	Wilmington	DE
12	642	Philadelphia Free Standing Dialysis Center	Philadelphia	PA
13	646	VA Pittsburgh HCS	Pittsburgh	PA
14	693	Wilkes-Barre VA Med Center	Wilkes-Barre	PA
15	688	Washington DC VA Med Center	Washington	DC
16	558	Durham VA Med Center	Durham	NC
17	558	Raleigh Dialysis Center	Raleigh	NC
18	565	Fayetteville VA Med Center	Fayetteville	NC
19	659	Charlotte Dialysis Center	Charlotte	NC
20	659	Kernersville Dialysis Center	Kernersville	NC
21	590	Hampton VA Med Center	Hampton	VA
22	652	Hunter Holmes McGuire VA Med Center	Richmond	VA
23	658	Salem VA Med Center	Salem	VA
24	508	Atlanta VA Med Center	Decatur	GA
25	521	Birmingham VA Med Center	Birmingham	AL
26	534	Ralph H. Johnson VA Med Center	Charleston	SC
27	544	Wm. Jennings Bryan Dorn VA Med Center	Columbia	SC
28	546	Miami VA HCS	Miami	FL
29	548	West Palm Beach VA Med Center	West Palm Beach	FL
30	573	North Florida/South Georgia HCS-Gainesville	Gainesville	FL
31	672	VA Caribbean HCS	San Juan	PR
32	673	James A. Haley Veterans' Hospital	Tampa	FL
33	675	Orlando	Orlando	FL
34	596	Lexington VA Med Center	Lexington	KY
35	614	Memphis VA Med Center	Memphis	TN

FY 2022 Outpatient Dialysis Centers

Dialysis Center Count	Station Number	Station Name	City	State
36	626	Tennessee Valley HCS	Nashville	TN
37	506	VA Ann Arbor HCS	Ann Arbor	MI
38	539	Cincinnati VA Med Center	Cincinnati	OH
39	541	Cleveland- Freestanding Dialysis Center	Cleveland	Oh
40	541	Louis Stokes Cleveland VA Med	Cleveland	OH
41	552	Dayton VA Med Center	Dayton	OH
42	553	John D. Dingell VA Med Center	Detroit	MI
43	583	Richard L. Roudebush VAMC	Indianapolis	IN
44	537	Jesse Brown VA Med Center	Chicago	IL
45	578	Edward Hines, Jr. VA Hospital	Hines	IL
46	695	Milo C Huempfner	Green Bay	WI
47	695	Milwaukee VA Med Center	Milwaukee	WI
48	589	Kansas City VA Med Center	Kansas City	MO
49	657	St. Louis VA Med Center	St. Louis	MO
50	598	Central Arkansas Veterans HCS	Little Rock	AR
51	549	VA North Texas HCS	Dallas	TX
52	671	South Texas Veterans HCS (STVHCS)	San Antonio	TX
53	501	New Mexico VA HCS	Albuquerque	NM
54	678	Southern Arizona VA HCS	Tucson	AZ
55	554	VA Eastern Colorado HCS	Denver	CO
56	648	Portland VA Med Center	Portland	OR
57	663	VA Puget Sound HCS	Seattle	WA
58	459	VA Pacific Islands HCS	Honolulu	HI
59	593	Southern Nevada HCS	North Las Vegas	NV
60	612	David Grant USAF Med Center (JV VA/DoD)	Travis AFB	CA
61	640	VA Palo Alto HCS	Palo Alto	CA
62	662	San Francisco VA Med Center	San Francisco	CA
63	600	VA Long Beach HCS	Long Beach	CA
64	605	VA Loma Linda HCS	Loma Linda	CA
65	664	VA San Diego HCS	San Diego	CA
66	691	VA Great Los Angeles HCS	Los Angeles	CA
67	568	VA Black Hills HCS	Hot Springs	SD
68	618	Minneapolis VA HCS	Minneapolis	MN
69	636	Iowa City VA HCS	Iowa City	IA
70	636	VA Nebraska-Western Iowa HCS	Omaha	NE

FY 2022 Community Resource and Referral Centers (CRRC)

CRRC Program Count	Station Name	Site Location
1	VA Connecticut Health Care System	West Haven, CT
2	VA New York Harbor Health Care System	Harlem, NY
3	Philadelphia VA Medical Center	Philadelphia, PA
4	VA Maryland Health Care System	Baltimore, MD
5	Washington DC VA Medical Center	Washington, DC
6	Huntington VA Medical Center	Huntington, WV
7	Ralph H. Johnson VA Medical Center	Charleston, SC
8	Atlanta VA Medical Center	Atlanta, GA
9	N. Florida/S. Georgia Veterans Health System	Jacksonville, FL
10	Louis Stokes Cleveland VA Medical Center-Akron CBOC	Akron, OH
11	Louis Stokes Cleveland VA Medical Center	Cleveland, OH
12	John D. Dingell VA Medical Center	Detroit, MI
13	Jesse Brown VA Medical Center	Chicago, IL
14	Clement J. Zablocki VA Medical Center	Milwaukee, WI
15	Michael E. DeBakey VA Medical Center	Houston, TX
16	Southeast Louisiana Veterans Health Care System	New Orleans, LA
17	VA North Texas Health Care System	Dallas, TX
18	VA North Texas Health Care System	Fort Worth, TX
19	VA Eastern Colorado Health Care System	Denver, CO
20	Portland VA Medical Center	Portland, OR
21	VA Puget Sound Health Care System	Seattle, WA
22	VA Southern Nevada Health Care System	Las Vegas, NV
23	San Francisco VA Medical Center	San Francisco, CA
24	VA Long Beach Healthcare System	Long Beach, CA
25	Phoenix VA Medical Center	Phoenix, AZ
26	Greater Los Angeles Health Care System	Los Angeles, CA
27	Iowa City VA Health Care System	Cedar Rapids, IA
28	VA Central Iowa Health Care System (636A8)	Davenport, IA
29	VA Central Iowa Health Care System (636A6)	Des Moines, IA
30	Minneapolis VA Health Care System	Minneapolis, MN
31	VA Nebraska-Western Iowa Health Care System	Omaha Nebraska-Western Iowa, NE
32	Fargo VA Health Care System	Fargo, ND

FY 2022 Vet Centers, Mobile Vet Centers and Vet Center Outstations

VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
1	523	Boston Vet Center	Boston	MA	0101V	N	N
1	631	Springfield Vet Center	West Springfield	MA	0103V	N	N
1	523	Brockton Vet Center	Brockton	MA	0104V	N	N
1	689	Hartford Mobile Vet Center	Rocky Hill	CT	0801MVC	Y	N
1	608	Manchester Vet Center	Hooksett	NH	0108V	N	N
1	608	Newington Outstation	Newington	NH	1081OS	N	Y
1	405	Keene Outstation	Keene	NH	1221OS	N	Y
1	650	Providence Vet Center	Warwick	RI	0113V	N	N
1	402	Portland Vet Center	Portland	ME	0115V	N	N
1	689	New Haven Vet Center	Orange	CT	0116V	N	N
1	689	Hartford Vet Center	Rocky Hill	CT	0117V	N	N
1	405	South Burlington Vet Center	South Burlington	VT	0118V	N	N
1	402	Northern Maine Vet Center	Caribou	ME	0119V	N	N
1	402	Bangor Vet Center	Bangor	ME	0121V	N	N
1	405	White River Junction Mobile Vet Center	White River Junction	VT	0803MVC	Y	N
1	405	White River Junction Vet Center	White River Junction	VT	0122V	N	N
1	518	Lowell Vet Center	Lowell	MA	0125V	N	N
1	631	Worcester Vet Center	Worcester	MA	0126V	N	N
1	689	Norwich Vet Center	Norwich	CT	0127V	N	N
1	402	Lewiston Mobile Vet Center	Lewiston	ME	0804MVC	Y	N
1	650	New Bedford Vet Center	Fairhaven	MA	0128V	N	N
1	402	Lewiston Vet Center	Lewiston	ME	0129V	N	N
1	402	Sanford Vet Center	Springvale	ME	0130V	N	N
1	405	Berlin Vet Center	Gorham	NH	0134V	N	N
1	650	Cape Cod Vet Center	Hyannis	MA	0136V	N	N
1	689	Danbury Vet Center	Danbury	CT	0140V	N	N
2	561	Secaucus Vet Center	Secaucus	NJ	0102V	N	N
2	630	Brooklyn Vet Center	Brooklyn	NY	0105V	N	N
2	630	Manhattan Vet Center	New York	NY	0106V	N	N
2	528	Buffalo Vet Center	Amherst	NY	0107V	N	N
2	630	Queens Vet Center	Woodhaven	NY	0109V	N	N
2	526	Bronx Vet Center	Bronx	NY	0110V	N	N
2	528A8	Albany Vet Center	Albany	NY	0111V	N	N
2	561	Bloomfield Vet Center	Bloomfield	NJ	0112V	N	N
2	561	Trenton Vet Center	Ewing	NJ	0114V	N	N
2	632	Babylon Vet Center	Babylon	NY	0120V	N	N
2	620	White Plains Vet Center	White Plains	NY	0123V	N	N
2	528A6	Rochester Vet Center	Rochester	NY	0124V	N	N
2	528A7	Syracuse Vet Center	Syracuse	NY	0131V	N	N
2	630	Staten Island Vet Center	Staten Island	NY	0132V	N	N
2	630	Harlem Vet Center	New York	NY	0133V	N	N
2	528A7	Watertown Vet Center	Watertown	NY	0135V	N	N
2	528A7	Binghamton Vet Center	Binghamton	NY	0137V	N	N
2	528A7	Watertown Mobile Vet Center	Watertown	NY	0805MVC	Y	N
2	632	Nassau Vet Center	Hicksville	NY	0138V	N	N
2	620	Middletown Vet Center	Middletown	NY	0139V	N	N
2	561	Lakewood Vet Center	Lakewood	NJ	0141V	N	N
2	561	Secaucus Mobile Vet Center	Secaucus	NJ	0857MVC	Y	N
2	528A6	Rochester Mobile Vet Center	Rochester	NY	0873MVC	Y	N
4	562	Erie Mobile Vet Center	Erie	PA	0809MVC	Y	N
4	642	Center City Philadelphia Vet Center	Philadelphia	PA	0210V	N	N
4	646	Pittsburgh Vet Center	Pittsburgh	PA	0211V	N	N
4	693	Williamsport Vet Center	Williamsport	PA	0212V	N	N
4	460	Wilmington Vet Center	Wilmington	DE	0215V	N	N

FY 2022 Vet Centers, Mobile Vet Centers and Vet Center Outstations

VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
4	595	Harrisburg Vet Center	Harrisburg	PA	0218V	N	N
4	642	Northeast Philadelphia Vet Center	Philadelphia	PA	0219V	N	N
4	646	White Oak Vet Center	White Oak	PA	0220V	N	N
4	693	Scranton Mobile Vet Center	Scranton	PA	0811MVC	Y	N
4	562	Erie Vet Center	Erie	PA	0222V	N	N
4	503	DuBois Vet Center	DuBois	PA	0227V	N	N
4	693	Scranton Vet Center	Scranton	PA	0229V	N	N
4	460	South Jersey Vet Center	Egg Harbor Township	NJ	0230V	N	N
4	646	Wheeling Vet Center	Wheeling	WV	0233V	N	N
4	642	Bucks County Vet Center	Bristol	PA	0238V	N	N
4	642	Norristown Vet Center	Norristown	PA	0239V	N	N
4	595	Lancaster Vet Center	Lancaster	PA	0242V	N	N
4	460	Sussex County Vet Center	Georgetown	DE	0243V	N	N
4	460	Sussex County Mobile Vet Center	Georgetown	DE	0874MVC	Y	N
4	503	DuBois Mobile Vet Center	DuBois	PA	0876MVC	Y	N
5	512	Baltimore Vet Center	Baltimore	MD	0201V	N	N
5	581	Huntington Mobile Vet Center	Huntington	WV	0807MVC	Y	N
5	581	Huntington Vet Center	Huntington	WV	0208V	N	N
5	512	Elkton Vet Center	Elkton	MD	0209V	N	N
5	688	Silver Spring Vet Center	Silver Spring	MD	0213V	N	N
5	688	Washington, D.C. Vet Center	Washington	DC	0214V	N	N
5	540	Morgantown Vet Center	Morgantown	WV	0216V	N	N
5	540	Parkersburg Outstation	Parkersburg	WV	2081OS	N	Y
5	512	Salisbury Outstation	Salisbury	MD	2091OS	N	Y
5	512	Aberdeen Outstation	Aberdeen	MD	2092OS	N	Y
5	517	Beckley Mobile Vet Center	Beckley	WV	0812MVC	Y	N
5	581	Charleston Vet Center	Charleston	WV	0223V	N	N
5	613	Martinsburg Vet Center	Martinsburg	WV	0224V	N	N
5	688	Alexandria Vet Center	Alexandria	VA	0228V	N	N
5	TBD	Leesburg Outstation	Leesburg	VA	TBD	N	Y
5	517	Beckley Vet Center	Beckley	WV	0231V	N	N
5	517	Princeton Vet Center	Princeton	WV	0232V	N	N
5	512	Annapolis Vet Center	Annapolis	MD	0235V	N	N
5	512	Dundalk Vet Center	Dundalk	MD	0236V	N	N
5	688	Prince George's County Vet Center	Clinton	MD	0237V	N	N
5	512	Baltimore Mobile Vet Center	Baltimore	MD	0858MVC	Y	N
6	652	Richmond Mobile Vet Center	Richmond	VA	0808MVC	Y	N
6	590	Chesapeake Vet Center	Chesapeake	VA	0207V	N	N
6	652	Richmond Vet Center	Richmond	VA	0217V	N	N
6	658	Roanoke Vet Center	Roanoke	VA	0226V	N	N
6	558	Greenville Mobile Vet Center	Greenville	NC	0814MVC	Y	N
6	590	Virginia Beach Vet Center	Virginia Beach	VA	0240V	N	N
6	565	Fayetteville Vet Center	Fayetteville	NC	0315V	N	N
6	659	Charlotte Vet Center	Charlotte	NC	0317V	N	N
6	558	Greenville Vet Center	Greenville	NC	0319V	N	N
6	659	Greensboro Vet Center	Greensboro	NC	0327V	N	N
6	558	Raleigh Vet Center	Raleigh	NC	0328V	N	N
6	558	Spindale Outstation	Spindale	NC	3271OS	N	Y
6	565	Jacksonville Vet Center	Jacksonville	NC	0343V	N	N
6	659	Greensboro Mobile Vet Center	Greensboro	NC	0862MVC	Y	N
7	544	Columbia Mobile Vet Center	Columbia	SC	0817MVC	Y	N
7	534	Charleston Vet Center	North Charleston	SC	0303V	N	N
7	508	Atlanta Vet Center	College Park	GA	0304V	N	N
7	557	Macon Mobile Vet Center	Macon	GA	0818MVC	Y	N
7	544	Greenville Vet Center	Greenville	SC	0316V	N	N

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VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
7	534	Savannah Vet Center	Savannah	GA	0323V	N	N
7	544	Columbia Vet Center	Columbia	SC	0324V	N	N
7	508	Lawrenceville Vet Center	Lawrenceville	GA	0329V	N	N
7	557	Macon Vet Center	Macon	GA	0333V	N	N
7	619	Montgomery Vet Center	Montgomery	AL	0334V	N	N
7	508	Marietta Vet Center	Marietta	GA	0342V	N	N
7	557	Augusta Vet Center	Augusta	GA	0346V	N	N
7	534	Myrtle Beach Vet Center	Myrtle Beach	SC	0347V	N	N
7	509	Columbus Vet Center	Columbus	GA	0349V	N	N
7	508	Atlanta Mobile Vet Center	College Park	GA	0860MVC	Y	N
7	521	Birmingham Mobile Vet Center	Hoover	AL	0866MVC	Y	N
7	521	Huntsville Vet Center	Huntsville	AL	0738V	N	N
7	521	Birmingham Vet Center	Hoover	AL	0739V	N	N
8	672	Arecibo Vet Center	Arecibo	PR	0802MVC	Y	N
8	573	Jacksonville Mobile Vet Center	Jacksonville	FL	0813MVC	Y	N
8	672	St. Croix Outstation	Kingshill	VI	3121OS	N	Y
8	516	Clearwater Mobile Vet Center	Clearwater	FL	0816MVC	Y	N
8	516	St. Petersburg Vet Center	St. Petersburg	FL	0301V	N	N
8	573	Jacksonville Vet Center	Jacksonville	FL	0305V	N	N
8	672	San Juan Vet Center	Guaynabo	PR	0307V	N	N
8	672	Arecibo Vet Center	Arecibo	PR	0309V	N	N
8	546	Miami Vet Center	Miami	FL	0310V	N	N
8	546	Fort Lauderdale Vet Center	Lauderdale Lakes	FL	0311V	N	N
8	672	Ponce Vet Center	Ponce	PR	0312V	N	N
8	675	Orlando Vet Center	Orlando	FL	0314V	N	N
8	673	Tampa Vet Center	Tampa	FL	0318V	N	N
8	516	Sarasota Vet Center	Sarasota	FL	0320V	N	N
8	573	Tallahassee Vet Center	Tallahassee	FL	0325V	N	N
8	548	Palm Beach Vet Center	Greenacres	FL	0326V	N	N
8	516	Fort Myers Vet Center	Fort Myers	FL	0330V	N	N
8	573	Gainesville Vet Center	Gainesville	FL	0331V	N	N
8	675	Melbourne Vet Center	Melbourne	FL	0332V	N	N
8	672	St. Thomas Outstation	St Thomas	VI	3122OS	N	Y
8	546	Pompano Beach Vet Center	Pompano Beach	FL	0336V	N	N
8	548	Jupiter Vet Center	Jupiter	FL	0337V	N	N
8	673	Pasco County Vet Center	New Port Richey	FL	0338V	N	N
8	516	Clearwater Vet Center	Clearwater	FL	0339V	N	N
8	673	Lakeland Vet Center	Lakeland	FL	0340V	N	N
8	675	Daytona Beach Vet Center	Daytona Beach	FL	0341V	N	N
8	573	Ocala Vet Center	Ocala	FL	0344V	N	N
8	675	Clermont Vet Center	Clermont	FL	0345V	N	N
8	516	Naples Vet Center	Naples	FL	0348V	N	N
8	672	Ponce Mobile Vet Center	Ponce	PR	0861MVC	Y	N
9	596	Lexington Mobile Vet Center	Lexington	KY	0806MVC	Y	N
9	603	Louisville Vet Center	Louisville	KY	0202V	N	N
9	596	Lexington Vet Center	Lexington	KY	0203V	N	N
9	621	Knoxville Mobile Vet Center	Knoxville	TN	0844MVC	Y	N
9	614	Memphis Mobile Vet Center	Memphis	TN	0848MVC	Y	N
9	675	Clermont Mobile Vet Center	Clermont	FL	0864MVC	Y	N
9	621	Johnson City Vet Center	Johnson City	TN	0701V	N	N
9	614	Memphis Vet Center	Memphis	TN	0719V	N	N
9	621	Knoxville Vet Center	Knoxville	TN	0720V	N	N
9	626	Chattanooga Vet Center	Chattanooga	TN	0722V	N	N
9	626	Nashville Vet Center	Nashville	TN	0724V	N	N
9	626	Clarksville Outstation	Clarksville	TN	7241OS	N	Y
10	539	Cincinnati Vet Center	Norwood	OH	0204V	N	N

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10	541	Cleveland Vet Center	Maple Heights	OH	0205V	N	N
10	541	Parma Vet Center	Parma	OH	0206V	N	N
10	552	Dayton Mobile Vet Center	Kettering	OH	0810MVC	Y	N
10	757	Columbus Vet Center	Columbus	OH	0221V	N	N
10	552	Dayton Vet Center	Kettering	OH	0225V	N	N
10	506	Toledo Vet Center	Toledo	OH	0234V	N	N
10	541	Stark County Vet Center	Canton	OH	0241V	N	N
10	553	Dearborn Vet Center	Dearborn	MI	0401V	N	N
10	553	Detroit Vet Center	Detroit	MI	0402V	N	N
10	515	Grand Rapids Vet Center	Grand Rapids	MI	0403V	N	N
10	610	Fort Wayne Vet Center	Fort Wayne	IN	0409V	N	N
10	583	Indianapolis Vet Center	Indianapolis	IN	0413V	N	N
10	655	Saginaw Vet Center	Saginaw	MI	0433V	N	N
10	553	Macomb County Vet Center	Clinton Township	MI	0437V	N	N
10	553	Pontiac Vet Center	Pontiac	MI	0438V	N	N
10	610	South Bend Vet Center	South Bend	IN	0444V	N	N
10	655	Traverse City Vet Center	Traverse City	MI	0445V	N	N
10	583	Indianapolis Mobile Vet Center	Indianapolis	IN	0852MVC	Y	N
10	553	Pontiac Mobile Vet Center	Pontiac	MI	0855MVC	Y	N
10	541	Stark County Mobile Vet Center	Canton	OH	0859MVC	Y	N
12	550	Springfield Mobile Vet Center	Springfield	IL	0822MVC	Y	N
12	585	Escanaba Mobile Vet Center	Escanaba	MI	0826MVC	Y	N
12	537	Chicago Heights Vet Center	Chicago Heights	IL	0407V	N	N
12	537	Chicago Vet Center	Chicago	IL	0410V	N	N
12	578	Forest Park Vet Center	Forest Park	IL	0411V	N	N
12	537	Gary Area Vet Center	Crown Point	IN	0412V	N	N
12	695	Milwaukee Vet Center	Milwaukee	WI	0415V	N	N
12	550	Peoria Vet Center	Peoria	IL	0417V	N	N
12	607	Madison Vet Center	Madison	WI	0419V	N	N
12	556	Evanston Vet Center	Evanston	IL	0420V	N	N
12	537	Wausau Outstation	Wausau	WI	4421OS	N	Y
12	550	Springfield Vet Center	Springfield	IL	0421V	N	N
12	585	Escanaba Vet Center	Escanaba	MI	0434V	N	N
12	578	Orland Park Vet Center	Orland Park	IL	0435V	N	N
12	578	Aurora Vet Center	Aurora	IL	0436V	N	N
12	695	Green Bay Vet Center	Green Bay	WI	0441V	N	N
12	676	La Crosse Vet Center	La Crosse	WI	0442V	N	N
12	556	Rockford Vet Center	Rockford	IL	0447V	N	N
12	556	Evanston Mobile Vet Center	Evanston	IL	0853MVC	Y	N
12	695	Green Bay Mobile Vet Center	Green Bay	WI	0856MVC	Y	N
15	589A7	Wichita Mobile Vet Center	Wichita	KS	0824MVC	Y	N
15	589	Kansas City Vet Center	Kansas City	MO	0408V	N	N
15	657	St. Louis Vet Center	Creve Coeur	MO	0414V	N	N
15	657A5	Evansville Vet Center	Evansville	IN	0418V	N	N
15	657	Metro East Vet Center	Swansea	IL	0422V	N	N
15	589A7	Wichita Vet Center	Wichita	KS	0426V	N	N
15	589	Manhattan Vet Center	Manhattan	KS	0432V	N	N
15	589A4	Columbia Vet Center	Columbia	MO	0443V	N	N
15	589	Kansas City Mobile Vet Center	Kansas City	MO	0851MVC	Y	N
15	657A5	Evansville Mobile Vet Center	Evansville	IN	0872MVC	Y	N
15	589A4	Columbia Mobile Vet Center	Columbia	MO	0875MVC	Y	N
16	520	Pensacola Mobile Vet Center	Pensacola	FL	0815MVC	Y	N
16	629	New Orleans Mobile Vet Center	New Orleans	LA	0847MVC	Y	N
16	598	Little Rock Mobile Vet Center	Little Rock	AR	0850MVC	Y	N
16	586	Jackson Mobile Vet Center	Jackson	MS	0863MVC	Y	N
16	667	Shreveport Vet Center	Shreveport	LA	0704V	N	N

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16	586	Jackson Vet Center	Jackson	MS	0709V	N	N
16	580	Houston Southwest Vet Center	Houston	TX	0710V	N	N
16	580	Houston West Vet Center	Houston	TX	0711V	N	N
16	598	Little Rock Vet Center	North Little Rock	AR	0713V	N	N
16	629	New Orleans Vet Center	New Orleans	LA	0717V	N	N
16	667	Shreveport Mobile Vet Center	Shreveport	LA	0877MVC	Y	N
16	629	Baton Rouge Vet Center	Baton Rouge	LA	0725V	N	N
16	564	Fayetteville Vet Center	Fayetteville	AR	0727V	N	N
16	580	Spring Vet Center	Houston	TX	0731V	N	N
16	502	Alexandria Vet Center	Alexandria	LA	0734V	N	N
16	580	Beaumont Vet Center	Beaumont	TX	0735V	N	N
16	564	Springfield Vet Center	Springfield	MO	0736V	N	N
16	520	Biloxi Vet Center	Biloxi	MS	0737V	N	N
16	520	Mobile Vet Center	Mobile	AL	0741V	N	N
16	520	Pensacola Vet Center	Pensacola	FL	0742V	N	N
16	520	Okaloosa County Vet Center	Shalimar	FL	0743V	N	N
16	520	Bay County Vet Center	Panama City	FL	0744V	N	N
17	504	Amarillo Mobile Vet Center	Amarillo	TX	0845MVC	Y	N
17	519	Abilene Mobile Vet Center	Abilene	TX	0846MVC	Y	N
17	671	San Antonio Northwest Mobile Vet Center	San Antonio	TX	0849MVC	Y	N
17	756	Las Cruces Vet Center	Las Cruces	NM	0530V	N	N
17	504	Amarillo Vet Center	Amarillo	TX	0702V	N	N
17	674	Austin Vet Center	Austin	TX	0703V	N	N
17	671	Corpus Christi Vet Center	Corpus Christi	TX	0705V	N	N
17	549	Dallas Vet Center	Dallas	TX	0706V	N	N
17	756	El Paso Vet Center	El Paso	TX	0707V	N	N
17	549	Fort Worth Vet Center	Westworth Village	TX	0708V	N	N
17	671	Laredo Vet Center	Laredo	TX	0712V	N	N
17	504	Lubbock Vet Center	Lubbock	TX	0714V	N	N
17	671	McAllen Vet Center	McAllen	TX	0715V	N	N
17	519	Midland Vet Center	Midland	TX	0716V	N	N
17	671	San Antonio Northeast Vet Center	San Antonio	TX	0721V	N	N
17	674	Killeen Heights Vet Center	Harker Heights	TX	0726V	N	N
17	671	San Antonio Northwest Vet Center	San Antonio	TX	0729V	N	N
17	671	McAllen Mobile Vet Center	McAllen	TX	0879MVC	Y	N
17	549	Mesquite Vet Center	Mesquite	TX	0730V	N	N
17	549	Arlington Vet Center	Pantego	TX	0732V	N	N
17	519	Abilene Vet Center	Abilene	TX	0733V	N	N
19	436	Billings Mobile Vet Center	Billings	MT	0829MVC	Y	N
19	660	Salt Lake City Mobile Vet Center	Murray	UT	0831MVC	Y	N
19	442	Casper Mobile Vet Center	Casper	WY	0834MVC	Y	N
19	554	Pueblo Mobile Vet Center	Pueblo	CO	0836MVC	Y	N
19	436	Missoula Mobile Vet Center	Missoula	MT	0837MVC	Y	N
19	442	Cheyenne Vet Center	Cheyenne	WY	0501V	N	N
19	554	Denver Vet Center	Denver	CO	0504V	N	N
19	436	Billings Vet Center	Billings	MT	0509V	N	N
19	660	Salt Lake City Vet Center	Murray	UT	0514V	N	N
19	442	Casper Vet Center	Casper	WY	0519V	N	N
19	554	Colorado Springs Vet Center	Colorado Springs	CO	0525V	N	N
19	575	Grand Junction Vet Center	Grand Junction	CO	0526V	N	N
19	554	Boulder Vet Center	Boulder	CO	0527V	N	N
19	436	Missoula Vet Center	Missoula	MT	0528V	N	N
19	660	Pocatello Vet Center	Pocatello	ID	0531V	N	N
19	660	Provo Vet Center	Orem	UT	0532V	N	N
19	436	Great Falls Vet Center	Great Falls	MT	0538V	N	N
19	436	Kalispell Vet Center	Kalispell	MT	0539V	N	N

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19	660	Saint George Vet Center	Saint George	UT	0540V	N	N
19	554	Pueblo Vet Center	Pueblo	CO	0542V	N	N
19	442	Fort Collins Vet Center	Fort Collins	CO	0543V	N	N
19	660	Major Brent Taylor Vet Center Outstation	North Ogden	UT	5141OS	N	Y
19	635	Lawton Mobile Vet Center	Lawton	OK	0865MVC	Y	N
19	660	Saint George Mobile Vet Center	Saint George	UT	0868MVC	Y	N
19	436	Helena Outstation	Helena	MT	5381OS	N	Y
19	635	Oklahoma City Vet Center	Oklahoma City	OK	0718V	N	N
19	623	Tulsa Vet Center	Tulsa	OK	0723V	N	N
19	635	Lawton Vet Center	Lawton	OK	0728V	N	N
19	442	Fort Collins Mobile Vet Center	Fort Collins	CO	0881MVC	Y	N
20	531	Boise Mobile Vet Center	Boise	ID	0827MVC	Y	N
20	663	Tacoma Mobile Vet Center	Tacoma	WA	0828MVC	Y	N
20	668	Spokane Mobile Vet Center	Spokane Valley	WA	0830MVC	Y	N
20	648	Salem Mobile Vet Center	Salem	OR	0840MVC	Y	N
20	463	Anchorage Vet Center	Anchorage	AK	0502V	N	N
20	531	Boise Vet Center	Boise	ID	0503V	N	N
20	663	Seattle Vet Center	Seattle	WA	0507V	N	N
20	663	Tacoma Vet Center	Tacoma	WA	0508V	N	N
20	668	Spokane Vet Center	Spokane	WA	0510V	N	N
20	463	Fairbanks Vet Center	Fairbanks	AK	0511V	N	N
20	463	Wasilla Vet Center	Wasilla	AK	0512V	N	N
20	663	Bellingham Vet Center	Bellingham	WA	0522V	N	N
20	663	Yakima Valley Vet Center	Yakima	WA	0523V	N	N
20	663	Everett Vet Center	Everett	WA	0529V	N	N
20	463	Kenai Outstation	Soldotna	AK	5021OS	N	Y
20	663	Federal Way Vet Center	Federal Way	WA	0535V	N	N
20	687	Walla Walla Vet Center	Walla Walla	WA	0541V	N	N
20	463	Lacey Outstation	Lacey	WA	5081OS	N	Y
20	648	Portland Vet Center	Portland	OR	0617V	N	N
20	648	Central Oregon Vet Center	Bend	OR	0622V	N	N
20	653	Eugene Vet Center	Eugene	OR	0626V	N	N
20	648	Salem Vet Center	Salem	OR	0640V	N	N
20	692	Grants Pass Vet Center	Grants Pass	OR	0645V	N	N
20	692	Grants Pass Mobile Vet Center	Grants Pass	OR	0871MVC	Y	N
21	593	Las Vegas Vet Center	Las Vegas	NV	0505V	N	N
21	654	Reno Vet Center	Reno	NV	0506V	N	N
21	640	Santa Cruz County Mobile Vet Center	Capitola	CA	0842MVC	Y	N
21	593	Henderson Vet Center	Henderson	NV	0534V	N	N
21	612A4	Concord Vet Center	Concord	CA	0602V	N	N
21	459	Honolulu Vet Center	Honolulu	HI	0609V	N	N
21	570	Citrus Heights Vet Center	Citrus Heights	CA	0610V	N	N
21	612A4	Oakland Vet Center	Oakland	CA	0612V	N	N
21	640	San Jose Vet Center	San Jose	CA	0615V	N	N
21	TBD	Solano County Outstation	Fairfield	CA	TBD	N	Y
21	TBD	Mariana Islands Outstation	Saipan	MP	TBD	N	Y
21	459	American Samoa Vet Center	Pago Pago	AS	0616V	N	N
21	662	San Francisco Vet Center	San Francisco	CA	0620V	N	N
21	459	Western Oahu Vet Center	Kapolei	HI	0621V	N	N
21	570	Fresno Vet Center	Fresno	CA	0628V	N	N
21	459	Kauai Vet Center	Lihue	HI	0633V	N	N
21	459	Maui Vet Center	Kahului	HI	0634V	N	N
21	459	Hilo Vet Center	Hilo	HI	0635V	N	N
21	459	Kailua-Kona Vet Center	Kailua-Kona	HI	0636V	N	N
21	612A4	Sacramento Vet Center	Sacramento	CA	0638V	N	N
21	640	Santa Cruz County Vet Center	Capitola	CA	0639V	N	N

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21	662	Eureka Vet Center	Eureka	CA	0644V	N	N
21	654	Reno Mobile Vet Center	Reno	NV	0867MVC	Y	N
21	662	Northbay Vet Center	Rohnert Park	CA	0646V	N	N
21	640	Peninsula Vet Center	Menlo Park	CA	0647V	N	N
21	459	Guam Vet Center	Maite	GU	0648V	N	N
21	612A4	Chico Vet Center	Chico	CA	0649V	N	N
21	640	Delta Vet Center	Manteca	CA	0650V	N	N
21	459	Western Oahu Mobile Vet Center	Kapolei	HI	0870MVC	Y	N
21	612A4	Sacramento Mobile Vet Center	Sacramento	CA	0880MVC	Y	N
21	593	Henderson Mobile Vet Center	Henderson	NV	0886MVC	Y	N
22	501	Hopi Mobile Vet Center	Hotevilla	AZ	0832MVC	Y	N
22	649	Prescott Mobile Vet Center	Prescott	AZ	0833MVC	Y	N
22	501	Santa Fe Mobile Vet Center	Santa Fe	NM	0835MVC	Y	N
22	501	Las Cruces Mobile Vet Center	Las Cruces	NM	0838MVC	Y	N
22	605	Corona Mobile Vet Center	Corona	CA	0839MVC	Y	N
22	691	Bakersfield Mobile Vet Center	Bakersfield	CA	0841MVC	Y	N
22	501	Albuquerque Vet Center	Albuquerque	NM	0515V	N	N
22	501	Farmington Vet Center	Farmington	NM	0516V	N	N
22	644	Phoenix Vet Center	Phoenix	AZ	0517V	N	N
22	649	Dr. Cameron McKinley Vet Center	Prescott	AZ	0518V	N	N
22	501	Santa Fe Vet Center	Sante Fe	NM	0520V	N	N
22	678	Tucson Vet Center	Tucson	AZ	0521V	N	N
22	644	Mesa Vet Center	Mesa	AZ	0524V	N	N
22	644	West Valley Vet Center	Peoria	AZ	0533V	N	N
22	649	Lake Havasu Vet Center	Lake Havasu	AZ	0536V	N	N
22	678	Yuma Vet Center	Yuma	AZ	0537V	N	N
22	691	Bakersfield Vet Center	Bakersfield	CA	0601V	N	N
22	691	Antelope Valley Vet Center	Palmdale	CA	0603V	N	N
22	600	South Orange County Vet Center	Mission Viejo	CA	0604V	N	N
22	691	Chatsworth Vet Center	Chatsworth	CA	0605V	N	N
22	691	Los Angeles Vet Center	Gardena	CA	0606V	N	N
22	691	West Los Angeles Vet Center	Culver City	CA	0607V	N	N
22	501	Navajo Outstation	Chinle	AZ	5161OS	N	Y
22	TBD	Sierra Vista Outstation	Sierra Vista	AZ	TBD	N	Y
22	605	Temecula Vet Center	Temecula	CA	0608V	N	N
22	605	Corona Vet Center	Corona	CA	0611V	N	N
22	605	High Desert Vet Center	Victorville	CA	0613V	N	N
22	664	Chula Vista Vet Center	Bonita	CA	0614V	N	N
22	664	San Diego Vet Center	San Diego	CA	0618V	N	N
22	691	San Luis Obispo Vet Center	San Luis Obispo	CA	0619V	N	N
22	691	East Los Angeles Vet Center	Commerce	CA	0623V	N	N
22	600	North Orange County Vet Center	Garden Grove	CA	0624V	N	N
22	605	San Bernardino Vet Center	San Bernardino	CA	0637V	N	N
22	664	San Marcos Vet Center	San Marcos	CA	0642V	N	N
22	691	Ventura Vet Center	Ventura	CA	0643V	N	N
22	600	South Orange County Mobile Vet Center	Mission Viejo	CA	0869MVC	Y	N
22	501	Hopi Outstation	Hotevilla	AZ	5162OS	N	Y
22	691	Sepulveda Outstation	Sepulveda	CA	6051OS	N	Y
22	501	Chinle Mobile Vet Center	Chinle	AZ	0882MVC	Y	N
22	664	San Marcos Mobile Vet Center	San Marcos	CA	0883MVC	Y	N
22	678	Yuma Mobile Vet Center	Yuma	AZ	0885MVC	Y	N
23	437	Bismarck Mobile Vet Center	Bismarck	ND	0819MVC	Y	N
23	437	Fargo Mobile Vet Center	Fargo	ND	0820MVC	Y	N
23	618	Brooklyn Park Mobile Vet Center	Brooklyn Park	MN	0821MVC	Y	N
23	568	Rapid City Mobile Vet Center	Rapid City	SD	0823MVC	Y	N
23	636	Lincoln Mobile Vet Center	Lincoln	NE	0825MVC	Y	N

FY 2022 Vet Centers, Mobile Vet Centers and Vet Center Outstations

VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
23	437	Grand Forks Outstation	Grand Forks	ND	4061OS	N	Y
23	437	Minot Vet Center	Minot	ND	0404V	N	N
23	636A6	Des Moines Vet Center	West Des Moines	IA	0405V	N	N
23	437	Fargo Vet Center	Fargo	ND	0406V	N	N
23	618	St. Paul Vet Center	Saint Paul	MN	0416V	N	N
23	TBD	St. Cloud Outstation	St. Cloud	MN	TBD	N	Y
23	568	Rapid City Vet Center	Rapid City	SD	0423V	N	N
23	636	Omaha Vet Center	Omaha	NE	0424V	N	N
23	438	Sioux Falls Vet Center	Sioux Falls	SD	0425V	N	N
23	636	Lincoln Vet Center	Lincoln	NE	0427V	N	N
23	438	Sioux City Vet Center	Sioux City	IA	0428V	N	N
23	618	Duluth Vet Center	Duluth	MN	0429V	N	N
23	636A8	Quad Cities Vet Center	East Moline	IL	0430V	N	N
23	636A8	Cedar Rapids Vet Center	Cedar Rapids	IA	0431V	N	N
23	618	Brooklyn Park Vet Center	Anoka	MN	0439V	N	N
23	437	Bismarck Vet Center	Bismarck	ND	0446V	N	N
23	636A8	Cedar Rapids Mobile Vet Center	Cedar Rapids	IA	0854MVC	Y	N

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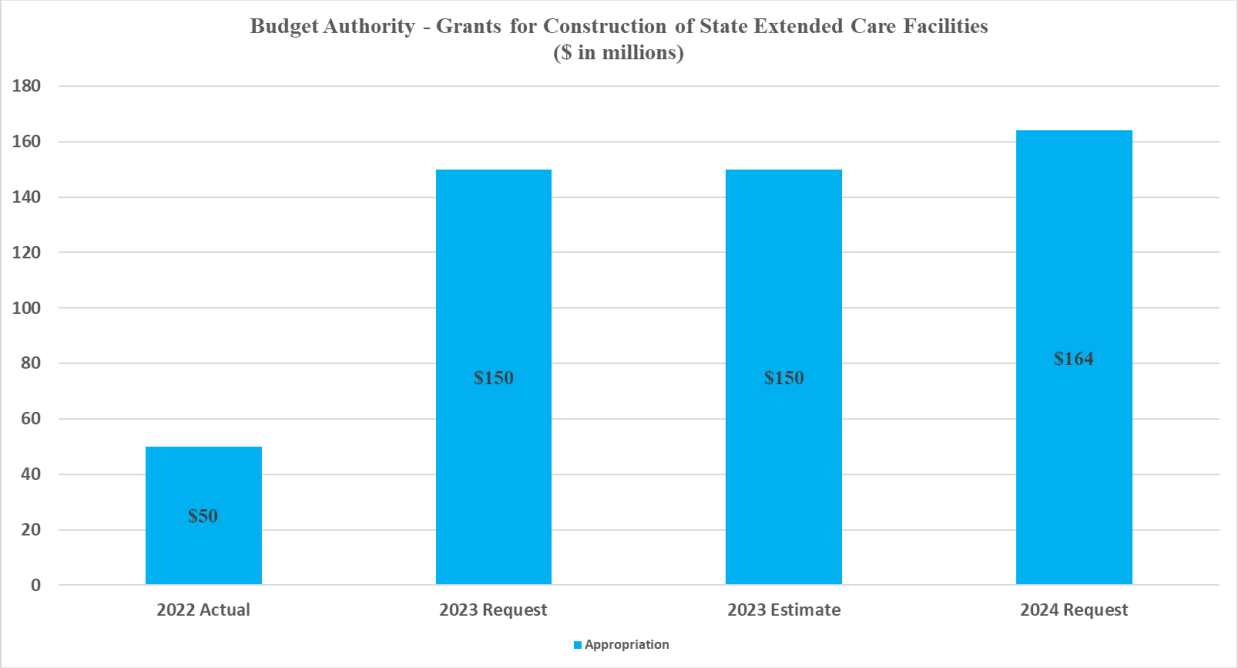
Grants for Construction of State Extended Care Facilities

Chart: Total Appropriations



2024 Budget Discussion

VA is requesting $164 million in 2024 for construction of state home facilities, for furnishing domiciliary or nursing home care to Veterans and to expand, remodel or alter existing buildings for furnishing domiciliary, nursing home care or adult day health care to Veterans in state homes. VA is required by section 8135 of Title 38 to prioritize state grant applications, and its highest priority is to protect Veterans from those conditions that threaten the lives and safety of residents of an existing facility. State homes are owned and operated by the state.

