FY 2022 BUDGET SUBMISSION

" To care for him who shall have borne the battle, and for his widow, and his orphan…."

Medical Programs and Information Technology Programs

6/1/21 v2

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Medical and Information Technology Programs

Table of Contents

Medical
Budget Overview 11
Mission Statement 11
Budget Request 11
2023 Advance Appropriation 12
Key Secretarial Priorities 12
Key VHA Priorities 17
Change from 2022 Advance Appropriation (AA) 18
Table: Update to the 2022 Advance Appropriation Request 18
Table: 2022 American Rescue Plan Highlights 22
American Families Plan 22
Methods Used to Formulate the Budget Request 22
Key Drivers of Growth in Projected Resource Requirements 23
Medical Care Budgetary Resources 23
Table: Medical Care Appropriations by Account and Medical Care Collections 24
Table: Medical Care Obligations by Discretionary and Mandatory Accounts 25
Table: Discretionary and Mandatory Obligations and FTE by Account 27
Table: Medical Care Total Obligations by Program 28
Table: Programs Included in Medical Care Obligations 30
Table: Veteran Population Obligations in Medical Care Obligations 31
Medical Care Collections Fund 31
VA Staffing 32
Table: Employment Summary (FTE) 33
Table: FTE by Type, Medical Care 34
Table: FTE by Type, Medical Services 34
Table: FTE by Type, Medical Support and Compliance 35
Table: FTE by Type, Medical Facilities 35

Table: Employment Summary, FTE by Grade (Includes Veterans Choice Act) 36
Table: FTE, 2020 Actual 37
Veteran Patient Workload 38
Table: Unique Patients 38
Table: Summary of Workloads for VA and Non-VA Facilities 40
Veteran Enrollment Priority Group Definitions 41
Table: Unique Patients Under Age 65 46
Table: Unique Patients Age 65 and Older 47
Table: Unique Obligations by Priority Group 48
Table: Obligations by Priority Group 49
Tables: Funding Crosswalks 2020-2023 50
American Rescue Plan Act, Section 8008: Employee Leave Fund 63
Tables: Obligations by Object Class by Medical Care Account 64
Medical Care 87
Medical Care Areas of Focus 87
Table: Total Medical Care Obligations by Program 87
Table: Medical Care Obligations by Program (Included Above) 88
Table: Programs for Select Veteran Populations 89
Ambulatory Care 90
Dental Care 96
Inpatient Care 99
Mental Health 105
Table: VA Mental Health Obligations by Treatment Modality and Major Characteristics 107
Substance Use Disorder Program 119
Suicide Prevention 134
Prosthetic and Sensory Aids Services 152
Rehabilitative Care 157
Long-Term Services & Supports (LTSS) and State Home Programs 165
Camp Lejeune Family Member Program (CLFMP) 191
CHAMPVA (Excluding Caregivers) Obligations 193
Caregiver Support Program 198
Readjustment Counseling 202
Activations 207

Education & Training 208
Health Care Professionals Educational Assistance Program 214
Hepatitis C 218
Indian Health Service (IHS)/Tribal Health Programs (THP) Reimbursement Agreements Program 221
Intensive Evaluation and Treatment Program (IETP) for Veterans and Service Members with Traumatic Brain Injury (TBI) and Polytrauma 222
Intimate Partner Violence Assistance Program (IPVAP) 225
National Center for Posttraumatic Stress Disorder (NCPTSD) 228
National Veterans Sports Program 233
Non-Recurring Maintenance (NRM) 236
Precision Oncology 237
Rural Health 240
Supply Chain Management 244
Telehealth 247
Veterans Homelessness Programs 250
Whole Health 263
Programs for Select Veteran Populations 269
AIDS / HIV Program 269
Post Deployment Health Services (PDHS) 273
Traumatic Brain Injury (TBI) and Polytrauma System of Care (PSC) 277
Headache Centers of Excellence (HCOE) 280
Women Veterans Health Care 282
Appropriation Language 291
Medical Services 291
Medical Community Care 292
Medical Support and Compliance 292
Medical Facilities 292
Explanation of changes 293
2020 Appropriation Transfers and Supplemental Appropriations 294
Medical Services 297
Table: Medical Services Discretionary Funding Crosswalk 2020-2023 298
Table: Medical Services Mandatory Funding Crosswalk 2020-2023 299
Table: Update to the 2022 Advance Appropriation Request 300
Table: Medical Services Discretionary Obligations by Program 301

Table: Medical Services Mandatory Obligations by Program 302
Summary of the 2023 Advance Appropriation Request 304
Activations 307
Medical Equipment 308
Medical Services Staffing 310
VA Long-Term Services and Supports Programs 313
Other Health Care Programs VA Care 314
Beneficiary Travel 314
Pharmacy 316
Prosthetics 320
Medical Community Care and Veterans Choice 321
Chart: Medical Community Care Appropriations and Collections 321
Chart: Medical Community Care Obligations 323
Tables: Community Care Funding Crosswalks 2020-2023 324
Summary of 2022 Revised Request 329
Table: Update to the 2022 Advance Appropriation Request 329
Tables: Community Care Obligations by Program 329
Summary of the 2023 Advance Appropriation Request 333
Medical Community Care Description 334
Outpatient and Inpatient Healthcare Claim Management 335
Camp Lejeune Family Member Program (CLFMP) 337
Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and Other Dependent Programs 338
Indian Health Service (IHS)/Tribal Health Programs (THP) Reimbursement Agreements Program 340
Medical Support and Compliance 343
Table: Update to the 2022 Advance Appropriations Request 344
Table: Medical Support and Compliance Crosswalk 345
Table: Summary of Obligations by Functional Area 347
Medical Support and Compliance Program Office Narratives 351
VA Medical Center (VAMC) and Veteran Integrated Service Networks (VISN) Based Activities 351
VA Medical Centers (VAMCs) 351
Veteran Integrated Service Networks (VISN) 352
VHA Central Office (VHACO) Based Activities 352

Community Care 352
Clinical Services 355
Discovery, Education, and Affiliate Networks 357
Operations 359
Patient Care Services 360
Quality and Patient Safety and Core Finance Administration 363
Support Services 366
Human Capital Management 367
Health Informatics 370
All Other Support and Program Offices 371
Medical Facilities 373
Table: Medical Facilities Crosswalk, 2020-2023 374
Table: Update to the 2022 Advance Appropriation Request 375
Table: Medical Facilities Total Obligations by Program 377
Summary of the 2023 Advance Appropriation Request 378
Engineering and Environmental Management Services 379
Engineering Service 380
Grounds Maintenance and Fire Protection 380
Leases 381
Non-Recurring Maintenance (NRM) 382
Operating Equipment Maintenance and Repair 384
Other Facilities Operation Support 384
Plant Operations 385
Recurring Maintenance and Repair 385
Textile Care Processing and Management 386
Transportation Services 386
Actuarial Model Projections 389
VA Enrollee Health Care Projection Model 389
Expenditure Requirements by Service Category 402
Civilian Health and Medical Program Model 411
The Program of Comprehensive Assistance for Family Caregivers (PCAFC) Model 412
Uncertainty Associated with Actuarial Projections in the VA Enrollee Health Care Projection Model 416
Medical Facilities by Type 443

Grants for Construction of State Extended Care Facilities **505**
DoD-VA Health Care Sharing Incentive Fund **513**
Joint DoD-VA Medical Facility Demonstration Fund **517**
Health Care Sharing and VA-DoD Sharing **523**
Medical and Prosthetic Research **541**
Table: Appropriations and Other Federal Resources 541
Medical and Prosthetic Research and Development Appropriation Language 541
Medical and Prosthetic Research and Development Program Overview 543
Table: Appropriation Highlights 543
Table: Net Change and 2022 Summary of Resource Requirements 544
Suicide Prevention Research 557
Table: Medical and Prosthetic Research Crosswalks 564
Table: Distribution of Program Resources 565
ORD Operational Units 565
Specifically Tracked Programs 567
Collaboration with Federal Agencies and Other Organizations 568
Overview of Ongoing Strategic Priorities 571
Supplemental Tables 585
Table: Appropriations by Designated Research Area (DRA)1 586
Table: Projects by Designated Research Area (DRA)1 587
Table: Obligations by Object Class 588
Table: American Rescue Plan 588
Canteen Service Revolving Fund **591**
Medical Center Research Organizations **597**
General Post Fund **601**
Electronic Health Record Modernization **607**
Budget Authority and Appropriation Language 607
Appropriation Highlights 608
Budget Overview 609
Accomplishments 616
DoD/VA Joint Electronic Health Record Collaboration 621
Total Obligations by Subaccount 623
Appendix 635
Appendix A: Obligations by Object Class 635

Appendix B: End of Year Staffing Level by Grade 636
Information Technology 639
Budget Authority and Appropriation Language 639
Appropriation Highlights 641
Budget Overview 642
Executive Summary 644
Staffing and Administrative Support Services 647
2022 Health Portfolio 651
2022 Benefits Portfolio 673
2022 Memorial Affairs Portfolio 682
2022 Corporate Portfolio 684
2022 Enterprise Portfolio 688
Technology Business Management Implementation 701
Accomplishments 704
Appendix A: Development Subaccount 711
Appendix B: Congressional Report Summary 712
Appendix C: Congressional Report Details 713
Appendix D: Operations and Maintenance Categories 714
Appendix E: Operations and Maintenance Subaccount 715
Appendix F: Operations and Maintenance Details 716
Appendix G: Amounts Available for Obligation 720
Appendix H: Object Classification 721
Appendix I: Budgetary Resources 722
Appendix J: Staffing and Admin Support by Object Class 723
Appendix K: Employment Summary – FTE by Grade 724
Appendix L: Staffing and Admin Support by OIT Organizations 725
Appendix M: Portfolio Details 726
Appendix N: Information Security Details 730
Appendix O: IT Investments by Portfolio 731
Appendix P: TBM Matrix 732
Appendix Q: IT Systems Appropriations History 7344
Appendix R: Office of Information Technology Organization Chart 735

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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; 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 2022 Revised Request (RR) reflects total discretionary appropriations of $97.5 billion for Veterans Health Administration (VHA) Medical Care. This includes a $3.3 billion annual appropriation request above the 2022 enacted advance appropriations.

Medical Care is composed of four appropriations:

Discretionary Appropriation Request

Dollars in Thousands ($000) Description	2022 Advance Approp. (AA)	2022 Revised Request (RR)	+/- 2022 AA 2022 RR	2023 Advance Approp. (AA)	+/- 2023 AA 2022 RR
Medical Services	$58,897,219	$58,897,219	$0	$70,323,116	$11,425,897
Medical Community Care	$20,148,244	$23,417,244	$3,269,000	$24,156,659	$739,415
Medical Support & Compliance	$8,403,117	$8,403,117	$0	$9,673,409	$1,270,292
Medical Facilities	$6,734,680	$6,734,680	$0	$7,133,816	$399,136
Appropriation [Subtotal]	$94,183,260	$97,452,260	$3,269,000	$111,287,000	$13,834,740
Collections	$4,084,952	$4,084,952	$0	$4,165,167	$80,215
Appropriations & Collections [Total]	$98,268,212	$101,537,212	$3,269,000	$115,452,167	$13,914,955

- **Medical Services**: Discretionary appropriation will remain at the 2022 advance appropriation of $58.9 billion, which when combined with $9.6 billion of unobligated balances from funding provided in the American Rescue Plan Act (Public Law 117-2) and all other resources, funds clinical staff salaries, pharmacy, prosthetics, beneficiary travel and medical equipment.

- **Medical Community Care:** Discretionary appropriation of $23.4 billion in 2022 (RR), an increase of $3.3 billion above the 2022 advance appropriation, which when combined with $2.0 billion of unobligated balances from funding provided in the American Rescue Plan

Act and all other resources, funds non-VA provided medical claims and grants for state home nursing, domiciliary and adult day care services.

- **Medical Support and Compliance:** Discretionary appropriation will remain at the 2022 advance appropriation of $8.4 billion, which when combined with $978 million of unobligated balances from funding provided in the American Rescue Plan Act and all other resources, funds community care claim processing, medical facility administrators, and police officers.

- **Medical Facilities:** Discretionary appropriation will remain at the 2022 advance appropriation of $6.7 billion, which when combined with $2.6 billion of unobligated balances from funding provided in the American Rescue Plan Act and all other resources, funds facility maintenance, leasing, and energy.

The request also includes $4.1 billion in estimated medical care collections for a combined discretionary resource amount of approximately $101.5 billion.

The 2022 request supports improved patient access to and timeliness of medical care services for approximately 9.2 million enrolled Veterans. The request fully supports the provision of health care that VA projects has been deferred during the COVID-19 pandemic, in addition to providing for health care services at the pre-pandemic levels. The 2022 budget ensures that all of our veterans, including women Veterans, Veterans of color, and LGBTQ+ Veterans, receive the care they have earned and prioritizes addressing veteran homelessness, suicide prevention, and caregiver support. The 2022 request further supports the Department's effort to address substance use disorders including a new $156 million initiative to expand peer support specialists, increase access to evidence-based residential and ambulatory detox programs, and collaborate with the Homeless Program Office to engage at-risk Veterans in the community. The 2022 budget also provides $621 million for VA's Opioid Prevention and Treatment programs, including programs in support of the Jason Simcakoski Memorial and Promise Act or Jason's Law.

2023 Advance Appropriation

The Budget requests $111.3 billion in 2023 discretionary advance appropriations for medical care programs, to ensure continuity of Veterans' health care services and sustain VA's increased capacity for care following the pandemic. The Budget includes $4.2 billion in estimated medical care collections for a combined discretionary resource of approximately $115.5 billion.

Key Secretarial Priorities

The VA welcomes all our Veterans, including women Veterans, Veterans of color and LGBTQ+ Veterans. The 2022 request supports the Secretary's top six priorities for VA medical care programs:

Establishing the Right Balance of Direct Care and Purchased Care:
Providing Veterans with timely access to high quality health care is absolutely essential. While it is clear that community care will continue to be a key part of how the Department cares for its Veterans, VA remains committed to strengthening the direct health care system, expanding access including via telehealth, and pushing the boundaries of what is possible in serving our 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 at VA to ensure Veterans have timely access to the highest quality health care services.

Delivering Timely Access to High Quality Mental Health Care and Preventing Suicide Among Veterans:
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, post-traumatic stress disorder (PTSD), problematic use of alcohol, experiences of military sexual trauma (MST), and suicide risk.

Suicide prevention continues to be a top clinical priority and as a part of our efforts, we are implementing a comprehensive public health approach to reach all Veterans. Suicide is a complex issue with no single cause or solution. 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.

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; it requires a nationwide effort. VA developed the National Strategy for Preventing Veteran Suicide with the intention of articulating how everyone can work together to prevent Veteran suicide. This national vision for preventing Veteran suicide is grounded in three major tenets that we firmly believe: (1) suicide is preventable, (2) suicide requires a public health approach, combining community-based and clinical approaches, and (3) everyone has a role to play in suicide prevention. While the development of the National Strategy was groundbreaking in defining the vision of reaching and serving Veterans within and outside VHA clinical care, VA moved to translate the vision of the 10-year National Strategy into operational plans of actions through Suicide Prevention 2.0 (SP 2.0) combined with the Suicide Prevention Now initiative.

This budget fully funds the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171) which authorized the new Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program to reduce Veteran suicide through a community-based grant program that provides or coordinates suicide prevention services. The 2022 budget also funds the projected costs of the provision of emergent suicide care authorized by the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (P.L. 116-214).

Increasing Support to Families and Caregivers:
VA's Caregiver Support Program (CSP) empowers family caregivers to provide care and support to Veterans with a wide range of resources through the Program of General Caregiver Support Services (PGCSS) and the Program of Comprehensive Assistance for Family Caregivers (PCAFC). As a result of the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, VA began a major expansion of PCAFC on October 1, 2020, when VA certified the implementation of the new information technology (IT) system, Caregiver Record Management Application (CARMA). CARMA automates manual processes and integrates with other VA systems, resulting in increased efficiencies and effectiveness for caregivers and VA staff.

The PCAFC expansion rolls out in two phases. The first phase, which commenced on October 1, 2020, includes eligible Veterans who incurred or aggravated a serious injury in the line of duty on or before May 7, 1975. Effective October 1, 2022, the second phase will include eligible Veterans who incurred or aggravated a serious injury in the line of duty between May 7, 1975, and September 11, 2001. As of May 17, 2021, VA has received more than 81,000 applications for the PCAFC since October 1, 2020, and approximately 7,000 of those have been approved for participation. More than 26,000 applications remain in process and are pending a determination of eligibility. This program expansion includes a new digital version of the application that allows individuals to apply for the PCAFC online.

VA also expedited the hiring of key staff with clinical qualifications and organizational skills to support program needs and standardize application processing and adjudication, ensuring consistent eligibility decision-making. The number of CSP staff has increased to over 1,740 staff as of May 2021, which is over 90% of the Department's goal of 1,900 CSP staff system wide. These changes will ensure Veterans and caregivers receive timely, accurate assessments and eligibility determinations, as well as an improved customer experience.

Better Supporting the Growing Number of Women Veterans Who Utilize VA Services:
We have seen the number of women Veterans enrolling in VA health care continue to increase, placing new demands on VA's health care system. Women make up 16.5% of today's Active Duty military forces and 19% of National Guard and Reserves. Based on the trend, the number of women Veterans using VA health care is expected to rise rapidly. 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 5 years. The number of women Veterans using VA health care services has more than tripled since 2001, growing from 159,810 to more than 550,000 today.

To address the growing number of women Veterans who are eligible for health care, VA is strategically enhancing services and access for women Veterans by investing $75 million in a hiring and equipment initiative in 2021, providing funding for a total of over 400 women's health personnel nationally--primary care providers, gynecologists, mental health providers and care coordinators. Funds are also available for programs that have traditionally not be offered by VA, such as pelvic floor physical therapy or lactation support.

Every one of the 170 VA medical centers (VAMCs) across the United States now has 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. Since 2008, more than 7,600 health care providers and nurses have been trained in the local and national programs.

To provide the highest quality of care to women Veterans, VA offers women Veterans assignments to trained and experienced designated Women's Health Primary Care Providers (WH-PCP). We find that women assigned to WH-PCP's are twice as likely to choose to stay in VA care over time. VA provides many services for women Veterans, including gynecology and maternity care, as well as mental health services and treatment and health care related to experiences of military sexual trauma.

The VA budget fully funds the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315) including Title V, the Deborah Sampson Act of 2020, which improves access for Women Veterans to the Department of Veterans Affairs. The Deborah Sampson Act focuses on enhancing the VAMC environment for women Veterans through facility retrofitting initiatives, setting environment of care standards, conducting inspections, and ending harassment. The Act also expands the mini-residency program for primary and emergency care clinics in women Veterans health care, introduces a pilot program to assist Veterans who experience intimate partner violence or sexual assault, and directs studies on: barriers for women Veterans to receive VA health care, infertility services furnished at VA, and staffing of women Veteran program managers and staff training at VAMCs.

Providing a Whole of Government Solution to Drive Progress to Eliminate Veteran Homelessness:

VA remains committed to ending Veteran homelessness. The goal is to ensure every Veteran has permanent, sustainable housing with access to high-quality health care and other supportive services to prevent Veteran homelessness. VA has partnered closely with other Federal agencies and with State and local programs across the country to:

- Identify all Veterans experiencing homelessness;
- Provide shelter immediately to any Veteran experiencing unsheltered homelessness;
- Provide service-intensive transitional housing to Veterans who prefer and choose such a program;
- Move Veterans swiftly into permanent housing; and
- Have resources, plans, partnerships and system capacity in place should any Veteran become homeless or be at risk of homelessness.

VA has made significant progress to prevent and end Veteran homelessness. The number of Veterans experiencing homelessness in the United States has declined by nearly half since 2010. On any given night in January 2020, an estimated 37,252 Veterans were experiencing homelessness. Since 2010, over 850,000 Veterans and their family members have been permanently housed or prevented from becoming homeless. Efforts to end Veteran homelessness have resulted in an expansion of services available to permanently house homeless Veterans and the implementation of new programs aimed at prevention, including low-threshold care/engagement strategies and monitoring homeless outcomes. As of March 10, 2021, there were 84 areas (81 communities and 3 states: Delaware, Connecticut and Virginia) that have publicly announced an effective end to Veteran homelessness. Those communities have met the benchmarks and criteria established by the United States (U.S.) Interagency Council on Homelessness, VA, and the Department of Housing and Urban Development (HUD), for declaring an end to Veteran homelessness. VA offers a wide array of interventions designed to find Veterans experiencing homelessness, engage them in services, find pathways to permanent housing and prevent homelessness from reoccurring.

The VA budget fully funds the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315) including Title IV, the Navy SEAL Bill Mulder Act of 2020, which provides assistance for homeless Veterans by allowing the HUD-VA Supportive Housing program (HUD-VASH) to provide assistance (such as food, shelter, clothing, blankets, and hygiene items), transportation required to support stability and health, and communications equipment during a covered public health emergency, and for contract HUD-

VASH case management. The Act also increases VA's grant authority for legal services and certain per diem payments for VA's Grant and Per Diem (GPD) program.

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 10.78 to 11.48 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 experience of responding to the COVID-19 pandemic brought critical lessons to U.S. health care broadly, and in particular to VA health care. Uncertainty regarding the timing and location of the next surge(s) in cases across the country underscored the importance of portable capabilities (e.g., 24 bed ICU that can be transported) for VA health care's "Fourth Mission" role in future public health emergencies.

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 prodigious, 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 telehealth and tele-service delivery bring 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 2022 Budget includes a Non-Recurring Maintenance funding level of $2.3 billion, of which $1.2 billion is for infrastructure projects required to support Electronic Health Record Modernization (EHRM).

The Budget also includes $18 billion of proposed infrastructure funding to modernize VA health care facilities as part of the American Jobs Plan. Please see volume 4 for additional information on the American Jobs Plan proposal.

Key VHA Priorities

Executing VA's Fourth Mission to Support the Nation's Response to COVID-19
VA has accepted over 150 COVID-19-related missions to date in 47 states, the District of Columbia, American Samoa and Guam from the Federal Emergency Management Agency (FEMA) to protect Veterans and non-Veterans alike. We deployed over 4,700 staff to support these missions. This included sharing medical equipment with health care facilities that were stressed and admitting almost 500 non-Veteran patients into VA facilities when stressed facilities needed to decompress their inpatient hospital bed demands. VA deployed staff, testing, and supplies to support community institutional care facilities across the country, including State Veterans Homes. Other assistance provided included laboratory specimen collection, laboratory analysis of COVID-19 samples and clinical staff augmentation at community and Indian Country hospitals and clinics.

Preparing for the Post-Pandemic Care Needs
While taking proactive steps to avoid unnecessary in-person appointments during the pandemic, in 2020, VA completed more than 75 million Veteran visits, including over 45 million in-person, 27 million by telephone, and over 3.4 million by video visits to-the-home. For care in VA, whether Veterans cancel their own appointment or VA cancels the appointment for safety reasons, VA carefully reviews each cancellation to ensure Veterans who need care receive it. VA has reviewed more than 96% of all appointments cancelled since January 2020, ensuring that those canceled appointments from early in the pandemic were reviewed first. VA wants to make sure that Veterans have the opportunity for an in-person appointment, had a telehealth visit or no longer need care.

VA will meet the needs of Veterans who deferred their care during the pandemic and is deeply appreciative of the funds Congress provided to help it do so in the American Rescue Plan Act. Part of this preparation includes installing referral coordination teams at each facility. These teams will coordinate care when a provider refers a Veteran for care with a specialist, either in VA or in the community. The teams will ensure Veterans are informed of their options for care, including face-to-face, video and phone, and then get their appointment scheduled quickly.

Leveraging Technology to Care for Veterans During the Pandemic
VA has long been considered a national leader in telehealth and expanding our telehealth capabilities is an essential part of our ongoing strategy to increase Veteran access to care. VA's early commitment to the innovative application of technology to engage patients remotely -- through our personal health record My HealtheVet, through mobile and other connected devices and applications, and through an extensive and multi-faceted telehealth program – provided a solid foundation for VA's agile and effective response to the COVID-19 pandemic. The Department moved immediately to serve Veterans where they are located and ensure continued care delivery by providing unprecedented numbers of telehealth health appointments.

Utilization of video telehealth services had been increasing at a rapid rate prior to the pandemic, and that growth became exponential during the pandemic. Many Veterans have chosen telehealth services like video-to-home telehealth visits. Video-to-home telehealth visits increased more than 1,700% between February 2020 and January 2021. VA leverages technology to augment care for Veterans within VA health care facilities, in Veterans' homes and anywhere with access to an internet-connected computer, mobile phone or tablet that Veterans choose to receive care. VA's

online patient portal, My HealtheVet, is accessible through VA's modernized web presence at www.VA.gov has over 5.6 million registered users and is accessed by more than 1 million individual Veterans each month. VA's video telehealth program was utilized by more than 1.35 million Veterans in 2020, 31% of whom lived in rural areas. Telehealth services are available at over 1,200 VA sites of care, and care is available through video telehealth in more than fifty specialties.

Change from 2022 Advance Appropriation (AA)

VA is requesting an additional $3.3 billion over the 2022 enacted Advance Appropriation amount. The table below highlights the use of unobligated balances from the American Rescue Plan Act, and details the activities associated with the increased appropriation request.

Table: Update to the 2022 Advance Appropriation Request

The table on the following page displays the update to the 2022 Advance Appropriation request for Medical Care.

Table: Update to the 2022 Advance Appropriation Request

Medical Care

(dollars in thousands)

Description	2022 Revised Estimate	Available Discretionary Funding: Approp. Incl. Transfers	Collections	Reimb.	Use of Unobl. Balance	Available Mand. Funding: VACAA: Use of Unobl. Balance Sec. 801	Use of Unobl. Balance Sec. 802	ARP Act: Use of Unobl. Balance Sec. 8002 3/	Use of Unobl. Balance Sec. 8007	AFP: Use of Unobl. Balance	Subtotal	Discretionary: Annual Approp. Adjust Required	Mandatory: American Families Plan Request	Grand Total: 2022 Revised Request Discretionary & Mandatory
Health Care Services:														
Ambulatory Care	$59,651,738	$45,635,329	$2,274,737	$190,287	$1,827,117	$4,798	$24,300	$7,479,095	$700,000	$0	$58,135,663	**$1,516,075**	**$0**	**$1,516,075**
Dental Care	$1,632,271	$1,368,607	$58,011	$0	$45,405	$259	$0	$110,680	$0	$0	$1,582,962	**$49,309**	**$0**	**$49,309**
Inpatient Care	$21,843,838	$14,489,346	$776,328	$0	$607,633	$1,815	$0	$5,191,839	$0	$0	$21,066,961	**$776,877**	**$0**	**$776,877**
Mental Health Care	$13,541,352	$12,273,374	$481,258	$0	$376,681	$1,556	$0	$363,181	$0	$0	$13,496,050	**$45,302**	**$0**	**$45,302**
Prosthetics	$4,934,411	$4,913,449	$20,649	$0	$0	$0	$0	$313	$0	$0	$4,934,411	**$0**	**$0**	**$0**
Rehabilitation Care	$1,097,033	$951,020	$38,988	$0	$0	$259	$0	$106,766	$0	$0	$1,097,033	**$0**	**$0**	**$0**
Health Care Services [Subtotal]	*$102,700,643*	*$79,631,125*	*$3,649,971*	*$190,287*	*$2,856,836*	*$8,687*	*$24,300*	*$13,251,874*	*$700,000*	*$0*	*$100,313,080*	***$2,387,563***	***$0***	***$2,387,563***
Long-Term Services and Supports:														
Institutional Care	$8,095,395	$6,445,719	$287,710	$0	$225,191	$778	$0	$691,342	$0	$0	$7,650,740	**$444,655**	**$0**	**$444,655**
Non-Institutional Care	$3,676,682	$3,196,191	$130,669	$0	$102,275	$259	$0	$43,784	$0	$0	$3,473,178	**$203,504**	**$0**	**$203,504**
VA Long-Term Services and Supports [Total]	$11,772,077	$9,641,910	$418,379	$0	$327,466	$1,037	$0	$735,126	$0	$0	$11,123,918	**$648,159**	**$0**	**$648,159**
Other Health Care Programs:														
Camp Lejeune Families (P.L. 112-154)	$2,909	$2,425	$0	$0	$0	$0	$0	$0	$0	$0	$2,425	**$484**	**$0**	**$484**
Caregivers 1/	$1,353,133	$1,353,133	$0	$0	$0	$0	$0	$0	$0	$0	$1,353,133	**$0**	**$0**	**$0**
CHAMPVA & Other Dependent Prgs	$2,378,170	$2,139,676	$0	$0	$0	$0	$5,700	$0	$0	$0	$2,145,376	**$232,794**	**$0**	**$232,794**
Homeless Program Grants 2/	$1,191,186	$705,186	$0	$0	$0	$0	$0	$486,000	$0	$0	$1,191,186	**$0**	**$0**	**$0**
Readjustment Counseling	$323,789	$323,789	$0	$0	$0	$0	$0	$0	$0	$0	$323,789	**$0**	**$0**	**$0**
Other Health Care Programs [Total]	$5,249,187	$4,524,209	$0	$0	$0	$0	$5,700	$486,000	$0		$5,015,909	**$233,278**	**$0**	**$233,278**
Legislative Proposal: American Families Plan	$30,000	$0	$0	$0	$0	$0	$0	$0	$0	($230,000)	($230,000)	**$0**	**$260,000**	**$260,000**
Obligations [Total]	$119,751,907	$93,797,244	$4,068,350	$190,287	$3,184,302	$9,724	$30,000	$14,473,000	$700,000	($230,000)	$116,222,907	**$3,269,000**	**$260,000**	**$3,529,000**

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

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

3/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the table displays the estimated total for all Medical Care categories. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

- **Health Care Services Medical Care (+$3.3 billion).** This increase is largely driven by revised actuarial trends based on the most recent data. The key drivers of these changes compared to the enacted Advance Appropriation level include:

    - **Medical Community Care (+$3.3 billion).** Supports updated community care projections based on 2020 actuals. The $3.3 billion is projected to afford an additional:

        - $1.5 billion in ambulatory and pharmacy services
        - $777 million for inpatient services
        - $648 million for Long Term Services and Supports
        - $233 million for family member programs
        - $49 million for dental services
        - $45 million for mental health services

American Rescue Plan Act Section 8002, the Veterans Medical Care and Health Fund Account (0173)

VA projects obligating $14.473 billion of the $14.482 billion in funding made available by the American Rescue Plan Act Section 8002 in 2022. The American Rescue Plan Act provides the tools and support critical to effectively tackle the urgent public health and economic crisis the Nation faces as a result of COVID-19. This funding enables VA to ensure Veterans have continued access to quality health care and protections against COVID-19, as well as providing needed economic relief. VA has prioritized the use of its Coronavirus Aid, Relief, and Economic Security (CARES) Act funding to meet COVID-related needs in 2021, allowing VA to reserve use of American Rescue Plan Act funds until 2022. The remaining $9 million from Section 8002 is estimated to be obligated in 2021 for COVID-19-related research, as detailed in the Medical and Prosthetics Research chapter later in this volume.

VA established a new budget account, the Veterans Medical Care and Health Fund, to execute the section 8002 funding.

- **Health Care Services Medical Care (+$14.5 billion).** These funds supplement the 2022 Advance Appropriation to meet updated actuarial model projections and to help fund non-model related costs. Below is a summary of how the Veterans Medical Care and Health Fund account augments the four medical care appropriations. Final funding allocations for the Veterans Medical Care and Health Fund account may change based on 2021 actuals and in response to workload demand requirements throughout 2022. For additional information and tables please see their respective chapters later in this volume.

    - **Medical Services (+$9.020 billion).** Funds 27,900 full-time equivalent (FTE), of which 15,701 are net increase over total 2021 FTE; supplies for the Regional Readiness Centers; VAMC contract support; medical equipment; sustainment of pandemic-related Veterans homelessness grant programs; and the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.

- **Medical Support and Compliance (+$978 million).** Funds support for supply chain modernization, regional readiness centers, and helps meet increased VAMC administrative demands.

- **Medical Facilities (+$2.573 billion).** Funds a significant portion of the Non-Recurring Maintenance (NRM) budget and provides additional resources to VAMCs to meet additional space requirements for higher patient and staffing levels.

- **Medical Community Care (+$1.901 billion).** Funds over 7% of the overall projected community care cost.

American Rescue Plan Act Section 8007

This section directs the VA to reimburse any Veteran who paid a copayment or other cost sharing for health care beginning on April 6, 2020 and ending on September 30, 2021, and to provide for any copayment or cost sharing with respect to health care under laws administered by the Secretary beginning on April 6, 2020 and ending on September 30, 2021. The law provided $1 billion for VA to carry out this section.

- **Copayment Reimbursement (+$300 million).** VA projects obligating an estimated $300 million in 2021 to reimburse Veterans, executed in the Medical Care Collections Fund account.

- **Health Care Services Medical Care (+$700 million).** VA estimates $700 million will be used to supplement the Medical Care budget in 2022, to account for first-party medical care collections foregone during the period between April 6, 2020 and September 30, 2021, as specified in the law. These funds will supplement the 2022 Advance Appropriation to meet the latest actuarial model projections and to help fund non-model-related costs and will be executed from the Medical Services and Medical Community Care accounts.

    - **Medical Services (+$628 million).** Provides additional resources for VAMCs.

    - **Medical Community Care (+$72 million).** Funds a portion of the overall projected community care cost.

Table: 2022 American Rescue Plan Highlights
(dollars in thousands)

	Veterans Medical Care and Health Fund 1/					ARP Act Section 8007			Grand Total
	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Sec. 8002 SubTotal	Medical Services	Community Care	Sec. 8007 Subtotal	Medical Care ARP Act
Health Care Services:									
Health Care Services:									
Ambulatory Care	$4,194,321	$359,352	$1,447,256	$1,478,166	$7,479,095	$627,900	$72,100	$700,000	$8,179,095
Dental Care	$110,205	$10	$465	$0	$110,680	$0	$0	$0	$110,680
Inpatient Care	$3,416,368	$551,650	$823,368	$400,453	$5,191,839	$0	$0	$0	$5,191,839
Mental Health Care	$248,901	$16,661	$77,449	$20,170	$363,181	$0	$0	$0	$363,181
Prosthetics	$313	$0	$0	$0	$313	$0	$0	$0	$313
Rehabilitation Care	$77,645	$6,808	$22,313	$0	$106,766	$0	$0	$0	$106,766
Health Care Services [Subtotal]	**$8,047,753**	**$934,481**	**$2,370,851**	**$1,898,789**	**$13,251,874**	**$627,900**	**$72,100**	**$700,000**	**$13,951,874**
Long-Term Services and Supports:									
Institutional Care	$448,023	$43,369	$199,950	$0	$691,342	$0	$0	$0	$691,342
Non-Institutional Care	$38,667	$583	$2,127	$2,407	$43,784	$0	$0	$0	$43,784
VA Long-Term Services and Supports [Total]	**$486,690**	**$43,952**	**$202,077**	**$2,407**	**$735,126**	**$0**	**$0**	**$0**	**$735,126**
Other Health Care Programs:									
Camp Lejeune Families (P.L. 112-154)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Caregivers 2/	$0	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA & Other Dependent Prgs	$0	$0	$0	$0	$0	$0	$0	$0	$0
Homeless Program Grants 3/	$486,000	$0	$0	$0	$486,000	$0	$0	$0	$486,000
Readjustment Counseling	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs [Total]	**$486,000**	**$0**	**$0**	**$0**	**$486,000**	$0	$0	**$0**	**$486,000**
Obligations [Total]	**$9,020,443**	**$978,433**	**$2,572,928**	**$1,901,196**	**$14,473,000**	$627,900	$72,100	**$700,000**	**$15,173,000**

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 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.
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.

American Families Plan

The 2022 Budget requests $260 million in support of the American Families Plan. With a growing population of women Veterans and younger Veterans, VA is committed to providing additional support to Veterans who are parents in order to offer a holistic, family-friendly approach to care. The proposal would place a Family Coordinator at each VA medical center, an expert in resources for children and families who would provide additional referrals, supports, and connections for Veteran parents. Of this amount, $30 million is projected to be obligated in 2022.

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.

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, children of women Vietnam Veterans), and new initiatives.

VA's EHCPM is an actuarial model that supports the formulation of over 90% of VA's Medical Care request and has been extensively validated. The EHCPM projects enrollment, utilization, and expenditures in more 100 categories of health care services for 20 years into the future.

Detailed information on the three actuarial models can be found in the Actuarial Model Projections chapter.

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 has been 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.
- The COVID-19 pandemic had a significant impact on VA health care in fiscal year (FY) 2020 and is expected to impact the amount of care provided for the next few years. During the pandemic, nationwide health care utilization saw a reduced amount of care provided in FY 2020 and FY 2021 as individuals chose to defer certain care. It is anticipated that there will be a resulting surge in care in late FY 2021 continuing through FY 2022 to fulfill previously deferred services. Additionally, the stay-at-home orders and social distancing mandates have had an impact on the U.S. economy, which is expected to increase reliance on VA for health care.
- 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. However, MISSION has a smaller impact than previous years because a significant portion of the impact is now incorporated into the 2019 and 2020 baselines.

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 and Medical Care Collections
(dollars in thousands)

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Appropriations							
Discretionary Regular Appropriations 1/							
Medical Services (0160)	$51,061,165	$56,655,483	$56,555,483	$58,897,219	$70,323,116	$2,341,736	$11,425,897
Medical Community Care (0140) 2/	$15,279,799	$18,511,979	$18,511,979	$23,417,244	$24,156,659	$4,905,265	$739,415
Medical Support & Compliance (0152)	$7,327,956	$8,214,191	$8,199,191	$8,403,117	$9,673,409	$203,926	$1,270,292
Medical Facilities (0162)	$6,141,880	$6,583,265	$6,583,265	$6,734,680	$7,133,816	$151,415	$399,136
Discretionary Regular Appropriations [Subtotal]	**$79,810,800**	**$89,964,918**	**$89,849,918**	**$97,452,260**	**$111,287,000**	**$7,602,342**	**$13,834,740**
MCCF Collections 3/	$3,429,116	$4,527,950	$2,965,446	$4,084,952	$4,165,167	$1,119,506	$80,215
Discretionary Families First Coronavirus Response Act Appropriations							
Medical Services (0160)	$30,000						
Medical Community Care (0140)	$30,000						
Families First Coronavirus Response Act Appropriations [Subtotal]	**$60,000**						
Discretionary CARES Act Appropriations 4/							
Medical Services (0160)	$14,432,000						
Medical Community Care (0140)	$2,100,000						
Medical Support & Compliance (0152)	$100,000						
Medical Facilities (0162)	$606,000						
Discretionary CARES Act Appropriations [Subtotal]	**$17,238,000**						
Discretionary Appropriations and Collections [Total]	**$100,537,916**	**$94,492,868**	**$92,815,364**	**$101,537,212**	**$115,452,167**	**$8,721,848**	**$13,914,955**
American Rescue Plan Act Mandatory Appropriations for Medical Care 5/							
Section 8002, the Veterans Medical Care and Health Fund (0173) 6/:							
Medical Services Category			$9,020,443			($9,020,443)	$0
Medical Community Care Category			$1,901,196			($1,901,196)	$0
Medical Support & Compliance Category			$978,433			($978,433)	$0
Medical Facilities Category			$2,572,928			($2,572,928)	$0
Veterans Medical Care and Health Fund [Subtotal]			**$14,473,000**			**($14,473,000)**	**$0**
Section 8004:							
Medical Community Care (0140)			$250,000			($250,000)	$0
Section 8004 [Subtotal]			**$250,000**			**($250,000)**	**$0**
Section 8007:							
Medical Services (0160)			$627,900			($627,900)	$0
Copayment Reimbursement (5287)			$300,000			($300,000)	$0
Medical Community Care (0140)			$72,100			($72,100)	$0
Section 8007 [Subtotal]			**$1,000,000**			**($1,000,000)**	**$0**
Mandatory ARP Act Funding Available [Subtotal]			**$15,723,000**			**($15,723,000)**	**$0**
Mandatory Appropriations American Families Plan							
Medical Services (0160)				$260,000		$260,000	($260,000)
Mandatory AFP Requested Appropriations [Subtotal]				**$260,000**		**$260,000**	**($260,000)**
Mandatory Appropriations [Total]	**$0**	**$0**	**$15,723,000**	**$260,000**	**$0**	**($15,463,000)**	**($260,000)**
Discretionary and Mandatory Appropriations (Including Discretionary Collections**) [Grandtotal]**	**$100,537,916**	**$94,492,868**	**$108,538,364**	**$101,797,212**	**$115,452,167**	**($6,741,152)**	**$13,654,955**

1/ Includes all rescissions but not transfers to the two joint Department of Defense (DoD)-VA health care accounts.
2/ Includes $615 million transfer in FY 2020 from the Veterans Choice Fund from P.L. 116-94.
3/ 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).
4/ Before transfers among VA accounts.
5/ Excludes $9 million of Medical and Prosthetics Research portion of ARP 8002. Excludes $500 million of Grants for Construction of State Extended Care Facilities from ARP 8004. ARP sections 8001, 8003, 8005, 8006, and 8008 are entirely excluded from the amounts in this table.
6/ 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 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

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

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Obligations 1/							
Discretionary Obligations:							
Regular Obligations:							
Medical Services (0160)	$53,531,251	$60,287,186	$58,162,214	$65,070,793	$73,673,419	$6,908,579	$8,602,626
Medical Community Care (0140)	$15,788,895	$19,268,033	$19,235,053	$23,996,704	$24,813,000	$4,761,651	$816,296
Pre P.L. 116-260 Title XVI section 1601 2/	*$5,007,990*						
Medical Support & Compliance (0152)	$7,643,310	$8,203,041	$8,215,180	$8,520,114	$9,690,000	$304,934	$1,169,886
Medical Facilities (0162)	$6,499,294	$7,073,882	$7,308,082	$6,921,572	$7,110,865	($386,510)	$189,293
Regular Obligations [Subtotal]	**$88,470,740**	**$94,832,142**	**$92,920,529**	**$104,509,183**	**$115,287,284**	**$11,588,654**	**$10,778,101**
Families First Coronavirus Response Act Obligations							
Medical Services (0160)	$30,000		$0			$0	$0
Medical Community Care (0140)	$0		$30,000			($30,000)	$0
Families First Coronavirus Response Act Appropriations [Subtotal]	**$30,000**		**$30,000**			**($30,000)**	**$0**
Discretionary CARES Act Appropriations							
Medical Services (0160)	$3,893,571		$6,177,429			($6,177,429)	$0
Medical Community Care (0140)	$1,968,868		$3,631,132			($3,631,132)	$0
Medical Support & Compliance (0152)	$77,456		$247,544			($247,544)	$0
Medical Facilities (0162)	$312,796		$393,204			($393,204)	$0
Discretionary CARES Act Appropriations [Subtotal]	**$6,252,691**		**$10,449,309**			**($10,449,309)**	**$0**
Discretionary Obligations [Subtotal]	**$94,753,431**	**$94,832,142**	**$103,399,838**	**$104,509,183**	**$115,287,284**	**$1,109,345**	**$10,778,101**
Mandatory Obligations:							
Veterans Choice Act Section 801 3/							
Medical Services (0160)	$2,191	$1,525	$2,276	$2,365	$2,171	$89	($194)
Medical Support & Compliance (0152)	$1,346	$3,262	$1,398	$1,453	$1,509	$55	$56
Medical Facilities (0162)	$5,471	$3,750	$5,684	$5,906	$6,136	$222	$230
Veterans Choice Act Section 801 [Subtotal]	**$9,008**	**$8,537**	**$9,358**	**$9,724**	**$9,816**	**$366**	**$92**
Veterans Choice Fund (0172) [Subtotal] 4/	**$2,110,538**	**$1,100,000**	**$119,690**	**$30,000**	**$0**	**($89,690)**	**($30,000)**
American Rescue Plan Act Mandatory Obligations for Medical Care 5/							
Section 8002, the Veterans Medical Care and Health Fund (0173) 6/:							
Medical Services Category			$0	$9,020,443		$9,020,443	($9,020,443)
Medical Community Care Category			$0	$1,901,196		$1,901,196	($1,901,196)
Medical Support & Compliance Category			$0	$978,433		$978,433	($978,433)
Medical Facilities Category			$0	$2,572,928		$2,572,928	($2,572,928)
Veterans Medical Care and Health Fund [Subtotal]			**$0**	**$14,473,000**		**$14,473,000**	**($14,473,000)**
Section 8004:							
Medical Community Care (0140)			$250,000			($250,000)	$0
Section 8004 [Subtotal]			**$250,000**			**($250,000)**	**$0**
Section 8007:							
Medical Services (0160)			$0	$627,900		$627,900	($627,900)
Copayment Reimbursement (5287)			$300,000	$0		($300,000)	$0
Medical Community Care (0140)			$0	$72,100		$72,100	($72,100)
Section 8007 [Subtotal]			**$300,000**	**$700,000**		**$400,000**	**($700,000)**
Mandatory ARP Act Obligations [Subtotal]			**$550,000**	**$15,173,000**		**$14,623,000**	**($15,173,000)**
Mandatory Obligations American Families Plan							
Medical Services (0160)				$30,000	$30,000	$30,000	$0
Mandatory AFP Obligations [Subtotal]				**$30,000**	**$30,000**	**$30,000**	**$0**
Mandatory Obligations [Subtotal]	**$2,119,546**	**$1,108,537**	**$679,048**	**$15,242,724**	**$39,816**	**$14,563,676**	**($15,202,908)**
Discretionary and Mandatory Obligations [Total]	**$96,872,977**	**$95,940,679**	**$104,078,886**	**$119,751,907**	**$115,327,100**	**$15,673,021**	**($4,424,807)**

1/ Obligations after transfers, reimbursements, changes in unobligated balances and lapse.
2/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health

care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.
3/ OI&T and Minor Construction Section 801 mandatory obligations data are excluded from this table.
4/ OI&T Section 802 Mandatory Obligations and FTE data are excluded from this table.
5/ Excludes $9 million of Medical and Prosthetics Research portion of ARP 8002. Excludes $500 million of Grants for Construction of State Extended Care Facilities from ARP 8004. ARP sections 8001, 8003, 8005, 8006, and 8008 are entirely excluded from the amounts in this table.
6/ 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 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

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

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary and Mandatory Obligations by Category 1/							
Medical Services	$57,457,013	$60,288,711	$64,341,919	$74,751,501	$73,705,590	$10,409,582	($1,045,911)
Copayment Reimbursement	$0	$0	$300,000	$0	$0	($300,000)	$0
Community Care	$19,868,301	$20,368,033	$23,265,875	$26,000,000	$24,813,000	$2,734,125	($1,187,000)
Pre P.L. 116-260 Title XVI section 1601 2/	*$5,007,990*					$0	$0
Medical Support & Compliance	$7,722,112	$8,206,303	$8,464,122	$9,500,000	$9,691,509	$1,035,878	$191,509
Medical Facilities	$6,817,561	$7,077,632	$7,706,970	$9,500,406	$7,117,001	$1,793,436	($2,383,405)
Obligations [Grand Total]	**$96,872,977**	**$95,940,679**	**$104,078,886**	**$119,751,907**	**$115,327,100**	**$15,673,021**	**($4,424,807)**
Full-Time Equivalent (FTE) 3/							
Discretionary Funding							
Medical Services	256,891	265,156	269,090	256,891	284,791	(12,199)	27,900
Medical Support & Compliance	55,537	60,219	57,190	57,725	58,225	535	500
Medical Facilities	25,644	26,709	26,147	26,654	26,654	507	0
Discretionary Funding [Subtotal]	**338,072**	**352,084**	**352,427**	**341,270**	**369,670**	**(11,157)**	**28,400**
Mandatory Funding							
Veterans Medical Care and Health Fund - Medical Services 4/	0	0	0	27,900	0	27,900	(27,900)
Veterans Medical Care and Health Fund - Medical Support & Compliance (0173) 4/	0	0	0	500	0	500	(500)
American Families Plan	0	0	0	160	160	160	0
Veterans Choice Act, Sec. 801, FTE 5/	17	9	17	17	17	0	0
Veterans Choice Act, Sec. 802, FTE	0	0	0	0	0	0	0
Mandatory Funding [Subtotal]	**17**	**9**	**17**	**28,577**	**177**	**28,560**	**(28,400)**
FTE [Total]	**338,089**	**352,093**	**352,444**	**369,847**	**369,847**	**17,403**	**0**

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 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.
2/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.
3/ 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.
4/ 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.
5/ 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
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Health Care Services:							
Ambulatory Care	$43,619,421	$48,519,222	$50,327,695	$59,651,738	$54,236,232	$9,324,043	($5,415,506)
Dental Care	$1,159,850	$1,509,600	$987,715	$1,632,271	$1,588,689	$644,556	($43,582)
Inpatient Care	$18,200,224	$15,531,600	$19,855,061	$21,843,838	$21,875,714	$1,988,777	$31,876
Mental Health Care 1/	$10,285,509	$10,257,500	$11,998,939	$13,541,352	$14,266,121	$1,542,413	$724,769
Prosthetic and Sensory Aids Services	$3,153,897	$4,072,900	$3,962,562	$4,934,411	$4,797,953	$971,849	($136,458)
Rehabilitation Care	$1,017,757	$1,083,800	$1,028,055	$1,097,033	$1,076,759	$68,978	($20,274)
Health Care Services [Subtotal]	**$77,436,658**	**$80,974,622**	**$88,160,027**	**$102,700,643**	**$97,841,468**	**$14,540,616**	**($4,859,175)**
Long-Term Services & Supports (LTSS):							
Institutional LTSS							
VA Community Living Centers (VA CLC)	$4,173,642	$4,011,400	$4,210,835	$4,423,856	$4,417,659	$213,021	($6,197)
Community Nursing Home	$1,409,969	$1,433,800	$1,552,172	$1,907,731	$2,011,293	$355,559	$103,562
State Home Nursing	$1,372,877	$1,580,455	$1,930,455	$1,707,451	$1,741,296	($223,004)	$33,845
State Home Domiciliary	$53,622	$56,346	$56,346	$56,357	$51,314	$11	($5,043)
Institutional LTSS [Subtotal]	$7,010,110	$7,082,001	$7,749,808	$8,095,395	$8,221,562	$345,587	$126,167
Non-Institutional LTSS							
State Home Adult Day Care	$2,635	$3,882	$3,882	$4,734	$4,902	$852	$168
Other Non-Institutional LTSS	$3,035,806	$3,473,900	$3,381,167	$3,671,948	$3,851,287	$290,781	$179,339
Non-Institutional LTSS [Subtotal]	$3,038,441	$3,477,782	$3,385,049	$3,676,682	$3,856,189	$291,633	$179,507
LTSS [Subtotal]	**$10,048,551**	**$10,559,783**	**$11,134,857**	**$11,772,077**	**$12,077,751**	**$637,220**	**$305,674**
Other Health Care Programs:							
Camp Lejeune Families (P.L. 112-154)	$3,114	$4,649	$4,649	$2,909	$3,043	($1,740)	$134
Caregivers 2/	$404,072	$1,195,486	$1,003,404	$1,353,133	$1,750,155	$349,729	$397,022
CHAMPVA & Other Dependent Prgs	$2,000,449	$2,274,182	$2,214,184	$2,378,170	$2,567,891	$163,986	$189,721
Homeless Program Grants 3/	$1,165,657	$604,732	$974,785	$1,191,186	$720,708	$216,401	($470,478)
Readjustment Counseling	$266,394	$286,980	$286,980	$323,789	$336,084	$36,809	$12,295
Copayment Reimbursement	$0	$0	$300,000	$0	$0	($300,000)	$0
Other Health Care Programs [Subtotal]	**$3,839,686**	**$4,366,029**	**$4,784,002**	**$5,249,187**	**$5,377,881**	**$465,185**	**$128,694**
Legislative Proposals:							
2021 President's Budget 4/	$0	$40,245	$0	$0	$0	$0	$0
American Families Plan	$0	$0	$0	$30,000	$30,000	$30,000	$0
Legislative Proposals	$0	$40,245	$0	$30,000	$30,000	$30,000	$0
Obligations [Subtotal]	**$91,324,895**	**$95,940,679**	**$104,078,886**	**$119,751,907**	**$115,327,100**	**$15,673,021**	**($4,424,807)**
Recoveries of prior year paid & unpaid obligations	$540,092						
Pre P.L. 116-260 Title XVI section 1601 5/	$5,007,990						
Obligations [Total]	$96,872,977	$95,940,679	$104,078,886	$119,751,907	$115,327,100	$15,673,021	($4,424,807)

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.
4/ For detail on the 2022 Legislative Proposals, please see the Legislative Proposal chapter in Volume 1.
5/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.

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
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Medical Care Programs: (Included Above)							
Activations	$126,687	$650,000	$650,000	$896,483	$500,000	$246,483	($396,483)
Blind Rehabilitation Treatment	$130,900	$134,260	$160,700	$159,700	$160,400	($1,000)	$700
Education & Training	$2,334,574	$2,502,543	$2,496,046	$2,586,956	$2,680,481	$90,910	$93,525
Health Professionals Educational Assistance Program	$115,540	$152,336	$156,336	$205,785	$258,785	$49,449	$53,000
Hepatitis C Treatment	$38,516	$38,428	$111,339	$108,280	$103,883	($3,059)	($4,397)
Indian Health Services	$15,469	$15,810	$26,810	$30,000	$33,000	$3,190	$3,000
Intensive Evaluation and Treatment Program Initiative	$0	$0	$5,188	$15,283	$25,912	$10,095	$10,629
Intimate Partner Violence program	$17,686	$21,512	$21,672	$30,602	$32,670	$8,930	$2,068
Leases	$1,173,175	$1,054,250	$1,053,903	$2,099,889	$1,000,000	$1,045,986	($1,099,889)
Mental Health Topics:							
Opioid Prevention:							
Treatment Modalities	$347,993	$382,848	$361,566	$375,668	$389,259	$14,102	$13,591
Opioid Prevention Programs (Include's Jason's Law) 1/	$42,287	$109,666	$111,012	$245,666	$245,754	$134,654	$88
Substance Use Disorder Initiative	$0	$0	$0	$155,970	$155,970	$155,970	$0
Suicide Prevention:							
Medical Treatment	$1,418,299	$1,626,694	$1,553,033	$1,741,344	$1,805,598	$188,311	$64,254
Outreach Programs	$240,774	$312,635	$311,363	$597,997	$602,587	$286,634	$4,590
National Center for Posttraumatic Stress Disorder	$34,713	$40,000	$40,000	$40,000	$40,000	$0	$0
National Veterans Sports Program	$21,259	$24,548	$27,048	$27,048	$27,048	$0	$0
Non-Recurring Maintenance (Lands & Structure only) 2/	$1,395,485	$1,859,022	$2,097,128	$2,263,896	$700,000	$166,768	($1,563,896)
Precision Oncology Initiative	$0	$75,000	$71,197	$100,017	$100,017	$28,820	$0
Rural Health	$299,097	$270,000	$300,000	$307,455	$315,135	$7,455	$7,680
Spinal Cord Injury Treatment	$616,200	$646,544	$672,500	$684,500	$703,900	$12,000	$19,400
Supply Chain Management	$66,564	$142,524	$142,524	$129,514	$140,193	($13,010)	$10,679
Telehealth:							
Home & Clinic Based Telehealth	$2,007,280	$1,029,566	$2,072,008	$2,135,182	$2,215,926	$63,174	$80,744
Office of Connected Care Program	$176,785	$300,000	$428,000	$450,000	$329,906	$22,000	($120,094)
Veterans Homelessness Programs	$2,499,444	$1,888,508	$2,305,147	$2,640,450	$2,197,414	$335,303	($443,036)
Whole Health	$56,911	$63,600	$73,600	$73,600	$73,600	$0	$0

1/ The Office of Patient Advocacy's budget is no longer displayed in this row.
2/ Please see the Medical Facilities chapter for the 2020 actual that include supporting FTE and contract-related costs pertaining to Non-Recurring Maintenance, which are not included in this table.

Table: Veteran Population Obligations in Medical Care Obligations
(Includes Veterans Choice Act Sec. 801, Veterans Choice Fund, and American Rescue Plan)
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
AIDS/HIV Program	$1,491,100	$1,365,680	$1,542,900	$1,599,500	$1,661,500	$56,600	$62,000
Post Deployment Health Services:							
Gulf War Program	$4,531,400	$4,678,634	$4,903,200	$5,308,700	$5,756,100	$405,500	$447,400
OEF/OIF/OND/OIR	$8,711,600	$8,753,769	$9,578,000	$10,458,500	$11,353,000	$880,500	$894,500
Traumatic Brain Injury and Polytrauma System of Care:							
OEF/OIF/OND/OIR	$225,400	$221,798	$236,300	$245,100	$251,800	$8,800	$6,700
All Veteran Care	$811,600	$739,911	$841,700	$870,600	$895,200	$28,900	$24,600
Women Veterans Health Care:							
Program Office & Initiative Budget	$11,288	$64,433	$99,433	$104,946	$137,791	$5,513	$32,845
Gender-Specific Care	$564,800	$625,691	$629,900	$705,500	$771,900	$75,600	$66,400
All Care	$7,260,400	$7,417,747	$7,820,800	$8,422,100	$9,061,500	$601,300	$639,400

Medical Care Collections Fund

VA estimates medical care collections of $4.085 billion in 2022 and $4.165 billion in 2023 The 2020 actual level and 2021 current estimate reflect recent collections trends, including the copayment billing suspension that began in April 2020 and continues through the end of FY 2021, as included in the American Rescue Plan Act section 8007. The 2022 and 2023 revenue projections also reflect recent 3rd party collections trends, including the increased use of telehealth as a provision of care.

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

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Medical Care Collections Fund:							
First Party Payments:							
1st Party Other Co-payments	$125,019	$226,496	$41,152	$170,420	$174,176	$129,268	$3,756
Community Care Collections 1st Party 3/	$12,753		$11,434	$21,063	$21,527	$9,629	$464
Long-Term Care Co-Payments	$1,693	$2,762	$468	$2,116	$2,062	$1,648	($54)
Pharmacy Co-payments	$307,001	$459,517	$184,959	$389,924	$397,285	$204,965	$7,361
First Party Payments [Subtotal]	**$446,466**	**$688,775**	**$238,013**	**$583,523**	**$595,050**	**$345,510**	**$11,527**
Third Party Payments:							
3rd Party Insurance Collections	$2,230,494	$2,829,564	$2,040,944	$2,647,973	$2,663,678	$607,029	$15,705
3rd Party RX Insurance	$141,136	$151,778	$150,608	$191,291	$189,451	$40,683	($1,840)
Community Care Collections 3rd Party 3/	$554,551	$784,446	$475,881	$602,165	$656,988	$126,284	$54,823
Third Party Payments [Subtotal]	**$2,926,181**	**$3,765,788**	**$2,667,433**	**$3,441,429**	**$3,510,117**	**$773,996**	**$68,688**
Other MCCF:							
Comp. & Pension Living Expenses	$2,023	$2,000	$1,635	$1,635	$1,635	$0	$0
Comp. Work Therapy Collections	$49,287	$66,000	$53,961	$53,961	$53,961	$0	$0
Enhanced-Use Revenue	$1,239	$1,387	$1,134	$1,134	$1,134	$0	$0
Parking Fees	$3,920	$4,000	$3,270	$3,270	$3,270	$0	$0
Other MCCF [Subtotal]	**$56,469**	**$73,387**	**$60,000**	**$60,000**	**$60,000**	**$0**	**$0**
Total Collections	**$3,429,116**	**$4,527,950**	**$2,965,446**	**$4,084,952**	**$4,165,167**	**$1,119,506**	**$80,215**
JALFHCC amount (included above)	$13,680	$18,328	$13,604	$16,602	$16,928	$2,998	$326

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 $3,309,178,836 were received by VA in 2020. 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 $3,429,116,441 was transferred from the Medical Care Collections Fund to the receiving accounts, reflecting collections received from September 2020 through August 2020: $2,846,296,640 to Medical Services, $569,138,965 to Medical Community Care, and $13,680,837 to the Joint DoD-VA Medical Demonstration Fund. The funds collected in September 2020 were transferred in 2021.
3/ The 2021 President's Budget did not separate out reveune generated by Community Care utilization between first and third party.

VA Staffing

The budget requests 369,847 FTE in 2022 and 369,847 FTE in 2023. The estimated staffing increase in 2022 allows VA to meet continued outpatient Relative Value Unit (RVU) growth for VA provided services, particularly due to COVID-19-related deferred care returning in 2022. Provider growth has increased recently despite a tightening provider labor market and will continue in 2022 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 2023, VA plans to retain the same FTE level in order to maintain timely access to care provided by VA facilities.

Table: Employment Summary (FTE)

Employment Summary (FTE)

Account	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Medical Services	256,891	265,156	269,090	256,891	284,791	(12,199)	27,900
Medical Community Care	0	0	0	0	0	0	0
Medical Support & Compliance	55,537	60,219	57,190	57,725	58,225	535	500
Medical Facilities	25,644	26,709	26,147	26,654	26,654	507	0
Total Discretionary Medical Care	338,072	352,084	352,427	341,270	369,670	(11,157)	28,400

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Veterans Medical Care and Health Fund - Medical Services 1/	0	0	0	27,900	0	27,900	(27,900)
Veterans Medical Care and Health Fund - Medical Support & Compliance 1/	0	0	0	500	0	500	(500)
Veterans Families Plan - Medical Services	0	0	0	160	0		
Veterans Choice Act, Sec. 801, FTE 2/	17	9	17	17	17	0	0
Veterans Choice Act, Sec. 802, FTE 3/	0	0	0	0	0	0	0
Total Mandatory Medical Care	17	9	17	28,577	17	28,400	(28,400)

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/ 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.
3/ 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.

Grand Total Medical Care FTE	**338,089**	**352,093**	**352,444**	**369,847**	**369,687**	**17,243**	**0**

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Estimate	+/- 2021-2022
Canteen Service	2,977	3,285	3,285	3,500	215
Medical & Prosthetic Research 4/	3,418	3,275	3,454	3,585	131
DOD-VA Health Care Sharing Fund	18	22	15	15	0
James A. Lovell Federal Healthcare Center					
Civilian	2,178	2,172	2,290	2,308	18
DoD Uniformed Military	906	806	906	906	0
Joint DoD-VA Med. Fac. Demo. Fund Total	3,084	2,978	3,196	3,214	18

4/Includes 34 FTE from the American Rescue Plan Act section 8002 in 2021

Table: FTE by Type, Medical Care

FTE by Type
Medical Care

Account	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Physicians	22,459	24,690	22,975	21,594	23,554	(1,381)	1,960
Dentists	1,208	1,370	1,265	1,188	1,338	(77)	150
Registered Nurses	66,363	69,009	69,315	62,595	73,035	(6,720)	10,440
LP Nurse/LV Nurse/Nurse Assistant	28,323	29,081	29,600	26,066	31,241	(3,534)	5,175
Non-Physician Providers	16,674	15,882	17,706	18,077	19,027	371	950
Health Technicians/Allied Health	78,178	77,883	83,001	84,044	89,144	1,043	5,100
Wage Board/Purchase & Hire	27,979	30,780	28,521	28,814	29,039	293	225
All Other 1/	96,888	103,389	100,044	98,892	103,292	(1,152)	4,400
SubTotal	338,072	352,084	352,427	341,270	369,670	(11,157)	28,400
American Rescue Plan, FTE	0	0	0	28,400	0	28,400	(28,400)
American Families Plan, FTE	0	0	0	160	160	160	0
Veterans Choice Act, Sec. 801, FTE	17	9	17	17	17	0	0
Veterans Choice Act, Sec. 802, FTE	0	0	0	0	0	0	0
Total	338,089	352,093	352,444	369,847	369,847	17,403	0

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

FTE by Type
Medical Services

Account	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Physicians	21,789	23,981	22,179	20,719	22,679	(1,460)	1,960
Dentists	1,195	1,353	1,252	1,175	1,325	(77)	150
Registered Nurses	63,111	65,876	65,959	59,172	69,612	(6,787)	10,440
LP Nurse/LV Nurse/Nurse Assistant	28,262	28,998	29,542	26,009	31,184	(3,533)	5,175
Non-Physician Providers	16,418	15,638	17,445	17,812	18,762	367	950
Health Technicians/Allied Health	77,008	76,754	81,767	82,770	87,870	1,003	5,100
Wage Board/Purchase & Hire	5,671	6,235	5,778	5,690	5,915	(88)	225
All Other 1/	43,437	46,321	45,168	43,544	47,444	(1,624)	3,900
SubTotal	256,891	265,156	269,090	256,891	284,791	(12,199)	27,900
American Rescue Plan, FTE	0	0	0	27,900	0	27,900	(27,900)
American Families Plan, FTE	0	0	0	160	160	160	0
Veterans Choice Act, Sec. 801, FTE	6	0	6	6	6	0	0
Total	256,897	265,156	269,096	284,957	284,957	15,861	0

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	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Physicians	670	709	796	875	875	79	0
Dentists	13	17	13	13	13	0	0
Registered Nurses	3,249	3,133	3,356	3,423	3,423	67	0
LP Nurse/LV Nurse/Nurse Assistant	60	83	58	57	57	(1)	0
Non-Physician Providers	255	244	261	265	265	4	0
Health Technicians/Allied Health	995	897	1,059	1,099	1,099	40	0
Wage Board/Purchase & Hire	1,230	2,378	1,371	1,459	1,459	88	0
All Other 1/	49,065	52,758	50,276	50,534	51,034	258	500
SubTotal	55,537	60,219	57,190	57,725	58,225	535	500
American Rescue Plan, FTE	0	0	0	500	0	500	(500)
Veterans Choice Act, Sec. 801, FTE	11	9	11	11	11	0	0
Total	55,548	60,228	57,201	58,236	58,236	1,035	0

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	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Physicians	0	0	0	0	0	0	0
Dentists	0	0	0	0	0	0	0
Registered Nurses	3	0	0	0	0	0	0
LP Nurse/LV Nurse/Nurse Assistant	1	0	0	0	0	0	0
Non-Physician Providers	1	0	0	0	0	0	0
Health Technicians/Allied Health	175	232	175	175	175	0	0
Wage Board/Purchase & Hire	21,078	22,167	21,372	21,665	21,665	293	0
All Other 1/	4,386	4,310	4,600	4,814	4,814	214	0
SubTotal	25,644	26,709	26,147	26,654	26,654	507	0
Veterans Choice Act, Sec. 801, FTE	0	0	0	0	0	0	0
Total	25,644	26,709	26,147	26,654	26,654	507	0

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 Veterans Choice Act)

	2020			
General Schedule Grade or Title 38	Medical Services 0160 & 0160XA	Medical Support & Compliance 0152 & 0152XA	Medical Facilities 0162 & 0162XA	Medical Care
Senior Executive Service.....	0	175	0	175
Title 38.....	97,376	4,293	18	101,687
15 or Higher.....	258	578	1	837
14.....	1,571	2,154	123	3,848
13.....	12,364	4,570	512	17,446
12.....	19,319	6,471	1,072	26,862
11.....	16,600	5,592	1,113	23,305
10.....	1,728	122	64	1,914
9.....	11,596	6,623	503	18,722
8.....	7,724	2,357	25	10,106
7.....	11,995	6,839	405	19,239
6.....	44,295	8,066	326	52,687
5.....	22,631	4,512	260	27,403
4.....	2,414	1,623	55	4,092
3.....	1,153	287	167	1,607
2.....	69	42	26	137
1.....	46	18	6	70
Wage Board.....	5,758	1,226	20,968	27,952
FTE Total.....	256,897	55,548	25,644	338,089

Table: FTE, 2020 Actual
(Includes VACAA Section 801)

Office of Personnel Management (OPM) Occupational Groups and Families	Medical Services (0160 & 0160XA)	Medical Support & Compliance (0152 & 0152XA)	Medical Facilities (0162 & 0162XA)	Total Medical Care
0000 –Miscellaneous Occupations Group	738	5,342	806	6,886
0100 – Social Science, Psychology, And Welfare Group	26,701	460	4	27,165
0200 – Human Resources Management Group	6	5,606	1	5,613
0300 – General Administrative, Clerical, And Office Services Group	10,984	13,181	955	25,120
0500 – Accounting And Budget Group	462	6,474	52	6,988
0600 –Medical, Hospital, Dental, And Public Health Group	207,482	12,534	647	220,663
0800 – Engineering And Architecture Group	330	151	1,497	1,978
0900 – Legal And Kindred Group	353	1,366	0	1,719
1000 – Information And Arts Group	230	533	191	954
1100 – Business And Industry Group	1,047	3,144	96	4,287
1300 – Physical Sciences Group	35	56	24	115
1400 – Library And Archives Group	92	56	0	148
1600 – Equipment, Facilities, And Services Group	1,176	28	176	1,380
1700 – Education Group	847	856	19	1,722
2000 – Supply Group	429	3,857	55	4,341
2100 – Transportation Group	121	568	132	821
2600 – Electronic Equipment Installation And Maintenance Family	12	0	271	283
2800 – Electrical Installation And Maintenance Family	24	0	811	835
3500 – General Services And Support Work Family	31	9	11,216	11,256
4100 – Painting And Paperhanging Family	1	5	441	447
4200 – Plumbing And Pipefitting Family	0	0	631	631
4600 –Wood Work Family	0	0	503	503
4700 – General Maintenance And Operations Work Family	5	8	2,296	2,309
4800 – General Equipment Maintenance Family	35	11	130	176
5000 – Plant And Animal Work Family	2	1	225	228
5300 – Industrial Equipment Maintenance Family1	6	0	886	892
5400 – Industrial Equipment Operation Family	1	0	770	771
5700 – Transportation/Mobile Equipment Operation Family	85	290	1,664	2,039
6900 –Warehousing And Stock Handling Family	38	890	53	981
7300 – Laundry, Dry Cleaning, And Pressing Family	0	0	832	832
7400 – Food Preparation And Serving Family	5,434	1	1	5,436
OPM Occupational Groups and Families Not Covered Above1/	190	121	259	570
Grand Total	256,897	55,548	25,644	338,089

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 2022 request supports the treatment of 7.1 million patients, a 1.3% increase above 2021, and 119 million outpatient visits, an increase of 3.7% above 2021.

Table: Unique Patients

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Priority Levels							
1-6	5,175,547	5,362,125	5,260,067	5,340,123	5,411,248	80,056	71,125
7-8	1,036,278	1,030,452	1,005,813	976,936	951,235	(28,877)	(25,701)
Veterans [Subtotal]	6,211,825	6,392,577	6,265,880	**6,317,059**	**6,362,483**	51,179	45,424
Non-Veterans [Subtotal] 2/	764,006	799,359	771,698	812,674	836,254	40,976	23,580
Unique Patients [Total]	**6,975,831**	**7,191,936**	**7,037,578**	**7,129,733**	**7,198,737**	**92,155**	**69,004**

Unique Enrollees 3/

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Priority Levels							
1-6	7,255,716	7,389,092	7,343,497	7,414,459	7,474,219	70,962	59,760
7-8	1,934,427	1,926,061	1,867,102	1,801,566	1,737,762	(65,536)	(63,804)
Unique Enrollees [Total]	**9,190,143**	**9,315,153**	**9,210,599**	**9,216,025**	**9,211,981**	**5,426**	**(4,044)**

Users as a Percent of Enrollees

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Priority Levels							
1-6	71.3%	72.6%	71.6%	72.0%	72.4%	0.4%	0.4%
7-8	53.6%	53.5%	53.9%	54.2%	54.7%	0.4%	0.5%
Unique Enrollees [Total]	**67.6%**	**68.6%**	**68.0%**	**68.5%**	**69.1%**	0.5%	0.5%

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 Veterans health care sometime during the course of the year, regardless of whether they received VA care as patients during that year.

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

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Outpatient Visits (000):							
Ambulatory Care:							
Staff	81,018	91,731	84,670	88,321	88,581	3,651	260
Community Care	31,254	32,829	28,215	28,602	29,157	387	555
Subtotal	112,272	124,560	112,885	116,923	117,738	4,038	815
Readjustment Counseling:							
Visits	1,606	1,932	1,836	2,067	2,102	231	35
Grand Total	113,878	126,492	114,721	118,990	119,840	4,269	850
Patients Treated:							
Inpatient Care	709,293	651,131	763,226	749,293	745,976	(13,933)	(3,317)
Rehabilitation Care	10,568	16,116	14,975	14,842	14,771	(133)	(71)
Mental Health Care Total	131,041	149,080	150,919	144,925	143,497	(5,994)	(1,428)
Acute Psychiatry	*70,516*	*86,136*	*82,742*	*82,465*	*80,702*	*(277)*	*(1,763)*
Community Care Hospital (Psych)	*32,668*	*21,534*	*29,477*	*24,092*	*24,771*	*(5,385)*	*679*
Residential Recovery Programs	*27,857*	*41,410*	*38,700*	*38,368*	*38,024*	*(332)*	*(344)*
Long-Term Care: Institutional 1/	103,602	123,178	119,078	119,965	118,835	887	(1,130)
Subacute Care	1,107	859	969	825	712	(144)	(113)
Inpatient Facilities, Total	955,611	940,364	1,049,167	1,029,850	1,023,791	(19,317)	(6,059)
Average Daily Census:							
Inpatient Care	11,952	9,377	9,781	9,856	9,961	75	105
Rehabilitation Care	891	1,158	1,104	1,101	1,103	(3)	2
Mental Health Care Total	5,896	8,147	5,618	5,273	4,898	(345)	(375)
Acute Psychiatry	*1,876*	*2,074*	*1,816*	*1,758*	*1,698*	*(58)*	*(60)*
Community Care Hospital (Psych)	*194*	*585*	*186*	*174*	*162*	*(12)*	*(12)*
Residential Recovery Programs	*3,825*	*5,488*	*3,616*	*3,341*	*3,039*	*(274)*	*(303)*
Long-Term Care: Institutional 1/	40,984	42,776	41,869	41,990	42,227	121	237
Subacute Care	32	30	32	32	31	0	(1)
Inpatient Facilities, Total	59,755	61,488	58,404	58,252	58,220	(152)	(32)
Length of Stay:							
Inpatient Care	6.2	5.3	4.7	4.8	4.9	0.1	0.1
Rehabilitation Care	30.9	26.2	26.9	27.1	27.3	0.2	0.2
Mental Health Care	16.5	19.9	13.6	13.3	12.5	(0.3)	(0.8)
Long-Term Care: Institutional 1/	144.8	126.8	128.3	127.8	129.7	(0.5)	1.9
Subacute Care	10.6	12.7	12.1	14.2	15.9	2.1	1.7
Dental Procedures (000)	3,641	6,656	5,071	6,501	7,073	1,430	572
CHAMPVA/FMP/Spina Bifida:							
Unique Patients	406,600	429,697	423,554	469,048	490,685	45,494	21,637

1/The 2021 PB excluded State Home Domiciliary Care from this line, which would have added 4,013 to the 2019 Actual for a combined total of 119,736 patients treated and an additional ADC of 2,764 for a combined ADC total of 42,083. The 2021 Budget Estimate has been increased by 3,725 to add back in the State Home Domiciliary Care

projected patients treated and by 2,717 for ADC. The 2019 Actual Length of Stay with State Home Domiciliary Care would have been 128.3, and the 2021 Budget Estimate has been adjusted accordingly.

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
- 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 (based on your resident zip code) adjusted income limits
- 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
- Veterans of Persian Gulf War who served between August 2, 1990, and November 11, 1998
- Veterans who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987

- Currently enrolled Veterans and new enrollees who served in a theater of combat operations after November 11, 1998, and those who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years post discharge

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)

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 has no other health care coverage (including Medicare and Medicaid).

In addition to CHAMPVA, other VA Community Care programs also include the Foreign Medical Program (FMP), Spina Bifida Health Care Benefits Program, and Children of Women Vietnam Veterans Health Care Benefits Program (CWVV).

Foreign Medical Program (FMP)
The Foreign Medical Program is a health care benefits program for United States Veterans with VA-rated service-connected conditions who 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.

Spina Bifida Health Care Program (SB)
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.

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.

CHAMPVA In-house Treatment Initiative (CITI)
CITI is a voluntary program that allows treatment of beneficiaries of the Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA) at VAMCs that have elected to participate in the initiative.

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	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Priority Levels							
Priority 1	2,459,544	2,601,411	2,601,985	2,736,929	2,856,879	134,944	119,950
Priority 2	479,124	490,190	475,215	471,512	468,220	(3,703)	(3,292)
Priority 3	785,568	825,598	794,180	802,339	809,592	8,159	7,253
Priority 4	154,518	148,655	146,949	139,778	133,404	(7,171)	(6,374)
Priority 5	1,063,567	1,062,471	1,014,706	968,403	927,208	(46,303)	(41,195)
Priority 6	233,226	233,800	227,031	221,163	215,945	(5,868)	(5,218)
Priority 7	211,433	219,843	218,995	226,151	232,496	7,156	6,345
Priority 8	824,845	810,609	786,818	750,785	718,738	(36,033)	(32,047)
Veterans [Subtotal]	6,211,825	6,392,577	6,265,879	**6,317,060**	**6,362,482**	51,181	45,422
Non-Veterans 2/							
CHAMPVA/SB/FMP/CW/CITI Non-Vets	396,265	422,880	413,719	453,820	475,777	40,101	21,957
N : Non-Veteran	3,344	7,661	3,731	4,118	4,505	387	387
N0: Non-Vet, Catastro Disab	38	48	42	46	50	4	4
N1: Non-Vet, CHAMPVA Ben	10,335	9,327	9,835	9,335	8,835	(500)	(500)
N2: Non-Vet, Collaterals	17,948	6,261	7,720	7,492	7,264	(228)	(228)
N3: Non-Vet, VA Employee	247,976	247,837	251,327	254,678	258,029	3,351	3,351
N4: Non-Vet, Other Federal	399	690	343	287	231	(56)	(56)
N5: Non-Vet, Allied Veterans	1,087	1,092	1,067	1,047	1,027	(20)	(20)
N6: Non-Vet, Humanitarian	23,916	26,026	24,372	24,828	25,284	456	456
N7: Non-Vet, Sharing Agreement	12,220	15,693	9,426	6,956	5,234	(2,470)	(1,722)
N9: Non-Vet, TRICARE/CHAMPUS	2,086	2,079	2,006	1,926	1,846	(80)	(80)
NF : FHC Active Duty 3/	48,392	59,765	48,110	48,141	48,172	31	31
Non-Veterans [Subtotal]	764,006	799,359	771,698	**812,674**	**836,254**	40,976	23,580
Unique Patients [Total]	**6,975,831**	**7,191,936**	**7,037,577**	**7,129,734**	**7,198,736**	92,157	69,002
OEF/OIF/OND/OIR (Incl. Above)	1,090,734	1,160,656	1,164,618	1,236,559	1,303,055	71,941	66,496

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

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Priority Levels							
Priority 1	1,464,473	1,598,471	1,583,897	1,690,999	1,791,011	107,102	100,012
Priority 2	266,263	279,234	263,796	259,201	255,998	(4,595)	(3,203)
Priority 3	361,361	390,989	365,154	364,313	365,328	(841)	1,015
Priority 4	37,111	38,000	34,189	30,212	27,107	(3,977)	(3,105)
Priority 5	468,332	483,122	443,638	411,623	385,860	(32,015)	(25,763)
Priority 6	73,206	69,206	70,224	67,108	64,374	(3,116)	(2,734)
Priority 7	89,085	97,046	94,642	99,106	103,575	4,464	4,469
Priority 8	288,913	318,093	286,737	278,866	275,407	(7,871)	(3,459)
Veterans [Subtotal]	3,048,744	3,274,161	3,142,277	**3,201,428**	**3,268,660**	59,151	67,232
Non-Veterans 2/							
CHAMPVA/SB/FMP/CW/CITI Non-Vets	376,434	401,697	393,055	431,174	452,036	38,119	20,862
N : Non-Veteran	2,680	5,830	2,965	3,692	4,410	727	718
N0: Non-Vet, Catastro Disab	35	47	39	41	45	2	4
N1: Non-Vet, CHAMPVA Ben	9,833	8,900	9,324	8,826	8,340	(498)	(486)
N2: Non-Vet, Collaterals	15,210	4,806	6,557	6,305	6,048	(252)	(257)
N3: Non-Vet, VA Employee	237,202	232,121	239,515	241,128	243,109	1,613	1,981
N4: Non-Vet, Other Federal	367	659	309	247	191	(62)	(56)
N5: Non-Vet, Allied Veterans	913	898	891	874	855	(17)	(19)
N6: Non-Vet, Humanitarian	21,015	22,994	21,433	21,805	22,190	372	385
N7: Non-Vet, Sharing Agreement	11,059	13,805	8,445	6,292	4,814	(2,153)	(1,478)
N9: Non-Vet, TRICARE/CHAMPUS	1,852	1,829	1,772	1,693	1,617	(79)	(76)
NF : FHC Active Duty 3/	48,392	59,765	48,110	48,141	48,172	31	31
Non-Veterans [Subtotal]	724,992	753,351	732,415	**770,218**	**791,827**	37,803	21,609
Unique Patients [Total]	**3,773,736**	**4,027,512**	**3,874,692**	**3,971,646**	**4,060,487**	96,954	88,841

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

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Priority Levels							
Priority 1	995,071	1,002,940	1,018,088	1,045,930	1,065,868	27,842	19,938
Priority 2	212,861	210,956	211,419	212,311	212,222	892	(89)
Priority 3	424,207	434,609	429,026	438,026	444,264	9,000	6,238
Priority 4	117,407	110,655	112,760	109,566	106,297	(3,194)	(3,269)
Priority 5	595,235	579,349	571,068	556,780	541,348	(14,288)	(15,432)
Priority 6	160,020	164,594	156,807	154,055	151,571	(2,752)	(2,484)
Priority 7	122,348	122,797	124,353	127,045	128,921	2,692	1,876
Priority 8	535,932	492,516	500,081	471,919	443,331	(28,162)	(28,588)
Veterans [Subtotal]	3,163,081	3,118,416	3,123,602	**3,115,632**	**3,093,822**	(7,970)	(21,810)
Non-Veterans 2/							
CHAMPVA/SB/FMP/CW/CITI Non-Vets	19,831	21,183	20,664	22,646	23,741	1,982	1,095
N : Non-Veteran	664	1,831	766	426	95	(340)	(331)
N0: Non-Vet, Catastro Disab	3	1	3	5	5	2	0
N1: Non-Vet, CHAMPVA Ben	502	427	511	509	495	(2)	(14)
N2: Non-Vet, Collaterals	2,738	1,455	1,163	1,187	1,216	24	29
N3: Non-Vet, VA Employee	10,774	15,716	11,812	13,550	14,920	1,738	1,370
N4: Non-Vet, Other Federal	32	31	34	40	40	6	0
N5: Non-Vet, Allied Veterans	174	194	176	173	172	(3)	(1)
N6: Non-Vet, Humanitarian	2,901	3,032	2,939	3,023	3,094	84	71
N7: Non-Vet, Sharing Agreement	1,161	1,888	981	664	420	(317)	(244)
N9: Non-Vet, TRICARE/CHAMPUS	234	250	234	233	229	(1)	(4)
NF : FHC Active Duty 3/	0	0	0	0	0	0	0
Non-Veterans [Subtotal]	39,014	46,008	39,283	**42,456**	**44,427**	3,173	1,971
Unique Patients [Total]	**3,202,095**	**3,164,424**	**3,162,885**	**3,158,088**	**3,138,249**	(4,797)	(19,839)

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

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Priority Levels							
1-6	5,175,547	5,362,125	5,260,067	**5,340,123**	**5,411,248**	80,056	71,125
7-8	1,036,278	1,030,452	1,005,813	**976,936**	**951,235**	(28,877)	(25,701)
Veterans [Subtotal]	6,211,825	6,392,577	6,265,880	**6,317,059**	**6,362,483**	51,179	45,424
Non-Veterans 2/	764,006	799,359	771,698	812,674	836,254	40,976	23,580
Unique Patients [Total]	**6,975,831**	**7,191,936**	**7,037,578**	**7,129,733**	**7,198,737**	**92,155**	**69,004**

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

	2020 Actual 3/	2021 Budget Estimate	2021 Current Estimate 4/	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Priority Levels							
1-6	$81,118,639	$85,311,086	$91,939,740	**$106,475,924**	**$102,208,285**	$14,536,184	($4,267,639)
7-8	$8,260,046	$7,960,944	$9,235,524	**$10,643,972**	**$10,313,245**	$1,408,448	($330,727)
Veterans [Subtotal]	$89,378,685	$93,272,030	$101,175,264	**$117,119,896**	**$112,521,530**	$15,944,632	($4,598,367)
Non-Veterans 2/	$2,486,302	$2,668,649	$2,603,622	**$2,602,011**	**$2,775,570**	($1,611)	$173,560
Obligations [Total]	**$91,864,987**	**$95,940,679**	**$103,778,886**	**$119,721,907**	**$115,297,100**	$15,943,021	($4,424,807)

Obligations Per Unique Patient
(dollars)

	2020 Actual 3/	2021 Budget Estimate	2021 Current Estimate 4/	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Priority Levels							
1-6	$15,673	$15,910	$17,479	**$19,939**	**$18,888**	$2,460	($1,051)
7-8	$7,971	$7,726	$9,182	**$10,895**	**$10,842**	$1,713	($53)
Veterans [Subtotal]	$14,388	$14,591	$16,147	**$18,540**	**$17,685**	$2,393	($855)
Non-Veterans 2/	$3,254	$3,338	$3,374	**$3,202**	**$3,319**	($172)	$117
Obligations Per Unique Patient [Total]	**$13,169**	**$13,340**	**$14,746**	**$16,792**	**$16,016**	**$2,046**	**($776)**

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/ 2020 Obligations exclude the obligations that VA recorded in September 2020 to comply with the VA OGC opinion on recording of Community Care obligations, to provide for a comparable program obligations level from year-to-year. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.
4/ 2021 Obligation projections exclude the $300 million projected to be reimbursed to Veterans for copayments paid from April 6, 2020 through September 30, 2021, as directed by section 8007 of the American Rescue Plan Act.

Table: Obligations by Priority Group
2020-2023

	2020 Actual 1/			2021 Current Estimate 2/			2022 Current Estimate			2023 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	2,459,544	$43,017,312	$17,490	2,601,985	$51,142,911	$19,655	2,736,929	$60,126,395	$21,969	2,856,879	$59,033,476	$20,664
Priority 2	479,124	$4,982,080	$10,398	475,215	$5,537,434	$11,652	471,512	$6,340,270	$13,447	468,220	$6,001,447	$12,818
Priority 3	785,568	$8,592,092	$10,937	794,180	$9,847,165	$12,399	802,339	$11,515,845	$14,353	809,592	$11,088,026	$13,696
Priority 4	154,518	$6,094,459	$39,442	146,949	$6,182,149	$42,070	139,778	$6,875,680	$49,190	133,404	$6,367,981	$47,735
Priority 5	1,063,567	$17,029,344	$16,012	1,014,706	$17,651,113	$17,395	968,403	$19,816,792	$20,463	927,208	$17,982,069	$19,394
Priority 6	233,226	$1,403,352	$6,017	227,031	$1,578,968	$6,955	221,163	$1,800,942	$8,143	215,945	$1,735,285	$8,036
P1-6 Subtotal	5,175,547	$81,118,639	$15,673	5,260,066	$91,939,740	$17,479	5,340,124	$106,475,924	$19,939	5,411,248	$102,208,285	$18,888
Priority 7	211,433	$2,068,797	$9,785	218,995	$2,472,828	$11,292	226,151	$2,939,892	$13,000	232,496	$2,925,969	$12,585
Priority 8	824,845	$6,191,249	$7,506	786,818	$6,762,696	$8,595	750,785	$7,704,080	$10,261	718,738	$7,387,276	$10,278
P7-8 Subtotal	1,036,278	$8,260,046	$7,971	1,005,813	$9,235,524	$9,182	976,936	$10,643,972	$10,895	951,234	$10,313,245	$10,842
Veterans [Subtotal]	6,211,825	$89,378,685	$14,388	6,265,879	$101,175,264	$16,147	6,317,060	$117,119,896	$18,540	6,362,482	$112,521,530	$17,685
Non-Veterans												
CHAMPVA/SB/FMP/CW Non-Vet (less CITI)	396,265	$2,033,230	$5,131	413,719	$2,176,714	$5,261	453,820	$2,188,018	$4,821	475,777	$2,372,715	$4,987
N: Non-Vet	3,344	$56,695	$16,954	3,731	$64,616	$17,319	4,118	$72,211	$17,536	4,505	$79,619	$17,673
N0: Non-Vet, Catastro Disab	38	$1,536	$40,421	42	$1,734	$41,290	46	$1,923	$41,807	50	$2,107	$42,136
N1: Non-Vet, CHAMPVA Ben	10,335	$89,479	$8,658	9,835	$77,607	$7,891	9,335	$64,611	$6,921	8,835	$51,040	$5,777
N2: Non-Vet, Collaterals	17,948	$28,396	$1,582	7,720	$12,477	$1,616	7,492	$12,260	$1,636	7,264	$11,980	$1,649
N3: Non-Vet, VA Employee	247,976	$132,019	$532	251,327	$136,679	$544	254,678	$140,236	$551	258,029	$143,198	$555
N4: Non-Vet, Other Federal	399	$1,110	$2,782	343	$975	$2,842	287	$826	$2,877	231	$670	$2,900
N5: Non-Vet, Allied Veterans	1,087	$9,314	$8,569	1,067	$9,339	$8,753	1,047	$9,279	$8,862	1,027	$9,173	$8,932
N6: Non-Vet, Humanitarian	23,916	$60,870	$2,545	24,372	$63,364	$2,600	24,828	$65,358	$2,632	25,284	$67,081	$2,653
N7: Non-Vet, Sharing Agreement	12,220	$62,933	$5,150	9,426	$49,587	$5,261	6,956	$37,052	$5,327	5,234	$28,098	$5,368
N9: Non-Vet, TRICARE/CHAMPUS	2,086	$10,720	$5,139	2,006	$10,530	$5,249	1,926	$10,237	$5,315	1,846	$9,889	$5,357
NF: FHC Active Duty 3/	48,392	$0	$0	48,110	$0	$0	48,141	$0	$0	48,172	$0	$0
Non-Veterans [Subtotal]	764,006	$2,486,302	$3,254	771,698	$2,603,622	$3,374	812,674	$2,602,011	$3,202	836,254	$2,775,570	$3,319
Total	**6,975,831**	**$91,864,987**	**$13,169**	**7,037,577**	**$103,778,886**	**$14,746**	**7,129,734**	**$119,721,907**	**$16,792**	**7,198,736**	**$115,297,100**	**$16,016**

1/ 2020 Obligations exclude the obligations that VA recorded in September 2020 to comply with the VA OGC opinion on recording of Community Care obligations, to provide for a comparable program obligations level from year-to-year. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.
2/ 2021 Obligation projections exclude the $300 million projected to be reimbursed to Veterans for copayments paid from April 6, 2020 through September 30, 2021, as directed by section 8007 of the American Rescue Plan Act.
3/ 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 2020-2023

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

2020 Actual
Dollars in Thousands ($000)

Description	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162	Medical Care Total
	Discretionary				
APPROPRIATION					
Advance Appropriation	$51,411,165	$10,758,399	$7,239,156	$6,141,880	$75,550,600
Annual Appropriation Adjustment	$0	$3,906,400	$98,800	$0	$4,005,200
Rescission (P.L. 116-94)	($350,000)	$0	($10,000)	$0	($360,000)
Families First Coronavirus Response Act (P.L. 116-127)	$30,000	$30,000	$0	$0	$60,000
CARES Act (P.L. 116-136)	$14,432,000	$2,100,000	$100,000	$606,000	$17,238,000
Appropriation [Subtotal]	$65,523,165	$16,794,799	$7,427,956	$6,747,880	$96,493,800
TRANSFERS TO (-)					
Medical Support & Compliance (0152)	($375,000)	$0	$0	$0	($375,000)
Medical Support & Compliance - CARES (0152)	($150,000)	$0	$0	$0	($150,000)
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($210,309)	($27,651)	($29,424)	($39,245)	($306,629)
Transfers To [Subtotal]	($750,309)	($27,651)	($29,424)	($39,245)	($846,629)
TRANSFERS FROM (+)					
Medical Services - (0160)	$0	$0	$375,000	$0	$375,000
Medical Services - CARES (0160)	$0	$0	$150,000	$0	$150,000
VCF (0172) Unobligated balance	$0	$615,000	$0	$0	$615,000
Transfers From [Subtotal]	$0	$615,000	$525,000	$0	$1,140,000
COLLECTIONS	$2,846,297	$569,139	$0	$0	$3,415,436
BUDGET AUTHORITY	$67,619,153	$17,951,287	$7,923,532	$6,708,635	$100,202,607
REIMBURSEMENTS	$124,257	$0	$47,610	$18,420	$190,287
UNOBLIGATED BALANCE (SOY)					
No-Year (Other)	$964,347	$48,806	$0	$11,153	$1,024,306
P.L. 115-141 sec 255 (NRM)	$0	$0	$0	$523,601	$523,601
P.L. 115-244 sec 248 (NRM)	$0	$0	$0	$662,524	$662,524
P.L. 116-20 (Disaster Relief)	$0	$0	$0	$1,333	$1,333
H1N1 No-Year (PL 111-32)	$0	$0	$112	$5	$117
2-Year	$1,117,755	$0	$21,454	$119,894	$1,259,103
4-Year Base Year 2017	$0	$19,662	$0	$0	$19,662
4-Year Base Year 2018	$0	$18,278	$0	$59,646	$77,924
4-Year Base Year 2019	$0	$56,387	$0	$0	$56,387
Unobligated Balance (SOY) [Subtotal]	$2,082,102	$143,133	$21,566	$1,378,156	$3,624,957
UNOBLIGATED BALANCE (EOY)					
No-Year (Other)	($1,218,065)	($9,075)	$0	($12,985)	($1,240,125)
Pre P.L. 116-260 Title XVI section 1601 1/	$0	$5,007,990	$0	$0	$5,007,990
P.L. 115-141 sec 255 (NRM)	$0	$0	$0	($299,657)	($299,657)
P.L. 115-244 sec 248 (NRM)	$0	$0	$0	($512,199)	($512,199)
P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	($7)	$0	($111)	($5)	($123)
2-Year (Other)	($853,821)	($173,389)	($98,481)	($137,079)	($1,262,770)
2-Year (P.L. 116-136)	($10,388,429)	($131,132)	($172,544)	($293,204)	($10,985,309)
3-Year (P.L. 116-127)	$0	($30,000)	$0	$0	($30,000)
4-Year Base Year 2017	$0	$0	$0	$0	$0
4-Year Base Year 2018	$0	($7,699)	$0	($46,071)	($53,770)
4-Year Base Year 2019	$0	($73,988)	$0	$0	($73,988)
Unobligated Balance (EOY) [Subtotal]	($12,460,322)	$4,582,707	($271,136)	($1,301,200)	($9,449,951)
LAPSE	($4,696)	$0	($973)	($644)	($6,313)
OBLIGATIONS [Total] NON-801/802	$57,360,494	$22,677,127	$7,720,599	$6,803,367	$94,561,587
PRIOR Year Recoveries	$94,328	$88,626	$167	$8,723	$191,844
OBLIGATIONS [Total] NON-801/802	$57,454,822	$22,765,753	$7,720,766	$6,812,090	$94,753,431
Obligations Post P.L. 116-260 Title XVI section 1601 2/	*$57,454,822*	*$17,757,763*	*$7,720,766*	*$6,812,090*	$89,745,441
FTE NON-801	256,891	0	55,537	25,644	338,072

1/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to

health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.
2/ 2020 Obligations exclude the obligations that VA recorded in September 2020 to comply with the VA OGC opinion on recording of Community Care obligations, to provide for a comparable program obligations level from year-to-year.

2020 Actual
Dollars in Thousands ($000)

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

	Mandatory								
						Information Technology			
Description	Medical Services 0160XA	Medical Support & Compl 0152XA 1/	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	$24,699	$14,480	$25,600	$64,779	$1,925	$12	$4,426	$0	$71,142
UNOBLIGATED BALANCE (EOY)									
No-Year	($25,089)	($13,134)	($30,437)	($68,660)	($4,296)	($218)	($1,821)	$0	($74,995)
OBLIGATIONS [Subtotal Total]	($390)	$1,346	($4,837)	($3,881)	($2,371)	($206)	$2,605	$0	($3,853)
PRIOR Year Recoveries	$2,581	$0	$10,308	$12,889	$7,318	$206	$250		$20,663
OBLIGATIONS [Total]	$2,191	$1,346	$5,471	$9,008	$4,947	$0	$2,855	$0	$16,810
FTE	6	11	0	17	0	0	0	0	17

2020 Actual
Dollars in Thousands ($000)

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

Description	Mandatory Admin. 0172XA	Mandatory Medical Care 0172XB	Mandatory Emerg. Hepatitis C 0172XC	Mandatory Emerg. Com. Care 0172XE	Med. Com Care (Mission) 0172XG	Medical Care Total (continued)	Mandatory Information Technology Dev. 0172XD	Mandatory Information Technology Sustain. 0172XO	Mandatory Information Technology Pay & Adm 0172XZ	Section 802 Grand Total
APPROPRIATION										
Appropriation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Appropriation [Subtotal]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
BUDGET AUTHORITY	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (SOY)										
Pre P.L. 116-260 Title XVI section 1601 1/	$0	($397,400)	$0	$0	$0	($397,400)	$0	$0	$0	($397,400)
No-Year	$201,473	$2,194,463	$0	$25,987	$100,000	$2,521,923	$6,158	$3,768	$0	$2,531,849
Unobligated Balance (SOY) [Subtotal]	$201,473	$1,797,063	$0	$25,987	$100,000	$2,124,523	$6,158	$3,768	$0	$2,134,449
Transfer of Unobligated Balance										
To Medical Community Care	($100,000)	($490,873)	$0	($15,000)	$0	($605,873)	($5,359)	($3,768)	$0	($615,000)
Within the Veterans Choice Fund	($71,179)	($1,761,727)	$0	($5,001)	$1,846,727	$8,820	($8,117)	($703)	$0	$0
UNOBLIGATED BALANCE (EOY)										
Pre P.L. 116-260 Title XVI section 1601 1/	$0	$397,400	$0	$0	$0	$397,400	$0	$0	$0	$397,400
No-Year	($39,231)	($89,675)	$0	($5,389)	($15,395)	($149,690)	$0	$0	$0	($149,690)
Unobligated Balance (EOY) [Subtotal]	($39,231)	$307,725	$0	($5,389)	($15,395)	$247,710	$0	$0	$0	$247,710
Subtotal Obligations	($8,938)	($147,812)	$0	$597	$1,931,332	$1,775,179	($7,318)	($703)	$0	$1,767,158
PRIOR YEAR RECOVERIES	$10,147	$324,060	$0	$1,152	$0	$335,359	$7,318	$703		$343,380
OBLIGATIONS [Total]	$1,209	$176,248	$0	$1,749	$1,931,332	$2,110,538	$0	$0	$0	$2,110,538
FTE [Total]	0	0	0	0	0	0	0	0	0	0

Medical Care Obligations Regular	**$94,753,431**
Medical Care Obls., VACAA, Section 801	**$9,008**
Medical Care Obls., VACAA, Section 802	**$2,110,538**
Medical Care Obligations [Grand Total]	**$96,872,977**
Obligations Post P.L. 116-260 Title XVI section 1601 2/	*$91,864,987*
Medical Care FTE, Regular	**338,072**
Medical Care FTE, VACAA, Section 801	**17**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**338,089**

1/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and adjusted obligations upwards by $397 million in the Veterans Choice Fund account. VA lacked sufficient funds within the account to cover the full obligations recorded consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in FY 2019 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.

2021 Budget Estimate
Dollars in Thousands ($000)

Description	Discretionary				
	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162	Medical Care Total
APPROPRIATION					
Advance Appropriation	$56,158,015	$17,131,179	$7,914,191	$6,433,265	$87,636,650
Annual Appropriation Adjustment	$497,468	$1,380,800	$300,000	$150,000	$2,328,268
Appropriation [Subtotal]	$56,655,483	$18,511,979	$8,214,191	$6,583,265	$89,964,918
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($215,945)	($28,392)	($30,213)	($40,297)	($314,847)
Transfers To [Subtotal]	($230,945)	($28,392)	($30,213)	($40,297)	($329,847)
TRANSFERS FROM (+)					
Transfers From {Subtotal]	$0	$0	$0	$0	$0
COLLECTIONS	$3,725,176	$784,446	$0	$0	$4,509,622
BUDGET AUTHORITY	$60,149,714	$19,268,033	$8,183,978	$6,542,968	$94,144,693
REIMBURSEMENTS	$137,472	$0	$19,063	$18,465	$175,000
UNOBLIGATED BALANCE (SOY)					
No-Year (Other)	$0	$0	$0	$0	$0
P.L. 115-141 sec 255 (NRM)	$0	$0	$0	$0	$0
P.L. 115-244 sec 248 (NRM)	$0	$0	$0	$512,449	$512,449
P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0
4-Year Base Year 2017	$0	$0	$0	$0	$0
4-Year Base Year 2018	$0	$0	$0	$0	$0
4-Year Base Year 2019	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$0	$0	$0	$512,449	$512,449
UNOBLIGATED BALANCE (EOY)					
No-Year (Other)	$0	$0	$0	$0	$0
P.L. 115-141 sec 255 (NRM)	$0	$0	$0	$0	$0
P.L. 115-244 sec 248 (NRM)	$0	$0	$0	$0	$0
P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0
4-Year Base Year 2017	$0	$0	$0	$0	$0
4-Year Base Year 2018	$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	$60,287,186	$19,268,033	$8,203,041	$7,073,882	$94,832,142
FTE NON-801	265,156		60,219	26,709	352,084

2021 Budget Estimate
Dollars in Thousands ($000)

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

Description	Mandatory								Section 801 Grand Total
	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	
UNOBLIGATED BALANCE (SOY)									
No-Year	$1,525	$9,846	$3,750	$15,121	$0	$0	$0	$0	$15,121
UNOBLIGATED BALANCE (EOY)									
No-Year	$0	($6,584)	$0	($6,584)	$0	$0	$0	$0	($6,584)
OBLIGATIONS [Total]	$1,525	$3,262	$3,750	$8,537	$0	$0	$0	$0	$8,537
FTE	0	9	0	9	0	0	0	0	9

2021 Budget Estimate
Dollars in Thousands ($000)

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

Description	Mandatory					Medical Care Total (continued)	Mandatory Information Technology			Section 802 Grand Total
	Admin. 0172XA	Medical Care 0172XB	Emerg. Hepatitis C 0172XC	Emerg. Com. Care 0172XE	Med. Com Care (Mission) 0172XG		Dev. 0172XD	Sustain. 0172XO	Pay & Adm 0172XZ	
APPROPRIATION										
Appropriation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Appropriation [Subtotal]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
BUDGET AUTHORITY	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (SOY)										
No-Year	$20,000	$180,000	$0	$0	$900,000	$1,100,000	$0	$0	$0	$1,100,000
Unobligated Balance (SOY) [Subtotal]	$20,000	$180,000	$0	$0	$900,000	$1,100,000	$0	$0	$0	$1,100,000
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]	$20,000	$180,000	$0	$0	$900,000	$1,100,000	$0	$0	$0	$1,100,000
FTE [Total]	0	0	0	0		0	0	0	0	0

Medical Care Obligations Regular	**$94,832,142**
Medical Care Obls., VACAA, Section 801	**$8,537**
Medical Care Obls., VACAA, Section 802	**$1,100,000**
Medical Care Obligations [Grand Total]	**$95,940,679**
Medical Care FTE Regular	**352,084**
Medical Care FTE., VACAA, Section 801	**9**
Medical Care FTE., VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**352,093**

2021 Current Estimate
Dollars in Thousands ($000)

Description	Discretionary				
	Medical Services 0160	Medical Community Care 0140	Medical Support & Compl 0152	Medical Facilities 0162	Medical Care Total
APPROPRIATION					
Advance Appropriation	$56,158,015	$17,131,179	$7,914,191	$6,433,265	$87,636,650
Annual Appropriation Adjustment	$497,468	$1,380,800	$300,000	$150,000	$2,328,268
Appropriation [Subtotal]	$56,655,483	$18,511,979	$8,214,191	$6,583,265	$89,964,918
RESCISSIONS (PL 116-260 §254)	($100,000)	$0	($15,000)	$0	($115,000)
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($215,945)	($28,392)	($30,213)	($40,297)	($314,847)
CARES Unob. Bal. to MCC (0140) (PL 116-260 §517)	($100,000)	$0	$0	$0	($100,000)
CARES Unob. Bal. to VBA/GOE (PL 116-260 §515)	($198,000)	$0	$0	$0	($198,000)
CARES Unob. Bal. to OI&T (PL 116-260 §515)	($45,000)	$0	$0	$0	($45,000)
CARES Unob. Bal. to VBA/GOE (PL 116-260 §514)	($140,000)	$0	$0	$0	($140,000)
CARES Unob. Bal. to NCA (PL 116-260 §514)	($12,000)	$0	$0	$0	($12,000)
CARES Unob. Bal. to BVA (PL 116-260 §514)	($1,000)	$0	$0	$0	($1,000)
CARES Unob. Bal. to Canteen (PL 116-159 §163)	($140,000)	$0	$0	$0	($140,000)
Transfers To [Subtotal]	($866,945)	($28,392)	($30,213)	($40,297)	($965,847)
TRANSFERS FROM (+)					
CARES Unob. Bal. fr. MS (0160) (PL 116-260 §517)	$0	$100,000	$0	$0	$100,000
Transfers From [Subtotal]	$0	$100,000	$0	$0	$100,000
COLLECTIONS	$2,464,526	$487,315	$0	$0	$2,951,841
BUDGET AUTHORITY	$58,153,064	$19,070,902	$8,168,978	$6,542,968	$91,935,912
REIMBURSEMENTS	$124,257	$0	$47,610	$18,420	$190,287
UNOBLIGATED BALANCE (SOY)					
No-Year (Other)	$1,218,065	$9,075	$0	$12,985	$1,240,125
Pre P.L. 116-260 Title XVI section 1601 1/	$0	($5,007,990)	$0	$0	($5,007,990)
Post P.L. 116-260 Title XVI section 1601 2/	$0	$5,007,990	$0	$0	$5,007,990
P.L. 115-141 sec 255 (NRM)	$0	$0	$0	$299,657	$299,657
P.L. 115-244 sec 248 (NRM)	$0	$0	$0	$512,199	$512,199
P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$7	$0	$111	$5	$123
2-Year	$853,821	$173,389	$98,481	$137,079	$1,262,770
2-Year (P.L. 116-136)	$10,388,429	$131,132	$172,544	$293,204	$10,985,309
3-Year (P.L. 116-127)	$0	$30,000	$0	$0	$30,000
4-Year Base Year 2017	$0	$0	$0	$0	$0
4-Year Base Year 2018	$0	$7,699	$0	$46,071	$53,770
4-Year Base Year 2019	$0	$73,988	$0	$0	$73,988
Unobligated Balance (SOY) [Subtotal]	$12,460,322	$425,283	$271,136	$1,301,200	$14,457,941
Transfer of UNOBLIGATED BALANCE					
CARES Unob. Bal. to MCC (0140) (PL 116-136 §20001)	($3,400,000)	$3,400,000	$0	$0	$0
CARES Unob. Bal. to MSC (0152) (PL 116-136 §20001)	($75,000)	$0	$75,000	$0	$0
CARES Unob. Bal. to MF (0162) (PL 116-136 §20001)	($100,000)	$0	$0	$100,000	$0
UNOBLIGATED BALANCE (EOY)					
No-Year (Other)	($1,323,000)	$0	$0	$0	($1,323,000)
P.L. 115-141 sec 255 (NRM)	$0	$0	$0	$0	$0
P.L. 115-244 sec 248 (NRM)	$0	$0	$0	($61,302)	($61,302)
P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$0	$0	$0	$0	$0
2-Year	($1,500,000)	$0	($100,000)	($200,000)	($1,800,000)
4-Year Base Year 2017	$0	$0	$0	$0	$0
4-Year Base Year 2018	$0	$0	$0	$0	$0
4-Year Base Year 2019	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($2,823,000)	$0	($100,000)	($261,302)	($3,184,302)
OBLIGATIONS [Total] NON-801/802	$64,339,643	$22,896,185	$8,462,724	$7,701,286	$103,399,838
FTE NON-801	269,090	0	57,190	26,147	352,427

1/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. 2/ Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to healthcare providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.

2021 Current Estimate Dollars in Thousands ($000)	Mandatory											
	Medical Care Purposes								Other Purposes			
	Veterans Medical Care and Health Fund											
Description	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Services	Medical Community Care	Copay Refunds	Medical Care Total	8002 Research	Grants for Construction of State Extended Care Facilites	Title 38 COVID Leave 0131	VHA ARP Sections Grand Total
Funds Made Available by												
ARP section 8002	$9,020,443	$978,433	$2,572,928	$1,901,196	$0	$0	$0	$14,473,000	$9,000	$0	$0	$14,482,000
ARP section 8004	$0	$0	$0	$0	$0	$250,000	$0	$250,000	$0	$500,000	$0	$750,000
ARP section 8007	$0	$0	$0	$0	$627,900	$72,100	$300,000	$1,000,000	$0	$0	$0	$1,000,000
ARP section 8008	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$80,000	$80,000
Funds Available [Subtotal]	$9,020,443	$978,433	$2,572,928	$1,901,196	$627,900	$322,100	$300,000	$15,723,000	$9,000	$500,000	$80,000	$16,312,000
UNOBLIGATED BALANCE (EOY)												
ARP section 8002 - 3 year	($9,020,443)	($978,433)	($2,572,928)	($1,901,196)	$0	$0	$0	($14,473,000)	$0	$0	$0	($14,473,000)
ARP section 8004 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP section 8004 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP section 8007 - no year	$0	$0	$0	$0	($627,900)	($72,100)	$0	($700,000)	$0	$0	$0	($700,000)
ARP section 8008 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($9,020,443)	($978,433)	($2,572,928)	($1,901,196)	($627,900)	($72,100)	$0	($15,173,000)	$0	$0	$0	($15,173,000)
OBLIGATIONS	$0	$0	$0	$0	$0	$250,000	$300,000	$550,000	$9,000	$500,000	$80,000	$1,139,000
FTE ARP	0	0	0	0	0	0	0	0	34	0	0	34

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 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

2021 Current Estimate
Dollars in Thousands ($000)

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

Description	Mandatory								Section 801 Grand Total
	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	
UNOBLIGATED BALANCE (SOY)									
No-Year	$25,089	$13,134	$30,437	$68,660	$0	$0	$0	$0	$68,660
UNOBLIGATED BALANCE (EOY)									
No-Year	($22,813)	($11,736)	($24,753)	($59,302)	$0	$0	$0	$0	($59,302)
OBLIGATIONS [Total]	$2,276	$1,398	$5,684	$9,358	$0	$0	$0	$0	$9,358
FTE	6	11	0	17	0	0	0	0	17

2021 Current Estimate
Dollars in Thousands ($000)

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

Description	Mandatory					Medical Care Total (continued)	Mandatory Information Technology			Section 802 Grand Total
	Admin. 0172XA	Medical Care 0172XB	Emerg. Hepatitis C 0172XC	Emerg. Com. Care 0172XE	Med. Com Care (Mission 0172XG		Dev. 0172XD	Sustain. 0172XO	Pay & Adm 0172XZ	
APPROPRIATION										
Appropriation	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Appropriation [Subtotal]	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
BUDGET AUTHORITY	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (SOY)										
Pre P.L. 116-260 Title XVI section 1601 1/	$0	($397,400)	$0	$0	$0	($397,400)	$0	$0	$0	($397,400)
Post P.L. 116-260 Title XVI section 1601 2/	$0	$397,400	$0	$0	$0	$397,400	$0	$0	$0	$397,400
No-Year	$39,231	$89,675	$0	$5,389	$15,395	$149,690	$0	$0	$0	$149,690
Unobligated Balance (SOY) [Subtotal]	$39,231	$89,675	$0	$5,389	$15,395	$149,690	$0	$0	$0	$149,690
UNOBLIGATED BALANCE (EOY)										
No-Year	($2,900)	($27,000)	$0	($100)	$0	($30,000)	$0	$0	$0	($30,000)
Unobligated Balance (EOY) [Subtotal]	($2,900)	($27,000)	$0	($100)	$0	($30,000)	$0	$0	$0	($30,000)
OBLIGATIONS [Total]	$36,331	$62,675	$0	$5,289	$15,395	$119,690	$0	$0	$0	$119,690
FTE [Total]	0	0	0	0	0	0	0	0	0	0

Medical Care Obligations Regular	**$103,399,838**
Medical Care Obls., ARP	**$550,000**
Medical Care Obls., VACAA, Section 801	**$9,358**
Medical Care Obls., VACAA, Section 802	**$119,690**
Medical Care Obligations [Grand Total]	**$104,078,886**
Medical Care FTE, Regular	**352,427**
Medical Care FTE, ARP	**0**
Medical Care FTE, VACAA, Section 801	**17**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**352,444**

1/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and adjusted obligations upwards by $397 million in the Veterans Choice Fund account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion.
2/ Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to healthcare providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.

2022 Revised Request
Dollars in Thousands ($000)

Description	Discretionary				
	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
Appropriation [Subtotal]	$58,897,219	$23,417,244	$8,403,117	$6,734,680	$97,452,260
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($203,805)	($43,768)	($30,613)	($92,830)	($371,016)
Transfers To [Subtotal]	($218,805)	($43,768)	($30,613)	($92,830)	($386,016)
TRANSFERS FROM (+)					
Transfers From [Subtotal]	$0	$0	$0	$0	$0
COLLECTIONS	$3,445,122	$623,228	$0	$0	$4,068,350
BUDGET AUTHORITY	$62,123,536	$23,996,704	$8,372,504	$6,641,850	$101,134,594
REIMBURSEMENTS	$124,257	$0	$47,610	$18,420	$190,287
UNOBLIGATED BALANCE (SOY)					
No-Year (Other)	$1,323,000	$0	$0	$0	$1,323,000
P.L. 115-141 sec 255 (NRM)	$0	$0	$0	$0	$0
P.L. 115-244 sec 248 (NRM)	$0	$0	$0	$61,302	$61,302
P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$0	$0	$0	$0	$0
2-Year	$1,500,000	$0	$100,000	$200,000	$1,800,000
4-Year Base Year 2017	$0	$0	$0	$0	$0
4-Year Base Year 2018	$0	$0	$0	$0	$0
4-Year Base Year 2019	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$2,823,000	$0	$100,000	$261,302	$3,184,302
UNOBLIGATED BALANCE (EOY)					
No-Year (Other)	$0	$0	$0	$0	$0
P.L. 115-141 sec 255 (NRM)	$0	$0	$0	$0	$0
P.L. 115-244 sec 248 (NRM)	$0	$0	$0	$0	$0
P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0
4-Year Base Year 2017	$0	$0	$0	$0	$0
4-Year Base Year 2018	$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	$65,070,793	$23,996,704	$8,520,114	$6,921,572	$104,509,183
FTE NON-801	256,891	0	57,725	26,654	341,270

2022 Revised Request
Dollars in Thousands ($000)

Description	Mandatory											
	Medical Care Purposes								Other Purposes			
	Veterans Medical Care and Health Fund											
	Medical Services	Medical Support & Compliance	Medical Facilities	Community Care	Medical Services	Medical Community Care	Copay Refunds	Medical Care Total	Research	Grants for Construction of State Extended Care Facilites	Title 38 COVID Leave 0131	VHA ARP Sections Grand Total
UNOBLIGATED BALANCE (SOY)												
ARP section 8002	$9,020,443	$978,433	$2,572,928	$1,901,196	$0	$0	$0	$14,473,000	$0	$0	$0	$14,473,000
ARP section 8004 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP section 8004 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP section 8007	$0	$0	$0	$0	$627,900	$72,100	$0	$700,000	$0	$0	$0	$700,000
ARP section 8008	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$9,020,443	$978,433	$2,572,928	$1,901,196	$627,900	$72,100	$0	$15,173,000	$0	$0	$0	$15,173,000
UNOBLIGATED BALANCE (EOY)												
ARP section 8002 - 3 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP section 8004 - 2 year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP section 8004 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP section 8007 - no year	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ARP section 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	$9,020,443	$978,433	$2,572,928	$1,901,196	$627,900	$72,100	$0	$15,173,000	$0	$0	$0	$15,173,000
FTE ARP	27,900	500	0	0	0	0	0	28,400	0	0	0	28,400

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 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

2022 Revised Request
Dollars in Thousands ($000)

Description	American Families Plan Mandatory Medical Services
APPROPRIATION	
Appropriation Request	$260,000
Appropriation [Subtotal]	**$260,000**
UNOBLIGATED BALANCE (EOY)	
No year	($230,000)
Unobligated Balance (EOY) [Subtotal]	**($230,000)**
OBLIGATIONS	$30,000
FTE AFP	160

2022 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	$22,813	$11,736	$24,753	$59,302	$0	$0	$0	$0	$59,302
UNOBLIGATED BALANCE (EOY)									
No-Year	($20,448)	($10,283)	($18,847)	($49,578)	$0	$0	$0	$0	($49,578)
OBLIGATIONS [Total]	$2,365	$1,453	$5,906	$9,724	$0	$0	$0	$0	$9,724
FTE	6	11	0	17	0	0	0	0	17

2022 Revised Request
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 (Missio 0172XG	Total (continued)	Dev. 0172XD	Sustain. 0172XO	Pay & Adm 0172XZ	Grand Total
UNOBLIGATED BALANCE (SOY)										
No-Year	$2,900	$27,000	$0	$100	$0	$30,000	$0	$0	$0	$30,000
Unobligated Balance (SOY) [Subtotal]	$2,900	$27,000	$0	$100	$0	$30,000	$0	$0	$0	$30,000
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]	$2,900	$27,000	$0	$100	$0	$30,000	$0	$0	$0	$30,000
FTE [Total]	0	0	0	0	0	0	0	0	0	0

Medical Care Obligations Regular	**$104,509,183**
Medical Care Obls., ARP	**$15,173,000**
Medical Care Obls., AFP	**$30,000**
Medical Care Obls., VACAA, Section 801	**$9,724**
Medical Care Obls., VACAA, Section 802	**$30,000**
Medical Care Obligations [Grand Total]	**$119,751,907**
Medical Care FTE, Regular	**341,270**
Medical Care FTE, ARP	**28,400**
Medical Care FTE, AFP	**160**
Medical Care FTE, VACAA, Section 801	**17**
Medical Care FTE, VACAA, Section 802	**0**
Medical Care FTE [Grand Total]	**369,847**

2023 Revised Request
Dollars in Thousands ($000)

Description	Discretionary				
	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
Appropriation [Subtotal]	$70,323,116	$24,156,659	$9,673,409	$7,133,816	$111,287,000
TRANSFERS TO (-)					
VA/DoD JIF (0165)	($15,000)	$0	$0	$0	($15,000)
JALFHCC (0169)	($206,504)	($44,348)	($31,019)	($41,371)	($323,242)
Transfers To [Subtotal]	($221,504)	($44,348)	($31,019)	($41,371)	($338,242)
TRANSFERS FROM (+)					
Transfers From [Subtotal]	$0	$0	$0	$0	$0
COLLECTIONS	$3,447,550	$700,689	$0	$0	$4,148,239
BUDGET AUTHORITY	$73,549,162	$24,813,000	$9,642,390	$7,092,445	$115,096,997
REIMBURSEMENTS	$124,257	$0	$47,610	$18,420	$190,287
UNOBLIGATED BALANCE (SOY)					
No-Year (Other)	$0	$0	$0	$0	$0
P.L. 115-141 sec 255 (NRM)	$0	$0	$0	$0	$0
P.L. 115-244 sec 248 (NRM)	$0	$0	$0	$0	$0
P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$0	$0	$0	$0	$0
ARP Section 8007	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0
ARP Section 8002	$0	$0	$0	$0	$0
4-Year Base Year 2017	$0	$0	$0	$0	$0
4-Year Base Year 2018	$0	$0	$0	$0	$0
4-Year Base Year 2019	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$0	$0	$0	$0	$0
UNOBLIGATED BALANCE (EOY)					
No-Year (Other)	$0	$0	$0	$0	$0
P.L. 115-141 sec 255 (NRM)	$0	$0	$0	$0	$0
P.L. 115-244 sec 248 (NRM)	$0	$0	$0	$0	$0
P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$0	$0	$0	$0	$0
2-Year	$0	$0	$0	$0	$0
4-Year Base Year 2017	$0	$0	$0	$0	$0
4-Year Base Year 2018	$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	$73,673,419	$24,813,000	$9,690,000	$7,110,865	$115,287,284
FTE NON-801	284,791	0	58,225	26,654	369,670

2023 Advance Appropriation
Dollars in Thousands ($000)

Description	American Families Plan Mandatory Medical Services
UNOBLIGATED BALANCE (EOY)	
ARP section 8002 - 3 year	$230,000
Unobligated Balance (EOY) [Subtotal]	$230,000
UNOBLIGATED BALANCE (EOY)	
ARP section 8002 - 3 year	($200,000)
Unobligated Balance (EOY) [Subtotal]	($200,000)
OBLIGATIONS	$30,000
FTE AFP	160

2023 Advance Appropriation
Dollars in Thousands ($000)

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

Description	Mandatory								
	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
UNOBLIGATED BALANCE (SOY)									
No-Year	$20,448	$10,283	$18,847	$49,578	$0	$0	$0	$0	$49,578
UNOBLIGATED BALANCE (EOY)									
No-Year	($18,277)	($8,774)	($12,711)	($39,762)	$0	$0	$0	$0	($39,762)
OBLIGATIONS [Total]	$2,171	$1,509	$6,136	$9,816	$0	$0	$0	$0	$9,816
FTE	6	11	0	17	0	0	0	0	17

Medical Care Obligations Regular	**$115,287,284**
Medical Care Obls., AFP	**$30,000**
Medical Care Obls., VACAA, Section 801	**$9,816**
Medical Care Obligations [Grand Total]	**$115,327,100**
Medical Care FTE, Regular	**369,670**
Medical Care FTE., AFP	**160**
Medical Care FTE., VACAA, Section 801	**17**
Medical Care FTE [Grand Total]	**369,847**

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 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. 2020 tables show actual obligations prior to the adjustments made pursuant to Public Law 116-260. The 2021 mandatory and grand total obligations include the projected $300 million in obligations to reimburse Veterans for copayments pursuant to section 8007 of the American Rescue Plan Act. The 2022 and 2023 mandatory and grand total obligations include obligations for the American Families Plan proposal to establish Family Coordinators and implement other family-friendly practices at VAMCs.

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. Final 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Obligations by Object - Medical Services (MS) - Discretionary

(dollars in thousands)

Description	Regular Appropriations (0160 excludes 801)				FAMILY FIRST & CARES ACT (0160 C3/C2)				Total Medical Services Discretionary			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
10 Personnel Compensation and Benefits:												
Physicians	$7,518,525	$7,540,329	$7,858,772	$8,907,415	$179,923	$560,820	$0	$0	$7,698,448	$8,101,149	$7,858,772	$8,907,415
Dentists	$319,449	$329,649	$338,959	$392,614	$6,621	$20,638	$0	$0	$326,070	$350,287	$338,959	$392,614
Registered Nurses	$8,797,431	$8,659,122	$9,151,306	$11,084,523	$381,486	$1,189,092	$0	$0	$9,178,917	$9,848,214	$9,151,306	$11,084,523
LP Nurse/LV Nurse/Nurse Assistant	$2,094,041	$2,110,009	$2,184,578	$2,740,385	$81,785	$254,924	$0	$0	$2,175,826	$2,364,933	$2,184,578	$2,740,385
Non-Physician Providers	$2,759,875	$2,934,505	$3,279,204	$3,583,973	$46,738	$145,682	$0	$0	$2,806,613	$3,080,187	$3,279,204	$3,583,973
Health Technicians/Allied Health	$8,387,977	$8,879,167	$9,799,097	$10,744,999	$141,950	$442,458	$0	$0	$8,529,927	$9,321,625	$9,799,097	$10,744,999
Wage Board/Purchase & Hire	$365,924	$367,419	$395,718	$422,245	$6,941	$21,635	$0	$0	$372,865	$389,054	$395,718	$422,245
All Other	$3,100,100	$3,098,702	$3,397,495	$3,802,680	$100,562	$313,452	$0	$0	$3,200,662	$3,412,154	$3,397,495	$3,802,680
Permanent Change of Station	$5,206	$5,284	$5,433	$5,543	$13	$41	$0	$0	$5,219	$5,325	$5,433	$5,543
Employee Compensation Pay	$222,456	$226,972	$231,580	$236,281	$0	$0	$0	$0	$222,456	$226,972	$231,580	$236,281
Subtotal	$33,570,985	$34,151,158	$36,642,142	$41,920,658	$946,019	$2,948,742	$0	$0	$34,517,004	$37,099,900	$36,642,142	$41,920,658
21 Travel & Transportation of Persons:												
Employee	$31,533	$35,200	$45,136	$45,000	$4,177	$4,624	$0	$0	$35,710	$39,824	$45,136	$45,000
Beneficiary	$876,915	$970,300	$1,009,100	$1,049,500	$1,906	$2,110	$0	$0	$878,821	$972,410	$1,009,100	$1,049,500
Other	$41,432	$46,300	$53,884	$53,800	$539	$597	$0	$0	$41,971	$46,897	$53,884	$53,800
Subtotal	$949,880	$1,051,800	$1,108,120	$1,148,300	$6,622	$7,331	$0	$0	$956,502	$1,059,131	$1,108,120	$1,148,300
22 Transportation of Things	$26,292	$29,400	$37,983	$37,900	$3,746	$4,147	$0	$0	$30,038	$33,547	$37,983	$37,900
23 Rent, Communications, and Utilities:												
Rental of Equipment	$189,631	$211,900	$255,736	$255,100	$10,714	$11,860	$0	$0	$200,345	$223,760	$255,736	$255,100
Communications	$368,811	$412,100	$476,786	$475,600	$2,258	$2,500	$0	$0	$371,069	$414,600	$476,786	$475,600
Utilities	$251	$0	$0	$0	$0	$0	$0	$0	$251	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$16,595	$0	$0	$0	$78	$86	$0	$0	$16,673	$86	$0	$0
Subtotal	$575,288	$624,000	$732,522	$730,700	$13,050	$14,446	$0	$0	$588,338	$638,446	$732,522	$730,700
24 Printing & Reproduction:	$13,592	$15,200	$17,638	$17,600	$130	$144	$0	$0	$13,722	$15,344	$17,638	$17,600
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$5,935	$6,600	$7,596	$7,600	$0	$0	$0	$0	$5,935	$6,600	$7,596	$7,600
Medical and Nursing Care in the Community	$278,010	$310,700	$363,400	$362,500	$5,253	$5,815	$0	$0	$283,263	$316,515	$363,400	$362,500
Repairs to Furniture/Equipment	$320,309	$357,900	$414,331	$413,300	$2,190	$2,424	$0	$0	$322,499	$360,324	$414,331	$413,300
Maintenance & Repair Contract Services	$42,393	$47,400	$54,897	$54,800	$311	$344	$0	$0	$42,704	$47,744	$54,897	$54,800
Care in the Community Hospital Care	-$6,937	$0	$0	$0	$0	$0	$0	$0	-$6,937	$0	$0	$0
Community Nursing Homes	$110	$0	$0	$0	$0	$0	$0	$0	$110	$0	$0	$0
Repairs to Prosthetic Appliances	$256,124	$321,795	$400,717	$389,636	$17,512	$19,386	$0	$0	$273,636	$341,181	$400,717	$389,636
Home Oxygen	$229,406	$288,226	$358,916	$348,990	$10	$0	$0	$0	$229,416	$288,226	$358,916	$348,990
Organ Procurement	$19,236	$21,500	$24,744	$24,700	$0	$0	$0	$0	$19,236	$21,500	$24,744	$24,700
Personal Services Contracts	$43,574	$48,700	$106,501	$106,200	$45,575	$50,452	$0	$0	$89,149	$99,152	$106,501	$106,200
House Staff Disbursing Agreement	$733,511	$819,700	$945,557	$943,300	$1,082	$2,164	$0	$0	$734,593	$821,864	$945,557	$943,300
Scarce Medical Specialists	$150,240	$167,900	$193,236	$192,800	$4,321	$0	$0	$0	$154,561	$167,900	$193,236	$192,800
Other Medical Contract Services	$1,353,429	$2,337,507	$4,221,235	$6,466,568	$85,822	$109,005	$0	$0	$1,439,251	$2,446,512	$4,221,235	$6,466,568
Administrative Contract Services	$811,991	$907,400	$1,159,728	$1,156,900	$104,247	$115,401	$0	$0	$916,238	$1,022,801	$1,159,728	$1,156,900
Training Contract Services	$65,980	$73,700	$84,842	$84,600	$19	$21	$0	$0	$65,999	$73,721	$84,842	$84,600
Caregiver Stipends	$353,253	$707,806	$1,022,919	$1,337,514	$0	$0	$0	$0	$353,253	$707,806	$1,022,919	$1,337,514
CHAMPVA	$0	$20,108	$23,040	$28,826	$0	$0	$0	$0	$0	$20,108	$23,040	$28,826
Subtotal	$4,656,564	$6,436,942	$9,381,659	$11,918,234	$266,342	$305,012	$0	$0	$4,922,906	$6,741,954	$9,381,659	$11,918,234

Obligations by Object - Medical Services (MS) - Discretionary

(dollars in thousands)

Description	Regular Appropriations (0160 excludes 801)				FAMILY FIRST & CARES ACT (0160 C3/C2)				Total Medical Services Discretionary			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:												
Provisions	$112,765	$126,000	$146,750	$146,400	$1,569	$1,737	$0	$0	$114,334	$127,737	$146,750	$146,400
Drugs & Medicines	$6,774,348	$7,388,680	$8,282,885	$8,765,516	$608,238	$673,319	$0	$0	$7,382,586	$8,061,999	$8,282,885	$8,765,516
Blood & Blood Products	$44,431	$50,941	$57,006	$60,343	$211	$234	$0	$0	$44,642	$51,175	$57,006	$60,343
Medical/Dental Supplies	$1,707,703	$1,908,400	$3,165,926	$3,158,300	$599,368	$969,548	$0	$0	$2,307,071	$2,877,948	$3,165,926	$3,158,300
Operating Supplies	$190,505	$212,900	$316,071	$315,300	$64,177	$71,044	$0	$0	$254,682	$283,944	$316,071	$315,300
Maintenance & Repair Supplies	$34,108	$0	$0	$0	$2,782	$3,080	$0	$0	$36,890	$3,080	$0	$0
Other Supplies	$174,350	$194,800	$426,977	$426,000	$183,182	$202,782	$0	$0	$357,532	$397,582	$426,977	$426,000
Prosthetic Appliances	$2,517,345	$3,162,796	$3,938,497	$3,829,580	$924	$1,023	$0	$0	$2,518,269	$3,163,819	$3,938,497	$3,829,580
Home Respiratory Therapy	$66,063	$83,002	$103,358	$100,500	$255	$282	$0	$0	$66,318	$83,284	$103,358	$100,500
Subtotal	$11,621,618	$13,127,519	$16,437,470	$16,801,939	$1,460,706	$1,923,049	$0	$0	$13,082,324	$15,050,568	$16,437,470	$16,801,939
31 Equipment	$1,355,115	$2,028,101	$0	$316,807	$588,488	$651,456	$0	$0	$1,943,603	$2,679,557	$0	$316,807
32 Lands & Structures:												
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$134	$0	$0	$0	$893	$989	$0	$0	$1,027	$989	$0	$0
Subtotal	$134	$0	$0	$0	$893	$989	$0	$0	$1,027	$989	$0	$0
41 Grants, Subsidies & Contributions:												
State Home	-$3	$0	$0	$0	$0	$0	$0	$0	-$3	$0	$0	$0
Grants	$659,385	$690,021	$705,186	$773,208	$637,575	$322,113	$0	$0	$1,296,960	$1,012,134	$705,186	$773,208
Veteran Adoption Reimbursement	$40	$40	$40	$40	$0	$0	$0	$0	$40	$40	$40	$40
Subtotal	$659,422	$690,061	$705,226	$773,248	$637,575	$322,113	$0	$0	$1,296,997	$1,012,174	$705,226	$773,248
42 - Insurance Claims and Indemnities	$8,033	$8,033	$8,033	$8,033	$0	$0	$0	$0	$8,033	$8,033	$8,033	$8,033
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$53,436,923	$58,162,214	$65,070,793	$73,673,419	$3,923,571	$6,177,429	$0	$0	$57,360,494	$64,339,643	$65,070,793	$73,673,419
Prior Year Recoveries	$94,328	$0	$0	$0	$0	$0	$0	$0	$94,328	$0	$0	$0
Obligations [Total]	**$53,531,251**	**$58,162,214**	**$65,070,793**	**$73,673,419**	**$3,923,571**	**$6,177,429**	**$0**	**$0**	**$57,454,822**	**$64,339,643**	**$65,070,793**	**$73,673,419**

Obligations by Object - Medical Services (MS) - Mandatory

(dollars in thousands)

Description	VACAA Section 801				American Rescue Plan Act and American Families Plan				Total Medical Services Mandatory			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
10 Personnel Compensation and Benefits:												
Physicians	$1,059	$1,100	$1,143	$1,188	$0	$0	$743,434	$0	$1,059	$1,100	$744,577	$1,188
Dentists	$0	$0	$0	$0	$0	$0	$43,271	$0	$0	$0	$43,271	$0
Registered Nurses	$26	$27	$28	$29	$0	$0	$1,614,609	$0	$26	$27	$1,614,637	$29
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$0	$0	$434,664	$0	$0	$0	$434,664	$0
Non-Physician Providers	$21	$22	$23	$24	$0	$0	$190,896	$0	$21	$22	$190,919	$24
Health Technicians/Allied Health	$0	$0	$0	$0	$0	$0	$603,784	$0	$0	$0	$603,784	$0
Wage Board/Purchase & Hire	$0	$0	$0	$0	$0	$0	$15,648	$0	$0	$0	$15,648	$0
All Other	$380	$395	$410	$426	$0	$0	$304,294	$0	$380	$395	$304,704	$426
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	$1,486	$1,544	$1,604	$1,667	$0	$0	$3,950,600	$0	$1,486	$1,544	$3,952,204	$1,667
21 Travel & Transportation of Persons:												
Employee	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$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
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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$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	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
House Staff Disbursing Agreement	-$1,229	$0	$0	$0	$0	$0	$0	$0	-$1,229	$0	$0	$0
Scarce Medical Specialists	-$153	$0	$0	$0	$0	$0	$0	$0	-$153	$0	$0	$0
Other Medical Contract Services	-$123	$0	$0	$0	$0	$0	$2,443,769	$0	-$123	$0	$2,443,769	$0
Administrative Contract Services	-$325	$0	$0	$0	$0	$0	$0	$0	-$325	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	-$1,830	$0	$0	$0	$0	$0	$2,443,769	$0	-$1,830	$0	$2,443,769	$0

Obligations by Object - Medical Services (MS) - Mandatory

(dollars in thousands)

Description	VACAA Section 801				American Rescue Plan Act and American Families Plan				Total Medical Services Mandatory			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:												
Provisions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$3,269	$732	$761	$504	$0	$0	$0	$0	$3,269	$732	$761	$504
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$0	$0	$0	$0	$0	$0	$1,000,000	$0	$0	$0	$1,000,000	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prosthetic Appliances	$0	$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	$3,269	$732	$761	$504	$0	$0	$1,000,000	$0	$3,269	$732	$1,000,761	$504
31 Equipment	-$3,315	$0	$0	$0	$0	$0	$1,746,224	$0	-$3,315	$0	$1,746,224	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$0	$0	$0	$0	$0	$0	$537,750	$0	$0	$0	$537,750	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0	$0	$0	$537,750	$0	$0	$0	$537,750	$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	-$390	$2,276	$2,365	$2,171	$0	$0	$9,678,343	$0	-$390	$2,276	$9,680,708	$2,171
Prior Year Recoveries	$2,581	$0	$0	$0	$0	$0	$0	$0	$2,581	$0	$0	$0
Obligations [Total]	**$2,191**	**$2,276**	**$2,365**	**$2,171**	**$0**	**$0**	**$9,678,343**	**$0**	**$2,191**	**$2,276**	**$9,680,708**	**$2,171**

Obligations by Object - Medical Support & Compliance (MSC) - Discretionary

(dollars in thousands)

Description	Regular Appropriations (0152 excludes 801)				CARES ACT (0152C2)				Total Medical Support & Compliance Discretionary			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
10 Personnel Compensation and Benefits:												
Physicians	$249,552	$296,899	$332,613	$335,327	$1,190	$2,428	$0	$0	$250,742	$299,327	$332,613	$335,327
Dentists	$4,619	$4,765	$4,951	$5,127	$0	$0	$0	$0	$4,619	$4,765	$4,951	$5,127
Registered Nurses	$498,574	$524,478	$560,352	$575,976	$3,236	$6,602	$0	$0	$501,810	$531,080	$560,352	$575,976
LP Nurse/LV Nurse/Nurse Assistant	$4,991	$5,184	$5,558	$6,045	$9	$18	$0	$0	$5,000	$5,202	$5,558	$6,045
Non-Physician Providers	$47,187	$49,602	$52,766	$54,603	$166	$338	$0	$0	$47,353	$49,940	$52,766	$54,603
Health Technicians/Allied Health	$134,802	$147,064	$158,658	$163,504	$192	$392	$0	$0	$134,994	$147,456	$158,658	$163,504
Wage Board/Purchase & Hire	$83,238	$94,796	$104,835	$107,640	$275	$562	$0	$0	$83,513	$95,358	$104,835	$107,640
All Other	$4,757,533	$4,982,702	$5,207,832	$5,407,364	$12,683	$25,874	$0	$0	$4,770,216	$5,008,576	$5,207,832	$5,407,364
Permanent Change of Station	$6,801	$6,939	$7,080	$7,224	$0	$0	$0	$0	$6,801	$6,939	$7,080	$7,224
Employee Compensation Pay	$39,585	$40,389	$41,209	$42,046	$0	$0	$0	$0	$39,585	$40,389	$41,209	$42,046
Subtotal	$5,826,882	$6,152,818	$6,475,854	$6,704,856	$17,751	$36,214	$0	$0	$5,844,633	$6,189,032	$6,475,854	$6,704,856
21 Travel & Transportation of Persons:												
Employee	$28,340	$31,670	$36,449	$36,400	$623	$647	$0	$0	$28,963	$32,317	$36,449	$36,400
Beneficiary	$20	$0	$0	$0	$0	$0	$0	$0	$20	$0	$0	$0
Other	$5,154	$5,760	$6,629	$6,600	$0	$0	$0	$0	$5,154	$5,760	$6,629	$6,600
Subtotal	$33,514	$37,430	$43,078	$43,000	$623	$647	$0	$0	$34,137	$38,077	$43,078	$43,000
22 Transportation of Things	$13,592	$15,189	$17,481	$17,400	$77	$80	$0	$0	$13,669	$15,269	$17,481	$17,400
23 Rent, Communications, and Utilities:												
Rental of Equipment	$41,925	$46,851	$53,921	$53,800	$87	$90	$0	$0	$42,012	$46,941	$53,921	$53,800
Communications	$63,889	$71,396	$85,170	$85,000	$274	$285	$0	$0	$64,163	$71,681	$85,170	$85,000
Utilities	-$6	$0	$0	$0	$0	$0	$0	$0	-$6	$0	$0	$0
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$4,626	$0	$0	$0	$9	$9	$0	$0	$4,635	$9	$0	$0
Subtotal	$110,434	$118,247	$139,091	$138,800	$370	$384	$0	$0	$110,804	$118,631	$139,091	$138,800
24 Printing & Reproduction:	$16,310	$18,226	$19,976	$19,900	$13	$14	$0	$0	$16,323	$18,240	$19,976	$19,900
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$2,643	$0	$0	$0	$0	$0	$0	$0	$2,643	$0	$0	$0
Repairs to Furniture/Equipment	$5,923	$6,619	$7,618	$7,600	$0	$0	$0	$0	$5,923	$6,619	$7,618	$7,600
Maintenance & Repair Contract Services	$1,279	$0	$0	$0	$0	$0	$0	$0	$1,279	$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	$465	$483	$0	$0	$465	$483	$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	$7,136	$7,974	$9,177	$9,200	$167	$174	$0	$0	$7,303	$8,148	$9,177	$9,200
House Staff Disbursing Agreement	$134	$0	$0	$0	$0	$0	$0	$0	$134	$0	$0	$0
Scarce Medical Specialists	$47	$0	$0	$0	$0	$0	$0	$0	$47	$0	$0	$0
Other Medical Contract Services	$16,170	$18,070	$20,797	$20,700	$0	$0	$0	$0	$16,170	$18,070	$20,797	$20,700
Administrative Contract Services	$1,387,455	$1,593,059	$1,502,139	$2,476,100	$54,870	$206,307	$0	$0	$1,442,325	$1,799,366	$1,502,139	$2,476,100
Training Contract Services	$62,738	$70,110	$80,690	$48,702	$1	$1	$0	$0	$62,739	$70,111	$80,690	$48,702
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	$1,483,525	$1,695,832	$1,620,421	$2,562,302	$55,503	$206,965	$0	$0	$1,539,028	$1,902,797	$1,620,421	$2,562,302

Obligations by Object - Medical Support & Compliance (MSC)

(dollars in thousands)

Description	Regular Appropriations (0152 excludes 801)				CARES ACT (0152C2)				Total Medical Support & Compliance Discretionary			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:												
Provisions	$2,777	$0	$0	$0	$0	$0	$0	$0	$2,777	$0	$0	$0
Drugs & Medicines	-$8	$0	$0	$0	$0	$0	$0	$0	-$8	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$1,058	$0	$0	$0	$64	$66	$0	$0	$1,122	$66	$0	$0
Operating Supplies	$37,983	$42,446	$48,851	$48,700	$1,493	$1,551	$0	$0	$39,476	$43,997	$48,851	$48,700
Maintenance & Repair Supplies	$380	$0	$0	$0	$37	$38	$0	$0	$417	$38	$0	$0
Other Supplies	$57,842	$71,638	$82,448	$82,300	$968	$1,006	$0	$0	$58,810	$72,644	$82,448	$82,300
Prosthetic Appliances	$4	$0	$0	$0	$0	$0	$0	$0	$4	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$100,036	$114,084	$131,299	$131,000	$2,562	$2,661	$0	$0	$102,598	$116,745	$131,299	$131,000
31 Equipment	$38,457	$42,976	$49,461	$49,342	$557	$579	$0	$0	$39,014	$43,555	$49,461	$49,342
32 Lands & Structures:												
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
All Other Lands & Structures	$15	$0	$0	$0	$0	$0	$0	$0	$15	$0	$0	$0
Subtotal	$15	$0	$0	$0	$0	$0	$0	$0	$15	$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	$0	$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	$0	$0	$0	$0
42 Insurance Claims and Indemnities	$20,378	$20,378	$23,453	$23,400	$0	$0	$0	$0	$20,378	$20,378	$23,453	$23,400
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$7,643,143	$8,215,180	$8,520,114	$9,690,000	$77,456	$247,544	$0	$0	$7,720,599	$8,462,724	$8,520,114	$9,690,000
Prior Year Recoveries	$167	$0	$0	$0	$0	$0	$0	$0	$167	$0	$0	$0
Obligations [Total]	**$7,643,310**	**$8,215,180**	**$8,520,114**	**$9,690,000**	**$77,456**	**$247,544**	**$0**	**$0**	**$7,720,766**	**$8,462,724**	**$8,520,114**	**$9,690,000**

Obligations by Object - Medical Support & Compliance (MSC) - Mandatory

(dollars in thousands)

Description	VACAA Section 801				American Rescue Plan (ARP)				Total Medical Support & Compliance Mandatory			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
10 Personnel Compensation and Benefits:												
Physicians	$254	$264	$274	$285	$0	$0	$0	$0	$254	$264	$274	$285
Dentists	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$121	$126	$131	$136	$0	$0	$0	$0	$121	$126	$131	$136
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Non-Physician Providers	$138	$143	$149	$155	$0	$0	$0	$0	$138	$143	$149	$155
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	$751	$780	$810	$842	$0	$0	$51,528	$0	$751	$780	$52,338	$842
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	$1,264	$1,313	$1,364	$1,418	$0	$0	$51,528	$0	$1,264	$1,313	$52,892	$1,418
21 Travel & Transportation of Persons:												
Employee	$2	$0	$0	$0	$0	$0	$0	$0	$2	$0	$0	$0
Beneficiary	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$2	$0	$0	$0	$0	$0	$0	$0	$2	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$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	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Administrative Contract Services	$75	$85	$89	$91	$0	$0	$926,905	$0	$75	$85	$926,994	$91
Training Contract Services	$1	$0	$0	$0	$0	$0	$0	$0	$1	$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	$76	$85	$89	$91	$0	$0	$926,905	$0	$76	$85	$926,994	$91

Obligations by Object - Medical Support & Compliance (MSC)

(dollars in thousands)

Description	VACAA Section 801				American Rescue Plan (ARP)				Total Medical Support & Compliance Mandatory			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:												
Provisions	$0	$0	$0	$0	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Operating Supplies	$1	$0	$0	$0	$0	$0	$0	$0	$1	$0	$0	$0
Maintenance & Repair Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$3	$0	$0	$0	$0	$0	$0	$0	$3	$0	$0	$0
Prosthetic Appliances	$0	$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	$4	$0	$0	$0	$0	$0	$0	$0	$4	$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	$0	$0	$0	$0	$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	$0	$0	$0	$0	$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	$1,346	$1,398	$1,453	$1,509	$0	$0	$978,433	$0	$1,346	$1,398	$979,886	$1,509
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$1,346**	**$1,398**	**$1,453**	**$1,509**	**$0**	**$0**	**$978,433**	**$0**	**$1,346**	**$1,398**	**$979,886**	**$1,509**

Obligations by Object - Medical Facilities (MF) - Discretionary

(dollars in thousands)

Description	Regular Appropriations (0162 excludes 801)				CARES ACT (0162C2)				Total Medical Facilities Discretionary			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
10 Personnel Compensation and Benefits:												
Physicians	-$214	$0	$0	$0	$168	$0	$0	$0	-$46	$0	$0	$0
Dentists	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Registered Nurses	$240	$0	$0	$0	$77	$0	$0	$0	$317	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$87	$0	$0	$0	$12	$0	$0	$0	$99	$0	$0	$0
Non-Physician Providers	$178	$0	$0	$0	$75	$0	$0	$0	$253	$0	$0	$0
Health Technicians/Allied Health	$11,284	$11,312	$12,602	$13,181	$342	$698	$0	$0	$11,626	$12,010	$12,602	$13,181
Wage Board/Purchase & Hire	$1,474,020	$1,493,678	$1,629,092	$1,668,575	$32,056	$66,072	$0	$0	$1,506,076	$1,559,750	$1,629,092	$1,668,575
All Other	$483,237	$502,013	$572,063	$585,250	$14,321	$29,214	$0	$0	$497,558	$531,227	$572,063	$585,250
Permanent Change of Station	$426	$435	$444	$453	$0	$0	$0	$0	$426	$435	$444	$453
Employee Compensation Pay	$39,994	$40,806	$41,634	$42,479	$0	$0	$0	$0	$39,994	$40,806	$41,634	$42,479
Subtotal	$2,009,252	$2,048,244	$2,255,835	$2,309,938	$47,051	$95,984	$0	$0	$2,056,303	$2,144,228	$2,255,835	$2,309,938
21 Travel & Transportation of Persons:												
Employee	$2,489	$2,489	$2,865	$3,000	$29	$30	$0	$0	$2,518	$2,519	$2,865	$3,000
Beneficiary	$8	$0	$0	$0	$0	$0	$0	$0	$8	$0	$0	$0
Other	$44,499	$44,499	$51,214	$53,200	$0	$0	$0	$0	$44,499	$44,499	$51,214	$53,200
Subtotal	$46,996	$46,988	$54,079	$56,200	$29	$30	$0	$0	$47,025	$47,018	$54,079	$56,200
22 Transportation of Things	$14,458	$16,157	$18,595	$19,300	$94	$98	$0	$0	$14,552	$16,255	$18,595	$19,300
23 Rent, Communications, and Utilities:												
Rental of Equipment	$10,196	$10,196	$11,735	$12,200	$2,307	$2,397	$0	$0	$12,503	$12,593	$11,735	$12,200
Communications	$36,191	$36,191	$41,652	$43,300	$0	$0	$0	$0	$36,191	$36,191	$41,652	$43,300
Utilities	$546,299	$546,299	$628,736	$653,300	$103	$107	$0	$0	$546,402	$546,406	$628,736	$653,300
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$751,476	$707,169	$898,727	$691,604	$1,170	$1,216	$0	$0	$752,646	$708,385	$898,727	$691,604
Subtotal	$1,344,162	$1,299,855	$1,580,850	$1,400,404	$3,580	$3,720	$0	$0	$1,347,742	$1,303,575	$1,580,850	$1,400,404
24 Printing & Reproduction:	$127	$142	$163	$169	$37	$38	$0	$0	$164	$180	$163	$169
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	-$324	$0	$0	$0	$0	$0	$0	$0	-$324	$0	$0	$0
Medical and Nursing Care in the Community	-$443	$0	$0	$0	$511	$531	$0	$0	$68	$531	$0	$0
Repairs to Furniture/Equipment	$24,416	$24,416	$28,100	$29,200	$846	$879	$0	$0	$25,262	$25,295	$28,100	$29,200
Maintenance & Repair Contract Services	$255,975	$255,975	$294,602	$306,100	$6,085	$6,322	$0	$0	$262,060	$262,297	$294,602	$306,100
Care in the Community Hospital Care	$0	$0	$0	$0	$17	$18	$0	$0	$17	$18	$0	$0
Community Nursing Homes	$0	$0	$0	$0	$1,011	$1,050	$0	$0	$1,011	$1,050	$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	$1,744	$1,744	$2,007	$2,100	$0	$0	$0	$0	$1,744	$1,744	$2,007	$2,100
House Staff Disbursing Agreement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$114	$0	$0	$0	$0	$0	$0	$0	$114	$0	$0	$0
Other Medical Contract Services	$13,975	$0	$0	$0	$2,920	$3,034	$0	$0	$16,895	$3,034	$0	$0
Administrative Contract Services	$503,633	$557,425	$1,059,039	$1,156,880	$84,104	$108,496	$0	$0	$587,737	$665,921	$1,059,039	$1,156,880
Training Contract Services	$1,355	$1,355	$1,559	$1,600	$5	$5	$0	$0	$1,360	$1,360	$1,559	$1,600
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	$800,445	$840,915	$1,385,307	$1,495,880	$95,499	$120,335	$0	$0	$895,944	$961,250	$1,385,307	$1,495,880

Obligations by Object - Medical Facilities (MF) - Discretionary

(dollars in thousands)

Description	Regular Appropriations (0162 excludes 801)				CARES ACT (0162C2)				Total Medical Facilities Discretionary			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:												
Provisions	$36	$0	$0	$0	$12	$12	$0	$0	$48	$12	$0	$0
Drugs & Medicines	$319	$0	$0	$0	$45	$47	$0	$0	$364	$47	$0	$0
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$2,579	$0	$0	$0	$2,193	$2,279	$0	$0	$4,772	$2,279	$0	$0
Operating Supplies	$135,803	$135,803	$156,296	$162,400	$29,379	$30,525	$0	$0	$165,182	$166,328	$156,296	$162,400
Maintenance & Repair Supplies	$170,080	$170,080	$195,745	$203,400	$16,243	$16,876	$0	$0	$186,323	$186,956	$195,745	$203,400
Other Supplies	$49,146	$49,146	$56,562	$58,800	$7,293	$7,577	$0	$0	$56,439	$56,723	$56,562	$58,800
Prosthetic Appliances	$0	$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	$357,963	$355,029	$408,603	$424,600	$55,165	$57,316	$0	$0	$413,128	$412,345	$408,603	$424,600
31 Equipment	$104,238	$116,581	$134,173	$133,851	$38,336	$39,831	$0	$0	$142,574	$156,412	$134,173	$133,851
32 Lands & Structures:												
Non-Recurring Maintenance	$1,330,548	$2,097,127	$491,374	$700,000	$69,927	$72,654	$0	$0	$1,400,475	$2,169,781	$491,374	$700,000
All Other Lands & Structures	$480,613	$485,275	$590,557	$568,423	$3,078	$3,198	$0	$0	$483,691	$488,473	$590,557	$568,423
Subtotal	$1,811,161	$2,582,402	$1,081,931	$1,268,423	$73,005	$75,852	$0	$0	$1,884,166	$2,658,254	$1,081,931	$1,268,423
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	$0	$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	$0	$0	$0	$0
42 - Insurance Claims and Indemnities	$1,769	$1,769	$2,036	$2,100	$0	$0	$0	$0	$1,769	$1,769	$2,036	$2,100
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$6,490,571	$7,308,082	$6,921,572	$7,110,865	$312,796	$393,204	$0	$0	$6,803,367	$7,701,286	$6,921,572	$7,110,865
Prior Year Recoveries	$8,723	$0	$0	$0	$0	$0	$0	$0	$8,723	$0	$0	$0
Obligations [Total]	**$6,499,294**	**$7,308,082**	**$6,921,572**	**$7,110,865**	**$312,796**	**$393,204**	**$0**	**$0**	**$6,812,090**	**$7,701,286**	**$6,921,572**	**$7,110,865**

Obligations by Object - Medical Facilities (MF) - Mandatory

(dollars in thousands)

Description	VACAA Section 801				American Rescue Plan (ARP)				Total Medical Facilities Mandatory			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
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	$22	$23	$24	$25	$0	$0	$0	$0	$22	$23	$24	$25
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	$22	$23	$24	$25	$0	$0	$0	$0	$22	$23	$24	$25
21 Travel & Transportation of Persons:												
Employee	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Beneficiary	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other	$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
22 Transportation of Things	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
23 Rent, Communications, and Utilities:												
Rental of Equipment	$3	$0	$0	$0	$0	$0	$0	$0	$3	$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	$257	$5,661	$5,882	$6,111	$0	$0	$800,406	$0	$257	$5,661	$806,288	$6,111
Subtotal	$260	$5,661	$5,882	$6,111	$0	$0	$800,406	$0	$260	$5,661	$806,288	$6,111
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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical and Nursing Care in the Community	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Repairs to Furniture/Equipment	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Maintenance & Repair Contract Services	-$2	$0	$0	$0	$0	$0	$0	$0	-$2	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Administrative Contract Services	$17	$0	$0	$0	$0	$0	$0	$0	$17	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$15	$0	$0	$0	$0	$0	$0	$0	$15	$0	$0	$0

Obligations by Object - Medical Facilities (MF) - Mandatory

(dollars in thousands)

Description	VACAA Section 801				American Rescue Plan (ARP)				Total Medical Facilities Mandatory			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:												
Provisions	$0	$0	$0	$0	$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	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Operating Supplies	$53	$0	$0	$0	$0	$0	$0	$0	$53	$0	$0	$0
Maintenance & Repair Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Supplies	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Prosthetic Appliances	$0	$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	$53	$0	$0	$0	$0	$0	$0	$0	$53	$0	$0	$0
31 Equipment	$84	$0	$0	$0	$0	$0	$0	$0	$84	$0	$0	$0
32 Lands & Structures:												
Non-Recurring Maintenance	-$4,990	$0	$0	$0	$0	$0	$1,772,522	$0	-$4,990	$0	$1,772,522	$0
All Other Lands & Structures	-$281	$0	$0	$0	$0	$0	$0	$0	-$281	$0	$0	$0
Subtotal	-$5,271	$0	$0	$0	$0	$0	$1,772,522	$0	-$5,271	$0	$1,772,522	$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	$0	$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	$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	-$4,837	$5,684	$5,906	$6,136	$0	$0	$2,572,928	$0	-$4,837	$5,684	$2,578,834	$6,136
Prior Year Recoveries	$10,308	$0	$0	$0	$0	$0	$0	$0	$10,308	$0	$0	$0
Obligations [Total]	**$5,471**	**$5,684**	**$5,906**	**$6,136**	**$0**	**$0**	**$2,572,928**	**$0**	**$5,471**	**$5,684**	**$2,578,834**	**$6,136**

Obligations by Object - Medical Community Care (MCC) - Discretionary

(dollars in thousands)

Description	Regular Appropriations (0140 excludes 801)				FAMILY FIRST & CARES ACT (0140C3/C2)				Total Medical Community Care Discretionary			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
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	-$6	$0	$0	$0	$0	$0	$0	$0	-$6	$0	$0	$0
Other	-$5	$0	$0	$0	$0	$0	$0	$0	-$5	$0	$0	$0
Subtotal	-$11	$0	$0	$0	$0	$0	$0	$0	-$11	$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:	$10	$0	$0	$0	$0	$0	$0	$0	$10	$0	$0	$0
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$282,960	$201,419	$378,057	$366,594	$20	$0	$0	$0	$282,980	$201,419	$378,057	$366,594
Medical and Nursing Care in the Community	$5,061,282	$7,231,850	$9,810,480	$10,087,392	$1,524,373	$2,818,902	$0	$0	$6,585,655	$10,050,752	$9,810,480	$10,087,392
Repairs to Furniture/Equipment	$46	$0	$0	$0	$0	$0	$0	$0	$46	$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	$4,511,048	$3,725,498	$5,053,883	$5,196,536	$414,435	$722,565	$0	$0	$4,925,483	$4,448,063	$5,053,883	$5,196,536
Community Nursing Homes	$1,170,657	$1,358,917	$1,670,206	$1,760,875	$0	$0	$0	$0	$1,170,657	$1,358,917	$1,670,206	$1,760,875
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	$13,468	$13,993	$14,539	$15,106	$0	$0	$0	$0	$13,468	$13,993	$14,539	$15,106
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	$3,218,029	$3,343,532	$3,473,930	$3,609,413	$11,279	$19,665	$0	$0	$3,229,308	$3,363,197	$3,473,930	$3,609,413
Administrative Contract Services	-$55	$0	$0	$0	$0	$0	$0	$0	-$55	$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	$32,644	$1,337,236	$1,416,606	$1,542,988	$0	$0	$0	$0	$32,644	$1,337,236	$1,416,606	$1,542,988
Subtotal	$14,290,079	$17,212,445	$21,817,701	$22,578,904	$1,950,107	$3,561,132	$0	$0	$16,240,186	$20,773,577	$21,817,701	$22,578,904

Obligations by Object - Medical Community Care (MCC) - Discretionary

(dollars in thousands)

Description	Regular Appropriations (0140 excludes 801)				FAMILY FIRST & CARES ACT (0140C3/C2)				Total Medical Community Care Discretionary			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:												
Provisions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$3,884	$381,925	$412,861	$439,284	$0	$0	$0	$0	$3,884	$381,925	$412,861	$439,284
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$2	$0	$0	$0	$0	$0	$0	$0	$2	$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	$484	$0	$0	$0	$0	$0	$0	$0	$484	$0	$0	$0
Prosthetic Appliances	-$30	$0	$0	$0	$0	$0	$0	$0	-$30	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$4,340	$381,925	$412,861	$439,284	$0	$0	$0	$0	$4,340	$381,925	$412,861	$439,284
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	$1,405,851	$1,640,683	$1,766,142	$1,794,812	$0	$100,000	$0	$0	$1,405,851	$1,740,683	$1,766,142	$1,794,812
Grants	$0	$0	$0	$0	$18,761	$0	$0	$0	$18,761	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,405,851	$1,640,683	$1,766,142	$1,794,812	$18,761	$100,000	$0	$0	$1,424,612	$1,740,683	$1,766,142	$1,794,812
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	$15,700,269	$19,235,053	$23,996,704	$24,813,000	$1,968,868	$3,661,132	$0	$0	$17,669,137	$22,896,185	$23,996,704	$24,813,000
Prior Year Recoveries	$88,626	$0	$0	$0	$0	$0	$0	$0	$88,626	$0	$0	$0
Pre P.L. 116-260 Title XVI section 1601	$5,007,990	$0	$0	$0	$0	$0	$0	$0	$5,007,990	$0	$0	$0
Obligations [Total]	**$20,796,885**	**$19,235,053**	**$23,996,704**	**$24,813,000**	**$1,968,868**	**$3,661,132**	**$0**	**$0**	**$22,765,753**	**$22,896,185**	**$23,996,704**	**$24,813,000**

Obligations by Object - Medical Community Care (MCC) - Mandatory
(dollars in thousands)

Description	American Rescue Plan (ARP)			
	FY 2020	FY 2021	FY 2022	FY 2023
10 Personnel Compensation and Benefits:				
Physicians	$0	$0	$0	$0
Dentists	$0	$0	$0	$0
Registered Nurses	$0	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$0	$0	$0	$0
Non-Physician Providers	$0	$0	$0	$0
Health Technicians/Allied Health	$0	$0	$0	$0
Wage Board/Purchase & Hire	$0	$0	$0	$0
All Other	$0	$0	$0	$0
Permanent Change of Station	$0	$0	$0	$0
Employee Compensation Pay	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0
21 Travel & Transportation of Persons:				
Employee	$0	$0	$0	$0
Beneficiary	$0	$0	$0	$0
Other	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0
22 Transportation of Things	$0	$0	$0	$0
23 Rent, Communications, and Utilities:				
Rental of Equipment	$0	$0	$0	$0
Communications	$0	$0	$0	$0
Utilities	$0	$0	$0	$0
GSA Rent	$0	$0	$0	$0
Other Real Property Rental	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0
24 Printing & Reproduction:				
25 Other Contractual Services:				
Care in the Community Outpatient Dental Care	$0	$0	$0	$0
Medical and Nursing Care in the Community	$0	$0	$1,572,843	$0
Repairs to Furniture/Equipment	$0	$0	$0	$0
Maintenance & Repair Contract Services	$0	$0	$0	$0
Care in the Community Hospital Care	$0	$0	$400,453	$0
Community Nursing Homes	$0	$0	$0	$0
Repairs to Prosthetic Appliances	$0	$0	$0	$0
Home Oxygen	$0	$0	$0	$0
Organ Procurement	$0	$0	$0	$0
Personal Services Contracts	$0	$0	$0	$0
House Staff Disbursing Agreement	$0	$0	$0	$0
Scarce Medical Specialists	$0	$0	$0	$0
Other Medical Contract Services	$0	$0	$0	$0
Administrative Contract Services	$0	$0	$0	$0
Training Contract Services	$0	$0	$0	$0
Caregiver Stipends	$0	$0	$0	$0
CHAMPVA	$0	$0	$0	$0
Subtotal	$0	$0	$1,973,296	$0

Obligations by Object - Medical Community Care (MCC) - Mandatory

(dollars in thousands)

Description	American Rescue Plan (ARP)			
	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:				
Provisions	$0	$0	$0	$0
Drugs & Medicines	$0	$0	$0	$0
Blood & Blood Products	$0	$0	$0	$0
Medical/Dental Supplies	$0	$0	$0	$0
Operating Supplies	$0	$0	$0	$0
Maintenance & Repair Supplies	$0	$0	$0	$0
Other Supplies	$0	$0	$0	$0
Prosthetic Appliances	$0	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0
31 Equipment	$0	$0	$0	$0
32 Lands & Structures:				
Non-Recurring Maintenance	$0	$0	$0	$0
All Other Lands & Structures	$0	$0	$0	$0
Subtotal	$0	$0	$0	$0
41 Grants, Subsidies & Contributions:				
State Home	$0	$250,000	$0	$0
Grants	$0	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0
Subtotal	$0	$250,000	$0	$0
42 - Insurance Claims and Indemnities	$0	$0	$0	$0
43 Imputed Interest	$0	$0	$0	$0
Subtotal	$0	$250,000	$1,973,296	$0
Prior Year Recoveries	$0	$0	$0	$0
Obligations [Total]	**$0**	**$250,000**	**$1,973,296**	**$0**

Obligations by Object - VA System Delivered & Administration of the Veterans Community Care Program and Other Non-VA Provider Programs
(dollars in thousands)

Description	Medical Services Total All Funding Sources (Discretionary & Mandatory)				Medical Support & Compiance Total All Funding Sources (Discretionary & Mandatory)				Medical Facilities Total All Funding Sources (Discretionary & Mandatory)			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
10 Personnel Compensation and Benefits:												
Physicians	$7,699,507	$8,102,249	$8,603,349	$8,908,603	$250,996	$299,591	$332,887	$335,612	-$46	$0	$0	$0
Dentists	$326,070	$350,287	$382,230	$392,614	$4,619	$4,765	$4,951	$5,127	$0	$0	$0	$0
Registered Nurses	$9,178,943	$9,848,241	$10,765,943	$11,084,552	$501,931	$531,206	$560,483	$576,112	$317	$0	$0	$0
LP Nurse/LV Nurse/Nurse Assistant	$2,175,826	$2,364,933	$2,619,242	$2,740,385	$5,000	$5,202	$5,558	$6,045	$99	$0	$0	$0
Non-Physician Providers	$2,806,634	$3,080,209	$3,470,123	$3,583,997	$47,491	$50,083	$52,915	$54,758	$253	$0	$0	$0
Health Technicians/Allied Health	$8,529,927	$9,321,625	$10,402,881	$10,744,999	$134,994	$147,456	$158,658	$163,504	$11,626	$12,010	$12,602	$13,181
Wage Board/Purchase & Hire	$372,865	$389,054	$411,366	$422,245	$83,513	$95,358	$104,835	$107,640	$1,506,098	$1,559,773	$1,629,116	$1,668,600
All Other	$3,201,042	$3,412,549	$3,702,199	$3,803,106	$4,770,967	$5,009,356	$5,260,170	$5,408,206	$497,558	$531,227	$572,063	$585,250
Permanent Change of Station	$5,219	$5,325	$5,433	$5,543	$6,801	$6,939	$7,080	$7,224	$426	$435	$444	$453
Employee Compensation Pay	$222,456	$226,972	$231,580	$236,281	$39,585	$40,389	$41,209	$42,046	$39,994	$40,806	$41,634	$42,479
Subtotal	$34,518,490	$37,101,444	$40,594,346	$41,922,325	$5,845,897	$6,190,345	$6,528,746	$6,706,274	$2,056,325	$2,144,251	$2,255,859	$2,309,963
21 Travel & Transportation of Persons:												
Employee	$35,710	$39,824	$45,136	$45,000	$28,965	$32,317	$36,449	$36,400	$2,518	$2,519	$2,865	$3,000
Beneficiary	$878,821	$972,410	$1,009,100	$1,049,500	$20	$0	$0	$0	$8	$0	$0	$0
Other	$41,971	$46,897	$53,884	$53,800	$5,154	$5,760	$6,629	$6,600	$44,499	$44,499	$51,214	$53,200
Subtotal	$956,502	$1,059,131	$1,108,120	$1,148,300	$34,139	$38,077	$43,078	$43,000	$47,025	$47,018	$54,079	$56,200
22 Transportation of Things	$30,038	$33,547	$37,983	$37,900	$13,669	$15,269	$17,481	$17,400	$14,552	$16,255	$18,595	$19,300
23 Rent, Communications, and Utilities:												
Rental of Equipment	$200,345	$223,760	$255,736	$255,100	$42,012	$46,941	$53,921	$53,800	$12,506	$12,593	$11,735	$12,200
Communications	$371,069	$414,600	$476,786	$475,600	$64,163	$71,681	$85,170	$85,000	$36,191	$36,191	$41,652	$43,300
Utilities	$251	$0	$0	$0	-$6	$0	$0	$0	$546,402	$546,406	$628,736	$653,300
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$16,673	$86	$0	$0	$4,635	$9	$0	$0	$752,903	$714,046	$1,705,015	$697,715
Subtotal	$588,338	$638,446	$732,522	$730,700	$110,804	$118,631	$139,091	$138,800	$1,348,002	$1,309,236	$2,387,138	$1,406,515
24 Printing & Reproduction:	$13,722	$15,344	$17,638	$17,600	$16,323	$18,240	$19,976	$19,900	$164	$180	$163	$169
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$5,935	$6,600	$7,596	$7,600	$0	$0	$0	$0	-$324	$0	$0	$0
Medical and Nursing Care in the Community	$283,263	$316,515	$363,400	$362,500	$2,643	$0	$0	$0	$68	$531	$0	$0
Repairs to Furniture/Equipment	$322,499	$360,324	$414,331	$413,300	$5,923	$6,619	$7,618	$7,600	$25,262	$25,295	$28,100	$29,200
Maintenance & Repair Contract Services	$42,704	$47,744	$54,897	$54,800	$1,279	$0	$0	$0	$262,058	$262,297	$294,602	$306,100
Care in the Community Hospital Care	-$6,937	$0	$0	$0	$0	$0	$0	$0	$17	$18	$0	$0
Community Nursing Homes	$110	$0	$0	$0	$0	$0	$0	$0	$1,011	$1,050	$0	$0
Repairs to Prosthetic Appliances	$273,636	$341,181	$400,717	$389,636	$465	$483	$0	$0	$0	$0	$0	$0
Home Oxygen	$229,416	$288,226	$358,916	$348,990	$0	$0	$0	$0	$0	$0	$0	$0
Organ Procurement	$19,236	$21,500	$24,744	$24,700	$0	$0	$0	$0	$0	$0	$0	$0
Personal Services Contracts	$89,149	$99,152	$106,501	$106,200	$7,303	$8,148	$9,177	$9,200	$1,744	$1,744	$2,007	$2,100
House Staff Disbursing Agreement	$733,364	$821,864	$945,557	$943,300	$134	$0	$0	$0	$0	$0	$0	$0
Scarce Medical Specialists	$154,408	$167,900	$193,236	$192,800	$47	$0	$0	$0	$114	$0	$0	$0
Other Medical Contract Services	$1,439,128	$2,446,512	$6,665,004	$6,466,568	$16,170	$18,070	$20,797	$20,700	$16,895	$3,034	$0	$0
Administrative Contract Services	$915,913	$1,022,801	$1,159,728	$1,156,900	$1,442,400	$1,799,451	$2,429,133	$2,476,191	$587,754	$665,921	$1,059,039	$1,156,880
Training Contract Services	$65,999	$73,721	$84,842	$84,600	$62,740	$70,111	$80,690	$48,702	$1,360	$1,360	$1,559	$1,600
Caregiver Stipends	$353,253	$707,806	$1,022,919	$1,337,514	$0	$0	$0	$0	$0	$0	$0	$0
CHAMPVA	$0	$20,108	$23,040	$28,826	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$4,921,076	$6,741,954	$11,825,428	$11,918,234	$1,539,104	$1,902,882	$2,547,415	$2,562,393	$895,959	$961,250	$1,385,307	$1,495,880

Obligations by Object - VA System Delivered & Administration of the Veterans Community Care Program and Other Non-VA Provider Programs

(dollars in thousands)

Description	Medical Services Total All Funding Sources (Discretionary & Mandatory)				Medical Support & Compiance Total All Funding Sources (Discretionary & Mandatory)				Medical Facilities Total All Funding Sources (Discretionary & Mandatory)			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:												
Provisions	$114,334	$127,737	$146,750	$146,400	$2,777	$0	$0	$0	$48	$12	$0	$0
Drugs & Medicines	$7,385,855	$8,062,731	$8,283,646	$8,766,020	-$8	$0	$0	$0	$364	$47	$0	$0
Blood & Blood Products	$44,642	$51,175	$57,006	$60,343	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$2,307,071	$2,877,948	$4,165,926	$3,158,300	$1,122	$66	$0	$0	$4,772	$2,279	$0	$0
Operating Supplies	$254,682	$283,944	$316,071	$315,300	$39,477	$43,997	$48,851	$48,700	$165,235	$166,328	$156,296	$162,400
Maintenance & Repair Supplies	$36,890	$3,080	$0	$0	$417	$38	$0	$0	$186,323	$186,956	$195,745	$203,400
Other Supplies	$357,532	$397,582	$426,977	$426,000	$58,813	$72,644	$82,448	$82,300	$56,439	$56,723	$56,562	$58,800
Prosthetic Appliances	$2,518,269	$3,163,819	$3,938,497	$3,829,580	$4	$0	$0	$0	$0	$0	$0	$0
Home Respiratory Therapy	$66,318	$83,284	$103,358	$100,500	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$13,085,593	$15,051,300	$17,438,231	$16,802,443	$102,602	$116,745	$131,299	$131,000	$413,181	$412,345	$408,603	$424,600
31 Equipment	$1,940,288	$2,679,557	$1,746,224	$316,807	$39,014	$43,555	$49,461	$49,342	$142,658	$156,412	$134,173	$133,851
32 Lands & Structures:												
Non-Recurring Maintenance	$0	$0	$0	$0	$0	$0	$0	$0	$1,395,485	$2,169,781	$2,263,896	$700,000
All Other Lands & Structures	$1,027	$989	$0	$0	$15	$0	$0	$0	$483,410	$488,473	$590,557	$568,423
Subtotal	$1,027	$989	$0	$0	$15	$0	$0	$0	$1,878,895	$2,658,254	$2,854,453	$1,268,423
41 Grants, Subsidies & Contributions:												
State Home	-$3	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Grants	$1,296,960	$1,012,134	$1,242,936	$773,208	$0	$0	$0	$0	$0	$0	$0	$0
Veteran Adoption Reimbursement	$40	$40	$40	$40	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,296,997	$1,012,174	$1,242,976	$773,248	$0	$0	$0	$0	$0	$0	$0	$0
42 Insurance Claims and Indemnities	$8,033	$8,033	$8,033	$8,033	$20,378	$20,378	$23,453	$23,400	$1,769	$1,769	$2,036	$2,100
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$57,360,104	$64,341,919	$74,751,501	$73,675,590	$7,721,945	$8,464,122	$9,500,000	$9,691,509	$6,798,530	$7,706,970	$9,500,406	$7,117,001
Prior Year Recoveries	$96,909	$0	$0	$0	$167	$0	$0	$0	$19,031	$0	$0	$0
Obligations [Total]	**$57,457,013**	**$64,341,919**	**$74,751,501**	**$73,675,590**	**$7,722,112**	**$8,464,122**	**$9,500,000**	**$9,691,509**	**$6,817,561**	**$7,706,970**	**$9,500,406**	**$7,117,001**

Obligations by Object - Payments for the Veterans Community Care Program and Other Non-VA Providers
(dollars in thousands)

Description	Medical Community Care Total All Funding Sources (Discretionary & Mandatory) except VCF				Veterans Choice Fund Total (Mandatory)				Medical Community Care & Veterans Choice Total (Discretionary & Mandatory)			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
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	-$6	$0	$0	$0	$11,112	$0	$0	$0	$11,106	$0	$0	$0
Other	-$5	$0	$0	$0	$0	$0	$0	$0	-$5	$0	$0	$0
Subtotal	-$11	$0	$0	$0	$11,112	$0	$0	$0	$11,101	$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:	$10	$0	$0	$0	$0	$0	$0	$0	$10	$0	$0	$0
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$282,980	$201,419	$378,057	$366,594	-$4,157	$0	$0	$0	$278,823	$201,419	$378,057	$366,594
Medical and Nursing Care in the Community	$6,585,655	$10,050,752	$11,383,323	$10,087,392	$448,291	$83,359	$27,100	$0	$7,033,946	$10,134,111	$11,410,423	$10,087,392
Repairs to Furniture/Equipment	$46	$0	$0	$0	$0	$0	$0	$0	$46	$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	$4,925,483	$4,448,063	$5,454,336	$5,196,536	$55,568	$0	$0	$0	$4,981,051	$4,448,063	$5,454,336	$5,196,536
Community Nursing Homes	$1,170,657	$1,358,917	$1,670,206	$1,760,875	-$169	$0	$0	$0	$1,170,488	$1,358,917	$1,670,206	$1,760,875
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	$13,468	$13,993	$14,539	$15,106	-$5,543	$0	$0	$0	$7,925	$13,993	$14,539	$15,106
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	$3,229,308	$3,363,197	$3,473,930	$3,609,413	$27,560	$0	$0	$0	$3,256,868	$3,363,197	$3,473,930	$3,609,413
Administrative Contract Services	-$55	$0	$0	$0	-$8,938	$36,331	$2,900	$0	-$8,993	$36,331	$2,900	$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	$32,644	$1,337,236	$1,416,606	$1,542,988	$925,808	$0	$0	$0	$958,452	$1,337,236	$1,416,606	$1,542,988
Subtotal	$16,240,186	$20,773,577	$23,790,997	$22,578,904	$1,438,420	$119,690	$30,000	$0	$17,678,606	$20,893,267	$23,820,997	$22,578,904

Obligations by Object - Payments for the Veterans Community Care Program and Other Non-VA Providers

(dollars in thousands)

Description	Medical Community Care Total All Funding Sources (Discretionary & Mandatory) except VCF				Veterans Choice Fund Total (Mandatory)				Medical Community Care & Veterans Choice Total (Discretionary & Mandatory)			
	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:												
Provisions	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Drugs & Medicines	$3,884	$381,925	$412,861	$439,284	$325,647	$0	$0	$0	$329,531	$381,925	$412,861	$439,284
Blood & Blood Products	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Medical/Dental Supplies	$2	$0	$0	$0	$0	$0	$0	$0	$2	$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	$484	$0	$0	$0	$0	$0	$0	$0	$484	$0	$0	$0
Prosthetic Appliances	-$30	$0	$0	$0	$0	$0	$0	$0	-$30	$0	$0	$0
Home Respiratory Therapy	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$4,340	$381,925	$412,861	$439,284	$325,647	$0	$0	$0	$329,987	$381,925	$412,861	$439,284
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	$1,405,851	$1,990,683	$1,766,142	$1,794,812	$0	$0	$0	$0	$1,405,851	$1,990,683	$1,766,142	$1,794,812
Grants	$18,761	$0	$0	$0	$0	$0	$0	$0	$18,761	$0	$0	$0
Veteran Adoption Reimbursement	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$1,424,612	$1,990,683	$1,766,142	$1,794,812	$0	$0	$0	$0	$1,424,612	$1,990,683	$1,766,142	$1,794,812
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	$17,669,137	$23,146,185	$25,970,000	$24,813,000	$1,775,179	$119,690	$30,000	$0	$19,444,316	$23,265,875	$26,000,000	$24,813,000
Prior Year Recoveries	$88,626	$0	$0	$0	$335,359	$0	$0	$0	$423,985	$0	$0	$0
Pre P.L. 116-260 Title XVI section 1601	$5,007,990	$0	$0	$0	$0	$0	$0	$0	$5,007,990	$0	$0	$0
Obligations [Total]	**$22,765,753**	**$23,146,185**	**$25,970,000**	**$24,813,000**	**$2,110,538**	**$119,690**	**$30,000**	**$0**	**$24,876,291**	**$23,265,875**	**$26,000,000**	**$24,813,000**

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 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
10 Personnel Compensation and Benefits:												
Physicians	$7,949,144	$8,400,476	$8,191,385	$9,242,742	$1,313	$1,364	$744,851	$1,473	$7,950,457	$8,401,840	$8,936,236	$9,244,215
Dentists	$330,689	$355,052	$343,910	$397,741	$0	$0	$43,271	$0	$330,689	$355,052	$387,181	$397,741
Registered Nurses	$9,681,044	$10,379,294	$9,711,658	$11,660,499	$147	$153	$1,614,768	$165	$9,681,191	$10,379,447	$11,326,426	$11,660,664
LP Nurse/LV Nurse/Nurse Assistant	$2,180,925	$2,370,135	$2,190,136	$2,746,430	$0	$0	$434,664	$0	$2,180,925	$2,370,135	$2,624,800	$2,746,430
Non-Physician Providers	$2,854,219	$3,130,127	$3,331,970	$3,638,576	$159	$165	$191,068	$179	$2,854,378	$3,130,292	$3,523,038	$3,638,755
Health Technicians/Allied Health	$8,676,547	$9,481,091	$9,970,357	$10,921,684	$0	$0	$603,784	$0	$8,676,547	$9,481,091	$10,574,141	$10,921,684
Wage Board/Purchase & Hire	$1,962,454	$2,044,162	$2,129,645	$2,198,460	$22	$23	$15,672	$25	$1,962,476	$2,044,185	$2,145,317	$2,198,485
All Other	$8,468,436	$8,951,957	$9,177,390	$9,795,294	$1,131	$1,175	$357,042	$1,268	$8,469,567	$8,953,132	$9,534,432	$9,796,562
Permanent Change of Station	$12,447	$12,699	$12,957	$13,220	$0	$0	$0	$0	$12,447	$12,699	$12,957	$13,220
Employee Compensation Pay	$302,035	$308,167	$314,423	$320,806	$0	$0	$0	$0	$302,035	$308,167	$314,423	$320,806
Subtotal	$42,417,940	$45,433,160	$45,373,831	$50,935,452	$2,772	$2,880	$4,005,120	$3,110	$42,420,712	$45,436,040	$49,378,951	$50,938,562
21 Travel & Transportation of Persons:												
Employee	$67,191	$74,660	$84,450	$84,400	$2	$0	$0	$0	$67,193	$74,660	$84,450	$84,400
Beneficiary	$878,843	$972,410	$1,009,100	$1,049,500	$11,112	$0	$0	$0	$889,955	$972,410	$1,009,100	$1,049,500
Other	$91,619	$97,156	$111,727	$113,600	$0	$0	$0	$0	$91,619	$97,156	$111,727	$113,600
Subtotal	$1,037,653	$1,144,226	$1,205,277	$1,247,500	$11,114	$0	$0	$0	$1,048,767	$1,144,226	$1,205,277	$1,247,500
22 Transportation of Things	$58,259	$65,071	$74,059	$74,600	$0	$0	$0	$0	$58,259	$65,071	$74,059	$74,600
23 Rent, Communications, and Utilities:												
Rental of Equipment	$254,860	$283,294	$321,392	$321,100	$3	$0	$0	$0	$254,863	$283,294	$321,392	$321,100
Communications	$471,423	$522,472	$603,608	$603,900	$0	$0	$0	$0	$471,423	$522,472	$603,608	$603,900
Utilities	$546,647	$546,406	$628,736	$653,300	$0	$0	$0	$0	$546,647	$546,406	$628,736	$653,300
GSA Rent	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Real Property Rental	$773,954	$708,480	$898,727	$691,604	$257	$5,661	$806,288	$6,111	$774,211	$714,141	$1,705,015	$697,715
Subtotal	$2,046,884	$2,060,652	$2,452,463	$2,269,904	$260	$5,661	$806,288	$6,111	$2,047,144	$2,066,313	$3,258,751	$2,276,015
24 Printing & Reproduction:	$30,219	$33,764	$37,777	$37,669	$0	$0	$0	$0	$30,219	$33,764	$37,777	$37,669
25 Other Contractual Services:												
Care in the Community Outpatient Dental Care	$288,591	$208,019	$385,653	$374,194	-$4,157	$0	$0	$0	$284,434	$208,019	$385,653	$374,194
Medical and Nursing Care in the Community	$6,871,629	$10,367,798	$10,173,880	$10,449,892	$448,291	$83,359	$1,599,943	$0	$7,319,920	$10,451,157	$11,773,823	$10,449,892
Repairs to Furniture/Equipment	$353,730	$392,238	$450,049	$450,100	$0	$0	$0	$0	$353,730	$392,238	$450,049	$450,100
Maintenance & Repair Contract Services	$306,043	$310,041	$349,499	$360,900	-$2	$0	$0	$0	$306,041	$310,041	$349,499	$360,900
Care in the Community Hospital Care	$4,918,563	$4,448,081	$5,053,883	$5,196,536	$55,568	$0	$400,453	$0	$4,974,131	$4,448,081	$5,454,336	$5,196,536
Community Nursing Homes	$1,171,778	$1,359,967	$1,670,206	$1,760,875	-$169	$0	$0	$0	$1,171,609	$1,359,967	$1,670,206	$1,760,875
Repairs to Prosthetic Appliances	$274,101	$341,664	$400,717	$389,636	$0	$0	$0	$0	$274,101	$341,664	$400,717	$389,636
Home Oxygen	$229,416	$288,226	$358,916	$348,990	$0	$0	$0	$0	$229,416	$288,226	$358,916	$348,990
Organ Procurement	$19,236	$21,500	$24,744	$24,700	$0	$0	$0	$0	$19,236	$21,500	$24,744	$24,700
Personal Services Contracts	$111,664	$123,037	$132,224	$132,606	-$5,543	$0	$0	$0	$106,121	$123,037	$132,224	$132,606
House Staff Disbursing Agreement	$734,727	$821,864	$945,557	$943,300	-$1,229	$0	$0	$0	$733,498	$821,864	$945,557	$943,300
Scarce Medical Specialists	$154,722	$167,900	$193,236	$192,800	-$153	$0	$0	$0	$154,569	$167,900	$193,236	$192,800
Other Medical Contract Services	$4,701,624	$5,830,813	$7,715,962	$10,096,681	$27,437	$0	$2,443,769	$0	$4,729,061	$5,830,813	$10,159,731	$10,096,681
Administrative Contract Services	$2,946,245	$3,488,088	$3,720,906	$4,789,880	-$9,171	$36,416	$929,894	$91	$2,937,074	$3,524,504	$4,650,800	$4,789,971
Training Contract Services	$130,098	$145,192	$167,091	$134,902	$1	$0	$0	$0	$130,099	$145,192	$167,091	$134,902
Caregiver Stipends	$353,253	$707,806	$1,022,919	$1,337,514	$0	$0	$0	$0	$353,253	$707,806	$1,022,919	$1,337,514
CHAMPVA	$32,644	$1,357,344	$1,439,646	$1,571,814	$925,808	$0	$0	$0	$958,452	$1,357,344	$1,439,646	$1,571,814
Subtotal	$23,598,064	$30,379,578	$34,205,088	$38,555,320	$1,436,681	$119,775	$5,374,059	$91	$25,034,745	$30,499,353	$39,579,147	$38,555,411

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 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023	FY 2020	FY 2021	FY 2022	FY 2023
26 Supplies & Materials:												
Provisions	$117,159	$127,749	$146,750	$146,400	$0	$0	$0	$0	$117,159	$127,749	$146,750	$146,400
Drugs & Medicines	$7,386,826	$8,443,971	$8,695,746	$9,204,800	$328,916	$732	$761	$504	$7,715,742	$8,444,703	$8,696,507	$9,205,304
Blood & Blood Products	$44,642	$51,175	$57,006	$60,343	$0	$0	$0	$0	$44,642	$51,175	$57,006	$60,343
Medical/Dental Supplies	$2,312,967	$2,880,293	$3,165,926	$3,158,300	$0	$0	$1,000,000	$0	$2,312,967	$2,880,293	$4,165,926	$3,158,300
Operating Supplies	$459,340	$494,269	$521,218	$526,400	$54	$0	$0	$0	$459,394	$494,269	$521,218	$526,400
Maintenance & Repair Supplies	$223,630	$190,074	$195,745	$203,400	$0	$0	$0	$0	$223,630	$190,074	$195,745	$203,400
Other Supplies	$473,265	$526,949	$565,987	$567,100	$3	$0	$0	$0	$473,268	$526,949	$565,987	$567,100
Prosthetic Appliances	$2,518,243	$3,163,819	$3,938,497	$3,829,580	$0	$0	$0	$0	$2,518,243	$3,163,819	$3,938,497	$3,829,580
Home Respiratory Therapy	$66,318	$83,284	$103,358	$100,500	$0	$0	$0	$0	$66,318	$83,284	$103,358	$100,500
Subtotal	$13,602,390	$15,961,583	$17,390,233	$17,796,823	$328,973	$732	$1,000,761	$504	$13,931,363	$15,962,315	$18,390,994	$17,797,327
31 Equipment	$2,125,191	$2,879,524	$183,634	$500,000	-$3,231	$0	$1,746,224	$0	$2,121,960	$2,879,524	$1,929,858	$500,000
32 Lands & Structures:												
Non-Recurring Maintenance	$1,400,475	$2,169,781	$491,374	$700,000	-$4,990	$0	$1,772,522	$0	$1,395,485	$2,169,781	$2,263,896	$700,000
All Other Lands & Structures	$484,733	$489,462	$590,557	$568,423	-$281	$0	$0	$0	$484,452	$489,462	$590,557	$568,423
Subtotal	$1,885,208	$2,659,243	$1,081,931	$1,268,423	-$5,271	$0	$1,772,522	$0	$1,879,937	$2,659,243	$2,854,453	$1,268,423
41 Grants, Subsidies & Contributions:												
State Home	$1,405,848	$1,740,683	$1,766,142	$1,794,812	$0	$250,000	$0	$0	$1,405,848	$1,990,683	$1,766,142	$1,794,812
Grants	$1,315,721	$1,012,134	$705,186	$773,208	$0	$0	$537,750	$0	$1,315,721	$1,012,134	$1,242,936	$773,208
Veteran Adoption Reimbursement	$40	$40	$40	$40	$0	$0	$0	$0	$40	$40	$40	$40
Subtotal	$2,721,609	$2,752,857	$2,471,368	$2,568,060	$0	$250,000	$537,750	$0	$2,721,609	$3,002,857	$3,009,118	$2,568,060
42 Insurance Claims and Indemnities	$30,180	$30,180	$33,522	$33,533	$0	$0	$0	$0	$30,180	$30,180	$33,522	$33,533
43 Imputed Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Subtotal	$89,553,597	$103,399,838	$104,509,183	$115,287,284	$1,771,298	$379,048	$15,242,724	$9,816	$91,324,895	$103,778,886	$119,751,907	$115,297,100
Prior Year Recoveries	$191,844	$0	$0	$0	$348,248	$0	$0	$0	$540,092	$0	$0	$0
Pre P.L. 116-260 Title XVI section 1601	$5,007,990	$0	$0	$0	$0	$0	$0	$0	$5,007,990	$0	$0	$0
ARP Act 8007 Compayment Reimbursement	$0	$0	$0	$0	$0	$300,000	$0	$0	$0	$300,000	$0	$0
Obligations [Total]	**$89,745,441**	**$103,399,838**	**$104,509,183**	**$115,287,284**	**$2,119,546**	**$379,048**	**$15,242,724**	**$9,816**	**$96,872,977**	**$104,078,886**	**$119,751,907**	**$115,297,100**

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

(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Health Care Services:							
Ambulatory Care	$43,619,421	$48,519,222	$50,327,695	$59,651,738	$54,236,232	$9,324,043	($5,415,506)
Dental Care	$1,159,850	$1,509,600	$987,715	$1,632,271	$1,588,689	$644,556	($43,582)
Inpatient Care	$18,200,224	$15,531,600	$19,855,061	$21,843,838	$21,875,714	$1,988,777	$31,876
Mental Health Care 1/	$10,285,509	$10,257,500	$11,998,939	$13,541,352	$14,266,121	$1,542,413	$724,769
Prosthetic and Sensory Aids Services	$3,153,897	$4,072,900	$3,962,562	$4,934,411	$4,797,953	$971,849	($136,458)
Rehabilitation Care	$1,017,757	$1,083,800	$1,028,055	$1,097,033	$1,076,759	$68,978	($20,274)
Health Care Services [Subtotal]	**$77,436,658**	**$80,974,622**	**$88,160,027**	**$102,700,643**	**$97,841,468**	**$14,540,616**	**($4,859,175)**
Long-Term Services & Supports (LTSS):							
Institutional LTSS							
VA Community Living Centers (VA CLC)	$4,173,642	$4,011,400	$4,210,835	$4,423,856	$4,417,659	$213,021	($6,197)
Community Nursing Home	$1,409,969	$1,433,800	$1,552,172	$1,907,731	$2,011,293	$355,559	$103,562
State Home Nursing	$1,372,877	$1,580,455	$1,930,455	$1,707,451	$1,741,296	($223,004)	$33,845
State Home Domiciliary	$53,622	$56,346	$56,346	$56,357	$51,314	$11	($5,043)
Institutional LTSS [Subtotal]	$7,010,110	$7,082,001	$7,749,808	$8,095,395	$8,221,562	$345,587	$126,167
Non-Institutional LTSS							
State Home Adult Day Care	$2,635	$3,882	$3,882	$4,734	$4,902	$852	$168
Other Non-Institutional LTSS	$3,035,806	$3,473,900	$3,381,167	$3,671,948	$3,851,287	$290,781	$179,339
Non-Institutional LTSS [Subtotal]	$3,038,441	$3,477,782	$3,385,049	$3,676,682	$3,856,189	$291,633	$179,507
LTSS [Subtotal]	**$10,048,551**	**$10,559,783**	**$11,134,857**	**$11,772,077**	**$12,077,751**	**$637,220**	**$305,674**
Other Health Care Programs:							
Camp Lejeune Families (P.L. 112-154)	$3,114	$4,649	$4,649	$2,909	$3,043	($1,740)	$134
Caregivers 2/	$404,072	$1,195,486	$1,003,404	$1,353,133	$1,750,155	$349,729	$397,022
CHAMPVA & Other Dependent Prgs	$2,000,449	$2,274,182	$2,214,184	$2,378,170	$2,567,891	$163,986	$189,721
Homeless Program Grants 3/	$1,165,657	$604,732	$974,785	$1,191,186	$720,708	$216,401	($470,478)
Readjustment Counseling	$266,394	$286,980	$286,980	$323,789	$336,084	$36,809	$12,295
Copayment Reimbursement	$0	$0	$300,000	$0	$0	($300,000)	$0
Other Health Care Programs [Subtotal]	**$3,839,686**	**$4,366,029**	**$4,784,002**	**$5,249,187**	**$5,377,881**	**$465,185**	**$128,694**
Legislative Proposals:							
2021 President's Budget 4/	$0	$40,245	$0	$0	$0	$0	$0
American Families Plan	$0	$0	$0	$30,000	$30,000	$30,000	$0
Legislative Proposals	$0	$40,245	$0	$30,000	$30,000	$30,000	$0
Obligations [Subtotal]	**$91,324,895**	**$95,940,679**	**$104,078,886**	**$119,751,907**	**$115,327,100**	**$15,673,021**	**($4,424,807)**
Recoveries of prior year paid & unpaid obligations	$540,092						
Pre P.L. 116-260 Title XVI section 1601 5/	$5,007,990						
Obligations [Total]	$96,872,977	$95,940,679	$104,078,886	$119,751,907	$115,327,100	$15,673,021	($4,424,807)

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.
4/ For detail on the 2022 Legislative Proposals, please see the Legislative Proposal chapter in Volume 1.
5/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Antideficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.

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

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Medical Care Programs: (Included Above)							
Activations	$126,687	$650,000	$650,000	$896,483	$500,000	$246,483	($396,483)
Blind Rehabilitation Treatment	$130,900	$134,260	$160,700	$159,700	$160,400	($1,000)	$700
Education & Training	$2,334,574	$2,502,543	$2,496,046	$2,586,956	$2,680,481	$90,910	$93,525
Health Professionals Educational Assistance Program	$115,540	$152,336	$156,336	$205,785	$258,785	$49,449	$53,000
Hepatitis C Treatment	$38,516	$38,428	$111,339	$108,280	$103,883	($3,059)	($4,397)
Indian Health Services	$15,469	$15,810	$26,810	$30,000	$33,000	$3,190	$3,000
Intensive Evaluation and Treatment Program Initiative	$0	$0	$5,188	$15,283	$25,912	$10,095	$10,629
Intimate Partner Violence program	$17,686	$21,512	$21,672	$30,602	$32,670	$8,930	$2,068
Leases	$1,173,175	$1,054,250	$1,053,903	$2,099,889	$1,000,000	$1,045,986	($1,099,889)
Mental Health Topics:							
Opioid Prevention:							
Treatment Modalities	$347,993	$382,848	$361,566	$375,668	$389,259	$14,102	$13,591
Opioid Prevention Programs (Include's Jason's Law) 1/	$42,287	$109,666	$111,012	$245,666	$245,754	$134,654	$88
Substance Use Disorder Initiative	$0	$0	$0	$155,970	$155,970	$155,970	$0
Suicide Prevention:							
Medical Treatment	$1,418,299	$1,626,694	$1,553,033	$1,741,344	$1,805,598	$188,311	$64,254
Outreach Programs	$240,774	$312,635	$311,363	$597,997	$602,587	$286,634	$4,590
National Center for Posttraumatic Stress Disorder	$34,713	$40,000	$40,000	$40,000	$40,000	$0	$0
National Veterans Sports Program	$21,259	$24,548	$27,048	$27,048	$27,048	$0	$0
Non-Recurring Maintenance (Lands & Structure only) 2/	$1,395,485	$1,859,022	$2,097,128	$2,263,896	$700,000	$166,768	($1,563,896)
Precision Oncology Initiative	$0	$75,000	$71,197	$100,017	$100,017	$28,820	$0
Rural Health	$299,097	$270,000	$300,000	$307,455	$315,135	$7,455	$7,680
Spinal Cord Injury Treatment	$616,200	$646,544	$672,500	$684,500	$703,900	$12,000	$19,400
Supply Chain Management	$66,564	$142,524	$142,524	$129,514	$140,193	($13,010)	$10,679
Telehealth:							
Home & Clinic Based Telehealth	$2,007,280	$1,029,566	$2,072,008	$2,135,182	$2,215,926	$63,174	$80,744
Office of Connected Care Program	$176,785	$300,000	$428,000	$450,000	$329,906	$22,000	($120,094)
Veterans Homelessness Programs	$2,499,444	$1,888,508	$2,305,147	$2,640,450	$2,197,414	$335,303	($443,036)
Whole Health	$56,911	$63,600	$73,600	$73,600	$73,600	$0	$0

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

2/ Please see the Medical Facilities chapter for the 2020 actual that include supporting FTE and contract-related costs pertaining to Non-Recurring Maintenance, which are not included in this table.

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

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
AIDS/HIV Program	$1,491,100	$1,365,680	$1,542,900	$1,599,500	$1,661,500	$56,600	$62,000
Post Deployment Health Services:							
Gulf War Program	$4,531,400	$4,678,634	$4,903,200	$5,308,700	$5,756,100	$405,500	$447,400
OEF/OIF/OND/OIR	$8,711,600	$8,753,769	$9,578,000	$10,458,500	$11,353,000	$880,500	$894,500
Traumatic Brain Injury and Polytrauma System of Care:							
OEF/OIF/OND/OIR	$225,400	$221,798	$236,300	$245,100	$251,800	$8,800	$6,700
All Veteran Care	$811,600	$739,911	$841,700	$870,600	$895,200	$28,900	$24,600
Women Veterans Health Care:							
Program Office & Initiative Budget	$11,288	$64,433	$99,433	$104,946	$137,791	$5,513	$32,845
Gender-Specific Care	$564,800	$625,691	$629,900	$705,500	$771,900	$75,600	$66,400
All Care	$7,260,400	$7,417,747	$7,820,800	$8,422,100	$9,061,500	$601,300	$639,400

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

FFCRA: Families First Coronavirus Response Act (Public Law 116-127)
CARES: Coronavirus Aid, Relief, and Economic Security Act (Public Law 116-136)
VACAA: Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113-146)

Ambulatory Care

Ambulatory Care with Pharmacy
(dollars in thousands)

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$27,383,643	$31,940,106	$30,197,654	$35,292,090	$37,508,120	$5,094,436	$2,216,030
Discretionary FFCRA/CARES Act Obligations	$1,521,058	$0	$3,082,816	$0	$0	($3,082,816)	$0
Discretionary Obligations [Subtotal]	**$28,904,701**	**$31,940,106**	**$33,280,470**	**$35,292,090**	**$37,508,120**	**$2,011,620**	**$2,216,030**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$5,352,852	$7,416,189	$5,568,936	$7,911,245	$7,726,120	$2,342,309	($185,125)
Discretionary FFCRA/CARES Act Obligations	$1,527,838	$0	$2,775,462	$0	$0	($2,775,462)	$0
Discretionary Obligations [Subtotal]	**$6,880,690**	**$7,416,189**	**$8,344,398**	**$7,911,245**	**$7,726,120**	**($433,153)**	**($185,125)**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$4,123,131	$4,448,886	$4,497,911	$4,664,392	$5,323,150	$166,481	$658,758
Discretionary CARES Act Obligations	$28,448	$0	$90,917	$0	$0	($90,917)	$0
Discretionary Obligations [Subtotal]	**$4,151,579**	**$4,448,886**	**$4,588,828**	**$4,664,392**	**$5,323,150**	**$75,564**	**$658,758**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$3,335,196	$3,651,604	$3,788,336	$3,575,961	$3,674,126	($212,375)	$98,165
Discretionary CARES Act Obligations	$175,945	$0	$221,175	$0	$0	($221,175)	$0
Discretionary Obligations [Subtotal]	**$3,511,142**	**$3,651,604**	**$4,009,511**	**$3,575,961**	**$3,674,126**	**($433,550)**	**$98,165**
Discretionary Total	**$43,448,111**	**$47,456,785**	**$50,223,207**	**$51,443,688**	**$54,231,516**	**$1,220,481**	**$2,787,828**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$4,194,321	$0	$4,194,321	($4,194,321)
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$627,900	$0	$627,900	($627,900)
VACAA, Section 801 (0160)	-$616	$925	$1,127	$1,172	$1,075	$45	($97)
Mandatory Obligations [Subtotal]	**-$616**	**$925**	**$1,127**	**$4,823,393**	**$1,075**	**$4,822,266**	**($4,822,318)**
Medical Community Care Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$1,478,166	$0	$1,478,166	($1,478,166)
American Rescue Plan Act, Section 8004 (0140)	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007 (0140)	$0	$0	$0	$72,100	$0	$72,100	($72,100)
Veterans Choice Fund (0172)	$171,700	$1,057,900	$99,990	$24,300	$0	($75,690)	($24,300)
Mandatory Obligations [Subtotal]	**$171,700**	**$1,057,900**	**$99,990**	**$1,574,566**	**$0**	**$1,474,576**	**($1,574,566)**
Medical Support and Compliance Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$359,352	$0	$359,352	($359,352)
VACAA, Section 801 (0152)	$222	$1,762	$231	$221	$252	($10)	$31
Mandatory Obligations [Subtotal]	**$222**	**$1,762**	**$231**	**$359,573**	**$252**	**$359,342**	**($359,321)**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$1,447,256	$0	$1,447,256	($1,447,256)
VACAA, Section 801 (0162)	$0	$1,850	$3,140	$3,262	$3,389	$122	$127
Mandatory Obligations [Subtotal]	**$0**	**$1,850**	**$3,140**	**$1,450,518**	**$3,389**	**$1,447,378**	**($1,447,129)**
Mandatory Total	**$171,306**	**$1,062,437**	**$104,488**	**$8,208,050**	**$4,716**	**$8,103,562**	**($8,203,334)**
Combined Discretionary and Mandatory by Category							
Medical Services	$28,904,085	$31,941,031	$33,281,597	**$40,115,483**	**$37,509,195**	$6,833,886	($2,606,288)
Medical Community Care	$7,052,390	$8,474,089	$8,444,388	**$9,485,811**	**$7,726,120**	$1,041,423	($1,759,691)
Medical Support and Compliance	$4,151,801	$4,450,648	$4,589,059	**$5,023,965**	**$5,323,402**	$434,906	$299,437
Medical Facilities	$3,511,142	$3,653,454	$4,012,651	**$5,026,479**	**$3,677,515**	$1,013,828	($1,348,964)
Obligations [Grand Total]	**$43,619,417**	**$48,519,222**	**$50,327,695**	**$59,651,738**	**$54,236,232**	**$9,324,043**	**($5,415,506)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Ambulatory care health service category includes funding for ambulatory care in VA medical centers (VAMCs) and community-based clinics, as well as ambulatory care provided in the community by non-VA providers. Community care is provided to eligible beneficiaries when VA cannot provide the care needed in accordance with the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 access standards.

Types of Services Provided / Method of Delivery

Primary Care
Patient Aligned Care Team (PACT) is a customized patient-centered medical home model of care adopted and branded by VHA. PACT staff includes Primary Care Providers (PCPs) (physicians, advanced practice nurses and physician assistants), Registered Nurses (RNs), Clinical Associates (licensed practical nurses (LPNs), licensed vocational nurses (LVNs), medical assistants, health technicians, and clerical associates. The extended PACT team staff includes, but is not limited to dieticians, clinical pharmacists, primary care mental health integration staff (psychologists, psychiatrists, licensed clinical social workers (LCSWs), registered nurses), and case managers. The PACT model has remained the foundational model for team-based primary care and over the years has incorporated virtual primary care (e.g., clinical video telehealth into the home, secure messaging, telephone care, clinic-based clinical video telehealth (CVT), e-consults, etc.).

Since 2018, VHA has expanded Clinical Resource Hubs (CRH) and broadened their scope to provide coverage for Primary Care, Mental Health, Specialty Care and other clinical services through the creation of Mobile Deployment Teams (MDT) as required by the MISSION Act. As of 2020, all 18 Veterans Integrated Service Networks (VISNs) have an operational CRH at various levels of maturity. The VHA Office of Primary Care, Office of Rural Health (ORH), Office of Mental Health & Suicide Prevention (OMHSP), and Office of Connected Care partnered to expand clinical services to underserved areas through a hub-and-spoke model catering to the clinical needs within the VISN. The CRH program addresses MISSION Act requirements by improving access to healthcare in underserved facilities as defined in section 401.

Nursing Services
VHA nursing services in the primary care (PC) setting include face to face and virtual visits for direct and indirect nursing care activities. These activities include immunizations, education, preventative health strategies, interprofessional care planning, group clinics, population health strategies, care coordination and management within VA as well as with community network providers. PC nurse staffing for 2020 included approximately 14,000 RNs and LPNs/ LVNs. Nursing visits were provided via face to face, VA Video Connect (VVC) and telephone modalities. These visits encompassed preventative health annual screenings, population health, care coordination and transitions management activities across the care continuum.

Pharmacy Services
Currently, 1,002 PACT Clinical Pharmacy Specialists (CPS) provide comprehensive medication management to initiate, modify, or discontinue medications, as well as providing disease management in areas such as pain management, diabetes, hypertension, anemia, chronic obstructive pulmonary disease (COPD), substance use disorder (SUD), heart failure, and

hyperlipidemia. Strong practices during COVID-19 include outpatient alcohol detoxification, population management for high risk Veterans and contacting patients who missed doses or had late medication refills for SUD.

Nutrition and Food Services

Nutrition and Food Service (NFS) provides nutrition education, counseling and medical nutrition therapy for Veterans to address conditions ranging from basic weight management to complex tube feeding therapies. Methods of delivery include group classes, individual sessions, and VA Healthy Teaching Kitchens through modalities such as in-person and virtual care.

Emergency Medicine Services

Emergency Medicine (EM) provides acute, emergent and urgent care on-demand through our 110 VHA emergency departments (ED) and 30 Urgent Care Centers (UCC). Tele-Emergent and Tele-Urgent Care services are under development at several VAMCs. VA also offers urgent care for eligible Veterans at in-network urgent care clinics in the community, closer to home. The 2022 budget request includes $266 million for in-network urgent care in the community.

Recent Trends

In 2020, VA continued to make the most of its legal and operational authority and business processes to integrate virtual care to Veterans at home. Due to social distancing requirements brought on by the COVID-19 pandemic, there were significant increases in utilization of these modalities to maintain connections with Veterans.

- VA Video Connect (VVC) visits increased by 1,037% from 99,000 Veterans in 2019 to more than 1.35 million Veterans in 2020;
- Continuing the 3-year enterprise initiative to integrate video care into Veteran homes and into the routine operation of all PC and Mental Health (MH) team clinicians;
- 90% of VHA PC and MH providers have completed at least one VA video connect encounter;
- Improving Access to Care for Primary Care in Collaboration with the Office of Veterans Access to Care through the Increasing Capacity, Efficiency and Productivity (ICEP) initiative;
- 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;
- In September 2020, the third annual national 'Veterans in Pain: Pain care, Opioid safety and Substance abuse Treatment (VIP POST)' was held virtually over three days in September. The conference brought together over 1,200 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;

- Section 134 of the MISSION Act provided federal supremacy to VA prescribers and their delegates to access state prescription drug monitoring programs (PDMP) and develop an IT solution providing real-time direct access to state PDMPs in CPRS that is aligned with VHA Directive 1306, Querying State Prescription Drug Monitoring Databases. This involved integrating a national gateway with each state, taking into account variability of rules and regulations governing each state's PDMP. Currently all but 10 states are participating, Successful pilot testing has been completed for the national installation of the "PDMP" button in CPRS, which is planned for November 2020;
- The US is confronted with a rise in OUD, opioid misuse, and opioid-associated harms. Medication treatment for opioid use disorder (MOUD)—including methadone, buprenorphine and naltrexone—are the gold standard treatments for OUD. MOUD reduces illicit opioid use, mortality, criminal activity, healthcare costs, and high-risk behaviors. In the Spring of 2018, the VHA initiated the Stepped Care for Opioid Use Disorder, Train the Trainer (SCOUTT) Initiative to facilitate access to MOUD in VHA non-SUD care settings. The SCOUTT Initiative's primary goal is to increase MOUD prescribing in VHA primary care, mental health, and pain clinics by training providers working in those settings on how to provide MOUD and to facilitate implementation by providing an ongoing learning collaborative. Early results indicate doubling of MOUD treatment and doubling the clinicians providing MOUD care within the SCOUTT clinics;
- Providing collaborative Primary Care-Mental Health (PCMHI) care to more than 7% of veterans enrolled at all primary care sites across 1.3 million encounters, which represent 96% of the encounter volume compared to the year prior and demonstrates the resilience of PACT clinical functions despite the COVID-19 pandemic;
- Total PC nursing encounters for 2020: 72,626 VVC; 4,548,248 telephone and 1,538,581 face to face visits covering the urban, rural and highly rural veteran populations. PC nursing staff also provided nursing support for 19.1 million PC provider face to face, VVC and telephone clinic visits;
- In 2020, PACT CPS completed 1,566,834 visits; 74% of these visits were virtual in response to the COVID-19 pandemic. This represented a 1,185% increase in utilization of VVC compared to the previous year;
- Through August 1, 2020, NFS dietitians had completed 63,247 VVC encounters, a 1,014% increase from 2019.

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 (HMOs) and Medicaid HMOs for all 16-outpatient effectiveness measures and was significantly better for 14 measures compared with Medicare HMOs (Price et al, 2018).
- Veterans generally rate the VA outpatient experience more highly than care received through purchased community care. Implementation of the Choice Act was largely successful in expanding veterans' choices of outpatient care sites without compromising their care experiences. As purchased care further expands under the MISSION Act,

monitoring of meaningful differences between settings should continue, with the results used to inform both VA purchasing decisions and patients' care choices (Vanneman et al, 2020).

- 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 PACT components in place had significantly larger improvements in five of seven chronic disease intermediate outcome measures (e.g., 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 PACT components. Clinics with moderate levels of PACT components showed few significantly larger improvements than the lowest PACT clinics (Rosland et al, 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 (VHA).
- A Primary Care Operations COVID-19 Field Guide has been developed to provide VHA medical facilities with general guidance to support patient care through the COVID-19 pandemic response.
- In response to challenges related to care delivery during COVID-19, VHA instituted the following: drive thru vaccinations and lab draws, enhanced outreach through registries to high-risk patients.
- A national strategy aimed at optimizing timely preventative care for all Veterans has been established for VHA-wide implementation.
- In 2020, all PACT clinical staff including PCPs and PCMHI staff contributed to the continued roll-out of the suicide screening initiative, which resulted in 93% performance compliance in the initial screening stage, 77% compliance in the subsequent stage when indicated, and ongoing collaborative improvement in this area consistent with a high-performing learning health system.
- In 2020, to improve quality ambulatory care sensitive measures, PC nursing encounters and interventions utilizing the VVC platform increased by 547% for all PC nursing VVC visits. PC nursing visits exclusive to patient encounters with a diagnosis of hypertension increased by 1,131% and included VVC blood pressure measurement visits.
- Ambulatory Care Nurses supported VHA's COVID-19 response by providing clinical support for drive up testing centers, mobile clinics and as facility entry screeners for real time access to diagnostic lab, treatment and acute care admission needs. Nurses of all role types within primary care, specialty and other ambulatory care practice settings rapidly updated their clinical competence in acute and long-term care and were deployed across the VA health system as well as in support of the VA's 4th Mission to the civilian sector.

- Among Veterans with heart failure, chronic obstructive pulmonary disease, hypertension and diabetes, PACT model implementation with a CPS seeing patients as part of a transitions of care program achieved a 13% reduction in 30-day readmissions and a 21% 90-day readmission for the disease state the Veteran was discharged with. (VA Tennessee Valley). Additionally, using a CPS for 20% of PCP-paneled patients created 3 extra weeks or 240 additional appointment slots per year for the referring PCP (VA Madison WI and VA Kansas City).

- 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 6 million Veterans since October 2017. Over 50 VA facilities host food pantries that distribute to those in need.
- Close collaboration with Office of Mental Health and Suicide Prevention to conduct aggressive suicide screening, risk mitigation, and safety planning in emergency departments in our EDs and UCs.
- ED/UC sites at high operational risk have been reduced by 67% since 2016.
- EM partnered with West Health, John A. Hartford Foundation, and the American College of Emergency Physicians to become accredited in Geriatric Emergency Care at 20 ED locations across the country.

References

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2. Megan E. Vanneman, Todd H. Wagner, Michael Shwartz, Mark Meterko, Joseph Francis, Clinton L. Greenstone, and Amy K. Rosen Veterans' Experiences With Outpatient Care: Comparing The Veterans Affairs System With Community-Based Care, DOI: 10.1377/hlthaff.2019.01375 HEALTH AFFAIRS 39, NO. 8 (2020): 1368–1376
3. Patient-Centered Medical Home Implementation and Improved Chronic Disease Quality: A Longitudinal Observational Study Ann-Marie Rosland, Edwin Wong, Matthew Maciejewski, Donna Zulman, Rebecca Piegari, Stephan Fihn, and Karin Nelson Published 2017. This article is a U.S. Government work and is in the public domain in the USA DOI: 10.1111/1475-6773.12805 RESEARCH ARTICLE

Dental Care

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$691,792	$835,094	$455,561	$886,171	$943,737	$430,610	$57,566
Discretionary FFCRA/CARES Act Obligations	$44,799	$0	$70,400	$0	$0	($70,400)	$0
Discretionary Obligations [Subtotal]	**$736,591**	**$835,094**	**$525,961**	**$886,171**	**$943,737**	**$360,210**	**$57,566**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$175,950	$388,206	$201,419	$378,057	$366,594	$176,638	($11,463)
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$175,950**	**$388,206**	**$201,419**	**$378,057**	**$366,594**	**$176,638**	**($11,463)**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$113,575	$144,200	$122,088	$126,588	$143,986	$4,500	$17,398
Discretionary CARES Act Obligations	$1	$0	$3	$0	$0	($3)	$0
Discretionary Obligations [Subtotal]	**$113,576**	**$144,200**	**$122,091**	**$126,588**	**$143,986**	**$4,497**	**$17,398**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$123,135	$141,100	$137,831	$130,524	$134,117	($7,307)	$3,593
Discretionary CARES Act Obligations	$57	$0	$71	$0	$0	($71)	$0
Discretionary Obligations [Subtotal]	**$123,191**	**$141,100**	**$137,902**	**$130,524**	**$134,117**	**($7,378)**	**$3,593**
Discretionary Total	**$1,149,308**	**$1,508,600**	**$987,373**	**$1,521,340**	**$1,588,434**	**$533,967**	**$67,094**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$110,205	$0	$110,205	($110,205)
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$61	$63	$58	$2	($5)
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$61**	**$110,268**	**$58**	**$110,207**	**($110,210)**
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)	$10,529	$800	$100	$0	$0	($100)	$0
Mandatory Obligations [Subtotal]	**$10,529**	**$800**	**$100**	**$0**	**$0**	**($100)**	**$0**
Medical Support and Compliance Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$10	$0	$10	($10)
VACAA, Section 801 (0152)	$12	$100	$12	$12	$14	$0	$2
Mandatory Obligations [Subtotal]	**$12**	**$100**	**$12**	**$22**	**$14**	**$10**	**($8)**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$465	$0	$465	($465)
VACAA, Section 801 (0162)	$0	$100	$169	$176	$183	$7	$7
Mandatory Obligations [Subtotal]	**$0**	**$100**	**$169**	**$641**	**$183**	**$472**	**($458)**
Mandatory Total	**$10,541**	**$1,000**	**$342**	**$110,931**	**$255**	**$110,589**	**($110,676)**
Combined Discretionary and Mandatory by Category							
Medical Services	$736,591	$835,094	$526,022	**$996,439**	**$943,795**	$470,417	($52,644)
Medical Community Care	$186,479	$389,006	$201,519	**$378,057**	**$366,594**	$176,538	($11,463)
Medical Support and Compliance	$113,588	$144,300	$122,103	**$126,610**	**$144,000**	$4,507	$17,390
Medical Facilities	$123,191	$141,200	$138,071	**$131,165**	**$134,300**	($6,906)	$3,135
Obligations [Grand Total]	**$1,159,850**	**$1,509,600**	**$987,715**	**$1,632,271**	**$1,588,689**	**$644,556**	**($43,582)**

1 The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Authority for Action
The 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 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 9.2 million Veterans enrolled in VA healthcare. Approximately 1.4 million enrolled Veterans are eligible for comprehensive dental care. During 2020, VA dental services managed the care of 402,000 Veterans eligible for comprehensive dental care. An additional 61,000 were eligible and provided dental care due to medical necessity (21% above eligibility for comprehensive dental care), for a total of 463,000 Veterans.

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 increase at a rate of approximately 8%. The number of Veterans eligible for comprehensive dental care increased by 5.3% in 2020. During 2020, Veteran enrollment and the number of compensation and pension exams decreased due to the COVID-19 pandemic. Had there not been a pandemic, these Veterans would have had their compensation and pension exams and potentially be found eligible for comprehensive dental care, and their dental needs would have been met. This lack of access created a backlog. The backlog estimate is 2.5 million dental procedures based upon historical utilization. In 2020, the 246 VA dental clinics managed the care of 494,000 Veterans. 463,000 Veterans received dental care on-site in a VA clinic. 3.6 million procedures were completed during 1.3 million visits. The remaining 31,000 Veterans received dental care exclusively through Community Care.

Projections for the Future
Due to the COVID-19 pandemic's impact on utilization in 2020, data for projections will continue to use 2019 and add an adjustment for the pandemic's backlog. The VA defines market share as the number of Veterans provided care during the 2019 that are eligible for comprehensive dental care (490,000) divided by the total number of Veterans eligible for comprehensive dental care (1.3 million). This gives a market share of 37%. The Office of Dentistry projects a target market share of 47% in the next five years.

Dental care provided to unique Veterans grew by an average of 2.9% per year from 2015 to 2019. However, the procedure workload has increased by 6.6%, with an increase of 3.0 % patient visits per year. Since 2015, the number of dental treatment rooms increased by 2.0% and dentist staffing increased by 2.4% per year. The Office of Dentistry projects a target market share of 47% within five years. Given the historical annual growth rate of 8.2% for Veterans eligible for comprehensive dental care, the VA Office of Dentistry forecasts about 2.05 million Veterans will be eligible for comprehensive care in five years. The number of unique Veterans to serve in 2025 is projected at 751,000 for comprehensive dental care and 142,000 for focused care due to medical necessity, for a total of 893,000.

Studies by the American Dental Association[1] (ADA) and the Centers for Disease Control and Prevention[2] (CDC) show yearly dental service utilization up to 60% for those with third-party payor coverage in the U.S. population. These studies show there is significant potential for growth.

Fiscal Year	Unique Veterans Seen	Market Share	Total Cost
Historical Data			
2015	471,059		$877,823,363
2016	480,950		$943,884,008
2017	493,900		$1,010,974,830
2018	512,290		$1,050,058,413
2019	541,291	37%	$1,117,934,060
2020 Pandemic	462,823	33%	$1,122,582,873
Forecast Market Share			
2021	660,955	39%	$1,837,436,054
2022	715,001	41%	$1,987,681,787
2023	771,626	43%	$2,145,096,489
2024	830,933	45%	$2,309,969,602
2025	893,032	47%	$2,482,601,331

*Note market share data is not available prior to 2019

[1] 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 .

[2] Centers for Disease Control and Prevention. Dental visits in the past year, by selected characteristics: United States, selected years 1997-2016. Available from: https://www.cdc.gov/nchs/data/hus/2017/078.pdf

Inpatient Care

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$7,859,374	$8,402,988	$7,203,728	$5,734,460	$10,134,739	($1,469,268)	$4,400,279
Discretionary FFCRA/CARES Act Obligations	$1,389,305	$0	$2,182,400	$0	$0	($2,182,400)	$0
Discretionary Obligations [Subtotal]	**$9,248,679**	**$8,402,988**	**$9,386,128**	**$5,734,460**	**$10,134,739**	**($3,651,668)**	**$4,400,279**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$5,660,560	$4,381,112	$6,597,533	$8,070,496	$8,642,668	$1,472,963	$572,172
Discretionary FFCRA/CARES Act Obligations	$399,554	$0	$742,975	$0	$0	($742,975)	$0
Discretionary Obligations [Subtotal]	**$6,060,114**	**$4,381,112**	**$7,340,508**	**$8,070,496**	**$8,642,668**	**$729,988**	**$572,172**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$1,414,903	$1,432,900	$1,520,813	$1,577,316	$1,793,904	$56,503	$216,588
Discretionary CARES Act Obligations	$43,670	$0	$139,568	$0	$0	($139,568)	$0
Discretionary Obligations [Subtotal]	**$1,458,573**	**$1,432,900**	**$1,660,381**	**$1,577,316**	**$1,793,904**	**($83,065)**	**$216,588**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$1,200,102	$1,277,100	$1,338,812	$1,267,966	$1,302,618	($70,846)	$34,652
Discretionary CARES Act Obligations	$100,098	$0	$125,830	$0	$0	($125,830)	$0
Discretionary Obligations [Subtotal]	**$1,300,200**	**$1,277,100**	**$1,464,642**	**$1,267,966**	**$1,302,618**	**($196,676)**	**$34,652**
Discretionary Total	**$18,067,566**	**$15,494,100**	**$19,851,659**	**$16,650,238**	**$21,873,929**	**($3,201,421)**	**$5,223,691**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$3,416,368	$0	$3,416,368	($3,416,368)
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$300	$427	$443	$407	$16	($36)
Mandatory Obligations [Subtotal]	**$0**	**$300**	**$427**	**$3,416,811**	**$407**	**$3,416,384**	**($3,416,404)**
Medical Community Care Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$400,453	$0	$400,453	($400,453)
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)	$137,411	$35,900	$1,700	$0	$0	($1,700)	$0
Mandatory Obligations [Subtotal]	**$137,411**	**$35,900**	**$1,700**	**$400,453**	**$0**	**$398,753**	**($400,453)**
Medical Support and Compliance Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$551,650	$0	$551,650	($551,650)
VACAA, Section 801 (0152)	$84	$600	$87	$84	$96	($3)	$12
Mandatory Obligations [Subtotal]	**$84**	**$600**	**$87**	**$551,734**	**$96**	**$551,647**	**($551,638)**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$823,368	$0	$823,368	($823,368)
VACAA, Section 801 (0162)	-$4,837	$700	$1,188	$1,234	$1,282	$46	$48
Mandatory Obligations [Subtotal]	**-$4,837**	**$700**	**$1,188**	**$824,602**	**$1,282**	**$823,414**	**($823,320)**
Mandatory Total	**$132,658**	**$37,500**	**$3,402**	**$5,193,600**	**$1,785**	**$5,190,198**	**($5,191,815)**
Combined Discretionary and Mandatory by Category							
Medical Services	$9,248,679	$8,403,288	$9,386,555	**$9,151,271**	**$10,135,146**	($235,284)	$983,875
Medical Community Care	$6,197,525	$4,417,012	$7,342,208	**$8,470,949**	**$8,642,668**	$1,128,741	$171,719
Medical Support and Compliance	$1,458,657	$1,433,500	$1,660,468	**$2,129,050**	**$1,794,000**	$468,582	($335,050)
Medical Facilities	$1,295,363	$1,277,800	$1,465,830	**$2,092,568**	**$1,303,900**	$626,738	($788,668)
Obligations [Grand Total]	**$18,200,224**	**$15,531,600**	**$19,855,061**	**$21,843,838**	**$21,875,714**	**$1,988,777**	**$31,876**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Overview
VA delivers inpatient acute and critical care in its 130 medical centers and through referral to hospitals in the community. Facilities partner with local hospitals to transfer Veterans back into the VA system to safeguard continuity of care. Inpatient Care includes a broad range of treating specialties: Acute and Critical Care Medicine, Cardiology, Surgery and Surgical Subspecialties, Acute Rehabilitation, and Neurology.

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 - PSIs); and Health Care Associated Infections (HAIs).

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[3] 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 four disease processes reported;
- Adverse events, as measured using patient safety indicators (PSIs), are generally similar or lower, with one exception[4]; and
- Rates of health care associated infection are comparable to or lower than the private sector.

CMS data, including hospital-specific data, for VA and the private sector is available for public download[5], 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.[6,7,8]

[3] Link: www.medicare.gov/hospitalcompare
[4] 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.
[5] https://data.medicare.gov/
[6] 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.
[7] Price RA, Sloss EM, Cefalu M et al. Comparing quality of care in Veterans Affairs and non-Veterans Affairs settings. *J Gen Intern Med* 2018;33:1631-8.
[8] 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

Quality Outcomes (Mortality and Readmission) Table

Quality Outcomes (Mortality & Readmission)	VA[9] July 1, 2016 – June 30, 2019	CMS[10] July 1, 2016 - June 30, 2019
Mortality	**Rate**	**Rate**
30-day risk standardized mortality rate - Congestive Heart Failure (CHF RSMR)	8.9	11.3
30-day risk standardized mortality rate - Pneumonia (Pneumonia RSMR)	12.4	15.4
30-day risk standardized mortality rate – Acute Myocardial Infarction (AMI RSMR)	11.8	12.7
30-day risk standardized mortality rate – Chronic Obstructive Pulmonary Disease (COPD RSMR)	7.7	8.4
Readmission	**Rate**	**Rate**
30-day risk standardized readmission rate - Congestive Heart Failure (CHF RSRR)	23.7	21.9
30-day risk standardized readmission rate - Pneumonia (Pneumonia RSRR)	17.8	16.6
30-day risk standardized readmission rate - Acute Myocardial Infarction (AMI RSRR)	17.9	16.1
30-day risk standardized readmission rate – Chronic Obstructive Pulmonary Disease (COPD RSRR)	20.4	19.6

Patient Safety Indicators (PSIs)	VA Risk Adjusted Rate per 1,000 Discharges from April 1, 2018 – March 31, 2020[11]	AHRQ Reported Nationwide Observed Rate per 1,000 Discharges from 2016 HCUP Project[12]
Pressure Ulcer Rate (PSI 03)	0.56	0.51
Inpatient Surgical Deaths (PSI 04)	118.49	146.36
Collapsed lung due to medical treatment (PSI 06)	0.24	0.21
Postoperative Hip Fracture (PSI 08)	0.12	0.08
Perioperative Bleeding/Bruise (PSI 09)	2.19	2.29

[9] VA National Average Risk Standardized Rate calculated by CMS.
[10] CMS National Observed Rate (Hospital Compare)
[11] Rates in this column calculated using International Classification of Diseases – 10th Edition (ICD-10) diagnoses and Agency for Health Research and Quality (AHRQ) PSI Software Version 2019 and are ***risk adjusted rates***.
[12] Data presented in this column are nationwide comparative ***observed rates*** based on an analysis of discharge data from the 2016 AHRQ Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID).

Patient Safety Indicators (PSIs)	VA Risk Adjusted Rate per 1,000 Discharges from April 1, 2018 – March 31, 2020[11]	AHRQ Reported Nationwide Observed Rate per 1,000 Discharges from 2016 HCUP Project[12]
Postoperative Kidney & Diabetic Complications (PSI 10)	0.80	0.73
Postoperative Respiratory Failure (PSI 11)	2.94	5.53
Perioperative Blood Clot/Embolism (PSI 12)	3.00	3.45
Postoperative Sepsis (PSI 13)	2.41	4.05
A wound that splits open after surgery on the abdomen or pelvis (PSI 14)	0.59	0.69
Accidental puncture or laceration from medical treatment (PSI 15)	1.25	1.06

Healthcare-Associated Infections (HAIs)	VA[13] (October 1, 2019-September 30, 2020)	NHSN/CDC[14]
	Mean	Median SIR[15]
1. Central Line Associated Bloodstream Infection Rate (CLABSI) per 1,000-line days		
Acute Care	0.72	0.6
ICU	1.24	0.64
2. Catheter Associated Urinary Tract Infection (CAUTI) per 1,000 catheter days		
Acute Care	1.01	0.79
ICU	.63	0.81
		NHSN[16]
3. Total Bloodstream (BSI) Infection rates per 100 patient months		
Outpatient Dialysis Treatment Center	0.56	0.64

[13] 2020 rates are based on incomplete reporting directly related to suspense of reporting data from March through June.
[14] National Healthcare Safety Network (NHSN) – Centers for Disease Control and Prevention (CDC). National and State Healthcare-Associated Infection Progress Report, March 2018 www.cdc.gov/hai/progress-report/index.html; https://www.cdc.gov/hai/surveillance/progress-report/index.html
[15] SIR: Standardized Infection Rate. VA rates are reported without standardization, so comparisons are not risk-adjusted
[16] Nguyen DB, Shugart A, Lines C, et al. National Healthcare Safety Network (NHSN) Dialysis Event Surveillance Report. *Clin J Am Soc Nephrol* 2017;12:1139-1146.

4. Access-Related Bloodstream (ARB) Infection rates per 100 patient months		
Outpatient Dialysis Treatment Center	0.26	0.49
5. Total Bloodstream Standardized Infection Ratio (SIR)		
Outpatient Dialysis Treatment Center	1.05	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, healthcare 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, healthcare 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.

Note that overall, in-hospital mortality is lower than in the subset from March 1 through May 31, 2020, concordant with observations outside VA that mortality rates are going down. Factors such as changing age demographics, medical comorbidities, and better evidence-based treatment may in part explain these differences.

COVID-19 Summary		
Feb 28 – Nov 12, 2020	Hospitalization for COVID-19	15,462
	ICU Admission*	7,029 (45.5%)
	Mechanical Ventilation	1610 (19.7% of ICU Admissions*)
	In-Hospital Mortality	1838 (11.9%)
	State Veterans Home Patients Hospitalized in VA	584
	4th Mission Civilian Patients Hospitalized in VA	296
Subset March 1 – May 31, 2020[17]	Veterans Hospitalized for COVID-19	3,948
	Length of Stay, days (IQR)	8.6 (3.9-18.6)
	ICU Admission	1421 (36.5%)
	In-Hospital Mortality	828 (21.0%)
*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.		

[17] Cates J, Lucero-Obusan C, Dahl RM, et al. 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.

Accomplishments/Highlights
During 2020, VHA Hospital Medicine was reorganized into 18 VISN Lead positions, appointed by each network in collaboration with central leadership. Hospital Medicine was transitioned from a Field Advisory Committee to a National Program Office within Specialty Care Service, including a centrally funded, field-based National Program Director position.

A Community of Practice website, email distribution group, and national and VISN-level meetings of facility-level Hospital Medicine chiefs was initiated and leveraged extensively throughout the remainder of 2020 in response to the pandemic and natural disasters, most notably being the fires in California and Oregon.

As part of the pandemic response, several VA Medical Centers provided regional support for COVID-19 care, serving Veterans, non-Veterans, and residents of State Veterans Homes.

Recent Trends/Projections for the Future:

- A Tele-Hospital Medicine Service was introduced in VISN 23, connecting an academic VA Medical Center to a rural 10-bed hospital. Hospital Medicine faculty at the hub site partnered with Advance Practice Providers at the spoke site to provide 2,015 episodes of care to 335 Veterans. This proof of concept pilot succeeded in reducing the mean length of stay from 3.0 to 2.3 days at the rural VA hospital, with no changes to performance metrics, readmission rates, or patient satisfaction.

- Tele-Hospital Medicine holds great promise as a methodology to support smaller VA medical centers, as a means of rapidly supporting any site experiencing a surge of admissions related to the pandemic and ensuring best practices and efficient care are leveraged across the organization.

- VHA Hospital Medicine, Emergency Medicine, and Pulmonary/Critical Care are exploring a strategic and structural partnership given their shared Inpatient Care mission. Opportunities exist to share and combine operational and performance data, quality improvement infrastructure, clinical pathways, education, faculty engagement, and more.

Mental Health

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$7,958,602	$7,768,085	$9,329,720	$10,642,464	$11,522,019	$1,312,744	$879,555
Discretionary FFCRA/CARES Act Obligations.....	$101,219	$0	$159,000	$0	$0	($159,000)	$0
**Discretionary Obligations [Subtotal].....	**$8,059,821**	**$7,768,085**	**$9,488,720**	**$10,642,464**	**$11,522,019**	**$1,153,744**	**$879,555**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$379,309	$442,715	$477,979	$579,327	$629,953	$101,348	$50,626
Discretionary FFCRA/CARES Act Obligations.....	$20,125	$0	$37,423	$0	$0	($37,423)	$0
**Discretionary Obligations [Subtotal].....	**$399,434**	**$442,715**	**$515,402**	**$579,327**	**$629,953**	**$63,925**	**$50,626**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations.....	$850,939	$991,400	$914,625	$948,628	$1,078,818	$34,003	$130,190
Discretionary CARES Act Obligations.....	$1,319	$0	$4,215	$0	$0	($4,215)	$0
**Discretionary Obligations [Subtotal].....	**$852,258**	**$991,400**	**$918,840**	**$948,628**	**$1,078,818**	**$29,788**	**$130,190**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations.....	$948,601	$1,053,800	$1,062,482	$1,006,242	$1,033,801	($56,240)	$27,559
Discretionary CARES Act Obligations.....	$9,416	$0	$11,836	$0	$0	($11,836)	$0
**Discretionary Obligations [Subtotal].....	**$958,017**	**$1,053,800**	**$1,074,318**	**$1,006,242**	**$1,033,801**	**($68,076)**	**$27,559**
**Discretionary Total	**$10,269,530**	**$10,256,000**	**$11,997,280**	**$13,176,661**	**$14,264,591**	**$1,179,381**	**$1,087,930**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/.....	$0	$0	$0	$248,901	$0	$248,901	($248,901)
American Rescue Plan Act, Section 8007 (0160).....	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160).....	$0	$200	$366	$380	$349	$14	($31)
**Mandatory Obligations [Subtotal].....	**$0**	**$200**	**$366**	**$249,281**	**$349**	**$248,915**	**($248,932)**
Medical Community Care Category							
Veterans Medical Care and Health Fund (0173) 1/.....	$0	$0	$0	$20,170	$0	$20,170	($20,170)
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).....	$15,907	$300	$200	$0	$0	($200)	$0
**Mandatory Obligations [Subtotal].....	**$15,907**	**$300**	**$200**	**$20,170**	**$0**	**$19,970**	**($20,170)**
Medical Support and Compliance Category							
Veterans Medical Care and Health Fund (0173) 1/.....	$0	$0	$0	$16,661	$0	$16,661	($16,661)
VACAA, Section 801 (0152).....	$72	$400	$75	$72	$82	($3)	$10
**Mandatory Obligations [Subtotal].....	**$72**	**$400**	**$75**	**$16,733**	**$82**	**$16,658**	**($16,651)**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/.....	$0	$0	$0	$77,449	$0	$77,449	($77,449)
VACAA, Section 801 (0162).....	$0	$600	$1,018	$1,058	$1,099	$40	$41
**Mandatory Obligations [Subtotal].....	**$0**	**$600**	**$1,018**	**$78,507**	**$1,099**	**$77,489**	**($77,408)**
**Mandatory Total	**$15,979**	**$1,500**	**$1,659**	**$364,691**	**$1,530**	**$363,032**	**($363,161)**
Combined Discretionary and Mandatory by Category							
Medical Services.....	$8,059,821	$7,768,285	$9,489,086	**$10,891,745**	**$11,522,368**	$1,402,659	$630,623
Medical Community Care.....	$415,341	$443,015	$515,602	**$599,497**	**$629,953**	$83,895	$30,456
Medical Support and Compliance.....	$852,330	$991,800	$918,915	**$965,361**	**$1,078,900**	$46,446	$113,539
Medical Facilities.....	$958,017	$1,054,400	$1,075,336	**$1,084,749**	**$1,034,900**	$9,413	($49,849)
**Obligations [Grand Total].....	**$10,285,509**	**$10,257,500**	**$11,998,939**	**$13,541,352**	**$14,266,121**	**$1,542,413**	**$724,769**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Authority for Action

- 38 CFR 17.38 Medical Benefits Package; 38 CFR 17.98 Mental Health Services
- 38 U.S.C. §1712A, §1720H, §1720I
- Public Law 114-2, *Clay Hunt Suicide Prevention for American Veterans Act*
- Executive Order (EO) 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 providing some mental health services augmented by use of other VA outpatient services.
- **VA Outpatient Clinics.** The full range of VA medical health clinics, providing encounters with Psychiatrists, Psychologist and Social Workers. The encounters may be individual or group sessions. The issue may be general mental health or care with special emphasis on posttraumatic stress disorder (PTSD), Substance Abuse and homelessness.
- **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 healthcare. 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 Emergency Room or may be managed in another setting like Primary Care.

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 primary care clinic.

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

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Treatment Modality ($000):							
VA Inpatient Hospital	$1,687,743	$1,713,430	$1,771,450	$1,910,186	$1,949,659	$138,736	$39,473
Contract Inpatient Hospital	$433,936	$414,531	$540,526	$627,759	$660,122	$87,233	$32,363
Psychiatric and VA Dom Res. Rehab. Trmt	$794,679	$851,982	$897,357	$1,020,739	$1,033,199	$123,382	$12,461
VA Outpatient Clinics	$5,699,729	$5,908,328	$6,886,439	$7,649,043	$8,210,710	$762,605	$561,667
Non-VA Outpatient	$164,464	$180,086	$204,862	$237,924	$250,190	$33,062	$12,266
Subtotal Direct Mental Health	$8,780,551	$9,068,357	$10,300,634	$11,445,652	$12,103,881	$1,145,018	$658,229
Non-Add included above:							
Suicide Prevention Treatment in MH setting	*$1,037,129*	*$1,254,105*	*$1,135,653*	*$1,219,755*	*$1,266,448*	*$84,102*	*$46,693*
Suicide Prevention Outreach 1/:							
Suicide Prevention Direct Program, SP	$183,762	$253,291	$252,019	$535,686	$537,160	$283,667	$1,474
Suicide Prevention Coordinators, GP	$57,012	$59,344	$59,344	$62,311	$65,427	$2,967	$3,116
Subtotal Suicide Prevention Program Subtotal	$240,774	$312,635	$311,363	$597,997	$602,587	$286,634	$4,590
Suicide Prevention Treatment in Non MH Setting	$381,170	*$372,589*	$417,380	$448,289	$465,450	$30,909	$17,161
Contract Homeless	$444,921	*$207,801*	$458,488	$472,644	$486,563	$14,156	$13,919
VA - Mental Health in non MH Setting	$438,093	$296,118	$511,074	$576,770	$607,640	$65,696	$30,870
Total Mental Health	**$10,285,509**	**$10,257,500**	**$11,998,939**	**$13,541,352**	**$14,266,121**	$1,542,413	$724,769
Major Characteristics of Program ($000):							
SMI - PTSD	$325,638	$370,474	$346,518	$363,230	$373,615	$16,712	$10,385
SMI - Substance Abuse	$576,969	$671,914	$630,611	$666,745	$690,630	$36,134	$23,885
SMI - Other Than PTSD & SA	$5,014,420	$5,515,883	$5,068,158	$5,156,379	$5,290,892	$88,221	$134,513
Subtotal, SMI	$5,917,027	$6,558,271	$6,045,287	$6,186,354	$6,355,137	$141,067	$168,783
Suicide Prevention Outreach	$240,774	$312,635	$311,363	$597,997	$602,587	$286,634	$4,590
Other Mental Health (Non-SMI)	$4,127,708	$3,386,594	$5,642,289	$6,757,001	$7,308,397	$1,114,712	$551,396
Total Mental Health	$10,285,509	$10,257,500	$11,998,939	$13,541,352	$14,266,121	$1,542,413	$724,769
Included Above:							
OEF/OIF/OND POPULATION *ONLY*:							
SMI - PTSD	$149,407	$161,359	$164,269	$179,370	$194,710	$15,101	$15,340
SMI - Substance Abuse	$143,146	$177,596	$157,385	$171,853	$186,550	$14,468	$14,697
SMI - Other Than PTSD & SA	$1,076,165	$1,244,045	$1,183,214	$1,291,986	$1,402,475	$108,772	$110,489
Subtotal, SMI	$1,368,718	$1,583,000	$1,504,868	$1,643,209	$1,783,735	$138,341	$140,526
Other Mental Health (Non-SMI)	$641,079	$526,796	$704,849	$769,645	$835,464	$64,796	$65,819
Total OEF/OIF/OND	$2,009,797	$2,109,796	$2,209,717	$2,412,854	$2,619,199	$203,137	$206,345
Average Daily Census:							
Acute Psychiatry	1,876	2,074	1,816	1,758	1,698	(58)	(60)
Contract Hospital (Psych)	194	585	186	174	162	(12)	(12)
Psy Residential Rehab	3,825	5,488	3,616	3,341	3,039	(274)	(303)
Total	5,895	8,147	5,618	5,273	4,898	(345)	(375)
Outpatient Visits:							
VA Care - Mental Health	16,176,419	18,613,771	16,827,884	17,479,350	17,606,263	651,466	126,914
Non-VA Care - Mental Health	1,122,325	1,051,475	998,434	1,015,849	1,024,725	17,415	8,876
Not Included Above:							
VA - Mental Health in non MH Setting	1,792,287	929,501	2,049,638	2,237,272	2,271,999	187,634	34,727

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 1.72 million Veterans (29% of all VHA users) receiving mental health services in a VHA specialty mental health setting in 2020.

Across VA settings of care, more than 525,000 Veterans were seen in 2020 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 in 2020 were men over age 50.

Type of Services Provided
Consistent with the Secretary's goal to innovate and deliver services more efficiently, the Office of Mental Health and Suicide Prevention (OMHSP) now includes the Veterans Crisis Line (VCL) and 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 primary care, geriatric and specialty medical care programs and clinics;
- Leading the nation in training mental health providers in evidence-based mental health treatments; and
- 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 2019 (from 10.7 million to 21.8 million), and during the COVID-19 pandemic VA provided 20.4 million encounters and telephone visits in 2020.
- Between 2006 and 2020, 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 FY 2006, 20% of VHA users received mental health services, and in 2020, 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 2020, 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. As of April 2021, VHA has trained over 16,500 clinicians in one or more of these EBPs.
- Between 2016 and 2020, same-day, warm hand-offs between the Primary Care Provider and a Primary Care – Mental Health Integration (PC-MHI) provider increased from about 33% to about 55% of PC-MHI appointments.
- In 2017, VA began offering emergent mental health services to former Servicemembers with Other than Honorable administrative discharges. In 2020, 3,246 Servicemembers with an "other than honorable" discharge received mental health services.
- The scale of the shift to telehealth in response to COVID-19 was dramatic. In 2020 nearly 550,000 Veterans received tele-mental health services during more than 2.4 million sessions. In contrast, in FY 2019, more than 230,000 Veterans received tele-mental health during more than 786,000 sessions. Of the Veterans receiving tele-mental health care, 86% of all tele-mental health visits were into the Veteran's home or other preferred location. More than 12,800 VA outpatient mental health providers (97%) had completed a clinical video visit as of April 2021.
- In 2020, work continued to establish integrated Clinical Resource Hubs (including both Primary Care and Mental Health) to support telehealth in all VA regional networks.
- 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. The REACH VET program has identified more than 87,000 Veterans since it began in 2017. Furthermore, data suggest that in comparison to control groups, Veterans identified by REACH VET exhibited:
    - More health care appointments
    - More mental health appointments
    - Decreases in the percent of missed appointments
    - Greater completion of suicide prevention safety plans
- 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. In 2020, almost 12,300 reviews were completed on these patients. A well-controlled evaluation of outcomes associated with reviews of these patients found that being mandated for review

was associated with a significant reduction in all-cause mortality risk over the next four months.

- 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 31,700 VHA prescribers, representing all VHA facilities, have prescribed naloxone, and more than 534,900 naloxone prescriptions have been dispensed to over 285,700 Veterans (as of April 2021). Through April 2021, as documented through spontaneous reporting of overdose reversal events as well as through a national note template, over 1,800 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 through 2030 (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, demonstrating high demand for mental health services. During the same period, the inpatient-bed-days-of-care measurement is expected to be stable at about 3,450,000.
- 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 VHA workforce by December 2018. VA embarked on a Mental Health Hiring Sustainability Initiative in 2019 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	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Treatment Modality ($000):							
MH Inpatient	$61,168	$62,496	$63,554	$66,033	$68,608	$2,479	$2,575
MH Clinics	$117,039	$112,454	$121,604	$126,347	$131,275	$4,743	$4,928
MH Dom/RRT	$62,391	$76,669	$64,824	$67,352	$69,979	$2,528	$2,627
Methadone	$39,453	$42,061	$40,992	$42,591	$44,252	$1,599	$1,661
Other Inpatient	$7,967	$10,311	$8,278	$8,601	$8,936	$323	$335
Other OPC	$34,796	$41,214	$36,153	$37,563	$39,028	$1,410	$1,465
Subtotal Treatment	$322,814	$345,205	$335,405	$348,487	$362,078	$13,082	$13,591
Pharmacy	$25,179	$37,643	$26,161	$27,181	$27,181	$1,020	$0
Total Treatment	**$347,993**	**$382,848**	**$361,566**	**$375,668**	**$389,259**	**$14,102**	**$13,591**
Jason Simcakoski Memorial and Promise Act (*Jason's Law*) 1/ 2/ 3/:							
Pain and Opioid Management Services	$14,998	$68,387	$76,987	$207,197	$207,197	$130,210	$0
Pain and Opioid Management Administration	$512	N/A	$1,419	$5,500	$5,588	$4,081	$88
Patient Centered Care Services	$26,777	$41,279	$29,611	$29,857	$29,857	$246	$0
Patient Centered Care Administration	$2,145	N/A	$2,995	$3,112	$3,112	$117	$0
Program [Subtotal]	**$42,287**	**$109,666**	**$111,012**	**$245,666**	**$245,754**	**$134,537**	**$88**
Total Opioid Prevention, Treatment and Program Cost	**$390,280**	**$492,514**	**$472,578**	**$621,334**	**$635,013**	**$148,639**	**$13,679**

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 million is no longer reflected in this table

Authority for Action

- 38 U.S.C. 1701
- 38 C.F.R. § 17.38
- Jason Simcakoski Memorial and Promise Act, P.L. 114-198 § 901-933

VA continues to pursue a comprehensive strategy to promote safe prescribing of opioids when indicated for effective pain management and to directly address treatment of opioid use disorder (OUD) and prevention of opioid overdose. The Pain Management Program in Specialty Care Services (SCS) expanded through funding established with the enactment of P.L. 114-198, title XI, the Jason Simcakoski Memorial and Promise Act[18], also referred to as *Jason's Law,* to form the Pain Management, Opioid Safety Program (PMOP) office. For 2022, the proposed increase of $148.6 million over the 2021 amount will allow for more targeted funding of pain management and opioid safety programs primarily at the facility level with national support to ensure successful implementation. Thus, we will increase access to care especially in rural areas. Despite national mandates, several facilities have no access to pain specialty care at all, and even if available, many facilities do not offer comprehensive pain care with adequate access to effectively support Veterans suffering from severe chronic pain. The funds will improve the quality and delivery of care by providing skill building and supportive resources to bring together the highest-level experts in every VA location.

[18] Previously cited as Comprehensive Addiction and Recovery Act of 2016 (CARA)

Funding established through *Jason's Law* beginning in 2020 allowed SCS to establish a small team that works closely with the National Pain Management Program p, now known as PMOP, to oversee *Jason's Law* implementation as it relates to opioid safety and pain management initiatives throughout VHA. Additional resources in 2022 will help to staff the newly established PMOP Office allowing the staff to continue to support the accomplishments to date and address the expansion, integration, and implementation of the programs listed below. The evolution of opioid and pain care necessitates the development of new monitoring efforts which would be supported by this budget.

Purpose:

1. <u>VHA Opioid Overdose Education and Naloxone Distribution (OEND):</u>
Naloxone is a medication used to block the effects of a potentially fatal opioid overdose and VA is a national and international leader in naloxone distribution to healthcare patients (Oliva et al., 2017). Based on VA achievements to date, including:

(1) dispensing naloxone medication without charge to over 534,000 patients with over 1,800 reported opioid overdose reversals from the start of the program;

(2) equipping 3,552 VA Police Officers and 1,087 AED Cabinets with naloxone (as of April 2021); and

(3) Academic Detailers (specially trained VA pharmacists) also promoted OEND through individualized, evidence-based educational outreach visits and consultation for clinicians by clinicians. Through 2021 Q2, academic detailers had completed more than 25,100 such visits with more than 18,500 health care professionals nationwide.

A portion of the requested increase above 2021 level will support continued growth and replenishment of VHA's Opioid Overdose Education and Naloxone Distribution (OEND) consisting of: 1) providing naloxone and education to VA patients at-risk for opioid overdose; 2) Rapid Naloxone Initiative effort to distribute naloxone to VA Police; and 3) Rapid Naloxone Initiative to deploy naloxone to Automated External Defibrillator (AED) cabinets. This includes continuing to fund naloxone free to the field (as is legislatively required by *Jason's Law*), 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 and in AED kits. In 2018 VA dispensed a naloxone prescription for 1 in 5 patients on high dose opioids compared to 1 in 69 patients in the private sector (Guy et al, 2019).

VA's requested pain and opioid management budget will ensure VA continues to expand its efforts to ensure rapid availability of lifesaving naloxone to patients and staff. This growth will be tracked utilizing the same metrics listed above.

COVID-19 Impact: The most recent provisional data available from the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) indicate that approximately 81,230 drug overdose deaths occurred in the United States in the 12-months ending in May 2020. This represents a worsening of the drug overdose epidemic in the United States and is the largest number of drug overdoses for a 12-month period ever recorded. The recent increase in drug overdose mortality began in 2019 and continues into 2020, prior to the declaration of the COVID-19 National Emergency in the United States in March. The increases in drug overdose

deaths appear to have accelerated during the COVID-19 pandemic. Synthetic opioids are the primary driver of the increases in overdose deaths. The 12-month count of synthetic opioid deaths increased 38.4 from the 12-months ending in June 2019 compared with the 12-months ending in May 2020 (HAN Archive, 2020). Continuing to provide naloxone by replacing expired or used medication and expanding availability and dissemination of naloxone is anticipated to save lives of Veterans suffering from mental health comorbidities and COVID-19 related mental health crisis resulting in accidental or intentional opioid overdose.

Evidence:
There are many studies to support the lifesaving potential of naloxone (Bird et al., 2016; McDonald & Strang, 2016; Walley et al., 2013; Wheeler et al., 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 et al., 2017).

Increasing naloxone availability is included in the Office of National Drug Control Policy (ONDCP)'s Federal National Drug Control Strategy 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).

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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)

2. **Opioid Stewardship**

VA's allocated FY21 pain and opioid management budget was utilized to initiate support and establishment of positions to support *Jason's Law*, including mandated expansion of the Opioid Safety Initiative (OSI). Funding provided to the field supports one PMOP Coordinator position per each VA Medical Center and network. These roles are critical to continued opioid stewardship and assessment of OSI effectiveness as well as addressing new and evolving evidence-based best practices and trends as seen in the opioid epidemic nationwide and mandated by The Joint Commission. In particular, this includes collaboration with the Office of Community Care regarding opioid stewardship and community care prescribers, as is mandated by legislation and OIG recommendations. Additionally, this includes collaboration with Office of Information Technology (OIT) and Office of Electronic Health Record Modernization (OEHRM) to integrate a network of state Prescription Drug Monitoring Program (PDMP) into VHA's electronic health record (EHR), as recommended in ONDCP's National Drug Control Strategy.

Efforts in 2022 and 2023 will include continuing to staff both at the national program and field level, training, supplies, equipment, and other tools needed to support the program and to assist in setting up and managing the program. On-going national program office resources will be required to support the effort throughout the life of the program.

Future Activities:

- Phased implementation at medical centers.
- Development and operationalization of performance measurement, compliance tracking, and the creation of education initiatives and task forces.

This growth will be tracked utilizing the following:

- Communicate routinely with identified Facility PMOP Coordinators on establishment and implementation of Opioid Stewardship Program and initiatives at their assigned facility.
- Communicate routinely with identified Facility PMOP Coordinators on review of VA Opioid Safety Initiative (OSI) metric performance through tools such as the Academic Detailing (AD) OSI Facility Trend Chart and identify opportunities for improvement.
- Require the reporting and submission of standardized data for opioid, pain management, and PDMP-related metrics.
- Communicate routinely with identified Facility PMOP Coordinators to evaluate progress and update action plans as outlined in PMOP-related guidance and memoranda to the field.
- Future efforts to measure compliance emerging from the thresholds set in PMOP-related guidance and memoranda to the field.

COVID-19 Impact: Additional training and support of the clinical staff with respect to opioid stewardship and safer prescribing will improve care and access to Veterans regardless of COVID-19. The impact will be more significant if limited access to care remains due to COVID-19. Due

to COVID-19, the nation has already seen a dramatic increase in overdose deaths with more overdoses recorded in the year prior to May 2020 than any other 12-month period in prior history (HAN Archive, 2020).

Evidence: 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 .
- 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)

3. Tele-Pain

VA efforts in 2022 and 2023 will include establishing a "tele" hub to provide opioid, chronic-pain, addiction prevention and treatment (such as Medication for Opioid Use Disorder, m-OUD), and related care via telehealth technology. This will include 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.

Expanding access to care via telehealth to ensure rural Veterans have access to the timely, quality care they deserve is one of VA's priorities. 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. To implement pain and opioid-related care using the existing tele-hub structure being established by VISN-based "Clinical Resource Hubs", additional specialists in the areas of chronic-pain, opioid use disorder treatment, and pharmacy will need to be added to each VISN hub site. Full time centralized support of the program was also defined as a requirement by VHA's Office of Connected Care for implementation. This would be an expansion of and complement to existing telehealth efforts by offering new care for complex pain and opioid safety that aligns with the VA goals for addressing the opioid epidemic as outlined to the White House Office of National Drug Control Policy (ONDCP). The ONDCP National Drug Control Strategy 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 in rural communities. VA is a member of the National Academy of Medicine Opioid Collaborative and supports the goals of the White House Rural Opioid Federal Interagency Working Group and as such is committed to

addressing the unique challenges presented by a rural population that has been ravaged by the impacts of the opioid crisis.

In addition to the staffing levels indicated above to achieve full operating capacity, the following goal will be monitored and tracked:

- Increasing access to chronic-pain care via telehealth encounters by 5% of which 65% of that increase will be in rural locations.

COVID-19 Impact: The use of telehealth technologies has increased nationwide, particularly in VA, due to COVID-19. In VA alone there has been a 1,731% increase in telehealth visits since March 1 thru April 17, 2021, 2020. (Source: US Department of Veterans Affairs COVID-19 Pandemic Response Weekly Report, April 17-April 23, 2021, https://www.va.gov/health/docs/VA_COVID_Response.pdf)

Additional resources to improve pain and opioid care delivery via these modalities are critical.

Evidence: 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, February 2020, https://trumpwhitehouse.archives.gov/wp-content/uploads/2020/02/2020-NDCS.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
- Elliott, V. L. (2019). *Department of Veterans Affairs (VA): A primer on telehealth* (CRS Report No. R45834). Retrieved from Federation of Research Scientists web site https://fas.org/sgp/crs/misc/R45834.pdf

4. Pain Management Team/Pain Clinic staffing

In 2021, VA supported the development and site integration of the *Jason's Law*-mandated interdisciplinary Pain Management Teams (PMTs) through funding of field resources to staff and active PMT at all field sites. Funding provided to the field also supports one Primary Care Pain Champion and Pain Management Point of Contact per each VA Medical Center and network. VAMCs have made great strides in establishing and beginning to staff and train the PMTs. Data gathered since the initial report indicates 95 of 140 sites have a pain team that includes all required provider types in some regard. Even at facilities that have created complete interdisciplinary PMTs, the volume of complex, high risk, chronic pain patients within VHA overwhelms capacity of these programs. This generates problematic pressure on other services, particularly primary

care, and limits Veteran access to evidence-based services, requiring additional staffing support of the PMTs created to address these complex cases.

Implementation: VA's pain and opioid management budget will continue to support dedicated resources at the VISN and facilities. VISNs and facilities will be able to apply a portion of existing resources for hiring and retaining staff, training/education, supplies/equipment. In addition to the staffing levels indicated in *Jason's* Law to achieve full operating capacity, the following goals will be monitored and tracked:

- PMTs will improve access to specialty care through at least one documented educational event provided to specialty clinics regarding awareness of the "Hub and Spoke" system of care and how to access the Pain Management Team.
- PMTs will improve patient care outcomes through increasing provider utilization of pain specialty care services including e-consults and pain behavioral health. PMTs will increase provider confidence and awareness of managing complex chronic pain through education and outreach initiatives.
- Pain Management Teams will complete a charter and establish a formal referral pathway for increasing the number of patients seen in Pain Management clinics.

COVID-19 Impact: Additional staffing and support of the clinical staff with respect to Pain Management Teams will improve care and access to Veterans regardless of COVID-19. The impact will be more significant if limited access to care remains due to COVID-19.

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

- VA/DoD Clinical Practice Guideline for Management of Opioid Therapy (OT) for Chronic Pain (2017). https://www.healthquality.va.gov/guidelines/Pain/cot/. The VA/Department of Defense (DoD) clinical practice guidelines (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/healthcare 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 U.S. Department of Defense and the U.S. Department of Veterans Affairs 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

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160):	$0	$0	$0	$0	$154,364	$0	$154,364
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$0	$0	$0	$0	$1,606	$0	$1,606
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$155,970**	**$0**	**$155,970**
Mandatory Obligations							
Veterans Medical Care and Health Fund (0173) Category 1/:							
Medical Services	$0	$0	$0	$104,418	$0	$104,418	($104,418)
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$0	$0	$0	$1,552	$0	$1,552	($1,552)
Medical Facilities	$0	$0	$0	$50,000	$0	$50,000	($50,000)
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$155,970**	**$0**	**$155,970**	**($155,970)**
Discretionary & Mandatory Obligations by Category:							
Medical Services	$0	$0	$0	$104,418	$154,364	$104,418	$49,946
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$0	$0	$0	$1,552	$1,606	$1,552	$54
Medical Facilities	$0	$0	$0	$50,000	$0	$50,000	($50,000)
Discretionary & Mandatory Obligations [Total]	**$0**	**$0**	**$0**	**$155,970**	**$155,970**	**$155,970**	**$0**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Authority for Action

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

While VA is a national leader in the prevention and treatment of SUD, gaps exist. As detailed in the National Drug Control Strategy – National Treatment Plan for Substance Use Disorder (NDCS-NTP) (Office of National Drug Control Policy (ONDCP), 2020), among the over 20 million individuals who met criteria for a SUD in 2018, roughly 89% did not receive specialized SUD treatment. Among Veterans receiving care within the Veterans Health Administration (VHA), over 520,000 had a SUD diagnosis in 2020 with less than 30% receiving SUD specialty services.

The Office of Mental Health and Suicide Prevention (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:

- 21 Internal & External Workgroups / Governance Councils

- 6 Federal Workgroups responsive to the NDCS or NDCS-NTP
- Member - Interdepartmental SUD Coordinating Committee established under PL 115-271 §7022, SUPPORT for Patients and Communities Act
- 5 Research Advisory Boards
- Conference/Education Planning

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 (New)
- NDCS-NTP action plan and performance updates

Audit and Oversight Activities

- GAO review of SUD services and GAO High Risk List: Opioids
- 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); and Public-Private Partnerships (2020)
- CMR: Capacity to Provide Services to Veterans with Disabilities of Spinal Cord Dysfunction, Amputations, Blindness, and Mental Illness

SUD treatment services are currently funded through existing appropriations that support the Veterans Equitable Resource Allocation (VERA) provided to the VISNs. Additional resources are required to comply with the ONDCP NDCS, the NDCS-NTP, and congressional and statutory requirements. In addition, funding will be used to address priorities outlined in "The Biden-Harris Administration's Statement of Drug Policy Priorities."

SUD cannot be characterized by use of any one substance but often involves the use of multiple substances. The number of Veterans served within VHA with amphetamine, cannabis, cocaine, and alcohol use disorders is rising. Veterans with an amphetamine use disorder has increased by 71% since 2016 and a 31% increase in cannabis use disorder. 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[19]	% Change 2016 – 2019
Alcohol	363,763	388,933	393,531	416,590	397,986	14.5%
Cannabis	103,815	112,910	123,754	135,766	128,732	30.8%
Cocaine	69,524	70,407	72,258	73,272	66,419	5.4%
Opioid	66,851	69,142	71,471	71,327	68,773	6.7%
Amphetamine	25,549	30,085	37,290	43,720	39,889	71.1%

Opioid Use Disorder

As detailed in the Opioid Prevention, Treatment, and Program Budget narrative, VHA has made significant progress with efforts targeted towards prevention of opioid use disorder (OUD) and opioid overdose deaths.[20] Emerging data suggest that the opioid crisis is evolving. Among Veterans receiving treatment within VHA who died from an opioid overdose, the rate increased from 14.5 per 100,000 person years in 2010 to 21.1 per 100,000 person years in 2016 (Lin et al., 2019).[21] While rates of overdose increased, among those who died from an opioid overdose, the percent receiving an opioid prescription in the 3 months prior to death decreased. The increases in opioid overdoses were largely driven by synthetic opioid (e.g., fentanyl) and heroin overdoses. This suggests VHA's expansive safe opioid prescribing efforts has had an impact while showing the need to target future efforts more directly to address opioid use disorders and use of illicit substances. Additionally, there is significant concern with rising rates of stimulant overdoses, specifically methamphetamine. While there was a slight decline in the number of overdose deaths during 2018, review of preliminary 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)

National Drug Control Strategy - National Treatment Plan (NDCS-NTP)

The NDCS-NTP was developed by ONDCP as required by the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) and outlines twenty-two areas of focus across three pillars (early intervention, improved services for individuals with SUD, and improved quality of treatment). The plan includes six factors and forty-one actions, thirty-one of which are applicable to VHA as a healthcare system or specifically identify VA as a federal agency expected to respond. VHA

[19] Data for 2020 were significantly impacted by changes in healthcare 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.

[20] 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, and includes support for Opioid Overdose Education and Naloxone Distribution, integration of SUD services within Pain Management Teams, and support for the Stratification Tool for Opioid Risk Mitigation (STORM).

[21] During 2017, over 4,500 Veterans died from a drug overdose with the majority categorized as unintentional. Unpublished data reflecting the most current national data, through 2017, from joint VA/Department of Defense Mortality Data Repository, based on comprehensive searches of the Centers for Disease Control and Prevention's National Death Index).

submitted an initial plan in February 2020 and has been meeting regularly with other federal partners to further refine the overall national response to the NDCS-NTP. VHA's response to the NDCS-NTP includes seventy actions/lanes of effort across the enterprise with strategic engagement across multiple program offices (e.g., Clinical Pharmacy Practice Office, Public Health, Primary Care, Community Care, Academic Affiliations, and the Homeless Program Office) and will require collaboration with other federal partners including the Department of Defense. The plan is also responsive to congressional expectations outlined in FY 2019 and FY 2020 appropriations conference reports (e.g., SUD services for women Veterans, universal screening for opioid use disorder, 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.

Consistent with actions identified in the NDCS-NTP, a recent State of the Art (SOTA) conference – Effective Management of Pain and Addiction: Strategies to Improve Opioid Safety sponsored by Health Services Research and Development (HSR&D) provided several policy recommendations with evidence deemed sufficient for implementation:

1. Reduce Stigma by approaching OUD like other life-threatening conditions
    a. Treat drug overdoses like suicide attempts
        i. Mandate the Suicide Behavior and Overdose Report (SBOR) for overdose
        ii. Require offering of FDA approved Medications for OUD (M-OUD) with close follow-up following an overdose and for those at risk
    b. Getting same-day access to M-OUD at every VA facility
        i. SUD staffing models to ensure timely & sustained M-OUD access
        ii. Remove barriers to Emergency Department (ED) and Acute Inpatient initiation
    c. Support medical management of OUD in Primary Care, Behavioral Health Interdisciplinary Program (BHIP), Pain Management and other non-SUD clinic settings
        i. CONDUIT & SCOUTT – VA Quality Enhancement Research Initiative (QUERI) Implementation Initiatives
        ii. Metrics for sustained M-OUD treatment (e.g. 6-month retention)
        iii. Staffing models to support chronic OUD management in Mental Health & Primary Care
    d. Replace administrative discharges for substance use with evidence-based treatment for co-occurring SUDs (e.g. Contingency Management for stimulant or cannabis use)
2. Improve provider knowledge and comfort in providing M-OUD by:
    a. National SUD consultation program modeled after the National PTSD Consultation and Suicide Risk Management Programs
    b. Provider & patient education tools to support M-OUD in "Level One" clinics
3. Align policy to support sustained engagement in M-OUD

The SUD Budget for 2022 and 2023 outlined below reflects VA's commitment to: 1) expanding access to care, closing the treatment gap, and responding to emerging drug threats; 2) enhancing employment opportunities for Veterans in recovery and 3) supporting ongoing education and training to ensure Veterans continue to have access to state of the art, evidence-based treatment for substance use concerns.

1. Access to Care / Responding to Emerging Drug Threats

1.1. Stepped Care for SUD.

Of the slightly more than 520,000 Veterans receiving care within VHA during 2020, less than 30% received specialty SUD treatment with less than 5% 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 44.4% of Veterans diagnosed with OUD and 10.2% of Veterans with AUD receiving clinical practice guideline recommended medications during 2020.

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

Substance	2016	2017	2018	2019	2020
Alcohol Use	26,680 (7.02%)	31,905 (8.2%)	37,651 (9.45%)	42,305 (10.2%)	42,530 (10.8%)
Opioid Use	22,606 (34.1%)	24,069 (34.8%)	24,696 (34.9%)	26,415 (40.4%)	27,571 (44.4%)

To address the low rates of evidence-based M-OUD treatment, VHA launched the Stepped Care for Opioid Use Disorder – Train the Trainer (SCOUTT) initiative in May 2018. Eighteen clinic-based teams comprised of staff from primary care, general mental health, and pain management participated in the training. Between August 2018 and March 2020, the teams evidenced a 162% increase in the number of Veterans receiving buprenorphine for the treatment of OUD and a 177% increase in the number of providers with a Drug Enforcement Administration (DEA) X-waiver allowing them to prescribe 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 access to SUD services outside of the specialty care setting, specifically targeting general mental health and primary care clinics[22]. There will also be additional support for the CRH in each VISN to address gaps in access to SUD services for Veterans who primarily receive care in Community Based Outpatient Clinics. The plan would provide for at least 2 Full-time Equivalent (FTE) per CRH 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. In addition, the plan provides expansion of current universal screening for at-risk alcohol use to include screening for drug use as recommended by the U.S. Preventive Services Task Force and as required by the NDCS-NTP. The resources request would support:

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

- Expansion of approximately 330 staff hired to provide SUD services with capacity for each CRH to provide medications for OUD and AUD as well as SUD counseling.
- QUERI partnered research to evaluate implementation of the stepped care model which expands SUD care beyond specialty care and into primary care, pain management and general mental health clinics.
- Pharmacy infrastructure for in-clinic medication administration.
- VA Central Office infrastructure to support facilitated implementation, training, and evaluation.

Metrics:

- SUD16: Percent of Veterans with OUD receiving guideline indicated medication
- Percent of Veterans with AUD receiving guideline indicated medication
- Percent of Veterans screened annually for drug use *(New)*
- Number of providers within VHA with DEA X-waiver (NDCS Performance Goal)

These efforts are responsive to the following recommendations and requirements:

- ONDCP NDCS: 2.3.2. Require primary care providers employed by the Federal government to obtain and utilize a waiver to prescribe buprenorphine for the treatment of OUD, routinely screen for alcohol and other drug use (AOD) use problems and, when indicated, provide early intervention or treatment services or offer referral to specialty treatment within forty-eight hours.
- NDCS-NTP:
    - Increase addiction and recovery workforce, including peer recovery specialists, addiction nurses, social workers, MSWs, psychologists, addiction psychiatrists and addiction medicine specialists.
    - Improve integrated care for physical and SUD services.
    - Educate healthcare professionals in Primary Care, Emergency Departments, Acute Care Hospitals, Mental Health clinics and other clinical settings with an enriched SUD population on how to make a "clinical assessment" and to engage in shared decision-making on the range of appropriate SUD treatment options, similar to how they would for other chronic diseases.
    - Increase rural access to evidence-based SUD care through outreach, primary care screening, telehealth, distance learning, and mobile units.
- 2019 Clay Hunt Independent Evaluation Report to Congress

1.2. <u>Access to Residential Treatment and Post-stabilization Engagement.</u>

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 2020, sixty-eight Domiciliary SUD programs were in operation with 1,873 beds focused specifically on intensive, medically monitored residential SUD treatment. The NDCS requires access to

SUD treatment within forty-eight hours of referral. The average time between screening for residential treatment and admission to a SUD residential bed within VHA was 21 days through second quarter of 2020, significantly longer than the target defined by the NCDS. Further, the 21 days does not include the time between referral and screening which in some cases may be a few weeks.

Results from the 2019 MH RRTP Annual Program review identified deficiencies impacting access for Veterans needing SUD treatment. Areas of concern identified were inadequate staff coverage, inappropriate referrals, no shows for admission, and long waits for required medical reviews. Factors related to staffing, appropriateness of referral, and medical needs often are related to the need for withdrawal management services. Residential treatment programs 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.

During 2019, each VISN completed a detailed market assessment for MH RRTP services as a subcomponent of a broader review of healthcare services. Review of information provided by facilities as part of that review identified that less than half of the VA medical centers 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. Twelve of eighteen VISNs identified the need for additional SUD services that would require medical facilities funding. At the end of quarter one, 2021 there were five Domiciliary SUD programs under development. These programs are critical to meeting requirements for reducing current wait times and providing admission within forty-eight hours.

Beyond the specific need for expansion of bed-based services for SUD treatment, the NDCS-NTP and 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. The 2022 SUD budget would provide the necessary funds to meet the national benchmarks established by the NDCS and the expectations of stakeholders. This will require:

- 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.
- National SUD program office infrastructure to support development of clinical informatic tools to facilitate referral and admission processes (e.g., real-time report with bed availability, number pending admission, and projected waits).
- Medical facility and activation funds to support the expansion of Domiciliary SUD services. Decisions about targeting of funds will be based on the final results of the market assessment process and will include at least two additional programs/tracks specific to women Veterans. Given the potential delays often associated with new construction, funding will prioritize locations that have identified opportunities for increasing capacity through minor construction and renovation with the ability to complete all renovations during 2022, allowing program operations to begin in 2023.

Metrics:

- Average time between screening and admission for residential SUD treatment
- Percent of Veterans who no show for admission
- Decreased utilization of high-cost services (i.e., acute inpatient admission, emergency department) 1-year post discharge

These efforts are responsive to the following recommendations and requirements:

- ONDCP NDCS: 2.3.2. Require primary care providers employed by the Federal government to obtain and utilize a waiver to prescribe buprenorphine for the treatment of OUD, routinely screen for AOD use problems and, when indicated, provide early intervention or treatment services or offer referral to specialty treatment within 48 hours.
- NDCS-NTP:
  - Explore the development of mobile and online applications/platforms providing up-to-date information on treatment slot availability, information on providers and types of treatment, and online appointment scheduling.
  - Increase addiction and recovery workforce, including peer recovery specialists, addiction nurses, social workers, MSWs, psychologists, addiction psychiatrists and addiction medicine specialists.

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

In order to close the treatment gap as required by the NDCS-NTP, services specific to Veteran engagement are required. The NDCS-NTP specifically requires VA "support peer recovery support services" and "continue peer and paraprofessional 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 et al., 2016; Chinman et al., 2015; Ashford et al., 2019; McCarthy et al., 2019) for individuals who received peer support services as part of their mental health care services. VHA has hired hundreds of Veterans providing such support as peer specialists and is now the single largest employer of peer specialists in the United States. The current 1,143 peer support staff work throughout the VA health care system in inpatient and outpatient mental health and SUD programs, intensive community mental health recovery services (formerly Mental Health Intensive Case Management (MHICM)),

Psychosocial Rehabilitation and Recovery Centers (PRRC), vocational rehabilitation services, and residential treatment programs. However, with the exception of the Domiciliary SUD programs, utilization of peer specialists to support SUD treatment within VHA is not required and there is not capacity within the current infrastructure to support expansion of services or to target SUD services.

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-NTP also requires VA to "increase access to treatment for homeless populations with increased outreach, mobile units". 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 would directly address the requirements of the NDCS-NTP 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 would 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 would provide additional support for SUD case managers to work with the Supportive Services for Veterans and their Families (SSVF) program. The principal objective of the proposal is to link a VA medical center SUD case manager to each SSVF grantee to coordinate MH and SUD care for VHA-eligible homeless Veterans, ensuring prompt access for this high-risk population. Once enrolled in SSVF, VHA-eligible Veterans identified as needing behavioral health services will be referred by grantees to a designated 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 the case manager will review care coordination during regularly scheduled case conferences.

Currently there are 271 SSVF grantees serving communities through the country and US territories. It is expected that they will serve approximately 75,000 Veterans in 2021. As approximately 85% of the Veterans served are VHA-eligible (63,750) and 60% of these Veterans will need assistance from a VA MH provider, potentially 38,250 Veterans would be linked to care.

Details of Peer Support Services – Health Navigators plan:

- Expansion of approximately 300 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.
- QUERI partnered research to evaluate implementation of SUD specific peer support services.
- Expansion of approximately 380 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:
- Post-discharge engagement with or receipt of SUD services including medication for OUD or AUD following acute inpatient admission.
- Decreased utilization of high-cost services (i.e., acute inpatient admission, emergency department) one-year post discharge.

These efforts are responsive to the following recommendations and requirements:
- NDCS-NTP:
  - Increase access to treatment for homeless populations with increased outreach and mobile units.
  - Continue peer and paraprofessional outreach, engagement, and intervention efforts.
  - Support peer recovery support services.
  - Increase addiction and recovery workforce, including peer recovery specialists, addiction nurses, social workers, MSWs, psychologists, addiction psychiatrists and addiction medicine specialists.

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 71% from 2016 through 2019 with cocaine use disorders increasing by 5%. Contingency Management (CM) is the most evidence-based treatment for stimulant 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. 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 would 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 Office of the Inspector General (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 similar to 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 are expected to support post-overdose follow-up and review with the expectation that the VHA infrastructure identified for monitoring and development of clinical informatic tools would also be responsive to this requirement.

Metrics:

- Number of facilities offering abstinence-based CM for stimulant use disorder
- 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 clinical practice guidelines and recommendations outlined in:

- Substance Abuse and Mental Health Services Administration (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
- NDCS-NTP: Increase access to treatment programs, especially for stimulants, benzodiazepines, and other non-opioid substances requiring management during the acute withdrawal process.

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-NTP outlines specific requirements for the expansion mobile technologies and mobile units to support access to SUD treatment. The CESATEs have completed pilot work exploring the feasibility of implementing mobile apps for the treatment of SUD within VHA (https://www.blogs.va.gov/VAntage/75258/help-hand-phone-apps-provide-veteran-support-24-7/).

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 seeks a phased deployment of mobile apps to support treatment of substance use disorders. Initial implementation will target at least one VA medical center in each VISN during 2022 with continued expansion in 2023. The budget would align resources within the CESATEs responsible for identifying the mobile app solution(s) that will be made available and developing the necessary infrastructure to support implementation. The budget seeks support for: QUERI partnered research to evaluate implementation of the stepped care model and CESATE infrastructure to support facilitated implementation, training, and evaluation.

Metrics:

- Percent of Veterans utilizing mobile app solution
- Outcome metrics as defined by the mobile app solution selected

These efforts are responsive to the following recommendations and requirements:

- NDCS-NTP:
  - Promote use of mobile SUD treatment units.
  - Explore the development of mobile and online applications/platforms providing up-to-date information on treatment slot availability, information on providers and types of treatment, and online appointment scheduling.
  - Increase rural access to evidence-based SUD care through outreach, primary care screening, telehealth, distance learning, and mobile units.

2. Enhancement of Employment Opportunities for Veterans in Recovery

During 2019, 65.8% (8,872) 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-NTP requires VA 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 would require 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 et al., 2017; Rosenheck & Mares, 2007; Mueser et al., 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 one FTE per VISN during 2022 (targeted to a single VA medical center) with anticipated expansion during 2023 to support 156 new staff.

Metrics:

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

These efforts are responsive to the following recommendations and requirements:

- NDCS-NTP:
  - Expand access to employment opportunities and support for people in treatment and recovery.

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), Motivational Interviewing (MI), and Behavioral Couples Therapy for SUD (BCT-SUD). *(NOTE: This list does not include contingency management which is considered an evidence-based practice, but not a psychotherapy).* Implementation of MI and BCT-SUD have 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, the current EBPs can only be delivered by licensed providers and via individual psychotherapy. This excludes a notable fraction of the SUD workforce within VA – Addiction Therapists (approximately 360). Further, the majority of care within VHA is provided in group settings particularly in intensive outpatient and residential settings. The SUD budget would address this treatment and training gap through the development, expansion, and implementation of at least six (6) evidence-based psychotherapies (pending any changes in the forthcoming update of the VA/DoD CPG for the Management of Substance Use Disorders) beginning in 2022:

- Cognitive Behavioral Therapy (CBT) for SUD
- Cognitive Behavioral Therapy Skills (CBT) and Relapse Prevention Group Intervention
- 12 Step Facilitation
- Motivational Enhancement Therapy
- Motivational Interviewing
- Behavioral Couples Therapy for SUD

Both relapse prevention groups and 12 Step Facilitation can be implemented by Addiction Therapists.

The SUD budget would provide the resources necessary for the development of needed training materials, validation that the materials 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:

- NDCS-NTP: Increase rural access to evidence-based SUD care through outreach, primary care screening, telehealth, distance learning, and mobile units.

3.2. Expanding the Addictions Workforce.

The NDCS-NTP defines a current gap in the number of trained addiction treatment professionals. VHA is a leader in training healthcare 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 funding for this Center is expected to terminate after 2021 without additional support to continue this critical resource. The Coordinating Center currently provides support for seven Advanced Addiction Fellowship sites with 19 current trainees. The SUD budget would align support for the Coordinating Center within OMHSP to build on the foundation already established by OAA. The alignment would sustain 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. Failure to find funding to continue the work of the Coordinating Center would likely have an adverse impact on the ability to sustain the current training activities supported by the Center. This would also limit future expansion of training opportunities. Further, VA has been identified as the co-lead for developing the national action plan in response to increasing the Addictions Workforce that is expected to address training issues such as these. Synergies gained by aligning within OMHSP and in coordination with the CESATEs is expected to enhance existing efforts to addressing training for current staff.

Metrics:

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

This effort is responsive to the following recommendations / requirements:

- NDCS – Performance Goal
- NDCS-NTP: Increase addiction and recovery workforce, including peer recovery specialists, addiction nurses, social workers, MSWs, psychologists, addiction psychiatrists and addiction medicine specialists.

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.

In response to COVID-19, OMHSP in collaboration with the National Tele-mental Health Center rapidly deployed a national consultation resource – AskTheExpert-SUD@va.gov.

Triaging of consults for this service is currently being managed largely by the Acting National Mental Health Director, SUD 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. Recommendations from the OUD Workgroup from the SOTA included the establishment of a National Consultation 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, the NDCS-NTP, highlights a role for consultation in directly addressing stigma and improving access to care. The SUD budget would formally establish a National SUD Consultation resource with dedicated resources to sustain operations. The plan would leverage expertise currently available within the CESATES and the Medication Addiction Treatment within VA program and align the consultation program with the CESATEs within OMHSP. The level of resources identified are consistent with recommendations from experts at the NC-PTSD.

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

- Field-based training consistent with initiatives outlined, i.e., expansion of SUD services into BHIP and Primary Care settings, initiation of care during inpatient treatment.
- Direct to provider messaging and 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:

- HSR&D State of the Art Conference, *Effective Management of Pain and Addiction*, Policy Recommendation, OUD Sub-group
- NDCS-NTP:
  - Provide training, consultation, and other support to increase the number of healthcare providers screening for and addressing all forms of SUD in general healthcare settings, including potential co-location of, consultation with, or telehealth services from addiction medicine specialists and other addiction professionals and paraprofessionals.
  - Educate healthcare professionals in Primary Care, Emergency Departments, Acute Care Hospitals, Mental Health clinics and other clinical settings with an enriched SUD population on how to make a "clinical assessment" and to engage in shared decision-making on the range of appropriate SUD treatment options, similar to how they would for other chronic diseases.
  - Increase addiction consultation services and integrated care

Suicide Prevention

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Treatment Modality ($000):							
Suicide Diagnosis	$1,113,665	$1,092,932	$1,219,459	$1,309,768	$1,359,906	$90,309	$50,138
MH care in the Emergency Room	$113,644	$120,493	$124,440	$133,655	$138,772	$9,215	$5,117
Reach Veteran in Crisis	$773	$5,196	$846	$909	$944	$63	$35
Suicide Safety Plan	$58,147	$64,858	$63,671	$68,386	$71,004	$4,715	$2,618
High Risk of Suicide	$129,306	$341,323	$141,590	$152,075	$157,897	$10,485	$5,822
MH Suicide Prevention PACT	$2,764	$1,892	$3,027	$3,251	$3,375	$224	$124
COMPACT Act				$73,300	$73,700		
Total Treatment	**$1,418,299**	**$1,626,694**	**$1,553,033**	**$1,741,344**	**$1,805,598**	**$115,011**	**$64,254**
Suicide Prevention Outreach Program:							
Veterans Crisis Line	$111,770	$115,163	$113,891	$255,968	$260,803	$142,077	$4,835
National Suicide Prevention Strategy Implementation	$35,807	$35,950	$41,258	$42,131	$43,897	$873	$1,766
Demonstration Projects	$6,109	$3,022	$5,763	$4,744	$4,821	($1,019)	$77
Suicide Prevention 2.0 Initiative	$4,216	$41,481	$31,361	$66,606	$67,535	$35,245	$929
PREVENTS	$21,251	$53,400	$53,400	$104,482	$97,482	$51,082	($7,000)
Centers of Excellence (includes MIRECC and SMITREC)	$3,899	$3,525	$5,596	$5,311	$5,365	($285)	$54
Local Facility and Community Outreach Activities	$710	$750	$750	$750	$750	$0	$0
Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program	$0	$0	$1,647	$55,694	$56,507	$54,047	$813
Specific Purpose [Subtotal]	$183,762	$253,291	$252,019	**$535,686**	**$537,160**	$283,667	$1,474
Suicide Prevention Coordinators and Teams	$57,012	$59,344	$59,344	$62,311	$65,427	$2,967	$3,116
Total Suicide Prevention Outreach Program	**$240,774**	**$312,635**	**$311,363**	**$597,997**	**$602,587**	**$286,634**	**$4,590**

Authority for Action

- Public Law (P.L.) 116-171, *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*
- Public Law 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)*
- Public Law 114-247, *No Veterans Crisis Line Call Should Go Unanswered Act*

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 2022 budget will support operational readiness in fulfillment of the National Suicide Hotline Designation Act of 2020, which requires the Federal Communications Commission (FCC) to designate 9-8-8 as the universal telephone number for the National Suicide Prevention Lifeline and the VCL. A volume increase of 122 to 154% is anticipated for VCL. The transition to 988 must be complete by July 16, 2022. VCL's 2022 budget request supports 2,452 FTE, an increase of 1,410 over 2021.

Implementation: Planning is currently underway to prepare for implementation of 988, with full transition to 988 occurring by July 2022. VA is proud to support the 988 expansion initiative alongside such partners as the Federal Communications Commission, the Substance Abuse and Mental Health Services Administration, and the National Suicide Prevention Lifeline. Once activated, the 988 expansion will directly address the need for ease of access and clarity in times of crisis, both for Veterans and non-Veterans alike. Several carriers, including T-Mobile, Verizon, and UScellular, have already activated the 988 number. By providing a universal, unique 3-digit

dialing code, it will give the VA an opportunity to work in greater collaboration with the suicide prevention community across the United States and open the door to engage new individuals in life-saving care. Based on initial data sources and various analyses, it is estimated that there could be an increase in call volume of 500,000 calls per year to 1.6 million calls per year. This means that VCL total calls per year could leap from 650,000 calls per year to anywhere between 1.2 million and 2.3 million calls per year.

COVID-19: In February 2020, VCL began implementation of processes for ensuring the well-being of staff and uninterrupted service for Veterans in crisis in light of the COVID-19 pandemic. By April 24, 2020, 100% of ready and willing VCL employees were working from home. Since that time, VCL has tracked and reviewed data across the Quadruple Aim considering quality care outcomes, Veteran and Employee Experience, and cost, efficiency, and access. We have found working in a telework status to be very effective for VCL's Mission as we have maintained our performance metrics while also being able to support our team members.

National Suicide Prevention Strategy:
Purpose: Serves as the core operational budget for the National Suicide Prevention Program (SPP) within the Office of Mental Health and Suicide Prevention (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.

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 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 and VA's SPP NOW work. The SPPs NOW Plan aims to initiate quick deployment of interventions which are deemed to most efficiently impact Veterans at high risk for suicide within one year's time. The five areas of focus are: 1) Lethal means safety; 2) Suicide prevention in medical populations; 3) Outreach and understanding prior Veterans Health Administration (VHA) Users; 4) Suicide Prevention Program enhancements; and 5) Paid media.

The National Suicide Prevention Strategy core operational budget supports the Suicide Prevention Program, which expanded the program from 27 FTE to 66 FTE. In coming year, the program projects the need for further expansion to approximately 110 total FTE to support the ongoing development and roll out of our public health work, primarily under the "Suicide Prevention 2.0 Initiative." The core budget also supports a number of contracts including those that focus on our communications and paid media efforts that aim to raise awareness about mental health and suicide prevention and educate Veterans, their families, and communities about the suicide prevention resources available to them. Contracts also support work for the P. L. 114-2, Clay Hunt Suicide Prevention for American Veterans Act, 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.

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.

COVID19: Suicide data collected during prior pandemics suggest that the long-term psychological and economic stressors associated with the COVID-19 pandemic may result in an increase in deaths by suicide in the United States. With suicide already being a national public health concern, Veterans will continue to be faced with additional challenges and risk factors due to the COVID-19 pandemic. While recognizing that there will likely be an increased demand for services and support, the Suicide Prevention Program is not requesting additional COVID-related funding at this point.

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.

Some specific examples of funded demonstration projects include:

- **Clinical Practice Guidelines Implementation**: - In 2019, the updated VA/DoD Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide was released, along with associated training materials (Patient and Provider Tools; Webinar; Guideline links: https://www.healthquality.va.gov/guidelines/MH/srb/) Within the CPG, 22 recommendations are provided regarding: Screening and Evaluation; Risk Management and Treatment; and, Other Management Modalities. Efforts to date have been focused on supporting Veteran suicide prevention by disseminating and implementing the CPGs across the enterprise, as well as facilitating uptake among community providers treating Veterans. As of the second quarter of 2021, the live monthly CPG lecture series continues, with an average of 196 attendees per lecture. Each live lecture is recorded and turned into an enduring TMS and TRAIN course. Continuing education credits are available to those working in VA and the community for each course. Additionally, a public facing website which will provide information on how to implement the CPG recommendations is in development. Furthermore, the release of the updated CPGs was the impetus for the development of the clinical components for the "Suicide Prevention 2.0 Initiative" (see specific SP 2.0 line item details below).

- **Cognitive Behavior Therapy for Suicide Prevention** (CBT-SP): a pilot looking at the delivery of CBT-SP through telehealth. From the most recent pilot data, which is focused in VISNs 10 and 19, over 375 Veterans were referred to the program, and over 190 began CBT-SP therapy. Among Veterans who enrolled in CBT-SP, symptom measures improved both within session (i.e., Veterans left sessions with lower urge to harm themselves than at the beginning of the session, despite focusing on difficult content during treatment) and over time (e.g., decreases from session 1 to 12 in depression and increases

in self-efficacy to stay safe over the same interval). The pilot continues to serve as one of the cornerstones in the development and implementation of the clinical components for the "Suicide Prevention 2.0 Initiative". In 2021, experts from the pilot led the development of a formal CBT-SP clinical training program and have enrolled 17 providers from 6 VISNs thus far.

- **Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) Caring Communications**: a project that is exploring how to best deliver an evidence-based caring contacts intervention, which is a recommended intervention in the CPGs. Although a recommended (optional) intervention for the REACH VET program, this pilot is examining procedures to reduce barriers to the use of caring contacts to potentially increase its use. If this pilot demonstrates an increase in the use of Caring Letters, it would be expected that there would be a reduction in suicides and other suicide behaviors based on prior caring contacts research. As of the second quarter of 2021, two VA pilot sites have seen the use of caring contacts increase by more than a factor of 14 compared to pre-program implementation. Over 1,000 Caring Contacts have been sent to high-risk Veterans identified by REACH VET. Practical tools are being developed to assist other VA facilities in considering these procedures for REACH VET. Additionally, this project is expanding to test these procedures with Veterans who are discharging from a psychiatric inpatient unit since this is a high-risk period and Caring Contacts were developed for these individuals. Furthermore, this project has helped to inform the caring communications effort being undertaken by the Veterans Crisis Line, which will reach 90,000 Veterans a year.

- **Native Veteran Suicide Prevention**: the overall goal of this project is to advance suicide prevention for Native American Veterans, a group at high-risk of suicide. In partnership with Tribal communities, this effort will develop and strategically test a model of suicide prevention that integrates VA evidence-based, system-wide approaches with culturally grounded Native American perspectives, traditions, and practices. The purpose of this project is to expand partnerships, implement piloting using developed materials and adapted tools, and prepare for national dissemination. To date, in Puget Sound, 29 tribes have been contacted by local Suicide Prevention Coordinators to establish partnerships and in Iron Mountain, 3 tribes have been contacted. As of the second quarter of 2021, the project team has completed a first pilot of the Native Veteran adapted SAVE training, with two more pilots scheduled.

- **Assessing Social and Community Environments with National Data (ASCEND) for Veteran Suicide Prevention:** The overarching goal of ASCEND is to design and implement a recurring national survey of Veterans that will serve as a national surveillance system to document prevalence and trends over time in non-fatal suicidal self-directed violence and provide estimates of the impact of social and community risk and protective factors in Veterans using and not using VHA care. Project development and implementation continues as a partnership between VA investigators, the vendor team, and the ASCEND Veterans Engagement Board (VEB). As of the second quarter of 2021, VEB continues to convene monthly or more and additional members have been recruited to increase VEB diversity. Pilot Survey data collection was completed on February 2, 2021

and total surveys collected exceeded expectations, with 567 completes from 3,796 individuals contacted. The Pilot Survey sampling approach resulted in meeting or exceeding the number of target completes for 3 out of 4 key Veteran subgroups. Preparations for the National Launch are now underway, including analysis of pilot data to inform the National Launch and revision of the survey instrument to include Veterans Crisis Line questions.

- **Comparative Effectiveness of Mental Health Apps for Veterans with Anxiety and Mood Disorders:** a project that aims to recruit Veterans to assess nine digital interventions that have been identified as best-practices and were created by different technology organizations or developed by the Department of Veterans Affairs (e.g., the VA's Mood Coach, Mindfulness Coach). Over the course of the project, the three-month remission of anxiety and depressive (A/D) disorders of Veterans will be assessed. At the conclusion of the project, the goal is to develop an *individualized intervention rule (IIR)* using information from the baseline assessment to determine which of the best-practice interventions is likely to be optimal for each Veteran in promoting three-month remission of A/D disorders. In the first quarter of 2021, the project is in the early stages of project implementation. The project is aiming to begin Veteran recruitment in the third quarter of 2021 with final Veteran follow up assessments to be conducted in the second quarter of 2022.

Implementation: Success for demonstration projects are those that demonstrate small scale measurable impacts on the care Veterans receive, their engagement with care, reduction in suicidal behaviors or suicide risk factors and/or gains in protective factors. 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 largest impact for our Veterans, as evidenced by some of the highlighted examples above.

COVID19: Some existing projects have had minor impacts due to COVID and the need for physical distancing, but the project teams are working on developing alternative approaches to out reaching Veterans. No additional COVID-related funding is being requested.

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 aims to move 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

healthcare 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) migrates and expands three legacy initiatives into a comprehensive approach to community-based suicide prevention to address needs at state and local community levels:

- **For state-level prevention**, OMHSP, in collaboration with our partners at the Substance Abuse and Mental Health Services Administration (SAMHSA), is supporting expanding the *Governor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families*, where state-level policymakers will partner with local leaders to implement a comprehensive suicide prevention plan, with a goal to invite all 50 states to participate by the end of 2022.

- **For local community action**, OMHSP is supporting expansion across all VISNs of a *Community Engagement and Partnerships – Suicide Prevention (CEP-SP)* program focused on community coalition-building coupled with targeted outreach and education, as well as the *Together With Veterans (TWV)* program, a VA Office of Rural Health program focused on empowering and supporting Veteran leadership for suicide prevention.
    - **The community-based interventions expand the capacity of VISNs to engage in community-based suicide prevention efforts in their region, thereby reducing population suicide rates among Veterans.**
    - This includes a comprehensive strategy to hire and train Community Engagement and Partnerships Coordinators (CEPC), who will collaborate at the community, regional, and state levels, to implement evidence-informed community-based suicide prevention interventions.

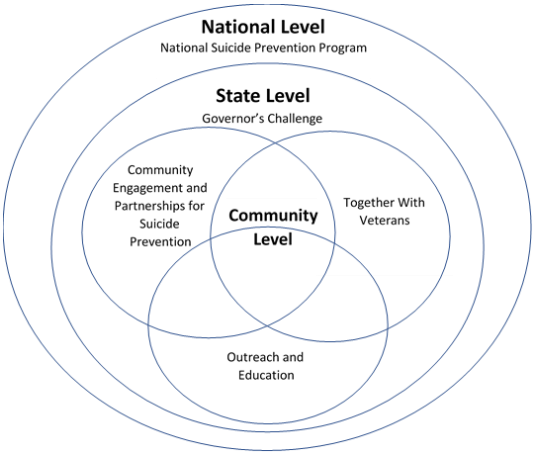

Figure 1: SP 2.0 – Community-Based Prevention

For the clinically-based strategy of SP 2.0, in partnership with VA's CRH, implementation of evidenced-based interventions for suicide prevention via telehealth is underway. 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 in 2021 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, and 4) the Advanced Training in the Safety Planning Intervention (ASPI). 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 identifying persons at-risk for suicide, are set in locations and sites the public would visit, and do not discriminate based on risk level by targeting the whole community. Selective prevention strategies are grounded in the premise of encouraging help-seeking behavior among persons at higher risk for suicidal behaviors, are set in most physical and health treatment locations, and are meant to identify person with risk factors for suicide. Indicated prevention strategies are grounded in the premise of creating no wrong door for accessing and engaging with 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), and indicated (few Veterans) areas.

Furthermore, partnerships promoted by healthcare organizations with communities have been shown to improve patient outcomes (Clyne et al., 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 et al., 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 et al., 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, et al., 2015). Goals to delay gun access during periods of immediate risk for suicide were shown to be feasible to implement, and effective (Walters, et al., 2012) and reducing immediate access to lethal means access has been shown to be most effective when implemented alongside other suicide prevention strategies (Sarchiapone et al., 2011). All of these noted elements are informing and being incorporated into the roll out of SP 2.0.

Implementation: SP 2.0 is planned for a phased roll out between Q4 2020-2023. 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, the National Suicide Prevention Program initiated a Request for Letters of Intent (LOI) approach, which helped to facilitate our phased implementation of this effort. Five additional VISNs were selected to start in the second quarter of 2021 and the remaining VISNs will be starting in the first quarter of 2022. The phased approach allows for us to adapt our approach based on lessons learned over time and to improve innovative community strategies, field 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.

The Suicide Prevention Program is in the process of:

- Establishing consistent reporting requirements for projects.
- Hiring, training, and supervising one Community Engagement and Partnership Program Manager for each VISN, who will be responsible for the overall coordination, integration, and reporting of the VISNs' local and state community coalition work.
- Developing a Technical Assistance Resource Center to provide consistent training, resources, tools, and expertise to support VISN and field implementation.

Furthermore, SP 2.0 remains focused on the continued emphasis of mental health staffing, as greater mental health and staff FTEs per 1,000 patients has been shown to be associated with lower risk for suicide (Richardson, McCarthy, & Katz, 2017). Likewise, increases in mental health staffing are associated with decreases in suicide rates (Katz, et al., 2013).

By the end of the phased roll out in 2023, the *Community Engagement and Partnerships – Suicide Prevention* will have expanded to all 18 VISNs and all 50 states will have been invited to participate in the Governor's Challenge.

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

Similar to the community component of SP 2.0, the clinical arm is in the process of a phased implementation roll out. By the end of 2022, the SP 2.0 Clinical Telehealth program plans to hire and train psychotherapists across all 18 VISNs to implement evidenced-based suicide prevention

interventions and deliver the treatments via video telehealth modalities. As of the second quarter of 2021, wave 1 VISNs have begun onboarding and training the necessary clinical and administrative staff to support the outlined telehealth treatments and interventions. Wave 2 is anticipated to start onboarding in the third quarter of 2021 while the third wave is expected to begin onboard in later 2021/early 2022. Additionally, three VISNs have been identified who will engage in a telehealth pilot utilizing Dialectical Behavior Therapy training and implementation planned for the third quarter of 2021.

Lessons learned from pilot programs (i.e. CBT-SP pilot) on administrative processes, clinician training/education, and strong practices will be utilized for phase 2 and phase 3 when the remaining VISN CRHs begin to onboard necessary clinical staff. Sustainment plans will include training treatment-specific trainers and consultants within the CRH system to ensure the continued capacity of trained therapists.

Furthermore, the National Suicide Prevention Program has dedicated staff and resources to design and implement program monitoring and evaluation protocols for SP2.0. 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 SP2.0. 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 6 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 424 FTE for 2022 and 2023.

COVID19: The National Suicide Prevention Program is currently working with its partners to continue to support Governor's Challenge teams and community-based coalitions during the COVID-19 pandemic. 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, VA/SAMHSA technical assistance activities shifted to a virtual setting. State teams adjusted their action plans and programming to take COVID-19 considerations into account, such as an increased focus on messaging campaigns and virtual trainings. Despite COVID-19, 20 new states joined the Governor's Challenge in 2020 and completed all activities virtually and an additional 8 states will join in 2021. All remaining states will be invited to join in 2022.

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.

PREVENTS

Purpose: The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) Task Force was formed as a result of Executive Order 13861, signed on March 5, 2019, with a call to action to amplify and accelerate the progress in addressing Veteran suicide in the United States.

The first recommendation in the Roadmap was to develop a national public health campaign. That national public health campaign, called Reach, Engage, Attend, Connect, Help (REACH), has garnered more than 5.3 billion impressions since it was launched in July 2020. The REACH website, https://www.reach.gov, has been visited more than 12 million times and PREVENTS-produced public service announcements have had nearly 1.3 million views. In March 2021, PREVENTS launched the *How We R.E.A.C.H Coaching Tool* to teach people how to REACH to help someone in need. In one month, the Coaching Tool was downloaded more than 1,600 times and its accompanying app nearly 900 times.

Evidence: Paid media is a critical component of any national public health campaign. Paid media will be directed through a variety of media platforms, including social media; television, radio; digital content, such as news websites; and online media streaming services (e.g., Pandora and Spotify) and include running public service announcements in communities that have had a high rates of Veteran suicide, and on during programming that are watched, listened to or visited by targeted audiences, and during events or activities attended by Veterans (e.g., the Army/Navy football game). Media placements drive traffic to a campaign website and messages directly, and since it is direct, it can be used to evaluate the effectiveness of the campaign and allow for modifications.

Implementation: During 2022 and 2023 PREVENTS communications will continue to target Veterans at risk for suicide, people in their communities, to get them the resources they need to prevent suicide with a goal of decreasing risk factors and increasing prevention factors. VA will also be evaluating the campaign to see what is effective and will adjust efforts, as needed. VA will also collaborate with partners to carry the public health campaign message forward when the PREVENTS Task Force sunsets. The budget during 2022 and 2023 would cover production and dissemination of a wide range of national campaign materials as well as the cost for evaluation.

COVID19: With the outbreak of COVID-19, the PREVENTS Office recognized the immediate need for resources and information to support Americans struggling with unprecedented psychological challenges. In March 2020, the PREVENTS Office launched More Than Ever Before, a national social media communications campaign focused on equipping all Americans with basic information to help protect them from the negative mental health implications of the pandemic. The campaign aimed to educate individuals about the importance of caring for their emotional well-being every day; the importance of caring for the emotional well-being of our loved ones; and, the importance of reaching out to those most vulnerable in our society. Through this social media effort, PREVENTS created over 150 videos on topics such as managing anxiety,

mitigating conflict, depression, conflict resolution, and the power of kindness. The More Than Ever Before initiative has been incorporated into REACH, the larger overall national public health campaign on suicide prevention.

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.

- *Rocky Mountain Mental Illness Research, Education and Clinical Center:* The mission of the Rocky Mountain Mental Illness Research, Education and Clinical Center (RM MIRECC) 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 (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 healthcare 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 (i.e., chart reviews, family members, 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: By September 30, 2021, the percent of Veterans targeted through predictive modeling algorithms (REACH VET) within the VHA system will reach 95% across the four required metrics (Coordinator Accepted; Provider Accepted; Care Evaluation; Outreach Attempted) and 80% for Successful Outreach.

In the second quarter (Q2) of 2021, national performance exceeded the abovementioned metrics goals.

Metric	**2021 Q2 Performance**
Coordinator Accepted	100%
Provider Accepted	100%
Care Evaluation	99%
Outreach Attempted	99%
Successful Outreach	88%

Furthermore, data suggest that in comparison to control groups, Veterans identified by REACH VET exhibited:

- More health care appointments
- More mental health appointments
- Decreases in the percent of missed appointments
- Greater completion of suicide prevention safety plans

SPED: By September 30, 2021, VA will increase implementation of Safety Planning in the Emergency Department (SPED), to ensure completion of safety planning for eligible Veterans in the ED/Urgent Care Center (UCC) from a baseline of 34 to 90% 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 second quarter of 2021, attempted safety plans for SPED-eligible Veterans reached 86%.

VA SRM Consultation Program: Providers worry and care for the Veterans they treat and want to do all they can to help mitigate their risk for suicide. Unfortunately, however, there is a paucity of training the assessment and management of suicide risk. Silva et al. (2016) illustrates the unfortunate irony in the vital importance of suicide risk management versus the training received and confidence in skills across mental health providers. "Strikingly, most behavioral healthcare 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." 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 Q2 2021 alone (123

consults: 113 VA, 10 community). Additionally, in Q2 2021, an average of 215 individuals attended each SRM lecture (range of attendance: 103-429).

Risk ID: Implementation of Risk ID is currently being measured in the Emergency Department/Urgent Care (ED/UC) setting as well as ambulatory (i.e., outpatient care). As of Q2 2021, 81% of Veterans who had a positive suicide risk screen in the ED/UC received a timely Comprehensive Suicide Risk Evaluation (CSRE).

A new annual screening requirement in ambulatory care was implemented at the beginning of Q2 2021. By the end of the quarter, 32% of Veterans who had the screening due and attended an appointment where it could have been completed were screened. Of those who screened positive, 63% had a timely CSRE.

BHAP: Psychological autopsies, like those conducted by the Behavioral Health Autopsy Program (BHAP), 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 (i.e., proximal risk factors; Conner et al., 2011).

Since 2012 when BHAP data collection began, there have been more than 8,600 BHAP chart reviews completed (approximately 1,080 per year). Since the BHAP Family Interview Program began in 2013, there have been more than 730 family interviews completed (approximately 100 per year). Since 2015, more than 395 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. 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. Additionally, the RM MIRECC team has made updates to the national note templates based

on field feedback. All training materials will be updated to accompany release of the updated templates. This will include an updated training in TMS.

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. 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. 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 51,053 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 2021 = 179) and email support (682 emails in the second quarter of 2021). 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* (e.g., BHAP team members work closely with SPCs in the field to ensure timely completion of chart reviews)
- *Interview Coordination* (e.g., COE-SP trained interviewers conduct structured interviews with bereaved family members and Suicide Prevention Coordinators)
- *Data Management and Collection* (e.g., BHAP programmers develop and manage BHAP collection tools and revise them as needed)
- *Data Analyses and Reporting* (e.g., BHAP team members analyze and report on findings through annual field reports, invited briefings, leadership requests and national conference presentations for key stakeholders [e.g., OMHSP, Mental Health & VISN leadership, 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.

Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP)

Purpose: Supports P.L. 116-171§ 201 of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*, 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 et al., 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 et al., 2019; Oyama et al., 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 2021, critical program infrastructure and regulation are being established to ensure successful implementation of the grants program. The first grant awards are expected in late 2022 or early 2023 (depending on Final Rule). 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.

Prosthetic and Sensory Aids Services

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$3,153,786	$4,072,800	$3,962,362	$4,934,098	$4,797,953	$971,736	($136,145)
Discretionary FFCRA/CARES Act Obligations	$111	$0	$200	$0	$0	($200)	$0
Discretionary Obligations [Subtotal]	**$3,153,897**	**$4,072,800**	**$3,962,562**	**$4,934,098**	**$4,797,953**	**$971,536**	**($136,145)**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$3,153,897**	**$4,072,800**	**$3,962,562**	**$4,934,098**	**$4,797,953**	**$971,536**	**($136,145)**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$313	$0	$313	($313)
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**	**$313**	**$0**	**$313**	**($313)**
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	$100	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$100**	**$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**	**$100**	**$0**	**$313**	**$0**	**$313**	**($313)**
Combined Discretionary and Mandatory by Category							
Medical Services	$3,153,897	$4,072,800	$3,962,562	**$4,934,411**	**$4,797,953**	$971,849	($136,458)
Medical Community Care	$0	$100	$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]	**$3,153,897**	**$4,072,900**	**$3,962,562**	**$4,934,411**	**$4,797,953**	**$971,849**	**($136,458)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

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 CFR 17.150, Sections 1701(6)(F) and 1710.

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/metabolic disease, peripheral vascular disease, cerebral vascular diseases, and other medical disorders.

In 2020, VA obligated $3.1 billion dollars to provide nearly 21 million devices/items to more than 3.3 million Veterans, approximately 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 (e.g., ramps, vehicle modifications, wheelchairs and mobility aids), and devices surgically placed in the Veteran (e.g., 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 2013, PSAS obligations have increased by 52% from $2.1 billion dollars to $3.1 billion dollars obligated in 2020. This is largely 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 2013, the number of unique Veterans served by PSAS has increased from 2.9 to 3.3 million Veterans and the number of devices/items provided by PSAS since has increased by approximately 42% from 12 million to 21 million in 2020.
- Since 2017, new requests for prosthetic items that were open greater than 90 days were reduced by 91% in 2020 due to streamlined policies and procedures for consult management, efficient scheduling initiatives, development of automation systems and data tools, and trainings and resources to support the PSAS workforce.

- 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.
- PSAS complied with the Veteran Appeals Improvement Modernization Act of 2017 and implemented new statutory appeal requirements and reduced all Veteran Prosthetic Benefit Legacy Appeals requiring PSAS action in 2020.
- PSAS supported the Improper Payment and Elimination Recovery Act, now the Payment Integrity Information Act, by reducing the improper payment error rate by 98% since 2017 by completing quarterly audit reports, determining causes of error, developing and deploying quality assurance tools, and conducting national educational trainings to promote compliance with authorizations, payments, and documentation.
- 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 52 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.
- Timeliness to fulfill prosthetic requests will continue improving as the VHA PSAS workforce and workload is right-sized. National staffing guidance will be developed to aid personnel management.
- 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. Continued collaboration with the VA Finance community helps ensure that PSAS budget requirements are met.

- 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.
- Improper payments and error rates will continue improving as processes are updated, systems are modernized, and more emphasis is placed on documentation and education to both PSAS and contracting staff.
- New prosthetics regulations will clarify Veteran eligibility and provide comprehensive regulatory authority to standardize types and quality of prosthetic items/services, update business processes and replace expired policies.
- New Automobile Adaptive Equipment regulations will 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.
- 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:
  - Exploring more prosthetic commodities to use Medical Surgical Prime Vendor services and the Denver Logistics Center to automate the ordering, shipping, of prosthetic consumable items by permitting flexibility to deliver items to VA facilities and 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.
  - Reducing fraud, waste, and abuse by implementing shipment tracking and delivery confirmation for prosthetic items shipped to Veterans' residence.
  - Improving inventory management practices by streamlining data system reporting and responsibilities with Supply Chain Partners and explore integration of the Defense Medical Logistics Standard Support information technology systems for increased efficiencies.
  - Deploying new information technology processes (FLOW3) to automate, integrate and standardize the management and acquisition of prosthetic limbs for Veterans with limb loss.
  - Transforming business practices through innovation and automation strategies through supporting 4Sight project implementation and testing to Automate eye-glass ordering.

Prosthetics Workload

2020 Prosthetic and Sensory Aids by Category		
Commodity Type	**Unique Orders**	**Unique Veterans**
Artificial Limbs	53,876	26,652
Beds/Lifts	108,344	54,686
Dialysis	7,173	4,759
Home Modifications	11,816	10,063
Implants	208,079	136,638
Misc. Equipment	4,059,770	1,954,118
Misc. Services	1,244,937	761,348
Orthoses/Orthotics/Shoes	1,235,462	754,043
Other	37,938	33,173
Oxygen/Respiratory	2,903,065	807,704
Restorations	6,708	5,173
Sensori-Neuro Aids	3,949,353	1,635,115
Telehealth	1,279,978	194,262
Walking Aids	301,000	237,144
Wheeled Mobility	290,746	148,097
Total	**14,441,571**	**3,269,128**

Rehabilitative Care

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$759,320	$826,500	$727,262	$747,304	$814,701	$20,042	$67,397
Discretionary FFCRA/CARES Act Obligations	$31,570	$0	$49,600	$0	$0	($49,600)	$0
Discretionary Obligations [Subtotal]	**$790,890**	**$826,500**	**$776,862**	**$747,304**	**$814,701**	**($29,558)**	**$67,397**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$101,963	$125,500	$109,588	$113,688	$129,286	$4,100	$15,598
Discretionary CARES Act Obligations	$539	$0	$1,722	$0	$0	($1,722)	$0
Discretionary Obligations [Subtotal]	**$102,502**	**$125,500**	**$111,310**	**$113,688**	**$129,286**	**$2,378**	**$15,598**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$121,640	$131,600	$136,231	$129,024	$132,517	($7,207)	$3,493
Discretionary CARES Act Obligations	$2,713	$0	$3,410	$0	$0	($3,410)	$0
Discretionary Obligations [Subtotal]	**$124,353**	**$131,600**	**$139,641**	**$129,024**	**$132,517**	**($10,617)**	**$3,493**
Discretionary Total	**$1,017,745**	**$1,083,600**	**$1,027,813**	**$990,016**	**$1,076,504**	**($37,797)**	**$86,488**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$77,645	$0	$77,645	($77,645)
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$0	$0	$61	$63	$58	$2	($5)
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$61**	**$77,708**	**$58**	**$77,647**	**($77,650)**
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	$6,808	$0	$6,808	($6,808)
VACAA, Section 801 (0152)	$12	$100	$12	$12	$14	$0	$2
Mandatory Obligations [Subtotal]	**$12**	**$100**	**$12**	**$6,820**	**$14**	**$6,808**	**($6,806)**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$22,313	$0	$22,313	($22,313)
VACAA, Section 801 (0162)	$0	$100	$169	$176	$183	$7	$7
Mandatory Obligations [Subtotal]	**$0**	**$100**	**$169**	**$22,489**	**$183**	**$22,320**	**($22,306)**
Mandatory Total	**$12**	**$200**	**$242**	**$107,017**	**$255**	**$106,775**	**($106,762)**
Combined Discretionary and Mandatory by Category							
Medical Services	$790,890	$826,500	$776,923	**$825,012**	**$814,759**	$48,089	($10,253)
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$102,514	$125,600	$111,322	**$120,508**	**$129,300**	$9,186	$8,792
Medical Facilities	$124,353	$131,700	$139,810	**$151,513**	**$132,700**	$11,703	($18,813)
Obligations [Grand Total]	**$1,017,757**	**$1,083,800**	**$1,028,055**	**$1,097,033**	**$1,076,759**	**$68,978**	**($20,274)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Rehabilitation Services coordinates the provision of a full range of rehabilitative services to promote the health, independence and quality of life for Veterans with disabilities. Rehabilitative care services include Physical Medicine and Rehabilitation, Traumatic Brain Injury, Blind Rehabilitation, Audiology and Speech-Language Pathology, and Recreation Therapy. Rehabilitation Services are committed to providing high quality, comprehensive care as well as promoting advances in treatment through research and technology.

Blind Rehabilitation Service

$ in 1,000s		Total Obligations	Total Patients
Description	2020 Act.	$130,900	14,935
	2021 BE	$134,260	18,113
	2021 CE	$160,700	18,109
	2022 RR	$159,700	17,675
	2023 AA	$160,400	17,374
+/-	2021-2022	($1,000)	-434
	2022-2023	$700	-301
+/-	2021-2022	-0.6%	-2.4%
	2022-2023	0.4%	-1.7%

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

Blind Rehabilitation Service (BRS) Continuum of Care 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

The specialized blind rehabilitation database provides a mechanism for coordinating system-wide care, management and data analyses. BRS personnel evaluate and determine best practices for selecting, training and providing Veterans with cutting-edge technology for peak performance. 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. Components of the model include the following:

- 13 inpatient blind rehabilitation centers;
- 9 outpatient blind rehabilitation clinics;
- 22 intermediate low vision clinics;
- 22 advance low vision clinics
- 163 Visual Impairment Services Team (VIST) Coordinators (case managers) for severely disabled blind Veterans; and
- 95 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.

Recent Trends

Recent trends in BRS Continuum of Care services include:

- *Shift in Demographics of Population Served*. Trends in visual impairment and blindness among Veterans show a rise in the incidence of age-related macular degeneration and diabetic retinopathy among aging Veterans. This is treatable early with intravitreal anti-vascular endothelial growth factor (VEGF) injections delaying the onset of severe visual impairment. Older patients with visual impairment also experience increased co-morbidities. The combination of vision impairment and other health conditions substantially compromises their performance of activities and social participation.
- *Workforce Management*. Development of a new monitor 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 29 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 (e.g., Alexa, Amazon Echo, etc.) 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 Telerehabilitation 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. BRS telehealth encounters in VA increased from 1,238 in 2018 to 1,580 encounters in 201, a 27.6% increase.

Projections for the Future

Projections for VA BRS Continuum of Care include:

- 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.
  - Inpatient Blind Rehabilitation Center programs will continue to adapt to the changing demands and needs of our Veteran population, with growing availability of specialty and technology-focused treatment options being provided. In FY 2019 inpatient BRC's discharged 2,410 Veterans. Among this total, 1,348 (55.1%) received training related to technology-related devices and equipment. This changing demand for services that are more individualized and targeted will continue to shorten length of stays in some facilities and will increasingly push BRS staff to develop additional training capacity and SME-knowledge related to training with this new and emerging technology. For a future workforce within VA to be highly effective and forward leaning to meet these future needs, BRS must adopt an ambitious goal of provider skill development with assistive technology for all staff who provide care to our Veteran population.

- Workload Productivity. In the future years, 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 to 75th percentile), with an expectation of 50th percentile or higher.
- 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.
- 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 include 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 with which BRS teams.
- 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 tele-rehabilitation as a viable platform and alternative for face-to-face clinical care has been demonstrated in past years and represents and exciting new mechanism to improve timeliness and access to BRS programs.

Spinal Cord Injuries and Disorders

$ in 1,000s		Total Obligations	Total Patients
Description	2020 Act.	$616,200	13,508
	2021 BE	$646,544	14,461
	2021 CE	$672,500	14,411
	2022 RR	$684,500	14,386
	2023 AA	$703,900	14,492
+/-	2021-2022	$12,000	-25
	2022-2023	$19,400	106
+/-	2021-2022	1.8%	-0.2%
	2022-2023	2.8%	0.7%

Authority for Action

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 2015."

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 (6) 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

- *COVID-19*

  As the COVID-19 public health emergency continues to be the highest priority across the agency, the SCI/D National Program Office has actively contributed to the response to ensure the safety of Veterans with SCI/D. The program office collaborated with the VA Office of Geriatrics and Extended Care on the development of testing guidelines, visitation guidelines, and prioritization of vaccination for Veterans with SCI/D. Additionally, SCI/D program office leadership supported efforts to expand vaccination eligibility for the spouses and caregivers of Veterans with SCI/D, which was included in legislation signed into law in the SAVE LIVES Act. Of note, as of 5/3/2021, 58.5% of Veterans on the SCI/D Registry had received at least one dose of the COVID-19 vaccine, compared to about 44.03% of all Veterans as of 5/7/2021.

- *Bowel & Bladder Program*

  In collaboration with the Office of Community Care, the SCI/D National Program Office has advanced prerogatives of the MISSION Act, particularly Section 111, through its activities supporting the Bowel & Bladder program. Together, the program offices have developed a standard form and two letters related to payments, which are currently pending Office of Management and Budget review prior to publication. In addition, the two offices are updating processes and communication related to payments. A standardization and consolidation process was developed and is underway as a pilot in four VISNs. Separately, the SCI/D National Program Office is making revisions to its intranet site to inform SCI/D System of Care staff regarding changes to the Bowel & Bladder Program processes and procedures.

- *Rehabilitation and Extended Care Integrated Clinical Community (REC ICC) Data Report*

  The SCI/D National Program Office is represented on the national and VISN REC ICC Committees, as well as the REC ICC Data Development Group and the REC ICC Data Trackers Group. The REC ICC Data Trackers Group is responsible for the review of the REC ICC data report and metrics. On multiple occasions, REC ICC VISN leads have had the opportunity to provide feedback and offer suggestions. Based on their input, the REC ICC Data trackers Group Sharepoint was created with links to more comprehensive data products for each program office area. Additionally, the SCI/D National Program Office provided all VSSC and PowerBI data product links and has presented twice to guide REC ICC VISN leads to where to go to get more context and detailed data if needed. Notably, there is an existing SCI/D uSPEQ Patient Experience PowerBI data product and a forthcoming SCI/D Registry and Critical Population Information PowerBI data product.

Projections for the Future

- *SCI/D Telehealth*
  The SCI/D System of Care is significantly invested in the advancement of telehealth to serve Veterans with SCI/D. As examples, there is a dedicated telehealth coordinator at each SCI/D Center, a national SCI/D Telehealth Advisory Council, regular SCI/D Telehealth Community of Practice webinars facilitated by the SCI/D National Program Office, and the SCI/D National Program Office previously hosted a national SCI/D Telehealth Summit. Notably, in FY 2020, as compared with FY 2019, there was a 143% increase in the overall use of telehealth and a 405% increase in unique Veterans with SCI/D touched by telehealth services. The SCI/D National Program Office will continue to promote the use of virtual care modalities in the delivery of care to Veterans with SCI/D by increasing education and training of SCI/D clinicians on emerging telehealth technologies, best practices in telehealth care, and policies and procedures related to telehealth.

- *SCI/D Data and Outcomes*
  The SCI/D Registry & Outcomes Modernization Initiative continues to be an important priority for the SCI/D National Program Office. Of note, during the public health emergency, positive COVID-19 cases, dispositions, and vaccine status are being monitored, driving Veteran vaccination outreach and completion. Additionally, FY 2021 analyses included examining inpatient and outpatient utilization trends since FY 2014, which supported VHA Chief Strategy Office planning. Recently, the SCI/D National Program Office partnered with subject matter experts in the field and national analytics partners to automate a set of critical SCI/D population data points that were designed into the SCI/D-specific Cerner documentation process, ensuring continued effective management of this vulnerable population.

- *Transition to New Cerner Electronic Health Record*
  The transition to the new Cerner electronic health record (EHR) system will continue over the next several years. The SCI/D National Program Office and System of Care continue the partnership with VA EHRM and Cerner in the development of SCI/D-specific templates, workflows, documentation, and outcomes instruments. Focus areas for SCI/D Cerner documentation include each of the major care settings (i.e., inpatient, outpatient, SCI/D home care, and SCI/D telehealth) and the interdisciplinary team (i.e., documentation for each discipline in addition to interdisciplinary team conference templates). There are also SCI/D unique problems that are addressed in Cerner powerforms, quick orders, and algorithms, including autonomic dysreflexia, neurogenic bladder and bowel documentation, catastrophic disability, and the SCI Pressure Ulcer Monitoring Tool. The SCI/D National Program Office continues to provide communication, education, and informatic support to SCI/D Hub and Spoke teams.