American Rescue Plan (ARP) Act

The ARP Act (P.L. 117-2) provided an additional $500 million in 2021 to remain available until expended. Approximately $104 million was obligated in 2021, $395 million in 2022 and the remaing $938 thousand is projected to be obligated by the end of 2023. As a result of this funding, the program was able to obligate ARP funds for two final grants.

Table: Total Funding Highlights

Total Funding Highlights
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Estimate	2022 to 2023 Inc/Dec
Appropriation	$50,000	$150,000	$150,000	$164,000	$14,000
Mandatory Appropriations (ARP Act Sec. 8004)	$0	$0	$0	$0	$0
Adjustments to Obligations:					
Unobligated Balance (SOY)	$566,963	$168,913	$210,551	$0	($210,551)
Unobligated Balance (EOY)	($210,551)	$0	$0	$0	$0
Change in Unobligated Balance	$356,412	$168,913	$210,551	$0	($210,551)
Prior Year Recoveries	$6,500	$0	$0	$0	$0
Obligations	$412,912	$318,913	$360,551	$164,000	($196,551)

Table: Annual Discretionary Funding Highlights

Annual Discretionary Funding Highlights
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Estimate	2023 to 2024 Inc/Dec
Appropriation	$50,000	$150,000	$150,000	$164,000	$14,000
Adjustments to Obligations:					
Unobligated Balance (SOY)	$171,367	$168,913	$209,613	$0	($209,613)
Unobligated Balance (EOY)	($209,613)	$0	$0	$0	$0
Change in Unobligated Balance	($38,246)	$168,913	$209,613	$0	($209,613)
Prior Year Recoveries	$3,941	$0	$0	$0	$0
Obligations	$15,695	$318,913	$359,613	$164,000	($195,613)

Table: ARP Act Funding Highlights

American Rescue Plan (ARP) Act 8004 Highlights
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Estimate	2023 to 2024 Inc/Dec
Mandatory Appropriations (Sec. 8004).....	$0	$0	$0	$0	$0
Adjustments to Obligations:					
Unobligated Balance (SOY).....	$395,596	$0	$938	$0	($938)
Unobligated Balance (EOY).....	($938)	$0	$0	$0	$0
Change in Unobligated Balance.....	$394,658	$0	$938	$0	($938)
Prior Year Recoveries.....	$2,559	$0	$0	$0	$0
Obligations.....	$397,217	$0	$938	$0	($938)

Program Description

VA conducts inspections, audits, and other oversight to ensure the state homes are providing quality care. States are required to fund at least 35% of a project's total estimated cost and VA may fund up to 65%.

In 2022, the program offered four grants to States; three were conditional awards and one was a final award. States must complete the entire grant application by August 1 of the fiscal year to be considered for a final grant award. States must complete the entire grant application by June 30 of the fiscal year to be considered for a conditional grant award. States that do not complete a final grant award by the deadline may apply for a conditional grant award with the expectation that the remaining grant process will be completed by the following June 30 deadline. If states cannot complete a grant that was offered for an award, they may request a deferment to the following year for reconsideration.

The total value of priority group one projects submitted by states is expected to grow by 65% from 2022 bringing the total value to $1.3 billion by the end of 2023.

The 2024 budget request, matched with state funding, will support essential life-safety renovation projects to help ensure quality care for Veterans. Remaining funds will be used to support new construction projects and non-life safety renovation projects.

Legislative History

This program was approved on August 19, 1964 and received appropriations in 1965. Public Law (P.L.) 95-62, dated July 5, 1977, authorized the VA to participate in the construction of new domiciliary as well as new nursing homes, and for sums appropriated to remain available until expended. The Veterans' Health Care Act of 1984 (P.L. 98-528, dated October 19, 1984) amended section 8132 to allow states to purchase facilities to be used as state nursing homes and domiciliary. The Veterans' Benefits Improvement and Health Care Authorization Act of 1986 (P.L. 99-576, dated October 28, 1986) amended section 8135 of title 38 to eliminate a limitation that prohibited any state from receiving in any fiscal year more than one-third of the amount appropriated in that fiscal year and required a priority list to be established on July 1 of each year. The Veterans'

Benefits and Services Act of 1988 (P.L. 100-322, dated May 20, 1988) further amended section 8135 of title 38 to change the date for compiling a priority list of grantees from July 1 to August 15. Construction grants are to be made from that list for the fiscal year beginning October 1.

The Veterans' Benefits and Services Act of 1988 also permitted VA to approve and award state home grants on a conditional basis and obligate funds for these awards. This law authorized VA to increase a conditionally approved grant amount if: (1) the estimated cost on which VA based the conditional approval increases; and (2) VA conditionally approved the grant before the state awarded a construction or acquisition contract for the project. The final grant award increase would be limited to 10% percent of the original obligation.

The Veterans Health Care Act of 1992 (P.L. 102-585, dated November 4, 1992) granted permanent authority for this program and extended – from 90 days to 180 days, the period within which a state must complete the application for a state home grant after receiving a conditional award. The Veterans' Health Care Eligibility Reform Act of 1996 (P.L. 104-262, dated October 9, 1996) added Adult Day Health Care as another type of care that may be provided by State homes.

Under current law, a grant may not exceed 65% of the total cost of the project. The Veteran's Millennium Health Care and Benefits Act of 1999 (P.L. 106-117, dated November 30, 1999) provided greater specificity in directing VA to prescribe regulations for the number of beds for which grant assistance may be furnished. The following changes were enacted:

- Requires VA to establish criteria for determining the relative need for additional beds on the part of a state which already has such state home beds;

- Strengthens the requirements governing award of a grant;

- Revises provisions governing the relative priority of each application (among those projects for which states have made their funding available in advance);

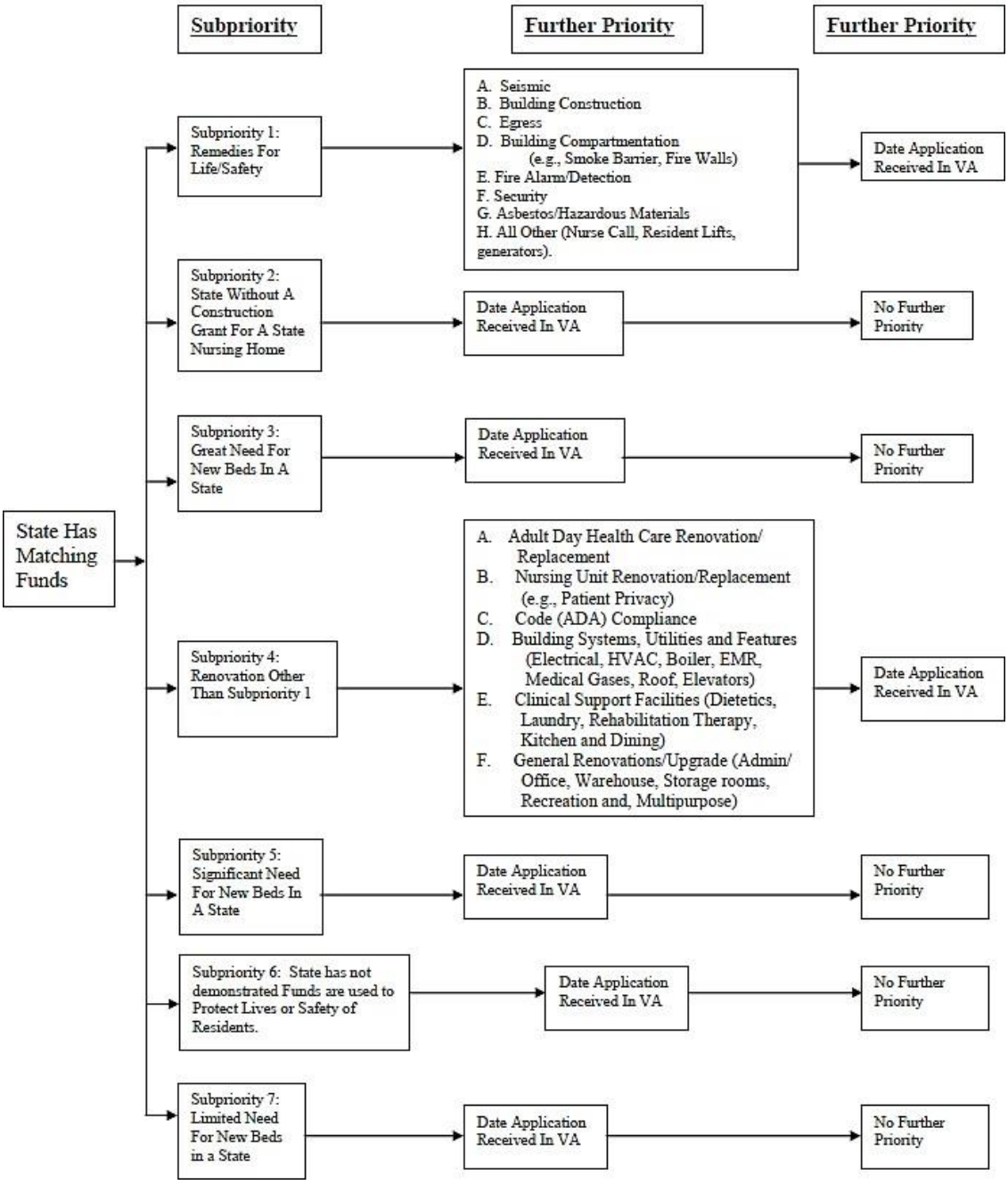
- Differentiates among applications for new bed construction by reference to the relative need for such beds, by assigning a higher priority to renovation projects (with a total cost exceeding $400,000), with highest priority to renovations involving patient life or safety and by assigning second highest priority to an application from a State that has not previously applied for award of a VA construction grant or a grant for a state nursing home; and

- Establishes a "transition" rule providing that current regulations and provisions governing applications for state home grants would continue in effect with respect to applications for a limited number of projects. Those "grandfathered" projects are limited to those projects on the list of approved projects, established by the Secretary on October 29, 1998, for which the State had made sufficient funds available and those priority one projects on VA's 2000 list, approved by the Secretary on November 3, 1999, submitted by states which had not received 1999 grant monies and are not included in the October 29 list. All of the "grandfathered" projects received grants and are no longer included in the priority list.

Project Prioritization

Currently, priority one projects are those with state matching funds set aside for the project. Within priority one, there are seven sub priority classifications. The following diagram illustrates the seven sub priority classifications and provides additional information on the methodology used to prioritize grants for the construction of state home facilities.

Prioritization for Priority Group 1



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Joint Medical Care Special Programs

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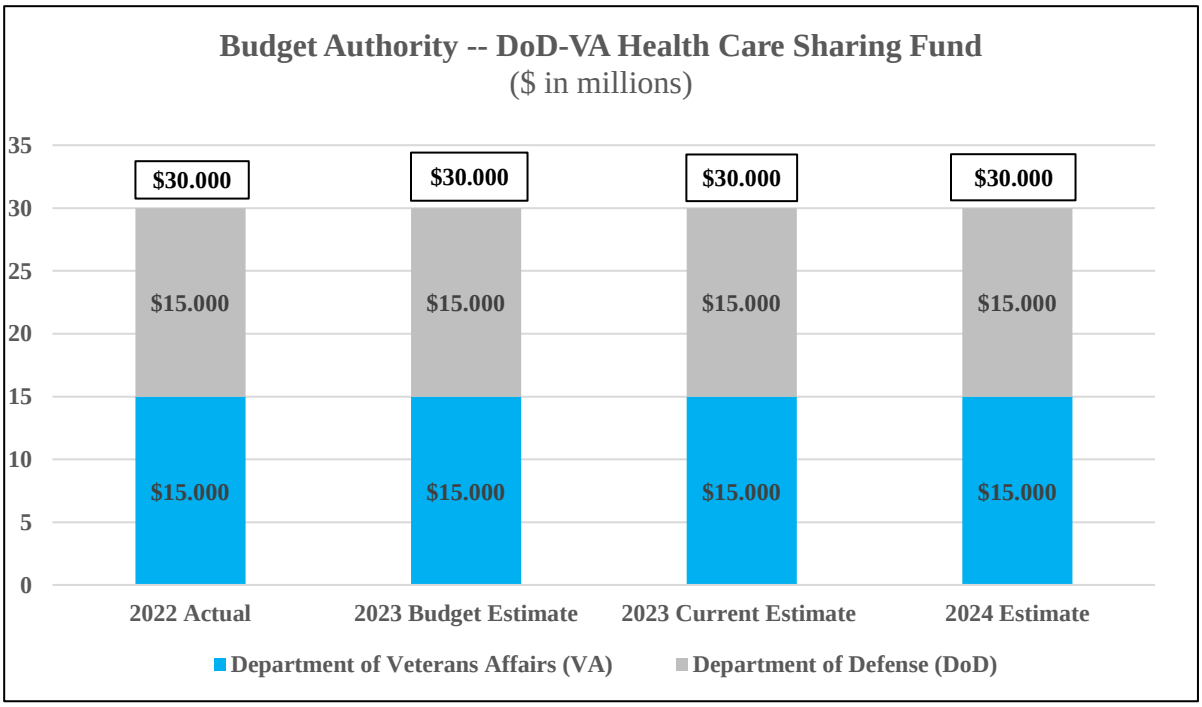
DoD-VA Health Care Sharing Incentive Fund



[1/]Funding contributions anticipated from VA and DoD.

Program Description

Congress created the DoD-VA Health Care Sharing Incentive Fund, regularly referred to as the Joint Incentive Fund (JIF), between the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to encourage development of sharing initiatives at the facility, intra-regional and nationwide level. The JIF program has been very successful in fostering collaboration and new approaches to problem solving that mutually benefit both VA and DoD.

Through the JIF, there is a minimum of $30 million available annually to enable VA and DoD to identify and provide incentives to implement creative sharing initiatives at the facility, intra-regional and nationwide levels. Pursuant to 38 U.S.C. § 8111(d), each Secretary is required to contribute a minimum of $15 million from the funds appropriated to that Secretary's Department. The JIF became effective on October 1, 2003. The Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023 (P.L. 117-180 § 103) and amended 38 U.S.C. § 8111(d)(3) extends the program to September 30, 2026. The funds are available until expended.

Administrative Provision

An administrative provision related to the JIF will be included in the VA chapter of the President's Budget Appendix:

> SEC. 222. Of the amounts available in this title for "Medical Services", "Medical Community Care", "Medical Support and Compliance" and "Medical Facilities", a minimum of $15,000,000 shall be transferred to the DoD–VA Health Care Sharing Incentive Fund, as authorized by section 8111(d) of title 38, United States Code, to remain available until expended, for any purpose authorized by section 8111 of title 38, United States Code.

Governance and Accountability

The VA-DoD Joint Executive Committee delegated the implementation of the fund to the Health Executive Committee (HEC). Veterans Health Administration (VHA) administers the fund under the policy guidance and direction of the HEC and executes funding transfers for projects approved by the HEC. The VHA Chief Financial Officer (CFO) provides periodic status reports of the financial balance of the Fund to the Defense Health Agency (DHA) CFO and to the HEC.

2023 Projects

JIF funding is considered to be an initial investment in the project to facilitate the mutually beneficial exchanges of health care resources, with the goal of improving the access to high quality and cost-effective health care provided to beneficiaries of both Departments. JIF funding is designed and programmed to cover the start-up costs during the initial two-year JIF financial support period, after which time sustainment funding will be provided by the designated Department(s) as appropriate. The approval and implementation of the following list of anticipated projects is subject to availability of funds and may execute over multiple years. Additional projects may be selected at a later date.

- ***96th Medical Group Eglin Air Force Base/Gulf Coast Health Care System (HCS) - Primary Care Clinic:*** Utilizing a mobile, modular clinic concept, and in partnership with municipal, DoD/or Veteran Service Organization partners, this initiative proposes to establish a primary presence in the Crestview, Florida community capable of meeting the urgent care needs of the active duty and beneficiary population as well as much-needed Veteran-centric primary care to Veterans. With this clinic both VA and DoD beneficiaries will receive screening that are not provided at traditional community care and urgent care clinics. The additional screenings will include suicide risk, traumatic brain injury, military sexual trauma and posttraumatic stress disorder. The providers in the newly established clinic will enhance medication management for patients and will be pivotal in monitoring the use of certain medications, such as opioids, that tend to be more readily prescribed by community providers. Beyond primary care, the clinic design will allow for expansion of services via a shared rotational exam room with telehealth capability, which can provide services such as pharmaceutical and dietary consultation, foundational behavioral health care and other medical specialties identified as a community need by the primary care teams. **Funding: $2 million**

- ***DoD/VA National - Comprehensive Health and Musculoskeletal (MSK) Prediction, Intervention, and Optimization (CHAMPION):*** The MSK health initiative proposes to conduct the CHAMPION project to achieve an integrative, holistic framework for MSK prevention, treatment and rehabilitation. This operational data-sharing collaboration between the DoD and VA would allow for building MSK and chronic pain risk predictive algorithms, tracking of high-risk Service members and developing targeted prevention and treatment programs that are essential for reducing the burden of MSK injuries and chronic conditions on active-duty Service members (ADSM) and Veterans. The collaboration will build on the substantive body of peer-reviewed research and predictive modeling-based programs already developed by members of this project team. **Funding: $4 million**

- ***DoD/VA National - Federal Electronic Health Record* (*FEHR) Medication Process Program:*** As a proof of concept, this project proposes to establish a pilot Joint FEHR Medication Process Management Program Office consisting of a total of 11 full time employee (FTE) equivalents, six (6) FTE for DoD Pharmacy Informatics and five (5) FTE for VA Pharmacy Benefits Management. The Office would resource staff and provide training for a Joint Pharmacy Informatics Team that will perform system updates, manage subject matter expert issue resolution, connect policy development and enterprise change management and govern business rules. This proposal aligns with the 2019-21 Joint Strategic Plan to improve information technology interoperability and capability and to increase the Federal resource coordination. **Funding: $6.5 million**

- ***DoD/VA National - Health Care Cost Compare Dashboard:*** This initiative proposes to produce a publicly available DoD/VA cost compare dashboard of all inpatient and outpatient care provided in DoD Military Treatment Facilities and VA Medical Centers (VAMC) and Community Based Outpatient Clinics using DoD and VA databases from 2016 to present. For inpatient care, five categories of hospitalization care or service lines will be used, as established by the Agency for Health Care Research and Quality Health Care Cost and Utilization Project as well as methods established and validated by the VA Health Economics Resource Center (HERC) for outpatient care. These five categories for hospitalization include trauma, mental health/substance use, medical, surgical and maternal. For outpatient care, a DoD/VA clinic crosswalk consistent with VA HERC categories will be created. In addition, opioid-related and COVID-19-related care will be examined. The dashboard to the public facing VA HERC website will allow for a simple and powerful visualization of cost of care between DoD and VA to identify potential cost-efficiencies in either system to provide more cost-effective care to active-duty military and Veterans within these two Federal systems. **Funding: $1.4 million**

- ***DoD/VA National - Patient Safety Incident Reporting:*** The primary goals of this JIF project are to improve patient safety by patient harm events by 5% in 2025, 10% in 2026 and in following years, sustain progress toward zero preventable harm. The innovative objectives to reduce patient harm include, but are not limited to, improving organizational transparency and safety culture with increased reporting and learning from near miss/close call events; the employment of integrated data sets to enable proactive risk assessment and improvement strategies, through interagency collaboration, to advance highly reliable care processes and the implementation and standardization of Comprehensive Systematic

Analysis capability to capture critical information effectively using a systems approach with human factors engineering methods and apply high reliability organization concepts to eliminate system vulnerabilities. **Funding: $7.2 million**

- ***Fort Belvoir Community Hospital/Washington VAMC - Joint Imaging Collaborative:*** This proposal will establish the first joint VA/DoD Magnetic Resonance Imaging and Breast Imaging collaboration between the National Capital Region (NCR) Market and Veterans Integrated Service Network 5 Capitol Health Care Network. The NCR Market has one of the largest concentrations of ADSM in the nation and Washington, DC VAMC has a substantial VA population. Female Veterans have comprised an increasing proportion of the number of Veterans nationwide. Female Veterans currently comprise 18% of the total Veteran population and there are more than 21,000 female Veterans enrolled at the Washington, DC VAMC; this is the second highest number of female Veterans by catchment area in the United States, and those numbers are expected to increase. **Funding: $5.1 million**

- ***Naval Hospital Charleston/Navy Medicine Readiness and Training Command Beaufort (NHB)/Ralph H. Johnson (RHJ) VA HCS - Cardiology Service:*** The intent of this initiative is to create a Joint Cardiovascular Clinic (JCC) between RHJ VA HCS, in Charleston, South Carolina, and NHB, in Beaufort, South Carolina. This JCC will improve quality of available Cardiovascular Care for more than 80,000 VA Beneficiaries and 12,000 NHB Beneficiaries. RHJ VA HCS is referring approximately 250 beneficiaries to civilian care each year at an estimated cost of $2,107.45 per beneficiary and this does not represent potential captures from the Savannah, Georgia area. This JCC is expected to improve RHJ VA HCS beneficiaries access to cardiology specialty care and to recapture approximately $590,000 per year of network purchased care. To meet American Heart Association and American College of Cardiology criteria, RHJ VA HCS and NHB require three staff positions for this JCC. **Funding: $801,000**

<u>Examples of successful JIF projects</u>

- ***DoD/VA National - Individual Longitudinal Exposure Record (ILER):*** The development of the ILER is a joint enterprise initiative between the DoD and VA to create a complete record of every Service member's environmental exposures over the course of their career. It profoundly changes the way DoD and the VA provide exposure-related medical care and process exposure-related claims and benefits. The ILER will be central to the documentation and tracking of exposures and providing an improved basis for delivering DoD and VA exposure-related health care, medical surveillance, research and development and disability benefits. **Funding: $16.8 million from 2013–22**

- ***Uniformed Services University of the Health Sciences/Miami VA HCS - Mobile Device Rehabilitation:*** In 2014, the Mobile Device Outcomes-based Rehabilitation Program introduced a home-based system of care designed to provide Service members and Veterans with limb loss a more comprehensive level of care. It called for the purchase of Rehabilitative Lower-limb Orthopedic Accommodating-feedback Devices, which use a system of electronic sensors, validated outcome measures, targeted exercises and a

feedback system that enables the patient to exercise at home and receive corrective feedback while the therapist monitors their progress from the clinic. This effort assists those with lower limb amputation(s) in the return to their everyday activities while reducing the risk of secondary co-morbidities related to limb loss that would limit activity. **Funding: $8.5 million from 2014 – 2023**

- ***DoD/VA National – Three-Dimensional (3D) Printing*:** The project will unify existing field-level DoD and VA 3D printing efforts into a scalable DoD/VA 3D Printing Consortium. It will allow rapid sharing of best practices and organizational knowledge across field sites which will increase the number of patients who receive 3D printing health care solutions. It will also provide for the adoption of a unified, Inter-Government 3D printing quality system that meets industry standards, enabling both agencies to build the infrastructure needed to maximize utilization of resources and return on investment. **Funding: $8.9 million from 2019 – 2023**

VA-DoD Health Care Sharing Incentive Fund Crosswalk

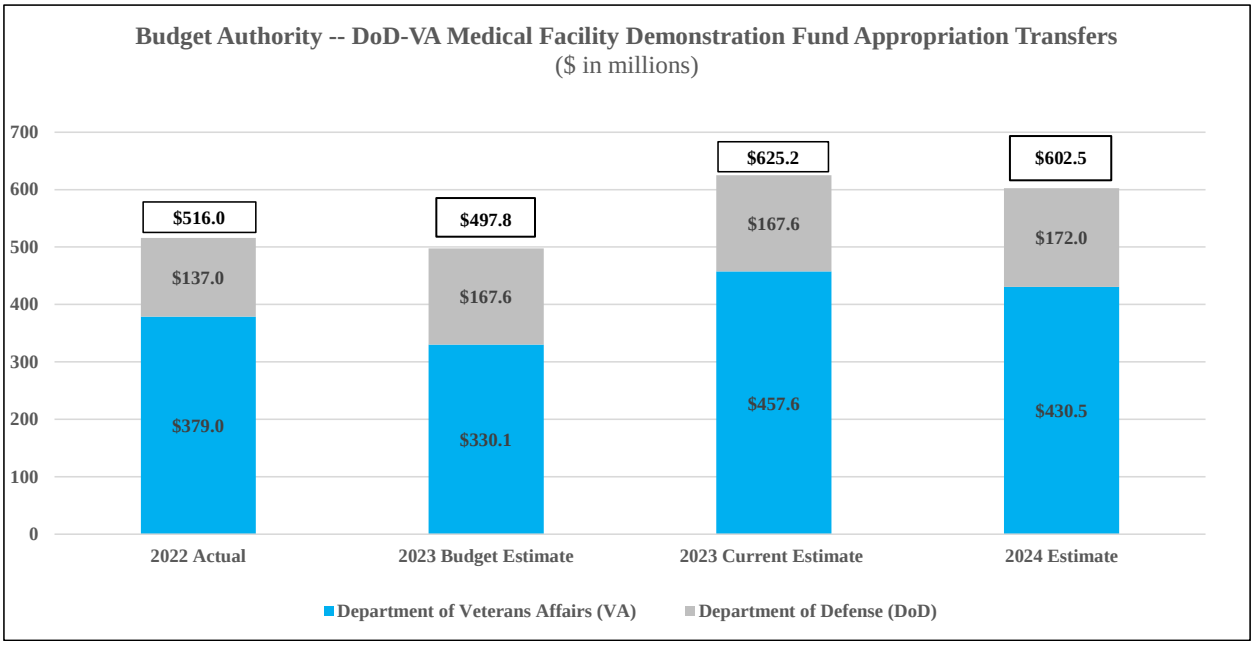
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Estimate	2023-2024 Increase/ Decrease
Transfer from Medical Services	$15,000	$15,000	$15,000	$15,000	$0
Transfer from DoD	$15,000	$15,000	$15,000	$15,000	$0
Transfers Total	$30,000	$30,000	$30,000	$30,000	$0
Total Budget Authority	$30,000	$30,000	$30,000	$30,000	$0
Adjustments to Obligations:					
No-Year Unobligated Balance (SOY)	$88,770	$94,959	$98,924	$103,582	$4,658
No-Year Unobligated Balance (EOY)	($98,924)	($101,148)	($103,582)	($108,240)	($4,658)
Recovery Prior Year Obligations	$1,414	$0	$0	$0	$0
Obligations	$21,261	$23,811	$25,342	$25,342	$0
FTE:					
VA Civilian*	31	29	34	34	0
DoD Personnel**	55	68	63	55	(8)
Total FTE	86	97	97	89	(8)

*Data source: VA Financial Management System. VA assumes a steady-state number of FTE through the budget years.

**Data source: DHA. The counts reflect all FTE working on active JIF projects across the country.

Joint DoD-VA Medical Facility Demonstration Fund For Captain James A. Lovell Federal Health Care Center, Illinois



Financial Highlights

(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate 1,8/	2024 Estimate 1/	2023-2024 Increase/ Decrease
Appropriation, Transfers From:					
Medical Services	$203,805	$190,377	$233,005	$263,141	$30,136
Medical Community Care	$43,768	$50,768	$67,500	$70,000	$2,500
Medical Support & Compliance	$30,613	$30,613	$32,144	$33,751	$1,607
Medical Facilities	$92,830	$50,297	$116,881	$55,452	($61,429)
VA Information Technology	$7,993	$8,085	$8,085	$8,188	$103
Subtotal, VA Contribution	$379,009	$330,140	$457,615	$430,532	($27,083)
Department of Defense (DoD) 2/	$137,000	$167,610	$167,610	$172,000	$4,390
Total Appropriations 3/	$516,009	$497,750	$625,225	$602,532	($22,693)
Collections 4/	$16,322	$15,598	$18,257	$20,444	$2,187
Reimbursements 5/	$9,951	$13,300	$13,300	$10,000	($3,300)
Unob. Bal. (SOY)	$213	$0	$566	$0	($566)
Unob. Bal. (EOY)	($566)	$0	$0	$0	$0
Recovery Prior Year Obligations	$10	$0	$0	$0	$0
Lapse	($17)	$0	$0	$0	$0
Obligations	$541,922	$526,648	$657,348	$632,976	($24,372)
Other DoD Contributions:					
MERHCF DoD reimbursement (Included Above)	*$7,740*	*$6,479*	*$6,479*	*$6,479*	$0
DoD "Stay Navy" (Excluded from Total Obligations) 6/	*$13,706*	*$4,100*	*$13,706*	*$1,706*	($12,000)
FTE:					
Civilian	2,285	2,324	2,440	2,490	50
DoD Uniformed Military 7/	832	776	826	826	0
Total FTE	3,117	3,100	3,266	3,316	50

1/ 2023-24 estimates are based upon the best available information at the time of the development of the budget. These estimates are subject to revision as operational estimates are refined for the Captain James A. Lovell Federal Health Care Center (JALFHCC). These estimates are in compliance with P.L. 111-84 which established this fund. P.L. 114-223 authorizes contributions from Medical Community Care beginning in 2017.

2/ The actual amount of the Medicare-Eligible Retiree Health Care Fund (MERHCF) reimbursement will impact Department of Defense (DoD) transfer amount.

3/ Total excludes Stay Navy contribution and MERHCF reimbursement.

4/ Reflects estimated medical care collections, as provided by the Department of Veterans Affairs (VA) Office of Integrated Veteran Care.

5/ Reflects estimated MERHCF reimbursement from DoD.

6/ Non-add for Personal Services Contract funded by DoD for the East Campus.

7/ 2023-24 Estimates are from the 2022 Navy Manning Plan. Estimates do not reflect the number of DoD Uniform Military full-time employee equivalents subject to reconciliation in the JALFHCC joint areas.

8/ The 2023 current estimate differs from the 2023 President's Budget Request, Volume II, VHA 549-554, as described in the text of the funding highlights section later in this chapter.

Funding Highlights

VA is requesting an increase of transfer authority above the 2023 Appropriations Act (P.L. 117-328) to allow VA to transfer up to $457.615 million, plus reimbursements, from the "Medical Services", "Medical Community Care", "Medical Support and Compliance", "Medical Facilities", "Construction, Minor Projects" and "Information Technology" accounts (from amounts appropriated for 2023) to the Joint DoD – VA Medical Facility Demonstration Fund (JMFDF) which supports operations at the integrated JALFHCC. This is an increase of $127.475 million above the amount requested in the 2023 President's Budget Request, Volume II, VHA 549-554, and is necessary to ensure the JALFHCC has sufficient funding in 2023. Factors impacting the increase in projected costs for 2023 include: pay inflation, Electronic Health Record Modernization (EHRM) rollout and community care access patterns.

The estimated transfers from VA and DoD in 2024 fund the projected financial needs for the JALFHCC, as determined by a health care workload analysis and an assessment of the Non-Recurring Maintenance (NRM) requirements for EHRM, Medical Community Care costs and salary rate increases. In 2024, the facility anticipates executing additional NRM projects to support EHRM. VA will work to achieve the right balance between care provided in the community and care provided through VA throughout the VA health care system, including at JALFHCC.

Program Description

On May 27, 2005, the VA - DoD Health Executive Council signed an agreement to integrate the North Chicago VA Medical Center (NCVAMC) and the Navy Health Clinic Great Lakes (NHCGL). This landmark agreement created an organization composed of all the medical and dental components on both VA and Department of Navy property under the leadership of a VA Senior Executive Service, Medical Center Director and a Navy Captain, Deputy Director. The leadership functions in concert with an Interagency Advisory Board and a local Stakeholder Advisory Board. To support the integration of NHCGL and NCVAMC, a $118 million DoD construction project was awarded to construct a new Federal ambulatory care clinic and parking facilities co-located with NCVAMC. The project was completed on September 27, 2010, and the first multiple specialty clinic opened on December 20, 2010. The approved Governance Model, with VA as the Lead Partner, relies on an extensive Resource Sharing Agreement (RSA) between the current NCVAMC and NHCGL. This RSA ensures strict adherence to 38 U.S.C. requirement that one entity may not endanger the mission of the other entity engaged in an RSA.

The integrated organization – JALFHCC – is comprised of two campuses, West and East Campuses. The West Campus has 48 buildings on 94 acres of land between Green Bay Road and Buckley Road in North Chicago, Illinois. The East Campus has four medical facilities on Naval Station Great Lakes, Illinois. There are two Community Based Outpatient Clinics in Evanston, Illinois and McHenry, Illinois and one in Kenosha, Wisconsin. The JALFHCC has 339 available beds and treated 808,718 outpatient encounters and 4,018 inpatient admissions in 2022.