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 & Short Stay
  - Patients Treated by Long & Short Stay
  - Obligations by Long & Short Stay
  - Per Diem by Long & Short Stay
- Non-Institutional Obligations & 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 & 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
- 2020 Unique Patients using Non-Institutional Long-Term Supportive Services by Fund

Obligations by Program and Overall Average Daily Census and Per Diem

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Obligations ($000)							
Institutional							
Community Nursing Home	$1,409,969	$1,433,800	$1,552,172	$1,907,731	$2,011,293	$355,559	$103,562
State Home Domiciliary	$53,622	$56,346	$56,346	$56,357	$51,314	$11	($5,043)
State Home Nursing	$1,372,877	$1,580,455	$1,930,455	$1,707,451	$1,741,296	($223,004)	$33,845
VA Community Living Centers	$4,173,642	$4,011,400	$4,210,835	$4,423,856	$4,417,659	$213,021	($6,197)
Institutional Obligations [Total]	$7,010,110	$7,082,001	$7,749,808	$8,095,395	$8,221,562	$345,587	$126,167
Non-Institutional							
Community Adult Day Health Care	$131,504	$162,100	$199,795	$236,193	$274,386	$36,398	$38,193
Community Residential Care	$86,521	$96,900	$95,226	$100,822	$100,306	$5,596	($516)
Home Hospice Care	$94,643	$110,700	$99,396	$105,292	$110,780	$5,896	$5,488
Home Respite Care	$47,061	$53,600	$51,671	$56,167	$60,474	$4,496	$4,307
Home Telehealth	$280,867	$269,100	$281,336	$276,726	$285,830	($4,610)	$9,104
Home-Based Primary Care	$911,761	$891,600	$1,001,275	$1,092,667	$1,128,961	$91,392	$36,294
Homemaker/Home Health Aide Prgs.	$920,293	$1,075,700	$1,036,479	$1,141,134	$1,203,007	$104,655	$61,873
Purchased Skilled Home Care	$539,176	$785,100	$591,016	$635,182	$656,858	$44,166	$21,676
Spinal Cord Injury & Disability Home Care	$11,776	$13,500	$12,397	$12,778	$13,191	$381	$413
State Home Adult Day Health Care	$2,635	$3,882	$3,882	$4,734	$4,902	$852	$168
VA Adult Day Health Care	$12,203	$15,600	$12,576	$14,987	$17,494	$2,411	$2,507
Non-Institutional Obligations [Total]	$3,038,441	$3,477,782	$3,385,049	$3,676,682	$3,856,189	$291,633	$179,507
Long-Term Services & Supports Obligations [Total]	$10,048,551	$10,559,783	$11,134,857	$11,772,077	$12,077,751	$637,220	$305,674
Institutional Average Daily Census							
Community Nursing Home	11,490	11,479	11,090	11,566	11,976	476	410
State Home Domiciliary	2,764	2,692	2,756	2,717	2,702	(39)	(15)
State Home Nursing	18,922	19,945	19,673	19,587	19,438	(86)	(149)
VA Community Living Centers	7,808	8,635	8,480	8,374	8,243	(106)	(131)
Institutional Average Daily Census [Total]	40,984	42,751	41,999	42,244	42,359	245	115
Institutional Per Diem							
Community Nursing Home	$335.28	$342.21	$383.46	$451.90	$460.12	$68.44	$8.22
State Home Domiciliary	$53.01	$57.34	$56.01	$56.83	$52.03	$0.82	($4.80)
State Home Nursing	$198.23	$217.10	$268.85	$238.83	$245.43	($30.02)	$6.60
VA Community Living Centers	$1,460.45	$1,272.74	$1,360.40	$1,447.30	$1,468.32	$86.90	$21.02
Institutional Per Diem [Total]	$467.33	$453.85	$505.55	$525.02	$530.31	$19.47	$5.29

Average Daily Census by Long & Short Stay

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Nursing Home Average Daily Census, Long & Short Stay							
Community Nursing Home							
Long Stay	9,434	9,146	8,916	9,312	9,666	396	354
Short Stay	2,056	2,333	2,174	2,254	2,311	80	57
Community Nursing Home Stays [Total]	11,490	11,479	11,090	11,566	11,976	476	410
State Home Nursing							
Long Stay	18,397	19,120	18,914	18,834	18,690	(80)	(144)
Short Stay	525	825	759	753	748	(6)	(5)
State Nursing Home Stays [Total]	18,922	19,945	19,673	19,587	19,438	(86)	(149)
VA Community Living Centers							
Long Stay	6,181	6,429	6,399	6,345	6,278	(54)	(67)
Short Stay	1,627	2,206	2,082	2,029	1,965	(52)	(64)
VA Community Living Centers Stays [Total]	7,808	8,635	8,480	8,374	8,243	(106)	(131)
All Nursing Home Average Daily Census, Long & Short Stay [Grand Total]	38,221	40,059	39,243	39,527	39,657	284	130
Nursing Home Average Daily Census by Age							
Community Nursing Home							
< 65	1,183	1,198	1,192	1,236	1,267	44	31
65 to 84	7,600	7,607	7,262	7,589	7,888	327	299
> 84	2,707	2,674	2,636	2,741	2,821	105	80
Community Nursing Home Stays [Total]	11,490	11,479	11,090	11,566	11,976	476	410
State Home Nursing							
	869	838	873	865	847	(8)	(18)
65 to 84	9,878	10,162	9,987	9,969	9,930	(18)	(38)
> 84	8,176	8,945	8,813	8,754	8,661	(59)	(93)
State Home Nursing Stays [Total]	18,922	19,945	19,673	19,587	19,438	(86)	(149)
VA Community Living Centers							
< 65	1,111	1,303	1,296	1,274	1,245	(22)	(29)
65 to 84	5,173	5,666	5,497	5,445	5,382	(52)	(63)
> 84	1,524	1,666	1,687	1,655	1,615	(32)	(40)
VA Community Living Centers Stays [Total]	7,808	8,635	8,480	8,374	8,243	(106)	(131)
All Nursing Home Average Daily Census by Age [Grand Total]	38,221	40,059	39,243	39,527	39,657	284	130
Nursing Home Average Daily Census by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	9,347	9,357	9,025	9,421	9,765	396	344
Non-Service Connected	1,308	1,285	1,250	1,299	1,338	49	39
Service-Connected	835	837	815	847	873	32	27
Community Nursing Home Stays [Total]	11,490	11,479	11,090	11,566	11,976	476	410
State Home Nursing							
Priority 1A	5,000	5,406	5,033	5,089	5,126	56	37
Non-Service Connected	10,712	11,175	11,291	11,173	11,023	(118)	(150)
Service-Connected	3,210	3,364	3,349	3,325	3,289	(24)	(35)
State Home Nursing Stays [Total]	18,922	19,945	19,673	19,587	19,438	(86)	(149)
VA Community Living Centers							
Priority 1A	4,676	5,045	4,963	4,918	4,851	(45)	(67)
Non-Service Connected	2,062	2,355	2,401	2,355	2,313	(46)	(42)
Service-Connected	1,070	1,235	1,200	2,273	1,165	1,073	(1,108)
VA Community Living Centers Stays [Total]	7,808	8,635	8,480	8,374	8,243	(106)	(131)
All Nursing Home Stays by Priority 1A, SC & Non-SC [Total]	38,221	40,059	39,243	39,527	39,657	284	130

Patients Treated by Long & Short Stay

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Patients Treated by Long & Short Stay							
Community Nursing Home							
Long Stay	13,167	13,208	13,247	13,825	13,713	578	(112)
Short Stay	27,069	31,789	30,943	32,394	32,249	1,451	(145)
Community Nursing Home Patients Trtd., [Total]	40,236	44,997	44,190	46,219	45,962	2,029	(257)
State Home Nursing							
Long Stay	22,052	23,518	23,185	22,959	22,819	(226)	(140)
Short Stay	4,330	6,788	6,255	6,185	6,113	(70)	(72)
State Home Nursing Patients Trtd., [Total]	26,382	30,306	29,440	29,144	28,932	(296)	(212)
VA Community Living Centers							
Long Stay	8,630	9,197	9,060	8,938	8,700	(122)	(238)
Short Stay	24,597	34,953	32,689	32,162	31,802	(527)	(360)
VA Community Living Centers Patients Trtd., [Total]	33,227	44,150	41,749	41,100	40,502	(649)	(598)
Grand Total Patients Treated by Long & Short Stay	99,845	119,453	115,379	116,463	115,396	1,084	(1,067)
Patients Treated by Age							
Community Nursing Home							
< 65	4,909	5,573	5,535	5,530	5,306	(5)	(224)
65 to 84	25,308	28,279	27,328	28,893	28,989	1,565	96
> 84	10,019	11,145	11,327	11,796	11,667	469	(129)
Community Nursing Home Stays [Total]	40,236	44,997	44,190	46,219	45,962	2,029	(257)
State Home Nursing							
< 65	1,105	1,087	1,206	1,087	974	(119)	(113)
65 to 84	13,410	15,313	14,139	14,151	14,306	12	155
> 84	11,867	13,906	14,095	13,906	13,652	(189)	(254)
State Home Nursing Stays [Total]	26,382	30,306	29,440	29,144	28,932	(296)	(212)
VA Community Living Centers							
< 65	5,749	7,539	7,374	6,877	6,455	(497)	(422)
65 to 84	20,964	28,091	25,727	25,729	25,731	2	2
> 84	6,514	8,520	8,648	8,494	8,316	(154)	(178)
VA Community Living Centers Stays [Total]	33,227	44,150	41,749	41,100	40,502	(649)	(598)
All Patients Treated by Age [Grand Total]	99,845	119,453	115,379	116,463	115,396	1,084	(1,067)
Patients Treated by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	25,028	17,944	26,782	28,022	27,881	1,240	(141)
Non-Service Connected	10,088	15,714	11,800	5,863	12,261	(5,937)	6,398
Service-Connected	5,120	11,339	5,608	12,334	5,820	6,726	(6,514)
Community Nursing Home Stays [Total]	40,236	44,997	44,190	46,219	45,962	2,029	(257)
State Home Nursing							
Priority 1A	6,764	14,000	6,116	6,067	6,032	(49)	(35)
Non-Service Connected	15,080	7,423	18,134	17,939	17,810	(195)	(129)
Service-Connected	4,538	8,883	5,190	5,138	5,090	(52)	(48)
State Home Nursing Stays [Total]	26,382	30,306	29,440	29,144	28,932	(296)	(212)
VA Community Living Centers							
Priority 1A	13,413	14,292	15,301	15,301	15,103	0	(198)
Non-Service Connected	13,414	6,888	18,347	17,698	17,437	(649)	(261)
Service-Connected	6,400	22,970	8,101	8,101	7,962	0	(139)
VA Community Living Centers Stays [Total]	33,227	44,150	41,749	41,100	40,502	(649)	(598)
All Patients Treated by Priority 1A, SC & Non-SC [Total]	99,845	119,453	115,379	116,463	115,396	1,084	(1,067)

Obligations by Long & Short Stay

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Obligations by Long & Short Stay							
Community Nursing Home							
Long Stay	$1,141,840	$1,111,455	$1,229,187	$1,513,062	$1,599,302	$283,875	$86,240
Short Stay	$268,129	$322,345	$322,985	$394,669	$411,991	$71,684	$17,322
Community Nursing Home Patients Trtd., [Total]	$1,409,969	$1,433,800	$1,552,172	$1,907,731	$2,011,293	$355,559	$103,562
State Home Nursing							
Long Stay	$1,334,224	$1,524,205	$1,854,952	$1,640,900	$1,673,362	($214,052)	$32,462
Short Stay	$38,653	$56,250	$75,503	$66,551	$67,934	($8,952)	$1,383
State Home Nursing Patients Trtd., [Total]	$1,372,877	$1,580,455	$1,930,455	$1,707,451	$1,741,296	($223,004)	$33,845
VA Community Living Centers							
Long Stay	$3,066,304	$2,742,872	$2,911,257	$3,074,484	$3,090,085	$163,227	$15,601
Short Stay	$1,107,338	$1,268,528	$1,299,578	$1,349,372	$1,327,574	$49,794	($21,798)
VA Community Living Centers Patients Trtd., [Total]	$4,173,642	$4,011,400	$4,210,835	$4,423,856	$4,417,659	$213,021	($6,197)
Grand Total Obligations by Long & Short Stay [Total]	$6,956,488	$7,025,655	$7,693,462	$8,039,038	$8,170,248	$345,576	$131,210
Obligations by Age							
Community Nursing Home							
< 65	$161,460	$176,876	$185,543	$226,732	$238,022	$41,189	$11,290
65 to 84	$935,798	$916,387	$1,019,472	$1,255,646	$1,325,087	$236,174	$69,441
> 84	$312,711	$340,537	$347,157	$425,353	$448,184	$78,196	$22,831
Community Nursing Home Obligations [Total]	$1,409,969	$1,433,800	$1,552,172	$1,907,731	$2,011,293	$355,559	$103,562
State Home Nursing							
< 65	$63,802	$56,316	$86,739	$76,317	$77,253	($10,422)	$936
65 to 84	$725,837	$960,536	$993,055	$880,526	$896,550	($112,529)	$16,024
> 84	$583,238	$563,603	$850,661	$750,608	$767,493	($100,053)	$16,885
State Home Nursing Obligations [Total]	$1,372,877	$1,580,455	$1,930,455	$1,707,451	$1,741,296	($223,004)	$33,845
VA Community Living Centers							
< 65	$627,003	$670,503	$679,157	$670,503	$694,596	($8,654)	$24,093
65 to 84	$2,752,530	$2,572,583	$2,715,353	$2,985,039	$2,929,243	$269,686	($55,796)
> 84	$794,109	$768,314	$816,325	$768,314	$793,820	($48,011)	$25,506
VA Community Living Centers Obligations [Total]	$4,173,642	$4,011,400	$4,210,835	$4,423,856	$4,417,659	$213,021	($6,197)
Grand Total Obligations by Age	$6,956,488	$7,025,655	$7,693,462	$8,039,038	$8,170,248	$345,576	$131,210
Obligations by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	$1,153,461	$1,160,985	$1,270,187	$1,562,525	$1,648,971	$292,338	$86,446
Non-Service Connected*	$156,867	$107,466	$171,013	$209,354	$219,632	$38,341	$10,278
Service-Connected*	$99,641	$165,349	$110,972	$135,852	$142,690	$24,880	$6,838
Community Nursing Home Obligations [Total]	$1,409,969	$1,433,800	$1,552,172	$1,907,731	$2,011,293	$355,559	$103,562
State Home Nursing							
Priority 1A	$397,505	$403,555	$541,810	$486,460	$503,247	($55,350)	$16,787
Non-Service Connected*	$745,899	$491,130	$1,064,486	$935,281	$947,715	($129,205)	$12,434
Service-Connected*	$229,473	$685,770	$324,159	$285,710	$290,334	($38,449)	$4,624
State Home Nursing Obligations [Total]	$1,372,877	$1,580,455	$1,930,455	$1,707,451	$1,741,296	($223,004)	$33,845
VA Community Living Centers							
Priority 1A	$2,354,334	$2,152,317	$2,316,479	$2,442,924	$2,445,300	$126,445	$2,376
Non-Service Connected*	$1,207,888	$603,390	$1,258,744	$1,313,831	$1,305,594	$55,087	($8,237)
Service-Connected*	$611,420	$1,255,693	$635,612	$667,101	$666,765	$31,489	($336)
VA Community Living Centers Obligations [Total]	$4,173,642	$4,011,400	$4,210,835	$4,423,856	$4,417,659	$213,021	($6,197)
Obligations by Priority 1A, SC & Non-SC [Total]	$6,956,488	$7,025,655	$7,693,462	$8,039,038	$8,170,248	$345,576	$131,210

Per Diems by Long & Short Stay

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Per Diems by Long & Short Stay							
Community Nursing Home							
Long Stay	$330.69	$332.94	$377.71	$445.17	$453.33	$67.46	$8.16
Short Stay	$356.36	$378.54	$407.03	$479.72	$488.51	$72.69	$8.79
Community Nursing Home Patients Trtd., [Total]	$335.28	$342.21	$383.46	$451.90	$460.12	$68.44	$8.22
State Home Nursing							
Long Stay	$198.15	$218.41	$268.69	$238.70	$245.29	($29.99)	$6.59
Short Stay	$201.04	$186.80	$272.61	$242.17	$248.87	($30.44)	$6.70
State Home Nursing Patients Trtd., [Total]	$198.23	$217.10	$268.85	$238.83	$245.43	($30.02)	$6.60
VA Community Living Centers							
Long Stay	$1,355.34	$1,168.88	$1,246.51	$1,327.54	$1,348.62	$81.03	$21.08
Short Stay	$1,859.85	$1,575.44	$1,710.50	$1,821.71	$1,850.63	$111.21	$28.92
VA Community Living Centers Patients Trtd., [Total]	$1,460.45	$1,272.74	$1,360.40	$1,447.30	$1,468.32	$86.90	$21.02
Overall Per Diem by Long & Short Stay	$497.29	$480.50	$537.12	$557.20	$564.45	$20.08	$7.25
Per Diem by Age							
Community Nursing Home							
< 65	$373.03	$404.50	$426.47	$502.60	$514.57	$76.13	$11.97
65 to 84	$336.43	$330.04	$384.63	$453.29	$460.23	$68.66	$6.94
> 84	$315.58	$348.91	$360.79	$425.20	$435.32	$64.41	$10.12
Community Nursing Home Overall Per Diem	$335.28	$342.21	$383.46	$451.90	$460.12	$68.44	$8.22
State Home Nursing							
< 65	$200.65	$184.12	$272.25	$241.85	$249.94	($30.40)	$8.09
65 to 84	$200.77	$258.97	$272.42	$241.99	$247.35	($30.43)	$5.36
> 84	$194.91	$172.62	$264.46	$234.93	$242.79	($29.53)	$7.86
State Home Nursing Overall Per Diem	$198.23	$217.10	$268.85	$238.83	$245.43	($30.02)	$6.60
VA Community Living Centers							
< 65	$1,542.03	$1,409.82	$1,435.58	$1,441.64	$1,528.18	$6.06	$86.54
65 to 84	$1,453.72	$1,243.94	$1,353.37	$1,501.99	$1,491.05	$148.62	($10.94)
> 84	$1,423.82	$1,263.49	$1,325.54	$1,271.74	$1,346.43	($53.80)	$74.69
VA Community Living Centers Overall Per Diem	$1,460.45	$1,272.74	$1,360.40	$1,447.30	$1,468.32	$86.90	$21.02
Overall Per Diem by Age	$497.29	$480.50	$537.12	$557.20	$564.45	$20.08	$7.25
Per Diem by Priority 1A, SC & Non-SC							
Community Nursing Home							
Priority 1A	$337.16	$339.94	$385.60	$454.42	$462.67	$68.82	$8.25
Non-Service Connected*	$327.69	$229.13	$374.78	$441.66	$449.68	$66.88	$8.02
Service-Connected*	$326.17	$541.23	$373.04	$439.62	$447.59	$66.58	$7.97
Community Nursing Home Overall Per Diem	$335.28	$342.21	$383.46	$451.90	$460.12	$68.44	$8.22
State Home Nursing							
Priority 1A	$217.23	$204.52	$294.94	$261.87	$268.97	($33.07)	$7.10
Non-Service Connected*	$190.24	$120.41	$258.30	$229.34	$235.56	($28.96)	$6.22
Service-Connected*	$195.30	$558.51	$265.17	$235.44	$241.82	($29.73)	$6.38
State Home Nursing Overall Per Diem	$198.23	$217.10	$268.85	$238.83	$245.43	($30.02)	$6.60
VA Community Living Centers							
Priority 1A	$1,375.57	$1,168.83	$1,278.79	$1,360.89	$1,380.94	$82.10	$20.05
Non-Service Connected*	$1,600.62	$701.96	$1,436.32	$1,528.47	$1,546.46	$92.15	$17.99
Service-Connected*	$1,561.33	$2,785.63	$1,451.48	$804.05	$1,567.42	($647.43)	$763.37
VA Community Living Centers Overall Per Diem	$1,460.45	$1,272.74	$1,360.40	$1,447.30	$1,468.32	$86.90	$21.02
Overall Per Diem for Priority 1A, SC & Non-SC	$497.29	$480.50	$537.12	$557.20	$564.45	$20.08	$7.25

Non-Institutional Obligations & Clinic Stops/Procedures

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2020-2021	+/- 2021-2022
Non-Institutional Obligations ($000)							
Community Adult Day Health Care	$131,504	$162,100	$199,795	$236,193	$274,386	$36,398	$38,193
Community Residential Care	$86,521	$96,900	$95,226	$100,822	$100,306	$5,596	($516)
Home Hospice Care	$94,643	$110,700	$99,396	$105,292	$110,780	$5,896	$5,488
Home Respite Care	$47,061	$53,600	$51,671	$56,167	$60,474	$4,496	$4,307
Home Telehealth	$280,867	$269,100	$281,336	$276,726	$285,830	($4,610)	$9,104
Home-Based Primary Care	$911,761	$891,600	$1,001,275	$1,092,667	$1,128,961	$91,392	$36,294
Homemaker/Home Health Aide Prgs.	$920,293	$1,075,700	$1,036,479	$1,141,134	$1,203,007	$104,655	$61,873
Purchased Skilled Home Care	$539,176	$785,100	$591,016	$635,182	$656,858	$44,166	$21,676
Spinal Cord Injury & Disability Home Care	$11,776	$13,500	$12,397	$12,778	$13,191	$381	$413
State Home Adult Day Health Care	$2,635	$3,882	$3,882	$4,734	$4,902	$852	$168
VA Adult Day Health Care	$12,203	$15,600	$12,576	$14,987	$17,494	$2,411	$2,507
Non-Institutional Obligations [Total]	**$3,038,441**	**$3,477,782**	**$3,385,049**	**$3,676,682**	**$3,856,189**	**$291,633**	**$179,507**
Non-Institutional Clinic Stops/Procedures							
Community Adult Day Health Care	453,565	702,613	538,723	588,072	638,511	49,349	50,439
Community Residential Care	42,082	86,342	61,949	76,413	89,287	14,464	12,874
Home Hospice Care	329,206	595,536	421,571	526,361	600,295	104,790	73,934
Home Respite Care	16,077	281,473	19,134	21,574	22,282	2,440	708
Home Telehealth 1/	823,999	794,408	796,992	773,112	751,469	(23,880)	(21,643)
Home-Based Primary Care	1,179,214	1,885,009	1,484,756	1,760,997	1,979,166	276,241	218,169
Homemaker/Home Health Aide Prgs.	7,496,511	14,504,304	11,376,922	14,535,236	14,902,437	3,158,314	367,201
Purchased Skilled Home Care	130,733	2,239,597	148,642	162,427	174,064	13,785	11,637
Spinal Cord Injury Home Care	18,385	22,910	20,734	23,248	23,421	2,514	173
State Adult Day Health Care	7,602	13,595	8,248	8,737	8,999	489	262
VA Adult Day Health Care	50,337	95,170	69,752	80,331	91,579	10,579	11,248
Non-Institutional Clinic Stops/Procedures [Total]	**10,547,711**	**21,220,957**	**14,947,423**	**18,556,508**	**19,281,510**	**3,609,085**	**725,002**
Non-Institutional Cost Per Clinic Stops/Procedures							
Community Adult Day Health Care	$289.94	$230.71	$370.87	$401.64	$429.73	$30.77	$28.09
Community Residential Care	$2,056.01	$1,122.28	$1,537.17	$1,319.44	$1,123.41	($217.73)	($196.03)
Home Hospice Care	$287.49	$185.88	$235.78	$200.04	$184.54	($35.74)	($15.50)
Home Respite Care	$2,927.26	$190.43	$2,700.48	$2,603.46	$2,714.03	($97.02)	$110.57
Home Telehealth	$340.86	$338.74	$353.00	$357.94	$380.36	$4.94	$22.42
Home-Based Primary Care	$773.19	$473.00	$674.37	$620.48	$570.42	($53.89)	($50.06)
Homemaker/Home Health Aide Prgs.	$122.76	$74.16	$91.10	$78.51	$80.73	($12.59)	$2.22
Purchased Skilled Home Care	$4,124.26	$350.55	$3,976.10	$3,910.57	$3,773.66	($65.53)	($136.91)
Spinal Cord Injury Home Care	$640.53	$589.26	$597.91	$549.64	$563.21	($48.27)	$13.57
State Adult Day Health Care	$1.38	$1.14	$1.88	$2.16	$2.17	$0.28	$0.01
VA Adult Day Health Care	$242.43	$163.92	$180.30	$186.57	$191.03	$6.27	$4.46
Non-Institutional Cost Per Clinic Stops/Procedures	**$288.07**	**$163.88**	**$226.46**	**$198.13**	**$199.99**	**($28.33)**	**$1.86**

VA Community Living Centers Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$2,940,928	$2,865,300	$2,758,242	$2,621,543	$3,218,702	($136,699)	$597,159
Discretionary FFCRA/CARES Act Obligations	$182,190	$0	$286,200	$0	$0	($286,200)	$0
Discretionary Obligations [Subtotal]	**$3,123,118**	**$2,865,300**	**$3,044,442**	**$2,621,543**	**$3,218,702**	**($422,899)**	**$597,159**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$470,446	$534,500	$505,621	$524,412	$596,402	$18,791	$71,990
Discretionary CARES Act Obligations	$3,433	$0	$10,972	$0	$0	($10,972)	$0
Discretionary Obligations [Subtotal]	**$473,879**	**$534,500**	**$516,593**	**$524,412**	**$596,402**	**$7,819**	**$71,990**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$552,102	$611,000	$619,000	$586,300	$602,300	($32,700)	$16,000
Discretionary CARES Act Obligations	$24,309	$0	$30,557	$0	$0	($30,557)	$0
Discretionary Obligations [Subtotal]	**$576,411**	**$611,000**	**$649,557**	**$586,300**	**$602,300**	**($63,257)**	**$16,000**
Discretionary Total	**$4,173,408**	**$4,010,800**	**$4,210,592**	**$3,732,255**	**$4,417,404**	**($478,337)**	**$685,149**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$448,023	$0	$448,023	($448,023)
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$158	$100	$164	$171	$157	$7	($14)
Mandatory Obligations [Subtotal]	**$158**	**$100**	**$164**	**$448,194**	**$157**	**$448,030**	**($448,037)**
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	$43,369	$0	$43,369	($43,369)
VACAA, Section 801 (0152)	$76	$200	$79	$88	$98	$9	$10
Mandatory Obligations [Subtotal]	**$76**	**$200**	**$79**	**$43,457**	**$98**	**$43,378**	**($43,359)**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$199,950	$0	$199,950	($199,950)
VACAA, Section 801 (0162)	$0	$300	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$300**	**$0**	**$199,950**	**$0**	**$199,950**	**($199,950)**
Mandatory Total	**$234**	**$600**	**$243**	**$691,601**	**$255**	**$691,358**	**($691,346)**
Combined Discretionary and Mandatory by Category							
Medical Services	$3,123,276	$2,865,400	$3,044,606	**$3,069,737**	**$3,218,859**	$25,131	$149,122
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$473,955	$534,700	$516,672	**$567,869**	**$596,500**	$51,197	$28,631
Medical Facilities	$576,411	$611,300	$649,557	**$786,250**	**$602,300**	$136,693	($183,950)
Obligations [Grand Total]	**$4,173,642**	**$4,011,400**	**$4,210,835**	**$4,423,856**	**$4,417,659**	**$213,021**	**($6,197)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Community Residential Care Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$68,387	$74,500	$74,619	$80,534	$80,406	$5,915	($128)
Discretionary FFCRA/CARES Act Obligations	$776	$0	$1,200	$0	$0	($1,200)	$0
Discretionary Obligations [Subtotal]	**$69,163**	**$74,500**	**$75,819**	**$80,534**	**$80,406**	**$4,715**	**($128)**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$433	$0	$805	$0	$0	($805)	$0
Discretionary Obligations [Subtotal]	**$433**	**$0**	**$805**	**$0**	**$0**	**($805)**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$8,003	$11,000	$8,600	$8,900	$10,100	$300	$1,200
Discretionary CARES Act Obligations	$1	$0	$2	$0	$0	($2)	$0
Discretionary Obligations [Subtotal]	**$8,004**	**$11,000**	**$8,602**	**$8,900**	**$10,100**	**$298**	**$1,200**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$8,921	$11,400	$10,000	$9,500	$9,800	($500)	$300
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$8,921**	**$11,400**	**$10,000**	**$9,500**	**$9,800**	**($500)**	**$300**
Discretionary Total	**$86,521**	**$96,900**	**$95,226**	**$98,934**	**$100,306**	**$3,708**	**$1,372**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$1,879	$0	$1,879	($1,879)
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**	**$1,879**	**$0**	**$1,879**	**($1,879)**
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	$9	$0	$9	($9)
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$9**	**$0**	**$9**	**($9)**
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**	**$1,888**	**$0**	**$1,888**	**($1,888)**
Combined Discretionary and Mandatory by Category							
Medical Services	$69,163	$74,500	$75,819	**$82,413**	**$80,406**	$6,594	($2,007)
Medical Community Care	$433	$0	$805	**$0**	**$0**	($805)	$0
Medical Support and Compliance	$8,004	$11,000	$8,602	**$8,909**	**$10,100**	$307	$1,191
Medical Facilities	$8,921	$11,400	$10,000	**$9,500**	**$9,800**	($500)	$300
Obligations [Grand Total]	**$86,521**	**$96,900**	**$95,226**	**$100,822**	**$100,306**	**$5,596**	**($516)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Home Telehealth Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$196,845	$182,900	$187,834	$182,113	$190,230	($5,721)	$8,117
Discretionary FFCRA/CARES Act Obligations	$2,496	$0	$3,900	$0	$0	($3,900)	$0
Discretionary Obligations [Subtotal]	**$199,341**	**$182,900**	**$191,734**	**$182,113**	**$190,230**	**($9,621)**	**$8,117**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$37,884	$42,000	$40,700	$42,200	$48,000	$1,500	$5,800
Discretionary CARES Act Obligations	$1	$0	$2	$0	$0	($2)	$0
Discretionary Obligations [Subtotal]	**$37,884**	**$42,000**	**$40,702**	**$42,200**	**$48,000**	**$1,498**	**$5,800**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$43,642	$44,200	$48,900	$46,300	$47,600	($2,600)	$1,300
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$43,642**	**$44,200**	**$48,900**	**$46,300**	**$47,600**	**($2,600)**	**$1,300**
Discretionary Total	**$280,868**	**$269,100**	**$281,336**	**$270,613**	**$285,830**	**($10,723)**	**$15,217**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$6,105	$0	$6,105	($6,105)
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**	**$6,105**	**$0**	**$6,105**	**($6,105)**
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	$8	$0	$8	($8)
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$8**	**$0**	**$8**	**($8)**
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**	**$6,113**	**$0**	**$6,113**	**($6,113)**
Combined Discretionary and Mandatory by Category							
Medical Services	$199,341	$182,900	$191,734	**$188,218**	**$190,230**	($3,516)	$2,012
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$37,884	$42,000	$40,702	**$42,208**	**$48,000**	$1,506	$5,792
Medical Facilities	$43,642	$44,200	$48,900	**$46,300**	**$47,600**	($2,600)	$1,300
Obligations [Grand Total]	**$280,868**	**$269,100**	**$281,336**	**$276,726**	**$285,830**	**($4,610)**	**$9,104**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Home Based Primary Care Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$711,812	$700,900	$775,760	$856,508	$908,394	$80,748	$51,886
Discretionary FFCRA/CARES Act Obligations	$12,025	$0	$18,900	$0	$0	($18,900)	$0
Discretionary Obligations [Subtotal]	**$723,837**	**$700,900**	**$794,660**	**$856,508**	**$908,394**	**$61,848**	**$51,886**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$89,194	$94,700	$95,898	$99,436	$113,247	$3,538	$13,811
Discretionary CARES Act Obligations	$37	$0	$120	$0	$0	($120)	$0
Discretionary Obligations [Subtotal]	**$89,231**	**$94,700**	**$96,018**	**$99,436**	**$113,247**	**$3,418**	**$13,811**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$97,497	$95,800	$109,300	$103,500	$106,300	($5,800)	$2,800
Discretionary CARES Act Obligations	$259	$0	$325	$0	$0	($325)	$0
Discretionary Obligations [Subtotal]	**$97,756**	**$95,800**	**$109,625**	**$103,500**	**$106,300**	**($6,125)**	**$2,800**
Discretionary Total	**$910,824**	**$891,400**	**$1,000,303**	**$1,059,444**	**$1,127,941**	**$59,141**	**$68,497**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$29,586	$0	$29,586	($29,586)
American Rescue Plan Act, Section 8007 (0160)	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0160)	$68	$0	$70	$73	$67	$3	($6)
Mandatory Obligations [Subtotal]	**$68**	**$0**	**$70**	**$29,659**	**$67**	**$29,589**	**($29,592)**
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	$473	$0	$473	($473)
VACAA, Section 801 (0152)	$868	$100	$902	$964	$953	$62	($11)
Mandatory Obligations [Subtotal]	**$868**	**$100**	**$902**	**$1,437**	**$953**	**$535**	**($484)**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$2,127	$0	$2,127	($2,127)
VACAA, Section 801 (0162)	$0	$100	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$100**	**$0**	**$2,127**	**$0**	**$2,127**	**($2,127)**
Mandatory Total	**$936**	**$200**	**$972**	**$33,223**	**$1,020**	**$32,251**	**($32,203)**
Combined Discretionary and Mandatory by Category							
Medical Services	$723,905	$700,900	$794,730	**$886,167**	**$908,461**	$91,437	$22,294
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$90,099	$94,800	$96,920	**$100,873**	**$114,200**	$3,953	$13,327
Medical Facilities	$97,756	$95,900	$109,625	**$105,627**	**$106,300**	($3,998)	$673
Obligations [Grand Total]	**$911,760**	**$891,600**	**$1,001,275**	**$1,092,667**	**$1,128,961**	**$91,392**	**$36,294**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Spinal Cord Injury & Disability Home Care Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$9,542	$10,900	$9,997	$10,421	$10,791	$424	$370
Discretionary FFCRA/CARES Act Obligations	$89	$0	$100	$0	$0	($100)	$0
Discretionary Obligations [Subtotal]	**$9,631**	**$10,900**	**$10,097**	**$10,421**	**$10,791**	**$324**	**$370**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$1,045	$1,300	$1,100	$1,100	$1,300	$0	$200
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$1,045**	**$1,300**	**$1,100**	**$1,100**	**$1,300**	**$0**	**$200**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$1,100	$1,300	$1,200	$1,100	$1,100	($100)	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$1,100**	**$1,300**	**$1,200**	**$1,100**	**$1,100**	**($100)**	**$0**
Discretionary Total	**$11,776**	**$13,500**	**$12,397**	**$12,621**	**$13,191**	**$224**	**$570**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$157	$0	$157	($157)
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**	**$157**	**$0**	**$157**	**($157)**
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**	**$157**	**$0**	**$157**	**($157)**
Combined Discretionary and Mandatory by Category							
Medical Services	$9,631	$10,900	$10,097	**$10,578**	**$10,791**	$481	$213
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$1,045	$1,300	$1,100	**$1,100**	**$1,300**	$0	$200
Medical Facilities	$1,100	$1,300	$1,200	**$1,100**	**$1,100**	($100)	$0
Obligations [Grand Total]	**$11,776**	**$13,500**	**$12,397**	**$12,778**	**$13,191**	**$381**	**$413**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

VA Adult Day Home Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$9,612	$11,600	$9,676	$12,030	$14,494	$2,354	$2,464
Discretionary FFCRA/CARES Act Obligations	$53	$0	$100	$0	$0	($100)	$0
Discretionary Obligations [Subtotal]	**$9,665**	**$11,600**	**$9,776**	**$12,030**	**$14,494**	**$2,254**	**$2,464**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$1,273	$2,000	$1,400	$1,500	$1,700	$100	$200
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$1,273**	**$2,000**	**$1,400**	**$1,500**	**$1,700**	**$100**	**$200**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$1,266	$2,000	$1,400	$1,300	$1,300	($100)	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$1,266**	**$2,000**	**$1,400**	**$1,300**	**$1,300**	**($100)**	**$0**
Discretionary Total	**$12,204**	**$15,600**	**$12,576**	**$14,830**	**$17,494**	**$2,254**	**$2,664**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$157	$0	$157	($157)
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**	**$157**	**$0**	**$157**	**($157)**
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**	**$157**	**$0**	**$157**	**($157)**
Combined Discretionary and Mandatory by Category							
Medical Services	$9,665	$11,600	$9,776	**$12,187**	**$14,494**	$2,411	$2,307
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$1,273	$2,000	$1,400	**$1,500**	**$1,700**	$100	$200
Medical Facilities	$1,266	$2,000	$1,400	**$1,300**	**$1,300**	($100)	$0
Obligations [Grand Total]	**$12,204**	**$15,600**	**$12,576**	**$14,987**	**$17,494**	**$2,411**	**$2,507**

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Community Nursing Home Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$68,909	$49,453	$78,455	$118,825	$115,718	$40,370	($3,107)
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$68,909**	**$49,453**	**$78,455**	**$118,825**	**$115,718**	**$40,370**	**($3,107)**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$1,234,419	$1,299,647	$1,358,917	$1,670,206	$1,760,875	$311,289	$90,669
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$1,234,419**	**$1,299,647**	**$1,358,917**	**$1,670,206**	**$1,760,875**	**$311,289**	**$90,669**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$103,602	$82,400	$111,400	$115,500	$131,400	$4,100	$15,900
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$103,602**	**$82,400**	**$111,400**	**$115,500**	**$131,400**	**$4,100**	**$15,900**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$3,041	$2,300	$3,400	$3,200	$3,300	($200)	$100
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$3,041**	**$2,300**	**$3,400**	**$3,200**	**$3,300**	**($200)**	**$100**
Discretionary Total	**$1,409,970**	**$1,433,800**	**$1,552,172**	**$1,907,731**	**$2,011,293**	**$355,559**	**$103,562**
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	$68,909	$49,453	$78,455	**$118,825**	**$115,718**	$40,370	($3,107)
Medical Community Care	$1,234,419	$1,299,647	$1,358,917	**$1,670,206**	**$1,760,875**	$311,289	$90,669
Medical Support and Compliance	$103,602	$82,400	$111,400	**$115,500**	**$131,400**	$4,100	$15,900
Medical Facilities	$3,041	$2,300	$3,400	**$3,200**	**$3,300**	($200)	$100
Obligations [Grand Total]	**$1,409,970**	**$1,433,800**	**$1,552,172**	**$1,907,731**	**$2,011,293**	**$355,559**	**$103,562**

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State Nursing Home Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$16	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$11	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$27**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$1,352,336	$1,579,155	$1,578,155	$1,705,051	$1,738,596	$126,896	$33,545
Discretionary FFCRA/CARES Act Obligations	$18,390	$0	$100,000	$0	$0	($100,000)	$0
Discretionary Obligations [Subtotal]	**$1,370,726**	**$1,579,155**	**$1,678,155**	**$1,705,051**	**$1,738,596**	**$26,896**	**$33,545**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$2,124	$1,300	$2,300	$2,400	$2,700	$100	$300
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$2,124**	**$1,300**	**$2,300**	**$2,400**	**$2,700**	**$100**	**$300**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$1,372,877**	**$1,580,455**	**$1,680,455**	**$1,707,451**	**$1,741,296**	**$26,996**	**$33,845**
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	$250,000	$0	$0	($250,000)	$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**	**$250,000**	**$0**	**$0**	**($250,000)**	**$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**	**$250,000**	**$0**	**$0**	**($250,000)**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$27	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$1,370,726	$1,579,155	$1,928,155	**$1,705,051**	**$1,738,596**	($223,104)	$33,545
Medical Support and Compliance	$2,124	$1,300	$2,300	**$2,400**	**$2,700**	$100	$300
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$1,372,877**	**$1,580,455**	**$1,930,455**	**$1,707,451**	**$1,741,296**	**($223,004)**	**$33,845**

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State Home Domiciliary

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$53,496	$56,346	$56,346	$56,357	$51,314	$11	($5,043)
Discretionary FFCRA/CARES Act Obligations	$126	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$53,622**	**$56,346**	**$56,346**	**$56,357**	**$51,314**	**$11**	**($5,043)**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$53,622**	**$56,346**	**$56,346**	**$56,357**	**$51,314**	**$11**	**($5,043)**
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	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$53,622	$56,346	$56,346	**$56,357**	**$51,314**	$11	($5,043)
Medical Support and Compliance	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$53,622**	**$56,346**	**$56,346**	**$56,357**	**$51,314**	**$11**	**($5,043)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

State Home Adult Day Health Care Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$2,021	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$2,021**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$614	$3,882	$3,882	$4,734	$4,902	$852	$168
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$614**	**$3,882**	**$3,882**	**$4,734**	**$4,902**	**$852**	**$168**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$2,635**	**$3,882**	**$3,882**	**$4,734**	**$4,902**	**$852**	**$168**
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	$2,021	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$614	$3,882	$3,882	**$4,734**	**$4,902**	$852	$168
Medical Support and Compliance	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$2,635**	**$3,882**	**$3,882**	**$4,734**	**$4,902**	**$852**	**$168**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Community Adult Day Health Care Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$6,808	$9,123	$14,191	$17,897	$20,991	$3,706	$3,094
Discretionary FFCRA/CARES Act Obligations	$9	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$6,817**	**$9,123**	**$14,191**	**$17,897**	**$20,991**	**$3,706**	**$3,094**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$109,146	$143,577	$178,902	$211,495	$245,695	$32,593	$34,200
Discretionary FFCRA/CARES Act Obligations	$1	$0	$2	$0	$0	($2)	$0
Discretionary Obligations [Subtotal]	**$109,147**	**$143,577**	**$178,904**	**$211,495**	**$245,695**	**$32,591**	**$34,200**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$5,862	$8,800	$6,300	$6,500	$7,400	$200	$900
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$5,862**	**$8,800**	**$6,300**	**$6,500**	**$7,400**	**$200**	**$900**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$274	$300	$300	$300	$300	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$274**	**$300**	**$300**	**$300**	**$300**	**$0**	**$0**
Discretionary Total	**$122,100**	**$161,800**	**$199,695**	**$236,192**	**$274,386**	**$36,497**	**$38,194**
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	$1	$0	$1	($1)
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)	$9,405	$300	$100	$0	$0	($100)	$0
Mandatory Obligations [Subtotal]	**$9,405**	**$300**	**$100**	**$1**	**$0**	**($99)**	**($1)**
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	**$9,405**	**$300**	**$100**	**$1**	**$0**	**($99)**	**($1)**
Combined Discretionary and Mandatory by Category							
Medical Services	$6,817	$9,123	$14,191	**$17,897**	**$20,991**	$3,706	$3,094
Medical Community Care	$118,552	$143,877	$179,004	**$211,496**	**$245,695**	$32,492	$34,199
Medical Support and Compliance	$5,862	$8,800	$6,300	**$6,500**	**$7,400**	$200	$900
Medical Facilities	$274	$300	$300	**$300**	**$300**	$0	$0
Obligations [Grand Total]	**$131,505**	**$162,100**	**$199,795**	**$236,193**	**$274,386**	**$36,398**	**$38,193**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Home Hospice Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$7,886	$5,761	$8,331	$8,975	$9,066	$644	$91
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$7,886**	**$5,761**	**$8,331**	**$8,975**	**$9,066**	**$644**	**$91**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$81,307	$101,039	$86,865	$92,017	$96,814	$5,152	$4,797
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$81,307**	**$101,039**	**$86,865**	**$92,017**	**$96,814**	**$5,152**	**$4,797**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$3,708	$3,700	$4,000	$4,100	$4,700	$100	$600
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$3,708**	**$3,700**	**$4,000**	**$4,100**	**$4,700**	**$100**	**$600**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$208	$200	$200	$200	$200	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$208**	**$200**	**$200**	**$200**	**$200**	**$0**	**$0**
Discretionary Total	**$93,109**	**$110,700**	**$99,396**	**$105,292**	**$110,780**	**$5,896**	**$5,488**
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)	$1,534	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$1,534**	**$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	**$1,534**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$7,886	$5,761	$8,331	**$8,975**	**$9,066**	$644	$91
Medical Community Care	$82,841	$101,039	$86,865	**$92,017**	**$96,814**	$5,152	$4,797
Medical Support and Compliance	$3,708	$3,700	$4,000	**$4,100**	**$4,700**	$100	$600
Medical Facilities	$208	$200	$200	**$200**	**$200**	$0	$0
Obligations [Grand Total]	**$94,642**	**$110,700**	**$99,396**	**$105,292**	**$110,780**	**$5,896**	**$5,488**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Home Respite Care Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$516	$805	$681	$289	($124)
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$516**	**$805**	**$681**	**$289**	**($124)**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$38,587	$50,800	$48,355	$52,562	$56,593	$4,207	$4,031
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$38,587**	**$50,800**	**$48,355**	**$52,562**	**$56,593**	**$4,207**	**$4,031**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$2,514	$2,600	$2,700	$2,800	$3,200	$100	$400
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$2,514**	**$2,600**	**$2,700**	**$2,800**	**$3,200**	**$100**	**$400**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$41,101**	**$53,400**	**$51,571**	**$56,167**	**$60,474**	**$4,596**	**$4,307**
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)	$5,961	$200	$100	$0	$0	($100)	$0
Mandatory Obligations [Subtotal]	**$5,961**	**$200**	**$100**	**$0**	**$0**	**($100)**	**$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	**$5,961**	**$200**	**$100**	**$0**	**$0**	**($100)**	**$0**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$516	**$805**	**$681**	$289	($124)
Medical Community Care	$44,548	$51,000	$48,455	**$52,562**	**$56,593**	$4,107	$4,031
Medical Support and Compliance	$2,514	$2,600	$2,700	**$2,800**	**$3,200**	$100	$400
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$47,061**	**$53,600**	**$51,671**	**$56,167**	**$60,474**	**$4,496**	**$4,307**

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Homemaker/Home Health Aide Programs Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$45,500	$43,637	$62,545	$73,718	$74,000	$11,173	$282
Discretionary FFCRA/CARES Act Obligations	$248	$0	$400	$0	$0	($400)	$0
Discretionary Obligations [Subtotal]	**$45,748**	**$43,637**	**$62,945**	**$73,718**	**$74,000**	**$10,773**	**$282**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$715,338	$964,063	$914,426	$1,008,773	$1,065,507	$94,347	$56,734
Discretionary FFCRA/CARES Act Obligations	$1,929	$0	$3,587	$0	$0	($3,587)	$0
Discretionary Obligations [Subtotal]	**$717,267**	**$964,063**	**$918,013**	**$1,008,773**	**$1,065,507**	**$90,760**	**$56,734**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$48,551	$63,200	$52,200	$54,100	$61,500	$1,900	$7,400
Discretionary CARES Act Obligations	$7	$0	$21	$0	$0	($21)	$0
Discretionary Obligations [Subtotal]	**$48,557**	**$63,200**	**$52,221**	**$54,100**	**$61,500**	**$1,879**	**$7,400**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$1,802	$1,800	$2,000	$1,900	$2,000	($100)	$100
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$1,802**	**$1,800**	**$2,000**	**$1,900**	**$2,000**	**($100)**	**$100**
Discretionary Total	**$813,374**	**$1,072,700**	**$1,035,179**	**$1,138,491**	**$1,203,007**	**$103,312**	**$64,516**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$626	$0	$626	($626)
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**	**$626**	**$0**	**$626**	**($626)**
Medical Community Care Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$1,933	$0	$1,933	($1,933)
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)	$106,919	$3,000	$1,300	$0	$0	($1,300)	$0
Mandatory Obligations [Subtotal]	**$106,919**	**$3,000**	**$1,300**	**$1,933**	**$0**	**$633**	**($1,933)**
Medical Support and Compliance Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$84	$0	$84	($84)
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$84**	**$0**	**$84**	**($84)**
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	**$106,919**	**$3,000**	**$1,300**	**$2,643**	**$0**	**$1,343**	**($2,643)**
Combined Discretionary and Mandatory by Category							
Medical Services	$45,748	$43,637	$62,945	**$74,344**	**$74,000**	$11,399	($344)
Medical Community Care	$824,186	$967,063	$919,313	**$1,010,706**	**$1,065,507**	$91,393	$54,801
Medical Support and Compliance	$48,557	$63,200	$52,221	**$54,184**	**$61,500**	$1,963	$7,316
Medical Facilities	$1,802	$1,800	$2,000	**$1,900**	**$2,000**	($100)	$100
Obligations [Grand Total]	**$920,293**	**$1,075,700**	**$1,036,479**	**$1,141,134**	**$1,203,007**	**$104,655**	**$61,873**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Purchased Skilled Home Care Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$32,221	$38,394	$40,430	$46,198	$42,717	$5,768	($3,481)
Discretionary FFCRA/CARES Act Obligations	$37	$0	$100	$0	$0	($100)	$0
Discretionary Obligations [Subtotal]	**$32,258**	**$38,394**	**$40,530**	**$46,198**	**$42,717**	**$5,668**	**($3,481)**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$406,720	$699,406	$498,706	$536,445	$555,241	$37,739	$18,796
Discretionary FFCRA/CARES Act Obligations	$472	$0	$878	$0	$0	($878)	$0
Discretionary Obligations [Subtotal]	**$407,192**	**$699,406**	**$499,584**	**$536,445**	**$555,241**	**$36,861**	**$18,796**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$45,558	$44,400	$49,000	$50,800	$57,800	$1,800	$7,000
Discretionary CARES Act Obligations	$1	$0	$2	$0	$0	($2)	$0
Discretionary Obligations [Subtotal]	**$45,558**	**$44,400**	**$49,002**	**$50,800**	**$57,800**	**$1,798**	**$7,000**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$1,089	$1,400	$1,200	$1,100	$1,100	($100)	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$1,089**	**$1,400**	**$1,200**	**$1,100**	**$1,100**	**($100)**	**$0**
Discretionary Total	**$486,097**	**$783,600**	**$590,316**	**$634,543**	**$656,858**	**$44,227**	**$22,315**
MANDATORY							
Medical Services Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$157	$0	$157	($157)
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**	**$157**	**$0**	**$157**	**($157)**
Medical Community Care Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$473	$0	$473	($473)
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)	$53,079	$1,500	$700	$0	$0	($700)	$0
Mandatory Obligations [Subtotal]	**$53,079**	**$1,500**	**$700**	**$473**	**$0**	**($227)**	**($473)**
Medical Support and Compliance Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$9	$0	$9	($9)
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$9**	**$0**	**$9**	**($9)**
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	**$53,079**	**$1,500**	**$700**	**$639**	**$0**	**($61)**	**($639)**
Combined Discretionary and Mandatory by Category							
Medical Services	$32,258	$38,394	$40,530	**$46,355**	**$42,717**	$5,825	($3,638)
Medical Community Care	$460,271	$700,906	$500,284	**$536,918**	**$555,241**	$36,634	$18,323
Medical Support and Compliance	$45,558	$44,400	$49,002	**$50,809**	**$57,800**	$1,807	$6,991
Medical Facilities	$1,089	$1,400	$1,200	**$1,100**	**$1,100**	($100)	$0
Obligations [Grand Total]	**$539,176**	**$785,100**	**$591,016**	**$635,182**	**$656,858**	**$44,166**	**$21,676**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

2020 Unique Patients using Non-Institutional Long-Term Supportive Services by Fund

FY20 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	1,005	1,005	1,005	0	0	0
Community Adult Day	8,343	8,343	8,343	49	8,296	0
Home-Based Primary	95,362	95,362	95,362	274	0	0
Home Respite Care	16,077	16,077	16,077	39	16,038	0
Purchased Skilled Care	127,585	128,835	128,835	951	128,835	2,238
Hospice Care	34,158	34,158	34,158	118	4,963	0
Homemaker/Home Health Aide	123,030	123,037	123,037	590	122,458	11
SCI Home Care	17,258	17,258	17,258	0	0	0
Community Residential	2,036	2,036	2,036	0	0	0
Home Telehealth	164,878	164,878	164,878	712	0	0
State Adult Day Health Care	0	156	0	0	156	0

Notes:
Medical Services (0160) funds the provision of these services in VA facilities, while MCC (0140) and CHOICE (0172) fund the purchase of these services from community providers;
All accounts are involved with the primarily purchased care programs due to care coordination requirements.

Authority for Action

- LTSS programs
  - 38 U.S.C. Chapter 17, 1710, 1710A, 1710B, 1720, 1720B, 1720C
  - 38 CFR § 17.38, 38 CFR § 17.4000 et seq.
- State Home programs
  - 38 U.S.C., 501, 1710, 1720, 1741-1745
  - CFR Parts 17.42, 17.46-47, 17.190, 17.194, 51, 52, 59

Population Covered

VA's health care system provides enrolled Veterans with a broad spectrum of long-term services and supports (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 (PL 106-117) to provide nursing home care for enrolled Veterans in need of nursing home care for a service-connected (SC) disability, as well as enrolled Veterans in need of nursing home care who has a single or combined SC 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 2020, the LTSS programs managed by the Office of Geriatrics and Extended Care (GEC) served 439,970 Veterans. The Veteran population served with these programs are all ages, with 73% 65 or older and 20% 85 or older. About one third (33.2%) of all Veterans that used VA LTSS lived

in rural areas, which is comparable to the percent of total Veterans that live in rural areas and use VA. Upon further breakdown by Priority Group for Veterans that use VA LTSS, Priority Group 1 Veterans make up 42.5% and Priority Group 1A Veterans make up 19.9%.

Types of Services Provided

Long-term services and supports include facility-based programs and home and community-based services (HCBS). There are six facility-based GEC programs: VA Community Living Centers; Community Nursing Homes; State Veterans Homes (nursing homes and domiciliaries); Inpatient Hospice; Inpatient Respite; and Traumatic 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, 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 increasing access to home and community-based services, serving 373,650 Veterans in 2020 – a 5.2% increase over 2019. In 2019, GeriPACT saw and increase of 12.65% in unique veterans over 2018 (69,851 in 2019, 61,021 in 2018). GeriPACT experienced a significant decrease in unique veterans in March of 2020 due to the COVID-19 pandemic. Before COVID measures were in effect, there was a 10.44% increase in GeriPACT unique veterans from 2019 to 2020 in the first five months (146,948 in 2019, 164,076 in 2020).

Despite the emergence of the COVID-19 pandemic, GEC arranged for 1.6% more Veterans to receive personal care services to keep them out of nursing homes. This includes a 22% increase in Veterans self-directing their home care in Veteran Directed Care. As community adult day health care (CADHC) centers temporarily closed or significantly altered their services following state guidance, GEC issued an amended service plan to give these centers state-based flexibility to provide home care to Veterans, yielding only a 14% decrease in Veterans served in CADHC overall. GEC also took action to support community nursing homes and the Veterans they serve by responding to reimbursement increases in line with state increases and reimbursing the greater costs of Veterans requiring isolation. In addition, HBPC increased overall contacts and interventions from the previous fiscal year, despite the pandemic, with the overall increase in video telehealth over 2,000% and the use of telephone visits. Despite overwhelming data supporting the need for VHA HBPC growth and population data indicating growing Veteran population demand for HBPC level of care, growth has been slow over the past five years, likely related to the start-up cost burden of the program and delayed 2-3 year return on investment.

Home Based Primary Care 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. VA and non-VA HBPC Studies have demonstrated significant cost savings through reduction in emergency room utilization, hospitalization utilization, outpatient, and long-term care placement with both VA and Medicare recipients, even with the addition of the

HBPC team. A recent study found when long term services and supports are integrated with HBPC in a targeted population, long term institutionalization is cut by 50% and delayed by 12.8 months, compared to cases of long term service and supports delivered without HBPC. 23 During the pandemic, HBPC increased overall contacts and interventions from the previous fiscal year with the overall increase in video telehealth over 2,000% and the use of telephone visits.

VA owns and operates a total of 134 Community Living Centers (CLC) 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 use for Care Compare. Between 3rd quarter 2019 and 3rd quarter 2020, VA CLCs improved in quality ratings from 10.4% being rated as one-star (lowest rating) to 0.7% being rated as one-star. The number of overall one star rated CLCs also remained at 0 during the same time-frame. Results on the 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 Geriatrics and Extended Care (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 immediately implemented strong strategies to mitigate the risk of SARS-CoV-2 transmission within the CLCs:

1. Screening residents and staff for symptoms consistent with COVID-19
2. Limiting admissions
3. Implementing a 14-day observation for Veterans returning to the CLC for continued care
4. Restricting non-essential personnel
5. Promoting consistent staffing
6. Promoting use of telehealth modalities for consults and clinic visits outside of the CLC
7. Establishing virtual communication between the CLC residents and families
8. Testing approaches of CLC residents and staff

[23] Valluru, et.al. Integrated Home and Community Based Services Improve Community Survival Among Independence at Home Medicare Beneficiaries Without Increasing Medicaid Costs. J Am Geriatr Soc 67:1495-1501, 2019.

9. Vaccination of CLC residents and staff
10. Expansion of safe visitation in line with Centers for Medicare and Medicaid (CMS) and Center for Disease Control (CDC).

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 will continue to actively monitor COVID-19 activity and adjust guidance with the evolving COVID-19 information.

In 2020, there are 158 recognized SVHs with 151 recognized SVH Nursing Homes programs, 51 recognized Domiciliary Care programs, and three ADHC programs, with an average daily census of over 21,000 Veterans, 1,700 Veteran Spouses and/or Gold Star Parents.

Projections for the Future

The Department of Veterans Affairs (VA) operates the Veterans Health Administration (VHA), the largest integrated healthcare system in America. Our mission is to provide the highest quality of care to our nation's Veterans and their families. VHA must meet many challenges to fulfill this 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 70% of its Geriatrics and Extended Care (GEC) program spending on institutional care in 2019, with overall spending totaling nearly 12% of VHA's overall budget[24, 25]. 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.

[24] Department of Veterans Affairs (2020). "FY 2021 Budget Submission: Medical Programs and Information Technology Programs, Volume 2 of 4." Retrieved from: https://www.va.gov/budget/docs/summary/fy2021VAbudgetVolumeIImedicalProgramsAndInformationTechnology.pdf

[25] VHA Office of Finance Allocation Resource Center (2020). "Long-Term Support Services Review." Data available on VHA Office of Healthcare Transformation intranet site at: https://vaww.project.visn11.portal.va.gov/VERC01/GEC_Strategy/Shared%20Documents/Forms/AllItems.aspx

Camp Lejeune Family Member Program (CLFMP)

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$329	$0	$29	$29	$0	$0	($29)
Discretionary FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$329**	**$0**	**$29**	**$29**	**$0**	**$0**	**($29)**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$2,682	$2,780	$4,520	$2,780	$2,943	($1,740)	$163
Discretionary FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$2,682**	**$2,780**	**$4,520**	**$2,780**	**$2,943**	**($1,740)**	**$163**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations.....	$103	$1,869	$100	$100	$100	$0	$0
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$103**	**$1,869**	**$100**	**$100**	**$100**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
**Discretionary Total	**$3,114**	**$4,649**	**$4,649**	**$2,909**	**$3,043**	**($1,740)**	**$134**
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.....	$329	$0	$29	**$29**	**$0**	$0	($29)
Medical Community Care.....	$2,682	$2,780	$4,520	**$2,780**	**$2,943**	($1,740)	$163
Medical Support and Compliance.....	$103	$1,869	$100	**$100**	**$100**	$0	$0
Medical Facilities.....	$0	$0	$0	**$0**	**$0**	$0	$0
**Obligations [Grand Total].....	**$3,114**	**$4,649**	**$4,649**	**$2,909**	**$3,043**	**($1,740)**	**$134**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

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. Additional details can be found in the Medical Community Care chapter.

CHAMPVA (Excluding Caregivers) Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$380,653	$373,866	$378,072	$489,308	$528,344	$111,236	$39,036
Discretionary FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$380,653**	**$373,866**	**$378,072**	**$489,308**	**$528,344**	**$111,236**	**$39,036**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$33,967	$1,605,523	$1,552,700	$1,605,523	$1,755,157	$52,823	$149,634
Discretionary FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$33,967**	**$1,605,523**	**$1,552,700**	**$1,605,523**	**$1,755,157**	**$52,823**	**$149,634**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations.....	$212,999	$152,500	$152,500	$157,303	$161,662	$4,803	$4,359
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$212,999**	**$152,500**	**$152,500**	**$157,303**	**$161,662**	**$4,803**	**$4,359**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations.....	$7,107	$8,700	$8,000	$8,700	$8,700	$700	$0
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$7,107**	**$8,700**	**$8,000**	**$8,700**	**$8,700**	**$700**	**$0**
**Discretionary Total	**$634,726**	**$2,140,589**	**$2,091,272**	**$2,260,834**	**$2,453,863**	**$169,562**	**$193,029**
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).....	$1,262,734	$0	$15,500	$5,700	$0	($9,800)	($5,700)
**Mandatory Obligations [Subtotal].....	**$1,262,734**	**$0**	**$15,500**	**$5,700**	**$0**	**($9,800)**	**($5,700)**
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	**$1,262,734**	**$0**	**$15,500**	**$5,700**	**$0**	**($9,800)**	**($5,700)**
Combined Discretionary and Mandatory by Category							
Medical Services.....	$380,653	$373,866	$378,072	**$489,308**	**$528,344**	$111,236	$39,036
Medical Community Care.....	$1,296,701	$1,605,523	$1,568,200	**$1,611,223**	**$1,755,157**	$43,023	$143,934
Medical Support and Compliance.....	$212,999	$152,500	$152,500	**$157,303**	**$161,662**	$4,803	$4,359
Medical Facilities.....	$7,107	$8,700	$8,000	**$8,700**	**$8,700**	$700	$0
**Obligations [Grand Total].....	**$1,897,460**	**$2,140,589**	**$2,106,772**	**$2,266,534**	**$2,453,863**	**$159,762**	**$187,329**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Foreign Medical Programs Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$4	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal].....	**$4**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$50,125	$59,395	$52,995	$55,861	$56,964	$2,866	$1,103
Discretionary FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal].....	**$50,125**	**$59,395**	**$52,995**	**$55,861**	**$56,964**	**$2,866**	**$1,103**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal].....	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal].....	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$50,129**	**$59,395**	**$52,995**	**$55,861**	**$56,964**	**$2,866**	**$1,103**
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.....	$4	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care.....	$50,125	$59,395	$52,995	**$55,861**	**$56,964**	$2,866	$1,103
Medical Support and Compliance.....	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities.....	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total].....	**$50,129**	**$59,395**	**$52,995**	**$55,861**	**$56,964**	**$2,866**	**$1,103**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Spina Bifida Program Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$52,859	$73,998	$54,217	$55,575	$56,864	$1,358	$1,289
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$52,859**	**$73,998**	**$54,217**	**$55,575**	**$56,864**	**$1,358**	**$1,289**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$52,859**	**$73,998**	**$54,217**	**$55,575**	**$56,864**	**$1,358**	**$1,289**
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	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$52,859	$73,998	$54,217	**$55,575**	**$56,864**	$1,358	$1,289
Medical Support and Compliance	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$52,859**	**$73,998**	**$54,217**	**$55,575**	**$56,864**	**$1,358**	**$1,289**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Children of Women Vietnam Vets Obligations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$2	$200	$200	$200	$200	$0	$0
Discretionary FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$2**	**$200**	**$200**	**$200**	**$200**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
**Discretionary Total	**$2**	**$200**	**$200**	**$200**	**$200**	**$0**	**$0**
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.....	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care.....	$2	$200	$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].....	**$2**	**$200**	**$200**	**$200**	**$200**	**$0**	**$0**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

VA is currently providing 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. Additional details can be found in the Medical Community Care chapter.

Caregiver Support Program

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$399,453	$1,191,686	$998,404	$1,347,933	$1,744,255	$349,529	$396,322
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$399,453**	**$1,191,686**	**$998,404**	**$1,347,933**	**$1,744,255**	**$349,529**	**$396,322**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$4,619	$3,800	$5,000	$5,200	$5,900	$200	$700
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$4,619**	**$3,800**	**$5,000**	**$5,200**	**$5,900**	**$200**	**$700**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$404,072**	**$1,195,486**	**$1,003,404**	**$1,353,133**	**$1,750,155**	**$349,729**	**$397,022**
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	$399,453	$1,191,686	$998,404	**$1,347,933**	**$1,744,255**	$349,529	$396,322
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$4,619	$3,800	$5,000	**$5,200**	**$5,900**	$200	$700
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$404,072**	**$1,195,486**	**$1,003,404**	**$1,353,133**	**$1,750,155**	**$349,729**	**$397,022**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

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 Program of Comprehensive Assistance for Family Caregivers.
- 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 Program of Comprehensive Assistance for Family Caregivers.
- 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.

Purpose: The Caregiver Support Program's mission is to promote the health and well-being of Family Caregivers who care for our nation's Veterans, though, education, resources, support, and services. CSP is comprised of two programs, the Program of Comprehensive Assistance for Family Caregivers (PCAFC) and the Program of General Caregiver Support Services (PGCSS).

The *MISSION Act of 2018* expands the PCAFC to Veterans in two phases, Phase 1 expands to include eligible Veterans injured on or before May 7, 1975 and Phase II, which expands eligibility to Veterans of all eras in 2022. The expansion of PCAFC and the other programs under the VA Caregiver Support Program (CSP) requires additional resources in the national program office to support all facets of operations. During 2021, CSP began efforts to hire 24.0 new full-time employees (FTE) or full-time equivalent employees (FTEE) to support CSP expansion and operations in the VA Caregiver Support Program national office. The 2022 CSP budget request would provide the funding required to support these positions and comply with the Purple Heart and Disabled Veterans Equal Access Act of 2018.

The *Caregivers and Veterans Omnibus Health Services Act of 2010* (P.L. 111-163) established 38 U.S.C. 1720G, which directed the VA to establish a PCAFC and a Program of General Caregiver Support Services (PGCSS). Both programs are managed by the VA's CSP Office. On June 6, 2018, the President signed into law the *VA Maintaining Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018*, or *VA MISSION Act 2018* (P.L. 115-182). The *VA MISSION Act of 2018* will fundamentally transform elements of the VA's healthcare system to include expansion of the PCAFC within the CSP (38 U.S.C. 1720G; 38 CFR Part 71).

In accordance with the P.L. 115-232 §621, *Purple Heart and Disabled Veterans Equal Access Act of 2018*, eligible caregivers are able to access certain Morale/Welfare/Recreation (MWR),

Exchange, and Commissary retail eligibility. Printing and mailing eligible caregivers' letters is the current practice used by VA to identify eligible caregivers and will also be utilized to verify access to MWR, Exchange and Commissary. The implementation of this practice and process will continue until an enterprise-wide credentialing/digital solution is developed, funded, and operationalized.

Implementation Plan:

CSP Central Oversite Expansion:

The national CSP office is responsible for management, coordination and evaluation of a complex VA wide continuum of support services for programs and operations including: the PCAFC, the PGCSS, the Caregiver Support Line, Centralized Eligibility and Appeals Teams and Caregiver Support Program Training and Education in addition to other complimentary programs.

CSP expansion would support:

- developing and deploying training and education of over 1,900 field-based staff;
- enhancing community partnerships and expanding new partnerships;
- conducting daily management and operations of the Caregiver Record Management Application (CARMA);
- completing program improvements to enhance current operations, using new technologies; and
- conducting extensive program evaluation and standardization.

The compliment of CSP staff are aligned under six collaborative workstreams. Each workstream is designed to address the components required to facilitate standardized, efficient, coordinated CSP operations.

1. Data Analytics, Performance and Audit/Compliance: Provides performance management, measurement and oversight, workload and productivity analysis, and data collection across VA's data systems and strategic operational planning.
2. CARMA and Electronic Health Record (EHR): Serves as the lead section to institute and develop a strategic plan to integrate the CSP into EHR development. The section is also responsible for management and daily operations of the CARMA tool, including uses of automation, investigate business practices, run and analyze reports and building reporting systems.
3. Policy and Regulations: this section is responsible for writing policy, developing field guides, and actions necessary for hearing preps and congressional and stakeholder briefings.
4. Education and Training: This team is responsible for the various levels of training necessary to ensure that consortium-wide training is provided to VHA Central Office (VHACO) staff offices and the 1,900+ field-based staff on the intricacies of CSP program operations. The section is also charged with developing caregiver specific trainings and educational opportunities.
5. Centralized Eligibility and Appeals Teams (CEAT): this section is charged with managing operations of the VISN-wide CEATs ensuring that all teams operate in a standardized way and are aligned in interpreting and implementing regulations and operationalizing the teams across the enterprise.

6. Field Operations: this section is responsible for the administration, coordination, and operationalization of the PCAFC and the compliment of programs that fall under the PGCSS to VISN and VAMCs. This section has a critical impact on day-to-day activities of the national office as well as all VAMC CSP operations. It is anticipated that Veteran and caregiver use of the services provided by the CSP will increase substantially compared to historical awareness of the program. This growth will result in increased demands, workload and support required by the national program office.

Purple Heart and Disabled Veterans Equal Access Act of 2018 Compliance:
In 2020, the initial rollout of the *Purple Heart and Disabled Veterans Equal Access Act of 2018*, was operationalized with a focus on approved Primary Family Caregivers enrolled in the PCAFC. Currently, VA prints a letter and mails it to the primary family caregivers as they are approved in PCAFC. In September 2020, approximately 19,000 letters were printed and mailed to family caregivers. An estimated 30,000 letters are expected to be sent to family caregivers in September 2021. These letters, paired with an accepted credential (valid U.S. photo identification), are used to enable the access to these retail privileges.

In Fall 2020, the Caregiver Support Program expanded to pre-9/11 Veterans and their Caregivers. These estimates were developed and adjusted using a two-phase expansion in which the VA first expands PCAFC eligibility to those Veterans injured prior to May 1975 (the end of the Vietnam War) and post September 11, 2001. In 2022, VA then will expand PCAFC to Veterans injured from all eras. A program ramp-up of 40, 70, and 90% for each phase of the PCAFC program expansion is assumed. Thus, the first and second phase will reach full enrollment (i.e., 100%) in 2025 and 2027, respectively.

COVID-19 Impact: In response to COVID-19, in June 2020, VA published an Interim Final Rule, *Home Visits in Program of Comprehensive Assistance for Family Caregivers During COVID-19 National Emergency*(RIN 2900-AQ96), intended to reduce the risk of exposure to and transmission of COVID-19 to individuals involved in PCAFC, as well as members of their households and others with whom they come into contact who may be affected, by providing facilities flexibility in the modalities used to conduct home visits other than in-person visits. This rule will remain in effect for the duration of the COVID-19 National Emergency.

In January 2021, VA extended COVID-19 testing and vaccination to PCAFC Primary and Secondary Family Caregivers. CSP observed a notable increase in interest in PCAFC program participation with an increase in PCAFC applications. In March 2021, the enactment of P.L. 117-4, *SAVES Lives Act*, further expanded eligibility to Veterans and their families; the expansion of vaccine availability has attracted additional interest to both the PCAFC and PGCSS programs offered by CSP.

Readjustment Counseling

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$222,546	$239,716	$237,354	$263,383	$274,053	$26,029	$10,670
Discretionary FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$222,546**	**$239,716**	**$237,354**	**$263,383**	**$274,053**	**$26,029**	**$10,670**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations.....	$0	$8,986	$10,136	$11,951	$12,345	$1,815	$394
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$0**	**$8,986**	**$10,136**	**$11,951**	**$12,345**	**$1,815**	**$394**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations.....	$43,848	$38,278	$39,490	$48,455	$49,686	$8,965	$1,231
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
**Discretionary Obligations [Subtotal].....	**$43,848**	**$38,278**	**$39,490**	**$48,455**	**$49,686**	**$8,965**	**$1,231**
**Discretionary Total	**$266,394**	**$286,980**	**$286,980**	**$323,789**	**$336,084**	**$36,809**	**$12,295**
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.....	$222,546	$239,716	$237,354	**$263,383**	**$274,053**	$26,029	$10,670
Medical Community Care.....	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance.....	$0	$8,986	$10,136	**$11,951**	**$12,345**	$1,815	$394
Medical Facilities.....	$43,848	$38,278	$39,490	**$48,455**	**$49,686**	$8,965	$1,231
**Obligations [Grand Total].....	**$266,394**	**$286,980**	**$286,980**	**$323,789**	**$336,084**	**$36,809**	**$12,295**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Authority for Action
Readjustment Counseling Service (RCS) is legislatively mandated through 38 USC Section 7309.

Population Covered
RCS clients include Veterans (95%) and active duty service members (5%), along with their families, who experience challenges from deployment, combat, or other military-related trauma. Approximately 86% of clients are male and 14% female. The average age of our clients is 54, and currently 49% are younger than 60 years.

Over 40% 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. Our second largest group of clients are Vietnam Veterans, representing 33% of those receiving Vet Center Services. Another 5% have served in other periods to include Bosnia, Panama, etc. 9% of those who come to RCS for services have experienced military sexual trauma, and approximately 1% of our clients come to us for bereavement care.

Our client population is diverse. By self-report, 59% of our clients are Caucasian, 20% African American, and 12% Hispanic. Approximately 3.5% are Asian Americans or Pacific Islander/Hawaiian, and 1.4% are Alaskan Native or Native American. RCS provides services to individuals who have both honorable (90%) and problematic (4%) discharges, as well as those currently engaged in discharge activities (2%).

Types of Services Provided
RCS currently consists of 300 Vet Centers, 83 Mobile Vet Centers, and 19 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 exposure to other traumatic situations. Services for eligible individuals include individual, group, marriage, and family counseling for challenges such as the symptoms associated with 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, active duty Service members, and their families.

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

Recent Trends

From the beginning of 2015 through 2020, RCS has seen a 1.3% increase in the total number of unique clients seen either through outreach or providing counseling services, For those to whom we provided both counseling and outreach, we experienced over 35% growth, and in outreach alone 20%.

Over the past five years, we have seen growth in the percentage of our clients who are female. The percentage of visits by female clients has also grown; of all visits provided by RCS in the course of a year, less than 10% were provided for women clients in 2016, growing to 14% in 2020.

RCS is beginning 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. The number of GWOT Veterans coming to RCS for services is increasing, as has their utilization.

Bereavement service demand has also increased with nearly 7% more clients in 2020 compared to 2016 receiving an increase in visits by 33%. Consequently, in response to this growing demand, RCS has increased the number of Outstations (satellites of Vet Centers) as well as Community Access Points (where counselors are available routinely, albeit not every day), where clients can access services. While Vet Centers are our main service delivery sites, nearly 23% of visits are provided outside of these settings. To meet the needs of Veterans and to provide greater access to services, RCS has community access points. In addition, hours of operation are adjusted to meet the needs of Veterans and to make access to RCS services convenient.

Suicide prevention and crisis intervention continue to be a focus of RCS with a 6% increase in acute counseling interventions since 2019. Recognizing the need for counseling among those in the National Guard and Reserves 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 2020:

- RCS has provided 1,753,428 readjustment counseling services visits & outreach contacts for 223,476 Veterans, Service members, and families (1.3% increase over 2015), 103,197 readjustment counseling family visits and 96,738 VA Video Connect visits; of these, 252,773 readjustment counseling visits were offered during non-traditional hours (before 8:00 a.m., after 4:30 p.m., and weekends).
- Vet Center staff provided services in over 1,000 CAPs. Over 23% of all Vet Center visits were provided in these distant locations.
- RCS has hosted and / or participated in 28,759 Outreach Events.
- RCS has processed 111,690 live telephone calls from Veterans, Service Members, families, and community stakeholders through the Vet Center Call Center.
- RCS continues to be an integral part of the VA 4th Mission (Emergency Response) such as the response to COVID-19, hurricanes, flooding, tornados, shootings and wildfires, providing services to 1,242 Veterans, 487 Service members, 208 families, and 1,725 citizens.
- In 2020 RCS awarded 27 leases totaling $13.6 million for Tenant Improvements/Buildouts. The buildout for 20 Vet Center relocations were completed and the space activated;

- Procured 3 Mobile Vet Center's (MVCs)

Recent Legislation

On October 1, 2020, the President signed into law, 6-159, "Continuing Appropriations Act, 2021 and Other Extensions Act." Division E, Section 5106, "Extension of Authority for Pilot Program on Counseling in Retreat Settings for Women Veterans Newly Separated from Service," extends the directive for RCS to provide retreats for women veterans newly separated from service to September 30, 2022. The original allocation for this program was $2 million for no less than three retreats per year, but no funding was directed in the expansion.

On October 17, 2020, the President signed into law, PL 116-171, *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*. Section 502, "Establishment of Department of Veterans Affairs Readjustment Counseling Service Scholarship Program," requires VA to set up a scholarship program for RCS along with the Specialty Education Loan Repayment Program, and to begin awarding scholarships within one year of enactment. The law did not come with funding, and it is estimated that the cost 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 would be approximately $590,000, third year approximately $897,600, and fourth approximately $1.3 million, etc., until first cohort graduates and a standing number of scholarships is achieved.

On October 20, 2020, the President signed into law, PL 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." The approximate cost to expand services is $36 million per year.

Public Law 115-141, *Consolidated Appropriations Act of 2018*, directed $2,500,000 be utilized to develop a program in which RCS partners with organizations that provide outdoor experiences for Veterans as part of a continuum of care that helps support Veterans in developing a community of support to treat combat-related injuries, including those related to behavioral health with the goal of the program was to build self-esteem, interpersonal confidence, and trusting relationships for participating Veterans. Throughout 2018, RCS implemented this program on a national basis with the $2.5 million earmarked allocation. In 2019, RCS continued this program by providing $3.3 million in funding within budget for additional outdoor events for Veterans.

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 2022 and beyond RCS will:

- Extend the directive for RCS to provide retreats for women veterans newly separated from service to September 30, 2022 (P.L. 116-159, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Act of 2021*);
- Implement the RCS scholarship program (P.L. 116-171, *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*);
- Increase capacity to expand eligibility for Vet Center services (P.L. 116-176, *Vet Center Eligibility Expansion Act*;
- Continue the Outdoor Experiences for Veterans Program into 2022 and beyond with the addition of necessary precautions to mitigate COVID-19 related risk (P.L. 115-141, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Act of 2018*);
- 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 three CAPS to Outstations;
- Continue to improve access to readjustment counseling in communities distant from existing Vet Center services through increasing the number of Vet Centers (projected increase of 5), Outstations (projected increase of 8), and Community Access Points in Rural and Highly Rural Areas.
- Continue to address the unmet mental health needs of veterans in rural and highly rural areas.
- 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 our 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 2022 to include, but not limited to, 1 additional Vet Center, the relocation of 17 Vet Centers, 5 expansions, and 43 contracted lease renewals.

RCS Workload

Readjustment Counseling Visits
(visits in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Advance Approp.	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Visits (000)	1,753	2,544	1,932	2,005	**2,275**	**2,388**	343	113
Uniques	223	333	333	347	359	379	26	20

The RCS budget request for fiscal years 2022 through 2023 would support the required resource needs created by the newly enacted legislation and expand capacity of health care services within

Readjustment Counseling Service. As a result of the current coronavirus pandemic, Readjustment Counseling expects a surge of mental health needs, outreach, and counseling services. Without the resources needed to address the growing future demand of these services, RCS will have insufficient funding to meet the legislation requirements and address the unmet needs of our growing population and the impact of COVID-19 on veterans and their families.

Activations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160):	$98,952	$447,856	$447,856	$609,608	$340,000	$161,752	($269,608)
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$15,213	$53,084	$53,084	$112,060	$62,500	$58,976	($49,560)
Medical Facilities (0162):	$12,524	$149,060	$149,060	$174,814	$97,500	$25,754	($77,314)
Mandatory Obligations							
VACAA, Section 801 (0162):	-$2	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$126,687**	**$650,000**	**$650,000**	**$896,483**	**$500,000**	**$246,483**	**($396,483)**

For details on VHA Activations, please see the Medical Services Chapter.

Education & Training

Education & Training Total

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):	$2,169,937	$2,319,884	$2,316,275	$2,400,650	$2,487,738	$84,375	$87,088
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$68,704	$72,759	$73,465	$76,128	$78,868	$2,663	$2,740
Medical Facilities (0162):	$95,741	$101,363	$102,363	$106,091	$109,926	$3,728	$3,835
Discretionary Total	**$2,334,382**	**$2,494,006**	**$2,492,103**	**$2,582,869**	**$2,676,532**	**$90,766**	**$93,663**
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)	-$1,345	$1,525	$2,276	$2,365	$2,171	$89	($194)
Mandatory Obligations [Subtotal]	**-$1,345**	**$1,525**	**$2,276**	**$2,365**	**$2,171**	**$89**	**($194)**
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)	$1,268	$3,262	$1,398	$1,453	$1,509	$55	$56
Mandatory Obligations [Subtotal]	**$1,268**	**$3,262**	**$1,398**	**$1,453**	**$1,509**	**$55**	**$56**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$269	$3,750	$269	$269	$269	$0	$0
Mandatory Obligations [Subtotal]	**$269**	**$3,750**	**$269**	**$269**	**$269**	**$0**	**$0**
Mandatory Total	**$192**	**$8,537**	**$3,943**	**$4,087**	**$3,949**	**$144**	**($138)**
Combined Discretionary and Mandatory by Category							
Medical Services	$2,168,592	$2,321,409	$2,318,551	$2,403,015	$2,489,909	$84,464	$86,894
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$69,972	$76,021	$74,863	$77,581	$80,377	$2,718	$2,796
Medical Facilities	$96,010	$105,113	$102,632	$106,360	$110,195	$3,728	$3,835
Obligations [Grand Total]	**$2,334,574**	**$2,502,543**	**$2,496,046**	**$2,586,956**	**$2,680,481**	**$90,910**	**$93,525**

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Graduate Medical Education (GME) Trainees

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):	$709,226	$782,338	$802,958	$832,212	$862,532	$29,254	$30,320
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	**$709,226**	**$782,338**	**$802,958**	**$832,212**	**$862,532**	**$29,254**	**$30,320**
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)	($1,345)	$1,525	$2,276	$2,365	$2,171	$89	($194)
Mandatory Obligations [Subtotal]	**($1,345)**	**$1,525**	**$2,276**	**$2,365**	**$2,171**	**$89**	**($194)**
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)	$1,268	$3,262	$1,398	$1,453	$1,509	$55	$56
Mandatory Obligations [Subtotal]	**$1,268**	**$3,262**	**$1,398**	**$1,453**	**$1,509**	**$55**	**$56**
Medical Facilities Category							
Veterans Medical Care and Health Fund (0173) 1/	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801 (0162)	$269	$3,750	$269	$269	$269	$0	$0
Mandatory Obligations [Subtotal]	**$269**	**$3,750**	**$269**	**$269**	**$269**	**$0**	**$0**
Mandatory Total	**$192**	**$8,537**	**$3,943**	**$4,087**	**$3,949**	**$144**	**($138)**
Combined Discretionary and Mandatory by Category							
Medical Services	$707,881	$783,863	$805,234	$834,577	$864,703	$29,343	$30,126
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$1,268	$3,262	$1,398	$1,453	$1,509	$55	$56
Medical Facilities	$269	$3,750	$269	$269	$269	$0	$0
Obligations [Grand Total]	**$709,418**	**$790,875**	**$806,901**	**$836,299**	**$866,481**	**$29,398**	**$30,182**

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Education and Training Non-GME Trainees

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):	$257,116	$263,268	$226,475	$234,727	$243,278	$8,252	$8,551
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$318	$357	$349	$349	$349	$0	$0
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Discretionary Total	**$257,434**	**$263,625**	**$226,824**	**$235,076**	**$243,627**	**$8,252**	**$8,551**
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	$257,116	$263,268	$226,475	$234,727	$243,278	$8,252	$8,551
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$318	$357	$349	$349	$349	$0	$0
Medical Facilities	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$257,434**	**$263,625**	**$226,824**	**$235,076**	**$243,627**	**$8,252**	**$8,551**

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Education and Training Support

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):	$1,203,595	$1,274,278	$1,286,842	$1,333,711	$1,381,928	$46,869	$48,217
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$68,386	$72,402	$73,116	$75,779	$78,519	$2,663	$2,740
Medical Facilities (0162):	$95,741	$101,363	$102,363	$106,091	$109,926	$3,728	$3,835
Discretionary Total	**$1,367,722**	**$1,448,043**	**$1,462,321**	**$1,515,581**	**$1,570,373**	**$53,260**	**$54,792**
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	$1,203,595	$1,274,278	$1,286,842	$1,333,711	$1,381,928	$46,869	$48,217
Medical Community Care	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance	$68,386	$72,402	$73,116	$75,779	$78,519	$2,663	$2,740
Medical Facilities	$95,741	$101,363	$102,363	$106,091	$109,926	$3,728	$3,835
Obligations [Grand Total]	**$1,367,722**	**$1,448,043**	**$1,462,321**	**$1,515,581**	**$1,570,373**	**$53,260**	**$54,792**

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Authority for Action

As one of four statutory missions, VA, through the VHA Office of Academic Affiliations (OAA) conducts an education and training program for health professions trainees "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", clinical education and training efforts are accomplished through coordinated programs and activities 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 at medical facilities of the Department of Veterans Affairs from 5 to 10 years (expiring August 7, 2024).

VA Staff Impacted

Over 124,000 clinical trainees, representing more than 100 health care program types, receive all or part of their clinical training in VA health care facilities annually. These trainees are either direct-paid clinical trainees (15,764), indirect-paid clinical trainees (45,363) and Without Compensation (unpaid) clinical trainees (63,000). Graduate Medical Education (GME) Physician Residents, primarily paid indirectly through disbursement agreements, account for approximately 78% of the clinical trainee budget; non-GME trainees account for the remainder. Non-GME trainees include nursing, allied health and non-physician trainees. OAA creates and maintains policy oversight of the health professions education mission in VA, and offers advice and consultation to field facilities, Veterans Integrated Service Networks, and other VA constituencies. OAA is the primary source for health professions trainee data in VA, and acts as the main liaison to external stakeholders such as professional and member organizations, specialty societies, and accrediting bodies for health professions education.

Type of Services Provided

Health professional trainees contribute substantially to VA's mission to deliver cost-effective, high-quality patient care for Veterans. Nearly a third of currently employed VA health professionals have received at least a portion of their clinical training in VA. To continue to meet its workforce needs while providing innovative and high-quality Veteran care, VA has identified and expanded clinical training programs in critical areas of need as defined by the VA and VHA strategic plans, VA Secretary's priorities and the Veterans Access, Choice, and Accountability Act of 2014 (Veterans Choice Act). VA's physician education program is conducted in collaboration with 144 of 152 MD granting medical schools and 34 of 34 DO granting medical schools. In addition, VA has affiliations with over 1,800 institutions, comprising nearly 6,000 individual programs, across more than 40 health professions. Among VA's affiliates are Hispanic Serving Institutions, Historically Black Colleges and Universities, Asian American and Native American Pacific Islander Serving Institutions, and Native American Serving Institutions.

VA health professions education programs have a major impact on the healthcare workforce within VA. For example, roughly 70% of current VA optometrists and VA psychologists and 60% of current VA physicians participated in VA training programs prior to employment. When trainees are queried about the impact of their recent training experiences in VA, their willingness to work for VA increases by 20%. VA's involvement in health professions education has thus been shown to be an effective mechanism to support VA's patient care mission.

The trainee portfolio is designed to augment VA workforce and align with Veteran's healthcare needs. For example, in partnership with the Office of Mental Health Services, OAA has been engaged in a six-year, phased expansion of mental health training positions in VA. Since 2012, mental health training has expanded by over 750 positions. The Licensed Professional Mental

Health Counselor and Marriage and Family Therapy training programs were added recently to the paid trainee portfolio.

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, including Veterans Affairs Nursing Academic Partnership Undergraduate and Graduate Education programs, RN and NP residency programs, Advanced Fellowships Programs and numerous sub-specialty pre-degree training programs. In 2019, more than 25,000 nursing trainees completed their clinical training at VA facilities.

Recent Trends

VA's health professions education mission has continued to add value for VA. Health professions education is seen as a cost-effective mechanism for creating a workforce pipeline to fill critical VA and national workforce needs. Much attention has been focused on augmenting workforce in rural and under-served communities and at small and low complexity VA medical centers through establishment or expansion of existing health professions education programs. Recent legislation affecting the health professions education mission in VA include the following:

The Veterans Choice Act of 2014 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, over 1425 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).

The *VA MISSION Act* contained numerous provisions to augment recruitment of trainees into the VA workforce. Section 301 established additional scholarships allocated to medical and dental students. Section 302 increased the ceiling on Education Debt Reduction Payments (loan repayments) for VA staff. Section 303 established an entirely new specialty loan repayment program geared to GME residents while still in their residency programs. Section 304, the Veterans Healing Veterans Medical Access and Scholarship Program (VHVMASP) was a unique medical student scholarship program. Section 305 increased caps for recruitment, retention and relocation payments. Section 403 enabled the establishment of unique relationships between VA and covered facilities including DoD, Indian Health Service, Tribes and Tribal Organizations, and Federal Qualified Health Care Centers and provided incentives for new residency programs to be created in rural and under-served areas.

Projections for the Future

VA continues to be a sought-after partner for health professions training programs, due to its size, national scope, and breadth of training opportunities. Veterans are a unique and grateful patient population, and trainees value their experiences working with Veterans. VA is the second largest federal payor of GME (secondary to the Center for Medicare and Medicaid Services) and is a major funder of residency programs across a variety of health professions. OAA expects continued growth in health professions education, due to accreditation of new professions as well as the continued addition of new levels of training (e.g., new residency programs for both nurse practitioners and physician assistants). As the VA footprint changes, health professions education will continue to align

itself with the needs of the healthcare system in producing the healthcare workforce that Veterans require.

The VA Choice and the MISSION Acts encourage health professions education in rural, under-served and remote locations in order to augment the VA and national healthcare workforce. The MISSION Act gives VA several methods to recruit trainees more easily, but with a "directed" service obligation, enabling VA to assign providers directly to VA facilities that are having difficulty recruiting, to gain a predictable supply of health professionals to meet shortages over a long term horizon, and to make financial incentives more competitive with the market. In the future, VA will be able to assess the impact these new programs and authorities have on recruitment of the optimal workforce.

Approved Graduate Medical Education (GME) Positions

Academic Year	Fiscal Year	Category	Filled GME Positions
2017 – 2018	2018	Actual	11,043
2018 – 2019	2019	Actual	11,245
2019 – 2020	2020	Actual	11,444
2020 – 2021	2021	Estimate	11,584
2021 – 2022	2022	Estimate	11,802
2022 – 2023	2023	Estimate	12,196

Health Care Professionals Educational Assistance Program

Description (Dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2023-2023
Obligations [Total]	**$115,540**	**$152,336**	**$156,336**	**$205,785**	**$258,785**	**$49,449**	**$53,000**
Education Debt Reduction Program (EDRP)	$70,028	$99,000	$103,000	$145,000	$190,000	$42,000	$45,000
Specialty Education Debt Reduction Program (SELRP)	$0	$4,000	$4,000	$8,000	$12,000	$4,000	$4,000
Employee Incentive Scholarship Program (EISP)	$3,052	$2,000	$2,000	$2,900	$3,600	$900	$700
VA National Education for Employees Program (VANEEP)	$15,177	$12,287	$12,287	$12,287	$12,287	$0	$0
Nat'l Nursing Education Initiative (NNEI)	$16,085	$17,049	$17,049	$17,049	$17,049	$0	$0
*Health Professional Scholarship Program (HPSP)	$10,893	$17,100	$17,100	$20,324	$23,624	$3,224	$3,300
Visual Impairment Education Assistance Program (VIOMPSP)	$305	$900	$900	$225	$225	($675)	$0

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. HPSP gives priority to applicants pursuing education or training towards a career in a clinical occupation experiencing the largest staffing shortages in the VA. The increased funding for the HPSP would expand the pipeline of qualified candidates to fill critical healthcare workforce shortage areas since the applicants awarded the scholarship must fulfil a service obligation at a VA medical facility.

Evidence
The intent of Title III of the *Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018* was to create a pipeline of medical doctors to fill vacancies and increase access to care for Veterans. The *VA MISSION Act of 2018*, Section 301 requires that not less than 50 scholarships are 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.

Since the inception of the HPSP in 2016 through September 30, 2020, VA has awarded 502 scholarships to HPSP participants in the following specialties: Physician Assistants, Nurses, Nurse Practitioners, Physical Therapists, and Medical Technologists. During 2020, the HPSP expanded to include medical students as directed by Section 301 of the *VA MISSION Act of 2018*. As of September 30, 2020, 54 medical students were awarded scholarships.

Each HPSP recipient agrees to a service obligation period at a VA medical facility which helps alleviate the health care workforce shortages in VA. 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 has placed over 169 clinicians in multiple disciplines across the Nation.

Implementation Plan
Section 301 of the *VA MISSION Act of 2018* required the HPSP supply scholarships to medical students. This program expansion began in 2020. In 2022 and 2023, HPSP will award a minimum of 50 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.

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. HPSP awards are made on a competitive basis to eligible students who meet certain selection criteria. During the selection process, students are ranked with their peers for each health care profession. Of the scholarships awarded, not less than 50 scholarships are awarded each year to individuals who are accepted for enrollment or 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. 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 and verified by VHA Finance. The $20,324 million request for 2022 and the $23,624 million request for 2023 would sustain all of HPSP including the portion of HPSP as required by the *VA MISSION Act* as well as the Physician Assistant Omnibus. This amount allows for new awards annually as well as funding for continuing awards from previous years.

Employee Incentive Scholarship Program (EISP):

Purpose: EISP authorizes the Department of Veterans Affairs to award scholarships to employees pursuing degrees or training in health care 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 increased funding for the EISP would provide increased opportunities for employees to transition into clinical occupations with a service obligation commitment at a VA medical facility.

Evidence: Since the inception of the EISP in 2000 through September 30, 2020, VA has awarded 2,422 scholarships to EISP participants. The top five active clinical occupations are registered nurse, pharmacist, physical therapy, licensed practical nurse, and physician assistant. The EISP helps alleviate the healthcare 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, 2020, a total of 1,274 EISP participants have completed their associated service obligation periods.

Implementation Plan: As recruitment and retention initiative, the EISP is poised to address the VHA critical clinical staffing shortages as well as build a highly qualified healthcare workforce capable of providing the best care to Veterans. In 2022 and 2023, EISP will award an additional 50 new awards annually while managing and funding the continuing EISP awards for active participants. Additionally, the Employee Incentive Scholarship Program/Intermediate Care Technician (ICT) Pathway Pilot Program proposes funding the education of up to five ICT personnel per year for three years using EISP scholarships. Priority consideration is given to applicants whose completion occupations align with the top clinical shortage occupations, those entering the mental health field, and those agreeing to fulfill their service obligations at a rural health facility.

Costs: EISP scholarship costs are based on the average total of educational assistance awarded (excluding replacement salaries and benefits) to all occupations. The current average annual award of $16,571 is based on historical disbursements to employees. For the EISP/ICT Pathway Pilot Program, the maximum amount of funding per participant is capped at $143,160 (including replacement salaries and benefits) with an annual total of $715,802 per 5-participant cohort. The added investment in the EISP provides increased opportunities for employees to transition into clinical occupations or remain in clinical occupations with a service obligation commitment. The EISP recruitment and retention initiative directly contributes to addressing VHA's staffing shortages in clinical occupations where recruitment and retention of qualified personnel may be challenging.

Education Debt Reduction Program:

Purpose: The Education Debt Reduction Program (EDRP), serves as a critical recruitment and retention tool used by VHA medical centers for recruitment and retention of their most difficult to fill clinical care positions. As a multi-year program that reimburses participant education loan

payments up to $40,000 per year for five years for a total of up to $200,000 per participant, the EDRP is an attractive incentive that permits VHA to better compete with the private sector, proving successful in both recruiting and retaining healthcare providers.

Evidence: Since program inception, EDRP has been used to recruit and retain over 20,000 individuals providing patient care to Veterans. During the 2020 application cycle, VHA awarded 1,987 new EDRP awards. Physicians historically receive the most EDRP awards followed by registered nurses (including advanced practice nurses) and then psychologists. The EDRP remains a strong recruiting tool for VHA used to help meet the immediate need to fill hard to recruit patient care providers.

Implementation Plan: EDRP will be used by medical centers to recruit and retain approximately 2,000 additional healthcare professionals annually in hard to fill patient care positions, while continuing to retain those already in the program for the remainder of their service periods, which typically lasts five years.

Costs: Section 302 of the MISSION Act of 2018 increased the maximum EDRP reimbursement amount up to $200,000 over five years from the previous $120,000 maximum. EDRP participants and average award amounts continue to increase due to the increased maximum award amount and program demand to meet VHA recruitment and retention healthcare provider needs. In comparison, prior to MISSION Act implementation in 2018, EDRP awards averaged $77,000. At the end of 2019, post-MISSION Act awards averaged $112,000 and have continued to trend upwards as demonstrated in the 2020 average of over $114,000. EDRP's previously requested budget of $103 million will be required to reimburse over 5000 EDRP participants due a payment in the current 2021. For 2022, the number of EDRP participants that will receive reimbursement is expected to climb to more than 7,000 participants requiring $145 million in EDRP reimbursement payments. For 2023 active EDRP participants are projected to reach over 9,000 and of that number, over 8,000 will be post MISSION Act participants requiring $190 million in EDRP loan reimbursement payments.

COVID-19 Impact: EDRP is used to recruit and retain the hardest to fill VHA clinical care positions and as such, COVID-19 could have considerable impact resulting in additional shortages in already hard to fill clinical occupations needed to meet VHA's critical hiring need. Greatest impact is expected for Physicians, Nurses, Respiratory Therapists and Psychologists.

<u>Specialty Education Loan Repayment Program</u>:

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: This is a new program mandated by the MISSION Act 2018; therefore, no prior program history exists. The Association of American Medical Colleges reported that 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. VHA is already competing against lucrative private sector offers to physicians during their residency training. It is imperative that VHA use financial incentive programs like the SELRP to obtain 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, and Psychiatrists, 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 is currently in development with implementation expected in 2021, beginning with an initial program cohort of 100 medical school graduates and expanding in future years based on physician specialty projections. The SELRP will offer loan payment up to $40,000 annually in return of 12 months of service for every $40,000 received. SELRP participants may receive up to $160,000 maximum for 4 years of service.

Costs: The 2021 budget of $4 million will cover the cost to reimburse 100 SELRP participants $40,000 each. The program is expected to expand to 200 participants in 2022 for a cost of $8 million.

COVID-19 Impact: COVID-19 could have considerable impact on the type of physician specialties required to meet future VA needs.

Hepatitis C

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160) 1/:	$38,516	$38,428	$111,339	$108,280	$103,883	($3,059)	($4,397)
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
Obligations [Grand Total]	**$38,516**	**$38,428**	**$111,339**	**$108,280**	**$103,883**	**($3,059)**	**($4,397)**

1/Obligations are drugs & medicine costs only. Outyear projections were based on 2019 actuals, pre-pandemic.

Authority for Action

VA's National Viral Hepatitis Program is governed by VHA Directive 1300.01 and Title 38 United States Code (U.S.C.) 7301(b). Treating and curing hepatitis C virus (HCV) among Veterans in VA care has been a high priority for VA and the Congress. VA places a high priority on ensuring that all enrolled Veterans who require hepatitis C treatment have access to evaluation and treatment. HCV is an infectious disease primarily affecting the liver and is often asymptomatic. Chronic infection can lead to scarring of the liver (e.g., fibrosis or cirrhosis), and in some cases, those with cirrhosis will go on to develop liver failure or liver cancer.

Population Covered
In 2020, 172,372 living Veterans in the Department of Veterans Affairs (VA) care had a history of chronic HCV infection. Of these, 150,250 have been cured of their infection, with the remainder awaiting treatment. Among those with a current or prior history of HCV infection, an estimated 39,522 have advanced liver disease or cirrhosis. Treatment of HCV can prevent development or progression of liver scarring, which greatly improves survival rates and lowers the risk of HCV-related disease complications.

Type of Services Provided
Starting in January 2014, the U.S. Food and Drug Administration (FDA) approved multiple, highly effective, less toxic direct acting antiviral (DAA) drugs for the treatment of HCV, all of which are available on the VA National Formulary (VANF). VA also provides HCV prevention, testing, care, and management for advanced liver disease (ALD) for those patients with cirrhosis related to HCV infection.

Recent Trends
Since the 2014 approval of DAAs to treat HCV, VA has treated 128,208 patients, with 83.6% confirmed cured (excluding 8,062 patients who have completed treatment but are not yet due for follow-up testing) as of September 2020. After a period of rapid uptake (weekly treatment starts of 700-800 patients per week) between January 2015 and June 2017, weekly treatment starts have maintained at 50-100 per week during 2020 as demand decreased. VA HCV providers continue active outreach to contact Veterans via phone and letters.

As of January 1, 2020, 75.0% of Veterans in care between ages 18-79 years have been screened for HCV, while 83.9% of Veterans in VA care in the 1945-1965 birth cohort, the highest risk population for HCV, have been screened for HCV. Based on current screening recommendations, testing of all remaining Veterans in care between ages 18-79 would identify an estimated 8,000-17,000 additional HCV patients yet to be diagnosed in the VA system.

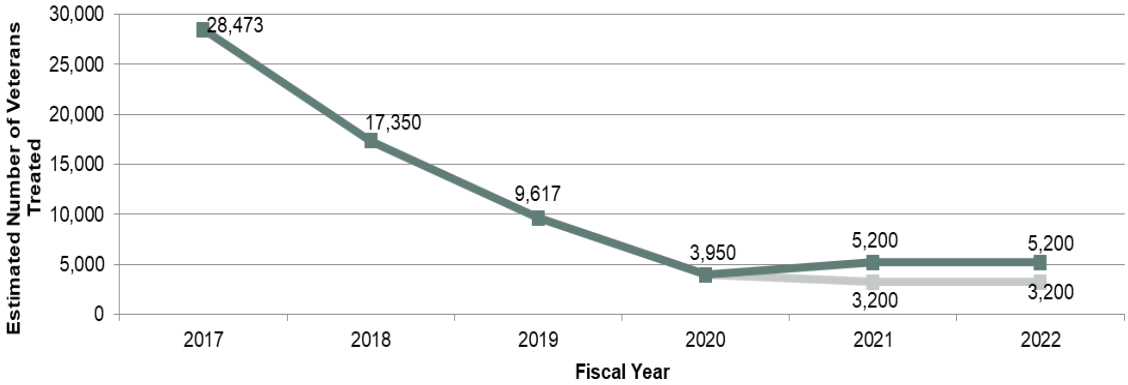
Projections for the Future

VA expects to be able to continue to offer treatment to all Veterans who are clinical candidates for anti-viral treatment and who are willing to be treated. As of September 2020, 18,695 Veterans in VA care diagnosed with HCV are potential candidates for treatment, although this includes some patients who are unwilling or unable to undergo treatment. As VA continues to move forward in the treatment of Veterans with HCV, those individuals who are unwilling or unable will continue to make up a progressively larger percentage of the untreated population. It is estimated that as many as 15,000-18,000 of the Veterans needing treatment are likely to be more difficult to engage in care despite outreach efforts, due to issues such as unstable housing, comorbid mental health and substance use disorders, competing medical conditions, or lack of interest in receiving HCV treatment. VA will continue outreach and remains committed to diagnosing and treating all veterans in care with HCV who are willing and able to be treated.

VA has developed a hepatitis C projection model to supplement the VA Enrollee Health Care Projection Model. The former model projects both the number of enrolled HCV-infected Veterans remaining to be treated, as well as HCV medication cost projections for 2018 through 2022; the

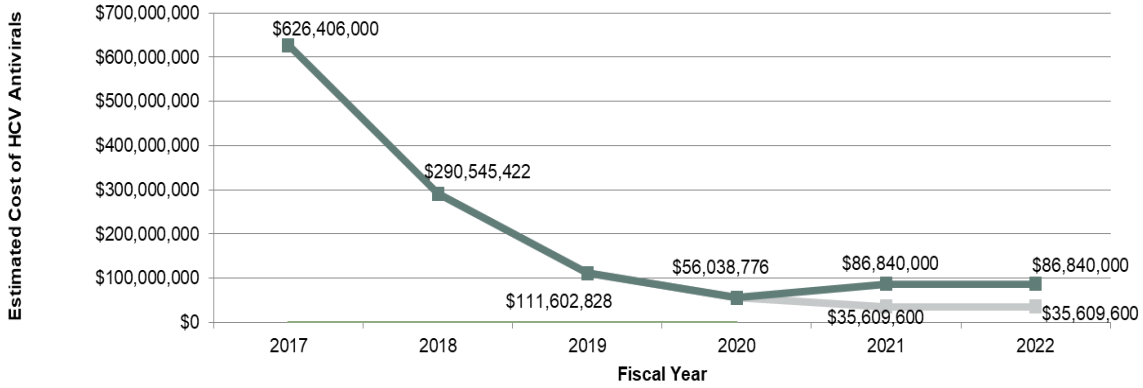
model assumes a stable, average treatment cost between $11,000 and $16,700 per treatment course for 2021 through 2022, shown in Figures A & B.

Figure A: Total number of Veterans enrolled in care remaining to be treated



Represents upper estimated treatment costs
Represents lower estimate treatment costs
Source: Population Health/Health Solutions (12POP2)

Figure B: Hepatitis C Medication Cost Projections



Represents upper estimated treatment costs
Represents lower estimate treatment costs
Source: Population Health/Health Solutions (12POP2)

Indian Health Service (IHS)/Tribal Health Programs (THP) Reimbursement Agreements Program

Indian Health Services
(dollars in thousands)

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160):	$0	$0	$0	$0	$0	$0	$0
Medical Community Care (0140):	$15,469	$15,810	$26,810	$30,000	$33,000	$3,190	$3,000
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]	**$15,469**	**$15,810**	**$26,810**	**$30,000**	**$33,000**	**$3,190**	**$3,000**

Under the authority of 25 U.S.C. §1645(c) and 38 U.S.C §8153, the Department of Veterans Affairs (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. Under these agreements, VA reimburses for Direct Care Services provided by IHS and THPs to eligible AI/AN Veterans that are included in the Medical Benefits Package under Title 38 Code of Federal Regulations (CFR) Section 17.38. In 2022, VA will begin implementation of the program to reimburse 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. VA also anticipates continued growth in its partnerships with 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.

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

Intensive Evaluation and Treatment Program (IETP) for Veterans and Service Members with Traumatic Brain Injury and Polytrauma
(dollars in thousands)

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160):	$0	$0	$5,022	$11,584	$11,740	$6,562	$156
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$0	$0	$166	$149	$127	($17)	($22)
Medical Facilities (0162):	$0	$0	$0	$3,550	$14,045	$3,550	$10,495
Obligations [Grand Total].....	**$0**	**$0**	**$5,188**	**$15,283**	**$25,912**	**$10,095**	**$10,629**

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. Expanding the program from one to five PRC locations will address evolving demand for IETP services, surge readiness, TBI research requirements, collaboration with DoD, and 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 terms of the integration of 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 and 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 consultants that address sleep, vision, pain, assistive technology needs, vestibular issues, musculoskeletal problems, cognitive difficulties, and other problems, as necessary.

Evidence: The Deloitte Consulting LLP team conducted a strategic review of the PRCs with oversight and support 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 review identified expansion of IETP as a critical step to modernize VA care and support DoD to maintain force readiness.

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 PREP, 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.

Program outcomes use standardized tools to measure changes in physical and mental health function, societal participation, satisfaction with life, and satisfaction with services. Review of Tampa IETP outcomes in 2019 shows that 89% of participants 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 FY 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 for 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.

Implementation Plan

The IETP expansion activities will take place at the Minneapolis, Palo Alto, Richmond, San Antonio and Tampa PRCs under guidance from the PMR Program Office. Expansion will be fully functional at all locations end of 2023; all five PRCs will be impacted in 2022 and 2023 as well as long term.

The 2022 budget request is to supplement clinical positions in order to support expanded IETP clinical programming. In 2022, 41% of the budget request is for FTE. The FTE portion of the budget becomes 95% in 2023 when the facility buildout/renovation is completed. The proposed staffing model is based on the proven success of the Tampa IETP model. Of the 47.25 number of proposed total staff, 41.25 (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.

Implementation Plan by Fiscal Year:

<u>2022</u>

- Expand IETP to a total of 36 bed capacity at Tampa, Palo Alto, San Antonio, and Richmond. 2022 budget: $10.6 million for personnel, and $738,000 for supplies, equipment, and information technology.

- Facility buildout/renovation at Minneapolis and San Antonio to allow bed unit expansions: 2022 budget $3.6 million.
- Finalize treatment protocols for Mental Health, Vestibular Rehab, and Sleep Assessment/Treatment.
- Establish consensus outcome metrics with DoD and implement data collection processes. 2022 budget: $141,240 for contractual services.
- Train other sites in protocol implementation and data collection via virtual and F2F training in Tampa. 2022 budget: $297,911.

2023

- Expand IETP by additional six beds at Minneapolis to a total of 42 beds at the five PRCs. 2023 budget: $10.9 million for personnel, $597,000 for supplies, equipment, and information technology.
- Complete buildout/renovation at Minneapolis: 2023 budget: $14 million
- Analyze outcome data of IETP and refine treatment protocols: 2023 budget: $153,200 for contractual services.
- Travel and training for the development of a fidelity of practice monitoring method: 2023 budget: $233,770.

Cost Impact: PMR Program Office has proposed a three-year budget to fund expansion of beds across all five PRC sites to meet evolving demand.

COVID-19 Impact: The budget for the IETP initiative is not affected by COVID-19 impact.

Intimate Partner Violence Assistance Program (IPVAP)

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160):	$17,686	$21,512	$21,512	$25,756	$27,794	$4,244	$2,038
Medical Community Care (0140):	$0	$0	$0	$4,000	$4,000	$4,000	$0
Medical Support and Compliance (0152):	$0	$0	$160	$846	$876	$686	$30
Medical Facilities (0162):	$0	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$17,686**	**$21,512**	**$21,672**	**$30,602**	**$32,670**	**$8,930**	**$2,068**

Authority for Action

The Veterans Health Administration (VHA) 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 million for VA's Intimate Partner Violence Program in both Public Law 115-141, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018*, and Public Law 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 healthcare 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.

The 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 established a designated IPVAP Coordinator at over 94% of VA medical facilities and is striving for 100% coverage. IPVAP funding is distributed from the National IPVAP to VA medical facilities in support of IPVAP staffing and program implementation.

Purpose of the Funding Request: The purpose of this funding increase request is two-fold:

1) Support of existing IPVAP Coordinator positions at each VA Medical Facility: The purpose of the increased allocation for the program is to support one Full-Time Employee Equivalent (FTEE) IPV Coordinator at every VA medical facility, allowing for attrition

and turnover of existing staff, and to support a cost of living adjustment for the salaries of existing staff.

2) Increase essential staffing at the national level: Currently, the program is staffed by a 1.0 FTEE VA Central Office position which is insufficient to effectively manage the expanding scope of the program and national implementation efforts. The National program requests Medical Support & Compliance funding to support the addition of 3.0 FTEE National Program staff. The additional staff will provide direct support for facility IPVAP Program Coordinators and stakeholders to ensure compliance, accountability, and data collection and analysis related to program operations. Coordinating these tasks at the national level are essential to the successful provision of IPVAP services for Veterans, their intimate partners and VA staff.

Evidence: Achieving the projected program goals of this high visibility program must be supported by a strong national and field-based organizational structure. Funding will directly support staff in the field who coordinate and provide IPVAP services to Veterans, their partners and VA staff. The IPVAP established an effective communication infrastructure and support between VA Central Office and the field through monthly training calls, weekly staff support office hours calls and dissemination of pertinent information. VHA Directive 1198, Intimate Partner Violence Assistance Program, requires each VA facility to implement and staff the IPVAP. Funding supports field-based staff, allows for cost of living adjustments (COLA), step raises and potential adjustments to the VA pay scale.

The IPVAP was implemented in over 94% of VA facilities nationwide, with identified Program Coordinators hired and providing essential services. Facility level Program Coordinators must implement a complex, high visibility, comprehensive program for Veterans, their partners and caregivers and VA staff. National program office support in the form of guidance, training, resources and data analysis is required for successful program implementation at the facility level. Additional FTEE in the national program office is required to support additional program expansion, and guide field-based endeavors, enhance accountability and provide ongoing quality evaluation of IPVAP services.

Implementation Plan: The IPVAP is currently staffed at over 94% of staffing required to implement and sustain the program in the field, consistent with the national VA attrition and vacancy rates. The National IPVAP will continue to work with VA facilities to support hiring and continue program expansion.

Costs

- **Field-Based Staff:** Each of the 172 'parent' facilities will have a designated IPVAP Coordinator who administrates the implementation of the IPVAP at that site and throughout the catchment area. The field-based staff must be a licensed independent practitioner (LIP) in their discipline and possess knowledge and experience in IPV programming.

- **National Program:** The program has grown to require four Full-Time Equivalent Employees (FTEE) to provide national program oversight, evaluation, consultative site visit, support to the field, and participate in outreach and training.
    - One GS-14 National Program Manager (existing)
    - Two GS-13 National Program Coordinators delegated to assist with administrative and clinical outreach to the field and program stakeholders (proposed).
    - One GS-12 Program Analyst to assist with data analysis, and administrative oversight (proposed).

National Center for Posttraumatic Stress Disorder (NCPTSD)

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160):	$19,504	$13,000	$13,000	$13,001	$13,001	$1	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$15,116	$26,842	$26,842	$26,999	$26,999	$157	$0
Medical Facilities (0162):	$93	$158	$158	$0	$0	($158)	$0
Obligations [Grand Total]	**$34,713**	**$40,000**	**$40,000**	**$40,000**	**$40,000**	**$0**	**$0**

Authority for Action

NCPTSD 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 a separate appropriation 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 seven divisions located at VA facilities, with headquarters in White River Junction, VT. Other division locations include Boston, MA; West Haven, CT; Palo Alto, CA; and Honolulu, HI. NCPTSD is an integral component of the Office of Mental Health and Suicide Prevention.

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 (www.ptsd.va.gov), publications, online resources, as well as nationwide trainings.

Recent Trends

Research Support:

- From 2015 through 2019, the Center had an average of 129 competitively-awarded research grants and produced an average of 307 peer-reviewed publications per year. In 2020, NCPTSD investigators led 146 funded studies (totaling $269.3 million), 33 studies were pending in 2021, and investigators had 246 publications with another 149 in press. Specific to the COVID-19 pandemic, the Center created a repository of COVID-19 resources for researchers. As of the end of 2020, we have published 10 COVID-19 papers,

created 7 measures of COVID-19 related risk, exposure, mental health responses, and distress, and have initiated 17 research projects or additions to existing projects to study mental health and traumatic responses to COVID-19.

- 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 2020, the Brain Bank had acquired 280 frozen hemispheres (roughly divided in thirds from donors with PTSD, donors with major depression, and controls without depression or PTSD) and 22 fixed hemispheres; 156 individuals have enrolled in our antemortem donor program. 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 Departments of Veterans Affairs and Defense, at the University of Texas and NCPTSD. The CAP focuses on novel clinical trials and identification of biomarkers for PTSD. As of 2020, all 11 CAP projects are completed; two 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 PTSD questionnaires and interviews for assessing PTSD according to the revised diagnostic criteria for PTSD in the 5th edition of the American Psychological 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 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 added to

the survey in 2020 in order to understand the impact of COVID-19 on male and female veterans from different ethnic and racial groups.

- 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.
- Produced the PTSD Trials Standardized Data Repository (PTSD-Repository) in 2020, a database that contains information extracted from 318 randomized controlled clinical trials for PTSD. In 2021, the Repository will be updated with newly published studies and it will expand to include those focused on PTSD and comorbid substance use. Publicly available and free to use, researchers, clinicians, Veterans, and family members can use it to better understand the treatment literature.

Provider Support:

- Responded to over 2,100 requests in the PTSD Consultation Program in 2020, over 21% 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. Many of these webinars are then developed into online courses with free continuing education units. With a continued focus on supporting providers in rural areas, the program trained an additional 28 non-VA providers in Prolonged Exposure, an evidence-based psychotherapy for PTSD, bringing the total up to close to 100 clinicians trained. A new training in assessment of PTSD and suicide risk for up to 150 non-VA providers is planned for 2021. Co-led a training for 160 VA specialists in treating comorbid PTSD and substance use disorder in best practices for treating this comorbidity.
- 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. Program activities in 2020 focused on adjusting to the COVID pandemic including curating information and rapidly disseminating information to the field, developing key updates to the PTSD Dashboard to track telemental health and providing individualized support to sites as they maneuvered multiple challenges. The program partnered with the QUERI for Team-Based Behavioral Health (Behavioral Health QUERI) to facilitate a training for VISN PTSD Mentors in Implementation Facilitation, a model of intensive site support.
- Expanded academic detailing and facilitation to improve the PTSD treatment of rural Veterans to eight sites at which uptake of evidence-based treatment is low. All sites saw significant improvement in their rates of delivery of evidence-based treatment and prescribing metrics for PTSD. The project was able to continue throughout the COVID pandemic utilizing telehealth delivery of academic detailing and facilitation to implement change at the sites.
- 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 1110 VA staff trained through this initiative reached more than 17,000 Veterans across the care continuum in 2020.

- Supported VA's efforts to implement measurement-based care (MBC). Collaborated with the VHA MBC Initiative to facilitate the first field-based workgroup for MBC within PTSD specialty programs. The workgroup was comprised of PTSD Mentoring participants who developed guidance for the implementation of MBC. The guide was informed by in-depth interviews with program directors and frontline providers. The PTSD Dashboard was updated to include MBC data that is utilized by the field to monitor implementation of MBC within PTSD specialty programs.
- Continued to develop and disseminate free online trainings to VA and community providers with continuing education credits, including a three-course curriculum that uses state-of-the-art responsive virtual patient technology to teach the administration of the Clinician-Administered PTSD Scale for *DSM-5*.
- 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 podcasts series for providers is being recorded that will launch within the toolkit in the coming year.
- New initiatives support the *VA MISSION Act of 2018* by enhancing community providers' knowledge of military culture and PTSD diagnosis, treatment, comorbidities, and resources.

Support of Veterans, family members, and the general public:

- Launched a new website design (www.ptsd.va.gov) with 8.2 million views in 2019.
- Partnered with Google in 2018 to add PTSD screening into the Google PTSD Knowledge Panel. The screening uses the Primary Care Screen for DSM-5 (PC-PTSD-5), developed and validated by the National Center for PTSD. The Center also advised Google on content related to PTSD and available treatments.
- Released 19 mobile apps, including self-help apps like COVID Coach and apps to support Cognitive Behavioral Therapy for Insomnia and Cognitive Processing Therapy. 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.
- 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 2020 we completed development of a new feature focused on MST that will launch in 2021.

- Created new educational products for family members including infographics, animated whiteboard videos, and traditional brochures. Spanish translations of these materials increase their reach.
- 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.
  - Continue a newly-established Center-wide Diversity in Research workgroup 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)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Direct Programs (Medical Services):							
VA National Rehabilitation Adaptive Sports and Therapeutic Arts Events	$3,895	$1,835	$3,335	$3,600	$3,437	$265	($163)
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	$14,958	$13,500	$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)	$2,406	$5,713	$5,713	$5,448	$5,611	($265)	$163
Grand Total.....	**$21,259**	**$24,548**	**$27,048**	**$27,048**	**$27,048**	**$0**	**$0**

Authority for Action

- 38 U.S. Code §322 establishes the Office of National Veterans Sports Programs and Special Events
  - 38 U.S. Code 322 (d) authorizes a monthly assistance allowance for Veterans with a disability training or competing in Paralympic or Olympic sports

- 38 U.S. Code 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

The Veteran population impacted will primarily include Veterans with spinal cord injuries, amputations, traumatic brain injuries, visual impairments, multiple sclerosis, stroke, post-traumatic stress disorder, and other neurological and mental health conditions. In addition, VA staff are offered training in adaptive sports and therapeutic arts through hands-on experience as well as (in-person training and online modules) offering continuing education credits.

Type of Services Provided

Veteran Monthly Assistance Allowance for Disabled Veterans Training in Paralympic and Olympic Sports Program

Provides a monthly stipend to Veterans 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 Team in a qualifying sport.

Grants for Adaptive Sports Programs for Disabled Veterans and Disabled Members of the Armed Forces Program

Awards grants to qualifying organizations to plan, develop, manage, and implement programs to provide adaptive sports, provider training, and other opportunities for Veterans and members of the Armed Forces. With the use of these grants, VA is helping community organizations promote community reintegration through sports. Eligible activities range from traditional and Paralympic sports to non-traditional outdoor recreational activities such as hiking, fishing, and adventure sports.

VA National Rehabilitation Adaptive Sports and Therapeutic Arts Events

Provides opportunities for Veterans to improve their independence, well-being, and quality of life through adaptive sports and therapeutic arts programs in accordance with 38 United States Code 322, 521, 521A. As leaders in adaptive sports and therapeutic arts programs that complement VA's rehabilitation system of care, the program encourages Veterans and members of the Armed Forces with disabilities to stretch beyond perceived limitations. In service of this mission, the VA directs six national rehabilitation events delivering direct patient care to Veterans eligible for VA health care. These programs embrace formalized adaptive sports medicine as a practice specialty and provide the largest coordinated therapeutic arts program for Veterans. Built on VA clinical expertise and operations, with essential support from Veteran Service Organizations, corporate sponsors, individual donors, and community partners, the programs allow VA to extend its level of care beyond the clinical setting. The rehabilitation events, held in cities across the nation, serve thousands of Veterans and train hundreds of VA rehabilitation providers across more than 125 VA medical centers annually.

- ***National Veterans Wheelchair Games (NVWG)***
  The National Veterans Wheelchair Games, co-presented by VA and Paralyzed Veterans of America, serves Veterans with spinal cord injuries, multiple sclerosis, amputations, stroke, and other neurological disorders. Since 1981, National Veterans Wheelchair Games have been inspiring Veterans to live healthier and more active lives through adaptive sports. It is the largest wheelchair sports rehabilitation event for Veterans with disabilities in the United States.

- ***National Veterans Golden Age Games (NVGAG)***
  Founded in 1985, this program serves Veterans ages 55 years and older who are eligible for VA health care. Through its "Fitness for Life" motto, the Golden Age Games offers sports competitions and health education sessions to demonstrate the value that sports, wellness, and fitness provide to assist senior Veterans live an active and healthy lifestyle. National Veterans Golden Age Games is a qualifying event for the National Senior Games.

- ***National Disabled Veterans Winter Sports Clinic (NDVWSC)***
  The National Disabled Veterans Winter Sports Clinic has served Veterans with traumatic brain injuries, spinal cord injuries, amputations, visual impairments, and certain neurological conditions since 1987. This clinic is presented by VA and DAV (Disabled American Veterans), and provides rehabilitation through adaptive winter sports, headlined with Alpine skiing, Nordic skiing, and snowboarding, the Winter Sports Clinic. The Winter Sports Clinic is hosted by the VA Western Colorado Health Care System and has helped many of our nation's most profoundly disabled Veterans overcome obstacles and challenge their perceived limitations.

- ***National Veterans Creative Arts Festival (NVCAF)***
  The National Veterans Creative Arts Competition and Festival recognizes the role creative arts therapy plays in the rehabilitation of Veterans. Veterans who showcase their achievements in the festival are selected gold medal winners of national art, music, dance, drama, and writing competitions in which thousands of Veterans enter from VA facilities across the nation. Established in 1989, the festival is presented by VA and the American

Legion Auxiliary and culminates with a stage performance, writing exhibition, and gallery-style showcase of artwork.

- ***National Disabled Veterans TEE (Training, Exposure, Experience) Tournament***
  The National Disabled Veterans TEE Tournament serves Veterans with visual impairments, amputations, traumatic brain injuries, psychological trauma, certain neurological conditions, spinal cord injuries, and other life changing disabilities. Presented by VA and DAV (Disabled American Veterans), the TEE Tournament provides adaptive golf instruction and a range of adaptive sports opportunities. Founded in 1994, this rehabilitation event is held in the Iowa City, Iowa area and hosted by the Iowa City VA Health Care System.

- ***National Veterans Summer Sports Clinic (NVSSC)***
  Founded in 2008, the National Veterans Summer Sports Clinic serves newly injured Veterans with complex disabilities, such as traumatic brain injury, post-traumatic stress disorder, visual impairments, neurological conditions, spinal cord injury, or loss of limb. The Summer Sports Clinic promotes the value of rehabilitation through adaptive summer sports, including surfing, sailing, kayaking, cycling, and new emerging sports. It is hosted by the VA San Diego Healthcare System.

Recent Trends

During the past few years, several important trends have been identified. All six national rehabilitation events have noted an increase in women Veterans. Women Veterans comprised 20% of the participants at the national rehabilitation events in 2020, which was an increase from 17.8% in the previous year. Increased outreach efforts to women Veterans accounted for this trend. Outreach efforts to women Veterans included focus groups, forums and other engagements tailored to women Veterans 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. There has been a consistent growth the National Veterans Creative Arts Festival and Competition of 3% overall participation per year for the past three years.

Interest in non-traditional sports has grown, and the National Veterans Sports Programs and Special Events has added adaptive esports and adaptive CrossFit to 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.

During the pandemic, many programs have pivoted to at-home or virtual versions through VA's national rehabilitation events and the VA Adaptive Sports Grant Program. Veterans' satisfaction with remote options has been well attended. VA's modernization efforts and ability to leverage technology have shown success in this new method of care delivery for VA adaptive sports and therapeutic arts.

The adaptive sports grant program awarded a record $14.9 million though a total of 119 grants to community based adaptive sports providers in 2020. 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 and the District of Columbia.

Projections for the Future

Over the next few years, it is expected that the trends outlined above will continue. We expect to see continued increases in participation in non-traditional sports in complement to the traditional sports at the national rehabilitation events with emphasis to reach underserved populations of Veterans including those with the most complex physical disabilities. The demand specifically for therapeutic arts programming will continue its consistent 3% annual growth in participation through the National Veterans Creative Arts Festival and Competition. Increased funding to accommodate the need for additional services and opportunities provided through the six national rehabilitation events for Veterans with disabilities is necessary to maintain modest growth trajectory.

Non-Recurring Maintenance (NRM)

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations - All Other	$985,332	$1,346,573	$1,273,920	$430,072	$700,000	($843,848)	$269,928
Discretionary P.L. 115-141 sec 255	$223,944	$0	$299,657	$0	$0	($299,657)	$0
Discretionary P.L. 115-244 sec 248	$150,325	$512,449	$450,897	$61,302	$0	($389,595)	($61,302)
Discretionary CARES Act Obligations	$72,242	$0	$72,654	$0	$0	($72,654)	$0
Discretionary Obligations [Subtotal]	**$1,431,843**	**$1,859,022**	**$2,097,128**	**$491,374**	**$700,000**	**-$1,605,754**	**$208,626**
Veterans Medical Care and Health Fund 1/	$0	$0	$0	$1,772,522	$0	$1,772,522	($1,772,522)
VACAA, Section 801	($4,990)	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**($4,990)**	**$0**	**$0**	**$1,772,522**	**$0**	**$1,772,522**	**($1,772,522)**
Obligations [Total]	**$1,426,853**	**$1,859,022**	**$2,097,128**	**$2,263,896**	**$700,000**	**$166,768**	**($1,563,896)**

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 & Materials, and Equipment.

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

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

Precision Oncology
(dollars in thousands)

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160):	$0	$75,000	$66,807	$95,337	$95,337	$28,530	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$0	$0	$3,991	$4,281	$4,281	$290	$0
Medical Facilities (0162):	$0	$0	$399	$399	$399	$0	$0
Obligations [Grand Total].....	**$0**	**$75,000**	**$71,197**	**$100,017**	**$100,017**	**$28,820**	**$0**

Purpose: With an estimated 50,000 new cases annually, VA is committed to providing access to the best possible cancer care through expansion and innovation. Programs will specifically address Women's Cancer Care, Rare Cancers, genetic counseling and genetic consultation in 2022 to build upon efforts in 2020 and 2021 to advance TeleOncology and Precision Oncology care.

VA is expanding the use of TeleOncology, which facilitates cutting-edge cancer care to Veterans anywhere reducing geographical disparities. VA is expanding clinical trial access through increased public and private partnerships, and virtual clinical trials.

The United States, and by default the VA, are facing a shortage in oncologists, geneticists, and genetic counselors over the next 4 years.[1,7] While the VA cannot compete with the salaries offered by the private sector for the best oncologists, the VA can 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.[2]

VA continues to expand Precision Oncology care through the National Precision Oncology Program (NPOP) which is providing cutting-edge clinical tumor DNA sequencing that guides cancer treatment decisions. The NPOP now provides access to standardized tumor sequence testing for nearly every oncology practice site in VA along with an expert consultation service to assist with interpretation of the complex test requests and a system-wide Molecular Oncology Tumor Board. The TeleOncology service will provide 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, and palliative care.

Evidence: There is a deficit in the ability to provide oncology in many areas of the country, which VA is able to address by providing Oncology services through Telehealth. In 2019, VA obligated more than $600 million in Community Care services for oncology treatment and in 2020 it is estimated that $1 billion in Community Care oncology treatment was paid. This care includes

hematology/oncology and chemotherapy/infusion services but excludes surgical oncology, radiation, and benign hematology. VA believes the quality of care is better in the VA because of the sub-specialized care utilizing TeleOncology that can be provided as well as the ability to coordinate oncology care with other VA-provided care.

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. In the VA annually, rare cancers comprise 8,000 new cases and make up approximately 16% of all cancer cases. Additionally, in 2017 it was estimated that $846 million was obligated to combat rare cancers and 85% of this was for treatment (these calculations include VA and Community Care).

According to available data, approximately 1 in 8 women will be diagnosed with breast cancer in their lifetime.[3] Women are more likely to be diagnosed with breast cancer after the age of 50.[4] Women Veterans are a rapidly growing population; and VA must ensure the appropriate treatment plans, research, and oncology care are in place to meet the needs of Women Veterans across the United States. It is estimated that approximately 700 Women Veterans are diagnosed with breast cancer annually.

Implementation Plan: Through the TeleOncology program developed in 2020 and 2021, the VA will build clinical and research teams in partnership with NCI designated cancer centers and nation-leading academic affiliates to address Women and Rare cancers. These teams are multidisciplinary and provide both care coordination and expert oncology services and will be developed with academic partners. In October, Duke University and Baylor School of Medicine agreed to partner with VA to develop the Women's Oncology System of Excellence.

The VA was awarded a grant for $4.5 million in 2020 by the Bristol, Meyer, Squibb Foundation to develop infrastructure for a national TeleOncology program which will reduce rural disparities in cancer treatment. VA is implementing TeleOncology across the country by the end of 2021.

Clinical pathways customized for VA for lung and prostate cancer will be developed and deployed the end of 2021. These 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.

Funding: The additional $28.8 million requested in 2022 above the 2021 Current Estimate is primarily medical services ($28.5 million), while the remaining is administrative and programmatic overhead ($0.3 million).

The 2022 request supports 219 clinical FTE (an increase of 48 from 2021) whom will be added to Oncology care teams including oncologists, advanced practice providers, nurses, pharmacists, care coordinators and telehealth technicians. VA will have 6 oncology care teams staffed by the end of 2021 and estimates adding at least 2 additional oncology care teams in 2022. These staff will be organized into teams that will focus on and have expertise in specific areas of oncology such as thoracic oncology (lung cancer), genitourinary cancer (prostate, bladder, kidney cancers) and

hematological malignancies (lymphoma, leukemia, myeloma) brain tumors, sarcomas, benign hematology, and breast cancer. Additionally, VA will also have specialists in genetic counseling and pharmacogenomics to support these oncology care systems. Moreover, VA will be offering virtual tumor boards and decentralized clinical trials, which require oncologist support.

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.

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 1,000,000 residents. [5]

VA will expand upon current clinical pathways to provide the best-in-class and system-wide standardized Oncology care. This includes developing breast cancer registry and breast cancer clinical pathways. VA is contracting with industry-leading, private sector cancer pathway developers to inform these pathways, which are frequently changing and shifting as new treatments are approved. VA will expand national expert consultation services through e-consultation and virtual tumor boards.

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. VA is contracting to assess those informatics needs and will utilize that assessment to build or buy the needed informatics system. This contract was awarded in September 2020.

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 healthcare 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."

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 healthcare systems where COVID-19 may be more prevalent.

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Rural Health

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160):	$269,896	$238,870	$268,870	$275,688	$282,710	$6,818	$7,022
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$19,803	$19,130	$19,130	$19,459	$19,799	$329	$340
Medical Facilities (0162):	$9,398	$12,000	$12,000	$12,308	$12,626	$308	$318
Obligations [Grand Total]	**$299,097**	**$270,000**	**$300,000**	**$307,455**	**$315,135**	**$7,455**	**$7,680**

Purpose: To enable the sustainment of programs, including but not limited to full sustainment funding for the VHA CRH, Rural Patient Tablet Program, and Tele-Critical Care Initiative. These programs directly support the accomplishment of the congressionally mandated functions of the ORH)(38USC§7308) directing the Office to

> *...assist the Under Secretary for Health in conducting, coordinating, promoting, and disseminating research into issues affecting veterans living in rural areas."* and to *"...work with all personnel and offices of the Department of Veterans Affairs to develop, refine, and promulgate policies, best practices, lessons learned, and innovative and successful programs to improve care and services for veterans who reside in rural areas of the United States."*

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) the following purposes:

> *...To improve the understanding of the challenges faced by Veterans living in rural areas.*
> *...To identify disparities in the availability of health care to Veterans living in rural areas.*
> *...To formulate practices or programs to enhance the delivery of health care to Veterans living in rural areas.*
> *...To develop special practices and products for the benefit of Veterans living in rural areas and for implementation of such practices and products in the Department system wide.*

Evidence: In 2020, the Office increased the Rural Health Initiative contributions to the program named above as well as to funding far reaching new programs in rural workforce training and

education, MISSION Act Emergency Room Medical Scribe Program, and continuing mental/behavioral health programs focused on rural Veterans. In all, ORH has worked with VHA clinical and non-clinical offices to create more than 50 mature Enterprise Wide Initiatives that reach veterans at more than 90% of all VHA sites that serve rural Veterans. The development of new programs will continue through 2021 and 2022. Historically, ORH receives approximately $50 million annually in requests for funding new Enterprise Wide Initiatives that go unfulfilled due to lack of available funding.

The Rural Health Initiative 2021 budget supported innovative programs in the rural space across these clinical and vital non-clinical access program areas:

- Primary Care
- Specialty Care
- Mental Health
- Workforce Training and Education
- Care Coordination and Health IT Modernization
- Transportation

Overall, in 2020, these programs touched the lives of more than 2.9 million Veterans at 600 rural serving sites across VHA. VA will see a significant expansion of many of these programs in 2021 and 2022 as new sites are added and new rural access programs are created.

Implementation Plan: ORH has already worked with partners across VHA program offices to project 2022 programming. Implementation and expansion plans for rural projects are being formulated now, with a significant portion of the 2022 budget going to third-year sustainment of thriving innovations, and the creation of long-term funding streams for the rural portion of vital initiatives such as Tele-Critical Care, Clinical Resource Hubs, and the Rural Veteran Tablet program. In addition, ORH has nearly $50 million in projected new Enterprise Wide Initiatives queued up for 2021 and 2022. ORH and its partners continue to purposefully manage program execution. Each ORH-funded initiative is required to have a strong implementation plan and quantitative implementation evaluation that is overseen by VHACO program offices, ORH, and ORH's new Center for the Evaluation of Enterprise Wide Initiatives.

ORH funded Tele-Critical Care (formerly TeleICU) reached 15 sites in 2020, providing inpatient care to 5,000 Veterans over more than 5,000 encounters. In 2021, this program will be expanding, and ORH will continue to fund sustainment and expansion in the rural space into 2022 and beyond.

CRHs are rural-serving telehealth hubs in every VISN across the country for primary care and mental health services. In 2021 and 2022, ORH is funding significant expansion in tele-specialty care services at the hubs, broadening access to specialty care in cardiology, pulmonology, 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 now have an operational primary care/mental health hub to meet the needs of underserved facilities across the VA. Specialty care service expansion is underway, funded in 2021 and ready for sustainment and further expansion in 2022 and 2023

1. CRHs assisted Clinical Contact Centers and covered inpatient services and emergency departments throughout the enterprise during the COVID-19 pandemic.

2. As of October 2020, CRHs provided coverage to 464 spoke sites with 683,000 active patients and 242,000 encounters.

The Rural Patient Tablet Program provides computer tablets to rural Veterans for delivery of telehealth care into their homes via secure internet connection.

1. As of October 2020, over 54,000 patients have received tablets in FY 2020 generating over 90,000 encounters.

2. 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.

ORH's five Veterans Rural Health Resource Centers (VRHRC) continue to fulfill their congressionally mandated mission to conduct research, innovate new rural access programs, and disseminate them system wide. In 2021, these resource centers will establish two new Rural Promising Practices, bringing the total number of Rural Promising Practices in system-wide mentored implementation to seven. The VRHRC promising practices range from training programs like Rural Clergy Training and Geriatric Scholars, to clinical programs such as In-home Cardiac Rehabilitation and HIV virtual teams. These rural promising practices are up and running at nearly 100 sites across VHA, and each of them expands to new sites every fiscal year. In addition to the seven programs in mentored implementation, the Resource Centers have created more than 20 additional promising practices with toolkits available at the ORH website. In 2022, ORH will see significant expansion of 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 such as women's health with specific programs focused on the challenges our rural women Veterans face in accessing the health care they have earned. These programs include Post Natal, Web Based Care (Mom Mood Booster) that reached out to 8,500 Veteran mothers and ultimately provided care to strategies to 335 participants. This important rural-focused effort complements the ORH-funded Enterprise Wide Initiative that conducts clinical skills training focused on women Veterans' care. In 2020 alone, this program

trained over 100 clinicians at 19 sites across the country in 12 courses of instruction for providers who care for our rural women Veterans.

In addition, some VRHRC programs focus on American Indian/Alaska Native rural Veterans, including ORH's latest: Rural Native Veteran Health Care Navigation. Under development now, the goal of this innovative new program is to ensure that VHA reaches all rural AI/AN Veterans and ensures they are informed on and have access to VHA health care. ORH anticipates first pilots in late 2021 and expansion of the program through 2022 and beyond. 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 2022 and beyond.

COVID-19 Impact: COVID-19 showed the value of the establishment of far-reaching telehealth programs. ORH devoted $180 million in 2020 to telehealth programs and has allocated nearly $200 million for telehealth programs in 2021, with anticipation of a similar commitment for 2022.

Supply Chain Management

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DISCRETIONARY							
Medical Services (0160):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care (0140):							
Discretionary Non-FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary FFCRA/CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance (0152):							
Discretionary Non-CARES Act Obligations	$66,564	$142,524	$142,524	$0	$140,193	($142,524)	$140,193
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$66,564**	**$142,524**	**$142,524**	**$0**	**$140,193**	**($142,524)**	**$140,193**
Medical Facilities (0162):							
Discretionary Non-CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Discretionary Total	**$66,564**	**$142,524**	**$142,524**	**$0**	**$140,193**	**($142,524)**	**$140,193**
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	$129,514	$0	$129,514	($129,514)
VACAA, Section 801 (0152)	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$129,514**	**$0**	**$129,514**	**($129,514)**
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**	**$129,514**	**$0**	**$129,514**	**($129,514)**
Combined Discretionary and Mandatory by Category							
Medical Services	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Community Care	$0	$0	$0	**$0**	**$0**	$0	$0
Medical Support and Compliance	$66,564	$142,524	$142,524	**$129,514**	**$140,193**	($13,010)	$10,679
Medical Facilities	$0	$0	$0	**$0**	**$0**	$0	$0
Obligations [Grand Total]	**$66,564**	**$142,524**	**$142,524**	**$129,514**	**$140,193**	**($13,010)**	**$10,679**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the rows display estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Supply Chain Management
(dollars in thousands)

Medical Care Appropriation Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Defense Medical Logistics Standard System (DMLSS).....	$18,900	$84,311	$84,311	$91,259	$101,938	$6,948	$10,679
Medical Surgical Prime Vendor (MSPV) 2.0.....	$15,006	$16,730	$16,730	$13,756	$13,756	-$2,974	$0
Defense Logistics Agency (DLA) Source Support for MSPV...	$22,506	$31,730	$31,730	$13,756	$13,756	-$17,974	$0
Supply Chain Master Catalog.....	$5,162	$5,138	$5,138	$5,175	$5,175	$37	$0
Point of Use.....	$2,395	$2,395	$2,395	$2,973	$2,973	$578	$0
Clinical Decision Strategic Sourcing.....	$2,595	$2,220	$2,220	$2,595	$2,595	$375	$0
Grand Total.....	$66,564	$142,524	$142,524	$129,514	$140,193	-$13,010	$10,679

VHA Defense Medical Logistics System (DMLSS)
(dollars in thousands)

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Medical Support and Compliance Category							
Discretionary Medical Support and Compliance (0152):	$18,900	$84,311	$84,311	$0	$101,938	-$84,311	$101,938
Mandatory Veterans Medical Care and Health Fund (0173) 1/.	$0	$0	$0	$91,259	$0	$91,259	-$91,259
MSC subtotal.....	$18,900	$84,311	$84,311	$91,259	$101,938	$6,948	$10,679
OIT Category							
Discretionary OI&T.....	$21,596	$111,520	$111,520	$107,263	$141,412	-$4,257	$34,149
Mandatory ARP Act, Section 8003.....	$0	$0	$0	$100,000	$0	$100,000	-$100,000
OIT subtotal.....	$21,596	$111,520	$111,520	$207,263	$141,412	$95,743	-$65,851
Grand Total.....	$40,496	$195,831	$195,831	$298,522	$243,350	$102,691	-$55,172

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the row display estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

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 of the focus areas 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 accelerated deployment of the Defense Medical Logistics Standard Support (DMLSS) system; Clinically-Driven Strategic Sourcing; development and deployment of the Supply Chain Master Catalog; and standardization of medical-surgical Point of Use (POU) systems.

Defense Medical Logistics Standard Support (DMLSS)

VA is replacing its 50-year old legacy inventory management system and standalone systems for its support with the DoD Defense Medical Logistics Standard Support (DMLSS) system; the same system used by the DoD. VA use of DMLSS is consistent with 38 U.S.C. §8111, Sharing of Department of Veterans Affairs and Department of Defense Health Care Resources.

DMLSS provides VA with 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 / equipment accountability management; facility and environmental management for building service equipment and work orders; assemblage management; business analytics; and total asset visibility.

DMLSS, and its future technical refresh LogiCole, are interoperable with the DoD electronic health record (Cerner), which is VA's new electronic health record. As a result, VA can reuse the interfaces developed by DoD with no additional cost for development. DMLSS is compliant with federal information security requirements including the Federal Information Security Management Act, Federal Financial Management Improvement Act.

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. As a result, VA is accelerating the program, with the requirement to complete deployment in 2025, rather than the planned completion in 2027. DMLSS enables standardization of VHA business practices across the enterprise consistent with federal and commercial best business practices and will enable VA to build a lean supply chain that provides timely access to meaningful data focused on improved patient and financial outcomes.

Clinically Driven Strategic Sourcing (CDSS)

CDSS is a commercial healthcare best practice which 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 and clinically preferred products, and clinical customer satisfaction. As a value analysis process, CDSS is structured to bridge collaboration with clinicians and other key stakeholders to support continuous improvement of the value analysis process. Further, CDSS will enable VHA to achieve increased cost avoidance by driving purchase order volume toward clinically- based, best-value contracts.

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, GAO 18-34, and the Logistics Satisfaction & Time Resource Survey, highlighted procedural and structural challenges in VA's supply chain processes that resulted in risks to patient care, clinician dissatisfaction, and missed opportunities for cost avoidance.

VA's use of CDSS will help reduce the variation of clinically equivalent medical supplies used across VHA. Reduced variation will cut down the amount of time it takes to train clinicians on proper product usage. VA clinicians will benefit by acquiring increased time for patient care. Ultimately, the benefits of clinician engagement result in better product selection to meet clinical needs, decreased clinical variation, and better patient outcomes.

Supply Chain Master Catalog (SCMC)

The VA 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 and is hosted in the Microsoft Azure Government (MAG) cloud.

The VA SCMC will harmonize contract information from VA and other approved Federal contract offices. It is a critical element in product oversight, visibility, and establishment of enterprise best practices. Further, the SCMC is essential to provide the standard product information necessary for operable, functioning modernized health record (Cerner) and financial (Momentum) systems.

Currently, VA lacks standardized enterprise business rules for its cataloging efforts, resulting in inconsistencies including incomplete records, duplicate records, stock-level discrepancies, incorrect dollar values, conversion factor errors and missing mandatory sources. Instead, multiple contract systems operate across the VA and VHA that do not share product or sourcing data. These multiple siloed systems led 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 establishment of enterprise best practices.

Point of Use (POU)

The POU program seeks to standardize the use of POU across medical centers while maintaining local efficiencies already realized. Doing so will provide the ability to manage secondary inventories from local and enterprise levels, track supply costs to the patient, reduce costs of on-hand inventory, and deliver a greater focus to patient care by clinical staff.

VA's use of POU will enable VA the ability to become more efficient and provide a higher level of patient care.

Telehealth

		2021		2022	2023		
Description	2020 Actual	Budget Estimate	Current Estimate	Revised Request	Advance Approp.	+/- 2021-2022	+/- 2022-2023
Treatment Modality ($000):							
Remote Patient Monitoring/Home Telehealth Prosthetics.....	$89,822	$32,484	$78,500	$83,600	$77,432	5,100	(6,168)
Telehealth Treatment.....	$1,917,458	$997,082	$1,993,508	$2,051,582	$2,138,494	58,074	86,912
Total Treatment.....	**$2,007,280**	**$1,029,566**	**$2,072,008**	**$2,135,182**	**$2,215,926**	**63,174**	**80,744**
Connected Care Program Funding: Sustainment and Expansion							
Home and Community Based Services.....	$12,024	$28,500	$2,000	$2,000	$70,232	0	68,232
Clinic Based Services.....	$1,018	$84,000	$48,329	$48,329	$32,708	0	(15,621)
Hospital and Emergency Services.....	$0	$42,345	$45,278	$45,278	$40,300	0	(4,978)
Program Foundations.....	$79,671	$145,155	$204,393	$204,393	$186,666	0	(17,727)
CARES Act.....	$84,072	$0	$128,000	$0	$0	(128,000)	0
Veterans Medicl Care and Health Fund (0173) 1/.....	$0	$0	$0	$150,000	$0	150,000	(150,000)
Sustainment and Expansion Total.....	**$176,785**	**$300,000**	**$428,000**	**$450,000**	**$329,906**	**22,000**	**(120,094)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Authority for Action
Recent legislation, such as Section 151 of the *VA MISSION Act of 2018*, authorizes the practice of telemedicine by VA healthcare providers 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 healthcare.

The Office of Connected Care – Telehealth/Connected Care Services
The Office of Connected Care, and its Telehealth/Connected Care Services, has the mission to improve Veteran's health outcomes, access, and healthcare experience by use of electronic health technologies.

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 (Advancing Telehealth Through Local Access 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 Tele-Dermatology, Tele-Eye Care, and Tele-Sleep medicine; and expansion of the national expert consultation services.

Hospital and Emergency Services
Purpose- Supports expansion of inpatient and emergency room telehealth programs including Tele-Stroke Care, and Tele-Critical 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. With telemedicine increasing and as the Office of Connected Care facilitates medical innovations and improving customer experience to Veterans, additional support resources are required to support the overall success of the VA mission.

COVID-19 Impact
Telemedicine has experienced a surge in adoption over the past year due to the coronavirus pandemic. In 2019 more than 99,000 Veterans or 1.6% of the Veterans who received care from the VA had more than 294,800 video visits into their homes. In 2020 the number of Veterans receiving a video visit to their home expanded to over 1.29 million Veterans who received more than 3.4 million video visits to their home. This represents close to 18.8% of Veteran's who receive care from the VA. There was a 79.8% increase in the Veterans who received any type of telehealth from 2019 (909,000) to 2020 (1.63 million). This represents 27% of all Veterans who receive care at VA. There were 21,674 Providers in Primary Care, Mental Health and other ambulatory care areas that had provided at least one visit to an offsite location by the end of

February 2020. At the end of September 2020, 35,947 providers had completed at least one offsite visit, an increase of 14,273 providers. Week-over-week telehealth video appointments have increased by 1,065% since February 2020, increasing from approximately 10,000 appointments a week in early February to more than 180,300 appointments during the last week in October. The impact of COVID on the growth of telemedicine is unprecedented. COVID has illustrated telemedicine's value in enhancing health care safety and accessibility. It is also accelerating a transformation of healthcare that will provide Veterans more quality options going into the future.

Justification:

Home and Community Based Services:

Connective Devices – Video-to-home telehealth utilization increased over tenfold in 2020 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 device program to support Veterans impacted by the digital divide. Further, the VA continues to provide telehealth technology (i.e. Web cameras) to health care professionals to ensure they are capable of delivering services through telehealth. In addition, VA is expanding it's capabilities to deliver comprehensive service to Veterans by increasing availability of peripheral technologies (i.e. digital stethoscopes) that can be provided to Veterans for use as part of their video visits from home.

CARES ACT funding supports further 2021 tablet program expansion and sustainment, health care professional telehealth equipment, and Veterans peripheral technology costs but will not be available in 2022.

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; however, it does appropriate additional funding for this effort. Connected Care's 2022 budget for Home and Community Based Services also includes the funding needed to support the law's intended purpose.

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.

Veterans Homelessness Programs

Description (Dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Homeless Veterans Treatment Costs	**$7,763,382**	**$7,868,860**	**$8,000,112**	**$8,247,124**	**$8,490,003**	**$247,012**	**$242,879**
Programs to Assist Homeless Veterans							
Permanent Housing Supportive Services							
HUD-VASH Case Management:							
HUD-VASH Case Management Base (I)	*$412,179*	*$438,300*	*$457,400*	*$483,900*	*$523,900*	*$26,500*	*$40,000*
HUD-VASH Case Management CARES Act (I)	*$0*	*$0*	*$4,000*	*$0*	*$0*	*($4,000)*	*$0*
HUD-VASH Case Management [Subtotal]:	$412,179	$438,300	$461,400	$483,900	$523,900	*$22,500*	*$40,000*
HUD-VASH (S)	$232,174	$199,132	$241,229	$250,637	$260,412	$9,408	$9,775
Perm. Housing Supp. Services [Subtotal]	**$644,353**	**$637,432**	**$702,629**	**$734,537**	**$784,312**	**$54,408**	**$89,775**
Transitional Housing							
Grant & Per Diem:							
Grant & Per Diem Base (I)	*$203,057*	*$230,589*	*$217,000*	*$235,201*	*$239,905*	*$18,201*	*$4,704*
Grant & Per Diem CARES Act (I)	*$38,341*	*$0*	*$132,419*	*$0*	*$0*	*($132,419)*	*$0*
Grant & Per Diem ARP Act 1/ (I)	*$0*	*$0*	*$0*	*$50,000*	*$0*	*$50,000*	*($50,000)*
Grant & Per Diem [Subtotal]:	$241,398	$230,589	$349,419	$285,201	$239,905	($64,218)	($45,296)
Grant & Per Diem Liaisons (I)	$34,236	$34,550	$34,550	$35,241	$35,945	$691	$704
Other (S)	$11,824	$19,919	$12,285	$12,764	$13,270	$479	$506
Health Care for Homeless Vets:							
Health Care for Homeless Base (I)	*$173,124*	*$179,864*	*$186,693*	*$202,464*	*$208,464*	*$15,771*	*$6,000*
Health Care for Homeless CARES Act (I)	*$12,854*	*$0*	*$65,262*	*$0*	*$0*	*($65,262)*	*$0*
Health Care for Homeless Vets [Subtotal]:	$185,978	$179,864	$251,955	$202,464	$208,464	*($49,491)*	*$6,000*
Transitional Housing [Subtotal]	**$473,436**	**$464,922**	**$648,209**	**$535,670**	**$497,584**	**($112,539)**	**($38,086)**
Prevention Services							
Supportive Svcs Low Income Vets & Families:							
Supportive Svcs Low Income Vets & Families Base (I)	*$381,300*	*$387,600*	*$420,000*	*$395,352*	*$403,259*	*($24,648)*	*$7,907*
Supportive Svcs Low Income Vets & Families CARES Act (I)	*$601,540*	*$0*	*$115,084*	*$0*	*$0*	*($115,084)*	*$0*
Supportive Svcs Low Income Vets & Families ARP Act 1/ (I)	*$0*	*$0*	*$0*	*$436,000*	*$0*	*$436,000*	*($436,000)*
Supportive Svcs Low Income Vets & Families [Subtotal]:	$982,840	$387,600	$535,084	$831,352	$403,259	$296,268	($428,093)
National Call Center for Homeless Veterans (I)	$6,274	$5,780	$5,780	$7,947	$8,044	$2,167	$97
Justice Outreach Homeless Prevention Base (I)	$45,323	$48,153	$49,339	$55,866	$56,983	$6,527	$1,117
Justice Outreach Homeless Prevention CARES Act (I)	$0	$0	$1,500	$0	$0	($1,500)	$0
Justice Outreach Homeless Prevention (S)	$13,188	$20,866	$13,702	$14,237	$14,792	$535	$555
Prevention Services [Subtotal]	**$1,047,625**	**$462,399**	**$605,405**	**$909,402**	**$483,078**	**$303,997**	**($426,324)**
Treatment							
Domiciliary Care for Homeless Vets (S)	$196,361	$191,370	$204,019	$211,976	$220,243	$7,957	$8,267
Homeless Patient Aligned Care Teams (I) 2/				$10,000	$10,000	$10,000	$0
Telephone Homeless Chronically Mental Ill (S)	$52,295	$29,683	$54,335	$56,454	$58,656	$2,119	$2,202
Treatment [Subtotal]	**$248,656**	**$221,053**	**$258,354**	**$278,430**	**$288,899**	**$20,076**	**$10,469**
Employment/Job Training							
Homeless Veterans Community Employment Prg (I)	$14,004	$15,182	$15,182	$15,182	$15,182	$0	$0
Homeless. Ther. Empl., CWT & CWT/TR (S)	$61,511	$76,062	$63,910	$66,402	$68,992	$2,492	$2,590
Employment/Job Training [Subtotal]	**$75,515**	**$91,244**	**$79,092**	**$81,584**	**$84,174**	**$2,492**	**$2,590**
Administrative							
Supportive Svces Low Income Vets & Families Adm.	$8,478	$8,877	$8,877	$9,060	$9,241	$183	$181
National Homeless Registry	$1,380	$2,581	$2,581	$2,762	$2,817	$181	$55
Administrative [Subtotal]	**$9,858**	**$11,458**	**$11,458**	**$11,822**	**$12,058**	**$364**	**$236**
NAVY SEAL Bill Mulder Act of 2020 (P.L. 116-315, Title IV)	**$0**	**$0**	**$0**	**$89,005**	**$47,309**	**$89,005**	**($41,696)**
Obligations [Total]	**$2,499,444**	**$1,888,508**	**$2,305,147**	**$2,640,450**	**$2,197,414**	**$335,303**	**($443,036)**
CARES Act [Total included above]	*$652,735*	*$0*	*$318,265*	*$0*	*$0*	*($318,265)*	*$0*
ARP Act 1/ [Total included above]	*$0*	*$0*	*$0*	*$486,000*	*$0*	*$486,000*	*($486,000)*
Breakout by Specific & General Purpose							
(I) Initiative Specific Purpose	$1,932,091	$1,351,476	$1,715,667	$2,027,980	$1,561,049	$312,313	($466,931)
(S) Sustainment General Purpose	$567,353	$537,032	$589,480	$612,470	$636,365	$22,990	$23,895
Obligations [Total]	**$2,499,444**	**$1,888,508**	**$2,305,147**	**$2,640,450**	**$2,197,414**	**$335,303**	**($443,036)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act. Final 2022 funding allocations among program activities may change based on 2021 actuals and in response to workload demand requirements throughout 2022.
2/ This program has been previously displayed within the HUD-VASH case management row.

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;
- 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 housing stability 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. Program goals include assisting homeless Veterans and their families in obtaining and maintaining housing stability while promoting maximum recovery and independence in the community. HUD-VASH targets Veterans with the greatest needs first, ensuring that the most vulnerable Veterans are moved into housing as quickly as possible.

HUD-VASH Voucher Utilization as of September 30, 2020:

- Vouchers Allocated: 100,570
- Vouchers Under Lease: 79,133
- Vouchers Issued to Veterans Seeking Housing: 4,465
- Vouchers Reserved for Veterans: 1,393

HUD-VASH Measures of Success:

- Voucher Utilization Rate: Target 92% (Utilization as of September 3-, 2010: 83%)
- HUD-VASH Case Manager Positions Filled: Target 90% (Positions filled as of September 30, 2020: 85%)

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 2020 allocation of 4,875 new vouchers in December 2020 and anticipates an additional voucher award of up to 5,000 vouchers will be made prior to the end of 2021. Additionally, HUD's Office of Native American Programs (ONAP) published a Notice of Funding Availability in January 2021. The NOFA makes available $3,234,432 of grant funding to expand the Tribal HUD-VASH Demonstration Program. Just under a third of these funds are designated for service expansion of existing Tribal HUD-VASH grantees, while the remaining funds are designated for tribes interested in implementing a new Tribal HUD-VASH program.

Upon HUD's publication of new HUD-VASH voucher awards and Tribal HUD-VASH grants, VA funds will be distributed to the 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 2022 total funding level of $734.5 million is projected to support the 110,000 vouchers that are anticipated to be available in 2022.

COVID-19 Impact: HUD-VASH Veterans are uniquely vulnerable to COVID-19 due to their living conditions, age, and high rate of chronic health problems. HUD-VASH plays a critical role in VA's overall COVID-19 response by assisting these Veterans in obtaining and sustaining permanent housing. HUD-VASH programs have been encouraged to consider every Veteran placed in a temporary accommodation (e.g. hotel, congregate shelter, isolation/quarantine facility) in response to the COVID-19 emergency for HUD-VASH, as admitting these Veterans to HUD-VASH ensures they have a safe and stable living environment while simultaneously freeing up capacity in temporary quarantine settings. CARES Act funding of $4 million has been provided in 2021 to support case management services to support these efforts. Additionally, the CARES Act has provided support for enhanced access to telehealth capabilities for Veterans enrolled in HUD-VASH.

Grant & Per Diem (GPD):

Purpose: VA's GPD Program is permanently authorized by 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/or supportive services with the goal of helping homeless Veterans achieve residential stability, increase their skill levels and/or income, and obtain greater self-determination. The program currently supports nearly 12,900 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 2% inflation factor in 2022 to support anticipated increases in the State Home per diem rate.

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 VA medical centers 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 evidence continues:

- VA's largest transitional housing program with nearly 12,900 beds nationwide (as of October 1, 2020).
- 17,730 Veterans entered GPD transitional housing in 2020.
- In 2020, 25,578 Veterans were served by GPD transitional housing grants.
- In 2020, 10,646 homeless Veterans exited GPD transitional housing to permanent housing.
- On August 19, 2020, VA announced that it will award three GPD grants that began on October 1, 2020.
    - **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 369 grants to organizations were awarded to provide 12,138 beds and 18 service centers totaling approximately $221 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 46 grants to organizations were awarded to provide 723 beds totaling $55.3 million.
    - **Special Need grants** provide funding to organizations that incur additional operational costs 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 11 grants to organizations were awarded totaling approximately $2.4 million.
- In 2021, VA announced three Notices of Funding Opportunity. All these grants will be awarded beginning October 1, 2021.
    - Case Management grant- VA offering approximately $30 million for two-year renewal funding. This is an opportunity for existing grantees providing housing retention services to formerly homeless Veterans and Veterans at risk for homelessness.
    - Special Need -VA is offering up to $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.
    - Capital grant- VA is offering $50 million 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.

Implementation Plan: With the aforementioned grant award announcement, GPD will have nearly 12,700 transitional housing beds in 2021, 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 2022 total funding level of $270 million is projected to support 12,700 transitional housing beds and 14 independent services centers Additionally, the GPD Program will use$50 million in ARP funds to offer a capital grant to create new individualized living spaces which will continue to transform the programs' housing resources to more safely serve Veterans experiencing homelessness.

COVID-19 Impact: The GPD Program received a total of $170.8 million in CARES Act funding, the majority of which is being used to support increased per diem rates in 2020 and 2021. The Secretary waived the current cap on per diem on April 28, 2020. This funding has allowed grantees to support the additional costs of providing services to homeless Veterans during COVID-19, including the cost to provide personal protective equipment, secure quarantine spaces, deep cleaning of facilities, etc. An additional $50 million in CARES Act funding was received to support the Capital grant to create individual living spaces in transitional housing. VA will continue to monitor any ongoing impacts of COVID-19 on program requirements and incorporate them in future budget requests.

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: HCHV program staff provided outreach services in 2020 to approximately 120,044 Veterans, case management to over 10,439 Veterans, served more than 49,180 through Stand Downs, and supports 3,890 operational CRS emergency transitional housing beds. It is expected that 140,000 Veterans will need outreach services in 2022 and 142,000 Veterans in 2023. Additionally, the percentage of homeless Veterans exiting the CRS transitional housing into permanent housing is 56% for 2020, surpassing the measure's goal of 55%. This percentage of Veterans exiting into permanent housing has increased each consecutive year from 48% in 2017, to 51% in 2018 and then 54% in 2019. The alternative would be to decrease staffing levels across all aspects of HCHV services, as well as decrease contracted bed capacity which would then leave more vulnerable homeless Veterans on the streets. Successful implementation of these funds will be evaluated through HCHV performance measures and the maintenance of current positions filled.

Implementation Plan: Each VA Medical Center across the country implements the HCHV program at the field level and ensures continuity of services each year. 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 2022 funding level of $270.5 million is projected to support 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; and 32 Community Resource and Referral Centers (CRRC) 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.

COVID-19 Impact: The HCHV program received $20 million in CARES Act funding in 2020 and 2021. These funds provided support during the national emergency by providing funds to HCHV CRS providers to cover the additional costs of providing services to homeless Veterans during COVID-19. This includes the cost to provide personal protective equipment, deep cleaning of facilities, isolation, and quarantine spaces. These funds also allowed sites to add additional bed capacity in HCHV CRS programs as a temporary remedy to assist more Veterans who entered homelessness during the pandemic a placement. VA will continue to monitor any ongoing impacts of COVID-19 on program requirements and incorporate them in future budget requests.

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 Public Law 110-387 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: Annual reports published since the inception of the SSVF program continue to demonstrate the efficiency and effectiveness of the SSVF program (reports are available at www.va.gov/homeless/ssvf/?page=/ssvf_university/research_library). SSVF interventions help keep families together. Research conducted by the National Center on Homelessness Among Veterans found that of those placed in permanent housing, only 12% of families and 15% of individuals re-enter the homeless system one year after discharge from SSVF. By comparison, estimates from the 2010 Annual Homelessness Assessment Report, the last year that the association between poverty and homelessness was assessed, indicate that 13% of all Veterans in poverty will become homeless at some point during the year. This means that those placed by SSVF are at no greater risk of returning to homelessness than any Veteran living in poverty. In 10 years of operation, SSVF has exited 80% of Veterans and their families to permanent housing with only 13% seeking any type of VA homeless assistance one year after exit. SSVF's success has significantly contributed to halving the numbers of homeless Veterans since 2010.

SSVF evidence continues:

- $400 million in support for 2021 grantees (through a combination of the 2021 annual appropriation and funding remaining from 2020) provided to non-profit organizations in all 50 states, Puerto Rico, the District of Columbia, Guam, and the Virgin Islands.
    - 2021 funding includes $12.5 million to extend support a new initiative known as Shallow Subsidies. Shallow Subsidies provide 2-years of continuous rental assistance (traditional SSVF rental assistance provides only 10 to 12 months of rental assistance in a 2-year period) for Veteran families who do not need intensive clinical supports and live in areas with high housing costs, and very low vacancy rates for affordable housing.
- In 2020 SSVF, in partnership with HUD and United States Interagency Council on Homelessness (USICH), implemented the Rapid Resolution Initiative. This Initiative reunifies imminently at-risk or homeless Veterans with family or friends as an alternative to entering the homeless system. This initiative seeks to reduce overall demand for traditional affordable housing resources while simultaneously reducing trauma for Veterans and their families who would otherwise become or remain homeless and is based on a 2019 pilot offered in 11 communities.
- In 2020, SSVF assisted 112,070 individuals; with 77,590 Veterans assisted; and 19,919 dependent children assisted.
- Of the Veterans assisted, 10,197, or 13% were female (compared to 8-9% of the homeless Veteran population).
- 80% of those discharged from the SSVF program obtained permanent housing.

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 as grantees are located in all 50 states, the District of Columbia, Puerto Rico, Guam, and the Virgin Islands. The 2022 total funding level of $831.4 million is projected to support the following.

- $445 million to sustain existing grant awards.
- $325 million to expand the current Shallow Subsidy initiative into a national effort.
- $30 million to expand access to legal services.
- $28 million to sustain the Health Care Navigator initiative.
- $3.4 million to expand contract technical assistance, launch training for new diversion training for VAMC homeless staff, and support the proposed national Shallow Subsidy rollout. Funding will also be used for SSVF faculty travel and VA staff travel where necessary to support training attendance.

COVID-19 Impact: SSVF has played a leading role in VA's response to mitigating COVID-19 risks to vulnerable homeless Veterans. Between March 2020 and March 2021, SSVF placed over 26,000 Veterans in hotels/motels. These Veterans were previously unsheltered or in congregate environments that put them at increased risk of contagion. Operational slowdowns among HUD supported Public Housing Authorities (PHAs) have meant that voucher issuance and completion

of required inspections have delayed in HUD-VASH placements. SSVF supported those waiting for HUD-VASH placement, assuring that permanent housing is secured despite these PHA delays. Between May 2020 and January 2021, SSVF assisted 5,382 Veterans, acting as a bridge to support moves into permanent housing while awaiting PHA voucher processing. Additional, SSVF has provided critical needed prevention services for Veterans facing eviction. The *CARES Act* has provided $716.6 million in additional support to SSVF grantees for additional COVID-19 specific enhancements.

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,"[26] 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 (HRO) 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 more 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.

Currently, there is no coordination between the Transition Assistance Program (TAP), 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 NVVHC contact prior to leaving active service will ensure at-risk 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.

Evidence: Commission on Accreditation of Rehabilitation Facilities (CARF) and International Customer Management Institute (ICMI) 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 like chat. Approximately 18,000 separating Service Members per year without Post Transition Housing Plans are projected to receive an

[26] Secretary McDonough, March 2021, End Homelessness Virtual Conference, Washington DC

inbound phone call. Each new Veteran served would receive at a minimum one (1) referral and one (1) follow-up review.

Implementation: NCCHV would rely on Health Resource Center's current Quality Monitoring Team to implement a plan specific to NCCHV. NCCHV can piggyback off/duplicate an already established text messaging process utilized by the Veterans Crisis Line. NCCHV would work with VBA, Homeless Program Office and DoD to establish a pilot and determine appropriate roles. The 2022 funding level of $7.9 million will support NCCHV's Quality Monitoring Pilot for VCL's already-established text messaging process and its coordination efforts with the Transition Assistance Program to better assist Service Members who are at risk for homelessness upon separation from the military.

COVID -19 Impact: The needs addressed by these requested increases are projected to close current gaps in service as well as provide for the continued natural growth of this program unrelated to the COVID-19 pandemic.

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 Fulltime Equivalent (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 increase significantly by 2022. 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.

The rapid growth in demand for VJO services is evidenced by VAMCs' continued requests for additional VJO FTE, despite receiving new VHACO-funded positions that increased the program's field FTE by nearly 30% between 2018 and 2019. As noted above, the *Veterans Treatment Court Improvement Act of 2018* required VA to hire 50 additional VJO Specialists in 2019. This growth in the program followed an award of 53 FTE in 2018. Even with the addition of more than 100 FTE in those two years, VAMCs continue to request additional positions based on their locally assessed needs for addressing increased demand for VJO services. The estimate of an additional 50 FTE needed by 2022 is conservative, as communities have continued to launch new Veteran-specific criminal justice programs requiring VJO support in the meantime.

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 2019, 97% of Veterans served by VJO Specialists went on to access face-to-face VHA services. Of these Veterans:

- 72% were diagnosed with one or more mental health disorders, and 94% of those with such diagnoses entered VHA mental health treatment.
- 56% were diagnosed with one or more substance use disorders, and 72% of those with such diagnoses entered VHA substance use disorder treatment.

Implementation Plan: Most of the requested additional funds would support VAMCs' hiring of additional VJO Specialists (up to 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 2022 funding level of $70.1 million is projected to support outreach and linkage to VA services for justice-involved Veterans by approximately 430 VJO staff in 2022. 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 601 VTCs in which they currently serve Veterans.

COVID-19 Impact: The needs addressed by these requested increases are projected to arise from the continued natural growth in demand for VJO services, unrelated to the COVID-19 pandemic.

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. To date there are 86 HPACT teams and providers operating at 54 VAMCs, Community Based Outpatient Clinics (CBOCs), and Community Resource and Referral Centers (CRRCs) across the country. HPACTs are located in every VISN with over 194 full time equivalent 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 assess, 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 Veteran 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 on-going 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. Additional specific purpose funds would support growth of the HPACT program to additional field sites serving homeless Veterans and expansion of effective services such as outreach, mobile health units, and telehealth for existing teams. Priority would be given to teams that had a strong core team identified and infrastructure to begin seeing patients immediately, strong local leadership buy-in, in-kind staff support, and clinical space that could accommodate multi-disciplinary team co-location. Specific purpose funding is an integral part of the growth, expansion, and sustainment of HPACT programs. The 2022 funding level of $10 million is projected to support active HPACT teams and efforts to expand the program in 2022.

COVID-19 Impact: The HPACT program continues to focus on the ongoing COVID-19 pandemic and supporting Veterans experiencing homelessness. VA will continue to monitor any

ongoing impacts of COVID-19 on program requirements and incorporate them in future budget requests.

Homeless Veterans Community Employment Services (HVCES):
Purpose: The HVCES provides employment services and resources to Veterans participating in Veterans Health Administration (VHA) homeless programs in order 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 2020 employment outcomes for homeless Veterans continued to trend in an upward direction, exceeding the national targets. Approximately 6,547 Veterans exited homeless residential programs with competitive employment (i.e., Grant & Per Diem (GPD), Low-Demand Supportive Housing (LDSH), and Healthcare for Homeless Veterans – Contract Residential Services (HCHV-CERS). Employment rates for Veterans housed through HUD-VASH exceeded the national target despite the impact of COVID-19 on employment nationally.

There were over 15,489 newly documented, unique instances of employment for Veterans engaged in or who exited from VA Homeless Programs or Services. In response to COVID-19, HVCES staff increased the use of telehealth and telephone visits and developed strategies for providing employment services and supports through virtual platforms by more than 50%.

Implementation Plan: 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 2022, 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 2022 funding level of $15.2 million is projected to support 154 FTE in 2022.

COVID-19 Impact: Given the increased unemployment rate among both the general population and Veterans as well as changes in the job market in response to COVID-19, VA will continue to monitor any ongoing impacts of COVID-19 on program requirements and incorporate them in future budget requests.

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 healthcare 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.

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.

COVID-19 Impact: The Registry is foundational in providing data to advance any potential homeless program development and research as it relates to COVID-19. The needs addressed by these requested increases are projected to arise from the continued natural growth of this program and are unrelated to the COVID-19 pandemic.

Navy Seal Bill Mulder Act of 2020: The 2022 and 2023 budget request for the Veterans Homelessness Program includes resources necessary to implement provisions in the NAVY SEAL Bill Mulder Act of 2020, included in P.L. 116-315, *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020,* Title IV, Subtitle B, signed into law to January 5, 2021. The 2022 and 2023 budget request will support implementation of a new grant program to provide legal services for homeless and at risk, improve VA's Grant and Per Diem program, and improve HUD-VASH voucher utilization.

Whole Health

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160):	$50,708	$54,627	$64,627	$64,627	$64,627	$0	$0
Medical Community Care (0140):	$0	$0	$0	$0	$0	$0	$0
Medical Support and Compliance (0152):	$6,159	$8,973	$8,973	$8,973	$8,973	$0	$0
Medical Facilities (0162):	$44	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	**$56,911**	**$63,600**	**$73,600**	**$73,600**	**$73,600**	**$0**	**$0**

1/Whole Health budget includes the entire $33 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, Executive Orders, and VA/VHA initiatives:

- Public Law (P.L.) 114-198, Title IX, §933, *Jason Simcakoski Memorial and Promise Act (Jason's Law)*, signed into law July 22, 2016. Efforts are underway across VHA addressing the requirements of P.L. 114-198, §932 and §933, which directed the planning for, and expansion of, Complementary and Integrative Health services. The Whole Health System creates the healthcare approach that optimizes the benefits of complementary and integrative health services and self-care.

  Section 933 requires VA, to conduct a pilot program to assess the feasibility and advisability of using complementary and integrative health services and wellness-based programs to complement the provision of pain management and related health care services, including mental health services, to Veterans. VA commenced this pilot program on October 1, 2017, designating one facility in each of VHA's 18 VISNs, three of which are polytrauma rehabilitation centers. These facilities are known as Whole Health Flagships.

- Executive Order 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life*, issued January 2018. It requires the Departments of Defense, VA, 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." A VA-specific component of the joint plan subsequently developed by the Departments includes VA's obligation to "[Expand] peer community outreach and group sessions in the VA Whole Health initiative from 18 Whole Health Flagship facilities to all facilities. Whole Health includes wellness and establishing individual health goals." Hence, the scope of services to be provided under the Whole Health Initiative (pilot program) was expanded to 1) include expanded peer community outreach and group sessions and 2) include new transitioning Veterans during their first year after their discharge, separation, or retirement. There have been over 50,000 participants in Introduction to Whole Health group sessions offered at 96% of VHA Health Care Systems and over 3,000 Transitioning Service members participating in these sessions

through 2021 Quarter 2. In addition, 14% of these have resulted in request for referrals to Mental Health.

- VA's 2018 – 2024 Strategic Plan includes strategy 2.1.4: "Emphasizing Veterans' and their Families' Whole Health and Wellness." The strategic plan highlights VA's focus on personalized, proactive, patient driven health care to empower, equip, and encourage Veterans to take charge of their well-being and adopt healthy living practices that deter or defer preventable health conditions. Programs like MyHealtheVet engage the Veteran in managing their own health and provide virtual access to their providers without the burden of traveling to a facility. Support and consideration of the needs of Veterans' families, caregivers, and supporters is included in this approach to Veteran wellness.
- Within the VHA Plan for Modernization, 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. The "2021 Transform Healthcare Deliver: Whole health" Lane of Effort 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 first stage of an evaluation of the outcomes of the Whole Health Flagship effort was completed by a team from VHA's Health Services Research and Development Service's (HSR&D) Quality Enhancement Research Initiative (QUERI) in January 2020. The report was the basis of the Congressional progress report mandated in *Jason's Law*, which was submitted to congress March 31, 2020. Even relatively early in the course of the Whole Health deployment at the flagships, the evaluation indicated 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 healthcare 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 March 2020, the VHA Governance Board approved the increased emphasis on Whole Health Clinical Care to reach more high-risk Veterans proactively in Mental Health, Primary Care/Mental Health Integration, and Primary Care by building upon the previously approved adoption of the Whole Health System of approach. The goals include training of all team primary care and mental health team members in basic whole health principles; establishment of local facility protocol for offering engagement in Whole Health, completion of a Personal

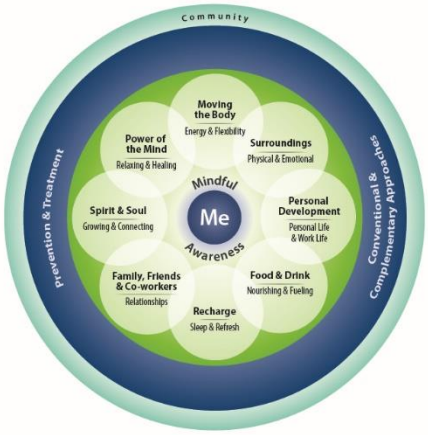
Health Inventory, beginning with those identified at high risk of suicide; and identifying a whole health champion on each clinic team. Launch of this initiative was delayed by the COVID-19 pandemic but, remains a priority for VA, and resumed at full speed in March 2021.

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/ and 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 increases the likelihood that the interventions will be effective.[27] [28] 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 that results in the best care for Veterans. VA has created support tools for employees, especially during and following the coronavirus pandemic, to support wellbeing 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.

[27] Witt, Martins, Willich, Schützler. 2012. "Can I help you? Physicians' Expectations as Predictor for Treatment outcome". *European Journal of Pain.*

[28] Frank, Dresner, Shani, Vinker. 2013. "The Association Between Physicians' and Patients' Preventive Health Practices. *Canadian Medical Association Journal.*

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 (e.g., 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 (i.e., 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).



This model is based on the experience of over 200 innovation projects, followed by a total of 25 Whole Health Design sites in 2016 through 2018. In addition to a detailed implementation guide, the Flagship facilities are receiving education and training, resources and tools, and onsite support. The next 37 facilities began Whole Health implementation in July 2019 and are receiving similar resources and support. All other sites not formally designated as Flagship sites or next wave sites have engaged in consultative services to begin exploration and implementation of aspects of the Whole Health approach.

Recent Trends: Nationally, there is a growing trend toward more patient-centered, value-based healthcare, with a focus on well-being as opposed to purely disease-management. Though leaders in healthcare 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.[29] The Whole Health System is the cornerstone of the VA strategy to implement this shift.

[29] Jonas, Schoomaker, Marzolf. 2019. "Finding the Cause of the Crises: Opioids, Pain, Suicide, Obesity, and Other "Epidemics". *NEJM Catalyst*.

Introduction to Whole Health sessions offer Veterans and family members an overview of the Whole Health approach and the opportunity to begin a Personal Health Inventory. Next, Veterans can choose to participate in the full program, *Taking Charge of My Life and Health*, which leads to development of a Personal Health Plan. With implementation of Executive Order 13822, 96% of VA medical centers now offer *Introduction to Whole Health* sessions in person or through telehealth modalities with over 50,000 participants through 2021 Quarter 2. In addition, 14% 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 partnered to offer Introduction to Whole Health, Taking Charge of My Life and Health and some complementary and integrative health modalities (e.g., yoga, tai chi) at local YMCA facilities. The VA Caregiver Support Program is also exploring opportunities for caregivers to participate in Whole Health coaching.

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 HSR&D QUERI to achieve the objective of the *Jason's Law*/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. Based on the outcomes we are seeing in the *Jason's* Law-mandated pilot sites, we conclude 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, improve overall well-being and other clinical outcomes. In addition, the VA can provide a model of healthcare delivery that will transform American healthcare.

During the first two quarters of 2021, there have been 529,495 Whole Health encounters in VHA bringing the total number of Veterans reached by Whole Health to 346,629 (7.41% of active Veterans). To reach an annual goal of 10% of Veterans receiving Whole Health at the intensive level (five Whole Health encounters) the projected cost is an average of $1.98 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.

Projections for the Future: VHA is leading the nation in transforming healthcare from a disease-based system of care to one that is centered on health and well-being by focusing on what matters to the patient.

VA continues expansion of Whole Health in the telehealth environment at individual (e.g., development of a Personal Health Plan, coaching) and group levels (e.g., yoga, mindfulness

training, 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 28,793 unique Veterans participating in 72,659 encounters through the month of March 2021. 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.

OPCC&CT continued collaboration with VHA program offices to offer virtual well-being resources to VA staff to support them through the pandemic. Through April 30, 2021 there have been a total of 60,679-page views. In response to COVID-19, VHA launched the *#LiveWholeHealth* self-care blog series for Veterans, offering 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 66 VAntage Point blog posts with embedded self-care videos and a total 4,931,884 reaches over the past year. VA has also continued the expansion of Employee Whole Health Coordinators and programs to additional sites.

OPCC&CT is 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 that can have significant negative impacts on Veterans physical and mental health.

VA continues 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. VA is also expanding its partnerships with Veterans Service Organizations to assist in spreading the word about VA's Whole Health services.

VA is also actively assessing 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.

Programs for Select Veteran Populations

This section provides narrative descriptions of selected programs that serve certain Veteran populations.[30] The obligations shown in each table below reflect the cost of total health care services provided to each designated Veteran population.[31] 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	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary & Mandatory Obligations by Category:							
Medical Services	$1,155,400	$1,071,323	$1,195,300	$1,239,000	$1,286,700	$43,700	$47,700
Medical Community Care	$114,500	$79,964	$118,800	$123,400	$128,500	$4,600	$5,100
Medical Support and Compliance	$119,000	$115,827	$123,100	$127,600	$132,600	$4,500	$5,000
Medical Facilities	$102,200	$98,566	$105,700	$109,500	$113,700	$3,800	$4,200
Obligations [Total]	$1,491,100	$1,365,680	$1,542,900	$1,599,500	$1,661,500	$56,600	$62,000

Authority for Action

VA's National HIV Program is governed by VHA Directive 1304 and Title 38 United States Code (U.S.C.) 7301(b). VHA's National Human Immunodeficiency Virus (HIV) Program is responsible for providing primary guidance and advice to the Under Secretary for Health on policy and services related to prevention, diagnosis, treatment, and care of Veterans living with HIV infection (VLHIV). This national program falls under the HIV, Hepatitis, and Related Conditions Programs Office (HHRC), within the Office of Specialty Care Services. Using a population-based approach, HHRC leads coordination of efforts to improve access and quality across the VHA health care system for HIV diagnosis, care, and treatment of VLHIV, as well as among uninfected Veterans at increased risk for acquiring HIV infection.

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 works to ensure that these Veterans receive the highest quality comprehensive clinical care, including testing, diagnosis, timely linkage to care, and treatment of co-morbidities. In addition, HHRC works to reduce health disparities among VLHIV, and promote evidence-based HIV care and preventive services.

Pharmacological HIV prevention interventions are now broadly available across VHA. There are currently two drugs approved by the FDA for pre-exposure prophylaxis to prevent HIV infection (PrEP), Truvada (emtricitabine/tenofovir disoproxil fumarate) and Descovy

[30] 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.

[31] Obligations exclude the Captain James A. Lovell Federal Health Care Center (JALFHCC) fund (0169).

(emtricitabine/tenofovir alafenamide). Both of these drugs are available on the VA National Formulary (VANF) for treatment of HIV infection. However, Descovy was only recently approved by FDA for the indication of PrEP, with approval for a more limited population than that of Truvada. VHA Pharmacy Benefits Management (PBM) has issued Criteria for Use (CFU) for use of both Truvada and Descovy for PrEP, making these drugs available to Veterans at increased risk for exposure to HIV. PBM will review newer drugs for PrEP as they are approved by the FDA for this indication and make them available to all VA patients according to the approved indications. VA continues to promote broader use of PrEP across the system by addressing local and systemic barriers to increased uptake, as well as working to increase availability to condoms and other risk reduction measures to all Veterans in VA care.

Population Covered

VHA policy requires that all Veterans be offered HIV testing at least once in their lifetime, with testing offered at least annually to those who have on-going risk of exposure. Multiple published studies have shown that HIV-infected individuals who know their HIV status are more likely to modify high-risk behaviors, decreasing their risk of transmitting HIV to uninfected individuals.

During calendar year (CY) 2020, 3,639,123 Veterans in care were candidates for HIV screening (meaning that they did not already have a diagnosis of HIV and not previously been tested). Of these, 4.0% received HIV screening during CY 2020; by the end of this CY, 46.8% of Veterans in care had been tested at least once for HIV.[32] VA continues to work to increase HIV testing among Veterans in care who are candidates for screening.

VA is the single largest provider of HIV care in the U.S., with over 31,000 Veterans diagnosed with HIV in care during 2020. Of these, 86% were on antiretroviral therapy (ART) during 2020; of those patients on ART who had labs drawn during 2020, 93% had complete suppression of HIV in the blood, a therapeutic goal known as viral suppression. Of VLHIV in VA care in FY2020, 78.4% were 50 years of age or older and 3.6% were women. Among VLHIV in VA care in 2020, 49% were Black, and 43% were White.

As of June 30, 2020, over 3,400 Veterans in VA care were receiving PrEP. The proportion of new HIV infections occurring among Black individuals and Hispanic individuals is disproportionate to the proportions of Black and Hispanic individuals in the general US population. Of note, the proportion of Veterans in VA care receiving PrEP is higher for Black as well as for Hispanic Veterans compared to the proportions of Black and Hispanic Veterans in the overall population of Veterans in care, both for VA as a whole and for most VISNs.

Type of Services Provided

VA provides comprehensive HIV prevention and clinical care across the VHA healthcare system, from prevention of HIV to diagnosis, linkage to care, management, and treatment, as well as comprehensive care management for co-morbid mental health and medical comorbidities. All anti-retroviral medications approved for treatment of HIV infection are available on the VANF. All VA medical centers and outpatient clinics provide HIV testing as well as PrEP, and each facility has a designated HIV lead clinician. VA healthcare facilities have ready access to annual HIV

[32] These data do not include testing at the Mann-Grandstaff VA Medical Center in Spokane, WA, because of the transition at the Cerner HER at that facility.

testing rates at the VHA, VISN, and facility levels, as well as to a database with a clinical dashboard function allowing population health management of VLHIV enrolled in care at a particular facility to promote linkage to care, ART treatment, and viral suppression.

The VA has also deployed electronic clinical reminders for HIV testing and for PrEP, which alert providers at the point of care that a Veteran may be a candidate for HIV testing or for PrEP. HHRC provides regular educational training on HIV prevention and care for VA providers and clinical staff through Webinars and teleconferences. These trainings also provide opportunities for VA providers to discuss local issues and compare solutions with colleagues across the VHA system.

Federal Partnerships

VA is a federal partner in the National HIV/AIDS Strategy (NHAS), an ongoing initiative by the White House Office of National AIDS Policy (ONAP to create, implement, and update a Federal Action Plan to combat HIV in the United States. The first NHAS plan was released in 2010 and updated in 2015. The NHAS Federal Interagency Workgroup is currently developing strategic targets based on the HIV Care Continuum model, aimed at having 95% of people living with HIV in the US aware of their status by 2030, with 95% of these retained in care by 2030, and 95% of those on ART achieving virally suppression by 2030.

The VHA's National HIV Program has implemented a VA-specific plan to meet the targets specified in the 2015 NHAS plan update, with revisions as needed to meet the expected 2030 targets. VA utilizes the HIV Care Continuum model to assess gaps in care in diagnosis, linkage to care, retention in care, initiation of ART, and viral suppression.

During his State of the Union address in February 2019, the President announced a historic goal of ending the HIV epidemic in the U.S. over the next 10 years. The U.S. Department of Health and Human Services (DHHS) subsequently released an ambitious plan, *Ending the HIV Epidemic: A Plan for America*, designed to end new HIV infections in the U.S. by decreasing transmission from infected persons and decreasing transmission to uninfected persons. The plan's core objectives are diagnosing people with HIV as soon as possible after infection; ensuring that individuals diagnosed with HIV infection are linked to care, receive treatment, and achieve viral suppression as soon as possible; increasing PrEP uptake among individuals at increased risk for HIV; and responding as rapidly as possible to local HIV outbreaks. The initial phase of the plan concentrates on 48 counties and seven states identified as HIV "hot spots," with later phases involving other areas of the U.S.