The JALFHCC began using a single unified budget in 2011 to operate the integrated facility and execute funding using the VA Financial Management System. An account under the VA JMFDF was effective beginning in fourth quarter 2011.

VA and DoD determine the JALFHCC expenses that can be attributed to VA and DoD, based on cost, workload and the consumption of resources by each Department's beneficiaries. This reconciliation model is used as the basis for preparing future budgets. The reconciliation methodology uses agreed-upon full costing methods and execution data to determine the costs attributable to each Department. The reconciliation methodology uses industry standard measurements such as Relative Value Units and Relative Weighted Products for the determinations of workload values to be compared to VA's Decision Support System full costs. Both Departments will continue to work together to improve upon an equitable reconciliation process and ensure respective Department financial controls are implemented.

The authorities to use JMFDF shall terminate on September 30, 2024.

Administrative Provisions

VA is proposing continuing the following administrative provisions in accordance with National Defense Authorization Act (NDAA) of 2010 (P.L. 111-84), for 2024, as included in the President's Budget:

> SEC. 219. Of the amounts appropriated to the Department of Veterans Affairs for fiscal year 2024 for "Medical Services", "Medical Community Care", "Medical Support and Compliance", "Medical Facilities", "Construction, Minor Projects", and "Information Technology Systems", up to $430,532,000, plus reimbursements, may be transferred to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2571) and may be used for operation of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500): Provided, That additional funds may be transferred from accounts designated in this section to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund upon written notification by the Secretary of Veterans Affairs to the Committees on Appropriations of both Houses of Congress: Provided further, That section 220 of title II of division J of Public Law 117-328 is repealed.
>
> SEC. 220. Of the amounts appropriated to the Department of Veterans Affairs which become available on October 1, 2024, for "Medical Services", "Medical Community Care", "Medical Support and Compliance", and "Medical Facilities", up to $456,547,000, plus reimbursements, may be transferred to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2571) and may be used for operation of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500): Provided, That additional funds may be transferred from accounts designated in this section to the

Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund upon written notification by the Secretary of Veterans Affairs to the Committees on Appropriations of both Houses of Congress.

SEC. 221. Such sums as may be deposited to the Medical Care Collections Fund pursuant to section 1729A of title 38, United States Code, for healthcare provided at facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500) shall also be available: (1) for transfer to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund, established by section 1704 of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2571); and (2) for operations of the facilities designated as combined Federal medical facilities as described by section 706 of the Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (Public Law 110–417; 122 Stat. 4500): Provided, That, notwithstanding section 1704(b)(3) of the National Defense Authorization Act for Fiscal Year 2010 (Public Law 111–84; 123 Stat. 2573), amounts transferred to the Joint Department of Defense—Department of Veterans Affairs Medical Facility Demonstration Fund shall remain available until expended.

Also, in accordance with NDAA 2010 (P.L. 111-84), DoD is proposing the following general provision, for 2024, as included in the President's Budget:

Section 8048. From within the funds appropriated for operation and maintenance for the Defense Health Program in this Act, up to $172,000,000 shall be available for transfer to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund in accordance with the provisions of section 1704 of the National Defense Authorization Act for Fiscal Year 2010, Public Law 111-84: Provided, That for purposes of section 1704(b), the facility operations funded are operations of the integrated Captain James A. Lovell Federal Health Care Center, consisting of the North Chicago Veterans Affairs Medical Center, the Navy Ambulatory Care Center, and supporting facilities designated as a combined Federal medical facility as described by section 706 of Public Law 110-417: Provided further, That additional funds may be transferred from funds appropriated for operation and maintenance for the Defense Health Program to the Joint Department of Defense-Department of Veterans Affairs Medical Facility Demonstration Fund upon written notification by the Secretary of Defense to the Committees on Appropriations of the House of Representatives and the Senate.

Justification for VA Administrative Provisions

The first VA provision (Section 219) is required to permit the transfer of funds from specific VA appropriations to JMFDF, which was established by P.L. 111-84 § 1704. P.L. 111-84 § 1704(a)(2)(A) and (B) specify that JMFDF will consist of amounts transferred from amounts authorized and appropriated for the DoD and VA specifically for the purpose of providing resources for JMFDF. The second provision (Section 220) permits the transfer of funds for 2024.

The second provision (Section 220) in the 2024 budget includes the funding requested to be appropriated and transferred to JMFDF within the advance appropriations request for Medical Services, Medical Support and Compliance, Medical Facilities and Medical Community Care.

The third provision (Section 221) authorizes the transfer of funds from Medical Care Collections to JMFDF. P.L. 111-84 § 1704 allows VA and DoD to deposit medical care collections to JMFDF. P.L. 111-84 § 1704(b)(2) specifies that the availability of funds transferred to JMFDF under subsection (a)(2)(C) shall be subject to the provisions of U.S.C. 38 § 1729A. U.S.C. 38 § 1729A(e) requires that: (e) amounts recovered or collected under the provisions of law referred to in subsection (b) shall be treated for the purposes of sections 251 and 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. § 901-902) as offsets to discretionary appropriations to the extent that such amounts are made available for expenditure in appropriations acts for the purposes specified in subsection (c).

Health Care Sharing and VA/DoD Sharing

Health Care Sharing

The Department of Veterans Affairs (VA) procures medical services to strengthen the medical programs at VA medical centers (VAMC) and to improve the quality of health care provided to Veterans under 38 U.S.C. 38 U.S.C. § 8153 authorizes contracting officers to sole source directly to educational institutions when that institution is affiliated with a VA Residency Program and the "health-care resource required is a commercial service, the use of medical equipment or space, or research." As a result, VA purchases medical care services from its academic affiliates, and the obligations associated with this activity are reported on the line, "Services Purchased by VA." The bulk of these contracts are for providing locum tenens physicians and so forth, to fill in gaps when there are no VA physicians available or the internal VA workload is heavy. Services procured through this program are generally performed by academic affiliate providers at VAMCs. The VA statute also enables the opportunity for VA to collect reimbursements by providing medical care services, equipment or space to its academic affiliate partners. The obligations associated with this activity are reported on the line, "Services Provided by VA."

This authority is a critical component of VA's education and training mission. As one of four statutory missions, VA conducts an Education and Training Program for health profession students and residents to enhance the quality of care provided to Veteran patients within the Veterans Health Administration (VHA) health care system.

Although VA relies on several 38 U.S.C. authorities for procuring services outside VA, the following information discusses activities conducted by VA's Office of Acquisition Logistics and Construction and VHA Office of Procurement and Logistics pursuant to 38 U.S.C. § 8153 for activity from 2022.

Health Care Sharing Obligations and Reimbursements

(dollars in thousands)

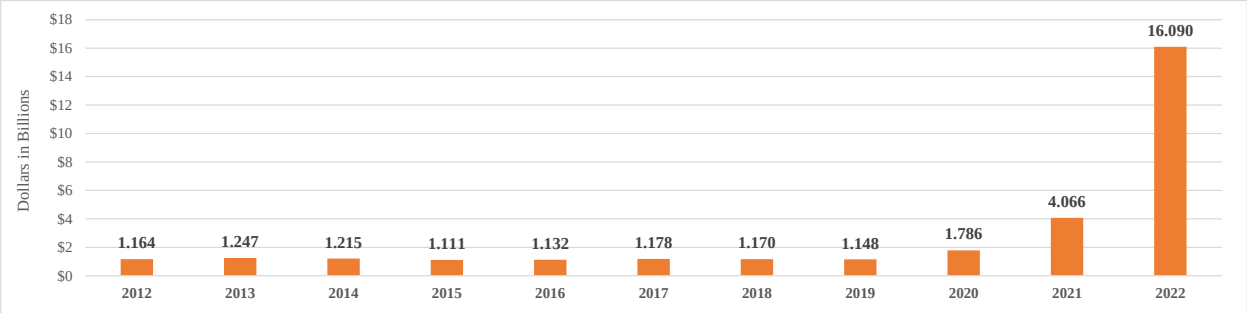
Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Advance Approp.	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
Services Purchased by VA:								
Medical Service (0160) VHA Contracting Obligations	$764,489	$832,798	$779,779	$832,798	**$779,779**	**$779,779**	$0	$0
Medical Service (0160) National Contracting Obligations /1	$15,263,105	$3,146,585	$15,568,367	$3,146,585	**$15,568,367**	**$15,568,367**	$0	$0
Medical Service (0160) Obligations Total	$16,027,594	$3,979,383	$16,348,146	$3,979,383	**$16,348,146**	**$16,348,146**	$0	$0
Services Provided by VA:								
Medical Service (0160) Reimbursements /2	$62,824	$44,599	$63,453	$43,599	**$64,453**	**$65,453**	$1,000	$1,000
Medical Service (0160) Obligations and Reimbursements Total	$16,090,418	$4,023,982	$16,411,599	$4,022,982	**$16,412,599**	**$16,413,599**	$1,000	$1,000

1/ Includes Department-wide national contracting data. A new approach has been used to assess and finalize the end of year data, which enables a more accurate and comprehensive reporting of community care expenditures.
2/ Estimated reimbursements are based on historical execution of reimbursement amounts.

The total amount of health care resource sharing for 2022 was approximately $16.1 billion. This represents procurements of approximately $16.0 billion and reimbursements totaling approximately $62.8 million.

Chart 1 presents the growth of the Health Care Resource Sharing Program since 2012. The bars represent the total health care resource services procured and revenue generated by VA contracting officers during a year.

Chart 1. Health Care Resources Sharing Program



Source: VA, Annual Report on Sharing of Health Care Resources, 2022.

VA Health Care Facilities and Sharing

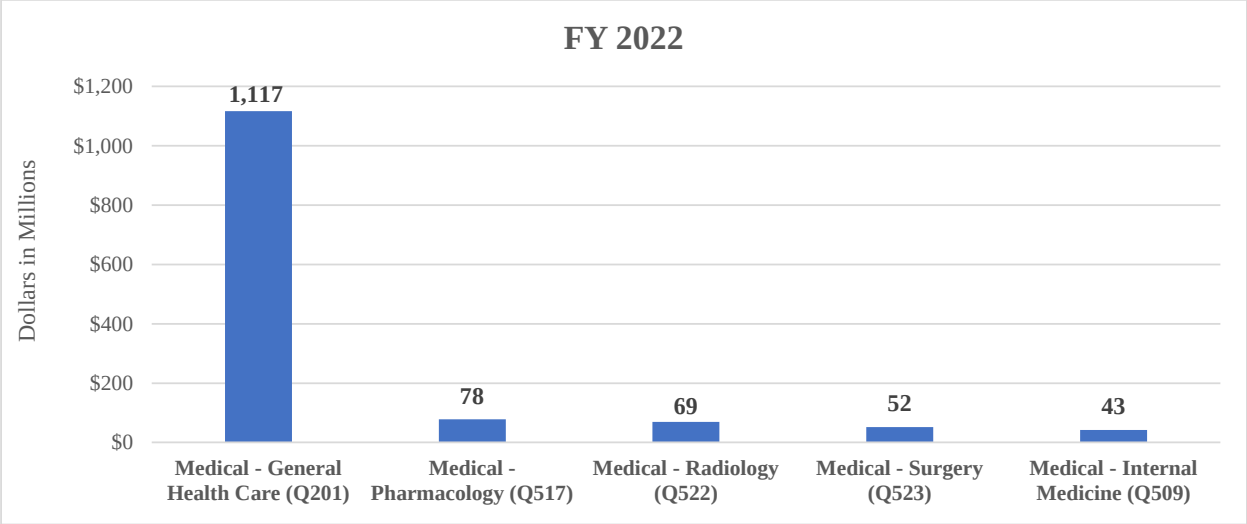
Traditionally, large VAMCs are more likely to have more extensive sharing arrangements. The referral system of medical practices enhances the size of these sharing programs as patients flow from smaller hospitals and clinics to tertiary care centers. The diversity of sharing arrangements is also influenced by the specialized capability of larger academic medical centers to manage difficult medical care problems. VAMCs in small metropolitan areas rely heavily on sharing agreements to provide health care resources not available at the VA facility.

Procurements

The procurements are primarily in the following areas: general health care, pharmacology, radiology, surgery and internal medicine. Patients from small hospitals in need of specialty services, such as open-heart surgery, are often referred to large affiliated medical centers under this sharing authority.

Chart 2 presents the categories of services purchased by VA with the highest total obligation levels in 2022. These categories account for $1.4 billion of total VA purchases of $16.1 billion in obligations that year.

Chart 2. Common Health Care Resources Procured



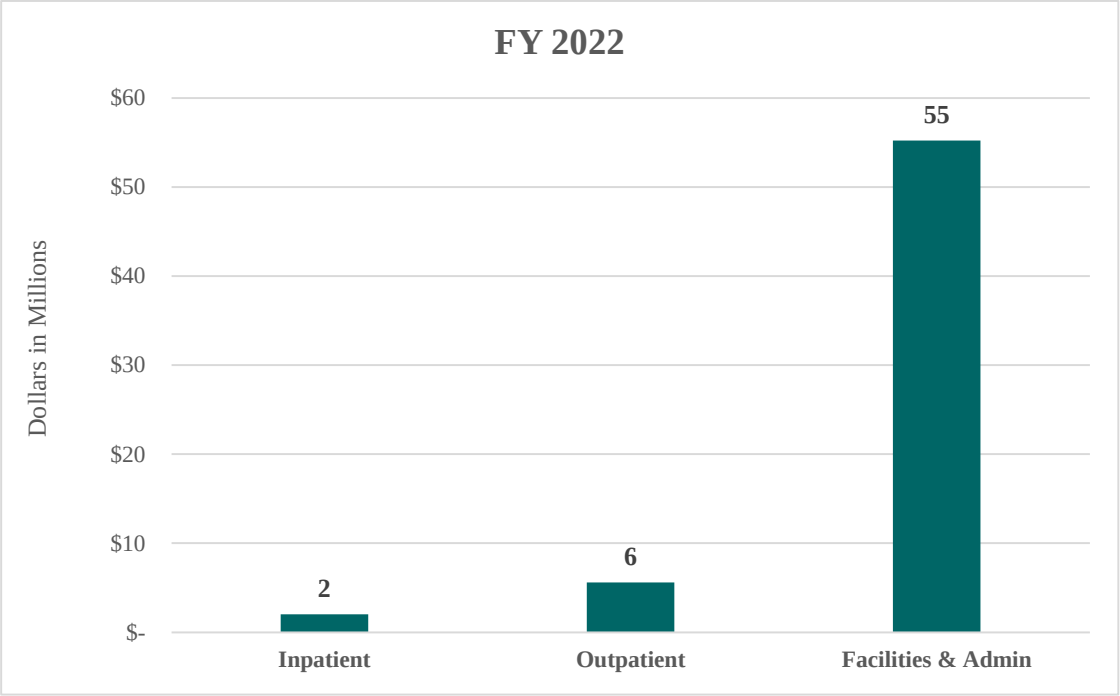
Source: VA, Annual Report on Sharing of Health Care Resources, 2022.

Reimbursements

VA provides a limited number of resources, including unused medical space, to affiliated medical colleges, community hospitals and other sharing partners such as State Veterans Homes. VAMCs that have particular resources not fully utilized for the care of Veterans may share these resources with other community entities. Such resources are more cost effective when shared. The reimbursements received from these sharing agreements are retained by the VAMC and are used to enhance services and support.

Chart 3 presents total reimbursements in 2022 from affiliated medical colleges, community hospitals and other sharing partners.

Chart 3. Reimbursements from Health Care Resource Sharing



VA / Department of Defense (DoD) Sharing

Title 38 U.S.C. § 8111 authorizes VA and DoD to enter into sharing agreements for the mutually beneficial coordination, use or exchange of health care resources, with the goal of improving access, quality and cost effectiveness of health care services provided by VA and the Military Health System to the beneficiaries of both Departments.

VA / DoD Sharing Obligations and Reimbursements

(dollars in thousands)

Description	2022 Actual 1/	2023 Budget Estimate	2023 Current Estimate	2024 Advance Approp.	**2024 Revised Request**	**2025 Advance Approp.**	+/- 2023-2024	+/- 2024-2025
DoD-Provided Services Purchased by VA								
Medical Community Care (0140) Obligations	$112,843	$107,131	$116,228	$114,630	**$119,715**	**$123,306**	$3,487	$3,591
VA-Provided Services Purchased by DoD								
Medical Services (0160) Reimbursements	$78,438	$70,899	$80,791	$69,481	**$83,214**	**$85,711**	$2,424	$2,496

1/ Itemized detail of DoD-Provided Services Purchased by VA in 2022 is as follows:

Obligations	
(8321) Army	$40,446
(8322) Air Force	$55,094
(8323) Navy	$17,261
(8324) Defense Health Agency	$42
Obligations Total	$112,843

1/ Itemized detail of VA-Provided Services Purchased by DoD in 2022 is as follows:

Reimbursements	
DoD Sharing - All Other	$21,307
DoD Sharing - Inpatient	$31
DoD Sharing - Outpatient	$285
CHAMPUS - Inpatient	$0
CHAMPUS - Outpatient	$0
CHAMPUS - All Other	$39
TRICARE - Inpatient	$5,187
TRICARE - Outpatient	$9,138
TRICARE - All Other	$731
TRICARE - Pharmacy	$0
TRICARE - Active Duty Dental	$0
DoD Disability Evaluation - IDES	$74
DoD Spinal Cord Injury - Inpatient	$3,048
DoD Spinal Cord Injury - Outpatient	$28
DoD Spinal Cord Injury - Other	$1,694
DoD Brain Injury - Inpatient	$33,078
DoD Brain Injury - Outpatient	$198
DoD Brain Injury - Other	$3,433
DoD Blind Rehab - Inpatient	$69
DoD Blind Rehab - Outpatient	$2
DoD Blind Rehab - Other	$95
Reimbursements Total	$78,438

The tables that follow represent 162 active sharing agreements[77] with 2,072 services offered between 74 VA and 85 DoD facilities nationwide in 2022, an 87% increase in the number of services offered in agreements since 2021.[78]

[77] Excluding the Health Care Sharing Fund and the Joint DoD-VA Medical Facility Demonstration Fund.

[78] The VA / DoD Sharing Program has been systematically engaged in assessing and improving the quality of fiscal data in preparation for the US Treasury mandated implementation of G-Invoicing, as well as in VA's transitions to the new Integrated Financial and Asset Management System and Electronic Health Record. In addition, VA is in the process of standardizing several VA / DoD resource sharing and fiscal processes to improve data capture and reliability. This has resulted in a more comprehensive capture of data on shared health care resources between VA and DoD. VA will continue to monitor the factors affecting the quality of data and expects to see fluctuation over the next several years.

2022 VA / DoD Health Care Resource Sharing Summary

VISN	SHARED SERVICE TYPE	PROVIDER	# of Services Offered
0 (VACO)	Administration & Support	DoD/VA	1
	Ancillary Services	DoD	1
0 (VACO) Total			**2**
1	Competency / Readiness Training	VA	1
1 Total			**1**
2	Administration & Support	DoD	1
		VA	1
	Ambulatory Care Services	DoD	10
		VA	1
	Ancillary Services	DoD	3
		VA	3
	Competency / Readiness Training	DoD/VA	1
	Inpatient Services	DoD	2
2 Total			**22**
4	Ambulatory Care Services	DoD	57
	Ancillary Services	DoD	8
	Competency / Readiness Training	DoD/VA	1
		VA	3
	Inpatient Services	DoD	40
4 Total			**109**
5	Administration & Support	DoD	15
		DoD/VA	2
	Ambulatory Care Services	DoD	9
		DoD/VA	47
		VA	1
	Ancillary Services	DoD	3
		DoD/VA	6
	Competency / Readiness Training	VA	1
	Dental Services	VA	1
	Inpatient Services	DoD	2
		DoD/VA	27
	Other & Military Unique	DoD	1
5 Total			**115**

VISN	SHARED SERVICE TYPE	PROVIDER	# of Services Offered
6	Administration & Support	DoD	5
		DoD/VA	1
	Ambulatory Care Services	DoD	136
		DoD/VA	3
	Ancillary Services	DoD	50
	Competency / Readiness Training	DoD/VA	1
		VA	1
	Dental Services	DoD	7
		VA	1
	Inpatient Services	DoD	112
		DoD/VA	2
		VA	2
	Other & Military Unique	DoD	1
6 Total			**322**
7	Administration & Support	DoD	20
		DoD/VA	2
		VA	2
	Ambulatory Care Services	DoD	105
		DoD/VA	5
		VA	8
	Ancillary Services	DoD	33
		DoD/VA	2
		VA	5
	Competency / Readiness Training	DoD/VA	2
		VA	3
	Dental Services	DoD	4
	Inpatient Services	DoD	83
		DoD/VA	1
		VA	2
	Other & Military Unique	DoD	2
7 Total			**279**
8	Administration & Support	DoD	8
		VA	2
	Ambulatory Care Services	DoD	73
		VA	4
	Ancillary Services	DoD	21
	Competency / Readiness Training	VA	4
	Dental Services	DoD	3
	Inpatient Services	DoD	48
8 Total			**163**

VISN	SHARED SERVICE TYPE	PROVIDER	# of Services Offered
9	Administration & Support	DoD	5
	Ambulatory Care Services	DoD/VA	4
		VA	1
	Ancillary Services	DoD	1
		DoD/VA	3
	Inpatient Services	DoD/VA	1
9 Total			**15**
10	Administration & Support	DoD	5
	Ambulatory Care Services	DoD	10
		VA	1
	Ancillary Services	DoD	3
	Competency / Readiness Training	DoD/VA	3
		VA	3
	Inpatient Services	DoD	58
	Other & Military Unique	VA	1
10 Total			**84**
12	Ambulatory Care Services	VA	1
	Ancillary Services	VA	1
12 Total			**2**
15	Administration & Support	DoD	2
		VA	1
	Ambulatory Care Services	DoD	24
		VA	79
	Ancillary Services	DoD	8
		VA	21
	Competency / Readiness Training	VA	1
	Dental Services	VA	5
	Inpatient Services	DoD	24
		VA	53
	Other & Military Unique	VA	1
15 Total			**219**
16	Administration & Support	DoD	1
		DoD/VA	1
		VA	10
	Ambulatory Care Services	DoD	56
		DoD/VA	1
		VA	6
	Ancillary Services	DoD	13
		VA	1
	Competency / Readiness Training	DoD/VA	1
		VA	4
	Dental Services	DoD	2
	Inpatient Services	DoD	14
	Other & Military Unique	DoD/VA	1
16 Total			**111**

VISN	SHARED SERVICE TYPE	PROVIDER	# of Services Offered
17	Administration & Support	DoD	2
		VA	1
	Ambulatory Care Services	DoD	75
		VA	1
	Ancillary Services	DoD	24
		VA	1
	Competency / Readiness Training	DoD/VA	5
		VA	1
	Dental Services	DoD	5
	Inpatient Services	DoD	55
	Other & Military Unique	DoD	2
17 Total			**172**
19	Administration & Support	DoD	1
		VA	5
	Ambulatory Care Services	DoD	3
		DoD/VA	6
		VA	6
	Ancillary Services	DoD	9
		DoD/VA	1
	Competency / Readiness Training	DoD/VA	3
		VA	1
	Inpatient Services	DoD	2
		DoD/VA	2
19 Total			**39**
20	Administration & Support	DoD	9
		DoD/VA	1
		VA	5
	Ambulatory Care Services	DoD	93
		DoD/VA	4
		VA	3
	Ancillary Services	DoD	34
		DoD/VA	1
		VA	1
	Competency / Readiness Training	DoD/VA	1
		VA	3
	Dental Services	DoD	7
	Inpatient Services	DoD	69
		DoD/VA	2
		VA	2
	Other & Military Unique	DoD/VA	1
20 Total			**236**

VISN	SHARED SERVICE TYPE	PROVIDER	# of Services Offered
21	Administration & Support	DoD	3
		DoD/VA	1
		VA	8
	Ambulatory Care Services	DoD	37
		DoD/VA	2
		VA	13
	Ancillary Services	DoD	8
		VA	8
	Competency / Readiness Training	DoD/VA	1
		VA	4
	Dental Services	DoD	2
	Inpatient Services	DoD	25
		DoD/VA	2
		VA	5
21 Total			**119**
22	Administration & Support	DoD	1
		DoD/VA	4
		VA	15
	Ambulatory Care Services	DoD	2
		VA	3
	Ancillary Services	DoD/VA	2
		VA	4
	Competency / Readiness Training	DoD/VA	3
		VA	4
	Dental Services	DoD/VA	1
	Inpatient Services	DoD	4
		DoD/VA	2
		VA	1
	Other & Military Unique	DoD/VA	3
22 Total			**49**
23	Administration & Support	DoD	1
		VA	1
	Ambulatory Care Services	DoD/VA	1
	Ancillary Services	VA	2
	Competency / Readiness Training	DoD/VA	2
		VA	5
	Inpatient Services	VA	1
23 Total			**13**

Medical and Prosthetic Research

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Medical and Prosthetic Research

Table: Appropriations and Other Federal Resources

(dollars in thousands)

	2022 Actual	2023 Request	2023 Estimate	2024 Request	2024 Req-2023 Est
Medical and Prosthetic Research Appropriation	$882,000	$916,000	$916,000	$938,000	$22,000
American Rescue Plan Appropriation/Reallocation	$30,000	$0	$0	$0	$0
Cost of War Toxic Exposure Fund (P.L. 117-168 & P.L. 117-328)	$0	$0	$2,480	$46,000	$43,520
Intramural Research Total (VA Appropriations)	**$912,000**	**$916,000**	**$918,480**	**$984,000**	**$65,520**
VERA Research Support (Medical Care Support)	$749,700	$778,600	$777,890	$836,400	$58,510
Extramural Funding (Other Federal and Non-Federal Resources)	$527,688	$540,000	$540,000	$540,000	$0
Reimbursement Activity	$48,050	$61,000	$61,000	$61,000	$0
Total Budgetary Resources	**$2,237,438**	**$2,295,600**	**$2,297,370**	**$2,421,400**	**$124,030**
Federal Employment Distribution					
Medical and Prosthetic Research Appropriation	*4,237*	*4,410*	*4,590*	*4,716*	*126*
American Recovery Plan (P.L. 117-2, Section 8002) (Mandatory) [2]	*8*	*113*	*109*	*0*	*-109*
Toxic Exposure Fund (P.L. 117-168)	0	0	11	113	102
Total FTE	**4,245**	**4,523**	**4,710**	**4,829**	**119**

1. Through the Veterans Equitable Resource Allocation (VERA), Research Support includes funding from the Medical Services, Medical Support and Compliance, and Medical Facilities Appropriations to support Research.
2. Includes Direct and Reimbursable FTE.

Medical and Prosthetic Research and Development Appropriation Language

For necessary expenses in carrying out programs of medical and prosthetic research and development as authorized by chapter 73 of title 38, United States Code, [$916,000,000] *$938,000,000*, plus reimbursements, shall remain available until September 30, [2024] *2025*: *Provided*, That the Secretary of Veterans Affairs shall ensure that sufficient amounts appropriated under this heading are available for prosthetic research specifically for female veterans, and for toxic exposure research.

(*Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2023*.)

Medical Research Discretionary and Mandatory Appropriation Requests:

To fulfill the commitment of the Department of Veterans Affairs (VA) to provide superior healthcare to Veterans, the Office of Research and Development (ORD) requests $984 million, an increase of 7% or $66 million above the 2023 enactment, in total appropriated resources to fund the intramural research program.

This amount is comprised of the following:

Discretionary Appropriations: A request of $938 million in the Medical and Prosthetic Research Appropriation, an increase of 2% or $22 million above the 2023 enactment.

Mandatory Appropriations: A request of $46 million from the Cost of War Toxic Exposures Fund (TEF) to support medical and other research relating to exposure to environmental hazards.

Details on VA Research Funding Sources

Efficient and effective VA Research utilizes a combination of VA appropriated resources and other resources to deliver on our promise to improve Veterans' health through medical research. The details below provide further explanation of the funding sources depicted on the previous page:

- **Intramural Research:** ORD utilizes VA appropriations, including Medical and Prosthetics Research and the Toxic Exposures Fund, to support research Merit Awards (studies), Research Career Scientist Awards, Research infrastructure, and overall capacity building for the Research enterprise. The 2024 intramural research estimate is **$984 million**.

- **Veterans Equitable Resource Allocation (VERA), Research Support:** VA Research at VA Medical Centers (VAMCs) is further supported through VERA Research Support Allocations. Funding through the VERA model is distributed through the VA Medical Care Appropriations, including Medical Service, Medical Support & Compliance, and Medical Facilities. The allocation is intended for use by the facilities in support of VAMC-costs associated with research, including protected effort for clinicians to conduct research, research equipment maintenance contracts, biomedical maintenance support, research infrastructure costs (both space and personnel), other general and direct administrative support for committees and other expenses for research compliance and oversight. VERA may also be used to support the Quality Enhancement Research Initiative (QUERI), which is part of the ORD organization, but funded through the Medical Services Appropriation. The 2024 VERA estimate is **$836 million**.

- **Extramural Funding:** VA Researchers also independently can apply and receive extramural funding from private and federal grants. This funding is typically managed at the local level at individual VAMCs, largely through 78 VA Affiliated Non-Profit Research Corporations (NPCs) or a University Affiliate. The 2024 estimate is **$540 million**.

- **Reimbursable Resources:** VA Research also earns collections and reimbursements. This can include Interagency Agreements with other Federal Partners (within VA and outside), reimbursements from the Medical Care Appropriation, and reimbursements from NPCs and University Affiliates. The 2024 Estimate is **$61 million**.

VA Research Background

For more than 95 years, VA Research has been improving the lives of Veterans and all Americans through healthcare discovery and innovation through ORD. VA Research is part of the nation's largest integrated healthcare system and fosters collaboration with university affiliates, other federal agencies, nonprofit organizations, and private industry.

ORD is responsible for the execution of VA's research mission (as authorized by 38 U.S.C § 7303), which includes the following objectives:

- To improve Veterans' health and well-being via basic, translational, clinical health services, and rehabilitation, genomic and data science research, and to apply scientific knowledge to develop effective individualized care solutions for Veterans.
- To attract, train, and retain the highest-caliber investigators, and nurture their development as leaders in their fields.
- To assure a culture of professionalism, collaboration, accountability, and the highest regard for research volunteers' safety and privacy.

VA Research Strategic and Cross-Cutting Clinical Priorities

VA Research leverages the input from various stakeholders to establish our Strategic and Cross Cutting Priorities. Our stakeholders include the Quality Enhancement Research Initiative (QUERI), the National Research Advisory Council (NRAC), Veterans Service Organizations (VSOs), Veterans, Congress, and the Administration.

VA Research's Five Strategic Priorities	Cross Cutting Clinical Priorities
1. Increasing Veterans' access to high-quality clinical trials. 2. Increasing the substantial real-world impact of VA research. 3. Putting VA data to work for Veterans 4. Actively promoting diversity, equity, and inclusion within our sphere of influence. 5. Building community through VA research.	1. Pain and Opioid Use 2. Traumatic brain injury (TBI) 3. Posttraumatic stress disorder (PTSD) 4. Military environmental exposures, including 5. Cancer, with a focus on precision oncology 6. Suicide prevention

Table: Medical Research Resources

Medical Research Resources Summary
(dollars in thousands)

Description	2022 Actual	2023 Request	2023 Estimate	2024 Request	2024 Req-2023 Est Inc/Dec
DISCRETIONARY RESOURCES					
Medical and Prosthetic Research Annual Appropriation	$882,000	$916,000	$916,000	$938,000	$22,000
APPRROPIATION [Subtotal]	$882,000	$916,000	$916,000	$938,000	$22,000
REIMBURSEMENTS	$48,050	$61,000	$61,000	$61,000	$0
BUDGET AUTHORITY	**$882,000**	**$916,000**	**$916,000**	**$938,000**	**$22,000**
UNOBLIGATED BALANCE (SOY)					
No-year	$3,642	$4,500	$4,334	$4,500	$166
2-year	$98,988	$130,000	$96,380	$100,000	$3,620
5-year	$12,500	$6,250	$12,500	$8,000	-$4,500
Unobligated Balance (SOY) [Subtotal]	$115,130	$140,750	$113,214	$112,500	-$714
UNOBLIGATED BALANCE (EOY)					
No-year	-$4,334	-$4,500	-$4,500	-$4,500	$0
2-year (Annual Appropriation)	-$96,380	-$100,000	-$90,000	-$90,000	$0
5-year	-$12,500	$0	$0	$0	$0
Lapse (Two Year)	-$881		$0	$0	$0
Supplemental					
Unobligated Balance (EOY) [Subtotal]	-$114,095	-$104,500	-$94,500	-$94,500	$0
PRIOR YEAR RECOVERIES	$53,138		$50,000	$50,000	$0
OBLIGATIONS	**$984,223**	**$1,013,250**	**$1,045,714**	**$1,067,000**	**$21,286**
Full-Time Equivalents (FTE):					
Direct FTE	4,063	4,272	4,410	4,536	126
Reimbursable FTE	174	138	180	180	0
Total FTE	**4,237**	**4,410**	**4,590**	**4,716**	**126**
MANDATORY RESOURCES					
American Rescue Plan § 8002 (ARP)					
REALLOCATION	$30,000	$0	$0	$0	**$0**
BUDGET AUTHORITY	**$30,000**	**$0**	**$0**	**$0**	**$0**
UNOBLIGATED BALANCE (SOY)					
ARP section 8002 - 3 year	$1,772	$30,000	$30,109	$0	-$30,109
UNOBLIGATED BALANCE (EOY)					
ARP section 8002 - 3 year	-$30,109	$0	$0	$0	$0
PRIOR YEAR RECOVERY	$314	$0	$0	$0	$0
OBLIGATIONS	$1,977	$30,000	$30,109	$0	-$30,109
Total FTE	8	113	109	-	-109
Cost of War Toxic Exposure Fund (TEF)					
TEF (P.L 117-168, Section 806) - 3 year	$0	$0	$650	$0	$0
TEF (P.L 117-328) - 5 year	$0	$0	$1,830	$0	($1,830)
TEF (FY 24 Request)	$0	$0	$0	$46,000	$46,000
APPRROPIATION [Subtotal]	$0	$0	$2,480	$46,000	$43,520
BUDGET AUTHORITY	$0	$0	$2,480	$46,000	$43,520
UNOBLIGATED BALANCE (SOY)	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)	$0	$0	$0	$0	$0
PRIOR YEAR RECOVERY	$0	$0	$0	$0	$0
OBLIGATIONS	$0	$0	$2,480	$46,000	$43,520
Total FTE	0	0	11	113	102

Table: Total Resources Summary

(dollars in thousands)

	2022 Actual	2023 Request	2023 Estimate	2024 Request	2024-2023 Req-Est
APPROPIATIONS/TRANSFERS	**$912,000**	**$916,000**	**$918,480**	**$984,000**	**$65,520**
Medical and Prosthetic Research	$882,000	$916,000	$916,000	$938,000	**$22,000**
American Rescue Plan	$30,000	$0	$0	$0	**$0**
Toxic Exposure Fund	$0	$0	$2,480	$46,000	**$43,520**
REIMBURSMENTS	$48,050	$61,000	$61,000	$61,000	**$0**
BUDGET AUTHORITY	$960,050	$977,000	$979,480	$1,045,000	**$65,520**
UNOBLIGATED BALANCE (SOY)	$116,902	$170,750	$143,323	$112,500	**($30,823)**
UNOBLIGATED BALANCE (EOY)	($144,204)	($104,500)	($94,500)	($94,500)	**$0**
PRIOR YEAR RECOVERIES	$53,452	$0	$50,000	$50,000	**$0**
OBLIGATIONS	**$986,200**	**$1,043,250**	**$1,078,303**	**$1,113,000**	**$34,697**
Total Funding Awards[1]	2,737	2,871	2,871	3,012	**141**
Employment Distribution					
Discretionary FTE[2]	4,237	4,410	4,590	4,716	**126**
Mandatory (ARP, Section 8002)[1]	8	113	109	0	**(109)**
Toxic Exposure Fund (P.L. 117-168)	0		11	113	**102**
Total	**4,245**	**4,523**	**4,710**	**4,829**	**119**

1. For the FY 24 President's Budget, the methodology for reporting projects changed to report the total funding awards which includes Research Merit Awards (studies), Research Career Scientist Awards, infrastructure, and overall capacity building for the Research enterprise.
2. Includes Direct and Reimbursable FTE.

2024 Request Highlights

The 2024 request increases investment in the following high priority areas of Veteran's Health. Here, we present highlights of the areas of increased total investment, inclusive of both the discretionary Medical and Prosthetics Research appropriation and the mandatory Toxic Exposures Fund appropriation, which will be detailed subsequently.

- **Military Environmental Exposures (+$17 million above 2023 estimate, including $15 million increase and $2 million for pay/non-pay inflation):** In 2024, ORD will continue to expand its investment in this important area and to coordinate with environmental exposure focused programs as part of the implementation of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022. Critical components of this effort include building capacity, such as the number of researchers funded to conduct military exposures research and building inter-governmental partnerships. One major step is convening an interagency workgroup, as is called for in Section 501 of the PACT Act, which will serve as a forum for identifying evidence gaps and crafting a strategic plan to address the gaps.