VA has long anticipated national efforts to end HIV infection. For more than two decades, VA has been deploying programs and products aimed at decreasing new HIV infections among Veterans in VA care, both by reducing transmission from VLHIV in VA care, and decreasing transmission to uninfected Veterans in care. Since the 2015 update of the NHAS Federal Action incorporated use of PrEP as a core component, VA has moved aggressively to increase availability of PrEP to Veterans. VA rapidly aligned itself with the White House's plan to end new HIV infections in the U.S. by launching a VA-wide campaign aimed at ending new infections among Veterans in care, along with standing up Affinity Groups to increase HIV testing, linkage to care, and ART initiation among VLHIV and intensifying efforts to promote PrEP uptake. As with the national plan, VA is focusing on Veterans in the 48 counties and seven states with HIV hot spots.

Recent Trends

Since 2009, HIV testing has more than quadrupled among Veterans in VHA, with 43.5% of all enrolled Veterans having received an HIV test by the end of CY 2019. From CY 2014 to CY 2017, 100% of Veterans in VA newly diagnosed were linked to VHA care within 90 days of their diagnosis, consistent with the recommendations in the 2010 NHAS plan that newly diagnosed individuals be linked to care within three months of their HIV diagnosis. VA transitioned to a new data source in the beginning of FY18 and updated its linkage to care definition as receipt of an HIV-specific lab (HIV viral load or genotype test) within 30 days of initial diagnosis, based on the 2015 update to the NHA plan and 2018 update to the HIV Care Continuum model used by the US Centers for Disease Control and Prevention. Under this revised linkage to care definition, in 2019 VA linked 84% of newly diagnosed Veterans to care within 30 days, with a decrease to 83% in 2020. VHA will continue to expand HIV testing, particularly for Veterans at high risk due to the on-going opioid crisis in the U.S.

Indicator	2016	2017	2018	2019	2020
Annual HIV testing	41%[1, 5]	43%[1, 5]	43%[4,]	44 %[4, 5]	47 %[4, 5, 6]
Confirmed new HIV diagnosis linked to care within 90 days[1]	100%	100%	--	--	--
Confirmed new HIV diagnosis linked to care within 30 days[2]	--	--	85%	83%	78%
Unique patients on ART[2]	85%	85%	86%	86%	86%
% virally suppressed of those with viral load testing[2]	88%	88%	91%	92%	93%
Unique patients on PrEP in CY[3, 6]	1,349	2,041	,2,879	3,711	4,157

Data sources:

[1] Population Health Service (10P4-V)

[2] VSSC HIV Clinical Data Cube

[3] HHRC Data and Analysis Group: PrEP Indicators Facility Report

[4] HHRC Indicators: HIV Testing Report

[5] Value determined for CY

[6] Does not include data from the Spokane VA due to the Center transition

Projections for the Future

Based on the trend data presented above for the last five years, VA expects the following projections:

a. HIV testing rates in VA have plateaued since 2017; rates decreased slightly during 2020, most likely due to the effects of COVID-19 on VHA operations. VA is working to increase HIV testing rates in 2021 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 2% annual increase in cumulative HIV testing rates in 2021 and 2022.

b. In 2019, VA linked 83.1% of newly diagnosed Veterans in care to care within 30 days, with a decrease to 77.9% in 2020. Again, this is likely due to the effects of COVID-19 and limitations on face-to-face encounters. VA expects to reverse this trend and increase linkage to care rates for newly diagnosed Veterans in 2021 and 2022.

c. Since 2015, VA has steadily increased the proportion of Veterans with HIV who are prescribed ART from 84 to 86%. VA's internal goal is to have ART prescribed to 90% of VLHIV in care by 2030.

d. Over the next 3 to 5 years, VA also expects to see a steady increase in PrEP uptake.

AIDS / HIV Workload

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Advance Approp.	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Unique Patients [Total]	31,780	30,749	32,067	31,927	**32,356**	**32,649**	289	293

Post Deployment Health Services (PDHS)

PDHS: Gulf War Program

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary & Mandatory Obligations by Category:							
Medical Services	$3,129,900	$3,147,076	$3,386,000	$3,665,300	$3,973,400	$279,300	$308,100
Medical Community Care	$493,700	$682,732	$534,600	$579,200	$628,400	$44,600	$49,200
Medical Support and Compliance	$442,600	$449,258	$479,000	$518,700	$562,600	$39,700	$43,900
Medical Facilities	$465,200	$399,568	$503,600	$545,500	$591,700	$41,900	$46,200
Obligations [Total]	$4,531,400	$4,678,634	$4,903,200	$5,308,700	$5,756,100	$405,500	$447,400

PDHS: Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF)/Operation New Dawn (OND)/Operation Inherent Resolve (OIR) Program

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary & Mandatory Obligations by Category:							
Medical Services	$5,911,300	$5,969,611	$6,497,200	$7,092,500	$7,696,600	$595,300	$604,100
Medical Community Care	$1,265,700	$1,110,258	$1,394,700	$1,525,800	$1,659,800	$131,100	$134,000
Medical Support and Compliance	$788,900	$868,289	$867,100	$946,600	$1,027,300	$79,500	$80,700
Medical Facilities	$745,700	$805,611	$819,000	$893,600	$969,300	$74,600	$75,700
Obligations [Total]	$8,711,600	$8,753,769	$9,578,000	$10,458,500	$11,353,000	$880,500	$894,500

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.

Public Laws /Federal Registry /Initiatives

- Public Law 102-4, 38 USC. 527, 38 USC 1116; PL 102-585 Section 703, and PL 100-687 governs the Agent Orange Registry
- Public Law 110-389: covers the Gulf War and Health Updates and a Multiple Sclerosis Study

- Public Laws 102-585, 103-446 and Title 38 United States Code (U.S.C.) 1117: Gulf War Registry (GWR)
- Public Law 105-368: War Related Illness and Injury Study Center (WRIISC), Ionizing Radiation
- Public Law 102-585, 703(b) (2): governs the Depleted Uranium Program
- Public Law 105-368 and Public Law 105-277: general laws that provide program oversight
- Public Law 112-260, Section 201: governs Airborne Hazards and Open Burn Pits Registry
- Public Law 98-542, Public Law 99-576, 38 CFR 3.311 (Ionizing Radiation)
- Pending proposed legislation for Karshi-Khanabad (K2)

Types of Services Provided

Post-Deployment Health Services assesses the impact of deployment/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:

1) Agent Orange (AO) Veterans: Vietnam, Korean DMZ at certain times, and certain Thai bases and certain occupational series, certain C-123 crews, does not include most Blue Water Navy. Approximately 3.1 million Veterans served in Vietnam and are presumed to have Agent Orange exposure.
2) Atomic Veterans exposed to ionizing radiation (above and some below-ground tests)
3) 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.
4) Airborne Hazard Open Burn Pit Veterans: served in Djibouti, Africa on or after September 11, 2001, Operations Desert Shield or Desert Storm, Southwest Asia theater of operations on or after August 2, 1990. Note: includes GWR eligible Veterans and OEF/ OIF/ OND/OIR
5) Garrison-related environmental health concerns, such as Camp Lejeune and fire-fighting foam exposures in garrison water supplies (PFAS).
6) Karshi-Khanabad (K2) – possibly exposed to various hazards; fuels, DU, asbestos, lead, etc. at a former Soviet airbase in Uzbekistan from 2001-2005.
7) Reviews of other emerging issues such as exposures to prophylactic medications and vaccines and concerns for intergenerational and gender issues.

Vietnam War

- PDHS 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.

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 Data to create a longitudinal exposure 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.
- Includes Karshi-Khanabad (K2) where Service Members were possibly exposed to various hazards; fuels, DU, asbestos, lead, etc. at a former Soviet airbase in Uzbekistan from 2001-2005.

War Related Illness and Injury Study Center (New Jersey, District of Columbia, California)

- The War Related Illness and Injury Study Center (WRIISC) is a Congressionally mandated VA program devoted to the post-deployment health concerns of Veterans. Overseen by the Post-Deployment Health Service, the three WRIISC sites are located within VA medical centers in Washington, DC; East Orange, NJ; and, Palo Alto, CA. 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.

Recent Trends

Social media and Veterans special interest groups have had a great influence on emerging issues. PDHS monitors, conducts, and interprets the scientific research for stakeholders and interested parties.

- Increasing interest by Congress, media, and Veterans groups in environmental issues.
    - Karshi-Khanabad (K2)
    - Intergenerational effects
    - Burn pit and airborne hazard exposures
- Continued interest in separate registry development by Congress
- Movement of Compensation and Pension (C&P) exams to VBA contracted services. Many of the Congressionally mandated registry examinations have been performed in VA C&P clinics and as these close VA needs to look at new solutions. Primary care is already over-subscribed so possible solutions may be a centralized telemedicine registry exam system.

- Estimated costs would be $5.2 million per year to centralize this service.

- Increasing interest in Garrison exposures, such as seen on Camp Lejeune (water); Ft Benning (lead paint in housing); Ft McClellan (industrial off post contamination).
- Concerns with groundwater contamination by Perfluorinated Alkyl Substances (PFAS), such as firefighting foams and Teflon compounds at many military bases.
- Increasing interest in Burn Pit related exposures.
- Increasing interest in the use of the VA to cover Camp Lejeune Family Member health concerns.
- Increase interest in creation of self-reported registries despite known limitations. VA and DoD are working on the Individual Longitudinal Exposure Record (ILER) which will replace registries with a record for each Service Member with location, time/date and exposure monitoring noted.

Projections for the Future

- Steady growth in concern surrounding military environmental exposures and garrison exposures due to continued military conflicts.
- Continued development of the Individual Longitudinal Exposure Record (ILER) with DoD and adding ILER as a key and essential component to the Electronic Health Record. ILER would match individual Service Members and Veterans with a time, place and exposure based on authoritative records. This would minimize the need for creation and maintenance of multiple self-reported registries for identifying those exposed and improve care and benefits determinations for Veterans.

PDHS Workload

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Advance Approp.	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Unique Patients								
Gulf War	417,298	446,520	432,389	463,370	**446,118**	**458,816**	13,729	12,698
OEF/OIF/OND/OIR	1,090,734	1,160,656	1,164,618	1,230,705	**1,236,559**	**1,303,055**	71,941	66,496

Centralized Call Center for Registries

PDHS oversees six Congressionally mandated registries with exams that are done at VAMCs. There is a great deal of variability at each VAMC and this produces a fragmented service across VHA. Backlogs in providing these exams greatly exacerbated by the pandemic and the closure of VA Compensation and Pension Clinics (where about 2/3rds of exams currently done). During the pandemic, Post Deployment Health Services has moved to a tele-medicine platform for the registry exams. This has offered the opportunity for great savings.

We propose to dramatically improve the process through a centralized call center and decentralized examiners. The Call Center Centralized (CCC) will have 22 full time staff composed of 20 Environmental Health (EH) coordinators and 2 clinicians (MD, PA, NPs) instead of the current

170 coordinators. The EH coordinators will serve as a central resource to schedule registry exams and provide educational materials to the Veterans.

CCC staff would schedule tele-medicine exams for decentralized physicians who currently provide this service, only using an estimated one third of the current 170. This would improve service to Veterans overall, but especially in remote areas.

Traumatic Brain Injury (TBI) and Polytrauma System of Care (PSC)

TBI: OEF/OIF/OND/OIR*

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary & Mandatory Obligations by Category:							
Medical Services	$166,300	$160,198	$174,400	$25,000	$185,800	($149,400)	$160,800
Medical Community Care	$9,500	$10,953	$10,000	$10,300	$10,600	$300	$300
Medical Support and Compliance	$23,000	$24,067	$24,100	$180,900	$25,700	$156,800	($155,200)
Medical Facilities	$26,600	$26,580	$27,800	$28,900	$29,700	$1,100	$800
Obligations [Total]	$225,400	$221,798	$236,300	$245,100	$251,800	$8,800	$6,700

*TBI: All Veteran Care***

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary & Mandatory Obligations by Category:							
Medical Services	$550,600	$507,834	$571,100	$87,300	$607,600	($483,800)	$520,300
Medical Community Care	$89,100	$63,325	$92,100	$95,200	$97,700	$3,100	$2,500
Medical Support and Compliance	$81,300	$80,782	$84,400	$590,800	$89,800	$506,400	($501,000)
Medical Facilities	$90,600	$87,970	$94,100	$97,300	$100,100	$3,200	$2,800
Obligations [Total]	$811,600	$739,911	$841,700	$870,600	$895,200	$28,900	$24,600

*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 the "Consolidated Appropriations Act, 2008", Public Law 110-161, 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:

- *Public Law 104-262, 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.

- *Public Law 108-447*: 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.
- *Public Law 110-181, 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;
- 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 Veterans 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.
- 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 2020, the growth was accelerated by the conditions created by COVID-19and the number of telehealth encounters to home rose from 636 in quarter one to over 12,000 in quarter four. Overall, 32.2% of the unique patients treated in polytrauma clinic top codes had telehealth encounters, representing a six-fold increase compared to 2019.

- 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)

Authority for Action
Public Law 115-141: Directs VA to create Headache Centers of Excellence

Type of Services Provided
The covered populations include Veterans with a history of polytrauma, TBI, migraines and multiple co-morbidities who present with refractory headaches. The services include:

- Appropriate pharmacologic management of headaches;
- Non-pharmacologic options including cognitive behavioral therapy, physical modalities, and devices;
- Interdisciplinary team interventions.

Recent Trends

In 2020:

- Funding was distributed to seven VA medical centers to develop HCOE programs and serve as hub referral centers.
- Funding was also provided to five VA medical centers to serve as HCOE Consortium sites to expand the network of headache specialists and improve access to interdisciplinary headache management for Veterans.
- Funding was also distributed to the Pain Research, Informatics, Multi-morbidities, and Education Center at the West Haven VA Medical Center to establish a centralized process to compile and aggregate data and provide analysis to improve understanding of current practice, and guide enhancements to care and education of Veterans, caregivers and clinicians, and understand how to implement care program by learning from Veterans with headaches.
- In collaboration with DoD, Clinical Practice Guidelines for the Management of Headaches was published and disseminated to ensure evidence-based management of headaches.
- During 2020, the growth in virtual care accelerated secondary to the COVID-19 pandemic. Telehealth encounters to home rose from 242 in quarter one to over 8,000 in quarter four at the12 HCOE sites.

Projections for the Future

In 2021 and beyond:

- Expand the network of VA Medical Center sites with Headache expertise through the addition of Consortium network sites;
- Provide innovative-interdisciplinary clinical care;
- Develop protocols for appropriate use of devices marketed for headache management;
- Drive advances in clinical research and promote opportunities for Veterans to participate in clinical research trials; and
- Disseminate best practices to all health care providers.

TBI Workload

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Advance Approp.	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Unique Patients								
TBI-OEF/OIF/OND/OIR 1/	54,618	57,555	55,953	58,572	**56,690**	**57,026**	737	336
TBI-All Veteran Care	105,262	108,804	107,379	110,766	**108,872**	**109,703**	1,493	831

1/ Included in TBI-All Veteran Care.

Women Veterans Health Care

Women Veterans Health: Gender-Specific Care [1/2]

Gender-Specific Care
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary & Mandatory Obligations by Category:							
Medical Services	$339,100	$377,453	$378,100	$423,400	$463,300	$45,300	$39,900
Medical Community Care	$128,100	$130,030	$142,900	$160,100	$175,200	$17,200	$15,100
Medical Support and Compliance	$50,500	$63,489	$56,300	$63,100	$69,000	$6,800	$5,900
Medical Facilities	$47,100	$54,719	$52,600	$58,900	$64,400	$6,300	$5,500
Obligations [Total]	$564,800	$625,691	$629,900	$705,500	$771,900	$75,600	$66,400

[1/] Included in Women Veterans Health-All Care.
[2/] FY 2021 Current Estimate – As directed in the Joint Explanatory statement accompanying PL 116-260, the Current Estimate provides an additional $35 million above the Budget Estimate to the Program Office and Initiative Budget (shown below) for the purposes of expanding programmatic support specific to women's health care.

Women Veterans Health: All Care

All Women Veterans Care
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary & Mandatory Obligations by Category:							
Medical Services	$4,755,100	$4,911,081	$5,122,900	$5,517,500	$5,937,300	$394,600	$419,800
Medical Community Care	$1,284,400	$1,151,809	$1,382,600	$1,487,900	$1,599,700	$105,300	$111,800
Medical Support and Compliance	$643,200	$722,777	$692,900	$746,200	$802,900	$53,300	$56,700
Medical Facilities	$577,700	$632,080	$622,400	$670,500	$721,600	$48,100	$51,100
Obligations [Total]	$7,260,400	$7,417,747	$7,820,800	$8,422,100	$9,061,500	$601,300	$639,400

Program Office & Initiative Budget
(dollars in thousands)

Description (Dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary & Mandatory Obligations:							
Obligations	$11,288	$64,433	$99,433	$104,946	$137,791	$5,513	$32,845

Authority for Action

VA Public Law 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. Public Law 103-452 provided authority and priority for counseling and treatment for sexual trauma incurred while on duty in the military.

Public Law 114-223, Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017, authorized VA to offer in-vitro fertilization (IVF) and Public Law 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.

Population Covered

In FY 2020, approximately 34% of women Veteran VHA patients were 18-44 years old, 42% were 45-64 years old, and 25% were 65+ years old. Within these age groups, gender-specific care was provided to 39, 48, and 13% of patients respectively. As of May 2021, 82% of women overall were assigned to specially trained, and /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 referrals to the community. In addition, VA is providing infertility counseling and treatment and assistive reproductive technology/ in vitro fertilization services through Care in the Community.

Recent Trends

The number of women Veterans using VHA services has increased from 423,642 in 2014 to 560,737 in 2020, placing new demands on VA's health care system. 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. This 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 4800 primary care providers 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. Beginning in 2018, in partnership with ORH, Women's Health Services is providing mini-residency for rural providers and nurses, reaching nearly 40 rural clinical sites per year. VA has at least two WH-PCP's at all of VA's health care systems and 90% 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. In 2017, Women's Health and the ORH began a partnership to bring the Mini-Residency directly to rural facilities. As a result of this mobile training program thus far, VA has trained 770 rural clinicians to enhance rural women Veterans' VA experience. Despite all of these initiatives, 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 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 in 2019 a text option to increase access for women Veterans. During 2020, the WVCC received 11,381 inbound calls, 835 inbound chats, and made 172,464 outbound calls with 76,628 of these calls being successful (spoke with Veteran or left a voice message) and mailed 5,441 informational packets.

Projections for the Future

Women comprise 16.9% of today's active duty military forces and 19% of National Guard and Reserves. Women are now the fastest growing cohort within the Veteran community. The percent of women Veterans is projected to increase to about 16% of the total Veteran population in 2040 from 6% in 2000. The overall Veteran population is decreasing at a rate of about 1.5% per year, while the women Veteran population is increasing at a rate of 1% per year.

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 rise rapidly, the complexity of injuries of returning troops is likely to increase, and the cost associated with their care will grow accordingly.

Women's Health Innovation and Staffing Enhancement (WHISE) Initiative Description

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 special purpose

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.

Relevant Background: With the enactment of P.L. 116-94, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2020*, Congress directed VA to continue redesigning its women's healthcare delivery system and facilities to ensure women receive equitable, timely, and high-quality health care. The population of women Veterans has grown dramatically, now exceeding 550,000 active female VA users. This growth has in some cases exceeded the capacity of VA to provide needed care to women Veterans. Consequently, more women Veterans are waiting longer for primary care and some specialty care appointments than men, and women's trust in VA is lower than male Veterans. VA policy requires that women are assigned to WH-PCP's and yet only 82% of women are so assigned. In addition, approximately 10% of CBOCs do not have even one WH-PCP. The WHISE Initiative supports the Secretary's priority of enhanced customer service by improving women Veterans trust in VA.

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 higher quality of care than women assigned to other providers. In addition, the Barriers to Care Survey completed in 2015 of over 8,000 women Veterans found that women assigned to women's health providers were more satisfied overall with their care, comfort, and safety in VA facilities.

Gynecology: Women Veterans receive high quality gynecologic surgical care through VA. The numbers of women Veterans who require gynecologic and obstetrical services and coordination of their care are significant. In 2020, 34% of women Veterans were of childbearing age (between age 18 and 44), making the need for gynecologic services well-established. At the end of 2019, 80% of VA health care systems had a gynecologist on site. While prenatal care and delivery is not provided in VA facilities, pregnant women seek care in VA for other conditions and may also need primary care, emergency care, and require coordination of Community Care services.

Mental Health: VA has witnessed a 154% increase in the number of women Veterans accessing VA mental health care over the past decade. Over 40% 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, Office of Mental Health and Suicide Prevention (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. As a pilot

project across FY 2021-FY 2022, a full-time Women's Peer Specialist (WMH PS) will be designated within each VISN. These key staff members will specialize in providing gender-specific peer support services to women Veterans who are using the local VHA mental health services. As part of their work, the WMH PS will pilot the adapted VHA version of Women Veterans Network (WoVeN), a specific peer support group intervention for women Veterans which can be delivered both in-person and via telehealth.

Care Coordination: VA is focusing on ensuring primary care providers, Patient Aligned Care Team (PACT) staffing, gynecologists, mental health providers, and care coordination personnel are available for women's health programs at each VAMC, particularly in the area of breast and cervical cancer. Breast and cervical cancer screening programs require meticulous tracking to ensure that all eligible women receive screening, results are received, and actionable results followed up with next step in care. VA policy requires that each facility have a process for tracking and timely follow-up, and breast and cervical cancer care coordination duties are assigned appropriately. To ensure accuracy and reliability, VA tracks the availability of breast and cervical cancer care coordinators across the system. In 2020, 79% of sites had a full or part time Breast Cancer Screening Coordinator, 72% of sites had a full or part time Cervical Cancer Screening Coordinator.

To support pregnant Veterans, every VA offers maternity care coordination. Eighty-two percent of sites have a full or part time Maternity Care Coordinator. All seven facilities in VISN 1 are covered by two MCCs.VA Maternity Care Coordinators (MCC) support 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.

Activity and Implementation timeframe:

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 2020, 135 sites had a full or part time WVPM. In addition, 138 sites had a Women's Health Medical Director.

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 FY 2021, VA launched the Women's Health Innovation and Staffing Enhancements (WHISE) program. WHISE provides an opportunity for sites to apply for funding for women's health personnel or innovative programs such as pelvic floor physical therapy or lactation support, to mitigate local gaps in availability of women's health personnel.

Of the appropriated FY 2021 Budget, over $40 million was distributed to the field in November 2020 across all 18 Veteran Integrated Service Networks in support of over 400 positions and

programs nationally. An additional $35 million in funding will be distributed to the field in summer 2021 to support projects such as advanced mammography equipment, specialty equipment for women Veterans with limited mobility to assist in transporting Veterans to and from exam tables in a safe manner and additional staffing needs. This will improve access and comfort for women with limited mobility to many female specific services such as pelvic exams and mammograms. We also are supporting Healthy Teaching Kitchens educational programs.

Performance Goal & Evaluation: Women's Health Services tracks 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 and other projects to monitor success of the program. Ongoing tracking of Non-VA care use and quality measures will be conducted.

Legislative Impacts:

P.L. 116-171, *Hannon Mental Health Improvement Act,* Title VI:
IMPROVEMENT OF 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:
IMPROVEMENT OF CARE AND SERVICES FOR WOMEN VETERANS

§301- Gap analysis of Department of Veterans Affairs programs that provide assistance to women veterans who are homeless.
§302- Report on locations where women veterans are using health care from Department of Veterans Affairs.

P.L. 116-260, *Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2021*:

MEDICAL FACILITIES

- The agreement provides $10,000,000 for women's health and mental health nonrecurring maintenance (NRM) projects, as described in House Report 116-445. Within the mental health NRM projects, the agreement directs VA to prioritize construction to increase the number of beds available for overnight mental health treatment for veterans.

GENDER-SPECIFIC CARE FOR WOMEN

Gender-Specific Care for Women

- The agreement includes $660,691,000 for gender-specific care for women, which is $35,000,000 above the budget request. The additional $35,000,000 is provided for the purpose of expanding programmatic support for women's healthcare, and includes

$1,000,000 for peer support programs for women veterans, as described in House Report 116-445.

Sexual Assault and Harassment at VA Facilities

- In addition to the direction provided in House Report 116-445, the Department is directed to conduct a report on incidents of reported sexual harassment and assault by veterans at VA facilities, and to develop a plan to address this issue no later than one year after enactment of this Act.

Barriers to Women's Care Report

- The Department is directed to provide a report within 180 days of enactment of this Act, detailing the corrective actions taken to address each of the challenges outlined in the VA Office of Women's Health Services 2015 report titled, "Barriers to Women's Care."

Fertility Treatment and Infertility Services Report

- §252 specified the amount from the four medical care accounts for gender-specific care for women.
- VA is required to provide a report within 180 days of enactment of this Act regarding the fertility treatment and counseling furnished by VA over the past five fiscal years. The report should include the following: (1) the number of Veterans who received fertility treatment or counseling furnished by the Department of Veterans Affairs, disaggregated by era of military service of such Veterans; (2) the number of spouses of Veterans who received fertility treatment or counseling furnished by the Department; (3) the cost to the Department of furnishing fertility treatment and counseling, disaggregated by cost of services and administration; (4) the average cost to the Department per recipient of fertility treatment and counseling; (5) in cases in which the Department furnished fertility treatment through the use of assisted reproductive technology, the average number of cycles per person furnished, disaggregated by type of treatment; (6) a description of how fertility treatment and counseling services of the Department are coordinated with similar services of the Department of Defense; and (7) the number of women veterans who are ineligible for in vitro fertilization treatment or other forms of assisted reproductive services currently provided by the Department for certain veterans, disaggregated by state of residence, race, age, and marital status.

P.L. 116-283 §764, *National Defense Authorization Act for FY 2021*: Inclusion Of Members of Reserve Components in Mental Health Programs of Department Of Veterans Affairs.

P.L. 116-315, *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020* :

§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.

P.L. 116-315, 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, MST, and gender-specific prosthetics.

Women Veterans Workload

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Advance Approp.	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Unique Patients								
Women Veterans Health-Gender-Specific Care 1/.....	300,172	349,991	330,565	368,598	**358,933**	**380,836**	28,368	21,903
Women Veterans Health-All Care.....	560,737	587,856	580,632	610,667	**600,900**	**621,305**	20,268	20,405

1/ Included in Women Veterans Total Unique Patients.

Gender-Specific Care 2/

	2020 Actual		**2021 Estimate**		**2022 Estimate**		**2023 Estimate**	
Category of Care	**VA Care**	**Community Care**	**VA Care**	**Community Care**	**VA Care**	**Community Care**	**VA Care**	**Community Care**
Cancer and Screening	67%	33%	67%	33%	67%	33%	68%	32%
Genitourinary Care	83%	17%	83%	17%	83%	17%	83%	17%
Osteoporosis	92%	8%	92%	8%	93%	7%	93%	7%
Pregnancy and Postpartum	13%	87%	13%	87%	13%	87%	14%	86%
Womans Clinic	100%	0%	100%	0%	100%	0%	100%	0%

2/ Gender-Specific Care is included in Women Veterans Health-All Care. The above Women Veterans data reflects the percentages of the VA and Community care by gender-specific categories.

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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; **[**$497,468,000, which shall be in addition to funds previously appropriated under this heading that became available on October 1, 2020; and, in addition, $58,897,219,000**]** *$70,323,116,000*, plus reimbursements, shall become available on October 1, **[**2021**]***2022*, and shall remain available until September 30, **[**2022**]** *2023*: *Provided*, that, of the amount made available on October 1, **[**2021**]** *2022*, under this heading, $1,500,000,000 shall remain available until September 30, **[**2023**]** *2024*: *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. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2021.)*

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, **[**$1,380,800,000**]** *$3,269,000,000*, which *shall remain available until September 30, 2023, and* shall be in addition to funds previously appropriated under this heading that became available on October 1, **[**2020**]** *2021*; and, in addition, **[**$20,148,244,000**]** *$24,156,659,000*, plus reimbursements, shall become available on October 1, **[**2021**]** *2022*, and shall remain available until September 30, **[**2022: *Provided*, That, of the amount made available on October 1, 2021, under this heading, $2,000,000,000 shall remain available until September 30, 2023**]** *2024*. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2021.)*

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.), **[**$300,000,000, which shall be in addition to funds previously appropriated under this heading that became available on October 1, 2020; and, in addition, $8,403,117,000**]** *$9,673,409,000*, plus reimbursements, shall become available on October 1, **[**2021**]** *2022*, and shall remain available until September 30, **[**2022**]** *2023*: *Provided*, That, of the amount made available on October 1, **[**2021**]** *2022*, under this heading, **[**$200,000,000**]** *$300,000,000* shall remain available until September 30, **[**2023**]** *2024*. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2021.)*

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; **[**$150,000,000, which shall be in addition to funds previously appropriated under this heading that became available on October 1, 2020; and, in addition, $6,734,680,000**]** *$7,133,816,000*, plus reimbursements, shall become available on October 1, **[**2021**]** *2022*, and shall remain available until September 30, **[**2022**]** *2023*: *Provided*, That, of the amount made available on October 1, **[**2021**]** *2022*, under this heading, **[**$350,000,000**]** *$500,000,000* shall remain available until September 30, **[**2023**]** *2024*. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2021.)*

Explanation of changes

Medical Community Care

VA requests that its full appropriation for Medical Community Care be provided with two-year availability. This change will reduce payment rejections and delays in processing of claims, which will improve VA's relationships with our Community Care partners. In addition, simplifying how funding is provided for this program will reduce the likelihood of lapsed funds or improper payments and result in more efficient use of funds for our Veterans' health care needs.

VA anticipates processing approximately 6.4 million Community Care authorizations in 2021. VA's financial and claims processing systems necessitates designating, at the time the authorization is issued, the financial account that will eventually pay the community care claim once the claim is adjudicated and the obligation established. If funds are not available in the pre-designated account, payments will be rejected, delaying the payment to the Third-Party Administrators or Community Care providers. This process contributed to an estimated 500,000 claims rejected in 2020. Given the current multiple periods of availability for this program and VA's account-designation system requirements, VA must do numerous cost transfers among its one-year and multi-year accounts to ensure adequate funding is available to accurately process claims. The complexity of managing the resources to ensure minimal lapse of funds under the current period-of-availability structure is heightened by the high-volume of locations issuing authorizations for care and recording eventual obligations. Claims rejections and workload could potentially decrease if VA is provided all Medical Community Care funding with two-year availability.

The administrative effort to manage the multiple funds within the Medical Community Care appropriation requires the assistance of the Financial Services Center (FSC), Veterans Affairs Medical Centers (VAMCs), and OCC staff. These organizations must monitor fund balances, process cost-transfers, identify and correct cost-transfer errors, and assist in clearing rejects. Additionally, VHA finance staff must process funding transfers between 151 medical centers and 18 categories of healthcare. Providing full two-year availability would eliminate the need for hundreds of thousands of financial transactions annually that move billions of dollars in cost-transfers and Transfer of Disbursing Authority (TDAs). This significant volume of transactions is inefficient and prone to errors and negatively impacts timeliness and accuracy of payment and thus Veteran care.

Medical Support and Compliance

VA is requesting an increase of two-year funding from $200 million to $300 million. This request is largely due to anticipated increases in the contracting needs to implement the new Community Care Networks and the new logistics system DMLSS. Due to the complexity of these systems migrations, VA is concerned that contracting dates may slip, and wants to ensure these priorities remain adequately funded without rushing major decisions and change-management that could help their progress.

Medical Facilities
VA is requesting an increase of two-year funding from $350 million to $500 million. Over the last few years, VA major leases have faced unexpected delays due to the size and complexity of the sites being sought and ongoing churn in the real estate market. Greater two-year availability of funding will improve our lease contracting process by preventing funding uncertainty and allowing for unexpected delays in acquisition (e.g., additional traffic studies, hazardous waste abatement, etc.).

2020 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 Emergency Appropriations for Coronavirus Aid, Relief, and Economic Security (CARES) Act

- **$14,432,000,000 Addition to the Medical Services Appropriation.** Public Law 116-136, signed on March 27, 2020, designated specific amounts as an emergency supplemental appropriation to prevent, prepare for, and respond to coronavirus, domestically or internationally, including related impacts on health care delivery, and for support to veterans who are homeless or at risk of becoming homeless. The funding will remain available until September 30, 2021.

- **$2,100,000,000 Addition to the Medical Community Care Appropriation.** Public Law 116-136, signed on March 27, 2020, designated specific amounts as an emergency supplemental appropriation to prevent, prepare for, and respond to coronavirus, domestically or internationally, including related impacts on health care delivery. The funding will remain available until September 30, 2021.

- **$100,000,000 Addition to the Medical Support and Compliance Appropriation**. Public Law 116-136, signed on March 27, 2020, designated specific amounts as an emergency supplemental appropriation to prevent, prepare for, and respond to coronavirus, domestically or internationally, including related impacts on health care delivery. The funding will remain available until September 30, 2021.

- **$606,000,000 Addition to the Medical Facilities Appropriation.** Public Law 116-136, signed on March 27, 2020, designated specific amounts as an emergency supplemental appropriation to prevent, prepare for, and respond to coronavirus, domestically or internationally, including related impacts on health care delivery. The funding will remain available until September 30, 2021.

Explanation of Additional Supplemental Appropriations for Families First Coronavirus Response Act, 2020

- **$30,000,000 Addition to the Medical Services Appropriation.** Public Law 116-127, signed on March 18, 2020, designated specific amounts as a supplemental appropriation for health

services consisting of SARS-CoV-2 or COVID-19 related items and services. The funding will remain available until September 30, 2022.

- **$30,000,000 Addition to the Medical Community Care Appropriation.** Public Law 116-127, signed on March 18, 2020, designated specific amounts as a supplemental appropriation for health services consisting of SARS-CoV-2 or COVID-19 related items and services. The funding will remain available until September 30, 2022.

Annual Appropriation Adjustment in 2020

- **$3,906,400,000 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, 2019. The authority for the addition to the Medical Community Care Appropriation is provided in the Further Consolidated Appropriation Act, 2020, (Public Law 116-94), Division F, Title II, signed on December 20, 2019.

- **$98,800,000 Addition to the Medical Support and Compliance Appropriation.** This reflects an addition to the funds previously appropriated in the Advance Appropriation under Medical Support and Compliance that became available on October 1, 2019. The authority for the addition to the Medical Facilities Appropriation is provided in the Further Consolidated Appropriation Act, 2020, (Public Law 116-94), Division F, Title II, signed on December 20, 2019.

Explanation of Rescissions in 2020

- **$350,000,000 Rescission to the Medical Services Appropriation.** This reflects a rescission of $350,000,000 from unobligated balances available to the Department of Veterans Affairs from prior appropriations Acts. The authority for the rescission is provided in the Further Consolidated Appropriation Act, 2020, (Public Law 116-94), Division F, Title II, Section 253, signed on December 20, 2019.

- **$10,000,000 Rescission to the Medical Support and Compliance Appropriation.** This reflects a rescission of $10,000,000 from unobligated balances available to the Department of Veterans Affairs from prior appropriations Acts. The authority for the rescission is provided in the Further Consolidated Appropriation Act, 2020, (Public Law 116-94), Division F, Title II, Section 253, signed on December 20, 2019.

Explanation of Appropriation Transfers in 2020

- **$615,000,000 Transfer to Medical Community Care Appropriations from Veterans Choice Fund.** This reflects a transfer of $615,000,000 to the Medical Community Care Appropriation from the Veterans Choice Fund. The authority for this transfer is provided in the Further Consolidated Appropriation Act, 2020, (Public Law 116-94), Division F, Title II, signed on December 20, 2019. The transfer supported critical funding to support furnishing health care to individuals at non-Department facilities.

- **$375,000,000 Transfer of 1% to Medical Support and Compliance Appropriation from Medical Services Appropriation.** This reflects a transfer to Medical Support and Compliance

Appropriation from Medical Services of less than 1%. The authority for this transfer is provided in the Further Consolidated Appropriation Act, 2020, (Public Law 116-94), Division F, Title II, Section 202, signed on December 20, 2019. The transfer supported the funding necessary to cover administrative costs to support Veteran care at medical centers and networks and properly align the funds to the correct account for execution.

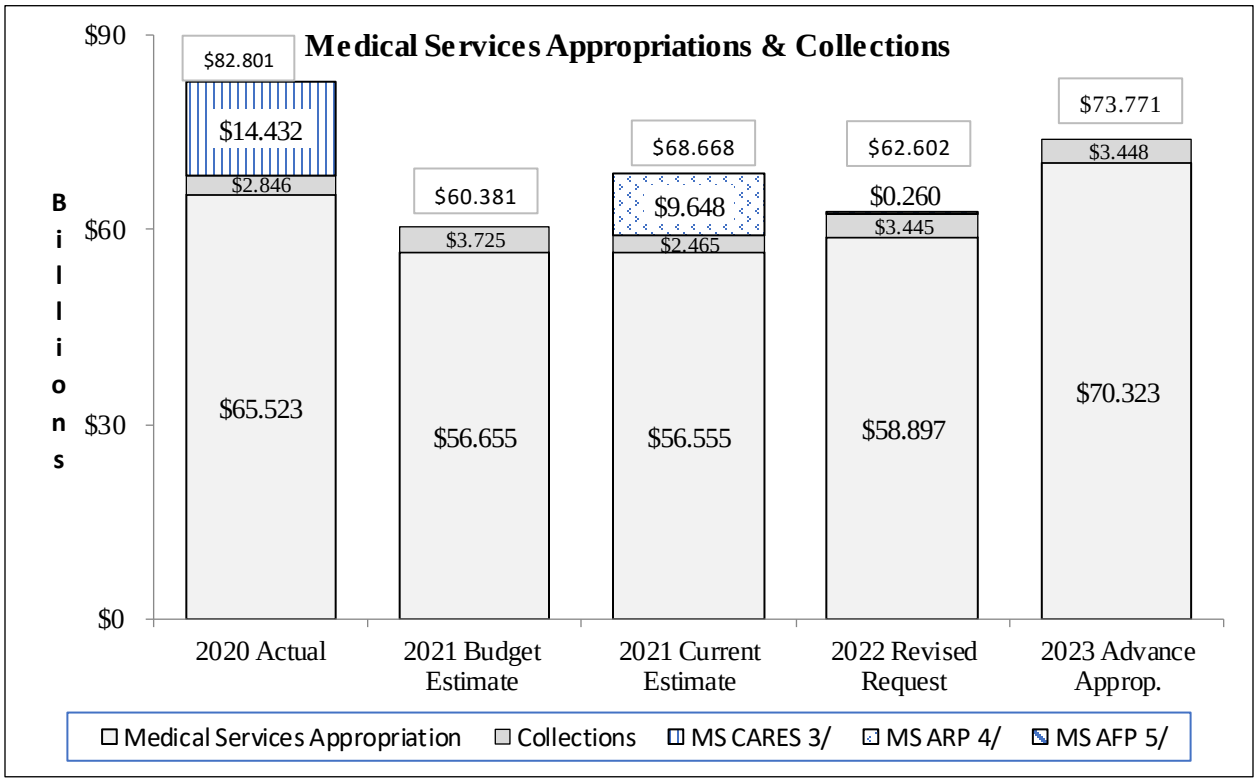
- **$150,000,000 Transfer of 1% to Medical Support and Compliance Emergency Appropriation from Medical Services Appropriation.** This reflects a transfer to Medical Support and Compliance Emergency Appropriation from Medical Services Emergency Appropriation of less than 2%. The authority for this transfer is provided in the Coronavirus Aid, Relief, and Economic Security Act (Public Law 116-136), Division B, Title III, Section 20001, signed on March 27, 2020. The transfers supported the funding necessary to cover administrative costs to prevent, prepare to, and respond to coronavirus, domestically and internationally, including related impacts on health care delivery.

- **$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 this transfer is provided in the Energy and Water, Legislative Branch, and Military Construction and Department of Veterans Affairs Appropriation, 2019, (Public Law 115-244), Division C, Title II, Section 222 signed on September 21, 2018.

- **$306,629,000 Transfer to Joint DoD–VA Medical Facility Demonstration Fund**. This reflects transfers to the Joint DoD–VA Medical Facility Demonstration Fund from Medical Services ($210,309,000), Medical Community Care ($27,651,000), Medical Support and Compliance ($29,424,000), and Medical Facilities ($39,245,000). The authority for this transfer is provided in the Further Consolidated Appropriation Act, 2020, (Public Law 116-94), Division F, Title II, Section 219, signed on December 20, 2019. 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.

Medical Services

Chart: Medical Services Appropriations and Collections[1 2],
(dollars in millions)



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

2/ The 2020 Actuals and 2021 Current Estimate reflect the $350 million and $100 million rescissions to unobligated balances, respectively.

3/ This includes by the Families First Coronavirus Response Act (P.L. 116-127) and CARES Act (P.L. 116-136) pre-transfers to other VA accounts.

4/ Medical Services American Rescue Plan Act includes the allocation from the Veterans Medical Care and Health Fund (VMCHF), established to execute Section 8002 of the American Rescue Plan Act, as well as the estimated allocation of funding provided by Section 8007 of the ARP Act for copayments not collected. Final allocations of Section 8002 funding among account-level categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

5/ Medical Services American Families Plan (AFP) includes the requested 2022 mandatory appropriation of $260 million.

Table: Medical Services Discretionary Funding Crosswalk 2020-2023
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Appropriation Medical Services (0160)							
Advance Appropriation Medical Services (0160)	$51,411,165	$56,158,015	$56,158,015	$58,897,219	$70,323,116	$2,739,204	$11,425,897
Annual Appropriation Adjustment Medical Services (0160)	$0	$497,468	$497,468	$0	$0	($497,468)	$0
Rescission (P.L. 116-94) (P.L.116-260)	($350,000)	$0	($100,000)	$0	$0	$100,000	$0
Families First Coronavirus Response Act (P.L. 116-127)	$30,000	$0	$0	$0	$0	$0	$0
CARES Act (P.L. 116-136)	$14,432,000	$0	$0	$0	$0	$0	$0
Appropriations Request Subtotal	**$65,523,165**	**$56,655,483**	**$56,555,483**	**$58,897,219**	**$70,323,116**	**$2,341,736**	**$11,425,897**
Tranfers To:							
North Chicago Demo. Fund (0169) from Medical Services (0160)	($210,309)	($215,945)	($215,945)	($203,805)	($206,504)	$12,140	($2,699)
DoD-VA Hlth Care Sharing Incentive Fund (0165) from Medical Services (0160)	($15,000)	($15,000)	($15,000)	($15,000)	($15,000)	$0	$0
Medical Support & Compliance (0152) from Medical Services (0160)	($375,000)	$0	$0	$0	$0	$0	$0
CARES Medical Support & Compliance (0152) from Medical Services (0160)	($150,000)	$0	$0	$0	$0	$0	$0
CARES Unob. Bal. to MCC (0140) (PL 116-260 §517)	$0	$0	($100,000)	$0	$0	$100,000	$0
CARES Unob. Bal. to VBA/GOE (PL 116-260 §515)	$0	$0	($198,000)	$0	$0	$198,000	$0
CARES Unob. Bal. to OI&T (PL 116-260 §515)	$0	$0	($45,000)	$0	$0	$45,000	$0
CARES Unob. Bal. to VBA/GOE (PL 116-260 §514)	$0	$0	($140,000)	$0	$0	$140,000	$0
CARES Unob. Bal. to NCA (PL 116-260 §514)	$0	$0	($12,000)	$0	$0	$12,000	$0
CARES Unob. Bal. to BVA (PL 116-260 §514)	$0	$0	($1,000)	$0	$0	$1,000	$0
CARES Unob. Bal. to Canteen (PL 116-159 §163)	$0	$0	($140,000)	$0	$0	$140,000	$0
Transfers To [Subtotal]	($750,309)	($230,945)	($866,945)	($218,805)	($221,504)	$648,140	($2,699)
Collections:							
Transfer from Medical Care Collections Fund (5287)	$2,846,297	$3,725,176	$2,464,526	$3,445,122	$3,447,550	$980,596	$2,428
Collections [Subtotal]	$2,846,297	$3,725,176	$2,464,526	$3,445,122	$3,447,550	$980,596	$2,428
Budget Authority Total	$67,619,153	$60,149,714	$58,153,064	$62,123,536	$73,549,162	$3,970,472	$11,425,626
Reimbursements Medical Services (0160)	$124,257	$137,472	$124,257	$124,257	$124,257	$0	$0
						$0	$0
Unobligated Balance (SOY):						$0	$0
No-Year Medical Services (0160)	$964,347	$0	$1,218,065	$1,323,000	$0	$104,935	($1,323,000)
H1N1 No-Year (PL 111-32)	$0	$0	$7	$0	$0	($7)	$0
2-Year (Medical Services)	$1,117,755	$0	$853,821	$1,500,000	$0	$646,179	($1,500,000)
2-Year (P.L. 116-136)	$0	$0	$10,388,429	$0	$0	($10,388,429)	$0
Unobligated Balance (SOY) [Subtotal]	$2,082,102	$0	$12,460,322	$2,823,000	$0	$751,107	($2,823,000)
Transfer of Unobligated Balance (PL 116-136 §20001)							
CARES Unob. Bal. to MCC (0140) (PL 116-136 §20001)	$0	$0	($3,400,000)	$0	$0	$3,400,000	$0
CARES Unob. Bal. to MSC (0152) (PL 116-136 §20001)	$0	$0	($75,000)	$0	$0	$75,000	$0
CARES Unob. Bal. to MF (0162) (PL 116-136 §20001)	$0	$0	($100,000)	$0	$0	$100,000	$0
Unobligated Balance (EOY):							
No-Year Medical Services (0160)	($1,218,065)	$0	($1,323,000)	$0	$0	$1,323,000	$0
H1N1 No-Year (PL 111-32)	($7)	$0	$0	$0	$0	$0	$0
2-Year (Medical Services)	($853,821)	$0	($1,500,000)	$0	$0	$1,500,000	$0
2-Year (P.L. 116-136)	($10,388,429)	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($12,460,322)	$0	($2,823,000)	$0	$0	$2,823,000	$0
Lapse Medical Services (0160)	($4,696)	$0	$0	$0	$0	$0	$0
Subtotal	$57,360,494	$60,287,186	$64,339,643	$65,070,793	$73,673,419	$731,150	$8,602,626
Prior Year Recoveries	$94,328	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0160) [Subtotal]	**$57,454,822**	**$60,287,186**	**$64,339,643**	**$65,070,793**	**$73,673,419**	**$731,150**	**$8,602,626**

Table: Medical Services Mandatory Funding Crosswalk 2020-2023
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Veterans Medical Care and Health Fund (0173MS) 1/							
Mandatory Appropriation, Section 8002	$0	$0	$9,020,443	$0	$0	($9,020,443)	$0
Unobligated Balance (SOY)	$0	$0	$0	$9,020,443	$0	$9,020,443	($9,020,443)
Unobligated Balance (EOY)	$0	$0	($9,020,443)	$0	$0	$9,020,443	$0
Obligations, ARP Act Section 8002 (0173MS) [Total]	$0	$0	$0	$9,020,443	$0	$9,020,443	($9,020,443)
ARP Act Section 8007 (0160XP)							
Mandatory Appropriation, Section 8007	$0	$0	$627,900	$0	$0	$0	$0
Unobligated Balance (SOY)	$0	$0	$0	$627,900	$0	$627,900	($627,900)
Unobligated Balance (EOY)	$0	$0	($627,900)	$0	$0	$627,900	$0
Obligations, ARP Act Section 8007 (0160XP) [Total]	$0	$0	$0	$627,900	$0	$627,900	($627,900)
American Rescue Plan Act Obligations [Subtotal]	**$0**	**$0**	**$0**	**$9,648,343**	**$0**	**$9,648,343**	**($9,648,343)**
American Families Plan							
Mandatory Appropriation Request, AFP	$0	$0	$0	$260,000	$0	$260,000	($260,000)
Unobligated Balance (SOY)	$0	$0	$0	$0	$230,000	$0	$230,000
Unobligated Balance (EOY)	$0	$0	$0	($230,000)	($200,000)	($230,000)	$30,000
Obligations, AFP [Total]	$0	$0	$0	$30,000	$30,000	$30,000	$0
VACAA, Section 801 (0160XA)							
Unobligated Balance (SOY):							
No-Year	$24,699	$1,525	$25,089	$22,813	$20,448	($2,276)	($2,365)
Unobligated Balance (EOY):							
No-Year	($25,089)	$0	($22,813)	($20,448)	($18,277)	$2,365	$2,171
Subtotal	($390)	$1,525	$2,276	$2,365	$2,171	$89	($194)
Prior Year Recoveries	$2,581	$0	$0	$0	$0	$0	$0
Obligations (0160XA) [Total]	$2,191	$1,525	$2,276	$2,365	$2,171	$89	($194)
Mandatory Budget Authority [Subtotal]	$0	$0	$9,648,343	$260,000	$0	($8,760,443)	($260,000)
Mandatory Obligations [Subtotal]	**$2,191**	**$1,525**	**$2,276**	**$9,680,708**	**$32,171**	**$9,678,432**	**($9,648,537)**
Budget Authority [Grand Total]	$67,619,153	$60,149,714	$67,801,407	$62,383,536	$73,549,162	$3,970,472	$11,165,626
Obligations [Grand Total]	**$57,457,013**	**$60,288,711**	**$64,341,919**	**$74,751,501**	**$73,705,590**	**$10,409,582**	**($1,045,911)**
FTE							
Medical Services (0160)	256,891	265,156	269,090	256,891	284,791	(12,199)	27,900
Veterans Medical Care and Health Fund (0173MS)	0	0	0	27,900	0	27,900	(27,900)
American Families Plan	0	0	0	160	160	160	0
VACAA, Section 801 (0160XA)	6	0	6	6	6	0	0
FTE [Total]	256,897	265,156	269,096	284,957	284,957	15,861	0

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 2022 funding allocations among account-level categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Summary of 2022 Revised Request

The Department of Veterans Affairs (VA) is not requesting additional discretionary resources for Medical Services above the enacted 2022 Advance Appropriation of $58.9 billion. In 2022, VA projects obligating $9.6 billion out of unobligated balances provided by sections 8002 and 8007 of the American Rescue Plan Act for activities traditionally funded by the Medical Services

discretionary appropriation, as authorized in the Act. In addition, the 2022 Budget requests $260 million in support of the President's American Families Plan. With a growing population of women Veterans and younger Veterans, VA is committed to providing additional support to Veterans who are parents in order to offer a holistic, family-friendly approach to care. The proposal would place a Family Coordinator at each VA medical center, an expert in resources for children and families who would provide additional referrals, supports, and connections for Veteran parents. Of this amount, VA projects obligating $30 million in 2022, with the total amount obligated over ten years.

When these resources are combined with available anticipated collections, transfers, reimbursements, and other net unobligated balances, Medical Services will meet the projected 2022 obligation level of $74.8 billion, as detailed in the tables below.

Table: Update to the 2022 Advance Appropriation Request

(dollars in thousands)

		Available Discretionary Funding				Available Mand. Funding					
						Net Use of Unobl. Balances					
Description	2022 Revised Estimate	Enacted AA Incl. Transfers	Collections	Reimb.	Use of Unobl. Balances Discretionary	VACAA 801	Use of Unobl. Balances ARP - 8002	Use of Unobl. Balances ARP - 8007	American Familes Plan	Subtotal	Mandatory Approp. Request
Health Care Services:											
Health Care Services [Total]	$66,914,361	$52,489,694	$3,090,274	$124,257	$2,532,362	$2,121	$8,047,753	$627,900	$0	$66,914,361	**$0**
Non-Add included Throughout:											
Activations	*$609,608*	*$609,608*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$609,608*	***$0***
Beneficiary Travel	*$1,009,100*	*$959,657*	*$49,443*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$1,009,100*	***$0***
Medical Equipment	*$1,746,224*	*$0*	*$0*	*$0*	*$0*	*$0*	*$1,746,224*	*$0*	*$0*	*$1,746,224*	***$0***
Medical Staffing	*$40,578,346*	*$30,768,215*	*$2,952,511*	*$98,416*	*$2,823,000*	*$1,604*	*$3,934,600*	*$0*	*$0*	*$40,578,346*	***$0***
Pharmacy	*$10,424,057*	*$8,880,968*	*$443,168*	*$25,841*	*$0*	*$761*	*$1,073,319*	*$0*	*$0*	*$10,424,057*	***$0***
Prosthetics	*$4,934,411*	*$4,934,098*	*$0*		*$0*	*$0*	*$313*	*$0*	*$0*	*$4,934,411*	***$0***
Long-Term Services and Supports:											
VA Long-Term Services and Supports [Total]	$4,516,501	$3,384,081	$354,848	$0	$290,638	$244	$486,690	$0	$0	$4,516,501	**$0**
Other Health Care Programs:											
CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers	$489,308	$489,308	$0	$0	$0	$0	$0	$0	$0	$489,308	**$0**
Caregivers (Including CHAMPVA))	$1,347,933	$1,347,933	$0	$0	$0	$0	$0	$0	$0	$1,347,933	**$0**
Camp Lejeune - Family	$29	$29	$0	$0	$0	$0	$0	$0	$0	$29	**$0**
Homeless Grants	$1,189,986	$703,986	$0	$0	$0	$0	$486,000	$0	$0	$1,189,986	**$0**
Readjustment Counseling	$263,383	$263,383	$0	$0	$0	$0	$0	$0	$0	$263,383	**$0**
Other Health Care Programs [Total]	$3,290,639	$2,804,639	$0	$0	$0	$0	$486,000	$0	$0	$3,290,639	**$0**
VA Legislative Proposals:											
American Families Plan	$30,000	$0	$0	$0	$0	$0	$0	$0	($230,000)	($230,000)	**$260,000**
Obligations [Total]	$74,751,501	$58,678,414	$3,445,122	$124,257	$2,823,000	$2,365	$9,020,443	$627,900	($230,000)	$74,491,501	**$260,000**

Table: Medical Services Discretionary Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Health Care Services:							
Health Care Services without Families First Act and CARES Act	$47,806,517	$53,845,573	$51,876,287	$58,236,587	$65,721,269	$6,360,300	$7,484,682
Health Care Services - Families First Act and CARES Act Only	$3,088,062	$0	$5,544,416	$0	$0	($5,544,416)	$0
Health Care Services [Total]	**$50,894,579**	**$53,845,573**	**$57,420,703**	**$58,236,587**	**$65,721,269**	**$815,884**	**$7,484,682**
Non-Add included above:							
Activations	*$98,952*	*$447,856*	*$447,856*	*$609,608*	*$340,000*	*$161,752*	*($269,608)*
Beneficiary Travel	*$878,821*	*$1,080,235*	*$972,410*	*$1,009,100*	*$1,049,500*	*$36,690*	*$40,400*
Medical Contracts	*$4,922,906*	*$6,288,133*	*$6,741,954*	*$9,381,659*	*$11,918,234*	*$2,639,705*	*$2,536,575*
Medical Equipment	*$1,943,603*	*$854,000*	*$2,679,557*	*$0*	*$316,807*	*($2,679,557)*	*$316,807*
Medical Staffing	*$34,517,004*	*$36,362,064*	*$37,099,900*	*$36,642,142*	*$41,920,658*	*($457,758)*	*$5,278,516*
Pharmacy	*$8,176,024*	*$9,250,101*	*$9,415,355*	*$9,349,216*	*$11,292,166*	*($66,139)*	*$1,942,950*
Prosthetics	*$3,153,897*	*$4,072,800*	*$3,962,562*	*$4,934,098*	*$4,797,953*	*$971,536*	*($136,145)*
Long-Term Services and Supports VA Care:							
LTSS without Families First Act and CARES Act	$4,100,487	$3,992,468	$4,020,596	$4,029,567	$4,686,190	$8,971	$656,623
LTSS - CARES Act Only	$197,934	$0	$310,900	$0	$0	($310,900)	$0
VA Long-Term Services and Supports [Total]	**$4,298,421**	**$3,992,468**	**$4,331,496**	**$4,029,567**	**$4,686,190**	**($301,929)**	**$656,623**
Other Health Care Programs VA Care without Families First Act and CARES Act:							
CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers	$380,657	$373,866	$378,072	$489,308	$528,344	$111,236	$39,036
Caregivers (Including CHAMPVA)	$399,453	$1,191,686	$998,404	$1,347,933	$1,744,255	$349,529	$396,322
Camp Lejeune - Family	$329	$0	$29	$29	$0	$0	($29)
Homeless Grants	$526,934	$603,632	$651,472	$703,986	$719,308	$52,514	$15,322
Readjustment Counseling	$222,546	$239,716	$237,354	$263,383	$274,053	$26,029	$10,670
Other Health Care Programs without FF Act and CARES Act [Total]	$1,529,919	$2,408,900	$2,265,331	$2,804,639	$3,265,960	$539,308	$461,321
Homeless Grants - CARES Act Only	$637,575	$0	$322,113	$0	$0	($322,113)	$0
VA Legislative Proposals /1:							
Total	$0	$40,245	$0	$0	$0	$0	$0
Obligations without Families First Act and CARES Act [Subtotal]	$53,436,923	$60,287,186	$58,162,214	$65,070,793	$73,673,419	$6,908,579	$8,602,626
Obligations - Families First Act and CARES Act Only [Subtotal]	$3,923,571	$0	$6,177,429	$0	$0	($6,177,429)	$0
Obligations [Total]	**$57,360,494**	**$60,287,186**	**$64,339,643**	**$65,070,793**	**$73,673,419**	**$731,150**	**$8,602,626**
VA Prior-Year Recoveries	$94,328	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	$57,454,822	$60,287,186	$64,339,643	$65,070,793	$73,673,419	$731,150	$8,602,626

1/ For detail on the 2022 Legislative Proposals, please see the Legislative Proposal chapter in Volume 1.

Table: Medical Services Mandatory Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Health Care Services:							
Health Care Services - Veterans Medical Care and Health Fund	$0	$0	$0	$8,047,753	$0	$8,047,753	($8,047,753)
Health Care Services - American Rescue Plan Act, Section 8007	$0	$0	$0	$627,900	$0	$627,900	($627,900)
Health Care Services - VACAA Section 801	($616)	$1,425	$2,042	$2,121	$1,947	$79	($174)
Health Care Services [Total]	**($616)**	**$1,425**	**$2,042**	**$8,677,774**	**$1,947**	**$8,675,732**	**($8,675,827)**
Non-Add included above:							
Activations	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Beneficiary Travel	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Medical Contracts	*($1,830)*	*$0*	*$0*	*$2,443,769*	*$0*	*$2,443,769*	*($2,443,769)*
Medical Equipment	*($3,315)*	*$0*	*$0*	*$1,746,224*	*$0*	*$1,746,224*	*($1,746,224)*
Medical Staffing	*$1,486*	*$0*	*$1,544*	*$3,952,204*	*$1,667*	*$3,950,660*	*($3,950,537)*
Pharmacy	*$3,269*	*$0*	*$732*	*$1,074,080*	*$504*	*$1,073,348*	*($1,073,576)*
Prosthetics	*$0*	*$0*	*$0*	*$313*	*$0*	*$313*	*($313)*
Long-Term Services and Supports VA Care:							
LTSS - Veterans Medical Care and Health Fund	$0	$0	$0	$486,690	$0	$486,690	($486,690)
LTSS - VACAA Section 801	$226	$100	$234	$244	$224	$10	($20)
VA Long-Term Services and Supports [Total]	**$226**	**$100**	**$234**	**$486,934**	**$224**	**$486,700**	**($486,710)**
Other Health Care Programs VA Care - Veterans Medical Care and Health Fund							
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	$486,000	$0	$486,000	($486,000)
Readjustment Counseling	$0	$0	$0	$0	$0	$0	$0
Other Health Care Programs - VCMF [Total]	$0	$0	$0	$486,000	$0	$486,000	($486,000)
VA Legislative Proposals /1:							
American Families Plan	$0	$0	$0	$30,000	$30,000	$30,000	$0
Obligations - Veterans Medical Care and Health Fund [Subtotal]	$0	$0	$0	$9,020,443	$0	$9,020,443	($9,020,443)
Obligations - American Rescue Plan Act [Subtotal]	$0	$0	$0	$627,900	$0	$627,900	($627,900)
Obligations - VACAA Section 801 [Subtotal]	($390)	$1,525	$2,276	$2,365	$2,171	$89	($194)
Obligations [Total]	**($390)**	**$1,525**	**$2,276**	**$9,650,708**	**$2,171**	**$9,648,432**	**($9,648,537)**
VA Prior-Year Recoveries	$2,581	$0	$0	$0	$0	$0	$0
Obligations [Grand Total]	$2,191	$1,525	$2,276	$9,680,708	$32,171	$9,678,432	($9,648,537)

Table: Medical Services Total Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Health Care Services:							
Health Care Services [Total]	$50,893,963	$53,846,998	$57,422,745	$66,914,361	$65,723,216	$9,491,616	($1,191,145)
Non-Add included above:							
Activations	*$98,952*	*$447,856*	*$447,856*	*$609,608*	*$340,000*	*$161,752*	*($269,608)*
Beneficiary Travel	*$878,821*	*$1,080,235*	*$972,410*	*$1,009,100*	*$1,049,500*	*$36,690*	*$40,400*
Medical Contracts	*$4,921,076*	*$6,288,133*	*$6,741,954*	*$11,825,428*	*$11,918,234*	*$5,083,474*	*$92,806*
Medical Equipment	*$1,940,288*	*$854,000*	*$2,679,557*	*$1,746,224*	*$316,807*	*($933,333)*	*($1,429,417)*
Medical Staffing	*$34,518,490*	*$36,362,064*	*$37,101,444*	*$40,594,346*	*$41,922,325*	*$3,492,902*	*$1,327,979*
Pharmacy	*$8,179,293*	*$9,250,101*	*$9,416,087*	*$10,423,296*	*$11,292,670*	*$1,007,209*	*$869,374*
Prosthetics	*$3,153,897*	*$4,072,800*	*$3,962,562*	*$4,934,411*	*$4,797,953*	*$971,849*	*($136,458)*
Long-Term Services and Supports VA Care:							
VA Long-Term Services and Supports [Total]	$4,298,647	$3,992,568	$4,331,730	$4,516,501	$4,686,414	$184,771	$169,913
Other Health Care Programs VA Care:							
CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers	$380,657	$373,866	$378,072	$489,308	$528,344	$111,236	$39,036
Caregivers (Including CHAMPVA)	$399,453	$1,191,686	$998,404	$1,347,933	$1,744,255	$349,529	$396,322
Camp Lejeune - Family	$329	$0	$29	$29	$0	$0	($29)
Homeless Grants	$1,164,509	$603,632	$973,585	$1,189,986	$719,308	$216,401	($470,678)
Readjustment Counseling	$222,546	$239,716	$237,354	$263,383	$274,053	$26,029	$10,670
Other Health Care Programs [Total]	$2,167,494	$2,408,900	$2,587,444	$3,290,639	$3,265,960	$703,195	($24,679)
VA Legislative Proposals:							
Total	$0	$40,245	$0	$30,000	$30,000	$30,000	$0
Obligations [Subtotal]	**$57,360,104**	**$60,288,711**	**$64,341,919**	**$74,751,501**	**$73,705,590**	**$10,409,582**	**($1,045,911)**
VA Prior-Year Recoveries	$96,909	$0	$0	$0	$0	$0	$0
Total Obligations	$57,457,013	$60,288,711	$64,341,919	$74,751,501	$73,705,590	$10,409,582	($1,045,911)

In 2022, total obligations are projected to increase by $10.4 billion above the 2021 current estimate in the following areas:

- **Health Care Services (+$9.5 billion).** Ongoing health care services are projected to increase by $3.0 billion, driven largely by increased staffing, pharmacy and prosthetics costs, as well as updated adjustments to reflect anticipated medical equipment requirements. Significant drivers for this increase include the following:

  - **Medical Staffing (+$3.5 billion)**. Medical Services full-time equivalent (FTE) are projected to increase by 15,861 (5.9% above the 2021 current estimate level), allowing VA to accelerate growth in projected appointments at VA facilities. The increase includes support for precision oncology, suicide prevention, and opioid abuse prevention initiatives and increased caregiver support staff.

  - **Medical Contracts (+$5.1 billion).** Medical Services contracts are projected to directly support VA Medical Centers (VAMCs) in meeting their health care workload demand, post-COVID, as deferred care returns to the health care system, and to provide temporary support to VAMCs as they transition to the new electronic health record system (EHRM). 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. Nearly half of the increase is anticipated to be funded by the Veterans Medical Care and Health Fund. Final 2022 funding allocations in the Veterans Medical Care and Health Fund among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

- **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 (+$972 million).** Estimates are based on the latest programmatic trends.

- **Medical Equipment (-$933 million).** This adjustment reflects a return to a minimum historic level of annual equipment purchases, following the significant increase in 2021 that occurred due to the pandemic.

- **Long-Term Services and Support (+$185 million).** Estimates are projected to increase due latest demographic trends and modes of care delivery.

- **Other Health Care Programs (+$703 million).** VA-provided health service programs not projected by the Enrollee Health Care Projection Model (EHCPM) are expected to yield a net increase of $703 million, driven largely by Caregiver program costs associated with the MISSION Act expanded eligibility.

- **American Families Plan Legislative Proposal (+$30 million).** VA anticipates obligating $30 million in 2022 in support of the President's American Families Plan to provide additional support to Veterans who are parents in order to offer a holistic, family-friendly approach to care.

Summary of the 2023 Advance Appropriation Request

The Medical Services discretionary advance appropriations request is $70.3 billion, an increase of $11.4 billion from the 2022 revised discretionary request. The 2023 request ensures continuity of Veterans' health care services and sustains VA's increased capacity for care following the pandemic. In 2023, total obligations are projected to be $1.2 billion less than total obligations in 2022. VA projects that a significant amount of health care that was delayed during the pandemic will return to the VA health care system in 2022, coupled with the return of care to pre-pandemic levels. The infusion of funding included in the American Rescue Plan Act provides VA with the resources necessary to address total demand in 2022. After VA addresses the return of deferred care, the Department projects that growth in workload levels will stabilize in comparison to pre-pandemic levels, thus requiring fewer total resources in 2023.

In 2023, total obligations are projected to decrease by $1.0 billion from the 2022 revised request level in the following areas:

- **Health Care Services (-$1.2 billion).** Significant drivers of this change are the following:

    - **Medical Staffing (+$1.3 billion)**. Medical Services FTE are projected to remain at the 2022 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 (+$92 million).** Medical Services contracts are projected to continue to directly support 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. Final 2023 funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022 and 2023.

    - **Pharmacy (+$869 million)**. Estimates are increased to reflect the latest actuarial and programmatic trends which include growing outpatient prescription demand and price inflation.

    - **Prosthetics (-$136 million).** Estimates are based on the latest programmatic trends.

    - **Medical and Dental Supplies (-$1.0 billion)**. Supplies are projected to decrease after VAMCs fully meet the post-COVID, deferred care returning health care workload demand and fulfill the regional readiness center stockpile in 2022. The regional readiness centers build resiliency into VA's internal supply chain to enable the Veterans Health Administration (VHA) to sustain continuous services to Veterans even when there are interruptions in support from the commercial supply chain.

    - **Medical Equipment (-$1.4 billion).** This adjustment reflects funding required for VA to begin the fiscal year. The overall equipment needs of the agency will be reassessed during the 2023 budget cycle.

    - **Activations (-$270 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 2023 budget cycle.

- **Long-Term Services and Supports (+$170 million).** Estimates reflect the latest programmatic trends and modes of care delivery.

- **Other Health Care programs (-$24 million).** The decrease is largely driven by the Homeless Program pandemic response concluding.

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 by balancing services provided by VA and the community, 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 2022 that will target resources to improve Veterans' access to timely, high-quality care through an expanded telehealth program, improved care coordination, and targeted hiring. 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.

- Telehealth Expansion: Many Veterans prefer the convenience, timeliness, and efficiency of telehealth appointments. VA will augment its clinical resource telehealth hubs with 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.

- 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.

The 2022 request supports meeting the workload demand created by the pandemic in 2022 by increasing staff and resources to ensure VA provides timely primary care, specialty care, and care coordination with community providers. The Budget also requests funds to expand eligibility for VA's caregiver benefit program.

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

Activations 1/
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations	$98,952	$447,856	$447,856	$609,608	$340,000	$161,752	($269,608)
Medical Services Obligations [Grand Total]	**$98,952**	**$447,856**	**$447,856**	**$609,608**	**$340,000**	**$161,752**	**($269,608)**

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

VA Medical Equipment 1/
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations	$1,943,603	$854,000	$2,679,557	$0	$316,807	($2,679,557)	$316,807
Mandatory Obligations (including VMCHF)	($3,315)	$0	$0	$1,746,224	$0	$1,746,224	($1,746,224)
Obligations [Grand Total]	**$1,940,288**	**$854,000**	**$2,679,557**	**$1,746,224**	**$316,807**	**($933,333)**	**($1,429,417)**

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.

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 $1,000,000 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 $1,000,000. 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 $9.8 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; providing leadership, consultation, and expertise in technology management configuration; and the deployment, commissioning, technical sustainment, and technical refresh of medical equipment and clinical systems in VHA. The Healthcare Technology Management Office manages this program on behalf of the AUSH-S and is accountable, in coordination with Biomedical Engineering field operations managers, for program execution and oversight.

VHA deployed approximately 149,000 new medical devices, worth $950 million, during 2020 to refresh VHA's health technology infrastructure. VHA business process and systems re-engineering initiatives enhance clinical capabilities, patient safety and access to care, and medical technology cybersecurity.

Medical Services funding in 2022 will address medical equipment replacement deferred for replacement during the pandemic. Modernizing VHA's medical equipment, while improving its safety, cybersecurity, and compatibility with VA's EHR, requires deliberate systems engineering and extensive collaboration across VA lines of business and VHA clinical programs.

Plans for New and Replacement Equipment in 2021-2023

Medical equipment and health technology refresh are based on a lifecycle replacement model applied to existing VHA medical equipment. The model incorporates equipment lifespans based upon clinical utility of equipment, evolving clinical functionality, and technical supportability. Equipment lifecycle management also facilitates strategic sourcing of medical technology. 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 Veterans Integrated Services Network (VISN) and fiscal year.

VA's response to the COVID-19 pandemic prompted adjustment of planned medical equipment replacement in FY 2020. The pandemic demanded near exclusive management attention and curtailed otherwise-programmed activities. Resources were shifted to assure capacity and capability to treat critically ill Veterans and VA Fourth Mission patients. Additionally, in the coming years, VA will upgrade or replace medical equipment and clinical systems to be compliant with the new Cerner EHR interface requirements.

Impact of VA Medical Equipment on Medical Care and Staff Productivity

Medical equipment is foundational to the provision of healthcare for Veterans. Some examples of lifesaving equipment are 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 induce and maintain anesthesia in surgical patients; and laboratory analyzers that determine blood glucose measurements.

In response to the most critical and time-sensitive needs, VA deployed new medical equipment at all medical centers and across all clinical programs and sub-specialties in 2020. 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. VA currently uses approximately 1,292,000 discrete medical devices across the enterprise to deliver healthcare to Veterans. Approximately 104,200 medical devices communicate with electronic health records via the VA information technology network and must be specially managed and routinely updated to address known and emerging cybersecurity 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 use of the technology, and systems integration. Medical equipment directly contributes to improving the timeliness of services by ensuring VAMCs have the technology essential to provide medical care to Veterans.

Medical Services Staffing

VA Medical Services Staffing 1/
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations	$34,517,004	$36,362,064	$37,099,900	$36,642,142	$41,920,658	($457,758)	$5,278,516
Mandatory Obligations (including VMCHF)	$1,486	$0	$1,544	$3,936,204	$1,667	$3,934,660	($3,934,537)
Obligations [Grand Total]	**$34,518,490**	**$36,362,064**	**$37,101,444**	**$40,578,346**	**$41,922,325**	**$3,476,902**	**$1,343,979**

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; and
- Health Technicians/Allied Health, such as respiratory therapists, physical therapists, dietitians, social works, radiology technologists, pharmacists, audiologist and speech pathologists, nuclear medicine technologists, and laboratory aids and workers.
- Wage Board/Purchase & Hire;
- All Other

As part of VA's multi-pronged initiative in 2021 and 2022 to improve Veterans' access to timely, high-quality care, and to meet the health care needs presented by the pandemic health, VA will increase VA hiring. Medical Services will have 284,957 FTE in 2022, an increase of 15,861 FTE over the 2021 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 pandemic-induced deferred care. The 2023 FTE level sustains 2022 FTE levels to further meet Veteran demand for VA provided services.

FTE by Type
Medical Services

Account	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary FTE							
Physicians	21,789	23,981	22,179	20,719	22,679	(1,460)	1,960
Dentists	1,195	1,353	1,252	1,175	1,325	(77)	150
Registered Nurses	63,111	65,876	65,959	59,172	69,612	(6,787)	10,440
LP Nurse/LV Nurse/Nurse Assistant	28,262	28,998	29,542	26,009	31,184	(3,533)	5,175
Non-Physician Providers	16,418	15,638	17,445	17,812	18,762	367	950
Health Technicians/Allied Health	77,008	76,754	81,767	82,770	87,870	1,003	5,100
Wage Board/Purchase & Hire	5,671	6,235	5,778	5,690	5,915	(88)	225
All Other	43,437	46,321	45,168	43,544	47,444	(1,624)	3,900
Discretionary Medical Service FTE [Subtotal]	**256,891**	**265,156**	**269,090**	**256,891**	**284,791**	**(12,199)**	**27,900**
Veterans Medical Care and Health Fund							
Mandatory FTE							
Physicians	0	0	0	1,960	0	1,960	(1,960)
Dentists	0	0	0	150	0	150	(150)
Registered Nurses	0	0	0	10,440	0	10,440	(10,440)
LP Nurse/LV Nurse/Nurse Assistant	0	0	0	5,175	0	5,175	(5,175)
Non-Physician Providers	0	0	0	950	0	950	(950)
Health Technicians/Allied Health	0	0	0	5,100	0	5,100	(5,100)
Wage Board/Purchase & Hire	0	0	0	225	0	225	(225)
All Other	0	0	0	3,900	0	3,900	(3,900)
VMCHF FTE [Subtotal]	**0**	**0**	**0**	**27,900**	**0**	**27,900**	**(27,900)**
American Families Plan							
Mandatory FTE							
Non-Physician Providers	0	0	0	160	160	160	0
American Families Plan FTE [Subtotal]	**0**	**0**	**0**	**160**	**160**	**160**	**0**
Veterans Choice Act (P.L. 113-146)							
Section 801							
Mandatory FTE							
Physicians	2	0	2	2	2	0	0
All Other	4	0	4	4	4	0	0
Veterans Choice Act FTE [Subtotal]	**6**	**0**	**6**	**6**	**6**	**0**	**0**
Total Medical Services FTE							
Physicians	21,791	23,981	22,181	22,681	22,681	500	0
Dentists	1,195	1,353	1,252	1,325	1,325	73	0
Registered Nurses	63,111	65,876	65,959	69,612	69,612	3,653	0
LP Nurse/LV Nurse/Nurse Assistant	28,262	28,998	29,542	31,184	31,184	1,642	0
Non-Physician Providers	16,418	15,638	17,445	18,922	18,922	1,477	0
Health Technicians/Allied Health	77,008	76,754	81,767	87,870	87,870	6,103	0
Wage Board/Purchase & Hire	5,671	6,235	5,778	5,915	5,915	137	0
All Other	43,441	46,321	45,172	47,448	47,448	2,276	0
Medical Services FTE [Grand Total[	**256,897**	**265,156**	**269,096**	**284,957**	**284,957**	**15,861**	**0**

VA's Medical Provider Recruitment & Retention Practices

As the Nation's largest integrated health care delivery system, VHA faces workforce challenges similar to those of the health care industry as a whole. 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 2020 accounted for 354,245 FTE of the total 399,674 FTE (88.6%). VHA turnover rates compare favorably with the health care industry, including for those occupations identified as mission critical, such as physician, registered nurse, psychologist, and human resources management. VHA hired a record 43,464 new employees in 2020 for a net increase of just over 13,800 employees and a 4.0% annual growth rate, compared to the 5-year average annual growth rate of 3.1%.

Over the last five years (2016-2020), VHA grew by 50,795 additional health care providers and support staff, the majority of which (60.7%) was in clinical occupations. Of the clinical growth, 68.8% occurred in top clinical staffing shortage occupations. VHA typically hires approximately 2,700 physicians and upwards of 7,500 or more registered nurses annually to replace losses and grow the workforce to meet access standards and provide the best possible care to Veterans.

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; full utilization of the Education Debt Reduction Program (EDRP); 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 Department of Defense (DoD)/VA Transitioning Military Program (TMP) to recruit transitioning service members in health care specialties; and, exhibiting regularly at key healthcare conferences and job fairs.

In 2020, VHA invested over $148 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 human resource

(HR) modernization in 2021. Continuation and expansion of these efforts will ensure that VA achieves its projected growth in 2022.

VA Long-Term Services and Supports Programs

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Services (0160) Institutional							
VA Community Living Centers (VA CLC)	$3,123,118	$2,865,300	$3,044,442	$2,621,543	$3,218,702	($422,899)	$597,159
Medical Services (0160) Non-Institutional							
Community Residential Care	$69,163	$74,500	$75,819	$80,534	$80,406	$4,715	($128)
Home Telehealth	$199,341	$182,900	$191,734	$182,113	$190,230	($9,621)	$8,117
Home-Based Primary Care	$723,837	$700,900	$794,660	$856,508	$908,394	$61,848	$51,886
Spinal Cord Injury & Disability Home Care	$9,631	$10,900	$10,097	$10,421	$10,791	$324	$370
VA Adult Day Health Care	$9,665	$11,600	$9,776	$12,030	$14,494	$2,254	$2,464
Non-Institutional [Subtotal]	**$1,011,637**	**$980,800**	**$1,082,086**	**$1,141,606**	**$1,204,315**	**$59,520**	**$62,709**
Care Coordination for Community Care LTSS programs	$163,666	$146,368	$204,968	$266,418	$263,173	$61,450	($3,245)
Discretionary Obligations [Subtotal]	**$4,298,421**	**$3,992,468**	**$4,331,496**	**$4,029,567**	**$4,686,190**	**($301,929)**	**$656,623**
Mandatory Obligations (including VMCHF)							
Medical Services (0160) Institutional							
VA Community Living Centers (VA CLC)	$158	$100	$164	$448,194	$157	$448,030	($448,037)
Medical Services (0160) Non-Institutional							
Community Residential Care	$0	$0	$0	$1,879	$0	$1,879	($1,879)
Home Telehealth	$0	$0	$0	$6,105	$0	$6,105	($6,105)
Home-Based Primary Care	$68	$0	$70	$29,659	$67	$29,589	($29,592)
Spinal Cord Injury & Disability Home Care	$0	$0	$0	$157	$0	$157	($157)
VA Adult Day Health Care	$0	$0	$0	$157	$0	$157	($157)
Non-Institutional [Subtotal]	**$68**	**$0**	**$70**	**$37,957**	**$67**	**$37,887**	**($37,890)**
Care Coordination for Community Care LTSS programs	$0	$0	$0	$783	$0	$783	($783)
Mandatory Obligations [Subtotal]	**$226**	**$100**	**$234**	**$486,934**	**$224**	**$486,700**	**($486,710)**
Discretionary and Mandatory Obligations							
Medical Services (0160) Institutional							
VA Community Living Centers (VA CLC)	$3,123,276	$2,865,400	$3,044,606	$3,069,737	$3,218,859	$25,131	$149,122
Medical Services (0160) Non-Institutional							
Community Residential Care	$69,163	$74,500	$75,819	$82,413	$80,406	$6,594	($2,007)
Home Telehealth	$199,341	$182,900	$191,734	$188,218	$190,230	($3,516)	$2,012
Home-Based Primary Care	$723,905	$700,900	$794,730	$886,167	$908,461	$91,437	$22,294
Spinal Cord Injury & Disability Home Care	$9,631	$10,900	$10,097	$10,578	$10,791	$481	$213
VA Adult Day Health Care	$9,665	$11,600	$9,776	$12,187	$14,494	$2,411	$2,307
Non-Institutional [Subtotal]	**$1,011,705**	**$980,800**	**$1,082,156**	**$1,179,563**	**$1,204,382**	**$97,407**	**$24,819**
Care Coordination for Community Care LTSS programs	$163,666	$146,368	$204,968	$267,201	$263,173	$62,233	($4,028)
Obligations [Grand Total]	**$4,298,647**	**$3,992,568**	**$4,331,730**	**$4,516,501**	**$4,686,414**	**$184,771**	**$169,913**

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

Other Health Care Programs VA Care
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary							
CHAMPVA Medical Staff, Pharmacy Costs, excludes Caregivers.....	$380,657	$373,866	$378,072	$489,308	$528,344	$111,236	$39,036
Caregivers (Including CHAMPVA).....	$399,453	$1,191,686	$998,404	$1,347,933	$1,744,255	$349,529	$396,322
Camp Lejeune - Family.....	$329	$0	$29	$29	$0	$0	($29)
Homeless Grants.....	$1,164,509	$603,632	$973,585	$703,986	$719,308	($269,599)	$15,322
Readjustment Counseling.....	$222,546	$239,716	$237,354	$263,383	$274,053	$26,029	$10,670
Discretionary Obligations [Subtotal].....	$2,167,494	$2,408,900	$2,587,444	$2,804,639	$3,265,960	$217,195	$461,321
Mandatory (including VMCHF)							
Homeless Grants.....	$0	$0	$0	$486,000	$0	$486,000	($486,000)
Obligations [Total].....	**$2,167,494**	**$2,408,900**	**$2,587,444**	**$3,290,639**	**$3,265,960**	**$703,195**	**($24,679)**

1/ This table only displays obligations for Medical Services; for total obligations across all appropriations please see the Medical Care chapter.

Medical Services FTE and Pharmacy costs associated with the CHAMPVA program remain in the Medical Services Appropriation. 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 Care chapter for more information about these programs.

Medical Services Support for VA- and Community-Provided Care

Beneficiary Travel

Beneficiary Travel 1/
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations.....	$876,915	$1,080,235	$970,300	$1,009,100	$1,049,500	$38,800	$40,400
Discretionary CARES Act Obligations.....	$1,906	$0	$2,110	$0	$0	($2,110)	$0
Obligations [Grand Total].....	**$878,821**	**$1,080,235**	**$972,410**	**$1,009,100**	**$1,049,500**	**$36,690**	**$40,400**

1/ This table displays obligations only in Medical Services. Total funding can be found in the Medical Care chapter, Obligations by Object table.

Beneficiary Travel by Type
(dollars in thousands)

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Beneficiary Travel-Mileage.....	$298,906	$454,202	$456,556	$474,818	$493,811	$18,262	$18,993
Beneficiary Travel-Special Mode.....	$520,290	$546,228	$451,969	$470,048	$488,850	$18,079	$18,802
All Other Beneficiary Travel.....	$70,760	$68,655	$63,885	$64,234	$66,840	$349	$2,605
Beneficiary Travel Total.....	**$889,956**	**$1,069,085**	**$972,410**	**$1,009,100**	**$1,049,500**	**$36,690**	**$40,400**

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 United States Code (U.S.C.), § 111, "Payments or allowances for beneficiary travel," as regulated in 38 Code of Federal Regulations (CFR) §§ 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;
- 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

Pharmacy 1/ 2/
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Medical Services:							
Discretionary Non-CARES Act Obligations	$7,595,945	$9,249,901	$8,742,768	$10,423,296	$11,292,670	$1,680,528	$869,374
Discretionary CARES Act Obligations	$583,348	$0	$673,319	$0	$0	($673,319)	$0
Discretionary Obligations [Subtotal]	**$8,179,293**	**$9,249,901**	**$9,416,087**	**$10,423,296**	**$11,292,670**	**$1,007,209**	**$869,374**
Medical Community Care:							
Discretionary Non-CARES Act Obligations	$44,291	$0	$51,315	$55,471	$59,015	$4,156	$3,544
Discretionary CARES Act Obligations	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal]	**$44,291**	**$0**	**$51,315**	**$55,471**	**$59,015**	**$4,156**	**$3,544**
Medical Support and Compliance:							
Discretionary Non-CARES Act Obligations	$586,085	$705,700	$629,900	$653,300	$743,000	$23,400	$89,700
Discretionary CARES Act Obligations	$4,338	$0	$13,863	$0	$0	($13,863)	$0
Discretionary Obligations [Subtotal]	**$590,423**	**$705,700**	**$643,763**	**$653,300**	**$743,000**	**$9,537**	**$89,700**
Medical Facilities:							
Discretionary Non-CARES Act Obligations	$327,999	$414,300	$367,700	$348,300	$357,800	($19,400)	$9,500
Discretionary CARES Act Obligations	$27,765	$0	$34,902	$0	$0	($34,902)	$0
Discretionary Obligations [Subtotal]	**$355,764**	**$414,300**	**$402,602**	**$348,300**	**$357,800**	**-$54,302**	**$9,500**
Medical Services and Veterans Medical Care and Health Fund:							
Veterans Medical Care and Health Fund	$0	$0	$0	$1,073,319	$0	$1,073,319	-$1,073,319
American Rescue Plan Act, Section 8007	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801	$0	$200	$0	-$1,073,319	$0	-$1,073,319	$1,073,319
Mandatory Obligations [Subtotal]	**$0**	**$200**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Community Care, Veterans Choice Fund, and Veterans Medical Care and Health Fund:							
Veterans Medical Care and Health Fund	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8004	$0	$0	$0	$0	$0	$0	$0
American Rescue Plan Act, Section 8007	$0	$0	$0	$0	$0	$0	$0
Veterans Choice Fund	$0	$500	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$500**	**$0**	**$0**	**$0**	**$0**	**$0**
Medical Support and Compliance and Veterans Medical Care and Health Fund:							
Veterans Medical Care and Health Fund	$0	$0	$0	$54,796	$0	$54,796	-$54,796
VACAA, Section 801	$0	$300	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$300**	**$0**	**$54,796**	**$0**	**$54,796**	**-$54,796**
Medical Facilities and Veterans Medical Care and Health Fund:							
Veterans Medical Care and Health Fund	$0	$0	$0	$228,381	$0	$228,381	-$228,381
VACAA, Section 801	$0	$200	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$200**	**$0**	**$228,381**	**$0**	**$228,381**	**-$228,381**
Discretionary and Mandatory Obligations by Category:							
Medical Services	$8,179,293	$9,250,101	$9,416,087	**$10,423,296**	**$11,292,670**	$1,007,209	$869,374
Medical Community Care and Veterans Choice Fund	$44,291	$500	$51,315	**$55,471**	**$59,015**	$4,156	$3,544
Medical Support and Compliance	$590,423	$706,000	$643,763	**$708,096**	**$743,000**	$64,333	$34,904
Medical Facilities	$355,764	$414,500	$402,602	**$576,681**	**$357,800**	$174,079	-$218,881
Obligations [Grand Total]	**$9,169,771**	**$10,371,101**	**$10,513,767**	**$11,763,544**	**$12,452,485**	**$1,249,777**	**$688,941**

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.
2/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and this table displays estimated allocations by category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Pharmacy Program Data

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Number of 30-Day RXs (Millions).....	301	304	305	309	313	4	4

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 evidenced-based process that places a premium on drug safety and effectiveness and had s 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 (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 replace the Pharmacy VistA system component of VA's Electronic Health Record. VA's Pharmacy Product System (PPS)/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.

Clinical Pharmacy Program Office- The primary focus of this program office is to maximize the utilization of Clinical Pharmacists as advanced practice providers with a scope of practice, thus improving care by performing essential medication management services, enhancing medication safety, and significantly improving chronic disease management in our Veteran population. Since the inception of this program office, there has been a 90% increase in Clinical Pharmacists practicing as advanced practice providers. Additionally, the program office has developed robust and comprehensive data collection tools, including metrics that illustrate both the performance and quality of clinical pharmacy practice in VHA.

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 12,500 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.

Academic Detailing- The mission of the PBM National Academic Detailing Service (ADS) is to innovate strategies to promote evidence-based practices, build relationships with healthcare teams, and resolve barriers to improve Veterans' care through academic detailing. The ADS provides central resources for VA clinical pharmacist specialists to deliver knowledge translation services and eliminate the gap between clinical practice and evidence-based care. The ADS core services include the development of educational resources, hands-on training and clinical informatics tools. The ADS' groundwork on VVC (VA Video Connect) prepared detailers to pivot from in-person face-to-face visits to even more video virtual care during the onset of the COVID-19 pandemic. Each VISN was involved in e-detailing during FY 2020, and in the second half of the year, detailers more than doubled the number of video visits compared to the entirety of FY 2019.

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 Pharmacy Benefits Management (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 Pharmacy Benefits Management (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 is 58%. The enrollee population age 65 and over, for which the VHA collects detailed data, prescription drug reliance by cohort is as follows:

Cohort	2019 Reliance
Enrollees with Medicare Part D	31%
Enrollees with Medicare RDS Coverage	27%
Enrollees without Medicare Part D or RDS Coverage	60%

Regardless of coverage, prescription utilization is lower for enrollees age 65 and over, presumably as enrollees become less reliant on VA health care. Enrollees in Priorities 1a, 1b, and 4 tend to have the highest utilization, while enrollees in Priorities 6 – 8 tend to have the lowest utilization.

Prescription drug reliance was projected to increase by approximately 0.50% in 2020 due to the 14-day Rx Urgent/Emergent adjustment. This amount then trends mildly each year, reaching 0.58% in 2023.

Recent Trends- As expected, the drug ingredient cost per outpatient prescription, the total cost of outpatient prescription drug ingredients, the total number of outpatient prescriptions filled, and the number of Veterans receiving outpatient prescriptions all trended slightly upward from 2018 through 2019 by 3.71%, 13.29%, 2.88%, and 1.35% respectively.

Projected outpatient prescription workload through 2022 is largely driven by demographic changes. An increase in workload is projected due to enrollees transitioning to higher enrollment priority levels over time and aging. The percentage of enrollees is gradually shifting from the younger ages to the older ages in both the under age 65 and ages 65 and over populations and enrollees use more prescriptions as they age.

Prosthetics

Prosthetics 1/
(dollars in thousands)

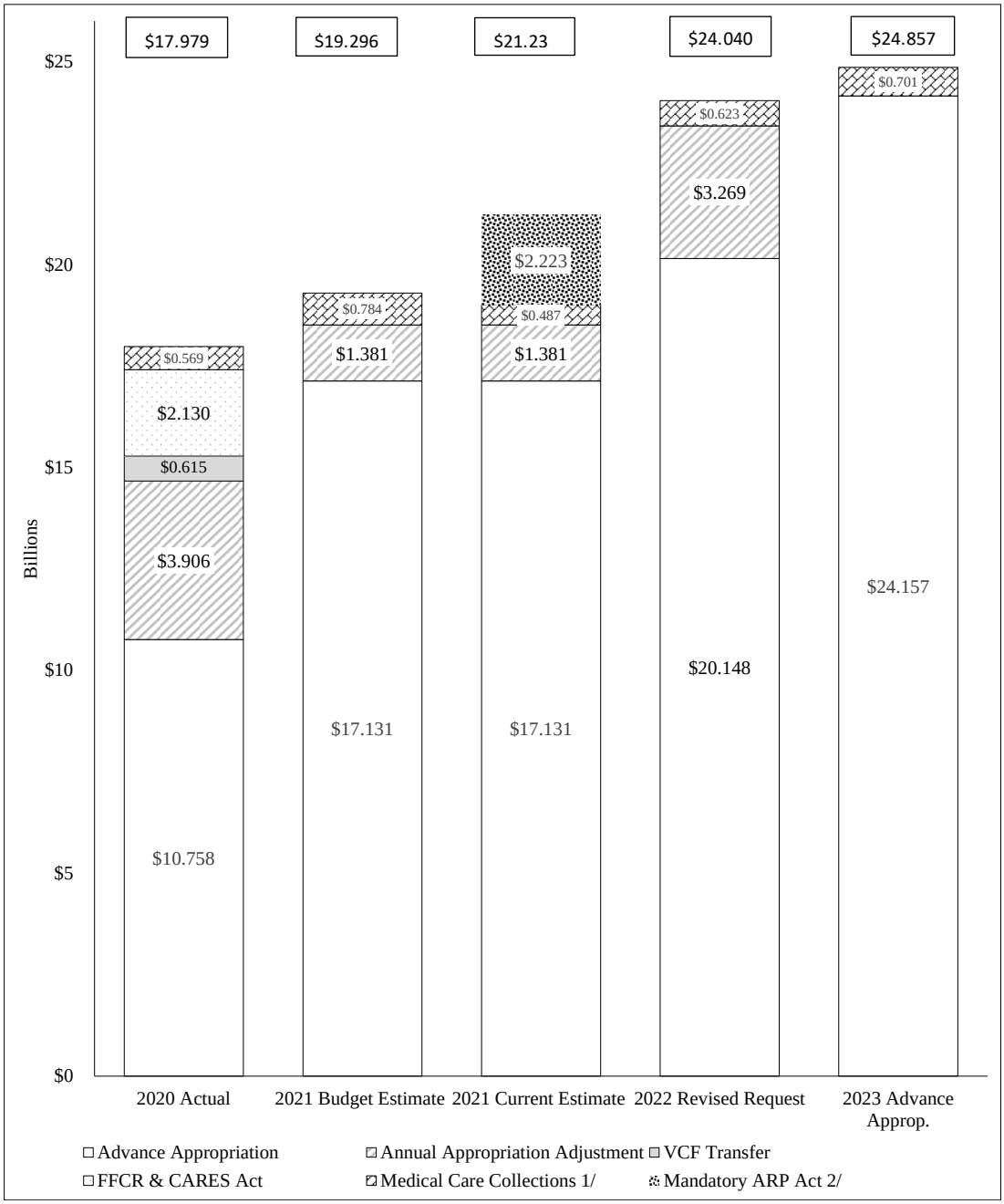
Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations	$3,153,897	$4,072,800	$3,962,562	$4,934,098	$4,797,953	$971,536	($136,145)
Mandatory Obligations (including VMCHF)	$0	$0	$0	$313	$0	$313	($313)
Obligations [Grand Total]	**$3,153,897**	**$4,072,800**	**$3,962,562**	**$4,934,411**	**$4,797,953**	**$971,849**	**($136,458)**

1/ 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 with the remaining obligations in the Veterans Choice Program. The Medical Community Care Appropriation will not fund Prosthetic obligations. Prosthetic and Sensory Aids Services (PSAS) are foundational at the VA. 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

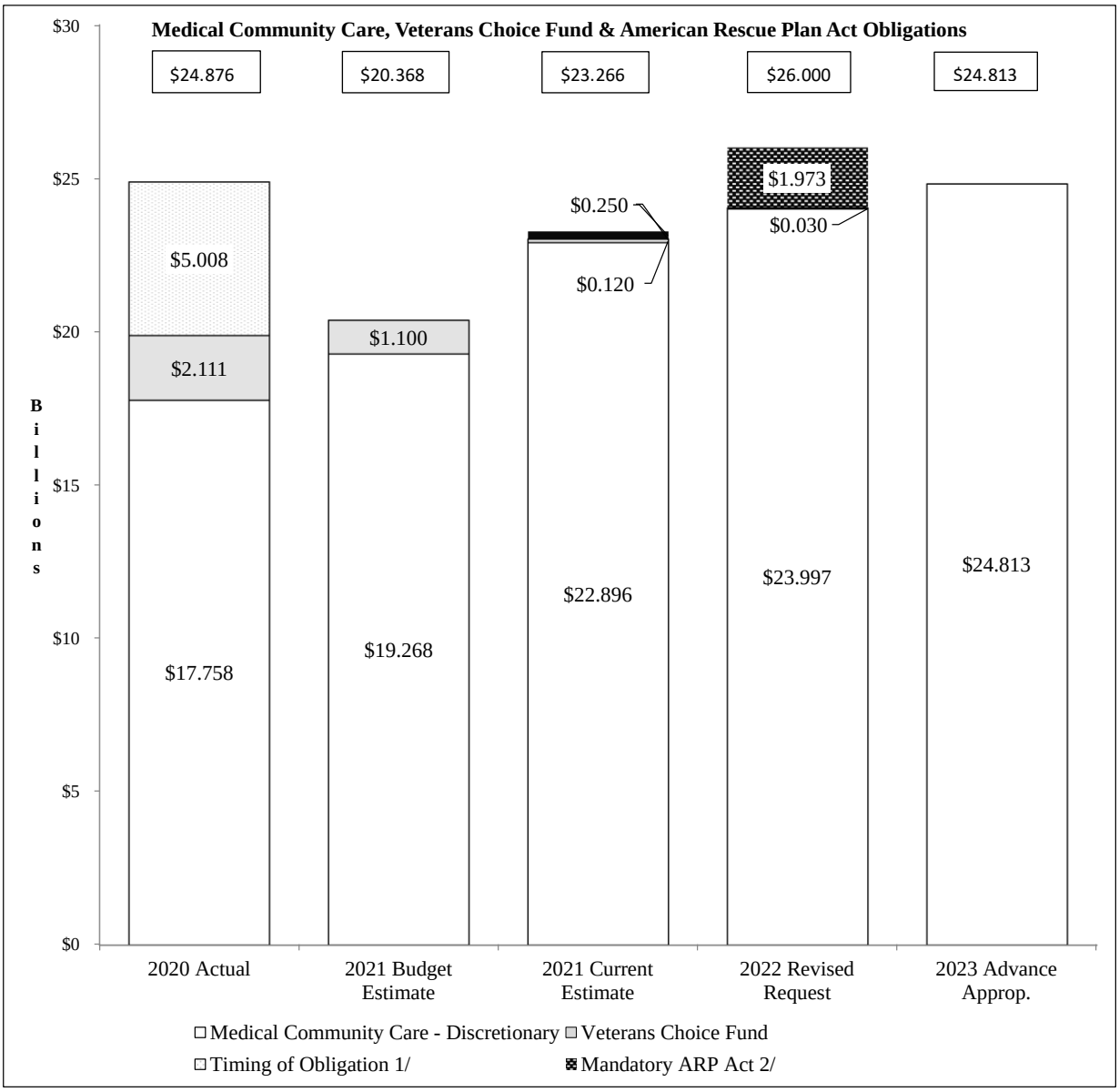
Chart: Medical Community Care Appropriations and Collections
(dollars in billions)



1/ Collections exclude the portion of Medical Care Collections Fund (MCCF) collections actually or anticipated to be transferred to Medical Community Care or the Joint DoD-VA Medical Facility Demonstration Fund, in support of the Captain James A. Lovell Federal Health Care Center (JALFHCC).
2/ Included in this total is the Veterans Medical Care and Health Fund which was established to execute section 8002 of the American Rescue Plan Act, and the chart includes the estimated allocation for the Medical Community Care category. Final funding allocations among account-level categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Providing Veterans with timely access to high quality health care is absolutely essential through a Department of Veterans Affairs (VA) facility or community provider. It is clear that community care will continue to be a key part of how the Department cares for its 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. In the Medical Community Care account, VA is requesting an additional $3.269 billion to supplement the enacted 2022 advance appropriation (AA) and funds made available by the American Rescue Plan Act, and other resources, to fund a revised estimate of community care costs based on 2020 actuals and updated actuarial projections.

Chart: Medical Community Care Obligations
(dollars in billions)



1/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Anti-deficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.

2/ Included in this total is the Veterans Medical Care and Health Fund which was established to execute section 8002 of the American Rescue Plan Act, and the chart includes the estimated allocation for the Medical Community Care

category. Final funding allocations among account-level categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Tables: Community Care Funding Crosswalks 2020-2023
(dollars in thousands)

The following four tables show funding crosswalks for 2020 through 2023 for the VA community care program, separately by funding sources as follows:

- Medical Community Care (MCC), discretionary funding, including emergency discretionary funding provided by the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act and the Families First Coronavirus Response Act
- Veterans Choice Fund (VCF), mandatory funding for Medical Care only
- American Rescue Plan Act, mandatory funding
- MCC, VCR, and American Rescue Plan Act, grand total all funding sources

Table: Medical Community Care (0140) Discretionary Funding Crosswalk 2020-2023
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Appropriation Medical Community Care (0140)							
Advance Appropriation Medical Community Care (0140)	$10,758,399	$17,131,179	$17,131,179	$20,148,244	24,156,659	$3,017,065	$4,008,415
Annual Appropriation Adjustment Medical Community Care (0140)	$3,906,400	$1,380,800	$1,380,800	$3,269,000	$0	$1,888,200	($3,269,000)
Families First Coronavirus Response Act (P.L. 116-127)	$30,000	$0	$0	$0	$0	$0	$0
CARES Act (P.L. 116-136)	$2,100,000	$0	$0	$0	$0	$0	$0
Appropriations Request Subtotal	$16,794,799	$18,511,979	$18,511,979	$23,417,244	$24,156,659	$4,905,265	$739,415
Tranfers To:							
North Chicago Demo. Fund (0169) from Medical Community Care (0140)	($27,651)	($28,392)	($28,392)	($43,768)	($44,348)	($15,376)	($580)
Transfers To [Subtotal]	($27,651)	($28,392)	($28,392)	($43,768)	($44,348)	($15,376)	($580)
Transfers From:							
CARES Unob. Bal.fr.to MCC (0160) (PL 116-260 §517)	$0	$0	$100,000	$0	$0	($100,000)	$0
Veterans Choice Fund (0172)	$615,000	$0	$0	$0	$0	$0	$0
Transfers From [Subtotal]	$615,000	$0	$100,000	$0	$0	$0	$0
Collections:							
MCCF Transfer to Medical Community Care (0140)	$569,139	$784,446	$487,315	$623,228	$700,689	$135,913	$77,461
Collections [Subtotal]	$569,139	$784,446	$487,315	$623,228	$700,689	$135,913	$77,461
Budget Authority Total	$17,951,287	$19,268,033	$19,070,902	$23,996,704	$24,813,000	$4,925,802	$816,296
Unobligated Balance (SOY):							
No-Year Medical Community Care (0140)	$48,806	$0	$9,075	$0	$0	($9,075)	$0
Pre P.L. 116-260 Title XVI section 1601 1/	$0	$0	($5,007,990)	$0	$0	$5,007,990	$0
Post P.L. 116-260 Title XVI section 1601 1/	$0	$0	$5,007,990	$0	$0	($5,007,990)	$0
2-Year	$0	$0	$173,389	$0	$0	($173,389)	$0
2-Year (P.L. 116-136)	$0	$0	$131,132	$0	$0	($131,132)	$0
3-Year (P.L. 116-127)	$0	$0	$30,000	$0	$0	($30,000)	$0
4-Year Base Year 2017	$19,662	$0	$0	$0	$0	$0	$0
4-Year Base Year 2018	$18,278	$0	$7,699	$0	$0	($7,699)	$0
4-Year Base Year 2019	$56,387	$0	$73,988	$0	$0	($73,988)	$0
Unobligated Balance (SOY) [Subtotal]	$143,133	$0	$425,283	$0	$0	($425,283)	$0
Transfer of UNOBLIGATED BALANCE							
CARES Unob. Bal. from MS (0160C2) to MCC (0140C2) (PL 116-136 §20001)	$0	$0	$3,400,000	$0	$0	($3,400,000)	$0
Unobligated Balance (EOY):							
No-Year Medical Community Care (0140)	($9,075)	$0	$0	$0	$0	$0	$0
Pre P.L. 116-260 Title XVI section 1601 1/	$5,007,990	$0	$0	$0	$0	$0	$0
2-Year	($173,389)	$0	$0	$0	$0	$0	$0
2-Year (P.L. 116-136)	($131,132)	$0	$0	$0	$0	$0	$0
3-Year (P.L. 116-127)	($30,000)	$0	$0	$0	$0	$0	$0
4-Year Base Year 2018	($7,699)	$0	$0	$0	$0	$0	$0
4-Year Base Year 2019	($73,988)	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	$4,582,707	$0	$0	$0	$0	$0	$0
Subtotal	$22,677,127	$19,268,033	$22,896,185	$23,996,704	$24,813,000	$1,100,519	($48,809,704)
Prior Year Recoveries	$88,626	$0	$0	$0	$0	$0	$0
Obligations (0140) [Total]	$22,765,753	$19,268,033	$22,896,185	$23,996,704	$24,813,000	$1,100,519	$816,296
Obligations Post P.L. 116-260 Title XVI section 1601 2/	*$17,757,763*						

1/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Anti-deficiency

Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.
2/ To provide for a comparable program obligations level from year-to-year, the obligations level shown in this row removes the obligations that VA recorded in September 2020 to comply with the VA OGC opinion on recording of Community Care obligations.

Table: Veterans Choice Fund (0172) Medical Care Only Crosswalk [1/]

(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate 1/	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Appropriation Veterans Choice Fund (0172)							
Appropriation	$0	$0	$0	$0	$0	$0	$0
Appropriation [Subtotal]	$0	$0	$0	$0	$0	$0	$0
Budget Authority Total	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY):							
Pre P.L. 116-260 Title XVI section 1601 2/	($397,400)	$0	($397,400)	$0	$0	$397,400	$0
Post P.L. 116-260 Title XVI section 1601 2/	$0	$0	$397,400	$0	$0	($397,400)	$0
No-Year	$2,521,923	$1,100,000	$149,690	$30,000	$0	($119,690)	($30,000)
Unobligated Balance (SOY) [Subtotal]	$2,124,523	$1,100,000	$149,690	$30,000	$0	($119,690)	($30,000)
Transfer of Unobligated Balance To Medical Community Care	($605,873)	$0	$0	$0	$0	$0	$0
Transfer of Unobligated Balances within Veterans Choice Fund	$8,820	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY):							
Pre P.L. 116-260 Title XVI section 1601 2/	$397,400	$0	$0	$0	$0	$0	$0
No-Year	($149,690)	$0	($30,000)	$0	$0	$30,000	$0
Unobligated Balance (EOY) [Subtotal]	$247,710	$0	($30,000)	$0	$0	$30,000	$0
Subtotal	$1,775,180	$1,100,000	$119,690	$30,000	$0	($89,690)	($30,000)
Prior Year Recoveries	$335,359	$0	$0	$0	$0	$0	$0
Obligations (0160) [Total]	$2,110,539	$1,100,000	$119,690	$30,000	$0	($89,690)	($30,000)

1/ Excludes OI&T Obligations
2/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and adjusted obligations upwards by $397 million in the Veterans Choice Fund account. VA lacked sufficient funds within the account to cover the full obligations recorded consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Anti-deficiency Act (ADA) violation that would have occurred in FY 2019 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.

Table: Medical Community Care American Rescue Plan Act Crosswalk 2020-2023

(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate 1/	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Mandatory Appropriations							
Veterans Medical Care and Health Fund							
Community Care (Section 8002)/1	$0	$0	$1,901,196	$0	$0	($1,901,196)	$0
Section 8004 - Medical Community Care	$0	$0	$250,000	$0	$0	($250,000)	$0
Section 8007 - Medical Community Care	$0	$0	$72,100	$0	$0	($72,100)	$0
Funds Available [Subtotal]	$0	$0	$2,223,296	$0	$0	($250,000)	$0
Total Budget Authority	$0	$0	$2,223,296	$0	$0	$0	$0
Unobligated Balance (SOY):							
Veterans Medical Care and Health Fund Community Care - 3 year	$0	$0	$0	$1,901,196	$0	$1,901,196	($1,901,196)
Section 8007 - Medical Community Care - no year	$0	$0	$0	$72,100	$0	$72,100	($72,100)
Unobligated Balance Mandatory (SOY) [Subtotal]	$0	$0	$0	$1,973,296	$0	$1,973,296	($1,973,296)
Unobligated Balance (EOY):							
Veterans Medical Care and Health Fund							
Community Care (Section 8002) - 3 year	$0	$0	($1,901,196)	$0	$0	$1,901,196	$0
Section 8007 - Medical Community Care - no year	$0	$0	($72,100)	$0	$0	$72,100	$0
Unobligated Balance (EOY) [Subtotal]	$0	$0	($1,973,296)	$0	$0	$1,973,296	$0
Obligations [Subtotal]	$0	$0	$250,000	$1,973,296	$0	$1,723,296	($1,973,296)

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 based on 2021 actuals and in response to workload demand requirements throughout 2022.

Table: Medical Community Care, Veterans Choice Fund (Medical Care Only) and American Rescue Plan Act Crosswalk

(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations							
Medical Community Care (0140) - Non COVID Supplemental	$15,700,269	$19,268,033	$19,235,053	$23,996,704	$24,813,000	$4,761,651	$816,296
Families First Act	$0	$0	$30,000	$0	$0	($30,000)	$0
CARES Act	$1,968,868	$0	$3,631,132	$0	$0	($3,631,132)	$0
Discretionary Obligations [SubTotal]	$17,669,137	$19,268,033	$22,896,185	$23,996,704	$24,813,000	$1,100,519	$816,296
Prior-Year Recoveries	$88,626	$0	$0	$0	$0	$0	$0
Pre P.L. 116-260 Title XVI section 1601 1/	*$5,007,990*	*$0*	*$0*	*$0*	*$0*	*$0*	*$0*
Discretionary Obligations [Total]	**$22,765,753**	**$19,268,033**	**$22,896,185**	**$23,996,704**	**$24,813,000**	**$1,100,519**	**$816,296**
Mandatory Obligations							
Veterans Choice Act (P.L. 113-146)							
Veterans Choice Fund, Medical Care							
Administration (0172XA)	($8,938)	$20,000	$36,331	$2,900	$0	($33,431)	($2,900)
Medical Care (0172XB)	($147,812)	$180,000	$62,675	$27,000	$0	($35,675)	($27,000)
Emergency Hepatitis C (0172XC)	$0	$0	$0	$0	$0	$0	$0
Emergency Community Care (0172XE)	$597	$0	$5,289	$100	$0	($5,189)	($100)
Medical Community Care (0172XG)	$1,931,332	$900,000	$15,395	$0	$0	($15,395)	$0
Veterans Choice Fund Prior-Year Recoveries	$335,359	$0	$0	$0	$0	$0	$0
Veterans Choice Fund [Subtotal]	**$2,110,538**	**$1,100,000**	**$119,690**	**$30,000**	**$0**	**($89,690)**	**($30,000)**
American Rescue Plan (ARP) Act							
Veterans Medical Care and Health Fund							
Community Care (Section 8002) 2/	$0	$0	$0	$1,901,196	$0	$1,901,196	($1,901,196)
Section 8004 - Medical Community Care	$0	$0	$250,000	$0	$0	($250,000)	$0
Section 8007 - Medical Community Care	$0	$0	$0	$72,100	$0	$72,100	($72,100)
American Rescue Plan [Subtotal]	**$0**	**$0**	**$250,000**	**$1,973,296**	**$0**	**$1,723,296**	**($1,973,296)**
Mandatory Obligations [Total]	**$2,110,538**	**$1,100,000**	**$369,690**	**$2,003,296**	**$0**	**$1,633,606**	**($2,003,296)**
Obligations [Grand Total]	**$24,876,291**	**$20,368,033**	**$23,265,875**	**$26,000,000**	**$24,813,000**	**$2,734,125**	**($1,187,000)**
Obligations Post P.L. 116-260 Title XVI section 1601 3/	*$19,868,301*						

1/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Anti-deficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.

2/ 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 based on 2021 actuals and in response to workload demand requirements throughout 2022.

3/ To provide for a comparable program obligations level from year-to-year, the obligations level shown in this row removes the obligations that VA recorded in September 2020 to comply with the VA OGC opinion on recording of Community Care obligations.

Summary of 2022 Revised Request

The 2022 President's Budget request of an additional $3.269 billion helps support an overall projected budget requirement of $26.000 billion in 2022. This adjustment reflects the following increases to help purchase the following types of care from community providers:

- $1.516 billion for ambulatory care claims;
- $49.309 million for dental care claims;
- $776.877 million for inpatient care claims;
- $45.302 million for mental health care claims;
- $648.159 million for long-term services and supports (LTSS);
- $233.278 million for other health care programs.

Table: Update to the 2022 Advance Appropriation Request

(dollars in thousands)

		Available Discretionary Funding			Available Mand. Funding				
Description	2022 Revised Request	Enacted AA Incl. Transfer	Collections	Use of Unobl. Balances Discretionary	Use of Unobl. Veterans Choice Fund	Use of Unobl. Balances ARP - 8002 1/	Use of Unobl. Balances ARP - 8007	Subtotal	Annual Approp. Adjust Required
Health Care Services:									
Ambulatory Care	$9,430,340	$6,097,581	$242,118	$0	$24,300	$1,478,166	$72,100	$7,914,265	**$1,516,075**
Dental Care	$378,057	$319,042	$9,706	$0	$0	$0	$0	$328,748	**$49,309**
Inpatient Care	$8,470,949	$7,076,133	$217,486	$0	$0	$400,453	$0	$7,694,072	**$776,877**
Mental Health Care	$599,497	$518,633	$15,392	$0	$0	$20,170	$0	$554,195	**$45,302**
Prosthetics	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
Pharmacy	$55,471	$54,047	$1,424	$0	$0	$0	$0	$55,471	**$0**
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
Health Care Services [Subtotal]	*$18,934,314*	$14,065,436	$486,126	*$0*	*$24,300*	*$1,898,789*	*$72,100*	*$16,546,751*	**$2,387,563**
Long-Term Services and Supports:									
Institutional Care	$3,375,257	$2,843,945	$86,657	$0	$0	$0	$0	$2,930,602	**$444,655**
Non-Institutional Care	$1,964,790	$1,708,434	$50,445	$0	$0	$2,407	$0	$1,761,286	**$203,504**
VA Long-Term Services and Supports [Total]	$5,340,047	$4,552,379	$137,102	$0	$0	$2,407	$0	$4,691,888	**$648,159**
Other Health Care Programs:									
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,722,859	$1,484,365	$0	$0	$5,700	$0	$0	$1,490,065	**$232,794**
Caregivers	$0	$0	$0	$0	$0	$0	$0	$0	**$0**
Camp Lejeune Family	$2,780	$2,296	$0	$0	$0	$0	$0	$2,296	**$484**
Other Health Care Programs [Total]	$1,725,639	$1,486,661	$0	$0	$5,700	$0	$0	$1,492,361	**$233,278**
Obligations [Total]	$26,000,000	$20,104,476	$623,228	$0	$30,000	$1,901,196	$72,100	$22,731,000	**$3,269,000**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the table displays the estimated allocation for the Medical Community Care category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

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)
- Families First and CARES Act
- American Rescue Plan Act
- MCC, CARES Act and ARP Act
- Veterans Choice Fund (VCF)
- MCC, Families First and CARES Act, American Rescue Plan Act, and VCF

Medical Community Care Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Health Care Services MISSION Act Affected:							
Ambulatory Care	$5,308,561	$7,416,189	$5,517,621	$7,855,774	$7,667,105	$2,338,153	($188,669)
Dental Care	$175,950	$388,206	$201,419	$378,057	$366,594	$176,638	($11,463)
Inpatient Care	$5,660,560	$4,381,112	$6,597,533	$8,070,496	$8,642,668	$1,472,963	$572,172
Mental Health Care	$379,309	$442,715	$477,979	$579,327	$629,953	$101,348	$50,626
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$44,291	$0	$51,315	$55,471	$59,015	$4,156	$3,544
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$11,568,671	$12,628,222	$12,845,867	$16,939,125	$17,365,335	$4,093,258	$426,210
Long-Term Services and Supports Community Care:							
Community Nursing Home	$1,234,419	$1,299,647	$1,358,917	$1,670,206	$1,760,875	$311,289	$90,669
Community Non-Institutional Care	$1,351,098	$1,958,885	$1,727,254	$1,901,292	$2,019,850	$174,038	$118,558
State Nursing Home	$1,352,336	$1,579,155	$1,578,155	$1,705,051	$1,738,596	$126,896	$33,545
State Home Domiciliary	$53,496	$56,346	$56,346	$56,357	$51,314	$11	($5,043)
State Home Adult Day Care	$614	$3,882	$3,882	$4,734	$4,902	$852	$168
Community Long-Term Services and Supports [Total]	$3,991,963	$4,897,915	$4,724,554	$5,337,640	$5,575,537	$613,086	$237,897
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$136,953	$1,739,116	$1,660,112	$1,717,159	$1,869,185	$57,047	$152,026
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$2,682	$2,780	$4,520	$2,780	$2,943	($1,740)	$163
Other Health Care Programs community care [Total]	$139,635	$1,741,896	$1,664,632	$1,719,939	$1,872,128	$55,307	$152,189
Obligations [Subtotal]	**$15,700,269**	**$19,268,033**	**$19,235,053**	**$23,996,704**	**$24,813,000**	**$4,761,651**	**$816,296**
VA Prior-Year Recoveries	$88,626	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	$15,788,895	$19,268,033	$19,235,053	$23,996,704	$24,813,000	$4,761,651	$816,296
Pre P.L. 116-260 Title XVI section 1601 1/	*$5,007,990*						
Obligations [Total]	$20,796,885	$19,268,033	$19,235,053	$23,996,704	$24,813,000	$4,761,651	$816,296

Families First and CARES Act Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Health Care Services MISSION Act Affected:							
Ambulatory Care	$1,527,838	$0	$2,775,462	$0	$0	($2,775,462)	$0
Dental Care	$0	$0	$0	$0	$0	$0	$0
Inpatient Care	$399,554	$0	$742,975	$0	$0	($742,975)	$0
Mental Health Care	$20,125	$0	$37,423	$0	$0	($37,423)	$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]	$1,947,517	$0	$3,555,860	$0	$0	($3,555,860)	$0
Long-Term Services and Supports Community Care:							
Community Nursing Home	$0	$0	$0	$0	$0	$0	$0
Community Non-Institutional Care	$2,835	$0	$5,272	$0	$0	($5,272)	$0
State Nursing Home	$18,390	$0	$100,000	$0	$0	($100,000)	$0
State Home Domiciliary	$126	$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]	$21,351	$0	$105,272	$0	$0	($105,272)	$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]	**$1,968,868**	**$0**	**$3,661,132**	**$0**	**$0**	**($3,661,132)**	**$0**
VA Prior-Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$1,968,868	$0	$3,661,132	$0	$0	($3,661,132)	$0

ARP Act Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request/2	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Health Care Services MISSION Act Affected:							
Ambulatory Care	$0	$0	$0	$1,550,266	$0	$1,550,266	($1,550,266)
Dental Care	$0	$0	$0	$0	$0	$0	$0
Inpatient Care	$0	$0	$0	$400,453	$0	$400,453	($400,453)
Mental Health Care	$0	$0	$0	$20,170	$0	$20,170	($20,170)
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	$1,970,889	$0	$1,970,889	($1,970,889)
Long-Term Services and Supports Community Care:							
Community Nursing Home	$0	$0	$0	$0	$0	$0	$0
Community Non-Institutional Care	$0	$0	$0	$2,407	$0	$2,407	($2,407)
State Nursing Home	$0	$0	$250,000	$0	$0	($250,000)	$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	$250,000	$2,407	$0	($247,593)	($2,407)
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**	**$250,000**	**$1,973,296**	**$0**	**$1,723,296**	**($1,973,296)**
VA Prior-Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Obligations [Total]	$0	$0	$250,000	$1,973,296	$0	$1,723,296	($1,973,296)

Medical Community Care, CARES Act and ARP Act Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request/2	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Health Care Services MISSION Act Affected:							
Ambulatory Care	$6,836,399	$7,416,189	$8,293,083	$9,406,040	$7,667,105	$1,989,851	($1,738,935)
Dental Care	$175,950	$388,206	$201,419	$378,057	$366,594	($10,149)	($11,463)
Inpatient Care	$6,060,114	$4,381,112	$7,340,508	$8,470,949	$8,642,668	$4,089,837	$171,719
Mental Health Care	$399,434	$442,715	$515,402	$599,497	$629,953	$156,782	$30,456
Prosthetics	$0	$0	$0	$0	$0	$0	$0
Pharmacy	$44,291	$0	$51,315	$55,471	$59,015	$55,471	$3,544
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$13,516,188	$12,628,222	$16,401,727	$18,910,014	$17,365,335	$6,281,792	$963,608
Long-Term Services and Supports Community Care:							
Community Nursing Home	$1,234,419	$1,299,647	$1,358,917	$1,670,206	$1,760,875	$370,559	$90,669
Community Non-Institutional Care	$1,353,933	$1,958,885	$1,732,526	$1,903,699	$2,019,850	($55,186)	$116,151
State Nursing Home	$1,370,726	$1,579,155	$1,928,155	$1,705,051	$1,738,596	$125,896	$33,545
State Home Domiciliary	$53,622	$56,346	$56,346	$56,357	$51,314	$11	($5,043)
State Home Adult Day Care	$614	$3,882	$3,882	$4,734	$4,902	$852	$168
Community Long-Term Services and Supports [Total]	$4,013,314	$4,897,915	$5,079,826	$5,340,047	$5,575,537	$442,132	$235,490
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$136,953	$1,739,116	$1,660,112	$1,717,159	$1,869,185	($21,957)	$152,026
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$2,682	$2,780	$4,520	$2,780	$2,943	$0	$163
Other Health Care Programs community care [Total]	$139,635	$1,741,896	$1,664,632	$1,719,939	$1,872,128	($21,957)	($1,719,939)
Obligations [Subtotal]	**$17,669,137**	**$19,268,033**	**$23,146,185**	**$25,970,000**	**$24,813,000**	**$6,701,967**	**($1,157,000)**
VA Prior-Year Recoveries	$88,626	$0	$0	$0	$0	$0	$0
Obligations [SubTotal]	$17,757,763	$19,268,033	$23,146,185	$25,970,000	$24,813,000	$2,823,815	($1,157,000)
Pre P.L. 116-260 Title XVI section 1601 1/	*$5,007,990*						
Obligations [Total]	$22,765,753	$19,268,033	$23,146,185	$25,970,000	$24,813,000	$2,823,815	($1,157,000)

Veterans Choice Fund Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Health Care Services MISSION Act Affected:							
Ambulatory Care	$171,701	$1,057,400	$99,990	$24,300	$0	($75,690)	($24,300)
Dental Care	$10,529	$800	$100	$0	$0	($100)	$0
Inpatient Care	$137,411	$35,900	$1,700	$0	$0	($1,700)	$0
Mental Health Care	$15,907	$300	$200	$0	$0	($200)	$0
Prosthetics	$0	$100	$0	$0	$0	$0	$0
Pharmacy	$0	$500	$0	$0	$0	$0	$0
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$335,549	$1,095,000	$101,990	$24,300	$0	($77,690)	($24,300)
Long-Term Services and Supports Community Care:							
Community Nursing Home	$0	$0	$0	$0	$0	$0	$0
Community Non-Institutional Care	$176,897	$5,000	$2,200	$0	$0	($2,200)	$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]	$176,897	$5,000	$2,200	$0	$0	($2,200)	$0
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,262,734	$0	$15,500	$5,700	$0	($9,800)	($5,700)
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]	$1,262,734	$0	$15,500	$5,700	$0	($9,800)	($5,700)
Obligations [Subtotal]	**$1,775,180**	**$1,100,000**	**$119,690**	**$30,000**	**$0**	**($89,690)**	**($30,000)**
VA Prior-Year Recoveries	$335,359	$0	$0	$0	$0	$0	$0
Total Obligations	$2,110,539	$1,100,000	$119,690	$30,000	$0	($89,690)	($30,000)

Medical Community Care, VCF, CARES Act and ARP Act Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request/2	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Health Care Services MISSION Act Affected:							
Ambulatory Care	$7,008,100	$8,473,589	$8,393,073	$9,430,340	$7,667,105	$1,037,267	($1,763,235)
Dental Care	$186,479	$389,006	$201,519	$378,057	$366,594	$176,538	($11,463)
Inpatient Care	$6,197,525	$4,417,012	$7,342,208	$8,470,949	$8,642,668	$1,128,741	$171,719
Mental Health Care	$415,341	$443,015	$515,602	$599,497	$629,953	$83,895	$30,456
Prosthetics	$0	$100	$0	$0	$0	$0	$0
Pharmacy	$44,291	$500	$51,315	$55,471	$59,015	$4,156	$3,544
Rehabilitation Care	$0	$0	$0	$0	$0	$0	$0
Health Care Services [Subtotal]	$13,851,737	$13,723,222	$16,503,717	$18,934,314	$17,365,335	$2,430,597	($1,568,979)
Long-Term Services and Supports Community Care:							
Community Nursing Home	$1,234,419	$1,299,647	$1,358,917	$1,670,206	$1,760,875	$311,289	$90,669
Community Non-Institutional Care	$1,530,830	$1,963,885	$1,734,726	$1,903,699	$2,019,850	$168,973	$116,151
State Nursing Home	$1,370,726	$1,579,155	$1,928,155	$1,705,051	$1,738,596	($223,104)	$33,545
State Home Domiciliary	$53,622	$56,346	$56,346	$56,357	$51,314	$11	($5,043)
State Home Adult Day Care	$614	$3,882	$3,882	$4,734	$4,902	$852	$168
Community Long-Term Services and Supports [Total]	$4,190,211	$4,902,915	$5,082,026	$5,340,047	$5,575,537	$258,021	$235,490
Other Health Care Programs Community Care:							
CHAMPVA, Spina Bifida, FMP, & CWVV	$1,399,687	$1,739,116	$1,675,612	$1,722,859	$1,869,185	$47,247	$146,326
Caregivers	$0	$0	$0	$0	$0	$0	$0
Camp Lejeune Family	$2,682	$2,780	$4,520	$2,780	$2,943	($1,740)	$163
Other Health Care Programs community care [Total]	$1,402,369	$1,741,896	$1,680,132	$1,725,639	$1,872,128	$45,507	$146,489
Obligations [Subtotal]	**$19,444,316**	**$20,368,033**	**$23,265,875**	**$26,000,000**	**$24,813,000**	**$2,734,125**	**($1,187,000)**
VA Prior-Year Recoveries	$423,985	$0	$0	$0	$0	$0	$0
Obligations [Subtotal]	$19,868,301	$20,368,033	$23,265,875	$26,000,000	$24,813,000	$2,734,125	($1,187,000)
Pre P.L. 116-260 Title XVI section 1601 1/	*$5,007,990*						
Obligations [Total]	$24,876,291	$20,368,033	$23,265,875	$26,000,000	$24,813,000	$2,734,125	($1,187,000)

1/ Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. In September 2020, to comply with a VA General Counsel (OGC) opinion following significant changes to VA's Community Care program, VA reverted to its old practice of recording obligations at the time of authorization and recorded obligations of $5.008 billion for FY 2020 in the Medical Community Care account. VA lacked sufficient funds within the account to cover the full obligations recorded in FY 2020 consistent with VA OGC's opinion. Section 1601 of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260) authorized the practice of recording obligations at the time of approval of payment to health care providers and contractors, and also made it retroactive to October 1, 2018, thereby voiding an Anti-deficiency Act (ADA) violation that would have occurred in FY 2020 absent its enactment. To implement the law, VA made an accounting adjustment in FY 2021, the year Public Law 116-260 was enacted.
2/ 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 and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

In 2022, total obligations are projected to increase by $2.7 billion above the 2021 current estimate in the following areas

- **Health Care Services (+$2.431 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.

- **Long-Term Services and Support (+$258 million).** Estimates are projected to increase due to the latest demographic trends and modes of care delivery. The projected increase is less than otherwise would be projected due to the decrease in payments to State Veterans Homes compared to 2021. The decrease is attributable to the additional funding provided in 2021 for payments to State Veterans Homes in the CARES Act and American Rescue Plan Act (section 8004) and the cost projection returning to a pre-CARES Act trend in 2022.

- **Other Health Care Programs (+$46 million).** VA-provided health service programs not projected by the Enrollee Health Care Projection Model (EHCPM) are expected to yield a net increase of $46 million, driven largely by CHAMPVA program costs.

Summary of the 2023 Advance Appropriation Request

The Medical Community Care discretionary advance appropriations request is $24.2 billion, an increase of $739 million from the 2022 revised discretionary request. The 2023 request ensures continuity of Veterans' health care services and sustain VA's increased capacity for care following the pandemic. In 2023, total obligations are projected to be $1.2B less than total obligations in 2022. VA projects that a significant amount of health care that was delayed during the pandemic will return to the VA community care network system in 2022, coupled with the return of care to pre-pandemic levels. The infusion of resources included in the American Rescue Plan Act provide VA with the resources necessary to address total demand in 2022. After the return of deferred care works its way through the system, VA projects that workload levels will stabilize in comparison to pre-pandemic levels, thus requiring fewer total resources in 2023.

In 2023, total obligations are projected to decrease by $1.2 billion from the 2022 revised request estimate in the following areas

- **Health Care Services (-$1.569 billion).** Estimates are projected to decrease following a return to the pre-pandemic trajectory.

- **Long-Term Services and Support (+$235 million).** Estimates are projected to increase due latest demographic trends and modes of care delivery.

- **Other Health Care Programs (+$146 million).** VA-provided health service programs not projected by the EHCPM are expected to yield a net increase of $146 million, driven largely by CHAMPVA program costs.

Medical Community Care Description

VA provides health care for Veterans from providers in the local community. 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 the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). This care is also provided based on specific eligibility requirements, which varies 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 account funds clinical service delivery requirements for community care, such as care coordination including referrals, eligibility verification, enrollment, and establishing care network requirements such as developing contracts that serve as vehicles for VA to purchase care for Veterans from community providers as well as development and maintenance of IT functions.. MCC also funds short-term prescription medications for a 14-day or fewer supply that are 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. The list below depicts some of the key IT systems that support the Office of Community Care and planned enhancements.

IT System	Capability
Community Care Referral and Authorization System (CCR&A)	Automates and standardizes the Community Care referral and authorization processes.
Standard Episode of Care (SEOC)	National standardized list of services that are authorized as one bundle of care for community care.
Provider Profile Management System (PPMS)	Master database of community provider information.
Community Care Reimbursement System (CCRS)	Ability to reimburse Community Care Network (CCN) contractors for health care claims paid timely and accurately.
Decision Support Tool (DST)	Display and document veteran's eligibility criteria for community care to assist in determining appropriate location for care in a standard and reportable format.
Enterprise Program Reporting System (EPRS)	Operational and analytics and reporting for Community Care Network (CCN) contract activity.
Consult Toolbox (CTB)	Consolidated and standardized processes for tracking and reporting of Community Care Consults

After a Veteran is enrolled in VA health care, there are separate eligibility criteria for community care. VA is responsible for payment of care and services furnished under this program. VA will use existing authority to bill and collect from third party insurance, if applicable, for care that is provided for a non-service/service-connected condition. VA will also bill veterans for copayments, if applicable, when care is received.

Outpatient and Inpatient Healthcare Claim Management

The following narrative describes how community care claims related to health care services are executed. Please see the Medical Care chapter for a description of the various health care services.

eCAMS is the system VA uses to process out of network claims, which include claims from providers under Veterans Care Agreements, emergency room visits at non-network hospitals, and providers that are not in network but provide care that was authorized under Community Care Network (CCN). eCAMS is one of the many tools VA has implemented in order to achieve claims processing timeliness standards. From January 2020, the overall inventory was reduced from 3.5 million to fewer than 95 thousand claims as of March 31, 2021. Claims processing timeliness has steadily improved to 96% of all veteran community care claims processed in 30 days by VA in April 2021, as compared to 67% in FY 2019.

These improvement projects include:

- eCAMS implementation increased auto-adjudication (10% at initial deployments to 33% at current state).
- Increased the volume of electronic claims and attachments for more accurate and efficient processing.
- Increased contract support for claims processing and customer service support for the national call center for Veterans and providers
- Conducted provider outreach through education, monthly webinars, newsletters and website updates, resulting in cleaner claims and faster processing.

- A reduction in the volume of incoming claims as a result of full implementation of CCN, which covers all U.S. states and territories and relies on Third Party Administrators (TPA) to develop and administer regional networks of high-performing licensed health care providers on behalf of VA.

Status of the Community Care Network Contracts

VA awarded the Community Care Network contracts in Regions 1, 2, 3, 4, and 5. Although all five regions have been awarded, Regions 1-4 are fully deployed. CCN Region 5 launched in April 2021 with full health care delivery expected by the end of FY 2021. VA continues to work on an award for Region 6. Until a CCN contract is awarded, VA will continue to use the existing Patient-Centered Community Care (PC3) contracted network and Veterans Care Agreements (VCAs) to provide healthcare to Veterans in Region 6.

Region 1	Region 2	Region 3	Region 4	Region 5
Connecticut	Illinois	Alabama	Arizona	Alaska
Delaware	Indiana	Arkansas	California	
District of Columbia	Iowa	Florida	Colorado	**Region 6**
Maine	Kansas	Georgia	Hawaii	American Samoa
Maryland	Kentucky	Louisiana	Idaho	Gaum
Massachusetts	Michigan	Mississippi	Montana	Northern Mariana Islands
New Hampshire	Minnesota	Oklahoma	New Mexico	
New Jersey	Missouri	Puerto Rico	Nevada	
New York	Nebraska	South Carolina	Oregon	
North Carolina	North Dakota	Tennessee	Texas	
Pennsylvania	Ohio	Virgin Islands (U.S.)	Utah	
Rhode Island	South Dakota		Washington	
Vermont	Wisconsin		Wyoming	
Virginia				
West Virginia				

The total obligations in 2022 for medical community care include Third Party Administration obligations of $1,234,235,000. This will cover costs associated with CCN contract modification, CCN pharmacy costs, and CCN per member per month (PMPM) administrative fees.

Medical Community Care Programs

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 (Public Law 113-235), which was signed on December 16, 2014, increased 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 Camp Lejeune Family Member Program (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

The current trend shows an annual decrease of 14% from October 2019 to October 2020 in new enrollment for both administrative and clinical eligibility. 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. There are 2,375 administratively eligible family members and 758 clinically eligible family members that receive medical reimbursement for one or more of the 15 approved conditions. A relatively small number of family members lived on Camp Lejeune or have contracted one of the specified illnesses or conditions. The program continues to communicate with family members and their concerns.

Projections for the Future

Over the next 3-5 years, 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 known expectations. Medical claims obligations increased from $1,763,054.31 in 2019 to $2,708,981.37 in 2020. CLFMP anticipates a similar increase in 2021 obligations for a total amount of $3,792,573.92. We anticipate a similar annual increase of approximately 40% in obligations for both 2022 and 2023.

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and Other Dependent Programs

VA is currently providing 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.

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.

Type of Services Provided

VA is currently providing Healthcare Benefit administration for the beneficiaries of these programs. 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.

Recent Trends

The number of enrolled beneficiaries in CHAMPVA has increased by 5.0% on an annual basis from 2015 to 2020, and the number of unique users of CHAMPVA has increased by 4.84% annually. In 2020, CHAMPVA served 417,203 unique beneficiaries, which amounted to an annual increase of 21,849 beneficiaries.

CHAMPVA met the Improper Payments Elimination and Recovery Act (IPERA) target accuracy rate by achieving a 99.32% payment accuracy rate in the 2020 CHAMPVA IPERA Audit. As part of the 2019 CHAMPVA IPERA Corrective Action Plan, OCC set a reduction target of 0.12 percentage points for the CHAMPVA to reduce improper payments to 1.5% in 2020. The 2020 CHAMPVA IPERA improper payment rate was only 0.68%, which exceeded the reduction target by 0.82%. The Program Office is not requesting additional funding for IPERA compliance purposes in 2022.

Indian Health Service (IHS)/Tribal Health Programs (THP) Reimbursement Agreements Program

Authority for Action

Under the authority of 25 U.S.C. §1645(c) and 38 U.S.C §8153, the Department of Veterans Affairs (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. Under these agreements, VA reimburses for Direct Care Services provided by IHS and THPs 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 THPs to increase health care options for all eligible AI/AN Veterans (especially those in remote, rural areas) facilitating enhanced

coordination, collaboration, and resource-sharing between VA and IHS and/ or THPs. In addition to AI/AN Veterans and because of the highly rural nature of Alaska, agreements with Alaska THPs also cover non- Native Veterans.

In 2022, VA will begin implementation of the program to reimburse 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. VA also anticipates continued growth in its partnerships with 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.

Population Covered
The population covered under the IHS/THP reimbursement agreements are eligible AI/AN Veterans and non-Native Veterans (Alaska only). Eligible AI/AN Veterans may choose to seek health care through IHS or THP facilities without preauthorization, while non-Native Veterans in Alaska need 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. Also, these agreements allow AI/AN Veterans to seek care in a culturally sensitive environment.

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 hospitals, clinics or facilities. Purchased/referred care services are provided away from an IHS or THP facility.

Trends
2020 experienced a decrease in obligations due to COVID-19, a pause in certain pharmacy reimbursements, and an overall delay in issuing reimbursements. The 2021 Budget also displayed incorrect estimates for the 2021 Current Estimate, 2021 Revised Request, and 2022 Advance Appropriation that were half the obligation levels that should have been reported. Estimates have been corrected in the 2022 Budget. The 2021 Current Estimate is expected to total $27 million, which consists of $16 million in MCC funds and $11 million in COVID supplemental funding provided by the CARES Act and Families First Act.

In 2022, obligations are projected to be $30 million. In general, this funding supports an estimated 116 agreements with THPs, in addition to 74 IHS sites included in the National Reimbursement Agreement with IHS. VA anticipates providing reimbursement to more than 5,500 unique veterans per year. The funding level supports the expansion of VA reimbursement to include UIOs as well as to reimburse IHS/THPs for eligible purchased/referred care.

Recording of Obligations
Prior to FY 2019, VA recorded obligations for Community Care at the time the care was authorized by a VA health care provider. The recorded obligation reflected the total value of care a Veteran might receive under the authorization, which in practice resulted in significant over-obligation.

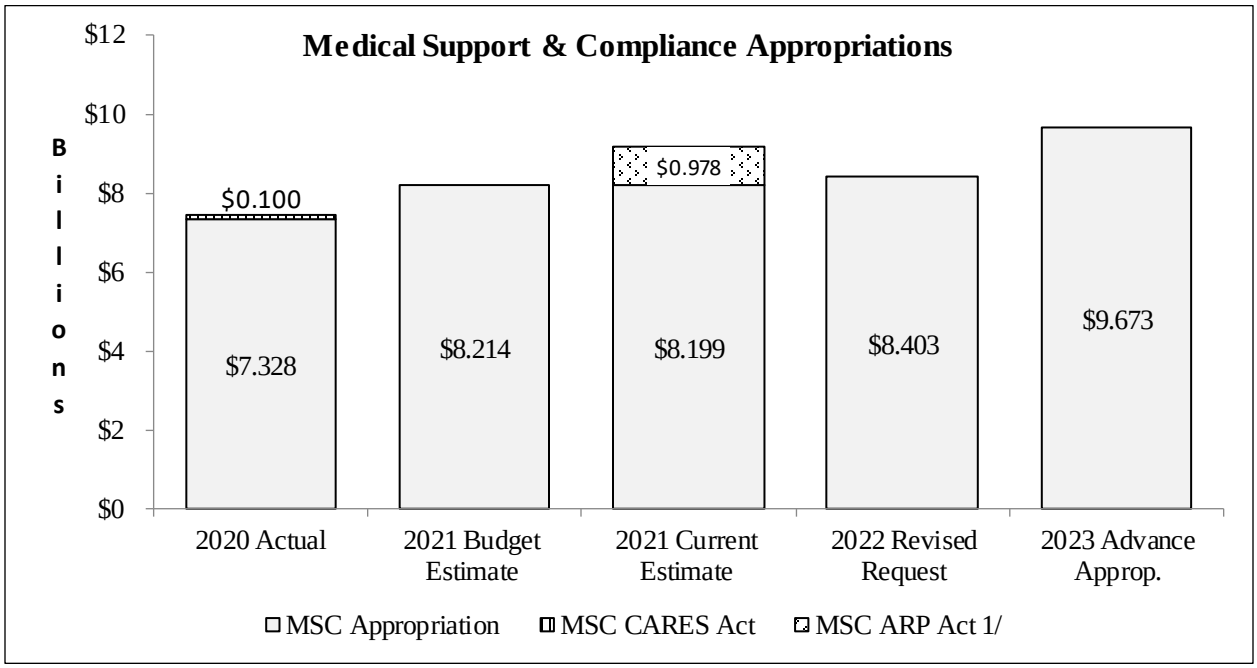
For example, in case of a knee injury, a VA health care provider's authorization would cover a variety of possible medical interventions, to include up to ten physical therapy sessions, an MRI, and even surgery, at a total cost of thousands of dollars. VA would record the obligation for the total care possible under the authorization; but the Veteran might complete only three physical therapy sessions, costing only a few hundred dollars. Several months or years later, VA would de-obligate the unused funds, making it more difficult to efficiently optimize resource allocation and planning, and increasing the risk that funds could expire instead of being available to provide care for Veterans.

In FY 2019, VA started recording obligations for Community Care at the time VA issued payment to health care providers and to third-party administrators. This change was based on the quasi-adjudicative processes described in two Government Accountability Office (GAO) opinions[33]. , in which GAO opined that the Government incurred its liability for a health care claim upon the completion of a quasi-adjudicative process in which the reviewer determined whether the individual was eligible for the treatment, whether the treatment was necessary and proper in the light of the disability record, and whether the amount billed was proper. This change had no impact on the actual cost of Veteran care, but it did produce a one-time budgetary savings of about $1.8 billion in FY 2019 by shifting the recording of obligations to subsequent fiscal years. In FY 2019, enacted appropriations for Community Care reflected the 2019 President's Budget level, which included these budgetary savings.

Since implementing the change in the timing of Community Care obligations, VA has made significant changes to its Community Care program. The VA MISSION Act of 2018 (P.L. 115-182) expanded eligibility and changed administrative practices for the program. In addition, VA implemented new Community Care Network contracts with third party providers to administer the program. In February 2020, VA's Office of General Counsel (OGC) opined that the VA processes were unlike those in the precedential GAO opinions, and that VA violated the Recording Statute (31 U.S.C. § 1501) when it recorded Community Care obligations at the time of payment for care delivered under the Community Care contracts. In September 2020, to comply with the Recording Statute, VA reverted to its old practice of recording obligations at the time of authorization. VA lacked sufficient funds in the Medical Community Care and Veterans Choice Fund accounts to cover the full obligations that were recorded in FY 2019 and FY 2020 consistent with VA OGC's opinion. The deficiency was noted in the agency's FY 2020 Agency Financial Report. This deficiency would have resulted in Anti-deficiency Act (ADA) violations absent the enactment of section 1601 of title XVI of division FF of the Consolidated Appropriations Act, 2021 (Public Law 116-260), which made the practice of recording obligations at the time of approval of payment to health care providers and contractors (such as third-party administrators) retroactive to October 1, 2018. To implement the law, VA made accounting adjustments in FY 2021 in the Medical Community Care and Veterans Choice Fund accounts, the year Public Law 116-260 was enacted.

[33] GAO opinion B-287619 on TRICARE pass through medical care claims (July 5, 2001), and B-92679 VA fee-basis outpatient treatment claims (June 30, 1967).

Medical Support and Compliance



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 Support and Compliance category. Final funding allocations among account-level categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022

Update to the 2022 Advance Appropriations Request

The Department of Veterans Affairs (VA) is not requesting any additional amount for Medical Support and Compliance (MSC) above the enacted 2022 Advance Appropriation of $8.403 billion. In addition to the Advance Appropriation, VA intends to use $978 million of unobligated balances from the mandatory appropriation provided in the American Rescue Plan Act to meet projected requirements in 2022. This funding, combined with $47.610 million in projected reimbursements and $100 million in unobligated balances from discretionary appropriations, will provide a total resource level of $9.500 billion in 2022.

The 2022 MSC budget helps VA Medical Centers (VAMCs) provide administrative support to meet the pandemic-caused deferred care returning to the system, provides administrative support for the Veterans Health Administration's (VHA's) expansion of suicide prevention and substance use disorder treatment, helps afford contract costs associated with expansion of VA's Community Care Network (CCN), and assists in VHA's effort to accelerate its supply chain modernization.

Table: Update to the 2022 Advance Appropriations Request

Update to the 2022 Advance Appropriation Request
Medical Support & Compliance
(dollars in thousands)

		Available Discretionary Funding				Available Mand. Funding			
Description	2022 Revised Estimate	Adv. Approp. Incl. Transfers	Transfers To	Reimb.	Use of Unobl. Balance	Sec 801 Use of Unobl. Balance	Veterans Medical Care and Health Fund Use of Unobl. Balance 1/	Subtotal	Annual Approp. Adjust. Required
VISN & Medical Center Based:									
VAMC	$5,475,741	$5,158,744	($30,613)	$47,610	$0	$0	$300,000	$5,475,741	**$0**
VISN	$650,084	$650,084	$0	$0	$0	$0	$0	$650,084	**$0**
VHA Central Office Based:									
Community Care	$1,037,856	$1,037,856	$0	$0	$0	$0	$0	$1,037,856	**$0**
Clinical Services	$172,040	$172,040	$0	$0	$0	$0	$0	$172,040	**$0**
Discovery, Education and Affiliate Networks	$44,051	$42,598	$0	$0	$0	$1,453	$0	$44,051	**$0**
Operations	$188,867	$188,867	$0	$0	$0	$0	$0	$188,867	**$0**
Patient Care Services	$194,174	$194,174	$0	$0	$0	$0	$0	$194,174	**$0**
Quality and Patient Safety and Core Finance Administration.	$453,789	$453,789	$0	$0	$0	$0	$0	$453,789	**$0**
Support Services	$678,433	$0	$0	$0	$0	$0	$678,433	$678,433	**$0**
Human Capital Management	$233,778	$233,778	$0	$0	$0	$0	$0	$233,778	**$0**
Health Informatics	$109,403	$109,403	$0	$0	$0	$0	$0	$109,403	**$0**
All Other Support and Program Offices	$261,785	$161,785	$0	$0	$100,000	$0	$0	$261,785	**$0**
Central Office Based Obligations [Subtotal]	$3,374,175	$2,594,289	$0	$0	$100,000	$1,453	$0	$3,374,175	**$0**
Obligations [Total]	$9,500,000	$8,403,117	($30,613)	$47,610	$100,000	$1,453	$978,433	$9,500,000	**$0**

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 for the Medical Support and Compliance category. Final 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

2022 Funding and 2023 Advance Appropriations Request

The MSC appropriation finances the supporting structures that underlie VHA's ability to deliver high-quality health care services to our Veterans. Approximately 66% of the 2022 total funding for this appropriation is designated for VAMCs and Veteran Integrated Service Networks (VISNs) direct allocations. The remaining 34% of the funding is designated for VHA Central Office Programs to support their staff as well as 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.

Table: Medical Support and Compliance Crosswalk

Medical Support & Compliance Crosswalk, 2020-2023
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2022-2021	+/- 2023-2022
Appropriation Medical Support & Compliance (0152)							
Advance Appropriation	$7,239,156	$7,914,191	$7,914,191	$8,403,117	$9,673,409	$488,926	$1,270,292
Annual Appropriation Adjustment	$98,800	$300,000	$300,000	$0	$0	($300,000)	$0
Families First Coronavirus Response Act (P.L. 116-127)	$0	$0	$0	$0	$0	$0	$0
CARES Act (P.L. 116-136)	$100,000	$0	$0	$0	$0	$0	$0
Appropriations Request [Subtotal]	$7,437,956	$8,214,191	$8,214,191	$8,403,117	$9,673,409	$188,926	$1,270,292
Rescission (PL 116-94)	($10,000)	$0	($15,000)	$0	$0	$15,000	$0
Net Appropriation	**$7,427,956**	**$8,214,191**	**$8,199,191**	**$8,403,117**	**$9,673,409**	**$203,926**	**$1,270,292**
Tranfers To							
JALFHCC (0169)	($29,424)	($30,213)	($30,213)	($30,613)	($31,019)	($400)	($406)
Transfers To [Subtotal]	($29,424)	($30,213)	($30,213)	($30,613)	($31,019)	($400)	($406)
Tranfers From							
Medical Services - (0160)	$375,000	$0	$0	$0	$0	$0	$0
Medical Services - CARES (0160)	$150,000	$0	$0	$0	$0	$0	$0
Transfers From [Subtotal]	$525,000	$0	$0	$0	$0	$0	$0
Budget Authority [Total]	$7,923,532	$8,183,978	$8,168,978	$8,372,504	$9,642,390	$203,526	$1,269,886
Reimbursements	$47,610	$19,063	$47,610	$47,610	$47,610	$0	$0
Unobligated Balance (SOY)							
No-Year	$0	$0	$0	$0	$0	$0	$0
H1N1 No-Year (PL 111-32)	$112	$0	$111	$0	$0	($111)	$0
2-Year	$21,454	$0	$98,481	$100,000	$0	$1,519	($100,000)
2-Year (P.L. 116-136)	$0	$0	$172,544	$0	$0	($172,544)	$0
Unobligated Balance (SOY) [Subtotal]	$21,566	$0	$271,136	$100,000	$0	($171,136)	($100,000)
Transfer of Unobligated Balance (PL 116-136 §20001)							
From Medical Services CARES Unob. Bal.	$0	$0	$75,000	$0	$0	($75,000)	$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)	($98,481)	$0	($100,000)	$0	$0	$100,000	$0
2-Year (P.L. 116-136)	($172,544)	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($271,136)	$0	($100,000)	$0	$0	$100,000	$0
Lapse	($973)	$0	$0	$0	$0	$0	$0
Subtotal	$7,720,599	$8,203,041	$8,387,724	$8,520,114	$9,690,000	$132,390	$1,169,886
Prior Year Recoveries	$167	$0	$0	$0	$0	$0	$0
Obligations (0152) [Total]	**$7,720,766**	**$8,203,041**	**$8,462,724**	**$8,520,114**	**$9,690,000**	**$57,390**	**$1,169,886**
Veterans Medical Care and Health Fund (0173SC) 1/							
Funding made available by VMCHF	$0	$0	$978,433	$0	$0	($978,433)	$0
						$0	$0
Unobligated Balance (SOY)	$0	$0	$0	$978,433	$0	$978,433	($978,433)
Unobligated Balance (EOY)	$0	$0	($978,433)	$0	$0	$978,433	$0
Obligations (0173SC) [Total]	**$0**	**$0**	**$0**	**$978,433**	**$0**	**$978,433**	**($978,433)**
VACAA, Section 801 (0152XA)							
Unobligated Balance (SOY)	$14,480	$9,846	$13,134	$11,736	$10,283	($1,398)	($1,453)
Unobligated Balance (EOY)	($13,134)	($6,584)	($11,736)	($10,283)	($8,774)	$1,453	$1,509
Subtotal	$1,346	$3,262	$1,398	$1,453	$1,509	$55	$56
Prior Year Recoveries	$0	$0	$0	$0	$0	$0	$0
Obligations (0152XA) [Total]	**$1,346**	**$3,262**	**$1,398**	**$1,453**	**$1,509**	**$55**	**$56**
Obligations [Grand Total]	**$7,722,112**	**$8,206,303**	**$8,464,122**	**$9,500,000**	**$9,691,509**	**$1,035,878**	**$191,509**
FTE							
Medical Support & Compliance (0152)	55,537	60,219	57,190	57,725	58,225	535	500
CARES Act	109	0	218	0	0	(218)	0
Veterans Medical Care and Health Fund (0173SC)	0	0	0	500	0	500	(500)
VACAA, Section 801 (0152XA) 1/	11	9	11	11	11	0	0
FTE [Total]	**55,657**	**60,228**	**57,419**	**58,236**	**58,236**	**817**	**0**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the column displays the estimated allocation for the Medical Support and Compliance category. Final 2022 funding allocations may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

The funding levels shown below include the program's total discretionary budget authority plus reimbursements, as well as the budget authority available due to unobligated start-of-year mandatory balances from Sec. 801 of the Choice Act and the Veterans Medical Care and Health Fund. The programmatic funding levels are shown with both funding sources combined to allow for a comprehensive picture of the program's operations.

VHA Reorganization

On January 1, 2020, VA announced the redesign of the Veterans Health Administration Central Office (VHACO) as part of its modernization efforts to reflect leading health care industry practices, better clarify office roles, and streamline responsibilities to eliminate fragmentation, overlap, and duplication. The redesign allows VHA to be more agile, effectively respond to changes, expedite decision-making, and better support VISNs and facilities directly serving Veterans. The display of resources in this chapter is aligned to the new VHACO structure after the reorganization.

Program Resources

- **$9.500 billion in 2022**
- **$9.692 billion in 2023**

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 & Compliance Obligations by Activity - Discretionary Funds
(dollars in thousands)

Description:	2020 Actual 1/	2021 Budget Estimate 1/	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Annual Appropriations							
VISN & Medical Center Based 2/:							
VAMC	$4,279,120		$4,597,539	$5,175,652	$5,754,542	$578,113	$578,890
VISN	$582,966		$605,701	$650,084	$663,085	$44,382	$13,002
VHA Central Office Based:							
Community Care			$1,023,240	$1,037,856	$1,064,391	$14,616	$26,535
Clinical Services			$142,921	$172,040	$176,616	$29,119	$4,576
Discovery, Education and Affiliate Networks			$39,469	$42,687	$43,511	$3,217	$824
Operations			$175,973	$188,867	$192,645	$12,894	$3,778
Patient Care Services			$180,586	$194,174	$198,029	$13,588	$3,855
Quality and Patient Safety and Core Finance Administration			$422,808	$453,789	$462,865	$30,981	$9,076
Support Services			$485,248	$0	$517,236	($485,248)	$517,236
Human Capital Management			$217,140	$233,778	$238,476	$16,638	$4,698
Health Informatics			$101,934	$109,403	$111,591	$7,469	$2,188
All Other Support and Program Offices			$222,621	$261,785	$267,013	$39,164	$5,228
Central Office Based Obligations [Subtotal]	**$2,781,057**	**$0**	**$3,011,940**	**$2,694,378**	**$3,272,372**	**($317,562)**	**$577,994**
Prior Year Recoveries	$167	$0	$0	$0	$0	$0	$0
CARES Act:							
VAMC	**$22,381**	**$0**	**$198,772**	$0	$0	**($198,772)**	**$0**
Central Office	**$55,075**	**$0**	**$48,772**	$0	$0	**($48,772)**	**$0**
MSC Obligations - Discretionary Funds [Total]	**$7,720,766**	**$0**	**$8,462,724**	**$8,520,114**	**$9,690,000**	**$57,390**	**$1,169,886**

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.
2/ In previous budgets, the funding displayed for VAMC and VISN headquarters included Specific Purpose funds in addition to General Purpose funds. The budget data displayed in this year's budget reflects the VHA Reorganization and includes only General Purpose funds for these two line items.

Medical Support & Compliance Obligations by Activity - Mandatory Funds
(dollars in thousands)

Description:	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Veterans Medical Care and Health Fund 1/							
VAMC	$0	$0	$0	$300,000	$0	$300,000	($300,000)
Support Services	$0	$0	$0	$678,433	$0	$678,433	($678,433)
VMCHF Obligations [Subtotal]	**$0**	**$0**	**$0**	**$978,433**	**$0**	**$978,433**	**($978,433)**
Section 801							
Discovery, Education and Affiliate Networks	$0	$0	$1,398	$1,453	$1,509	$55	$56
Section 801 Obligations [Subtotal]	**$0**	**$0**	**$1,398**	**$1,453**	**$1,509**	**$55**	**$56**
MSC Obligations - Mandatory Funds [Total]	**$0**	**$0**	**$1,398**	**$979,886**	**$1,509**	**$978,488**	**($978,377)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the column displays the estimated allocation for the Medical Support and Compliance category. Final 2022 funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Medical Support & Compliance Obligations by Activity - Total
(dollars in thousands)

Description:	2020 Actual 1/	2021 Budget Estimate 1/	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
VISN & Medical Center Based 2/:							
VAMC	$4,301,501		$4,796,311	$5,475,652	$5,754,543	$679,341	$278,890
VISN	$582,966		$605,701	$650,084	$663,085	$44,382	$13,002
VHA Central Office Based:							
Community Care			$1,023,345	$1,037,856	$1,064,391	$14,511	$26,535
Clinical Services			$143,810	$172,040	$176,616	$28,230	$4,576
Discovery, Education and Affiliate Networks			$45,867	$44,140	$45,020	($1,727)	$880
Operations			$175,973	$188,867	$192,645	$12,894	$3,777
Patient Care Services			$181,189	$194,174	$198,029	$12,985	$3,855
Quality and Patient Safety and Core Finance Administration			$428,130	$453,789	$462,865	$25,659	$9,076
Support Services			$493,957	$678,433	$517,236	$184,476	($161,197)
Human Capital Management			$217,140	$233,778	$238,476	$16,638	$4,698
Health Informatics			$101,934	$109,403	$111,591	$7,469	$2,188
All Other Support and Program Offices			$250,765	$261,785	$267,013	$11,020	$5,228
Central Office Based Obligations [Subtotal]	**$2,837,478**	**$0**	**$3,062,110**	**$3,374,264**	**$3,273,881**	**$312,155**	**($100,383)**
Prior Year Recoveries	$167	$0	$0	$0	$0	$0	$0
MSC Obligations [Total]	**$7,722,112**	**$8,206,303**	**$8,464,122**	**$9,500,000**	**$9,691,509**	**$1,035,878**	**$191,509**

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.
2/ In previous budgets, the funding displayed for VAMC and VISN headquarters included Specific Purpose funds in addition to General Purpose funds. The budget data displayed in this year's budget reflects the VHA Reorganization and includes only General Purpose funds for these two line items.

VHA Pre-Reorganization Displays

As a result of the VHA Reorganization and the timing of its finalization, detailed data is unavailable for a number of line items displayed in the tables above. The following list provides a general reconciliation of the line items shown in previous budgets (pre-VHA Reorganization) and the line items now shown in this year's budget (post-VHA Reorganization):

- Consolidated Mail Outpatient Pharmacies (CMOP) costs are now primarily captured in Patient Care Services and Community Care;
- Employee Education Service Center costs are now primarily captured in Human Capital Management;
- National Center for Patient Safety costs are now primarily captured in Quality and Patient Safety;
- Office of Community Care (OCC) costs are now primarily captured in Community Care;
- Office of Health Informatics costs are now primarily captured in Health Informatics;
- Readjustment Counseling Service costs are now primarily captured within All Other Support and Program Offices;
- VHACO costs have been distributed across all VHACO based line items;
- VHA Member Services costs are now primarily captured in Community Care and Operations; and,
- VHA Service Center costs are now primarily captured in All Other Support and Program Offices.

The three tables below show detail for 2020 Actuals and the 2021 President's Budget Request in the same format as included in the 2021 President's Budget, prior to the VHA Reorganization.

Medical Support & Compliance Obligations by Activity - Discretionary Funds
(dollars in thousands)

Description:	2020 Actual	2021 Budget Estimate
Annual Appropriations		
VA Medical Centers, VISNs & Other Field Activities 1/:		
VAMCs and Other Field Activities	$4,364,789	$5,248,238
VISN Headquarters	$582,965	$203,501
Subtotal	**$4,947,754**	**$5,451,739**
VHACO & National Consolidated Activities:		
Consolidated Mail Outpatient Pharmacies (CMOP)	$20,581	$20,499
Employee Education Service Center	$81,671	$85,518
National Center for Patient Safety	$8,443	$7,499
Office of Community Care	$935,053	$1,023,240
Office of Health Informatics	$187,413	$203,525
Readjustment Counseling Service	$4,384	$8,277
VHA Central Office	$1,040,960	$901,017
VHA Member Services	$213,075	$222,689
VHA Service Center	$281,265	$279,038
Subtotal	**$2,772,845**	**$2,751,302**
Prior Year Recoveries	$167	$0
MSC Obligations - Discretionary Funds [Total]	**$7,720,766**	**$8,203,041**

1/ In 2020, prior to the VHA Reorganization, VAMCs and VISNs underwent administrative service-level consolidation from the VAMC to the VISN, resulting in a higher 2020 Actual than what had been previously projected as the 2020 Current Estimate and 2021 Budget Estimate in the 2021 President's Budget.

Medical Support & Compliance Obligations by Activity - Mandatory Funds

(dollars in thousands)

Description:	2020 Actual	2021 Budget Estimate
Section 801		
Staffing Shortage & Report (Sect. 301).....	$1,346	$3,262
Section 801 Obligations [Subtotal].....	**$1,346**	**$3,262**
MSC Obligations - Mandatory Funds [Total]..	**$1,346**	**$3,262**

Medical Support & Compliance Obligations by Activity - Total

(dollars in thousands)

Description:	2020 Actual	2021 Budget Estimate
VA Medical Centers, VISNs & Other Field Activities 1/:		
VAMCs and Other Field Activities.....	$4,366,135	$5,251,500
VISN Headquarters.....	$582,965	$203,501
Subtotal.....	**$4,949,100**	**$5,455,001**
VHACO & National Consolidated Activities:		
Consolidated Mail Outpatient Pharmacies (CMOP).....	$20,581	$20,499
Employee Education Service Center.....	$81,671	$85,518
National Center for Patient Safety.....	$8,443	$7,499
Office of Community Care.....	$935,053	$1,023,240
Office of Health Informatics.....	$187,413	$203,525
Readjustment Counseling Service.....	$4,384	$8,277
VHA Central Office.....	$1,040,960	$901,017
VHA Member Services.....	$213,075	$222,689
VHA Service Center.....	$281,265	$279,038
Subtotal.....	**$2,772,845**	**$2,751,302**
Prior Year Recoveries.....	$167	$0
MSC Obligations [Total].....	**$7,722,112**	**$8,206,303**

1/ In 2020, prior to the VHA Reorganization, VAMCs and VISNs underwent adminstrative service-level consolidation from the VAMC to the VISN, resulting in an actual higher 2020 Actual than what had been previously projected as the 2020 Current Estimate and 2021 Budget Estimate in the 2021 President's Budget.

Medical Support and Compliance 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.

VA Medical Center (VAMC) and Veteran Integrated Service Networks (VISN) Based Activities

The obligations shown in the tables below reflect discretionary budget authority plus reimbursements.

VA Medical Centers (VAMCs)

VA Medical Centers 1/
(dollars in thousands)

Description	2020 Actual/2	2021 Budget Estimate/2	2021 Current Estimate	2022 Revised Request	2023 Advance $5,754,542	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations	$4,301,501		$4,796,311	$5,175,652	$5,754,542	$379,341	$578,890
Mandatory Obligations 3/	$0		$0	$300,000	$0	$300,000	($300,000)
Obligations [Total]	$4,301,501		$4,796,311	$5,475,652	$5,754,542	$679,341	$278,890

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.
2/ In previous budgets, the funding displayed for VAMC and VISN headquarters included Specific Purpose funds in addition to General Purpose funds. The budget data displayed in this year's budget reflects the VHA Reorganization and includes only General Purpose funds for these two line items.
3/ 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 for the Medical Support and Compliance category. Final 2022 funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

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 medical center leadership teams (Director, Chief of Staff, Chief Medical Officer, and Chief Nurse), medical center support functions (quality of care oversight, security services, legal services, billing and coding activities, acquisition, procurement, and logistics activities), human resource 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 medical centers and clinics with the verification of insurance and the coding of inpatient and outpatient encounters. The increase in obligation projections for 2021 - 2023 are directly related to inflationary and programmatic growth for implementing initiatives.

Veteran Integrated Service Networks (VISN)

Veterans Integrated Service Networks (VISN)
(dollars in thousands)

Description	2020 Actual/1 2	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations [Total].....	$582,966		$605,701	$650,084	$663,085	$44,382	$13,002

1/ In previous budgets, the funding displayed for VAMC and VISN headquarters included Specific Purpose funds in addition to General Purpose funds. The budget data displayed in this year's budget reflects the VHA Reorganization and includes only General Purpose funds for these two line items.
2/ In 2020, prior to the VHA Reorganization, VAMCs and VISNs underwent administrative service-level consolidation from the VAMC to the VISN, resulting in an actual higher 2020 Actual than what had been previously projected as the 2020 Current Estimate and 2021 Budget Estimate in the 2021 President's Budget.

Program Description

These funds provide the necessary resources for the VISN offices that provide regional support, management and oversight to the medical centers, 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 of the VA health care facilities within the VISN. The increase in obligation projections for 2021-2023 are directly related to inflationary and programmatic growth for implementing initiatives.

VHA Central Office (VHACO) Based Activities

Community Care

Community Care
(dollars in thousands)

Description	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations [Total].....			$1,023,345	$1,037,856	$1,064,391	$14,511	$26,535

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.

Program Description

The OCC was established in 2015 by the VHA Under Secretary for Health. The goal of OCC is to deliver a program that is easy to understand, simple to administer, and meets the needs of Veterans and their families, community providers, and VA staff. OCC provides Veterans access to health care by community providers when services are not available at a VA facility, are not available within a clinically appropriate timeframe, or when distance makes these services inaccessible. OCC currently uses multiple programs to increase Veterans access to high-quality care outside of VA. Through these programs, OCC also has responsibility for the Revenue Operations program

that oversees billing and collections for non-service-connected hospital care and medical services for certain Veterans. VA has authority to bill third- party health insurance and bill copayments to certain Veterans for non-service-connected care when provided in the VA or through community care programs. OCC served just over 2 million Veterans in 2020 and provides services to eligible caregivers and dependents through family programs. MSC obligations includes the cost of personnel services for 7,246 FTE, contracts for operational and Program Management Office (PMO) support, claims processing support and commercial off the shelf (COTS) claims processing systems.

Assistant Under Secretary for Health for Community Care & Deputy Assistant Under Secretary for Health for Community Care

The offices of the Assistant Under Secretary for Community Care and Deputy Assistant Under Secretary for Community Care serve Veterans by collaborating with colleagues and stakeholders to provide excellence in health care operations and administration. OCC leads VA in advancing business practices that support patient care and delivery of health benefits and provides executive program support to the Under Secretary for Health on a wide range of health benefit administration programs, activities, development of administrative processes, policy, regulations, and directives associated with the delivery of VA health benefit programs.

OCC manages six Directorates: Business Operations and Administration, Revenue Operations, Delivery Operations, Clinical Integration and Field Operations, Network Management, and Chief Health Informatics Office. Headquartered in Washington, DC, OCC has field offices in Denver, Colorado; Lebanon, Pennsylvania; Las Vegas, Nevada; Leavenworth, Kansas; Asheville, North Carolina; Middleton, Wisconsin; Smyrna, Tennessee; and Orlando, Florida.

Business Operations and Administration (BOA)

Business Operations and Administration (BOA) is a shared service organization that provides key supporting infrastructure for OCC, with executive oversight for development of administrative regulations and processes; budgeting for salary, travel, and payroll; employee protections, communications and congressional correspondence. The following offices are aligned under BOA: Policy and Planning, Financial Management, Equal Employment Opportunity, Communications, Program Administration Support Services, Project and Portfolio Services and Congressional Correspondence. Each office is led by a senior manager and is staffed with professionals responsible for delivering core services throughout the VHA OCC organization, VA, and directly to Veterans and their families.

Clinical Integration and Field Operations (CIFO)

The Office of Clinical Integration and Field Operations (CIFO) develops and guides the field with implementation of OCC's standardized operating model. This includes standard processes for how resources (people, process, technology and data) should be organized and operate within their local VA Community Care departments to best enable community care for Veterans. The following offices are aligned under CIFO: Administrative Field Operations, Clinical Field Operations, and Medical Policy, Quality and Safety.

Chief Health Informatics Officer (CHIO)
The Chief Health Informatics Executive Directorate is an integral OCC component that provides support services to areas that have high impact to the OCC organization and its mission. Operationally, CHIO is responsible for consultation, and data-driven analysis. The following offices are aligned under CHIO: Office of Informatics and Data Analytics (IDA) and Medical Cost Management (MCM). Through these organizations, CHIO plays a strategic role in supporting advanced technology implementations, informs future planning and budget formulations.

Delivery Operations (DO)
Delivery Operations administers congressional mandated healthcare programs that allow Veterans and their family members to receive care and services through community providers outside of VA (i.e., Veterans Community Care) and manages Veteran and family member programs that pay for care outside of VA (i.e., Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) and Foreign Medical Program (FMP). The following offices are aligned under DO: Payment Operations & Management, Customer Experience, Resource Management, and Family Member & Special Veteran Programs.

Network Management (NM)
Network Management (NM) develops and oversees contracts for Veteran healthcare services within the United States. The directorate ensures quality network providers are enrolled to serve Veterans and provides contract/agreement administration and support for those community healthcare services. NM ensures contracted/agreement health care under the Veterans Community Care Program (CCN, PC3, VCAs and National Dialysis) provides the best health care to our Veterans. In addition, NM further supports the contracts with provider education and outreach, along with detailed responses to customers and community stakeholders. NM also updates contracts as necessary with modifications to ensure the best health coverage for our Veterans. The following offices are aligned under NM: Provider Experience, Contracts & Agreements Management, Acquisition, Network Support, and Operations & Administrations.

Revenue Operations (RO)
Revenue Operations manages the centralized processes that allow VA to collect revenue from private health insurance carriers for non-service-connected care provided to insured Veterans. Funds that are collected go back to VA medical facilities to provide health care services to Veterans. VHA Revenue Operations is responsible for managing back-end revenue cycle processes that take place at the seven Consolidated Patient Account Centers (CPACs) located across the country. With the 2022 resources request, Revenue Operations will continue to support collection operations. The following offices are aligned under RO: Payer Relations & Services, Quality & Performance, eBusiness, and Operations.

Combating Fraud, Waste, and Abuse
The OCC has implemented several initiatives to combat fraud, waste, and abuse. Using the Program Integrity Tools, OCC deploys pre-payment business rules to identify potential improper payments before claims are paid. OCC's Business Integrity & Compliance (BIC) directorate provides oversight to claims payments through a robust internal auditing program, as well as development and testing of internal controls. The 2020 Payment Integrity Information Act (PIIA) audits resulted in the CHAMPVA program achieving an improper payment rate under 1.5%, and

the VA Community Care program demonstrating a reduction in improper payments. BIC also conducts post-payment data analytics to identify "outliers" that may be an indication of fraud, waste, and abuse. Where evidence of criminal fraud exists, OCC collaborates with the VA Office of Inspector General (OIG) to pursue prosecution and recovery of payments.

Clinical Services

Clinical Services
(dollars in thousands)

Description	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations [Total].....			$143,810	$172,040	$176,616	$28,230	$4,576

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.

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, and 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. The medical support funds are 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 million in contractual services. Of the 93 FTE, 57 FTE provide direct support to seven Homeless Programs Initiatives: **HUD-VASH**, 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 (HCHV)**, which provides contract residential services, outreach, and case

management to Veterans who are homeless or at-risk of homelessness; **Veterans Justice Outreach (VJO)**, which aims to prevent homelessness and avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans; **Homeless Veterans Community Employment Services**, which assists Veterans with accessing employment opportunities to support their housing needs, improve the quality of their lives, and assist in their community reintegration efforts; the **Grant and Per Diem (GPD)** program that awards grants to community-based agencies to create transitional housing programs and offer per diem payment to GPD funded organization; the **Supportive Services for Veteran and Families (SSVF)** program that provides supportive services to homeless and at-risk Veteran families; and the **Veterans National Homeless Registry,** which maintains a comprehensive repository of Veterans who have been identified as homeless or at risk for homelessness. 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 Homeless Programs section in the Medical Care chapter for more information.

Mental Health and Suicide Prevention

The Office of Mental Health and Suicide Prevention (OMHSP) employs national and international subject matter experts (958 FTE, of which 94 are funded by MSC) 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. OMHSP 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.

OMHSP'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, OMHSP manages some of the Department's largest outreach campaigns, such as #BeThere, Make the Connection, AboutFace, and other public-facing resources. OMHSP's National Center for Post-Traumatic Stress Disorder (PTSD), VA's Center of Excellence in research and education on PTSD, developed the COVID Coach app and other tools for dealing with stressors, which have been downloaded over 135,000 times and 90,000 times respectively since the pandemic began. Please see the Mental Health and Suicide Prevention 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 (DMA) 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 (C&P) and the Integrated Disability Evaluation System (IDES) programs. These responsibilities include securing and

execution of funding, quality performance improvement, clinician certification and training, providing analytics support, and development of national C&P 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 SCI/D National program office utilizes MSC funding to support salary expenses, travel, education/conferences for staff, and printing expenses. In addition to the above, the MSC funding also supports contracts for Long Term Care Institute surveys and uSPEQ customer satisfaction surveys.

Surgery
The National Surgery Office 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 selected special purpose funds for the delivery of transplant and related services.

Discovery, Education, and Affiliate Networks

Discovery, Education and Affiliate Networks
(dollars in thousands)

Description	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations			$44,469	$42,687	$43,511	($1,782)	$824
Mandatory Obligations			$1,398	$1,453	$1,509	$55	$56
Obligations [Total]			$45,867	$44,140	$45,020	($1,727)	$880

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.

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 Title 38 Section 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 healthcare innovations in the field to better serve Veterans.

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 as outlined in Title 38 United States Code Section 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 healthcare workforce in VA. OAA's MSC funding supports (1) OAA staff salaries and travel, (2) Funding for mission critical conferences and committees (e.g., National Academic Affiliations Council, National Designated Education Officer Conference, and Request for Proposal Review Committees), (3) Funding for National Coordinating Centers for VA-based advanced fellowships, and (4) Fees and payments for accreditation of VA-based health professions programs.

Community Engagement

The Office of Community Engagement (OCE) program office 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.

Innovation Ecosystem

The Innovation Ecosystem (IE) uses the MSC appropriation to fund staff salaries and travel. Additionally, the appropriation allows for project support through the IE portfolios: Diffusion of Excellence (DoE), Innovators Network (iNet), Care & Transformational Initiatives (CTI), Fellowships and Community, and National Centers for Collaborative Healthcare Innovation (NCCHI). The funding also allows funding of a support services contract that serves the Ecosystem as a whole.

Research and Development

The Office of Research and Development program office 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 (VIReC) 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 sub-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 (VSMS) 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	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations [Total].....			$175,973	$188,867	$192,645	$12,894	$3,778

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.

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 Assistant Under Secretary for Health for Operations 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 Veterans Access to Care; Office of Emergency Management; Member Services; and the Healthcare Operations Center.

Access
The Office of Veterans Access to Care (OVAC) MSC funds are utilized to offer Veterans timely and quality access to care activities and operations across VACO, VISNs and VAMCs. The funds are used to advance VA access priorities: support and sustain the MISSION Act, oversee the virtual care delivered through the clinical contact centers and video-to-home, expand and sustain same-day services in Primary Care and Mental Health, offer Patient-Centered Scheduling, expand direct scheduling, modernize patient scheduling, and provide the oversight and accountability for access improving solutions in emerging technology and the community. OVAC uses MSC funds to collaborate with the OCC, Office of Healthcare Transformation, and other VHA Program Offices, which directly supports the tenets of the myVA Access Declaration that outlines a consistent set of expectations regarding what a Veteran deserves when he or she enters any VHA facility.

Emergency Management
Funding in this account for the OEM 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.

Healthcare 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 Healthcare Operations Center provides rapid, near real-time information and analyses to support senior leader decision-making and problem-solving and improve VHA's ability to provide Veterans timely access to the highest quality care.

Member Services
Member Services' (MS) 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 (HEC), which enrolls eligible Veterans who apply for VA health care in addition to providing other enrollment and related services; Health Resource Center (HRC), which assists Veterans in understanding and obtaining benefits; Veterans Transportation Program (VTP) which helps alleviate the costs of travel to medical appointments for eligible Veterans; and Pharmacy Services (PS), which assists Veterans with management of prescription issues and co-payments 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.

Patient Care Services

Patient Care Services
(dollars in thousands)

Description	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations [Total].....			$181,189	$194,174	$198,029	$12,985	$3,855

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.

Program Description
The Office of Patient Care Services leads VHA in delivering the highest quality, Veteran-centric care, supporting health and well-being through leveraging technology, and providing clinical services across the continuum of care. The Assistant Under Secretary for Health for Patient Care Services 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 patient care services. 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. The Office of PCS is comprised of the following health care services/programs:

Care Management and Social Work Services
This office leads VA's transformation towards a Veteran-Centric organization by providing personalized care management, clinical interventions and supportive programming for Veterans, their families and caregivers. These goals are achieved through the coordination of care, services

and benefits afforded to Veterans by VA programs and in collaboration with community partners. Care Management and Social Work (CM/SW) provides oversight and leadership of clinical and supportive programming across the VHA focusing on assisting wounded, injured and ill Servicemembers, Veterans, their family members and caregivers with resolving Social Determinants of Health challenges to health and well-being.

The programs that fall under CM/SW are the Intimate Partner Violence Assistance Program; VA Liaison Program; Caregiver Program; the Fisher House and Family Hospitality Program that encompasses policy development and implementation, construction planning, activation and operations oversight and community engagement for all non-clinical temporary lodging programs including: VA Fisher Houses and other Temporary Lodging; Social Work, which assists Veterans, their families, and caregivers in resolving Social Determinants of Health challenges to health and well-being, using a person in environment perspective; and the Transition and Care Management Program, which provides comprehensive transition assistance and longitudinal case management to Post 9/11-era wounded, ill, and injured Servicemembers and Veterans.

Chaplain Services
MSC funds are utilized for necessary expenses (Personnel Compensation, Travel and Transportation of Persons, Printing and Reproduction and other contractual services) in the provision of oversight and management of the National Chaplain Services and the planning and directing a Spiritual and Pastoral Care Program consistent with the overall mission of health care delivery in VHA.

Connected Care
Provides VA digital technology to Veterans and health care professionals, through virtual technology. VA is able to deliver care to patients where and when they need it. MSC funds are used for Program Office salaries, contracts, travel supplies, and MOU) to support services that improve convenience to Veterans by providing access to care from their homes or local communities. Additionally, the office provides support for some field cost which represents the gap between current state and strategic plan standards at the VISN, facilities, and CBOCs for Telehealth (TH) Technology Managers, Connected Health (CH) Coordinators, CH Assistants, Facility Telehealth Coordinators, Home Telehealth leads, and VISN TH leads. Funding would be provided to field as directed funding in conjunction with a Connected Care Staffing policy that requires the positions.

Geriatrics and Extended Care
Provides national guidance on the long-term services and support for geriatric Veterans and those requiring extended care. This includes: Facility Based Programs, Home & Community Based and Purchased Care Programs, and the Data Analytics, Quality Improvement and Research support. GEC manages the Community Living Centers (CLC) and State Veteran Home (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 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 fund 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 & 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 (PBM) 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 healthcare 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 Services advises the VA senior management of all matters relating to the employment and effective utilization of the 2,600 Physician Assistants (PA) 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 accessible, evidence-based, equitable, and high value Veteran-centric interactions. The office has oversight for the Office of Rural Health, Post Deployment Health Services; Health Equity, which 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 tools; the Lesbian, Gay, Bisexual, and Transgender Health Program that oversees policy, education, consultation, and implementation of best clinical practices to reduce health disparities in sexual and gender minority Veterans; the National Center for Health Promotion and Disease Prevention, which provides programs, resources, training, and guidance to promote health promotion, disease prevention, and health education for Veterans through the Veterans Health Library and the HealtheLiving Assessment; Public Health, which leads public health activities, surveillance and investigations for high consequence infections through the VA National Public Health Laboratory, staff and technology to conduct investigations and surveillance, VHA's All-Hazards Emergency Cache program, and interagency activities; and Health Solutions, which deploys and refines electronic medical record solutions to monitor and optimize health care delivery as exemplified by Clinical Case Registries, Cerner HealtheRegistries and Health Maintenance, and interfaces to State/Territory Public Health Immunization Information Systems.

Rehabilitation and Prosthetic Services
Rehabilitation and Prosthetic Services oversees program and policy development for 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 eight national programs with 11 different rehabilitation disciplines: Physical Medicine & Rehabilitation; Blind Rehabilitation; Chiropractic Care; Audiology and Speech Pathology; Recreation Therapy; Orthotic, Prosthetic, and Pedorthic Clinical Services; Prosthetics and Sensory Aids; and the National Veterans Sports Program. 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

Sterile Processing Services (SPS)
The National Program Office of Sterile Processing utilizes MSC funds to support consultative contracts such as the current contract with Booz Allen Hamilton in the development of a Risk Identification Triage Mitigation Sustainment (RiTMS) tool. This tool supports early identification of risk and major vulnerabilities faced by SPS departments and provides opportunities to mitigate in advance of an adverse event.

Quality and Patient Safety and Core Finance Administration

Quality and Patient Safety and Core Finance Administration
(dollars in thousands)

Description	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations [Total].....			$428,130	$453,789	$462,865	$25,659	$9,076

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.

Program Description
The Office of Quality and Patient Safety (QPS) provides oversight, expertise, and support to advance the highest standards of care, innovation, responsible stewardship, and ethical practice within the VA health care system.

Core Finance Administration fund supports Activations, replacement of the Financial Management System (FMS), fingerprinting and security checks, and other administrative support for Central Office. In the 2023 Budget Submission, this will align within the All Other Support and Program Offices.

Clinical Risk Management
The Clinical Risk Management program office uses MSC funds to support salaries, travel, and training for staff who provide oversight to facilities and VISNS. Funds also support contracts for the Medical Advisory Opinion project, the External Clinical Peer Review Program, and for a provider locator service to assist in finding valid addresses for providers named in administrative tort claims.

Evidence-Based Practice
Evidence Based Practice MSC dollars support salaries, travel, and training for staff, in addition to contract costs for an independent vendor to facilitate development of congressionally mandated clinical practice guidelines, and for a third-party certified evidence-based practice center by the US Agency for Healthcare Research and Quality (AHRQ).

External Accreditation
MSC funds are utilized to pay for VHA national accreditation contracts securing required accreditation for all VHA facilities/programs, as well as salaries, travel, and training for staff. VHA policy requires health care facilities providing care to our nation's Veterans maintain ongoing compliance with regulatory standards that demonstrate the provision of safe, high-quality care. Program Office role/responsibility is focused on oversight of VHA national contracts for accreditation services, specifically for Healthcare Accreditation (with current vendor The Joint Commission), Rehabilitation Program Accreditation (with current vendor Commission on Accreditation for Rehabilitations Programs) and Healthcare Accreditation Survey Readiness (current vendor Critical Management Solutions). VHA national accreditation contracts ensure enterprise-wide standardization to obtain and maintain required accreditation for all VHA facilities/programs in addition to providing preparedness resources and support, such as tailored consultation for all facilities, educations/webinars, and electronic tools/publications.

Medical-Legal Affairs
The Office of Medical-Legal Affairs serves Veterans by fulfilling VA's memorandum of understanding with the Department of Health and Human Services (HHS) to participate in the National Practitioner Data Bank reporting process, supporting quality improvement efforts by communicating identified issues in patient care associated with poor patient outcomes, and facilitating Regional Counsels' investigations of filed tort claims nationwide. The office's MSC funds are used for salaries, travel, professional conferences, education, and oversight to facilities and VISNs.

Medical Staff Affairs
The Office of Medical Staff Affairs has policy oversight for credentialing and privileging of health care providers, reporting to state licensing boards and reporting to the National Practitioner Data Bank. Medical Staff Affairs provides extensive training, support, and consultation to credentialing staff members nationwide, Chiefs of Staff, VISN leadership, and other Central Office Program Offices. The office also maintains the national electronic credentialing system and uses MSC funds to support staff salaries travel, professional conferences, education, and oversight to facilities and VISNs. Additionally, funds also go into four different contracts: Federation of State Medical Boards (FSMB) Disciplinary Alerts; American Board of Medical Specialties (ABMS) Certification Data; Clinical Privileges Library (Health Stream) and Dept. of HHS - VetPro Web Hosting.

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 High Reliability Organization (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 healthcare solutions, technology, 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 (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 (CSAR), which develops the Strategic Analytics for Improvement and Learning (SAIL) report to measure, evaluate and benchmark quality and efficiency at VA medical facilities, in addition to utilizing data from the Centers for Medicare and Medicaid Services (CMS) for comparisons to the private sector; the Inpatient Evaluation Center (IPEC), which produces innovative products focused on tracking and improving the outcomes of hospitalized Veterans; and the Office of Productivity, Efficiency, and Staffing, which is dedicated to enhancing VHA healthcare 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 Healthcare Experiences of Patients (SHEP) to measure patient experiences in the VA; 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.

Systems Redesign and Improvement

The Office of Systems Redesign and Improvement (SR&I) was established to oversee the Systems Redesign and Quality Improvement activities enterprise wide in VHA. In this role, SR&I provides policy guidance to VISNs and VAMCs regarding the organization and execution of their Systems Redesign and Quality Improvement programs and activities. A national policy developed by SR&I also supports the direction of this work. In addition, SR&I acts as the authoritative source of information for questions and guidance from the VISNs or VAMCs. SR&I has developed standardized training in improvement methods, and both delivers this training and provides “train the trainer” support. Collectively, this support for VHA continuous process improvement links directly to the VHA HRO transformation.

Systems Reliability and Consultation

High Reliability Systems & Consultation (HRSC) utilizes its MSC funds for staff salaries, education, and travel to support the VHA's goal to be an HRO by using quality management system (QMS) principles to ensure safe healthcare for Veterans. HRSC promotes process standardization and continual improvement within a “Just Culture” to achieve the ultimate goal of “Zero Harm” to Veterans and their caregivers.

Center for Improvement Coordination

The Center for Improvement Coordination (CIC) utilizes its MSC funds for staff salaries, travel, and training to partner collaboratively with VHA Senior Leaders, VHA Program Offices, VISN Leadership teams, and VAMCs on quality improvement initiatives. CIC's multidisciplinary team engages closely with VISN and VAMC leadership and staff to strengthen quality and patient safety at their facilities. CIC's mission is to promote high-quality care informed by data and strengthened by supportive leadership who embrace change management processes.

Support Services

Support Services
(dollars in thousands)

Description	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations			$493,957	$0	$517,236	($493,957)	$517,236
Mandatory Obligations /2			$0	$678,433	$0	$678,433	($678,433)
Obligations [Total]			$493,957	$678,433	$517,236	$184,476	($161,197)

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.
2/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the column displays the estimated allocations for the Medical Support and Compliance category. Final 2022 funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Program Description

The Office of the Assistant Under Secretary for Health for Support provides facilities, engineering, equipment, occupational safety and health, and procurement/logistics support services, expertise, and program oversight to enable effective and efficient medical facility Operations, Clinical Services, and Patient Care Services.

Healthcare Environment and Facilities Programs

Healthcare Environment and Facilities Programs (HEFP) uses MSC funds to provide oversight in the areas of capital asset management, healthcare 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.

Healthcare Technology Management

The Healthcare Technology Management (HTM) office uses MSC funds to employ biomedical engineers and other support staff to provide oversight to Biomedical Engineering (BME) 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.

Procurement and Logistics
The Procurement and Logistics (P&LO) 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 healthcare products and services for all facilities; provide world-class logistics and acquisition services to VHA's integrated healthcare system and medical facilities; and develops, implements, and oversees policies and processes compliant with all applicable laws and regulations.

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 & facilities as a self-sustaining entity with one Mission; "Providing Comfort and Well-being." 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 Veterans Canteen Service Revolving Fund section in the Revolving and Trust Activities chapter for more information.

VA Logistics Redesign
The VA Logistics Redesign (VALOR) program office is tasked with modernizing VA by conducting the enterprise deployment of the Department of Defense (DoD) Defense Medical Logistics Standard Support (DMLSS) system as VA's single, integrated logistics and medical support services management solution. DMLSS, and its technical refresh solution LogiCole supports VHA's business processes across multiple service lines, including logistics/supply, facilities management/engineering, environmental program services, biomedical/healthcare technology management, interior design, emergency management, occupational safety and health, information technology, finance/acquisitions, and prosthetics. 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	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations [Total].....			$217,140	$233,778	$238,476	$16,638	$4,698

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.

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 more than 363,000 VHA employees and over 120,000 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 Department-wide 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: Employee Education System (EES), Healthcare Leadership Talent Institute (HLTI), National Center for Organization Development (NCOD), 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.

Employee Education System (EES)

Employee Education System (EES) provides training solutions and services to empower VA's development of a high performing workforce that delivers exceptional care to our Veterans. EES serves as the largest single provider of accredited learning, alignment with 19 major health care accrediting bodies which provides 2 million continuing education credits earned by 200,000 clinical learners. EES 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 EES for high-quality, impactful education and training support. Together with partners in learning across the administration, EES learning consultants, project teams, and support staff assess learning requirements, design curricula and courses, and deliver and evaluate education and training to meet the workforce development and continuing education needs of more than 363,000 clinical, administrative, and technical employees. EES serves as managing partner for the Federal Healthcare Training Partnership, consisting of agencies (including DoD) that collaborate and share continuing medical education training programs among partner organizations with a clinical and public health training mission. EES 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 Affiliated 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.

Healthcare Leadership Talent Institute (HLTI)

Healthcare Leadership Talent Institute (HLTI) develops and implements an integrated talent management system from the local to the national level. HLTI is responsible for linking together 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. HLTI promotes and manages leadership programs and developmental opportunities that maximize the acquisition of leadership and healthcare leadership competencies through growth activities that are 70% experiential (e.g., activities, details, assignments, committees), 20% exposure (e.g., coaching, mentoring, shadowing), and 10% traditional didactic training. HLTI 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. MSC funds support leadership development of VHA staff throughout the organization at all levels.

National Center for Organization Development (NCOD)

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 Department of Veterans Affairs. 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 coaches that are eligible for the International Coaching Federation (ICF) 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)

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 human resources issues. WMC provides full-service HR operations for 45,000 VA employees (including VHACO, specific VA staff office organizations, and VA's Office of Information and Technology) and serves as the delegated examining unit for all VHA. WMC also provides Personnel Security and Credentialing oversight to VISNs and Medical Centers through issuance of policy, technical guidance, and consultative services focused on establishing consistency in suitability and credentialing-related practices. MSC funds support essential human resources staff salaries, human capital recruitment, and retention programs such as employee scholarship programs, and critical human resources contracts and services supporting VHA employees nationwide.

Health Informatics

Health Infomatics
(dollars in thousands)

Description	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations [Total].....			$101,934	$109,403	$111,591	$7,469	$2,188

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.

Program Description

Office of Health Informatics (OHI) oversees the collection, exchange, and use of Electronic Health Record (EHR) data, optimizes the current EHR to promote evidence based decision-making and patient-centered care, and delivers health information technology (HIT) 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 the Electronic Health Record Modernization (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.
- Partnering with VHA Programs and VA's Office of Information and Technology OIT to deploy enterprise applications and databases to support strategic goals and objectives for VHA.

Clinical Informatics and Data Management Office

Clinical Informatics and Data Management Office (CIDMO), formerly known as Health Informatics (HI), is the focal point for advancing VA's EHR and information systems. CIDMO serves as the primary advocate for field clinicians regarding HIT . The office provides program support to HIT solutions such as the Veterans Health Information Exchange (VHIE) and the enterprise Health Management Platform (eHMP).

Health Information Governance

Health Information Governance (HIG) represents VA on national and international health care policy initiatives regarding Veterans' data. HIG serves as VHA's subject matter and policy expert regarding privacy, health care security, and on data contained in Veterans' EHR and in national data systems. They provide 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 confidentiality statutes and HIPAA 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) facilitates sound decision-making for the development, acquisition, and maintenance of health-focused IT investments by providing leadership with a comprehensive understanding of needed VHA business capabilities including business requirements, processes, information needs, IT strategy and priorities, and investment analysis. SIM provides a wide range of services including, business requirements/architecture development for health IT solution development or acquisition, business process re-engineering, software release management, health IT governance management, health IT analysis and budget development, health IT strategic planning and business transformation, as well as VistA Standardization coordination with the Open Source Community.

All Other Support and Program Offices

All Other Support and Program Offices
(dollars in thousands)

Description	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations [Total].....			$250,765	$261,785	$267,013	$11,020	$5,228

1/ Detailed budget data for 2020 Actuals and the 2021 Budget Estimate that align with the VHA Reorganization are not available. Additional detail for 2020 Actuals is displayed in the VHA Pre-Reorganization section.

Program Description

The VHA program offices in this line include: Patient Advocacy, Readjustment Counseling, Women's Health, Healthcare Transformation, Finance, Strategy, Risk Management, the Chief of Staff, Office of the Deputy Under Secretary for Health, and the Office of the Under Secretary for Health.

Prior-Year Recoveries

Prior Year Recoveries
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations.....	$167	$0	$0	$0	$0	$0	$0
Mandatory Obligations.....	$0	$0	$0	$0	$0	$0	$0
Obligations [Total].....	$167	$0	$0	$0	$0	$0	$0

VA's accounting system now records prior-year recoveries as required by Federal accounting policy under Office of Management and Budget (OMB) Circular No. A-11 guidance. Because this is a technical change that does not affect the actual resource levels provide for Veterans services, there are no projections for future years. VA has modified its financial accounting system to be able to accurately monitor and record recoveries.

Veterans Choice Act, Public Law 113-146, Medical Support and Compliance, Section 801 (0152XA)

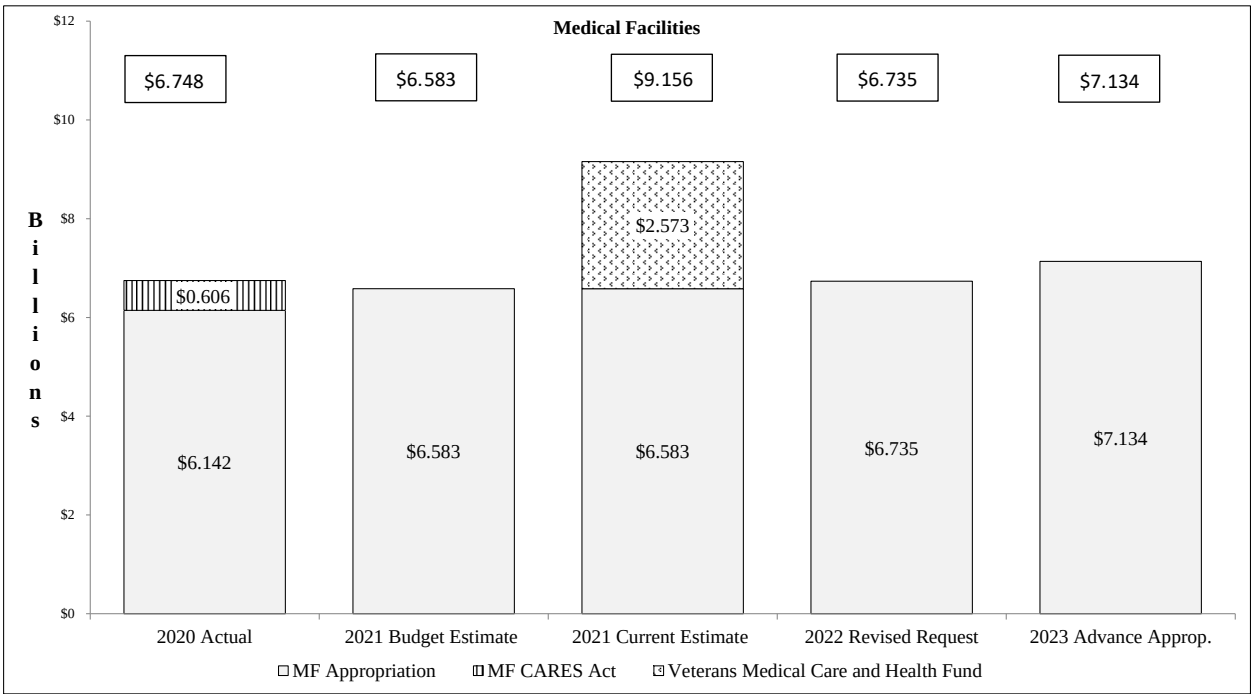
Veterans Choice Act - Section 801
Medical Support and Compliance
(dollars in thousands)

Description	2020 Actual/1	2021 Budget Estimate/1	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Mandatory Obligations [Total].....	$1,346	$3,262	$1,398	$1,453	$1,509	$55	$56

Within the Medical Support and Compliance appropriation, estimates of obligations for 2022 and 2023 are $1.453 million and $1.509 million respectively. The obligations will be spent on staffing and contracts to support Section 301 (GME).

Medical Facilities

Chart: Medical Facilities Appropriations [1/]



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 Facilities category. Final funding allocations among account-level categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Table: Medical Facilities Crosswalk, 2020-2023
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Appropriation Medical Facilities (0162)							
Advance Appropriation	$6,141,880	$6,433,265	$6,433,265	$6,734,680	$7,133,816	$301,415	$399,136
Annual Appropriation Adjustment	$0	$150,000	$150,000	$0	$0	($150,000)	$0
CARES Act (P.L. 116-136)	$606,000	$0	$0	$0	$0	$0	$0
Appropriations Request [Subtotal]	$6,747,880	$6,583,265	$6,583,265	$6,734,680	$7,133,816	$151,415	$399,136
Net Appropriation	**$6,747,880**	**$6,583,265**	**$6,583,265**	**$6,734,680**	**$7,133,816**	**$151,415**	**$399,136**
Tranfers To							
JALFHCC (0169)	($39,245)	($40,297)	($40,297)	($92,830)	($41,371)	($52,533)	$51,459
Transfers To [Subtotal]	($39,245)	($40,297)	($40,297)	($92,830)	($41,371)	($52,533)	$51,459
Budget Authority [Total]	$6,708,635	$6,542,968	$6,542,968	$6,641,850	$7,092,445	$98,882	$450,595
Reimbursements	$18,420	$18,465	$18,420	$18,420	$18,420	$0	$0
Unobligated Balance (SOY)							
No-Year	$11,153	$0	$12,985	$0	$0	($12,985)	$0
P.L. 115-141 sec 255 (NRM)	$523,601	$0	$299,657	$0	$0	($299,657)	$0
P.L. 115-244 sec 248 (NRM)	$662,524	$512,449	$512,199	$61,302	$0	($450,897)	($61,302)
H1N1 No-Year (PL 111-32)	$5	$0	$5	$0	$0	($5)	$0
2-Year	$119,894	$0	$137,079	$200,000	$0	$62,921	($200,000)
2-Year CARES Act (P.L. 116-136)	$0	$0	$293,204	$0	$0	($293,204)	$0
4-Year Base Year 2018	$59,646	$0	$46,071	$0	$0	($46,071)	$0
5-Year Base Year 2019 - P.L. 116-20 (Disaster Relief)	$1,333	$0	$0	$0	$0	$0	$0
Unobligated Balance (SOY) [Subtotal]	$1,378,156	$512,449	$1,301,200	$261,302	$0	($1,039,898)	($261,302)
Transfer of Unobligated Balance (PL 116-136 §20001)							
From Medical Services CARES Unob. Bal.	$0	$0	$100,000	$0	$0	($100,000)	$0
Unobligated Balance (EOY)							
No-Year (Other)	($12,985)	$0	$0	$0	$0	$0	$0
P.L. 115-141 sec 255 (NRM)	($299,657)	$0	$0	$0	$0	$0	$0
P.L. 115-244 sec 248 (NRM)	($512,199)	$0	($61,302)	$0	$0	$61,302	$0
H1N1 No-Year (PL 111-32)	($5)	$0	$0	$0	$0	$0	$0
2-Year	($137,079)	$0	($200,000)	$0	$0	$200,000	$0
2-Year CARES Act (P.L. 116-136)	($293,204)	$0	$0	$0	$0	$0	$0
4-Year Base Year 2018	($46,071)	$0	$0	$0	$0	$0	$0
5-Year Base Year 2019 - P.L. 116-20 (Disaster Relief)	$0	$0	$0	$0	$0	$0	$0
Unobligated Balance (EOY) [Subtotal]	($1,301,200)	$0	($261,302)	**$0**	**$0**	$261,302	$0
Lapse	($644)	$0	$0	$0	$0	$0	$0
Subtotal	$6,803,367	$7,073,882	$7,701,286	$6,921,572	$7,110,865	($779,714)	$189,293
Prior Year Recoveries	$8,723	$0	$0	$0	$0	$0	$0
Discretionary Obligations (0162) [Total]	**$6,812,090**	**$7,073,882**	**$7,701,286**	**$6,921,572**	**$7,110,865**	**($779,714)**	**$189,293**
Veterans Medical Care and Health Fund (0173MF) 1/							
Mandatory Appropriations	$0	$0	$2,572,928	$0	$0	($2,572,928)	$0
						$0	$0
Unobligated Balance (SOY)	$0	$0	$0	$2,572,928	$0	$2,572,928	($2,572,928)
Unobligated Balance (EOY)	$0	$0	($2,572,928)	$0	$0	$2,572,928	$0
Obligations (0173MF) [Total]	**$0**	**$0**	**$0**	**$2,572,928**	**$0**	**$2,572,928**	**($2,572,928)**
VACAA, Section 801 (0162XA)							
Unobligated Balance (SOY)	$25,600	$3,750	$30,437	$24,753	$18,847	($5,684)	($5,906)
Unobligated Balance (EOY)	($30,437)	$0	($24,753)	($18,847)	($12,711)	$5,906	$6,136
Subtotal	($4,837)	$3,750	$5,684	$5,906	$6,136	$222	$230
Prior Year Recoveries	$10,308	$0	$0	$0	$0	$0	$0
Obligations (0162XA) [Total]	**$5,471**	**$3,750**	**$5,684**	**$5,906**	**$6,136**	**$222**	**$230**
Mandatory Budget Authority	$0	$0	$2,572,928	$0	$0	($2,572,928)	$0
Mandatory Obligations [Total]	**$5,471**	**$3,750**	**$5,684**	**$2,578,834**	**$6,136**	**$2,573,150**	**($2,572,698)**
Obligations [Grand Total]	**$6,817,561**	**$7,077,632**	**$7,706,970**	**$9,500,406**	**$7,117,001**	**$1,793,436**	**($2,383,405)**
FTE							
Medical Facilities (0162)	25,254	26,709	25,367	26,654	26,653	1,287	(1)
CARES Act	390	0	780	0	0	(780)	0
Veterans Medical Care and Health Fund	0	0	0	0	0	0	0
VACAA, Section 801 (0162XA)	0	0	0	0	0	0	0
FTE [Total]	**25,644**	**26,709**	**26,147**	**26,654**	**26,653**	**507**	**(1)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the table displays the estimated allocation for the Medical Facilities category. Final funding allocations among account-level categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Summary of 2022 Revised Request

VA is not requesting additional discretionary resources for Medical Facilities above the enacted 2022 Advance Appropriation of $6.735 billion. In 2022, VA projects obligating $2.6 billion out of unobligated balances provided by sections 8002 of the American Rescue Plan Act for activities traditionally funded by the Medical Facilities discretionary appropriation, as authorized in the Act.

When these resources are combined with available transfers, reimbursements, and other net unobligated balances, Medical Facilities will meet the projected 2022 obligation level of $9.5 billion, as detailed in the tables below.

Table: Update to the 2022 Advance Appropriation Request
(dollars in thousands)

		Available Discretionary Funding			Available Mand. Funding			
					Use of Unobligated Balance			
Description	2022 Revised Estimate	Enacted Approp. Incl. Transfers	Reimb.	Use of Unobl. Balance	VACAA Sec. 801	Veterans Medical Care And Health Fund 1/	Subtotal	Annual Approp. Adjust. Required
Engineering & Environmental Management	$1,092,505	$1,092,505	$0	$0	$0	$0	$1,092,505	$0
Engineering Service	$1,204,840	$986,396	$18,420	$200,000	$24	$0	$1,204,816	$0
Ground Maintenance & Fire Protection	$139,805	$139,805	$0	$0	$0	$0	$139,805	$0
Leases	$2,099,889	$1,293,601	$0	$0	$5,882	$800,406	$1,293,601	$0
Non-Recurring Maintenance	$2,263,896	$430,072	$0	$61,302	$0	$1,772,522	$491,374	$0
Operating Equipment Maintenance & Repair	$349,511	$349,511	$0	$0	$0	$0	$349,511	$0
Other Facilities Operation Support	$140,932	$140,932	$0	$0	$0	$0	$140,932	$0
Plant Operation	$937,884	$937,884	$0	$0	$0	$0	$937,884	$0
Recurring Maintenance & Repair	$767,798	$767,798	$0	$0	$0	$0	$767,798	$0
Textile Care Processing & Maintenance	$269,462	$269,462	$0	$0	$0	$0	$269,462	$0
Transportation	$233,884	$233,884	$0	$0	$0	$0	$233,884	$0
Obligations [Total]	$9,500,406	$6,641,850	$18,420	$261,302	$5,906	$2,572,928	$6,921,572	$0

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the table displays the estimated allocation for the Medical Facilities category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Table: Discretionary Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Revised Request	2023 Advance Approp.	+/- 2021-2022	+/- 2022-2023
Discretionary Program (0162) - Excluding CARES Act							
Engineering & Environmental Management	$737,830	$781,170	$854,349	$1,092,481	$1,364,783	$238,132	$272,302
Engineering Service	$958,159	$951,971	$980,308	$1,204,840	$1,270,606	$224,532	$65,766
Ground Maintenance & Fire Protection	$112,847	$123,470	$120,787	$139,805	$174,651	$19,018	$34,846
Leases	$1,173,288	$1,054,250	$1,048,239	$2,094,007	$993,889	$1,045,768	($1,100,118)
Non-Recurring Maintenance	$1,359,601	$1,859,022	$2,024,474	$491,374	$700,000	($1,533,100)	$208,626
Operating Equipment Maintenance & Repair	$271,936	$280,449	$299,224	$349,511	$436,625	$50,287	$87,114
Other Facilities Operation Support	$32,819	$42,504	$60,639	$140,932	$176,059	$80,293	$35,127
Plant Operation	$818,987	$883,514	$825,136	$937,884	$1,171,648	$112,748	$233,764
Recurring Maintenance & Repair	$616,183	$656,384	$660,496	$767,798	$959,169	$107,302	$191,371
Textile Care Processing & Maintenance	$206,059	$205,043	$230,133	$269,462	$336,624	$39,329	$67,162
Transportation	$202,862	$236,105	$204,297	$233,884	$292,179	$29,587	$58,295
Obligations Before Prior Year Recoveries (0162)	$6,490,571	$7,073,882	$7,308,082	$7,721,978	$7,876,233	$413,896	$154,255
Prior Year Recoveries	$8,723	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$6,499,294**	**$7,073,882**	**$7,308,082**	**$7,721,978**	**$7,876,233**	**$413,896**	**$154,255**
Discretionary Program (0162) - CARES Act							
Engineering & Environmental Management	$86,022	$0	$114,628	$0	$0	($114,628)	$0
Engineering Service	$66,285	$0	$88,328	$0	$0	($88,328)	$0
Ground Maintenance & Fire Protection	$2,411	$0	$3,213	$0	$0	($3,213)	$0
Leases	$2	$0	$3	$0	$0	($3)	$0
Non-Recurring Maintenance	$72,242	$0	$72,654	$0	$0	($72,654)	$0
Operating Equipment Maintenance & Repair	$8,087	$0	$10,776	$0	$0	($10,776)	$0
Other Facilities Operation Support	$48,299	$0	$64,361	$0	$0	($64,361)	$0
Plant Operation	$5,045	$0	$6,723	$0	$0	($6,723)	$0
Recurring Maintenance & Repair	$15,387	$0	$20,504	$0	$0	($20,504)	$0
Textile Care Processing & Maintenance	$6,654	$0	$8,867	$0	$0	($8,867)	$0
Transportation	$2,362	$0	$3,147	$0	$0	($3,147)	$0
CARES Act Obligations [Subtotal]	**$312,796**	**$0**	**$393,204**	**$0**	**$0**	**($393,204)**	**$0**
Discretionary Obligations [Total] (0162)	**$6,812,090**	**$7,073,882**	**$7,701,286**	**$7,721,978**	**$7,876,233**	**$20,692**	**$154,255**

Table: Medical Facilities Mandatory Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Mandatory Program (0173MF) - Veterans Medical Care and Health Fund 1/							
Leases	*$0*	*$0*	*$0*	$800,406	$0	$800,406	($800,406)
Non-Recurring Maintenance	$0	$0	$0	$1,772,522	$0	$1,772,522	($1,772,522)
Obligations Veterans Medical Care and Health Fund	$0	$0	$0	$2,572,928	$0	$2,572,928	($2,572,928)
Mandatorty Program (0162) -VACAA Sec. 801							
Engineering & Environmental Management	$91	$0	$23	$24	$25	$1	$1
Engineering Service	$0	$0	$0	$0	$0	$0	$0
Ground Maintenance & Fire Protection	$0	$0	$0	$0	$0	$0	$0
Leases	($115)	$0	$5,661	$5,882	$6,111	$221	$229
Non-Recurring Maintenance	($4,990)	$0	$0	$0	$0	$0	$0
Operating Equipment Maintenance & Repair	($1)	$0	$0	$0	$0	$0	$0
Other Facilities Operation Support	$64	$0	$0	$0	$0	$0	$0
Plant Operation	$0	$3,750	$0	$0	$0	$0	$0
Recurring Maintenance & Repair	$114	$0	$0	$0	$0	$0	$0
Textile Care Processing & Maintenance	$0	$0	$0	$0	$0	$0	$0
Transportation	$0	$0	$0	$0	$0	$0	$0
Obligations Before Prior Year Recoveries [Subtotal]	**($4,837)**	**$3,750**	**$5,684**	**$5,906**	**$6,136**	**$222**	**$230**
Prior Year Recoveries	$10,308	$0	$0	$0	$0	$0	$0
Obligations After Prior Year Recoveries [Subtotal]	**$5,471**	**$3,750**	**$5,684**	**$5,906**	**$6,136**	**$222**	**$230**
Mandatory Obligations [Total] (0162)	**$5,471**	**$3,750**	**$5,684**	**$2,578,834**	**$6,136**	$2,573,150	($2,572,698)

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the table displays the estimated allocation for the Medical Facilities category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Table: Medical Facilities Total Obligations by Program
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Program:							
Engineering & Environmental Management	$823,943	$781,170	$969,000	$1,092,505	$1,364,808	$123,505	$272,303
Engineering Service	$1,024,445	$951,971	$1,068,636	$1,204,840	$1,270,606	$136,204	$65,766
Ground Maintenance & Fire Protection	$115,258	$123,470	$124,000	$139,805	$174,651	$15,805	$34,846
Leases	$1,173,175	$1,054,250	$1,053,903	$2,099,889	$1,000,000	$1,045,986	($1,099,889)
Non-Recurring Maintenance 1/	$1,426,853	$1,859,022	$2,097,128	$2,263,896	$700,000	$166,768	($1,563,896)
Operating Equipment Maintenance & Repair	$280,021	$280,449	$310,000	$349,511	$436,625	$39,511	$87,114
Other Facilities Operation Support	$81,182	$42,504	$125,000	$140,932	$176,059	$15,932	$35,127
Plant Operation	$824,032	$887,264	$831,859	$937,884	$1,171,648	$106,025	$233,764
Recurring Maintenance & Repair	$631,684	$656,384	$681,000	$767,798	$959,169	$86,798	$191,371
Textile Care Processing & Maintenance	$212,713	$205,043	$239,000	$269,462	$336,624	$30,462	$67,162
Transportation	$205,224	$236,105	$207,444	$233,884	$292,179	$26,440	$58,295
Obligations Before Prior Year Recoveries (0162)	$6,798,530	$7,077,632	$7,706,970	$9,500,406	$7,882,369	$1,793,436	($1,618,037)
Prior Year Recoveries	$19,031	$0	$0	$0	$0	$0	$0
Obligations Total After Prior Year Recoveries (0162)	**$6,817,561**	**$7,077,632**	**$7,706,970**	**$9,500,406**	**$7,882,369**	$1,793,436	($1,618,037)

1/ 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 & Materials, and Equipment.

In 2022, total obligations are projected to increase by $1.8 billion above the 2021 current estimate in the following areas:

- **Leases (+$1.0 billion).** Leases are projected to increase by $1.0 billion to expand the space necessary for VA system delivered care.
- **Non-Recurring Maintenance (+$167 million).** Non-Recurring Maintenance is projected to increase by $167 million to update existing VA system space for care delivery.
- **Engineering Services (+$136 million).** Engineering Services is projected to increase by $136 million to expand oversight and management of engineering environmental management services.
- **Engineering and Environmental Management (+$123 million).** Engineering and Environmental Management is projected to increase by $123 million to expand project management.
- **Plant Operations (+$106 million).** Plant Operations are projected to increase by $106 million for utility costs.
- **All Other Increases (+$261 million).** This amount covers the projected increased cost of textile care processing, transportation, maintenance, and repairs.

Summary of the 2023 Advance Appropriation Request

The Medical Facilities discretionary advance appropriations request is $7.134 billion, an increase of $399 million from the 2022 revised discretionary request. The 2023 request ensures continuity of Veterans' health care services. In 2023, total obligations are projected to be $1.6 billion less than total obligations in 2022. VA projects that a significant amount of health care that was delayed during the pandemic will return to the VA health care system in 2022, coupled with the return of care to pre-pandemic levels. The infusion of funding included in the American Rescue Plan Act provides VA with the resources necessary to address total demand in 2022. After VA addresses the return of deferred care, the Department projects that growth in workload levels will stabilize in comparison to pre-pandemic levels, thus requiring fewer total resources in 2023.

In 2023, total obligations are projected to decrease by $1.6 billion from the 2022 revised request level in the following areas:

- **Leases (-$1.1 billion).** Leases are projected to decrease by -$1.1 billion as the need for additional space becomes less necessary. Space needs will be reassessed as part of the 2023 President's Budget.
- **Non-Recurring Maintenance (-$1.6 billion).** Non-Recurring Maintenance (NRM) is projected to decrease by $1.6 billion after updating existing VA system space in 2022. NRM needs will be reassessed as part of the 2023 President's Budget.
- **All Other Increases (+$1.0 billion)** 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 Department of Veterans Affairs (VA) hospitals, community-based outpatient clinics (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. The Veterans Health Administration (VHA) operates a portfolio of approximately 5,625 owned buildings with a total of 152.8 million square feet of space on 16,373 acres of land. The portfolio also includes 1,690 leases with a total of 20.1 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.

VA plans to allocate $2.573 billion of the Veterans Medical Care and Health Fund in addition to the enacted $6.735 billion 2022 Advance Appropriation. When combined with available carryover balances and anticipated collections, transfers and reimbursements, Medical Facilities has $9.5 billion in resources to meet projected 2022 Medical Facilities obligations, as detailed in the table below. The following chart details the 2022 obligation activity by funding source for the 11 functions funded by the Medical Facilities appropriation and the Veterans Medical Care and Health Fund.

Each section below details the operations of each of the account's 11 programs.

Engineering and Environmental Management Services

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations	$737,830	$781,170	$854,349	$1,092,481	$1,152,114	$238,132	$59,633
Discretionary CARES Act Obligations	$86,022	$0	$114,628	$0	$0	($114,628)	$0
Discretionary Obligations [Subtotal]	**$823,852**	**$781,170**	**$968,977**	**$1,092,481**	**$1,152,114**	**$123,504**	**$59,633**
Veterans Medical Care and Health Fund	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801	$91	$0	$23	$24	$25	$1	$1
Mandatory Obligations [Subtotal]	**$91**	**$0**	**$23**	**$24**	**$25**	**$1**	**$1**
Obligations [Total]	**$823,943**	**$781,170**	**$969,000**	**$1,092,505**	**$1,152,139**	**$123,505**	**$59,634**

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

Engineering Service
(dollars in thousands)

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations	$958,159	$951,971	$980,308	$1,204,840	$1,270,606	$224,532	$65,766
Discretionary CARES Act Obligations	$66,285	$0	$88,328	$0	$0	($88,328)	$0
Discretionary Obligations [Subtotal]	**$1,024,444**	**$951,971**	**$1,068,636**	**$1,204,840**	**$1,270,606**	**$136,204**	**$65,766**
Veterans Medical Care and Health Fund	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$1,024,444**	**$951,971**	**$1,068,636**	**$1,204,840**	**$1,270,606**	**$136,204**	**$65,766**

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)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations	$112,847	$123,470	$120,787	$139,805	$147,436	$19,018	$7,631
Discretionary CARES Act Obligations	$2,411	$0	$3,213	$0	$0	($3,213)	$0
Discretionary Obligations [Subtotal]	**$115,258**	**$123,470**	**$124,000**	**$139,805**	**$147,436**	**$15,805**	**$7,631**
Veterans Medical Care and Health Fund	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$115,258**	**$123,470**	**$124,000**	**$139,805**	**$147,436**	**$15,805**	**$7,631**

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)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations.....	$1,173,288	$1,054,250	$1,048,239	$2,094,007	$993,889	$1,045,768	($1,100,118)
Discretionary CARES Act Obligations.....	$2	$0	$3	$0	$0	($3)	$0
Discretionary Obligations [Subtotal].....	**$1,173,290**	**$1,054,250**	**$1,048,242**	**$2,094,007**	**$993,889**	**$1,045,765**	**($1,100,118)**
Veterans Medical Care and Health Fund 1/.....	$0	$0	$0	$800,406	$0	$800,406	($800,406)
VACAA, Section 801.....	-$115	$0	$5,661	$5,882	$6,111	$221	$229
Mandatory Obligations [Subtotal].....	**-$115**	**$0**	**$5,661**	**$806,288**	**$6,111**	**$800,627**	**($800,177)**
Obligations [Total].....	**$1,173,175**	**$1,054,250**	**$1,053,903**	**$2,900,295**	**$1,000,000**	**$1,846,392**	**($1,900,295)**

1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the table displays the estimated allocation for the Medical Facilities category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Leases can have many functions, including clinical space for in 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 2022 request seeks authorization for twenty-one major leases, including eight new requests from VA's Strategic Capital Investment Planning (SCIP) process and thirteen major leases that were submitted in prior year requests. The new SCIP 2022 major lease request consists of five replacement outpatient clinic leases, two new clinic leases, and one new Community Living Center lease. See Volume 4 for additional detail.

VA uses both in-house Lease Contracting Officers and the Government Services Administration (GSA) to procure medical facility space (VA) 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)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Obligations - All Other.....	$985,332	$1,346,573	$1,273,920	$430,072	$700,000	($843,848)	$269,928
Discretionary P.L. 115-141 sec 255.....	$223,944	$0	$299,657	$0	$0	($299,657)	$0
Discretionary P.L. 115-244 sec 248.....	$150,325	$512,449	$450,897	$61,302	$0	($389,595)	($61,302)
Discretionary CARES Act Obligations.....	$72,242	$0	$72,654	$0	$0	($72,654)	$0
**Discretionary Obligations [Subtotal].....	**$1,431,843**	**$1,859,022**	**$2,097,128**	**$491,374**	**$700,000**	**-$1,605,754**	**$208,626**
Veterans Medical Care and Health Fund 1/.....	$0	$0	$0	$1,772,522	$0	$1,772,522	($1,772,522)
VACAA, Section 801.....	($4,990)	$0	$0	$0	$0	$0	$0
**Mandatory Obligations [Subtotal].....	**($4,990)**	**$0**	**$0**	**$1,772,522**	**$0**	**$1,772,522**	**($1,772,522)**
**Obligations [Total].....	**$1,426,853**	**$1,859,022**	**$2,097,128**	**$2,263,896**	**$700,000**	**$166,768**	**($1,563,896)**

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 & Materials, and Equipment.
1/ The Veterans Medical Care and Health Fund was established to execute section 8002 of the American Rescue Plan Act, and the table displays the estimated allocation for the Medical Facilities category. Final funding allocations among account-level categories and among activities within each category may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

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 Strategic Capital Investment Planning (SCIP) process. This inclusion ensures a research focus for mitigation within a ten-year window of identified research infrastructure deficiencies.

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 2022 request supports continued implementation of EHRM with $1.243 billion 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 Veteran Integrated Service Networks (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)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations	$271,936	$280,449	$299,224	$349,511	$368,589	$50,287	$19,078
Discretionary CARES Act Obligations	$8,087	$0	$10,776	$0	$0	($10,776)	$0
Discretionary Obligations [Subtotal]	**$280,023**	**$280,449**	**$310,000**	**$349,511**	**$368,589**	**$39,511**	**$19,078**
Veterans Medical Care and Health Fund	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801	($1)	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	($1)	$0	$0	$0	$0	$0	$0
Obligations [Total]	**$280,022**	**$280,449**	**$310,000**	**$349,511**	**$368,589**	**$39,511**	**$19,078**

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)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations	$32,819	$42,504	$60,639	$140,932	$148,625	$80,293	$7,693
Discretionary CARES Act Obligations	$48,299	$0	$64,361	$0	$0	($64,361)	$0
Discretionary Obligations [Subtotal]	**$81,118**	**$42,504**	**$125,000**	**$140,932**	**$148,625**	**$15,932**	**$7,693**
Veterans Medical Care and Health Fund	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801	$64	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$64**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$81,182**	**$42,504**	**$125,000**	**$140,932**	**$148,625**	**$15,932**	**$7,693**

This function includes other costs associated with inpatient and outpatient providers and miscellaneous benefits and services.

Plant Operations

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations.....	$818,987	$883,514	$825,136	$937,884	$989,078	$112,748	$51,194
Discretionary CARES Act Obligations.....	$5,045	$0	$6,723	$0	$0	($6,723)	$0
**Discretionary Obligations [Subtotal]..... **	**$824,032**	**$883,514**	**$831,859**	**$937,884**	**$989,078**	**$106,025**	**$51,194**
Veterans Medical Care and Health Fund.....	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801.....	$0	$3,750	$0	$0	$0	$0	$0
**Mandatory Obligations [Subtotal]..... **	**$0**	**$3,750**	**$0**	**$0**	**$0**	**$0**	**$0**
**Obligations [Total]..... **	**$824,032**	**$887,264**	**$831,859**	**$937,884**	**$989,078**	**$106,025**	**$51,194**

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)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations.....	$616,183	$656,384	$660,496	$767,798	$809,708	$107,302	$41,910
Discretionary CARES Act Obligations.....	$15,387	$0	$20,504	$0	$0	($20,504)	$0
**Discretionary Obligations [Subtotal]..... **	**$631,570**	**$656,384**	**$681,000**	**$767,798**	**$809,708**	**$86,798**	**$41,910**
Veterans Medical Care and Health Fund.....	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801.....	$114	$0	$0	$0	$0	$0	$0
**Mandatory Obligations [Subtotal]..... **	**$114**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
**Obligations [Total]..... **	**$631,684**	**$656,384**	**$681,000**	**$767,798**	**$809,708**	**$86,798**	**$41,910**

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, and ceiling and floor tiles.

Textile Care Processing and Management

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations	$206,059	$205,043	$230,133	$269,462	$284,170	$39,329	$14,708
Discretionary CARES Act Obligations	$6,654	$0	$8,867	$0	$0	($8,867)	$0
Discretionary Obligations [Subtotal]	**$212,713**	**$205,043**	**$239,000**	**$269,462**	**$284,170**	**$30,462**	**$14,708**
Veterans Medical Care and Health Fund	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$212,713**	**$205,043**	**$239,000**	**$269,462**	**$284,170**	**$30,462**	**$14,708**

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)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations	$202,862	$236,105	$204,297	$233,884	$246,650	$29,587	$12,766
Discretionary CARES Act Obligations	$2,362	$0	$3,147	$0	$0	($3,147)	$0
Discretionary Obligations [Subtotal]	**$205,224**	**$236,105**	**$207,444**	**$233,884**	**$246,650**	**$26,440**	**$12,766**
Veterans Medical Care and Health Fund	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801	$0	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal]	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total]	**$205,224**	**$236,105**	**$207,444**	**$233,884**	**$246,650**	**$26,440**	**$12,766**

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.

Prior Year Recoveries

Description (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
Discretionary Non-CARES Act Obligations.....	$8,723	$0	$0	$0	$0	$0	$0
Discretionary CARES Act Obligations.....	$0	$0	$0	$0	$0	$0	$0
Discretionary Obligations [Subtotal].....	**$8,723**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Veterans Medical Care and Health Fund.....	$0	$0	$0	$0	$0	$0	$0
VACAA, Section 801.....	$10,308	$0	$0	$0	$0	$0	$0
Mandatory Obligations [Subtotal].....	**$10,308**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**
Obligations [Total].....	**$19,031**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

This is a change in VA's accounting system to record prior-year recoveries as required by Federal accounting policy under OMB Circular No. A-11 guidance. Because this is a technical change that does not affect the actual resource levels provide for Veterans services, there are no projections for future years. VA has modified its financial accounting system to be able to accurately monitor and record recoveries.

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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.

VA Enrollee Health Care Projection Model

The VA EHCPM supports approximately 90% 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 2020 EHCPM (Base Year 2019, i.e., based on fiscal year 2019 actual enrollment, utilization, and expenditures), was used to build the 2022 and 2023 Veterans Health Administration (VHA) Medical Care budget request. Additionally, 2020 experience was incorporated to recalibrate the 2020 EHCPM. See additional details later in the chapter in the section "Impact of the 2020 EHCPM Update." The expenditure basis used to build the 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 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 has been 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 2020 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, grandfathered Veterans Choice and Accountability (Choice) Act of 2014 enrollees, urgent care benefits, and emergency room pre-authorization. Impacts for the wait time standards, standards for timeliness or quality, and organ and bone marrow transplant policies are provided as national estimates outside of the 2020 EHCPM.

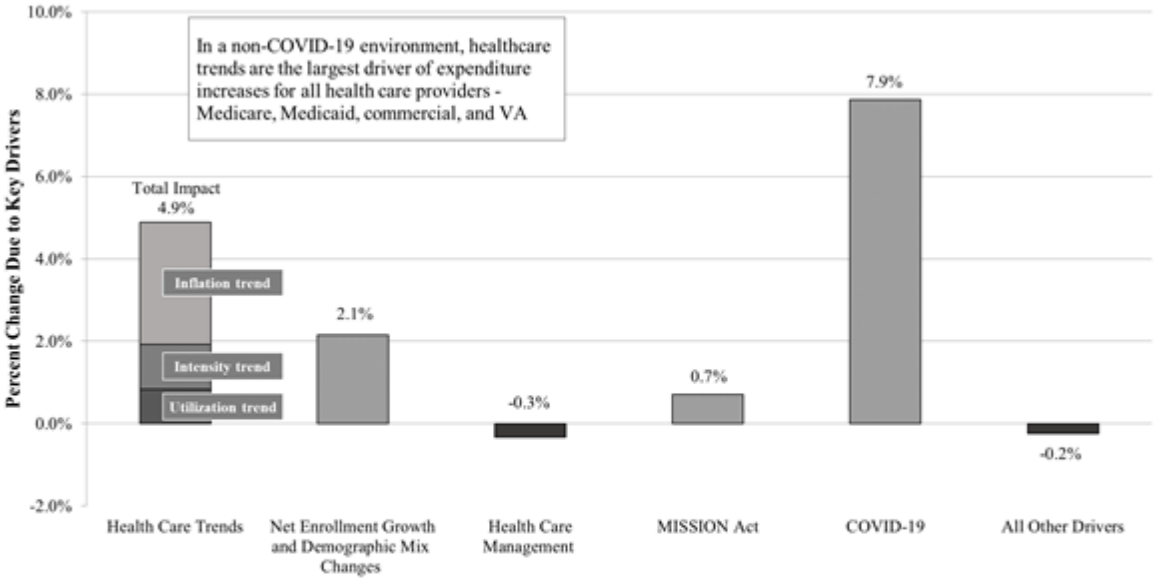
The MISSION Act policies continue to drive increases in services available in both VA facilities and the community, particularly the use of outpatient primary and specialty care and inpatient care. However, MISSION has a smaller impact than previous years because a significant portion of the impact is now incorporated into the 2019 and 2020 baselines.

The COVID-19 pandemic had a significant impact on VA health care in FY 2020 and is expected to impact the amount of care provided for the next few years. During the pandemic, nationwide health care utilization saw a reduced amount of care provided in FY 2020 and FY 2021 as individuals chose to defer certain care. It is anticipated that there will be a resulting surge in care in late FY 2021 continuing through FY 2022 to fulfill previously deferred services. Additionally,

the stay-at-home orders and social distancing mandates have had an impact on the United States (U.S.) economy, which is expected to increase reliance on VA for health care.

Figure A quantifies the key drivers of the projected increase in expenditure requirements for 2022 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, FY 2021 - 2022



- MISSION impacts include provisions for geographic access, urgent care, emergency room pre-authorization, 14-day community care urgent prescription fills, and wait times. Impacts for the MISSION standards for timeliness or quality and organ and bone marrow transplant policies are provided as national estimates and have not been incorporated in the 2020 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 services that VA routinely purchases (for example, maternity services).

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 new 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.

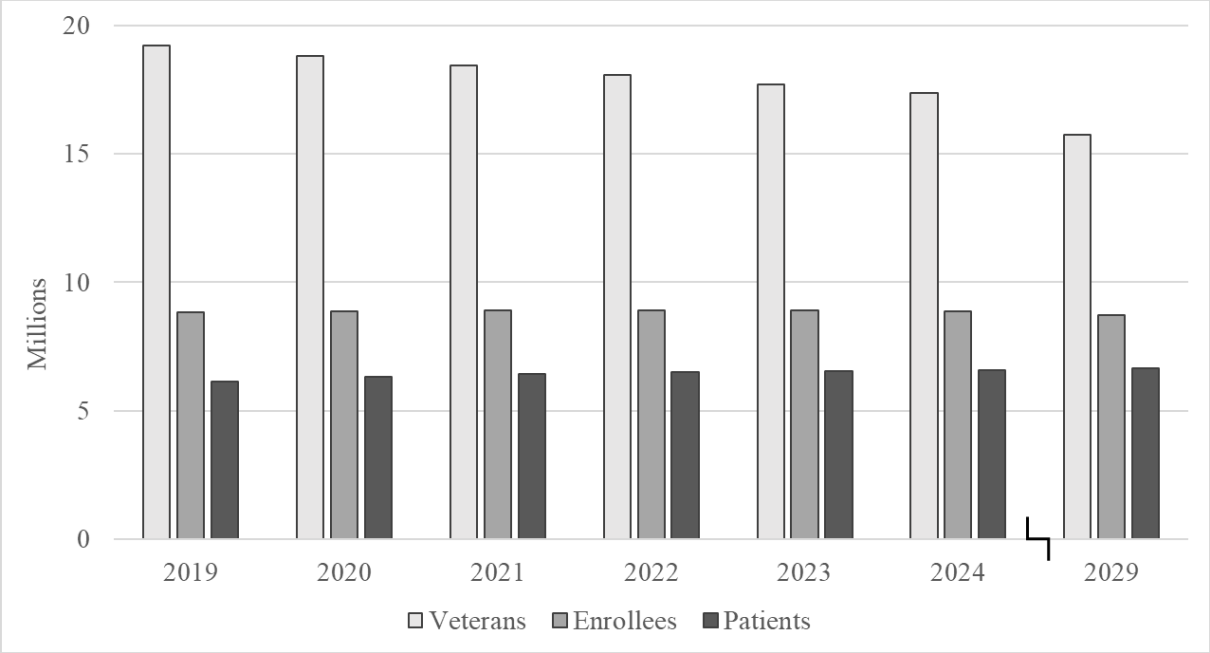
VA's utilization and intensity trends for Medicare-covered medical services are informed by anticipated Medicare utilization and intensity trends, as projected by the Center for Medicare & Medicaid Services' Office of the Actuary. They have been adjusted downward for efficiencies in the VA health care 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, etc.).

- 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 2020 EHCPM projects Veteran enrollment in VHA to remain relatively steady from 2019 to 2029, even though the Veteran population is declining (Figure B).

Figure B. National Veterans, Enrollees, and Patients, FY 2019-2029



High enrollment rates for Post-9/11 Era Combat Veterans and Gulf War Veterans are largely causing the steady enrollment level despite the declining Veteran population. After 2023, enrollment is projected to decline slightly as the impact of mortality in the enrollee population begins 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.

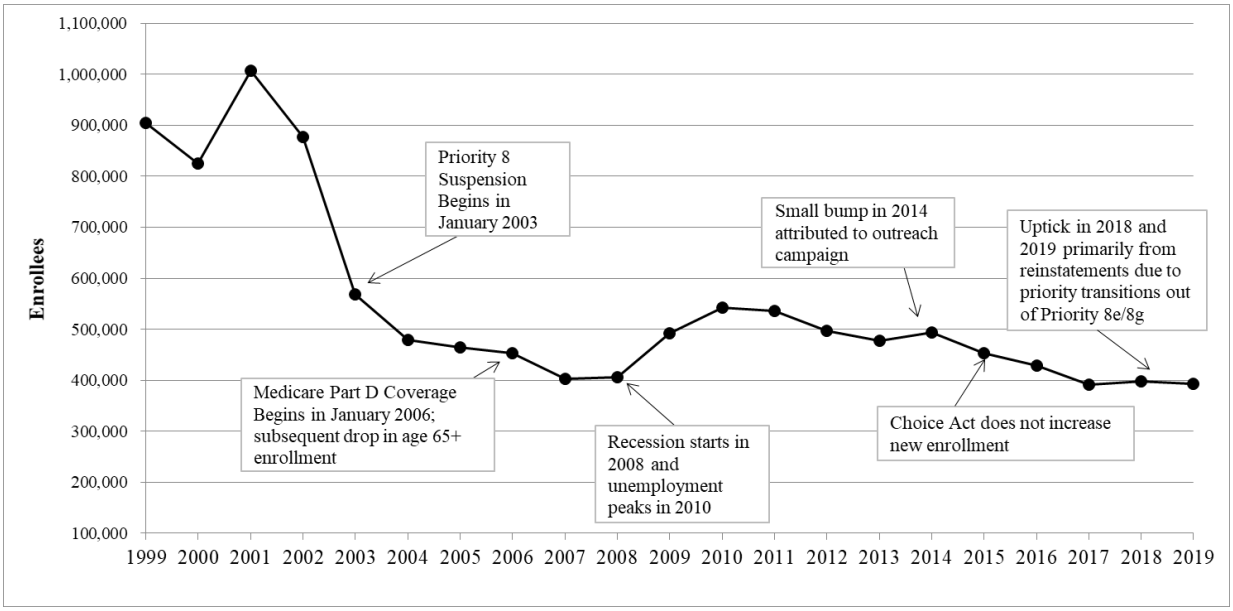
Veteran enrollment in VA is dynamic and responds to all of the demographic factors discussed above. Changes in the broader environment also impact Veterans' decisions to enroll. The lower new enrollment in 2007 and 2008 seen in Figure C was partially driven by the availability of the new Medicare drug 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, 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.). Similar enrollee behavior is expected as a result of the MISSION Act policies. See the section on Enrollee Reliance in this chapter for details.

The new enrollment counts in Figure C include Veterans who successfully enroll in VHA the first time they apply and also Veterans who were previously determined to be ineligible for enrollment but subsequently are deemed eligible (reinstatements). Reinstatements can happen for many

reasons, such as Veterans becoming eligible due to a change in income. Actual new enrollment in 2018 and 2019 was slightly higher than projected due to a higher rate of reinstatements.

Figure C. New Enrollment Over Time

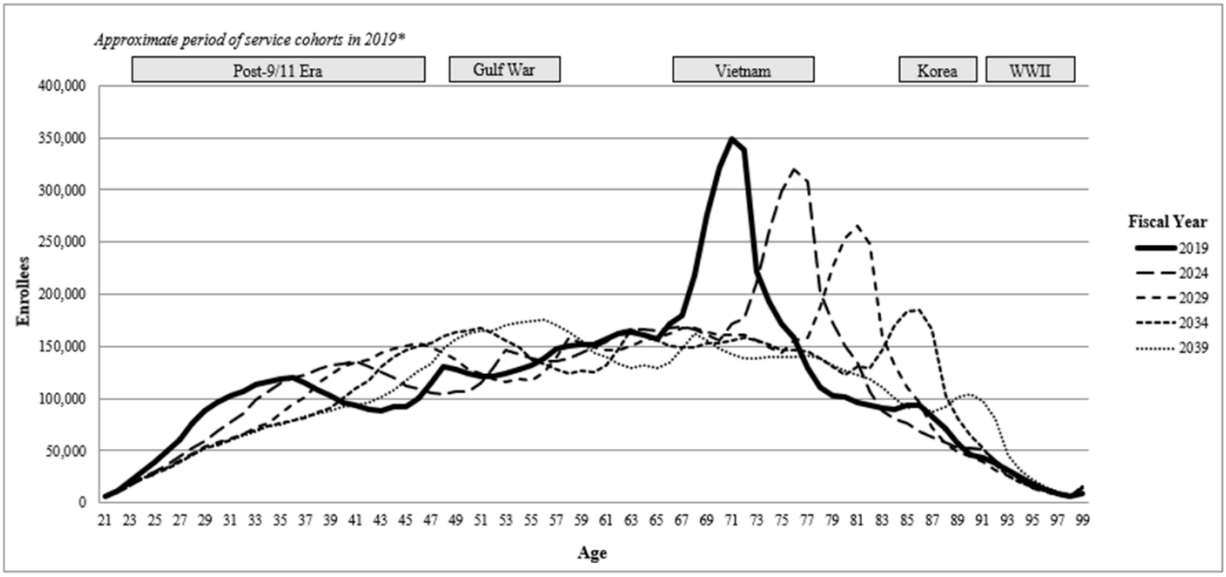


Net enrollment growth (new enrollment minus deaths) is not a significant driver of increases in annual expenditure requirements for VA health care. Enrollees who are dying are generally sicker and more reliant on VA health care than new enrollees, so even modest increases in the number of enrollees can 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 2019 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



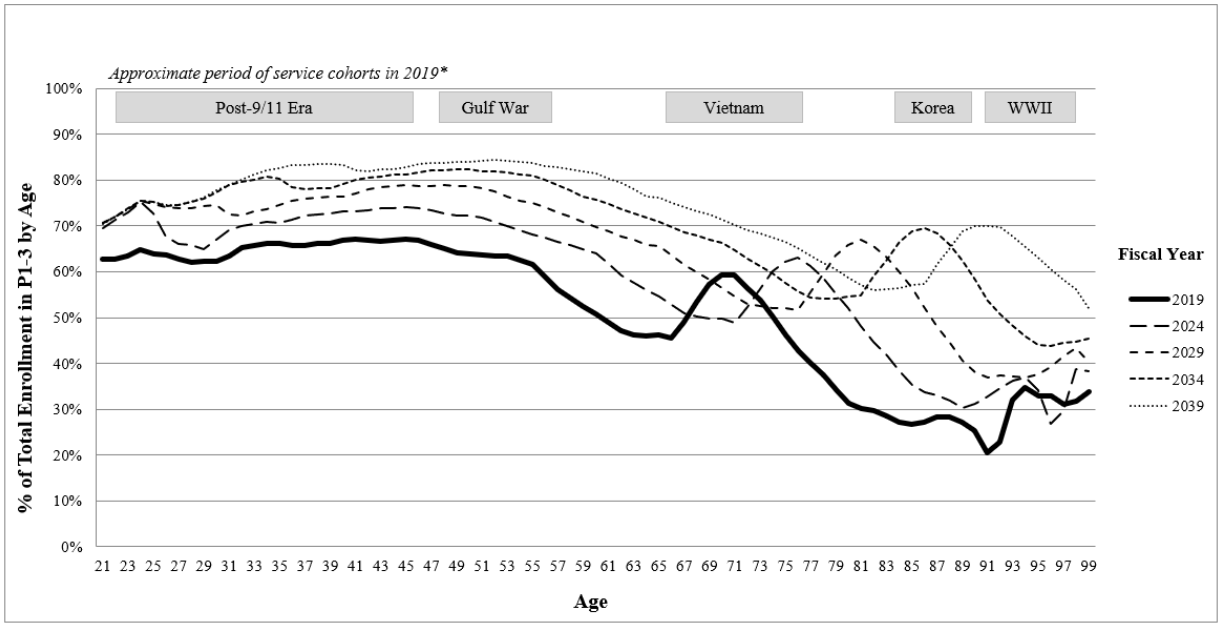
*Approximated by enrollee age in 2019 based on dates of conflict and ages at time of conflict. Enrollees can be in the age range for a cohort and not have served in the conflict.

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 Long Term Services and Supports, 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 29% 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. 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 in Priorities 5, 7, and 8 is declining.

Figure E. Percent of Enrollees in Priority 1-3, by Age



*Approximated by enrollee age in 2019 based on dates of conflict and ages at time of conflict. Enrollees can be in the age range for a cohort and not have served in the conflict.

As a result of the previously mentioned trend of enrollees being adjudicated to higher service connected priorities, as of 2019, 7% of enrollees had transitioned into Priority 1a (70% or higher service-connected disability) over the previous three years, compared with 3% as of 2009. The Priority 1a population is projected to continue to grow by 22% between 2019 and 2022 and 65% between 2019 and 2029.

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 75) 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

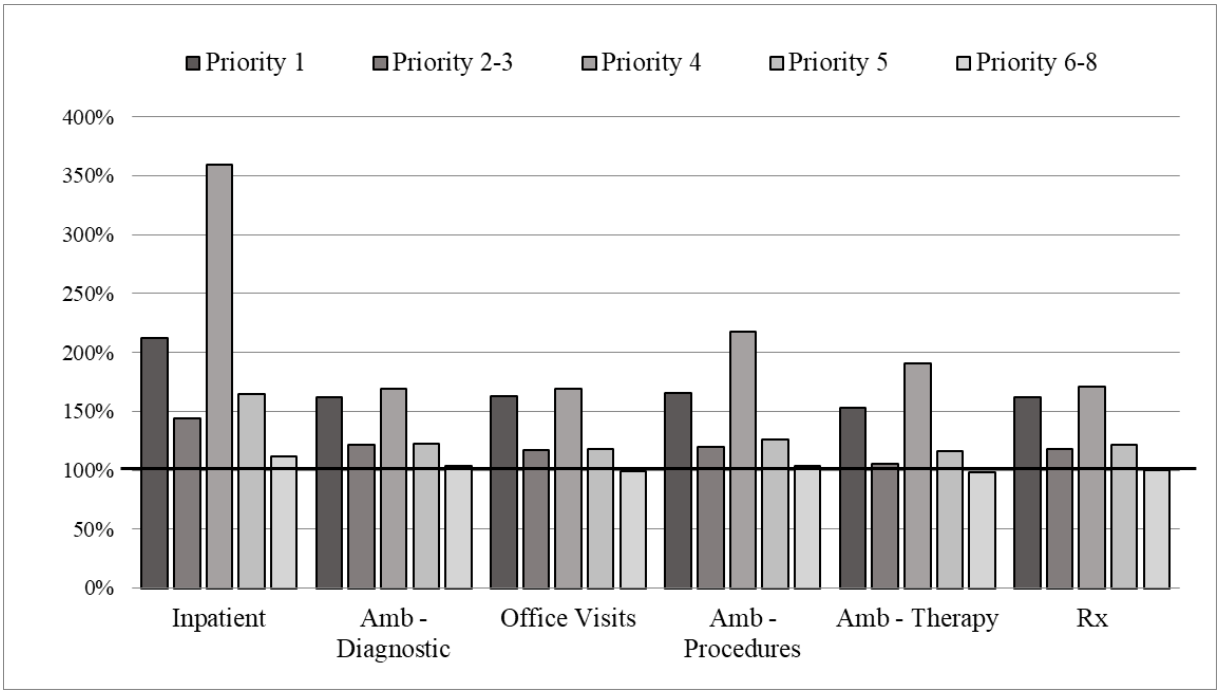
The VA enrollee population consists largely of older males, which is typically the segment of the population with the highest health care costs. Even after accounting for the age and gender mix of the enrollee population, the VA enrollee population is significantly more morbid (sicker) than the general population in the U.S., and this higher morbidity further increases VA's cost of providing care.

In the 2018 VA Survey of Veteran Enrollees' Health and Use of Health Care, 26% of enrollees rated their health as "fair" or "poor" compared to other people their age. Only 12% of the U.S. adult population responded similarly in Centers for Disease Control's (CDC) National Center for Health Statistics' 2018 National Health Interview Survey. Similarly, only 40% of enrollees rated their health as "excellent" or "very good" compared to 62% of the U.S. population in the CDC

survey. Using a diagnosis-based methodology, the average morbidity of the VA enrollee population is estimated to be approximately 32% higher than that of the general U.S. population.

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 three and a half 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.

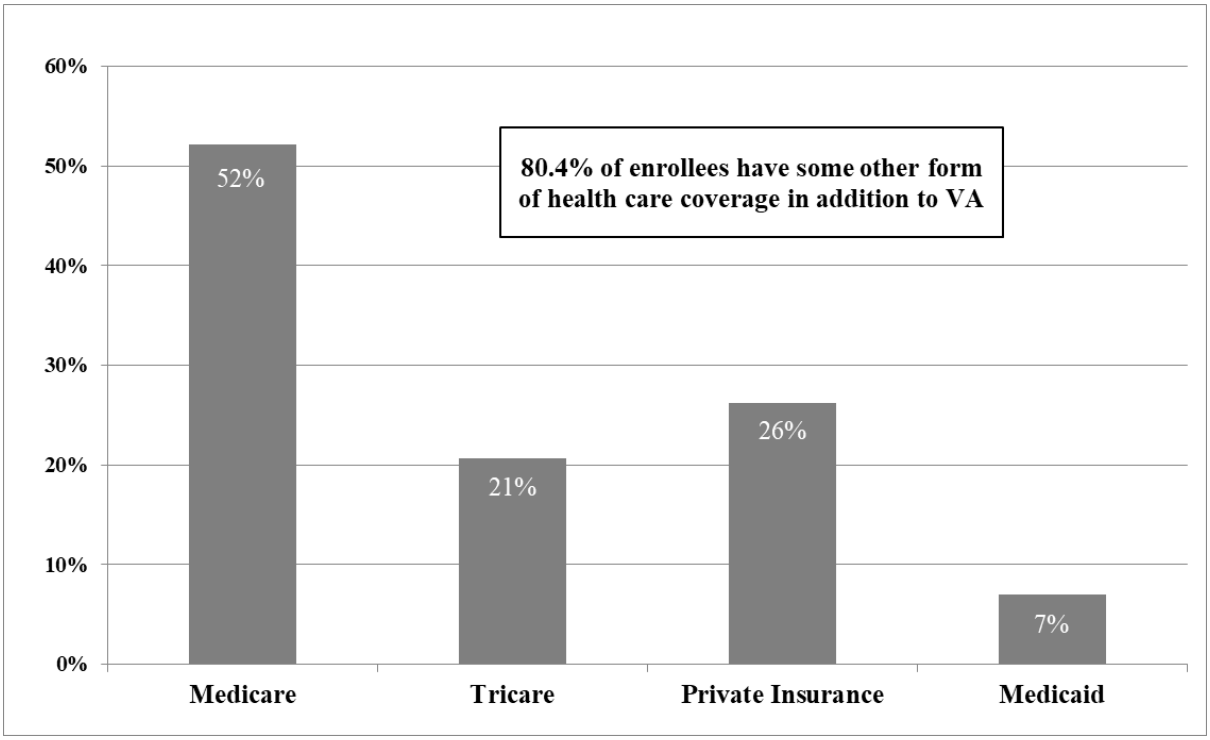
Figure F. Relative Morbidity of Veteran Enrollees vs. General Population



Enrollee Reliance on VA Health Care

Reliance refers to the portion of an enrollee's total health care needs that are paid for by VA, either in VA facilities or through community care. 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 2019 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



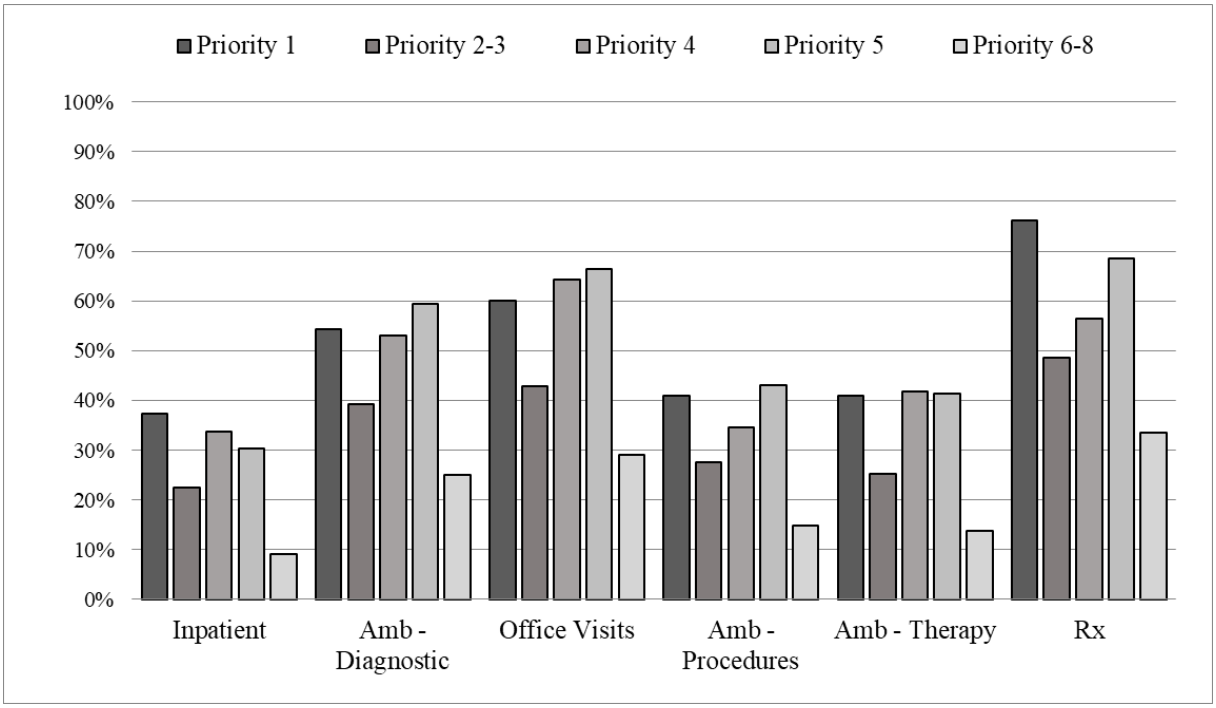
As a result, most enrollees do not use VA as their sole source of health care. On average, enrollees rely on VA for only 38% of their health care needs (excluding LTSS). This represented $75 billion in 2019. If the Veterans enrolled in 2019 had chosen to receive all of their health care in VA (100% reliance), this would have required an additional $129 billion for a total of $204 billion in 2019.

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 example, enrollees age 65-69 in 2019 had, on average, higher reliance than enrollees age 65-69 in 2014, at 34% in 2019 versus 31% in 2014 for inpatient medical services. 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 34% 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 Veteran represents 20% of the enrollee population in 2019 and is expected to grow to 26% in 2029.
- 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 14% of enrollees in 2019 but accounted for 29% 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 9% of the population by 2029, but still account for 17% of expenditures.

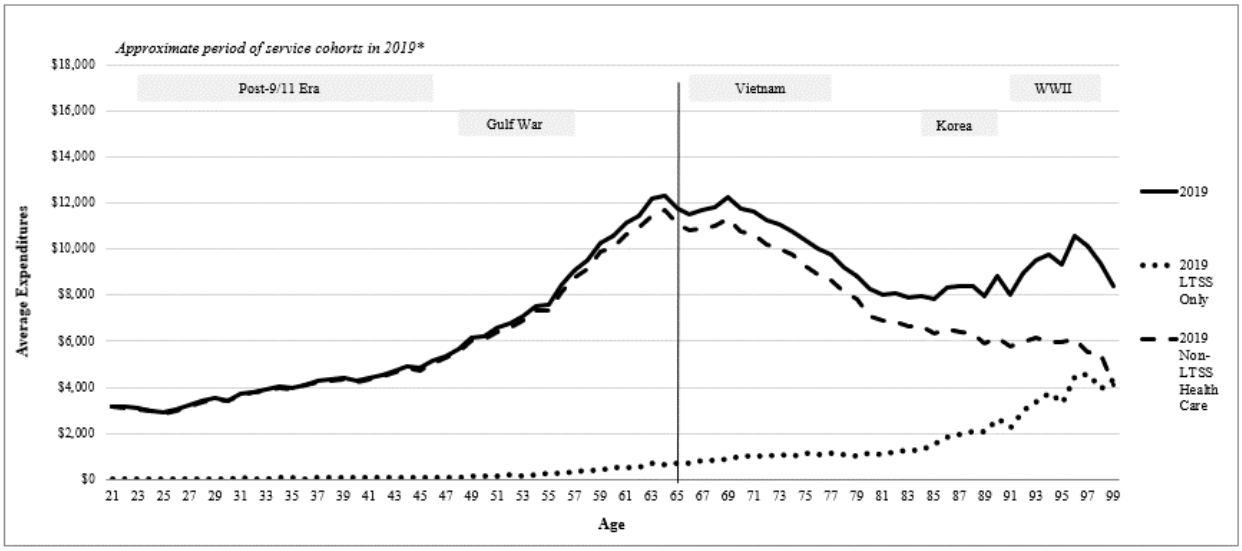
- Enrollees who served immediately after Vietnam have the highest healthcare utilization relative to other enrollees when they were at the same age. These enrollees exhibit higher than expected needs for almost all mental health and substance abuse services. This cohort represents about 17% of the enrollee population in 2019.
- 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 30% of the enrollee population in 2019.
- World War II Era enrollees are high utilizers of LTSS, since those services are typically provided to older enrollees. This cohort represents about 2% of overall enrollment in 2019.
- Women are one of the fastest growing enrollee cohorts. Women comprised 9% of the enrollee population in 2019 and are expected to grow to 12% by 2029. 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 enrollees. For example, women are more likely to use physical therapy and preventive services, but less likely to use cardiovascular 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 2019 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. However, enrollees who have become Medicare eligible more recently have shown a slightly lower decline in reliance than older enrollees. 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



*Approximated by enrollee age in 2019 based on dates of conflict and ages at time of conflict. Enrollees can be in the age range for a cohort and not have served in the conflict.

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 discussions in the next section.

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 (NUMI)

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 key drivers of increases in expenditure requirements for categories of health care services in a non-COVID-19 environment because COVID-19 is a temporary disruption to the provision of health care services.

Ambulatory Primary and Specialty Care

Ambulatory care projections are developed for the 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,

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

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 2022 and 2023. 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 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.

Changes in enrollee reliance are increasing VA's expenditure requirements for providing dialysis services. Enrollee reliance on VA for dialysis services increased from 29% in 2011 to an estimated 44% in 2019 and is expected to continue to increase through 2027. This increase in reliance is due in part to lower cost sharing in VA compared to Medicare.

Modeled Ambulatory Primary and Specialty Care (cont'd)

Diagnostics cont'd

- Ophthalmology Services and Diagnostic Exams
- Pathology
- Pulmonology Services, Diagnostic Exams, and Ventilator Management
- Radiology – CT
- Radiology – General
- Radiology – Mammography Diagnostic
- Radiology – Mammography Screening
- Radiology – MRI
- Radiology – Nuclear Medicine
- Radiology – PET and PET/CT
- Radiology – Radiation Oncology
- Radiology – Ultrasound
- Vision Exams

Evaluation and Management Services

- Rehabilitation Case Management
- Compensation & Pension Exams (only those provided in VA facilities)
- Medication Therapy Management
- Office Visits, including Physical Exams, Urgent Care Visits, and Telephone Care Visits (non-Mental Health)

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
- Maternity
- Nutritional Counseling
- Observation Care
- Prosthetics and Orthotics Services

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
- Recreational Therapy

Pharmacy – Outpatient Prescriptions

Pharmacy workload projections are developed for prescription drugs that are typically covered under a private sector health plan, as well as pharmacy items that are not, but that are covered by VA, such as over-the-counter (OTC) medication and supplies.

Modeled Pharmacy

Outpatient Prescriptions

- Prescription Drugs

Expenditures required to provide pharmacy services to enrolled Veterans are expected to increase in the coming years. However, a sharp decline in the volume of expensive Hepatitis C drugs has been observed in recent years as most enrollees with the Hepatitis C virus have been treated. As a result, the volume of these drugs has stabilized at lower levels. VA moderates the impact of inflation on prescription drugs with its well managed pharmacy benefit management program and contracting practices; however, inflation is still increasing 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

- Medicine
- Surgery
- Maternity Deliveries
- Maternity Non-Deliveries

Inpatient Encounters

- 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, Ventilator Management
- Radiology – CT
- Radiology – General
- Radiology – Mammography (All)
- Radiology – MRI
- Radiology – Nuclear Medicine
- Radiology – PET and PET/CT
- Radiology – Radiation Oncology
- Radiology – Ultrasound
- Vision Exams
- Rehabilitation Case Management

Expenditures required to provide inpatient acute services to enrolled Veterans are expected to grow in both 2022 and 2023. 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.

Modeled Inpatient Acute Care cont'd

Inpatient Encounters cont'd

- Inpatient Evaluation & Management (E&M) Services - Non- Mental Health
- Medication Therapy Management
- Emergency Room Visits
- Eye Glasses Services
- Hearing Aid Services
- Maternity
- Nutritional Counseling
- Prosthetic and Orthotic Services
- Surgical Procedures
- Dialysis and Related Services
- Nephrology – End Stage Renal Disease Services

VA's cost of providing inpatient maternity care is increasing due to high health care trends for maternity services in the private sector (most maternity care is purchased) and an increase in utilization due to the growth in enrollment for younger, female Veterans.

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 health conditions 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 2022 and 2023. 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

Modeled Mental Health Care

Mental Health Inpatient

- Inpatient Acute Mental Health
- Inpatient Acute Mental Health Extended Stays
- Acute Substance Abuse
- Mental Health Residential Rehabilitation
- Compensated Work Therapy/Transitional Residence (CWT/TR)
- Sustained Treatment and Rehabilitation (STAR)

Mental Health Inpatient Encounters

- Mental Health
- Mental Health Inpatient E&M Services
- Psychotherapy
- Substance Abuse
- Psychosocial Rehabilitation and Recovery Centers
- Intensive Community Mental Health Recovery Services
- Work Therapy
- Mental Health Residential Rehabilitation Treatment Program Inpatient Encounters
- Homeless

to mental health care. The growth in expenditure requirements slows after 2022 as the access initiatives end and utilization changes are primarily based on the demographics of the enrollee population.

Modeled Mental Health Care cont'd

Mental Health Outpatient

- Outpatient Mental Health
- Psychotherapy
- Outpatient Substance Abuse
- 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 Encounters
- Homeless

Utilization of mental health services is expected to grow (independent of any change due to enrollment dynamics) due to VA's initiatives to increase capacity and patient referrals. For example, Mental Health Residential Rehabilitation is projected to grow 4% through 2022 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 2020 EHCPM includes a 10% increase in utilization via community care from FY 2020 through FY 2022.

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 (10% from 2019-2022) and their increase in service-connected conditions (over 70% of Post-9/11 Era Combat Veteran enrollees are projected to be in service-connected Priorities 1-3 by FY 2022) are driving increases in utilization for this population. From 2019 to 2022, the utilization of Mental Health services by the Post-9/11 Era Combat Veteran population is expected to increase by 19% for inpatient services and increase by 30% for ambulatory. This growth varies by service, ranging between 5 and 35% except for Inpatient Sustained Treatment and Rehab (STAR) which is being replaced by other mental health treatment programs.

- 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 Mental Health Residential Rehabilitation and Compensated Work Therapy services peaks between ages 50 and 60 then drops off dramatically by age 65.

Rehabilitative Care

Projections are developed for two special rehabilitative care inpatient services provided by VA: 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 2022 and 2023. 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)

Requirements to provide prosthetic services to enrolled Veterans are expected to grow in both 2022 and 2023. The projected increase in expenditures is 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 best value for VA. The cost of prosthetic devices such as glasses, surgical implants, 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 diversify. 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, wheelchairs, VA specialized products and services, and oxygen.

The continued growth of the Post-9/11 Era Combat Veteran enrollee population (10% from 2019-2022), 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 this population is not yet eligible for Medicare (with the corresponding decline in reliance on VA), aging is driving increases in this population's use of prosthetics, particularly for oxygen, VA specialized products and services, and hearing aids.

Long-Term Services and Supports

LTSS include the full range of services provided to help Veterans with functional limitations and chronic health conditions in non-acute settings. These services are provided through facility-based care (nursing homes) or via home and community-based services (HCBS).

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

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 (cont'd)

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 2022 and 2023. The projected growth for expenditures is primarily the impact of two enrollment dynamics that are having a very significant impact on LTSS in both facility and HCBS settings: priority transitions and the aging of the enrollee population. Inflation is also driving some growth for 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 (PL 106-117) to provide continuing nursing home 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 nursing home 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 impacted less 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 nursing homes 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

Modeled Dental Care

- Preventive and Basic Dental Services
- Minor Restorative Dental Services
- Major Restorative Dental Services

different than eligibility criteria for other VA medical care benefits. Providing preventive and basic dental services to enrollees aligns with VA's 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 2022 and 2023. The projected increase is primarily due to the increase in service-connected conditions (and the transition into service-connected Priorities 1-3) and the resulting increase in eligibility for dental services. VA's cost of providing dental services is also expected to increase due to inflation.

Impact of 2020 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 economic recessions, 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 2020 EHCPM was used to build the 2022 and 2023 VHA Medical Care budget requests. The EHCPM was updated to 2019 experience, and all EHCPM assumptions were updated based on 2019 data. Typically, the EHCPM is updated annually to reflect emerging information on the enrollee population and their utilization of VHA healthcare. These analyses are generally tied to the most recent fiscal years of data and establish assumptions that are based on this recent information. The later submission of the President's Budget allowed for integration of some aspects of the 2020 experience in addition to the 2019 baseline. Incorporation of the 2020 experience captures a number of factors, the most notable of which are the COVID-19 pandemic and the associated COVID-19 economic recession, the MISSION Act access and wait time impacts, and normal year-to-year variation.

Historically, the most significant factors changing the EHCPM's projections have been external and could not have been anticipated in advance, such as the COVID-19 pandemic and associated COVID-19 recession, the MISSION Act, the civilian wage freeze policy, and American Reinvestment and Recovery Act (ARRA) funding. 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 sources of risk inherent in modeling.

Table: 2022 Revised Estimate and 2023 Advance Appropriation EHCPM Model & Non Model Obligations
(dollars in thousands)

Description	2022 Revised Estimate			2023 Advance Appropriation		
	EHCPM	Non-EHCPM	Total	EHCPM	Non-EHCPM	Total
Health Care Services	$97,681,675	$5,018,968	$102,700,643	$97,163,753	$677,715	$97,841,468
Non-Add Included Above:						
Non-Recurring Maintenance	*$0*	*$2,263,896*	*$2,263,896*	$0	$700,000	$700,000
Non-Veterans	*$0*	*$316,278*	*$316,278*	$0	$335,722	$335,722
Long-Term Care	$9,741,214	$2,030,863	$11,772,077	$9,996,997	$2,080,754	$12,077,751
Non-Add Included Above:						
State Home Programs	*$0*	*$1,768,542*	*$1,768,542*	*$0*	*$1,797,512*	*$1,797,512*
Other Health Care Programs:						
Camp Lejeune Families (P.L. 112-154)	$0	$2,909	$2,909	$0	$3,043	$3,043
Caregivers (Including CHAMPVA)	$0	$1,353,133	$1,353,133	$0	$1,750,155	$1,750,155
CHAMPVA & Other Dependent Prgs	$0	$2,378,170	$2,378,170	$0	$2,567,891	$2,567,891
Homeless Program Grants 2/	$0	$1,191,186	$1,191,186	$0	$720,708	$720,708
Readjustment Counseling	$0	$323,789	$323,789	$0	$336,084	$336,084
American Families Plan	$0	$30,000	$30,000	$0	$30,000	$30,000
Obligations [Grand Total]	$107,422,889	$12,329,018	$119,751,907	$107,160,750	$8,166,350	$115,327,100

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 2019, CHAMPVA covered 501,194 beneficiaries. The number of beneficiaries is expected to rise to approximately 587,000 in 2022 and 615,000 in 2023.

The 2020 CHAMPVA Model was developed using data from fiscal years 2005 to 2019, 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., are

not also an eligible spouse or child of a sponsor) are not modeled in the CHAMPVA projection model. Such caregivers are projected as part of the BY19 PCAFC Model.

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 actual historical CHAMPVA paid claims data. The projected beneficiaries from the enrollment model are then linked to the claims cost model to generate expenditures.

The Program of Comprehensive Assistance for Family Caregivers (PCAFC) 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, healthcare expense reimbursement through the CHAMPVA program (if they have no other health insurance), education and training, mental health care services, respite care services, and 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 program changes required by the MISSION Act, the 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 FY 2022 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 healthcare 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 FY 2016, there was a steady increase in the number of caregivers enrolled in the PCAFC. From FY 2017 to 2019, 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 is expected to grow through FY 2024.

2022 Budget Discussion

The Department of Veterans Affairs (VA) is not requesting additional appropriations in 2022, as VA estimates $596 million will be carried forward into 2022 from prior appropriations and supplementals. The American Rescue Plan (ARP) Act (Public Law (P.L.) 117-2, Sec. 8004), provided $500 million in 2021 to for grants to states to acquire or construct state nursing home and domiciliary facilities, and to remodel, modify, or alter nursing home and domiciliary facilities in state homes to provide care to Veterans. VA expects to carry over the full amount into 2022 to cover future grant applications.

Coronvirus Aid, Relief, and Economic Security (CARES) Act

Public Law (P.L.) 116-136 provided an additional $150,000,000, to remain available until September 30, 2021, to prevent, prepare for, and respond to coronavirus, domestically or internationally, including to modify or alter existing hospital, nursing home, and domiciliary facilities in state homes.

American Rescue Plan (ARP) Act

The ARP Act (P.L. 117-2) provides an additional $500,000,000 to remain available until expended. Of this funding, $250 million will be utilized for state Home construction projects in 2022.

Table: Total Funding Highlights

Total Funding Highlights
(dollars in thousands)

Description	2020 Actual	2021		2022 Estimate	2021 to 2022 Inc/Dec
		2021 Budget Estimate	2021 Current Estimate		
Appropriation	$240,000	$90,000	$90,000	$0	($90,000)
Mandatory Appropriations (ARP Act Sec. 8004)	$0	$0	$500,000	$0	($500,000)
Adjustments to Obligations:					
Unobligated Balance (SOY)	$159,195	$0	$266,151	$596,151	$330,000
Unobligated Balance (EOY)	($266,151)	$0	($596,151)	($250,000)	$346,151
Change in Unobligated Balance	($106,956)	$0	($330,000)	$346,151	$676,151
Prior Year Recoveries	$27,955	$0	$0	$0	$0
Obligations	$160,999	$90,000	$260,000	$346,151	$86,151

Table: Annual Funding Highlights

Annual Funding Highlights
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Estimate	2021 to 2022 Inc/Dec
Appropriation	$90,000	$90,000	$90,000	$0	($90,000)
Adjustments to Obligations:					
Unobligated Balance (SOY)	$159,195	$0	$116,151	$96,151	($20,000)
Unobligated Balance (EOY)	($116,151)	$0	($96,151)	$0	$96,151
Change in Unobligated Balance	$43,044	$0	$20,000	$96,151	$76,151
Prior Year Recoveries	$27,955	$0	$0	$0	$0
Obligations	$160,999	$90,000	$110,000	$96,151	($13,849)

Table: CARES Act Funding Highlights

CARES Act Funding Highlights (dollars in thousands)					
		2021			
Description	2020 Actual	Budget Estimate	Current Estimate	2022 Estimate	2021 to 2022 Inc/Dec
Appropriation	$150,000	$0	$0	$0	$0
Adjustments to Obligations:					
Unobligated Balance (SOY)	$0	$0	$150,000	$0	($150,000)
Unobligated Balance (EOY)	($150,000)	$0	$0	$0	$0
Change in Unobligated Balance	($150,000)	$0	$150,000	$0	($150,000)
Prior Year Recoveries	$0	$0	$0	$0	$0
Obligations	$0	$0	$150,000	$0	($150,000)

Table: ARP Act Funding Highlights

American Rescue Plan (ARP) Act 8004 Highlights (dollars in thousands)					
		2021			
Description	2020 Actual	Budget Estimate	Current Estimate	2022 Estimate	2021 to 2022 Inc/Dec
Mandatory Appropriations (Sec. 8004)	$0	$0	$500,000	$0	($500,000)
Adjustments to Obligations:					$0
Unobligated Balance (SOY)	$0	$0	$0	$500,000	$500,000
Unobligated Balance (EOY)	$0	$0	($500,000)	($250,000)	$250,000
Change in Unobligated Balance	$0	$0	($500,000)	$250,000	$250,000
Prior Year Recoveries	$0	$0	$0	$0	$0
Obligations	$0	$0	$0	$250,000	$250,000

Uncertainty Associated with Actuarial Projections in the VA Enrollee Health Care Projection Model

The Department of Veterans Affairs (VA) develops the VA Enrollee Health Care Projection Model (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 section fulfills part of this communication to stakeholders and describes the activities that comprise VA's assessment of uncertainty associated with the actuarial projections.

This section identifies sources of risk and describes the degree of projection uncertainty that they add to the actuarial projections in general and specifically for the projections supporting the 2022 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 section 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 the 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 facility care and community care paid by VA, versus other health care options. For example, if an enrollee received four office visits from VA and six through Medicare, that enrollee would be considered 40% reliant on VA for office visits (4/10).

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.

In FY 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 3% unexpected increase in reliance levels is estimated to cause the EHCPM's budget projection to increase by around 8%, or around $6 billion from a FY 2019 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, including 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

Level of Uncertainty Due to Risks	Assumptions	Contributes most to which projection output
Greater	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
Lesser	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 2020 EHCPM was FY 2019. 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. VA uses a Medicare data match to assist in the review of overall health care utilization for Veterans ages 65 and over. This information is very helpful 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 generally spread across numerous private sector and government programs. As a result, modeling for Veterans under age 65 is primarily based on VA health care data 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). 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.

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.

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 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. For example, as the COVID-19 pandemic emerged, a high-level estimate of the resources required to respond to the pandemic was quickly provided to leadership. The Budget Scenario discussed in this document includes an updated estimate, and future updates to the estimates are expected as the pandemic unfolds.

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 scenario supporting the budget. 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. For example, the COVID-19 pandemic involves droplet transmission through the air and by touch, leading to social distancing and an abrupt reduction in common activities, including going to the doctor. On the other hand, the response to the HIV pandemic did not disrupt most public interactions as HIV is primarily a sexually transmitted infection.

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

The scenario supporting the budget assumes a $1.1 billion increase in expenditures in FY 2021 (relative to FY 2020) and a $6.1 billion increase in FY 2022, based on the current projection of the return of deferred care. If the care returns faster, the FY 2021 expenditures could increase by an additional $2.5 billion and the FY 2022 expenditures could be $3.8 billion lower. If the care returns slower than projected, then the FY 2021 and 2022 expenditures could be lower by $0.6 billion and $0.1 billion, respectively, while FY 2023 expenditures could increase by $2.1 billion.
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.

COVID-19 has led to a significant decline in nationwide health care utilization since mid-March 2020. A portion of this 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 foregone care from 2020 is performed in 2022, in addition to normal levels of care in 2022, then there will be an unexpectedly higher strain on VA facility and community care capacity at that time.

The results above are highly sensitive to changes in the rate and timing of care deferral and the eventual return of some of that deferred care. The FY 2021 and FY 2022 projections in particular, include a significant deferral of care and returning care. If enrollees return to historical care patterns and have previously deferred care needs met sooner, this would cause some of the increase in expenditures currently projected in FY 2022 to instead occur in FY 2021. On the other hand, if deferred care returns more slowly than currently projected, then this could reduce FY 2021 expenditures, but cause further increases in projected FY 2022 expenditures.

The reduction in health care utilization did not lead to proportional reductions in VA facility 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 during the pandemic, though it is expected to decline as care approaches pre-pandemic levels.

The terms of reimbursement to community providers could change to a higher rate if community care providers look to recoup losses incurred during the pandemic or if new capacity constraints emerge due to a reduction in community providers.

COVID-19 has also led to an economic downturn, which affects enrollment and reliance. See the Economic Conditions section for discussion.

Even after the economy recovers, the pandemic could disrupt enrollee reliance patterns or preferences for VA facility vs. community care. See the Enrollee and Veteran Preferences section for discussion.

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 the budget uses the Office of Management and Budget February 2021 economic projections to assume that the unemployment rates will decline from 7.3% in FY 2020 to 3.9% in FY 2023. This projected change in the economy results in a $43 million reduction in projected FY 2023 expenditures, relative to a scenario in which the economic conditions in FY 2020 persist.

Higher reliance and enrollment rates are anticipated due to the spike in unemployment resulting from the pandemic. Modeling these changes is confounded by the much larger impact of deferred/cancelled care and hesitation to enroll, brought about by social distancing and other responses to COVID-19.

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 assumptions

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. The full impact of the MISSION Act is still uncertain, but it is expected drive increases in utilization and expenditures, similar to the Choice Act.

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, urgent care benefit and wait time benefit. While these provisions went into effect in June 2019, enrollee behavior is still evolving over time in response. As a result, enrollee reliance was projected to increase through FY 2021 as the program implementation and enrollee behavior matures.

Initial experience from FY 2020 shows a larger than expected increase in community care workload and costs. This growth can be traced to an acceleration in growth beginning in June 2019; while some acceleration was projected due to the MISSION Act, actual growth has been higher than modeled. Based on currently available data, VA cannot determine whether the higher than expected growth so far is an indication that the MISSION Act is increasing enrollee reliance more quickly than anticipated or that the MISSION Act will have a larger ultimate impact. This adds to overall model uncertainty.

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; 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 Harvoni and related Hepatitis C drugs 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 could affect 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 does not assume any changes in health care practice due to COVID-19. VA

continues to evaluate emerging experience and available information to assess this assumption and will revise the assumption if appropriate.

Demand Allocation between VA Facility and Community Care

The EHCPM projects enrollees' total demand for VA health care. Then, the total projected demand is allocated to VA facility 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 facility 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 facility 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.

In addition, 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 facility 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 facilities 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 facility 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

	FY 2016	FY 2017	FY 2018	FY 2019
Estimated Aggregate Reliance	35.6%	36.5%	37.0%	38.3%

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 due to the COVID-19 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 facility 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[34].

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

[34] 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.

rather than an underlying change in morbidity, a 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 facility 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 broader population, then diversification no longer reduces risk and the overall demand for health care will begin to change.

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 currently unknown. However, a number of factors could cause declines in health status:

- 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.

Because of the level of uncertainty, 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 long periods. 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.

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. Therefore, the cost of those services is directly tied to those fee schedules. Uncertainty about the fee schedule is low during the contract period but increases as fee schedules are re-negotiated in the future.

Time horizon

Short-term and long-term

Divergence of actual inflation trends over the model's assumptions will have a small impact over the short-term, but they may compound substantially over time. 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.

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 long-term services and supports (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 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, individual health insurance, and others. As the availability and affordability of external health care options 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 expansions to State Medicaid coverage.

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 and Medicaid programs are available to all seniors ages 65 and over and to lower income Veterans under age 65. Policy is set at the federal level for Medicare and it is set by both the Federal government and the states for Medicaid programs. 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.

Even if other sources of health insurance are unchanged, they 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, and a declining capture of non-VA utilization for enrollees ages 65 and over due to increasing Medicare Advantage enrollment.

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 30% of current enrollees) have different health care needs than WWII Veterans (currently representing about 2% 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 9% of enrollees, a share that continues to increase and which is projected to reach 12% by 2029. 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[35]. 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)[36,37]
- Own Risk and Solvency Assessment (ORSA)[38]

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 led to the difference are identified and adjusted, as appropriate. Other corrective action, including but not limited to operational and funding changes are considered.

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[35] Standards for internal control in the Federal Government, Government Accountability Office, September 2014, https://www.gao.gov/assets/670/665712.pdf
[36] RBC Overview: https://content.naic.org/cipr_topics/topic_riskbased_capital.htm
[37] RBC Model Act: https://content.naic.org/sites/default/files/inline-files/MDL-312.pdf
[38] ORSA Guidance Manual: https://www.naic.org/documents/prod_serv_fin_recievership_ORSA-2014.pdf

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 model across all assumptions and risks is discussed in this section. 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[39]. 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.

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

[39] https://www.medicaid.gov/medicaid/managed-care/guidance/rate-review-and-rate-guides/index.html

cautions regarding possible uncertainty or risk in any results are disclosed in communications to stakeholders.

The model report sections include these communications on a topical basis for each major assumption in the model. 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

The Veterans Health Administration (VHA) operates a portfolio of approximately 5,625 owned buildings with a total of 152.8 million square feet of space on 16,373 acres of land. The portfolio also includes 1,690 leases with a total of 20.1 million square feet of space.

The table below provides a more granular level of detail based on services provided to Veterans. 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

		2021		2022		2023		
Description	2020 Actual 1/	Budget Estimate	Current Estimate	Advance Approp.	Revised Request	Advance Approp.	+/- 2021-2022	+/- 2022-2023
Veterans Integrated Service Networks (VISN)	**18**	**18**	**18**	**18**	**18**	**18**	0	0
VA Medical Centers (VAMC), Total	**172**	**170**	**172**	**170**	**172**	**172**	0	0
Included in VA Medical Centers, Total:								
VA Hospitals	146	148	146	148	146	146	0	0
Community Living Centers (CLC)	134	135	134	135	134	134	0	0
Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)	115	122	118	122	120	124	2	4
VAMC-Based Outpatient Care Sites	172	170	172	170	172	172	0	0
Health Care Centers (HCC)	**13**	**13**	**13**	**13**	**13**	**13**	0	0
Community-Based Outpatient Clinics (CBOC)	**775**	**777**	**772**	**777**	**783**	**783**	11	0
Multi-Specialty CBOC	226	222	222	222	222	222	0	0
Primary Care CBOC	549	555	550	555	561	561	11	0
Other Outpatient Services (OOS) Sites, Total	**321**	**325**	**321**	**325**	**321**	**321**	0	0
Included in OOS Sites, Total:								
Dialysis Centers	73	73	72	73	72	72	0	0
Community Resource and Referral Centers (CRRC)	32	32	32	32	32	32	0	0
Vet Centers	**300**	**300**	**300**	**300**	**300**	**300**	0	0
Mobile Vet Centers	**83**	**80**	**83**	**80**	**83**	**83**	0	0
Vet Center Outstations	**19**	**20**	**19**	**20**	**19**	**19**	0	0

1/ Reflects historical data as of September 30, 2020.

Annual Changes in Medical Care Installations

Veterans Integrated Service Networks (VISN)

In the late 1990s, VHA was geographically separated into 21 areas known as 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 has a new realigned map with five districts. The VISN structure has been modified to reduce the number of VISNs from 21 to 18, and to bring the VISNs in line with the districts. Multiple factors were considered in the realignment process, including alignment within state boundaries, the population of Veterans served, and the number of health care systems within each VISN. The analysis supported a reduction in the number of VISNs from 21 to 18 to allow for a reasonable span of control, with 6 to 11 health care systems in the majority of the VISNs, while simultaneously reducing variation in Veteran population, enrollees, patients, full-time equivalent (FTE) staff, and budget.

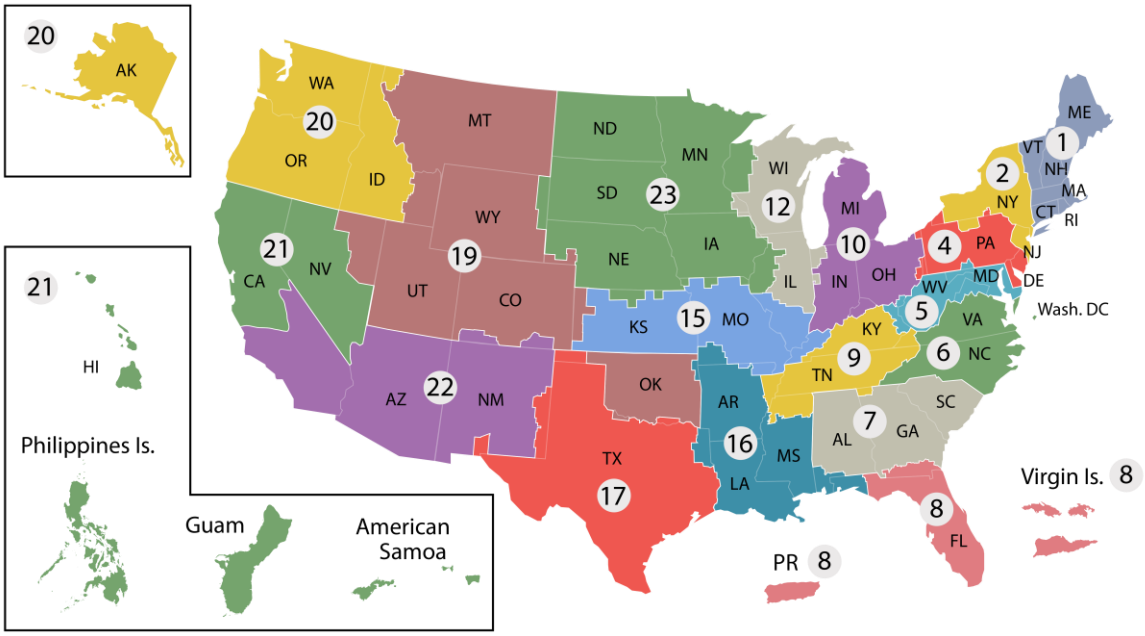
VA Districts by VISN

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

Impact on the facilities

- All facilities in VISN 3 have been integrated into VISN 2.
- All West Virginia VAMCs have been integrated into VISN 5: Clarksburg, WV (formerly VISN 4), Beckley, WV (formerly VISN 6), Huntington, WV (formerly VISN 9). The Martinsburg, WV VAMC was already part of VISN 5.
- Except for the Danville, IL VAMC, the facilities in VISN 11 have been integrated into VISN 10. The Danville, IL VAMC is now part of VISN 12.
- The Oklahoma VAMCs (Oklahoma City, OK and Musckogee, OK) have been moved from VISN 16 to VISN 19.
- The Las Vegas, NV VAMC has been moved from VISN 22 to VISN 21.
- The following VISN 18 Texas VAMCs have been integrated into VISN 17: Amarillo, West Texas, and El Paso.
- The remaining VISN 18 VAMCs in Arizona and New Mexico have been integrated into VISN 22: Tucson, Prescott, Phoenix, and Albuquerque.
- The Houston, TX VAMC has been moved from VISN 16 to VISN 17.

New 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.

<u>VAMC changes in 2020</u>
Based on 2019 workload data, 2 new sites have been activated (+2 VAMC), resulting in a net increase from 170 to 172 (+2 VAMC):

- +1 VAMC: VISN 8 Jacksonville Navy VA Medical Center, Jacksonville, FL (573A5)
- +1 VAMC: VISN 17 Garland VA Medical Center, Garland, TX (549A5)

Of the 172 VAMCs, 146 were classified as VA Hospitals in 2020. To meet the criteria of a VA Hospital, a facility must report over 500 inpatient acute bed days of care. The other 26 VAMCs provided a mix of other bed-care services, such as CLCs and/or residential rehabilitation care, thus meeting the VAMC criteria.

<u>VA Hospital changes in 2020</u>
Based on 2019 workload data, 2 VAMCs provided less than 500 bed days of acute inpatient care, thus no longer meeting the classification criteria of a hospital, resulting in a net decrease from 148 to 146 (-2 VA Hospital):

- -1 VA Hospital: VISN 5 Perry Point VA Medical Center, Perry Point, MD (512A5)
- -1 VA Hospital: VISN 21 Palo Alto VA Medical Center, Livermore, CA (640A4)

Please refer to the section titled "FY 2020 VA Medical Centers and Hospitals" for the complete list of VA Medical Centers and Hospitals in 2020.

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.

As of September 30, 2020, there were 134 active CLC facilities. Please refer to the section titled "FY 2020 Community Living Centers (CLC)" for the complete list of CLCs in 2020.

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 2020
Based on 2019 workload data, 2 MH RRTPs have been activated, and 1 MH RRTP was deactivated resulting in a net increase from 114 to 115 (+1 MH RRTP):

- +1 Domiciliary Substance Use Disorder (DOM SUD): VISN 21 Southern Nevada VA Medical Center, Las Vegas, NV (593)
- +1 General Domiciliary (GEN DOM): VISN 8 West Palm Beach VAMC, West Palm Beach, FL (548)
- -1 Domiciliary Posttraumatic Stress Disorder (DOM PTSD): VISN 19 Denver VA Domiciliary, Denver, CO (554A5)

Please refer to the section titled "FY 2020 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)" for the complete list of MH RRTPs in 2020.

MH RRTP changes in 2021
In 2021, MH RRTPs are projected to increase from 115 to 118 (+3 MH RRTP):

- +1 DOM SUD, Wichita, KS
- +1 DOM SUD, Huntington, WV
- +1 DOM SUD, Grand Junction, CO

MH RRTP changes in 2022
In 2022, MH RRTPs are projected to increase from 118 to 120 (+2 MH RRTP):

- +1 DOM SUD, Oklahoma City, OK
- +1 Domiciliary Care for Homeless Veterans, Houston, TX

MH RRTP changes in 2023
In 2023, MH RRTPs are projected to increase from 120 to 124 (+4 MH RRTP)

- +1 General Domiciliary, San Juan, PR
- +1 DOM PTSD, Denver, CO
- +1 DOM SUD, Alexandria, LA
- +1 DOM SUD, Poplar Bluff, MO

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: VHA Support Service Center (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 above 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.

<u>HCC changes in 2020</u>
Based on 2019 workload data, 2 MS CBOC facilities have been reclassified into HCC, resulting in a net increase from 11 to 13 (+2 HCC)

- +1 HCC: VISN 6 Kernersville VA Clinic, Kernersville, NC (659BY)
- +1 HCC: VISN 6 South Charlotte VA Clinic, Charlotte, NC (659BZ)

Please refer to the section titled "FY 2020 Health Care Centers (HCC)" for the complete list of HCCs in 2020.

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 2020

Based on 2019 workload data, 1 MS CBOC has been activated, 4 OOS sites and 25 PC CBOCs have been reclassified into MS CBOC (+30 MS CBOC), 2 MS CBOCs have been reclassified into HCC, 2 MS CBOCs have been reclassified into OOS, 19 MS CBOCs have been reclassified into PC CBOC (-23 MS CBOC), resulting in a net increase from 219 to 226 (+7 MS CBOC).

Activations (+1 MS CBOC):

- +1 MS CBOC: VISN 22 Gardena VA Clinic, Gardena, GA (600GF)

OOS sites reclassified into MS CBOCs (+4 MS CBOC):

- +1 MS CBOC: VISN 8 Lakeland VA Clinic, Lakeland, FL (673GB)
- +1 MS CBOC: VISN 10 Terre Haute VA Clinic, Terre Haute, IN (583GA)
- +1 MS CBOC: VISN 10 Georgetown VA Clinic, Georgetown, OH (539GF)
- +1 MS CBOC: VISN 10 Shelbyville VA Clinic, Shelbyville, IN (583GG)

PC CBOCs reclassified into MS CBOCs (+25 MS CBOC):

- +1 MS CBOC: VISN 4 Johnstown VA Clinic, Johnstown, PA (503GA)
- +1 MS CBOC: VISN 4 Cumberland County VA Clinic, Mechanicsburg, PA (595GA)
- +1 MS CBOC: VISN 4 Lancaster County VA Clinic, Willow Street, PA (595GC)
- +1 MS CBOC: VISN 4 Fayette County VA Clinic, Uniontown, PA (646GE)
- +1 MS CBOC: VISN 8 South Hillsborough VA Clinic, Riverview, FL (673GG)
- +1 MS CBOC: VISN 9 Somerset VA Clinic, Somerset, KY (596GA)
- +1 MS CBOC: VISN 10 Lake County VA Clinic, Willoughby, OH (541GF)
- +1 MS CBOC: VISN 10 Grove City VA Clinic, Grove City, OH (757GB)
- +1 MS CBOC: VISN 12 Springfield VA Clinic, Springfield, IL (550GD)
- +1 MS CBOC: VISN 15 Marshfield VA Clinic, Marshfield, MO (589JD)
- +1 MS CBOC: VISN 16 Fort Smith VA Clinic, Fort Smith, AR (564GB)
- +1 MS CBOC: VISN 16 Hot Springs VA Clinic, Hot Springs, AR (598GC)
- +1 MS CBOC: VISN 16 Slidell VA Clinic, Slidell, LA (629GC)
- +1 MS CBOC: VISN 17 Corpus Christi VA Clinic, Corpus Christi, TX (740GC)
- +1 MS CBOC: VISN 19 Kalispell VA Clinic, Kalispell, MT (436GF)
- +1 MS CBOC: VISN 19 South Oklahoma City VA Clinic, Oklahoma City, OK (635QB)
- +1 MS CBOC: VISN 20 Fairview VA Clinic, Fairview, OR (648GE)
- +1 MS CBOC: VISN 21 Guam VA Clinic, Agana Heights, GU (459GE)
- +1 MS CBOC: VISN 21 Oakhurst VA Clinic, Oakhurst, CA (570GC)
- +1 MS CBOC: VISN 23 Rapid City VA Clinic, Rapid City, SD (568GA)
- +1 MS CBOC: VISN 23 Norfolk VA Clinic, Norfolk, NE (636GA)

- +1 MS CBOC: VISN 23 Quad Cities VA Clinic, Davenport, IA (636GF)
- +1 MS CBOC: VISN 23 Lane A. Evans VA Clinic, Galesburg, IL (636GI)
- +1 MS CBOC: VISN 23 Carroll VA Clinic, Carroll, IA (636GM)
- +1 MS CBOC: VISN 23 Decorah VA Clinic, Decorah, IA (636GU)

MS CBOCs reclassified into HCC (-2 MS CBOC):

- -1 MS CBOC: VISN 6 Kernersville VA Clinic, Kernersville, NC (659BY)
- -1 MS CBOC: VISN 6 South Charlotte VA Clinic, Charlotte, NC (659BZ)

MS CBOCs reclassified into OOS sites (-2 MS CBOC):

- -1 MS CBOC: VISN 19 Dr. Joseph Medicine Crow VA Clinic, Billings, MT (436GN)
- -1 MS CBOC: VISN 21 North Reno VA Clinic, Reno, NV (654GF)

MS CBOCs reclassified into PC CBOCs (-19 MS CBOC):

- -1 MS CBOC: VISN 1 Worcester VA Clinic, Worcester, MA (631GE)
- -1 MS CBOC: VISN 4 Michael A. Marzano VA Clinic, Hermitage, PA (529GA)
- -1 MS CBOC: VISN 4 Sayre VA Clinic, Sayre, PA (693GA)
- -1 MS CBOC: VISN 7 Guntersville VA Clinic, Guntersville, AL (521GI)
- -1 MS CBOC: VISN 7 Myrtle Beach VA Clinic, Myrtle Beach, SC (534GB)
- -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 Key West VA Clinic, Key West, FL (546GB)
- -1 MS CBOC: VISN 10 Sandusky VA Clinic, Sandusky, OH (541GC)
- -1 MS CBOC: VISN 10 Ravenna VA Clinic, Ravenna, OH (541GK)
- -1 MS CBOC: VISN 10 Cadillac VA Clinic, Cadillac, MI (655GG)
- -1 MS CBOC: VISN 19 South Jordan VA Clinic, South Jordan, UT (660GJ)
- -1 MS CBOC: VISN 20 Silverdale VA Clinic, Silverdale, WA (663GB)
- -1 MS CBOC: VISN 21 Faleomavaega VA Clinic, Pago Pago, AS (459GF)
- -1 MS CBOC: VISN 21 Mare Island VA Clinic, Mare Island, CA (612GE)
- -1 MS CBOC: VISN 22 Northwest VA Clinic, Surprise, AZ (644GA)
- -1 MS CBOC: VISN 22 Show Low VA Clinic, Show Low, AZ (644GB)
- -1 MS CBOC: VISN 22 Palm Desert VA Clinic, Palm Desert, CA (605GC)
- -1 MS CBOC: VISN 22 Phoenix Midtown VA Clinic, Phoenix, AZ (644GH)

Please refer to the section titled "FY 2020 Multi-Specialty Community Based Clinics (MS CBOC)" for the complete list of MS CBOCs in 2020.

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 2020

Based on 2019 workload data, 19 PC CBOCs have been activated, 19 MS CBOCs and 21 OOS sites have been reclassified into PC CBOCs (+59 PC CBOC), 3 PC CBOCs have been deactivated, 25 PC CBOCs have been reclassified into MS CBOCs, 18 PC CBOCs have been reclassified into OOS sites (-46 PC CBOC), resulting in a net increase from 536 to 549 (+13 PC CBOC).

Activations (+19 PC CBOC):

- +1 PC CBOC: VISN 1 Orange VA Clinic, Orange, CT (689GF)
- +1 PC CBOC: VISN 5 Lexington Park VA Clinic, Lexington Park, MD (688GG)
- +1 PC CBOC: VISN 6 Clayton-East Raleigh VA Clinic, Clayton, NC (558GH)
- +1 PC CBOC: VISN 6 Jacksonville 4 VA Clinic, Jacksonville, NC (565GN)
- +1 PC CBOC: VISN 6 Portsmouth VA Clinic, Portsmouth, VA (590GE)
- +1 PC CBOC: VISN 8 Middleburg VA Clinic, Middleburg, FL (573GO)
- +1 PC CBOC: VISN 9 Mountain City VA Clinic, Mountain City, TN (621GO)
- +1 PC CBOC: VISN 10 Wright-Patterson VA Clinic, Wright-Patterson Air Force Base, OH (552GF)
- +1 PC CBOC: VISN 12 Bloomington VA Clinic, Bloomington, IL (550GG)
- +1 PC CBOC: VISN 12 Gladstone VA Clinic, Gladstone, MI (585GG)
- +1 PC CBOC: VISN 16 Sugar Land VA Clinic, Sugar Land, TX (580GL)
- +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 17 El Paso Northeast VA Clinic, El Paso, TX (756GD)
- +1 PC CBOC: VISN 19 Clinton VA Clinic, Clinton, OK (635GH)
- +1 PC CBOC: VISN 19 Norman VA Clinic, Norman, OK (635GI)
- +1 PC CBOC: VISN 19 Yukon VA Clinic, Yukon, OK (635GJ)
- +1 PC CBOC: VISN 20 North Seattle VA Clinic, Seattle, WA (663GG)
- +1 PC CBOC: VISN 22 San Gabriel Valley VA Clinic, Arcadia, CA (691GP)

MS CBOCs reclassified into PC CBOCs (+19 PC CBOC):

- +1 PC CBOC: VISN 1 Worcester VA Clinic, Worcester, MA (631GE)
- +1 PC CBOC: VISN 4 Michael A. Marzano VA Clinic, Hermitage, PA (529GA)
- +1 PC CBOC: VISN 4 Sayre VA Clinic, Sayre, PA (693GA)
- +1 PC CBOC: VISN 7 Guntersville VA Clinic, Guntersville, AL (521GI)
- +1 PC CBOC: VISN 7 Myrtle Beach VA Clinic, Myrtle Beach, SC (534GB)
- +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 Key West VA Clinic, Key West, FL (546GB)
- +1 PC CBOC: VISN 10 Sandusky VA Clinic, Sandusky, OH (541GC)
- +1 PC CBOC: VISN 10 Ravenna VA Clinic, Ravenna, OH (541GK)
- +1 PC CBOC: VISN 10 Cadillac VA Clinic, Cadillac, MI (655GG)
- +1 PC CBOC: VISN 19 South Jordan VA Clinic, South Jordan, UT (660GJ)
- +1 PC CBOC: VISN 20 Silverdale VA Clinic, Silverdale, WA (663GB)

- +1 PC CBOC: VISN 21 Faleomavaega VA Clinic, Pago Pago, AS (459GF)
- +1 PC CBOC: VISN 21 Mare Island VA Clinic, Mare Island, CA (612GE)
- +1 PC CBOC: VISN 22 Northwest VA Clinic, Surprise, AZ (644GA)
- +1 PC CBOC: VISN 22 Show Low VA Clinic, Show Low, AZ (644GB)
- +1 PC CBOC: VISN 22 Palm Desert VA Clinic, Palm Desert, CA (605GC)
- +1 PC CBOC: VISN 22 Phoenix Midtown VA Clinic, Phoenix, AZ (644GH)

OOS sites reclassified into PC CBOCs (+21 PC CBOC):

- +1 PC CBOC: VISN 1 Gloucester VA Clinic, Gloucester, MA (518GE)
- +1 PC CBOC: VISN 2 Catskill VA Clinic, Catskill, NY (528G7)
- +1 PC CBOC: VISN 4 Huntingdon County VA Clinic, Mapleton Depot, PA (503GD)
- +1 PC CBOC: VISN 5 Montgomery County VA Clinic, Gaithersburg, MD (688GF)
- +1 PC CBOC: VISN 5 Braxton County VA Clinic, Gassaway, WV (540GC)
- +1 PC CBOC: VISN 6 Hillandale Road VA Clinic, Durham, NC (558GE)
- +1 PC CBOC: VISN 6 Brunswick County VA Clinic, Supply, NC (565GH)
- +1 PC CBOC: VISN 7 Dothan 2 VA Clinic, Dothan, AL (619QA)
- +1 PC CBOC: VISN 9 Holly Springs VA Clinic, Holly Springs, MS (614GC)
- +1 PC CBOC: VISN 15 Shawnee VA Clinic, Shawnee, KS (589JC)
- +1 PC CBOC: VISN 16 Kosciusko VA Clinic, Kosciusko, MS (586GA)
- +1 PC CBOC: VISN 17 San Antonio VA Clinic, San Antonio, TX (671GK)
- +1 PC CBOC: VISN 17 LaGrange VA Clinic, La Grange, TX (674HB)
- +1 PC CBOC: VISN 19 Denver VA Domiciliary, Denver, CO (554A5)
- +1 PC CBOC: VISN 19 Lamar VA Clinic, Lamar, CO (554GH)
- +1 PC CBOC: VISN 19 Glenwood Springs VA Clinic, Glenwood Springs, CO (575QA)
- +1 PC CBOC: VISN 19 McCurtain County VA Clinic, Idabel, OK (623GC)
- +1 PC CBOC: VISN 19 Idaho Falls VA Clinic, Idaho Falls, ID (660QA)
- +1 PC CBOC: VISN 21 Chico VA Clinic, Chico, CA (612GG)
- +1 PC CBOC: VISN 22 Alamogordo VA Clinic, Alamogordo, NM (501GI)
- +1 PC CBOC: VISN 22 Taos VA Clinic, Taos, NM (501GN)

Deactivations (-3 PC CBOC):

- -1 PC CBOC: VISN 2 Elizabeth VA Clinic, Elizabeth, NJ (561GB)
- -1 PC CBOC: VISN 10 McCafferty VA Clinic, Cleveland, OH (541GE)
- -1 PC CBOC: VISN 12 Sierra Foothills VA Clinic, Auburn, CA (654GA)

PC CBOCs reclassified into MS CBOCs (-25 PC CBOC):

- -1 PC CBOC: VISN 4 Johnstown VA Clinic, Johnstown, PA (503GA)
- -1 PC CBOC: VISN 4 Cumberland County VA Clinic, Mechanicsburg, PA (595GA)
- -1 PC CBOC: VISN 4 Lancaster County VA Clinic, Willow Street, PA (595GC)
- -1 PC CBOC: VISN 4 Fayette County VA Clinic, Uniontown, PA (646GE)
- -1 PC CBOC: VISN 8 South Hillsborough VA Clinic, Riverview, FL (673GG)
- -1 PC CBOC: VISN 9 Somerset VA Clinic, Somerset, KY (596GA)
- -1 PC CBOC: VISN 10 Lake County VA Clinic, Willoughby, OH (541GF)
- -1 PC CBOC: VISN 10 Grove City VA Clinic, Grove City, OH (757GB)
- -1 PC CBOC: VISN 12 Springfield VA Clinic, Springfield, IL (550GD)
- -1 PC CBOC: VISN 15 Marshfield VA Clinic, Marshfield, MO (589JD)
- -1 PC CBOC: VISN 16 Fort Smith VA Clinic, Fort Smith, AR (564GB)

- -1 PC CBOC: VISN 16 Hot Springs VA Clinic, Hot Springs, AR (598GC)
- -1 PC CBOC: VISN 16 Slidell VA Clinic, Slidell, LA (629GC)
- -1 PC CBOC: VISN 17 Corpus Christi VA Clinic, Corpus Christi, TX (740GC)
- -1 PC CBOC: VISN 19 Kalispell VA Clinic, Kalispell, MT (436GF)
- -1 PC CBOC: VISN 19 South Oklahoma City VA Clinic, Oklahoma City, OK (635QB)
- -1 PC CBOC: VISN 20 Fairview VA Clinic, Fairview, OR (648GE)
- -1 PC CBOC: VISN 21 Guam VA Clinic, Agana Heights, GU (459GE)
- -1 PC CBOC: VISN 21 Oakhurst VA Clinic, Oakhurst, CA (570GC)
- -1 PC CBOC: VISN 23 Rapid City VA Clinic, Rapid City, SD (568GA)
- -1 PC CBOC: VISN 23 Norfolk VA Clinic, Norfolk, NE (636GA)
- -1 PC CBOC: VISN 23 Quad Cities VA Clinic, Davenport, IA (636GF)
- -1 PC CBOC: VISN 23 Lane A. Evans VA Clinic, Galesburg, IL (636GI)
- -1 PC CBOC: VISN 23 Carroll VA Clinic, Carroll, IA (636GM)
- -1 PC CBOC: VISN 23 Decorah VA Clinic, Decorah, IA (636GU)

PC CBOCs reclassified into OOS sites (-18 PC CBOC):

- -1 PC CBOC: VISN 4 Columbia County VA Clinic, Berwick, PA (693GF)
- -1 PC CBOC: VISN 7 Pickens County VA Clinic, Jasper, GA (508GM)
- -1 PC CBOC: VISN 7 Covington VA Clinic, Covington, GA (508GN)
- -1 PC CBOC: VISN 7 Northeast Cobb County VA Clinic, Marietta, GA (508GO)
- -1 PC CBOC: VISN 7 South Cobb County VA Clinic, Smyrna, GA (508GP)
- -1 PC CBOC: VISN 8 Lecanto VA Clinic, Lecanto, FL (673GH)
- -1 PC CBOC: VISN 10 Bloomington VA Clinic, Bloomington, IN (583GB)
- -1 PC CBOC: VISN 10 Colonel Demas T. Craw VA Clinic, Traverse City, MI (655GB)
- -1 PC CBOC: VISN 15 Paola VA Clinic, Paola, KS (589GC)
- -1 PC CBOC: VISN 15 Manchester Avenue VA Clinic, St. Louis, MO (657GY)
- -1 PC CBOC: VISN 19 Wheatland VA Mobile Clinic, Wheatland, WY (442HK)
- -1 PC CBOC: VISN 19 Denver VA Clinic, Denver, CO (554GJ)
- -1 PC CBOC: VISN 19 North May VA Clinic, Oklahoma City, OK (635QA)
- -1 PC CBOC: VISN 20 Lincoln City VA Clinic, Lincoln City, OR (648GK)
- -1 PC CBOC: VISN 20 Federal Way VA Clinic, Federal Way, WA (663GF)
- -1 PC CBOC: VISN 21 Sierra Foothills VA Clinic, Auburn, CA (612GK)
- -1 PC CBOC: VISN 22 Green Valley VA Clinic, Green Valley, AZ (678GE)
- -1 PC CBOC: VISN 23 Fort Dodge VA Clinic, Fort Dodge, IA (636GK)

Please refer to the section titled "FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)" for the complete list of PC CBOCs in 2020.

<u>PC CBOC changes in 2021</u>

In 2021, PC CBOCs are projected to increase from 549 to 550 (+1 PC CBOC):

- +1 PC CBOC: VISN 12 Urbana PC CBOC, Urbana, IL

<u>PC CBOC changes in 2022</u>

In 2022, PC CBOCs are projected to increase from 550 to 561 (+11 PC CBOC):

- +1 PC CBOC: VISN 12 Oconomowoc PC CBOC, Oconomowoc, WI

- +1 PC CBOC: VISN 15 Madison County PC CBOC, Madison County, IL
- +1 PC CBOC: VISN 17 Paris PC CBOC, Paris, TX
- +1 PC CBOC: VISN 17 Weatherford PC CBOC, Weatherford, TX
- +1 PC CBOC: VISN 17 Waxahachie PC CBOC, Waxahachie, TX
- +1 PC CBOC: VISN 17 San Marcos PC CBOC, San Marcos, TX
- +1 PC CBOC: VISN 17 Pflugerville PC CBOC, Pflugerville, TX
- +1 PC CBOC: VISN 22 Banning PC CBOC, Banning, CA
- +1 PC CBOC: VISN 22 Barstow PC CBOC, Barstow, CA
- +1 PC CBOC: VISN 22 Hemet PC CBOC, Hemet, CA
- +1 PC CBOC: VISN 22 Riverside PC CBOC, Riverside, CA

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.

<u>OOS site changes in 2020</u>

Based on 2019 workload data, 14 OOS sites have been activated, 2 MS CBOCs and 18 PC CBOCs have been reclassified into OOS (+34 OOS), 10 OOS sites have been deactivated, 4 OOS sites have been reclassified into MS CBOCs, 21 OOS sites have been reclassified into PC CBOCs (-35 OOS), resulting in a net decrease from 322 to 321 (-1 OOS).

Activations (+14 OOS):

- +1 OOS: VISN 7 North DeKalb County VA Clinic, Brookhaven, GA (508QI)
- +1 OOS: VISN 8 Palm Bay VA Clinic, Palm Bay, FL (675QG)
- +1 OOS: VISN 9 Johnson City VA Clinic, Johnson City, TN (621QF)
- +1 OOS: VISN 9 Glenis Drive 2 VA Clinic, Murfreesboro, TN (626QE)
- +1 OOS: VISN 9 Dalton Drive VA Clinic, Clarksville, TN (626QF)
- +1 OOS: VISN 10 Crane VA Clinic, Crane, IN (583QF)
- +1 OOS: VISN 17 El Paso South Central VA Clinic, El Paso, TX (756QA)
- +1 OOS: VISN 19 Browning VA Clinic, Browning, MT (436QD)
- +1 OOS: VISN 19 Cheyenne VA Mobile Clinic, Cheyenne WY (442QF)
- +1 OOS: VISN 19 Grand Junction 28 Road VA Clinic, Grand Junction, CO (575QD)
- +1 OOS: VISN 19 Lawton North VA Clinic, Fort Sill, OK (635QD)
- +1 OOS: VISN 19 Tinker VA Clinic, Oklahoma City, OK (635QE)
- +1 OOS: VISN 20 Elmendorf-Richardson VA Clinic, Anchorage, AK (463QA)
- +1 OOS: VISN 23 North Fargo VA Clinic, Fargo, ND (437QA)

MS CBOCs reclassified into OOS sites (+2 OOS):

- +1 OOS: VISN 19 Dr. Joseph Medicine Crow VA Clinic, Billings, MT (436GN)

- +1 OOS: VISN 21 North Reno VA Clinic, Reno, NV (654GF)

PC CBOCs reclassified into OOS sites (+18 OOS):

- +1 OOS: VISN 4 Columbia County VA Clinic, Berwick, PA (693GF)
- +1 OOS: VISN 7 Pickens County VA Clinic, Jasper, GA (508GM)
- +1 OOS: VISN 7 Covington VA Clinic, Covington, GA (508GN)
- +1 OOS: VISN 7 Northeast Cobb County VA Clinic, Marietta, GA (508GO)
- +1 OOS: VISN 7 South Cobb County VA Clinic, Smyrna, GA (508GP)
- +1 OOS: VISN 8 Lecanto VA Clinic, Lecanto, FL (673GH)
- +1 OOS: VISN 10 Bloomington VA Clinic, Bloomington, IN (583GB)
- +1 OOS: VISN 10 Colonel Demas T. Craw VA Clinic, Traverse City, MI (655GB)
- +1 OOS: VISN 15 Paola VA Clinic, Paola, KS (589GC)
- +1 OOS: VISN 15 Manchester Avenue VA Clinic, St. Louis, MO (657GY)
- +1 OOS: VISN 19 Wheatland VA Mobile Clinic, Wheatland, WY (442HK)
- +1 OOS: VISN 19 Denver VA Clinic, Denver, CO (554GJ)
- +1 OOS: VISN 19 North May VA Clinic, Oklahoma City, OK (635QA)
- +1 OOS: VISN 20 Lincoln City VA Clinic, Lincoln City, OR (648GK)
- +1 OOS: VISN 20 Federal Way VA Clinic, Federal Way, WA (663GF)
- +1 OOS: VISN 21 Sierra Foothills VA Clinic, Auburn, CA (612GK)
- +1 OOS: VISN 22 Green Valley VA Clinic, Green Valley, AZ (678GE)
- +1 OOS: VISN 23 Fort Dodge VA Clinic, Fort Dodge, IA (636GK)

Deactivations (-10 OOS):

- -1 OOS: VISN 2 Bath VA Mobile Clinic, Bath, NY (528QL)
- -1 OOS: VISN 2 Mount Hope VA Clinic, Bronx, NY (528QD)
- -1 OOS: VISN 2 Montrose 2 VA Mobile Clinic, Montrose, NY (620QB)
- -1 OOS: VISN 10 Dayton 1 VA Mobile Clinic, Dayton, OH (552QA)
- -1 OOS: VISN 10 Dayton Third Street 2 VA Mobile Clinic, Dayton, OH (552QB)
- -1 OOS: VISN 10 Grand Traverse VA Clinic, Traverse City, MI (655QB)
- -1 OOS: VISN 15 Salem VA Clinic, Salem, MO (657GN)
- -1 OOS: VISN 15 Enterprise Way VA Clinic, Marion, IL (657QC)
- -1 OOS: VISN 22 Long Beach VA Mobile Clinic, Long Beach, CA (600QB)
- -1 OOS: VISN 23 O'Neill VA Clinic, O'Neill, NE (636GV)

OOS sites reclassified into MS CBOCs (-4 OOS):

- -1 OOS: VISN 8 Lakeland VA Clinic, Lakeland, FL (673GB)
- -1 OOS: VISN 10 Terre Haute VA Clinic, Terre Haute, IN (583GA)
- -1 OOS: VISN 10 Georgetown VA Clinic, Georgetown, OH (539GF)
- -1 OOS: VISN 10 Shelbyville VA Clinic, Shelbyville, IN (583GG)

OOS sites reclassified into PC CBOCs (-21 OOS):

- -1 OOS: VISN 1 Gloucester VA Clinic, Gloucester, MA (518GE)
- -1 OOS: VISN 2 Catskill VA Clinic, Catskill, NY (528G7)
- -1 OOS: VISN 4 Huntingdon County VA Clinic, Mapleton Depot, PA (503GD)
- -1 OOS: VISN 5 Montgomery County VA Clinic, Gaithersburg, MD (688GF)
- -1 OOS: VISN 5 Braxton County VA Clinic, Gassaway, WV (540GC)
- -1 OOS: VISN 6 Hillandale Road VA Clinic, Durham, NC (558GE)
- -1 OOS: VISN 6 Brunswick County VA Clinic, Supply, NC (565GH)

- -1 OOS: VISN 7 Dothan 2 VA Clinic, Dothan, AL (619QA)
- -1 OOS: VISN 9 Holly Springs VA Clinic, Holly Springs, MS (614GC)
- -1 OOS: VISN 15 Shawnee VA Clinic, Shawnee, KS (589JC)
- -1 OOS: VISN 16 Kosciusko VA Clinic, Kosciusko, MS (586GA)
- -1 OOS: VISN 17 San Antonio VA Clinic, San Antonio, TX (671GK)
- -1 OOS: VISN 17 LaGrange VA Clinic, La Grange, TX (674HB)
- -1 OOS: VISN 19 Denver VA Domiciliary, Denver, CO (554A5)
- -1 OOS: VISN 19 Lamar VA Clinic, Lamar, CO (554GH)
- -1 OOS: VISN 19 Glenwood Springs VA Clinic, Glenwood Springs, CO (575QA)
- -1 OOS: VISN 19 McCurtain County VA Clinic, Idabel, OK (623GC)
- -1 OOS: VISN 19 Idaho Falls VA Clinic, Idaho Falls, ID (660QA)
- -1 OOS: VISN 21 Chico VA Clinic, Chico, CA (612GG)
- -1 OOS: VISN 22 Alamogordo VA Clinic, Alamogordo, NM (501GI)
- -1 OOS: VISN 22 Taos VA Clinic, Taos, NM (501GN)

Please refer to the section titled "FY 2020 Other Outpatient Services (OOS) Sites" for the complete list of OOS sites in 2020.

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.

As of September 30, 2020, there were 73 active Dialysis Centers. Please refer to the section titled, "FY 2020 Outpatient Dialysis Centers" for the complete list of Dialysis Centers in 2020.

Dialysis Center changes in 2021

In 2021, the number of Dialysis Centers is projected to decrease from 73 to 72 (-1 Dialysis Center):

- -1 Dialysis Center: VISN 16 G.V. (Sonny) Montgomery VA Medical Center, Jackson, MS (586)

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.

CRRC changes in 2020

Based on 2019 workload data, the number of CRRC facilities has increased from 31 to 32 (+1 CRRC):

- +1 CRRC: VISN 23 Fargo VA Medical Center, Fargo, ND (437)

For the complete list, please refer to the section titled "FY 2020 Community Resource and Referral Centers (CRRC)."

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.

During the COVID-19 pandemic, VA has deployed the MVC units to expand direct counseling, outreach, and care coordination to Veterans in the affected communities. The MVC units were dispatched to various cities, including New York, San Francisco, New Orleans, and Los Angeles. These mobile units help VA reach those who may not otherwise seek VA services for counseling and mental health support. Vet Center staff can assist those who may be facing extreme isolation during this period of "social distancing"—a practice that is needed to reduce the COVID-19 infection rate—but one that may likewise increase the vulnerability of some Veterans.

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.

There were 300 Vet Centers in 2020. For the complete list, please refer to the section titled "FY 2020 Vet Centers, Mobile Vet Centers and Vet Center Outstations."