- **Traumatic Brain Injury (TBI)/Brain Health (+$17 million above 2023 estimate, including $15 million increase and $2 million for pay/non-pay inflation):** Increased investment in TBI remains critical as it is the signature injury of post-9/11 Veterans who served in the wars in Iraq and Afghanistan. While acute care of TBI has improved, treatments for the longer-term consequences most relevant to Veterans have proven elusive. This injury can lead to lifelong disabilities that can vary by severity, the characteristics of the event or events that caused the injury (e.g., blast versus blunt force), and the number of incidents of injury.

- **Cancer and Precision Oncology (+$11 million above 2023 estimate, including $10 million increase and $700,000 for pay/non-pay inflation):** VA plays a major role in the President's Cancer Moonshot efforts, and ORD is a central player in these efforts. ORD will continue to invest in cancer and precision oncology research to build a more robust cancer knowledge base that integrates genetic and clinical data to identify better treatments, guide care decisions, and identify opportunities for further investigation. Additionally, ORD will pursue efforts to address rare cancer and rare subtypes of major cancers or those associated with military /toxic exposures as part of our precision oncology efforts and as invoked in the PACT Act.

- **Mental Health, (+$6 million above 2023 estimate, including $5 million increase and $800,000 for pay/non-pay inflation):** This request supports mental health and suicide prevention research, including the Commander John Scott Hannon Mental Health Care Improvement Act (Hannon Act). This effort also includes clinical trials and epidemiological studies on risk and prevention factors, as well as biomarker-driven precision mental health projects done in collaboration with VHA's Office of Mental Health and Suicide Prevention (OMHSP).

Table: Net Change and 2024 Summary of Resource Requirements

(dollars in thousands)		
2023 Enactment	*$*	*916,000*
TEF Funding Resources Reallocated	*$*	*(46,000)*
Adjusted Based Resources (subtotal)	***$***	***870,000***
2024 Current Services Increases		
Pay Raise (5.2%)	*$*	*17,644*
Biomedical Research and Dev Price Index (2.3%) [1]	*$*	*10,405*
Subtotal	***$***	***28,049***
2024 Current Services	***$***	***898,049***
Adjustments		
Estimated Projects Deferred	*$*	*(4,804)*
Subtotal	***$***	***(4,804)***
Funding Increases for 2024 Initiatives:		
1. Military Environmental Exposure (MEE)	*$*	*15,000*
2. Traumatic Brain Injury (TBI)/Brain Health	*$*	*15,000*
3. Cancer and Precision Oncology	*$*	*10,000*
4. Mental Health/including continued execution of projects under the Hannon Act	*$*	*4,755*
Subtotal		***44,755***
2024 Total Medical and Prosthetics Research Budget	***$***	***938,000***
TEF Funding Resource Allocation	*$*	*46,000*
Total Budget Authority	***$***	***984,000***

Key Funding Increases for 2024

VA Research is uniquely positioned to address the biomedical and health ecosystem research needs of Veterans, VA, and the nation by leveraging its capabilities and resources as part of the largest integrated healthcare system in the country. The requested funding increases below are based on VA Research's unique role, in which scientific discovery not only improves Veterans' health and well-being, but also solves specific, real-world problems faced by Veterans, clinicians, and the entire healthcare system.

Military Environmental Exposures (MEE)

Generating high-quality evidence through military exposures research is a high visibility, high priority topic. VHA has two complementary offices with different strengths to generate evidence and inform policy on military exposures.

Health Outcomes Military Exposures (HOME): Funded by the Medical Care Appropriations and not part of ORD, HOME assesses the impact of deployment/military environmental exposures on Veterans and develops related policy, research, education, and health care strategies. The Epidemiology Service manages several surveillance programs on specific military/combat exposures and conducts original research to understand the effects of military service and deployment on Veterans' health.

Office of Research and Development (ORD): This budget chapter, focuses on ORD funded Research, from both the Medical and Prosthetic Research Appropriation and the TEF that was authorized by the PACT Act of 2022. These combined resources will be coordinated through the ORD Military Exposure Research Program (MERP) to support peer-reviewed and program-directed research as a source of evidence stream to inform care and policy.

These resources are critical in providing the necessary enterprise research infrastructure including MEE data/biorepository, exposure assessment for individual-level analyses, administration/governance, the Cooperative Studies Program and the Million Veteran Program, which together proactively break down barriers and allow fluid initiation of projects to ensure timely execution and information to the field. Moreover, the MERP will support a legacy exposure repository of data and specimens for the broader research community to validate and translate research findings.

The MERP program's objective is to improve individual exposure assessments for producing research-grade data while also having a data strategy that focuses on common data elements and phenotypes that will lead to a more precise determination of the type and number of specific exposures incurred by Servicemembers. Those details can then inform care, policy, and ongoing research. ORD MERP will work closely with Federal and academic subject matter experts in developing and refining exposure methodologies and applying emerging technologies to fill this gap. Validation and implementation of promising qualitative and quantitative methodologies will be applied by leveraging the new ORD MERP military exposure biorepository and key partnerships. These efforts will, in turn, prepare VA for filling research gaps identified under the PACT Act (Section 501).

Those who served may have been exposed to a wide variety of environmental agents with the potential for deleterious health impacts. For example, rare cancers and other illnesses have been reported by Veterans deployed to Karshi-Khanabad Air Base (K2), and respiratory, cardiopulmonary, and other disorders have been reported from exposures in Iraq and Afghanistan. Exposures experienced while in service can include fuels, radiofrequencies, exposures associated with explosive ordinance disposal, and per- and polyfluoroalkyl substances (PFAS). In addition, Veteran-specific factors, such as genetic variations, may play a role in how each individual responds to exposures.

With such a broad range of potential exposures and impacts, we must attract new researchers to the field of military exposures, must be systematic, and must collaborate with others both inside (e.g., VBA) and outside of VA to get Veterans the answers they need and have earned.

One of these major efforts will be the continued implementation of Section 501 of the PACT Act. ORD is the leading office to support implementation of Section 501, which directs the Secretary of Veterans Affairs to convene an interagency working group to identify collaborative research activities and resources. The interagency workgroup will have members from the VA, the Department of Defense (DoD), the Department of Health and Human Services (HHS), the Environmental Protection Agency (EPA), and other federal partners involved in research activities regarding the health consequences of toxic exposures experienced during active military, naval, air, or space service.

This interagency workgroup will provide guidance on new research related to health consequences of toxic exposure during military service by developing a five-year strategic plan for collaborative research activities and opportunities for advancing the field. Timely reports to Congress will be submitted as outlined in PACT Act Section 501, with an initial report submitted to Congress in the late summer of 2023. Development of the five-year strategic plan and roadmap will be submitted in the late summer of 2024.

ORD has socialized PACT Act Section 501 to several Federal partners and is in the process of inviting members to serve. To provide a robust interagency Federal Agency interaction, ORD is working with the infrastructure of Office of Science, Technology, & Policy (OSTP) to leverage efficient communication, subject matter expertise, and other resources and lessons learned from their experience and success. This interaction has been socialized, approved, and is now underway. The interagency workgroup will submit a report to Congress on the collaborative research activities identified, and the strategic plan developed by the Working Group (as detailed above).

Exposure assessment at the individual level has been identified as the major gap in the military exposures field. Therefore, identifying and ideally quantifying the toxicant(s) a servicemember or Veteran was exposed will inform health outcomes, clinical care, and policy (prevention, detection, presumption, and clinical practice guidelines). There are numerous potential sources of data, such as the Individual Longitudinal Exposure Record (ILER), a Veteran's own recollections, and markers of the exposure that may have been left on the Veteran, such as genetic markers of particular exposures, just to name a few. The mission of ORD Military Exposure Research Program (MERP) is to establish a system-wide capability to advance military exposure assessments and understand the effects of military exposures on Veterans' health outcomes.

***Activities to be continued or undertaken**:*

- Full activation of ORD MERP's exposure assessment core to support toxicologists with a nucleus of collaborators and resources to develop, test, and validate exposure assessments to support the broader VA research enterprise that works on military environmental exposures will continue. Partial activation of this Core took place Fall 2022 where a strategic planning meeting was executed, and goals and objectives were developed. The Core is in the hiring and resource gathering phase of their development. These efforts will serve as an enterprise resource for a broader set of field investigators.
- Fund exposure assessment projects to focus on generating evidence that fills knowledge gaps for Veterans with military environmental exposures. ORD will take both a top-down and bottom-up approach to funding by both directing what certain types of research will be done and continuing to support a wide range of meritorious projects conceived by VA researchers embedded within VA medical centers. Along the way, ORD will coordinate with the patient care services policy team in HOME, VBA, and other relevant groups through PACT Act SEC 501.
- Establish an ORD MERP military toxic exposures biospecimen repository. This will be the first ever military exposure biorepository. Biospecimens are a precious resource for both developing and validating exposure assessments, as well as understanding the health effects of these exposures. ORD is hiring additional biorepository regulatory and policy expertise. ORD will build on the progress of VA SHIELD, the enterprise-wide biobank initially established by ORD in response to COVID, and data/biobanking subject matter experts to collect trusted specimens for wide use. Additionally, ORD will can leverage Million Veterans Program (MVP) to shed light on how a servicemember's genes may impact the effect of MEE on their health.
- Further explore the relationship between military exposures and rare cancer. Studies have shown that exposure to environmental contaminants and toxic chemicals can lead to a higher risk of certain types of cancer. MERP will complement the work being done by ORD's Precision Oncology Program by focusing on the mechanisms by which military environmental and toxic carcinogenic factors may give rise to rare cancers, a poorly understood area. Shedding light on how military exposures lead to disease can help to identify preventive, diagnostic, and treatment strategies. The ORD MERP environmental- and toxic-exposure biospecimen repository and outside federal and academic partnerships will be leveraged to catalyze progress.
- Continue the gap-analysis portfolio to identify gaps in needs, capabilities, technologies, and resources. ORD has already held a planning meeting where resource, process, and expertise gaps were articulated by researchers in the field. We have identified gaps for trusted data and biospecimens, toxicology expertise and technologies for exposure assessment, and agency agreements for efficient and timely execution of research.
- Expand the workforce in military exposures research and training, with an emphasis on finding Veterans and descendants of Veterans who are enrolled with VA academic affiliates and want to pursue a career in environmental and military exposure research. In addition to benefiting the research, it will open new career opportunities for these Veterans and military family members.

- Through QUERI's Partnered Evidence-based Policy Resource Center (PEPReC), we will undertake a national evaluation on the impact of legislative initiatives related to military exposures on access to, and demand for, VA care over time. To support VA's efforts to increase access to care for Veterans with military toxic exposures as part of the PACT Act, PEPReC is working with the Human Resources Administration to develop an evidence-based approach for estimating ideal staffing levels for achieving VHA access goals (e.g., wait time targets) at VA medical centers across the US.
- QUERI and the VHA Evidence-based Policy Subcommittee will work with VA clinical operational partners to conduct evaluation plans under development including plans focused on military exposures for the VA 2024 Evidence Act. An example evaluation topic under development is examining the extent military exposures may have harmed Veterans, particularly latent or chronic health effects of exposures (e.g., toxins at Camp Lejeune).
- Continue the congressionally mandated Gulf War Program, which is overseen by the Research Advisory Committee (RAC) on Gulf War Veterans' Illnesses. The goal of this program is to improve the health of Gulf War Veterans experiencing debilitating symptoms, such as persistent headaches, joint and muscle pain, fatigue and sleep disturbances, attention and memory problems, gastrointestinal symptoms, and skin abnormalities. Continue outreach engagement sessions with Gulf War Veterans to better understand their health concerns as they age and on the value of participating in research.
- Continue the "In-Depth" project to systematically document the health characteristics of Veterans living with Gulf War Illness in collaboration with NIH National Institute of Neurological Disorders and Stroke (NINDS) clinical services.
- Continue study of Collaborative Specialty Care for Gulf War Illness to examine the best model of care to deliver treatments to Gulf War Veterans with Gulf War Illness and to examine the under-recognition of medically unexplained symptom conditions among US Veterans with Gulf War Illness.
- Analyze differences in mortality between Vietnam War era Veterans and civilians.
- Enable use of the Vietnam Veteran Air Force Health Study (aka 'the Ranch Hand Study') biospecimens and data by the broad VA and non-VA research community to evaluate generational, cancer and other health concerns of this cohort, in consultation with Vietnam Veterans of America and other stakeholders.
- Continue to test the research usability of the Individual Longitudinal Exposure Record (ILER), a VA-DoD collaboration to track in-service exposures. Progress in this area has been made by adding subject matter experts from our Exposure Assessment Core to the ILER user interface. Their training and usage of ILER will facilitate important capabilities for future users of the research and help mitigate potential barriers.
- Continue a large observational study run by the Cooperative Studies Program to assess impacts of deployment on respiratory health, particularly in context of burn pit exposures, while using data from NASA to provide insights into how particulate matter may have been distributed in particular regions of the Middle East.

Recent accomplishments in MEE research:

- Demonstrated (publication in preparation), in a scientific survey of Vietnam Veterans, differences in exposures among those who served in the ground war theater, those who served in offshore waters (Blue Water Navy sailors), those who served outside the war theater at the time, and civilians with several chronic health conditions.
- Developed a research dataset of all individuals who served in the Vietnam era by merging several large DoD, VA, and CDC databases. Key variables in the dataset include whether these people served in the war theater and their vital status.

Traumatic Brain Injury/Brain Health

TBI continues to be a signature injury from the wars in Iraq and Afghanistan. TBI can lead to lifelong disabilities that can vary by TBI severity, the characteristics of the event or events that caused the injury, and the number of exposures. Due to the nature of combat and previously unknown injuries that may have occurred from training, TBIs are frequently not recognized at the time of injury. This culminates in a diagnosis occurring in VA medical facilities sometimes years after the patient's most recent TBI, a situation that has been termed "remote" TBI. This delay in diagnosis and associated care can magnify neurobehavioral conditions that negatively impact Veterans' quality of life.

Each year, VA sees some 100,000 patients who have a TBI diagnosis. TBI symptoms include headaches, irritability, sleep disorders, visual and balance deficits, memory lapses, slowed thinking, and depression. TBI manifests not only in cognitive deficits, but also with problems in behavioral health; sensory perception; and motor, endocrine, and autonomic nervous system function. Potential consequences of TBI include neurodegenerative disease, prolonged sensory processing deficits, substance misuse, and mental health issues. most TBI cases are mild and difficult to diagnose. VA investigators are examining various approaches to detect, monitor, and treat Veterans with TBI.

ORD will continue to focus on developing objective tools and resources to improve the diagnosis and monitoring of brain health in Veterans who have sustained TBI. ORD will also focus on the needs of Veterans with a lifetime history of one or more TBIs. This includes success in their community, understanding TBI-related mental health conditions, and exploring ways for improving self-management of their TBI symptoms.

Recent Accomplishments and Related Ongoing Work:

- TBI-related Mental Health Conditions. Previous research has established that a lifetime history of TBI dramatically increases the risk for various mental health challenges, including but not limited to, PTSD, depression, suicidality, substance use disorder, and personality disorders. Research funding will span mechanistic preclinical research (e.g., the impact of loss of prefrontal cortical input to limbic structures and chronic neuroinflammation on behavior) to clinical research to ascertain the efficacy of established therapies on mental health conditions in Veterans with a lifetime history of TBI.

- Self-management of Chronic Health and Psychosocial Issues in Veterans with TBI. Growing evidence demonstrates moderate/severe TBI or repetitive mild TBI is often a chronic, dynamic health condition with persistent health and psychosocial issues. Chronically symptomatic TBI requires development of an approach to proactively manage health system modifications, education, and self-management strategies for individuals and caregivers. There is growing consensus in the clinical research community that chronic symptomatic TBI be identified and managed as a lifelong condition to improve health, independent function, and societal participation. There is a need for new knowledge regarding the development and feasibility of implementing Veteran-directed brain injury care that includes multi-dimensional triage of acuity, self-management, and integrated treatment of mental health and medical comorbidities, suicide risk, and substance misuse. This effort will fund VA investigators who will collaborate with non-VA investigators funded through the National Institute for Disability, Independent Living, and Rehabilitation Research (NIDILRR) in a network to improve the health of those who have TBI.
- Develop Novel TBI/Brain Health Positron Emission Tomography (PET) Ligands: PET ligands assess chronic TBI/brain health conditions for tau and amyloid markers. Recent clinical trials based on amyloid clearing therapeutics have shown subsequent reduction ligand binding without any clinically relevant improvement in the patient. Ongoing research suggests that progressive brain changes related to cognitive and behavioral impairments could be the result of chronic neuroinflammation and aberrant metabolism.

  Currently, there are scarcity of PET ligands being developed that are specific to central nervous system immune cells responsible for persistent inflammation. The current PET ligands for identifying inflammation lack the specificity for clinical utility for the identification of altered neurological functional status. This research funding will support development of novel PET radioligands with enhanced neuroimaging capabilities suitable for product development involving preclinical to clinical PET neuroimaging. This will have potential beneficial applications in the performance of future large-scale and sequential studies that explore the time-dependent changes that occur after TBI.
- Build the VA Biorepository Brain Bank, which consists of a registry and a network of human tissue banking sites that collects, processes, stores, and provides research specimens as a resource for research on TBI/Brain Health conditions.
- Continue to provide research funding regarding the impact of TBI on multiple sensory systems. Veteran-centric impairments of vision, hearing, balance, and sense of smell due to combat and/or training adversely affect their quality of life and increase the risk of substance misuse, psychological health conditions, and loss of employment. The end goal of the research is to effectively diagnose and treat Veterans with service connected TBI that have resulted in multisensory system impairment.
- Maintain the development of Brain Stimulation (magnetic, electrical, and electromagnetic modalities) Standards for Clinical Trials in Treatment of TBI and Brain Health conditions.
- Provide additional support for TBI-specific laboratory animal major equipment and the Shared Equipment Evaluation Program to increase research capacity and infrastructure, especially in locations where TBI research is currently in need of such resources.

- The journal, Brain Injury, dedicated a special issue to the achievements of the Long-term Impact of Military-relevant Brain Injury Consortium-Chronic Effects of Neurotrauma Consortium (LIMBIC-CENC). The special issue contained 12 original research articles and was released in February 2022, titled, "Practical Approaches to Assessing and Mitigating the Risk of Cognitive Decline after Concussion: Findings from the Long-term Impact of Military-relevant Brain Injury Consortium (LIMBIC)."
- Completed the planning process of the VA Biorepository, with sites selected, including investment in standardization of processes and equipment. This included demonstrating that many symptoms and concurrent disorders associated with mild TBI (mTBI) are risk factors for Alzheimer's disease (AD), dementia, and neurodegeneration, and that providers must optimize the symptomatic treatment and underlying cause of these risk factors to meaningfully reduce the risk of AD, dementia, and other neurodegenerative conditions.

Activities to be continued or undertaken:

- Ongoing Cooperative Studies Program supported clinical trial examining growth hormone replacement therapy in Veterans with mild TBI and adult growth hormone deficiency.
- Continue the Clinical Health Imaging Portability Standards (CHIPS) initiative. Currently, magnetic resonance imaging (MRI) clinical scans performed in the United States are not calibrated to a shared standard. There are no established quantitative norms in MRI diagnosis. Quantitative metrics are necessary to assess brain health over time. The absence of calibration standards impedes the ability to do cross-site or quantitative instrument comparisons, a critical need for VA health care.
- CHIPS will allow an MRI to become a reliable noninvasive assessment to monitor brain health not only for Veterans, but for all people who have sustained one or more TBIs. A VA-based team is collaborating with industry and academic partners to create and implement these standards.
- To meet the requirements of the Hannon Act, VA will continue to develop a collaborative network to develop Total Brain Diagnostics (TBD). TBD will be a collaborative network to develop and integrate fluid biomarkers, imaging, and physiological measures to enable objective diagnoses and the ability to better monitor complex TBI-related brain health and common mental health conditions. This ORD-wide initiative will leverage VA's National Artificial Intelligence Institute (NAII) to integrate diagnostics to provide a complete view of brain health that personalizes diagnosis, prognosis, and treatment. The VA-based team is collaborating with NIH, DoD, and several not-for-profit organizations.
- Continue QUERI Partnered Evaluation Initiative to characterize, evaluate, and implement the TBI Intensive Evaluation and Treatment Program (IETP), an innovative approach for delivering evidence-based care in a residential inpatient format.
- Provide additional research funds to support scientifically meritorious TBI research studies. This will include a joint funding announcement with the National Institute on Aging (NIA) to investigate the impacts of TBI on aging and dementia.
- Continue the implementation of virtual care across the VHA Polytrauma System of Care. The aim is to validate virtual care programs and identify opportunities to enhance and

standardize the services VA provides. Investments include a three-year study designed to evaluate the impact of virtual care programming on completing the Comprehensive TBI Evaluation (CTBIE) and providing care to Veterans with TBI. Additional funding will improve TBI screening and the processes for completing the comprehensive TBI evaluations that Veterans returning from deployment receive. Currently, more than a third of Veterans who screen positive for TBI do not return for a follow-up appointment to undergo a comprehensive evaluation. Improving completion rate of the CTBIE by Veterans with suspected TBI could improve access to care, benefits, and overall quality of life.

- Continue to support the longitudinal TBI research for moderate to severe TBI, including Veterans with disorders of consciousness -- an understudied VA population. We will develop Veteran-based scientific literature on longitudinal outcomes, comorbidity, and rehabilitation needs. This mechanism will support a clinical trial infrastructure that can be leveraged in future clinical trials to advance the treatment of moderate to severe TBI. Research on this critical TBI population would benefit both quality of life for Veterans and family members who are often their caregivers.

Cancer/Precision Oncology

In 2024, VA Research will continue to serve as an integral part of the President's Cancer Moonshot initiative and enable VA's continued leadership in cancer research and translation of discoveries into care. ORD's support of Moonshot activities will include activities in molecular diagnostics and application of novel technologies to refine and characterize the genetic basis of cancer across the diverse VA patient population; identifying genomic signatures that may be associated with carcinogens from environmental/military exposures; identifying targets for drug treatments and pathways in rare and common cancers based on understanding of their unique characteristics; and applying precision oncology approaches to cancer screening and early detection. VA Research will also aim to close the knowledge gap in cancer by emphasizing disparities in disproportionately affected populations and inform clinical management to reduce inequities in access to care.

A key emphasis of VA Research has been in precision oncology care, which seeks to match the appropriate treatment to the right patient at the right time based on an understanding of the molecular characteristics of patients and their cancer. This strategy includes using a molecular testing program that can help to better identify and characterize mutations in advanced cancers and then inform clinical care, including the ability to determine if a clinical trial is a better option. Precision cancer care already is adding years to Veterans' lives while minimizing side effects: continued research is necessary to ensure that as many Veterans as possible benefit. To further gain insights into these alterations, VA is conducting studies to understand how these alterations drive cancer development, the molecular mechanisms and cellular pathways involved, and whether the genes and pathways are potential therapeutic targets.

Additionally, VA will support innovative, high impact investigations using novel techniques, cutting edge technologies, bioinformatics tools and team science to accelerate our understanding of risk factors (genetic, age, obesity, environment, etc.) that contribute to cancer. These efforts will help to address early detection, diagnosis, and survival in multiple cancers, including lung, colorectal, prostate, bladder, kidney, skin, pancreatic, esophageal, brain, and female-specific

cancers such as breast, cervical and ovarian cancer, as well as lymphomas, melanomas, and other rare cancers. Precision oncology also needs to consider patient preferences in areas where the patients may influence the balance of benefits and risks of interventions. VA Research has also helped improve decision aids for patients and test approaches to shared decision-making in areas such as prostate and lung cancer screening.

Another capability of VA research in studying and treating cancer is using "big data", such as artificial intelligence and machine learning. These data-driven approaches seek to validate genomic, pathomic and radiomic data and information from patient electronic records to predict risk for cancer and develop clinical decision support tools to aid in clinical management. Some of these activities are being done in partnership with other federal agencies or entirely within the VA health care system, for example, using the recently established Computer Vision and Machine Learning in Precision Oncology hub.

VA Research is fully realizing the promise of genomic-driven cancer care through innovative partnerships that increase the sharing of data and knowledge so advances can be realized faster to benefit Veterans and the general patient population. One example is a collaboration between VA and the University of Chicago to establish a Veterans Precision Oncology Data Commons. This platform enables data sharing across studies and healthcare systems and has been a part of Cancer Moonshot efforts to support the Applied Proteogenomics Organizational Learning and Outcomes (APOLLO) collaboration between VA, the National Cancer Institute, and the Department of Defense.

Mutational changes that give rise to cancer leave signatures (or fingerprints) in the genome that can be identified through whole genome sequencing. These can be brought about by defects or abnormalities in how DNA is replicated or repaired in the cell, insults from exposure to mutagens or changes in the DNA caused by enzymes. The ability to identify specific/unique mutational signatures in tumors from Veterans associated with military exposures (burn pits, Agent Orange, herbicides, etc.) would be beneficial in categorizing select cohorts of Veterans for screening, prognostication and treatment. Consequently, the APOLLO research will expand to include additional biospecimen collection sites in VA for all cancer types. This effort will synergize with the DoD's Project for Military Exposures and Toxin History Evaluation in U.S. (PROMETHEUS) to understand the origin or connection of military-related environmental exposure to cancer development and potentially identify opportunities for early interventions and diagnosis of impacted Veterans and Service members. By leveraging DoD's unique resources and integrating it with the ongoing work of APOLLO, we hope to create new opportunities to identify DNA mutational signatures in rare cancers and rare subtypes of major cancers that may be associated with carcinogens from military environmental exposures, thereby addressing the goals of Moonshot and cancer healthcare needs under the PACT Act.

VA's forwarding thinking approach in this area also includes the support of the Big Data Scientist Training Enhancement Program (BD-STEP) in collaboration with the National Cancer Institute and VA Office of Academic Affiliations. BD-STEP focuses on training fellows to understand, use and analyze large VA data sets to establish a cadre of future investigators who can advance "big data" research specifically involving Veterans and VA's data. This effort is complemented by a VA Research investment in the recruitment and retention of experienced data scientists to

collaborate with other clinical and molecular scientists in a team-based approach to address critical clinical problems through research.

In 2024, funding increases will further strengthen previous investments in VA's cancer research program. These efforts include support for a partnership between the National Cancer Institute (NCI) and VA to enable NCI-supported clinical trials to be conducted within VA. The success of the program has shown the ability to enroll more Veterans in NCI-supported clinical trials, thus providing Veterans with additional therapeutic options for their cancer. This model has further served to highlight VA leadership in cancer trials recruitment, especially for reaching out to populations that often are underrepresented in cancer trials research.

In addition to these NCI trials, VA has the capability to conduct its own trials that fill gaps and complement the work of other agencies. For example, clinical trials that combine chemotherapy drugs with checkpoint inhibitors (immunotherapy) can reduce cancer progression while increasing anti-tumor immune response. This approach is one area that is available for clinical trial investigation by VA researchers using traditional therapeutic approaches within our clinical trial network.

Another example is the VA Standard Systemic therapy With or Without PET-directed Local Therapy for Oligorecurrent Prostate Cancer (STARPORT) trial, which is being conducted using the VA's Cooperative Studies Program (CSP) and conducted across 16 VA medical centers. The study is examining a treatment approach using targeted surgery or radiation for men whose prostate cancer has spread within the body after initial curative therapy (i.e., surgery or radiation). Other clinical trials in colorectal, prostate, lung, and hepatocellular done specifically within VA have used CSP expertise and CSP-managed networks to provide Veterans access to clinical trials. In turn, CSP has facilitated a learning health care system model for trials under the Precision Oncology Program (RePOP) initiative that includes the Veteran Precision Oncology Data Common. RePOP further provides a mechanism to recruit patients for broader sharing of data and to reuse tumor tissue. These infrastructure activities support a broader range of VA clinical trials work that can also be leveraged in partnerships with other agencies.

VA Research also features several partnerships with VHA's National Oncology Program to establish a national consortium of 23 lung cancer and seven genitourinary cancer clinical and research centers (also referred to as "hub sites") across Veteran Integrated Service Networks (VISNs). This expansion in clinical trial infrastructure will create even more demand for novel clinical trials in 2024. Potentially, it will also open more therapeutic options for Veterans across the VA Research enterprise. An increase in clinical trial funding support will help to meet this rapidly growing demand and will create opportunities for Veterans, VA investigators, and VA facilities to contribute to state-of-the-art research on novel therapies and approaches to care.

Importantly, as part of VA's commitment to female Veterans, ORD will continue building mechanisms to give them greater access to clinical trials by leveraging the VA National Tele-Oncology (NTO) Program to facilitate decentralized trials (virtual) and access to care. VA Research is building networks involving its Women's Health Practice Based Research Network to advance research and initiate rare new cancer activities with partner agencies, including NCI and the DoD, to support a center for women's cancer research focusing on breast and gynecological cancers.

This effort will help remove potential barriers that might exclude certain subsets of patients from precision oncology and from the potential genomic insights that could be obtained by studying the biology of cancer in these patients. Both breast cancer and rare cancers will involve offering virtual trials across the system because of the comparatively smaller number of both conditions in VA. Together, these efforts will create a larger precision oncology ecosystem to enable advancements in research and care.

Recent accomplishments in precision oncology:

- Initiated two new multisite bladder cancer clinical trials (Phase I and Phase II) with the Precision Oncology Program for Cancer of the Prostate (POPCaP, funded through a donation by the Prostate Cancer Foundation)/GU network.
- Expanded the Phase 2/3 STARPORT trial to additional sites within and outside the POPCaP network.
- Increased the number of clinical trial offerings at the 7 genitourinary (GU) sites to provide Veterans with additional therapeutic options.
- Hired and onboarded POPCaP regulatory staff to facilitate remote opening of studies at a clinical trial site. This approach provides additional support to local facilities interested in providing Veterans access to trials while building out the local facilities' clinical research infrastructure.
- Expanded the number of Lung Precision Oncology Program (LPOP) sites to 98 to conduct lung cancer screening, lung cancer clinical trials and lung cancer research sites.
- Developed 4 novel therapeutic trials to address advanced non-small cell lung cancer, including one immunotherapy de-escalation trial to enhance durability and quality of life improvement while lowering toxicity. Expanded standardized germline sequencing for metastatic prostate cancer across the nation.
- Expanded Veteran access to an industry Phase 2 combination trial of the RAS GTPase family inhibitor Adagrasib and the checkpoint inhibitor Pembrolizumab in non-small cell lung cancer.
- Established the Computer Vision and Machine Learning in Precision Oncology (CoMPL) hub that integrates and applies artificial intelligence, computer vision and machine learning tools to pathomic and radiomic data to enable translational and clinical research efforts with the goal of improving Veteran care.
- Initiated a study to predict and characterize response to immunotherapy in stage III non-small cell lung cancer using AI/machine learning along with pathomic and electronic health record (EHR) data.
- Commenced work on Precision Augmented Initiative for lung cancer screening towards refining United States Preventive Services Taskforce guidelines for lung cancer screening.

Activities to be continued or undertaken*:*

- VA Research will collaborate with the DoD and the NCI Multi-Cancer Early Detection research program as part of the President's Cancer Moonshot. These efforts will begin with

laying the groundwork for a large-scale network to evaluate multi-cancer early detection (MCED) assays. MCEDs hold great promise to identify cancer early when it is more curable. At the same time, MCEDs can yield false positives, which both impact the Veteran and consume healthcare resources. These tests also can yield false negatives, which can create a false sense of security.

- Will expand support for the coordination and management of the clinical trial networks (NAVIGATE, LPOP, POPCaP, GU) across multiple cancers, including expansion of enrollment sites to stand-up enterprise-wide clinical studies to support expanded clinical trial offerings to Veterans.
- Support the planning and development of a pan-cancer study focused on identifying patterns of genetic mutations that may be associated with military environmental exposures. This study is poised to both identify carcinogenic mechanisms of exposures and inform treatment.
- Support efforts within CoMPL to provide AI and machine learning support to develop prognostic and predictive companion diagnostic tools for head, neck and lung cancer.
- Provide support for establishing a coordinating center within VA for APOLLO expansion and establish a project team to provide administrative coordination and management of sites and VA contributions to the NIH-DoD-VA APOLLO program.
- VA Research will support a large national screening study of over 4,000 Veterans comparing abbreviated magnetic resonance imaging versus ultrasound to determine which method is better at detecting and reducing liver cancer deaths in high-risk patients.
- Expand support for the development of investigator-initiated clinical trials and partnerships with industry, NCI and others to provide Veterans increased access to novel clinical trials and therapeutic options.
- Conduct a pilot feasibility study by combining rare highly penetrant germline variants and transancestry polygenic risk scores to evaluate whether precision risk stratification can identify men who are most likely to benefit from prostate cancer screening.
- Support the planning and development of decentralized clinical trials to address rare cancers.

Mental Health, including continued execution of projects under the Commander John Scott Hannon Mental Health Care Improvement Act

The request supports mental health and suicide prevention research, including the Hannon Act, clinical trials, and epidemiological studies on risk and prevention factors. The Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act) was signed into law on October 17, 2020. The law enhances VA programs for mental health care, suicide prevention, care for female Veterans, and telehealth care for Veterans and transitioning Servicemember. The Hannon Act is advancing efforts to prevent suicide and promote mental health and general well-being among Veterans.

The Hannon Act accelerated VA's research into causes of mental health issues and to identify, improve and expand mental health treatment protocols and health professional training. It will examine how VA manages mental health and suicide prevention resources and how it provides care in these areas. Overall, it will advance efforts by VA, other federal partners, and local communities in preventing suicide and promoting mental health and well-being among Veterans. The Hannon Act consists of 34 sections, five of which ORD is the designated lead and seven where ORD serves in a key support role.

ORD is the designated lead for:

- Section 204(a). *Department of Veterans Affairs study of all-cause mortality of veterans including by suicide*. [This section specifically concerns the effects of opioids and benzodiazepines.]
- Section 301. *Study on connection between living at high altitude and suicide risk factors among veterans.*
- Section 305. *Precision medicine mental health initiative.*
- Section 306. *Statistical analysis and data evaluation by Department of Veterans Affairs.*
- Section 704. *Use by the Department of Veterans Affairs of commercial institutional review boards in sponsored research trials*.

ORD is in a supporting role for:

- Section 405. *Joint mental health programs by the Department of Veterans Affairs and Department of Defense*.
- Section 702. *Partnerships with non-Federal Government entities to provide hyperbaric oxygen therapy for treatment of post-traumatic stress disorder and traumatic brain injury.*
- Section 705. *Creation of Office of Research Reviews within the VA Office of Information and Technology*.
- Section 101. *Strategic plan on expansion of health care coverage for Veterans transitioning from service in the Armed Forces.*
- Section 201. *Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP).*

The Scott Hannon Initiative for Precision Brain and Mental Health (SHIPBMH; Section 305) will identify and validate brain and mental health biomarkers specifically for depression, anxiety, post-traumatic stress disorder, bipolar disorder, and traumatic brain injury. SHIPBMH will integrate this wide range of biomarkers to provide clinically actionable diagnostics, including neuroimaging, biofluids, electroencephalography, and genetic and neurobehavioral assessments. This will leverage discoveries from ongoing research programs such as MVP, LIMBIC-CENC, the Translational Research Center for TBI and Stress Disorders TRACTS, and newly launched programs such MVP-MIND (Measures Investigating Neuropsychiatric Disorders).

In addition, SHIPBMH will expand the public availability of rich, deidentified data with respect to the large-scale collection of standardized data and open data sharing through both the Federal

Interagency TBI Research (FITBIR) Informatics System and the VA Data Commons. The third goal of SHIPBMH will be to execute the clinical translation of SHIPBMH identified targets. The first target will focus on Cytochrome P450 (CYP450) pharmacogenomic markers of gene variants responsible for the differential metabolism of commonly prescribed opioids. All activities under SHIPBMH will be coordinated by a Coordinating Center funded and established in the field.

Recent accomplishments:

- MVP-MIND aims at having 50,000 Veterans with mental health conditions and substance use disorders complete the MIND survey over the next five years. In 2024, this activity will be launched at six sites and several recruitment strategies tested. As part of quality improvement initiatives of the Office of Mental Health and Suicide Prevention, clinical decision support regarding use of the pharmacogenomic variants in the CYP450 gene 2D6 has been added to the STORM database. Further, a survey of providers who have prescribed opioids after a patient has been tested for genetic variants in the CYP2D6 gene has been launched.
- Initiated a contract with National Academies of Science, Engineering and Medicine (NASEM) for an independent study on the effect of opioid and benzodiazepine prescriptions on all-cause mortality in Veterans in accordance with the requirements of Section 204 of the Hannon Act.
- In support of Section 301, ORD funded investigators examined the putative relationship between altitude and suicide and published their findings in 2022. Their results show that there is a strong association between altitude and suicide death, and a moderately strong relationship between altitude and suicide attempts. This relationship was observed after controlling for certain known covariates. Current efforts involve examining the validity of potential models that could explain this observed relationship. In support of Section 101, co-funded through QUERI, in partnership with more than 30 community and VA partners (e.g., VISN 17), the evaluation of a National Sponsorship Program for Transitioning Servicemembers was included in the 2023 VA Annual Evaluation Plan. Four toolkits and training manuals have been produced to support uptake of the Program. Dissemination efforts include: a website that has garnered more than 120,000 visits, eight journal publications including a peer-reviewed article that received 8,868 views, and briefings to US Congress House Veterans Affairs Committee staffers and other leadership including with III Armored Corps commanding general that resulted in his decision to expand the initiative to 5 military installations with an anticipated 22,000 soldiers enrolling in the initiative annually moving forward.