<u>Mobile Vet Centers changes in 2020</u>
Based on 2019 workload data, 6 MVCs were opened and 3 MVCs were closed, resulting in a net increase from 80 to 83 (+3 MVC):

- +1 MVC: VISN 8 Clearwater Mobile Vet Center, Clearwater, FL (516)
- +1 MVC: VISN 9 Knoxville Mobile Vet Center, Knoxville, TN (621)
- +1 MVC: VISN 21 Henderson Mobile Vet Center, Henderson, NV (593)

- +1 MVC: VISN 22 Chinle Mobile Vet Center, Chinle, AZ (501)
- +1 MVC: VISN 22 San Marcos Mobile Vet Center, San Marcos, CA (664)
- +1 MVC: VISN 22 Yuma Mobile Vet Center, Yuma, AZ (678)
- -1 MVC: VISN 8 Pasco County Mobile Vet Center, New Port Richey, FL (673)
- -1 MVC: VISN 9 Johnson City Mobile Vet Center, Johnson City, TN (621)
- -1 MVC: VISN 22 Farmington Mobile Vet Center 2, Farmington, NM (501)

Veteran Center Outstation changes in 2020

Based on 2019 workload data, 1 VC Outstation was closed, resulting in a net decrease from 20 to 19 (-1 VC Outstation):

- -1 VC Outstation: VISN 10 McCafferty Outstation, Cleveland, OH (541)

FY 2020 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	FY 2020 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)	Yes
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 2020 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	FY 2020 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	573A5	Jacksonville Navy VA Medical Center	VA Medical Center (VAMC)	No
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

FY 2020 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	FY 2020 Hospital (Yes / 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
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	549A5	Garland VA Medical 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	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

FY 2020 VA Medical Centers and Hospitals

VISN	Station Number	Station Name	Classification	FY 2020 Hospital (Yes / No)
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
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 2020 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 2020 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 2020 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

FY 2020 Community Living Centers (CLC)

CLC Program Count	VISN	Station Number	Official Name
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
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	656	St. Cloud VA

FY 2020 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

MH RRTP Program Count	VISN	Station #	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	VA Medical Center (VAMC)	CWT/TR Program
6	1	689	Connecticut VA-West Haven	VA Medical Center (VAMC)	Domiciliary Program
7	2	528	Western New York VA-Buffalo	VA Medical Center (VAMC)	Domiciliary Program
8	2	528A4	Western New York VA-Batavia	VA Medical Center (VAMC)	Domiciliary Program
9	2	528A5	Canandaigua VA	VA Medical Center (VAMC)	Domiciliary Program
10	2	528A6	Bath VA	VA Medical Center (VAMC)	Domiciliary Program
11	2	528A8	Samuel S. Stratton VA- Albany	VA Medical Center (VAMC)	Domiciliary Program
12	2	561	New Jersey VA-East Orange	VA Medical Center (VAMC)	Domiciliary Program
13	2	561A4	New Jersey VA-Lyons	VA Medical Center (VAMC)	Dom & CWT/TR Program
14	2	620	Franklin Delano Roosevelt VA	VA Medical Center (VAMC)	Domiciliary Program
15	2	630A4	New York Harbor VA-Brooklyn Division	VA Medical Center (VAMC)	Domiciliary Program
16	2	632	Northport VA	VA Medical Center (VAMC)	Domiciliary Program
17	4	529	Butler VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
18	4	542	Coatesville VA	VA Medical Center (VAMC)	Domiciliary Program
19	4	595	Lebanon VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
20	4	642BU	Philadelphia VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary
21	4	646A4	Pittsburgh VA-H.J. Heinz VA	VA Medical Center (VAMC)	Domiciliary Program &
22	4	562	Erie VA	VA Medical Center (VAMC)	Domiciliary Program
23	4	693	Wilkes-Barre VA	VA Medical Center (VAMC)	Domiciliary Program
24	5	512A5	Maryland VA-Perry Point	VA Medical Center (VAMC)	Dom & CWT/TR Program
25	5	540	Louis A. Johnson VA (Clarksburg)	VA Medical Center (VAMC)	Domiciliary Program
26	5	613	Martinsburg VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
27	6	590	Hampton VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
28	6	637	Charles George VA (Asheville)	VA Medical Center (VAMC)	Domiciliary Program
29	6	652	Hunter Holmes McGuire VA (Richmond)	VA Medical Center (VAMC)	Domiciliary Program
30	6	658	Salem VA	VA Medical Center (VAMC)	Domiciliary Program
31	6	659	W.G. (Bill) Hefner VA (Salisbury)	VA Medical Center (VAMC)	Dom & CWT/TR Program
32	7	508	Atlanta VA - Decatur	VA Medical Center (VAMC)	CWT/TR Program
33	7	508GA	Atlanta VA - Fort McPherson	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary
34	7	509A0	Augusta VA-Uptown	VA Medical Center (VAMC)	Domiciliary Program
35	7	521	Birmingham VA	VA Medical Center (VAMC)	CWT/TR Program
36	7	557	Carl Vinson VA (Dublin)	VA Medical Center (VAMC)	Domiciliary Program
37	7	619A4	Central Alabama VA-Tuskegee	VA Medical Center (VAMC)	Dom & CWT/TR Program
38	7	679	Tuscaloosa VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
39	8	516	C.W. Bill Young VA (Bay Pines)	VA Medical Center (VAMC)	Domiciliary Program
40	8	546	Miami VA	VA Medical Center (VAMC)	Domiciliary Program
41	8	548	West Palm Beach	VA Medical Center (VAMC)	Domiciliary Program
42	8	573A4	North Florida-South Georgia VA-Lake City	VA Medical Center (VAMC)	Domiciliary Program
43	8	573BU	Gainesville VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary
44	8	673BV	Tampa VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary
45	8	675GG	Orlando VA (Lake Baldwin)	VA Medical Center (VAMC)	Domiciliary Program

FY 2020 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

MH RRTP Program Count	VISN	Station #	Official Name	Classification	Type of Service
46	8	675	Orlando VA (Lake Nona)	VA Medical Center (VAMC)	Domiciliary Program
47	9	596	Lexington VA-Leestown	VA Medical Center (VAMC)	Domiciliary Program
48	9	603	Robley Rex VA (Louisville)	VA Medical Center (VAMC)	Domiciliary Program
49	9	614	Memphis VA	VA Medical Center (VAMC)	Domiciliary Program
50	9	621	James H. Quillen VA (Mountain Home)	VA Medical Center (VAMC)	Domiciliary Program
51	9	626A4	Alvin C. York VA (Murfreesboro)	VA Medical Center (VAMC)	Domiciliary Program
52	10	538	Chillicothe VA	VA Medical Center (VAMC)	Domiciliary Program
53	10	539	Cincinnati VA	VA Medical Center (VAMC)	Domiciliary Program
54	10	539A4	Cincinnati VA-Fort Thomas	VA Medical Center (VAMC)	Domiciliary Program
55	10	541	Louis Stokes VA (Cleveland - Wade Park Division)	VA Medical Center (VAMC)	Dom & CWT/TR Program
56	10	552	Dayton VA	VA Medical Center (VAMC)	Domiciliary Program
57	10	515	Battle Creek VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
58	10	553BU	Detroit VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary
59	10	583BU	Indianapolis VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary
60	10	610	Northern Indiana VA (Marion)	VA Medical Center (VAMC)	Domiciliary Program
61	12	537	Jesse Brown VA (Chicago)	VA Medical Center (VAMC)	Domiciliary Program
62	12	550	Illiana VA-Danville	VA Medical Center (VAMC)	Dom & CWT/TR Program
63	12	556	Captain James A. Lovell VA (North Chicago)	VA Medical Center (VAMC)	Dom & CWT/TR Program
64	12	578	Edward Hines Jr. VA	VA Medical Center (VAMC)	Domiciliary Program
65	12	607	William S. Middleton VA (Madison)	VA Medical Center (VAMC)	Dom & CWT/TR Program
66	12	676	Tomah VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
67	12	695	Clement J. Zablocki VA (Milwaukee)	VA Medical Center (VAMC)	Dom & CWT/TR Program
68	15	589	Kansas City VA	VA Medical Center (VAMC)	Dom & CWT/TR Program
69	15	589A4	Harry S. Truman VA (Columbia MO)	VA Medical Center (VAMC)	Dom & CWT/TR Program
70	15	589A5	Eastern Kansas VA - Topeka Division	VA Medical Center (VAMC)	Dom & CWT/TR Program
71	15	589A6	Eastern Kansas VA - Dwight D. Eisenhower	VA Medical Center (VAMC)	Domiciliary Program
72	15	657A0	St. Louis VA-Jefferson Barracks	VA Medical Center (VAMC)	Domiciliary Program
73	15	657A5	Marion IL VA	VA Medical Center (VAMC)	Domiciliary Program
74	16	520	Gulf Coast VA-Biloxi	VA Medical Center (VAMC)	Domiciliary Program
75	16	564	Veterans HCS of the Ozarks - Fayetteville	VA Medical Center (VAMC)	Domiciliary Program
76	16	586BU	Jackson VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary
77	16	598A0	Central Arkansas VA-Eugene J. Tobin	VA Medical Center (VAMC)	Dom & CWT/TR Program
78	17	549	North Texas VA-Dallas	VA Medical Center (VAMC)	Dom & CWT/TR Program
79	17	549A4	North Texas VA-Sam Rayburn (Bonham)	VA Medical Center (VAMC)	Dom & CWT/TR Program
80	17	671	South Texas VA-Audie L. Murphy (San Antonio)	VA Medical Center (VAMC)	Domiciliary Program
81	17	674	Central Texas VA-Olin E. Teague (Temple)	VA Medical Center (VAMC)	Dom & CWT/TR Program
82	17	674A4	Central Texas VA-Waco	VA Medical Center (VAMC)	Domiciliary Program
83	17	519	West Texas VA-George H. O'Brien, Jr. (Big Spring)	VA Medical Center (VAMC)	Domiciliary Program
84	19	436	Montana VA-Fort Harrison	VA Medical Center (VAMC)	Domiciliary Program
85	19	442	Cheyenne	VA Medical Center (VAMC)	Domiciliary Program
86	19	554BU	Valor Point VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary
87	19	660	George E. Wahlen VA (Salt Lake)	VA Medical Center (VAMC)	Domiciliary Program
88	19	635	Oklahoma City VA	VA Medical Center (VAMC)	CWT/TR Program
89	19	666	Sheridan VA	VA Medical Center (VAMC)	Domiciliary Program
90	20	463	Alaska VA-Anchorage	VA Medical Center (VAMC)	Dom & CWT/TR Program
91	20	531	Boise VA	VA Medical Center (VAMC)	Domiciliary Program

FY 2020 Mental Health Residential Rehabilitation Treatment Programs (MH RRTP)

MH RRTP Program Count	VISN	Station #	Official Name	Classification	Type of Service
92	20	648A4	Portland VA-Vancouver	VA Medical Center (VAMC)	Domiciliary Program
93	20	653	Roseburg VA	VA Medical Center (VAMC)	Domiciliary Program
94	20	663A4	Puget Sound VA-American Lake	VA Medical Center (VAMC)	Dom & CWT/TR Program
95	20	687	Jonathan M. Wainwright VA (Walla Walla)	VA Medical Center (VAMC)	Domiciliary Program
96	20	692	Southern Oregon VA-White City	VA Medical Center (VAMC)	Domiciliary Program
97	21	459	Pacific Islands VA-Spark M. Matsunaga	VA Medical Center (VAMC)	Domiciliary Program
98	21	593	Southern Nevada (Las Vegas)	VA Medical Center (VAMC)	Domiciliary Program
99	21	640A0	Palo Alto VA-Menlo Park	VA Medical Center (VAMC)	Dom & CWT/TR Program
100	21	640BV	Palo Alto VA	VA Medical Center (VAMC)	Domiciliary
101	21	662	San Francisco VA	VA Medical Center (VAMC)	CWT/TR Program
102	22	664	San Diego VA	VA Medical Center (VAMC)	Domiciliary Program
103	22	664BV	San Diego VA Domiciliary	Residential Care Site (MH RRTP/DRRTP)	Stand Alone Domiciliary
104	22	501	New Mexico VA-Raymond G. Murphy (Albuquerque)	VA Medical Center (VAMC)	Dom & CWT/TR Program
105	22	644	Carl T. Hayden VA (Phoenix)	VA Medical Center (VAMC)	Domiciliary Program
106	22	649	Northern Arizona VA-Prescott	VA Medical Center (VAMC)	Domiciliary Program
107	22	678	Southern Arizona VA-Tucson	VA Medical Center (VAMC)	Domiciliary Program
108	22	691	Greater Los Angeles VA-West Los Angeles	VA Medical Center (VAMC)	Domiciliary Program
109	23	568	Black Hills VA-Fort Meade	VA Medical Center (VAMC)	CWT/TR Program
110	23	568A4	Black Hills VA-Hot Springs	VA Medical Center (VAMC)	Dom & CWT/TR Program
111	23	568A4	Black Hills VA - Hot Springs (Pine Ridge)	Residential Care Site (CWT/TR)	CWT/TR Program
112	23	636	Nebraska-Western Iowa VA-Omaha	VA Medical Center (VAMC)	Domiciliary Program
113	23	636A4	Grand Island VA Clinic	VA Medical Center (VAMC)	Dom & CWT/TR Program
114	23	636A6	Central Iowa VA-Des Moines	VA Medical Center (VAMC)	Domiciliary Program
115	23	656	St. Cloud VA	VA Medical Center (VAMC)	Domiciliary Program

FY 2020 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	8	573BY	Jacksonville 1 VA Clinic, FL
6	8	675GA	Viera VA Clinic, FL
7	10	757	Chalmers P. Wylie Veterans Outpatient Clinic, Columbus, OH
8	12	695GD	Milo C. Huempfner VA Outpatient Clinic, Green Bay, WI
9	15	657GJ	Evansville VA Clinic, IN
10	17	740	Harlingen VA Clinic, TX
11	17	756	El Paso VA Clinic, TX
12	19	436GH	Billings VA Clinic, MN
13	20	653BY	Eugene VA Clinic, OR

FY 2020 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
1	1	402GE	Lewiston VA Clinic	Lewiston, Maine	Multi-Specialty CBOC
2	1	402HB	Bangor VA Clinic	Bangor	Multi-Specialty CBOC
3	1	405HA	Burlington Lakeside VA Clinic	Burlington Lakeside	Multi-Specialty CBOC
4	1	523BY	Lowell VA Clinic	Lowell	Multi-Specialty CBOC
5	1	631BY	Springfield VA Clinic	Springfield, Massachusetts	Multi-Specialty CBOC
6	1	689A4	Newington VA Clinic	Newington	Multi-Specialty CBOC
7	2	528GE	Rochester Westfall VA Clinic	Rochester, New York	Multi-Specialty CBOC
8	2	528GM	Donald J. Mitchell Department of Veterans Affairs Outpatient Clinic	Rome, New York	Multi-Specialty CBOC
9	2	528GN	Binghamton VA Clinic	Binghamton	Multi-Specialty CBOC
10	2	561BZ	James J. Howard Veterans' Outpatient Clinic	Brick	Multi-Specialty CBOC
11	2	620GA	New City VA Clinic	New City	Multi-Specialty CBOC
12	2	630GB	Staten Island Community VA Clinic	Staten Island	Multi-Specialty CBOC
13	4	460GA	Sussex County VA Clinic	Sussex County	Multi-Specialty CBOC
14	4	460GC	Kent County VA Clinic	Kent County	Multi-Specialty CBOC
15	4	460HG	Cumberland County VA Clinic	Cumberland County New Jersey	Multi-Specialty CBOC
16	4	503GA	Johnstown VA Clinic	Johnstown	Multi-Specialty CBOC
17	4	503GB	DuBois VA Clinic	DuBois	Multi-Specialty CBOC
18	4	503GC	State College VA Clinic	State College	Multi-Specialty CBOC
19	4	529	Abie Abraham VA Clinic	Butler	Multi-Specialty CBOC
20	4	595GA	Cumberland County VA Clinic	Cumberland County Pennsylvania	Multi-Specialty CBOC
21	4	595GC	Lancaster County VA Clinic	Lancaster County	Multi-Specialty CBOC
22	4	595GE	York VA Clinic	York	Multi-Specialty CBOC
23	4	642GA	Burlington County VA Clinic	Burlington County	Multi-Specialty CBOC
24	4	642GC	Victor J. Saracini Department of Veterans Affairs Outpatient Clinic	Horsham	Multi-Specialty CBOC
25	4	642GD	Gloucester County VA Clinic	Gloucester County	Multi-Specialty CBOC
26	4	646GA	Belmont County VA Clinic	Belmont County	Multi-Specialty CBOC
27	4	646GC	Beaver County VA Clinic	Beaver County	Multi-Specialty CBOC
28	4	646GD	Washington County VA Clinic	Washington County	Multi-Specialty CBOC
29	4	646GE	Fayette County VA Clinic	Fayette County	Multi-Specialty CBOC
30	4	693B4	Allentown VA Clinic	Allentown	Multi-Specialty CBOC
31	5	512GA	Cambridge VA Clinic	Cambridge, Maryland	Multi-Specialty CBOC
32	5	512GC	Glen Burnie VA Clinic	Glen Burnie	Multi-Specialty CBOC
33	5	512GG	Fort Meade VA Clinic	Fort Meade, Maryland	Multi-Specialty CBOC
34	5	581GB	Charleston VA Clinic	Charleston, West Virginia	Multi-Specialty CBOC
35	5	613GA	Cumberland VA Clinic	Cumberland	Multi-Specialty CBOC
36	5	613GC	Stephens City VA Clinic	Stephens City	Multi-Specialty CBOC
37	5	613GG	Fort Detrick VA Clinic	Fort Detrick	Multi-Specialty CBOC
38	6	558GA	Greenville VA Clinic	Greenville, North Carolina	Multi-Specialty CBOC
39	6	565GC	Wilmington VA Clinic	Wilmington, North Carolina	Multi-Specialty CBOC
40	6	637GC	Hickory VA Clinic	Hickory	Multi-Specialty CBOC
41	6	652GE	Charlottesville VA Clinic	Charlottesville	Multi-Specialty CBOC
42	6	659GA	North Charlotte VA Clinic	North Charlotte	Multi-Specialty CBOC
43	7	508GE	Oakwood VA Clinic	Oakwood	Multi-Specialty CBOC
44	7	508GH	Lawrenceville VA Clinic	Lawrenceville	Multi-Specialty CBOC
45	7	508GI	Newnan VA Clinic	Newnan	Multi-Specialty CBOC
46	7	508GJ	Blairsville VA Clinic	Blairsville	Multi-Specialty CBOC
47	7	508QF	Atlanta VA Clinic	Atlanta North Arcadia Avenue	Multi-Specialty CBOC
48	7	521GA	Huntsville VA Clinic	Huntsville	Multi-Specialty CBOC
49	7	521GJ	Birmingham VA Clinic	Birmingham 7th Avenue South	Multi-Specialty CBOC
50	7	534BY	Savannah VA Clinic	Savannah, Georgia	Multi-Specialty CBOC

FY 2020 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
51	7	534GD	Goose Creek VA Clinic	Goose Creek	Multi-Specialty CBOC
52	7	534QA	Market Commons VA Clinic	Market Commons	Multi-Specialty CBOC
53	7	544BZ	Greenville VA Clinic	Greenville, South Carolina	Multi-Specialty CBOC
54	7	544GD	Anderson VA Clinic	Anderson	Multi-Specialty CBOC
55	7	557GA	Macon VA Clinic	Macon	Multi-Specialty CBOC
56	7	557GB	Albany VA Clinic	Albany, Georgia	Multi-Specialty CBOC
57	7	557GE	Brunswick VA Clinic	Brunswick	Multi-Specialty CBOC
58	7	619GA	Columbus VA Clinic	Columbus, Georgia	Multi-Specialty CBOC
59	7	619GD	Wiregrass VA Clinic	Wiregrass	Multi-Specialty CBOC
60	7	619GF	Central Alabama Montgomery VA Clinic	Central Alabama Montgomery	Multi-Specialty CBOC
61	8	516GA	Sarasota VA Clinic	Sarasota	Multi-Specialty CBOC
62	8	516GD	Bradenton VA Clinic	Bradenton	Multi-Specialty CBOC
63	8	516GE	Port Charlotte VA Clinic	Port Charlotte	Multi-Specialty CBOC
64	8	546BZ	William "Bill" Kling Department of Veterans Affairs Outpatient Clinic	Sunrise	Multi-Specialty CBOC
65	8	546GC	Homestead VA Clinic	Homestead	Multi-Specialty CBOC
66	8	573GE	Saint Augustine VA Clinic	Saint Augustine	Multi-Specialty CBOC
67	8	573GF	Sergeant Ernest I. "Boots" Thomas VA Clinic	Tallahassee	Multi-Specialty CBOC
68	8	573GI	The Villages VA Clinic	The Villages	Multi-Specialty CBOC
69	8	573QJ	Jacksonville 2 VA Clinic	Jacksonville 2	Multi-Specialty CBOC
70	8	672B0	Eurípides Rubio Department of Veterans Affairs Outpatient Clinic	Ponce	Multi-Specialty CBOC
71	8	672BZ	Mayaguez VA Clinic	Mayaguez	Multi-Specialty CBOC
72	8	673BZ	New Port Richey VA Clinic	New Port Richey	Multi-Specialty CBOC
73	8	673GB	Lakeland VA Clinic	Lakeland	Multi-Specialty CBOC
74	8	673GC	Brooksville VA Clinic	Brooksville	Multi-Specialty CBOC
75	8	673GG	South Hillsborough VA Clinic	South Hillsborough	Multi-Specialty CBOC
76	8	673QJ	Hidden River VA Clinic	Hidden River	Multi-Specialty CBOC
77	8	675GB	William V. Chappell, Jr. Veterans' Outpatient Clinic	Daytona Beach	Multi-Specialty CBOC
78	9	596GA	Somerset VA Clinic	Somerset	Multi-Specialty CBOC
79	9	603GE	Newburg VA Clinic	Newburg	Multi-Specialty CBOC
80	9	614GF	Nonconnah Boulevard VA Clinic	Nonconnah Boulevard	Multi-Specialty CBOC
81	9	621BY	William C. Tallent Department of Veterans Affairs Outpatient Clinic	Knoxville, Tennessee	Multi-Specialty CBOC
82	9	626GE	Clarksville VA Clinic	Clarksville	Multi-Specialty CBOC
83	9	626GF	Chattanooga VA Clinic	Chattanooga	Multi-Specialty CBOC
84	10	506GA	Toledo VA Clinic	Toledo	Multi-Specialty CBOC
85	10	506GC	Jackson VA Clinic	Jackson, Michigan	Multi-Specialty CBOC
86	10	515BY	Wyoming VA Clinic	Wyoming	Multi-Specialty CBOC
87	10	538GC	Marietta VA Clinic	Marietta	Multi-Specialty CBOC
88	10	539GB	Clermont County VA Clinic	Clermont County	Multi-Specialty CBOC
89	10	539GC	Dearborn VA Clinic	Dearborn	Multi-Specialty CBOC
90	10	539GD	Florence VA Clinic	Florence, Kentucky	Multi-Specialty CBOC
91	10	539GE	Hamilton VA Clinic	Hamilton, Ohio	Multi-Specialty CBOC
92	10	539GF	Georgetown VA Clinic	Georgetown	Multi-Specialty CBOC
93	10	541BY	Canton VA Clinic	Canton, Ohio	Multi-Specialty CBOC
94	10	541BZ	Youngstown VA Clinic	Youngstown	Multi-Specialty CBOC
95	10	541GB	Lorain VA Clinic	Lorain	Multi-Specialty CBOC
96	10	541GD	David F. Winder Department of Veterans Affairs Community Based Outpatient Clinic	Mansfield	Multi-Specialty CBOC
97	10	541GF	Lake County VA Clinic	Lake County	Multi-Specialty CBOC
98	10	541GG	Akron VA Clinic	Akron	Multi-Specialty CBOC
99	10	541GL	Parma VA Clinic	Parma	Multi-Specialty CBOC
100	10	552GA	Middletown VA Clinic	Middletown, Ohio	Multi-Specialty CBOC

FY 2020 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
101	10	552GC	Richmond VA Clinic	Richmond, Indiana	Multi-Specialty CBOC
102	10	552GD	Springfield VA Clinic	Springfield, Ohio	Multi-Specialty CBOC
103	10	553GB	Pontiac VA Clinic	Pontiac	Multi-Specialty CBOC
104	10	583GA	Terre Haute VA Clinic	Terre Haute	Multi-Specialty CBOC
105	10	583GD	Indianapolis West VA Clinic	Indianapolis West	Multi-Specialty CBOC
106	10	583GF	Wakeman VA Clinic	Wakeman	Multi-Specialty CBOC
107	10	583GG	Shelbyville VA Clinic	Shelbyville	Multi-Specialty CBOC
108	10	610BY	St. Joseph County VA Clinic	St. Joseph County	Multi-Specialty CBOC
109	10	655GA	Gaylord VA Clinic	Gaylord	Multi-Specialty CBOC
110	10	655GD	Lieutenant Colonel Clement C. Van Wagoner Department of Veterans Affairs Clinic	Alpena	Multi-Specialty CBOC
111	10	655GE	Clare VA Clinic	Clare	Multi-Specialty CBOC
112	10	757GB	Grove City VA Clinic	Grove City	Multi-Specialty CBOC
113	10	757GD	Daniel L. Kinnard VA Clinic	Newark, Ohio	Multi-Specialty CBOC
114	12	537BY	Adam Benjamin Jr., Veterans' Administration Outpatient Clinic	Crown Point	Multi-Specialty CBOC
115	12	550BY	Bob Michel Department of Veterans Affairs Outpatient Clinic	Peoria	Multi-Specialty CBOC
116	12	550GA	Decatur VA Clinic	Decatur, Illinois	Multi-Specialty CBOC
117	12	550GD	Springfield VA Clinic	Springfield, Illinois	Multi-Specialty CBOC
118	12	578GA	Joliet VA Clinic	Joliet	Multi-Specialty CBOC
119	12	607HA	Rockford VA Clinic	Rockford	Multi-Specialty CBOC
120	12	676GD	Wisconsin Rapids VA Clinic	Wisconsin Rapids	Multi-Specialty CBOC
121	12	695BY	John H. Bradley Department of Veterans Affairs Outpatient Clinic	Appleton	Multi-Specialty CBOC
122	15	589G1	Warrensburg VA Clinic	Warrensburg	Multi-Specialty CBOC
123	15	589G8	Jefferson City VA Clinic	Jefferson City	Multi-Specialty CBOC
124	15	589JD	Marshfield VA Clinic	Marshfield	Multi-Specialty CBOC
125	15	657GV	Sikeston VA Clinic	Sikeston	Multi-Specialty CBOC
126	16	502GB	Lafayette VA Clinic	Lafayette	Multi-Specialty CBOC
127	16	520BZ	Pensacola VA Clinic	Pensacola	Multi-Specialty CBOC
128	16	520GA	Mobile VA Clinic	Mobile	Multi-Specialty CBOC
129	16	520GC	Eglin Air Force Base VA Clinic	Eglin Air Force Base	Multi-Specialty CBOC
130	16	564BY	Gene Taylor Veterans' Outpatient Clinic	Springfield, Missouri	Multi-Specialty CBOC
131	16	564GB	Fort Smith VA Clinic	Fort Smith	Multi-Specialty CBOC
132	16	564GC	Branson VA Clinic	Branson	Multi-Specialty CBOC
133	16	580BY	Beaumont VA Clinic	Beaumont	Multi-Specialty CBOC
134	16	580BZ	Charles Wilson Department of Veterans Affairs Outpatient Clinic	Lufkin	Multi-Specialty CBOC
135	16	580GD	Conroe VA Clinic	Conroe	Multi-Specialty CBOC
136	16	580GE	Katy VA Clinic	Katy	Multi-Specialty CBOC
137	16	580GG	Richmond VA Clinic	Richmond, Texas	Multi-Specialty CBOC
138	16	580GH	Tomball VA Clinic	Tomball	Multi-Specialty CBOC
139	16	580GJ	Texas City VA Clinic	Texas City	Multi-Specialty CBOC
140	16	598GC	Hot Springs VA Clinic	Hot Springs, Arkansas	Multi-Specialty CBOC
141	16	598GG	Conway VA Clinic	Conway, Arkansas	Multi-Specialty CBOC
142	16	629BY	Baton Rouge VA Clinic	Baton Rouge	Multi-Specialty CBOC
143	16	629GB	Hammond VA Clinic	Hammond	Multi-Specialty CBOC
144	16	629GC	Slidell VA Clinic	Slidell	Multi-Specialty CBOC
145	16	667GA	Texarkana VA Clinic	Texarkana	Multi-Specialty CBOC
146	16	667GB	Monroe VA Clinic	Monroe	Multi-Specialty CBOC
147	16	667GC	Longview VA Clinic	Longview	Multi-Specialty CBOC
148	17	504BY	Lubbock VA Clinic	Lubbock	Multi-Specialty CBOC
149	17	519GA	Wilson and Young Medal of Honor VA Clinic	Permian Basin	Multi-Specialty CBOC
150	17	519HC	Abilene VA Clinic	Abilene	Multi-Specialty CBOC

FY 2020 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
151	17	549BY	Fort Worth VA Clinic	Fort Worth	Multi-Specialty CBOC
152	17	549QC	Tyler Broadway VA Clinic	Tyler Broadway	Multi-Specialty CBOC
153	17	671BY	Frank M. Tejeda Department of Veterans Affairs Outpatient Clinic	San Antonio Eckert Road	Multi-Specialty CBOC
154	17	671GO	North Central Federal VA Clinic	North Central Federal	Multi-Specialty CBOC
155	17	671GP	Balcones Heights VA Clinic	Balcones Heights	Multi-Specialty CBOC
156	17	674BY	Austin VA Clinic	Austin	Multi-Specialty CBOC
157	17	740GA	Harlingen VA Clinic-Treasure Hills	Harlingen Treasure Hills	Multi-Specialty CBOC
158	17	740GB	McAllen VA Clinic	McAllen	Multi-Specialty CBOC
159	17	740GC	Corpus Christi VA Clinic	Corpus Christi	Multi-Specialty CBOC
160	17	740GH	South Enterprize VA Clinic	South Enterprize	Multi-Specialty CBOC
161	17	756GB	El Paso Eastside VA Clinic	El Paso Eastside	Multi-Specialty CBOC
162	19	436GC	David J. Thatcher VA Clinic	Missoula	Multi-Specialty CBOC
163	19	436GF	Kalispell VA Clinic	Kalispell	Multi-Specialty CBOC
164	19	442GC	Fort Collins VA Clinic	Fort Collins	Multi-Specialty CBOC
165	19	442GD	Loveland VA Clinic	Loveland	Multi-Specialty CBOC
166	19	554GC	Golden VA Clinic	Golden	Multi-Specialty CBOC
167	19	554GD	PFC James Dunn VA Clinic	Pueblo, Colorado	Multi-Specialty CBOC
168	19	554GE	PFC Floyd K. Lindstrom Department of Veterans Affairs Clinic	Colorado Springs	Multi-Specialty CBOC
169	19	623BY	Ernest Childers Department of Veterans Affairs Outpatient Clinic	Tulsa	Multi-Specialty CBOC
170	19	635GA	Lawton VA Clinic	Lawton	Multi-Specialty CBOC
171	19	635QB	South Oklahoma City VA Clinic	South Oklahoma City	Multi-Specialty CBOC
172	20	531GG	Caldwell VA Clinic	Caldwell	Multi-Specialty CBOC
173	20	648GA	Bend VA Clinic	Bend	Multi-Specialty CBOC
174	20	648GB	Salem VA Clinic	Salem, Oregon	Multi-Specialty CBOC
175	20	648GE	Fairview VA Clinic	Fairview	Multi-Specialty CBOC
176	20	648GF	Hillsboro VA Clinic	Hillsboro	Multi-Specialty CBOC
177	20	663GC	Mount Vernon VA Clinic	Mount Vernon, Washington	Multi-Specialty CBOC
178	20	668GA	Wenatchee VA Clinic	Wenatchee	Multi-Specialty CBOC
179	20	668GB	Coeur d 'Alene VA Clinic	Coeur d 'Alene	Multi-Specialty CBOC
180	21	459GE	Guam VA Clinic	Guam	Multi-Specialty CBOC
181	21	570GA	Merced VA Clinic	Merced	Multi-Specialty CBOC
182	21	570GC	Oakhurst VA Clinic	Oakhurst	Multi-Specialty CBOC
183	21	612B4	Redding VA Clinic	Redding	Multi-Specialty CBOC
184	21	612BY	Oakland VA Clinic	Oakland	Multi-Specialty CBOC
185	21	612GD	Fairfield VA Clinic	Fairfield	Multi-Specialty CBOC
186	21	612GH	McClellan VA Clinic	McClellan Park	Multi-Specialty CBOC
187	21	640BY	San Jose VA Clinic	San Jose	Multi-Specialty CBOC
188	21	640HC	Major General William H. Gourley VA-DoD Outpatient Clinic	Monterey	Multi-Specialty CBOC
189	21	662GA	Santa Rosa VA Clinic	Santa Rosa	Multi-Specialty CBOC
190	21	662GC	Eureka VA Clinic	Eureka	Multi-Specialty CBOC
191	21	662GD	Ukiah VA Clinic	Ukiah	Multi-Specialty CBOC
192	21	662GE	San Bruno VA Clinic	San Bruno	Multi-Specialty CBOC
193	21	662GG	Clearlake VA Clinic	Clearlake	Multi-Specialty CBOC
194	22	600GB	Santa Ana VA Clinic	Santa Ana	Multi-Specialty CBOC
195	22	600GF	Gardena VA Clinic	Gardena	Multi-Specialty CBOC
196	22	605BZ	Loma Linda VA Clinic	Loma Linda Redlands	Multi-Specialty CBOC
197	22	644BY	Southeast VA Clinic	Southeast Gilbert	Multi-Specialty CBOC
198	22	664BY	Mission Valley VA Clinic	Mission Valley	Multi-Specialty CBOC
199	22	664GB	Oceanside VA Clinic	Oceanside	Multi-Specialty CBOC
200	22	664GC	Chula Vista VA Clinic	Chula Vista	Multi-Specialty CBOC

FY 2020 Multi-Specialty Community Based Outpatient Clinics (MS CBOC)

MS CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
201	22	678GA	Sierra Vista VA Clinic	Sierra Vista	Multi-Specialty CBOC
202	22	678GB	Yuma VA Clinic	Yuma	Multi-Specialty CBOC
203	22	678GC	Casa Grande VA Clinic	Casa Grande	Multi-Specialty CBOC
204	22	678GF	Northwest Tucson VA Clinic	Northwest Tucson	Multi-Specialty CBOC
205	22	678GG	Southeast Tucson VA Clinic	Southeast Tucson	Multi-Specialty CBOC
206	22	691GD	Bakersfield VA Clinic	Bakersfield	Multi-Specialty CBOC
207	22	691GE	Los Angeles VA Clinic	Los Angeles	Multi-Specialty CBOC
208	22	691GL	Santa Maria VA Clinic	Santa Maria	Multi-Specialty CBOC
209	22	691GM	Oxnard VA Clinic	Oxnard	Multi-Specialty CBOC
210	23	438GD	Aberdeen VA Clinic	Aberdeen	Multi-Specialty CBOC
211	23	568GA	Rapid City VA Clinic	Rapid City	Multi-Specialty CBOC
212	23	618BY	Twin Ports VA Clinic	Twin Ports	Multi-Specialty CBOC
213	23	618GI	Northwest Metro VA Clinic	Northwest Metro Minnesota	Multi-Specialty CBOC
214	23	636A5	Lincoln VA Clinic	Lincoln, Nebraska	Multi-Specialty CBOC
215	23	636GA	Norfolk VA Clinic	Norfolk	Multi-Specialty CBOC
216	23	636GC	Mason City VA Clinic	Mason City	Multi-Specialty CBOC
217	23	636GD	Marshalltown VA Clinic	Marshalltown	Multi-Specialty CBOC
218	23	636GF	Quad Cities VA Clinic	Quad Cities	Multi-Specialty CBOC
219	23	636GI	Lane A. Evans VA Community Based Outpatient Clinic	Galesburg	Multi-Specialty CBOC
220	23	636GM	Carroll VA Clinic	Carroll	Multi-Specialty CBOC
221	23	636GN	Cedar Rapids VA Clinic	Cedar Rapids	Multi-Specialty CBOC
222	23	636GR	Knoxville VA Clinic	Knoxville, Iowa	Multi-Specialty CBOC
223	23	636GS	Ottumwa VA Clinic	Ottumwa	Multi-Specialty CBOC
224	23	636GT	Sterling VA Clinic	Sterling, Illinois	Multi-Specialty CBOC
225	23	636GU	Decorah VA Clinic	Decorah	Multi-Specialty CBOC
226	23	656GA	Brainerd VA Clinic	Brainerd	Multi-Specialty CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
1	1	402GA	Caribou VA Clinic	Caribou	Primary Care CBOC
2	1	402GB	Calais VA Clinic	Calais	Primary Care CBOC
3	1	402GC	Rumford VA Clinic	Rumford	Primary Care CBOC
4	1	402GD	Saco VA Clinic	Saco	Primary Care CBOC
5	1	402GF	Lincoln VA Clinic	Lincoln, Maine	Primary Care CBOC
6	1	402HC	Portland VA Clinic	Portland, Maine	Primary Care CBOC
7	1	405GA	Bennington VA Clinic	Bennington	Primary Care CBOC
8	1	405GC	Brattleboro VA Clinic	Brattleboro	Primary Care CBOC
9	1	405HC	Littleton VA Clinic	Littleton	Primary Care CBOC
10	1	405HE	Keene VA Clinic	Keene	Primary Care CBOC
11	1	405HF	Rutland VA Clinic	Rutland	Primary Care CBOC
12	1	405QB	Newport VA Clinic	Newport, Vermont	Primary Care CBOC
13	1	518GA	Lynn VA Clinic	Lynn	Primary Care CBOC
14	1	518GB	Haverhill VA Clinic	Haverhill	Primary Care CBOC
15	1	518GE	Gloucester VA Clinic	Gloucester	Primary Care CBOC
16	1	523BZ	Causeway VA Clinic	Causeway	Primary Care CBOC
17	1	523GA	Framingham VA Clinic	Framingham	Primary Care CBOC
18	1	608GA	Portsmouth VA Clinic	Portsmouth, New Hampshire	Primary Care CBOC
19	1	608GC	Somersworth VA Clinic	Somersworth	Primary Care CBOC
20	1	608GD	Conway VA Clinic	Conway, New Hampshire	Primary Care CBOC
21	1	608HA	Tilton VA Clinic	Tilton	Primary Care CBOC
22	1	631GC	Pittsfield VA Clinic	Pittsfield	Primary Care CBOC
23	1	631GD	Greenfield VA Clinic	Greenfield	Primary Care CBOC
24	1	631GE	Worcester VA Clinic	Worcester	Primary Care CBOC
25	1	631GF	Fitchburg VA Clinic	Fitchburg	Primary Care CBOC
26	1	650GA	New Bedford VA Clinic	New Bedford	Primary Care CBOC
27	1	650GB	Hyannis VA Clinic	Hyannis	Primary Care CBOC
28	1	650GD	Middletown VA Clinic	Middletown, Rhode Island	Primary Care CBOC
29	1	689GA	Waterbury VA Clinic	Waterbury	Primary Care CBOC
30	1	689GB	Stamford VA Clinic	Stamford	Primary Care CBOC
31	1	689GC	Willimantic VA Clinic	Willimantic	Primary Care CBOC
32	1	689GD	Winsted VA Clinic	Winsted	Primary Care CBOC
33	1	689GE	Danbury VA Clinic	Danbury	Primary Care CBOC
34	1	689GF	Orange VA Clinic	Orange	Primary Care CBOC
35	1	689HC	John J. McGuirk Department of Veterans Affairs Outpatient Clinic	New London	Primary Care CBOC
36	1	689QA	Errera VA Clinic	Errera	Primary Care CBOC
37	2	526GA	White Plains VA Clinic	White Plains	Primary Care CBOC
38	2	526GB	Yonkers VA Clinic	Yonkers	Primary Care CBOC
39	2	528G3	Bainbridge VA Clinic	Bainbridge	Primary Care CBOC
40	2	528G4	Elmira VA Clinic	Elmira	Primary Care CBOC
41	2	528G5	Auburn VA Clinic	Auburn	Primary Care CBOC
42	2	528G6	Fonda VA Clinic	Fonda	Primary Care CBOC
43	2	528G7	Catskill VA Clinic	Catskill	Primary Care CBOC
44	2	528G8	Wellsville VA Clinic	Wellsville	Primary Care CBOC
45	2	528G9	Tompkins County VA Clinic	Tompkins County	Primary Care CBOC
46	2	528GB	Jamestown VA Clinic	Jamestown, New York	Primary Care CBOC
47	2	528GC	Dunkirk VA Clinic	Dunkirk	Primary Care CBOC
48	2	528GD	Niagara Falls VA Clinic	Niagara Falls	Primary Care CBOC
49	2	528GK	Lockport VA Clinic	Lockport	Primary Care CBOC
50	2	528GL	Massena VA Clinic	Massena	Primary Care CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
51	2	528GO	Watertown VA Clinic	Watertown, New York	Primary Care CBOC
52	2	528GP	Oswego VA Clinic	Oswego	Primary Care CBOC
53	2	528GQ	Lackawanna VA Clinic	Lackawanna	Primary Care CBOC
54	2	528GR	Olean VA Clinic	Olean	Primary Care CBOC
55	2	528GT	Glens Falls VA Clinic	Glens Falls	Primary Care CBOC
56	2	528GV	Plattsburgh VA Clinic	Plattsburgh	Primary Care CBOC
57	2	528GZ	Kingston VA Clinic	Kingston	Primary Care CBOC
58	2	528QK	Saranac Lake VA Clinic	Saranac Lake	Primary Care CBOC
59	2	561GA	Hamilton VA Clinic	Hamilton, New Jersey	Primary Care CBOC
60	2	561GD	Hackensack VA Clinic	Hackensack	Primary Care CBOC
61	2	561GE	Jersey City VA Clinic	Jersey City	Primary Care CBOC
62	2	561GF	Piscataway VA Clinic	Piscataway	Primary Care CBOC
63	2	561GH	Morristown VA Clinic	Morristown, New Jersey	Primary Care CBOC
64	2	561GI	Tinton Falls VA Clinic	Tinton Falls	Primary Care CBOC
65	2	561GJ	Paterson VA Clinic	Paterson	Primary Care CBOC
66	2	561GK	Sussex VA Clinic	Sussex	Primary Care CBOC
67	2	620GB	Carmel VA Clinic	Carmel	Primary Care CBOC
68	2	620GD	Goshen VA Clinic	Goshen, New York	Primary Care CBOC
69	2	620GE	Port Jervis VA Clinic	Port Jervis	Primary Care CBOC
70	2	620GG	Poughkeepsie VA Clinic	Poughkeepsie	Primary Care CBOC
71	2	630GA	Harlem VA Clinic	Harlem	Primary Care CBOC
72	2	632GA	East Meadow VA Clinic	East Meadow	Primary Care CBOC
73	2	632HA	Valley Stream VA Clinic	Valley Stream	Primary Care CBOC
74	2	632HB	Riverhead VA Clinic	Riverhead	Primary Care CBOC
75	2	632HC	Bay Shore VA Clinic	Bay Shore	Primary Care CBOC
76	2	632HD	Patchogue VA Clinic	Patchogue	Primary Care CBOC
77	4	460GD	Cape May County VA Clinic	Cape May County	Primary Care CBOC
78	4	460HE	Atlantic County VA Clinic	Atlantic County	Primary Care CBOC
79	4	503GD	Huntingdon County VA Clinic	Huntingdon County	Primary Care CBOC
80	4	503GE	Indiana County VA Clinic	Indiana County	Primary Care CBOC
81	4	529GA	Michael A. Marzano Department of Veterans Affairs Outpatient Clinic	Hermitage	Primary Care CBOC
82	4	529GB	Lawrence County VA Clinic	Lawrence County	Primary Care CBOC
83	4	529GC	Armstrong County VA Clinic	Armstrong County	Primary Care CBOC
84	4	529GF	Cranberry Township VA Clinic	Cranberry Township	Primary Care CBOC
85	4	542GA	Delaware County VA Clinic	Delaware County	Primary Care CBOC
86	4	542GE	Spring City VA Clinic	Spring City	Primary Care CBOC
87	4	562GA	Crawford County VA Clinic	Crawford County	Primary Care CBOC
88	4	562GB	Ashtabula County VA Clinic	Ashtabula County	Primary Care CBOC
89	4	562GD	Venango County VA Clinic	Venango County	Primary Care CBOC
90	4	562GE	Warren County VA Clinic	Warren County	Primary Care CBOC
91	4	595GD	Berks County VA Clinic	Berks County	Primary Care CBOC
92	4	595GF	Schuylkill County VA Clinic	Schuylkill County	Primary Care CBOC
93	4	642GF	Camden VA Clinic	Camden	Primary Care CBOC
94	4	642GH	West Philadelphia VA Clinic	West Philadelphia	Primary Care CBOC
95	4	646GB	Westmoreland County VA Clinic	Westmoreland County	Primary Care CBOC
96	4	693GA	Sayre VA Clinic	Sayre	Primary Care CBOC
97	4	693GB	Williamsport VA Clinic	Williamsport	Primary Care CBOC
98	5	512GE	Pocomoke City VA Clinic	Pocomoke City	Primary Care CBOC
99	5	512GF	Eastern Baltimore County VA Clinic	Eastern Baltimore County	Primary Care CBOC
100	5	517GB	Greenbrier County VA Clinic	Greenbrier County	Primary Care CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
101	5	540GB	Wood County VA Clinic	Wood County	Primary Care CBOC
102	5	540GC	Braxton County VA Clinic	Braxton County	Primary Care CBOC
103	5	540GD	Monongalia County VA Clinic	Monongalia County	Primary Care CBOC
104	5	581GA	Prestonsburg VA Clinic	Prestonsburg	Primary Care CBOC
105	5	613GB	Hagerstown VA Clinic	Hagerstown	Primary Care CBOC
106	5	613GE	Petersburg VA Clinic	Petersburg	Primary Care CBOC
107	5	613GF	Harrisonburg VA Clinic	Harrisonburg	Primary Care CBOC
108	5	688GA	Fort Belvoir VA Clinic	Fort Belvoir	Primary Care CBOC
109	5	688GD	Charlotte Hall VA Clinic	Charlotte Hall	Primary Care CBOC
110	5	688GE	Southern Prince George's County VA Clinic	Southern Prince George's County	Primary Care CBOC
111	5	688GF	Montgomery County VA Clinic	Montgomery County Maryland	Primary Care CBOC
112	5	688GG	Lexington Park VA Clinic	Lexington Park	Primary Care CBOC
113	6	558GB	Raleigh VA Clinic	Raleigh, North Carolina	Primary Care CBOC
114	6	558GC	Morehead City VA Clinic	Morehead City	Primary Care CBOC
115	6	558GE	Hillandale Road VA Clinic	Hillandale Road	Primary Care CBOC
116	6	558GG	Raleigh III VA Clinic	Raleigh III	Primary Care CBOC
117	6	558GH	Clayton-East Raleigh VA Clinic	Clayton-East Raleigh	Primary Care CBOC
118	6	565GA	Jacksonville VA Clinic	Jacksonville, North Carolina	Primary Care CBOC
119	6	565GD	Hamlet VA Clinic	Hamlet	Primary Care CBOC
120	6	565GE	Robeson County VA Clinic	Robeson County	Primary Care CBOC
121	6	565GF	Goldsboro VA Clinic	Goldsboro	Primary Care CBOC
122	6	565GG	Lee County VA Clinic	Lee County, North Carolina	Primary Care CBOC
123	6	565GH	Brunswick County VA Clinic	Brunswick County	Primary Care CBOC
124	6	565GN	Jacksonville 4 VA Clinic	Jacksonville 4	Primary Care CBOC
125	6	590GB	Virginia Beach VA Clinic	Virginia Beach	Primary Care CBOC
126	6	590GC	Albemarle VA Clinic	Albemarle	Primary Care CBOC
127	6	590GD	Chesapeake VA Clinic	Chesapeake	Primary Care CBOC
128	6	590GE	Portsmouth VA Clinic	Portsmouth, Virginia	Primary Care CBOC
129	6	637GA	Franklin VA Clinic	Franklin, North Carolina	Primary Care CBOC
130	6	637GB	Rutherford County VA Clinic	Rutherford County	Primary Care CBOC
131	6	652GA	Fredericksburg VA Clinic	Fredericksburg	Primary Care CBOC
132	6	652GB	Fredericksburg 2 VA Clinic	Fredericksburg 2	Primary Care CBOC
133	6	652GF	Emporia VA Clinic	Emporia	Primary Care CBOC
134	6	658GA	Tazewell VA Clinic	Tazewell	Primary Care CBOC
135	6	658GB	Danville VA Clinic	Danville, Virginia	Primary Care CBOC
136	6	658GC	Lynchburg VA Clinic	Lynchburg	Primary Care CBOC
137	6	658GD	Staunton VA Clinic	Staunton	Primary Care CBOC
138	6	658GE	Wytheville VA Clinic	Wytheville	Primary Care CBOC
139	7	508GF	West Cobb County VA Clinic	West Cobb County	Primary Care CBOC
140	7	508GG	Stockbridge VA Clinic	Stockbridge	Primary Care CBOC
141	7	508GL	Rome VA Clinic	Rome, Georgia	Primary Care CBOC
142	7	508QE	Gwinnett County VA Clinic	Gwinnett County	Primary Care CBOC
143	7	509GA	Athens VA Clinic	Athens, Georgia	Primary Care CBOC
144	7	509GB	Aiken VA Clinic	Aiken	Primary Care CBOC
145	7	509QA	Ray Hendrix Department Of Veterans Affairs Clinic	Statesboro	Primary Care CBOC
146	7	521GC	Florence VA Clinic	Florence, Alabama	Primary Care CBOC
147	7	521GD	Rainbow City VA Clinic	Rainbow City	Primary Care CBOC
148	7	521GE	Oxford VA Clinic	Oxford	Primary Care CBOC
149	7	521GF	Jasper VA Clinic	Jasper	Primary Care CBOC
150	7	521GG	Bessemer VA Clinic	Bessemer	Primary Care CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
151	7	521GH	Childersburg VA Clinic	Childersburg	Primary Care CBOC
152	7	521GI	Guntersville VA Clinic	Guntersville	Primary Care CBOC
153	7	534GB	Myrtle Beach VA Clinic	Myrtle Beach	Primary Care CBOC
154	7	534GC	Beaufort VA Clinic	Beaufort	Primary Care CBOC
155	7	534GE	Hinesville VA Clinic	Hinesville	Primary Care CBOC
156	7	544GB	Florence VA Clinic	Florence, South Carolina	Primary Care CBOC
157	7	544GC	Rock Hill VA Clinic	Rock Hill	Primary Care CBOC
158	7	544GE	Orangeburg VA Clinic	Orangeburg	Primary Care CBOC
159	7	544GF	Sumter VA Clinic	Sumter	Primary Care CBOC
160	7	544GG	Spartanburg VA Clinic	Spartanburg	Primary Care CBOC
161	7	557GC	Milledgeville VA Clinic	Milledgeville	Primary Care CBOC
162	7	557GF	Tifton VA Clinic	Tifton	Primary Care CBOC
163	7	557HA	Perry VA Clinic	Perry, Georgia	Primary Care CBOC
164	7	619GE	Monroe County VA Clinic	Monroe County Alabama	Primary Care CBOC
165	7	619QA	Dothan 2 VA Clinic	Dothan 2	Primary Care CBOC
166	7	619QB	Fort Benning VA Clinic	Fort Benning	Primary Care CBOC
167	7	679GA	Selma VA Clinic	Selma	Primary Care CBOC
168	8	516GB	St. Petersburg VA Clinic	St. Petersburg	Primary Care CBOC
169	8	516GC	Palm Harbor VA Clinic	Palm Harbor	Primary Care CBOC
170	8	516GF	Naples VA Clinic	Naples	Primary Care CBOC
171	8	516GH	Sebring VA Clinic	Sebring	Primary Care CBOC
172	8	546GA	Miami Flagler VA Clinic	Miami Flagler	Primary Care CBOC
173	8	546GB	Key West VA Clinic	Key West	Primary Care CBOC
174	8	546GD	Pembroke Pines VA Clinic	Pembroke Pines	Primary Care CBOC
175	8	546GE	Key Largo VA Clinic	Key Largo	Primary Care CBOC
176	8	546GF	Hollywood VA Clinic	Hollywood	Primary Care CBOC
177	8	546GH	Deerfield Beach VA Clinic	Deerfield Beach	Primary Care CBOC
178	8	548GA	Fort Pierce VA Clinic	Fort Pierce	Primary Care CBOC
179	8	548GB	Delray Beach VA Clinic	Delray Beach	Primary Care CBOC
180	8	548GC	Stuart VA Clinic	Stuart	Primary Care CBOC
181	8	548GD	Boca Raton VA Clinic	Boca Raton	Primary Care CBOC
182	8	548GE	Vero Beach VA Clinic	Vero Beach	Primary Care CBOC
183	8	548GF	Okeechobee VA Clinic	Okeechobee	Primary Care CBOC
184	8	573GA	Valdosta VA Clinic	Valdosta	Primary Care CBOC
185	8	573GD	Ocala VA Clinic	Ocala	Primary Care CBOC
186	8	573GJ	St. Marys VA Clinic	St. Marys	Primary Care CBOC
187	8	573GK	Marianna VA Clinic	Marianna	Primary Care CBOC
188	8	573GL	Palatka VA Clinic	Palatka	Primary Care CBOC
189	8	573GM	Waycross VA Clinic	Waycross	Primary Care CBOC
190	8	573GO	Middleburg VA Clinic	Middleburg	Primary Care CBOC
191	8	573QG	Jacksonville Southpoint VA Clinic	Jacksonville Southpoint	Primary Care CBOC
192	8	672GC	Arecibo VA Clinic	Arecibo	Primary Care CBOC
193	8	672GD	Ceiba VA Clinic	Ceiba	Primary Care CBOC
194	8	672GE	Guayama VA Clinic	Guayama	Primary Care CBOC
195	8	675GC	Kissimmee VA Clinic	Kissimmee	Primary Care CBOC
196	8	675GD	Deltona VA Clinic	Deltona	Primary Care CBOC
197	8	675GE	Tavares VA Clinic	Tavares	Primary Care CBOC
198	8	675GF	Clermont VA Clinic	Clermont	Primary Care CBOC
199	9	596GB	Morehead VA Clinic	Morehead	Primary Care CBOC
200	9	596GC	Hazard VA Clinic	Hazard	Primary Care CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
201	9	596GD	Berea VA Clinic	Berea	Primary Care CBOC
202	9	603GA	Fort Knox VA Clinic	Fort Knox	Primary Care CBOC
203	9	603GB	New Albany VA Clinic	New Albany	Primary Care CBOC
204	9	603GC	Shively VA Clinic	Shively	Primary Care CBOC
205	9	603GD	Stonybrook VA Clinic	Stonybrook	Primary Care CBOC
206	9	603GF	Grayson County VA Clinic	Grayson County	Primary Care CBOC
207	9	603GG	Scott County VA Clinic	Scott County	Primary Care CBOC
208	9	603GH	Carrollton VA Clinic	Carrollton, Kentucky	Primary Care CBOC
209	9	614GA	Tupelo VA Clinic	Tupelo	Primary Care CBOC
210	9	614GB	Jonesboro VA Clinic	Jonesboro	Primary Care CBOC
211	9	614GC	Holly Springs VA Clinic	Holly Springs	Primary Care CBOC
212	9	614GD	Savannah VA Clinic	Savannah, Tennessee	Primary Care CBOC
213	9	614GE	Covington VA Clinic	Covington	Primary Care CBOC
214	9	614GG	Jackson VA Clinic	Jackson, Tennessee	Primary Care CBOC
215	9	614GI	Dyersburg VA Clinic	Dyersburg	Primary Care CBOC
216	9	614GN	Helena VA Clinic	Helena, Arkansas	Primary Care CBOC
217	9	621GC	Norton VA Clinic	Norton	Primary Care CBOC
218	9	621GG	Morristown VA Clinic	Morristown, Tennessee	Primary Care CBOC
219	9	621GI	Dannie A. Carr Veterans Outpatient Clinic	Sevierville	Primary Care CBOC
220	9	621GJ	Bristol VA Clinic	Bristol	Primary Care CBOC
221	9	621GK	Campbell County VA Clinic	Campbell County	Primary Care CBOC
222	9	621GO	Mountain City VA Clinic	Mountain City	Primary Care CBOC
223	9	626GA	Dover VA Clinic	Dover	Primary Care CBOC
224	9	626GC	Bowling Green VA Clinic	Bowling Green	Primary Care CBOC
225	9	626GG	Tullahoma VA Clinic	Tullahoma	Primary Care CBOC
226	9	626GH	Cookeville VA Clinic	Cookeville	Primary Care CBOC
227	9	626GJ	Hopkinsville VA Clinic	Hopkinsville	Primary Care CBOC
228	9	626GK	McMinnville VA Clinic	McMinnville	Primary Care CBOC
229	9	626GL	Roane County VA Clinic	Roane County	Primary Care CBOC
230	9	626GM	Maury County VA Clinic	Maury County	Primary Care CBOC
231	9	626GN	Athens VA Clinic	Athens, Tennessee	Primary Care CBOC
232	9	626GO	International Plaza VA Clinic	International Plaza	Primary Care CBOC
233	9	626GP	Gallatin VA Clinic	Gallatin	Primary Care CBOC
234	9	626QA	Albion Street VA Clinic	Albion Street	Primary Care CBOC
235	9	626QB	Charlotte Avenue VA Clinic	Charlotte Avenue	Primary Care CBOC
236	10	506GB	Flint VA Clinic	Flint	Primary Care CBOC
237	10	515GA	Muskegon VA Clinic	Muskegon	Primary Care CBOC
238	10	515GB	Lansing South VA Clinic	Lansing South	Primary Care CBOC
239	10	515GC	Benton Harbor VA Clinic	Benton Harbor	Primary Care CBOC
240	10	538GA	Athens VA Clinic	Athens, Ohio	Primary Care CBOC
241	10	538GB	Portsmouth VA Clinic	Portsmouth, Ohio	Primary Care CBOC
242	10	538GD	Lancaster VA Clinic	Lancaster	Primary Care CBOC
243	10	538GE	Cambridge VA Clinic	Cambridge, Ohio	Primary Care CBOC
244	10	538GF	Wilmington VA Clinic	Wilmington, Ohio	Primary Care CBOC
245	10	539GA	Bellevue VA Clinic	Bellevue, Kentucky	Primary Care CBOC
246	10	541GC	Sandusky VA Clinic	Sandusky	Primary Care CBOC
247	10	541GH	East Liverpool VA Clinic	East Liverpool	Primary Care CBOC
248	10	541GI	Warren VA Clinic	Warren	Primary Care CBOC
249	10	541GJ	New Philadelphia VA Clinic	New Philadelphia	Primary Care CBOC
250	10	541GK	Ravenna VA Clinic	Ravenna	Primary Care CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
251	10	552GB	Lima VA Clinic	Lima	Primary Care CBOC
252	10	552GF	Wright-Patterson VA Clinic	Wright-Patterson	Primary Care CBOC
253	10	553GA	Yale VA Clinic	Yale	Primary Care CBOC
254	10	553QA	Piquette Street VA Clinic	Piquette Street	Primary Care CBOC
255	10	583GC	Martinsville VA Clinic	Martinsville	Primary Care CBOC
256	10	583GE	West Lafayette VA Clinic	West Lafayette	Primary Care CBOC
257	10	610GB	Muncie VA Clinic	Muncie	Primary Care CBOC
258	10	610GC	Goshen VA Clinic	Goshen, Indiana	Primary Care CBOC
259	10	610GD	Peru VA Clinic	Peru	Primary Care CBOC
260	10	655GC	Oscoda VA Clinic	Oscoda	Primary Care CBOC
261	10	655GF	Bad Axe VA Clinic	Bad Axe	Primary Care CBOC
262	10	655GG	Cadillac VA Clinic	Cadillac	Primary Care CBOC
263	10	655GH	Cheboygan County VA Clinic	Cheboygan County	Primary Care CBOC
264	10	655GI	Grayling VA Clinic	Grayling	Primary Care CBOC
265	10	757GA	Zanesville VA Clinic	Zanesville	Primary Care CBOC
266	10	757GC	Marion VA Clinic	Marion, Ohio	Primary Care CBOC
267	12	537GA	Chicago Heights VA Clinic	Chicago Heights	Primary Care CBOC
268	12	537GD	Lakeside VA Clinic	Lakeside	Primary Care CBOC
269	12	537HA	Auburn Gresham VA Clinic	Auburn Gresham	Primary Care CBOC
270	12	550GF	Mattoon VA Clinic	Mattoon	Primary Care CBOC
271	12	550GG	Bloomington VA Clinic	Bloomington, Illinois	Primary Care CBOC
272	12	556GA	Evanston VA Clinic	Evanston, Illinois	Primary Care CBOC
273	12	556GC	McHenry VA Clinic	McHenry	Primary Care CBOC
274	12	556GD	Kenosha VA Clinic	Kenosha	Primary Care CBOC
275	12	578GC	Kankakee County VA Clinic	Kankakee County	Primary Care CBOC
276	12	578GD	Aurora VA Clinic	Aurora, Illinois	Primary Care CBOC
277	12	578GE	Hoffman Estates VA Clinic	Hoffman Estates	Primary Care CBOC
278	12	578GF	LaSalle VA Clinic	LaSalle	Primary Care CBOC
279	12	578GG	Oak Lawn VA Clinic	Oak Lawn	Primary Care CBOC
280	12	585GA	Hancock VA Clinic	Hancock	Primary Care CBOC
281	12	585GB	Rhinelander VA Clinic	Rhinelander	Primary Care CBOC
282	12	585GC	Menominee VA Clinic	Menominee	Primary Care CBOC
283	12	585GD	Ironwood VA Clinic	Ironwood	Primary Care CBOC
284	12	585GF	Manistique VA Clinic	Manistique	Primary Care CBOC
285	12	585GG	Gladstone VA Clinic	Gladstone	Primary Care CBOC
286	12	585HA	Marquette VA Clinic	Marquette	Primary Care CBOC
287	12	585HB	Sault Saint Marie VA Clinic	Sault Saint Marie	Primary Care CBOC
288	12	607GC	Janesville VA Clinic	Janesville	Primary Care CBOC
289	12	607GD	Baraboo VA Clinic	Baraboo	Primary Care CBOC
290	12	607GE	Beaver Dam VA Clinic	Beaver Dam	Primary Care CBOC
291	12	607GF	Freeport VA Clinic	Freeport	Primary Care CBOC
292	12	607GG	Madison West VA Clinic	Madison West	Primary Care CBOC
293	12	676GA	Wausau VA Clinic	Wausau	Primary Care CBOC
294	12	676GC	River Valley VA Clinic	River Valley	Primary Care CBOC
295	12	676GE	Clark County VA Clinic	Clark County	Primary Care CBOC
296	12	695GA	Union Grove VA Clinic	Union Grove	Primary Care CBOC
297	12	695GC	Cleveland VA Clinic	Cleveland, Wisconsin	Primary Care CBOC
298	15	589G2	Dodge City VA Clinic	Dodge City	Primary Care CBOC
299	15	589G4	Hays VA Clinic	Hays	Primary Care CBOC
300	15	589G5	Parsons VA Clinic	Parsons	Primary Care CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
301	15	589G7	Hutchinson VA Clinic	Hutchinson	Primary Care CBOC
302	15	589GB	Belton VA Clinic	Belton	Primary Care CBOC
303	15	589GD	Nevada VA Clinic	Nevada	Primary Care CBOC
304	15	589GE	Kirksville VA Clinic	Kirksville	Primary Care CBOC
305	15	589GF	Waynesville VA Clinic	Waynesville	Primary Care CBOC
306	15	589GH	Lake of the Ozarks VA Clinic	Lake of the Ozarks	Primary Care CBOC
307	15	589GI	St. Joseph VA Clinic	St. Joseph	Primary Care CBOC
308	15	589GJ	Wyandotte County VA Clinic	Wyandotte County	Primary Care CBOC
309	15	589GR	Lieutenant General Richard J. Seitz Community-Based Outpatient Clinic	Junction City	Primary Care CBOC
310	15	589GU	Lawrence VA Clinic	Lawrence	Primary Care CBOC
311	15	589GV	Fort Scott VA Clinic	Fort Scott	Primary Care CBOC
312	15	589GW	Salina VA Clinic	Salina	Primary Care CBOC
313	15	589GX	Mexico VA Clinic	Mexico	Primary Care CBOC
314	15	589GY	St. James VA Clinic	St. James, Missouri	Primary Care CBOC
315	15	589JA	Sedalia VA Clinic	Sedalia	Primary Care CBOC
316	15	589JB	Excelsior Springs VA Clinic	Excelsior Springs	Primary Care CBOC
317	15	589JC	Shawnee VA Clinic	Shawnee	Primary Care CBOC
318	15	589JE	Platte City VA Clinic	Platte City	Primary Care CBOC
319	15	589JF	Honor VA Clinic	Honor	Primary Care CBOC
320	15	657GA	St. Clair County VA Clinic	St. Clair County	Primary Care CBOC
321	15	657GB	St. Louis County VA Clinic	St. Louis County	Primary Care CBOC
322	15	657GD	St. Charles County VA Clinic	St. Charles County	Primary Care CBOC
323	15	657GF	West Plains VA Clinic	West Plains	Primary Care CBOC
324	15	657GG	Paragould VA Clinic	Paragould	Primary Care CBOC
325	15	657GH	Cape Girardeau VA Clinic	Cape Girardeau	Primary Care CBOC
326	15	657GI	Farmington VA Clinic	Farmington, Missouri	Primary Care CBOC
327	15	657GK	Mount Vernon VA Clinic	Mount Vernon, Illinois	Primary Care CBOC
328	15	657GL	Paducah VA Clinic	Paducah	Primary Care CBOC
329	15	657GM	Effingham VA Clinic	Effingham	Primary Care CBOC
330	15	657GP	Owensboro VA Clinic	Owensboro	Primary Care CBOC
331	15	657GQ	Vincennes VA Clinic	Vincennes	Primary Care CBOC
332	15	657GR	Mayfield VA Clinic	Mayfield	Primary Care CBOC
333	15	657GS	Franklin County VA Clinic	Franklin County	Primary Care CBOC
334	15	657GT	Carbondale VA Clinic	Carbondale	Primary Care CBOC
335	15	657GU	Harrisburg VA Clinic	Harrisburg	Primary Care CBOC
336	15	657GW	Pocahontas VA Clinic	Pocahontas	Primary Care CBOC
337	15	657GX	Washington Avenue VA Clinic	Washington Avenue	Primary Care CBOC
338	15	657QA	Olive Street VA Clinic	Olive Street	Primary Care CBOC
339	15	657QD	Heartland Street VA Clinic	Heartland Street	Primary Care CBOC
340	16	502GA	Jennings VA Clinic	Jennings	Primary Care CBOC
341	16	502GE	Douglas Fournet Department of Veterans Affairs Clinic	Lake Charles	Primary Care CBOC
342	16	502GF	Fort Polk VA Clinic	Fort Polk	Primary Care CBOC
343	16	502GG	Natchitoches VA Clinic	Natchitoches	Primary Care CBOC
344	16	520GB	Panama City Beach VA Clinic	Panama City Beach, Florida	Primary Care CBOC
345	16	564GD	Ozark VA Clinic	Ozark	Primary Care CBOC
346	16	564GE	Jay VA Clinic	Jay	Primary Care CBOC
347	16	564GF	Joplin VA Clinic	Joplin	Primary Care CBOC
348	16	580GC	Galveston County VA Clinic	Galveston County	Primary Care CBOC
349	16	580GF	Lake Jackson VA Clinic	Lake Jackson	Primary Care CBOC
350	16	580GL	Sugar Land VA Clinic	Sugar Land	Primary Care CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
351	16	586GA	Kosciusko VA Clinic	Kosciusko	Primary Care CBOC
352	16	586GB	Meridian VA Clinic	Meridian	Primary Care CBOC
353	16	586GC	Greenville VA Clinic	Greenville, Mississippi	Primary Care CBOC
354	16	586GD	Hattiesburg VA Clinic	Hattiesburg	Primary Care CBOC
355	16	586GE	Natchez VA Clinic	Natchez	Primary Care CBOC
356	16	586GF	Columbus VA Clinic	Columbus, Mississippi	Primary Care CBOC
357	16	586GG	McComb VA Clinic	McComb	Primary Care CBOC
358	16	598GA	Mountain Home VA Clinic	Mountain Home, Arkansas	Primary Care CBOC
359	16	598GB	El Dorado VA Clinic	El Dorado	Primary Care CBOC
360	16	598GD	Mena VA Clinic	Mena	Primary Care CBOC
361	16	598GE	Pine Bluff VA Clinic	Pine Bluff	Primary Care CBOC
362	16	598GF	Searcy VA Clinic	Searcy	Primary Care CBOC
363	16	598GH	Russellville VA Clinic	Russellville	Primary Care CBOC
364	16	629GA	Houma VA Clinic	Houma	Primary Care CBOC
365	16	629GD	St. John VA Clinic	St. John	Primary Care CBOC
366	16	629GE	Franklin VA Clinic	Franklin, Louisiana	Primary Care CBOC
367	16	629GF	Bogalusa VA Clinic	Bogalusa	Primary Care CBOC
368	17	504BZ	Clovis VA Clinic	Clovis	Primary Care CBOC
369	17	519GB	Hobbs VA Clinic	Hobbs	Primary Care CBOC
370	17	519HF	San Angelo VA Clinic	San Angelo	Primary Care CBOC
371	17	549GD	Denton VA Clinic	Denton	Primary Care CBOC
372	17	549GE	Decatur VA Clinic	Decatur, Texas	Primary Care CBOC
373	17	549GH	Greenville VA Clinic	Greenville, Texas	Primary Care CBOC
374	17	549GJ	Sherman VA Clinic	Sherman	Primary Care CBOC
375	17	549GL	Plano VA Clinic	Plano	Primary Care CBOC
376	17	549GM	Grand Prairie VA Clinic	Grand Prairie	Primary Care CBOC
377	17	671GB	Victoria VA Clinic	Victoria	Primary Care CBOC
378	17	671GF	South Bexar County VA Clinic	South Bexar County	Primary Care CBOC
379	17	671GK	San Antonio VA Clinic	San Antonio Woodcock Drive	Primary Care CBOC
380	17	671GQ	Shavano Park VA Clinic	Shavano Park	Primary Care CBOC
381	17	671GR	North Bexar VA Clinic	North Bexar	Primary Care CBOC
382	17	674GA	Palestine VA Clinic	Palestine	Primary Care CBOC
383	17	674GB	Brownwood VA Clinic	Brownwood	Primary Care CBOC
384	17	674GC	Bryan VA Clinic	Bryan	Primary Care CBOC
385	17	674GD	Cedar Park VA Clinic	Cedar Park	Primary Care CBOC
386	17	674GF	Temple VA Clinic	Temple South General Bruce Drive	Primary Care CBOC
387	17	674HB	LaGrange VA Clinic	LaGrange	Primary Care CBOC
388	17	740GD	Laredo VA Clinic	Laredo	Primary Care CBOC
389	17	756GA	Las Cruces VA Clinic	Las Cruces	Primary Care CBOC
390	17	756GC	El Paso Westside VA Clinic	El Paso Westside	Primary Care CBOC
391	17	756GD	El Paso Northeast VA Clinic	El Paso Northeast	Primary Care CBOC
392	19	436GA	Anaconda VA Clinic	Anaconda	Primary Care CBOC
393	19	436GB	Great Falls VA Clinic	Great Falls	Primary Care CBOC
394	19	436GD	Bozeman VA Clinic	Bozeman	Primary Care CBOC
395	19	436GK	Glendive VA Clinic	Glendive	Primary Care CBOC
396	19	436HC	Merril Lundman Department of Veterans Affairs Outpatient Clinic	Havre	Primary Care CBOC
397	19	554A5	Denver VA Domiciliary	Denver, Colorado	Primary Care CBOC
398	19	554GB	Aurora VA Clinic	Aurora, Colorado	Primary Care CBOC
399	19	554GF	Alamosa VA Clinic	Alamosa	Primary Care CBOC
400	19	554GG	La Junta VA Clinic	La Junta	Primary Care CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
401	19	554GH	Lamar VA Clinic	Lamar	Primary Care CBOC
402	19	575QA	Glenwood Springs VA Clinic	Glenwood Springs	Primary Care CBOC
403	19	623GA	McAlester VA Clinic	McAlester	Primary Care CBOC
404	19	623GB	Vinita VA Clinic	Vinita	Primary Care CBOC
405	19	623GC	McCurtain County VA Clinic	McCurtain County	Primary Care CBOC
406	19	635GB	Wichita Falls VA Clinic	Wichita Falls	Primary Care CBOC
407	19	635GD	Ada VA Clinic	Ada	Primary Care CBOC
408	19	635GE	Stillwater VA Clinic	Stillwater	Primary Care CBOC
409	19	635GF	Altus VA Clinic	Altus	Primary Care CBOC
410	19	635GH	Clinton VA Clinic	Clinton	Primary Care CBOC
411	19	635GI	Norman VA Clinic	Norman	Primary Care CBOC
412	19	635GJ	Yukon VA Clinic	Yukon	Primary Care CBOC
413	19	635HB	Ardmore VA Clinic	Ardmore	Primary Care CBOC
414	19	660GA	Pocatello VA Clinic	Pocatello	Primary Care CBOC
415	19	660GB	Ogden VA Clinic	Ogden	Primary Care CBOC
416	19	660GE	Orem VA Clinic	Orem	Primary Care CBOC
417	19	660GG	St. George VA Clinic	St. George	Primary Care CBOC
418	19	660GJ	South Jordan VA Clinic	South Jordan	Primary Care CBOC
419	19	660QA	Idaho Falls VA Clinic	Idaho Falls	Primary Care CBOC
420	19	666GB	Casper VA Clinic	Casper	Primary Care CBOC
421	19	666GC	Riverton VA Clinic	Riverton	Primary Care CBOC
422	19	666GD	Cody VA Clinic	Cody	Primary Care CBOC
423	19	666GE	Gillette VA Clinic	Gillette	Primary Care CBOC
424	19	666GF	Rock Springs VA Clinic	Rock Springs	Primary Care CBOC
425	20	463GA	Fairbanks VA Clinic	Fairbanks	Primary Care CBOC
426	20	463GB	Kenai VA Clinic	Kenai	Primary Care CBOC
427	20	463GC	Mat-Su VA Clinic	Mat-Su	Primary Care CBOC
428	20	463GE	Juneau VA Clinic	Juneau	Primary Care CBOC
429	20	531GE	Twin Falls VA Clinic	Twin Falls	Primary Care CBOC
430	20	531GI	Mountain Home VA Clinic	Mountain Home, Idaho	Primary Care CBOC
431	20	531GJ	Salmon VA Clinic	Salmon	Primary Care CBOC
432	20	648GD	North Coast VA Clinic	North Coast	Primary Care CBOC
433	20	648GG	West Linn VA Clinic	West Linn	Primary Care CBOC
434	20	648GH	Newport VA Clinic	Newport, Oregon	Primary Care CBOC
435	20	648GI	Portland VA Clinic	Portland 1st Avenue	Primary Care CBOC
436	20	648GJ	Loren R. Kaufman VA Clinic	The Dalles	Primary Care CBOC
437	20	653GA	North Bend VA Clinic	North Bend	Primary Care CBOC
438	20	653GB	Brookings VA Clinic	Brookings	Primary Care CBOC
439	20	663GA	Bellevue VA Clinic	Bellevue, Washington	Primary Care CBOC
440	20	663GB	Silverdale VA Clinic	Silverdale	Primary Care CBOC
441	20	663GD	South Sound VA Clinic	South Sound	Primary Care CBOC
442	20	663GE	North Olympic Peninsula VA Clinic	North Olympic Peninsula	Primary Care CBOC
443	20	663GG	North Seattle VA Clinic	North Seattle	Primary Care CBOC
444	20	687GA	Richland VA Clinic	Richland	Primary Care CBOC
445	20	687GB	Lewiston VA Clinic	Lewiston, Idaho	Primary Care CBOC
446	20	687GC	La Grande VA Clinic	La Grande	Primary Care CBOC
447	20	687HA	Yakima VA Clinic	Yakima	Primary Care CBOC
448	20	692GA	Klamath Falls VA Clinic	Klamath Falls	Primary Care CBOC
449	20	692GB	Grants Pass VA Clinic	Grants Pass	Primary Care CBOC
450	21	459GA	Maui VA Clinic	Maui	Primary Care CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
451	21	459GB	Hilo VA Clinic	Hilo	Primary Care CBOC
452	21	459GC	Kailua-Kona VA Clinic	Kailua-Kona	Primary Care CBOC
453	21	459GD	Lihue VA Clinic	Lihue	Primary Care CBOC
454	21	459GF	Faleomavaega Eni Fa'aua'a Hunkin VA Clinic	American Samoa	Primary Care CBOC
455	21	459GG	Leeward Oahu VA Clinic	Leeward Oahu	Primary Care CBOC
456	21	570GB	Tulare VA Clinic	Tulare	Primary Care CBOC
457	21	593GC	Pahrump VA Clinic	Pahrump	Primary Care CBOC
458	21	593GD	Northwest Las Vegas VA Clinic	Northwest Las Vegas	Primary Care CBOC
459	21	593GE	Southeast Las Vegas VA Clinic	Southeast Las Vegas	Primary Care CBOC
460	21	593GF	Southwest Las Vegas VA Clinic	Southwest Las Vegas	Primary Care CBOC
461	21	593GG	Northeast Las Vegas VA Clinic	Northeast Las Vegas	Primary Care CBOC
462	21	593GH	Master Chief Petty Officer Jesse Dean VA Clinic	Laughlin	Primary Care CBOC
463	21	612GE	Mare Island VA Clinic	Mare Island	Primary Care CBOC
464	21	612GG	Chico VA Clinic	Chico	Primary Care CBOC
465	21	612GI	Yuba City VA Clinic	Yuba City	Primary Care CBOC
466	21	612GJ	Yreka VA Clinic	Yreka	Primary Care CBOC
467	21	640GA	Capitola VA Clinic	Capitola	Primary Care CBOC
468	21	640GB	Sonora VA Clinic	Sonora	Primary Care CBOC
469	21	640GC	Fremont VA Clinic	Fremont	Primary Care CBOC
470	21	640HA	Stockton VA Clinic	Stockton	Primary Care CBOC
471	21	640HB	Modesto VA Clinic	Modesto	Primary Care CBOC
472	21	654GB	Carson Valley VA Clinic	Carson Valley	Primary Care CBOC
473	21	654GC	Lahontan Valley VA Clinic	Lahontan Valley	Primary Care CBOC
474	21	654GD	Diamond View VA Clinic	Diamond View	Primary Care CBOC
475	21	654GE	Reno East VA Clinic	Reno East	Primary Care CBOC
476	21	662GF	San Francisco VA Clinic	San Francisco Downtown	Primary Care CBOC
477	22	501G2	Las Vegas VA Clinic	Las Vegas, New Mexico	Primary Care CBOC
478	22	501GA	Artesia VA Clinic	Artesia	Primary Care CBOC
479	22	501GB	Farmington VA Clinic	Farmington, New Mexico	Primary Care CBOC
480	22	501GC	Silver City VA Clinic	Silver City	Primary Care CBOC
481	22	501GD	Gallup VA Clinic	Gallup	Primary Care CBOC
482	22	501GH	Truth or Consequences VA Clinic	Truth or Consequences	Primary Care CBOC
483	22	501GI	Alamogordo VA Clinic	Alamogordo	Primary Care CBOC
484	22	501GJ	Durango VA Clinic	Durango	Primary Care CBOC
485	22	501GK	Santa Fe VA Clinic	Santa Fe	Primary Care CBOC
486	22	501GM	Northwest Metro VA Clinic	Northwest Metro New Mexico	Primary Care CBOC
487	22	501GN	Taos VA Clinic	Taos	Primary Care CBOC
488	22	600GA	Anaheim VA Clinic	Anaheim	Primary Care CBOC
489	22	600GC	Cabrillo VA Clinic	Cabrillo	Primary Care CBOC
490	22	600GD	Santa Fe Springs VA Clinic	Santa Fe Springs	Primary Care CBOC
491	22	600GE	Laguna Hills VA Clinic	Laguna Hills	Primary Care CBOC
492	22	605GA	Victorville VA Clinic	Victorville	Primary Care CBOC
493	22	605GB	Murrieta VA Clinic	Murrieta	Primary Care CBOC
494	22	605GC	Palm Desert VA Clinic	Palm Desert	Primary Care CBOC
495	22	605GD	Corona VA Clinic	Corona	Primary Care CBOC
496	22	605GE	Rancho Cucamonga VA Clinic	Rancho Cucamonga	Primary Care CBOC
497	22	644GA	Northwest VA Clinic	Northwest Surprise	Primary Care CBOC
498	22	644GB	Show Low VA Clinic	Show Low	Primary Care CBOC
499	22	644GC	Southwest VA Clinic	Southwest Phoenix	Primary Care CBOC
500	22	644GE	Thunderbird VA Clinic	Thunderbird	Primary Care CBOC

FY 2020 Primary Community Based Outpatient Clinics (PC CBOC)

PC CBOC Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
501	22	644GF	Globe VA Clinic	Globe	Primary Care CBOC
502	22	644GG	Northeast Phoenix VA Clinic	Northeast Phoenix	Primary Care CBOC
503	22	644GH	Phoenix Midtown VA Clinic	Phoenix Midtown	Primary Care CBOC
504	22	649GA	Kingman VA Clinic	Kingman	Primary Care CBOC
505	22	649GB	Flagstaff VA Clinic	Flagstaff	Primary Care CBOC
506	22	649GC	Lake Havasu City VA Clinic	Lake Havasu City	Primary Care CBOC
507	22	649GD	Anthem VA Clinic	Anthem	Primary Care CBOC
508	22	649GE	Cottonwood VA Clinic	Cottonwood	Primary Care CBOC
509	22	664GA	Imperial Valley VA Clinic	Imperial Valley	Primary Care CBOC
510	22	664GD	Escondido VA Clinic	Escondido	Primary Care CBOC
511	22	678GD	Safford VA Clinic	Safford	Primary Care CBOC
512	22	691GB	Santa Barbara VA Clinic	Santa Barbara	Primary Care CBOC
513	22	691GC	Gardena VA Clinic	Gardena	Primary Care CBOC
514	22	691GF	East Los Angeles VA Clinic	East Los Angeles	Primary Care CBOC
515	22	691GG	Antelope Valley VA Clinic	Antelope Valley	Primary Care CBOC
516	22	691GK	San Luis Obispo VA Clinic	San Luis Obispo	Primary Care CBOC
517	22	691GP	San Gabriel Valley VA Clinic	San Gabriel Valley	Primary Care CBOC
518	23	437GB	Bismarck VA Clinic	Bismarck	Primary Care CBOC
519	23	437GC	Fergus Falls VA Clinic	Fergus Falls	Primary Care CBOC
520	23	437GD	Minot VA Clinic	Minot	Primary Care CBOC
521	23	437GE	Bemidji VA Clinic	Bemidji	Primary Care CBOC
522	23	437GF	Williston VA Clinic	Williston	Primary Care CBOC
523	23	437GI	Grand Forks VA Clinic	Grand Forks	Primary Care CBOC
524	23	437GJ	Dickinson VA Clinic	Dickinson	Primary Care CBOC
525	23	437GK	Jamestown VA Clinic	Jamestown, North Dakota	Primary Care CBOC
526	23	438GA	Spirit Lake VA Clinic	Spirit Lake	Primary Care CBOC
527	23	438GC	Sioux City VA Clinic	Sioux City	Primary Care CBOC
528	23	438GF	Watertown VA Clinic	Watertown, South Dakota	Primary Care CBOC
529	23	568HH	Scottsbluff VA Clinic	Scottsbluff	Primary Care CBOC
530	23	618GB	Hibbing VA Clinic	Hibbing	Primary Care CBOC
531	23	618GD	Maplewood VA Clinic	Maplewood	Primary Care CBOC
532	23	618GE	Chippewa Valley VA Clinic	Chippewa Valley	Primary Care CBOC
533	23	618GG	Rochester VA Clinic	Rochester, Minnesota	Primary Care CBOC
534	23	618GH	Hayward VA Clinic	Hayward	Primary Care CBOC
535	23	618GJ	Shakopee VA Clinic	Shakopee	Primary Care CBOC
536	23	618GK	Albert Lea VA Clinic	Albert Lea	Primary Care CBOC
537	23	618GL	Minneapolis VA Clinic	Minneapolis Harmon Place	Primary Care CBOC
538	23	618GM	Rice Lake VA Clinic	Rice Lake	Primary Care CBOC
539	23	618GN	Lyle C. Pearson Community Based Outpatient Clinic	Mankato	Primary Care CBOC
540	23	636GB	North Platte VA Clinic	North Platte	Primary Care CBOC
541	23	636GG	Quincy VA Clinic	Quincy, Illinois	Primary Care CBOC
542	23	636GH	Waterloo VA Clinic	Waterloo	Primary Care CBOC
543	23	636GJ	Dubuque VA Clinic	Dubuque	Primary Care CBOC
544	23	636GL	Bellevue VA Clinic	Bellevue, Nebraska	Primary Care CBOC
545	23	636GP	Shenandoah VA Clinic	Shenandoah	Primary Care CBOC
546	23	636GQ	Holdrege VA Clinic	Holdrege	Primary Care CBOC
547	23	636GW	Coralville VA Clinic	Coralville	Primary Care CBOC
548	23	656GB	Montevideo VA Clinic	Montevideo	Primary Care CBOC
549	23	656GC	Max J. Beilke Department of Veterans Affairs Outpatient Clinic	Alexandria, Minnesota	Primary Care CBOC

FY 2020 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
1	1	402HL	Bingham VA Mobile Clinic	Bingham Mobile	Other Outpatient Services (OOS)
2	1	402QA	Fort Kent VA Clinic	Fort Kent	Other Outpatient Services (OOS)
3	1	402QB	Houlton VA Clinic	Houlton	Other Outpatient Services (OOS)
4	1	523GC	Quincy VA Clinic	Quincy, Massachusetts	Other Outpatient Services (OOS)
5	1	523GD	Plymouth VA Clinic	Plymouth	Other Outpatient Services (OOS)
6	1	631QA	Plantation Street VA Clinic	Plantation Street	Other Outpatient Services (OOS)
7	1	631QB	Lake Avenue VA Clinic	Lake Avenue	Other Outpatient Services (OOS)
8	1	650QA	Eagle Square VA Clinic	Eagle Square	Other Outpatient Services (OOS)
9	1	650QB	Eagle Street VA Clinic	Eagle Street	Other Outpatient Services (OOS)
10	2	526GD	Thomas P. Noonan Jr. Department of Veterans Affairs Outpatient Clinic	Sunnyside	Other Outpatient Services (OOS)
11	2	526QA	Bronx VA Mobile Clinic	Bronx Mobile	Other Outpatient Services (OOS)
12	2	528G2	Westport VA Clinic	Westport	Other Outpatient Services (OOS)
13	2	528GW	Schenectady VA Clinic	Schenectady	Other Outpatient Services (OOS)
14	2	528GX	Troy VA Clinic	Troy	Other Outpatient Services (OOS)
15	2	528GY	Clifton Park VA Clinic	Clifton Park	Other Outpatient Services (OOS)
16	2	528QA	Buffalo VA Clinic	Buffalo Main Street	Other Outpatient Services (OOS)
17	2	528QB	Packard VA Clinic	Packard	Other Outpatient Services (OOS)
18	2	528QC	Rochester Calkins VA Clinic	Rochester Calkins	Other Outpatient Services (OOS)
19	2	528QE	Coudersport VA Clinic	Coudersport	Other Outpatient Services (OOS)
20	2	528QF	Wellsboro VA Clinic	Wellsboro	Other Outpatient Services (OOS)
21	2	528QG	Erie West VA Clinic	Erie West	Other Outpatient Services (OOS)
22	2	528QH	South Salina VA Clinic	South Salina	Other Outpatient Services (OOS)
23	2	528QI	Erie East VA Clinic	Erie East	Other Outpatient Services (OOS)
24	2	528QN	Watertown 2 VA Clinic	Watertown 2	Other Outpatient Services (OOS)
25	2	561BY	Newark VA Clinic	Newark, New Jersey	Other Outpatient Services (OOS)
26	2	620GF	Monticello VA Clinic	Monticello	Other Outpatient Services (OOS)
27	2	620GH	Eastern Dutchess VA Clinic	Eastern Dutchess	Other Outpatient Services (OOS)
28	2	620QA	Montrose 1 VA Mobile Clinic	Montrose 1 Mobile	Other Outpatient Services (OOS)
29	2	620QC	Montrose 3 VA Mobile Clinic	Montrose 3 Mobile	Other Outpatient Services (OOS)
30	2	630QA	New York Harbor 1 VA Mobile Clinic	New York Harbor 1 Mobile	Other Outpatient Services (OOS)
31	2	630QB	New York Harbor 2 VA Mobile Clinic	New York Harbor 2 Mobile	Other Outpatient Services (OOS)
32	2	632QA	Northport 1 VA Mobile Clinic	Northport 1 Mobile	Other Outpatient Services (OOS)
33	2	632QB	Northport 2 VA Mobile Clinic	Northport 2 Mobile	Other Outpatient Services (OOS)
34	4	460HK	Wilmington VA Mobile Clinic	Wilmington Mobile	Other Outpatient Services (OOS)
35	4	529GD	Clarion County VA Clinic	Clarion County	Other Outpatient Services (OOS)
36	4	562GC	McKean County VA Clinic	McKean County	Other Outpatient Services (OOS)
37	4	595QA	Fort Indiantown Gap VA Clinic	Annville	Other Outpatient Services (OOS)
38	4	642QA	Chestnut Street VA Clinic	Chestnut Street	Other Outpatient Services (OOS)
39	4	642QB	Fourth Street VA Clinic	Fourth Street	Other Outpatient Services (OOS)
40	4	693GC	Tobyhanna VA Clinic	Tobyhanna	Other Outpatient Services (OOS)
41	4	693GF	Columbia County VA Clinic	Columbia County	Other Outpatient Services (OOS)
42	4	693GG	Northampton County VA Clinic	Northampton County	Other Outpatient Services (OOS)
43	4	693QA	Wayne County VA Clinic	Wayne County	Other Outpatient Services (OOS)
44	5	512QA	Baltimore VA Clinic	Baltimore West Fayette Street	Other Outpatient Services (OOS)
45	5	517HK	Beckley VA Mobile Clinic	Beckley Mobile	Other Outpatient Services (OOS)
46	5	517QA	Princeton VA Clinic	Princeton	Other Outpatient Services (OOS)
47	5	540GA	Tucker County VA Clinic	Tucker County	Other Outpatient Services (OOS)
48	5	540HK	Clarksburg VA Mobile Clinic	Clarksburg Mobile	Other Outpatient Services (OOS)
49	5	581GG	Gallipolis VA Clinic	Gallipolis	Other Outpatient Services (OOS)
50	5	581GH	Lenore VA Clinic	Lenore	Other Outpatient Services (OOS)

FY 2020 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
51	5	581QA	Huntington Ninth Street VA Clinic	Huntington Ninth Street	Other Outpatient Services (OOS)
52	5	581QB	Huntington VA Mobile Clinic	Huntington Mobile	Other Outpatient Services (OOS)
53	5	613GD	Franklin VA Clinic	Franklin, West Virginia	Other Outpatient Services (OOS)
54	5	688GB	Southeast Washington VA Clinic	Southeast Washington	Other Outpatient Services (OOS)
55	5	688QA	Franklin Street VA Clinic	Franklin Street	Other Outpatient Services (OOS)
56	6	558GD	Durham County VA Clinic	Durham County	Other Outpatient Services (OOS)
57	6	558GF	Wake County VA Clinic	Wake County	Other Outpatient Services (OOS)
58	6	558QA	Brier Creek VA Clinic	Brier Creek	Other Outpatient Services (OOS)
59	6	565GJ	Jacksonville 2 VA Clinic	Jacksonville 2	Other Outpatient Services (OOS)
60	6	565GM	Jacksonville 3 VA Clinic	Jacksonville 3	Other Outpatient Services (OOS)
61	6	565QA	Robeson Street VA Clinic	Robeson Street	Other Outpatient Services (OOS)
62	6	565QB	Fayetteville VA Mobile Clinic	Fayetteville Mobile	Other Outpatient Services (OOS)
63	6	565QC	Fayetteville 2 VA Mobile Clinic	Fayetteville 2 Mobile	Other Outpatient Services (OOS)
64	6	565QD	Raeford Road VA Clinic	Raeford Road	Other Outpatient Services (OOS)
65	6	565QE	Womack VA Clinic	Womack	Other Outpatient Services (OOS)
66	6	590QA	Hampton VA Mobile Clinic	Hampton 1 Mobile	Other Outpatient Services (OOS)
67	6	590QB	Hampton City County VA Mobile Clinic	Hampton City County Mobile	Other Outpatient Services (OOS)
68	6	652GG	Richmond 1 VA Mobile Clinic	Richmond 1 Mobile	Other Outpatient Services (OOS)
69	6	652GH	Hunter Holmes McGuire 2 VA Mobile Clinic	Richmond 2 Mobile	Other Outpatient Services (OOS)
70	7	508GM	Pickens County VA Clinic	Pickens County	Other Outpatient Services (OOS)
71	7	508GN	Covington VA Clinic	Covington	Other Outpatient Services (OOS)
72	7	508GO	Northeast Cobb County VA Clinic	Northeast Cobb County	Other Outpatient Services (OOS)
73	7	508GP	South Cobb County VA Clinic	South Cobb County	Other Outpatient Services (OOS)
74	7	508QB	East Point VA Clinic	East Point	Other Outpatient Services (OOS)
75	7	508QC	Henderson Mill VA Clinic	Henderson Mill	Other Outpatient Services (OOS)
76	7	508QD	Fulton County VA Clinic	Fulton County	Other Outpatient Services (OOS)
77	7	508QH	South Fulton County VA Clinic	South Fulton County	Other Outpatient Services (OOS)
78	7	508QI	North DeKalb County VA Clinic	North DeKalb County	Other Outpatient Services (OOS)
79	7	508QJ	North Fulton County VA Clinic	North Fulton County	Other Outpatient Services (OOS)
80	7	521QA	Callahan VA Clinic	Callahan	Other Outpatient Services (OOS)
81	7	534GF	Trident 1 VA Clinic	Trident 1	Other Outpatient Services (OOS)
82	7	534QB	Trident 2 VA Clinic	Trident 2	Other Outpatient Services (OOS)
83	7	534QC	Charleston VA Clinic	Charleston City Hall Lane	Other Outpatient Services (OOS)
84	7	544HK	Columbia VA Mobile Clinic	Columbia Mobile	Other Outpatient Services (OOS)
85	7	619GB	Dothan 1 VA Clinic	Dothan 1	Other Outpatient Services (OOS)
86	7	679HK	Tuscaloosa VA Mobile Clinic	Tuscaloosa Mobile	Other Outpatient Services (OOS)
87	8	548QA	Port Saint Lucie VA Clinic	Port Saint Lucie	Other Outpatient Services (OOS)
88	8	573GN	Perry VA Clinic	Perry, Florida	Other Outpatient Services (OOS)
89	8	573QA	Gainesville Sixteenth Street VA Clinic	Gainesville 1-16th Street	Other Outpatient Services (OOS)
90	8	573QB	Gainesville Ninety Eighth Street VA Clinic	Gainesville 2-98th Street	Other Outpatient Services (OOS)
91	8	573QC	Gainesville Sixty Fourth Street 1 VA Clinic	Gainesville 3-64th Street (C)	Other Outpatient Services (OOS)
92	8	573QD	Gainesville Sixty Fourth Street 2 VA Clinic	Gainesville 4-64th Street (O)	Other Outpatient Services (OOS)
93	8	573QE	Gainesville Sixty Fourth Street 3 VA Clinic	Gainesville 5-64th Street (D)	Other Outpatient Services (OOS)
94	8	573QF	Gainesville Twenty Third Avenue VA Clinic	Gainesville 6-23rd Avenue	Other Outpatient Services (OOS)
95	8	573QH	Ocala West VA Clinic	Ocala West	Other Outpatient Services (OOS)
96	8	573QK	Lake City VA Clinic	Lake City Commerce Drive	Other Outpatient Services (OOS)
97	8	672GA	Saint Croix VA Clinic	Saint Croix	Other Outpatient Services (OOS)
98	8	672GB	Saint Thomas VA Clinic	Saint Thomas	Other Outpatient Services (OOS)
99	8	672QA	Comerio VA Clinic	Comerio	Other Outpatient Services (OOS)
100	8	672QB	Utuado VA Clinic	Utuado	Other Outpatient Services (OOS)

FY 2020 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
101	8	672QC	Vieques VA Clinic	Vieques	Other Outpatient Services (OOS)
102	8	673GF	Zephyrhills VA Clinic	Zephyrhills	Other Outpatient Services (OOS)
103	8	673GH	Lecanto VA Clinic	Lecanto	Other Outpatient Services (OOS)
104	8	673QA	Forty Sixth Street North VA Clinic	Forty Sixth Street North	Other Outpatient Services (OOS)
105	8	673QB	Forty Sixth Street South VA Clinic	Forty Sixth Street South	Other Outpatient Services (OOS)
106	8	673QC	West Lakeland VA Clinic	West Lakeland	Other Outpatient Services (OOS)
107	8	673QD	Deer Park VA Clinic	Deer Park	Other Outpatient Services (OOS)
108	8	673QE	Highway Nineteen VA Clinic	Highway Nineteen	Other Outpatient Services (OOS)
109	8	673QF	Winners Circle VA Clinic	Winners Circle	Other Outpatient Services (OOS)
110	8	673QG	Little Road VA Clinic	Little Road	Other Outpatient Services (OOS)
111	8	673QH	Bruce B. Downs Boulevard VA Clinic	Bruce B. Downs Boulevard	Other Outpatient Services (OOS)
112	8	673QI	Medical View Lane VA Clinic	Medical View Lane	Other Outpatient Services (OOS)
113	8	673QK	Tampa 1 VA Mobile Clinic	Tampa 1 Mobile	Other Outpatient Services (OOS)
114	8	673QL	Tampa 2 VA Mobile Clinic	Tampa 2 Mobile	Other Outpatient Services (OOS)
115	8	675QB	Port Orange VA Clinic	Port Orange	Other Outpatient Services (OOS)
116	8	675QC	Westside Pavilion VA Clinic	Westside Pavilion	Other Outpatient Services (OOS)
117	8	675QD	Crossroads VA Clinic	Crossroads	Other Outpatient Services (OOS)
118	8	675QE	Orlando 1 VA Mobile Clinic	Orlando 1 Mobile	Other Outpatient Services (OOS)
119	8	675QG	Palm Bay VA Clinic	Palm Bay	Other Outpatient Services (OOS)
120	9	614QA	Union Avenue VA Clinic	Union Avenue	Other Outpatient Services (OOS)
121	9	621GA	Rogersville VA Clinic	Rogersville	Other Outpatient Services (OOS)
122	9	621QA	Jonesville VA Clinic	Jonesville	Other Outpatient Services (OOS)
123	9	621QB	Marion VA Clinic	Marion, Virginia	Other Outpatient Services (OOS)
124	9	621QC	Vansant VA Clinic	Vansant	Other Outpatient Services (OOS)
125	9	621QD	Knox County VA Clinic	Knox County	Other Outpatient Services (OOS)
126	9	621QE	Downtown West VA Clinic	Downtown West	Other Outpatient Services (OOS)
127	9	621QF	Johnson City VA Clinic	Johnson City	Other Outpatient Services (OOS)
128	9	626QC	Pointe Centre VA Clinic	Pointe Centre	Other Outpatient Services (OOS)
129	9	626QD	Glenis Drive VA Clinic	Glenis Drive	Other Outpatient Services (OOS)
130	9	626QE	Glenis Drive 2 VA Clinic	Glenis Drive 2	Other Outpatient Services (OOS)
131	9	626QF	Dalton Drive VA Clinic	Dalton Drive	Other Outpatient Services (OOS)
132	10	506QA	Packard Road VA Clinic	Ann Arbor Packard Road	Other Outpatient Services (OOS)
133	10	506QB	Green Road VA Clinic	Green Road	Other Outpatient Services (OOS)
134	10	515QA	Lansing North VA Clinic	Lansing North	Other Outpatient Services (OOS)
135	10	515QB	Century Avenue VA Clinic	Century Avenue	Other Outpatient Services (OOS)
136	10	538QA	Chillicothe VA Mobile Clinic	Chillicothe Mobile	Other Outpatient Services (OOS)
137	10	539QA	Cincinnati VA Mobile Clinic	Cincinnati Mobile	Other Outpatient Services (OOS)
138	10	539QB	Highland Avenue VA Clinic	Highland Avenue	Other Outpatient Services (OOS)
139	10	539QC	Vine Street VA Clinic	Vine Street	Other Outpatient Services (OOS)
140	10	539QD	Norwood VA Clinic	Norwood	Other Outpatient Services (OOS)
141	10	541GM	Cleveland VA Clinic-Superior	Cleveland Superior Avenue	Other Outpatient Services (OOS)
142	10	541QA	Summit County VA Clinic	Summit County	Other Outpatient Services (OOS)
143	10	541QB	Cleveland VA Clinic-Euclid	Cleveland Euclid Avenue	Other Outpatient Services (OOS)
144	10	541QC	Cleveland 1 VA Mobile Clinic	Cleveland 1 Mobile	Other Outpatient Services (OOS)
145	10	541QD	Cleveland 2 VA Mobile Clinic	Cleveland 2 Mobile	Other Outpatient Services (OOS)
146	10	541QE	Cleveland East Boulevard 3 VA Mobile Clinic	Cleveland East Boulevard 3 Mobile	Other Outpatient Services (OOS)
147	10	541QF	Cuyahoga County 4 VA Mobile Clinic	Cuyahoga County 4 Mobile	Other Outpatient Services (OOS)
148	10	552QC	Montgomery County 3 VA Mobile Clinic	Montgomery County 3 Mobile	Other Outpatient Services (OOS)
149	10	583GB	Bloomington VA Clinic	Bloomington	Other Outpatient Services (OOS)
150	10	583QA	Monroe County VA Clinic	Monroe County Indiana	Other Outpatient Services (OOS)

FY 2020 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
151	10	583QB	Indianapolis VA Clinic	Indianapolis Meridian Street	Other Outpatient Services (OOS)
152	10	583QC	Vigo County VA Clinic	Vigo County	Other Outpatient Services (OOS)
153	10	583QD	Indianapolis YMCA VA Clinic	Indianapolis YMCA	Other Outpatient Services (OOS)
154	10	583QE	Cold Spring Road VA Clinic	Cold Spring Road	Other Outpatient Services (OOS)
155	10	583QF	Crane VA Clinic	Crane	Other Outpatient Services (OOS)
156	10	610QA	Fort Wayne VA Clinic	Fort Wayne East State Boulevard	Other Outpatient Services (OOS)
157	10	610QB	Columbia Place VA Clinic	Columbia Place	Other Outpatient Services (OOS)
158	10	655GB	Colonel Demas T. Craw VA Clinic	Traverse City	Other Outpatient Services (OOS)
159	10	655QA	Saginaw VA Clinic	Saginaw Barnard Road	Other Outpatient Services (OOS)
160	10	757QA	Columbus 1 VA Mobile Clinic	Columbus 1 Mobile	Other Outpatient Services (OOS)
161	10	757QB	North James Road 2 VA Mobile Clinic	North James Road 2 Mobile	Other Outpatient Services (OOS)
162	10	757QC	Columbus VA Clinic	Columbus Airport Drive	Other Outpatient Services (OOS)
163	12	537QA	Chicago VA Clinic	Chicago South California Avenue	Other Outpatient Services (OOS)
164	12	676QA	Tomah VA Mobile Clinic	Tomah Mobile	Other Outpatient Services (OOS)
165	12	695QA	Milwaukee VA Clinic	Milwaukee MLK Drive	Other Outpatient Services (OOS)
166	15	589G3	Liberal VA Clinic	Liberal	Other Outpatient Services (OOS)
167	15	589GC	Paola VA Clinic	Paola	Other Outpatient Services (OOS)
168	15	589GM	Chanute VA Clinic	Chanute	Other Outpatient Services (OOS)
169	15	589GP	Garnett VA Clinic	Garnett	Other Outpatient Services (OOS)
170	15	589GZ	Cameron VA Clinic	Cameron	Other Outpatient Services (OOS)
171	15	589HK	Kansas City VA Mobile Clinic	Kansas City Mobile	Other Outpatient Services (OOS)
172	15	589QA	Overland Park VA Clinic	Overland Park	Other Outpatient Services (OOS)
173	15	589QB	Sedgwick County VA Clinic	Sedgwick County	Other Outpatient Services (OOS)
174	15	589QC	South Parklane VA Clinic	South Parklane	Other Outpatient Services (OOS)
175	15	589QD	Wichita VA Mobile Clinic	Wichita Mobile	Other Outpatient Services (OOS)
176	15	657GO	Hanson VA Clinic	Hanson	Other Outpatient Services (OOS)
177	15	657GY	Manchester Avenue VA Clinic	Manchester Avenue	Other Outpatient Services (OOS)
178	15	657QB	Washington Boulevard VA Clinic	Washington Boulevard	Other Outpatient Services (OOS)
179	15	657QE	Scott Air Force Base VA Clinic	Scott Air Force Base	Other Outpatient Services (OOS)
180	16	502QB	Lafayette Campus B VA Clinic	Lafayette Campus B	Other Outpatient Services (OOS)
181	16	520QA	Panama City Beach West VA Clinic	Panama City Beach West	Other Outpatient Services (OOS)
182	16	564GA	Harrison VA Clinic	Harrison	Other Outpatient Services (OOS)
183	16	564QA	Township VA Clinic	Township	Other Outpatient Services (OOS)
184	16	564QB	Sunbridge VA Clinic	Sunbridge	Other Outpatient Services (OOS)
185	16	580QB	Houston VA Mobile Clinic	Houston Mobile	Other Outpatient Services (OOS)
186	16	586QA	Jackson VA Mobile Clinic	Jackson Mobile	Other Outpatient Services (OOS)
187	16	586QB	Dogwood View Parkway VA Clinic	Dogwood View Parkway	Other Outpatient Services (OOS)
188	16	598QA	Little Rock VA Clinic	Little Rock Main Street	Other Outpatient Services (OOS)
189	16	598QB	Little Rock VA Mobile Clinic	Little Rock Mobile	Other Outpatient Services (OOS)
190	16	629QA	Baton Rouge South VA Clinic	Baton Rouge South	Other Outpatient Services (OOS)
191	16	667QA	Knight Street VA Clinic	Knight Street	Other Outpatient Services (OOS)
192	17	504GA	Childress VA Clinic	Childress	Other Outpatient Services (OOS)
193	17	504HB	Dalhart VA Clinic	Dalhart	Other Outpatient Services (OOS)
194	17	519GD	Fort Stockton VA Clinic	Fort Stockton	Other Outpatient Services (OOS)
195	17	549GF	Granbury VA Clinic	Granbury	Other Outpatient Services (OOS)
196	17	549GK	Polk Street VA Clinic	Polk Street	Other Outpatient Services (OOS)
197	17	549HK	North Texas VA Mobile Clinic	North Texas Mobile	Other Outpatient Services (OOS)
198	17	549QA	Dallas VA Clinic	Dallas South Lancaster Road	Other Outpatient Services (OOS)
199	17	549QB	East Lancaster VA Clinic	East Lancaster	Other Outpatient Services (OOS)
200	17	671GH	Beeville VA Clinic	Beeville	Other Outpatient Services (OOS)

FY 2020 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
201	17	671GL	New Braunfels VA Clinic	New Braunfels	Other Outpatient Services (OOS)
202	17	671GN	Seguin VA Clinic	Seguin	Other Outpatient Services (OOS)
203	17	671QA	South Texas VA Mobile Clinic	South Texas Mobile	Other Outpatient Services (OOS)
204	17	671QB	Data Point VA Clinic	Data Point	Other Outpatient Services (OOS)
205	17	740GI	Old Brownsville VA Clinic	Old Brownsville	Other Outpatient Services (OOS)
206	17	740GJ	North Tenth Street VA Clinic	North Tenth Street	Other Outpatient Services (OOS)
207	17	740QA	Texas Valley Coastal Bend VA Mobile Clinic	Texas Valley Coastal Bend Mobile	Other Outpatient Services (OOS)
208	17	756QA	El Paso South Central VA Clinic	El Paso South Central	Other Outpatient Services (OOS)
209	17	756QB	El Paso Central VA Clinic	El Paso Central	Other Outpatient Services (OOS)
210	19	436GI	Glasgow VA Clinic	Glasgow	Other Outpatient Services (OOS)
211	19	436GL	Cut Bank VA Clinic	Cut Bank	Other Outpatient Services (OOS)
212	19	436GM	Lewistown VA Clinic	Lewistown	Other Outpatient Services (OOS)
213	19	436GN	Dr. Joseph Medicine Crow VA Clinic	Billings Spring Creek Lane	Other Outpatient Services (OOS)
214	19	436QA	Hamilton VA Clinic	Hamilton, Montana	Other Outpatient Services (OOS)
215	19	436QB	Plentywood VA Clinic	Plentywood	Other Outpatient Services (OOS)
216	19	436QC	Helena VA Clinic	Helena, Montana	Other Outpatient Services (OOS)
217	19	436QD	Browning VA Clinic	Browning	Other Outpatient Services (OOS)
218	19	442GB	Sidney VA Clinic	Sidney	Other Outpatient Services (OOS)
219	19	442HK	Wheatland VA Mobile Clinic	Wheatland Mobile	Other Outpatient Services (OOS)
220	19	442QA	Rawlins VA Clinic	Rawlins	Other Outpatient Services (OOS)
221	19	442QB	Torrington VA Mobile Clinic	Torrington Mobile	Other Outpatient Services (OOS)
222	19	442QD	Laramie VA Mobile Clinic	Laramie Mobile	Other Outpatient Services (OOS)
223	19	442QE	Sterling VA Clinic	Sterling, Colorado	Other Outpatient Services (OOS)
224	19	442QF	Cheyenne VA Mobile Clinic	Cheyenne VA Mobile	Other Outpatient Services (OOS)
225	19	554GI	Burlington VA Clinic	Burlington	Other Outpatient Services (OOS)
226	19	554GJ	Denver VA Clinic	Denver East 9th Avenue	Other Outpatient Services (OOS)
227	19	554QA	York Street VA Clinic	York Street	Other Outpatient Services (OOS)
228	19	554QB	Jewell VA Clinic	Jewell	Other Outpatient Services (OOS)
229	19	554QC	Salida VA Clinic	Salida	Other Outpatient Services (OOS)
230	19	575GA	Montrose VA Clinic	Montrose, Colorado	Other Outpatient Services (OOS)
231	19	575GB	Major William Edward Adams Department of Veterans Affairs Clinic	Craig	Other Outpatient Services (OOS)
232	19	575QB	Moab VA Clinic	Moab	Other Outpatient Services (OOS)
233	19	575QC	Grand Junction VA Mobile Clinic	Grand Junction Mobile	Other Outpatient Services (OOS)
234	19	575QD	Grand Junction 28 Road VA Clinic	Grand Junction 28 Road	Other Outpatient Services (OOS)
235	19	623QA	Muskogee East VA Clinic	Muskogee East	Other Outpatient Services (OOS)
236	19	623QB	Tulsa Eleventh Street VA Clinic	Tulsa Eleventh Street	Other Outpatient Services (OOS)
237	19	623QC	Yale Avenue VA Clinic	Yale Avenue	Other Outpatient Services (OOS)
238	19	635GC	Blackwell VA Clinic	Blackwell	Other Outpatient Services (OOS)
239	19	635GG	Enid VA Clinic	Enid	Other Outpatient Services (OOS)
240	19	635QA	North May VA Clinic	North May	Other Outpatient Services (OOS)
241	19	635QC	Fourteenth Street VA Clinic	Fourteenth Street	Other Outpatient Services (OOS)
242	19	635QD	Lawton North VA Clinic	Lawton North	Other Outpatient Services (OOS)
243	19	635QE	Tinker VA Clinic	Tinker	Other Outpatient Services (OOS)
244	19	660GD	Roosevelt VA Clinic	Roosevelt	Other Outpatient Services (OOS)
245	19	660GK	Elko VA Clinic	Elko	Other Outpatient Services (OOS)
246	19	660QB	Price VA Clinic	Price	Other Outpatient Services (OOS)
247	19	660QC	Weber County VA Clinic	Weber County	Other Outpatient Services (OOS)
248	19	666QA	Afton VA Clinic	Afton	Other Outpatient Services (OOS)
249	19	666QB	Evanston VA Clinic	Evanston, Wyoming	Other Outpatient Services (OOS)
250	19	666QC	Worland VA Clinic	Worland	Other Outpatient Services (OOS)

FY 2020 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
251	20	463GD	Homer VA Clinic	Homer	Other Outpatient Services (OOS)
252	20	463QA	Elmendorf-Richardson VA Clinic	Elmendorf-Richardson	Other Outpatient Services (OOS)
253	20	531GH	Eastern Oregon VA Clinic	Eastern Oregon	Other Outpatient Services (OOS)
254	20	648GK	Lincoln City VA Clinic	Lincoln City	Other Outpatient Services (OOS)
255	20	653QA	Downtown Eugene VA Clinic	Downtown Eugene	Other Outpatient Services (OOS)
256	20	663GF	Federal Way VA Clinic	Federal Way	Other Outpatient Services (OOS)
257	20	663HK	Puget Sound VA Mobile Clinic	Puget Sound Mobile	Other Outpatient Services (OOS)
258	20	668HK	Spokane VA Mobile Clinic	Spokane Mobile	Other Outpatient Services (OOS)
259	20	668QB	Libby VA Clinic	Libby	Other Outpatient Services (OOS)
260	20	668QD	Sandpoint VA Clinic	Sandpoint	Other Outpatient Services (OOS)
261	20	668QE	Spokane VA Clinic	Spokane 2nd Avenue	Other Outpatient Services (OOS)
262	20	687QB	Morrow County VA Clinic	Morrow County	Other Outpatient Services (OOS)
263	20	687QC	Wallowa County VA Clinic	Wallowa County	Other Outpatient Services (OOS)
264	21	358	Manila VA Clinic	Manila	Other Outpatient Services (OOS)
265	21	459GH	Saipan VA Clinic	Saipan	Other Outpatient Services (OOS)
266	21	459QA	Lanai VA Clinic	Lanai	Other Outpatient Services (OOS)
267	21	459QB	Molokai VA Clinic	Molokai	Other Outpatient Services (OOS)
268	21	593QC	West Cheyenne VA Clinic	West Cheyenne	Other Outpatient Services (OOS)
269	21	612GK	Sierra Foothills VA Clinic	Sierra Foothills	Other Outpatient Services (OOS)
270	21	612QB	Twenty First Street VA Clinic	Twenty First Street	Other Outpatient Services (OOS)
271	21	612QC	Cypress Avenue VA Clinic	Cypress Avenue	Other Outpatient Services (OOS)
272	21	612QD	Howe Road VA Clinic	Howe Road	Other Outpatient Services (OOS)
273	21	640QA	Palo Alto 1 VA Mobile Clinic	Palo Alto 1 Mobile	Other Outpatient Services (OOS)
274	21	640QB	Palo Alto 2 VA Mobile Clinic	Palo Alto 2 Mobile	Other Outpatient Services (OOS)
275	21	654GF	North Reno VA Clinic	North Reno	Other Outpatient Services (OOS)
276	21	654QA	Kietzke VA Clinic	Kietzke	Other Outpatient Services (OOS)
277	21	654QB	Capitol Hill VA Clinic	Capitol Hill	Other Outpatient Services (OOS)
278	21	654QC	Winnemucca VA Clinic	Winnemucca	Other Outpatient Services (OOS)
279	21	654QD	Virginia Street VA Clinic	Virginia Street	Other Outpatient Services (OOS)
280	22	501GE	Espanola VA Clinic	Espanola	Other Outpatient Services (OOS)
281	22	501HB	Raton VA Clinic	Raton	Other Outpatient Services (OOS)
282	22	600QA	West Santa Ana VA Clinic	West Santa Ana	Other Outpatient Services (OOS)
283	22	605QA	Blythe VA Clinic	Blythe	Other Outpatient Services (OOS)
284	22	644GD	Payson VA Clinic	Payson	Other Outpatient Services (OOS)
285	22	644QA	Phoenix VA Clinic	Phoenix East Thomas Road	Other Outpatient Services (OOS)
286	22	644QB	Phoenix VA Mobile Clinic	Phoenix Mobile	Other Outpatient Services (OOS)
287	22	649QA	Chinle VA Clinic	Chinle	Other Outpatient Services (OOS)
288	22	649QB	Holbrook VA Clinic	Holbrook	Other Outpatient Services (OOS)
289	22	649QD	Page VA Clinic	Page	Other Outpatient Services (OOS)
290	22	649QF	Tuba City VA Clinic	Tuba City	Other Outpatient Services (OOS)
291	22	649QG	Polacca VA Clinic	Polacca	Other Outpatient Services (OOS)
292	22	649QH	Kayenta VA Clinic	Kayenta	Other Outpatient Services (OOS)
293	22	664QA	Rio VA Clinic	Rio	Other Outpatient Services (OOS)
294	22	678GE	Green Valley VA Clinic	Green Valley	Other Outpatient Services (OOS)
295	22	678QA	Cochise County VA Clinic	Cochise County	Other Outpatient Services (OOS)
296	22	678QB	Pinal County VA Clinic	Pinal County	Other Outpatient Services (OOS)
297	23	437GA	Grafton VA Clinic	Grafton	Other Outpatient Services (OOS)
298	23	437GL	Devils Lake VA Clinic	Devils Lake	Other Outpatient Services (OOS)
299	23	437QA	North Fargo VA Clinic	North Fargo	Other Outpatient Services (OOS)
300	23	438GE	Wagner VA Clinic	Wagner	Other Outpatient Services (OOS)

FY 2020 Other Outpatient Services (OOS) Sites

OOS Site Count	VISN	Station Number	Official Station Name	Location (Descriptive Name)	Classification
301	23	568GB	Pierre VA Clinic	Pierre	Other Outpatient Services (OOS)
302	23	568HA	Newcastle VA Clinic	Newcastle	Other Outpatient Services (OOS)
303	23	568HB	Gordon VA Clinic	Gordon	Other Outpatient Services (OOS)
304	23	568HF	Pine Ridge VA Clinic	Pine Ridge	Other Outpatient Services (OOS)
305	23	568HJ	Mission VA Clinic	Mission	Other Outpatient Services (OOS)
306	23	568HK	McLaughlin VA Clinic	McLaughlin	Other Outpatient Services (OOS)
307	23	568HP	Winner VA Clinic	Winner	Other Outpatient Services (OOS)
308	23	618GA	St. James VA Clinic	St. James, Minnesota	Other Outpatient Services (OOS)
309	23	618QA	Fort Snelling VA Clinic	Fort Snelling	Other Outpatient Services (OOS)
310	23	618QB	Ely VA Clinic	Ely	Other Outpatient Services (OOS)
311	23	636GK	Fort Dodge VA Clinic	Fort Dodge	Other Outpatient Services (OOS)
312	23	636GX	Fort Dodge North VA Clinic	Fort Dodge North	Other Outpatient Services (OOS)
313	23	636QA	Omaha VA Clinic	Omaha Dorcas Street	Other Outpatient Services (OOS)
314	23	636QB	Des Moines VA Clinic	Des Moines Center Street	Other Outpatient Services (OOS)
315	23	636QC	Linn County VA Clinic	Linn County	Other Outpatient Services (OOS)
316	23	636QD	Macomb VA Clinic	Macomb	Other Outpatient Services (OOS)
317	23	636QG	Iowa City VA Mobile Clinic	Iowa City Mobile	Other Outpatient Services (OOS)
318	23	636QH	Des Moines VA Mobile Clinic	Des Moines Mobile	Other Outpatient Services (OOS)
319	23	636QI	Davenport VA Clinic	Davenport	Other Outpatient Services (OOS)
320	23	636QJ	Iowa City VA Clinic	Iowa City South Clinton Street	Other Outpatient Services (OOS)
321	23	656QA	St. Cloud VA Mobile Clinic	St. Cloud Mobile	Other Outpatient Services (OOS)

FY 2020 Outpatient Dialysis Centers

Dialysis Center Count	Station Number	Station Name	City	State
1	523	VA Boston HCS	Boston	MA
2	650	Providence VA Medical Center	Providence	RI
3	689	VA Connecticut HCS	West Haven	CT
4	526	James J. Peters VA Medical Center	Bronx	NY
5	528	Albany Stratton VA Medical 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 Medical Center	Northport	NY
11	460	Wilmington VA Medical Center	Wilmington	DE
12	642	Philadelphia Free Standing Dialysis Center	Philadelphia	PA
13	646	VA Pittsburgh HCS	Pittsburgh	PA
14	693	Wilkes-Barre VA Medical Center	Wilkes-Barre	PA
15	688	Washington DC VA Medical Center	Washington	DC
16	558	Durham VA Medical Center	Durham	NC
17	558	Raleigh Dialysis Center	Raleigh	NC
18	565	Fayetteville VA Medical Center	Fayetteville	NC
19	659	Charlotte Dialysis Center	Charlotte	NC
20	659	Kernersville Dialysis Center	Kernersville	NC
21	590	Hampton VA Medical Center	Hampton	VA
22	652	Hunter Holmes McGuire VA Medical Center	Richmond	VA
23	658	Salem VA Medical Center	Salem	VA
24	508	Atlanta VA Medical Center	Decatur	GA
25	521	Birmingham VA Medical Center	Birmingham	AL
26	534	Ralph H. Johnson VA Medical Center	Charleston	SC
27	544	Wm. Jennings Bryan Dorn VA Medical Center	Columbia	SC
28	516	Bay Pines VA HCS	Bay Pines	FL
29	546	Miami VA HCS	Miami	FL
30	548	West Palm Beach VA Medical Center	West Palm	FL
31	573	North Florida/South Georgia HCS-Gainesville	Gainesville	FL
32	672	VA Caribbean HCS	San Juan	PR
33	673	James A. Haley Veterans' Hospital	Tampa	FL
34	675	Orlando VA Medical Center	Orlando	FL
35	596	Lexington VA Medical Center	Lexington	KY
36	614	Memphis VA Medical Center	Memphis	TN

FY 2020 Outpatient Dialysis Centers

Dialysis Center Count	Station Number	Station Name	City	State
37	626	Tennessee Valley HCS	Nashville	TN
38	506	VA Ann Arbor HCS	Ann Arbor	MI
39	539	Cincinnati VA Medical Center	Cincinnati	OH
40	541	Cleveland- Freestanding Dialysis Center	Cleveland	OH
41	541	Louis Stokes Cleveland VA Medical Center	Cleveland	OH
42	552	Dayton VA Medical Center	Dayton	OH
43	553	John D. Dingell VA Medical Center	Detroit	MI
44	583	Richard L. Roudebush VA Medical Center	Indianapolis	IN
45	537	Jesse Brown VA Medical Center	Chicago	IL
46	578	Edward Hines, Jr. VA Hospital	Hines	IL
47	695	Milo C. Huempfner Health Care Center	Green Bay	WI
48	695	Milwaukee VA Medical Center	Milwaukee	WI
49	589	Kansas City VA Medical Center	Kansas City	MO
50	657	St. Louis VA Medical Center	St. Louis	MO
51	586	G.V. (Sonny) Montgomery VA Medical Center	Jackson	MS
52	598	Central Arkansas Veterans HCS	Little Rock	AR
53	549	VA North Texas HCS	Dallas	TX
54	671	South Texas Veterans HCS	San Antonio	TX
55	501	New Mexico VA HCS	Albuquerque	NM
56	678	Southern Arizona VA HCS	Tucson	AZ
57	554	VA Eastern Colorado HCS	Denver	CO
58	660	VA Salt Lake City HCS	Salt Lake City	UT
59	648	Portland VA Medical Center	Portland	OR
60	663	VA Puget Sound HCS	Seattle	WA
61	459	VA Pacific Islands HCS	Honolulu	HI
62	593	Southern Nevada HCS	North Las	NV
63	612	David Grant USAF Medical Center	Travis AFB	CA
64	640	VA Palo Alto HCS	Palo Alto	CA
65	662	San Francisco VA Medical Center	San Francisco	CA
66	600	VA Long Beach HCS	Long Beach	CA
67	605	VA Loma Linda HCS	Loma Linda	CA
68	664	VA San Diego HCS	San Diego	CA
69	691	VA Great Los Angeles HCS	Los Angeles	CA
70	568	VA Black Hills HCS	Hot Springs	SD
71	618	Minneapolis VA HCS	Minneapolis	MN
72	636	Iowa City VA HCS	Iowa City	IA
73	636	VA Nebraska-Western Iowa HCS	Omaha	NE

FY 2020 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 2020 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	402	Portland Vet Center	Portland	ME	0115V	N	N
1	402	Northern Maine Vet Center	Caribou	ME	0119V	N	N
1	402	Bangor Vet Center	Bangor	ME	0121V	N	N
1	402	Lewiston Vet Center	Lewiston	ME	0129V	N	N
1	402	Sanford Vet Center	Springvale	ME	0130V	N	N
1	402	Lewiston Mobile Vet Center	Lewiston	ME	0804MVC	Y	N
1	405	South Burlington Vet Center	South Burlington	VT	0118V	N	N
1	405	White River Junction Vet Center	White River Junction	VT	0122V	N	N
1	405	Berlin Vet Center	Gorham	NH	0134V	N	N
1	405	White River Junction Mobile Vet Center	White River Junction	VT	0803MVC	Y	N
1	405	Keene Outstation	Keene	NH	1221OS	N	Y
1	518	Lowell Vet Center	Lowell	MA	0125V	N	N
1	523	Boston Vet Center	Boston	MA	0101V	N	N
1	523	Brockton Vet Center	Brockton	MA	0104V	N	N
1	608	Manchester Vet Center	Hooksett	NH	0108V	N	N
1	608	Newington Outstation	Newington	NH	1081OS	N	Y
1	631	Springfield Vet Center	West Springfield	MA	0103V	N	N
1	631	Worcester Vet Center	Worcester	MA	0126V	N	N
1	650	Providence Vet Center	Warwick	RI	0113V	N	N
1	650	New Bedford Vet Center	Fairhaven	MA	0128V	N	N
1	650	Cape Cod Vet Center	Hyannis	MA	0136V	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	689	Norwich Vet Center	Norwich	CT	0127V	N	N
1	689	Danbury Vet Center	Danbury	CT	0140V	N	N
1	689	Hartford Mobile Vet Center	Rocky Hill	CT	0801MVC	Y	N
2	526	Bronx Vet Center	Bronx	NY	0110V	N	N
2	528	Buffalo Vet Center	Amherst	NY	0107V	N	N
2	561	Secaucus Vet Center	Secaucus	NJ	0102V	N	N
2	561	Bloomfield Vet Center	Bloomfield	NJ	0112V	N	N
2	561	Trenton Vet Center	Ewing	NJ	0114V	N	N
2	561	Lakewood Vet Center	Lakewood	NJ	0141V	N	N
2	561	Secaucus Mobile Vet Center	Secaucus	NJ	0857MVC	Y	N
2	620	White Plains Vet Center	White Plains	NY	0123V	N	N
2	620	Middletown Vet Center	Middletown	NY	0139V	N	N
2	630	Brooklyn Vet Center	Brooklyn	NY	0105V	N	N
2	630	Manhattan Vet Center	New York	NY	0106V	N	N
2	630	Queens Vet Center	Woodhaven	NY	0109V	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	632	Babylon Vet Center	Babylon	NY	0120V	N	N
2	632	Nassau Vet Center	Hicksville	NY	0138V	N	N
2	528A6	Rochester Vet Center	Rochester	NY	0124V	N	N
2	528A6	Rochester Mobile Vet Center	Rochester	NY	0873MVC	Y	N
2	528A7	Syracuse Vet Center	Syracuse	NY	0131V	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	528A8	Albany Vet Center	Albany	NY	0111V	N	N

FY 2020 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	460	Wilmington Vet Center	Wilmington	DE	0215V	N	N
4	460	South Jersey Vet Center	Egg Harbor Township	NJ	0230V	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 Vet Center	DuBois	PA	0227V	N	N
4	503	DuBois Mobile Vet Center	DuBois	PA	0876MVC	Y	N
4	562	Erie Vet Center	Erie	PA	0222V	N	N
4	562	Erie Mobile Vet Center	Erie	PA	0809MVC	Y	N
4	595	Harrisburg Vet Center	Harrisburg	PA	0218V	N	N
4	595	Lancaster Vet Center	Lancaster	PA	0242V	N	N
4	642	Center City Philadelphia Vet Center	Philadelphia	PA	0210V	N	N
4	642	Northeast Philadelphia Vet Center	Philadelphia	PA	0219V	N	N
4	642	Bucks County Vet Center	Bristol	PA	0238V	N	N
4	642	Norristown Vet Center	Norristown	PA	0239V	N	N
4	646	Pittsburgh Vet Center	Pittsburgh	PA	0211V	N	N
4	646	White Oak Vet Center	White Oak	PA	0220V	N	N
4	646	Wheeling Vet Center	Wheeling	WV	0233V	N	N
4	693	Williamsport Vet Center	Williamsport	PA	0212V	N	N
4	693	Scranton Vet Center	Scranton	PA	0229V	N	N
4	693	Scranton Mobile Vet Center	Scranton	PA	0811MVC	Y	N
5	512	Baltimore Vet Center	Baltimore	MD	0201V	N	N
5	512	Elkton Vet Center	Elkton	MD	0209V	N	N
5	512	Annapolis Vet Center	Annapolis	MD	0235V	N	N
5	512	Dundalk Vet Center	Dundalk	MD	0236V	N	N
5	512	Baltimore Mobile Vet Center	Baltimore	MD	0858MVC	Y	N
5	512	Salisbury Outstation	Salisbury	MD	2091OS	N	Y
5	512	Aberdeen Outstation	Aberdeen	MD	2092OS	N	Y
5	512	Logan Outstation	Henlawson	WV	2231OS	N	Y
5	517	Beckley Vet Center	Beckley	WV	0231V	N	N
5	517	Princeton Vet Center	Princeton	WV	0232V	N	N
5	517	Beckley Mobile Vet Center	Beckley	WV	0812MVC	Y	N
5	540	Morgantown Vet Center	Morgantown	WV	0216V	N	N
5	540	Parkersburg Outstation	Parkersburg	WV	2081OS	N	Y
5	581	Huntington Vet Center	Huntington	WV	0208V	N	N
5	581	Charleston Vet Center	Charleston	WV	0223V	N	N
5	581	Huntington Mobile Vet Center	Huntington	WV	0807MVC	Y	N
5	613	Martinsburg Vet Center	Martinsburg	WV	0224V	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	688	Alexandria Vet Center	Alexandria	VA	0228V	N	N
5	688	Prince George's County Vet Center	Clinton	MD	0237V	N	N
6	558	Greenville Vet Center	Greenville	NC	0319V	N	N
6	558	Raleigh Vet Center	Raleigh	NC	0328V	N	N
6	558	Greenville Mobile Vet Center	Greenville	NC	0814MVC	Y	N
6	558	Spindale Outstation	Spindale	NC	3271OS	N	Y
6	565	Fayetteville Vet Center	Fayetteville	NC	0315V	N	N
6	565	Jacksonville Vet Center	Jacksonville	NC	0343V	N	N
6	590	Chesapeake Vet Center	Chesapeake	VA	0207V	N	N
6	590	Virginia Beach Vet Center	Virginia Beach	VA	0240V	N	N
6	652	Richmond Vet Center	Richmond	VA	0217V	N	N

FY 2020 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)
6	652	Richmond Mobile Vet Center	Richmond	VA	0808MVC	Y	N
6	658	Roanoke Vet Center	Roanoke	VA	0226V	N	N
6	659	Charlotte Vet Center	Charlotte	NC	0317V	N	N
6	659	Greensboro Vet Center	Greensboro	NC	0327V	N	N
6	659	Greensboro Mobile Vet Center	Greensboro	NC	0862MVC	Y	N
7	508	Atlanta Vet Center	College Park	GA	0304V	N	N
7	508	Lawrenceville Vet Center	Lawrenceville	GA	0329V	N	N
7	508	Marietta Vet Center	Marietta	GA	0342V	N	N
7	508	Atlanta Mobile Vet Center	College Park	GA	0860MVC	Y	N
7	509	Columbus Vet Center	Columbus	GA	0349V	N	N
7	521	Huntsville Vet Center	Huntsville	AL	0738V	N	N
7	521	Birmingham Vet Center	Hoover	AL	0739V	N	N
7	521	Birmingham Mobile Vet Center	Hoover	AL	0866MVC	Y	N
7	534	Charleston Vet Center	North Charleston	SC	0303V	N	N
7	534	Savannah Vet Center	Savannah	GA	0323V	N	N
7	534	Myrtle Beach Vet Center	Myrtle Beach	SC	0347V	N	N
7	544	Greenville Vet Center	Greenville	SC	0316V	N	N
7	544	Columbia Vet Center	Columbia	SC	0324V	N	N
7	544	Columbia Mobile Vet Center	Columbia	SC	0817MVC	Y	N
7	557	Macon Vet Center	Macon	GA	0333V	N	N
7	557	Augusta Vet Center	Augusta	GA	0346V	N	N
7	557	Macon Mobile Vet Center	Macon	GA	0818MVC	Y	N
7	619	Montgomery Vet Center	Montgomery	AL	0334V	N	N
8	516	St. Petersburg Vet Center	St. Petersburg	FL	0301V	N	N
8	516	Sarasota Vet Center	Sarasota	FL	0320V	N	N
8	516	Fort Myers Vet Center	Fort Myers	FL	0330V	N	N
8	516	Clearwater Vet Center	Clearwater	FL	0339V	N	N
8	516	Naples Vet Center	Naples	FL	0348V	N	N
8	516	Clearwater Mobile Vet Center	Clearwater	FL	0816MVC	Y	N
8	546	Miami Vet Center	Miami	FL	0310V	N	N
8	546	Fort Lauderdale Vet Center	Lauderdale Lakes	FL	0311V	N	N
8	546	Pompano Beach Vet Center	Pompano Beach	FL	0336V	N	N
8	548	Palm Beach Vet Center	Greenacres	FL	0326V	N	N
8	548	Jupiter Vet Center	Jupiter	FL	0337V	N	N
8	573	Jacksonville Vet Center	Jacksonville	FL	0305V	N	N
8	573	Tallahassee Vet Center	Tallahassee	FL	0325V	N	N
8	573	Gainesville Vet Center	Gainesville	FL	0331V	N	N
8	573	Ocala Vet Center	Ocala	FL	0344V	N	N
8	573	Jacksonville Mobile Vet Center	Jacksonville	FL	0813MVC	Y	N
8	672	San Juan Vet Center	Guaynabo	PR	0307V	N	N
8	672	Arecibo Vet Center	Arecibo	PR	0309V	N	N
8	672	Arecibo Vet Center	Arecibo	PR	0802MVC	Y	N
8	672	Ponce Vet Center	Ponce	PR	0312V	N	N
8	672	Ponce Mobile Vet Center	Ponce	PR	0861MVC	Y	N
8	672	St. Croix Outstation	Kingshill	VI	3121OS	N	Y
8	672	St. Thomas Outstation	St Thomas	VI	3122OS	N	Y
8	673	Tampa Vet Center	Tampa	FL	0318V	N	N
8	673	Pasco County Vet Center	New Port Richey	FL	0338V	N	N
8	673	Lakeland Vet Center	Lakeland	FL	0340V	N	N
8	675	Orlando Vet Center	Orlando	FL	0314V	N	N

FY 2020 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)
8	675	Melbourne Vet Center	Melbourne	FL	0332V	N	N
8	675	Daytona Beach Vet Center	Daytona Beach	FL	0341V	N	N
8	675	Clermont Vet Center	Clermont	FL	0345V	N	N
9	596	Lexington Vet Center	Lexington	KY	0203V	N	N
9	596	Lexington Mobile Vet Center	Lexington	KY	0806MVC	Y	N
9	603	Louisville Vet Center	Louisville	KY	0202V	N	N
9	614	Memphis Vet Center	Memphis	TN	0719V	N	N
9	614	Memphis Mobile Vet Center	Memphis	TN	0848MVC	Y	N
9	621	Johnson City Vet Center	Johnson City	TN	0701V	N	N
9	621	Knoxville Vet Center	Knoxville	TN	0720V	N	N
9	621	Knoxville Mobile Vet Center	Knoxville	TN	0844MVC	Y	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
9	675	Clermont Mobile Vet Center	Clermont	FL	0864MVC	Y	N
10	506	Toledo Vet Center	Toledo	OH	0234V	N	N
10	515	Grand Rapids Vet Center	Grand Rapids	MI	0403V	N	N
10	539	Cincinnati Vet Center	Norwood	OH	0204V	N	N
10	541	Cleveland Vet Center	Maple Heights	OH	0205V	N	N
10	541	Parma Vet Center	Parma	OH	0206V	N	N
10	541	Stark County Vet Center	Canton	OH	0241V	N	N
10	541	Stark County Mobile Vet Center	Canton	OH	0859MVC	Y	N
10	552	Dayton Vet Center	Kettering	OH	0225V	N	N
10	552	Dayton Mobile Vet Center	Kettering	OH	0810MVC	Y	N
10	553	Dearborn Vet Center	Dearborn	MI	0401V	N	N
10	553	Detroit Vet Center	Detroit	MI	0402V	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	553	Pontiac Mobile Vet Center	Pontiac	MI	0855MVC	Y	N
10	583	Indianapolis Vet Center	Indianapolis	IN	0413V	N	N
10	583	Indianapolis Mobile Vet Center	Indianapolis	IN	0852MVC	Y	N
10	610	Fort Wayne Vet Center	Fort Wayne	IN	0409V	N	N
10	610	South Bend Vet Center	South Bend	IN	0444V	N	N
10	655	Saginaw Vet Center	Saginaw	MI	0433V	N	N
10	655	Traverse City Vet Center	Traverse City	MI	0445V	N	N
10	757	Columbus Vet Center	Columbus	OH	0221V	N	N
12	537	Chicago Heights Vet Center	Chicago Heights	IL	0407V	N	N
12	537	Chicago Vet Center	Chicago	IL	0410V	N	N
12	537	Gary Area Vet Center	Crown Point	IN	0412V	N	N
12	537	Wausau Outstation	Wausau	WI	4421OS	N	Y
12	550	Peoria Vet Center	Peoria	IL	0417V	N	N
12	550	Springfield Vet Center	Springfield	IL	0421V	N	N
12	550	Springfield Mobile Vet Center	Springfield	IL	0822MVC	Y	N
12	556	Evanston Vet Center	Evanston	IL	0420V	N	N
12	556	Rockford Vet Center	Rockford	IL	0447V	N	N
12	556	Evanston Mobile Vet Center	Evanston	IL	0853MVC	Y	N
12	578	Forest Park Vet Center	Forest Park	IL	0411V	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	585	Escanaba Vet Center	Escanaba	MI	0434V	N	N

FY 2020 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)
12	585	Escanaba Mobile Vet Center	Escanaba	MI	0826MVC	Y	N
12	607	Madison Vet Center	Madison	WI	0419V	N	N
12	676	La Crosse Vet Center	La Crosse	WI	0442V	N	N
12	695	Milwaukee Vet Center	Milwaukee	WI	0415V	N	N
12	695	Green Bay Vet Center	Green Bay	WI	0441V	N	N
12	695	Green Bay Mobile Vet Center	Green Bay	WI	0856MVC	Y	N
15	589	Kansas City Vet Center	Kansas City	MO	0408V	N	N
15	589	Manhattan Vet Center	Manhattan	KS	0432V	N	N
15	589	Kansas City Mobile Vet Center	Kansas City	MO	0851MVC	Y	N
15	657	St. Louis Vet Center	Creve Coeur	MO	0414V	N	N
15	657	Metro East Vet Center	Swansea	IL	0422V	N	N
15	589A4	Columbia Vet Center	Columbia	MO	0443V	N	N
15	589A4	Columbia Mobile Vet Center	Columbia	MO	0875MVC	Y	N
15	589A7	Wichita Vet Center	Wichita	KS	0426V	N	N
15	589A7	Wichita Mobile Vet Center	Wichita	KS	0824MVC	Y	N
15	657A5	Evansville Vet Center	Evansville	IN	0418V	N	N
15	657A5	Evansville Mobile Vet Center	Evansville	IN	0872MVC	Y	N
16	502	Alexandria Vet Center	Alexandria	LA	0734V	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
16	520	Pensacola Mobile Vet Center	Pensacola	FL	0815MVC	Y	N
16	564	Fayetteville Vet Center	Fayetteville	AR	0727V	N	N
16	564	Springfield Vet Center	Springfield	MO	0736V	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	580	Spring Vet Center	Houston	TX	0731V	N	N
16	580	Beaumont Vet Center	Beaumont	TX	0735V	N	N
16	586	Jackson Vet Center	Jackson	MS	0709V	N	N
16	586	Jackson Mobile Vet Center	Jackson	MS	0863MVC	Y	N
16	598	Little Rock Vet Center	North Little Rock	AR	0713V	N	N
16	598	Little Rock Mobile Vet Center	Little Rock	AR	0850MVC	Y	N
16	629	New Orleans Vet Center	New Orleans	LA	0717V	N	N
16	629	Baton Rouge Vet Center	Baton Rouge	LA	0725V	N	N
16	629	New Orleans Mobile Vet Center	New Orleans	LA	0847MVC	Y	N
16	667	Shreveport Vet Center	Shreveport	LA	0704V	N	N
16	667	Shreveport Mobile Vet Center	Shreveport	LA	0877MVC	Y	N
17	504	Amarillo Vet Center	Amarillo	TX	0702V	N	N
17	504	Lubbock Vet Center	Lubbock	TX	0714V	N	N
17	504	Amarillo Mobile Vet Center	Amarillo	TX	0845MVC	Y	N
17	519	Midland Vet Center	Midland	TX	0716V	N	N
17	519	Abilene Vet Center	Abilene	TX	0733V	N	N
17	519	Abilene Mobile Vet Center	Abilene	TX	0846MVC	Y	N
17	549	Dallas Vet Center	Dallas	TX	0706V	N	N
17	549	Fort Worth Vet Center	Westworth Village	TX	0708V	N	N
17	549	Mesquite Vet Center	Mesquite	TX	0730V	N	N
17	549	Arlington Vet Center	Pantego	TX	0732V	N	N
17	671	Corpus Christi Vet Center	Corpus Christi	TX	0705V	N	N

FY 2020 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)
17	671	Laredo Vet Center	Laredo	TX	0712V	N	N
17	671	McAllen Vet Center	McAllen	TX	0715V	N	N
17	671	San Antonio Northeast Vet Center	San Antonio	TX	0721V	N	N
17	671	San Antonio Northwest Vet Center	San Antonio	TX	0729V	N	N
17	671	San Antonio Northwest Mobile Vet Center	San Antonio	TX	0849MVC	Y	N
17	671	McAllen Mobile Vet Center	McAllen	TX	0879MVC	Y	N
17	674	Austin Vet Center	Austin	TX	0703V	N	N
17	674	Killeen Heights Vet Center	Harker Heights	TX	0726V	N	N
17	756	Las Cruces Vet Center	Las Cruces	NM	0530V	N	N
17	756	El Paso Vet Center	El Paso	TX	0707V	N	N
19	436	Billings Vet Center	Billings	MT	0509V	N	N
19	436	Missoula Vet Center	Missoula	MT	0528V	N	N
19	436	Great Falls Vet Center	Great Falls	MT	0538V	N	N
19	436	Kalispell Vet Center	Kalispell	MT	0539V	N	N
19	436	Billings Mobile Vet Center	Billings	MT	0829MVC	Y	N
19	436	Missoula Mobile Vet Center	Missoula	MT	0837MVC	Y	N
19	436	Helena Outstation	Helena	MT	5381OS	N	Y
19	442	Cheyenne Vet Center	Cheyenne	WY	0501V	N	N
19	442	Casper Vet Center	Casper	WY	0519V	N	N
19	442	Fort Collins Vet Center	Fort Collins	CO	0543V	N	N
19	442	Casper Mobile Vet Center	Casper	WY	0834MVC	Y	N
19	442	Fort Collins Mobile Vet Center	Fort Collins	CO	0881MVC	Y	N
19	554	Denver Vet Center	Denver	CO	0504V	N	N
19	554	Colorado Springs Vet Center	Colorado Springs	CO	0525V	N	N
19	554	Boulder Vet Center	Boulder	CO	0527V	N	N
19	554	Pueblo Vet Center	Pueblo	CO	0542V	N	N
19	554	Pueblo Mobile Vet Center	Pueblo	CO	0836MVC	Y	N
19	575	Grand Junction Vet Center	Grand Junction	CO	0526V	N	N
19	623	Tulsa Vet Center	Tulsa	OK	0723V	N	N
19	635	Oklahoma City Vet Center	Oklahoma City	OK	0718V	N	N
19	635	Lawton Vet Center	Lawton	OK	0728V	N	N
19	635	Lawton Mobile Vet Center	Lawton	OK	0865MVC	Y	N
19	660	Salt Lake City Vet Center	Murray	UT	0514V	N	N
19	660	Pocatello Vet Center	Pocatello	ID	0531V	N	N
19	660	Provo Vet Center	Orem	UT	0532V	N	N
19	660	Saint George Vet Center	Saint George	UT	0540V	N	N
19	660	Salt Lake City Mobile Vet Center	Murray	UT	0831MVC	Y	N
19	660	Saint George Mobile Vet Center	Saint George	UT	0868MVC	Y	N
19	660	Major Brent Taylor Vet Center Outstation	North Ogden	UT	5141OS	N	Y
20	463	Anchorage Vet Center	Anchorage	AK	0502V	N	N
20	463	Fairbanks Vet Center	Fairbanks	AK	0511V	N	N
20	463	Wasilla Vet Center	Wasilla	AK	0512V	N	N
20	463	Kenai Outstation	Soldotna	AK	5021OS	N	Y
20	463	Lacey Outstation	Lacey	WA	5081OS	N	Y
20	531	Boise Vet Center	Boise	ID	0503V	N	N
20	531	Boise Mobile Vet Center	Boise	ID	0827MVC	Y	N
20	648	Portland Vet Center	Portland	OR	0617V	N	N
20	648	Central Oregon Vet Center	Bend	OR	0622V	N	N
20	648	Salem Vet Center	Salem	OR	0640V	N	N
20	648	Salem Mobile Vet Center	Salem	OR	0840MVC	Y	N

FY 2020 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)
20	653	Eugene Vet Center	Eugene	OR	0626V	N	N
20	663	Seattle Vet Center	Seattle	WA	0507V	N	N
20	663	Tacoma Vet Center	Tacoma	WA	0508V	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	663	Federal Way Vet Center	Federal Way	WA	0535V	N	N
20	663	Tacoma Mobile Vet Center	Tacoma	WA	0828MVC	Y	N
20	668	Spokane Vet Center	Spokane	WA	0510V	N	N
20	668	Spokane Mobile Vet Center	Spokane Valley	WA	0830MVC	Y	N
20	687	Walla Walla Vet Center	Walla Walla	WA	0541V	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	459	Honolulu Vet Center	Honolulu	HI	0609V	N	N
21	459	American Samoa Vet Center	Pago Pago	AS	0616V	N	N
21	459	Western Oahu Vet Center	Kapolei	HI	0621V	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	459	Guam Vet Center	Maite	GU	0648V	N	N
21	459	Western Oahu Mobile Vet Center	Kapolei	HI	0870MVC	Y	N
21	570	Citrus Heights Vet Center	Citrus Heights	CA	0610V	N	N
21	570	Fresno Vet Center	Fresno	CA	0628V	N	N
21	593	Las Vegas Vet Center	Las Vegas	NV	0505V	N	N
21	593	Henderson Vet Center	Henderson	NV	0534V	N	N
21	593	Henderson Mobile Vet Center	Henderson	NV	0886MVC	Y	N
21	640	San Jose Vet Center	San Jose	CA	0615V	N	N
21	640	Santa Cruz County Vet Center	Capitola	CA	0639V	N	N
21	640	Peninsula Vet Center	Menlo Park	CA	0647V	N	N
21	640	Delta Vet Center	Manteca	CA	0650V	N	N
21	640	Santa Cruz County Mobile Vet Center	Capitola	CA	0842MVC	Y	N
21	654	Reno Vet Center	Reno	NV	0506V	N	N
21	654	Reno Mobile Vet Center	Reno	NV	0867MVC	Y	N
21	662	San Francisco Vet Center	San Francisco	CA	0620V	N	N
21	662	Eureka Vet Center	Eureka	CA	0644V	N	N
21	662	Northbay Vet Center	Rohnert Park	CA	0646V	N	N
21	612A4	Concord Vet Center	Concord	CA	0602V	N	N
21	612A4	Oakland Vet Center	Oakland	CA	0612V	N	N
21	612A4	Sacramento Vet Center	Sacramento	CA	0638V	N	N
21	612A4	Chico Vet Center	Chico	CA	0649V	N	N
21	612A4	Sacramento Mobile Vet Center	Sacramento	CA	0880MVC	Y	N
22	501	Albuquerque Vet Center	Albuquerque	NM	0515V	N	N
22	501	Farmington Vet Center	Farmington	NM	0516V	N	N
22	501	Santa Fe Vet Center	Sante Fe	NM	0520V	N	N
22	501	Hopi Mobile Vet Center	Hotevilla	AZ	0832MVC	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	501	Chinle Mobile Vet Center	Chinle	AZ	0882MVC	Y	N
22	501	Navajo Outstation	Chinle	AZ	5161OS	N	Y

FY 2020 Vet Centers, Mobile Vet Centers and Vet Center Outstations

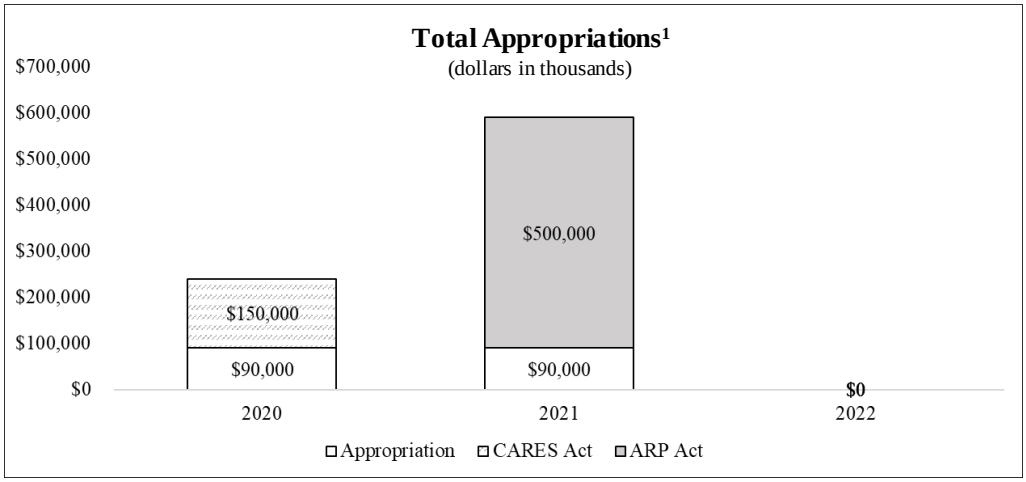
VISN	Station Number	Station Name	City	State	VC / MVC / Outstation Number	MVC (Yes / No)	VC Outstation (Yes / No)
22	501	Hopi Outstation	Hotevilla	AZ	5162OS	N	Y
22	600	South Orange County Vet Center	Mission Viejo	CA	0604V	N	N
22	600	North Orange County Vet Center	Garden Grove	CA	0624V	N	N
22	600	South Orange County Mobile Vet Center	Mission Viejo	CA	0869MVC	Y	N
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	605	San Bernardino Vet Center	San Bernardino	CA	0637V	N	N
22	605	Corona Mobile Vet Center	Corona	CA	0839MVC	Y	N
22	644	Phoenix Vet Center	Phoenix	AZ	0517V	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	Dr. Cameron McKinley Vet Center	Prescott	AZ	0518V	N	N
22	649	Lake Havasu Vet Center	Lake Havasu	AZ	0536V	N	N
22	649	Prescott Mobile Vet Center	Prescott	AZ	0833MVC	Y	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	664	San Marcos Vet Center	San Marcos	CA	0642V	N	N
22	664	San Marcos Mobile Vet Center	San Marcos	CA	0883MVC	Y	N
22	678	Tucson Vet Center	Tucson	AZ	0521V	N	N
22	678	Yuma Vet Center	Yuma	AZ	0537V	N	N
22	678	Yuma Mobile Vet Center	Yuma	AZ	0885MVC	Y	N
22	691	Bakersfield Vet Center	Bakersfield	CA	0601V	N	N
22	691	Antelope Valley Vet Center	Palmdale	CA	0603V	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	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	691	Ventura Vet Center	Ventura	CA	0643V	N	N
22	691	Bakersfield Mobile Vet Center	Bakersfield	CA	0841MVC	Y	N
22	691	Sepulveda Outstation	Sepulveda	CA	6051OS	N	Y
23	437	Minot Vet Center	Minot	ND	0404V	N	N
23	437	Fargo Vet Center	Fargo	ND	0406V	N	N
23	437	Bismarck Vet Center	Bismarck	ND	0446V	N	N
23	437	Bismarck Mobile Vet Center	Bismarck	ND	0819MVC	Y	N
23	437	Fargo Mobile Vet Center	Fargo	ND	0820MVC	Y	N
23	437	Grand Forks Outstation	Grand Forks	ND	4061OS	N	Y
23	438	Sioux Falls Vet Center	Sioux Falls	SD	0425V	N	N
23	438	Sioux City Vet Center	Sioux City	IA	0428V	N	N
23	568	Rapid City Vet Center	Rapid City	SD	0423V	N	N
23	568	Rapid City Mobile Vet Center	Rapid City	SD	0823MVC	Y	N
23	618	St. Paul Vet Center	Saint Paul	MN	0416V	N	N
23	618	Duluth Vet Center	Duluth	MN	0429V	N	N
23	618	Brooklyn Park Vet Center	Anoka	MN	0439V	N	N
23	618	Brooklyn Park Mobile Vet Center	Brooklyn Park	MN	0821MVC	Y	N
23	636	Omaha Vet Center	Omaha	NE	0424V	N	N
23	636	Lincoln Vet Center	Lincoln	NE	0427V	N	N
23	636	Lincoln Mobile Vet Center	Lincoln	NE	0825MVC	Y	N
23	636A6	Des Moines Vet Center	West Des Moines	IA	0405V	N	N

FY 2020 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	636A8	Quad Cities Vet Center	East Moline	IL	0430V	N	N
23	636A8	Cedar Rapids Vet Center	Cedar Rapids	IA	0431V	N	N
23	636A8	Cedar Rapids Mobile Vet Center	Cedar Rapids	IA	0854MVC	Y	N

Grants for Construction of State Extended Care Facilities

Chart: Total Appropriations



1/The total funds authorized by ARP in 2021 will be carryover in 2022.

2022 Budget Discussion

The Department of Veterans Affairs (VA) is not requesting additional appropriations in 2022, as VA estimates $596 million will be carried forward into 2022 from prior appropriations and supplementals. The American Rescue Plan (ARP) Act (Public Law (P.L.) 117-2, Sec. 8004), provided $500 million in 2021 to for grants to states to acquire or construct state nursing home and domiciliary facilities, and to remodel, modify, or alter nursing home and domiciliary facilities in state homes to provide care to Veterans. VA expects to carry over the full amount into 2022 to cover future grant applications.

Coronvirus Aid, Relief, and Economic Security (CARES) Act
Public Law (P.L.) 116-136 provided an additional $150,000,000, to remain available until September 30, 2021, to prevent, prepare for, and respond to coronavirus, domestically or internationally, including to modify or alter existing hospital, nursing home, and domiciliary facilities in state homes.

American Rescue Plan (ARP) Act
The ARP Act (P.L. 117-2) provides an additional $500,000,000 to remain available until expended. Of this funding, $250 million will be utilized for state Home construction projects in 2022.

Table: Total Funding Highlights

Total Funding Highlights (dollars in thousands)					
		2021			
Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Estimate	2021 to 2022 Inc/Dec
Appropriation	$240,000	$90,000	$90,000	$0	($90,000)
Mandatory Appropriations (ARP Act Sec. 8004)	$0	$0	$500,000	$0	($500,000)
Adjustments to Obligations:					
Unobligated Balance (SOY)	$159,195	$0	$266,151	$596,151	$330,000
Unobligated Balance (EOY)	($266,151)	$0	($596,151)	($250,000)	$346,151
Change in Unobligated Balance	($106,956)	$0	($330,000)	$346,151	$676,151
Prior Year Recoveries	$27,955	$0	$0	$0	$0
Obligations	$160,999	$90,000	$260,000	$346,151	$86,151

Table: Annual Funding Highlights

Annual Funding Highlights (dollars in thousands)					
		2021			
Description	2020 Actual	Budget Estimate	Current Estimate	2022 Estimate	2021 to 2022 Inc/Dec
Appropriation	$90,000	$90,000	$90,000	$0	($90,000)
Adjustments to Obligations:					
Unobligated Balance (SOY)	$159,195	$0	$116,151	$96,151	($20,000)
Unobligated Balance (EOY)	($116,151)	$0	($96,151)	$0	$96,151
Change in Unobligated Balance	$43,044	$0	$20,000	$96,151	$76,151
Prior Year Recoveries	$27,955	$0	$0	$0	$0
Obligations	$160,999	$90,000	$110,000	$96,151	($13,849)

Table: CARES Act Funding Highlights

CARES Act Funding Highlights (dollars in thousands)					
		2021			
Description	2020 Actual	Budget Estimate	Current Estimate	2022 Estimate	2021 to 2022 Inc/Dec
Appropriation	$150,000	$0	$0	$0	$0
Adjustments to Obligations:					
Unobligated Balance (SOY)	$0	$0	$150,000	$0	($150,000)
Unobligated Balance (EOY)	($150,000)	$0	$0	$0	$0
Change in Unobligated Balance	($150,000)	$0	$150,000	$0	($150,000)
Prior Year Recoveries	$0	$0	$0	$0	$0
Obligations	$0	$0	$150,000	$0	($150,000)

Table: ARP Act Funding Highlights

American Rescue Plan (ARP) Act 8004 Highlights (dollars in thousands)					
		2021			
Description	2020 Actual	Budget Estimate	Current Estimate	2022 Estimate	2021 to 2022 Inc/Dec
Mandatory Appropriations (Sec. 8004)	$0	$0	$500,000	$0	($500,000)
Adjustments to Obligations:					$0
Unobligated Balance (SOY)	$0	$0	$0	$500,000	$500,000
Unobligated Balance (EOY)	$0	$0	($500,000)	($250,000)	$250,000
Change in Unobligated Balance	$0	$0	($500,000)	$250,000	$250,000
Prior Year Recoveries	$0	$0	$0	$0	$0
Obligations	$0	$0	$0	$250,000	$250,000

Program Description

VA plans to provide $596.151 million in Grants for Construction of State Extended Care Facilities in 2022 by utilizing unobligated balances from 2021. 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 each state. VA conducts inspections, audits, and other oversight to ensure the state homes are providing quality care, and can share in the costs to construct, maintain, and upgrade them. For each of the projects, states are required to fund at least 35% of a project's total estimated cost, and VA may provide up to 65% of the total estimated cost.

In 2020, the program offered 32 grants to states. Of the 32 grants awarded, 6 were final awards, 16 were conditional awards, and 10 were deferred to 2021. To receive a final grant award, states must complete the entire grant application by June 30th of the fiscal year. If states cannot complete a final grant award, they may apply for a conditional grant award by completing part of the grant application. If states cannot a complete grant that was offered for an award, they may request a deferment to the following year.

In 2021, the value of projects submitted and funded by states is expected to be $260 million at the end of the fiscal year, an increase of $99 million from $161 million in 2020. Approximately $150 million was provided by the CARES) Act (P.L. 116-136, Title X) and approximately $90 million was provided by the annual 2021 appropriation and carryover balances from prior years.

Unobligated balances from prior appropriations including the mandatory appropriations from Section 8004 of the ARP Act, matched with state funding, will support essential life-safety renovation projects, new construction projects, and non-life safety renovation projects in 2022, ensuring quality care for Veterans will not be compromised.

Legislative History

This program was approved on August 19, 1964 and received appropriations in 1965. On July 5, 1977, P.L. 95-62 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% 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);

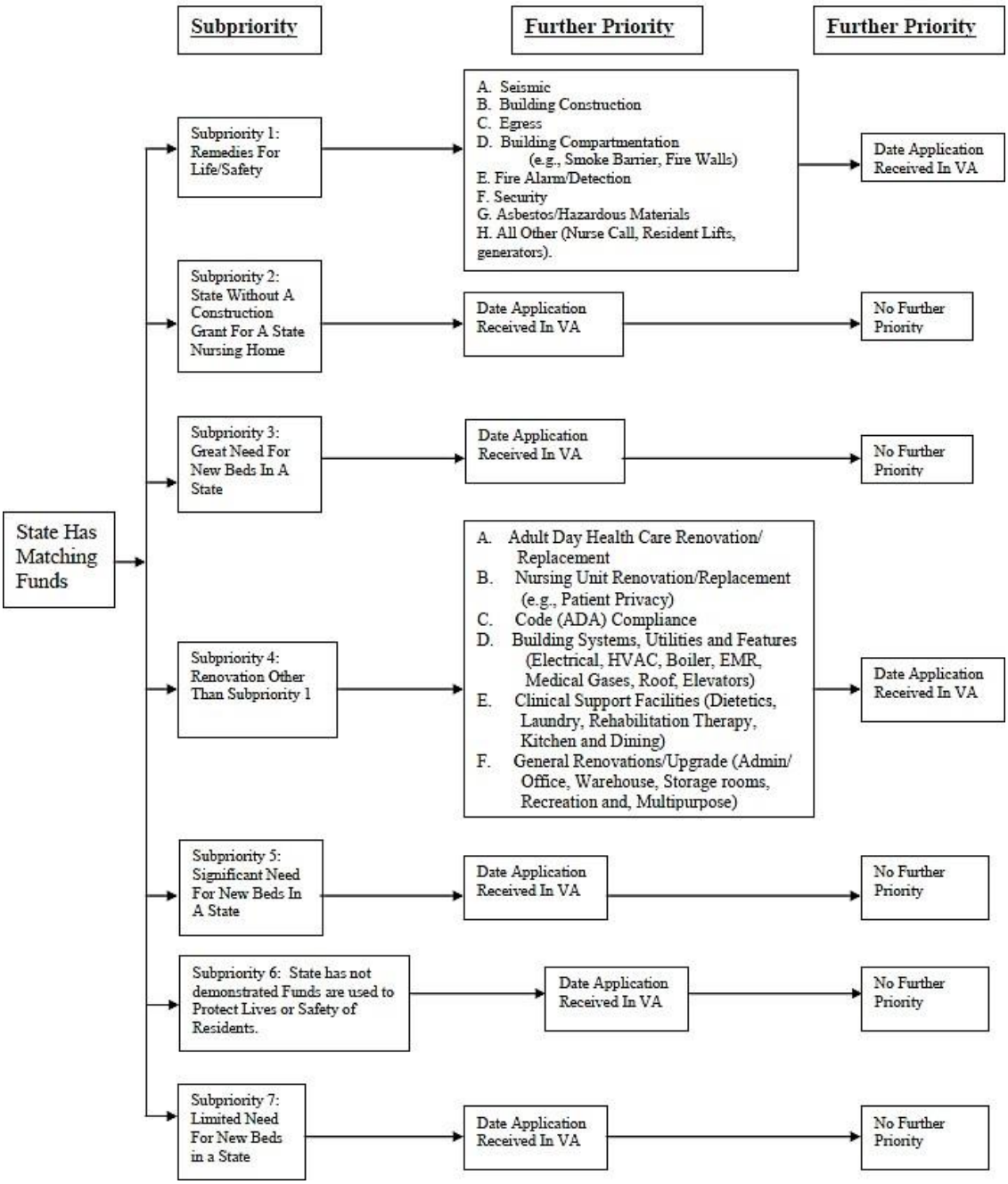
- Differentiates among applications for new bed construction by reference to the relative need for such beds, by assigning a higher priority to renovation projects (with a total cost exceeding $400,000), with highest priority to renovations involving patient life or safety and by assigning second highest 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 29th 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



Joint Medical Care Special Programs

Part 2

DoD-VA Health Care Sharing Incentive Fund **513**
Joint DoD-VA Medical Facility Demonstration Fund **517**
Health Care Sharing and VA-DoD Sharing **523**

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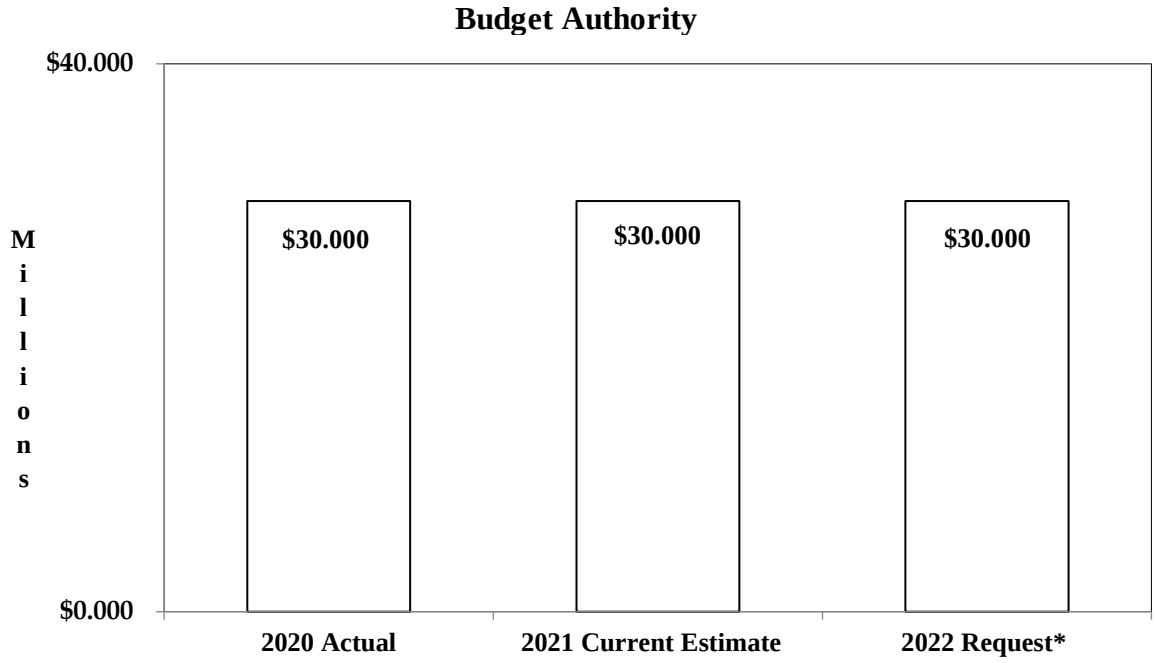
DoD-VA Health Care Sharing Incentive Fund



*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. Section 8111(d) of title 38, United States Code (U.S.C.) requires each Secretary to contribute a minimum of $15 million from the funds appropriated to that Secretary's Department. The DoD-VA Health Care Sharing Incentive Fund became effective on October 1, 2003. Public Law 116-92, the National Defense Authorization Act for 2020, section 736, amended section 8111(d)(3) of title 38, U.S.C. to extend the program to September 30, 2023. This is a no-year account.

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). 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.

2021 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. Implementation of the following list of anticipated projects is subject to availability of funds and may execute over multiple years.

1. Joint VA/DoD Operating Room (OR) Expansion - David Grant USAF Medical Center (MC), Travis & VA Northern California Health Care System - Increase Operating Room (OR) capacity from 5 to 6 ORs and establish a dedicated perioperative program to facilitate patient throughput by capturing extra OR days using a dedicated, embedded OR staff and associated support care team. **Funding: $4,438,200**

2. Enterprise Tele-Critical Care Patient Management - DHA & VA - Develop a Tele-Critical Care (Tele-CC) collaborative for the bi-directional management of critically ill VHA and DoD patients by both VHA and DoD intensivists. This will create an integrated Tele-CC network that provides high-quality, standardized Tele-CC support to both VA and DoD facilities and is capable of shifting virtual critical care management between Tele-CC provider hubs and across organizations. **Funding: $8,551,444**

3. Behavioral Health Unit (BHU) Expansion - 673rd Medical Group (MDG) & Alaska VA - This is to expand BHU services to both DoD and VA patients with psychiatric diagnoses who need care for acute psychiatric treatment as well as short-term substance abuse treatment. **Funding: $1,380,000**

4. Surgical Capacity Program - Naval Medical Center San Diego and VA San Diego Healthcare System (VASDHS) – This partnership is to increase access to surgical care, reduce network spending, and increase surgical team knowledge, skills, and abilities through operating room sharing. **Funding: $3,263,476**

5. Active Duty & Veterans' Holistic Musculoskeletal Management and Enhancement (ADVET HOMME) - Uniformed Services University of the Health Sciences (USUHS) and Dayton VA, VISN 10 – This project is to create a virtual platform to serve as a centralized modality that enables holistic self-guided rehabilitative care. Programs will be made available by referral from MSK-trained DoD and VA primary care providers who received the training and education. **Funding: $2,571,347**

6. Tele-Kidney Transplant Services – Walter Reed National Military Medical Center (WRNMMC) and Veterans Integrated Service Network (VISN) 5 - This proposal will establish a scalable model for optimizing access and quality of care for kidney transplants utilizing telemedicine, significantly improve care for DoD and VA beneficiaries, recapture workload, and support DoD readiness and Graduate Medical Education (GME) training programs. **Funding: $1,514,689**

7. Acute Inpatient Dialysis Project - Womack Army Medical Center, Fort Bragg, Central North Carolina Market and Fayetteville VA Coastal Healthcare System, VISN 6 - This project aims to create a comprehensive chronic kidney disease program, which will address all areas of care across the renal disease continuum. **Funding: $9,409,339**

DoD-VA Health Care Sharing Incentive Fund Crosswalk					
(dollars in thousands)					
		2021			2021-2022
Description	2020 Actual	Budget Estimate	Current Estimate	2022 Estimate*	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
Unobl Bal Rescission (Public Law 116-94)	($15,949)	$0	$0	$0	$0
Total Budget Authority	$14,051	$30,000	$30,000	$30,000	$0
Adjustments to Obligations:					
No-Year Unobligated Balance (SOY)	$79,849	$80,400	$80,620	$98,120	$17,500
No-Year Unobligated Balance (EOY)	($80,620)	($94,000)	($98,120)	($115,620)	($17,500)
Recovery Prior Year Obligations	$1,156	$0	$0	$0	$0
Obligations	$14,436	$16,400	$12,500	$12,500	$0
FTE:					
VA Civilian**	11	7	11	11	0
DoD Personnel***	7	15	4	4	0
Total FTE	18	22	15	15	0

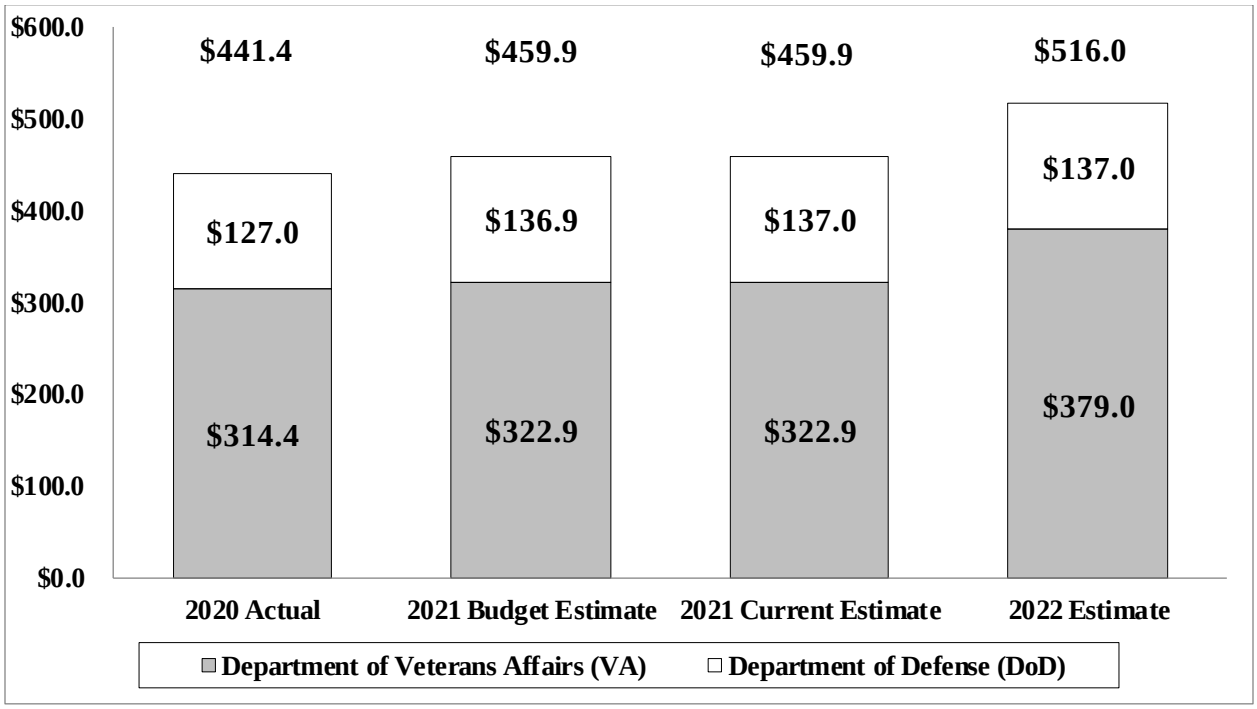
*Anticipates VA and DoD will each transfer the required minimum of $15 million to this fund.

**Data source: VA Financial Management System (FMS). VA assumes a steady-state number of FTEs through the budget years.

***Data source: Defense Health Agency (DHA).

Joint DoD-VA Medical Facility Demonstration Fund
For Captain James A. Lovell Federal Health Care Center, Illinois

DoD-VA Medical Facility Demonstration Fund Appropriation Transfers
($ in millions)



Financial Highlights 1/

(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate 2/	2022 Estimate 2/	2021-2022 Increase/ Decrease
Appropriation, Transfers From:					
Medical Services	$210,309	$215,945	$215,945	$203,805	($12,140)
Medical Community Care	$27,651	$28,392	$28,392	$43,768	$15,376
Medical Support & Compliance	$29,424	$30,213	$30,213	$30,613	$400
Medical Facilities	$39,245	$40,297	$40,297	$92,830	$52,533
VA Information Technology	$7,780	$8,085	$8,085	$7,993	($92)
Subtotal, VA Contribution	$314,409	$322,932	$322,932	$379,009	$56,077
Department of Defense (DoD) 3/	$127,000	$136,947	$137,000	$137,000	$0
Total Appropriations/4	$441,409	$459,879	$459,932	$516,009	$56,077
Collections 5/	$13,681	$18,328	$13,604	$16,602	$2,998
Reimbursements 6/	$10,675	$12,995	$13,040	$13,300	$260
Unobl Bal (SOY)	$10,528	$3,000	$6,943	$0	($6,943)
Unobl Bal (EOY)	($6,943)	($10,000)	$0	$0	$0
Recovery Prior Year Obligations	$6	$0	$0	$0	$0
Lapse	($9)	$0	$0	$0	$0
Obligations	$469,347	$484,202	$493,519	$545,911	$52,392
Other DoD Contributions:					
MERHCF DoD reimbursement (Included Above)	*$7,000*	*$7,400*	*$7,740*	*$7,740*	*$0*
DoD "Stay Navy" (Excluded from Total Obligations)	*$14,403*	*$17,314*	*$14,599*	*$4,100*	*($10,499)*
FTE:					
Civilian	2,178	2,172	2,290	2,308	18
DoD Uniformed Military 8/	906	806	906	906	0
Total FTE	3,084	2,978	3,196	3,214	18

1/ Displayed funding does not include resources from section 8002 or 8007 of the American Rescue Plan Act. Final allocation of American Rescue Plan Act funding may change based on 2021 actuals and in response to workload demand requirements throughout 2022. 2/ FY 2021 and 2022 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 Healthcare Center (JALFHCC). These estimates are in compliance with Public Law 111-84 which established this fund. P.L. 114-223 authorizes contributions from Medical Community

Care beginning in FY 2017.
3/ The actual amount of the MERHCF reimbursement will impact DoD transfer amount.
4/ Total does not include the Stay Navy contribution or MERHCF reimbursement.
5/ Collections estimate provided by the VA Office of Community Care.
6/ Includes estimated MERHCF reimbursement from DoD.
7/ Non-add for Personal Services Contract funded by DoD for the East Campus.
8/ Estimates in fiscal years 2021 and 2022 are based on estimates from the Navy Manning Plan in FY 2020. Estimates do not reflect the number of DoD Uniform Military FTE subject to Reconciliation in the JALFHCC Joint Areas.

Funding Highlights

The 2022 projected transfers from Department of Veterans Affairs (VA) and the Department of Defense (DoD) fund the projected financial needs for the Captain James A. Lovell Federal Health Care Center (JALFHCC), as determined by a health care workload analysis and an assessment of the Non-Recurring Maintenance (NRM) requirements for Electronic Health Record Modernization (EHRM). In 2022, 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 the JALFHCC.

Program Description

On May 27, 2005, the VA/ DoD Health Executive Council (HEC) 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 (SES) Medical Center Director and a Navy Captain (O-6) 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 the title 38 requirement that one entity may not endanger the mission of the other entity engaged in a RSA.

The integrated organization – the Captain James A. Lovell Federal Health Care Center (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 (CBOCs) in Evanston and McHenry, Illinois, and one in Kenosha, Wisconsin. The JALFHCC has 365 available beds and treated 822,950 outpatients and 6,047 inpatient admissions in 2020.

The JALFHCC began using a single unified budget in 2011 to operate the integrated facility and execute funding using the VA Financial Management System (FMS). An account under the Department of Veterans Affairs, "Joint Department of Defense - Department of Veterans Affairs Medical Facility Demonstration Fund" (referred to as the "Fund"), was effective beginning in 2011 (4th Quarter).

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 (RVUs) and Relative Weighted Products (RWPs) for the determinations of workload values to be compared to VA's Decision Support System (DSS) 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 this Fund shall terminate on September 30, 2022.

Administrative Provisions

VA is proposing continuing the following administrative provisions in accordance with Public Law 111-84, NDAA 2010, for 2022, as included in the President's Budget:

> SEC. 219. Of the amounts appropriated to the Department of Veterans Affairs for fiscal year 2022 for ''Medical Services'", ''Medical Community Care'', ''Medical Support and Compliance'', ''Medical Facilities'', ''Construction, Minor Projects'', and ''Information Technology Systems'', up to $379,009,000, 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. 3571) 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 116–260 is repealed.
>
> SEC. 220. Of the amounts appropriated to the Department of Veterans Affairs which become available on October 1, 2022, for "Medical Services", "Medical Community Care", "Medical Support and Compliance", and "Medical Facilities", up to $323,242,000, 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. 3571) 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. 3571); 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 Public Law 111-84, NDAA 2010, DoD is proposing the following general provision, for 2022, as included in the President's Budget:

Section 8055. From within the funds appropriated for operation and maintenance for the Defense Health Program in this Act, up to $137,000,000 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 (Sec. 219) is required to permit the transfer of funds from specific VA appropriations to the Fund, which was established by Public Law 111-84, section 1704. Section 1704(a)(2)(A) and (B) specify that the Fund will consist of amounts transferred from amounts authorized and appropriated for the DoD and VA specifically for the purpose of providing resources for this Fund. The second provision (Sec. 220) permits the transfer of funds for fiscal year 2023.

The VA's 2022 budget request includes funding to be appropriated and transferred to the Fund within the appropriations request for Medical Services, Medical Support and Compliance, Medical Facilities, Medical Community Care, and Information Technology Systems.

The third provision (Sec. 221) will permit the transfer of funds from the Medical Care Collections Fund to the Fund. Section 1704 of Public Law 111-84 allows VA and DoD to deposit medical care collections to this Fund. Section 1704(b)(2) specifies that the availability of funds transferred to the Fund under subsection (a)(2)(C) shall be subject to the provisions of 1729A of title 38, United States Code (U.S.C). Title 38, U.S.C., section 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).

To treat the collections as offsets to discretionary appropriations, language is needed in the appropriations act regarding the authority to use collections to pay for the expenses of furnishing health care at the JALFHCC. This proposal would allow the JALFHCC to leverage no-year funds from the joint account to the same extent as other VA medical facilities. The JALFHCC needs this flexibility because it is the only medical center financed from this appropriation and is unable to utilize funding from other VA or DoD medical centers to support emerging requirements or prior year adjustments.

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 (VAMCs) and to improve the quality of health care provided to Veterans under title 38 United States Code (USC). 38 USC 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, etc., 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 the VA medical centers.

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 professions students and residents to enhance the quality of care provided to veteran patients within the VHA healthcare system.

Although VA relies on several title 38 authorities for procuring services outside the VA, the following information discusses activities conducted by VA's Office of Acquisition Logistics and Construction (OALC) and VHA Office of Procurement and Logistics pursuant to 38 USC Section 8153 for activity from Fiscal Year (FY) 2020.

Health Care Sharing Obligations and Reimbursements

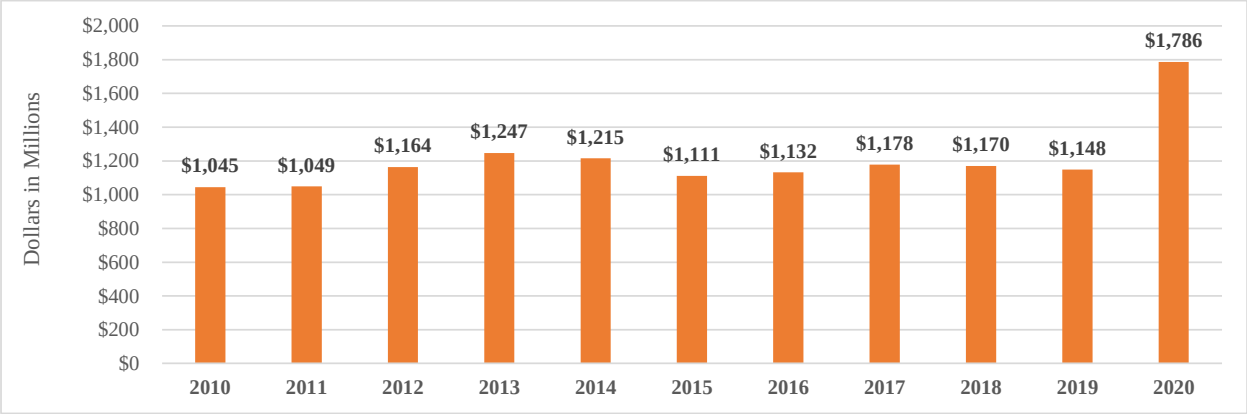
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Advance Approp.	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2022-2021	+/- 2023-2022
Services Purchased by VA:								
Medical Service (0160) Obligations	$1,741,920	$1,192,828	$1,742,000	$1,070,152	$1,742,000	$1,742,000	$0	$0
Services Provided by VA:								
Medical Service (0160) Reimbursements	$43,941	$48,800	$42,900	$43,242	$41,900	$40,900	($1,000)	($1,000)
Total Medical Service (0160) Health Care Sharing	$1,785,861	$1,241,628	$1,784,900	$1,113,394	$1,783,900	$1,782,900	($1,000)	($1,000)

The total amount of $1.786 billion in health care resource sharing for 2020 represents procurement of approximately $1.742 billion and reimbursements totaling approximately $44 million.

Chart 1 reflects the growth of the health care resources sharing program since 2010. The bars represent the total health care resource services procured and revenue generated by VA contracting officers during a fiscal year.

Chart 1. Health Care Resources Sharing Program



Source: Department of Veterans Affairs, Annual Report on Sharing of Health Care Resources, 2020

VA Health Care Facilities and Sharing

Traditionally, large VAMCs are more likely to have more extensive sharing arrangements. The referral system of medical practice 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.

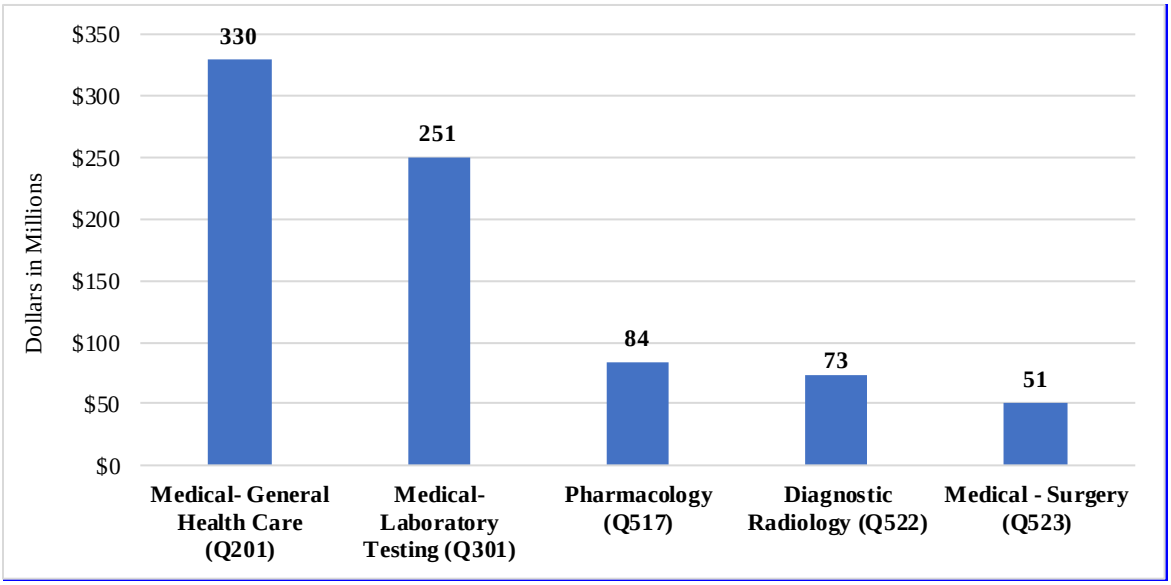
Procurements

The procurements are primarily in the following areas: radiation therapy, diagnostic radiology, cardiology, cardio-vascular surgery, anesthesiology and orthopedics. 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 2020. These categories account for $789 million of total VA purchases of $1.742 billion in obligations that year.

Chart 2. Common Health Care Resources Procured



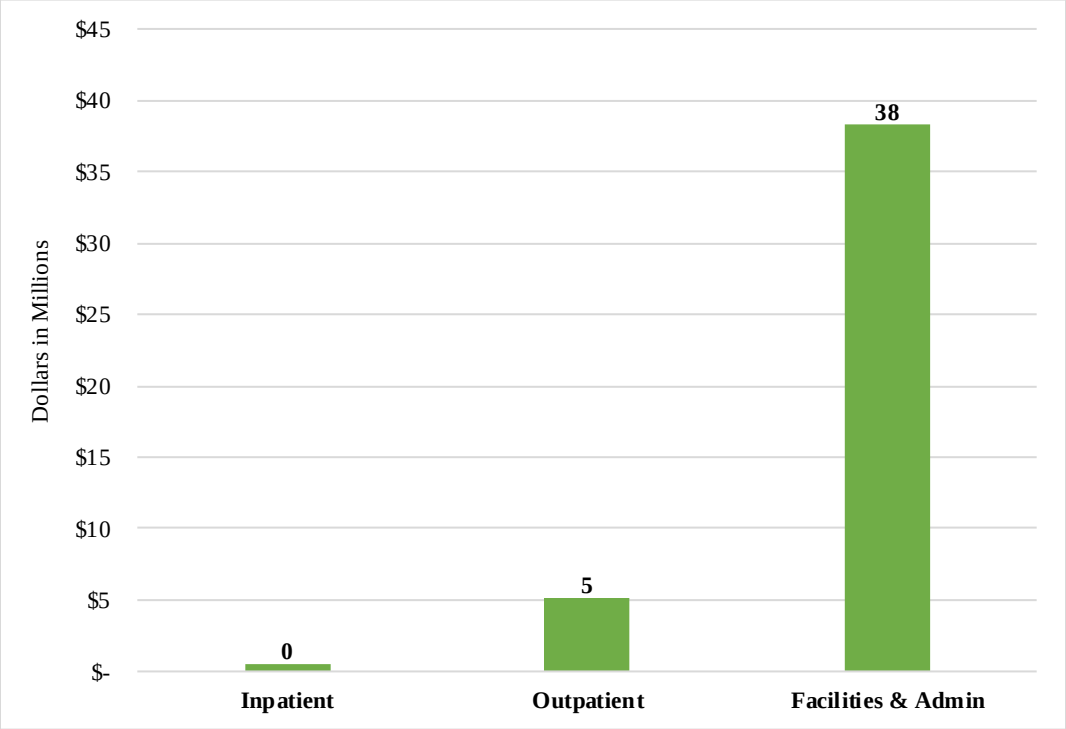
Source: Department of Veterans Affairs, Annual Report on Sharing of Health Care Resources, 2020

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 supports.

Chart 3 presents total reimbursements in 2020 from affiliated medical colleges, community hospitals, and other sharing partners.

Chart 3. Reimbursements from Health Care Resources Sharing



Source: Department of Veterans Affairs, Annual Report on Sharing of Health Care Resources, 2020

VA / DoD Sharing Obligations and Reimbursements

(dollars in thousands)

Description	2020 Actual 1/	2021 Budget Estimate	2021 Current Estimate	2022 Advance Approp.	**2022 Revised Request**	**2023 Advance Approp.**	+/- 2021-2022	+/- 2022-2023
DoD-Provided Services Purchased by VA								
Medical Community Care (0140) Obligations	$103,201	$106,609	$110,425	$114,071	$118,155	$126,426	$7,730	$8,271
VA-Provided Services Purchased by DoD								
Medical Services (0160) Reimbursements	$64,355	$76,891	$63,068	$75,353	$61,807	$60,570	($1,261)	($1,236)

1/ Itemized detail of DoD-Provided Services Purchased by VA in 2020 is as follows:

Obligations	
Army	$59,868
Air Force	$33,468
Navy	$9,865
Obligations Total	$103,201

1/ Itemized detail of VA-Provided Services Purchased by DoD in 2020 is as follows:

Reimbursements	
DoD Sharing - Inpatient	$8,176
DoD Sharing - Outpatient	$2,164
DoD Sharing - All Other	$21,807
CHAMPUS - Inpatient	$5
CHAMPUS - Outpatient	$0
CHAMPUS - All Other	$0
TRICARE - Inpatient	$15,359
TRICARE - Outpatient	$15,071
TRICARE - All Other	$1,773
Reimbursements Total	$64,355

Title 38 U.S.C. Section 8111 authorizes VA and the Department of Defense (DoD) to enter into sharing agreements for the mutually beneficial coordination, use, or exchange of health care resources, with the goal of improving the access to, and quality and cost effectiveness of, the health care provided by VHA and the Military Health System to the beneficiaries of both Departments. The obligations and reimbursements shown above[40] are the result of 138 active sharing agreements with 743 shared services between 137 facilities (60 VA and 77 DoD) nationwide as of September 2020. This is a 57.4%[41] increase in the number of shared services included in agreements since September 2019; they do not reflect the funding that the two Departments contribute to the two joint VA-DoD accounts, the DoD-VA Health Care Sharing Incentive Fund and the Joint DoD-VA Medical Facility Demonstration Fund.

The following chart represents a summary of the 138 active sharing agreements as of September 2020.

[40] VA/DoD Sharing Program has been assisting VA/VHA Finance in assessing and improving fiscal data in preparation for US Treasuries mandated implementation of G-Invoicing, VA's transition to its new Integrated Financial and Asset Management System (I-FAMS), as well as VA's and DoD's transition to a new electronic health record (EHR).

[41] VA has been standardizing several VA/DoD resource sharing and fiscal processes to improve data capture and reliability. This has resulted in the capture of more potentially shared healthcare 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.