- QUERI launched a Rapid Response Team to support evaluation plan development leading to OMHSP enlisting the QUERI team to provide consultation and implementation support and co-develop the congressional report of the SSG Fox SPGP (Section 201).

2024 Priorities and Updates

ORD's 2024 priorities emanate from ORD's mission to improve Veterans' health and well-being via basic, translational, clinical, genomic and data science, health services and rehabilitative research; applying scientific knowledge to develop effective individualized care solutions for Veterans; attracting, training and retaining the highest-caliber investigators and nurturing their development as leaders in their fields; and assuring a culture of professionalism, collaboration, accountability, and the highest regard for research volunteers' safety and privacy.

In 2024, these priorities will support new research approaches and additional capacity in high-priority areas of Veterans' health, including coronavirus-related research and impacts, suicide prevention, pain management and opioid use, PTSD, and the prosthetic needs of female Veterans with limb loss. In addition, we continue to work to reduce, refine, and replace the use of sensitive animal species in VA research and invest in research in artificial intelligence (AI) related to medical research.

Details about each of these efforts can be found below:

Suicide Prevention

Preventing suicide, a national public health priority, is critical for Veterans. This request will result in new tools to identify and manage risk factors, identify more effective prevention strategies, and better ensure effective strategies are implemented to prevent Veteran suicide. A key research focus continues to be on the risks present in the period of transition from active-duty military service to civilian life, as well as research directed toward reducing access to lethal means of suicide among individuals with identified suicide risk.

A number of coordinated efforts are focused on reducing suicide by developing and implementing a scientifically sound evidence base. These efforts include supporting clinical trials as well as epidemiological studies on risk and prevention factors and annual Evidence Act-required evaluation plans through QUERI in partnership with VA national program offices (2022-2024). Other specific discoveries of genetic risk factors and clinical trials for continued the value of behavioral interventions for reducing suicidality.

Recent accomplishments:

- Established the utility of the REACH VET Program, which was associated with having completion of more new suicide prevention safety plans and completed outpatient appointments.

- Contributed to the development of a Suicide Prevention Trials database (SPTD), which will provide a detailed database of harmonized data from all published trials in suicide prevention. This database will be made publicly available in March 2023. Establishment of the SPTD was a 2022 Agency Action, satisfying a requirement of the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) initiative to "develop and implement a clinical trials database of suicide prevention research, which will be publicly accessible as a tool for all researchers."
- Expanded the Suicide Prevention Research Impact Network (SPRINT) through funding of a Suicide Prevention Clinical Resource Center to focus on growing clinical suicide prevention research. The primary aim of the funded center is to develop enterprise-wide resources that will allow for development of precision medicine approaches for suicide prevention.
- Advanced our knowledge of suicides and found firearms are most frequently used by Veterans recently separated from the military (2022 National Veteran Suicide Prevention Annual Report, VA Suicide Prevention, Office of Mental Health and Suicide Prevention, September 2022). ORD convened two field-based meetings for experts to discuss and plan how to advance Lethal Means Safety (LMS) research and intervention. Information from these meetings will be used to develop LMS research initiatives for 2024.
- ORD is funding, through QUERI, an evaluation of the Caring Contacts roll-out in suicide prevention. Caring Contacts refer to non-demanding messages of support being sent to high-risk individuals: contacts can be digital (text messages) or physical (postcards or letters). ORD is funding a study to determine the effects of Caring Letters on care utilization, mental health outcomes and suicide behaviors of VCL callers, and identify facilitators and barriers to program implementation.
- ORD funded research designed to better understand suicide risk associated with opiate discontinuation. This project will include a chart review and an interview with family member of suicide decedents to understand if and how opiate taper contributes to suicide.
- QUERI, in partnership with OMHSP and other VHA national program offices and VISNs, launched ten national evaluations related to suicide prevention, including support for transitioning Servicemembers, Veterans Crisis Line, Life Goals treatment, Clinical Resource Hub referrals, impact of Veterans benefits on suicide risk, impact of mental health clinic capacity and efficiency fluctuations on suicide-related events, utilization of Whole Health on suicide risk, and electronic risk identification in health care settings.

Activities to be continued or undertaken:

We will continue to prioritize research topics and create research roadmaps related to specific focus areas identified as high-risk targets, such as military-to-Veteran transition and lethal means safety, precision medicine, and machine learning approaches to risk identification.

- Through the establishment of the Suicide Prevention Clinical Resource Center, organize and expand a community of researchers to increase awareness of and attention to suicide prevention research, to encourage networking, and to help develop the next generation of suicide prevention researchers.

- Develop coordinated data science research activities throughout the research program, as well as with other VA program offices. This effort includes the establishment of a Suicide Prevention Research Advisory Group that is designed to provide oversight of the ORD suicide prevention portfolio to ensure that Suicide Prevention research initiatives are responsive to operational issues and challenges. Members of the Advisory group includes leadership personnel from OMHSP, Rocky Mountain MIRECC, Suicide Prevention Center of Excellence, Suicide Prevention Research Impact Network (SPRINT), ORD, DoD, and NIH.

- In partnership with QUERI, continue evaluations of several national initiatives focused on suicide risk assessment using the electronic health record; impact of VA benefits on suicide risk and prevention; Veterans Crisis Line; Life Goals treatment; Clinical Resource Hub referrals; impact of mental health clinic capacity and efficiency fluctuations on suicide-related events; utilization of Whole Health on suicide risk; suicide prevention among transitioning Servicemembers; and the implementation of Caring Contacts to reduce the risk of suicide among Veterans.

- Continue to fund SPRINT to support networking within and outside VA through cyberseminars and meetings that promote interactions between VA investigators and federal partners engaged in suicide prevention. SPRINT also works closely with OMHSP to speed the sharing of reaching findings with the field, thereby hastening improvements in care and reducing Veteran deaths by suicide.

- In response to the Commander John Scott Hannon Veterans Mental Health Care Improvement Act (2020), conduct large-scale data analyses, using computing resources from the Department of Energy, to assess the impact of altitude on suicidal thinking and behaviors among Veterans.

- Partner with DoD, the Department of the Army, and NIMH in the third phase of the Study To Assess Risk and Resilience in Servicemembers– Longitudinal Study (STARRS-LS). VA investigators are working with STARRS-LS investigators in developing analyses and papers to inform issues of critical importance to Veterans, such as homelessness and transition from military status. Efforts are underway to facilitate the sharing of VA health data with DoD to further analyses looking at the impact of the military experience on suicidality among Veterans. An emphasis of our 2024 efforts will be to establish a training program for VA investigators. Through the partnership with SPRINT, we intend to establish a Researcher-in-Residence program to provide necessary training and mentorship for STARRS-LS data sets, including DoD administrative data. VA/STARRS-LS collaborations will assist in pursuing other aims, including use of machine learning, to identify suicide risk and understanding suicide risks when transitioning from military to civilian life.

- Provide data on VA research programs for a joint VA/DoD report on mental health programs.

- Use findings from a current study on altitude and suicide risk to inform VA policy and help ORD determine which types of follow-up studies are most appropriate to further our

understanding of the biological mechanisms underlying the relationship between altitude and suicide. These findings will also be used to inform the development of effective interventions for suicidality and depression among Veterans living in high-altitude areas.

- Enhance the availability of and incentivizing the analysis of longitudinal data, including imaging and EEG data, from Veterans with mental health conditions or traumatic brain injury while ensuring data security and Veterans' privacy. (Section 305).
- Launch prospective data collection through a network of clinical research sites for the precision medicine for mental health initiative (Section 305).
- Fully embrace a public health model for suicide prevention in managing the ORD suicide prevention portfolio. Specific components of the portfolio should include risk identification research, risk mitigation research, and implementation and dissemination of research.
- Collaborate with OMHSP and Office of Women's Health on the implementation and QUERI evaluation of the Reach Out Stay Strong, Essentials (ROSE) initiative to support suicide prevention efforts among female Veterans.

Million Veteran Program

The Million Veteran Program (MVP) is a national voluntary research program that partners with Veterans receiving their care in the VA health care system to study how genes affect health. To do this, MVP is building one of the world's largest databases of genes and health by safely collecting blood samples and health information from 1 million Veteran volunteers. As of January 2023, MVP has enrolled over 925,000 Veterans. Data collected from MVP is stored in a secure manner and is coded for researchers so Veterans cannot be directly identified. Researchers are using MVP data to study diseases like diabetes, cancer and military-related conditions, and 75 peer-reviewed publications have resulted from the program thus far – many appearing in prominent, high-impact journals. MVP data access was opened to all VA researchers in 2022, and access to deidentified data to non-VA researchers through the VA Data Commons will begin in 2024. The amount and types of data generated by MVP and curated for researchers is expanding, including whole genome sequence data, methylation, metabolomes, and proteomes.

Recent Accomplishments:

- Crossed the 925,000-enrollee milestone, with 15 sites reaching total enrollment of 20,000 to 29,000, 20 sites reaching total enrollment of 10,000 to 19,000; and enrolled over 25,000 participants online.
- Completed piloting the Measures for Investigating Neuropsychiatric Disorders (MIND) survey and obtained Institutional Review Board (IRB) approval for a national launch in 2023.
- Opened MVP data access to all VA researchers through all current ORD funding mechanisms: over 75 ongoing MVP studies.

- Partnered with the National Heart, Lung and Blood Institute to obtain their TOPMed (Trans-omics for Precision Medicine) sequence data, completed imputation of MVP genotype data and provisioned to all approved MVP researchers.
- Completed processing over 100,000 whole genome sequences and provisioned 10,000 as a pilot to all approved MVP researchers.
- Contributed maximum number of phenotypes (over 3,000) to the Centralized Interactive Phenomics Resource (CIPHER).
- Completed the largest genome-phenome association analysis in partnership with the Department of Energy on their supercomputer, SUMMIT, and provisioned summary results to all VA researchers in 2022. In 2023, these summary results will be made available to all researchers via the public access portal of NIH's database of genotypes and phenotypes (dbGaP).
- Published over 175 peer-reviewed papers in high-impact journals.
- Launched the Data Commons pilots (with the goal of expanding access to deidentified MVP data to non-VA researchers in the future).
- Established a 5-year Strategic plan for MVP.
- Established 2 task forces, Clinical Translation and Industry Partnerships, and obtained recommendations.
- Expanded MVP's outreach, awareness and presence nationally in an unprecedented way. This included being featured in national VA campaigns, podcasts (Borne the Battle and Standing Ready), History of VA in 100 Objects (featured MVP), MVP and testimonial videos (MVP 101 video, testimonial videos), several news articles highlighting groundbreaking MVP research (suicide prevention, heart disease, non-alcoholic fatty liver disease, nutrition, height).

Activities to be continued or undertaken:

In 2024, additional types of health data including images, nutrition data, and military exposures will be added. MVP will focus on increasing the diversity of its cohort (in terms of race, ethnicity, gender, age and medical conditions), expanding types and amount of health data, expanding data access, and clinical translation of its discoveries in 2024. In addition, MVP will also establish centralized core resources and services for the VA research enterprise, such as a Genetic Validation Core and a Genomics-Based Drug Discovery Core. MVP also plans to recontact participants and obtain a second biospecimen from 100,000 participants to enhance scientific discovery and clinical translation. MVP is establishing several internal and external partnerships as follows:

- MVP is partnering with MERP and HOME to begin assessing how military deployment-related exposures interact with genetics and lifestyle to impact health. A special focus will be on developing risk assessment tools related to gene/environment interactions as they relate to cancer risk, with a focus on carcinogens and other environmental pollutants. A task force is being established to assess how current MVP data can contribute towards this goal, and what additional data and partnerships are needed to enhance research capabilities. Partnership with the DOD and getting access to their databases on military exposure and

pre-deployment biospecimens will be critical for identifying the potential long-term health consequences of exposure to burn pit emissions and environmental pollutants for Servicemembers.

- MVP is partnering with the Precision Oncology to enhance discovery and clinical translation of genetic risk factors as well as genetic determinants of treatment response for prostate cancer, lung cancer and other cancers. MVP will bring in new data types such as images, tumor sequences etc.
- MVP is partnering with the National Precision Oncology Program (NPOP) to build an informatics platform to receive, store, integrate and annotate the NPOP data to enable clinical precision oncology, leveraging the MVP scientific computing platform architecture and design.
- MVP is part of VA's response to the Hannon Act requirements and has launched the Measures Investigating Neuropsychiatric Disorders (MIND) survey with the goal of having 50,000 Veterans with mental illness and substance use disorders complete the survey over the next 5 years. In 2023, 6 new sites will be launched for recruiting Veterans to complete the MIND survey. A total of 20 to 25 sites are envisioned over the next 2 to 3 years.

  These efforts also include a partnership funded through an interagency agreement (IAA) between VA and the Department of Energy (DOE) to combine health and genomic data from MVP with DOE's expertise in AI and machine learning. Through the IAA, a secure computing enclave for personal health information has been established at the Oak Ridge National Laboratory. Copies of the VA Corporate Data Warehouse (CDW) data and MVP data have been moved. Three joint exemplar projects were initiated in 2019 on using AI to predict risk for death by suicide and to better understand metastatic prostate cancer and cardiovascular disease in Veterans.
- Develop decision-support tools for VA clinicians to predict risk for suicide, as well as other conditions that show promise for precision medicine.
- Complete eight new projects selected through the request for concept proposals: improving treatment for heart failure, improving risk prediction of suicide, predicting negative side effects of antipsychotic medications for better management of care, Long COVID, enabling precision care for sleep disorders, improving lung cancer screening, improving precision treatment for lung cancer, and improving risk prediction and management of complications from diabetes.
- Collaborate with VA operations partners, HSR&D, and QUERI to enhance recruitment, retention, and inclusion of under-represented groups – including vulnerable, at-risk, and marginalized Veteran populations – to achieve community-engaged R&D goals.

Addressing the Needs of Veterans with Tinnitus

Auditory system injuries, which include tinnitus, hearing loss, and balance problems, occur often after military-related noise and blast exposures. Tinnitus and hearing loss are among the 10 most prevalent service-connected disabilities of new compensation recipients. Research in auditory system injuries remains a VA priority to ensure the development of diagnostic tests to identify tinnitus and other auditory related injuries, novel intervention treatments, and self-management

tools to alleviate auditory system injuries. Funding for tinnitus is reported under the Sensory Loss DRA.

ORD has a dedicated, funded hearing research center, The National Center for Rehabilitative Auditory Research (NCRAR), which was established 26 years ago by the VA Rehabilitation Research & Development Service. In addition to this Center, ORD funds research investigators in other VA Medical Centers working to resolving issues of auditory system injuries in our Veterans. Several investigators also obtain funding from agencies such as National Institutes of Health: National Institute of Deafness and Other Communication Disorders (NIDCD), the Department of Defense (DoD), and academic institutions to cohesively leverage funding to address tinnitus outcomes. VA ORD scientific staff serve on various Federal agency (e.g., NIH, DoD) committees, councils, and panels, which fosters collaboration in research related to auditory system injuries and accelerates advances in solutions for Servicemembers and Veterans.

Recent accomplishments:

- Development of a Tinnitus Clinical Decision Guide to improve identification of healthcare needs. Healthcare providers may be unfamiliar with management of patients with tinnitus. In a recent publication, VA researchers provided a clinical decision-making guide to assist otolaryngologists with making referrals for their patients with tinnitus. Topics addressed in the guide include characterization of tinnitus and decreased sound tolerance (also referred to as "hyperacusis.") Also provided are noise-exposure screening questions and ototoxicity (hearing loss and/or balance problems as side effects of medications) monitoring schedules that could be used with the clinical decision-making guide to facilitate appropriate recommendations for patients with tinnitus related to these exposures.
- ORD, in collaboration with DoD, funded a longitudinal study to evaluate the effects of noise and other exposures on auditory functioning in post-911 Veterans. Little is known regarding the epidemiology, etiology, pathophysiology, and comorbidities of hearing loss and tinnitus in the military population. The full risk of long-term hearing disorders in Servicemembers exposed to noise is unknown. Compounding this problem, many other military and non-military exposures can cause auditory injury, including solvents, blasts, other sources of traumatic brain injury (TBI), and certain other injuries and medical conditions. This study is the first contemporary longitudinal assessment of hearing loss and tinnitus in a Veteran and Servicemember cohort and is a good example of VA and DoD collaboration. This study offers insight into estimates of incidence of hearing loss and tinnitus following military service, which can lead to prevention, intervention, and rehabilitation efforts.
- Funding a study to establishing normative standards for measurement of tinnitus perception using a computer-automated Tinnitus Evaluation System (TES) developed by NCRAR researchers. There currently are no established methods to measure changes in tinnitus to determine treatment and rehabilitation success, and Computer-automated TES can address this need.
- Identifying somatosensory tinnitus, a type of tinnitus that may occur with injuries to the spine or temporomandibular joint. It is suspected when perceptual characteristics can be modified with manipulations of head, neck, and jaw positions. Reports from an ORD

preliminary study indicates that many Veterans in the study had somatosensory tinnitus, which may be lessened after physical therapy. A follow-up large scale study is ongoing to develop a standardized diagnostic test to identify somatosensory tinnitus and to create standardized treatment tools for physical therapists.

- Funding NCRAR research in collaboration with The Université Aix-Marseille in France, to use objective measures such as electroencephalography (EEG) and auditory evoked potentials (AEP) to identify tinnitus. EEG and AEP measures may help differentiate tinnitus from non-tinnitus patients and, in previous studies, provided evidence for changes in patients when comparing post from pre-treatment responses.
- Funding a Genome-wide association study of tinnitus using the Million Veterans Program (MVP) database, with emphasis on TBI. Tinnitus is correlated with hearing loss, secondary to age, noise, and TBI. Diverse genomic profiles may lead to tinnitus when triggered by environmental stimuli, such as noise, blast, or head trauma. The goal of this study is to characterize a phenotype for tinnitus in a Veteran population and to identify genes and gene-by-environment (GxE) interactions that predict development of tinnitus. The MVP study uses genomic data, hearing loss, tinnitus, TBI and related medical history and military exposures to separate tinnitus into etiologies and distinguish among phenotypes in order to improve treatment customization. The study also includes data from DoD health records to help predict relationships between TBI, mild cognitive impairment, hearing loss and tinnitus.
- Funding a study evaluating possible auditory and psychological biomarkers of sound intolerance. Hyperacusis and noise sensitivity are types of decreased sound tolerance (DST) disorders and frequently reported in patients with tinnitus and head injury, respectively. Severe DST manifests as everyday sounds being perceived as too loud, overwhelming, and annoying. The study will evaluate a critical need to understand the pathophysiology that leads to severe DST. The investigators will examine the relationship between auditory and psychological biomarkers to provide clinically relevant information on where deficits exist in sensory and/or neurological structures that lead to severe DST. This knowledge will guide future studies so that rehabilitative treatments can be developed targeting the underlying mechanisms.
- Funding a study evaluating hearing loss risk prediction among patients exposed to ototoxic drugs or noise. This modeling study will be published in a special issue of the Journal of the Acoustical Society of America.
- Funding a study to help identify potential noise related damage (hidden hearing loss) to synapses (synaptopathy) in the auditory system using electrophysiological markers (middle and late auditory evoked potentials). Preliminary results of this clinical trial showed that specialized electrophysiological tests may provide evidence of auditory system damage after noise exposure, like evidence from animal studies after noise trauma. Two publications have resulted to disseminate these findings.
- In 2022, the VA/DoD Tinnitus Working Group (individuals from VA, DoD, VA/DoD Hearing Centers of Excellence, and other stakeholders) received funding for 2023 from the VA Evidence-Based Practice Program (EBPP) to develop a Clinical Practice Guideline (CPG) for tinnitus clinical management. The project involves a systematic review of all

randomized controlled trials on tinnitus management. The CPG will be published in a peer-reviewed journal to educate providers and ensure Servicemembers, and Veterans have access to evidence-based clinical tinnitus services.

- In 2023 VA ORD – with other agencies such as the National Institute on Deafness and Other Communication Disorders (NIDCD), Congressional Direct Medical Research Programs (CDMRP) Hearing Restoration Research Program, and the American Tinnitus Association – are developing a Hearing Funders Network to foster communication and collaborations among international organizations to advance hearing and tinnitus research.
- In 2023 a Special Emphasis Area was added to the Request for Applications (RFAs) to address the effects of blast, noise, and/or TBI on one or multiple sensory systems and communication disorders (e.g., tinnitus, vestibular, vision, speech, and related disorders).

Activities to be continued:

- VA ORD-funded NCRAR Center developed online Tinnitus Training Courses on VA's Talent Management System (TMS). The tinnitus educational materials are used to assist Veteran patients and VA clinicians that will be continued to be provided into FY 2024.
    - NCRAR provides a tinnitus training course that contains four training modules that were posted on TMS and on the TRAIN national learning network to make the course available to DoD providers.
    - The VA team created and maintains fifth training course posted on TMS (#44933, Setting up a Tele-PTM Program) which provides detailed information and instructions for setting up a telehealth tinnitus management program. The telehealth version of PTM, i.e., Tele-PTM, allows VA clinicians to provide tinnitus counseling remotely and research-based tinnitus services to Veterans.
    - In 2022, the VA team completed and maintains a sixth EES online training course (#131002413) focused on clinical management of sound tolerance disorders (e.g., hyperacusis, misophonia, noise sensitivity, and phonophobia).

Scientific Computing

VA is the largest integrated health care system in the country. As such, VA's EHR is one of the most comprehensive health data sets available to researchers, including information on diagnoses, medications, health factors, lab results, images, and clinical notes on over 24 million Veterans, amounting to tens of billions of data points including image data. In addition, MVP is generating increased amounts of genetic and molecular data, including whole genome sequences, metabolomes and proteomes, nutrition data, image data, and military exposure data, which require sophisticated and high-performance computing resources for analysis. These unique health and genetic data resources put the Department in an ideal position to drive scientific discovery to better personalize care for Veterans and realize the goals of precision medicine. ORD will invest in the following tools to modernize data infrastructure.

Recent Accomplishments:

- Implemented the ability to purchase scientific computing with software and storage of research data hosted in the VA enterprise cloud environment as a service purchase. Created a portal to receive and prioritize requests and track expenditures.
- The first analytic pilot project, which is underway in the newly established process, will be a genome-wide association study of MVP data. Copies of deidentified MVP genetic and health data have been moved to the VA Data Commons, and operational testing completed. The first set of 13 approved analyses for beta-testing will begin in 2023.
- Completed the Brain Injury Data Sharing (BIDS) project linking VA and DoD health records for Veterans and Servicemembers with private sector systems affiliated with the national Patient-Centered Clinical Research Network (PCORNet). BIDS uses privacy-preserving records linkage technology that protects individual privacy but allows data linkage between federal agencies and between federal agencies and state or non-governmental entities.
- Transformed EHR data from Cerner Millennium into the OMOP common data model to allow for integrated analysis across already transformed data with the VA Corporate Data Warehouse (CDW), VA-linked DoD records from the DoD/VA Infrastructure for Clinical Intelligence (DaVINCI), and VA-linked Centers for Medicare and Medicaid Services (CMS).

Activities to be continued:

- Continue to expand and modernize the existing VA computing infrastructures, such as VA Informatics and Computing Infrastructure (VINCI) and Genomic Informatics System for Integrative Sciences (GenISIS) to enable use of AI, machine learning, and high-performance computing with VA and MVP data by the large number of VA researchers.
- Enhance cloud-based analytic tools in the VA Enterprise Cloud (VAEC) (VINCI Prospect and the Research Analytics Scientific Platform (RASP)) and Software-as-a-Service (SaaS) systems to better support VA research.
- Expand the available data types and number of analyses within the VA Data Commons, a system that expands the number of qualified researchers who can analyze de-identified EHR and genetic data from MVP.
- Support implementation and data feeds to cloud-based dashboards and decision support tools used by senior VA leadership.
- Utilize Artificial Intelligence (AI) and other advanced methods to bring together research and clinical teams to meet the needs of Veterans.
- Leverage VA's partnerships with the Department of Energy to utilize DOE's supercomputers and expertise in AI and machine learning.
- Strengthen VA's capability to support interagency and community federated network studies using common data models, such as Observational Medical Outcomes Partnership (OMOP) and standard methods for translating statistical and machine learning models between VA and other health care systems.

- Advance real-world evidence/data and causal inference methodologies that can use original (e.g., clinical trials) or existing (e.g., EHR) data to conduct analyses to provide additional insights for clinicians that and scientists on treatment effectiveness and/or other pathways for improvements in care.
- Continue to build on models of centralized data cores that coordinate across research and operations groups to curate and validate electronic health record and genetic test data, such as the Prostate Cancer data core, the Genetic and Molecular Diagnostic Test (GDx) data core and the Pharmacogenomics Action for Cancer Survivorship (PHASeR) data core in VINCI.
- Complete the requirements review of the 17 IT systems/applications that are maintained primarily in Falling Waters, West Virginia, and have identified the systems to sunset or modernize and incorporate existing data and/or processes with the new ORD enterprise infrastructure system: the VA Innovation and Research Review System (VAIRRS).
- As the scientific computing program matures, more data analytic software is added to the cloud environments and more MVP genome-phenome based studies are performed. This budget item will likely grow accordingly.

Pain and Opioid Use

Chronic pain is more prevalent and of a greater intensity in the Veteran population than in the general population. It is often accompanied by coexisting mental health problems and overlapping painful conditions. This places Veterans at risk for harm from opioid medication, especially opioid use disorder (OUD). VA Research supports the generation of new knowledge to improve the prevention, diagnosis and treatment of OUD, as well as the development and testing of innovative approaches for chronic pain management for Veterans. This work is guided by the requirements of the Comprehensive Addiction and Recovery Act (CARA), the Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand, VHA's Opioid Safety Initiative, and the Hannon Act.

Recent accomplishments:

- In the previous reporting period, the Cartilage Repair Strategies to Alleviate Arthritic Pain (CaRe-AP) consortium of VA investigators was included. The team used a cell/biologic (tissue engineering) and rehabilitative approach to repair damage to the knee resulting in pain and osteoarthritis. In the current report, the consortium held its second annual Symposium focusing on how to perform multi-site preclinical studies with standardized models, functional assays, data analyses and interpretation of results. This approach will ensure replicability of results and clinical meaningfulness of the studies performed to facilitate translation.
- The "Pain in a Dish" project used induced pluripotent stem cells (iPSCs) from patients to screen novel non-opioid drugs and to identify genes that modulate pain (e.g., worsen or decrease pain) and the role of sodium channels in osteoarthritis. Chondrocytes, the building blocks of cartilage, possess sodium channels that modulate pain. In addition, the group is continuing to study the role of sodium channels in painful conditions relevant to the

Veteran population (e.g., phantom limb pain, chemotherapy induced neuropathy, osteoarthritis, and spinal cord injury).

- Continued to develop non-opioid therapeutics to treat painful conditions.
    - Gene therapy as a treatment for spinal cord injury (SCI)-induced neuropathic pain. Neuropathic pain as a result of SCI occurs in approximately 60% of people living with SCI and is refractory to available drug treatments. This study uses a gene therapy approach specifically targeting the spinal cord to ameliorate pain.
    - A second study targets melanocortin receptors expressed in the central nervous system to treat chronic pain due to inflammation. The study uses a unique intranasal delivery approach to reduce hyperalgesia and inflammatory pain.
    - A third study focuses on the pursuance of endomorphins – naturally occurring molecules in the brain - as alternatives to opioids. This study is moving towards preclinical testing for Food and Drug Administration approval.
- Studied the effects of COVID-19 on pain management in VA. The goal of this project is to understand changes in VA chronic pain care after COVID-19 and their associated impacts and to use these data to develop strategies to optimize future delivery of VA pain services in a post-COVID-19 environment. The project focuses on Veterans living with chronic low back pain. This study is ongoing.
- Studied the effects of electrical stimulation to alleviate chronic painful conditions including ocular pain and headache. These approaches use non-invasive methods to stimulate nervous tissue to interfere with maladaptive pain processing. The stimulation units used are adapted for in-home use, making them available to Veterans living in rural communities.
- Developed novel means to diagnose and potentially quantify joint pain using MRI. This study solves the discordance of using of x-rays to identify joint degeneration and patient-reported pain by introducing imaging of pH changes within the joint as a measure of pain. Studies on Veterans with osteoarthritis of the knee using this imaging technique support use of pH as a biomarker for joint pain.
- Stepped Care for Opioid Use Disorder Treatment (SCOUTT), a national initiative launched by QUERI in partnership with the OMHSP increased evidence-based prescribing for opioid use disorder treatment. This work is nearing completion.
- Used informatics tools such as machine learning to predict risk for incident and recurrent OUD. The study examines gender, race/ethnicity, deployment-related trauma (e.g., traumatic brain injury and prevalent psychiatric and substance disorders), and close-blast exposure as moderators of the risk of OUD and overdose. It also investigates the short- and long-term impact of the COVID-19 pandemic on the risk of OUD and overdose.
- The Opioid Education and Naloxone Distribution (OEND) initiative was rolled out several years ago. Currently, more than 395,000 Veterans have been prescribed naloxone by over 44,600 prescribers with over 3,300 reported overdose reversals. This project is being continued.

- The QUERI-funded VISN Partnered Implementation Initiative for opioid and pain treatment has developed 30 products, supporting close to 1,900 VA providers and other frontline staff across 60 VA sites in delivering evidence-based treatments for pain and opioid use disorder across primary and specialty care, emergency departments, hospitals, and via telehealth (e.g., Teleprescribing Medications for Opioid Use Disorder has served nearly 1,300 Veterans from 19 sites). TelePain has reached more than 4,300 Veterans and is expanding to 10 additional VISNs. The QUERI-supported Cooperative Pain Education and Self-management (COPES) initiative provides a centralized and effective form of cognitive behavioral therapy for chronic pain to Veterans, insulates against disruption of services from staff turnover, and conserves pain psychologist effort for higher tiered care. It has been adopted nationally by VHA.

Activities to be continued or undertaken:

- Continue to build upon a collaboration with the Arthritis Foundation (HAP Partnership Impact - National Center for Healthcare Advancement and Partnerships).
- Continue to interact with OMHSP, VHA's Pain Management, the Opioid Safety Initiative, and the Prescription Drug Monitoring Program to coordinate clinical care needs with research. A better alignment of the Pain Management and Opioid portfolio with clinical care will facilitate translation of research products to the Veteran.
- Continue to focus on non-opioid approaches for chronic painful conditions. Studies include:
    - Activity-based modalities, including exercise and corticosteroid injections for knee osteoarthritis.
    - The "rage against pain" yoga project for chronic low back pain that was highlighted last budget period is nearing completion.
    - Electrical stimulation – mentioned previously.
    - Non-opioid therapeutic development – mentioned previously, including non-opioid drug and tissue engineering approaches.
    - Gut microbiota – role of the gut microbiome and its role in intestinal pain.
    - Orthotic devices for painful peripheral artery disease.
- Pharmacogenomics. Three studies utilize MVP data to identify genetic risk factors for:
    - OUD and alcohol use disorder, with co-existing depression in European and African American Veterans.
    - Identification and validation of substance use disorder phenotypes using MVP and electronic healthcare records and extending results to painful conditions in European, African American, and Latino populations.
    - Using MVP's phenotype and genotype data to identify and validate genetic predictors of opioid sensitivity.

- Continue to develop safe strategies for reducing opioid use, improving use of medication therapy for Opioid Use Disorder (OUD), and improving the co-management of OUD and pain. Studies include:
    - Biobehavioral approaches include cognitive behavioral therapy provided post-operatively to reduce the reliance on opioids, and acceptance and commitment therapy to motivate behavioral change in adherence to medication for OUD.
    - Activity-based methodologies in conjunction with pain education for pain management coincident with OUD. This study emphasizes a self-care approach for Veterans.
- Conduct a study on diagnosing and treating Veterans with chronic pain and opioid misuse. This study targets Veterans living with chronic pain and on long-term opioid therapy with misuse but without OUD, and who asked to participate in a trial comparing continued opioid use, opioid tapering, or switching to buprenorphine. Patient-centered outcomes will be collected on pain intensity and mental health symptoms. The goal is to improve misuse identification methodologies and to guide treatment strategies.
- Use predictive analysis to identify risk factors to determine who is at risk for OUD, and to determine when it is safe to discontinue medication for OUD.
- Continue the Pain Management Collaboratory with NIH and DoD. The Collaboratory is comprised of trials of non-drug approaches for the management of pain and common co-occurring conditions. This endeavor is ongoing and is in discussion for renewal.
- Continue a proof-of-concept trial of cannabis derivatives, which examines the use of cannabis and its derivatives in a clinical trial to determine efficacy, safety, and tolerability in patients living with painful diabetic neuropathy.
- Continue to promote programs to support Food and Drug Administration (FDA) Investigational New Drug and Investigational Device Exempt status aimed at evaluating novel chemical entities, devices, biologics and promising interventions to accelerate translational research on non-opioid pain management. Several RFAs have been developed and posted as the first steps to promote translation of VA-developed products to FDA approval. FDA approval is required before any therapy can be tested in clinical trials.
- Continue to encourage the development and testing of innovative approaches to treat painful conditions and OUD. These approaches may include combining complementary treatments (e.g., medication, activity and cognitive behavioral therapy) to address chronic pain and/or OUD in vulnerable populations. Develop better ways of reporting accidental harm and standardizing post-harm care within VA. Apply neuromodulation technology to painful conditions with an unmet need. Lastly, understand the importance of how different organ systems interact with each other to modulate the pain response to injury (e.g., involvement of the gut microbiome).

In summary, ORD plans to continue to support investigator-initiated studies of the treatment of acute and chronic painful conditions and long-term opioid treatment and/or OUD, including 144 active awards addressing painful conditions, 45 awards addressing opioid use, and 3 awards examining both conditions.

Post-traumatic Stress Disorder (PTSD)

VA Research has led the way in developing and testing effective psychotherapies for PTSD and in exploring other approaches to treat the disorder, such as medications, behavioral interventions and therapeutic devices. Research is directed at understanding the underlying biology and etiology of PTSD to identify potential treatment targets. We also support treatment-related research focused on expanding the evidence base consisting of psychotherapy, medications, and other approaches.

This PTSD program continues to grow through our support of mentoring and training for new clinical trialists and our active outreach to identify suitable drug candidates, including the possibility to identify molecular targets from analyses conducted on MVP samples. A major clinical trial has been launched in VA, to determine which medications commonly used for sleep disorders will be most effective for sleep disorders in PTSD. This is one of the largest trials to examine insomnia, targeting enrollment of over 1,200 Veterans with PTSD. Three medications will be evaluated, providing key clinical information regarding which is the most effective for decreasing insomnia related to PTSD

Altogether, the research focused on biological understanding will lead to improved treatments. Our research on medications, therapies, and other treatments will improve Veterans' quality of life by increasing the number and type of evidence-based treatments and identifying personalized approaches for treatment.

Recent accomplishments:

- VA has a strong track record of facilitating the implementation of research findings in this area directly into clinical practice. This research investment is important because Veterans with PTSD may respond differentially to treatment than non-Veterans. There are recommended treatments for PTSD, including counseling and medications, but these treatments may not work for everyone. VA Research is developing and testing new treatments for Veterans with military-related PTSD, so that every affected Veteran has the opportunity to get relief from their symptoms.
- ORD has been executing our strategic plan to examine the efficacy and effectiveness of new medications for PTSD under the PTSD Psychopharmacology Initiative. This initiative is focused specifically on increasing the number and type of available evidence-based treatments over the two currently approved medications. ORD started with two clinical trials in 2016. The initiative now funds one ongoing trial, with three which were recently completed. Through these trials, we hope to identify one or more compounds that improve PTSD symptoms.
- Launched a telehealth program to serve Veterans living in rural areas who have PTSD. Researchers at the Puget Sound VA helped deploy Telemedicine Outreach for PTSD, a program based on research conducted in VA that demonstrated the effectiveness of virtual team-based care for rural Veterans with PTSD.
- Identified eight novel genetic variants associated with re-experiencing symptoms, a major symptom of PTSD, in more than 165,000 Veterans — one of the largest genome-wide association studies to date on PTSD.

- Provided a PTSD Repository that is used by VA's PTSD Consultation Program. The repository provides an evidence base for questions that program staff receive from national clinicians and other stakeholders. The repository has also been used by the National Center for PTSD to address urgent "hot topic" requests and media inquiries.
- Funded a large multi-site clinical trial to investigate the feasibility and efficacy of stellate ganglion block as a treatment for PTSD in Veterans.
- Funded rapid turnaround studies to understand the challenges faced by Veterans with PTSD during the COVID-19 pandemic and to test new strategies to meet these challenges.

Activities to be continued or undertaken:

- Recruit Veterans with a variety of mental health conditions, including PTSD, to participate in MVP under the MVP-MIND effort. MVP-MIND is designed to increase the representation of Veterans with PTSD and other mental health conditions that commonly affect Veterans in MVP.
- Over 1,200 participants have been enrolled into an adaptative multi-site clinical trial of multiple medications to treat insomnia in Veterans with PTSD.
- Continue to launch new meritorious clinical trials addressing medication, therapy, and other approaches.
- Support studies to explore the impact of support from peers, family members, and caregivers on the treatment outcomes of Veterans with PTSD and test the effectiveness of complementary, integrative interventions such as yoga.

Spinal Cord Injury and Disorders (SCI/D)

Approximately 17,000 new cases of spinal cord injury occur each year, of which several hundred involve Veterans. The VA Healthcare System provides care for up to 27,000 Veterans living with Spinal Cord Injury and Disorders (SCI/D), such as Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS). These various conditions can result in permanent neurologic changes leading to paralysis. ORD supports innovative research on SCI/D to repair and/or replace damaged and lost tissue, restore lost function, and mitigate secondary consequences; all to maximize function, independence, and social reintegration for the Veteran considering their resultant disability.

Recent accomplishments:

- Advanced tissue regeneration and engineering through development and testing of a cell-based therapy to repair the injured spinal cord. This project has progressed to an FDA Initial Targeted Engagement for Regulatory Advice on Center for Biologics Evaluation and Research Products meeting. This is a first step towards conducting safety and toxicology studies prior to FDA approval of the product for human clinical trials. The

product is a human Neural Progenitor Cell (NPC) combined with rehabilitation for restoration of upper limb function. The team is also examining the use of bioengineered scaffolds to repair the spinal cord.

- Powered Exoskeletons for Persons with Spinal Cord Injury could help Veterans restore, replace and rehabilitate for functional recovery. This study provided Veterans with SCI exoskeletons for overground ambulation and was the first take-home study of its kind. Due to the promising study findings, the VA has developed a clinical protocol for the use of powered exoskeletons, as well as offering exoskeleton training to eligible Veterans (Spinal Cord Injuries and Disorders System of Care Home (va.gov)).
- Restoration of bladder function using electrical stimulation of the genital nerve. This is a take home study to reduce incontinence and improve Veterans' quality of life. The study is nearing completion.
- Restoration of ambulation using a combination of spinal cord epidural stimulation and exoskeletal assisted walking, or trans-spinal (non-invasive) stimulation and exoskeletal assisted walking. This is a comparative-effectiveness pilot study to determine which approach is most effective in walk speed, bladder function and cardiovascular performance.
- Conducted a needs assessment for women Veterans using mobility devices. This study focused on the priorities and views of women Veterans regarding the use of prosthetics and assistive technologies. This study is nearing completion with future studies examining the design of mobility devices that address women's needs.
- Transferring from the wheelchair to a chair or bed and back requires training after injury, and for some individuals with severe paralysis involving the upper and lower extremities, this may involve transfer devices. An automated system would aid in conduction of the proper sequence of events when performing transfers and minimize falls. This powered system is a prototype currently being tested.
- Neurogenic bladder leads to catheter-associated urinary tract infection (CAUTI). As time goes on, repeated infections become antibiotic resistant and may lead to death in the SCI population. To mitigate this risk, investigators are testing use of bacteriophages – organisms adept at killing bacteria – then determine whether bacteria develop resistance to bacteriophages.
- Community-acquired pressure ulcers (PU) are more frequent than hospital-acquired PU, and even after the wound has healed and the patient is returned home, the likelihood of recurrence is roughly 50%. This study seeks to identify risk factors associated with recurring PU formation upon return to the home setting and to develop a risk factor tool that specifies actions and resources needed to reduce recurrence.

Activities to be continued or undertaken:

- Pressure ulcers (PU) are unintended consequences of SCI. They are difficult to treat, debilitating, and can be life threatening. VA researchers are using muscle biopsies to identify anatomical correlates associated with susceptibility to PU development. Researchers have identified muscle quality as a key biomarker towards the prevention of PU formation. Individuals with muscle high in fat content were prone to develop PU and

recurrent PU. The study team is expanding the study to examine the role of genomics in the development of muscle with high fat content that can lead to PU.

- Spasticity and pain are unintended consequences of SCI regardless of the level of injury, occurring in a significant number of Veterans living with SCI. There is a very limited number of approaches to alleviate both conditions, leaving many individuals unrelieved. VA researchers are repurposing drugs used for other indications to treat spasticity and collaborating with industry to test new drugs for neuropathic pain. The VA has two patents on the use of romidepsin to treat spasticity, and this study is starting toxicology testing in animal models of SCI.
- An alternative to invasive spinal cord stimulation, transcutaneous electrical spinal stimulation and transcranial magnetic stimulation are being used to modulate neural circuitry to retore function to the upper limbs. These studies are progressing to larger scale clinical trials.
- The VA has been leading the field with respect to employment following SCI. Initial studies supported placement of Veterans with prospective positions, and due to the success, became a multi-center study. The current study goes one step further and now examines customized employment vs placement to further promote employment and longevity of employment in the Veteran community.
- Studying the needs and experiences felt by lesbian, gay, bisexual, transgender, and queer identities (LGBTQ+) Veterans who live with SCI and the care they receive within the VA system. The goal is to identify areas for future study and to develop strategies to better meet the needs of this population.
- Multiple Sclerosis (MS) and Amyotrophic Lateral Sclerosis (ALS), this study examines the relationship between repetitive head impacts, ensuing neurodegeneration and ALS. The group has identified a gene that may play a role in disease progression in the repetitive head injury and neurodegeneration population – *TMEM106B*. The study examines whether *TMEM106B* is associated with pathology in ALS participants and whether gene expression is correlated with clinical outcome. MS is an autoimmune disease resulting in the demyelination of nerves. Remyelination is limited, resulting in motor, sensory and behavior deficits. This study explores the use of a drug, lanthionine ketamine, to facilitate the remyelination of nerves by promoting the maturation of the cells that myelinate nerves. If successful, the drug will undergo toxicology testing for FDA approval and move to clinical trial.

Emerging Infectious Diseases and Pandemic Preparedness/Prevention Research and Impacts

Following the start of the COVID-19 pandemic, VA Research organized an enterprise-wide research response that demonstrated its strength across a range of biomedical research. By leveraging its unique position as part of the nation's largest integrated health care system, ORD has conducted and partnered in preclinical, clinical trials (including vaccine and therapeutic studies), health services, 3D printing, and "big data" studies. VA COVID-19 research funding supports efforts that began during the pandemic and enabled a readily available capability to partner with other federal agencies.

VA is fortunate to have nationally recognized experts in infectious diseases that include physician scientists, applied researchers, epidemiologists, pharmacologists, and data scientists. We have leveraged our expertise and unique capabilities to conduct and participate in major national research studies. We will build on this work in collaboration with our clinical partners and other agencies to expand the enterprise projects originally established for COVID-19 to other emerging infectious diseases so we can continue to inform care in VA and across the country and prepare for and prevent other pandemics.

For instance, VA researchers have been generating real-world evidence of the effectiveness of COVID-19 vaccines and therapeutics across the country. These efforts will now be expanded to monkeypox and other infectious diseases. Through collaborations with FDA, CDC and NIH, this knowledge helps to inform decisions on significant issues, such as the need for boosters, new vaccine targets, and administration guidelines for therapeutics. In addition, we are working with DoD on a project to closely follow several thousand people from the time of diagnosis, including detailed bio sample collection. This will help to understand the mechanisms of different clinical trajectories following COVID-19 and for other infectious diseases.
VA will continue to build coordination through curation, dissemination, and documentation of relevant data resources in the VA COVID-19 Shared Data Resource, as well as through core methodological and technical coordination among central working groups. VA is also collaborating with national and international health care systems on the analysis of real-world data on COVID-19 through networks like the Observational Health Data Sciences and Informatics collaborative. Some of these activities will involve a collaborative effort between ORD and the VA Office of Information Technology (OIT), with support from the Department of Health and Human Services' Biomedical Advanced Research and Development Authority (BARDA) and FDA. This partnership will allow VA to provide access and support to the Department's research and analysis, supported VINCI and VA Pharmacy Benefits Management. More recently, these capabilities have been more focused on post-acute sequelae of SARS-CoV-2 infection (PASC, also referred to as long COVID) and monkeypox infection. Efforts are centered on a coordinated real-world evidence capability for treatments and health outcomes associated with COVID-19 infection and monkeypox vaccination/infection. A key goal over time is to also leverage VA's Corporate Data Warehouse data in these efforts to better understand the effectiveness of vaccines or therapeutics that Veterans receive.

Recent accomplishments:

- Released seminal findings on the impacts of post-COVID conditions and "long-COVID." VA investigators analyzed electronic health data on eight million Veterans to produce some of the most comprehensive analyses of the wide-ranging impacts of COVID-19 on post-COVID conditions occurring after three months, or "long COVID," including increased risks of cardiovascular disease, renal disease, diabetes, and new neurologic or mental health diagnoses.
- Established the ORD Biorepository/VA SHIELD. This repository of biospecimens and associated data from infectious and emerging diseases is now available for research studies. It will help advance scientific understanding of infectious and other diseases;

support clinical research; and further diagnostic, therapeutic and preventative strategies for immediate deployment in VA clinics.

- Coordinated enterprise-wide research on variant sequencing. This project, known as VA SeqCURE (Sequencing Collaborations United for Research and Epidemiology), supports a network of VA research labs established to conduct variant sequencing to monitor the genomic evolution of infectious pathogens, such as SARS-CoV-2. This effort is critical to monitor trends of variants due to concerns that emerging variants may escape the immunity generated by vaccines or prior infections.
- Accrued Veterans into Epidemiology, Immunology and Clinical Characteristics of COVID-19 (EPIC^3). This observational study, done in collaboration with the EPIC^2 study at DoD, collects Veterans' data and biospecimens to gain a detailed understanding of COVID-19's impact on different people. Among other contributions, the study will shed light on why certain people have more severe disease symptoms and why some develop post-acute sequelae SARS-CoV-2 infection (PASC, or "long COVID").
- Established a program on COVID-19 Disrupted Care National Program (DCNP). The COVID-19 pandemic has been marked worldwide by increases in all-cause mortality that track with pandemic severity but exceed the number of deaths attributed directly to COVID-19. An especially concerning national statistic is the marked increase in overdose deaths and other deaths associated with substance abuse. But concern has also been raised about delayed diagnosis of chronic conditions and delayed care for acute conditions. The DCNP includes a Coordinating Center to support a community of VA investigators and partners who are conducting research related to disrupted care due to COVID-19 and exploring excess non-COVID mortality during the COVID-19 pandemic. They have also begun mapping pre-pandemic and pandemic mortality and analyzing these changes in relation to disruptions in VA healthcare use during the pandemic.

It is not yet known to what extent these deaths are related to disruptions in care caused by overcrowded hospitals, delayed elective procedures, a dramatic drop in medical encounters, changes in patient behaviors during the pandemic, or conversely due to undiagnosed or delayed effects of COVID-19 infection.

- National Study of All-Cause Mortality: VA's national study of all-cause mortality among its patients during the pandemic has documented changes in excess mortality during 2020-2021 and is examining which populations were most affected. With the arrival of cause-of-death data from the CDC, VA will examine how specific causes of death are related to local conditions and local policies, as well as the possible contribution of undiagnosed COVID-19 or delayed effects of COVID-19 to excess mortality. The Coordinating Center supports a community of VA investigators and partners who are conducting research related to disrupted care due to COVID-19 and exploring excess non-COVID mortality during the COVID-19 pandemic. DCNP is holding monthly meetings to coordinate collaboration and engagement between research projects on COVID-19 disrupted care. It has also begun mapping pre-pandemic and pandemic mortality and tracking and analyzing these changes in relation to disruptions in VA health care use during the pandemic.
- Impact of COVID-19 on Mental Health Care, Acute Care, and Chronic Disease Outcomes: ORD completed 22 rapid COVID-19 projects to examine effects of the pandemic on mental

health and suicide risk in veterans, the implementation of telehealth, the staffing of nurses in VA facilities, the volume of cardiovascular procedures, and the care of chronic diseases like diabetes.

- Initiated nine projects that examine various aspects of pandemic disruptions to care across the VHA, including mental health care, acute care, telehealth, opioid use disorder, and chronic disease outcomes.
- Created the COVID-19 Observational Research Collaboratory (CORC). The CORC is a multi-site Coordinating Center that coordinates ongoing research related to long-term COVID outcomes and facilitates new studies by promoting common data and methods. The Center has:
    - Examined electronic record data and begun to conduct surveys with thousands of patients from 6-36 months post-infection to assess the effect of COVID-19 on clinical diagnoses, health care utilization, costs, symptoms, and other patient-reported outcomes (compared to matched patients without COVID-19).
    - Conducted 45 semi-structured qualitative interviews of Veterans with long COVID diagnosis.
    - Identified a cohort of over 200,000 SARS-CoV-2 infected Veterans and developed a matched set of controls to be available to other researchers.
    - Established a methods group to review ongoing studies, manuscripts, and produce guidance (white papers). The goal is to ensure coordinated and consistent approaches across these projects.
    - Launched a study of vaccine hesitancy. Although vaccine administration has been very effective among the VA population, there remains an important subset of the Veteran population that has not yet been fully vaccinated (including receiving recommended booster shots). Unvaccinated patients remain at high risk of infection and poor outcomes. Reasons for their hesitancy vary. VA has initiated a study to test whether training frontline staff (including doctors, nurses and support staff) in the technique of motivational interviewing will increase vaccination rates among vaccine-hesitant Veterans. So far, over 1,000 VA employees have been trained across five study sites. The study will also inform VA how to implement such trainings, which can improve VA's responses to future infectious disease outbreaks.

Activities to be continued or undertaken:

Additionally, ORD will continue to fund new investigator-initiated projects on COVID-19 and other emerging diseases. Of note are the following:

- Long COVID: ORD will pursue additional studies into priority questions related to long COVID in Veterans, some of which were identified through an expert meeting in August 2021. They will be led by individual research programs within VA, clinical program office partners, and other federal funders. Funding will support collaborative teams that will address questions, such as functional impairment in long COVID, its effects on cognition and mental health, and the effects of different viral variants and immunization on the severity of long COVID.

- Vaccine and therapeutic effectiveness: VA investigators continue to publish major studies examining the relative effectiveness of different vaccines, with and without boosters; the relative protection against infection, re-infection, and severe disease; and the durability of that protection. Efforts have recently focused on developing a platform for conducting real-world evidence analyses in partnership with BARDA and the U.S. Food and Drug Administration to look at therapeutics as they become available in the VA health care system.
- Variant Sequencing: Through the VA SeqCURE effort mentioned above, VA Research is partnering with VA clinical operations, other federal partners, and state public health agencies to study emerging SARS-CoV-2 variants that may escape immunity generated by vaccines or prior infection and to understand the risk factors and clinical progression associated with different variants through public health surveillance. This enterprise project is also involved in conducting real-world evidence and sequence analysis for COVID-19 vaccines/therapeutics and mpox/smallpox vaccines and therapeutics in Veterans.
- Workforce impacts: In response to VHA priorities related to clinical efficiency, particularly after the unprecedented disruption in workflow, staffing, and access to preventative services during the COVID-19 pandemic, QUERI plans to evaluate clinical workflow adaptations to help improve preventative services.

Investment in the VA Research Enterprise

The goal of the VA Research enterprise initiative is to efficiently deliver on our mission of improving the well-being of Veterans' research in a way that is respectful of the investment of taxpayer dollars. This is best achieved by equipping our system to function as a coordinated whole rather than independent VA medical centers. We have thus defined the VA Research enterprise as *"the entire set of people, tools, and processes committed to a whole-of-VA approach for fulfilling our mission and supporting researchers, clinicians and Veterans."*

The VA Research Enterprise aspires to embody five key qualities:

- **A Unique Value Proposition:** VA Research uniquely contributes to the biomedical research ecosystem by focusing on the needs of Veterans and the Veterans Health Administration, as well as being embedded in the largest integrated health care system in the country.
- **Real-world Outcomes:** The VA Research enterprise improves Veterans' well-being by efficiently solving specific, real-world problems.
- **Engaged People:** The VA Research enterprise involves and relies upon its diverse staff, researchers, and communities, who feel a sense of belonging and empowerment and who share the purpose to improve Veterans' well-being.
- **Integration:** The VA Research enterprise is an integral part of the VA enterprise and the nation's biomedical and health ecosystem, strategically leveraging its relationships and partnerships.
- **Operational Excellence:** The VA Research enterprise is efficient and flexible in its operations. It offers streamlined processes, effective communication and collaboration, high-quality

customer service, and the right tools and resources to support staff, researchers, and communities as they work to improve the well-being of Veterans.

Recent accomplishments:

In 2022, created a set of coordinated initiatives to establish the foundations of the VA Research Enterprise are underway, as described below.

- **ORD Governance and Success Measures**: An enterprise transformation governance system is the foundation of all the initiatives listed below. By establishing a governance plan we defined processes and owners (including program and change management roles). This help will ORD successfully support coordination, prioritization, and implementation of enterprise efforts.
- **IT and Data Governance:** Resources that can only be supported through VA's IT appropriation are among the most sought-after by VA Researchers for both development and sustainment. Effective governance is especially important in the context of limited resources. The IT and Data Governance is rationalizing research IT and data efforts across the enterprise to make the best use of available resources and tools.
- **Actively Managed Portfolios:** This initiative piloted a new research portfolio management model for selected high priority research areas to address the need for greater real-life impact and the alignment of VA research with Veterans' needs. The strategy, processes, funding mechanisms, and metrics to actively managed research portfolios will enable ORD to contribute more efficiently to solving concrete problems faced by Veterans and VA.
    - **Central Research HR Function:** Time-to-hire researchers and research team members have been identified as a major contributor to slow execution of appropriated funds and delays in accomplishment of research objectives. Because researcher staff represent a relatively small group compared to clinical and operations staff, and because of the specialized skills needed to conduct research, timely research benefits from HR staff who specialize in supporting research hiring.
    - **Rationalization of ORD's Organization**: This effort aims to ensure alignment of ORD's organizational structure and roles to support the new VA Research enterprise functions. By so doing, we will be better able to coordinate our resources to improve Veterans' well-being through research. We have completed the first phase of what is anticipated to be a three-year process.
- **Leadership Mentoring Program:** We established an effort to develop an executive training program for Associate Chiefs of Staff for Research in the field. This approach is using a Human Centered Design approach to tailor efforts that will provide skills and knowledge to field research leaders for developing and running programs at their facilities.
- **Finance Processes:** We implemented a process to maximize the impact of VA research funding by increasing knowledge of Financial Management practices for staff, formalizing financial processes across VAMCs, and established standardized, transparent processes for allocating, obligating, and expending ORD funds.
- **Enhanced Partnered Research Program (PRP):** We evaluated methods to further improve VA's ability to effectively cooperate with the industry and to enhance Veterans' access to high-

quality clinical trials by further building out the PRP. This will likely include expansion of the PRP team, new tools and processes, and enhanced communications and training efforts.

- **Field Contract Support:** This initiative aims to expand ORD-funded researchers' access to necessary research resources by providing them with centralized contract resources, including contract management, relevant access tools and processes for research studies, and administrative requirements in support of facility-based research.

Activities to be continued or undertaken:

- **ORD Governance and Success Measures**: We will shift from an enterprise transformation governance structure to a sustainment governance structure. Governance is foundational to enterprise-wide decision-making and oversight of processes.
- **IT and Data Governance:** In 2024, a more streamlined research IT and data governance process will be established including adding IT resource needs into our funding proposal requirements. We will then focus on approaches to identify and fill the resource gaps necessary to support contemporary world-class research, as well as integration of processes to ensure that funded research projects are feasible given the available IT and data resources.
- **Actively Managed Portfolios and Integration with VHA Decision making:** In 2024, ORD will focus on maturing existing actively managed portfolios and establishing new portfolios based on VA and Veteran needs. In addition, based on the actively managed portfolio experience, we will begin advancing repeatable processes to ensure integration with VHA decision making.
    - **Central Research HR Function and Protected Time for Research:** In collaboration with Workforce Management, we are rolling out national, specialized, HR support for research hiring. We anticipate that in 2024 the Central Research HR initiative will be completed and will subsequently shift to monitoring, quality improvement, and sustainment. Furthermore, on these foundations, we will then work with clinical and operations partners to begin establishing mutually agreed-upon and enforceable norms regarding the protection of time for research among funded clinician investigators.
- **Rationalization of ORD's Organization**: In 2024, the ORD organizational alignment will be completed, and we will establish a policy for periodic organizational alignment review.
- **Leadership Mentoring and Workplace Culture:** In 2024, we will have the leadership mentoring program in place and will expand the scope of this work to intentionally promote an engaged and accountable workforce in ORD through a healthy workplace culture.
- **Finance Processes:** In 2024, we will continue to implement tools, staff training, and streamline processes that make the process of enterprise-wide financial management more reliable and efficient.
- **Enhanced Partnered Research Program (PRP**): In 2024, we will develop processes to more efficiently assess large multi-site trial feasibility based on medical center data.
- **Field Contract Support:** In 2024, we will continue to identify areas that would benefit from enterprise-wide contracts rather than site-by-site contracts, and we will right-size our ORD contracting team to manage the scale of the work.

ORD Support of VA's Electronic Health Record Modernization (EHRM)

The ORD Strategic Initiative for Research and EHR Synergy (OSIRES) addresses the requirements for VA research continuity, success, and growth throughout the years-long Electronic Health Record Modernization (EHRM) process. OSIRES' primary objectives are to represent and support research's transition to the new EHR by leading the National Research EHR Council and to work across all aspects of the EHR implementation for research to maintain the highest standards for cutting-edge patient care, patient safety, regulatory compliance, and scientific integrity.

Recent accomplishments:

- Escalated research risks and impacts related to going live with the new EHR, with a focus on maintaining continuity, integrity, and safety of clinical trials. Research is now a high-priority focus area in the Undersecretary-sponsored VHA Collaborative Readiness initiative.
- Advocated for higher visibility of the research mission and its functional requirements, resulting in the creation of a national EHRM Research Council with distinct consideration, authority, and reporting under the Discovery Education and Affiliate Networks (DEAN) AUSH.
- Established an enterprise program to support research sustainment in the new EHR, including advocating for appropriate system access and contract inclusion of system training.
- Ongoing participation in the Federal Research Working Group (FRWoG) under the Federal EHR Modernization (FEHRM) office, working with Department of Defense counterparts for collaborative governance of research configuration and content decisions and solutioning relative to the new EHR.

Activities to be continued or undertaken:

- Identify research functional requirements for using the new EHR and its data and work with the Electronic Health Record Modernization Integration Office (EHRM-IO) and the Oracle Cerner implementation and deployment teams to solution requirements.
- Facilitate research functionality and successful workflows within the new EHR, including functional integration, research roles and permissions, training needs, workflow design, and data access, governance, and provisioning.
- Support local VA Research & Development offices and field researchers at VA medical centers from the start of their deployment period to identify risks and affected projects, facilitate onboarding of current projects into the Oracle Cerner system, and support change management by providing supplemental training and technical support.
- Develop and implement national communication, education, and resources for the research field regarding transition activities, deployment impacts, and the use of the new EHR and its data.

- Work closely with ORD as the sponsoring program office to align system and process decisions with enterprise policy and to develop enterprise-level standards for research activities related to the use of the new EHR.
- Escalate impacts, risks, and barriers for higher-level advocacy and support within VHA and VA.

Refining, Replacing, and Reducing VA Research with Sensitive Species

The number of animals of each of the sensitive species (canines, felines, and non-human primates) that has been needed in VA research has decreased over the past two decades by more than 90%. This reflects both changes in the nature of the research questions being addressed, consideration of alternative models, and unique research opportunities that have opened with the many new strains of genetically modified mice and rats that have been bred.

There have also been new techniques developed that now make it possible to conduct some of the research that in the past could only be done with sensitive species. At the same time, understanding of the optimal ways to care for animals involved in research continues to grow. VA is committed to continuing to meet or exceed all applicable animal welfare standards.

VA maintains an unwavering commitment to conducting research that is needed to improve Veterans' lives. An external review of VA research with animals by the NIH Office of Laboratory Animal Welfare concluded that the VA programs are effectively supporting the humane programs of animal care in use at their institutions and are conducting research with vertebrate species in compliance with the Public Health Service Policy and all applicable rules and regulations.

A report by NASEM that focused specifically on VA's research with canines was released in July 2020. It affirmed the continuing scientific necessity of work with canines in some areas of research, including all the currently active VA research with canines. The report further concluded that VA animal research programs were complying with and exceeding federal regulations and guidelines on humane animal care and use.

Since 2018, Congress has placed limits on canine research within the VA. In 2020, Congress introduced additional constraints and expanded the species subject to those constraints to include felines and non-human primates. Processes have been set up to comply with all congressional mandates. Collectively, VA's monitoring and evaluation processes for studies with sensitive species of animals are by far the most stringent of any in the nation.

Recent accomplishments:

- Funded studies by investigators who seek to develop alternative methodologies. These investigations are decreasing the need for sensitive species. Additional opportunities to develop alternative methodologies decreases the need for using sensitive species and has resulted in increased applications for funding.

- Continued active membership in the Interagency Coordinating Committee on the Validation of Alternative Methods. ORD (Office of Chief Veterinary Medical Officer) currently maintains membership on two subcommittees on alternatives by active participation. VA has contributed to the development of guidance on alternatives by active editing and participation on a position paper.
- Successfully utilized the expanded secondary review process for securing the written approval of the VA Secretary for research protocols involving sensitive species of animals before research work can begin.
- Executive Committee and Working Group continued executing the five-year plan. The executive committee representative presented successful progress reports to the National Research Advisory Council in the 2nd and 4th quarters of 2022.
- The Memorandum of Understanding with the National Center to Advance Translational Research continued to expand the training available to VA investigators on translational alternatives, including a proposal for an ORD RFA on "Developing and Validating Alternatives to the Use of Canines, Felines, and Non-Human Primates in VA Research."
- Established a binding agreement with an independent Contract Research Organization (CRO) to review and assess the VA Five Year Plan; and extended transparency efforts by opening Sensitive Species Executive Committee meetings to the CRO. Requirements for biannual reports to the VA and a yearly appraisal for the required report to Congress are firmly established.

Activities to be continued or undertaken:

- Continue support for and participation in the NASEM Roundtable working group on best practices for the reduction, replacement, and refinement of canine research in VA.
- Participate as a full member on the Interagency Coordinating Committee on the Validation of Alternative Methods (ICCVAM).
- Look for additional opportunities to fund research on alternatives to the use of canines, felines, and non-human primates.
- Develop a targeted funding program to foster collaborations with veterinary schools to conduct more clinical trials with client-owned pets, for work that can benefit both Veterans and pets.
- Provide support to NASEM for their update to the *Guide for the Care and Use of Laboratory Animals*, a key compliance document for all VA animal care and use programs. The VA has been able to contribute operational funds and established informational working groups for field perspectives.
- Continue a collaboration with the National Center to Advance Translational Science to promote the use of micro physiological systems to replace animal models.

Addressing the Prosthetic Needs of Women Veterans with Amputations

In conjunction with the priority to ensure disabled Veterans who require a prosthesis can access the most modern prosthetics technology available, and to support the growing number of women Veterans who use VA services, VA Research continues to encourage the development and translation of prosthetic devices for women. As directed by Congress in HR 115-673, ORD has emphasized and prioritized funding for projects in this area. Prosthetic components are typically designed for men, as most prosthetic users are male. However, the number of female Veterans is growing, and VA must be able to meet their prosthetic needs as well.

ORD has added a statement to our RFAs that "Prosthetic and other assistive technology needs of women Veterans" are an area of special emphasis for us. This request has increased the number of VA researchers proposing studies that consider the needs of women Veterans in the design of prosthetic devices. The most meritorious applications we receive are selected for funding based on the results of rigorous scientific peer review.

Recent accomplishments:

- Funded a supplement to allow comparisons by gender in an existing DoD-funded project, "Needs, Preferences, and Functional Abilities of Veterans and Servicemembers with Upper Limb Amputation." The project's findings confirm that women with upper-limb amputation are less likely than men to have ever used or to currently use prostheses, to have received prosthetic training, or to use devices controlled with body movement. However, they are more likely than men to use similar devices that serve a cosmetic purpose exclusively. These results highlighted a need to develop prostheses for women that are cosmetically acceptable, yet lightweight and functional.
- Produced redesigned 3D-printed metal prosthetic fingers in smaller sizes that are more appropriate for women. The fingers were licensed to an industry partner (Point Designs) that can rapidly make these smaller sizes available to Veterans.
- Developed a novel prosthetic ankle/foot attachment system that can be quickly adapted for use with different footwear, such as high heels, with assistance from the ORD Technology Transfer Program (TTP). The Investigators signed a licensing agreement in January 2021 with an industry partner (UNYQ) who announced the final commercial version of the device at the International Orthopedic Technology Trade Show and World Congress in Leipzig, Germany in May 2022.
- Funded a study to evaluate and refine outcome measures of upper-limb prosthetic use in women Veterans to ensure test items and scores reflect issues important to them in research and clinical care. One paper has been published and three more are forthcoming to disseminate these new and improved outcome measures for clinicians and researchers.
- Funded a study in women Veterans with major lower-limb amputation to characterize prosthetic prescriptions, use, satisfaction, barriers and facilitators to successful functional mobility, and health-related quality of life in order to promote gender-sensitive prosthetic care and equitable outcomes. Preliminary findings are encouraging they suggest there are minimal gender differences in prosthetic prescription and time to prescription within the VA, unlike findings in the general community where women often fare worse than men.

Activities to be continued or undertaken:

- Develop a roadmap to conduct a definitive evaluation to seek FDA approval of an Osseo-integrated prosthetic device for women and men with lower-limb amputation.
- Determine if women with lower-limb loss are at greater risk of developing secondary musculoskeletal conditions.
- Study the effects of carrying loads, specifically infants and toddlers, on Veterans with lower-limb amputation and apply the results to generate guidance for prosthetic prescribing.
- Characterize the healthcare needs of women Veterans as relates to mobility devices based on the following criteria: access to care, needs, priorities, preferences, and experiences, then identify potential solutions to any challenges discovered.
- Determine if a commercially available socket for lower limb prostheses that can quickly adjust volume and compression is better than more commonly prescribed non-adjustable sockets. Study aims for half of participants to be women to elucidate any gender-related effects.
- Further develop and evaluate a women-specific transhumeral prosthetic suspension system based on integration with a sports bra (Brasthesis™).

Investing in Artificial Intelligence (AI)

VA is the largest integrated health care system in the country. It has established several big data repositories, including the largest genomic knowledge base in the world linked to health care information. It also trains the largest number of nurses and doctors in the United States. Given these factors, VA is uniquely positioned to advance AI research and development.

The National Artificial Intelligence Institute (NAII) seeks to develop AI research and development capabilities in VA to support Veterans and their families, survivors, and caregivers. The NAII designs and collaborates on AI R&D initiatives, national AI policy, and partnerships across agencies, industries, and academia. The NAII is dedicated to advancing AI research and development for real-world impact and outcomes to ensure Veteran health and well-being.

Recent accomplishments:

- Increased VA AI capacity and capabilities through the expansion of the AI Network to four sites (Kansas City, MO, Long Beach, CA, Tampa, FL, and Washington D.C.), and continued support of the AI@VA Community.
- Increased Veteran and stakeholder trust and confidence in AI through the development and piloting of an AI Institutional Review Board (IRB) module and the establishment of principles for trustworthy AI. The AI IRB module has since started trials at the IRB in VA Long Beach.

- Developed the Responsible AI Official (RAIO) Support Council to enable VA to benefit from inter-agency AI-governance coordination and further fulfill compliance with EO 13960.
- Received the FedHealth IT Innovation Award for an AI Tech Sprint use case involving AI and a provider directory.
- Led VA participation in a government-wide hiring sprint to recruit an AI workforce and helped sites across VA diffuse position descriptions and other documents to aid in their own recruitment efforts.
- Provided technical expertise for the VA/Department of Energy (DOE) Million Veteran Program (MVP) and the evaluation of potential projects.
- Provided direct input, subject matter expertise, and counsel to leaders and groups across the federal government regarding AI-policy, ethics, and implementation, including contributions to White House efforts such the AI Bill of Rights and the Executive Order Promoting the Trustworthy Use of Artificial Intelligence in Government (EO 13960), the White House National AI Strategy, especially on Workforce, Partnerships, and International/Transnational R&D strategies.
- Led and contributed to the broader ongoing trustworthy AI discussion to enable VA to benefit from the latest in this emerging area, including presenting and participating at major industry and government forums, including:
    - Healthcare Information and Management Systems Society Annual Conference
    - American Council for Technology and Industry Advisory Council Digital Transformation Summit
    - Councils of the Inspectors General on Integrity and Efficiency Emerging Tech Symposium

Activities to be continued or undertaken:

- Continue implementing Executive Order 13960, "Promoting the Trustworthy Use of Artificial Intelligence in Government," including a VA-wide data call for use cases, the cataloging of AI, and the creation/establishment of a Trustworthy AI Framework to evaluate AI use cases.
- Continue the AI@VA Community, an AI community of practice providing training, networking, and collaboration opportunities to VA employees. AI@VA also connects with academia and industry, highlighting VA's AI accomplishments through a newsletter. The community includes more than 500 VA employee members and over 300 external members from academia or private industry. It also has the messaging capabilities to reach over 25,000 people within the VA.
- Plan and host the AI Summit Series to bring experts and researchers from government, academia, and private industry together to explore AI technologies for enhancing care and treatments for Veterans. Key events, such as the International Summit for AI in Health Care, bring together a diverse group of participants for collaboration around core Veterans' health issues such as cancer, mental health, and traumatic brain injury.

- Launch additional AI Tech Sprints, focused on AI Workforce Development and Cardiothoracic image diagnostic analysis, while also planning future sprints and partnerships focused on quantum computing for privacy, preserving AI, and AI for imaging. NAII has reviewed several use cases in which quantum computing has a unique potential to enable AI to be applied for the benefit of Veterans, while ensuring their privacy.
- Launch VA prize for fostering AI Research Collaboration, an initiative between VA and academic institutions aimed at developing collaborative research efforts through innovative approaches to faculty recruitment and support.
- Expand pilots of the Digital Command Center (DCC), a critical effort focused on safely and ethically centralizing data from disparate source across VA to provide VA leaders with greater context and information to enhance operations and enable R&D analysis with near real-time data. VA Research will attempt to design an approach in which models from AI R&D can be tested against VA data to ensure ethical, trustworthy, and human-centered design principles are built into every step of our translational AI processes.
- Coordinate the AI@VA Community to pursue collaborative research projects.
- Continue supporting collaborative AI-backed research studies.
- Continue to research and design approaches for workforce diagnostics and education/upskilling.
- Provide ongoing AI subject matter expertise and Education subject matter expertise to the Human Capital Services Center, Office of Enterprise and Integration, and others working to refine and design position, career, and education definitions and requirements for data science, AI, and related efforts.
- Further refine, and then extend the use and authority of, our AI IRB module.

Diversity, Equity, and Inclusion (DEI)

Research across the continuum, from preclinical to clinical and from rehabilitation research to health services research, requires diversity in skill sets, experiences, and perspectives. Scientists and trainees from diverse backgrounds and life experiences can bring different perspectives, creativity, and individual enterprise to address complex health-related problems. ORD's ability to ensure innovations in healthcare for the benefit of the nation's Veterans is dependent upon fostering a pool of highly talented, motivated scientists from diverse backgrounds who will help to further VA's mission. ORD supports and is in compliance with both M-22-15 "Memorandum for the Heads of Executive Departments and Agencies," dated July 22, 2022, and Executive Order 13985 of January 20, 2021, "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government." VA Research is dedicated to increasing representation of underserved communities in our workforce and promoting innovative funding mechanisms and programs for equity. Current and future initiatives are centered on stimulating health equity research and diversifying the VA STEM workforce, which will lead to a diverse, innovative STEM ecosystem and an inclusive, non-discriminatory workplace.
This request will support ORD structures and funding mechanisms to foster research collaborations between VA and under-resourced institutions, such as Minority Serving Institutions. Additionally, the request will provide funding for two-year mentored research projects

for early career scientists from MSIs and other underrepresented populations as they apply for VA Career development funding. It will also provide funding for health equity research, professional development for underrepresented VA research employees, research proposal writing workshops, and funding for research experiences for underrepresented students from the high school to the post-graduate education level.

Recent accomplishments:

- A scientific proposal writing workshop for underrepresented (UR) scientists:
    - 10 of 16 attendees from the March 2021 workshop received their first VA funding following their participation.
    - Post-workshop survey responses were overwhelmingly positive.
    - The July 2022 workshop expanded to deliver proposal writing training to 33 UR scientists.
- Held summer research programs for UR high school, undergraduate and health professions students:
    - Funded 21 VA sites in 2022 for a three-year pilot program.
    - Provided Research opportunities to 115 students in year one, which included 74 college student, 8 graduate students, 11 high school students, and 20 medical & Allied health students.
- Added special emphasis areas to all VA ORD funding opportunity announcements to ensure that VA funding opportunities target health disparities research for persons with disabilities, females, minorities, and LGBTQ+ Veterans.
- Host a quarterly DEI Sub council of the NRAC with representatives from 12 key stakeholder offices across VA to advise ORD on specific research recruitment and promotional activities.
- DEI training and professional development opportunities for VA field researchers provided funds for DEI training to 4 VA field research offices and funding for professional development training to 7 underrepresented VA field researchers.
- Developed key partnerships with Veteran Service Organizations, Historically Black Colleges and Universities (HBCUs) and other Minority Serving Institutions (MSIs).
    - Created a stakeholder engagement board composed of MSI members, professional associations, and other educational institutions focused on groups with historically low representation.
    - Participated in the 2022 Student Veterans Conference and presented at the 2022 Annual National HBCU Week Conference
    - Expanded partnerships with diverse affinity organizations, professional associations, and educational institutions to disseminate VA ORD job postings.
    - Created an Advisory subcommittee on DEI to the National Research Advisory Council. The DEI Advisory subcommittee has assisted the Million Veteran Program in its recruitment and advertisement campaign for increased participation

by women Veterans. The subcommittee will assist other national research efforts to increase DEI in research.