VISN	SHARED TYPE	PROVIDER
0	AMBULATORY CARE SERVICES	DOD
0	ADMINISTRATION & SUPPORT	BOTH
0	ANCILLARY SERVICES	DOD
1	CLINICAL COMPETENCY / READINESS TRAINING	DOD
10	CLINICAL COMPETENCY / READINESS TRAINING	VA
10	ADMINISTRATION & SUPPORT	DOD
10	AMBULATORY CARE SERVICES	VA
10	AMBULATORY CARE SERVICES	DOD
10	INPATIENT SERVICES	DOD
10	ANCILLARY SERVICES	DOD
10	INPATIENT SERVICES	DOD
10	AMBULATORY CARE SERVICES	DOD
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10	ADMINISTRATION & SUPPORT	DOD
10	ADMINISTRATION & SUPPORT	DOD
15	ADMINISTRATION & SUPPORT	VA
15	OTHER & MILITARY UNIQUE	VA
15	CLINICAL COMPETENCY / READINESS TRAINING	VA
15	AMBULATORY CARE SERVICES	DOD
15	ANCILLARY SERVICES	DOD
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15	ANCILLARY SERVICES	DOD
15	INPATIENT SERVICES	DOD

VISN	SHARED TYPE	PROVIDER
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15	INPATIENT SERVICES	DOD
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15	INPATIENT SERVICES	DOD
15	AMBULATORY CARE SERVICES	DOD
15	ADMINISTRATION & SUPPORT	DOD
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VISN	SHARED TYPE	PROVIDER
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20	AMBULATORY CARE SERVICES	VA
20	ADMINISTRATION & SUPPORT	VA
20	CLINICAL COMPETENCY / READINESS TRAINING	VA
20	ADMINISTRATION & SUPPORT	VA
20	ANCILLARY SERVICES	VA

VISN	SHARED TYPE	PROVIDER
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21	CLINICAL COMPETENCY / READINESS TRAINING	VA
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21	INPATIENT SERVICES	BOTH
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21	CLINICAL COMPETENCY / READINESS TRAINING	VA
22	AMBULATORY CARE SERVICES	VA
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22	CLINICAL COMPETENCY / READINESS TRAINING	VA
22	OTHER & MILITARY UNIQUE	BOTH
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23	CLINICAL COMPETENCY / READINESS TRAINING	VA
23	INPATIENT SERVICES	DOD
23	ADMINISTRATION & SUPPORT	VA
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7	OTHER & MILITARY UNIQUE	DOD
7	AMBULATORY CARE SERVICES	VA
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8	COMPETENCY / READINESS TRAINING	VA
8	COMPETENCY /READINESS TRAINING	DOD
8	CLINICAL COMPETENCY / READINESS TRAINING	DOD
8	ANCILLARY SERVICES	DOD
8	ANCILLARY SERVICES	DOD
8	AMBULATORY CARE SERVICES	VA
8	ADMINISTRATION & SUPPORT	DOD
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8	ADMINISTRATION & SUPPORT	VA
8	ADMINISTRATION & SUPPORT	VA
8	AMBULATORY CARE SERVICES	DOD
8	AMBULATORY CARE SERVICES	DOD
8	CLINICAL COMPETENCY / READINESS TRAINING	VA
8	CLINICAL COMPETENCY / READINESS TRAINING	VA
8	ADMINISTRATION & SUPPORT	VA
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9	ANCILLARY SERVICES	BOTH
9	ANCILLARY SERVICES	BOTH

Medical and Prosthetic Research

Part 3

Medical and Prosthetic Research 541
Table: Appropriations and Other Federal Resources 541
Medical and Prosthetic Research and Development Appropriation Language 541
Medical and Prosthetic Research and Development Program Overview 543
Table: Appropriation Highlights 543
Table: Net Change and 2022 Summary of Resource Requirements 544
Suicide Prevention Research 557
Table: Medical and Prosthetic Research Crosswalks 564
Table: Distribution of Program Resources 565
ORD Operational Units 565
Specifically Tracked Programs 567
Collaboration with Federal Agencies and Other Organizations 568
Overview of Ongoing Strategic Priorities 571
Supplemental Tables 585
Table: Appropriations by Designated Research Area (DRA)1 586
Table: Projects by Designated Research Area (DRA)1 587
Table: Obligations by Object Class 588
Table: American Rescue Plan 588

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Medical and Prosthetic Research

Table: Appropriations and Other Federal Resources

Appropriation and Other Federal Resources (dollars in thousands)	2020 Actual	2021 Enacted	2022 Request	% Change 2021-2022
Medical and Prosthetic Research Appropiation[1]	$750,000	$795,000	$882,000	11%
American Rescue Plan (P.L. 117-2, Section 8002)[2]	$0	$9,000	$0	-100%
Medical Care Support[3]	$647,700	$668,950	$749,700	12%
Other Federal and Non-Federal Resources	$523,460	$540,000	$540,000	0%
Reimbursements	$28,279	$81,000	$61,000	-25%
Total Budgetary Resources	**$1,949,439**	**$2,093,950**	**$2,232,700**	**7%**
Total FTE	**3,418**	**3,454**	**3,585**	4%
Medical and Prosthetic Research Appropriation (Discretionary) [4]	*3,418*	*3,420*	*3,585*	
American Recovery Plan (P.L. 117-2, Section 8002) (Mandatory) [2]	*0*	*34*	*0*	

1. The appropriation amounts for 2020 and 2021 are net of a rescission of $50 Million for P.L.116-94 (2020) and $20 Million from P.L. 116-260 (2021) to align with Congressional scoring.
2. VA plans to use $9 Million of the funding provided in section 8002 of the American Rescue Plan Act for Research, which will be executed out of a new budget account, the Veterans Medical Care and Health Fund. Final 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.
3. Medical Care Support includes funding from the Medical Services, Medical Support and Compliance, and Medical Facilities Appropriations to support Research.
4. 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, [$815,000] *$882,000,000*, plus reimbursements, shall remain available until September 30, [2022] *2023: 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.

Medical and Prosthetic Research and Development Appropriation Request

To fulfill the Department of Verteans Affairs (VA's) commitment to provide superior health care to Veterans, the Medical and Prosthetics Research and Development Program, through the Veterans Health Administration (VHA) Office of Research and Development (ORD) program, requests $882 million in direct appropriations in 2022.

This is the largest year-over-year increase in recent history, for medical and prosthetic research. This historic investment will advance the Department's research mission, including critical studies to understand the impact of traumatic brain injury (TBI) and toxic exposure on long-term health outcomes. ORD will also continue to prioritize research focused on the needs of disabled veterans including mental health and suicide prevention, precision oncology, and prosthetics as well as other disease areas. The funding request supports VA in fulfilling one of its key missions, research and development, and will sustain investments in several critical areas of research important to the Veteran community and their needs. This funding request will enable ORD to fund approximately 2,563 total projects, support more than 1,700 investigators with direct ORD funds, and partner with more than 200 medical schools and other academic institutions in 2022.

ORD will continue to make substantive progress toward an enterprise-wide approach to advancing our three strategic priorities: increasing Veterans' access to high-quality clinical trials, increasing the substantial real-world impact of VA research, and putting VA data to work for Veterans. In addition, we will advance research on our cross-cutting priorities: suicide prevention, pain management and opioid use, TBI, posttraumatic stress disorder (PTSD), Gulf War illness and military exposures (expanded from Gulf War illness alone), and precision oncology. "Cross-cutting" refers to our special focus on these health issues across all three of our overarching strategic priorities.

As an intramural program, the Medical and Prosthetic Research Program (in which research funding is provided to research investigators employed by VA) receives support through VA Medical Care Appropriations (Medical Services, Medical Support and Compliance, and Medical Facilities). Medical Care Support funding provides needed support for VA researchers and for projects directly funded through the Medical and Prosthetic Research Program. The Medical Care Support funding is distributed as part of the Veterans Equitable Research Allocation (VERA) Model and recognizes the additional expenses required of facilities supporting the research mission. This includes clinician allowable time, equipment maintenance contracts and bio-medical maintenance support, committee support, and other general and direct administrative support. The 2022 request for Medical Care Support is $750 million.

VA's research program is also supported by private and federal grants from other agencies awarded directly to VA investigators. This funding is not managed centrally by ORD, but on a local level at individual VA medical centers (VAMCs).

In 2022, grants from other federal organizations, such as the National Institutes of Health (NIH), the Department of Defense (DoD), and the Centers for Disease Control and Prevention (CDC), are estimated at $370 million. Funding from other non-federal sources in 2022 is estimated at $170 million, with a total estimated amount of $540 million.

Medical and Prosthetic Research and Development Program Overview

Table: Appropriation Highlights

Appropriation Highlights (dollars in thousands)	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Request	2021-2022
Appropriations…..	**$750,000**	**$787,000**	**$804,000**	**$882,000**	**$78,000**
Discretionary [1]	$750,000	$787,000	$795,000	$882,000	**$87,000**
Mandatory (ARP, Section 8002) [2]	$0	$0	$9,000	$0	**($9,000)**
Obligations.....	**$847,255**	**$864,000**	**$961,100**	**$971,100**	**$10,000**
Discretionary	$847,255	$864,000	$952,100	$971,100	$19,000
Mandatory (ARP, Section 8002) [2]	$0	$0	$9,000	$0	($9,000)
Total Projects.....	2,406	2,200	2,415	2,563	148
Average Employment.....	3,418	3,275	3,454	3,585	131
Employment Distribution					
Discretionary FTE[3]	3,418	3,275	3,420	3,585	165
Mandatory (ARP, Section 8002)[2]	0	0	34	0	(34)
Total.....	**3,418**	**3,275**	**3,454**	**3,585**	131

1. The discretionary appropriation amounts for 2020 and 2021 are net of a rescission of $50 Million for P.L. 116-94 (2020) and $20 Million from P.L. 116-260 (2021) to align with Congressional scoring.
2.VA plans to use $9 Million of the funding provided in section 8002 of the American Rescue Plan Act for Research, which will be executed out of a new budget account, the Veterans Medical Care and Health Fund. Final 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.
3. Includes Direct and Reimbursable FTE.

Table: Net Change and 2022 Summary of Resource Requirements

Net Change and 2022 Summary of Resource Requirements (dollars in thousands)		
		BA
2021 Enacted		***$815,000***
Rescission from P.L. 116-260		*-$20,0000*
American Rescue Plan, (Public Law 117-2, Section 8002)[1]		*$9,000*
Adjusted 2021 Budget Estimate		***$804,000***
2021 Efficiencies / Offsets		
Consortium to Alleviate PTSD		*-$5,000*
Reduced Investment in Centralized Equipment		*-$5,000*
Centralized Contract Modifications		*-$3,500*
	Subtotal	***-$13,500***
2022 Current Services Increases		
Pay Raise (2.7%)		*$9,973*
Biomedical Research and Dev Price Index (2.4%)		*$10,562*
	Subtotal	***$20,535***
2022 Total Current Services		***$811,035***
Funding Increases for 2022 Initatives:		
1) Traumatic Brain Injury		*$20,000*
2) Military Exposures		*$6,965*
3) Coronavirus Related Research and Impacts		*$25,000*
4) Cloud Computing and Storage		*$10,000*
5) Data Security/Counterintelligence		*$2,000*
6) Precision Oncology		*$5,000*
7) DOE Expanded Collaboration		*$2,000*
	Subtotal	***$70,965***
2022 Total Budget Authority Request		***$882,000***

1. VA plans to use $9 Million of the funding provided in section 8002 of the American Rescue Plan Act for Research, which will be executed out of a new budget account, the Veterans Medical Care and Health Fund. Final 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

New Initiatives for 2022 and Updates

In order to best serve Veterans now and into the future, it is imperative for VA Research to be responsive to the emerging and pressing clinical needs of Veterans and remain on the cutting edge of technology. VA Research will increase funding to advance the Department's understanding of the impact of TBI and toxic exposure(s) on long-term health outcomes, coronavirus related research and impacts, and precision oncology.

To remain on the cutting edge of technology, VA Research will focus on software-as-a-service, cloud computing, and data security. ORD will also continue to partner with the Department of Energy (DOE) to capitalize on DOE's computing power and technical expertise to put Veteran data to work.

1. Traumatic Brain Injury (TBI) (+$20 Million)

TBI is a signature injury of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND). TBI can lead to lifelong disabilities that can vary with TBI severity, number of blast exposures, and characteristics of explosion. 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 TBI diagnosis occurring in VA medical facilities sometime years after the most recent TBI, which has been termed "remote" TBI. This delay in diagnosis and associated care can magnify neurobehavioral conditions that negatively impact Veterans' quality of life.

More than 120,000 Veterans who receive VA health care have been diagnosed with at least one TBI. TBI symptoms include headaches, irritability, sleep disorders, memory lapses, slower 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, substance abuse, and other mental health issues. The majority of TBI cases are mild and difficult to diagnose. Currently, VA investigators are examining various approaches to detect, monitor, and treat Veterans with TBI.

ORD will focus on developing objective diagnostics to improve the diagnosis and monitoring of brain health in Veterans who have sustained TBI, including:

- **Clinical Health Imaging Portability Standards (CHIPS):** Currently, magnetic resonance imaging (MRI) clinical scans performed in the US 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 (longitudinally). Lack of calibration standards impedes the ability to do cross site/instrument quantitative comparison, which is mission critical for VA healthcare.
  Developing a standard will allow MRI to become a reliable noninvasive assessment to monitor brain health not only for Veterans, but all people who have sustained one or more TBIs. There is a VA-based team collaborating with industry and academia partners to create and implement these standards.

- **TBI Biomarker Interdisciplinary Development Technology Center (TBIDeTeC):** A multisite center that will collaborate on developing and integrating fluid biomarkers, imaging, and physiological measures for objective diagnoses and monitoring previously acquired TBI. This ORD-wide initiative will leverage existing efforts to develop diagnostics that will give a complete view of 'remote' TBI to objectively diagnose TBI, monitor any post-injury progression, and to personalize interventions. The VA-based team is collaborating with NIHDoD, and not-for-profit foundations.

- **Infrastructure Investments in the Open-field Blast Core Site:** Adding a second site to establish year-round operations. VA invested in a core facility to study the long-term effects of blast exposure in preclinical (animal) models to advance translation of findings to Veterans. The goal being to identify and treat consequences of blast that occurred during training and/or deployment. The current outdoor blast core site is limited in operation by weather conditions and lacking infrastructure. Improving infrastructure and adding a second site (i.e., indoor, milder year-round temperatures) will provide VA investigators a year-round testing resource.

- **Additional funds to support scientifically meritorious TBI research studies**: This will include a joint funding announcement with National Institute on Aging (NIA) to investigate the impacts of TBI, aging and dementia.

- **New investment in the Implementation of Virtual Care across the VHA Polytrauma System of Care**: The aim of this effort is to validate virtual care programming and identify opportunities to enhance and standardize services provided. A three-year study designed to evaluate the impact of virtual care programming on completion of the Comprehensive TBI Evaluation (CTBIE) and provision of care to Veterans with TBI. Additional funding provided to improve TBI screening and comprehensive evaluation completion process for Veterans returning from deployment. Currently over a third of Veterans who screen positive for TBI have not returned for their next appointment to undergo a comprehensive evaluation. Improving completion rate of the CTBIE by Veterans with suspected TBI could improve access to both care and benefits, as well as overall quality of life.

- **Increased investment in ORD Health Services Research:** Initiatives to increase access to supported employment for Veterans with TBI. TBI is known to increase the risk for unemployment which increases marital/partnership and housing instability. Maintaining employment has long-term positive implications on quality of life for Veterans, their families, as well for preventing homelessness.

- **Invest in longitudinal TBI research for moderate to severe TBI including Disorders of Consciousness (an under studied VA population):** Develop Veteran-based scientific literature on longitudinal outcomes, comorbidity, and rehabilitation needs. This mechanism would support a clinical trial infrastructure

that could be leveraged in future clinical trials to advance the treatment of moderate to severe TBI. Research in this critical TBI population would benefit both the quality of life for the Veteran, but also for their families who are often the caregivers.

Recent accomplishments in TBI:

- Completed the Chronic Effects of Neurotrauma Consortium (CENC) funding cycle. The CENC Epidemiological group made significant progress in understanding TBI as a chronic condition. CENC showed a higher occurrence of neurodegenerative disease in Veterans with a history of TBI. Suicide, dementia, chronic pain, and opioid use were also found to be associated with TBI. CENC has also enrolled the largest prospective cohort of Veterans in the nation with a lifetime history of TBI, with the goal of accelerating the development of diagnostics and therapeutics.
- Discovered promising biomarkers for diagnostic tests, which indicate ongoing neurodegenerative and chronic neuroinflammatory processes in Veterans with repetitive mild TBI and related neurobehavioral conditions.
- Published results from a VA imaging study that revealed mild TBI changes to the microstructure of specific brain areas linked to PTSD. These changes are associated with greater severity of symptoms and poorer prognosis. These findings could help personalize therapy in cases of treatment-resistant PTSD.
- Published results from a VA registry study that confirmed Veterans with TBI are three times more susceptible to overdose from opiates compared with Veterans without TBI.

Major activities in ORD's TBI research include the continuation of two studies that explore the longitudinal effects of one or more TBIs in Veterans and a preclinical research center to study the effects of blast:

- The Rehabilitation Research & Development Service (RR&D) Translational Research Center for TBI and Stress Disorders (TRACTS) promotes multidisciplinary research aimed at improving our understanding of the complex cognitive and emotional problems faced by Iraq and Afghanistan Veterans.
- The VA/DoD Long-term Impact of Military-relevant Brain Injury Consortium (LIMBIC) continues the activities of CENC. LIMBIC's overarching goal is to improve understanding of the impact of TBI on service members and Veterans. This program will fund a longitudinal study and associated TBI research to include the collection of relevant imaging and tissue samples. Ultimately, this knowledge will inform acute and chronic TBI care.
- The VA Open Field Blast Core facility in Columbia, Missouri, will enable the conduct of preclinical studies to provide key insights into the disease processes associated with primary blast exposure and may provide links to neuronal degeneration, cognitive, and neurobehavioral decline.

Activities to be continued/undertaken include:

- Investigating the role genomics plays in resilience and recovery from blast exposure. In-depth studies will be conducted at the VA Open Field Blast Core facility.

- Initiating funding for a multi-center award to study the link between TBI and suicide in animal models and translate the animal findings to Veterans at risk of suicidal behavior.
- Establishing an Interagency Resource Center for preclinical models of TBI, including preclinical common data elements and an online catalog of preclinical models of TBI with standardized procedures.
- Conducting a Million Veteran Program (MVP) study focused solely on TBI by assessing genetic variables associated with long-term cognitive and psychiatric outcomes in Veterans with documented TBI.
- Launching an ORD Health Services Research and Development (HSR&D) innovation initiative called "Does Protecting Service-Connected Disability Income Motivate Return to Work in Veterans with TBI and PTSD?" The initiative's long-term goal is to determine whether protection of disability benefits is associated with return to work or increase in work hours among Veterans with TBI/PTSD.
- Sponsoring a meeting of experts to harmonize protocols for VA biorepositories, with the long-term goal of developing biomarkers of treatment response in TBI and PTSD.
- Funding a multisite clinical trial to evaluate the efficacy of human growth hormone for improving quality of life in Veterans with mild TBI.

2. Toxic Exposure/Military Exposures Research (+$6.965 Million)

ORD will invest in better understanding the impact of toxic exposures (including burn pits) on long-term health outcomes and continue to drive research focused on the needs of disabled veterans. This includes the following investments:

Increase Military Toxic Exposures Research: A wide range of exposures including chemical, physical, and environmental during military service give rise to adverse health outcomes. VA research is uniquely able to study these military exposures and foster new approaches to prevent and treat the consequences of such exposures. One in three Veterans have reported an exposure while serving in the Military. ORD recognizes the long delay that can exist between a service member's military exposure(s) and their potential impact on health outcomes.

In part, understanding the nexus between military exposures and health outcomes has been hampered by gaps in knowledge including exposure assessment, quantifying combinations of exposures, doses of exposures, and modeling exposures to health outcomes. Exposures may lead not only to short-term acute health outcomes, but also long-term chronic multi-symptom illnesses such as those seen in the Southwest Asia area of operations: pre-911 Gulf War Veterans of Operation Desert Shield/Desert Storm and post-911 Veterans of OEF/OIF/OND. Moreover, 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 burn pit exposures while in Iraq and Afghanistan. Notably, generational effects from military exposures are currently unclear and gender differences in rates and health outcomes resulting from military exposures.

Launch Military Exposure Research Program (MERP): ORD will launch MERP in 2022 to focus on gap-filling, evidence-based knowledge for Veterans with toxic exposure. This will include collaboration with VA, DoD, National Academy of Science, Engineering, and Medicine (NASEM), and other stakeholders. This diverse, interdisciplinary team of subject matter experts will conduct the following activities:

- Identify existing agencies/resources for military exposure research.
- Identify and synthesize knowledge/priority needs for military exposure research
- Develop overarching program goals, structure, and timelines needed to initiate a successful MERP at ORD.
- Advance military exposure assessments and understand the effects of military exposures on Veterans' health outcomes to inform care and policy.
- Expand the workforce in military exposures research and training. Emphasis will be placed on Veterans and Veteran descendants who are enrolled with VA academic affiliates and want to pursue a career in environmental and military exposure research. Veteran engagement and outreach will be a critical tool toward identifying exposure-related health issues. Additionally, these wide-reaching efforts will build trust in VA.

Build Capacity: Intra- and inter-federal partnership-building are imperative to move military exposure assessment and health research forward efficiently and uniformly. Infrastructure can be leveraged within ORD, including cross cutting service support, multi-omic platforms and informatics for data interpretation, and within VHA Post-Deployment Health Services (which oversees the Burn Pit Centers of Excellence, clinical exposure registries, and the individual longitudinal exposure record (ILER)).
In addition, strategic collaborations with other federal agencies outside VA with expertise in environmental research, occupational hazard research, toxicology and risk assessment will provide unique resources, skills, and databases so military exposures research can build on rather than repeating existing unpublished knowledge.

With the additional efforts mentioned, ORD will continue to supports studies on health outcomes of military exposures through its traditional mechanisms of investigator-initiated research, including epidemiologic studies, clinical trials, and basic research, and through collaborations with other VHA program offices, including Post-Deployment Health Services in the Office of Population Health.

This includes 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 ill 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.

Recent accomplishments Toxic Exposure/Military Exposures Research:

- Demonstrated, in a scientific survey of Vietnam Veterans, differences among those who served in the ground-war theater, those who served in offshore waters (Blue

Water), those who served concurrently outside the war theater, and civilians, in a number of 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 include whether these individuals served in the war theater, and their vital status.
- Partnered with NIH to launch a deep phenotyping of Gulf War Illness called "In-Depth."
- Analyzed the feasibility of conducting VA-sponsored research on intergenerational effects of toxic military exposures.
- Conducted education sessions with Gulf War Veterans on their health interests and the value of participating in research.

Activities to be continued/undertaken include:

- Continuing the "In-Depth" project on Gulf War Veterans.
- Analyzing differences in mortality between Vietnam-era Veterans and civilians.
- Testing the research usability of the Individual Longitudinal Exposure Record, a VA-DoD collaboration to track in-service exposures.
- Funding the continuation of longitudinal studies in service members who have embedded fragments from blasts and projectiles. An observational study assessing the association of previous land-based deployments to Iraq, Afghanistan, and neighboring regions and burn pit exposure with current measures of pulmonary health among a study cohort of 4,500 Veterans.
- Issuing requests for applications (RFAs) and funding studies on genomics and the phenotyping of military exposures.
- Issuing RFAs and funding studies on recommendations of the National Academies of Science, Engineering, and Medicine, including on burn pits and airborne hazards, anti-malarial drugs, and intergenerational effects.

3. Coronavirus Related Research and Impacts (+$25 Million)

The COVID-19 pandemic has led to an unprecedented set of research actions and requirements for the nation. Research is the only way effective prevention and treatment approaches will be established for COVID-19. VA has a unique ability to contribute to these efforts given its expertise, infrastructure, and organization. VA research covers a spectrum of activities that will require an investment into the underlying infrastructure to maximize the impact VA can have in the battle against COVID-19 and future emerging infectious diseases.

Thus in 2022, VA will expand and strengthen its national clinical research enterprise to conduct clinical trials of new treatments, diagnostics, and vaccines more effectively and rapidly. This investment will fund more research scientists, supporting administrators, regulatory support, and Veteran/community advocates. This will ensure that research can meet its goals in a timely way to subsequently inform clinical practice and policies. Furthermore, these personnel need to be highly coordinated to allow a more efficient approach to starting up and executing studies.

Prior to COVID-19, individual study budgets formed the basis of the predominant business model for many research organizations. COVID-19 research requires an enterprise-wide approach, which directly invests in a ready infrastructure rather than investing secondarily through individual scientific projects that enable a response capability that is adequate for addressing the needs of a pandemic. ORD will invest in the infrastructure itself, central coordination, and core support to generate scientific evidence that will benefit Veterans and will increase Veterans' access to high-quality clinical trials.

ORD will invest its informatics and data-science capabilities for COVID-19 research. VA has been a leader in organizing and curating data for research through its Veterans Informatics and Computing Infrastructure (VINCI) and Genomic Information System for Integrative Science (GenISIS) platform. To be most effective, though, researchers and projects should be coordinated across VA so that best practices are encouraged, and duplication is avoided. National VA data can also offer value to the nation because it provides real-world evidence on disease patterns and treatment safety and effectiveness.

In 2022, ORD will invest in biospecimens that are an essential resource in biomedical research and are vital to defeating emerging infectious diseases like COVID-19. With clinical and research sites across VA, there is also an opportunity to create a nationally coordinated COVID-19 biorepository that can be adapted as future needs arise concerning other diseases. Biospecimens collected will be obtained from activities done as part of routine clinical care and from specific COVID-19 research studies.

Through the American Rescue Plan Act (Public Law 117-2, Section 8002), VA will allocate an initial investment of $9 million for COVID-19-related research to establish a national specimen biorepository, conduct clinical studies on therapies and longer-term follow-up of Veterans infected by COVID-19, support data science/analytical activities for determining associated risk factors and outcomes of infection and impact on care and develop artificial intelligence-based models for supporting care decisions. These efforts are multi-year activities requiring further support to achieve overall goals. Funding will be executed out of a new budget account, the Veterans Medical Care and Health Fund.

Underlying all these efforts would be a robust regulatory support system, building on current infrastructure and helping transform VA into a more robust enterprise-driven system of evidence generation. Such support is integral to ensuring VA research meets the highest levels of quality and safety for Veterans.

4. Software-as-a-Service and Cloud Computing (+$10 Million)

As the largest integrated health care system in the country, VA's electronic health record (EHR), genetics, and imaging data put it in a unique position to drive scientific discovery and personalize Veteran care. ORD will invest in the following tools to modernize data infrastructure:

- Expanding the available data types and number of analyses within the VA Data Commons, which is a system that expands the number of qualified researchers who

are able to analyze de-identified EHR and genetic data from over 800,0000 Veterans enrolled in the MVP.
- Enhancing cloud-based analytic tools in the EHR to better support VA research.
- Supporting implementation and data feeds to cloud-based dashboards and decision support tools used by senior VA leadership.
- Using artificial intelligence (AI) and other advanced methods to bring together research and clinical teams to meet the needs of Veterans.

5. Data Security/Counterintelligence (+$2 Million)

ORD will receive reimbursable FTE support from the VA Defensive Counterintelligence (CI) Program in 2022. The mission of the CI program is to conduct defensive CI activities to detect, deter, and neutralize espionage, sabotage, or other intelligence activities conducted for or on behalf of foreign powers, organizations or persons, and international terrorist activities. The goal of this initiative is to protect ORD personnel, infrastructure, and sensitive research programs.

The (CI) Program will expand current staffing, to focus on geographically dispersed sensitive research facilities across the U.S. These facilities are likely targets for research data theft by foreign actors.

This will provide support to major research projects such as the MVP Program and other high-risk research projects by providing the following:
- Critical threat awareness briefings
- Investigative leads intake
- CI Inquiries
- Liaison and as required by law
- Referral of counterintelligence activities to FBI
- Other defensive counterintelligence activities

This strategy reflects a more proactive defensive counterintelligence program with CI personnel at decisive VHA/ORD sites.

6. Precision Oncology (+$5 Million)

In 2022, ORD will continue to invest in the Precision Oncology. Efforts will build off previous support to facilitate a partnership between the National Cancer Institute and VA (see below) and develop. Additionally, a more robust cancer knowledge base that integrates genetic and clinical data is needed to identify better treatments, guide care decisions, and identify opportunities for further investigation. The usefulness of any knowledge base depends on the data, mechanisms for sharing them, and the ability to translate findings into care. Fully realizing the promise of genomic-driven cancer care will require adequate resources and innovative partnerships that increase the sharing of data and knowledge, so advances can be realized more quickly to benefit both Veterans and the general patient population.

In partnership with the VHA's National Oncology Office, ORD will expand its precision oncology footprint by establishing 18 new lung cancer and 8 new genitourinary sites across VISNs. This expansion in clinical trial infrastructure will create even more demand for novel clinical trials in 2022 and potentially significantly 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 as well as opportunities for Veterans, VA investigators and VA facilities to contribute to state-of-the-art research on novel therapies and approaches to care. An increasing number of Veterans with advanced lung, genitourinary and other cancers are being provided with genetic sequencing to identify actionable mutations for potential match to novel therapy. The data derived from genetic sequencing provide opportunities for designing innovative biomarker-driven precision oncology clinical trials using new and repurposed Food and Drug Administration (FDA) drugs. In addition to precision clinical trials, VA investigators are working to enhance traditional therapeutic trial opportunities. For example, immunotherapy has shown durable benefit in approximately 20% of lung cancer patients but most of the lung cancer population shows resistance and/or no benefit from immunotherapy due to immune checkpoint blockade.

Clinical trials that combines chemotherapy drugs with checkpoint inhibitors (immunotherapy) can reduce cancer progression while increasing anti-tumor immune response thereby increasing the efficacy of checkpoint inhibitors (i.e. enhance the efficacy of immunotherapy). This combinatorial approach is one area that is prime for clinical trial investigation by VA researchers using traditional therapeutic approaches within our clinical trial network and would benefit from additional funding support.

Also, in 2022, to address the needs of Veterans, ORD is expanding precision oncology to genitourinary cancers (e.g., bladder, kidney, etc). We anticipate that these efforts will generate robust research activities to continually inform the development of new clinical trials, therapeutics, and predictive markers for cancer detection, diagnosis, and therapeutic response.

ORD launched the Research for the Precision Oncology Program (RePOP) and the Precision Oncology Data Repository (PODR) in 2016 to acquire knowledge and establish the capabilities necessary to improve the care of Veterans with cancer. RePOP provides a mechanism to recruit patients for broader sharing of data and to reuse tumor tissue, while PODR serves as a repository for their data and supports research activities such as creating predictive models, developing advanced analytic techniques, and building clinical applications.

These efforts are intended to share data with the larger research community and help put that data to work on behalf of Veterans. PODR will meet its goals through a partnership with the University of Chicago. The university will host a hybrid cloud infrastructure to provide greater access to both VA data and robust computing resources for the larger research community. These efforts complement and integrate with VA's partnerships with DoD and the National Cancer Institute (NCI).

VA Research is investing in a nationwide lung cancer network to diagnose lung cancer at earlier stages, which have higher survival, and to increase opportunities for Veterans with lung cancer to participate in clinical trials. The network will use a hub and spoke model to facilitate the participation of Veterans in rural and less urban centers while leveraging the use of telehealth and teleoncology to reach all Veterans.

Another area of progress in precision oncology concerns prostate cancer, a common condition in VA's patient population. To date, clinicians have been unable to target molecular changes in advanced prostate cancer that may improve survival and quality of life. Consequently, ORD has facilitated and coordinated a partnership with the Prostate Cancer Foundation (PCF) to establish the Precision Oncology Program for Cancer of the Prostate (POPCaP) in VA. This partnership launched in 2016 with the aim of using precision medicine to provide prostate cancer treatment to Veterans that is equal to, or exceeds, that provided by private and academic cancer centers. An important part of VA's transformation into a System of Excellence for Precision Oncology, POPCaP provides Veterans access to genetic testing and genetic counseling, biomarker-driven clinical trials, and on- and off-label FDA-approved drugs paired with specific mutations identified in metastatic prostate cancer.

To leverage the sequencing efforts of the National Precision Oncology Program (NPOP) and offer a broad scope of treatment options to Veterans, VA will launch the Prostate Cancer Analysis for Therapy Choice (PATCH). This effort will increase the number of VHA facilities involved in precision prostate cancer clinical trials, improve access for Veterans to those trials, and increase the number of Veterans enrolled in targeted therapeutic and immunotherapy studies while increasing the number of physician-scientists providing care and working in prostate cancer research. Adding new prostate cancer network hubs to the existing 10 sites will increase Veterans' access to cutting-edge therapies, particularly for those living in rural and remote areas of the country. PATCH brings together the power of the VA research enterprise with integrated clinical care to provide access to the most advanced therapies in cancer care.

PATCH is well-positioned to leverage data gathered from clinical trials and electronic medical records, access to high-quality biospecimens, and a VA patient population that includes high numbers of African Americans, who traditionally have had poorer prostate cancer outcomes. These assets are fueling new discoveries and enhanced translation of those discoveries into clinical practice, geared to improve the health and well-being of Veterans.

Finally, as part of the VA commitment to women Veterans, ORD will establish mechanisms to give Veterans with breast cancer greater access to clinical trials. VA Research is building networks to advance research and initiate new rare-cancer activities with partner agencies such as NCI and the National Institute of Dental and Craniofacial Research. This effort will help to remove potential barriers that might exclude certain subsets of patients from precision oncology and 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 in VA. Together, these efforts will create a larger precision oncology ecosystem to enable advancements in research and care.

Furthermore, VA Research recognizes the value and importance of sharing information across the VHA enterprise to facilitate the fluid transfer of knowledge from bedside to bench and back to bedside. This sharing of information across the research enterprise has the potential to accelerate translation of new findings into clinically relevant improvements in care. Therefore, VA Research will be harmonizing data systems to enhance data-sharing across the VHA system. This effort will support the growing development of new biomarkers and targeted and immunotherapy strategies and further enhance the use of technologies to refine data that informs precision oncology and facilitate discoveries that can be translated.

Recent accomplishments in Precision Oncology:

- Launched several multisite precision-oncology trials supported by ORD, the Prostate Cancer Foundation, and private industry.
- Established the POPCaP program and leadership to provide strategic, organizational, and administrative oversight of network operations.
- Established PATCH leadership to develop and refine the infrastructure necessary to employ an umbrella approach to new precision oncology clinical trials to test novel interventions based on specific alterations for men with prostate cancer.
- Launched a pilot project establishing an infrastructure for efficient germline screening of Veterans with metastatic prostate cancer. This innovative approach also enables increased access to clinical genetics and genetic counseling to support increased volume of genetic testing of Veterans with cancer.

Activities to be continued/undertaken include:

- Selecting and operationalizing VAMC-based hubs to conduct lung cancer screening and lead precision clinical trials, as part of a larger lung cancer precision oncology plan, to take place in 2021/2022.
- Working to establish eight additional POPCaP sites, to form a distributed network of sites nationwide with at least one site in every Veteran Integrated Service Network (VISN).
- Supporting the development of new data analytics to improve the quality and efficiency of existing but underutilized cancer registry systems so that their data can be used for research purposes.
- Validating the performance characteristics of algorithms developed to measure precision oncology care performance in men with metastatic prostate cancer.
- Supporting multisite validation of an imaging-based risk decision web-based support tool for lung nodule diagnosis on screening low dose CT scans. This validation will make it easier to distinguish benign from malignant nodules based on radiomic features and will aid clinicians in lung cancer screenings throughout VA.
- Supporting the development of business requirements necessary to build an integrated database of clinical and research oncological data, genetic testing, and

other data to enable decision-making and research in precision oncology that informs development of new therapies, clinical trials and measure performance.

- Supporting the development of a virtual clinical trial infrastructure to facilitate rapid start up and accrual to clinical studies for malignancies with rare biomarkers. These studies are expected to help Veterans in less urban and remote geographic areas.
- Expanding precision oncology clinical trial opportunities to other cancers that harbor somatic and germline mutations in DNA damage repair and homologous recombination pathways.
- Supporting new initiatives using pathomics, radiomics and AI to identify signatures and clinical phenotypes for cancer diagnosis, prognosis, and decision support in treatment.
- Supporting the development of a centralized process for requesting next generation sequencing of prostate tissue specimens to speed the identification of novel molecular targets, prognostics, and predictive biomarkers that precisely phenotype metastatic prostate cancer and inform development of biomarker-driven clinical trials.
- Establishing new collaboration with the NCI around rare cancers and exploring opportunities for joint clinical trials in this area in VA.
- Facilitating a new initiative focused on high risk localized prostate cancer and supporting research addressing biochemical failure and disease recurrence.
- Supporting the implementation of institutional review board (IRB) and clinical trials software to increase efficiency in clinical trial protocol review and execution.

7. Sustaining VA/Department of Energy Collaboration (+$2 Million)

VA and the DOE are partnering to combine health and genomic data from MVP with DOE's expertise in AI and machine learning. Through an inter-agency agreement, a secure personal health information (PHI) computing enclave has been established at the Oak Ridge National Laboratory, and 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.

In 2022, additional funding will allow additional investment in support of the VA-Department of Energy (DOE) partnership will allow current VA and DOE scientists to complete the ongoing exemplar projects on risk prediction for suicide, metastatic prostate cancer, and cardiovascular disease and developing clinical decision support tools to be brought back into the VA, as well as initiate the new high priority projects relevant to improving Veterans' health.

This includes:

- Complete the development of risk prediction and clinical decision support tools for suicide, metastatic prostate cancer, cardiovascular disease.
- Initiate new joint research projects on COVID-19, traumatic brain injury/PTSD, opioids, pharmacogenomics and polypharmacy.

2021 Priorities and Updates

ORD's 2021 priorities are closely aligned with VHA's and the Secretary's priorities, notably in the areas of mental health care for Veterans and suicide prevention, EHR modernization, and high-reliability organization and learning health system advancement. Additional investments were made in clinical priority areas with a strong focus on conditions that are major concerns for Veterans: suicide prevention, pain management and opioid use, PTSD, TBI, military exposures (expanded from Gulf War illness to include a broader range of conditions due to exposures occurring during military service), and precision oncology. These priorities factor into funding decisions and underpin enhanced central coordination of research on these priorities. In addition, ORD responded to timely priorities identified by Congress, Veteran Service Organizations, and other key stakeholders. The 2021 priorities outlined below have emerged as important areas for ORD to focus on in the near term, even as we diligently pursue the longer-term strategic priorities described later in this chapter. These investments are multi-year and will continue into 2022.

Suicide Prevention Research

Preventing suicide is critical for Veterans and is a public health priority for the nation. Research can identify which factors increase the risk of suicide, and ORD is able to plan studies to prevent suicide by directly responding to an individual's risk profile. Resources resulting from this budget submission will build new tools to help identify and manage risk factors, identify more effective prevention strategies, and better ensure that effective strategies are implemented to prevent Veteran suicide. A key focus of research will 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 newer focus will be on the impacts of COVID-19 over time in hopes of reducing pandemic-related suicides.

A number of other highly coordinated efforts are focused on reducing suicide by developing and implementing a scientifically established evidence base. These efforts include supporting clinical trials as well as epidemiological studies on risk and prevention factors. Other specific highlights include the use of MVP data to identify Veterans who have died by suicide for further query and discovery of genetic risk factors and continued examination of behavioral interventions for reducing suicidality.

Recent accomplishments:

- Announced a program of suicide prevention research with a focus on prevention, lethal means safety, risk factors, and broader mental health impacts related to the COVID-19 pandemic.
- Documented that a medical-records flag for suicide risk increased VA health care visits among Veterans with substance use disorders.
- Worked closely with the Office of Mental Health and Suicide Protection (OMHSP) to develop a program to promote messaging about firearms safety in primary care. The program includes staff training, patient brochure, and a pocket card to assist primary care teams to discuss firearm safety with Veterans. The pocket card is available on the OMHSP website, and its content is included in the 2019 VA/DoD Clinical Practice Guidelines for Suicide Prevention.

- Released a new RFA for a targeted solicitation for service-directed research on Veteran suicide prevention. u

Activities to be undertaken include:

- Mapping plans related to specific focus areas identified as high-risk targets, such as military-to-Veteran transition.
- Organizing and expanding a community of science to increase awareness of and attention to suicide prevention research.
- Developing prominent data science research activities throughout the research program as well as with other VA program offices.
- Continuing to fund the Suicide Prevention Research Impact Network (SPRINT) to accelerate health services suicide prevention research that will lead to improvements in care and reduce Veteran deaths by suicide.

Pain Management/Opioid Use

Chronic pain is more prevalent and of greater intensity in the Veteran population than in the general population. It is often accompanied by co-existing mental health and overlapping painful conditions. This places Veterans at risk for harms 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, guided by the requirements of the Comprehensive Addiction and Recovery Act (CARA), the Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand, and VHA's Opioid Safety Initiative.

Recent accomplishments:

- Completed a State-of-the-Art (SOTA) Conference on Effective Management of Pain and Addiction: Strategies to Improve Opioid Safety.
- Funded a multi-center, multi-disciplinary Consortium of Research on Pain and Opioids to coordinate health services research on these areas. The overall goal of this initiative, jointly supported by NIH, DoD, and VA, is to develop the capacity to implement cost-effective large-scale clinical research in military and Veteran health care delivery organizations that focuses on non-pharmacological approaches to pain management and other comorbid conditions.
- Funded the APPROACH (Assessing Pain, Patient Reported Outcomes and Complementary and Integrative Health) trial, whose main objective is to answer the question of whether adding self-care strategies to practitioner-delivered complementary and integrative care increases the effectiveness of pain management.
- Released an RFA for research on priorities identified by the SOTA conference.
- Expanded a current national study to examine outcomes of opioid tapering in over 9,000 Veterans taking long-term opioids in response to the National Academy of Science's report titled "An Approach to Evaluate the Effects of Concomitant Prescribing of Opioids and Benzodiazepines on Veteran Deaths and Suicides."
- Funded two partnered evaluations on facilitating and evaluating a Stepped-Care Model and Medication Treatment for Opioid Use Disorder, and three partnered implementation initiatives on improving access to medications for OUD in primary care settings,

facilitating practice re-design of opioids care, and delivering effective hospital practices to improve pain outcomes while preventing and delaying opioid adverse events.

Activities to be undertaken include:

- Developing RFAs across all ORD services for new studies on opioid addiction, including a targeted solicitation for service-directed research on strategies to improve opioid safety based on strategic prioritization by partners and researchers at the SOTA Conference described above.
- Developing safe strategies for reducing opioid use, improving use of medication therapy for OUD, and improving the co-management of OUD and pain.
- Continuing the Pain Management Collaboratory with NIH and DoD.
- Launching a phase 2 clinical trial of transcranial direct current stimulation combined with a brief cognitive intervention to reduce perioperative pain and opioid requirements in Veterans, following the encouraging results of a pilot study.

Posttraumatic Stress Disorder (PTSD)

VA Research has led the way in developing effective psychotherapies for PTSD and in exploring other approaches to treat the disorder such as medications, behavioral interventions, and therapeutic devices. VA has a strong track record of facilitating the implementation of research findings in this area directly into clinical practice. For example, VA researchers demonstrated, in 2013, the effectiveness of prolonged exposure therapy for treating PTSD and depression in male and female Veterans of all eras. Prolonged exposure therapy is now one of two main forms of psychotherapy VA offers as evidenced-based treatments for the disorder. We continue to work to better understand the underlying biology of PTSD, advance new treatments, and refine diagnostic approaches.

VA has a set of recommended treatments for PTSD, including counseling or medications, but we know 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 developed a strategic plan to examine the efficacy and effectiveness of new medications for PTSD, specifically to increase the possible treatments over the currently limited two approved medications. This effort started with two clinical trials in 2016 under our PTSD Psychopharmacology Initiative and has grown to an additional ten trials all examining potential benefits of different compounds trials to identify more effective medications. This is an ambitious program that continues to grow through our support of mentoring and training for new clinical trialists and active outreach to identify suitable drug candidates.

Our research will improve Veterans' quality of life by increasing the number and type of evidence-based treatments and identifying personalized approaches for treatment.

Recent accomplishments:

- 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 the VA that demonstrated the effectiveness of virtual team-based care for rural Veterans with PTSD.

- Found, in a large multisite clinical trial, that the drug prazosin, used widely in VA to help ease nightmares from PTSD, did no better overall than placebo pills, although the researchers pointed to subgroups of Veterans they believe do benefit from the treatment.
- Showed the value of mantram therapy—a form of meditation in which the person repeats a word or phrase with spiritual meaning to him or her—to reduce PTSD symptoms and insomnia in Veterans.
- Identified eight novel genetic variants associated with a major symptom of PTSD, re-experiencing symptoms, 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 repositiory provids an evidence base for questions they 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.

Activities to be undertaken include:

- Recruiting, under the MVP-MIND effort, Veterans with a variety of mental health conditions to participate in the MVP program. MVP-MIND is designed to increase the representation in MVP of Veterans with PTSD and other mental health conditions that commonly affect Veterans.
- Continuing an adaptative multi-site clinical trial of multiple medications to treat insomnia in Veterans with PTSD.
- Launching new clinical trials including the focus on potential new medication treatments for PTSD under the PTSD Psychopharmacology Initiative, and including a large multisite trial comparing agents to determine the most effective approach for related sleep disorders. PTSD trials will also consider the question of whether other non-medication based treatments are effective.

Exoskeleton Use in the Context of Stroke, TBI, and Other Non-SCI/D Conditions

Exoskeletons, including externally powered motorized prostheses, may benefit Veterans with disabling conditions. Exoskeletons are currently being used by persons with spinal cord injuries and disorders (SCI/D) to help them stand and walk. Veterans with SCI from 14 different sites are participating in a large VA clinical trial that seeks to learn the additional benefits to health and quality of life these Veterans may gain by using exoskeletons. Because of a temporary pause on recruitment in response to the COVID-19 pandemic and efforts to reduce and avoid exposures from in-person contacts with research staff, the trial is now on-track for completion in 2022.

A special emphasis area, "Exoskeleton research, including externally powered motorized orthoses for stroke, traumatic brain injury or other non-SCI/D Veteran populations," has been added to ORD's RFA. This request has increased the number of VA researchers proposing studies involving the use of exoskeletons for Veterans with conditions other than SCI/D. The most meritorious applications received are selected for funding, based on the results of rigorous scientific peer review.

Recent accomplishments:

- Gained approval from the Centers for Medicare and Medicaid Services for a code for the ReWalk exoskeleton for people with spinal cord injury who are eligible to use this device.
- Selected four research applications examining the use of exoskeletons for stroke, traumatic brain injury or other non-SCI/D Veteran populations for funding.
- Established and maintained an extensive VA trial network for large exoskeleton study, including readiness of devices for use.

Activities to be undertaken include:

- Completing analysis of a large multisite clinical trial on the use of exoskeletons by Veterans with SCI.
- Conducting a study on stroke survivors that combines an exoskeleton with muscle stimulation to improve walking function.
- Conducting another study of Veteran stroke survivors using powered orthotic exoskeletons to promote improved squatting ability, knee motion, and weight bearing on the affected leg.
- Conducting research on peripheral arterial disease using a footwear exoskeleton spring orthosis to address pain and improve walking ability.
- Conducting a study of a robotic knee exoskeleton for Veterans with medial compartment knee osteoarthritis to reduce joint loading and improve mobility.

Reduction, Replacement, and Refinement of the Use of Canines in Research

ORD has reduced the number of canines used in VA research tenfold over the past 20 years, while improving the safeguards under which canine research takes place. Of more than 2,000 research studies currently supported by VA, only six currently involve the use of canines. ORD will continue its efforts to reduce, replace, and refine the use of canines in research and will focus on the humane care of canines, while also maintaining our commitment to improving Veterans' lives. An external review by the NIH Office of Laboratory Animal Welfare concluded that VA canine research programs "are effectively supporting the humane programs of animal care and use at their institutions and conducting research with canines and other vertebrate species in compliance with the PHS [Public Health Service] Policy, and all applicable rules and regulations."

A National Academies report on VA's canine research program was released in July 2020 and affirmed the need for canines in VA research for a limited set of studies. The report specifically concluded that dogs were scientifically necessary in all six currently active VA canine studies, and that VA animal research programs were complying and exceeding federal regulations and guidelines on humane animal care and use.

Since 2018 Congress has placed limits on canine research, and in 2020 Congress expanded those limits 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 canine studies are by far the most stringent of any in the country.

Recent Accomplishments:

- Invested $2.5M in applications submitted by investigators who seek to develop alternatives to canines in cardiology work, and will continue to look for additional opportunities to fund other such studies.
- Initiated studies to determine whether a porcine model can replace an existing canine model of arrhythmia induced heart failure.

Activities to be undertaken include:

- Continuing support for the National Academies of Sciences, Engineering, and Medicine (NASEM) Roundtable working group on best practices for the reduction, replacement, and refinement of canine research in VA.
- Looking for additional opportunities to fund research on alternatives to dogs, cats, and non-human primates.
- Developing a targeted funding program to foster collaborations with veterinary schools to conduct more clinical trials on pets that can benefit both Veterans and pets.
- Providing support to NASEM in their effort to revise the *Guide for the Care and Use of Laboratory Animals*, a key compliance document for all VA animal care and use programs.
- Implementing a new RFA to validate replacements for animal models.

Addressing the Prosthetic Needs of Women Veterans with Amputations

In conjunction with the Administration priority to ensure disabled veterans that require a prosthesis are able to access the most modern prosthetics technology available and to support the growing number of women Veterans who utilize VA services, research continues to encourage the development and translation of prosthetic devices for women. As directed by Congress in House Report 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 women Veterans with amputations is growing, and VA must be able to meet their prosthetic needs as well.

ORD added a statement to an RFA that "prosthetic needs of women Veterans with amputation (are) of particular interest" to 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 received are selected for funding based on the results of rigorous scientific peer review.

Recent accomplishments:

- Funded a supplement to an existing DoD-funded project, "Needs, Preferences and Functional Abilities of Veterans and Service Members with Upper Limb Amputation." VA's funding increased the number of women Veterans in the study to allow comparisons by sex. Longitudinal data analysis is in progress.
- Commercialized 3D-printed metal prosthetic fingers in sizes more appropriate for women Veterans.
- Funded six meritorious research applications addressing the prosthetic needs of women Veterans.

- Funded the project "Improving Footwear Options for Women and Men with Amputation" to test a novel prosthetic ankle/foot attachment system that can be quickly adapted for use with different footwear, such as high heels.

Activities to be undertaken include:

- Conducting a study in women Veterans with major lower-limb amputation to characterize prosthetic prescription, use, and satisfaction and identify barriers and facilitators to successful functional mobility and health-related quality of life. We will apply our findings to VA programs and processes that promote gender-sensitive prosthetic care and equitable outcomes.
- Conducting a definitive evaluation to seek FDA approval of an osseointegrated prosthetic device for lower-limb amputees in both men and women.
- Conducting 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. Current measures predominantly have input from men.
- Determining if women with lower-limb loss are at greater risk of developing secondary musculoskeletal conditions.
- Studying the effects of carrying loads, specifically infants and toddlers, on Veterans with lower-limb amputation, and applying the results to generate guidance for prosthetic prescribing.
- Completing the final design and testing phase of 3D-printed metal prosthetic fingers in smaller sizes more appropriate for women Veterans.

Table: Medical and Prosthetic Research Crosswalks

Medical and Prosthetic Research Summary (Discretionary)
(dollars in thousands)

	2020 Actual	2021 Current	2022 Request	2021 -2022 Inc/Dec
APPROPRIATION				
Medical and Prosthetic Research Annual Appropriation.....	$800,000	$815,000	$882,000	$67,000
Rescission.....	($50,000)	($20,000)	$0	$20,000
APPRROPIATION [Subtotal]	$750,000	$795,000	$882,000	$87,000
REIMBURSEMENTS.....	$28,279	$81,000	$61,000	($20,000)
BUDGET AUTHORITY.....	**$778,279**	**$876,000**	**$943,000**	**$67,000**
UNOBLIGATED BALANCE (SOY)				
No-year.....	$4,686	$4,199	$4,500	$301
2-year.....	$150,301	$131,502	$65,600	($65,902)
5-year.....	$25,000	$23,000	$12,500	($10,500)
Prior Year Recoveries.....		$0		
Unobligated Balance (SOY) [Subtotal].....	$179,987	$158,701	$82,600	($76,101)
UNOBLIGATED BALANCE (EOY)				
No-year.....	($4,199)	($4,500)	($4,500)	$0
2-year (Annual Appropriation).....	($131,502)	($65,600)	($50,000)	$15,600
5-year…….....	($23,000)	($12,500)	$0	$12,500
Unobligated Balance (EOY) [Subtotal].....	($158,701)	($82,600)	($54,500)	$28,100
PRIOR YEAR RECOVERIES	$47,690	$0	$0	$0
OBLIGATIONS	**$847,255**	**$952,100**	**$971,100**	**$18,999**
Full-Time Equivalents (FTE):				
Direct FTE.....	3,311	3,282	3,447	165
Reimbursable FTE.....	107	138	138	0
Total FTE.....	3,418	3,420	3,585	165

American Rescue Plan (Mandatory)
(dollars in thousands)

Description	2020 Actual	2021 Current Estimate	2022 Request	2021 -2022 Inc/Dec
APPROPRIATION[1]				
American Rescue Plan (Public Law 117-2, Section 8002).....	$0	$9,000	$0	($9,000)
APPRROPIATION [Subtotal]	$0	$9,000	$0	($9,000)
BUDGET AUTHORITY.....	$0	$9,000	$0	($9,000)
UNOBLIGATED BALANCE (EOY)				
ARP section 8002 - 3 year.....			$0	$0
OBLIGATIONS	$0	$9,000	$0	$0
Full-Time Equivalents (FTE):	$0	34	0	-34

1. VA plans to use $9 Million of the funding provided in section 8002 of the American Rescue Plan Act for Research, which will be executed out of a new budget account, the Veterans Medical Care and Health Fund. Final 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Table: Distribution of Program Resources

Office of Research and Development Program Distribution (Dollars in Thousands)				
Program	**2020 Actual**	**2021 Enacted**	**2022 Request**	**Change from FY2021 to FY2022**
Research Administration (820)	$93,705	$137,477	$148,778	$11,302
Biomedical Laboratory R&D (821)	$210,085	$185,124	$200,342	$15,219
Rehabilitation R&D (822)	$108,636	$104,656	$113,259	$8,604
Health Services R&D (824)	$116,239	$113,598	$122,936	$9,339
Cooperative Studies Program (825)	$92,983	$104,077	$112,633	$8,556
Clinical Science R&D (829)	$76,424	$82,732	$89,534	$6,801
Million Veteran Program (826)	$101,929	$87,337	$94,517	$7,180
Discretionary Appropriation Total[1]	**$800,000**	**$815,000**	**$882,000**	**$67,000**
Mandatory, American Rescue Plan (Public Law 117-2, Section 8002)[2]	$0	$9,000	$0	-$9,000
TOTAL	**$800,000**	**$824,000**	**$882,000**	

1. The total amounts above reflect the total annual appropriation allocated to the programs above during the year of enactment. Rescissions are executed out of prior year funding.
2. VA plans to use $9 Million of the funding provided in section 8002 of the American Rescue Plan Act for Research, which will be executed out of a new budget account, the Veterans Medical Care and Health Fund. Final 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Specifically tracked programs executed in Services Above:				
VA-DoD Long-Term Impact of Military-Relevant Brain Injury Consortium (Previously CENC)	$5,000	$5,000	$5,000	$0
Consortium to Alleviate PTSD[1]	$1,495	$0	$0	$0
Military Exposures Research from the Gulf War	$14,609	$16,000	$16,000	$0
Diversity Action Program including HBCU	$0	$2,500	$2,500	$0
TOTAL	**$21,104**	**$23,500**	**$23,500**	**$0**

1. The Consortium to Alleviate PTSD steering committee did not make a recommendation for a renewal the Consortium and the program ended in FY 2020.

ORD Operational Units

ORD supports its priorities through the funding distribution shown in the table above. These areas are described below.

Research Administration

Research Administration supports the Technology Transfer Program (TTP); ORD Fiscal Management; the Office for Research Protection, Policy, and Education (ORPP&E); Communications; and Operations. Salary support for all of ORD is also captured in the Research Administration category, along with administrative support distributed to the field but not linked to specific projects.

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; new 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.

VA's Quality Enhancement Research Initiative (QUERI), administratively located within HSR&D, improves Veterans' health by accelerating the implementation of scientifically supported treatments and interventions into real-world clinical care settings. QUERI's mission is threefold and is geared towards VA's goal of achieving a learning health system. This threefold mission includes more rapidly implementing evidence-based practices and innovations supporting top VA priorities, conducting rigorous evaluations in partnership with local providers and national leaders, and supporting implementation and quality improvement science across the translation spectrum. QUERI is also leading VHA's efforts to comply with the Evidence Act.

HSR&D's Evidence-based Synthesis Program (ESP) is helping VA fulfill its vision of functioning as a learning health system to improve Veterans' health and health care by providing timely, targeted, thorough, unbiased, and innovative syntheses of the medical literature for VA to translate into evidence-based clinical practice and policy, and quality improvement and practice-based future research initiatives at the national level. ESP makes high-quality evidence synthesis available to clinicians, managers, and policymakers in a timely way as they work to improve the health and health care of Veterans.

Cooperative Studies Program

The VA Cooperative Studies Program (CSP) is responsible for the 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.

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.

Million Veteran Program

The MVP is a national voluntary research program whose goal is to partner 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 June 30, 2020, the number of enrolled Veterans was 829,188. Data collected from MVP is stored in a secure manner and is coded for researchers so that Veterans cannot be directly identified. Researchers are using MVP data to study diseases like diabetes and cancer and military-related conditions such as PTSD, risk of suicide, and Gulf War illness. Three patent applications and 43 peer-reviewed publications have resulted from the program thus far, with many of those publications appearing in prominent, high-impact journals.

Specifically Tracked Programs

To honor internal commitments within VA and commitments ORD has made to Congress and DoD, ORD specifically tracks the following programs to ensure appropriate funding levels are maintained:

Long-term Impact of Military-relevant Brain Injury Consortium (LIMBIC) is a coordinated multicenter collaboration linking basic science, translational, and clinical neuroscience researchers from VA, the military, and academia to effectively address the long-term effects of mild TBI and its diagnosis and treatment.

Military Exposures Research from the Gulf War 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 that was created by Congress in 1998 (Public Law 105-368) and first appointed by the Secretary of Veterans Affairs in January 2002. The committee directs VA to commit at least $15 million to Gulf War research annually.

The Diversity Action Program was created to increase the number of underrepresented minority scientists in VA research. The centerpiece of this program is a Historically Black Colleges and Universities (HBCU)-focused Career Development Award to support early-career scientists affiliated with HBCUs in collaboration with their local VA medical centers. More recently, VA has established a new system of Core Recruitment Sites (CRS) at HBCUs with medical schools, with plans to expand the system further to other underrepresented institutions. The goal of the program is to provide early exposure and training to develop future scientists from underrepresented populations.

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 service members, Veterans, and family; toxic 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 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. Additional projects on polypharmacy, pharmacogenomics, and TBI are being planned.
In addition, an inter-agency partnership called COVID-19 INSIGHTS is underway between VA, DOE, and HHS under a public health authority to advance knowledge on risk factors and potential treatments for COVID-19.

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 toxic 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 NCI and NIA as described below. Through the Pain Management Collaboratory, VA collaborates with the NIH and DoD on a series of trials of non-opioid treatments for chronic pain in Veterans and active-duty military members.

VA and NCI have been collaborating through a joint network focused on improving and increasing Veteran participation in cancer clinical trials through a partnered called the NCI And VA Interagency Group to Accelerate Trials Enrollment (NAVIGATE). This effort combines the scientific, operational and regulatory expertise of both agencies to enable more Veterans to participate in cancer treatment and prevention trials, which often are considered a standard of care for those affected. The network has 12 dedicated cancer trial enrollment sites that share best

practices and provide a coordinated approach to working with NCI, oncology groups, and other stakeholders to provide more opportunities for Veterans and cancer researchers to contribute to the knowledge of effective cancer therapies. NAVIGATE sites have enrolled more Veterans into NCI trials than non-NAVIGATE sites, highlighting the success of the program.

VA and NIA are collaborating on the VA-NIA Alzheimer's Disease Veteran-Centric Alliance Network for Health Care Excellence (AD-VANCE) Initiative, a partnership to fast-track 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. An estimated 5.5 million Americans, most of them age 65 or older, have AD/ADRD. In 2020, the prevalence of Veterans with AD/ADRD is 758,000; as many as 409,000 of them are enrolled with VA for their health care. The prevalence of VA enrollees with AD/ADRD is expected to increase by 20% to 492,000 by 2033.

The burdens on caregivers and health care costs from AD/ADRD are enormous. A Veteran focus is an essential part of this initiative. The collaborative research will have a long-term impact on older Veterans' health by leveraging MVP and phenotype data and recruiting Veterans for high-quality clinical trials.

Four key strategies are employed to accomplish the mission of this initiative, with each strategy aligning with the mission of ORD. They include:

- Integrating resources and expertise from VA and NIA for basic clinical health services and rehabilitative research in AD/ADRD.
- Using Veterans' data to accelerate scientific discovery to improve prevention, diagnosis, treatment, and care of AD/ADRD.
- Building capacity to increase Veterans' participation in clinical studies of AD/ADRD and access to cutting-edge clinical trials.
- Leveraging support from the larger VA and NIA research community to attract, develop, and retain talented VA investigators in AD/ADRD research.

Activities to be undertaken include:

- Issuing joint VA-NIA funding announcements to support the VA-NIA Genetics Initiative for Alzheimer's Disease, and to support geroscience-guided research on Alzheimer's disease and dementia care.
- Supporting the use of Veterans' data for drug development and repurposing for the treatment of Alzheimer's disease.
- Continuing to support VA-NIA mentored research for career development.

VA also fosters dynamic collaborations with its university affiliates and with nonprofit organizations, and private industry.

Examples include:

- Partnering 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 already producing state-of-the-art results for individualized care.
- Establishing a new Core Recruitment Site to attract and train applicants from HBCUs. This represents an enhanced partnership with Morehouse School of Medicine to increase diversity in the scientific workforce.
- Collaborating with the nonprofit organization PINK Concussions to encourage women to donate their brains upon death for research into the effects of TBI and PTSD.
- Licensing to a commercial partner (PointDesigns) of 3D-printed metal prosthetic fingers in smaller sizes for women Veterans and others, developed by VA researchers. The fingers are light and strong.
- Launching a clinical trial in lower-limb osseointegration across multiple VA sites in collaboration with industry partner DJO Global. If successful, this will lead to the first FDA approval of osseointegrated limb prostheses, which replaces the need for a standard socket to attach a prosthetic limb.
- Translating 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 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.
- Collaborating 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.
- Working with scientists from Stanford, Columbia, and Harvard universities; Clalit Research Institute in Tel Aviv; and Swansea University Medical School in Wales to build a framework for training and validating predictive models across multiple health care systems.
- Establishing, under the Access to Clinical Trials (ACT) for Veterans initiative described below, capabilities and policies to facilitate partnerships to more quickly start high-quality, multisite clinical trials with the pharmaceutical industry. Several of these efforts have resulted in access to new therapeutics and vaccines for the COVID-19 pandemic and also helped with oncology trials.
- Developing 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.

Overview of Ongoing Strategic Priorities

ORD's three strategic priorities are aligned with VHA's strategic goal of promoting a learning health system and with VHA's modernization objective to support management improvements that lead to a "clinically-integrated, community-supported, highly reliable system of care focused on providing the highest-quality and safest outcomes" for Veterans. These goals also support the Foundations of Evidence-based Policymaking Act (the "Evidence Act", U.S. Public Law 115-435). The Evidence Act requires cabinet-level agencies to ensure that budgets and policies are tied to, supported by, and justified by evidence. As one of the largest bodies generating health care evidence in VA and nationally, ORD is taking on a leading role in supporting VA's compliance with the Evidence Act through the development of learning agendas, capacity assessments, and evaluation best practices. Additionally, the Evidence Act supports VHA's overall goal of achieving learning health system principles, including those of high-reliability organizations (HROs), including the more consistent spread of effective practices and making continuous real-time improvements in care.

In addition, ORD is involved in VA's IT and EHR modernization process by embedding opportunities for clinical trials through informing the implementation of the Cerner Power Trials platform; updating research infrastructures in VA Informatics and Computing Infrastructure (VINCI) and Genomic Information System for Integrated Science (GenISIS); and piloting scalable research platforms using VA Enterprise GovCloud, VA Data Commons, and the Cerner HealtheDataLab. It is critical to meet the needs related to research infrastructure, including but not limited to IT resources, in order to accomplish cutting-edge scientific work. Non-IT infrastructure examples include establishing and maintaining biospecimen collections, expanding clinical trial networks, and increasing translational capabilities so the results of studies are returned to Veterans as quickly and completely as possible. Translational capabilities will also focus on complementary and alternative medicine approaches to care.

VA Research has always focused on enhancing the well-being of Veterans and our nation through discovery and innovation. VA Research's strategic priorities are designed to make the best use of our current and planned resources, including our unique position as part of VHA's integrated health care system, to achieve the broadest and most meaningful positive impacts possible on Veterans' health.

ORD will continue to focus on the following strategic priorities in 2022:

- **Increase Veterans' access to high-quality clinical trials:** VA is a leader and epicenter for a range of groundbreaking clinical trials that address national health care problems. One current trial, VA's Colonoscopy Versus Fecal Immunochemical Test in Reducing Mortality from Colorectal Cancer (CONFIRM), completed enrollment of 50,000 Veterans in late 2017, making it the largest single clinical trial in VA history. The trial is expected to provide definitive guidance on the best methods of colorectal cancer screening to prevent death.

Another current trial is a head-to-head comparison of the two leading evidence-based psychotherapies for PTSD. Besides influencing medical care in VA and throughout the nation and the world, VA clinical trials offer Veterans hope when their conditions require more help than routine clinical care can offer by increasing their access to potentially life-enhancing and life-lengthening treatments, diagnostics, and vaccines.

Activities in this priority area capitalize on key strengths of the national VA clinical research enterprise, such as the department's unparalleled nationwide network of clinician-investigators and study sites. Leveraging this experience and capabilities, ORD's efforts focus on building partnerships with federal and industry partners and on creating the underlying processes, resources, and policies for successful collaboration that offer Veterans and VA clinician-investigators more opportunities to participate in high quality, multisite clinical studies.

- **Increase the substantial real-world impact of VA research:** VA makes significant investments in basic science, rehabilitation, clinical, and health services research. These investments advance the development of new discoveries, and it is the department's responsibility to ensure these discoveries are translated into real-world clinical applications and rapidly implemented into routine clinical practice. This goal is also a core component of ORD's response to the Evidence Act, notably through the development of an ORD learning agenda and through technical assistance to other VHA program offices on evidence-building activities, capacity assessments for evidence generation, and evaluation plans.

- **Put VA data to work for Veterans:** VA has among the richest health datasets in the world, including those associated with MVP. These datasets hold information that benefits Veterans and the nation. To accelerate the rate of these discoveries, VA is taking necessary steps to expand access to MVP data through the VA Data Commons initiative and to ensure that research with a translational trajectory will be conducted at larger scale through the establishment of Coordinating Centers for research translation. In addition, VA will expand its partnership with DOE to develop risk prediction tools with clinical decision support for suicide, metastatic prostate cancer, cardiovascular disease and initiate/continue joint research projects on COVID-19, TBI/PTSD, opioids, and polypharmacy.

Strategic Priorities in Detail
Below is additional information on each strategic priority.

Strategic Priority #1: **Increase Veterans' access to high-quality clinical trials**

Clinical trials are the gold standard for evidence-based medicine and practice. They enable clinicians, patients, and policymakers to know whether new treatments are effective and safe and which options among existing therapies may be better to use in different situations. ORD has a robust program of clinical trials, including a quality-certified clinical research program embedded within VA's health care system and partnerships with industry, other federal agencies, and foundations. These partnered trials provide additional opportunities for Veterans and VA clinicians to participate in important studies that advance health outcomes for Veterans and the nation. Increasing Veterans' access to clinical trials gives them more options to receive promising new

treatments in a highly regulated environment, while also enabling them to continue to serve our nation through their voluntary participation in research.

To increase access to high-quality clinical trials, ORD has undertaken a set of major coordinated activities aimed at establishing capabilities and processes within VA under a national clinical research enterprise framework. These activities leverage the existing infrastructure and expertise VA maintains as a leader in the national clinical research enterprise. They will also provide Veterans with more opportunities to participate in partnered multisite clinical trials and improve how clinical trials are conducted within VA.

Recent accomplishments:

- Development of the NCI and VA Interagency Group to Accelerate Trial Enrollment (NAVIGATE). This has enabled a network of dedicated cancer trial sites to NCI clinical trials that are leveraged for other sponsored studies to test new therapies for patients impacted by this disease.
- Facilitated partnerships with industry companies that have promising new treatments, diagnostics, and vaccines available only through clinical trials through the establishment of the Partnered Research Program in collaboration with the National Association of Veterans' Research and Education Foundation.
- Began to shift ORD's focus from start-up processes and policies to the infrastructure needed to enable VA's clinical research network to support a broader range of trials, and to enable new approaches to reach out to Veterans to provide them with opportunities to participate in studies—especially those living far from VA facilities. These major activities include the following:

  - Established a new Partnered Research Program to streamline start up of externally partnered clinical trials, which included each of the major COVID-19 vaccine trials.
  - Developing efficient processes to enable externally partnered clinical trials within VA to get up and running more rapidly. These efforts emphasize stronger coordination among stakeholders, including VA clinicians, program offices, administrators, industry, VA nonprofit corporations, and patient advocacy groups. The effort also focuses on regulatory and other requirements for supporting these multisite activities.
  - Promoting the NAVIGATE model to provide Veterans greater access to cancer clinical trials, often considered an essential part of optimal cancer care. Our partnership with the NCI serves as a model for federally partnered research and for conducting clinical trials within VA's Precision Oncology Program network.
  - Continuing development of VA's clinical trials infrastructure to produce innovative approaches in Veteran recruitment, especially among Veterans in rural locations; the use of informatics and analytic tools; and quality assurance. Key to this development is enterprise-level investment in clinical trials infrastructure and coordination. Initiatives will look to accelerate our ability to scale up studies to get answers more quickly and to establish infrastructure, policies, and processes for virtual and remote/centralized recruitment models.

These efforts will enhance and expand VA's ability to conduct clinical trials with external partners and will capitalize on the department's unique role as the nation's largest integrated health care system.

Strategic Priority #2: **Increase the substantial real-world impact of VA research**

ORD's goal of increasing the substantial real-world impact of research is guided by the VA Research Lifecycle, as described in the October 2019 issue of *Medical Care*. Before research can be effectively translated into real-world practice, innovations generated by researchers require additional development, validation, and implementation. This ensures all Veterans can benefit from the outcomes of research discoveries.

Advances in genomics and other areas of basic science have accelerated the rate of development of new therapies in animal models. These advances, in turn, will inform new clinical treatments for Veterans. Advances in technology can lead to the development of new devices that improve Veterans' ability to function and their quality of life. VA is also at the forefront of creating new models of care to help frontline providers enhance Veteran access to effective innovations and treatments, notably through telemedicine, mobile technology, and EHR innovations that promote Veteran-centered care.

Before any such treatment or care models can benefit Veterans, however, their effectiveness and feasibility in real-world settings must be evaluated and strategies to scale and spread them must be developed.

ORD aims to ensure Veterans benefit in tangible ways from advances across the spectrum of VA research, including genomics and the basic sciences, rehabilitation and technology, and clinical and implementation science studies. Key activities in this area include the following:

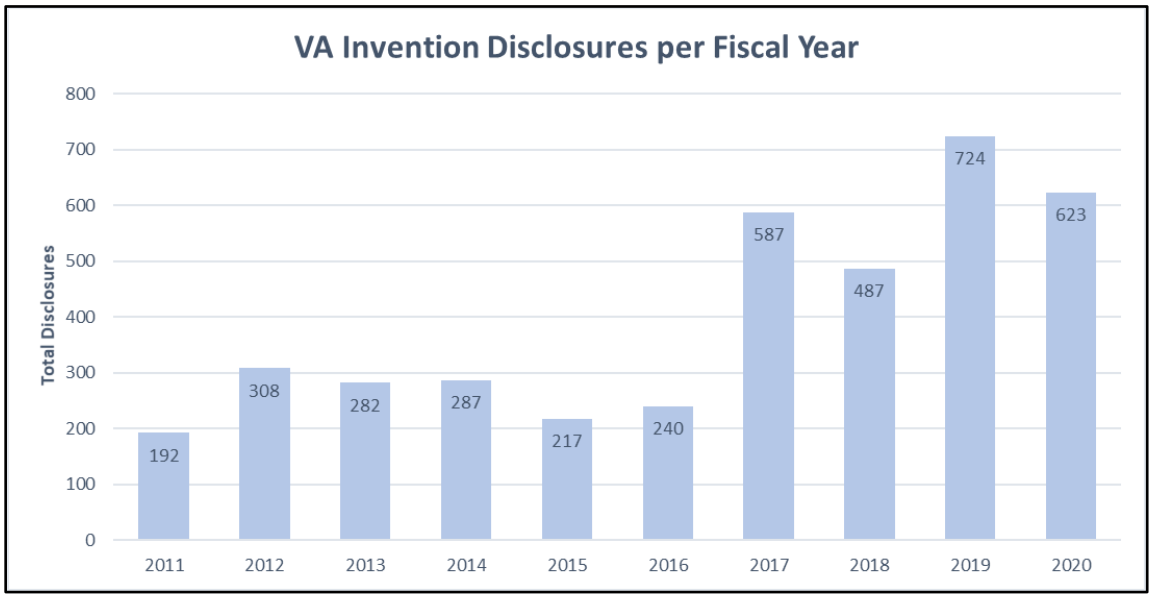
1) **Real-world Impact Programs**

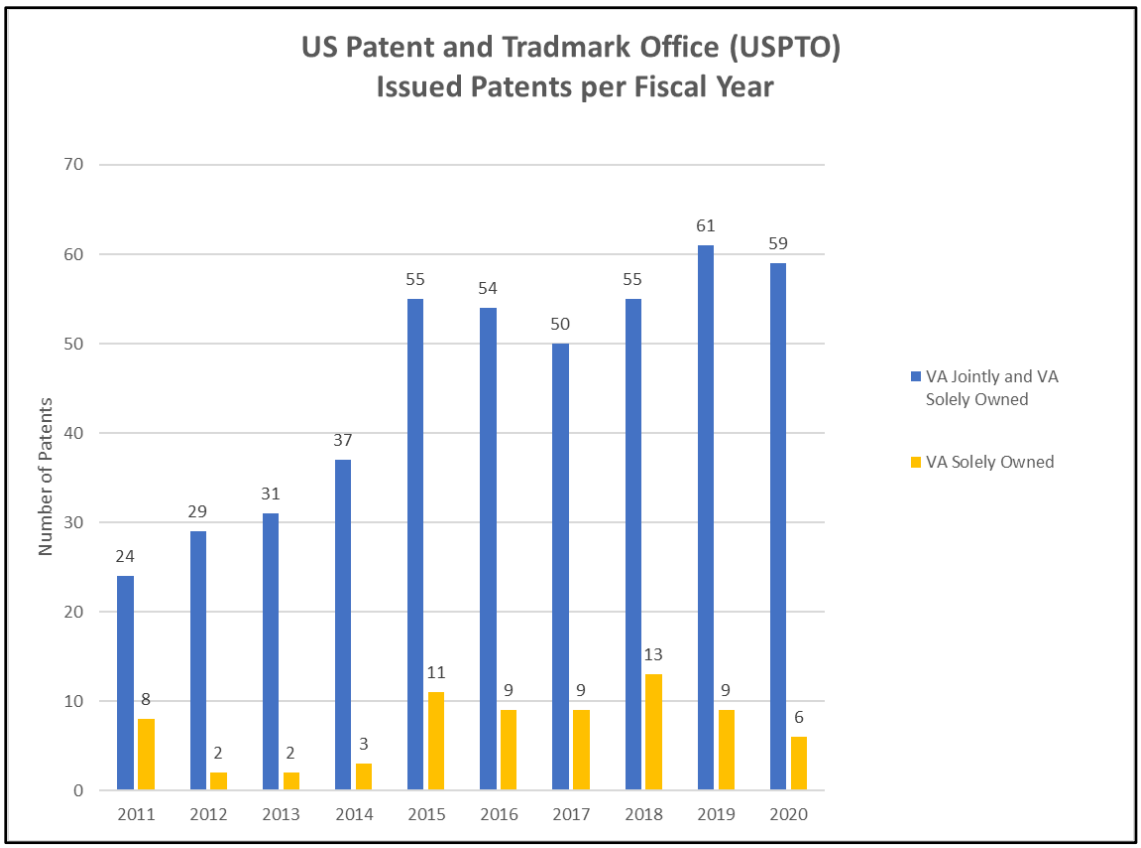
- **High-Priority Veterans Health Issues and Gap Assessment**: ORD leads many initiatives to help inform VA leaders of high-priority health issues affecting Veterans and to let them know where gaps in research exist. Through the Evidence Act, the ORD QUERI program assesses the strength of evidence of VA legislative proposals and identifies and refines evaluation priorities. ORD researchers also produce research roadmaps for major health priorities such as suicide prevention and pain treatment to identify gaps in the science in order to inform further discovery.

  High-priority evaluations of the real-world impact of research on Veteran care include:
  - Launching RFAs to fund research related to the social determinants of health.
  - Implementing the MISSION Act. Fifteen currently active projects are focused on community care and MISSION Act implementation. Research teams are looking at network adequacy; quality of, access to, and cost of care (surgery and mental health); care coordination; measuring systems and networks (including the development of new access measures); community care referrals (hip and knee pain and heart failure); and quality of care for PTSD, depression, and chronic pain care.
  - Implementing the Evidence Act: ORD developed a Strength of Evidence Assessment that VHA now uses to evaluate legislative proposals. The assessment also informs VA's Evaluation Directive and Learning Agenda plans.

- **VA's Technology Transfer Program (TTP):** TTP facilitates the commercialization of VA inventions to benefit Veterans and other Americans. In 2022, ORD will undertake major activities in support of TTP modernization, including:

    - Transitioning the technology transfer knowledge management system to the commercial cloud with certification from the Federal Risk and Authorization Management Program (FedRAMP) and an Approval-to-Operate (ATO) agreement to enable collaboration with TTP's non-VA partners such as VA's academic affiliates and with patent counsel. The knowledge management system in the commercial cloud will also enable online submission of invention disclosures.
    - Expanding the Technology Transfer Assistance Project (TTAP) to include the Cleveland and Minneapolis VAMCs, in addition to the already existing agreement with the Pittsburgh VAMC, to help VA researchers turn technological advancements into devices and products that can be evaluated and deployed to benefit Veterans.
    - Initiating a BRAVE (Bringing Research Advancement for Veterans to Everyone) fund to provide financial support to current researchers with existing VA-owned intellectual property (IP) to help with developing, marketing, and licensing their IP.
    - Building on the partnership established in 2019 with the TechLink Center at Montana State University to help market and license VA IP.
    - Establishing local Technology Transfer Specialists (TTS) at VAMCs to better serve local investigators and help evaluate IP ownership, protect IP, and commercialize IP to help Veterans. A TTS is already located at the Atlanta VAMC and others are being hired at the Tampa and Cleveland VAMCs.





2) Translation of Basic Science Findings

ORD identifies researchers' most promising discoveries for further design, validation, and clinical testing. Specifically, ORD supports initiatives that facilitate the translation of research discoveries to human trials of new treatments that have been shown to be effective in small animals by:

- Increasing the number of licensing agreements that allow private industry to support required studies.
- Increasing the use of interagency partnerships by matching investigators to existing programs in other agencies.
- Encouraging and supporting stronger networking among groups of VA investigators conducting related research and funding translational merit awards to help move discoveries from bench to bedside.

3) Implementation Initiatives to Scale up and Spread Effective Treatments

ORD conducts research to inform scientifically sound implementation strategies to promote uptake of effective innovations by frontline providers. Implementation science (sometimes referred to as knowledge translation) is the study of strategies or methods that facilitate the use of evidence-based treatments in real-world practice to improve access and effectiveness of treatments among Veterans. Implementation science is an interdisciplinary field that strives to develop, refine, and

test specific strategies that support providers in the adoption or adaptation of evidence-based practices (or in some cases, to stop using low-value practices), especially when faced with organizational constraints, such as limited resources and time. ORD has been a national leader in this emerging science, notably through HSR&D. Implementation science is also a core component of the Evidence Act learning agenda, as it ensures effective treatments are handed off to VA practitioners to ultimately reach Veterans. ORD will continue to invest in greater implementation research that benefits Veterans through the following programs:

- **VA Cooperative Studies Program (CSP) Implementation Programs**:
  The goal of these programs is to ensure interventions currently being tested in clinical trials are developed and deployed for real-world use. These programs will support implementation scientists and staff, who will be responsible for applying the CSP Implementation Plan. This involves conducting empirical research on the implementation process of treatments tested in the clinical trials and developing practical strategies to further deploy treatments shown to be effective, including handoffs to VA national leaders, providers, and other stakeholders.

  The CSP Implementation initiative is engaging with stakeholders to tailor each intervention so that it is feasible for use by Veterans or their providers in routine care (for example, by ensuring user-centered design), ascertaining data on the implementation process of the treatment to identify how the intervention will need to be tailored across different health care settings, and determining a process for further deployment of the treatment if it is proven to be effective.

  The effort engages national stakeholders (such as VA clinical operations), who will be responsible for deploying the intervention once the trial is over. Long-term measures of success for the CSP Implementation program include the time it takes from a treatment having proven effective until it has been implemented at sites not participating in the original trial, the number of providers using the treatment, and the number of Veterans receiving the treatment once the trial has been completed. More immediate metrics will focus on the number of studies and interventions for which implementation activities can be included, and developing underlying support for a more systematic approach for incorporating this innovation in CSP trials.

- **Health Services Research and Development Implementation Research programs**: As one of the largest single funders of health services research, HSR&D funds science related to the organization, delivery, and quality of care; health equity; outcomes; and implementation of health care for Veterans. Implementation strategies are theory-based, highly specific methods used to enhance the adoption, implementation, and sustainability of a clinical program or practice, especially by frontline providers once the research funding ends. They have been described as the "how-to" of implementation research.

  VHA has shown it can provide better care than other health systems, but wide variation still exists between facilities in terms of quality. Health services research will address VHA's priority goals to become a high-reliability organization (HRO) and spread best practices more consistently and efficiently across all sites by studying optimal implementation strategies to scale up and spread effective practices.

Projects under ORD's Implementation Research Initiative will test generalizable strategies that scale up and spread effective treatments for Veterans, especially those at high risk of poor outcomes. Program activities will also seek to:

- Capitalize on multilevel partnerships across VHA leaders, providers, consumers (Veterans), and caregivers.
- Leverage our current knowledge of treatment interventions and implementation strategies addressing major health risks and disabilities facing Veterans across the U.S.
- Identify barriers and facilitators to implementation.
- Develop and maintain partnerships that will drive intervention uptake and long-term sustainability.
- Enhance ORD's research capacities to improve health outcomes for Veterans at high risk of poor outcomes.
- Work to define the evidence base for complementary and integrative approaches to care: from testing in clinical trials to establishing evidence-based practices in VA.
- Disseminate the two-year results from 20 Research to Impact for Veterans (RIVR) projects.
- Transition successful projects receiving VA Innovation Ecosystem awards to long-term funding.
- Identify successful new models of care and scaling them to multiple VISNs.

Recent accomplishments:

- Investigators at the Boston VAMC developed a Behavioral Health Interdisciplinary Program of team-based care that reduced mental health hospitalizations and has been adopted for national rollout by VA's Office of Mental Health and Suicide Prevention.
- Research by the Women's Health Research Network on Gender-based Harassment resulted in a national Stand Up to Harassment campaign.
- Researchers at the Bedford and Greater Los Angeles VAMCs evaluated the national implementation of VA's Whole Health initiative and documented the growing use of complementary and integrative health practices among Veterans.
- The STRIDE program to reduce disability among hospitalized patients was scaled to 15 sites and then adopted nationally.
- A quality-improvement program to increase team collaboration among Community Living Center (CLC) staff, developed by VA researchers, improved quality at eight low-performing sites and was adopted for use at all VA CLCs in 2020.
- Lung cancer screening coordinators at three VA medical centers used an online tool developed by VA researchers to discuss the risks and benefits of lung cancer screening. The tool uses a validated lung cancer prediction model to tailor discussions about lung cancer screening to individual patients' risk of developing lung cancer.
- VA providers are implementing best practices in stroke care based on a national directive informed by researchers at the Indianapolis VAMC through the Acute Ischemic Stroke (AIS) Directive. These best practices led to improvements in the rate of thrombolysis (breaking down of blood clots formed in blood vessels through medication) among eligible Veterans from 8.4% in 2007 to 69% in 2017. The AIS Directive was further supported by

a VA national stroke quality-improvement group that implemented stroke care best practices for more than 5,600 Veterans at 86 VA facilities.

- Virtual Care Consortium of Research (CORE): VA has been a longstanding early adopter of virtual care (VC) technologies to support health care delivery, yet evidence has lagged regarding how best to implement such technologies, their impacts on care, and the associated experiences of Veterans and clinical team members. The consortium's goal is to accelerate research that will enhance the accessibility, capacity, and quality of VA health care for Veterans, their families, and their caregivers throughout the nation by taking advantage of emergent telehealth and virtual health technologies deployed by VHA program offices.
- Recent accomplishments in scientific study:
  - Posted an RFA for Merit Awards to support pre-Investigational New Drug (IND) studies required by the FDA before a new drug or biological treatment can be tested in human subjects to cover a current gap in our funding portfolio. Other requests for applications recently posted included awards to validate findings in larger animal species before testing new drugs or biologics in human subjects and for a technology transfer center to support VA investigators with inventions requiring further development.
  - Successfully worked with NIH's National Center for Advancing Translational Sciences to negotiate development support for VA-funded investigators.
  - Concentrated efforts across ORD on translating findings related to complementary and integrative medicine approaches for diseases and disorders impacting Veterans.
  - Launched two "Return of Results" pilots with MVP: one focused on germline genetic mutations in familial hypercholesteremia, and the other on genetic mutations in metastatic prostate cancer. These pilots will determine the clinical utility of the respective genetic mutations in improving clinical care, as well as determine infrastructure requirements within the VA system to scale up these findings.

Activities to be undertaken include:

- **High-priority Veterans' health issues**
  - MISSION Act: Evaluate VHA's program to improve access to care in underserved areas (mandated by Section 401 of the act).
  - Suicide prevention: Evaluate VHA's "caring letters" program, which provides direct patient care for Veterans to prevent suicide among those contacting VA's crisis line.
  - Social Determinants of Health: Fund applications for this special solicitation that will identify, evaluate, and implement evidence-based practices to integrate social care and health care and to mitigate unmet social needs of Veterans.

- **Translational Science Initiatives:** ORD will invest in translational science initiatives that lead to a more substantial real-world impact by further developing or validating discoveries for clinical application and moving clinical trial results for use in real-world settings. These efforts will fill gaps in our translational pipeline, foster crucial linkages to real-world practices to disseminate and implement research, and support VA efforts to develop a VHA workforce that uses research findings in day-to-day practice. VA will focus on efforts to support translations from biomedical research to the preclinical phase to clinical intervention.

- **FDA Authorizations for Human Trials:** We will provide an increased emphasis on support for studies needed to obtain FDA authorization for human trials, and on the funding of phase 1, 2, and 3 clinical trials. Key activities in this area will include:

    - Funding a greater array of translational research activities, to include Merit Awards designed to better advance discoveries through the research pipeline and implementation studies that test different methods for promoting the uptake of effective interventions in real-world practice settings.
    - Translating findings from MVP studies that can improve Veterans' health by advancing treatments for conditions such as PTSD, substance use disorders, diabetes, and cardiovascular disease.
    - Funding ORD Translational Research Development programs in conjunction with Innovation Ecosystem (IE) centers in Puget Sound, Palo Alto, Tampa, Richmond, and Cleveland.
    - Focusing on situations in which complementary and alternative integrative health approaches to diseases and disorders impacting Veterans can be successfully used so that findings are systematically translated across the research spectrum.
    - Organizing and developing additional capabilities for collecting, analyzing, and using real world evidence to inform clinical practice and policies.
    - More effectively disseminating and implementing research findings to end-users and VA stakeholders and supporting strategic partnerships with VA clinical operations. This will be accomplished through the support of technology transfer of innovations derived from VA research, as well as the funding of implementation research initiatives. We will measure success through the adoption of common research impact metrics across projects, including the number of invention disclosures, the number of providers trained in the effective treatment, and the number of Veterans receiving the treatment once the research funding ends.
    - Supporting implementation of clinical treatments proven effective from ORD research.
    - Supporting the development of a VHA workforce that appreciates and understands the value of implementation science and practice-based research. We will do this through training and encouraging participation in state-of-the-art methods in discovery, risk reduction, rigorous evaluation, and implementation science.
    - Supporting the HSR&D Coordinating Hub to Promote Research Optimizing Veteran-Centric Electronic Health Record (EHR) Networks (PROVEN).The PROVEN Hub is designed to provide a single point of contact for the VA research community to design, conduct, and disseminate cutting-edge, operationally prioritized research and evaluation in support of a safe, effective, and efficient implementation of the Cerner Millennium EHR throughout VA.

Strategic Priority #3: **Put VA data to work for Veterans**

VA aims to accelerate scientific discovery by reducing the time and effort needed to appropriately access, properly understand, and effectively use Veteran data for improving Veterans' well-being. VA's investment in health information technology and scientific discovery is coupled with its status as the largest provider of health care and mental health services in the nation. This enables the department to develop some of the most comprehensive and complex medical data in the world, covering diagnoses, medications, procedures, and test results. Much of this information has been

linked to the MVP mega-biobank and to other clinical projects that include both genomic and patient-reported information.

These data resources create possibilities for unparalleled scientific discovery. Maximizing the potential of the data will require key activities in data preparation, infrastructure modernization, strategic partnerships, and dissemination, as detailed below.

Data Preparation
To improve our ability to collect data with the broadest scientific utility and applicability, ORD will link health, demographic, and environmental data sources to better understand exposures, risk profiles, and outcomes of Veterans.
In addition, ORD will curate and standardize these linked records into community-supported standard data models to enable seamless analysis.

Recent accomplishments:

- A centralized VA Phenotype Library (Version 1) was established as a Wiki platform and opened up to VA researchers in May 2020, almost a year ahead of schedule. Our goal is to populate the library with 1,000 phenotypes and their associated metadata by the end of 2021.

Activities to be undertaken include:

- Continuing to recruit VA patients into clinical studies and expanding our recruitment efforts to include Veterans who are not currently using the VA health care system.
- Continuing to collect biospecimens for genomic analysis and investing in next-generation genomic data sequencing.
- Continuing to partner with other federal agencies, including DoD and HHS, and beginning to partner with community health care systems to link health, demographic, and environmental data.
- Developing new methods and tools as part of a national VA infrastructure for conducting causal inference studies that can help evaluate comparative effectiveness and safey of therapies as part of learning healthcare system.
- Curating and standardizing linked data sources so they can be analyzed together seamlessly.
- Supporting the interaction of new medical data with historic VA data as the department transitions to its new EHR system.

Infrastructure Modernization
VA will prioritize information technology resources to improve scientific computing capabilities. This includes continued maintenance of existing infrastructure within VA and an investment in modern, secure, scalable systems that allow incorporation of cutting-edge methods in machine learning and artificial intelligence. Part of the infastrucutre modernization includes the the National Artificial Intelligence (NAII) institute that is dedicated to improving outcomes and experiences for our Veterans by increasing the VA's Artificial Intelligence capacity and capabilities.

Recent accomplishments:

- Received approval to pilot the VA Data Commons through the VA concurrence process. Final IT approvals for granting the VA Data Commons an "Authority to Operate" are underway.
- Began piloting compute space within the VA Enterprise GovCloud to expand functionality available in our on-premise systems.
- Developed a new tool, called VINCI Abstract, to support case reporting for COVID-19. The tool adds natural language processing and structured algorithms to help focus and assist the clinical experts who review medical records to consistently and efficiently identify and record pertinent information. The tool is being expanded to support cancer registry documentation and research use.
- Installed an Observational Health Data Sciences and Informatics (OHDSI) analysis framework that is being used to support network studies where VA contributes to package design and runs the same analysis as several other sites. The resulting aggregate data are then shared and combined in a meta-analysis.
- Installed the OHDSI APHDRODITE probabilistic phenotype package to support MVP projects.
- The VA's National Artificial Intelligence Institute (NAII) worked across VA offices to resource AI models around COVID-19, and took the lead in developing and operationalizing a COVID-19 morbidity/mortality model in coordination with the Washington DC VAMC.
- The NAII contributed language and subject matter expertise to policy makers in support of the Executive Order Promoting the Trustworthy Use of Artificial Intelligence in Government (EO 13960).
- The NAII led VA participation a government-wide hiring sprint to recruit Data Scientists and helped sites across VA diffuse the position descriptions and other documents to aid in their own recruitment efforts.
- In January 2021, the NAII kicked off its second VA Tech Sprint. Participation from industry was up more than 300%, due in-large part to leveraging GSA's Challenge.GOV platform to publicize the invent and provide incentives. More than 30 teams completed the Tech Sprint in May providing unique opportunities for pilots and refinement of future AI Use Cases.

Activities to be undertaken include:

- Maintaining a secure computing environment that allows credentialed researchers access to analysis tools and services that enable them to perform studies on approved VA data.
- Cultivating VA expertise in artificial intelligence and machine learning.
- Expanding scientific computing capability to take advantage of cloud technology that supports machine learning and artificial intelligence.
- Establishing the capability for using and analyzing VA data to advance a learning health care system model focused on population-wide trends of diseases and outcomes, the organization of available research datasets for secondary use, and the collection and evaluation of real-world evidence and training to enhance the available expertise within VA.
- Supporting the interaction of new medical data with historic VA data as the department transitions to its new EHR system.

- Leveraging partnerships with DOE and the University of Chicago to optimize the analysis and eventual clinical impact of large amounts of genomic data.
- Working to implement Executive Order 13960, Promoting the Trustworthy Use of Artificial Intelligence in Government including a VA-wide data call for use cases and cataloging operational AI.
- As part of trustworthy AI initiative, designing an AI-To-Go environment where models from AI researchers can be tested against VA data and receiver user acceptance testing from clinicians/users to ensure human-centered design principles are built into every step of our translational AI processes.
- Working to establish a standard for AI knowledge certification and execute a pilot to evaluate that knowledge.
- Planning an "AI and the Brain" forum to bring researchers and private industry together in this field.

  Planning educational partnerships and AI Tech Sprint focused on quantum computing for privacy preserving AI and/or AI for imaging. NAII has reviewed a number of use cases around privacy preserving AI where quantum computing has unique potential to enable AI to be applied for benefit of Veterans while ensuring their privacy.

Strategic Partnerships

VA can accelerate scientific discovery by engaging in partnerships that benefit Veterans. Such partnerships build on innovations across federal partners, academic institutions, non-profit organizations, and private industry. VA will seek partnerships with the potential to yield the greatest value to Veterans.

VA's partnership with DOE will continue in 2022 to translate findings from initial projects on predictive analytics for suicide, lethal prostate cancer, and cardiovascular disease into clinical decision support tools. Additional joint projects are planned addressing topics such as polypharmacy, COVID-19, pharmacogenomics, and TBI.

In 2022, ORD will launch MERP (Military Exposure Research Program (MERP) in order focus on gap-filling, evidence-based knowledge for Veterans with toxic exposure. This will include callobration with VA, DoD, National Academy of Science, Engineering, and Medicine (NASEM), and other stakeholders. ORD will also maintain its long standing relationship with the Millenium Cohort Study (within DoD) that conducts prospective epidemiological research to evaluate the impact of military exposures, including deployment on long-term health outcomes.

Recent accomplishments:

- Launched the Artificial Intelligence (AI) Tech Sprint. The Sprint seeks to build collaborations and potential partnerships by designing AI-enabled research and development tools that leverage federal research and development data to address Veterans' needs. In 2019, based on the results of the Sprint, an industry team and a non-profit team/industry combination team were recognized by a national competition run by the U.S. Department of Commerce and the White House Chief Information Officer. They won a first place prize for their submission, "Creating the Future of Health."
- Worked with the National Science Foundation to design and co-launch a cross-federal National AI Research Institutes program.

Activities to be undertaken include:

- Working with the Veteran community to better understand the value they perceive from the use of their data to support scientific discovery.
- Streamlining researchers' access to VA data, and ensuring appropriate safeguards are in place.
- Developing methods to efficiently manage and track the use of Veteran data in research.
- Preparing new AI Tech Sprints engagements around datasets that will foster collaborations and potential partnerships with industry, Veterans, and others.

Public Access

In response to directives and instructions from the White House Office of Science and Technology Policy (OSTP) and the Office of Management and Budget, VA developed and enacted a plan to increase public access to scientific publications and digital data from VA-funded research. As a result of a request from Congress in House Report 115-673, a status update on this effort is provided here.

- Through December 2019, ORD had received more than 2,500 applications from investigators in that calendar year under its required Data Management Plan policy. These plans detail proposed activities related for publishing results and preserving and managing study data, as well as addressing human subject protection and privacy concerns.
- As of December 2019, 1,355 articles had published in that calendar year resulting from VA-funded research had been deposited by VA investigators in PubMed Central, as per the plan's requirements. As of June 2020, more than 18,000 VA publications were listed in PubMed Central.
- Activities in this area also help support the Foundations for Evidence-Based Policymaking (FEBP) Act by providing data and evidence for decision making, especially in the area of clinical care.

Recent accomplishments:

- Established a centralized website to help investigators identify potential clinical research datasets that may be available for further secondary analyses.
- Created VA Data Commons, a secure research environment that will allow managed access to clinical and genetic resources that have been consented by persons enrolled in the Million Veteran Program.

Activities to be undertaken include:

- Continuing to build the number of included research datasets in a national clearinghouse as a resource for investigators interested in secondary use of data, with a new focus on multisite clinical trial datasets.
- Continuing to pursue steps that will enable a cloud-based or other data repository capability for storing digital data to be made available for research under a VA Data Commons model.
- Evaluating capabilities in Cerner as part of VHA's Electronic Health Record Modernization activities to determine how the reporting of clinical trials results into Clinicaltrials.gov may be transitioned.
- Leveraging VA activities focused on precision oncology and genomics research to help provide a broader set of data that may be used for advancing research.

- Through VINCI, working with DOE and HHS on a COVID-19 Insights Partnership, an initiative to coordinate and share health data as well as research and expertise to aid in the fight against COVID-19.

Supplemental Tables

Designated Research Areas (DRA) represent areas of importance to our Veteran patient population. The amounts shown for these research areas are not mutually exclusive and detail projects tracked in the Research Analysis and Forecasting Tool (RAFT). 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.

The funding made available by the American Rescue Plan Act (Public Law 117-2, Section 8002) is included within the Infectious Disease DRA and will be executed out of a new budget account, the Veterans Medical Care and Health Fund.

Table: Appropriations by Designated Research Area (DRA)[1]

(dollars in thousands)

Description	2020 Estimate	2021 Budget Estimate	2021 Current Estimate	2022 Request	2021-2022 Inc/Dec
Acute & Traumatic Injury	$25,893	$30,434	$25,893	$25,893	$0
Aging	$147,704	$150,345	$147,704	$147,704	$0
Autoimmune, Allergic & Hematopoietic Disorders	$38,912	$35,296	$38,912	$38,912	$0
Cancer	$64,285	$64,684	$64,285	$69,285	$5,000
CNS Injury & Associated Disorders	$107,111	$110,807	$107,111	$127,111	$20,000
Degenerative Diseases of Bones & Joints	$41,136	$41,783	$41,136	$41,136	$0
Dementia & Neuronal Degeneration	$41,633	$36,847	$41,633	$41,633	$0
Diabetes & Major Complications	$47,144	$48,846	$47,144	$47,144	$0
Digestive Diseases	$26,071	$25,132	$26,071	$26,071	$0
Emerging Pathogens/Bio-Terrorism	$3,043	$1,949	$3,043	$3,043	$0
Gulf War Veterans Illness	$15,539	$16,000	$15,539	$15,539	$0
Health Systems	$69,915	$69,030	$69,915	$69,915	$0
Heart Disease/Cardiovascular Health	$71,637	$73,222	$71,637	$71,637	$0
Infectious Diseases	$38,079	$34,027	$47,079	$57,079	$10,000
Kidney Disorders	$18,225	$19,332	$18,225	$18,225	$0
Lung Disorders	$27,877	$27,359	$27,877	$27,877	$0
Mental Illness	$121,644	$116,940	$121,644	$121,644	$0
Military Occupations & Environ. Exposures	$23,389	$23,186	$23,389	$30,354	$6,965
Other Chronic Diseases	$7,610	$5,315	$7,610	$7,610	$0
Prosthetics	$25,451	$24,147	$25,451	$25,451	$0
Sensory Loss	$23,171	$20,523	$23,171	$23,171	$0
Special Populations	$42,823	$30,690	$42,823	$42,823	$0
Substance Abuse	$29,937	$32,017	$29,937	$29,937	$0

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.

Table: Projects by Designated Research Area (DRA)[1]

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Request	2021-2022 Inc/Dec
Acute & Traumatic Injury….	110	120	110	110	0
Aging….	719	680	719	719	0
Autoimmune, Allergic & Hemaptopoietic Disorders….....	185	160	185	185	0
Cancer….	281	276	281	299	18
Central Nervous System Injury & Associated Disorders…	420	400	420	490	70
Degenerative Diseases of Bones & Joints….....	176	160	176	176	0
Dementia & Neuronal Degeneration….....	175	173	175	175	0
Diabetes & Major Complications….....	188	180	188	188	0
Digestive Diseases….....	142	120	142	142	0
Emerging Pathogens/Bio-Terrorism….....	21	10	21	21	0
Gulf War Research Illness….....	42	51	42	42	0
Health Systems….....	258	218	258	258	0
Heart Disease….....	299	283	299	299	0
Infectious Diseases….....	180	140	189	224	35
Kidney Disorders….....	108	100	108	108	0
Lung Disorders….....	124	118	124	124	0
Mental Illness….....	500	460	500	500	0
Military Occupations & Environ. Exposures	96	91	96	121	25
Other Chronic Diseases….....	44	28	44	44	0
Prosthetics….....	85	76	85	85	0
Sensory Loss….....	101	88	101	101	0
Special Populations….....	170	130	170	170	0
Substance Abuse….....	127	128	127	127	0

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.

Table: Obligations by Object Class

(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Request	2021-2022 Inc/Dec
10 Personal Services	$409,740	$388,000	$443,574	$448,000	$4,426
21 Travel & Transportation of Persons:					
Employee Travel	$2,504	$6,200	$1,000	$3,000	$2,000
All Other	$100	$100	$100	$100	$0
Subtotal	$2,604	$6,300	$1,100	$3,100	$2,000
22 Transportation of Things	$449	$300	$300	$300	$0
23 Communication, Utilities & Misc	$576	$1,000	$600	$1,000	$400
24 Printing & Reproduction	$0	$400	$400	$400	$0
25 Other Services:					
Medical Care Contracts & Agree. w/Insts. & Orgs	$88,349	$137,233	$100,396	$93,000	($7,396)
Fee Basis - Medical & Nursing Services, On-Station	$9	$150	$9	$150	$141
Consultants & Attendance	$50	$100	$50	$100	$50
Scarce Medical Specialist	$0	$170	$0	$170	$170
Repair of Furniture & Equipment	$2,792	$2,400	$3,000	$2,400	($600)
Maintenance & Repair Services	$1,000	$1,000	$10	$1,000	$990
Administrative Contractual Services	$257,486	$217,447	$297,806	$328,980	$31,174
Training Contractual Services	$1,500	$1,500	$1,500	$1,500	$0
Subtotal	$351,186	$360,000	$402,771	$427,300	$24,529
26 Supplies & Materials	$45,823	$49,000	$48,595	$46,000	($2,595)
31 Equipment	$36,737	$59,000	$54,760	$45,000	($9,760)
32 Lands & Structures	$0	$0	$0	$0	$0
Total Obligations	$847,115	$864,000	$952,100	$971,100	$19,000

Table: American Rescue Plan

Description	2020 Actual	2021 Budget Estimate	2021 Current[1]	2022 Request	2021-2022 Inc/Dec
10 Personal Services	$0	$0	$4,000	$0	($4,000)
25 Other Services:					
Administrative Contractual Services	$0	$0	$5,000	$0	($5,000)
Subtotal			$5,000		($5,000)
Total Obligations	$0	$0	$9,000	$0	($9,000)

VA plans to use $9 Million of the funding provided in section 8002 of the American Rescue Plan Act for Research, which will be executed out of a new budget account, the Veterans Medical Care and Health Fund. Final 2022 funding allocations among categories may change based on 2021 actuals and in response to workload demand requirements throughout 2022.

Revolving and Trust Activities

Part 4

Canteen Service Revolving Fund **589**
Medical Center Research Organizations **595**
General Post Fund **599**

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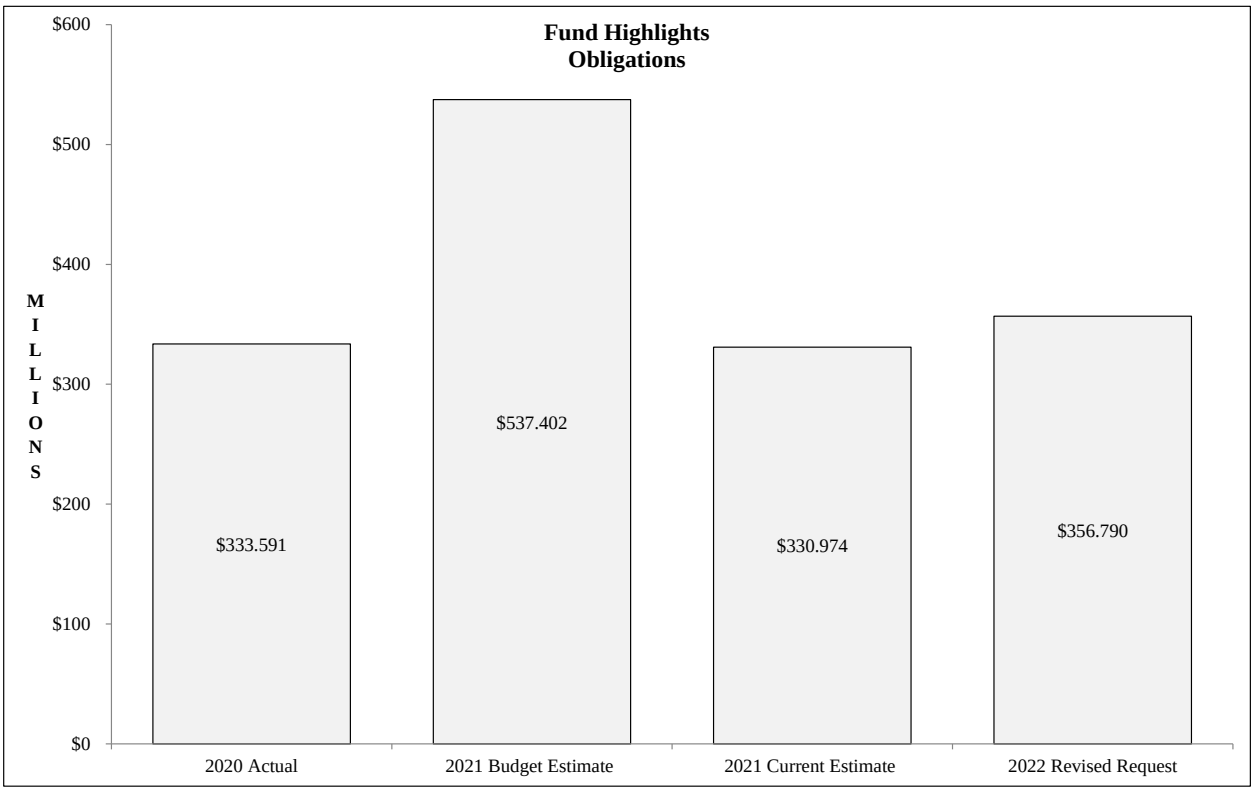
Veterans Canteen Service Revolving Fund



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 Department of Veterans Affairs (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 Healthcare 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 2021 and beyond.

Fund Highlights /1
(dollars in thousands)

Description	2020 Actual /2	2021 Budget Estimate	2021 Current Estimate	2022 Estimate	+/- 2021-2022
Total revenue.....	$310,406	$537,402	$330,974	$364,071	$33,097
Obligations.....	$310,406	$537,402	$330,974	$356,790	$25,816
FTE.....	2,977	3,285	3,285	3,500	215

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.
2/ Due to the timing of the file interface between VCS' financial system and FMS, the Budgetary Resources were revised downward by $124 million. A final reconciliation of the financial systems had not been completed in-time to correct the official end of year report. This will be addressed in future year end accounting reports

The retail-calendar-fiscal-year reporting cycle has been adopted in order 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 2022. 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 2021 Budget Request
(dollars in thousands)

Description	2021 Budget Estimate	2021 Current Estimate	Increase/ Decrease
Total revenue.....	$537,402	$330,974	($206,428)
Obligations.....	$537,402	$330,974	($206,428)
FTE.....	3,285	3,285	0

As a result of the COVID-19 Pandemic in 2020, VA Canteen Service closed for much of the year. The Canteen Service is beginning to see a gradual increase in customers; however, it is still approximately 100,000 visitors per day below average. It is anticipated that this trend will continue until facilities are able to re-open at full capacity and resume pre-pandemic operations.

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 employment (FTE) for 2020 through 2022:

Summary of Employment

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Estimate	+/- 2021-2022
FTE.....	2,977	3,285	3,285	3,500	215

Revenues and Expenses
(dollars in thousands)

	2020 Actual *	2021 Budget Estimate	2021 Current Estimate	2022 Estimate	+/- 2021-2022
Sales Program:					
Revenue.....	$310,406	$537,402	$330,974	$364,071	$33,097
Less operating expenses.....	($350,726)	($526,654)	($346,889)	($374,640)	($27,751)
Net operating income-sales.....	($40,320)	$10,748	($15,915)	($10,569)	$5,346
Net non-operating income.....	($8,480)	($9,000)	($8,480)	($9,328)	($848)
Net income for the year.....	($48,800)	$1,748	($24,395)	($19,897)	$4,498

* Due to the timing of the file interface between VCS' financial system and FMS, the Budgetary Resources were revised downward by $124 million. A final reconciliation of the financial systems had not been completed in-time to correct the official end of year report. This will be addressed in future year end accounting reports

Financial Condition

The schedule below reflects the anticipated financial condition of the VCS through 2022. Changes from year to year are the result of anticipated changes in revenues, obligations, and outlays previously portrayed.

As a result of the COVID-19 pandemic, VCS operations in 2021 are operating at a $25 million loss. In addition to the loss, cash flow was negative, disbursements were on average $2 million more than collections. By legislative authority, VCS is an independent unit within the VA, and operations, including personnel costs, are paid using our revolving fund. To account for loss revenue, the CARES Act provided authority to transfer $140 million from Medical Services to VCS, without which the revolving fund would have been depleted and service to our Veterans adversely impacted.

Financial Condition
(dollars in thousands)

		2021			
	2020 Actual	Budget Estimate	Current Estimate	2022 Estimate	+/- 2021-2022
Assets:					
Cash with Treasury, in banks, in transit	$35,000	$33,765	$33,765	$32,422	($1,343)
Accounts receivable (net)	$55,000	$57,750	$57,750	$60,638	$2,888
Inventories	$23,346	$24,513	$24,513	$25,739	$1,226
Real property and equipment (net)	$25,000	$26,250	$26,250	$27,563	$1,313
Other assets	$500	$525	$525	$551	$26
Total assets	$138,846	$142,803	$142,803	$146,912	$4,109
Liabilities:					
Accounts payable including funded accrued liabilities	$48,125	$49,643	$49,643	$51,280	$1,637
Unfunded annual leave and coupons books	$12,791	$13,431	$13,431	$14,102	$672
Total liabilities	$60,916	$63,074	$63,074	$65,382	$2,309
Assets Minus Liabilities:					
Unexpended balance:					
Unobligated balance	$33,346	$35,013	$35,013	$36,764	$1,751
Undelivered orders	$0	$0	$0	$0	$0
Invested capital	$44,584	$44,716	$44,716	$44,766	$50
Assets Minus Liabilities	$77,930	$79,729	$79,730	$81,530	$1,800

Retained Income
(dollars in thousands)

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Estimate	+/- 2021-2022
Retained Income:					
Opening Balance	$75,682	$77,930	$50,567	$26,224	($24,343)
Transactions:					
Net Operating Income	($25,615)	$1,748	($24,395)	($19,897)	$4,498
Net Non-Operating Gain	$500	$52	$52	$52	$0
Closing Balance	$50,567	$79,730	$26,224	$6,379	($19,845)

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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 Department of Veterans Affairs 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, 81 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 81 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 at September 30th or December 31st. The table below reflects estimated revenues and expenses from 2020 to 2022.

Table: Contribution Highlights

Contribution Highlights
(dollars in thousands)

	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Estimate	+/- 2021-2022
Contributions.....	$258,295	$252,933	$259,449	$261,574	$2,125
Expenses.....	$258,295	$252,933	$247,846	$248,256	$410

The following table is a list of research corporations that have received approval for formation along with their actual 2020 contributions 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, to date, received any contributions:

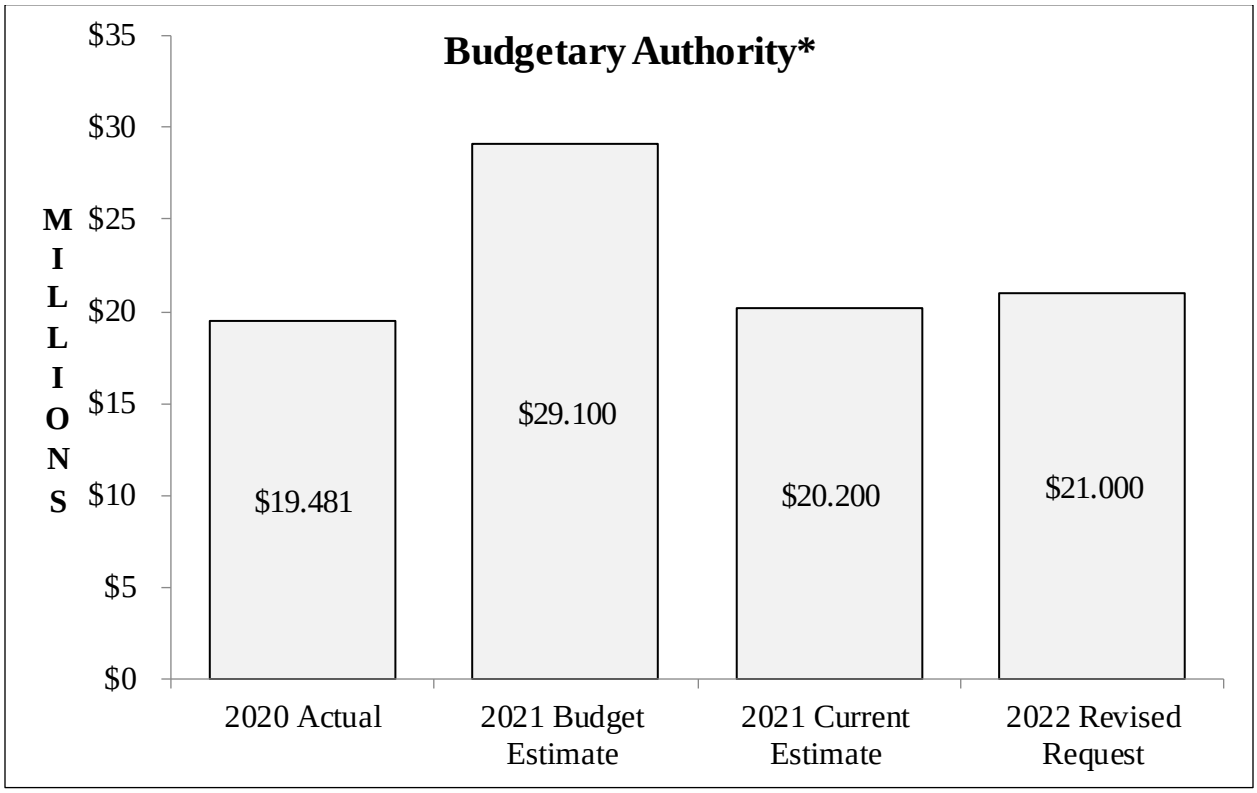
Table: Nonprofit Corporations

	Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2020	Estimated Revenues (Contributions) 2021	Estimated Revenues (Contributions) 2022
1.	Albany Research Institute, Inc.	Albany	NY	900,000	1,000,000	1,100,000
2.	Arizona Veterans Research and Education Foundation	Phoenix	AZ	2,051,000	2,250,000	2,400,000
3.	Asheville Medical Research and Education Corporation	Asheville	NC	40,000	110,000	140,000
4.	Augusta Biomedical Research Corporation	Augusta	GA	60,000	60,000	60,000
5.	Baltimore Research and Education Foundation	Baltimore	MD	3,240,000	3,402,000	3,572,000
6.	Bedford VA Research Corporation, Inc.	Bedford	MA	152,000	121,000	121,000
7.	Biomedical Research and Education Foundation of Southern Arizona	Tucson	AZ	1,600,000	1,700,000	1,800,000
8.	Biomedical Research Foundation	Little Rock	AR	1,150,000	1,400,000	1,500,000
9.	Biomedical Research Institute of New Mexico	Albuquerque	NM	7,457,000	7,681,000	7,911,000
10.	Boston VA Research Institute, Inc.	Boston	MA	11,900,000	11,800,000	11,700,000
11.	Brentwood Biomedical Research Institute	Los Angeles	CA	6,751,000	6,702,000	6,654,000
12.	Bronx Veterans Medical Research Foundation, Inc.	Bronx	NY	4,500,000	4,000,000	4,000,000
13.	Buffalo Institute for Medical Research, Inc.	Buffalo	NY	871,000	1,170,000	1,200,000
14.	Center for Veterans Research and Education	Minneapolis	MN	5,653,000	5,936,000	6,233,000
15.	Central Texas Veterans Research Foundation	Temple	TX	1,069,000	1,415,000	864,000
16.	Chicago Association for Research and Education in Science	Hines	IL	4,000,000	4,000,000	4,000,000
17.	Cincinnati Education & Research for Veterans Foundation	Cincinnati	OH	2,015,000	2,176,000	2,350,000
18.	Clinical Research Foundation, Inc.	Louisville	KY	63,000	69,000	76,000
19.	Dallas VA Research Corporation	Dallas	TX	1,575,000	1,622,000	1,700,000
20.	Dayton VA Research and Education Foundation	Dayton	OH	112,000	200,000	200,000
21.	Denver Research Institute, Inc.	Denver	CO	848,000	667,000	710,000
22.	Dorn Research Institute, Inc.	Columbia	SC	358,000	430,000	480,000
23.	East Bay Institute for Research and Education	Sacramento	CA	1,100,000	1,300,000	1,500,000
24.	Foundation for Advancing Veterans' Health Research, Inc.	San Antonio	TX	3,422,000	3,809,000	4,162,000
25.	Foundation for Atlanta Veterans Education and Research, Inc.	Atlanta	GA	8,741,000	8,828,000	8,916,000
26.	Great Plains Veterans Research Foundation	Sioux Falls	SD	45,000	50,000	100,000
27.	Houston VA Research and Education Foundation	Houston	TX	800,000	900,000	1,000,000
28.	Indiana Institute for Medical Research, Inc.	Indianapolis	IN	1,065,000	1,097,000	1,130,000

	Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2020	Estimated Revenues (Contributions) 2021	Estimated Revenues (Contributions) 2022
29.	Institute for Clinical Research, Inc.	Washington	DC	4,000,000	4,500,000	4,700,000
30.	Institute for Medical Research, Inc.	Durham	NC	2,110,000	2,250,000	900,000
31.	Idaho Veterans Research and Education Foundation	Boise	ID	2,200,000	1,900,000	1,000,000
32.	Iowa City VA Medical Research Foundation	Iowa City	IA	625,000	675,000	700,000
33.	Lexington Biomedical Research Institute, Inc.	Lexington	KY	400,000	300,000	300,000
34.	Loma Linda Veterans Association for Research and Education, Inc.	Loma Linda	CA	750,000	800,000	800,000
35.	Louisiana Veterans Research and Education Corporation	New Orleans	LA	107,000	134,000	168,000
36.	Lowcountry Center for Veterans Research	Charleston	SC	1,201,000	1,321,000	1,453,000
37.	McGuire Research Institute, Inc.	Richmond	VA	3,350,000	4,000,000	4,100,000
38.	Metropolitan Detroit Research and Education Foundation	Detroit	MI	150,000	200,000	250,000
39.	Middle Tennessee Research Institute, Inc.	Nashville	TN	750,000	750,000	750,000
40.	Midwest Veterans' Biomedical Research Foundation	Kansas City	MO	2,500,000	3,000,000	3,000,000
41.	Mountain Home Research and Education Corporation	Mountain Home	TN	400,000	400,000	200,000
42.	Narrows Institute for Biomedical Research, Inc.	Brooklyn	NY	275,000	275,000	275,000
43.	Nebraska Educational Biomedical Research Association	Omaha	NE	220,000	242,000	266,000
44.	North Florida Foundation for Research and Education, Inc.	Gainesville	FL	325,000	357,000	393,000
45.	Northern California Institute for Research and Education, Inc.	San Francisco	CA	49,485,000	47,011,000	46,071,000
46.	Ocean State Research Institute, Inc.	Providence	RI	883,000	884,000	884,000
47.	Overton Brooks Research Corporation	Shreveport	LA	35,000	35,000	35,000
48.	Pacific Health Research and Education Institute	Honolulu	HI	2,000,000	1,500,000	1,500,000
49.	Palo Alto Veterans Institute for Research	Palo Alto	CA	31,315,000	32,097,000	33,060,000
50.	Philadelphia Research and Education Foundation	Philadelphia	PA	398,000	438,000	469,000
51.	Portland VA Research Foundation, Inc.	Portland	OR	7,000,000	7,200,000	7,400,000
52.	Research! Mississippi, Inc.	Jackson	MS	140,000	190,000	375,000
53.	Research, Incorporated	Memphis	TN	1,800,000	1,900,000	1,950,000
54.	Salem Research Institute, Inc.	Salem	VA	1,500,000	1,350,000	1,500,000
55.	Salisbury Foundation for Research and Education, Inc.	Salisbury	NC	762,000	853,000	950,000

	Nonprofit Corporations	City	State	Actual Revenues (Contributions) 2020	Estimated Revenues (Contributions) 2021	Estimated Revenues (Contributions) 2022
56.	Seattle Institute for Biomedical and Clinical Research	Seattle	WA	16,325,000	15,640,000	15,300,000
57.	Sepulveda Research Corporation	Sepulveda	CA	2,646,000	2,619,000	2,594,000
58.	Sierra Veterans Research and Education Foundation	Reno	NV	234,000	240,000	245,000
59.	Sociedad de Investigacion Cientificas, Inc	San Juan	PR	490,000	500,000	700,000
60.	South Florida Veterans Affairs Foundation for Research and Education, Inc.	Miami	FL	3,000,000	3,000,000	3,000,000
61.	Southern California Institute for Research and Education	Long Beach	CA	2,900,000	3,500,000	4,100,000
62.	Tampa VA Research and Education Foundation, Inc	Tampa	FL	2,200,000	2,000,000	2,000,000
63.	The Bay Pines Foundation, Inc	Bay Pines	FL	942,000	1,036,000	1,140,000
64.	The Cleveland VA Medical Research and Education Foundation	Cleveland	OH	5,038,000	5,189,000	5,345,000
65.	The Research Corporation of Long Island, Inc	Northport	NY	464,000	145,000	100,000
66.	Truman VA Medical Research Foundation	Columbia	MO	333,000	500,000	625,000
67.	Tuscaloosa Research and Education Advancement Corporation	Tuscaloosa	AL	1,269,000	1,179,000	210,000
68.	VA Black Hills Research and Education Foundation	Fort Meade	SD	10,000	12,000	15,000
69.	VA Connecticut Research and Education Foundation	West Haven	CT	1,500,000	1,750,000	1,750,000
70.	Veterans Bio-Medical Research Institute, Inc	East Orange	NJ	2,043,000	2,448,000	2,315,000
71.	Veterans Education and Research Association of Michigan	Ann Arbor	MI	1,300,000	1,400,000	1,500,000
72.	Veterans Education and Research Ass'n. of Northern New England, Inc	White River Junction	CT	3,216,000	3,377,000	3,546,000
73.	Veterans Health Research Institute of Central New York, Inc	Syracuse	NY	1,184,000	1,196,000	1,208,000
74.	Veterans Medical Research Foundation of San Diego	San Diego	CA	15,000,000	14,000,000	15,000,000
75.	Veterans Research and Education Foundation	Oklahoma City	OK	410,000	450,000	500,000
76.	Veterans Research and Education Foundation of St. Louis	St Louis	MO	2,138,000	2,352,000	2,588,000
77.	Veterans Research Foundation of Pittsburgh	Pittsburgh	PA	2,017,000	2,118,000	2,224,000
78.	VISTAR, Inc	Birmingham	AL	125,000	140,000	158,000
79.	Western Institute for Biomedical Research	Salt Lake City	UT	5,762,000	5,934,000	6,113,000
80.	Westside Institute for Science and Education	Chicago	IL	1,266,000	0	0
81.	Wisconsin Corporation for Biomedical Research	Milwaukee	WI	264,000	267,000	270,000
	Totals			**$258,295,000**	**$259,449,000**	**$261,574,000**

General Post Fund



***Fund consists of gifts, bequests and proceeds from the sale of property.**

Program Description

This trust fund consists of gifts, bequests, and proceeds from the sale of property left in the care of Department of Veterans Affairs 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

Fund Highlights
(dollars in thousands)

Description	2020 Actual	2021 Budget Estimate	2021 Current Estimate	2022 Estimate	+/- 2021-2022
Budget Authority (permanent, indefinite).....	$19,481	$29,100	$20,200	$21,000	$800
Projected Receipts :					
Trust Fund and Donation.....	$15,530	$23,700	$22,600	$23,700	$1,100
Therapeutic Residences.....	$1,564	$1,200	$1,600	$1,700	$100
Total Projected Receipts.....	$17,094	$24,900	$24,200	$25,400	$1,200

Table 2: Changes From Original 2021 Budget Estimate

Changes From Original 2021 Budget Estimate
(dollars in thousands)

Description	2021 Budget Estimate	2021 Current Estimate	Increase/ Decrease
Budget Authority (permanent, indefinite).....	$29,100	$20,200	($8,900)
Projected Receipts:			
Trust Fund and Donation.....	$23,700	$22,600	($1,100)
Therapeutic Residences.....	$1,200	$1,600	$400
Total Projected Receipts.....	$24,900	$24,200	($700)

Program Activity

Trust Fund and Donations
Estimates of trust fund obligations for 2021 and 2022 are $20,200,000 and $21,000,000 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)

Cash receipts from donations and estates for both fiscal years 2021 and 2022 are estimated to reach $22,600,000 and $23,700,000 respectively. The invested reserve at the start of 2021 was $98,975,000 as shown in Table 3.

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 $500,000 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

Financial Actions and Conditions
(dollars in thousands)

	2020 Actual
Balance beginning of year:	
Cash	$2,236
Investments	$120,205
Property, Plant, Equipment & Other Assets	$40,273
Total	$162,714
Increase during period:	
Cash	$64,357
Investments	$26,237
Property, Plant, Equipment & Other Assets	$13,793
Total	$104,387
Decrease during period:	
Cash	$39,964
Investments	$47,467
Property, Plant, Equipment & Other Assets	$3,555
Total	$90,986
Balance at end of year:	
Cash	$26,629
Investments	$98,975
Property, Plant, Equipment & Other Assets	$50,511
Total	$176,115

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Electronic Health Record Modernization

Part 5

Electronic Health Record Modernization..... 607
Budget Authority and Appropriation Language 607
Appropriation Highlights..... 608
Budget Overview 609
Accomplishments..... 616
DoD/VA Joint Electronic Health Record Collaboration 621
Total Obligations by Subaccount 623
Appendix..... 635
Appendix A: Obligations by Object Class..... 635
Appendix B: End of Year Staffing Level by Grade 636

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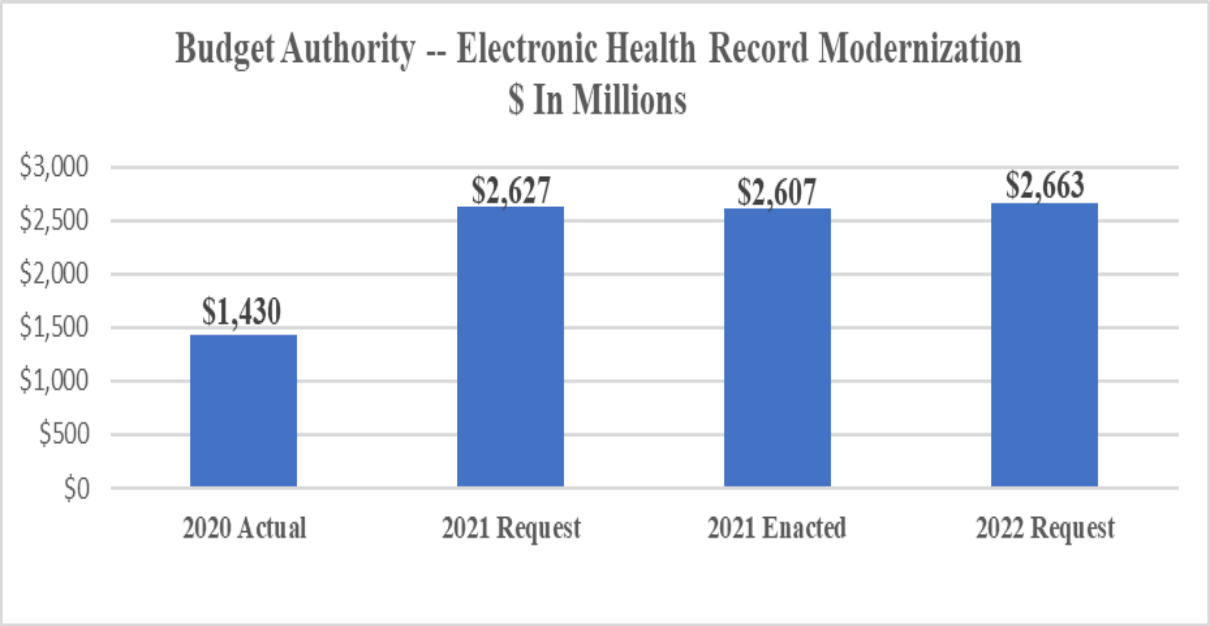
Electronic Health Record Modernization

Budget Authority and Appropriation Language



Note: 2021 Enacted reflects a rescission of $20 million from unobligated balances required by P.L. 116-260, Consolidated Appropriations Act, 2021, Division J, Title II, section 254.

Appropriation Language

Veterans Electronic Health Record

For activities related to implementation, preparation, development, interface, management, rollout, and maintenance of a Veterans Electronic Health Record system, including contractual costs associated with operations authorized by section 3109 of title 5, United States Code, and salaries and expenses of employees hired under titles 5 and 38, United States Code, **[**$2,627,000,000**]** *$2,663,000,000*, to remain available until September 30, **[**2023**]** *2024*: *Provided*, That the Secretary of Veterans Affairs shall submit to the Committees on Appropriations of both Houses of Congress quarterly reports detailing obligations, expenditures, and deployment implementation by facility, including any changes from the deployment schedule: *Provided further*, That the funds provided in this account shall only be available to the Office of the Deputy Secretary, to be administered by that Office [*Provided further*, That none of the funds made available under this heading may be obligated in a manner inconsistent with deployment schedules provided to the Committees on Appropriations unless the Secretary of Veterans Affairs provides notification to the Committees on Appropriations of such change and an approval is issued**]**.

Appropriation Highlights

Appropriation Highlights (Dollars in Thousands)					
		2021		2022	2021-2022
	2020 Actual	President's Budget	Current Estimate	Request	Increase/ Decrease
Appropriation by Subaccounts:					
EHR Contract	$1,003,500	$1,191,000	$1,191,000	$1,425,498	$234,498
Infrastructure Support	$327,900	$1,181,000	$1,181,000	$951,797	($229,203)
Program Management	$168,600	$255,000	$255,000	$285,705	$30,705
Appropriation Subtotal:	**$1,500,000**	**$2,627,000**	**$2,627,000**	**$2,663,000**	**$36,000**
PL 116-94, PL 116-260 Rescission	($70,000)		($20,000)		$20,000
Planned Budget Authority:	**$1,430,000**	**$2,627,000**	**$2,607,000**	**$2,663,000**	**$56,000**
Funding Sources:					
Appropriation	**$1,500,000**	**$2,627,000**	**$2,627,000**	**$2,663,000**	**$36,000**
FY 18/20 Carryover SOY:					
EHR Contract	$1,000				$0
Program Management	$15,892				$0
Infrastructure Support					$0
Subtotal	$16,892	$0	$0	$0	$0
FY 19/21 Carryover SOY:					
EHR Contract	$21,326				$0
Program Management	$15,004		$11,648		($11,648)
Infrastructure Support	$40,904				$0
Subtotal	$77,234	$0	$11,648	$0	($11,648)
FY 20/22 Carryover SOY:					
EHR Contract			$4,172		($4,172)
Program Management			$277		($277)
Infrastructure Support			$8,333		($8,333)
Subtotal	$0	$0	$12,782	$0	($12,782)
Total Carryover Balance SOY (+)	$94,126	$0	$24,430	$0	($24,430)
Carryover Rescission:					
FY 18/20 Carryover					
EHR Contract	($1,000)				$0
Infrastructure Support	($200)				$0
Program Management	($5,700)		($11,648)		$11,648
FY 19/21 Carryover					
EHR Contract	($21,326)		($4,172)		$4,172
Infrastructure Support	($40,903)		($277)		$277
Program Management	($871)		($3,903)		$3,903
Subtotal	($70,000)	$0	($20,000)	$0	$20,000
FY 18/20 Carryover EOY:					
Program Management	($113)				$0
Subtotal	($113)	$0	$0	$0	$0
FY 19/21 Carryover EOY:					
Program Management	($11,648)		$0		$0
Subtotal	($11,648)	$0	$0	$0	$0
FY 20/22 Carryover EOY:					
EHR Contract	($4,172)		$0		$0
Infrastructure Support	($277)		$0		$0
Program Management	($8,333)		$0		$0
Subtotal	($12,782)	$0	$0	$0	$0
Total Carryover Balance EOY (-)	**($24,543)**	**$0**	**$0**	**$0**	**$0**
Prior Year Recoveries	**$10,446**				
Total Obligations	**$1,510,029**	**$2,627,000**	**$2,631,430**	**$2,663,000**	**$31,570**
Staffing (FTE)	**114**	**256**	**226**	**337**	**111**
End of Year Staffing Level	**215**	**316**	**385**	**539**	**154**

Budget Overview

2022 Budget Request at a Glance	
($ in thousands)	
2021 Enacted Level	$2,607,000
Program Changes	$56,000
2022 Budget Request	$2,663,000
Change from 2021 Enacted Level	2.1%

VA is requesting $2.663 billion for the Veterans Electronic Health Record. This will provide for the purchase of licenses and activities for twenty-five additional future medical center deployments, site assessments, training of staff, purchase and installation of computer hardware and interface development. Lessons learned from deployments of the new electronic health record (EHR) solution at the initial operating capability (IOC) sites in 2020 and deployments in 2021 will inform future budgetary requirements and the implementation path moving forward. VA's request for 2022 reflects a strategic revision to the original Electronic Health Record Modernization (EHRM) deployment schedule to enable flexibility and agility amid Coronavirus 2019 (COVID-19). The revised 10-year schedule shown by Veterans Integrated Service Network (VISN) which was approved by Congress in August 2020, is shown in the Deployment Activities section below.

VA's $2.663 billion request includes:

- **$1.425 billion for EHR Contract** – This request aligns with VA's revised full EHRM deployment plan, is based on the unpredictable COVID-19 environment while optimizing resources, providing flexibility, preserving momentum and supporting the continued alignment with the Department of Defense (DOD). The 2022 funding will support contracts for site assessments, site transitions, enterprise integration, sustainment and site implementation support for the post Go-Live activities and deployment efforts at future VISNs. This investment will fund twenty-five deployments planned for Waves L-R, VISN 23, 15 and 19, including medical centers, clinics, Veteran centers, and mobile units.
- **$952 million for Infrastructure Readiness** – Funds will aid in supplying deployment sites with updated computers and network infrastructure capable of supporting the EHR solution six to eighteen months in advance of deployment. The funding will also support system interfaces and cybersecurity efforts.

- **$286 million for Project Management Office (PMO)** – The funding will support an increase to 337 FTE leading the up-tempo deployment at a larger number of medical centers to deliver effective change management as the EHR solution is implemented throughout the nation. The goal is to retain qualified experts who understand VA's legacy systems, computer programming languages and interfaces. The request supports reimbursement of 202 VHA experts that are critical to the change management and effective deployment. OEHRM will support the Federal Electronic Health Record Program Office (FEHRM) for $18 million; part of this request includes federal staff pay, contract support staff, funding for travel, training, equipment and supplies.

Mission

The health and safety of Veterans is one of VA's highest priorities. VA is committed to providing a seamless network of care for all Veterans, which includes access to a comprehensive EHR. VA's current electronic health information system, Veterans Health Information Systems and Technology Architecture (VistA), is not sustainable and cannot deliver critical capabilities, such as supporting interoperability within VA and with DOD and community care providers.

VA's new EHR solution will create a longitudinal health record of a Veteran. This system is the same that DOD uses to store service member records, from enlistment to discharge; and migration from service member to Veteran. VA's new EHR solution is critical to the delivery of healthcare in the modern era; allowing information sharing among providers, such as timely reminders to clinicians about Veterans' medical conditions, adverse drug interactions, physician notes and referrals, pharmacy notes and lab results; the complete medical history can be shared amongst the medical community. This will enhance the delivery of quality health care to our nation's Veterans.

Designed to accommodate health care delivery priorities that are unique to VA and bring industry best practices to Veteran health care, the EHR solution will integrate modern functionality and infrastructure into a simple experience, allowing the system to operate seamlessly with community care providers. This will eliminate dependencies on legacy systems and the risks associated with using multiple products to share Veteran medical records.

VA's new EHR solution provides administrative services to VA healthcare providers such as the scheduling and cancellation of appointments, allowing medical providers to interact with Veterans via smartphone and web-based technologies, providing the ability to update and validate Veteran data on a real-time basis. It will also provide a more efficient and effective way of collecting, managing and tracking Veteran medical information, while reducing medical information intake time, thus improving the ease of sharing among authorized medical users and the storing of Veteran medical information.

Program Background

For more than a decade, DOD and VA engaged in a series of initiatives intended to achieve seamless and efficient electronic exchange of patient health information as military service members transition from DOD to VA health care systems. Although the two Departments have worked

together for many years to advance EHR integration between their many separate applications, the Departments did not adopt the same EHR system, until recently.

To improve VA's services and enhance the coordination of care for Veterans who receive medical care from VA, DOD and community partners, on June 5, 2017, VA announced it would purchase a new EHR solution from the Cerner Corporation - the same system DOD is currently deploying. Without improved and consistently implemented national integration standards, VA and DOD will continue to face significant challenges in providing the highest quality health care for our Veterans. Having a Veteran's complete and accurate health information in a common EHR solution is critical to patient care and safety. The new EHR solution will enable VA to incorporate improvements in health information technology and cybersecurity which the current system, VistA, is unable to do.

VA understands the challenges and obstacles DOD faces as it deploys MHS GENESIS and continues to work closely with DOD to capture lessons learned and ensure the deployment of an EHR that is fully interoperable between the departments. VA held a series of eight national and local workshops to educate diverse clinical end-users and validate workflows to ensure VA's new EHR solution meets the Department's needs. Additionally, VA held a series of 18 road shows designed to provide early education and promote user adoption to approximately 1,200 leaders across VA's VISNs. Understanding a significant factor of the program's success relies on effective user adoption, VA is deploying a change management strategy that includes working with end-users, beginning with VAMC leadership, managers/supervisors, and clinicians to provide the necessary training.

Additionally, VA established 18 Electronic Health Record Councils (EHRC) that represent each of the functional areas of the new EHR solution, including VHA clinicians. Each council is responsible for reviewing and finalizing the design of standardized clinical requirements and business processes to be implemented across the enterprise at all VISNs. The EHRCs serve as change agents at the local level and are composed of 60 percent practicing VHA clinicians and 40 percent VA Central Office subject matter expert staff.

The EHRM effort will continue to be an evolving process as technological advancements are made. VA's approach involves deploying the EHR solution at VA medical facilities to identify challenges, hone governance, identify efficient strategies, and reduce risk to the portfolio by solidifying workflows and detecting course correction opportunities prior to deployment at additional sites. As part of the deployment process, VA and Cerner will continue to conduct current state reviews (CSR). CSRs are collaborative current functional and technical assessments, which start with a one to seven-day site visit conducted at VAMCs and their associated sites 180 days prior to deployment, depending on the complexity of the facility. CSRs result in identification of necessary remediation unique to the respective facility. The time period between CSR and kickoff allows VA and Cerner to review the findings and refine the site-specific deployment plan.

In July 2020, VA began the first of several training sessions for VA medical and administrative support staff in use of the new EHR solution at the Mann-Grandstaff VAMC in Spokane, Washington. The Kansas City Data Center, responsible for holding all the Veterans health record data, has been established, configured and is operational. Veterans' health information from VistA has been migrated to the Kansas City Data Center and is updated daily while the EHR solution is

deployed. This data center is planned to support VA EHR operations for the rollout period of the program.

Electronic Health Record Implementation and the COVID-19 Environment

In March 2020, to prioritize the health and safety of our Veterans and front-line staff, VA entered a non-intrusive posture with VA facility staff to respect and support increased patient demand and staffing requests. Since Washington state was an early COVID-19 outbreak site, VA shifted the initial Go-Live event to allow hospital staff to focus on the treating of COVID-19 patients in their facilities, re-scheduling the Go-Live event to October 2020. While maintaining a non-intrusive posture, VA continued to advance its mission to the greatest extent possible through virtual meetings and activities.

The EHR national standard design and build reached over 99 percent completion toward meeting the needs of clinicians who require training for the new system. VA continued design and configuration efforts for additional capabilities, providing greater functionality for Veterans and end-users at Go-Live events. Substantial progress has been made with programming the interfaces to support the EHRM effort, revising strategies to preserves the 10-year deployment timeline. Even though COVID-19 forced VA's health care providers to shift operations, medical resources and required clinical personnel to focus on caring for our Veterans and the Nation, the EHRM effort continued to move forward successfully with the support of Congress and external stakeholders.

On August 21, 2020, despite the national pandemic, VA launched a new appointment-management system at the VA Central Ohio Healthcare System, giving Veterans and staff a new tool to request and book medical visits online. The Centralized Scheduling Solution (CSS) is an all-in-one software system that helps Veterans by providing cutting-edge capabilities to book and manage their appointments. The new resourced-based scheduling solution also adds an extra layer of patient safety by enabling staff to identify Veterans at risk for missing critical health care visits. The solution launch marks the first time VA schedulers and clinicians are using the system. With VA's previous system, schedulers would log in to multiple software applications to coordinate timing, equipment, and personnel.

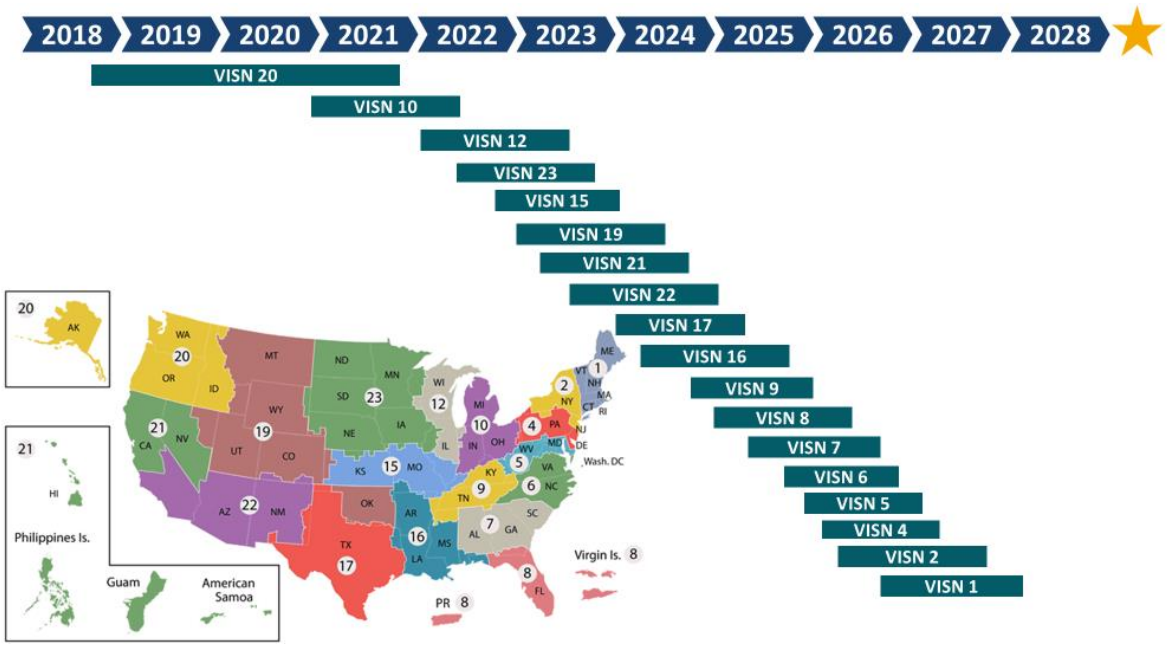
VA completed a successful Go-Live of its new EHR system on October 24, 2020, at Mann-Grandstaff VA Medical Center (VAMC) in Spokane, Washington, its four community-based and rural outpatient clinics and the administrative West Consolidated Patient Account Center (WCPAC) in Las Vegas. Facilities reported no disruptions to the continuity of Veteran care during the transition to the new system. The new EHR solution went live, migrating over 30 years of health care records for 29 million Veterans; with over 800 users across the U.S. that support Spokane VAMC, integrated with five Consolidated Mail Order Pharmacies (CMOPs) across the country. The VA staff is embracing the new EHR solution, providing positive feedback on its improved processes and how it will improve Veteran health care delivery.

Full Deployment Activities

The chart below reflects the revised deployment schedule, approved by Congress in August 2020, from 2018 thru 2028. The chart reflects the year in which the VISN is scheduled to have the new EHR solution deployed. Infrastructure upgrade is made six to eighteen months before the go-live event—switching over to the new system.

VA will undertake 18 CSRs at VA medical centers in 2021 and 22 CSRs in 2022. These reviews are the first step in preparing the VA medical center and related clinics for implementation of the new solution. The functional portion identifies clinical capabilities that must be configured for the services that the medical facility provides. The technical portion of the CSR identifies deficiencies in the existing computer hardware networks, equipment, electrical power, air conditioning capacity and space requirements that must be improved before installation of the new EHR solution.

VA actively coordinated with DOD on their implementation plan to ensure both organizations work closely together. The chart below shows the current VISN alignment of the hospital system across the country. The circled numbers on the map represent the VISN number.



During the multi-year transition effort, VA will continue to use VistA and related clinical systems until all legacy VA electronic health record modules are replaced by the new solution. For the purposes of ensuring uninterrupted health care delivery, existing systems will run concurrently with the deployment of VA's EHR solution while facilities are transitioning. As previously mentioned, VA's approach involves deploying the EHR solution at the initial sites to identify potential problems and correct them before deploying to additional sites. Understanding the importance of IOC and ensuring successful Go-Live efforts is VA's priority for the EHRM effort.

VA has acquired and configured network protection suites and routers for the facilities and purchased additional bandwidth for the IOC sites. Expanding wireless capability mitigates the need

for 25 percent or more of the cabling requirement identified during the CSRs. Installations took place in 2019 and in 2020 allowed VA and DOD to finalize the Medical Community of Interest (MedCOI) agreements. VA has installed data storage capability in Austin, Texas that allows for data migration and synchronization with the Cerner Data Center. Additionally, VA has built an enclave at the Cerner Data Center which improves the availability of patient data during transition and deployment. VA has established, with DOD, a Joint Cybersecurity service provider agreement to efficiently and effectively secure medical data and readily accommodate changes to the environment as new medical devices are added. Clinicians across the DOD and VA enterprise have access to data that was previously isolated to local facility staff only.

Budget Request

VA established the Office of Electronic Health Record Modernization (OEHRM) to ensure successful preparation, deployment, and continued operation of the new EHR solution; and the health information technology tools dependent upon it. VA's main priority for 2022 is to ensure that the EHRM effort judiciously balances speed of implementation with no risk to cost, schedule, and performance objectives to ensure optimal care of our Veterans, their families, and VA medical staff.

For 2022, VA requests $2.663 billion, which is an increase of $56.0 million (2.1 percent) relative to the 2021 enacted level. The 2022 request is separated into three subaccounts detailed below.

Electronic Health Record Modernization - $1.425 billion

The request includes estimated cost for activities required to plan for and deploy the Cerner Millennium solution such as site activation, change management, training, data migration, data normalization, data hosting, interoperability, workflow development, testing, sustainment, help desk support, licenses, data analytics, and innovations. In 2022 these funds will start deployment in VISNs 23, 15, and 19 VAMCs and their related clinics. The new EHR solution will help simplify health care delivery for both patients and clinical providers. Medical providers will have instant and seamless access to a Veterans' full-service health records and history. VA will compile data from service members' records to guarantee it is available to be accessed years later by DOD, VA and private sector doctors, providing clinicians with a full picture of a Veterans' medical history. Through national and local workflow design processes, VA partnered with DOD and commercial vendors, and is working to strengthen and improve health care for all Veterans and active duty service members, and to improve the productivity and user experience for VA system users.

Infrastructure Readiness - $952 million

The request includes estimated infrastructure support costs such as modifications to legacy systems, interfaces, wired and wireless networks at VA medical centers and their associated sites. Infrastructure readiness is a critical component of the success of the EHRM effort, and VA's strategy includes ensuring upgrades are in place six to eighteen months in advance of a respective go-live. Components of VA, namely OIT, VHA, and OEHRM, collaborate to improve VA's current IT infrastructure to a point of efficiency that supports VA's new EHR solution and

positions VA to effectively deploy the solution across the enterprise. IT infrastructure investments will be made in VISNs 15, 19, 21 and part of 22 at 26 VA medical centers.

Program Management Office - $286 million

The request includes estimated cost of program management, including government and contract personnel, administrative, and overhead expenses. OEHRM will ensure successful execution, oversight, active coordination, and proactive management of the program. Specifically, it ensures contractors perform to the cost, schedule, and performance objectives, and the corresponding management of associated project risks while guaranteeing that VA infrastructure is ready for the system's deployment. OEHRM employs highly trained government and contractor personnel to provide this expert oversight in a myriad of professional disciplines.

EHRM Deployment Plan

VA plans to complete deployment of the full EHR solution to all VA facilities by calendar year 2028. VA began deploying features of the new EHR solution, CSS, on August 21, 2020, at the VA Central Ohio Healthcare System. The new CSS has been providing Veterans and staff a new tool to request and book medical visits online and is an all-in-one software system that helps Veterans by providing cutting-edge capabilities to book and manage their appointments.

On October 24, 2020, Mann-Grandstaff VAMC in Spokane, Washington, including its four community-based and rural outpatient clinics, successfully received capability set 1.1 of the full deployment suites. VA plans to continue with full deployment go-live events of the EHR solution in 9 hospital sites in VISN 20 (Washington, Oregon, and Idaho) and in 2022 with 13 hospital sites in VISN 10 (Ohio, Michigan, and Indiana). In 2023, with an increased tempo of deployments, we expect to move to VISN 12, 23 and 15.

In preparation of the hospitals switch to the new solution, the facilities IT is assessed and upgraded. The goal is to have the equipment ordered 12 to 18 months prior to the go-live date and operational 6 months prior. This requires advance purchase of infrastructure readiness investments such as workstations, monitors, system interfaces, Local Area Network (LAN) upgrades, switches, WIFI access points, and national networks for future go-live sites in 2022 and 2023, to include several medical facilities for VISNs 15, 19, 21, and part of 22. These IT infrastructure investments comply with the recent Executive Order providing guidance for cybersecurity such as a multifactor authentication and encryption.

Accomplishments

1. **CSS Go-Live**: Successfully launched CSS at VA Central Ohio Healthcare System in Columbus, Ohio. CSS is an all-in-one software system that helps Veterans by providing cutting-edge capabilities to book and manage their appointments. The resource-based solution increases scheduler productivity, tracks provider utilization to ensure efficient use of VA resources and makes scheduling and medical visits seamless for the 42,000 Veterans who receive care at VA Central Ohio Healthcare System. This deployment included 8 system interfaces, 26 Authorities to Connect (ATCs), and 5 site connections which went into operations successfully and ahead of schedule.

   On June 22, 2020, the VA Central Ohio Healthcare System enabled OEHRM to return to the facility to complete onsite CSS Go-Live preparation activities due to the impact of COVID-19 on facility operations. Leading up to the August 22, 2020 go-live deployment, OEHRM successfully prepared over 200 schedulers and 700 providers at the healthcare system for provisioning, migrated demographic data for an estimated 60,000 patients, completed the last of three Integration Validation (IV) testing events and conducted a Mock Go-Live event to simulate go-live activities and practice workflows.

2. **Infrastructure Readiness**: OEHRM Technology and Integration Office (TIO) infrastructure readiness teams developed and improved upon requirements and plans for the new EHRM platform. The main areas addressed were LAN, wide area network, wireless LAN, end user devices (e.g., computers, monitors, printers), Joint Security Architecture (JSA), training spaces, and general construction. These new standards were incorporated into OIT and VHA enterprise standards. These requirements and plans complimented the 7 current state reviews conducted at sites in VISN 20 and 6 CSRs in VISN 10 were initiated, which provided a baseline for EHRM infrastructure readiness activities at sites in both VISNs. The CSRs informed the OEHRM TIO infrastructure readiness teams on what equipment and upgrades were needed to support the new EHR solution. These activities improved network and system performance by upgrading aging infrastructure and increasing network bandwidth to ensure the sites were equipped to support the system requirements of the new EHR solution. The upgrades provided several improvements including reduced end user login times from up to 30-45 minutes to less than 15 seconds and average system response times of 27-milliseconds, significantly below the 85-millisecond target maximum. In all, approximately 24,300 workstations/laptops were deployed across VISN 20 by October 2019. At the Mann-Grandstaff VAMC and WCPAC IOC sites, OEHRM also upgraded 3,792 biomedical devices to improve clinical workflows and enhance patient experience.

   At the VISN 10 VA Central Ohio Healthcare System Columbus facility, the telecommunications network was upgraded, and 266 CSS scheduler end user devices (e.g., computers, voice over IP phones and printers) were acquired and deployed. The improved telecommunications network and upgraded end user equipment reduced login times, improved the CSS scheduling application performance, reliability training efforts and call center support for Veterans. All of which, supported the successful Go-Live of CSS.

After the Columbus CSS Go-Live OEHRM quickly deployed the Cerner Forward Deployed Solution Set (FDSS) and the JSA at Columbus to support the full suite EHRM deployment at the Ambulatory Care Center. The FDSS provided managed services include hardware, software and support for the EHR, as well as storage requirements, remote operational management, and monitoring; it requires 2 racks of specialized application servers, 23 management tools, and associated networking. The JSA ensures secure connectivity to the Cerner Enclave and is required for interface testing and evaluation and medical device isolation; it allows secure communication across 400 ports.

The FDSS and JSA were also deployed at the VA Northwest Health Network in VISN 20 at the EHRM IOC Go-Live sites at Mann-Grandstaff in Spokane WA, WCPAC in Las Vegas, NV, and their secondary sites, and VAMC facilities at Walla Walla, Puget Sound, Roseburg, Vancouver and Portland. supporting EHRM capabilities. Both the FDSS and the JSA be deployed across all VAMCs in advance of future EHR implementations.

3. **Interfaces and Authorities-To-Connect (ATCs):** Completed 8 system interfaces required to support CSS at VA Central Ohio Healthcare System. OEHRM also completed 73 interfaces and over 250 ATCs and change request submissions, over 650 joint change control board actions and over 750 network test and troubleshooting sessions required to support deployment of the Joint Health Information Exchange (JHIE), CSS in Columbus, Ohio and VA's new EHR solution at Mann-Grandstaff VAMC**.** In comparison, DOD Healthcare Management System Modernization (DHMSM) initially completed 27 interfaces for the Military Health System Genesis over approximately a two year period before finishing with 34 interfaces overall. In addition, during the development of capabilities for areas such as ambulatory health and community care, OEHRM identified and completed enhancements on 18 interfaces. This effort required updating the design and build for each interface and conducting supplemental technical testing on each enhancement.

   Additionally, OEHRM collaborated with DOD to establish the Joint Cyber Operations and Integration Center (JCOIC) to improve interoperability. The new EHR solution is not reliant on any one Department: it integrates engineering and cybersecurity elements used by both VA and the Defense Health Agency (DHA). JCOIC efforts enabled the analysis of 1,200 supporting ATC artifacts to ensure that interfaces, networks, hardware and software were prepared for CSS, the new EHR solution and connection to the JHIE.

4. **Data Migration and Syndication**: Aggregated and migrated 38 years of health data for 23.9 million Veterans to support the launch of the new EHR solution. The migrated data included many clinical domains such as vital signs, lab tests, pharmacy fills, outpatient visits and inpatient admissions with a total count of over 204 billion database rows. VA migrated and aggregated this data from 130 disparate instances of VistA, VA's legacy system, to the new EHR solution to provide a complete longitudinal medical record that is interoperable with DOD, U.S. Coast Guard and community care providers. In particular, VA transferred the records of 88,000 Veterans in the Spokane area that were required to support the launch of the new EHR solution at Mann-Grandstaff VAMC. OEHRM also integrated the new EHR solution with the JHIE, instituted cybersecurity safeguards, migrated enterprise level data and performed functional and system testing in support of JHIE, CSS and EHR implementations.

In a separate effort, OEHRM formed a team to facilitate receipt of data from Cerner to support enterprise reporting requirements. The initial data syndication was completed in February 2020 when over 900 tables from the Cerner Test EHR were delivered to VA and made available to VA report developers in raw form. The data syndication mapping team then focused their attention on converging data from the EHR into the existing Cerner Data Warehouse data model to ensure high-priority data domains representing approximately 70% of the critical fields (including vital signs, lab tests, pharmacy fills, outpatient visits, and inpatient admissions) were available for use by the end of August 2020. As the VHA report building team leverages these domains to develop reporting tools they are using the raw data from Cerner Millennium, which ensures that they have access to 100% of the Cerner EHR data acquired since Go-Live.

In light of the restrictions on travel due to the pandemic, in April 2020 OEHRM established in-house Millennium-based training for data handling to teach VA analysts best practices in the Millennium environment prior to working with live data. Production data began streaming into the environment shortly after the CSS go-live in Columbus, Ohio, and by November 2, 2020, data syndication was loading all production data from the Cerner EHR daily. The data syndication team continues to deliver weekly educational updates every Friday.

5. **Testing:** OEHRM's extensive testing program for the new EHR solution included three rounds of Integration Validation (IV) testing**,** which is comprised of staff-run simulations of the EHR solution to validate that site-identified workflows such as patient registration and billing align with VA clinical and financial processes used in real-life patient scenarios.

   At the close of these testing efforts, over 2,800 critical and high test findings related to VA's CSS and IOC go-lives were properly adjudicated in advance of the respective launches, which resulted in zero patient safety issues and ensured that 100 percent of Veterans' targeted, most clinically-relevant health care data was transitioned from the legacy systems into the new EHR solution. Additionally, 100 percent of over 5,900 test findings documented prior to go-live in Spokane were closed out before and/or during the go-live period.

6. **Training Efforts:** Converted 40 percent of Instructor-Led Training to virtual Instructor-Led Training (vILT) in approximately seven weeks to ensure training objectives advanced in the face of the COVID-19 pandemic. The vILT was developed to meet VA's training needs while minimizing the impact of social distancing requirements. For Mann-Grandstaff VAMC, OEHRM doubled the number of training rooms, introduced 30 percent more trainers, reduced in-person class sizes by more than half and had 75 percent more personnel providing at-the-elbow support during the first two weeks of sustainment. OEHRM updated the training domain to closely align with the final EHR solution build in order to give end users a realistic training experience.

   OEHRM provided super user and end user training for both the EHR and CSS implementation efforts to effectively train VA staff on system applications and workflows. Super users receive specialized training on the new EHR solution that allows them to support their peers during training and the go-live time period. OEHRM trained 117 super users at Mann-Grandstaff

VAMC, 17 super users at WCPAC, and 26 super users at remote site locations in support of EHRM IOC Go-Live. Training for end users encompassed 299 unique roles to maximize user readiness for the CSS and EHRM implementations. OEHRM trained over 200 end users at VA Central Ohio Healthcare System in support of CSS Go-Live, over 1,300 end users at Mann-Grandstaff VAMC, over 90 end users at WCPAC and over 800 end users at remote site locations in support of EHRM IOC Go-Live.

In addition, VA collaborated with DOD to fast-track training for telemedicine intensive care unit (Tele-ICU) staff who support both Mann-Grandstaff VAMC and Nellis Air Force Base (AFB). This partnership ensured 38 Tele-ICU providers and nurses were trained and available in time for the September 25 Go-Live of Military Health System GENESIS at Nellis AFB.

7. **VA/Cerner Millennium Build:** Set the VA national standard for the new EHR solution, comprised of 216 core capabilities supporting 43 key areas of patient care to enable clinicians to provide the best care for Veterans. OEHRM leveraged 18 EHR Councils comprised of over 1,200 subject matter experts (SMEs) as well as DOD's EHR Solution Experts and SMEs to the inform the design of the EHR solution. These initial capabilities offer many enhancements to current EHR functionality, realize new efficiencies such as a significant decrease in the number of logins required by caregivers and improve the flow of information from one module to another to decrease duplicate charting and provide consistent documentation across disciplines. The new EHR solution continues to add to the national standard through additional capabilities that are developed to enhance the enterprise solution.

8. **VA/DOD Joint Health Information Exchange**: Collaborated with DOD, and coordinated with the FEHRM program office, to launch the JHIE on April 18, 2020 as a modernized health data sharing capability. JHIE is a complex platform that coordinates and integrates a combination of Cerner solutions and existing VA and DOD legacy applications across multiple environments to ensure safe and effective data exchange among federal and community care partners. JHIE allows providers in both Departments to quickly and securely access EHR data for patients who have been seen by a participating community partner or health system. These participating community providers also have a single point of entry to request and access DOD and VA electronic health records for use in patient care. More than 2,000 hospitals, 8,800 pharmacies, 33,000 clinics, 1,100 labs, 800 federally qualified health centers and 300 nursing homes throughout the country currently have access to health care data via the JHIE. VA and DOD will continue to increase the number of JHIE participants; for example, a huge step forward was realized when the CommonWell network of more than 15,000 community providers connected to the JHIE on October 9, 2020.

   To specifically handle the connection with the JHIE, VA developed new interfaces to seamlessly transmit data between VA, DOD, U.S. Coast Guard, Cerner, pharmacies and community care providers. These interfaces included the Social Security Administration (SSA) Integration, Walgreens Integration, Defense Enrollment Eligibility Reporting System (DEERS), VA Profile, Veterans Data Integration and Federation (VDIF), Joint Legacy Viewer (JLV), and legacy direct web portal integration. The JHIE was also integrated with the Patient Unified Lookup System for Emergencies (PULSE) to facilitate response to the COVID-19 pandemic. This integration allows disaster healthcare providers in temporary locations across

the country to access VA and DOD health information while treating Veterans, Servicemembers and their families and allows VA and DOD healthcare providers to access health information on civilians as they support healthcare treatments in epidemic areas. In preparation for Capability Set 1.1 and the go-live at Mann-Grandstaff VAMC, the JHIE connected to Millennium and HealtheIntent as VA's Health Information Service Provider (HISP) for Mann-Grandstaff specific data transitioned to the Cerner HISP to facilitate direct messaging and integrated with a prescription drug monitoring platform (PDMP) to cover reporting throughout the state of Washington.

9. **OEHRM Workforce** Strengthened the OEHRM's organizational foundation by funding and onboarding government detailed staff and contractors while simultaneously growing the permanent workforce to 176 government FTEs. This workforce provides the clinical, technical and functional oversight required to successfully deploy VA's new EHR solution. Despite the challenges of COVID-19, OEHRM increased personnel by 42 percent — from 102 FTEs to 176 throughout 2020. OEHRM's hiring targets for 2021 would bring its workforce to 305 FTEs supporting the 24 deployment activities that will be underway.

DoD/VA Joint Electronic Health Record Collaboration

Modernizing the electronic health record has been and continues to be one of our highest national priorities; along with ensuring the health and safety of our Veterans. VA remains committed to this effort and is working diligently to ensure its success through direct engagement with the Federal Electronic Health Record Modernization Program (FEHRM) Office, as authorized by the 2020 National Defense Authorization Act.

FEHRM Resource Support:

EHRM's budget request includes $17.8 million to fund joint responsibilities between DOD and VA for support of the FEHRM joint activities

FEHRM Support (Dollars in Thousands)					
		2021		2022	2021-2022
Program Element:	2020 Actual	President's Budget	Current Estimate	Budget Request	Increase/ Decrease
Pay & Benefits	$44	$0	$400	$1,298	$898
Contract Support	$4,442	$0	$16,500	$16,500	$0
Equipment	$16	$0	$60	$12	($48)
Travel	$0	$0	$50	$75	$25
Total Obligations	**$4,502**	**$0**	**$17,010**	**$17,885**	**$875**
Federal Staffing	1	0	6	7	1
Contractor Staff Support	12	0	55	55	0

Federal Electronic Health Record Modernization

DOD and VA share a common mission to support a lifetime of high-quality health care for Service members, Veterans and their families. In support of this mission, the FEHRM, chartered in December 2019, leads DOD, VA and other partners in implementing a single, common electronic health record that enhances patient care and provider effectiveness, wherever care is provided.

With experts in analytics, clinical care, information technology and training, the FEHRM is driving federal solutions for more efficient, safer care and a better health care experience for all by working toward the following joint objectives with DOD and VA:

- Actively manage risks and the operation of the Kansas City Data Center, where all VA and DOD health data resides;
- Minimize risk to EHR solution deployment/implementation;
- Identify opportunities for efficiency, standardization and system and process optimization; and
- Advance interoperability across the federal and private sectors.

2020 Accomplishments

Significant FEHRM accomplishments 2020

Spearheaded a common approach to sharing sites (where healthcare resources are shared between DOD and VA); navigated complexities requiring careful collaboration, joint decision-making and thorough understanding of the possible impacts of the EHR deployment. The FEHRM led the analysis and integration of deployment activities at sharing sites with specific focus on technical, functional and programmatic issues, including implementation schedules, joint access and network security.

Launched the JHIE in April 2020, building on the success of DOD and VA's health information exchange work. The JHIE is an enhanced network of private sector providers across the United States who have agreed to securely share clinical information with DOD and VA providers. It expands the ability of DOD and VA providers to quickly and securely access patient electronic health information from participating private sector providers and vice versa. The JHIE connects DOD and VA providers with hundreds of private sector partners, representing more than 2,000 hospitals, 8,800 pharmacies, 33,000 clinics, 1,100 labs, 800 federally qualified health centers and 300 nursing homes, to help them make more informed treatment decisions. This single exchange establishes the foundation for integration with the single, common EHR and for future expansion of health information exchange networks.

Total Obligations by Subaccount

EHRM 2022 - Obligations					
	2020	2021		2022	2022-2021
	Actuals	Original Budget Request	Planned Obligations	Budget Request	Increase / Decrease
Grand Total ($ in thousands)	**$1,510,029**	**$2,627,000**	**$2,631,430**	**$2,663,000**	**$31,570**
EHR	**$1,002,916**	**$1,191,000**	**$1,191,000**	**$1,425,498**	**$234,498**
Site Transitions	$321,016	$828,000	$801,151	$852,000	$50,849
EHR Operations	$167,410	$49,000	$213,041	$286,020	$72,979
Enterprise Integration	$390,563	$218,000	$98,992	$192,478	$93,486
VA Current Site Assessments	$45,705	$45,000	$38,371	$60,000	$21,629
Vendor Site Implementation Support	$78,222	$51,000	$39,445	$35,000	-$4,445
Infrastructure	**$332,148**	**$1,181,000**	**$1,181,000**	**$951,797**	**-$229,203**
Site Specific:	**$22,969**	**$396,245**	**$289,088**	**$16,000**	**-$273,088**
End User Devices	$22,969	$396,245	$289,088	$16,000	-$273,088
Enterprise:	**$97,829**	**$367,565**	**$176,451**	**$219,732**	**$43,281**
Data Migration & Syndication	$15,454	$46,028	$14,163	$18,988	$4,825
Identity & Access Management	$21,768	$138,718	$32,159	$43,472	$11,313
Security	$19,066	$43,695	$32,782	$77,146	$44,364
Testing Activities	$17,949	$77,791	$64,624	$57,807	-$6,817
Interoperability	$23,592	$61,333	$32,723	$22,319	-$10,404
Hybrid:	**$211,350**	**$417,190**	**$715,461**	**$716,065**	**$604**
VA LAN	$37,949	$182,610	$317,920	$130,375	-$187,545
Joint Security Architecture & WAN	$48,818	$75,121	$105,757	$99,631	-$6,126
Legacy System Mods & Interfaces	$124,583	$159,459	$291,784	$193,603	-$98,181
Medical Devices	$0	$0	$0	$292,455	$292,455
PMO	**$174,965**	**$255,000**	**$259,430**	**$285,705**	**$26,275**
PMO Support Contracts	$131,547	$155,098	$182,746	$186,017	$3,271
Pay & Benefits (including reimbursements)	$38,129	$50,319	$59,791	$83,471	$23,680
Travel	$1,201	$10,923	$1,379	$5,342	$3,963
Equipment, Supplies, Leases & Other	$4,088	$38,660	$15,514	$10,875	-$4,639

Electronic Health Record Modernization - $1.425 billion

The 2022 request includes $1.425 billion for the Cerner EHR Millennium solution and all activities required to plan for and deploy the solution, which is an increase of $234.5 million (19.7 percent) relative to 2021 planned obligations. This request aligns with VA's revised full EHRM deployment plan, based on the COVID-19 environment, which optimizes resources, provides flexibility, preserves deployment momentum and supports alignment with the Department of Defense. The 2022 funding will fund contracts for site assessments, site transitions, enterprise integration, sustainment, and site implementation support for the post Go-Live activities and deployment efforts at future VISNs. There are concurrent waves of deployment planned per VISN, that will result in deployments overlapping at some VAMCs, but each wave will be on a different timeline. Funding will support the concurrent deployment of VAMCs, their associated clinics, Veteran centers, mobile units and ancillary facilities in VISNs 23, 15, and 19. The increase from the 2021 request addresses the increased number of VAMCs operating the new EHR solution in 2022 relative to 2021. As

more facilities come online and operate the new EHR solution, there will be corresponding cost increases in sustainment, data hosting and licensing.