- Expanded VA ORD's Career Development Award program to scientists from all categories of Minority Serving Institutions. These institutions provide over 14,000 VA health professions trainees per year.
    - VA ORD had a previous Career Development Award funding opportunity that was only offered to early career investigators with an HBCU affiliation, and since its creation had only 5 funded awards.
    - The new Minority Serving Institution funding opportunity will expand this training opportunity to all MSIs, which added 300 institutions and increases the pool of eligible applicants.
    - Provided 32 research supplements with mentored research experiences for early career scientists and clinicians from underrepresented groups such as: racial and ethnic minorities, Veterans, persons with disabilities, and LGBTQ+ individuals. Supported 6 MSI and HBCU-affiliated early career investigators.
    - Supported 4 Veteran early career investigators.

Activities to be continued or undertaken:

- A comprehensive portfolio analysis of the current activities related to VA-funded research involving racial and ethnic minorities. A comprehensive examination of these DEI research activities will provide valuable information in developing ORD strategies that will improve and expand:
    - A diverse scientific workforce through training and funding opportunities.
    - Research focused on minority health and reducing health disparities.
    - A culture of inclusion within ORD.
- Continue to host the quarterly DEI Advisory Sub council of the National Research Advisory Committee.
- A new research supplement program to promote collaborations between VA and mid-career UR investigators at non-VA institutions such as MSIs.
    - Applications for the inaugural funding period are under review.
    - ORD has committed a minimum of $500,000 to this program.
- Continue and expand proposal writing workshops to offer more seats for participants.
- Expand support for MSI Career Development programs to offer 5 or more new awards.
- Continue and expand research supplements to provide up to 10 mentored research experiences for early career scientists and clinicians from underrepresented groups.
- Continue and expand funding for DEI training and professional development opportunities for up to 10 VA field researchers from underrepresented groups.

- Continue to expand the QUERI Advancing Diversity in Implementation Leadership (ADIL) to train a research workforce committed to leading implementation and evaluation/policy science projects in VA. QUERI has supported 13 ADIL awardees to date, including 7 new early career investigators in 2022. ADIL projects address key VA priorities such as access, virtual care, medication safety, care coordination, chronic pain and opioid overdose, workforce wellbeing, antimicrobial stewardship, and health disparities.
- Continuing the pilot summer research program pilots:
    - Develop best practice guides for student hiring, summer research program curriculum, program administration, and educational resources for mentors.
    - Expand and centralize recruitment activities in order to expand reach of the program.
    - Develop plans for expansion of the program into underserved geographic regions.
- Continue to develop key partnerships with MSIs, HBCUs, and other federal agencies to promote and expand VA's health equity research and scientific workforce diversification efforts.

Promoting Open Science and Community-engaged R&D

VA Research promotes open science and community-engaged R&D through its process of promoting open access to data, dissemination of scientific findings, as well as identifying research priorities as noted above, and through its scientific peer review process, which uses Federal Advisory Committee standards.

Open access to data: Through the Office of Science Technology (OSTP) policy for Public Access to Scientific Publications and Digital Data from Research, ORD has implemented an enterprise transformation initiative to enable further advancement of Public Access to research data goals through establishment of a Data and IT Governance Subcommittee, creation of enterprise-level resources and tools for promoting data sharing among VA investigators and working with OIT on the creation of a VA Research Data Commons. ORD also has infrastructures and resources for enterprise-wide data curation and management through the Veterans Informatics and Computing Infrastructure (VINCI), Cooperative Studies Program Integrated Veteran Epidemiologic Study Data Resource, and Million Veteran Program and related Genotypes and Phenotypes summary statistics programs.

Dissemination of scientific findings: In addition, through multiple communication channels such as the ORD Office of Communications, HSR&D Center for Information Dissemination and Education Resources (CIDER) and the QUERI Center for Evaluation and Implementation Resources (CEIR), there is active communication, dissemination, and translation of research findings to communities and different stakeholder groups.

Optimization of translation, implementation, and dissemination of research findings to Veterans, their providers and their caregivers is also a major VA Research priority, enabling VA Research to consistently accelerate and improve the overall translation process, as described in the 2020

GAO Report and QUERI Implementation Roadmap Guide on efforts to successfully translate research into clinical practice. Recognizing that it can take years for effective treatments to reach patients due to resource constraints, VA Research is a national leader in the study and application of implementation science, or the use of strategies to accelerate effective treatments into the hands of Veterans and their families/caregivers.

VA Research also invests in the science of community and Veteran engagement, i.e., identifying and using best practices to optimize active participation in research among the different groups. Strategies promoting open science include an enterprise-wide process for making VA data available as well as communicating research results through websites, social media, town halls, and through other modalities, such as trainings/cyberseminars, consultation, evidence-based quality improvement methods, and other technologies.

VA Research's Rehabilitation Research and Development Program (RR&D) focuses on improving functioning among Veterans though rigorous research that is actively informed by multiple stakeholder groups including Veterans, families/caregivers, Veterans Service Organizations, and providers/policymakers. Notably, RR&D's Center for Social and Community Reintegration Research is developing strategies to improve employment and social functioning, as informed by community-engaged research methods.

MVP is embarking on an open science initiative that will enhance access to data sources on Veteran health through is national data sources. MVP is the nation's largest genomic biorepository of Veteran data and is one of the most diverse cohorts of any genetic research program in the world. MVP's genomic and phenotypic data is currently available to VA investigators and approved partners through a research merit review process within VA's Office of Research and Development (ORD).

VA Research's Cooperative Studies Program uses standard operating procedures that include active engagement of multi-level stakeholders in the design, planning, and execution of clinical trials and epidemiologic studies, including the Health of Vietnam-Era Women's Study (Health VIEWS) and the Evidence-based Supported Employment study. VA Research CSP continues to expand opportunities to translate effective treatments more rapidly into real-world practice through the development and execution of implementation science plans based on the QUERI Implementation Roadmap during its trials.

Recent accomplishments:

- Established a Veteran Engagement Council under the oversight of our Health Services Research and Development Program (HSR&D) to promote the use of evidence-based research methods for engaging Veterans across all aspects of research. This includes engagement with Veterans from the inception of scientific questions to the development of treatments and their implementation in routine care. HSR&D Requests for Applications require that Veteran Engagement Plans be included in application submissions, where applicable, and HSR&D priorities have been updated to place a greater emphasis on the science of Veteran Engagement. Examples of products include VA Research's Strengthening Excellence in Research through Veteran Engagement (SERVE) Toolkit, cyberseminars (e.g., on Understanding Military Culture for researchers, integrating

Veteran engagement from research plan to publication), and a joint HSR&D/PCORI JGIM supplement focused on Veteran/patient engagement (published in 2022).

- To better train the VA workforce (including researchers) to communicate more readily with Veterans and their caregivers, providers, communities, and policymakers, the QUERI Center for Evaluation and Implementation Resources (CEIR) developed and disseminated the QUERI Evaluation Guide, the Implementation Roadmap, and the Cooperative Studies Program trial Implementation Planning Assessment Tool. The Implementation Planning Assessment Tool is being used in multiple VA clinical trials, including Cooperative Studies Program trials, and has been disseminated to several large research audiences inside and outside the VA.
- The QUERI Communication Strategy was launched to more rapidly and effectively report scientific impacts to stakeholders using the QUERI ACTION framework (Alignment, Commitment, Tailoring, Informing the field, Observing healthcare changes, and generating New questions/projects) to disseminate research impacts from ORD-funded studies, including the number of Veterans served, number of employees in the VA workforce trained in new treatments and programs, and if research findings informed major policies to improve Veteran care.
- VA Research, through QUERI, established the QUERI-VISN Partnered Implementation Initiative, in which implementation projects addressing VISN priorities and incorporating VA provider and Veteran input are launched across multiple sites in order to make a direct impact on Veteran access and quality of care. Results are communicated back to VA leaders and providers on a regular basis.
- Accomplishments of the QUERI-VISN Partnered Implementation Initiatives include national implementation and dissemination of an effective suicide prevention program (Caring Contacts); scale-up and spread of seven evidence-based practices addressing pain and opioid use disorders; and implementation of a critical time intervention in case management programs for homeless-experienced Veterans. The newest QUERI-VISN Partnered Implementation Initiative is focused on optimizing tobacco dependence treatment among Veterans participating in lung cancer screening.

Activities to be Continued or Undertaken:

- ORD will enable investigator-initiated projects to have adequate resourcing for execution of Open Access Data Management Plans including data curation and sharing.
- The 2023 HSR&D/QUERI national meeting will include four Veteran Engagement forums and more than a dozen presentations by Veterans and caregivers. Investigators are also testing novel technologies such as photovoice, which uses photo narratives by end-users to convey lived experiences in health and in health care in order to inform novel treatments and implementation strategies.
- In collaboration with the Veterans Experience Office, MVP is actively engaging in Veterans and other stakeholders in enhancing strategies to recruit and retain MVP participants and actively disseminate results from MVP studies. MVP is also working on plans for expanding to non-VA investigators in the future.

- QUERI will also support open science and community-engaged research goals through the continued support of the VA workforce as well as optimization of strategies that promote Veteran engagement.
- In partnership with NAVIGATE, Precision Oncology, and MVP, QUERI will identify and help deploy strategies that enhance the diversity and inclusion of different Veteran populations (e.g., ethnicity, gender, age, disability) into clinical trials (e.g., oncology trials, MVP return of results) based on state-of-the-art research on implementation science, Veteran engagement and community-based participatory research, as well as technology innovations to enhance workforce training and infrastructure in clinical trial recruitment (VHA priority).
- In partnership with CoMPL, QUERI will help support cancer treatment optimization by developing strategies to maximize provider training and implementation of the precision oncology platform that integrates next-generation sequencing data, bioinformatics, machine learning, and mathematics.
- In partnership with the MERICs, QUERI will help identify and optimize multi-level strategies that support the VA workforce in delivering high-quality care for Veterans with military exposures and Gulf War illness, including the use of computerized decision support and collaborative care models. Lessons learned from cancer and military exposures to identify and train the VA workforce and VA researchers (e.g., Cooperative Studies Program trialists) will be applied to strategies that support Veterans, their providers, and clinical environments in order to optimize translation of other scientifically supported treatments, e.g., mental health, tinnitus, etc.
- Support mentoring for the VA's Advancing Diversity in Implementation Leadership (ADIL) program.
- HSR&D plans to continue several ongoing trials to optimize community engagement principles to improve quality, equity, experience, and outcomes of care for Veterans with PTSD, suicidal ideation, substance abuse, and/or who are experiencing homelessness, incarceration, and other adverse social events among marginalized, at-risk, and vulnerable groups. HSR&D will also support enhancements to research studies by supporting additional opportunities to include Veterans and other stakeholders in the development and implementation of research projects.
- RR&D is supporting an effectiveness implementation study to optimize community coalition building as a strategy to facilitate and optimize translation of effective community support services for Veterans with TBI.
- In partnership with VA Office of Enterprise Integration, the Homeless Programs Office and other VHA clinical partners, VA Research (QUERI) will develop and execute evaluations based on the VA Strategic Plan Learning Agenda supplement, which is focused on ending homelessness and reducing risk of homelessness (VA Strategic Plan Goal 2). Homelessness was also identified as a research priority by the VA Research National Research Advisory Council (NRAC), and research and evaluation initiatives plan to focus on designing and implementing effective programs that address the multilevel determinants of homelessness at the individual, environmental, socio-economic, and system levels and

assess impacts of these programs by quality, value, outcomes, end-user experience, and equity.

Table: Distribution of Program Resources

Program	(Dollars in Thousands) 2022 Actual	2023 Request	2023 Estimate	2024 Request	2024 Req-2023 Est
Research Administration (820)[1]	**$141,073**	**$138,456**	**$164,249**	**$168,194**	**$3,945**
Investigators, Scientific Review, and Management (ISRM)	**$539,561**	**$561,308**	**$549,442**	**$562,639**	**$13,196**
Biomedical Laboratory R&D (821)	$208,492	$218,516	$207,039	$212,012	$4,973
Rehabilitation R&D (822)	$116,567	$116,342	$118,088	$120,924	$2,836
Health Services R&D (824)	$123,604	$138,363	$122,743	$125,691	$2,948
Clinical Science R&D (829)	$90,898	$88,087	$101,573	$104,012	$2,440
Enterprise Optimization (EO)	**$201,366**	**$216,236**	**$202,309**	**$207,167**	**$4,859**
Cooperative Studies Program (825)	$110,468	$111,505	$110,222	$112,870	$2,647
Million Veteran Program (826)	$90,898	$104,731	$92,086	$94,298	$2,212
Discretionary Appropriation Total	**$882,000**	**$916,000**	**$916,000**	**$938,000**	**$22,000**
Mandatory, American Rescue Plan (Public Law 117-2, Section 8002)	$0	$30,000	$30,000	$0	-$30,000
Cost of War Toxic Exposure Fund	$0	$0	$2,480	$46,000	$43,520
Total Program Distribution	**$882,000**	**$946,000**	**$948,480**	**$984,000**	**$35,520**

1. Research Administration includes Strategy Partnerships, Outreach and Communications (SPOC); Enterprise Protections, Regulatory, and Outreach Systems (EROS) Office of Finance; Operations and Workplace Culture (OWC), and the National Artificial Intelligence Institute (NAII).

ORD Operational Units

As described earlier in the Investment in the VA Research Enterprise section, ORD will continue the implementation to undertake a major effort to align the organizational structure of the office with its functions, with the goal to more effectively and efficiently fulfilling our mission. We are aligning our structure to serve not just as funders of research but also the strategic headquarters of the largest integrated biomedical research organization in the nation.

This will involve, seven units reporting to the Chief Research and Development Officer (CRADO).

Under Research Administration Structure (820)

Strategy, Partnerships, Outreach, and Communications (SPOC)

This unit is charged with creating forward-looking strategies, governance processes for establishing priorities and programs, and measuring the impact serving Veterans. It will develop and maintain ORD's long-term strategy by anticipating future trends in strategic healthcare priorities and maintaining a proactive stance, to ensure the effective communication of ORD's strategy and vision and build a community among ORD's stakeholders, and to enforce organizational alignment with strategic priorities and measure the success of ORD. SPOC will support centralized functions within ORD, such as Communications.

Enterprise Protections, Regulatory, and Outreach Systems (EPROS):

This unit is charged with ensuring the protection of human participants in VA conducted research as well as with developing and managing VHA's research regulatory policies and associated education and training. It is developing, coordinating, and managing enterprise-wide access to central research repositories and digital research systems and ensuring the protection of VA's intellectual property. EPROS also provides a centralized core for ethical, regulatory, and educational programs for human research and provides key central systems for data and

biospecimen management. The following sub-units are currently housed under EPROS: Technology Transfer Program (TTP), Central IRB, Central Policy and Regulatory, Research IT and Data Governance, Research Education and Training, and Registries and Repositories.

Office of Finance

Finance is charged with managing all aspects of budget, finance, and accounting for ORD and the Field and evaluating the strategic use of ORD's financial resources. This unit works to ensure ORD is operating with fiscal responsibility in supporting the VA Research Enterprise's mission of improving Veterans' lives through research. Finance supports centralized functions within ORD, such as budgeting and operations, and the Non-Profit Program Office (NPPO).

Operations and Workplace Culture (OWC)

The Operations and Workplace Culture unit is working on centralizing internal ORD operations functions. It will focus on our staff – providing our staff with dedicated resources like HR, contracting, leadership development, talent management and employee engagement – and will be rooted in solving problems efficiently and effectively so that the day-to-day ORD processes run smoothly. The OWC unit also strives to continually improve the efficiency of internal operations and ensure timely responses to external requests and requirements. The following units are housed under OWC: Central Administration, Contracting and Operations.

National Artificial Intelligence Institute (NAII)

As described earlier, The National Artificial Intelligence Institute (NAII) seeks to develop AI research and development capabilities in VA to support Veterans and their families, survivors, and caregivers. The NAII designs and collaborates on AI R&D initiatives, national AI policy, and partnerships across agencies, industries, and academia. The NAII is dedicated to advancing AI research and development for real-world impact and outcomes to ensure Veteran health and well-being.

Investigators, Scientific Review, and Management (ISRM)

ISRM contributes to the VA Research Enterprise mission of improving Veterans lives through research by funding research, management of research portfolios, collaboration with stakeholders, and the recruitment and retention of a diverse set of investigators

Biomedical Laboratory Research and Development Service

Biomedical Laboratory Research and Development (BLR&D) supports and conducts preclinical research to understand life processes from the molecular, genomic, and physiological levels, with the goal of gaining new insight and knowledge regarding diseases that affect Veterans and ultimately contribute to new and better preventive measures and medical treatments.

Rehabilitation Research and Development Service

Rehabilitation Research and Development (RR&D) advances scientific knowledge and fosters innovations to maximize Veterans' functional independence, quality of life, and participation in their lives and community. RR&D also invests in building rehabilitation research capacity and developing the next generation of VA rehabilitation researchers. RR&D integrates clinical, preclinical, and applied rehabilitation research to enable translation of research results into clinical practice to improve the health and well-being of Veterans and the nation.

Health Services Research and Development Service

Health Services Research and Development (HSR&D) pursues research that addresses all aspects of VA health care. This includes patient care practices; models of care delivery (including telehealth); access to care; quality, safety and costs of care; health equity; patient and provider experience; and implementation of evidence-based clinical interventions into real-world practice. HSR&D also addresses critical issues for Veterans who have returned home from Iraq and Afghanistan with conditions that may require care over their lifetimes, most notably PTSD, pain, and risk of suicide.

HSR&D oversees and facilitates VA's QUERI program, which leverages scientifically supported quality improvement methods (paired with a deep understanding of Veterans' preferences and needs) to implement research discoveries and evidence-based practices rapidly into routine care to improve the quality and safety of care delivered to Veterans. The QUERI program is funded by the VERA Model, as detailed earlier in this chapter (and does not receive funding from the Medical and Prosthetics Research Appropriation.

QUERI's national network of programs and partnered evaluation initiatives include more than 200 clinicians and ORD-supported experts in health services research who collaborate with VA leaders, administrators, and frontline providers to ensure VA's transformation to a learning healthcare system. QUERI is also managing VHA's fulfillment of the Evidence Act, including the Evidence-based Policy Subcommittee, fostering cross-VHA operational partnership and VA Research collaborations on annual evaluations addressing VA strategic priorities. In partnership with more than 70 VISN and VA national program office leaders, QUERI has disseminated over 200 research-informed strategies and products, supporting over 26,000 VA employees across the U.S. in delivering evidence-based care to Veterans and their families.

HSR&D's Evidence Synthesis Program (ESP) provides timely, targeted, thorough, unbiased, and innovative syntheses of the medical literature for VA to translate into evidence-based clinical practice and policy. ESP reports are made available to clinicians, managers, and policymakers in a timely way as they work to improve the health and health care of Veterans. In addition to helping to guide quality-improvement efforts, ESP reports help guide future research.

Clinical Science Research and Development Service

Clinical Science Research and Development (CSR&D) is focused on advancing Veterans' health care by developing the evidence base for new and improved treatments through clinical trials and

moving ideas along the translational pathway from scientific discovery to clinical application. CSR&D research encompasses interventional and effectiveness studies, clinical trials, clinical methodology, and epidemiology, as well as related infrastructure needs.

Enterprise Optimization (EO)

The EO unit is charged with supporting the execution of ORD's agenda particularly as it relates to a national enterprise-wide approach toward planning for, coordinating, and managing the VA Research Enterprise resources and producing impactful scientific findings that translate to the healthcare system, such as Field Support, so that the field may execute the VA research strategy efficiently and successfully. It supports centralizing existing field resources and developing them to provide researchers with effective and accessible tools and resources. It will also work towards increasing the accessibility of VA scientific resources and products to ensure a cooperative approach and facilitation of innovative scientific research. EO supports centralized functions within ORD, such as Field Operations, the Partnered Research Program, the Cooperative Studies Program, and the Million Veteran Program.

Cooperative Studies Program (825)

The Cooperative Studies Program is responsible for planning and conducting large multicenter clinical trials and epidemiological studies. It serves as a foundational part of the VA national clinical research enterprise and seeks to advance the health and health care of Veterans through cooperative research studies that produce innovative, definitive, and effective solutions to Veteran and national health care problems.

Million Veteran Program (826)

The Million Veteran Program (MVP) is a national voluntary research program that partners with Veterans receiving their care in the VA health care system to study how genes affect health. To do this, MVP is building one of the world's largest databases of genes and health by safely collecting blood samples and health information from 1 million Veteran volunteers.

Collaboration with Federal Agencies and Other Organizations

To expand the scope and impact of VA research, ORD collaborates whenever possible with others in the research community who share our mission of improving health care. Partnering with others with common research interests allows VA to leverage resources and expand the impact of our nation's investment in research. Collaboration supports the swift transition of medical findings into real-life strategies to improve life for Veterans and all Americans.

VA and DoD share a commitment to honor those who have served our nation by providing them with the best health care available. Our collaborative research projects cover a wide range of topics, including the long-term health effects of military service on Servicemembers, Veterans and family; military environmental exposure; TBI, polytrauma, prosthetics and amputation care; PTSD and other mental health issues; suicide prevention; and pain management. VA and DoD have agreements allowing for the transfer of medical record data to support research, among other

activities, that is stored in a joint database maintained by ORD as the DoD/VA Infrastructure for Clinical Intelligence (DaVINCI). VA and DoD are partnering in several development tasks to support research using Cerner tools.

VA also is a formal partner with DoD, the Department of the Army, and the National Institute of Mental Health (NIMH) in the third phase of the STARRS-LS. As study participants continue to transition out of the military, this collaboration seeks to link DoD and VA data to better study the pathways military Servicemembers take as they leave the military, with an overall goal of reducing military and Veteran suicide.

VA and DOE are collaborating in the VA-DOE Big Data Science Initiative, a partnership focused on the secure analysis of large amounts of digital health and genomic data (so-called "big data") from VA, including MVP and other federal sources to help advance health care for Veterans and others, while also driving DOE's next generation supercomputing designs. Current collaborative projects include developing risk-prediction tools for suicide, lethal prostate cancer, and cardiovascular disease, as well as assessing the relationship between altitude and suicide. Eight new joint projects have been selected and will be launched in 2023. The topics include improving treatment for heart failure, improving the risk prediction of suicide, predicting negative side effects of antipsychotic medications for better management of care, Long COVID, enabling precision care for sleep disorders, improving lung cancer screening, improving precision treatment for lung cancer, and improving risk prediction and management of complications from diabetes.

VA and the Department of Health and Human Services (HHS) are collaborating on diabetes management; patient safety; the use of health information data; the identification of strategies and designs for military environmental exposures research; characterization of Gulf War illness; cancer clinical trials; and research on COVID-19 preventives, diagnostics, and therapeutics.

VA Research also collaborates with the Indian Health Service, part of HHS, to improve access to care for American Indian Veterans. VA collaborates with other components of HHS, such as the National Cancer Institute (NCI) and the National Institute on Aging (NIA), as described below. Through the Pain Management Collaboratory, VA collaborates with NIH and DoD on a series of trials of non-opioid treatments for chronic pain in Veterans and active-duty military members.

NAVIGATE sites have enrolled more Veterans into NCI trials than other VA sites that have not received dedicated funding for local clinical trials infrastructure, highlighting the success of the program.

ORD, through QUERI, actively collaborates with the National Institutes of Health to provide national training in implementation research and health system science methods to promote translation of research findings into real-world health care settings through the Implementation Research Institutes sponsored by NIMH and NCI.

VA and NIA are collaborating on the VA-NIA Alzheimer's Disease Veteran-Centric Alliance Network for Health Care Excellence (AD-VANCE) Initiative. That partnership is aimed at fast-tracking the development of new treatments and cures for Alzheimer's disease and related dementias (AD/ADRD), and to improve the care of Veterans with AD/ADRD and the well-being of their caregivers.

VA also fosters dynamic collaborations with its university affiliates and with nonprofit organizations and private industry.

Examples of accomplishments in this area include the following:

- Partnered with the Prostate Cancer Foundation to speed the development of new treatments and cures for prostate cancer. This partnership has resulted in new clinical trials that are already producing state-of-the-art results for individualized care. One example is a trial titled "Carboplatin or Olaparib for BrcA Deficient Prostate Cancer," or COBRA, which is recruiting up to 100 Veterans with an aggressive form of prostate cancer.
- Established a new Core Recruitment Site to attract applicants from HBCUs. This represents an enhanced partnership with the Morehouse School of Medicine to increase diversity in the scientific workforce.
- Collaborated with the nonprofit organization PINK Concussions to encourage women to donate their brains upon death for research into the effects of TBI and PTSD.
- Licensed production of 3D-printed metal prosthetic fingers in smaller sizes for women Veterans and others to a commercial partner (PointDesigns). VA researchers developed the fingers.
- Initiated a clinical trial in lower limb osseointegration across multiple VA sites in collaboration with industry partner DJO Global. If successful, this will lead to FDA approval of an Osseo integrated limb prosthesis, providing an alternative to the standard socket used to attach a prosthetic limb.
- Translated three inventions by the Minneapolis Adaptive Design and Engineering Program at the Minneapolis VA Health Care System into the commercial phase so they can be available for wide use by Veterans and others. The licensing agreements were facilitated by demonstrating the research technology at a Paralyzed Veterans of America (PVA) annual convention. They include:
    - An arm cycle exercise device that can be used by patients while they lie in bed. The Multi-Purpose Arm Cycle Ergometer for Rehabilitation (M-PACE) allows patients with conditions such as spinal cord injury to participate in a wider range of exercise and rehabilitation activities. This ergometer is now licensed to Action Manufacturing.
    - A standing mobile wheelchair that allows the user physiological benefits by being in an upright position and psychological benefits by interacting with others at eye-level. LEVO now holds the license.
    - The SKINSYTE camera system, which allows self-examination for early detection and monitoring of skin breakdown, wounds, and other conditions in hard-to-see body locations. VA has a license agreement with Derek Herrera.
- Collaborated with the University of Chicago and the Open Commons Consortium, organizations already supporting similar NIH initiatives, to help ORD create a VA Data Commons to jump start its research infrastructure modernization. This effort is setting up

and measuring the cost of performing large genomic analyses in a secure cloud environment.

  - Served as a contributing member of the OHDSI community along with hundreds of collaborators in 30 countries across six continents.

- Established, under the Access to Clinical Trials (ACT) for Veterans initiative, capabilities and policies to facilitate partnerships to start high-quality, multisite clinical trials more quickly with the pharmaceutical industry. Several of these efforts have resulted in access to new therapeutics and vaccines for the COVID-19 pandemic and have also helped with oncology trials.
- Developed a partnership between ORD's HSR&D program and the Elizabeth Dole Foundation to support a landmark RAND Corporation research blueprint for Veterans and their caregivers. This expands VA's ability to deliver integrated, Veteran- and caregiver-partnered, data-driven approaches to care. It serves as a model for excellence in peer-reviewed research on innovation, training, implementation, evaluation, adoption and dissemination of best practices in supporting Veterans' caregivers across VA and in private and non-profit sectors.

2024 Estimates by Designated Research Area (DRA)[1]

Designated Research Areas (DRAs) are reporting categories that are recorded in the Research Analysis Forecasting Tool (RAFT) that help track all ORD allocated funds distributed to these Research Areas. DRAs represent areas of importance to our Veteran patient population. The description below details the types of Veterans related Medical Research performed in each category as depicted in the table below. Research will focus on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization, and delivery of care.

Funding provides for Merit Awards, multi-site clinical trials, research centers, capacity-building awards (e.g., Career Development Awards and supplemental awards to promote diversity, equity, and inclusion in the workforce), and other research career awards (e.g., Research Career Scientist Awards, Presidential Early Career Awards for Scientists and Engineers).

The amounts shown for these research areas are not mutually exclusive. Research projects that span multiple areas may be counted in several categories. For example, a single study may cover both cancer and military exposures. Thus, amounts depicted within this table total more than the total appropriations for intramural research. This method of reporting is consistent with that of other federal agencies.

Table: Appropriations and Projects by Designated Research Area (DRA)

Dollars in Thousands										
Description	**2022 Actual**		**2023 Request**		**FY 2023 Estimate**		**FY 2024 Request[2]**		**FY 2024 Request- FY 2023 Estimate**	
	Dollars	**Projects**	**Dollars**	**Projects**	**Dollars**	**Projects**	**Dollars**	**Projects**	**Dollars**	**Projects**
Military Occupations & Environ. Exposures (e.g. Burn Pits and Agent Orange)	$ 27,592	119	$ 51,414	198	$ 51,414	198	$ 68,012	254	$16,598	56
Medical and Prosthetics Research (non-add)	*$ 27,592*	*119*	*$ 51,414*	*198*	*$ 49,014*	*189*	*$ 22,012*	*$ 82*	-$27,002	-107
Toxic Exposure Fund (non-add)	*$ -*	*0*	*$ -*	*0*	$ 2,400	9	*$ 46,000*	*$ 172*	$43,600	163
Gulf War Veterans Illness	$ 15,226	33	$ 15,226	40	$ 15,226	40	$ 15,226	40	$0	0
Medical and Prosthetics Research (non-add)	*$ 15,226*	*33*	*$ 15,226*	*40*	*$ 15,226*	*40*	*$ 4,928*	*$ 13*	-$10,298	**-27**
Toxic Exposure Fund (non-add)	*$ -*	*0*	*$ -*	*0*	$ -	0	*$ 10,298*	*$ 27*	$10,298	27
Acute & Traumatic Injury	$ 23,315	114	$ 26,155	108	$ 26,155	108	$ 26,968	108	$813	-1
Aging (e.g. Alzheimer's)	$ 151,422	744	$ 151,328	716	$ 151,328	716	$ 156,032	716	$4,704	-1
Autoimmune, Allergic & Hematopoietic Disorders	$ 38,562	210	$ 39,601	183	$ 39,601	183	$ 40,832	183	$1,231	-1
Cancer	$ 80,665	334	$ 81,295	341	$ 81,295	341	$ 93,822	369	$12,527	28
CNS Injury & Associated Disorders (e.g. TBI)	$ 112,343	451	$ 140,776	527	$ 140,776	527	$ 160,151	585	$19,376	57
Degenerative Diseases of Bones & Joints	$ 36,252	184	$ 41,601	173	$ 41,601	173	$ 42,894	173	$1,293	-1
Dementia & Neuronal Degeneration	$ 40,882	159	$ 42,344	173	$ 42,344	173	$ 43,660	173	$1,316	-1
Diabetes & Major Complications	$ 48,675	195	$ 47,729	185	$ 47,729	185	$ 49,213	185	$1,484	-1
Digestive Diseases	$ 28,269	142	$ 26,256	139	$ 26,256	139	$ 27,072	139	$816	-1
Emerging Pathogens/Bio-Terrorism	$ 5,714	18	$ 2,833	19	$ 2,833	19	$ 2,921	19	$88	-1
Gulf War Veterans Illness	$ 12,486	33	$ 15,226	40	$ 15,226	40	$ 15,699	40	$473	-1
Health Systems	$ 81,473	272	$ 71,094	255	$ 71,094	255	$ 73,304	255	$2,210	-1
Heart Disease/Cardiovascular Health	$ 73,735	314	$ 72,963	296	$ 72,963	296	$ 75,231	296	$2,268	-1
Infectious Diseases	$ 56,997	198	$ 58,200	222	$ 58,200	222	$ 60,009	222	$1,809	-1
Kidney Disorders	$ 20,636	102	$ 18,230	105	$ 18,230	105	$ 18,796	105	$567	-1
Lung Disorders	$ 27,641	126	$ 28,218	122	$ 28,218	122	$ 29,095	122	$877	-1
Mental Illness (e.g. Suicide Prevention)	$ 129,112	515	$ 130,137	519	$ 130,137	519	$ 138,937	537	$8,800	18
Other Chronic Diseases	$ 7,443	42	$ 7,474	42	$ 7,474	42	$ 7,706	42	$232	-1
Prosthetics	$ 25,272	105	$ 25,569	83	$ 25,569	83	$ 26,363	83	$795	-1
Sensory Loss	$ 25,659	106	$ 23,367	99	$ 23,367	99	$ 24,093	99	$726	-1
Special Populations	$ 48,107	197	$ 43,280	167	$ 43,280	167	$ 44,625	167	$1,345	-1
Substance Abuse	$ 29,516	131	$ 30,073	124	$ 30,073	124	$ 31,007	124	$935	-1

1. Research projects that span multiple areas may be counted in several categories. Thus, amounts depicted within this table total to more than the VA research appropriation. This method of reporting is consistent with that of other federal agencies.

2. Funding increases reflect a pay raise (5.2%), biomedical inflation (2.3%), and funding for new initiatives in 2024.

Table: Select Appropriations and Projects by Research Priority Area (RPA) 1/

The selected research areas by Research Priority Area (RPA) are a subcategory of Designated Research Areas (DRA) that also represent areas of importance to our Veteran patient population. RPAs allow more granularity for reporting on research project areas. The selected RPAs below reflect increase levels within the 2024 Request.

Dollars in Thousands										
Description	**2022 Actual**		**2023 Request**		**FY 2023 Estimate**		**FY 2024 Request[3]**		**FY 2024 Request- FY 2023 Request**	
	Dollars	**Projects**	**Dollars**	**Projects**	**Dollars**	**Projects**	**Dollars**	**Projects**	**Dollars**	**Projects**
Traumatic Brain Injury (part of CNS & Associated Disorders DRA)	$ 54,908	217	$ 76,935	304	$ 76,935	304	94,326	361	$17,391	57
Precision Oncology (part of Cancer DRA)	$ 14,724	38	$ 22,550	66	$ 22,550	66	33,251	95	$10,701	28
Suicide Prevention (part of Mental Health DRA)	$ 28,675	101	$ 20,806	92	$ 28,675	101	34,321	119	$5,646	18

1. Research projects that span multiple areas may be counted in several categories. Thus, amounts depicted within this table total to more than the VA research appropriation. This method of reporting is consistent with that of other federal agencies.
2. Funding increases reflect a pay raise (5.2%), biomedical inflation (2.3%), and funding for new initiatives in 2024 (within the Medical and Prosthetics Research Appropriation).

Designated Research Area (DRA) and Research Priority Area (RPA) Descriptions

The areas of research below represent areas where VA has a particularly strong strategic interest because of the prevalence of conditions within VA patient populations, the uniqueness of a specific patient population, and its disease burden to the VA system or the importance of the question to health care delivery within VA.

Acute & Combat-Related Injury (Acute and Traumatic Injury): Research focuses on surgical approaches and post-operative care of injuries or chronic conditions prevalent in Veterans. This includes amputation, burn treatment, fracture repair strategies, shock, wound repair/healing, sepsis, and polytrauma.

Aging, Older Veterans' Health and Care (e.g., Alzheimer's): Research focuses on the physiological aspects of the aging process, geriatric syndromes, disease prevention in the elderly, geriatric pharmacology (polypharmacy), and care of elderly Veterans, which includes delivery and outcome measures of geriatric care in outpatient facilities, hospitals, long term care settings, caregiver issues, and questions about the financing of healthcare for Medicare-eligible Veterans. Funding also supports projects focused on diseases or issues that are the most common or more prevalent in older Veterans (cardiovascular disease, stroke, Alzheimer's Disease, Parkinson's Disease, certain cancers, Type II diabetes, chronic lung disease, age-related sensory loss, end of life issues), as well as projects involving a study population that is 60+ years old or has research results likely to contribute to the healthcare of older Veterans.

Autoimmunity, Allergy, and Inflammation (Autoimmune, Allergic & Hematopoietic Disorders): Focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization, and delivery of care for autoimmune diseases, immunodeficiency, immune-complex disorders, and diseases related to allergic or delayed hypersensitivity reactions and the effects of aging on these functions, such as immunosenescence, systemic inflammation, gut microbiome dependent effects on immune function, and sexual dimorphism of immune inflammatory responses. This also includes Lupus, Long COVID, immunotherapy, cells of the immune system, and immunology of organ transplantation.

Brain and Spinal Cord Injuries and Disorders (incl. TBI) (CNS Injury & Associated Disorders): Focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization, and delivery of care for brain and spinal cord injuries sustained during active-duty military service and subsequently. Neurotrauma may be the result of a blast, penetrating or crush injury, blunt force trauma, ischemic event, hemorrhage, etc. This also includes Epilepsy, neuropathic pain, Multiple Sclerosis, neural plasticity, peripheral nerve injury, and chronic traumatic encephalopathy.

Cancer (e.g., Precision Oncology): Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, prognosis, treatment, and prevention of cancer as well as healthcare utilization and delivery of care to cancer patients. This includes the delivery, efficacy, and effectiveness of therapies (incl. chemo, radiation, immuno-, gene therapy, bone marrow transplants) for the treatment of adult leukemia/lymphoma, solid tumors, and cancer pain.

Precision oncology studies focus on the characterization of a patient tumor (or other biospecimen) using next generation sequencing (NGS profiling) or other histologies for diagnosis, treatment, prediction or prognosis. Studies may include the use of targeted therapies (or in combination with immunotherapy) aimed at treating cancer cells, use of biomarker(s) to test for cancer or clinical/treatment response, outcome, screening or patient stratification; use of NGS profiling to understand resistance to therapy in a patients tumor and/or molecular characteristics of resistant samples derived from patient biopsies (e.g., patients enrolled in clinical trials), or to understand the molecular drivers of response to immunotherapy. Studies may use data analytics such as artificial intelligence/machine learning/neural networks/algorithms to interrogate pathomic and radiomic images or genomic/transcriptomic/proteomic data for cancer diagnosis, prognosis, risk stratification and prediction of treatment response.

Cardiovascular Disease (Heart Disease/Cardiovascular Health): Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization and delivery of care for disease and disorders of the heart, central and peripheral vasculature. Includes studies on heart failure, coronary artery disease, pacemakers, defibrillators, idiopathic hypertension, peripheral artery disease, aneurysms and atherosclerosis. This also includes studies on the cellular and non-cellular constituents of blood (e.g., hemostasis, blood coagulation, hematopoiesis, anemia) and stroke.

Diabetes and Other Endocrine Disorders (Diabetes & Major Complications): Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization, and delivery of care for diseases associated with the regulation of glucose, insulin, and metabolism.

Digestive Diseases: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization and delivery of care for diseases associated with the gastrointestinal system and associated organs such as liver, spleen, gallbladder, and pancreas. This includes GI motility, acid reflux (GERD), inflammatory bowel disease (IBD), irritable bowel syndrome (IBS), digestion, nutrition, and liver transplants.

Emerging Pathogens and Bioterrorism: Funds research on new or re-emerging pathogenic agents and those that are expanding into hosts and areas where they have not previously been reported. The category includes any pathogen reported with high incidence in an epidemic or pandemic outbreak, and includes proposals on microbes, vector-borne pathogens or Select Agents with potential for use in bioterrorism.

Gulf War Veterans Illness: Research aims to better understand and treat health problems experienced by some Veterans following exposures to toxic substances and environmental hazards during the Gulf War. These efforts are guided by a strategic plan by the Research Advisory Committee on Gulf War Veterans' Illnesses, a committee created by Congress in 1998 (Public Law 105-368) and first appointed by the VA Secretary in January 2002. The committee directs VA to commit at least $15 million to Gulf War research annually.

Health Systems: Research focuses on a systematic study of organizational structures, design and delivery methods to improve Veteran health, with a particular focus on the Quintuple Aim

outcomes (e.g., efficiency, equity and quality of care for Veterans as well as Veteran and provider experience). This includes studying gaps in the care process and implementation, developing innovations and best practices in existing care delivery systems (both human and systems design), performance and quality of care, human safety issues, resource utilization, cost-benefit, management and human resource factors affecting care, Veteran and community engagement methods, and developing models to improve the overall efficiency of the healthcare organization and the care delivery process.

Infectious Diseases: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, and prevention of infectious diseases of humans and relevant animal infection models, including studies of effects of aging on infectious diseases and healthcare utilization and delivery of care for Veterans infected with SARS-CoV, Hepatitis A, B & C, HIV, TB, Flu (H5N1), bacteria, fungi, parasites, and vector-borne agents.

Kidney Disorders: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization and delivery of care for diseases and disorders of the kidney, including the effect of aging. This also includes end-stage renal diseases, dialysis, and renal function after transplantation.

Lung Disorders: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization and delivery of care for diseases and disorders of the lung. Also includes effect of toxic exposure, autoimmunity, infectious diseases, effect of transplantation on pulmonary function, ventilator studies, and Chronic Obstructive Pulmonary Disease (COPD).

Mental, Cognitive and Behavioral Disorders Mental Illness: This DRA is used for proposals which focus on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization and delivery of mental health services for psychiatric and behavioral disorders including psychotic disorders, depression, mood and anxiety disorders, adjustment disorders, post-traumatic stress disorder (PTSD), behavioral and cognitive disorders, vascular dementia, and frontotemporal dementia. It also includes studies of sleep disorders, memory loss, or other neuro-cognitive impairments that occur due to an aging-related disease or following brain injury (such as a TBI or stroke).

Military and Environmental Exposures (Military Occupations & Environmental Exposures): Research focuses on chronic health effects of conditions or substances encountered during military service, and the healthcare utilization and delivery of care to Veterans with these exposures. This DRA emphasizes repeated or long-term exposures and includes studies on Agent Orange, dioxins, industrial chemicals, industrial materials, oil fires, insecticides/pesticides, burn pits, micro-particulates, jet fuel, radiation, electromagnetic, and acoustic exposures. It also includes studies of novel animal or organoid/tissue chip exposure models.

Musculoskeletal Disorders (Degenerative Diseases of Bones & Joints): Focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization and delivery of care for musculoskeletal disorders common in Veterans either as a result of a combat-related injury, or the result of a progressive disease affecting the body's muscles, joints, tendons,

ligaments, bones, or normal aging. This includes chronic low back pain, osteoarthritis, osteoporosis, muscular dystrophy, fracture healing, osteomyelitis, degenerative disc disease, and joint replacement as a treatment.

Neurodegenerative Diseases (Dementia & Neuronal Degeneration): Focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization and delivery of care for neurodegenerative diseases of the central and peripheral nervous system (including progressive loss of structure or function of neurons, death of neurons), which are prevalent in Veteran populations. This includes Alzheimer's Disease, amyotrophic lateral sclerosis, Huntington's Disease, Parkinson's Disease, and prion diseases.

Other Conditions (Other Chronic Diseases): This DRA is used to code dental research and other conditions that cannot be classified under any other DRA.

Prosthetics, Orthotics, and Assistive Technology (Prosthetics): Research focuses on the studies of new devices or the improvement of existing devices to replace missing body parts or to supplement defective body parts. This includes research on the engineering design, development, implementation, prototype testing, or fitting of an artificial limb, orthotics research, neural prostheses, assistive technology, restorative devices, and rehabilitation services for improving Veteran's prognosis and functioning (e.g., communication, ambulation, mobility, cognition, vision, bowel/bladder function, etc.). This includes research into the delivery and quality of care for patients requiring prosthetics, orthotics, neural prostheses, or assistive technology. Implanted devices for specific health conditions such as pacemakers (e.g., cardiac or deep brain stimulators), heart valves, and total joint replacements would not fall under this DRA.

Sensory Loss: Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, prevention, healthcare utilization and delivery of care for sensory loss common in Veterans either as a result of a combat-related injury or military environmental exposure, the result of a progressive disease process, or normal aging. Include tinnitus and rehabilitation for sensory and other communication disorders. Sensory loss research may double code with the Aging DRA (e.g., macular degeneration), Diabetes DRA (e.g., diabetic retinopathy), Cancer DRA (e.g., chemotherapy-related ototoxicity) or Prosthetics DRA (e.g., cochlear and retinal implants) as appropriate.

Special Populations: Research focuses on VA, VHA, and Administration strategic goals related to improving care and outcomes for underserved, marginalized, and at-risk Veteran populations across the life journey (VA Strategic Plan Goal 2), includes a special emphasis on innovative research focused on equity, experience, value, quality, and outcomes. Also focuses on Veterans experiencing – or who are at risk of – homelessness, suicide, and other adverse events, and those experiencing adverse social determinants and/or gaps in quality and access to care in VA and elsewhere.

Substance Use Disorders (Substance Abuse): Research focuses on the etiology, pathogenesis, epidemiology, diagnosis, treatment, and prevention of abuse of alcohol, nicotine, and drugs, individually and/or in combination. Includes studies of specialized VA Health Care services provided to substance-abusing and substance-addicted Veterans. Studies include mechanistic

studies of diseases caused by substance abuse, substance abuse in patients with PTSD, anxiety disorders, depression, schizophrenia, and studies on pain management or anesthetics.

Table: Obligations by Object Class

(dollars in thousands)						
	Medical and Prosthetics Research (Disc.)			American Rescue Plan Act (Mand.)		
Description	2022	2023	2024	2022	2023	2024
10 Personnel Compensation and Benefits:	$519,957	$553,527	$564,704	$1,038	$15,809	$0
21 Travel & Transportation of Persons:	$2,241	$2,348	$2,399	$5	$71	$0
22 Transportation of Things.....	$236	$248	$253	$0	$8	$0
23 Rent, Communications, and Utilities:	$9,517	$9,962	$10,177	$20	$304	$0
24 Printing & Reproduction:	$245	$257	$262	$1	$8	$0
25 Other Contractual Services:	$362,277	$385,182	$393,000	$726	$11,058	$0
26 Supplies & Materials:	$57,880	$60,769	$62,066	$121	$1,836	$0
31 Equipment.....	$31,845	$33,395	$34,111	$67	$1,013	$0
41 Grants, Subsidies & Contributions:	$26	$28	$28	$0	$1	$0
**Obligations [Total].....	**$984,223**	**$1,045,714**	**$1,067,000**	**$1,977**	**$30,109**	**$0**

Obligations by Object Class						
(dollars in thousands)						
	Toxic Exposure Fund (Mand.)			Total Obligations		
	2022	2023	2024	2022	2023	2024
10 Personnel Compensation and Benefits:	$0	$1,913	$24,153	$520,995	$571,249	$588,857
21 Travel & Transportation of Persons:	$0	$6	$109	$2,246	$2,425	$2,508
22 Transportation of Things.....	$0	$1	$12	$237	$256	$265
23 Rent, Communications, and Utilities:	$0	$25	$465	$9,537	$10,291	$10,642
24 Printing & Reproduction:	$0	$1	$12	$245	$265	$274
25 Other Contractual Services:	$0	$300	$16,895	$363,003	$396,540	$409,895
26 Supplies & Materials:	$0	$151	$2,804	$58,001	$62,755	$64,871
31 Equipment.....	$0	$83	$1,548	$31,911	$34,492	$35,660
41 Grants, Subsidies & Contributions:	$0	$0	$1	$27	$29	$30
**Obligations [Total].....	**$0**	**$2,480**	**$46,000**	**$986,200**	**$1,078,303**	**$1,113,000**

Revolving and Trust Activities

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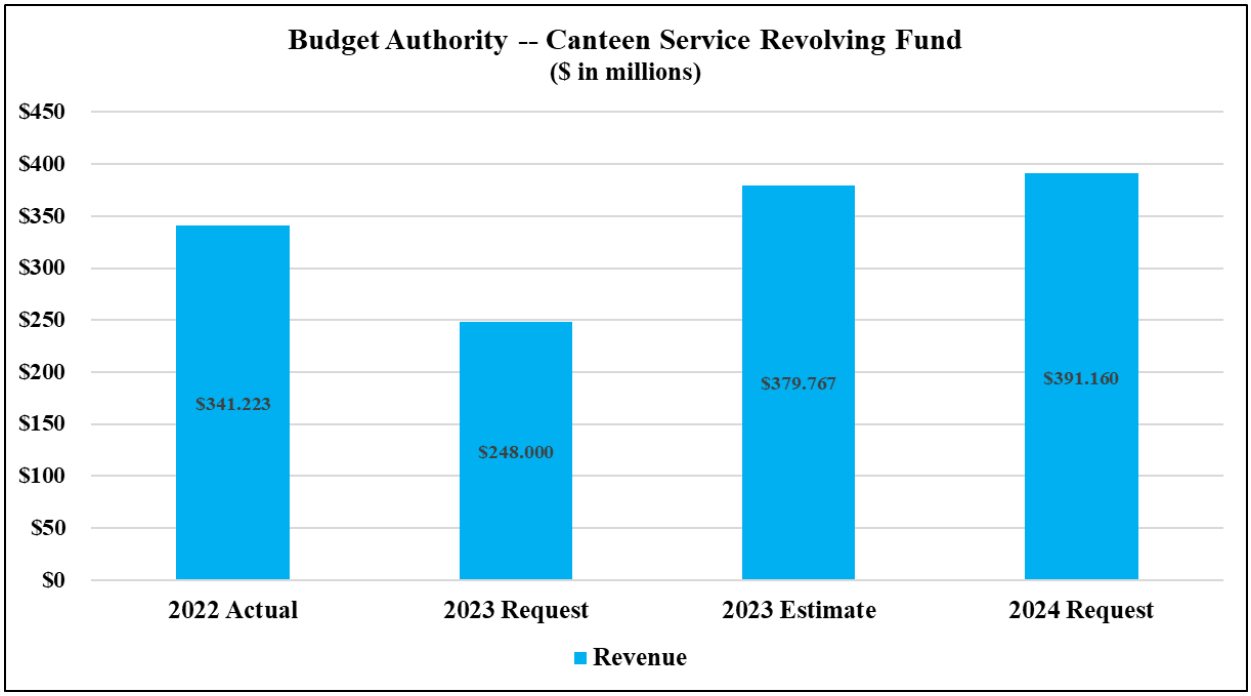
Veterans Canteen Service Revolving Fund



Program Description

The Veterans Canteen Service (VCS) was established by Congress in 1946 to furnish, at reasonable prices, meals, merchandise and services necessary for the comfort and well-being of Veterans in hospitals and domiciliaries operated by the VA (Title 38 U.S.C. 7801-10). It has since expanded to provide reasonably priced merchandise and services to America's Veterans enrolled in VA's health care system, their families, caregivers, VA employees, volunteers and visitors.

Congress originally appropriated a total of $5.0 million for the operation of the VCS and no additional appropriations have been required. Funds in excess of the needs of the Service totaling $12.1 million have been returned to the U.S. Treasury. However, provisions of the Veterans' Benefits Act of 1988 (Public Law 100-322) eliminated the requirement that excess funds be returned to the Treasury and authorized such funds to be invested in interest-bearing accounts, specifically Treasury Bills and Notes. Gains realized from these accounts are used to fund business operations. Currently, VCS has no interest-bearing investments.

Creating an environment where patrons can truly enjoy their shopping or dining experience has become a necessity for modern businesses. Providing VA customers the same high-quality service

found in private industry has been, and will continue to be, necessary for VCS. This philosophy will take VCS into 2023 and beyond.

Fund Highlights [1]
(dollars in thousands)

Description	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Estimate	+/- 2023-2024
Total revenue.....	$341,223	$248,000	$379,767	$391,160	$11,393
Obligations.....	$381,501	$262,000	$398,755	$402,895	$4,139
FTE.....	2,101	2,318	2,075	2,065	(10)

[1] The numbers in the chart above reflect an estimate of the activity during the Federal Government Fiscal Year (October – September), as the Veterans Canteen Service uses a retail industry fiscal year (February – January) used by similar private sector retailers to enhance their ability to compare their operations to their private sector peers.

The retail-calendar-fiscal-year reporting cycle has been adopted to better align VCS operations with the financial reporting structure of the retail industry. The calendar uses a (4-5-4) weekly cycle for the monthly reporting schedule. The 4-5-4 retail accounting calendar divides the year, beginning with the month of February, into quarters with the first and last month of each quarter consisting of four weeks each and the middle month of each quarter consisting of five weeks. Although the retail accounting calendar is used for management purposes, VCS will continue to report to VA on a Federal fiscal year basis.

Summary of Budget Request

No appropriation by Congress will be required for VCS to operate during 2024. The VCS is a self-sustaining, revolving fund activity that obtains its revenues from non-Federal sources; therefore, no Congressional action is required. Within VA, VCS functions independently and has primary control over its major activities, including sales, procurement, supply, finance and personnel management.

Changes From 2023 Budget Request
(dollars in thousands)

Description	2023 Budget Estimate	2023 Current Estimate	Increase/ Decrease
Total revenue.....	$248,000	$379,767	$131,767
Obligations.....	$262,000	$398,755	$136,755
FTE.....	2,318	2,075	(243)

Summary of Employment

For personnel management, VCS uses techniques generally applied in commercial retail chain store, food and vending operations. Primary consideration is given to salary expenses in relation to sales. Salary expense data are provided to management personnel for each department in each Canteen, as well as VCS in total. These data are compared to the corresponding period from the previous year and to personnel cost thresholds and standards prior to making decisions regarding employment increases or decreases. Personnel cost as a percent of sales is the standard by which VCS measures personnel cost management.

The following chart reflects the full-time equivalent (FTE) employment for 2022 through 2024:

Summary of Employment

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Estimate	+/- 2023-2024
FTE	2,101	2,318	2,075	2,065	(10)

Revenues and Expenses
(dollars in thousands)

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Estimate	+/- 2023-2024
Sales Program:					
Revenue	$341,223	$391,160	$379,767	$391,160	$11,393
Less operating expenses	($348,893)	($374,640)	($363,040)	($363,349)	($308)
Net operating income-sales	($7,670)	$16,520	$16,727	$27,811	$11,085
Net non-operating income	($839)	($924)	($840)	($924)	($84)
Net income for the year	($8,509)	$15,596	$15,887	$26,888	$11,001

Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2024. Changes from year to year are the result of anticipated changes in revenues, obligations and outlays previously portrayed.

Financial Condition
(dollars in thousands)

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Estimate	+/- 2023-2024
Assets:					
Cash with Treasury, in banks, in transit	$114,209	$114,283	$92,000	$77,000	($15,000)
Accounts receivable (net)	$41,756	$25,476	$40,921	$40,102	($818)
Inventories	$15,198	$14,205	$15,502	$15,812	$310
Real property and equipment (net)	$37,906	$39,028	$25,000	$26,250	$1,250
Other assets	$194	$214	$500	$525	$25
Total assets	$209,263	$193,205	$173,923	$159,689	($14,233)
Liabilities:					
Accounts payable including funded accrued liabilities	$11,047	$29,444	$11,047	$10,711	($336)
Unfunded annual leave and coupons books	$6,426	$12,006	$6,426	$6,747	$321
Total liabilities	$17,473	$41,450	$17,473	$17,459	($14)
VHA equity:					
Unexpended balance:					
Unobligated balance	$8,742	$15,191	$8,742	$9,179	$437
Undelivered orders	$0	$0	$0	$0	$0
Invested capital	$169,373	$162,666	$128,274	$117,254	($11,020)
Total Government equity (end-of-year)	$178,115	$177,857	$137,016	$126,433	($10,583)

Retained Income
(dollars in thousands)

	2022 Actual	2023 Budget Estimate	2023 Current Estimate	2024 Estimate	+/- 2023-2024
Retained Income:					
Opening Balance	$61,958	$50,018	$12,601	($7,949)	($20,549)
Transactions:					
Net Operating Income	($28,808)	($11,492)	($20,549)	($10,583)	$9,966
Net Non-Operating Gain	$0	$0	$0	$0	$0
Closing Balance	$33,150	$38,526	($7,949)	($18,532)	($10,583)

Medical Center Research Organizations

Program Description

The Veterans' Benefits and Services Act of 1988 (Public Law 100-322) authorizes "Medical Center Research Organizations" to be created at VA Medical Centers (VAMC). These nonprofit corporations (NPCs) provide flexible funding mechanisms for the conduct of VA-approved research and educational activities. They administer funds from non-VA Federal and private sources to operate various research and educational activities in VA. These corporations are private, state-chartered entities. They are self-sustaining and funds are not received into a government account. No appropriation is required to support these activities.

Prior to June 1, 2004, 93 VAMCs had received approval for the formation of nonprofit research corporations. Presently, 79 are active. Most of the corporations have indefinite, ongoing operations. However, recent changes in the law permit NPC mergers. This may result in a decrease in the number of NPCs overall.

All 79 NPCs have received their authority from the Internal Revenue Service Code of 1986, under Article 501(c)(3) or similar Code Sections. The fiscal years for these organizations vary, with most having year-ends on September 30 or December 31. The table below reflects estimated revenues and expenses from 2022 to 2024.

Table: Contribution Highlights

			2023			
	2021 Actual 1/	2022 Estimated 2/	Budget Estimate	Current Estimate	2024 Estimate	+/- 2023-2024
Contributions.....	$313,078	$288,695	$289,374	$295,564	$309,430	$13,866
Expenses.....	$294,225	$278,617	$276,570	$283,082	$293,011	$9,929

1/ The actual amounts for 2021 were reported by the NPCs in June and July 2022
2/ The FY 2022 actuals will be reported by the NPCs in July 2023 as part of the annual reporting requirement in conjunction with the NPC Annual Report to Congress (ARC)

The following table is a list of research corporations that have received approval for formation along with their actual 2021 contribution from the non-VA Federal and private sources. In addition, NPCs with no contributions have been approved for operation. Some have received contributions in the past, others have not received any contributions to date:

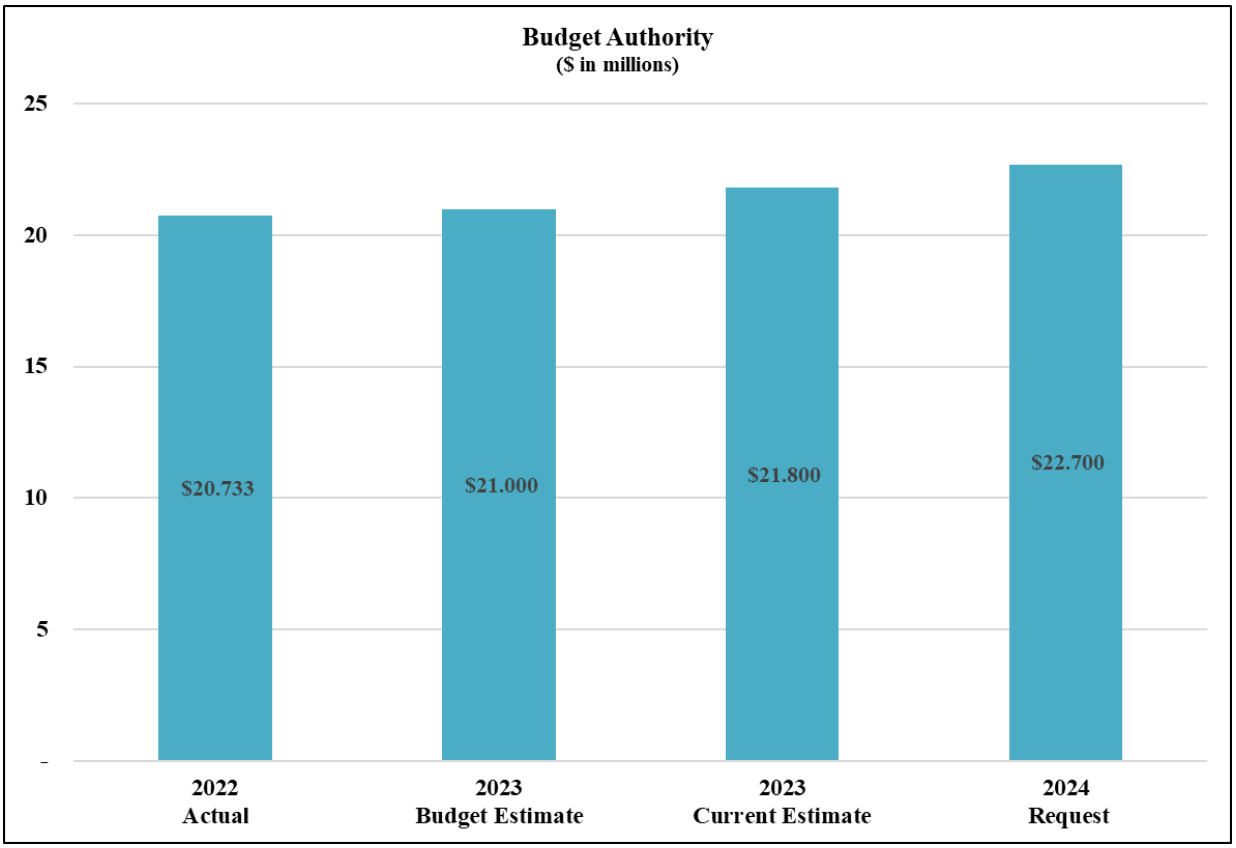
Table: Nonprofit Corporations

	Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2021	Estimated Revenues (Contributions) 2022	Estimated Revenues (Contributions) 2023	Estimated Revenues (Contributions) 2024
1.	Albany Research Institute, Inc	Albany	NY	2,997,000	1,910,000	1,876,000	519,000
2.	Arizona Veterans Research and Education Foundation	Phoenix	AZ	1,867,000	2,050,000	1,800,000	2,000,000
3.	Asheville Medical Research and Education Corporation	Asheville	NC	113,000	120,000	140,000	160,000
4.	Augusta Biomedical Research Corporation	Augusta	GA	102,000	34,000	50,000	50,000
5.	Baltimore Research and Education Foundation	Baltimore	MD	4,941,000	5,188,000	5,447,000	5,720,000
6.	Bedford VA Research Corporation, Inc	Bedford	MA	720,000	121,000	180,000	150,000
7.	Biomedical Research and Education Foundation of Southern Arizona	Tucson	AZ	627,000	650,000	900,000	1,500,000
8.	Biomedical Research Foundation	Little Rock	AR	1,760,000	1,500,000	1,600,000	1,700,000
9.	Biomedical Research Institute of New Mexico	Albuquerque	NM	8,153,000	7,875,000	8,000,000	8,250,000
10.	Boston VA Research Institute, Inc	Boston	MA	10,948,000	11,000,000	10,000,000	10,000,000
11.	Bronx Veterans Medical Research Foundation, Inc	Bronx	NY	8,273,000	5,000,000	4,500,000	4,500,000
12.	Buffalo Institute for Medical Research, Inc	Buffalo	NY	879,000	871,000	710,000	680,000
13.	Center for Veterans Research and Education	Minneapolis	MN	7,313,000	6,124,000	6,430,000	6,752,000
14.	Chicago Association for Research and Education in Science	Hines	IL	6,312,000	6,500,000	7,000,000	7,000,000
15.	Cincinnati Education & Research for Veterans Foundation	Cincinnati	OH	2,055,000	2,079,000	2,287,000	2,516,000
16.	Clinical Research Foundation, Inc	Louisville	KY	628,000	290,000	300,000	300,000
17.	Dallas VA Research Corporation	Dallas	TX	2,339,000	1,650,000	1,675,000	1,700,000
18.	Dayton VA Research and Education Foundation	Dayton	OH	95,000	70,000	70,000	70,000
19.	Denver Research Institute, Inc	Denver	CO	9,166,000	10,699,000	11,073,000	12,036,000
20.	Dorn Research Institute, Inc	Columbia	SC	481,000	594,000	604,000	614,000
21.	East Bay Institute for Research and Education	Sacramento	CA	874,000	1,500,000	1,750,000	2,500,000
22.	Foundation for Advancing Veterans' Health Research, Inc	San Antonio	TX	4,965,000	4,803,000	5,083,000	5,429,000
23.	Foundation for Atlanta Veterans Education and Research, Inc	Atlanta	GA	13,849,000	11,080,000	10,552,000	10,900,000
24.	Great Plains Veterans Research Foundation	Sioux Falls	SD	78,000	80,000	100,000	125,000
25.	Greater Los Angeles Research and Education Foundation	Los Angeles	CA	7,083,000	7,104,000	7,175,000	7,247,000
26.	Houston VA Research and Education Foundation	Houston	TX	1,839,000	800,000	1,000,000	1,000,000
27.	Idaho Veterans Research and Education Foundation, Inc	Boise	ID	1,736,000	1,000,000	500,000	600,000
28.	Indiana Institute for Medical Research, Inc	Indianapolis	IN	1,141,000	1,282,000	1,295,000	1,307,000

Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2021	Estimated Revenues (Contributions) 2022	Estimated Revenues (Contributions) 2023	Estimated Revenues (Contributions) 2024
29. Institute for Clinical Research, Inc.	Washington	DC	12,644,000	9,000,000	8,000,000	8,500,000
30. Institute for Medical Research, Inc.	Durham	NC	5,925,000	8,500,000	10,500,000	14,000,000
31. Iowa City VA Medical Research Foundation	Iowa City	IA	334,000	350,000	400,000	450,000
32. Lexington Biomedical Research Institute, Inc.	Lexington	KY	390,000	350,000	350,000	350,000
33. Loma Linda Veterans Association for Research and Education, Inc.	Loma Linda	CA	4,191,000	4,200,000	4,000,000	4,300,000
34. Louisiana Veterans Research and Education Corporation	New Orleans	LA	361,000	230,000	265,000	305,000
35. Lowcountry Center for Veterans Research	Charleston	SC	1,331,000	2,445,000	2,822,000	3,104,000
36. McGuire Research Institute, Inc.	Richmond	VA	5,785,000	4,100,000	4,300,000	4,300,000
37. Middle Tennessee Research Institute, Inc.	Nashville	TN	987,000	750,000	750,000	750,000
38. Midwest Veterans' Biomedical Research Foundation	Kansas City	MO	2,084,000	2,000,000	1,700,000	1,750,000
39. Truman VA Medical Research Foundation	Columbia	MO	378,000	500,000	600,000	720,000
40. Mountain Home Research and Education Corporation	Mountain Home	TN	1,210,000	400,000	300,000	200,000
41. Narrows Institute for Biomedical Research, Inc.	Brooklyn	NY	3,708,000	275,000	275,000	275,000
42. Nebraska Educational Biomedical Research Association	Omaha	NE	909,000	500,000	525,000	551,000
43. North Florida Foundation for Research and Education, Inc.	Gainesville	FL	2,070,000	1,500,000	1,750,000	2,000,000
44. Northern California Institute for Research and Education, Inc.	San Francisco	CA	46,685,000	47,433,000	47,500,000	48,000,000
45. Ocean State Research Institute, Inc.	Providence	RI	5,427,000	996,000	1,016,000	1,036,000
46. Overton Brooks Research Corporation	Shreveport	LA	18,000	300,000	315,000	320,000
47. Pacific Health Research and Education Institute	Honolulu	HI	2,380,000	325,000	500,000	1,500,000
48. Palo Alto Veterans Institute for Research	Palo Alto	CA	29,400,000	30,038,000	31,540,000	32,486,000
49. Philadelphia Research and Education Foundation	Philadelphia	PA	1,954,000	338,000	397,000	425,000
50. Portland VA Research Foundation, Inc.	Portland	OR	7,210,000	8,000,000	8,500,000	9,000,000
51. Research! Mississippi, Inc.	Jackson	MS	190,000	215,000	250,000	300,000
52. Research, Inc.	Memphis	TN	875,000	920,000	930,000	950,000
53. Salem Research Institute, Inc.	Salem	VA	1,715,000	1,500,000	1,500,000	1,600,000
54. Salisbury Foundation for Research and Education, Inc.	Salisbury	NC	310,000	720,000	828,000	910,000
55. Seattle Institute for Biomedical and Clinical Research	Seattle	WA	17,751,000	17,200,000	17,500,000	17,500,000

Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2021	Estimated Revenues (Contributions) 2022	Estimated Revenues (Contributions) 2023	Estimated Revenues (Contributions) 2024
56. Sierra Veterans Research and Education Foundation	Reno	NV	793,000	400,000	350,000	400,000
57. Sociedad de Investigacion Cientificas, Inc	San Juan	PR	393,000	492,000	615,000	769,000
58. South Florida Veterans Affairs Foundation for Research and Education, Inc	Miami	FL	3,355,000	275,000	275,000	275,000
59. Southern California Institute for Research and Education	Long Beach	CA	3,556,000	3,500,000	4,000,000	4,000,000
60. Tampa VA Research and Education Foundation, Inc	Tampa	FL	3,416,000	2,800,000	3,500,000	3,500,000
61. Central Texas Veterans Research Foundation	Temple	TX	1,341,000	1,075,000	1,006,000	600,000
62. The Bay Pines Foundation, Inc	Bay Pines	FL	1,163,000	1,116,000	1,171,000	1,230,000
63. The Cleveland VA Medical Research and Education Foundation	Cleveland	OH	4,154,000	4,365,000	4,583,000	4,812,000
64. The Research Corporation of Long Island, Inc	Northport	NY	226,000	196,000	225,000	225,000
65. Tuscaloosa Research and Education Advancement Corporation	Tuscaloosa	AL	1,533,000	1,413,000	526,000	541,000
66. VA Black Hills Research and Education Foundation	Fort Meade	SD	13,000	16,000	18,000	20,000
67. VA Connecticut Research and Education Foundation, Inc.	West Haven	CT	1,339,000	1,300,000	1,400,000	1,600,000
68. Veterans Bio-Medical Research Institute, Inc	East Orange	NJ	1,989,000	2,378,000	2,238,000	2,238,000
69. Veterans Education and Research Ass'n. of Northern New England, Inc	White River Junction	CT	3,053,000	3,568,000	3,654,000	3,850,000
70. Veterans Education and Research Association of Michigan	Ann Arbor	MI	2,128,000	1,400,000	1,500,000	1,600,000
71. Metropolitan Detroit Research and Education Foundation	Detroit	MI	173,000	200,000	250,000	300,000
72. Veterans Health Foundation	Pittsburgh	PA	2,533,000	3,810,000	4,000,000	4,201,000
73. Veterans Health Research Institute of Central New York, Inc	Syracuse	NY	1,750,000	2,081,000	2,100,000	2,100,000
74. Veterans Medical Research Foundation of San Diego	San Diego	CA	14,783,000	15,000,000	16,000,000	17,000,000
75. Veterans Research and Education Foundation	Oklahoma City	OK	292,000	250,000	300,000	350,000
76. Veterans Research and Education Foundation of St. Louis	St. Louis	MO	2,589,000	2,848,000	3,133,000	3,446,000
77. VISTAR, Inc	Birmingham	AL	389,000	390,000	410,000	425,000
78. Western Institute for Veterans Research	Salt Lake City	UT	4,203,000	4,413,000	4,545,000	4,681,000
79. Wisconsin Corporation for Biomedical Research	Milwaukee	WI	360,000	350,000	355,000	360,000
Total			**312,720,000**	**288,695,000**	**295,564,000**	**309,430,000**

General Post Fund



Program Description

This trust fund consists of gifts, bequests and proceeds from the sale of property left in the care of VA facilities by former beneficiaries who die leaving no heirs or without having otherwise disposed of their estate. Such funds are used to promote the comfort and welfare of Veterans at hospitals and other facilities for which no general appropriation is available. Also, donations from pharmaceutical companies, non-profit corporations and individuals to support VA medical research can be deposited into this fund (title 38 U.S.C., Chapters 83, Acceptance of Gifts and Bequests and 85, Disposition of Deceased Veterans' Personal Property). The resources from this trust fund are utilized for the direct benefit of the patients.

Expenditures from this fund are for recreational activities and religious needs; specific equipment purchases; national recreational events; the vehicle transportation network; television projects; and other items as outlined in Veteran Health Administration Directive 4721, General Post Fund. In addition, Public Law 105-114 authorizes the receipts from the sale of a property acquired for transitional housing to be deposited in the General Post Fund and used for the acquisition, management and maintenance of other transitional housing properties.

Summary of Budget Request

Operations of this trust fund are financed from fund receipts. Congress has provided permanent, indefinite budget authority for this fund and no appropriation is requested.

Table 1: Fund Highlights

		2023			
Description (dollars in thousands)	2022 Actual	Budget Estimate	Current Estimate	2024 Estimate	+/- 2023-2024
Budget Authority (permanent, indefinite).....	$20,733	$21,000	$21,800	$22,700	$900
Projected Receipts :					
Trust Fund and Donation.....	$15,191	$15,300	$16,000	$16,600	$600
Therapeutic Residences.....	$771	$900	$800	$800	$0
Total Projected Receipts.....	$15,962	$16,200	$16,800	$17,400	$600

Table 2: Changes from 2023 Budget Estimate

	2023		
Description (dollars in thousands)	Budget Estimate	Current Estimate	Increase/ Decrease
Budget Authority (permanent, indefinite).....	$21,000	$21,800	$800
Projected Receipts:			
Trust Fund and Donation.....	$15,300	$16,000	$700
Therapeutic Residences.....	$900	$800	($100)
Total Projected Receipts.....	$16,200	$16,800	$600

Program Activity

Trust Fund and Donations

Estimates of trust fund obligations for 2023 and 2024 are $21.8 million and $22.7 million respectively. The obligations are consistent with the purposes for which proceeds from this fund may legally be expended (Comptroller General's Decision B 125715, November 10, 1955) and the intent of the donors. Donors usually specify that their donations be used for designated recreational or religious purposes, research projects, or equipment purchases (e.g., televisions, medical equipment and physical therapy equipment).

Compensated Work Therapy - Therapeutic Residences (CWT-TR)
Per title 38 U.S.C. 2032, funds received through the operation of the Therapeutic Housing Program are to be deposited in the General Post Fund. The Secretary has the discretionary authority to expend up to an additional $500 thousand from the fund above the amount credited to the fund in a fiscal year from proceeds of this program.

Table 3: Financial Actions and Conditions

Description (dollars in thousands)	2022 Actual
Balance beginning of year:	
Cash	$54,722
Investments	$77,693
Property, Plant, Equipment & Other Assets	$48,010
Total	$180,425
Increase during period:	
Cash	$66,662
Investments	$54,413
Property, Plant, Equipment & Other Assets	$104
Total	$121,179
Decrease during period:	
Cash	$87,763
Investments	$27,596
Property, Plant, Equipment & Other Assets	$2,385
Total	$117,744
Balance at end of year:	
Cash	$33,621
Investments	$104,510
Property, Plant, Equipment & Other Assets	$45,729
Total	$183,860

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