Site Transitions - $852.0 million

Site Transitions consist of all site-specific deployment related activities required to fully transition each VAMC and associated sites to the new EHR solution, more specifically including:

- Change management
- Training
- Localized workflow design
- Local communications
- Local interface design
- Local implementations
- Final testing
- User testing
- Site go-live activities
- Post go-live support

This list is the full range of site-specific activities that are required to implement the new EHR solution at the local facilities, which includes training and transitioning of staff at those sites. In 2022, the largest number of VA sites to date are projected to deploy with the new EHR solution. VA has twenty-five initial deployments activities planned for 2022: Waves L-R, VISNs 23, 15 and 19.

EHR Operations - $286.0 million

EHR operations are sustainment activities required to operate and maintain the new EHR solution as VA approaches site transitions. Activities include data hosting, help desk, software license maintenance, end user operations, forward deployed solution set (FDSS) and ongoing national and local level sustainment support to ensure proper maintenance and performance of the new solution.

Enterprise Integration - $192.5 million

Enterprise Integration activities are enterprise-level activities required to support the integration, installation, and design for the implementation of the new EHR solution software across the enterprise. These activities are planned for Waves L-R in VISNs 23, 15, and 19. Enterprise integration tasks include: data migration, interface development, design and implementation of enterprise level technical capabilities, food and nutrition services, national workflow design, national change management and training, and enterprise communications. These are cross-cutting activities that must be conducted at an enterprise level to ensure VA systems, organizations, and staff are ready for site-level transitions to occur.

VA Current Site Assessments - $60.0 million

Site assessments are pre-site transition activities that occur at each VAMC and associated facilities prior to a site's EHR transition. The purpose of these activities are two-fold: 1) a functional assessment allows VA to properly assess the current state of the site, to understand the services delivered at that site, and to properly estimate the level of effort required for site transition; and 2) a technical assessment that informs VA's site infrastructure modernization plans by providing VA with a gap analysis of current site infrastructure and upgrades required to support the new system. These upgrades must then be separately procured under non-Cerner contracts; some of which may have long lead times for actual delivery and installation, to support the capacity, security, and/or interoperability of the new EHR solution with site end-user devices. In 2022, VA aims to conduct approximately twenty-two site assessments.

Vendor Site Implementation Support - $35.0 million

Cerner will support VA with project management functions to accomplish coordination and management of the information technology to include execution of individual task orders. Project management support includes cross site coordination, reporting, quality assurance, quality management, project planning, and risk management.

Infrastructure Readiness - $951.8 million

The 2022 request includes $951.8 million for infrastructure readiness, which is a $229.2 million (19.4 percent) decrease relative to the 2021 planned activity level. This significant decrease is driven by a planned, expected decrease in the number of hospitals requiring technology infrastructure upgrades compared to the number requiring it in 2021. Because the information technology equipment must be ordered as much as two years ahead of site Go-Live, the 2021 level was larger than normal. Additionally, to adequately prepare for the deployment of the new EHR solution, VA is ensuring that the appropriate information technology infrastructure is in place at least six months to a year prior to deployment to conduct testing and connect medical devices. A minimum of six months' lead time is necessary to ensure VA delivers a secure, reliable, and efficient EHR solution that meets the needs of Veterans.

In 2022, OEHRM will conduct CSRs for Waves N-S in VISNs 15, 19, and part of VISN 21. Through these site assessments, VA will determine the specific infrastructure gaps that will require mitigation. Analysis of CSRs performed to date provides a gauge of probable infrastructure upgrades VA will address at all sites across the enterprise, including upgrades to specific types of end user devices, monitors, printers, scanners, and card readers. These CSRs will serve as lessons learned and provide VA with a better understanding of requirements in terms of infrastructure readiness.

Site Specific Costs - $16.0 million

This funding covers information technology infrastructure costs at VA medical facilities to support implementation of the new EHR solution. This includes costs directly related to facility information technology infrastructure readiness such as workstations, monitors, printers, scanners, and network equipment. EHRM works with VHA to coordinate their facilities infrastructure costs to support EHRM, and with OIT to coordinate IT costs aligned with their Infrastructure Refresh Plan (IRP).

End User EHR Devices - $16.0 million

The funding for End User Devices (EUDs) covers the Cerner-specific requirements for EUDs at each site; setup, maintenance, and breakdown of training spaces and command centers Training spaces are designed to provide clinicians hands on training on the new EHR solution in an environment that resembles the VA clinical environment. EUDs and support are provided for the setup of local command centers to support each Go-Live location. These command centers provide help desk support and allow staff to manage and monitor the transition of sites to the new EHR solution.

A comprehensive enterprise-wide technology analysis revealed that 96 to 100 percent of EUDs should be replaced to work with the new EHR solution. Most EUDs are more than five years old. Periodic hardware refreshes ensure devices meet mission requirements and the performance demands of applications. Additionally, newer hardware is less prone to failure. Laptop hardware refresh is recommended within 3 to 4 years from initial purchase; monitor (external) refresh is recommended within 5 to 6 years from initial purchase, or as required. Resources will be used to

cover costs for desktops, laptops and monitors as well as their supporting docking station terminals, bar code readers, and equipment deployment support.

Enterprise Costs - $219.7 million

This funding covers technology infrastructure costs that support implementation at the National level including data migration and syndication, identity and access management, cybersecurity, testing, and interoperability with the community and DOD. Enterprise costs are ongoing costs that broadly support EHRM and are not directly tied to site infrastructure.

Data Migration& Syndication - $18.9 million

This funding covers the overall data management required to ensure VA's VistA and the new EHR system properly account for all existing Veteran's data. These efforts include the support to the VX-130 system which provides a systematic method to replicate and transfer existing VistA data to the new system through a secure and effective method. This effort is critical as it ensures the new system will have all the relevant data on patients from the legacy system. Likewise, new data entered in the new system will need to be brought back into the VA legacy systems, through a data syndication strategy, which will allow health data from sites which both have and have not yet deployed the new EHR solution to share and update the same information on patients.

Identity & Access Management - $43.5 million

The funding for Identity & Access Management (IAM) includes the cost for Joint Patient Identity Management Services (JPIMS) provided by VA, DOD's Defense Manpower Data Center, and Cerner. JPIMS is required to manage the patient population for both agencies in a single system enabling VA's EHR solution to operate in a manner that minimizes patient safety risks. JPIMS will be used to manage patient identities for search and selection within the EHR. It is a critical component of the architecture and is needed to ensure that patients between VA and DOD are accurately correlated and true interoperability is achieved. To enable IAM, existing systems and services within VA and federally shared services must be upgraded, connected and configured to support the new electronic health record. VA will work in close coordination with all stakeholders to ensure that service requirements for the new EHR solution are accurately communicated and in line with VA standards. This support also includes any additional credentials (e.g., Personal Identification Verification [PIV] Cards) and federation services, which are needed to access the electronic health record.

Security - $77.1 million

Cybersecurity is vital to keep Veterans health care information safe and to assure that the new EHR operates without interruption to its fullest potential. The funding to support cybersecurity provides for additional security controls, Authority-to-Operate (ATO), joint security monitoring, medical device ATOs and security modifications, and ATO updates, required to the Cerner hosting environments to account for additional VA capabilities. VA needs to collaborate closely with DOD on system monitoring as well as developing policies and, processes to manage security controls across the electronic health record. Security expenses include the support to configuration

management as well as coordination with VA's Office of Information Security. Security activities support evaluating, updating and coordinating with DOD on VA's current security documentation to ensure all VA and DOD security requirements are met.

Testing Activities - $57.8 million

Provides for the design and fielding of pre-production test facilities, interconnecting with VA legacy systems (to include Joint Legacy Viewer), Cerner's data center, and DOD's Defense Manpower Data Center to validate systems are working properly prior to a respective Go-Live. Critical to a deployment is a robust testing methodology and plan. These activities include support for VA infrastructure and systems testing needed to ensure that electronic health record deployments do not disrupt patient safety or existing operations and have properly met VA standards. Testing services provides engineering expertise to conduct planning and assessments, as well as support for interagency coordination needed to test complex inter-agency workflows leveraging multiple systems in addition to the new EHR. Testing also includes coordination around both functional and technical testing.

Interoperability - $22.3 million

The new EHR solution is being implemented in phases to integrate health records between VA and DOD, that can be shared externally. The departments work together to implement a seamless, interoperable platform that shares the same source of data. In an effort to ensure joint systems satisfy existing and emergent interoperability mandates and guidance, additional funding is required to enhance VA legacy products as well as joint (VA/DOD) shared solutions. These investments will ensure we can perform the upgrades necessary to include engineering, development, application interfaces and system upgrades required to ensure interoperable health data, images and processes are maintained.

Hybrid Costs - $716.1 million

Hybrid costs cover technology infrastructure that apply to both the physical medical facility and the enterprise national program level. For example, VA Network (LAN) consists of site-specific costs to upgrade core switch equipment as well as costs to provide engineering and deployment support for that equipment across the enterprise.

VA Local Area Network (LAN) - $130.4 million

The funding for the LAN modernization includes replacing aging network cables, fiber optic cables, LAN switches (for wired and wireless networks, WIFI and Voice Over Internet Phones (VOIP) at all VAMCs, Community Based Outpatient Clinics (CBOCs), and Vet Centers prior to Go-Live. VA coordinates with all stakeholders to develop a plan of action for managing responsibilities related to the modernization. Updates require engineering services to assess current infrastructure in place and provide optimizations of the current LAN to support the new electronic health record. This includes reviewing configurations and assessing the hardware currently deployed and supported by VA. The upgrade includes the addition of switches, routers, cables,

adaptors as well as support needed to implement those items. The upgrades are focused on optimizations of information technology support to the electronic health record within a facility, and as such are coordinated with capital improvements to the infrastructure. This includes configurations, upgrades and assessments to improve the wireless networking needed to support the additional traffic within a facility. LAN infrastructure improvements will also consider support to the data and information needs of biomedical devices.

Joint Security Architecture and WAN - $99.6 million

The funding for Joint Security Architecture and wide area network (WAN) provides for additional security controls, ATO, Joint Security monitoring, medical device ATOs and security modifications, and ATO updates required for the Cerner hosting environments to account for additional VA capabilities. VA needs to collaborate closely with DOD on system monitoring as well as developing policies and processes to manage security controls across the electronic health record. Security expenses include the support to configuration management as well as coordination with VA's Office of Information Security. Security activities support evaluating, updating and coordinating with DOD on VA's current security documentation to ensure all VA and DOD security requirements are met.

The WAN Medical Community of Interest (MedCOI) is an enterprise Multi-Protocol Label Switched Layer 3 Virtual Private Network (VPN) that provides a secure logical medical enclave. It serves as a key enabler for full personal health care information interoperability between DOD and VA. The MedCOI implementation provides the security context that allows for seamless electronic exchanges and health care record portability in a secure format, to certify the highest quality and effective delivery of health care services for service members, veterans, and eligible family members. The funding for VA's MedCOI network and security boundary provides for telecommunications circuits, routers, security isolation equipment, security certificates, and support for interface testing/on-boarding to Cerner and with DOD to obtain an Authority to Connect (ATC). It also includes setting up monitoring at all VAMCs, CBOCs, and Vet Centers prior to Go-Live at those sites. Circuits for MedCOI will facilitate communication between the joint EHR enclave, existing VA data centers such as the Austin Information Technology Center, as well as the VA Enterprise Cloud, and existing WAN infrastructure. To implement MedCOI procurements of circuits, switches, security hardware as well as engineering services to implement these items are needed. Where possible existing networking equipment and circuits will be improved in close collaboration with VA OIT. The WAN is a critical component of the overall EHR solution as many electronic health record applications will be hosted in a data center. WAN improvements ensure efficient communications between sites and allow for VA to proactively manage the increase in the network traffic expected from the EHR deployment. MedCOI is the security controls built into the WAN and ensures that the WAN complies and leverages the existing architecture from DOD's implementation. The use of a common virtual network with common security is a key component in securing service member and Veteran information.

Legacy System Mods and Interfaces - $193.6 million

This area covers the associated effort of developing interfaces to legacy systems that will no longer be connected to VistA but need to connect to other systems in the VA enterprise. Currently

numerous systems are used to support the VA healthcare delivery process. These range from enterprise systems that provide common functions used by many users, facilities and processes, regional or special purpose systems that integrate and support across a subset of VA facilities, and local systems and devices that are unique to installations. Many of these systems are custom, government-built systems, which often do not utilize national industry standards for data or interfaces. EHRM's strategy is to focus on interfaces that improve information and capabilities to the clinician and patients at the point of care. VA uses a set of complex systems to deliver a variety of benefits. Even though the native systems may not be substantially modified, existing VistA interfaces need to be changed to support the new electronic health record and ensure that business processes such as benefits determination, do not have a break in functionality due to data loss. Interfaces must be designed, developed, tested and secured in line with VA and DOD systems development methodologies.

Medical Devices - $292.5 million

Implementing the new EHR solution requires updates to existing healthcare technology such as medical devices like infusion pumps, vital sign monitors, and other bedside patient monitors. These devices handle electronic patient data that will be automatically recorded into the new EHR. EHRM works with Cerner and other vendors to update the interfaces for these devices to ensure proper data transfer to the new system. Older medical devices may need to be replaced with equipment that is compatible with the new electronic health record. Funding for medical devices will be used for medical device integration, clinical application interfaces and clinical imaging integration.

Program Management - $285.7 million

The 2022 PMO request includes $285.7 million, which is a $26.2 million (10.1 percent) increase relative to the 2021 planned obligation level. The increase is a result of the need for additional staffing and contractual support for the continued deployment of the electronic health record modernization efforts. The PMO includes funding for government staff, government administrative expenses, and contractor support. PMO is charged with providing oversight of VA's EHRM contract with Cerner, management of associated project risks, and ensuring adherence to cost, schedule, and performance objectives.

The initial implementation efforts for the first eleven hospitals are underway. VA is scheduled to implement the new EHR in over 172 hospitals and 1,300 medical clinics, so having the appropriate number of personnel in place to ensure that the implementation is a success is critical. VA is currently determining the adequate size of federal and contractor support necessary for a successful implementation and initially has plans in place to increase the size of both to ensure appropriate oversight of this multi-year project.

PMO Support Contracts - $186.6 million

Includes the cost for contractor support staff working on EHRM, including travel and other direct costs. This support bolsters VA in its effort to provide oversight of all EHRM-related activities; to monitor Cerner's performance, and to manage associated project risks while ensuring that VA infrastructure is ready for the system's deployment. Contractor staff will work with government

personnel to provide expert oversight in a myriad of professional disciplines that include program management, clinical and technical engineering and architecture, security, testing, acquisition, contracting, data migration, communication, IV&V, training, change management, and governance. Additionally, this will also fund intra-agency financial services support and human resources management support.

Pay and Benefits - $83.5 million

Provides funding for pay and benefits of general services (GS) employees both direct and reimbursed to include detailed staff, and Title 38 from VHA and OIT supporting OEHRM. This funding level will support 337 direct staff and 195 detailed reimbursable federal support staff. Of the direct staff a total of 7 are supporting the joint VA / DOD FEHRM project management effort. Additional information is in the OEHRM staffing section.

Travel, Equipment, Supplies, Leases and Other - $16.2 million

Provides funding for travel, equipment, supplies, leases and other required resources for government and contractor staff, in support of EHRM's operations. Cost increases are due in large part to the planned increase in the deployment schedule and implementation of the EHR solution.

Staffing and Organization Structure

OEHRM is organized into various workstreams under the Office of the Executive Director, Chief of Staff and Administrative Support, Chief Medical Office (CMO), Program Management Office (PMO), and Technology Information Office (TIO), as outlined below:

Employee Staffing by Office				
	2020	**2021**	**2022**	**2021-2022**
Office of Electronic Health Record Modernization	**Actual**	**Current Estimate**	**Budget Request**	**Increase/ Decrease**
Office of the Executive Director	5	4	4	0
Chief of Staff and Administrative Support	36	38	46	8
Chief Medical Office	24	46	80	34
Program Management Office	36	43	47	4
Technology Integration Office	56	148	160	12
Total Direct Staffing	**157**	**279**	**337**	**58**
Federal Reimbursable Staff:				
Veterans Health Administration - Core Title 38	20	29	54	25
Veterans Health Administration - Field Staff	26	76	148	72
Office of Information and Technology	11	1	0	-1
Other Reimbursable Staff	1	0	0	0
Total Reimbursable Staff	**58**	**106**	**202**	**96**
Total Staff	**215**	**385**	**539**	**154**

The above chart reflects count of staff versus FTE levels

Office of the Executive Director (4 Staff)

The primary purposes of this office are to provide program management oversight, enable health IT product installation, and facilitate the adoption of new health IT products at VA related to the implementation of EHRM. The Office of the Executive Director also develops the communication strategy, conducts stakeholder engagements, and provides oversight of external and enterprise communication.

Chief of Staff and Administrative Support (46 Staff)

- Ensures program and organization operates effectively Chief of Staff operates to assure Executive Director's guidance and direction is followed. Oversee administrative functions of the EHRM.
- Provides budgeting, financial analysis, policy, human resources, and administrative functions for OEHRM, assists with onboarding and off boarding, processing timecards, facilities management (including supplies and equipment), meetings and logistics support, including general administrative support.

- Administrative functions include: Chief Financial Office, Communications, Workforce Management and Office of Administration.

Chief Medical Office (80 Staff)

- Serves as the functional voice of all users and the office responsible for patient safety, quality, value, functionality, usability, and change management.
- Ensures quality of care across multiple information systems and leverages medical and health data to improve services and daily operations.
- Clinical nucleus of the program includes managing the governance process for clinical systems, driving the optimization of the EHR, and participating in the strategy development for VAMCs' information systems.
- Provides leadership and guidance to define system and process requirements that will optimize clinical workflow and patient care. This office is responsible for collecting and analyzing patient data, ensuring the accuracy of patient records, ensuring the privacy of patient records and developing clinical training.
- Responsible for leading interoperability requirements identification and project implementation as it relates to information management.
- Responsibilities include monitoring platforms, development and maintenance of internal automation scripts and databases, development of tools to provide enhanced candidate experience, managing patient safety risks, oversight of interfacing registries, enterprise business process reengineering, operational strategy, and enterprise leadership across both business and clinical domains.

Program Management Office (47 Staff)

- Ensures program compliance with FITARA reporting in coordination with OIT Strategic Sourcing. The office provides overall program and contractor oversight and reporting, data analytics, and metrics for reporting.
- Manages task order analytics for the program, evaluating task orders analytics to determine strengths, weaknesses, deficiencies, and any modifications needed.
- Provides technical acquisition support to OEHRM for all activities
- Provides technical assistance with TIO and CMO on task order analytics and works with project teams and the contractor to address any outstanding requirements and changes.
- Verifies the contractor is performing the requirements of the contract in accordance with the contract terms, conditions, and specifications. The office also reviews all monthly performance and deliverable reports for verification of work performed.

Technology Integration Office (160 Staff)

- Provides interoperability between DOD and VA in such a way as to meet industry standards and customer needs.
- Serves as technical acquisition contracting and technical portfolio SME with responsibility for providing advice and guidance to Contracting Officers, EHRM leadership, and acquisition point of contacts and preparing the necessary acquisition, contracting, and portfolio artifacts for OEHRM.
- Directs and oversees IT project management associated with the operations.
- Analyzes, interprets, and prepares written guidance on policies, procedures, and issues for management and personnel relating to IT policies and procedures. Ensures compliance with specified security and privacy controls using the risk management framework (RMF), monitoring security and privacy-related events in a continuous manner, and responsible for enforcing patient privacy (e.g., privacy notification and requests) and compliance with VA policies and Federal regulations.
- Manages day-to-day activities of Systems Engineering with an extensive knowledge of IT Standards, Software Development Lifecycle, System Integration, Infrastructure and IT Implementation (primarily tactical-focused).
- Analyzes all current applications and recommends all future application data interfaces and interconnections according to mature and widely adopted industry standards.
- Serves as technical experts for application migration and integration of VistA. The office develops system security design that meets specified information protection needs to support VHA healthcare delivery operations.
- Responsible for cybersecurity and data protection strategic objectives as they relate to the EHRM effort. Responsible for developing program policies, governance processes, and guidelines that enable operational compliance using defined success measures.

Reimbursed VHA (202 Staff)

EHRM plans to utilize the expertise of other VA organizations to help manage the ongoing implementation of EHR. This includes 54 core medical staff and 148 field support staff for a total of 202 medical staff with specialized medical programmatic knowledge.

Appendix

Appendix A: Obligations by Object Class

Electronic Health Record Modernization Obligations by Object Class (Dollars in Thousands)					
		2021		2022	2022-2021
	2020 Actual	President's Budget	Current Estimate	Budget Request	Increase/ Decrease
Personal Services	$20,370	$50,319	$39,425	$56,217	$16,792
Travel	$1,201	$10,923	$1,379	$5,342	$3,963
Rent, communications and Utilities	$72,672	$25,717	$27,614	$29,011	$1,397
Printing and Reproduction	$25	$15	$25	$25	$0
Other Services	$1,305,026	$2,311,952	$2,173,085	$2,257,987	$84,902
Supplies and Materials	$345	$523	$172	$325	$153
Equipment	$110,390	$227,551	$389,730	$314,093	($75,637)
Lands and Structures	$0	$0	$0	$0	$0
Total Obligations	**$1,510,029**	**$2,627,000**	**$2,631,430**	**$2,663,000**	**$31,570**

Appendix B: End of Year Staffing Level by Grade

EHRM Employment Summary					
EHRM Direct Staff	2020 Actual	2021 Budget Request	2021 Current Estimate	2022 Request	2021-2022 Increase/ Decrease
SES	2	6	5	5	0
ST	1	1	1	1	0
GS-15	25	46	35	45	10
GS-14	59	107	126	123	-3
GS-13	60	137	92	127	35
GS-12	3	7	15	18	3
GS-11	5	11	5	14	9
GS-9	2	1	0	4	4
Total Direct	**157**	**316**	**279**	**337**	**58**
Reimbursable VHA Staff:					
SES EQV	1	16	4	4	0
VM 602-15	2	30	25	41	16
VN-610-V	3	9	10	15	5
VN-610-IV	8	19	16	45	29
VN-610-III	9	19	17	35	18
GS-15	1	6	6	6	0
GS-14	8	19	9	22	13
GS-13	7	0	12	18	6
GS-12	6	0	7	16	9
Subtotal	**45**	**118**	**106**	**202**	96
Reimbursable OIT Staff:					
GS-15	1	1	0	0	0
GS-14	4	3	0	0	0
GS-13	4	3	0	0	0
GS-12	2	1	0	0	0
GS-11	2	2	0	0	0
Subtotal	**13**	**10**	**0**	**0**	0
Total	**215**	**444**	**385**	**539**	**154**

The above chart reflects count of staff versus FTE levels

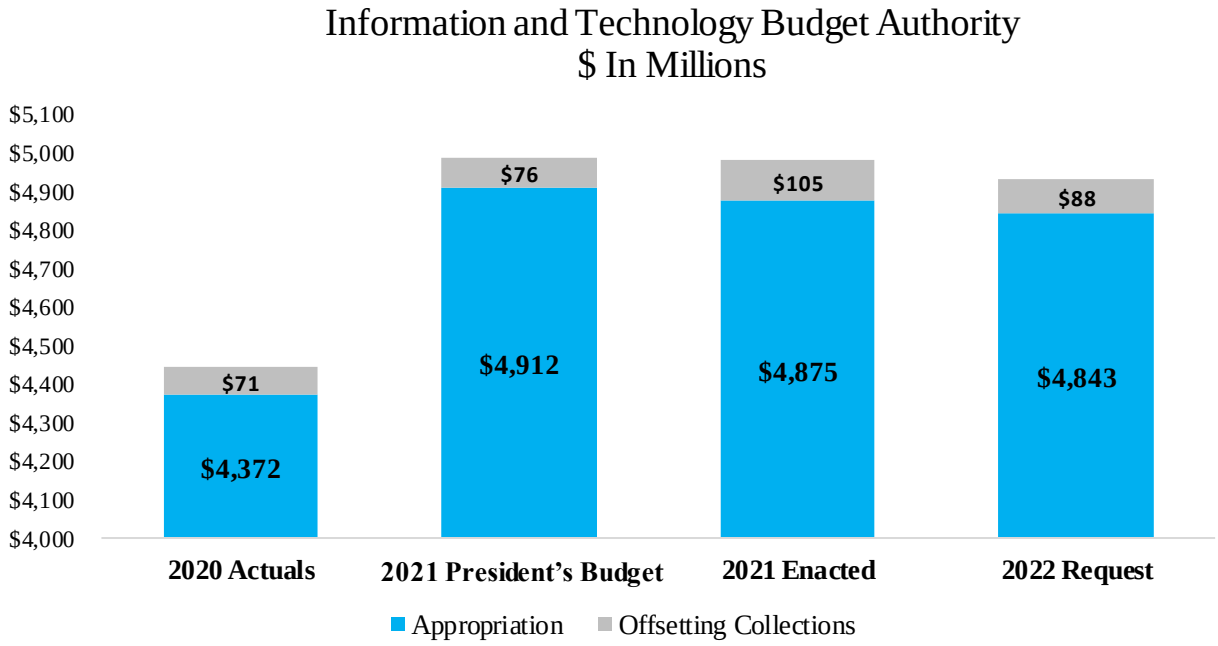
Information Technology

Part 6

Information Technology 639
Budget Authority and Appropriation Language 639
Appropriation Highlights 641
Budget Overview 642
Executive Summary 644
Staffing and Administrative Support Services 647
2022 Health Portfolio 651
2022 Benefits Portfolio 673
2022 Memorial Affairs Portfolio 682
2022 Corporate Portfolio 684
2022 Enterprise Portfolio 688
Technology Business Management Implementation 701
Accomplishments 704
Appendix A: Development Subaccount 711
Appendix B: Congressional Report Summary 712
Appendix C: Congressional Report Details 713
Appendix D: Operations and Maintenance Categories 714
Appendix E: Operations and Maintenance Subaccount 715
Appendix F: Operations and Maintenance Details 716
Appendix G: Amounts Available for Obligation 720
Appendix H: Object Classification 721
Appendix I: Budgetary Resources 722
Appendix J: Staffing and Admin Support by Object Class 723
Appendix K: Employment Summary – FTE by Grade 724

Appendix L: Staffing and Admin Support by OIT Organizations 725
Appendix M: Portfolio Details..... 726
Appendix N: Information Security Details 730
Appendix O: IT Investments by Portfolio..... 731
Appendix P: TBM Matrix..... 732
Appendix Q: IT Systems Appropriations History 734
Appendix R: Office of Information Technology Organization Chart 735

Budget Authority and Appropriation Language



Note: 2021 Enacted reflects a rescission of $37.5 million from unobligated balances required by P.L. 116-260, Consolidated Appropriations Act, 2021, Division J, Title II, section 254

Appropriation Language

For necessary expenses for information technology systems and telecommunications support, including developmental information systems and operational information systems; for pay and associated costs; and for the capital asset acquisition of information technology systems, including management and related contractual costs of said acquisitions, including contractual costs associated with operations authorized by section 3109 of title 5, United States Code, **[**$4,912,000,000**]***$4,842,800,000*, plus reimbursements: *Provided*, That **[**$1,211,238,000**]** *$1,414,215,000* shall be for pay and associated costs, of which not to exceed 3 percent shall remain available until September 30, **[**2022**]***2023*: *Provided further*, That **[**$3,205,216,000**]** *$3,131,585,000* shall be for operations and maintenance, of which not to exceed 5 percent shall remain available until September 30, **[**2022**]***2023*: *Provided further*, That **[**$495,546,000**]** *$297,000,000* shall be for information technology systems development, and shall remain available until September 30, **[**2022**]***2023*: *Provided further*, That amounts made available for

salaries and expenses, operations and maintenance, and information technology systems development may be transferred among the three subaccounts after the Secretary of Veterans Affairs **[**requests from**]** *submits notice thereof to* the Committees on Appropriations of both Houses of Congress**[**the authority to make the transfer and an approval is issued**]**: *Provided further,* That amounts made available for the "Information Technology Systems" account for development may be transferred among projects or to newly defined projects: *Provided further,* That no project may be increased or decreased by more than **[**$1,000,000**]***$3,000,000* of cost prior to submitting **[**a request**]***notice thereof* to the Committees on Appropriations of both Houses of Congress **[**to make the transfer and an approval is issued, or absent a response, a period of 30 days has elapsed: *Provided further*, That the funds made available under this heading for information technology systems development shall be for the projects, and in the amounts, specified under this heading in the explanatory statement described in section 4 (in the matter preceding division A of this consolidated Act)**]**. *(Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2021.)*

Explanation of Language Change

The Department of Veterans Affairs (VA) is proposing that the threshold at which a notice is required to be made to both Houses of Congress prior to the transfer of funds between projects, be raised to $3 million. In order to apply more agile or incremental development practices to help modernize Information Technology at VA, VA's Office of Information and Technology (OIT) requires the ability to reallocate funds between development project lines. Obligation savings sometimes occur as acquisition strategies are refined and tasks are often consolidated in ways not originally anticipated as initial budget estimates are prepared. Advancing the threshold from $1 million to $3 million will improve and rejuvenate the IT budget management process as OIT responds to maturing individual facets of VA mission needs. The $1 million threshold represents 0.4% of the Development budget and the proposed $3 million threshold still only represents one percent.

The term "project" refers to VA's congressional development projects report located in the budget Appendix B.

Appropriation Highlights

Appropriation Highlights (Dollars in Thousands)	2020/2021	2020/2021	2021		2022	2021-2022
	Year 1 Actuals	Year 2 of 2-Year Availability	President's Budget	Enacted	Budget Request	Increase / Decrease
Subaccounts:						
Development	427,780	67,251	495,546	495,546	297,000	-198,546
Operations and Maintenance	2,739,597	106,097	3,205,216	3,205,216	3,131,585	-73,631
Staffing and Administrative Support Services	1,204,238	34,362	1,211,238	1,211,238	1,414,215	202,977
Rescission from Unobligated Balance		-37,500				
Appropriation [1/]	**$4,371,615**	**$170,210**	**$4,912,000**	**$4,912,000**	**$4,842,800**	**-$69,200**
Funding Sources:						
Appropriation	**$4,371,615**		**$4,912,000**	**$4,912,000**	**$4,842,800**	**-$69,200**
Available Balance (SOY) (+)	111,701			207,710		-207,710
Available Balance (EOY) (-)	-207,710					
Rescission from Unobligated Balance				-37,500		37,500
North Chicago Facility Transfers	-7,780		-8,085	-8,085	-7,993	92
Veterans Choice Act 801 (SOY)	4,439			2,039		-2,039
Unobligated Choice Act 801 (EOY)	-2,039					
CARES Act, P.L. 116-136 (SOY)	2,150,000			973,938		-973,938
CARES Act, P.L. 116-136 (EOY)	-973,938					
VHA CARES Act Transfer (P.L.116-270)				45,000		-45,000
American Rescue Plan [P.L. 117-2 Section 8003] (SOY)				100,000	100,000	0
American Rescue Plan [P.L. 117-2 Section 8003] (EOY)				-100,000		
OEF/OIF Supplemental (P.L. 110-28) (SOY)	2,240					
OEF/OIF Supplemental unobligated (EOY)						
Reimbursements (+)	89,242		75,588	105,000	88,112	-16,888
Recurring Expenses Transformational Fund					670,000	670,000
Recoveries	2,722					
Unobligated expiring	-423					
Total Obligations	**$5,540,069**		**$4,979,503**	**$6,200,102**	**$5,692,919**	**-$607,183**
Total Full Time Equivalents (FTE)	**7,828**		**7,885**	**9,154**	**8,766**	**-388**
Direct civilian full-time equivalent employment	7,656		7,772	8,168	8,668	500
Reimbursable civilian full-time equivalent employment	71		113	83	98	15
CARES Act , P.L. 116-136 civilian full-time equivalent	101			903		-903

Numbers may not add due to rounding

1/ Numbers include Year 2 of 2-Year Availability but exclude reimbursements. Numbers shown are prior to transfers to and from other accounts

Budget Overview

2022 Budget Request at a Glance (Dollars in thousands)	
2021 Enacted Budget	$4,874,500
Program Changes	-$31,700
2022 Budget Request	$4,842,800
Change from 2021 President's Budget	-0.7%

Budget Request

The 2022 request is $4.843 billion, a decrease of $31.7 million (0.7%) below the 2021 Enacted Budget, to support Veteran focused IT systems and infrastructure. OIT is seeking a budget that will support our commitment to meeting our strategic goals and objectives to include the ability to meet the needs of our business partners/stakeholders (VA Administrations and staff offices). This is necessary to respond to increased demand for new IT Capabilities; increased growth identified by our business partners requesting new space, facility activations; and increased modernization to enhance and optimize the infrastructure.

Budgetary increases in the 2022 request allow OIT to support existing IT infrastructure and recurring operational expenses, focus IT growth identified by our customers and stakeholders, and transform IT with investments in new service capabilities.

The budget request is separated into the following subaccounts:

Development – The request of $297.0 million is $198.5 million (40.1%) below the 2021 Enacted Budget. The decrease in funding is to more appropriately align to VA's business line requirements by prioritizing Commercial Off the Shelf (COTS) products and shifting from developing new software, getting out of the business of building our own applications, and relying more on cloud managed and shared services,; to enhancing or modernizing products already in production. The request of $297.0 million will support:

- Mission-critical areas, including Education Benefits and LogiCole Enterprise Solution [formally Defense Medical Logistics Standard Support (DMLSS)]
- The replacement of legacy systems, such as Benefits Delivery Network (BDN), National Cemetery Administration's (NCA) Burial Operations Support System (BOSS), and Veterans Appeals Control and Locator System (VACOLS)

The Portfolio sections detail the OIT programs supporting these priorities.

Operations and Maintenance (OM) – The request of $3.132 billion is $73.6 million (2.3%) below the 2021 Enacted Budget. Operations and Maintenance (OM) funding is necessary to support demand and growth in critical programs, including:

- Continued support for Supply Chain Management (DMLSS/LogiCole), Education Benefits, Blue Water Navy (BWN), Enterprise Command Center, Enterprise Service Desk (ESD), Veterans Experience, Telehealth Services, and Managed Services, the transition to VA's Enterprise Cloud Solution (VAEC) and existing maintenance activities that support Enterprise Systems across VA.

OIT plans to supplement this request with $670.0 million from the Recurring Expenses Transformational Fund in 2022 to support Financial Management Business Transformation (FMBT), Infrastructure Readiness Program (IRP) and Human Resources.

Staffing and Administrative Support Services – The request of $1.414 billion, which funds 8,668 full-time equivalent (FTE) (500 above the 2021 Enacted Budget), is $203.0 million (16.8%) above the 2021 Enacted Budget level. The majority of these resources fund the hospital and regional office IT staff responsible for supporting VA's mission.

Transfer from Recurring Expenses Transformational Fund – VA plans to supplement OIT's request with resources from the Recurring Expenses Transformational Fund, authorized by Public Law 114-113, the Consolidated Appropriations Act of 2016, allowing for the transfer and use of unobligated balances of expired discretionary funds appropriated in this or any succeeding fiscal year from the General Fund of the Treasury. OIT plans to utilize $670.0 million from the Fund to support information technology systems improvements and sustainment for the following programs:

- $477.5 million to bolster the IRP
- $122.9 million for enhancement of the FMBT
- $69.6 million for modernization and sustainment of Human Resources systems

Reimbursements – In addition to the appropriated level, OIT anticipates $88.1 million in reimbursements which is $16.9 million (16.1%) below the 2021 estimated reimbursements amount: $68.9 million is non-pay and $19.2 million is pay. Reimbursements occur within VA, other Federal agencies, credit reform programs and non-appropriated insurance benefits programs. The increase in the 2021 Current Estimate for reimbursements reflect support for Veterans Benefits Administration Exam Management System (VBA EMS) and Biomedical Advanced Research and Development Authority Operation Warp Speed (BARDA OWS).

Executive Summary

Mission

The mission of OIT is to collaborate with our business partners Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), NCA and Staff Offices, to create the best experience for all Veterans. OIT provides strategic, technical, and customer-service direction, guidance, and policy to enhance and improve VA mission outcomes in the delivery of integrated IT services to Veterans and VA stakeholders.

Vision

OIT's vision is to become a world-class organization that provides a seamless, unified Veteran experience through the delivery of state-of-the-art technology. In 2022, OIT will continue to focus on building an IT infrastructure that is robust, adaptive, agile, secure, interoperable, and cost-effective.

OIT Strategic Priorities:

OIT provides IT support across VA to ensure that the mission, vision, strategic goals, and objectives of the Agency are met. The technology and resources required to support the Agency's strategic priorities underpin every aspect of the care, benefits, and services that are delivered to Veterans. VA's priorities help focus our energies to maximize our impact on Veteran care and services, as well as strengthen our stewardship of taxpayer resources. IT is a vehicle that enables VA to support critical areas such as *Customer Service, Greater Choice for Veterans, Business Transformation and VA/DoD Collaboration*.

OIT's five ***Imperatives*** drive our strategy and outcomes:

- **Exceptional Customer Experience –** Deliver exceptional customer service by reinvigorating partnerships with VA business lines to understand customer needs, align them with true business problems, and deliver IT solutions based on Veteran-centered design and product management, culminating in a world-class customer experience.

- **IT Modernization –** Drive IT and VA capability modernization through digital transformation, refreshing and decommissioning software and infrastructure, and an OIT business value framework that are designed around customer-driven requirements.

- **Strategic Sourcing –** Transform procurement and acquisition processes to support aggressive modernization efforts by optimizing all available sourcing capabilities and streamlining processes for selecting the right capability for each digital transformation requirement.

- **IT Workforce Transformation –** Inspire a culture of digital transformation, IT modernization, and customer service in every OIT employee through education, training, reskilling, and professional certifications, while transforming recruiting efforts to make

OIT an employer of choice for next generation IT workers, boosting recruitment of next generation professionals.

- **Seamless and Secure Interoperability** – Achieve seamless and secure data interoperability across VA, DoD, Federal, and commercial partners by identifying, documenting, and disseminating well-defined, standardized, and secure design, interfaces, and processes to access authoritative data that streamlines the Veteran experience.

OIT is committed to taking a "buy first" approach to new systems, getting out of the business of building our own applications, and relying more on cloud, managed and shared services, and COTS products. VA will continue focusing its efforts on modernizing the infrastructure while transforming our health care system to an integrated network that serves Veterans. VA will use programs like Community Care to partner with the private sector, and external health care experts to assist in designing a methodology that will streamline health care delivery based on population, demand, internal capacity, and external public and private-sector resources. OIT will also continue modernizing the infrastructure by replacing current legacy systems, moving to an Enterprise Cloud Solution, and implementing the IRP.

In support of OIT's Modernization Strategy, the 2022 request will fund the following focus areas:

- Manage Data: We are defining authoritative data sources and ensuring data is consistent and secure across VA so we can better leverage the vast data stores, improve data-driven decision making, and simplify the way Veterans interact with VA platforms.

- Migrate to the Cloud: We are migrating infrastructure and applications to commercial cloud providers to reduce operational costs and increase flexibility, allowing us to deliver services to Veterans more quickly and reliably.

- Improve Cybersecurity: We are developing an enterprise cybersecurity risk management framework, based on industry best practices, to stay at the forefront of protecting Veteran information from cyber threats.

- Digitize Business Processes: We are upgrading VA's customer-facing digital tools to give Veterans easier access to their care and benefits and using new technologies and services to streamline our internal business processes.

- Decommission Legacy Systems: We are moving critical functions from outdated and difficult to sustain platforms, into more modern systems that operate at lower maintenance costs. This cost savings will be reinvested in projects to improve services for all Veterans.

- Recruit and Retain a World-Class IT Workforce: We are not only dedicated to recruiting next generation IT workers to OIT, we are committed to training and re-skilling current employees and ensuring that VA has the right people powering its digital modernization when and where we need them.

President's Management Agenda

OIT supports the President's Management Agenda (PMA) which lays out a long-term vision for modernizing the Federal Government by making investments that enable VA to deliver mission outcomes, provide excellent benefits and services to Veterans, and efficiently manage taxpayer dollars. OIT's efforts toward IT modernization and transformation reform will yield Veteran-centric IT capabilities, aid employees and support personnel to efficiently and effectively accomplish VA's mission. OIT's 2022 budget request will allow VA to directly support the PMA by making investment proposals in the following priority areas:

PMA Priority: IT Modernization	
VA Enterprise Cloud Services	Optimizes the infrastructure and resources, reduces support cost to maintain legacy systems
Infrastructure Readiness Program	Identifies the current state of the IT infrastructure and manages the modernization strategy for IT assets
Divestiture of Legacy Systems	Focuses on the replacement of systems that are beyond their useful life and are costly to maintain
PMA Priority: Data Accountability and Transparency	
Office of Strategic Planning and Analysis (OSPA)	Provides leadership and guidance on strategic planning, performance management, data analytics and organizational governance
VA's Enterprise Cybersecurity Strategy Program (ECSP)	Committed to protecting the information of our Veterans, partners and employees
OIT's Strategic Sourcing	Manages the entire lifecycle, creating transparency, and ensuring that IT funds acquire the best value and services for its cost
PMA Priority: People Developing a Workforce for 21st Century	
IT Workforce Development (ITWD)	Provides IT employees with learning initiatives designed to create and maintain a skilled workforce through targeted, competency-based skill development programs
Human Resources	Leading human resource management strategies, policies, and practices that are engaging, proficient, and diverse
PMA Priority: Improving Customer Experience	
VA.GOV	Integrates customer self-service applications and information, for use by Veterans, into one modernized platform
Telehealth	Expanding the ability to remotely diagnose, consult, treat, transfer medical data, and provide patient education both synchronously and asynchronously
Enrollment System Modernization	Decreases the time it takes to approve eligibility and enroll Veterans and their families into health care and benefits programs
PMA Priority: Sharing Quality Services	
Community Care	Increases Veteran access to healthcare by utilizing partnerships in the private sector, academia and other government entities
PMA Priority: Shifting from Low-Value to High-Value Work	
OIT's Strategic Sourcing	Increases accountability, tying vendor performance to value for the Veteran, while improving responsible stewardship of taxpayer money

Staffing and Administrative Support Services

In 2022, the OIT Staffing and Administrative Support Services request of $1.414 billion supports 8,668 direct FTE), which is 500 above the 2021 Enacted Budget. The 98 FTE funded via reimbursement is an increase of 15 from the 2021 Enacted Budget.

The increase in funding will allow OIT to respond to the demand for new IT capabilities and continued growth in VA's administrations and staff offices. Although the staffing levels have increased in our stakeholder organizations, they have remained flat in OIT. An independent assessment of IT staffing requirements and results of the OIT's workforce planning analysis prior to the COVID-19 pandemic, identified the need for additional skilled IT staff which was only exacerbated by the crisis response. Other workload drivers include increasing telework support due to higher levels of mobile and telework employees and associated devices as well as the need for continued modernization of the infrastructure.

The additional IT staff will enable our OIT organizations to rapidly respond to emergencies, maintain our security posture and resolve incidents expeditiously, enabling service providers to maintain the capabilities required to provide services to Veterans. Shortfalls in staffing have led to backlogs of unresolved trouble tickets, at times in excess of 45,000 in 2020. The newly acquired IT staff will be placed at all major VA facilities, some of which lack the appropriate IT support onsite, meaning every incident requiring deskside support calls for an IT employee to travel to the facility, extending resolution timeframes and pulling resources away from services needed at their primary sites.

In addition to salaries, the Staffing and Administrative Support Services budget provides funding for travel, training, administrative support contracts, leases (including those supporting data centers), office equipment, and supplies. It supports the mass transit benefits program and worker's compensation related to OIT employees as well. With the requested funding, OIT will continue to provide strategy and technical direction, guidance, and policy to ensure that IT resources are acquired and managed for the VA in a manner that adheres to various federal laws, regulations, and policies.

Additional detail on the Staffing and Administrative Support Services account can be found in Appendices (J-L).

The table below displays Budget Authority (BA) FTE for all major organizational components within OIT:

OIT Organizational Components	2020 Actuals		2021 President's Budget	2021 Enacted		2022 Budget Request	2021-2022
	Base Appropriation	CARES Act	Base Appropriation	Base Appropriation	CARES Act	Base Appropriation	Increase / Decrease
Information Technology Operations and Services (ITOPS)	5,583	87	5,606	5,870	740	6,171	301
Enterprise Program Management Office (EPMO)	1,178	10	1,279	1,185	80	1,214	29
Office of Information Security (OIS)	234	-	248	265	22	281	16
Office of Quality, Privacy, and Risk (QPR)	196	1	167	262	14	287	25
IT Resource Management (ITRM)	191	-	211	221	14	261	40
Development, Security, and Operations (DevSecOps)	120	1	93	154	7	218	64
Strategic Sourcing	112	1	125	140	12	157	17
Account Management Office (AMO)	42	1	43	71	14	79	8
Total FTE	**7,656**	**101**	**7,772**	**8,168**	**903**	**8,668**	**500**

Table includes Budget Authority (BA) FTE only
Note: Numbers may not add due to rounding

The table below displays Reimbursable Authority (RA) FTE for all major organizational components within OIT:

OIT Organizational Components	2020 Actuals	2021 President's Budget	2021 Enacted	2022 Budget Request	2021-2022 Increase / Decrease
Enterprise Program Management Office (EPMO)	52	92	68	77	9
Information Technology Operations and Services (ITOPS)	17	19	15	19	4
IT Resource Management (ITRM)	2	2	-	2	2
Development, Security, and Operations (DevSecOps)	-	-	-	-	-
Office of Information Security (OIS)	-	-	-	-	-
Office of Quality, Privacy, and Risk (QPR)	-	-	-	-	-
Account Management Office (AMO)	-	-	-	-	-
Strategic Sourcing	-	-	-	-	-
Total FTE	**71**	**113**	**83**	**98**	**15**

Table includes Reimbursable Authority (RA) FTE only
Note: Numbers may not add due to rounding

Development, Security and Operations (DevSecOps)

DevSecOps is a culture-based software engineering approach that unifies software development and software operation, and relies on collaboration between the business and the IT organizations that develop, deliver, and manage applications for that business. DevSecOps will improve the experience of OIT customers, enable OIT to deploy new systems and update existing systems more quickly and frequently, and will lower costs by leveraging industry best practices and innovation. OIT is strategically shifting toward a DevSecOps approach—focused on collaboration, innovation, Agile principles, and automation—so that it can develop, enhance, maintain, and roll out better products at a faster pace than using the existing separate development and operations processes.

Information Technology Operations and Services (ITOPS)

ITOPS delivers enterprise-wide IT infrastructure engineering and operations services effectively, efficiently and securely to enhance the customer experience and enable VA to optimize service delivery to Veterans. OIT transformation drives a cultural shift that prioritizes improving the Veteran experience and turns OIT into a world-class organization that provides a seamless, unified Veteran experience through the delivery of state-of-the-art technology. ITOPS was developed with these ideas in mind; this new organization focuses on improving both the Veteran and employee experiences by providing more efficient and effective service delivery.

Enterprise Program Management Office (EPMO)

EPMO is the "control tower" for the OIT's major initiatives, monitoring key information like status and risks to improve project execution and deliver better outcomes to our VA business partners and Veterans. EPMO's mission is to provide a consolidated enterprise-wide approach to identify, select, prioritize, and successfully execute a technology portfolio of projects.

Office of Information Security (OIS)

OIS manages VA's Enterprise Cybersecurity Strategy Program (ECSP) and is committed to protecting the information of our Veterans, partners, and employees in support of the Department's mission. Under the ECSP, OIS continues to build upon the goals set forth by OIT's 2015 Enterprise Cybersecurity Strategy and evolve to combat growing cybersecurity threats, and the rapidly changing IT landscape.

Office of Quality, Privacy, and Risk (QPR)

QPR is OIT's forward-leaning posture for addressing OIT's audit approach, oversight bodies, and material weaknesses. QPR's mission is to instill and promote a culture of quality, performance, and risk management, in collaboration with our business partners, to enable a better Veteran experience. QPR oversees all aspects of quality and compliance within OIT and its integration with other quality-focused activities across VA. QPR plays an integral role in helping OIT realize its Digital Transformation Strategy.

IT Resource Management (ITRM)

ITRM advises the Chief Information Officer (CIO) and other senior OIT officials on OIT resource requirements. The office is responsible for the management of all IT resources, direction of financial and IT asset management, and the policies and strategic planning activities for OIT acquisitions. With primary responsibility for linking the budgeting process with IT programs, ITRM is responsible for directing fiscal activities related to linking the budget process to all established IT operations and enterprise-wide management initiatives. Offices within the organization include IT Budget and Finance, Space and Facilities Management, and IT Workforce Development.

Account Management Office (AMO)

AMO focuses on customer experience and serves as the liaison between OIT and its business partners. Information Technology Account Managers (ITAMs) and AMO Senior Advisors customize IT services to meet the needs of OIT's business partners and establish OIT as a trusted, valuable ally in serving Veterans. This team is dedicated to understanding the needs of their business partners, identifying and defining innovative solutions, and representing their customers' interests directly to the VA Chief Information Officer.

An Account Manager serves as the lead IT executive reporting to the CIO and is responsible for the creation and management of the business partner's portfolio. An Account Manager provides strategic leadership to maximize value by managing IT project prioritization, balancing portfolios, and allocating resources. He or she is the primary contact between IT and the business partner, interfaces with industry, and serves as a catalyst to drive innovation. Account Managers and AMO Senior Advisors collect data about OIT performance throughout all of VA.

Strategic Sourcing

Strategic Sourcing is responsible for managing the entire sourcing lifecycle, creating transparency, and ensuring that funds used to acquire IT products provide the best value and services for its cost. Strategic Sourcing is critical to OIT compliance with the Federal Information Technology Acquisition Reform Act (FITARA). It addresses the challenges of a multi-sourcing environment by transforming the way OIT does business, using an organized and collaborative approach so that VA can deliver state-of-the-art technology products and services to our Veterans. The organization increases accountability, tying vendor performance to value for the Veteran, while improving responsible stewardship of taxpayer money.

2022 Health Portfolio

The Health Portfolio provides advanced technology solutions positioned to ensure modern, high quality and efficient medical care delivery capabilities to our Nation's Veterans.

In 2022, the Health Portfolio funding will be used to support the Agency's top priorities of Greater Choice for Veterans, Customer Service and Business Transformation, while also supporting the maintenance of existing major medical systems.

In order to rapidly respond to the COVID-19 pandemic, the Health Portfolio utilized Coronavirus Aid, Relief, and Economic Security (CARES) Act funding in 2021. This work includes modernizing an aging Bed Management Solution, significant expansion of the VA Video Connect capabilities, replacement of the Occupational Health Record-Keeping System (OHRS) legacy tool used to manage mass vaccinations of the workforce, expansion of the data collection capabilities to increase the number of data sources, provide the space to researchers and operation teams surveying and studying the virus, and testing various hypotheses around interventions, treatments. The 2022 Budget request includes the necessary ongoing sustainment funding to maintain the deployed products. Further, OIT worked with VHA to better align sustainment-steady-state costs and in some instances, technology refreshes to support programs such as Business Intelligence Service Lines (BISL). In the 2022 Budget Request, several programs such as BISL and Veterans Data Integration and Federation (VDIF) have been realigned from the Enterprise Portfolio to the Health Portfolio to ensure that they best support VHA needs. This was done to support the Homelessness program and Corporate Data Warehouse clinical support.

Congressional Project (Dollars in thousands)	2020 Actuals DEV	2020 Actuals OM	2021 Enacted DEV	2021 Enacted OM	2022 Budget Request DEV	2022 Budget Request OM
Supply Chain Management[1/]	$ -	$ -	$ 67,120	$ 44,400	$ 76,105	$ 31,158
Community Care	$ 40,740	$ 26,598	$ 21,190	$ 130,266	$ 34,853	$ 97,368
Community Care - CARES Act	$ -	$ 26,465	$ -	$ -	$ -	$ -
Healthcare Administration Systems	$ 15,754	$ 37,435	$ 11,160	$ 80,440	$ 20,710	$ 82,423
Healthcare Administration Systems - CARES Act	$ -	$ 12,545	$ -	$ -	$ -	$ -
Digital Health Platform	$ 5,808	$ 5,162	$ 9,867	$ 9,502	$ 11,807	$ 41,034
Digital Health Platform CARES Act	$ -	$ 844	$ -	$ -	$ -	$ -
Patient Records [System (CPRS)]	$ 6,183	$ 309	$ 7,750	$ -	$ 9,000	$ 3,060
Research	$ -	$ -	$ 3,120	$ 1,114	$ 8,660	$ 12,913
Purchased Care	$ 6,972	$ 4,611	$ 8,410	$ 13,063	$ 6,836	$ 26,447
Purchased Care - CARES Act	$ -	$ 1,674	$ -	$ -	$ -	$ -
Telehealth Services	$ 5,772	$ 1,797	$ 5,600	$ 7,056	$ 6,600	$ 6,423
Telehealth Services - CARES Act	$ -	$ 1,567	$ -	$ -	$ -	$ -
My HealtheVet	$ 10,580	$ 7,424	$ 3,200	$ 12,061	$ 4,684	$ 14,480
My HealtheVet - CARES Act	$ -	$ 2,900	$ -	$ -	$ -	$ -
Health Data Interoperability	$ 8,719	$ 17,273	$ 8,423	$ 55,178	$ 2,125	$ 109,207
Health Data Interoperability - CARES Act	$ -	$ 9,804	$ -	$ -	$ -	$ -
IT Support Contracts	$ -	$ 109,899	$ -	$ 169,327	$ -	$ 179,013
Software Maintenance	$ -	$ 235,376	$ -	$ 139,965	$ -	$ 149,753
Hardware Maintenance	$ -	$ 53,999	$ -	$ 43,231	$ -	$ 43,000
Hardware Maintenance - CARES Act	$ -	$ 5,450	$ -	$ -	$ -	$ -
Pharmacy	$ 5,262	$ 357	$ 11,010	$ 10,490	$ -	$ 16,028
Pharmacy - CARES Act	$ -	$ 2,819	$ -	$ -	$ -	$ -
Connected Health/Mobile Apps	$ -	$ 1,816	$ -	$ 12,000	$ -	$ 14,230
Connected Health/Mobile Apps - CARES Act	$ -	$ 9,472	$ -	$ -	$ -	$ -
Scheduling	$ -	$ 4,550	$ -	$ 22,757	$ -	$ 12,150
Scheduling - CARES Act	$ -	$ 4,106	$ -	$ -	$ -	$ -
Registries	$ 2,550	$ 1,611	$ 200	$ 3,741	$ -	$ 8,500
Genomic Information System for Integrative Service (GenISIS)	$ -	$ 1,028	$ -	$ 2,194	$ -	$ 5,279
Access & Billing	$ 50	$ 339	$ -	$ 350	$ -	$ 4,500
Lab	$ -	$ 3,614	$ -	$ 3,988	$ -	$ 4,044
Registration, Eligibility, Enrollment	$ -	$ 208	$ -	$ 228	$ -	$ 3,500
Registration, Eligibility, Enrollment - CARES Act	$ -	$ 3,292	$ -	$ -	$ -	$ -
Beneficiary Travel	$ -	$ 318	$ 2,540	$ 900	$ -	$ 2,750
Total Health Portfolio	**$ 108,390**	**$ 594,661**	**$ 159,590**	**$ 762,251**	**$ 181,380**	**$ 867,260**

1/ Supply Chain Management Congressional Project was realigned to the Health Portfolio in 2021

Supply Chain Management - $107.3 million

VA's Supply Chain enables the delivery of clinical care to Veterans by managing the flow of medical supplies and equipment. Currently, VA's Supply Chain system is comprised of VistA-based legacy and COTS systems with disjointed capabilities. The lack of integration with other VA systems prevents the Department from achieving comprehensive financial, inventory, and Supply Chain management. VA has made multiple attempts to modernize its current Supply Chain management system in the past. Historically, these limited scope efforts to modernization portions

of the Supply Chain functionality has led to a proliferation of technologies, workarounds, and poorly integrated add-on systems. This has resulted in the fragmented supply chain environment that is missing critical functionality, is overly complex and costly to sustain.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Supply Chain Management[1/]	**$ -**	**$ 67,120**	**$ 76,105**
Enterprise Supply Chain (eSC)	$ -	$ 67,120	$ 76,105

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information
1/ Supply Chain Management Congressional Project was realigned to the Health Portfolio in 2021

Enterprise Supply Chain (eSC) - $76.1 million

VA's ongoing partnership with the Department of Defense (DoD) on the delivery of a Joint electronic health record (EHR), is a game-changer for the VHA Supply Chain Management program. VHA must adopt a Supply Chain system that is compatible with the FMBT initiatives, and supports VA's clinical, financial, and reporting requirements. Overall, this effort will consider people, training, processes, data, and automated systems by:

- Establishing a standardized supply chain organizational structure
- A robust supply chain training and development program
- An integrated data analysis capability, and
- Comprehensive equipment lifecycle management program.

Supply Chain Management Out-year Objectives

Key to this effort was the decision to partner with DoD to repurpose their expertise with supply chain operations, and to align with them on development of a joint product. DMLSS provides medical logistics support to VA medical facilities utilizing a digital platform and a graphical user interface. DMLSS supports all local medical logistics business practices including catalog research and purchase decisions, customer inventory management, medical inventory management, biomedical equipment maintenance, property management, facility management, assemblage management, plus distribution and transportation functions. DMLSS is integrating with the Electronic Health Records Modernization (EHRM) system and the modernized integrated Financial and Acquisitions Management System (iFAMS) and will enable the selection and ordering of medical supplies for the best value with JIT logistics and will ensure that the VA is compliant with federal standards.

Community Care - $132.2 million

Community Care is a nationwide program that utilizes partnerships with the private sector, academia, and government entities to improve access to care for Veterans. OIT works closely with VHA to identify operational efficiencies and innovative scalable technology solutions including

secure email technology that provides a safe, fast, and efficient mechanism for VA staff to share Veterans' protected health information with community providers; a safe health information sharing system that allows community providers to securely view Veteran health information; and a referral documentation tool that automatically converts Veterans' paper medical records into a PDF format that can then be directly uploaded to a Community Care provider's system.

VA's goal is to provide Veterans with the care they need at the right time and from the right provider. In some cases, this requires eligible Veterans to receive care from a local Community Care provider, paid for by VA. Community Care allows Veterans, providers, and VA staff to access VA tools for care coordination, referral and authorization management, review and update of medical information, provider portals, billing via electronic data interchange, provider payments, and revenue operations. However, VA's patchwork of multiple separate Community Care programs is a bureaucratic maze that is difficult for Veterans, their families, and VA employees to navigate.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	**2020 Actuals DEV**	**2021 Enacted DEV**	**2022 Budget Request DEV**
Community Care	**$ 40,740**	**$ 27,958**	**$ 34,853**
Community Care (CC) Electronic Data Interchange (EDI)	$ 17,833	$ 7,000	$ 9,382
Community Care (CC) Referrals and Authorizations	$ 9,657	$ 7,000	$ 7,350
Community Care (CC) Provider Payment Business	$ 7,474	$ 2,000	$ 6,668
Claims Processing Business Transformation	$ -	$ -	$ 6,368
Community Care (CC) One Consult	$ -	$ -	$ 2,985
State Home Community Provider	$ -	$ -	$ 2,000
Community Care Budget Management, Accounting, Accrual, Reconciliation	$ -	$ -	$ 100
Claims Adjudication and Reimbursement	$ -	$ 3,000	$ -
Revenue Operations (CPACs) VistA	$ -	$ 1,040	$ -
Revenue Operations (CPACs) Business Tools	$ -	$ 1,000	$ -
Revenue Operations BIO/BIS	$ -	$ 100	$ -
Community Care (CC) Provider Profile Management System	$ -	$ 50	$ -
Revenue Operations Workflow Tool Enhancements	$ 3,137	$ -	$ -
Community Care (CC) Care Coordination	$ 2,639	$ -	$ -
Unobligated balance brought forward, Oct 1	$ -	$ 6,768	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information
1/ State Veterans Home Program was realigned from Registries Congressional Project in the 2021 Enacted Budget to Community Care Congressional Project for the 2022 Budget Request

Community Care (CC) Electronic Data Interchange (EDI) - $9.4 million

Modifications to Community Care systems are needed to comply with new Standards and Operating Rules for Fee Processing and Payment Systems (FPPS) and Claims Processing and Eligibility (CPE). Veterans will experience reduced wait times for care due to automated (i.e., expedited) referral certifications and authorizations. Also, Veterans will receive more accurate explanations of benefits within shorter timeframes and benefit from provider efficiencies resulting from certified compliance in the end-to-end claim and EDI transactions enable data-driven service improvements to payment processing.

Community Care (CC) Referrals and Authorizations - $7.4 million

Community Care Referrals and Authorizations (CCRA) solution is an integral component of the VA Community Care IT architecture which allows Veterans to receive care from non-VA

community providers. The CCRA System will improve the Veterans access to Community Care and coordination of that care between community providers and the VA. This project will provide an automated tool to generate, monitor, track, and process referrals and authorizations to Community Care Network (CCN) providers so that Veterans who meet requirements and who opt-in to Community Care receive care according to the Choice Act. This is done through improving the electronic exchange of health information used in referrals and authorizations. Community Care staff members use the CCRA Software as a Service (SaaS) package to generate referrals and authorizations for episodes of care to community providers within the CCN.

Community Care (CC) Provider Payment Business - $6.7 million

Community Care Reimbursement System (CCRS) assists in providing additional healthcare options to Veterans by allowing them to visit community healthcare providers instead of VA facilities, and avoids creating a financial burden to Veterans due to unpaid healthcare bills. CCRS specifically supports timely reimbursement payments to providers by supporting all activities associated with receiving, validating, approving, issuing, and reconciling payments to third party medical providers for healthcare-related services to which the Veteran is entitled to through VA. The system ensures the scheduling of medical appointments in a timely manner and establishes a mechanism to receive medical records from non-VA providers. Additionally, it ensures continuity of care for Veterans, coordination among regional networks if the covered Veteran accesses care and services in a different network than which the covered Veteran resides, and that covered Veterans do not experience a lapse in care resulting from errors or delays. CCRS is the primary system used to pay CCN contractors who facilitate care in the community (TriWest & Optum). The Provider Payment Business will fulfill Digital Accountability and Transparency Act (DATA Act) mandates and requirements including:

- Incorporating a widely accepted, non-proprietary searchable platform computer readable format
- Producing consistent, comparable, and reconcilable data, including across program activities
- Automating financial reporting to increase efficiency and reduce cost to recipients of Federal awards

Claims Processing Business Transformation - $6.4 million

Claims Processing Business Transformation will support the modernization of the VA legacy claims systems and the consolidation of Veteran Community Care claims management systems into a single standardized solution. This project encompasses CCN and non-network claims and Veteran Family Member Program (VFMP) claims. The VFMP future state solution supports integration with the new SaaS Claims Processing Business Transformation providing for enhanced efficiency and improved performance of eligibility, claims processing, exceptions processing, appeals workflow, auditing, and analytics on claims data for Veterans and their beneficiaries receiving care in foreign locations. The consolidated claims management solution allows VA direct reimbursement to the third-party administrator (TPA) and allows TPAs to transmit the invoice and approved claims data back to the VA for further validation checks in a consolidated claims processing system, supporting Veterans who are receiving Community Care. Without funding, integration to Signature's Claims XM and decommissioning of CPE will not be possible. The current solutions are fragmented, introduce possible duplication in claims processing

and payment activities and do not support timely corrections/updates of data. Continuing current manual processes on outdated systems will have increased errors and delays in paying Veteran and beneficiary claims.

Community Care (CC) One Consult - $3.0 million

Community Care One Consult is supported through the VA by providing a method to collect vital information about the service needed for the Veteran, documenting the service information and making it available for downstream applications. The Consult Factors are used by these downstream applications to indicate the provisional diagnosis, the services needed and whether the services are to be performed within the VA or out in the community. The ability to use a single Consult both internally and externally for care coordination reduces the administrative burden of producing multiple consults depending on where the Veteran will be seen. This will provide comprehensive consults to Community Care and provide consult tracking, monitoring, and engagement with community providers.

State Home Community Provider - $2.0 million

State Home Community Provider will automate the State Home Per Diem Program (SHPDP) grants management processes and bring the SHPDP into DATA Act compliance. The system must facilitate transparent data and accounting reporting, as well as facilitate a seamless data flow between State Veteran Homes (SVH), Veterans Affairs Medical Centers (VAMC), and other effected SHPDP entities. The system should interface with VistA and other VA systems and migrate existing data into its new repository. Geriatrics and Extended Care (GEC) seeks to modernize technology for the SVH program with a necessary enhancement to the current two-part SVH Survey Software Program developed in 2007. Funding is critical to create a single step software with 100% functionality on the intranet. Investment is necessary to re-architect the current Short Cut to Field Level User's client application solution that utilizes Microsoft SQL Express, installed on each user's desktop or laptop computer and move all the current functionality of that VB.net application onto the SHOST/intranet site, giving VA staff one single location for conducting all SVH survey work.

Community Care Budget Management, Accounting, Accrual, Reconciliation - $0.1 million

Community Care Budget Management, Accounting, Accrual, Reconciliation will allow robotic process automation business solutions to provide work drivers and process automation to track and prioritize key financial components, drive metrics and analytics, develop metrics to measure and validate performance informatics, assess program actions, ensure adherence and compliance and business integrity to polices, processes and procedures. The Business Operation and Administration (BOA) also requires a server hosted solution to manage all appropriation lines for which BOA is charged with stewardship. The system provides expenditure management, forecast outlay, accruals for each appropriation line, and reconciliation of available funds to expenditures. In addition, the VA/DoD Reimbursement effort requires updates to CCRS which will allow for intake of either industry standard claims from DoD Military Treatment Facilities (MTFs), or standardized claim flat files, and payment of DoD in either scenario. Integration of the claims system with Intra-Governmental Payment and Collection (IPAC) system and G-Invoicing to support accounting and transmission of the payments.

Community Care Out-year Objectives

VHA is spending $50 billion annually on community-based care driving significant enhancements and modernized IT systems for Community Care to improve Veterans access to care, coordination of care, referrals and claims processing. Funding is also needed to develop new capabilities (i.e. to create and collect metrics to monitor effectiveness of billing and reimbursement processes, to create and collect metrics to monitor effectiveness of new authorization process, and to introduce automation, including auto adjudication, to billing and reimbursement processes).

Demand for Community Care is increasing, with numerous existing programs creating unnecessary complexity. Under the consolidated Community Care Program (CCP), VA will consolidate the disparate systems and processes for purchasing care into an integrated system for a seamless experience for all stakeholders.

The CCP will expand the availability of Community Care options to Veterans while simplifying processes and workflows. In effect, the program will simplify and standardize community providers' interaction with VA, providing straightforward eligibility criteria and a single set of systems and processes. Consolidation of Community Care services will improve Community Care operations, including interoperability between VHA, DoD, and community providers; reduce confusion among providers; and deliver effective coordinated care. Consequently, the CCP will simplify billing and co-payment requirements as well as ensure that Veterans have timely access to care and a shared understanding of their services and care options.

The new consolidated program will also position VA to collect critical health information with Federal and community partners in order to aggregate and integrate Veteran data. This will significantly increase VA's ability to utilize data analytics to improve Veteran outcomes. As the CCN and CCP mature, the use of data and analytics will be important tools for VA to identify gaps in services, quality issues, and changes in demand. This will enable VA to more effectively and efficiently address changes in how VA delivers health care.

Major cost drivers include enhancements/sustainment to the CCRA system, the EDI systems, and the CCRS. Furthermore, technology advancements—such as Application Programming Interface (APIs), Substitutable Medical Applications and Reusable Technologies (SMART) on Fast Healthcare Interoperability Resources (FHIR) apps, Health Information Exchange (HIEs), Artificial Intelligence (AI), big data analytics, and omnichannel customer relationship platforms—are shaping these Community Care capabilities.

Healthcare Administration Systems - $103.1 million

The Healthcare Administration Systems will provide tools to streamline claims, automate eligibility determinations and payment processing, detect improper payments, and improve reporting. This Congressional Project will be capable of handling mileage reimbursements, as well as meals, lodging, and other approved special transportation methods. This solution will be interfaced with existing VA systems that provide Veteran information, identity and access control, and Electronic Funds Transfer (EFT) information. VA has made VA and DoD collaboration a priority in VA's Strategic Plan, with focus on providing a seamless transition from military service

to Veteran status and enabling VA to anticipate needs and provide quality benefits, care, and services. Specifically, as an integrated health record is deployed, DoD will also collaborate on an enterprise-wide adoption of the LogiCole (formally DMLSS) to replace VA's existing logistics and supply chain solution.

Within the Healthcare Administration Systems Congressional Project, the Caregiver Record Management Application (CARMA) sub-project is a Congressional mandate. Supporting caregivers in their support of the Veteran's treatment plan and overall health and well-being is the ultimate objective. Caregivers work in collaboration with the Veteran's health care team and are recognized as a critical partner in care of the Veteran. They assist in navigating the complex health care system ensuring Veterans have increased access to the care they need and have better treatment compliance which have the potential to impact long term costs overtime. Caregivers also help Veterans maintain their independence to the extent possible and enable Veterans to remain in their homes who may otherwise require institutional long-term care in some cases which is costly to VA.

Health Care Administration includes systems, applications, and capabilities that enable the interoperability of Veteran data between non-VA providers and VA, as well as between VistA and the Cerner EHR to ensure Veterans' EHRs remain current across providers. Additionally, continuous analysis and business intelligence on comprehensive data sets are being conducted to improve health care for all Veterans. As VA continues to implement the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act and transitions from VistA to the Cerner EHR over the next 5 years, VA will need to ensure that each Veteran's EHR is up to date, complete, and not fragmented while multiple EHR systems are in operation at the same time.

Healthcare Administration maintains existing EHR interoperability and data sharing capabilities while VHA transitions to a new EHR solution. This initiative enables the aggregation and analysis of data by incorporating patient encounters (and all the data that is attached to the encounter, such as patient demographics, meds, labs, orders, reports, notes).

With improved interoperability with other systems, it will be easier for Veterans and their families to receive the right benefits and meet their expectations for quality, timeliness, and responsiveness. In addition, interoperability will help ensure that clinical data is not lost, and the medical record is complete and up-to-date, giving VA providers and their partners access to the critical patient information and avoiding risk of inappropriate and duplicated services that may jeopardize patient care and put Veterans at risk.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Healthcare Administration Systems	**$ 15,754**	**$ 11,165**	**$ 20,710**
Caregivers Expansion	$ -	$ 2,000	$ 10,000
HR Smart - Clinical Trainee Registration and Tracking System (CTRTS)	$ 723	$ 4,280	$ 4,280
Office of Integrity - Risk Management System	$ -	$ -	$ 1,900
Enterprise Precision Scanning and Indexing Automation (EPSI)	$ -	$ -	$ 1,600
National Center for Patient Safety (NCPS) Patient Safety Operations	$ -	$ 1,250	$ 1,530
Oversight and Accountability Reporting and Visualization Platform	$ -	$ 800	$ 800
Clinical Staffing and Scheduling	$ -	$ -	$ 600
Geographic Information Systems (GIS) Healthcare Enterprise Support and Services and Infrastructure	$ -	$ 1,130	$ -
Signature Informed Consent (SIC)	$ 702	$ 750	$ -
Clinical Staffing and Scheduling	$ -	$ 600	$ -
VHA Office of Integrity - Case Management System	$ -	$ 350	$ -
CareGivers Enhancement	$ 8,133	$ -	$ -
Occupational Health Record-Keeping System (OHRS) - CARES Act	$ 6,197	$ -	$ -
Unobligated balance brought forward, Oct 1	$ -	$ 2	$ -
Unobligated balance brought forward, Oct 1 - CARES Act	$ -	$ 3	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

Caregivers Expansion - $10.0 million

The VA is responsible for the expansion of the Program of Comprehensive Assistance for Family Caregivers (PCAFC) technology systems. This supports expansion, evaluates workflow and IT enhancements to resolve identified inefficiencies, increases data entry volume and interfaces with VA and DoD applications. The PCAFC provides qualified primary family caregivers of eligible Veterans with benefits including education, training, monthly stipend payment, access to health care if qualified through CHAMPVA, enhanced respite care, mental health care, travel, lodging, and subsistence.

HR Smart - Clinical Trainee Registration and Tracking System (CTRTS) - $4.3 million

HR Smart - Clinical Trainee Registration and Tracking System (CTRTS) is a SaaS Oracle PeopleSoft based Human Capital solution that is in production and accessible via web. HR Smart is the Authoritative Data Source for an Employee Record providing automated HR Information System services to HR Offices, VA managers and employees. This project supports the VA's Office of Human Resources and Administration (HR&A) mission of leading human resource management strategies, policies, and practices that cultivate an engaged, proficient, and diverse workforce to transform and continually improve services to Veterans and their families. HR Smart is currently undergoing a massive data cleansing effort that drives the reduction of payroll errors and equip HR Offices with automated solutions that drive accuracy of HR coding. HR Smart is mandated under the 2002 Presidents Management Agenda (to modernize HR using service providers) and the Chief Human Capital Officer Act of 2002.

Office of Integrity - Risk Management System - $1.9 million

This will provide a managed solution and create an API for the integration of an enterprise case management system will be used by all the evaluative program offices within the Office of Integrity; as this will allow for information sharing and case tracking across the Integrity workstream. Electronic case management software refers to applications that help businesses and nonprofits with managing their customer interactions through helpline and other digital channels

such as email and contact forms. Using case management software, VHA can automatically collect and organize customer interactions into one easy place, allowing for convenient access and a comprehensive view of each case. Case management software solutions enables VHA to address a range of business challenges and manage unpredictable, information-centric work. Critical capabilities include: 1) Task and Activity Management; 2) Customized Knowledge Worker Interface; 3) Content Management 4. Business Rules and Workflow; 5) Visibility and Reporting.

Enterprise Precision Scanning and Indexing Automation (EPSI) - $1.6 million

Precision Scanning and Indexing (PSI) will drastically reduce current backlog scanning time/importing requirements by standardizing the process across the enterprise through automated unattended robotics that operate 24 hours a day, 7 days a week that can upload approximately 15,120 records per license/application. PSI attaches the community providers clinical notes from the Veteran's appointment to the appropriate consult in the Veterans VA Health Record. With this solution, Veterans' Community Care health information is made available to their treating VA care teams at an incredibly accelerated timeline without the need for overtime or staff re-assignment.

National Center for Patient Safety (NCPS) Patient Safety Operations - $1.5 million

NCPS serves as an enterprise safety support system for a VHA wide network of Veterans Integrated Services Networks (VISN) Patient Safety Officers, facility Patient Safety Managers, VISN Chief Logistics Officers, facility logistics staff and other VISN and facility safety personnel trained to facilitate documentation and analysis of adverse events related to patient healthcare. VHA learns about adverse events through these applications (reporting), investigates safety events or vulnerabilities occurring outside and within VHA facilities and analyzes high risk events to understand the root cause (and the risks posed enterprise wide). Lessons learned are shared across VHA, actions (Alerts/Advisories/Notices) are communicated to prevent and mitigate risk, and assignments are made to designated users who physically remove items capable of causing harm to Veterans from unsafe medical devices, products, pharmaceuticals and food in our health care facilities.

Oversight and Accountability Reporting and Visualization Platform - $0.8 million

The VHA Office of Compliance and Business Integrity's (CBI) Oversight and Accountability Reporting and Visualization Platform (OARVP) will be a key tool towards achieving CBI's mission, as well as VHA's larger goal of being an accountable, learning organization. The OARVP will consist of an interactive web application that will enables VHA leadership, CBI Officers, and key internal stakeholders' access VHA compliance program management and leadership reports data in an interactive and dynamic manner. The goal of the OARVP is to provide VHA leadership, CBI Officers and key stakeholders the needed intelligence to detect and address emerging compliance risks and isolated or systemic issues of noncompliance identified having an adverse effect on a Veteran's experience. A centralized system will enable the nationwide comparison of facilities and VISNs and help with identifying outliers. With such capability, CBI seeks to increase awareness, transparency and accountability and to promote actions towards achieving an integrated VHA-wide compliance program.

Clinical Staffing and Scheduling - $0.6 million

The Clinical Staffing and Scheduling system will replace manual staffing methods by addressing deficits that currently exist in nursing workforce management data, replacing various commercial

systems that have been acquired independently by numerous facilities/VISN's, and addressing potential security/ privacy vulnerabilities that have emerged and that are currently being investigated. This funding is necessary for implementing a unified COTS/managed solution for the enterprise that will modernize and replace the manual staffing methods currently being used by VA and addressing security vulnerabilities that exist within the various commercial systems that have been acquired independently by numerous facilities/VISN's. Without this funding, VA will not be able to address potential security/ privacy vulnerabilities that have emerged as a result of not having an enterprise solution strategy that is compliant with national and agency regulations.

Healthcare Administration Systems Out-year Objectives

The Healthcare Administration products and services will ensure a complete Veteran EHR by integrating Veteran data from non-VA providers and between VistA and Cerner, as VA continues to implement the MISSION Act and transitions from VistA to Cerner over the next 10 years. The Veterans Data Integration and Federation (VDIF) will be key to this. Data analytics will be used to improve treatments and Veteran population health care facilitated by the Health Data and Analysis Platform and VDIF. Additionally, the enhancement and maintenance of administrative capabilities that will not be replaced by Cerner (e.g., Caregivers/CARMA, AudioCare, and Informed Consent) will streamline Health Care Administration processes and procedures. Other projects that have required additional support and enhancement and sustainment include the Clinical Trainee Registration and Tracking System (CTRTS), Fee Basis Claims System (FBCS), and the Occupational Health Record-Keeping System (OHRS).

Digital Health Platform - $52.8 million

Digital Health Platform (DHP) includes capabilities that deliver high quality, Veteran-centered care that provides access to coordinated VA healthcare services. Telehealth Services is currently increasing at 30% per year, partly due to increased demand by younger Veterans. DHP consists of many sub-projects, however, the sub-projects requesting the highest resourcing need for 2022 consists of VHA Software License Maintenance, VHA IT Support Contracts and VHA Hardware Maintenance, which represents the estimated OM charges for legacy system support for the specific and unique VHA systems that were not included in the OIT Consolidated Agreement [also referred to as the Service Level Agreement (SLA)].

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Digital Health Platform	**$ 5,808**	**$ 9,867**	**$ 11,807**
Health Data and Analytics Platform	$ -	$ 3,699	$ 6,402
Posttraumatic Stress Disorder Checklist 5 (PCL-5)	$ 2,440	$ 1,100	$ 3,200
Mental Health (MH) Screening and Identification	$ -	$ -	$ 2,000
4-SIGHT Automated Eyeglass Ordering	$ -	$ -	$ 205
Audiology IT Infrastructure Standardization and Software and Data Management	$ -	$ 2,963	$ -
Suicide High Risk Patient Enhancements	$ 3,368	$ 1,000	$ -
Women's Health Services	$ -	$ 625	$ -
Automated Patient Discharge	$ -	$ 200	$ -
Veterans Integrated Service Network (VISN) 10 Central Fabrication Unit	$ -	$ 160	$ -
Radiation Oncology Peer Review Program	$ -	$ 120	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

Health Data and Analytics Platform - $6.4 million

The Health Data and Analytics Program enables VA to leverage existing data and knowledge to discover new information; identify early indicators of diseases and illnesses; determine the most effective treatments; determine best practices by using algorithms to make inferences on individuals or cohorts and managing reports and inferences in clinical and administrative workflows. This capability should result in identifying the most effective and efficient treatments for our Veterans; expedite the identification of diagnoses indicators; and improve the implementation of treatment best practices. This platform enables VA to transition from outdated, expensive, customized, and vertically integrated solutions to a best-practice approach based upon enterprise data integration and management leveraging a system of commercial SaaS platforms for improved treatment practices. This approach will also facilitate VHAs ability to focus on creating new methods/strategies using algorithms for improved operations management rather than creating uncoordinated solutions for every solution/application.

Posttraumatic Stress Disorder Checklist 5 (PCL-5) - $3.2 million

Posttraumatic Stress Disorder Checklist 5 (PCL-5) will provide Mental Health (MH) clinicians and their patients with better tools to assess progress and wider flexibility for how they can provide data about the patient's clinical status and response to care, and thus better diagnose and manage Veterans at-risk for Suicide. Specifically, this platform is needed for VHA health care team members (e.g., referring provider, MH intake provider, MH treatment providers, etc.) who need to assess and care for Veterans at high risk from the point of identification of need for MH services through their care in mental health of capturing information (e.g., assessment and stratification data). The platform will help to manage information related to identifying the urgency of and progress in care of all MH referrals. It will ensure Veterans at risk for suicide receive timely and appropriate care in the proper setting based on the results of the initial and ongoing assessment and allow for tracking of disposition for timeliness and access to care. This effort directly impacts the VA's ability to reduce Veteran suicide. Additionally, this effort will provide 30 new instruments to the Mental Health Assistant (MHA) package, which will allow clinicians to electronically administer mental health assessments to patients in support of VA's Office of Mental Health and Suicide Prevention (OMHSP) Suicide Risk Assessment & Measurement Based Care Initiative. Failure to fully fund this effort would severely degrade our collective ability to reduce

suicide rates among the most vulnerable of our Veteran community. This would directly result in the loss of life.

Mental Health (MH) Screening and Identification - $2.0 million

VA MH programs provide a range of clinical services, from treatment of mild, uncomplicated mental health conditions in primary care to treatment in specialty mental health programs for conditions requiring more specialized intensive care, including the most severe complex mental health conditions. Core elements for the MH IT program continue to be organized around the transformation of mental health services to a measurement based system of care, providing same day access for urgent MH needs, and delivering evidence based treatments that meet the unique needs of patients in sub-specialty populations. The specific need addressed in this sub-program is a solution to allow audio recordings of therapy sessions to be captured and shared with internal consultants providing training and consultation to staff who have been trained in the delivery of specific evidence-based therapy protocols. This will enhance customizing treatment based on individual Veteran response to specific therapies and facilitate VA MH efforts to ensure highest level of quality mental health services at all facilities. This will also improve access to MH services by being able to deliver more efficient care and ensuring the right care at the right level for each individual Veteran.

4-Sight Automated Eyeglass Ordering - $0.2 million

4-Sight is a business model that promotes standardization of procurement of eyeglasses for Veterans by using data to perform automation actions in VistA. The 4-Sight Program works by collecting the implementing site's consult data overnight from the VA Corporate Data Warehouse (CDW) to be stored in the 4-Sight database. The 4-Sight application uses these data to perform automation actions in VistA that cover both ordering and reconciling payments so that the VA cost of eyeglasses provided reflect accurately on patients' records. 4 Sight has significantly reduced the burden of eyeglass ordering on purchasing agents and since 4-Sight's inception in July 2018, 4 Sight has processed 112,347 orders across two VISNs. The number of hours saved ordering eyeglasses in 2018 with 4 Sight is approximately 3,605 hours. The current process for eyeglasses is highly decentralized, repetitive, tedious, and riddled with inefficiencies. With 4 Sight, purchasing agents no longer needs to devote 20-25 hours per week ordering eyeglasses, reconciling those charges and following up with orders that either we not completed by the contract vendor or need to be re-done increasing overall procurement ability of the purchasing agent by approximately 19%.

Patient Records [System (CPRS)] - $12.1 million

Patient Records System supports the implementation of a national automated solution for pharmacy dispensing of methadone and its integration into the patient's record. The Computerized Patient Record System (CPRS) provides an integrated patient record system for clinicians, managers, Quality Assurance (QA) staff, and researchers.

CPRS is a VistA computer application and is the system interface used by providers, nurses, and other clinical staff to view patient information. It is also the electronic medical record that is used throughout VA in all health care settings (Inpatient, Outpatient, Long-term care), covering all aspects of patient care and treatment. The primary goal of CPRS is to provide a fast and easy-to-

use application that provides a framework that supports clinical workflow. It also supports the implementation of a national automated solution for pharmacy dispensing of methadone and its integration into the CPRS.

The VistA consists of over 170 clinical, financial, and administrative applications. The legacy system supports more than 1,600 VA facilities nationwide as part of the largest integrated delivery network in the U.S. As VA's legacy EHR system, VistA has been essential to the Department's ability to deliver health care to more than nine million Veterans and their families. Multiple modernization initiatives to enhance the legacy EHR system have led to more than 130 unique instances of VistA. As a result, VA lacks a comprehensive definition of VistA and cannot accurately report VistA costs.

These disparate instances create challenges in coordinating care across medical facilities and result in a lack of standardized processes and non-authoritative data sources. Providing quality health care is one of VA's highest priorities, and to operationalize this Veteran-centric approach, VA established the Office of Electronic Health Record Modernization (OEHRM) to oversee the implementation of the Cerner EHR, which will replace VistA and the CPRS. VA is in the process of implementing the Cerner EHR at Integrated Operations Center (IOC) sites and has successfully transferred 23.5 million Veterans' health records to a shared data center with DoD—a significant accomplishment setting the stage for the go-live of the EHR solution next year.

New pharmacy projects and enhancement to existing systems include upgrades to the Inbound ePrescribing, the pharmacist user interface Advanced Mediation Platform (AMPL) GUI, and enhancements to other operational Pharmacy software products. The Prescription Drug Monitoring Program consolidated all the individual state prescription drug monitoring programs (PDMPs) available to help reduce prescription drug overdoses by providing data on dispensing of controlled medications across clinicians and systems. Veterans who use VA healthcare have twice the risk of medication overdose deaths than non-Veterans. Reasons for this increased risk are unknown, but theories include the unique health characteristics of Veterans (e.g., combat-related, comorbid physical and mental health disorders) and/or prescribing practices among VA clinicians. It is also possible that large numbers of Veterans who receive VA prescriptions simultaneously receive prescription medications from non-VA prescribers.

Suicide is a National Public Health issue that affects all Americans, therefore preventing Veteran suicides is VA's highest clinical priority. On average, 20 Veterans, active-duty Service Members, and non-activated Guard or Reserve members die by suicide each day. Of those 20, 14 were not in VA's care. Therefore, VA is working to improve the transition from active duty to Veteran status, identification of at-risk Veterans, firearm and medication safety, and access to mental health services. Every day, more than 400 Suicide Prevention Coordinators and their teams—located at every VAMC—connect Veterans with care and educate the community about suicide prevention resources. Furthermore, VA and SoldierStrong have partnered on an initiative to use a virtual reality system to treat patients experiencing post-traumatic stress; through its StrongMind Virtual Reality System, SoldierStrong will donate virtual reality software and hardware to 10 VAMCs in the coming year with the goal to reduce the number of Veteran suicides across the country.

Additionally, VA offers a wide array of interventions designed to identify homeless Veterans, engage them in services, find pathways to permanent housing, and prevent homelessness from occurring. VA has made significant progress in ending Veteran homelessness. Since 2010, the number of Veterans experiencing homelessness in the U.S. has declined by nearly half, and over 700,000 Veterans and their families have been permanently housed or prevented from becoming homeless.

This includes an increased demand on patients seeking access to their care plans. It also requires enabling caregiver access with proper permissions. These changing requirements include the need to track and trace exposure for caregivers and family, thus requiring additional consent and permission and updated procedures.

VA pioneered EHR development with VistA. However, after more than 40 years of use, VistA lacks the interoperability with DoD and Community Care partners required to better serve Veterans. VistA is extremely costly to maintain as VA's sole health information system and limits the Department's ability to provide Veterans with a seamless care experience. VA has explored various options to modernize VistA since 2001, but these VistA modernization initiatives failed to truly transform the EHR system or achieve interoperability. Until the new electronic health record is deployed, legacy VistA, its components, and other clinical systems need to be maintained.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Project:

Congressional Projects/SubProjects *(Dollars in thousands)*	**2020 Actuals** DEV	**2021 Enacted** DEV	**2022 Budget Request** DEV
Patient Records [System (CPRS)]	**$ 6,183**	**$ 9,450**	**$ 9,000**
CPRS	$ 6,183	$ 6,000	$ 6,000
Methadone Dispensing Tracking	$ -	$ 900	$ 3,000
eScreening Alternative Suicide Prevention Efforts	$ -	$ 600	$ -
LGBT Program (10P4Y)	$ -	$ 250	$ -
Unobligated balance brought forward, Oct 1	$ -	$ 1,700	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

CPRS - $6.0 million

CPRS (Computerized Patient Record System) provides an integrated patient record system for clinicians, managers, QA (Quality Assurance) staff, and researchers through the development based on their requirements. The primary goal of CPRS is to provide a fast and easy-to-use application that provides providers information needed in the clinical workflow process. CPRS is the system interface used by providers, nurses, and other clinical staff to view patient centric information. The application integrates many other packages and provides an environment that coordinated care is reviewed, documented and preserved. This project's enhancements improve the quality and efficiency of Veterans' experiences in VA clinical settings. Each of the improvements in functionality directly improve user's abilities to navigate CPRS and more efficiently complete their documentation of Veteran care and the use of tools to communicate next steps in that care including placing orders and consults. Improvements in user's efficiencies allows for more time for direct patient care. CPRS include the tools to improve the ability to conduct

medication reconciliation, improve alerts, and reduce the inadvertent use of unsafe medications. As CPRS improves, care improves and becomes safer, users become more efficient, and the overall Veteran experience improves. This effort contributes to restoring trust and confidence of the Veteran in services VA provides.

Methadone Dispensing Tracking - $3.0 million

Methadone Dispensing Tracking improves patient outcomes and treatment for Veterans supporting best practices and quality by ensuring safe drug administration with proper documentation practices to improve surveillance of medication-assisted treatments of opioid use disorders across the Veteran population served by VA. Methadone Dispensing Tracking will manage referrals for the medication-assisted treatment of a Veteran participating in an opioid use disorder program, so that VA can ensure Veterans have seamless and timely access to mental health care. This will improve the coordination of care for Veterans in methadone treatment; reduce time involved in duplicating documentation of methadone orders in two systems, reduce errors including the potential for more episodes of intensive or acute care. By automating tools, data collection, data accuracy, and data availability will increase the quality, efficiency and effectiveness of care, freeing additional resources for direct patient services.

Patient Records [System (CPRS)] Out-year Objectives

Enhancement to systems including Pharmacy (e.g., Inbound ePrescribing, AMPL GUI, Pharmacy operational updates), health data analytics platform, MISSION-required State Prescription Drug Monitoring, and the current VistA transition to the cloud project require support. Additionally, enhancements to the Joint Longitudinal Viewer (JLV) and CPRS are required to support the legacy EHR. By 2026, we will be nearing end of life for these products as we completely transition to Cerner. However, many of the systems covered in Clinical Ancillary will not be included as capabilities in the new Cerner EHR, so these projects will continue to require support as long as they are needed.

Research - $21.6 million

Research is related to the Business Case submitted in 2020-2024 (Collaboration Workspace for VA and non-VA Access) but expanded to include requirements from the Office of Research and Development (ORD), the Office of Academic Affiliations (OAA) and the VHA Office of Innovation. This project focuses on the combined needs of these critical Title 38 VHA missions (beyond direct clinical care). This request builds on a long-standing requirement for having a collaboration workspace that is accessible by personnel from within and outside the VA. Research also includes the VHA Innovation Ecosystem which modernizes and enhances the customer experience for Veterans and their families by fostering Department-wide innovations that can quickly cultivate an idea from discovery to evaluation, to ultimately becoming implemented nationwide. Ideas within the core innovation ecosystem are generated through the VA Innovators Network, transformed into reality by the VHA Innovation Program, and are then disseminated throughout VA by the Diffusion of Excellence Initiative.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Research	**$ -**	**$ 3,120**	**$ 8,660**
VHA Innovation Ecosystem (previously VA Center for Innovation)	$ -	$ 3,120	$ 5,060
VA-Academic Collaboration Space for Research, Education and Innovation	$ -	$ -	$ 3,000
VAMC-Affiliate External Interconnections for Research & Education	$ -	$ -	$ 600

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

VHA Innovation Ecosystem (previously VA Center for Innovation) - $5.1 million

VHA Innovation Ecosystem will leverage existing VA strategic priorities to build comprehensive and collaborative innovation communities that engage the broader VHA innovation community. VHA Innovation Ecosystem will oversee the innovation landscape while providing integration of all VHA Innovation activities through improved planning, coordinating, organizing, leading, and controlling of all innovation activities within the Innovation Lifecycle. Veterans also benefit from a decreased amount of time under anesthesia, and an increased availability in operating rooms. From the simple to the complex, 3D printing innovations are enhancing VHA's ability to serve and create impactful solutions for Veterans. Introducing this new standard of care has saved lives and provided Veterans a new sense of involvement in their care. Replacing VA Center of Innovations (VACI), the VHA Innovations Ecosystem supports the following Healthcare Initiatives: (1) Logistics, Engineering, Acquisition, and Finance (LEAF); (2) Genomics Laboratory Management Information System (GLIMS); (3) Chemotherapy Orders Management System (COMS); (4) E-Screening; (5) One VA Pharmacy; (6) Digital Marketplace; and (7) Future Technology Laboratory.(See Volume II, Part 1, Medical Support and Compliance Section)

VA-Academic Collaboration Space for Research, Education and Innovation - $3.0 million

The VA-Academic Collaboration Space for Research, Education and Innovation project is to provide a Secure Collaboration Workspace plan that would clearly enhance Veteran patient care by providing efficient means for provider and team communication outside of the formal medical record. The Non-Secure Collaboration Workspace plan would enhance two statutory missions of VA - education and research, thereby enhancing academic partnerships and bringing excellence to the patient care enterprise. These collaboration tools are in Demilitarized Zone (DMZ) to allow VA investigators, educators, innovators and non-VA colleagues in academic affiliates and other agencies to collaborate on grant writing, publication writing and other shared document tasks.

VAMC-Affiliate External Interconnections for Research & Education - $0.6 million

VAMC-Affiliate External Interconnections for Research & Education will improve the Federal Information Security Management Act (FISMA) compliance of the VA when dealing with research and education external connections to affiliate institutions. It will decrease the risks of future Office of Inspector General (OIG) audits finding material weaknesses in this area and implement standard external connection to university affiliate for research and education at all VAMCs with research academic or education programs. This will include Authority to Operate (ATO) and Enterprise Security Change Control Board (ESCCB) processes for approval of external connections.

Purchased Care - $33.3 million

The Health Insurance Portability & Accountability Act (HIPPA) requires industry-wide standardization of Electronic Data Interchange (EDI) Transactions to achieve improved efficiency and cost effectiveness in US healthcare. Purchased Care adds system checks and reporting functions to the Medical Care Collections Fund (MCCF) and also extends eInsurance standards to eligibility, benefits and claims, data content, eligibility compliance, and insurance verification.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Progams/Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Purchased Care	**$ 6,972**	**$ 12,610**	**$ 6,836**
Medical Care Collections Fund (MCCF) EDI Transaction Applications Suite	$ 6,972	$ 8,410	$ 6,836
Unobligated balance brought forward, Oct 1	$ -	$ 4,200	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

Medical Care Collections Fund (MCCF) EDI Transaction Applications Suite - $6.8 million

MCCF EDI Transaction Applications Suite adds system checks and reporting functions to MCCF. To maintain HIPAA compliance, VHA must implement periodic changes to standards and implement new data fields and data field values. Implementing new EDI Standards and Operating rules allows VHA to continue exchanging data with insurance payers, maintaining the flow of revenue to VHA. This project is necessitated by congressional legislative mandates and compliance is dictated by the Administration Simplification portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) X12 Electronic Data Interchange (EDI) transactions, as amended by the Patient Protection and Affordable Care Act (PPACA). Administrative Simplification requires standardizations across eBilling, ePayments, eInsurance, and ePharmacy. This effort reduces the financial burden to the Veteran and his/her family for care received by the Veteran.

Telehealth Services - $13.0 million

Telehealth Services provide additional functionality and enable expansion increasing opportunities within the Home Telehealth / Remote Patient Monitoring program to improve care for more than 71,000 Veterans, 45% of whom live in rural areas where traveling to traditional medical appointments is difficult. This will improve Veterans' access to care by reducing travel and will help Veterans continue to live independently. Additionally, this will help to provide Veterans the knowledge and skills needed to more effectively self-manage their own health care needs. The Telehealth Management Platform (TMP) program continues to host and secure the system that supports the care of more than 71,000 Veterans enrolled in the TMP program nationwide.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Telehealth Services	**$ 5,772**	**$ 5,686**	**$ 6,600**
Home Telehealth Reporting (HTR)	$ 2,740	$ 4,200	$ 4,200
Telehealth Management Platform (TMP/CVT-TSS)	$ 2,320	$ 1,400	$ 2,400
Home Telehealth Reporting Enhancements (HTRE)	$ 711	$ -	$ -
Unobligated balance brought forward, Oct 1	$ -	$ 86	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

Home Telehealth Reporting (HTR) - $4.2 million

Home Telehealth (HT) improves tools that Care Coordination nurses use to manage their panel of patients enrolled in the HT program. The data from the tools are used by the VHA Office of Telehealth Services in the Office of Connected Care (OCC) to assess and improve HT program outcomes. HTR supports the HT program in improving clinical outcomes and access to care by reducing complications, hospitalizations, and clinic or emergency room visits for Veterans who are at high risk due to a chronic disease. The enhancements will help Veterans continue to live independently and spend less time at medical visits while enhancing their knowledge and skills on effectively managing their health care needs. Based on reporting data collected by this program, Veterans enrolled in HT for non-institutional care needs and chronic care management had a 53% decrease in VA bed days of care and a 33% decrease in VA hospital admissions.

Telehealth Management Platform (TMP/CVT-TSS) - $2.4 million

The Telehealth Management Platform (TMP) is a customer relations management software system. TMP automates previously manual work for three elements of virtual care services: 1) Scheduling 2) Resource Management and 3) Administrative Management. TMP allows sites sharing resources to communicate critical information to activate, manage and support Veteran virtual care/remote services. TMP is a critical software that supports the delivery of virtual care services that are a part of the overall Telehealth program growth and enable more efficient use of these services between the 970 VHA sites. TMP will help VHA meet the increasing need for clinical encounters for the 33% of all Veterans who live in rural areas and the 12% who live more than three hours from a tertiary care facility. The TMP project supports Digitizing Business Processes and Electronic Health Record Modernization.

Telehealth Services Out-year Objectives

Telehealth Services access for Veterans is currently increasing at a rate of 30% per year. By the end of 2026, it can be expected that 100% of the Veteran population will have the ability to access clinical care via Telehealth Services. The provision of existing critical clinical services provided via Telehealth to approximately 909,000 Veterans and the refinement of cost-effective programs that permit our clinical staff to treat tens of thousands of Veterans each month as both patients and clinicians can operate from remote sites.

My HealtheVet - $19.2 million

My HealtheVet (MHV) is a Web-based application that creates a new, online environment where Veterans, families, and clinicians may come together to optimize Veterans' health care. This Web technology combines essential health record information enhanced by online health resources to

enable and encourage patient/clinician collaboration. It improves Veteran health care by providing easy access to health information, online resources, and facilitates patient/health care provider interactions. MHV gives the Veteran access to VA benefits, special programs, and health information and services. It also provides the Veteran with web-based tools to increase their knowledge about health conditions, manage their health records, and communicate with health care providers. Veterans can now take a more proactive approach to manage their health and utilizing VA health services and benefits.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	**2020 Actuals** DEV	**2021 Enacted** DEV	**2022 Budget Request** DEV
My HealtheVet	**$ 10,580**	**$ 3,212**	**$ 4,684**
MHV Veteran-Facing	$ 6,140	$ 2,100	$ 2,592
MHV Infrastructure and Interface Enhancements	$ 4,440	$ 1,100	$ 2,092
Unobligated balance brought forward, Oct 1	$ -	$ 12	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

MHV Veteran-Facing - $2.6 million

Development of the MHV Veteran-Facing is to provide Veterans with electronic access to their health records; support Veterans in their self-managing weight care; provide Veterans access to Patient Education Management System (PEMS); and enhance MHVs Secure Message (SM) capabilities. The end users of the VA's Web portal are Veterans, whether they get their care from the VA or from an outside source. The purpose of the new development is to provide functionality, interfaces and capabilities ensuring Veterans have access to their individual electronic health record. It will also provide the ability to share their health record (as they direct through new Delegation) and have access to general and medical information, which ensures the Veteran community remains healthy and vibrant. Veteran-Facing Application is aligned with the Veteran Infrastructure and Interface team and the Cloud Support team to ensure a new code is installed and can deliver the functionality as requested by the business through their requirements process.

MHV Infrastructure and Interface Enhancements - $2.1 million

The My HealtheVet (MHV) Infrastructure and Interface Application program is an ongoing program designed to build and develop new interfaces, new API's, and new functionality as requested by the VHA, Veteran Consumer Health Informatics Office and agencies external to the VA (i.e. DoD, Indian Health Services), who wish to interface and collaborate with the VA's award winning Veteran focused Personal Health Record. With over five million Veterans currently enrolled in the MHV program, the purpose of the development is to provide new functionalities, interfaces and capabilities to ensure Veterans have a web platform accessible 24/7/365 to help ensure Veterans and their health care providers or family members have immediate access to the individual Veterans health information anywhere, whether on a computer or mobile app. The infrastructure and Interface Application in MHV closely align with all four of the OIT's priorities, with special focus on transforming and improving the Veterans benefits provided through Access to Care.

Health Data Interoperability - $111.3 million

The National Clozapine Registry provides VA with the tools to authorize, track and report the safe prescription and administration of clozapine for Veterans with serious mental illnesses. The project will address issues in several VistA Mental Health and Pharmacy processes to register, prescribe, and monitor patients taking clozapine in accordance with the Food and Drug Administration (FDA) guidelines through daily transmission and parsing of clozapine administrative data from VA facilities. This ensures the data is correct in the National Clozapine Registry and adheres to the required reporting to the FDA.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Health Data Interoperability	**$ 8,719**	**$ 10,440**	**$ 2,125**
National Clozapine Coordination	$ 1,869	$ 2,000	$ 2,125
eHealth Exchange Enhancements	$ 1,600	$ 3,623	$ -
Veterans Health Information Exchange (VHIE) Software Quality Assurance (SQA) (InterSystems Support) Phase 1	$ -	$ 800	$ -
Corporate Data Warehouse (CDW) Veterans Health Information Exchange (VHIE) Performance Analytics Phase 1	$ -	$ 500	$ -
Veterans Health Information Exchange (VHIE) Enhancements for Release of Information Office Phase 1	$ -	$ 500	$ -
Veterans Health Information Exchange (VHIE) Enhancements for VBA Phase 1	$ -	$ 500	$ -
Veterans Health Information Exchange (VHIE) Enhancements for Veterans Self-Service Integrations Phase 1	$ -	$ 500	$ -
Direct Secure Messaging Phase 3	$ 5,250	$ -	$ -
Unobligated balance brought forward, Oct 1	$ -	$ 2,017	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

National Clozapine Coordination - $2.1 million

Clozapine is the most efficacious medication available for the treatment of schizophrenia and is the only medication proven to reduce the suicidality of schizophrenic patients. The FDA has mandated that all patients receiving clozapine enroll in a national clozapine registry to monitor Absolute Granulocyte Counts. The National Clozapine Coordination (NCC) FDA enhancements enables the VA National Clozapine Coordinating Center (NCCC) to fulfill this FDA mandate in a manner that is safe, provider and patient friendly, and cost effective. NCC will work on moving the existing Clozapine tracking into a database structure that will meet VA standards and streamline the referral and approval process by providing an automated tool for management of referrals and approvals for initiating Clozapine therapy. NCC supports Managing Data by collecting and using data from several sources in order to adhere to FDA's REMS program and supports compliance with the new FDA Clozapine Risk Evaluation and Mitigation Strategy (REMS) Program by updating the allowable lab values to prescribe clozapine. Having NCC in place will significantly reduce the amount of work that needs to be done manually, saving time, increasing efficiencies, decreasing risk of errors, and allowing staff to work more effectively.

Health Operations and Maintenance - $867.3 million

Health Operations and Maintenance provides funding for existing technology that is critical to the success of the Veterans health care IT system mission to deliver reliable, accessible, and timely health care services to our nation's Veterans. It supports Veterans, doctors, nurses, other health care providers, and sustainment of mission-critical, patient safety applications.

In 2022, operations and maintenance funding covers software licenses, hardware maintenance, telecommunications, and IT support contracts that directly support the Health Portfolio. These items are considered as operational "must pay" requirements and recur on an annual basis. In addition to infrastructure maintenance, the Health Portfolio supports Health Provider Systems that cover all aspects of patient care and treatment, as well as web-based technologies and applications such as My HealtheVet. The Health Portfolio also supports Community Care and maintenance of supply chain management development products.

Community Care sustains IT applications that support Veterans receiving care in the community from the point of a consult through payment for care. Sustainment activities for VA systems enable Veterans, providers, and VA staff access to tools for care coordination, referrals and authorizations, provider portals, electronic data interchange, provider payments, and revenue operations.

The Sustainment of the Registries Congressional Project is responsible for the operations and maintenance of congressionally mandated registries. Most of these registries are hosted on the Veterans Integrated Registries Platform which will also be sustained as part of this effort. Additionally, the sustainment of the Veterans Re-entry Search Service is included in the Registries Congressional Project. The Registries Congressional Project serves many divergent business lines within VHA. Sustainment funds for Registries will provide 1) Enhancements to support the expansion of the Caregiver program to pre-9/11 Veterans, 2) Provide on-going maintenance support to two Class III COTS products in production while interface is built then support overall system once implemented, and 3) Provide on-going maintenance support to existing efforts.

Sustainment activities of the Health Data Interoperability systems ensure continuity of operations for VA systems which provides the exchange of Veteran health information between VA and non-VA partners. These Health Data Interoperability systems include the JLV, Direct Secure Messaging, Veterans Authorization and Preferences, and the Clinical Health Data Repository (CHDR). These services provide the integration services of HIE partners for integration within VA's query-based exchange system and the secure web mail-based system, VA Direct Secure Messaging. Sustainment services also provide technical support and troubleshooting for both existing and new health information exchange partners. The Health Data Information (HDI) Sustainment ensures software maintenance lifecycle support to deliver patches that address corrective, preventive, adaptive, and perfective maintenance, and security support requirements in addition to Operations and Maintenance support.

Through Bi-directional Health Information Exchange (BHIE), VA and DoD are currently able to transfer data of varying types from disparate systems and data sources located around the world. The current BHIE data set includes records extending from the present day back more than 20

years containing even deprecated data formats like Ambulatory Data Transaction System (ADTS), Laboratory, Pharmacy Data Transaction System (PDTS), Center for Healthcare Services (CHCS) Radiology (RAD), Pharmacy (RX), and Standard Ambulatory Data Record (SADR).

BHIE uses existing clinical systems and offers authorized VA clinicians, including those involved in claims adjudication, immediate access to DoD clinically relevant data about Service members who have separated from the Armed Forces. BHIE contains patient demographics, patient clinical data, and historical CHCS data.

Health Operations and Maintenance details are located in Appendix F and M.

2022 Benefits Portfolio

The Benefits Portfolio addresses the technology needs for the lines of business managed by the VBA: Compensation, Pension, Loan Guaranty, Insurance, Education, and Vocational Rehabilitation. The Benefits Portfolio provides support for essential programs and services to Veterans and their families.

In 2022, the Benefits Portfolio funding will be used to support VA priorities of Veterans Customer Experience (VCE), replacement of BDN, Education Benefits, BWN and Appeals Modernization.

Congressional Project *(Dollars in thousands)*	2020 Actuals		2021 Enacted		2022 Budget Request	
	DEV	OM	DEV	OM	DEV	OM
Education Benefits	$ 20,687	$ 13,448	$ 27,230	$ 10,721	$ 50,000	$ 4,814
Education Benefits - CARES Act	$ -	$ 1,976	$ -	$ -	$ -	$ -
Education Benefits - VHA CARES Act Transfer	$ -	$ -	$ 45,000	$ -	$ -	$ -
Veterans Benefits Management	$ 33,276	$ 35,090	$ 39,230	$ 40,342	$ 14,285	$ 65,223
Veterans Benefits Management - CARES Act	$ -	$ 15,428	$ -	$ -	$ -	$ -
Veterans Customer Experience - VCE	$ 52,313	$ 54,372	$ 66,296	$ 35,820	$ 9,880	$ 90,642
Veterans Customer Experience - VCE - CARES Act	$ -	$ 46,855	$ -	$ -	$ -	$ -
Benefit Systems	$ 36,504	$ 3,458	$ 20,630	$ 1,676	$ 9,825	$ 6,125
Benefits Appeals	$ 5,741	$ 10,002	$ 6,000	$ 4,850	$ 3,400	$ 9,100
IT Support Contracts	$ -	$ 78,980	$ -	$ 79,070	$ -	$ 79,000
Other Benefits IT Systems	$ -	$ 5,370	$ 830	$ 3,187	$ -	$ 21,370
Other Benefits IT Systems - CARES Act	$ -	$ 2,875	$ -	$ -	$ -	$ -
C&P Claims	$ 4,255	$ 5,256	$ -	$ -	$ -	$ -
Total Benefits Portfolio	**$ 152,776**	**$ 273,110**	**$ 205,216**	**$ 175,666**	**$ 87,390**	**$ 276,274**

Education Benefits - $54.8 million

Recent legislation such as the Colmery Act aims to enhance access to and availability of educational benefits for eligible Veterans and their beneficiaries through technical adjustments. Several requirements and enhancements are necessary to ensure the legal requirements of the

Colmery Act are carried out efficiently. For instance, Education Claims Processing Integration Consolidation (ECPIC) is required to continue to deliver and expedite education benefits in a timely manner, despite the increased volume in education benefit claims. Also, QA Web measures the quality and accuracy of Vocational Rehabilitation and Employment services administered to Veterans participating in the Chapter 31, Vocational Rehabilitation Program, and Chapter 36, Educational and Vocational Counseling Services. Another example is Digital GI Bill which minimizes the use of manual resources, allowing management of education benefits to be handled by an outside provider.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Education Benefits	**$ 20,687**	**$ 72,230**	**$ 50,000**
Digital GI Bill	$ -	$ -	$ 50,000
Education Benefits - VHA CARES Act Transfer	$ -	$ 45,000	$ -
Colmery Act	$ -	$ 27,230	$ -
Education Claims Processing Integration Consolidation	$ 20,687	$ -	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

Digital GI Bill - $50.0 million

Education Services (EDU) seeks to leverage a managed service model based on business-based performance outcomes. Digital GI Bill is planned to support the transformation of VBA Education Service's business toward managed services model. Digital GI Bill will allow the VA to provide improved customer service through an outcome driven service providing predictable and timely service for education claims. Additionally, the managed service approach will provide an in-place method to adapt to new legislative mandates, minimizing the risk of unfunded OIT mandates and providing service to Veterans in the timeframes required by new legislation. Lastly, this approach will allow OIT to focus on product integration, enterprise capabilities, and technical debt.

Education Benefits Out-year Objectives

EDU is exploring ways to modernize the entire IT environment to enable improved data management and customer experience that will lead to effective program decisions and evaluations into 2022. This will enable EDU to accurately report outcomes and Veteran participation in benefits services. EDU will have access to authoritative performance measures and trending data needed to plan benefits services and to evaluate performance outcomes. Digital GI Bill will move Education Services to a business managed service that will inherently digitize their process with a focus on predictable outcomes.

Veterans Benefits Management - $80.0 million

VBMS supports electronic claims processing solutions that support VBA's goal to provide fast, accurate, and integrated claims processing for Veterans, as well as an infrastructure to provide a platform of reusable features. The Benefits Integration Platform (BIP) is an initiative to help reduce

cost, effort and complexity of delivering new capability to current systems and applications. BIP consists of implementing modern, scalable, and cloud-based IT infrastructure using high-quality tools through a collaborative network of services. Implementing BIP allows participants to focus on solving their business problems knowing that compliance, controls, and logging are already incorporated into the platform. OIT deployed VBMS and BIP as part of VBA's organizational transformation effort. VBMS and BIP work together to provide an efficient and effective business capability to process claims and allow other VA systems to reuse the common services.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	**2020 Actuals DEV**	**2021 Enacted DEV**	**2022 Budget Request DEV**
Veterans Benefits Management	**$ 33,276**	**$ 39,391**	**$ 14,285**
Pension and Fiduciary Automation	$ -	$ -	$ 11,380
Benefits Integration Platform (BIP)	$ -	$ -	$ 2,905
Blue Water Navy (BWN)	$ -	$ 22,000	$ -
Claims Automation	$ 16,286	$ 15,000	$ -
Automated Rating for Select Disabilities	$ -	$ 2,230	$ -
Pension Automation	$ 16,990	$ -	$ -
Unobligated balance brought forward, Oct 1	$ -	$ 161	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

Pension and Fiduciary Automation - $11.4 million

Pension and Fiduciary Automation aims to implement automated decision-making and process improvements in order to increase claims completed, decrease inventory of claims in progress, decrease average days pending on in-process claims, and maintain or increase nationwide accuracy. These automations should free up FTEs to re-allocate toward BWN prioritized processing so that BWN applicants won't experience significant wait times. Further, these automations will get to Veterans and their surviving family members expeditiously. Without these automations, wait times for pension applicants will continue to increase, leaving some of our most vulnerable customers without immediate assistance. As a result, Veterans and family members submitting pension-related benefit applications, which result in almost $10 billion per year in payouts, will receive much-needed assistance immediately. Further, unexpected and additional claims spurred by laws like the BWN Vietnam Veterans Act of 2019 will not balloon wait times to years because automation infrastructure can scale.

Benefits Integration Platform (BIP) - $2.9 million

BIP is an information technology initiative, which provides for the reduction of the technology footprint supporting VBA and NCA through the expansion and reuse of VBMS technology solutions. BIP provides a platform that allows teams to quickly and easily develop, deploy, scale, and manage container-based applications in a multi-tenant cloud environment. These solutions can be leveraged by other programs within VA to reduce development costs and provide quicker to market solutions in order to better serve our Veterans. This effort will provide an updated and modernized replacement for older systems and applications in order to reduce cost and decrease the number of applications within VA OIT. Additionally, there are four key benefits of BIP: 1)

Increased speed and agility; 2) Increased security; 3) Increased availability; and 4) Lower cost of ownership.

Veterans Customer Experience (VCE) - $100.5 million

VCE is achieving its mission of developing VA's customer experience capabilities through a portfolio of projects. These projects include: 1) Veterans Experience Office (VEO) Digital Experience (DX), which delivers personalized self-service tools; 2) VEO Contact Center Modernization (CCM) and Enterprise Data Management (EDM) which delivers an enterprise model contact center, including consolidating the existing network of centers; and 3) VEO Master Data Management (MDM), which provides an enterprise master data management solution by consolidating silos of data across the VA enterprise.

VEO's Digital Experience develops user-friendly tools to help Veterans navigate the various VA services available to them and their families throughout their lifetime. VA is pursuing this enterprise self-service navigation capability, consistent with industry best-practices, to enable Veterans to access this information wherever and whenever they need it, in a way that is effective and easy to use.

The CCM initiative helps Veterans navigate the care, benefits, and services available to them within VA. This effort will seek to deliver a uniform and consistent enterprise model with an overarching governance and approval processes. CCM involves multiple projects, which require engagement and partnerships across VA, particularly OIT and external stakeholders, such as the OEHRM. Each of these projects is dependent on collaborative efforts and timelines.

Master Data Management projects are key to VEO's overall mission of improving Customer Experience (CX) as Veterans, family members and caregivers navigate through their journey from active military duty through the spectrum of VA benefits.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Veterans Customer Experience - VCE	**$ 52,313**	**$ 69,648**	**$ 9,880**
VA.GOV	$ 16,792	$ 18,756	$ 7,080
Contact Center Solutions (CCS)	$ -	$ -	$ 2,800
Enterprise Contact Center Modernization	$ 2,260	$ 19,860	$ -
Customer Relationship Management (CRM) Platform Enhancements	$ 17,021	$ 12,130	$ -
Enrollment System	$ 8,482	$ 7,000	$ -
Veterans Signals (Vsignals) [previously Veteran Oriented Interactive Customer Evaluation (VOICE)]	$ 5,262	$ 4,800	$ -
Customer Experience Data Warehouse (CxDW)	$ 2,496	$ 2,250	$ -
Veteran Identification Card (VIC)	$ -	$ 1,500	$ -
Unobligated balance brought forward, Oct 1	$ -	$ 3,352	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information.

VA.GOV - $7.1 million

The VA.GOV platform provides Veterans choice of online and remote access to VA benefits, claims processing information and associated support services. This helps Veterans navigate from the same platform vs. numerous websites and managing multiple logins to meet their needs. Funding allows for continued support of efforts such as: 1) Support services for all VA teams developing on VA.GOV including code review, content and design reviews, daily deployment, and ongoing production support; 2) Customers can also update their contact information in one location rather, than visiting multiple VA websites or making multiple phone calls; and 3) Accelerate the migration of health tools into the VA.GOV platform in order to better serve the needs of Veterans.

Contact Center Solutions (CCS) - $2.8 million

CCS will deliver a consistent enterprise model, leveraging industry best practices. These efforts will optimize existing technology and workforce investments, while drawing down Customer Relationship Management (CRM) legacy investments and enhancements. This approach includes consolidating the existing network of centers (clinical and non-clinical) and agents into an enterprise-wide Veteran Contact Center (VCC), redefining the network of Veteran touchpoints, modernizing contact center technology, leveraging outsourced agents to handle low complexity calls, and standardizing training and knowledge processes to align with VA's goal of having all VA contact centers on one system by 2028. Enhanced infrastructure will improve client services, increase first call resolution, decrease wait times and call length, increase self-service access to information and accurate answers to inquiries, and provide seamless customer experience by consolidating silos of data across VHA, VBA and NCA.

Benefit Systems - $16.0 million

Master Person Index (MPI) enables VBA to continue the development, decommissioning, and transitioning of critical programs that keep VBA on track to modernize outdated systems and increase service to Veterans and stakeholders. The Beneficiary Identification Records Locator Subsystem (BIRLS) legacy systems and related sub-systems will migrate/transition to their new format, reducing the risk of losing access to critical data that ensures a seamless experience for Veterans. This will cause an increase in benefits delivery to Veterans across VBA and NCA lines of business; continued development and integration of VA systems onto BIP is crucial in VBA's effort to retire and decommission antiquated systems.

Financial and Accounting System (FAS) will reduce deficiencies in configuration management and access controls and decrease complex and disjointed architecture, as well as difficulties meeting financial management and operational and security vulnerabilities. VETSNET Claim Development Products ensure Veterans will receive their annual Cost of Living Allowance increases automatically and reduces manual adjustments for 5.8 million awards. Monthly benefit payments to Veterans and beneficiaries, totaling $8.3 billion will be delivered timely.

Replacement of the BDN

BDN is the legacy system employed by VBA to process entitlements for three of the five business lines: Compensation and Pension, Education, and Vocational Rehabilitation and Employment. Application expertise is lost through attrition, and VA loses the ability to react to the increasing

risk of older system maintenance, requirements brought by external agencies through changes in law, and interfacing with internal and external systems. With a decreasing number of government programmers who can support changes to BDN, the system's operational risk continues to increase.

Modernization will permit the Education Service to synchronize with the VBA-wide move to the FAS, ensuring timely education benefits payments to Veterans and their beneficiaries. In 2017, OIT partnered with VBA to develop a decommissioning roadmap to migrate functions to a more modern and advanced system such as the BIP, while allowing the current system to continue to function and process benefits. The plan decouples each BDN component from the existing network so that individual components can receive maintenance or upgrades without shutting down the entire system. BIP is a web-based, modern platform that will allow a more accurate and integrated processing for Veterans.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Benefit Systems	**$ 36,504**	**$ 23,087**	**$ 9,825**
Other VBA Legacy System Migration/ Decommissioning	$ 13,454	$ 5,000	$ 6,837
BIRLS Migration / Decommissioning	$ 2,184	$ -	$ 2,988
VETSNET Finance Accounting System (FAS)	$ 15,035	$ 6,200	$ -
EFolder Enhancements	$ 5,831	$ 4,280	$ -
CAPRI Migration	$ -	$ 3,150	$ -
VETSNET Decommissioning	$ -	$ 2,000	$ -
Unobligated balance brought forward, Oct 1	$ -	$ 2,457	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

Other VBA Legacy System Migration/ Decommissioning - $6.8 million

This project will identify and replace/modernize VBA systems and applications that no longer meet VBA requirements and are difficult and costly to maintain. Other VBA Legacy System Migration/Decommissioning ceases enhancements to antiquated technologies, decommissions systems that are no longer utilized, and migrates essential functionality to automated and shared capabilities within modern VA systems. Legacy Decommissioning is targeting VBA legacy capabilities for decommissioning and re-platforming to support the simplification of the currently large number of business applications supporting each of VBA's business lines.

BIRLS Migration / Decommissioning - $3.0 million

BIRLS Migration / Decommissioning is to transition the 48 million Veteran records currently supported by the database mainframe into an enterprise supported system. Migration will allow for continuous functionality during the decommissioning of the Benefits Delivery Network and will support the transformation of the OIT away from high risk legacy systems by maximizing shared services. Decommissioning efforts support the replacement of legacy business functionality on a more capable and sustainable platform while modernization efforts for transitioning these legacy systems will ensure that the business lines and Veterans will have the most efficient and

secure experience. Integration efforts will create a streamlined process for a Veteran/Veteran Service Organization (VSO) to obtain their benefits.

Benefit Systems Out-year Objectives

For 2022-2026, the Benefit Systems Program consists of: 1) Integrate VBA Business Architecture with VA Enterprise Architecture to link IT investment to business value; 2) Standardize designs and tools to ensure a sustainable and supportable architecture; 3) Cut costs and reduce complexity by rationalizing application and technology portfolios through modernization, migration and/or retirement of legacy systems; and 4) Create/build upon a small number of highly reliable, flexible, and comprehensive core platforms to enable continuous modernization and accommodation of new requirements.

Benefits Appeals - $12.5 million

VA is replacing Veterans Appeals Control and Locator System (VACOLS) with a new automated, integrated, and end-to-end system, Caseflow. This Appeals Modernization project is also developing the Appeals Resource Management System (ARMS) which is a relational database and associated web application that enables the Board to manage and report personnel and other resource data both daily and strategically. ARMS will implement an HR specific Data Warehouse that will allow an expanded analysis and creation of HR-related toolsets. Delivery of these systems will enable the Veterans Appeals Improvement and Modernization Act of 2017 processing requirements of 365 days for the Board's direct appeal docket and 125 days for Higher-Level Review and Supplemental Claim decision reviews with the agency of original jurisdiction. The planned features will improve the efficiency, accuracy, and consistency of the adjudication of Veterans' and other appellants' appeals, while enabling the VA workforce to perform their jobs more effectively and reducing their reliance on outdated legacy applications.

Caseflow and Appeals RMS digitize the entire appeals process. From the use of Caseflow eFolder Express for creating a complete digital record in a matter of minutes by making a paper copy to using Caseflow Hearings to schedule and track Veteran notifications, the seven Caseflow products have digitized nearly every step in the process and removed non-value-added steps for the staff. The Appeals RMS system will do the same for tracking personnel performance and managing the workforce distribution for HR liaisons and supervisors at the Board.

The Board plans to deliver over 90,000 decisions per year. Wait times under the legacy system were over 5 years. Without the requested development and sustainment funding, automation of the new process will not be completed, system availability will be impacted and the wait times for appeals to the Board will increase.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects (Dollars in thousands)	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Benefits Appeals	**$ 5,741**	**$ 6,000**	**$ 3,400**
Appeals Modernization - Board of Veterans' Appeals (BVA)	$ 5,741	$ 6,000	$ 3,400

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

Appeals Modernization - Board of Veterans' Appeals (BVA) - $3.4 million

The Appeals Modernization effort will improve and streamline the end-to-end appeals process by increasing efficiency and providing transparency to all stakeholders involved in the multi-step process. This Board of Veterans Appeals initiative will result in the creation of a new tool, Caseflow, that will replace VACOLS with functionality that is required to more effectively and securely process appeals. Appeals Modernization will improve appeals processing throughout the Department to better serve Veterans and beneficiaries.

Benefits Operations and Maintenance - $276.3 million

Benefits Operations and Maintenance provides funding for existing technology that is critical to the success of providing Veterans timely access to benefits. It supports the VCE and existing systems such as Veterans Appeals, Education Benefits (previously Chapter 33), and Compensation. Operations and Maintenance funding will continue to support sustainment requirements for Contact Center Solutions, Customer Experience Data Warehouse, CRM Platform, E-Benefits Portal, VA.GOV and Veterans Signals (VSignals). In 2022, operations and maintenance funding also covers software license, hardware maintenance, Agent Orange conditions 1-3, telecommunications and IT support contracts that directly support the Benefits Portfolio. These items are considered as “must pay” requirements and recur on an annual basis. In addition to infrastructure, the Benefits Portfolio includes the existing VBMS and VETSNET, which is VBA’s mission-critical system, used at every VA Regional Office across the country and overseas to process compensation claims. Given the criticality of VBMS to VBA operations and delivery of benefits to the nation’s Veterans and beneficiaries, it is imperative that the system always has the appropriate infrastructure to remain operational. When the system is down, there is a direct impact to the number of claims being processed.

Sustainment funding will also be used to minimize the use of manual resources specifically related to persons and paper Digital GI Bill that would enable management of Education Benefits by an outside provider. The ECPIC effort will enable the retirement of multiple legacy systems and ultimately reduce VA Enterprise risk. VBA Education Services is seeking to leverage a managed service model based on business-based performance outcomes and this effort is dependent upon the success of ECPIC.

On January 29, 2019, The Federal Circuit Court has concluded that the clear intent of 38 U.S.C. section 1116 is that a Veteran who served in the territorial sea (within 12 nautical miles (NM) of coast) of the "Republic of Vietnam" is entitled to the presumption of exposure to Agent Orange. That decision requires VBA to extend the presumption of service connection to "blue water" Navy Veterans that will significantly increase the number of claims.

The 2022 Operations and Maintenance request reflects infrastructure and IT support needs to increase and sustain claims examiners' efficiency to address the anticipated increased claims volume.

Benefits Operations and Maintenance details are located in Appendix F and M.

2022 Memorial Affairs Portfolio

The Memorial Affairs Portfolio provides support for modernization of applications and services for National Cemeteries cared for by the NCA at 157 locations nationwide.

In 2022, the Memorial Affairs Portfolio funding will be used to support the Agency's priority of replacing the Burial Operations Support System (BOSS). This legacy system has been around for 27 years and no longer fully meets the needs of NCA and Veterans.

Congressional Project *(Dollars in thousands)*	2020 Actuals		2021 Enacted		2022 Budget Request	
	DEV	OM	DEV	OM	DEV	OM
Memorials Automation	$ 14,460	$ 6,696	$ 15,130	$ 10,600	$ 9,030	$ 19,208
IT Support Contracts	$ -	$ 95	$ -	$ 11,762	$ -	$ 11,762
Memorials Legacy	$ -	$ 2,738	$ -	$ -	$ -	$ 4,000
Total Memorial Affairs Portfolio	**$ 14,460**	**$ 9,529**	**$ 15,130**	**$ 22,362**	**$ 9,030**	**$ 34,970**

Memorials Automation - $28.2 million

Replacement of Burial Operations Support System (BOSS)

Memorials Automation will provide for modernizing NCA operations, taking the current operating environment and moving it to a digital operating environment with self-service functionality, single data entry, improved security and data accuracy, and new functionality leveraging the BIP and cloud solutions.

Memorials Automation funds the decommissioning of the BOSS-E legacy system, a legacy IT system that has been supporting NCA for decades. Memorials Automation also funds the development/fielding and maintenance of BOSS-E's replacement, Memorial Benefits Management System (MBMS). MBMS will be implemented through a series of successive builds that will provide continuous improvements in functionality while moving users off the legacy systems and conclude with BOSS-E's decommissioning targeted for 2022.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Memorials Automation	**$ 14,460**	**$ 16,991**	**$ 9,030**
Memorial Benefits Management System (MBMS)	$ 14,460	$ 15,130	$ 9,030
Unobligated balance brought forward, Oct 1	$ -	$ 1,861	$ -

Table includes Development subaccount only. See Appendix M for the Operations and Maintenance information

Memorial Benefits Management System (MBMS) - $9.0 million

This project will ensure that the active MBMS (that provides increased benefits delivery efficiency to Veterans and their families) and the Veterans Legacy Memorial platform (that provides a virtual memorialization page to honor the stories of our nations Veterans) are sustained in production environments, remain available to users, and has critical production operations support. MBMS will improve the quality and accessibility of memorial services to Veterans and their families at an emotionally difficult time (death of a loved one).

MBMS implementation provides increased benefits delivery efficiency to Veterans and their families by improving access to benefits tracking and delivery, enhancing end-user functionality, and providing increased customer service satisfaction through shorter claims processing times. MBMS supports the daily operations of NCA in scheduling burials at National Cemeteries, processing headstone and marker requests for deceased Veterans for burial in private cemeteries and processing Presidential Memorial Certificates. Additionally, MBMS supports Veterans and their loves ones in creating online memorialization pages through the Veterans Legacy Memorial.

Memorials Operations and Maintenance - $35.0 million

Memorials Operations and Maintenance provides funding for existing technology that is critical to the success of NCA programs. 2022 funding supports the following ongoing operations:

- MBMS: Enables technologies that support the NCA claims processor in delivering survivor benefits by capturing, processing, and finalizing benefits orders through a unified user interface
- Legacy Tier 3 support: Address defect remediation for the current backlog and support of transitioning functionality to a modernized system, which will provide more efficient performance and usability of the legacy applications

Memorials Operations and Maintenance details are located in Appendix F and M.

2022 Corporate Portfolio

The Corporate Portfolio consists of the back-office operations that are major contributors to running the business lines of the Department and support for the Office of Management; Office of Acquisition, Logistics and Construction; General Counsel; Human Resources, etc.

In 2022, the Corporate Portfolio funding will be used to support the Secretary's priority of replacing the Financial Management System (FMS) and maintaining existing major corporate systems.

Congressional Project (Dollars in thousands)	2020 Actuals		2021 Enacted		2022 Budget Request	
	DEV	OM	DEV	OM	DEV	OM
Financial and Acquisition Management Modernization[1/]	$ 58,525	$ 10,816	$ 93,070	$ 17,990	$ -	$ 122,886
IT Support Contracts	$ -	$ 2,374	$ -	$ 67,958	$ -	$ 91,943
TAC Fees[2/]	$ -	$ -	$ -	$ 75,257	$ -	$ 69,921
TAC Fees[2/] - CARES Act	$ -	$ -	$ -	$ -	$ -	$ -
Human Resources[1/]	$ 6,799	$ 1,695	$ 13,980	$ 2,644	$ -	$ 69,571
Human Resources[1/] - CARES Act	$ -	$ 3,000	$ -	$ -	$ -	$ -
Other IT Corporate Systems	$ -	$ 22,322	$ 3,500	$ 3,697	$ -	$ 16,315
General Counsel	$ -	$ 583	$ 4,000	$ 3,376	$ -	$ 1,950
Construction and Facilities Mgmt	$ -	$ 2,546	$ -	$ 2,822	$ -	$ -
Supply Chain Management	$ 21,596	$ 13,067	$ -	$ -	$ -	$ -
Innovations	$ 1,715	$ -	$ -	$ -	$ -	$ -
Total Corporate Portfolio	**$ 88,635**	**$ 56,402**	**$ 114,550**	**$ 173,744**	**$ -**	**$ 372,586**

1/ Congressional Projects Financial and Acquisition Management Modernization and Human Resources will be funded by Recurring Expenses Transformational Fund
2/ TAC Fee realigned from Enterprise Portfolio to Corporate Portfolio for 2021

Corporate Operations and Maintenance - $372.6 million

Corporate Operations and Maintenance provides funding for existing technology that is critical to the success of back-office operations that maintain the business lines of the Department. This includes support for the Office of Management; Office of Acquisition, Logistics and Construction; General Counsel; Human Resources; and others. Operations and Maintenance funding also supports Enterprise Architecture tools licenses and hosting, and the maintenance of the Centralized Administrative Accounting Transaction System (CAATS).

The FMBT program will provide the VA with a modern financial management solution transforming and standardizing business processes and capabilities enabling the VA to meet its goals and objectives in compliance with financial management legislation and directives. VA's current system, FMS, is over 30 years old. Due to its inability to update legacy code and the lack of integration between the legacy finance and acquisition systems, VA is unable to meet federal financial regulations and mandates, including the DATA Act. With over 100 primary interfaces with legacy systems, FMS and its hardware and software are obsolete and cannot be updated which

has led to a proliferation of enhancements and workarounds and the development of add-on systems. The resulting fragmented financial management environment must be replaced with modern software to bring the VA into compliance with federal financial rules and regulations. This project will directly support the President's Management Agenda (PMA), Cross-Agency Priority (CAP) Goals 1 (Improving Customer Experience), 9 (Getting Payments Right), and 11 (Improve Management of Major Acquisitions).

VA's FMBT program is implementing iFAMS as the modern financial and acquisition management system to replace FMS. iFAMS is a new capability that uses the Software-as-a-Service (SaaS) model to provide increased operational efficiency, productivity, agility, and flexibility with a modern Enterprise Resource Planning (ERP) cloud solution. The new cloud solution will also provide additional security, storage, and scalability. In addition, iFAMS will reduce the use of legacy systems and contribute to the goal of shifting human resources from low-value to high-value work. With each wave of implementation completed, iFAMS will support all five OIT imperatives in driving strategy outcomes while acting as a force multiplier for the guiding principles of Transparency, Accountability, Innovation and Teamwork. iFAMS will replace FMS and multiple related legacy capabilities with a modern, easier to maintain system. VA's FMS system is a standardized, VA-wide system that interfaces externally with the Department of Treasury , the General Service Administration (GSA), the Internal Revenue Service (IRS), the Defense Logistics Agency (DLA), and various commercial vendors and financial institutions for electronic billing and payment purposes.

FMBT will provide a system for standardizing, integrating, and streamlining financial processes including budgeting, procurement, accounting, and financial reporting; facilitating effective management by providing stronger analytics and projections for planning purposes; improving customer service and support of goods, supplies, and services for the Veteran; and improving the speed and reliability of communicating financial information throughout the VA and providing timely, robust, and accurate financial reporting. The FMBT initiative will enhance the VA's ability to execute its budget, pay Veterans accurately and efficiently, procure services in support of Veteran benefits and healthcare delivery, pay vendors, and produce accurate financial statements. Taxpayers and employees benefit from a transparent, accurate, timely, and reliable financial information system.

Specifically, the FMBT program will leverage economies of scale by achieving the following:

- Increasing efficiency
- Reducing audit findings ensuring Veteran's data is fully secure
- Minimizing administrative burden while increasing integration
- Automating business processes and internal controls with advanced technology
- Reducing the current risk of delayed or inaccurate Veteran and beneficiary payments due to system failure

CAATS is a web-based automated system that allows for the electronic input and approval of accounting source documents/transactions. It is the central interface to FMS for both VBA and NCA. CAATS is an existing, sustaining application with modules that maintain daily interfaces with FMS to keep a running total of balances.

VA will continue to have a clear and urgent need to modernize its legacy FMS, which will require Sustainment funding for ongoing operations. FMS is critical to VA's transition to iFAMS and the connections with 70 other VA systems. Should the system fail or otherwise become inoperable, it would impact the Department's ability to execute its budget; pay vendors, staff, and Veterans: and produce accurate financial statements. Implementation of FMBT will provide VA with a modem financial management solution, transforming business processes and capabilities, and meeting compliance with financial management legislation. However, until FMBT is fully implemented, sustainment of FMS is critical to VA operations and funding will be required for this in the out-years.

For 2022, the realignment from Development to Sustainment funding for FMBT is required as the initial configuration has been completed and enterprise interfaces deployed to production. The ongoing work for new waves is implementing what was already deployed with custom configurations.

Human Resources supports the implementation of modernized, automated, and standardized systems, tools, and capabilities to deliver a world-class workforce. The MPI's most prominent components are: 1) HRIT Directorate which implements modernized, automated, and standardized systems, tools, and capabilities; 2) Human Resources Information System (HR Smart), the authoritative data source for an employee record providing automated HR Information System services to HR Offices, VA managers, and staff; 3) Performance Management System, an enterprise-wide solution that automates employee performance management workflows (planning, developing, monitoring, rating, and rewarding employee contributions) for Title 5, Title 38 and SES VA employees; and 4) Talent Acquisition, which is critical to HRA to establish internal programs and procedures for attracting, recruiting, assessing, and selecting employees with the right skills and competencies. This sub-project provides capabilities that are used by HR specialists and managers in all administrations within the department. This capability will enable VA to more effectively compete for scarce labor resources to fill workforce vacancies including medical and professional positions.

VA was the first Cabinet-level agency to migrate HR to a private sector Shared Services Center (SSC) Provider and created the blueprint for the federal HR community on how to apply federal standards to an SSC solution in HRLOB implementations. HR Smart has also laid the groundwork for future self-service capabilities providing managers and employees more effective and efficient HR tools that create opportunity for VA personnel to focus on Veterans Initiatives and Programs.

Operations and Maintenance funding also covers systems, such as:

- Talent Acquisition: Case management and tracking tool will fill existing technological gaps to properly equip VA with the tools necessary to attract, recruit, assess, and select candidates with the right skills and competencies while increasing transparency and automation.

- Performance Management System: The enterprise-wide solution that automates employee performance management workflows (i.e. planning, developing, monitoring, rating, and rewarding employee contributions) for Title 5, Title 38 and SES VA employees.

- Data Warehouse & Business Intelligence: HR Data Warehouse will enable management through metrics/measures designed to meet organizational reporting needs.
- Matter Tracking System (MTS): The system will address the congressional mandate for real-time reporting requirements mandated by the Accountability and Whistleblower Protection Act of 2017.

For 2022, the realignment from Development to Sustainment funding for Human Resources will be used for enhancements to existing software products already in production rather than new development activities.

Corporate Operations and Maintenance details are located in Appendix F and M.

2022 Enterprise Portfolio

The Enterprise Portfolio provides the underlying infrastructure necessary to perform business functions and maintain a robust technology infrastructure for the Department. It includes such things as cybersecurity, data centers, cloud services, telephony, enterprise software, end-user hardware, data connectivity and the IT Activations Program.

Unlike the other portfolios, it cuts across the entire organization and serves as the foundation upon which the other portfolios are built. The Enterprise Portfolio includes capabilities that comprise VA's core IT infrastructure and services. These capabilities underpin VA's IT mission application environment and are essential to VA's ability to deliver a secure, seamless, and unified Veteran experience through the delivery of state-of-the-art technology. Operations and Maintenance programs that can be directly allocated to other portfolios are shown in those areas of this budget submission.

The 2022 budget includes an increased request to support modernization efforts such as the VA's VAEC and IRP, which are described in further detail in the operations and maintenance section of this portfolio.

Congressional Project *(Dollars in thousands)*	2020 Actuals		2021 Enacted		2022 Budget Request	
	DEV	OM	DEV	OM	DEV	OM
Cyber Security[2/]	$ 16,600	$ 280,739	$ 11,380	$ 291,657	$ 11,200	$ 307,548
Cyber Security - CARES Act	$ -	$ 20,487	$ -	$ -	$ -	$ -
Data Integration and Management	$ 24,457	$ 170,156	$ 34,680	$ 240,955	$ 8,000	$ 280,119
Data Integration and Management - CARES Act	$ -	$ 231,778	$ -	$ -	$ -	$ -
Infrastructure Readiness Program (IRP)[1/]	$ -	$ 172,774	$ -	$ 250,585	$ -	$ 477,543
Infrastructure Readiness Program (IRP)[1/] - CARES Act	$ -	$ 20	$ -	$ -	$ -	$ -
Telecommunications	$ -	$ 289,519	$ -	$ 284,084	$ -	$ 292,505
Telecommunications - CARES Act	$ -	$ 69,020	$ -	$ -	$ -	$ -
Software Maintenance	$ -	$ 417,389	$ -	$ 407,424	$ -	$ 243,983
Software Maintenance - CARES Act	$ -	$ 88,592	$ -	$ -	$ -	$ -
IT Support Contracts	$ -	$ 274,587	$ -	$ 283,368	$ -	$ 161,725
IT Support Contracts- CARES Act	$ -	$ 42,571	$ -	$ -	$ -	$ -
Activations	$ -	$ 48,502	$ -	$ 48,802	$ -	$ 112,072
Activations - CARES Act	$ -	$ 340,802	$ -	$ -	$ -	$ -
Hardware Maintenance	$ -	$ 123,877	$ -	$ 105,636	$ -	$ 91,814
Hardware Maintenance - CARES Act	$ -	$ 14,309	$ -	$ -	$ -	$ -
Enterprise Service Desk	$ -	$ 50,060	$ -	$ 48,599	$ -	$ 77,737
Enterprise Service Desk - CARES Act	$ -	$ 4,004	$ -	$ -	$ -	$ -
IT Service Management	$ -	$ -	$ -	$ 18,682	$ -	$ 55,660
End User Operations	$ -	$ -	$ -	$ -	$ -	$ 52,000
Privacy & Records Management[2/]	$ -	$ 22,585	$ -	$ 38,447	$ -	$ 42,000
Network Operations Center	$ -	$ -	$ -	$ 50,862	$ -	$ 39,866
Enterprise Command Center	$ -	$ -	$ -	$ -	$ -	$ 12,624
Repositories	$ -	$ 1,443	$ -	$ 2,092	$ -	$ 3,299
Enterprise Infrastructure	$ -	$ 25,778	$ -	$ -	$ -	$ -
TAC Fees	$ -	$ 40,317	$ -	$ -	$ -	$ -
TAC Fees - CARES Act	$ -	$ 53,032	$ -	$ -	$ -	$ -
Total Enterprise Portfolio	**$ 41,057**	**$ 2,782,340**	**$ 46,060**	**$ 2,071,193**	**$ 19,200**	**$ 2,250,495**

1/ In 2022, Congressional Projects IRP will be funded Recurring Expenses Transformational Fund
2/ See Appendix N for Information Security details. See Information Security section for Cybersecurity development and operations and maintenance narratives

Data Integration and Management - $288.1 million

The Data Integration and Management MPI provides for development of self-service API gateways, building out VA's capacity for cloud computing, and administration of numerous data, testing, and supercomputing research services that support the entire VA OIT enterprise. The nature and scope of these shared services covers a wide berth including: 1) Building API gateways to enable self-service capability where Veteran facing IT applications can enable provisioning and integration to backend shared services themselves; 2) Expanding VA's enterprise cloud hosting capacity and infrastructure to establish a foundation for migrating VA IT systems out of localized private hosting solutions to an approved public federal cloud that can scale on demand while realizing cost savings for VA; 3) Provisioning of data services ranging from authoritative Veteran data via efforts such as Vet360 which provide centralized access to source data; and 4) Providing standardized frameworks and constructs within which data is housed, ingested, exchanged inside and outside of VA, tested, manipulated, or used. The MPI also ensures that tailored, integrated test environments and appropriate risk-based test services for evaluating software product quality is available to OIT organizations, VA administrations, and other external agencies focused on improving patient safety and Veteran services.

The 2022 Budget Request for this Congressional Project includes the following Development Sub-Projects:

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Data Integration and Management	**$ 24,457**	**$ 47,420**	**$ 8,000**
API Management	$ 4,102	$ 7,000	$ 8,000
VA Profile	$ 12,522	$ 15,390	$ -
Core Enterprise Services (CES)	$ -	$ 8,290	$ -
Enterprise Cloud Fax (ECFax)	$ -	$ 2,000	$ -
Veterans Information Solution (VIS) VA DoD Identity Repository (VADIR) Support	$ 2,900	$ 2,000	$ -
Individual Longitudinal Exposure Record (ILER) - CARES Act	$ 2,417	$ -	$ -
Digital Transformation Center (DTC) - CARES Act	$ 1,385	$ -	$ -
Collaborative Terminology Tooling and Data Management	$ 1,131	$ -	$ -
Unobligated balance brought forward, Oct 1	$ -	$ 866	$ -
Unobligated balance brought forward, Oct 1 - CARES Act	$ -	$ 11,874	$ -

Table includes Development subaccount only. See Appendix F for the Operations and Maintenance information

API Management - $8.0 million

API Management is an ongoing effort to develop APIs across all VA administrations and systems to enable effective data exchanges from a number of underlying systems, including Corporate Data Warehouse (CDW), Enterprise Military Information Service (eMIS), Data Access Services (DAS), HRSmart and Enterprise Data Warehouse (EDW). This work will cover API development, security support, and acquisition support. All three are key areas to accelerate the analysis and onboarding of new SaaS applications that VA is procuring and external entities that want to consume VA's APIs. The work supports the consumption of APIs at developer.va.gov and VA's Lighthouse initiative. The API Management Project will create additional API's to provide faster associated

services to Veterans, beneficiaries, and family members which will replace outdated processes which are currently in place.

Enterprise Operations and Maintenance - $2,250.5 million

The VA's IT foundation has continued to deteriorate at a rate that is rendering it highly inefficient, capability bound and will render it significantly inoperable if continuous investment is not made to support its core technology foundation. Operational information technology is evolving at such an exponential rate that without strategic and consistent investment, VA's technical capabilities supporting the Veteran will not be able to sustain or support leading medical and physical devices and care, which are necessary to deliver adequate services to our Veterans.

Technological evolutions are widely known as "competitive substitutions"- one method or technology that satisfies the need or capability of another, that performs at a lower cost, greater efficiency and or expanded capability. The speed with which such substitutions or refresh take place is not a simple measure of the pace of technical advance or incremental upgrade, but it is, rather a measure of the imbalance between the competitive elements of the substitution, rate of growth or expandability of the substitution, capabilities realized and life cycle costs. VA's current operational technology infrastructure does not allow it to meet the needs of basic life cycle technology evolution.

The 2022 Enterprise Portfolio's operations and maintenance request of $2,250.5 million includes an increase of $179.3 million to support OIT major efforts, IRP and VAEC solutions, that will assist in mitigating the mounting "cumulative legacy life cycle refresh" and assist in optimizing the IT Infrastructure. The cost of replacing IT equipment that is "beyond useful lifecycle" or "capability bound" is considerable and continues to increase. Annual investments are required as part of a constant lifecycle replacement program. Accumulating obsolete equipment is tantamount to accumulating a sizable funding requirement for "legacy life cycle refresh" to be paid in the future. OIT plans to make consistent investments to reduce this cost and take steps to modernize the infrastructure that will ultimately support all of our major initiatives, including EHRM, BWN, Agent Orange conditions 1-3, collaborative services (email), Veteran self-services, as well as enable our end users to access all of their support requirements and functions.

Infrastructure Readiness Program (IRP) - $477.5 million *(will be funded by Recurring Expenses Transformational Fund)*

IRP guides the ongoing refresh and replacement of the IT Infrastructure that sustains all VA IT operations. IRP identifies the current state of the IT infrastructure and provides analysis for the strategy to refresh and modernize IT Infrastructure assets based on equipment age, expiration of warranty, support limitations, life cycle estimates, business requirements, technology roadmap, financial planning and policy changes. For IRP purposes, "cumulative legacy life cycle refresh" cost refers to the funding needed to bring legacy infrastructure components to a state of full efficacy. Cumulative legacy life cycle refresh multiplies annually and reduces available resources for allocation to VA business priorities.

Drivers and consequences of a robust cumulative life cycle refresh focusing on infrastructure include: Increased risk of catastrophic failure of critical systems; new software application performance inhibited by inherent limitations of existing operating systems; security requirements that cannot be enforced; technology that is no longer supported by the manufacturer; increasing operational maintenance costs (eclipsing the cost of acquiring new replacement technology); and legacy technology that is unable to respond to new and/or ever changing business requirements. Reducing cumulative legacy life cycle refresh will enable VA to more rapidly deliver IT solutions for joint VA business priorities that enable the exceptional customer experience, care, benefits, and services Veterans have earned. A robust, healthy IT infrastructure is necessary to ensure delivery of reliable, available, and responsive IT services to all VA staff offices and administration customers as well as Veterans. In addition to continuing to facilitate a successful transition to the new EHR, VA must ensure the existing infrastructure is modernized and optimized to handle additional enhancements that are centrally coordinated with the OEHRM and OIT offices.

The previous OIT funding strategy has been challenged in its efforts to adequately support the evolution, recommended scale and frequency of life cycle refresh to avoid the accumulation of infrastructure costs associated with maintaining various components that constitute the "eco-system" that supports mission critical business functions. This has placed a significant strain on VA's existing infrastructure.

In 2022, OIT will use the IRP resources to support several initiatives. OIT completed an enterprise-wide assessment of each of the critical infrastructure components identified to determine the scope of the IRP. Each component used criteria unique to that specific infrastructure element to derive the needs for improvement and basic capability evolution. For instance, desktop computing requirements were derived from review of literature for industry standard life cycle refresh recommendations (example: Gartner), a review against our installed base using automated tools such as Microsoft's System Center Configuration Manager (SCCM), and a replacement strategy informed by that research to create an optimized schedule of replacement. Bandwidth utilized a model based upon years of experience supporting business requirements across three administrations as well as utilization and consumption metrics from automated discovery tools such as Solar Winds to map out a logical, efficient and cost-conscious provisioning schedule.

In terms of Infrastructure Readiness by location/site, it is determined by individual assessment of the infrastructure item as well. For example, Network Bandwidth would be applied based upon present status and targeting locations of high utilization currently being provisioned on older copper-based technology.

- Modernizing Network Infrastructure: OIT has reduced its technical debt by 21% to date and now there are 12,150 routers, switches, and appliances at end of life out of a total of 50,764 devices. The 2022 request will support refresh of several thousand devices across the Enterprise. OIT's modernization strategy is to utilize a best value approach to move to a homogenous network stack and then deploy an agile self-service network with expandable services to our business and Veterans - the consumers of our network resources at our facilities. This will transform VA from over 20-year-old open standard protocols to modern vendor integrated expandable solution.

As we modernize our network, artificial intelligence will be incorporated to promote additional capabilities, automation and agility. Our goal is to utilize increased virtualization and a scalable architecture to better support modern and evolving technologies (e.g. Quantum Computing and Internet of Things (IoT)). This will improve integration with other solutions such as security storage, and Unified Communications (UC) critical to support health and benefits delivery outcomes in the future.

- Expand and Uplift Server/Storage Farm Infrastructure: The strategy for reduction of technical debt in this category is to utilize the Infrastructure as a Managed Service (IaaMS) contract and update/refresh on premise mission essential servers/storage infrastructure. Approximately 25,000 servers, storage arrays and systems require modernization and technological reengineering. The 2022 request will support the refresh of over 4,000 systems, with an allocation for growth and technological uplifts. The overall goal of Server/Storage modernization is to standardize the platform to support the Data Center Optimization Initiative (DCOI) and attendant support structure. We need similar platforms and storage at all Corporate Data Centers (CDC), Mission Support Centers (MSC), Campus Support Centers (CSC) and equipment closets. Furthermore, as we modernize the platform in these various locations, many of the hosting locations need physical infrastructure modernization including:
    - Working with facilities management to right size the remaining space and implement required access control systems.
    - Data Center infrastructure equipment modernization:
        - Structured cabling, cable trays, power distribution and racks/cabinets.
        - Environmental and Airflow Management Standardization and Optimization.
        - Uninterrupted Power Supply (UPS) and Battery System Replacement and Optimization.
    - Metering and monitoring standardization which is especially important in non-manned equipment hosting spaces.

  With respect to our storage infrastructure, OIT recently implemented a Storage Resource Management (SRM) tool, Enterprise Management Concept (EMC) Veteran-Focused Integration Process Request (VIPR) which now gives further visibility into our storage stack. This has allowed OIT to:
    - Gain a better understanding of growth trends for storage need, and
    - Identify lightly accessed data; suitable candidates to move to cloud storage.

  OIT plans to utilize the data gathered from SRM and engage our business partners via the Account Management Office (AMO) to develop realistic SLAs as to where data should be stored to properly balance customer access need to storage cost. OIT currently manages six unique infrastructure designs at a typical Campus Support Center. Through modernization and reengineering, we can cut this to two infrastructure solutions (with split life cycle, so they refresh at different intervals) and realize cost avoidance from unnecessary maintenance on underutilized hardware. OIT will pursue "Storage on Demand" options as a subscription service and move forward to replace 100 VAMC hosted storage arrays per

year that go Last Date of Support (LDoS) beginning in 2023 and leverage hyper-converged replacement strategy for on premise systems (next state evolution).

- Modernize and Converge Unified Communications: OIT continues to complete the foundational work for phase 1 and phase 2 encompassing over 90 major and remote sites requiring convergence and modernization. The goal of the Unified Communications (UC) and Video Teleconferencing (VTC) effort is to implement a standardized and modernized enterprise-wide UC and collaboration infrastructure. This will enable the capability that supports full convergence of all electronic communications onto a single, Internet Protocol (IP)- based enterprise system that seamlessly unifies all voice, video, and collaboration traffic supporting all VA end-users and Veterans.

  The key focuses are to eliminate standalone silos and infrastructure duplication, ratify and implement enterprise standards, integrate enterprise UC solutions nationwide, and lower VA's Total Cost of Ownership (TCO). Additionally, support future transitions to new services and features including managed service capabilities and integration into EHRM program. This will reduce the overall complexity and footprint of VA's existing UC environment and provide the foundational elements for the migration to enterprise-class UC applications and services.

  As part of our IP-based modernization strategy, OIT has moved to a model where all phone systems in a VISN are from the same Original Equipment Manufacturer (OEM), which allows Unified Communications to enable some VISN-centric business models. OIT will also modernize VTC Codec system that have reached Last Date of Support (LDoS) and no longer support security baselines. OIT will move VTC to a managed service while continuing to invest in central VTC infrastructure components. The modernization strategy also includes implementing Enterprise Private Cloud session control, building a foundation to allow exploration of telephony-as-a-service options and capabilities (such as contact center, voice mail, cloud hosted enterprise wide voice services).

- Modernize and Upgrade the National Wireless Program: OIT's modernization and upgrade strategy is to provide coverage for high throughput data devices, such as VA laptops, VA Apple devices, Voice applications (such as Nurse Call and Voice over Wireless Local Area Networks (WLAN) systems) and Video applications (such as Telehealth, multicast streams and point to point video conference). This modernization strategy allows VA to increase and expand our ability to provide for our expanding mobile environment and ensure our support for the IoT. Further, the strategy increases visibility into application performance, Quality of Service (QoS) performance and wireless security monitoring (i.e. rogue wireless devices and wireless attack vectors).
  As we modernize the VA WLAN systems, coupled with the rescission of requirements for air gapped networks providing public internet access on April 26, 2018; OIT will add capabilities to offer guest wireless services through the Enterprise platform. This ensures radio frequency ranges are no longer competing within VA buildings as well as paying long term dividends to VA's overall budget.

- Revitalize End User Desktop Infrastructure: While OIT has increased the total number of desktops/laptops as a result of the COVID-19 pandemic, IRP has successfully integrated its refresh life cycle into this event. As a result, IRP has reduced its overall technical debt in this category by 12%. There are currently approximately over 150,000 devices (Laptops and Desktops) are past either normal evolution or lifecycle of 4 years in service. The 2022 request supports the continued downward trend of refreshing end user devices. OIT's modernization strategy is moving to a more agile framework around a Provisioning-as-a-Service (PVaaS) model, which will allow us to more rapidly meet changing business needs. Characteristics of a PVaaS environment includes full management of the life cycle of devices to include imaging, provisioning, asset and inventory management and removal/refresh on a specified life cycle. PVaaS will also include a move to computing devices with solid state drives (SSD) and support for iterative versions of Windows Operating Systems. OIT is developing a managed service strategy targeting non-core/con-competitive areas of service delivery such as provisioning as first steps focusing on the largest business value to our customers.
  Transitioning current capital expense approach to an operations expense model would also add value in consistency of performance, obviating the current risks associated with diversion of funds for other needs, and creating cumulative legacy life cycle refreshing this category. In addition, OIT will strive towards a completely managed service desktop environment ("seat management").

- Modernize Wide Area Network (WAN) Bandwidth Capacity: OIT must continue to modernize its aging bandwidth infrastructure to adequately support VA's growing dependence on telemedicine and the increased number of teleworkers to minimize interactions at our VA Medical Centers due to the pandemic. With over 3,100 circuits currently active in VA, IRP has successfully reduced its overall technical debt in this category by 51%. As new technologies are implemented to place a greater demand on VA's WAN, it will be even more critical to ensure bandwidth capacity is met.

- Modernizing Very Small Aperture Transmission (VSAT) Infrastructure: OIT needs to modernize and uplift our legacy continuance of operation VSAT infrastructure over the next three years to increase capacity and ensure FIPS 140-2 encrypted transmissions.
  - Modernize Teleport Ground Stations (currently 15-years-old).
  - Modernize satellite modems (currently using 16-year-old technology).
  - Modernize router and switch modules (currently end of sale and end of life).
  - Modernize Satellite and ancillary antennas failing due to age (11-13-years-old).
  - Modernize OIT operated VSATs past end of expected life.
  - Modernize the Antenna Control Units (ACU) to allow remote control.

- Reengineer and Upgrade Printer/Scanner Infrastructure: OIT manages a fleet of over 140,000 print devices. Our modernization goals involve moving from a single function to multifunction devices where possible under a Managed Print Services (MPS) framework. Generally, VA operates our print infrastructure until the device is either no longer fit-for-

purpose or when device failure or performance makes it no longer economically viable to retain.

IT and Cloud Modernization - $61.6 million

In response to the VA Secretary's mandate for IT modernization, Enterprise Cloud Solutions Office (ECSO) implements and operates the VAEC environments in both Amazon Web Services (AWS) and Microsoft Azure (Azure) Government and additional cloud solutions that deliver secure and seamless cloud functionality to support the entire VA Enterprise. Funding will be used to plan, implement, deliver and evolve the VAEC in response to demand. The VAEC ecosystem is an essential enabler to both VA's Digital Transformation and its DCOI.

Based on proven success, demand for and use of VAEC is rapidly expanding. VAEC currently hosts over 75 systems (including many mission critical systems), thousands of end user virtual desktops, and clinical care systems. VAEC also provides significant additional capacity for nationwide telehealth and telework.

In addition, numerous systems are migrating to and/or developing new Veteran servicing capabilities in the VAEC.

ECSO funding will provide:

- Enterprise scale access to all the cloud services available from Azure and AWS Government Cloud Service Providers (CSP)
- Senior subject matter expertise to plan, architect, implement, optimize spending, acquisitions, operate and support the VAEC as an enterprise capability
- Cloud capacity, licenses and support services for critical common services and state of the art tools and services relied upon by hosted systems to effectively and efficiently operate and maintain and deliver cloud computing services to the VA enterprise and Veterans
- Maintenance and expansion of VA Authority to Operate (ATO) inherited by mission critical systems migrating to, being developed in, and hosted in the VAEC AWS and Azure environments
- Support the efficient migration to and utilization of cloud technologies by Portfolio and Product teams
- Support, facilitate and coordinate with VA's National Data Center Operations and Logistics (NDCOL) and its execution of the DCOI

Therefore, the VAEC is considered a must pay requirement not only to provide continuity of service to a growing list of mission critical systems and end user services but as an essential enabler for VA IT Modernization, Digital Transformation, innovation and service delivery. ECSO also supports all five OIT priorities (IT Modernization, Seamless and Secure Interoperability, Exceptional Customer Experience, Strategic Sourcing, and IT Workforce Transformation).

ECSO and VAEC will not be available to maintain multiple critical ATO and will not provide support, common services and tools to a rapidly growing list of production systems, 10,000's of end user virtual desktops, 10,000's of clinical users relying on streamed applications and provide telehealth video capacity.

Applications impacted would include these mission critical systems:

- Major Mission Critical Enterprise Applications like: Identity Access Management, Veterans Benefits Management System, My HealtheVet and VA.GOV
- Greater Choice for Veterans Supporting Systems including DST
- Education Benefits/Chapter 33/Blue Water Navy
- Cerner Integrated Sites like Veterans Data Integration and Federation, VA Profile and Master Veteran Index
- CPRS
- CARE2 Telehealth Capacity
- Two VistA Production Sites and over 70 VistA Disaster Recovery (DR) sites

In addition, ECSO and VAEC will not be available to enable ongoing IT Modernization and Digital Transformation via cloud adoption, to support the refactoring of applications using container technology, nor will it be able to continue the in-progress migration of numerous additional systems including mission critical systems such as JLV, additional VistA production sites, and Benefits Integration Platform.

Enterprise Operations and Maintenance details is located in Appendix F and M.

Information Security - $360.7 million

OIS integrates and collaborates with OIT entities to deliver enterprise-wide cybersecurity strategy, policy, governance, oversight, and network defense to protect Veterans' information and VA information systems. OIS provides the following activities:

- Drives alignment with federal cybersecurity priorities and requirements
- Monitors, detects, reports, contains, and mitigates risks and threats to VA's network and infrastructure
- Independently verifies and validates VA's cybersecurity posture and leads emerging and imminent threat preparation and defense efforts
- Collaborates with DoD to increase reciprocity and improve customer and Veteran experience
- Identifies, assesses, and monitors risk to the confidentiality, integrity, and availability of VA's organizational assets
- Provides enterprise-level cybersecurity architecture governance requirements and advisory services
- Adapts to the evolving cybersecurity threat landscape by continually centralizing and refreshing VA cybersecurity policy and guidance
- Recruits, develops, and retains a talented cybersecurity and privacy workforce

The 2022 Information Security request will support the following major areas:

<u>Information Security Operations (ISO) - $127.7 million</u>

ISO is responsible for Cyber Security Operations Center (CSOC), Information Security Risk Management, VA Privacy Service and VA Data Breach Response Service (DBRS)

- The mission of the CSOC is to protect VA's information on a daily basis by monitoring, responding to, and reporting cyber threats and vulnerabilities; managing the Trusted Internet Connection (TIC) gateways; conducting enterprise network security monitoring; and providing value-added network and security management services across the agency. In executing this mission, CSOC aims to provide customer-focused, reputable security services operations to facilitate consistent availability and protection of information.

- The Information Security Risk Management Team works to promote an agency-wide understanding of information security risk in alignment with OIS strategies and priorities. It also aims to maintain compliance with Federal requirements while anticipating new or emerging requirements and developing work plans to address them. The Team also oversees the Department's cybersecurity risk management activities, including Authorization processing, the Security Control Assessments (SCA) function, the PIV Card Issuance (PCI) Assessments, the Governance, Risk, and Compliance process (GRC), Case Manager function, and other information security program support activities.

- VA Privacy Service oversees and directs the development of VA's privacy programs to help protect Veterans, their beneficiaries, and VA employees' personal information. VA Privacy Service advises and makes recommendations to senior officials on privacy priorities and preserves and protects the Personally Identifiable Information (PII) of Veterans, their beneficiaries, and VA employees by promoting a culture of privacy awareness and maintaining the trust of those we serve. VA Privacy Service ensures VA policies are in compliance with regulatory requirements and legislated mandates governing those programs.

- The VA Data Breach Response Service (DBRS) is responsible for handling all Privacy and Security related events that are entered into the Privacy and Security Events Tracking System (PSETS) on a global level. The DBRS team consists of individuals that have extensive experience in the Information Security and Privacy within the VA and VA HealthCare field. The team reviews each incident and decisions are based on Federal and VA-specific data breach response requirements. The DBRS works to ensure that all decisions on Privacy and Security related incidents are dealt with in a timely manner and in accordance with Federal and VA-specific incident resolution guidelines. Complex breaches are referred to the National Data Breach Core Team (DBCT).

<u>Cybersecurity Implementation Strategy (also known as Enterprise Cybersecurity Strategy Program) - $60.0 million</u>

Enterprise Cybersecurity Strategy Program (ECSP) oversees VA's efforts to advance the overall cybersecurity posture of VA through enhanced visibility into VA IT systems and networks and by providing cutting edge guidance, support, and tools. It is responsible for the execution of OIT's cybersecurity strategy and for defining the set of actions, processes, and emerging security technologies required to further enhance the security state of VA's information and assets, while improving the resilience of VA networks.

Information Security Policy and Strategy - $45.3 million

Information Security Policy and Strategy is responsible for Enterprise Security Architecture, Policy and Compliance, and Cybersecurity Technology and Metrics.

- Enterprise Security Architecture integrates and aligns VA's security requirements with system and application engineering requirements throughout VA's system development lifecycle. Enterprise Security Architecture is an iterative, automated, enterprise security process that encompasses security attributes from architecture domains and helps VA's ECSP implement prioritized cybersecurity capabilities. The team gathers input and requirements from VA stakeholders to support and inform Enterprise Security Architecture activities and collaborate with the Enterprise Cloud Services Broker (ECSB) to broker, define, and deliver cloud security standards and policies tailored to meet VA customer requirements.

- Information Security Policy and Compliance is responsible for the development and maintenance of VA's cybersecurity policy, confirming that VA's policy is current and in compliance with Federal laws and regulations and The National Institute of Standards and Technology (NIST) guidelines. It also oversees the review of IT products and services that the Department plans to purchase to help facilitate compliance with Federal and Departmental cybersecurity policy and regulations. The Information Security Policy and Compliance team maintains the Knowledge Service (KS) to provide VA employees with a centralized, authoritative repository for VA policy guidance and to support the implementation of NIST SP 800-53 and CNSS 1253 security controls throughout VA.

- The Cybersecurity Technology and Metrics (CTM) group oversees the execution of capabilities and strategies to describe, assess, and continuously monitor VA's cybersecurity landscape in support of VA's cybersecurity program. It also leads the Security Architecture and Software Assurance (SASA) IAM Teams to support compliance with the FISMA and government-wide guidance and requirements associated with Federal Identity, Credential, and Access Management (FICAM) services. The SASA IAM Team also helps analyze that VA's FICAM services are used to fulfill cybersecurity control requirements. Further, CTM captures and displays key performance metrics in a single view facilitating risk decision and budget allocation prioritization for senior executives. CTM provides technical security expertise in support of various technologies and methodologies executed by the offices responsible for 44 U.S. Code 3554 FISMA areas.

Continuous Readiness in Information Security - $51.1 million

OIS Continuous Readiness in Information Security Protection (CRISP) is designed to reduce systemic information security risks across VA programs and systems and comply with Federal security and privacy regulations. This effort enables VA to provide improved customer service and provide a more secure and seamless experience. It aligns to the President's Management Agenda through the key transformation driver of IT Modernization, reducing cybersecurity risks to the Federal mission through the full implementation and management of FISMA requirements in systems located at all VA facilities. This request will assist the Department in continuing to

improve the security and resiliency of the underlying VA infrastructure facilitating enhanced visibility, access, and functionality across the spectrum of VA services for the Veteran. These investments help ensure Veteran and VA data and systems are protected from cyber threats and attacks.

Additionally, CRISP is designed to provide SME and staff support in conjunction with the IT Operations (ITOPS) Transformation Support Services (TSS). Services include providing direct support across the spectrum of operations functions including Cybersecurity Risk Management (CRM), Research and Development, Medical Device Protection, Systems Engineering, Configuration Management, Field Security Support, Vulnerability and Patch Management, Security Management, Access Management, and Continuity of Operations. The support provided is crucial to continuing past efforts designed to reduce information security risks across VA programs and systems and comply with Federal security and privacy regulations. This request provides direct operational cybersecurity support and includes remediation services related to material weakness findings, while offering surge support activities to address emerging shortfalls in capabilities. This effort enables VA to provide improved customer service and provide a more secure and seamless experience.

Network Operations Security (Field Security Services) - $1.5 million

Field Security Service (FSS) is a virtual organization that includes the Information Security Officers (ISOs) that supports our VA Medical Centers, Regional Offices, Data Centers, Field Program Offices, and VA Central Offices. ISOs are the on-site experts in security plans, policies and controls. FSS ensures the confidentiality, integrity, and availability of Veteran and beneficiary sensitive information, networks, and systems. FSS also strengthens Veteran and public confidence in the quality of VA services and decreases risks to healthcare operations and benefits processing by prevention and remediation of security breaches.

Privacy and Records Management - $42.0 million

The objective of the Office of FOIA, Records, and Assessment Privacy Information and Identity Protection (PIIP) is to ensure provisions are in place to protect all PII/PHI, and Sensitive Personal Information (SPI) of the Veteran and the employee, while also responding to any suspected or confirmed PII/PHI breaches. Privacy Impact Assessments (PIA) and data validation processes are used to ensure Veteran data is protected and used in accordance with applicable laws and statutes. Current and proposed systems will accurately process and track FOIA requests, legally release names and addresses, enhance role-based training, and provide Veteran services within the law and as allowed by policy. PIIP provides the tools required to successfully track and investigate privacy/security incidents, to include Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, across VA. The compliance requirements are set forth by various statutes and regulations to include the Privacy Act, HIPAA, FISMA, FOIA, Clinger Cohen Act, Office of Management and Budget (OMB) Circular A-108, OMB Circular A-130, FITARA, and various OMB mandates for records management activities to include electronic recordkeeping capabilities by close of each calendar year.

Additionally, the office evaluates and delivers enterprise-wide reporting of current compliance and sustainability postures of privacy, FOIA and records management programs and ensures that all VA records are managed in the most effective and cost-efficient manner and that VA's records management practices comply with the Federal Records Act of 1950.

Identity and Access Management - Enterprise (IAM) - $33.0 million ($11.2 million in Development, $21.8 million in Operations and Maintenance)

Congressional Projects/SubProjects *(Dollars in thousands)*	2020 Actuals DEV	2021 Enacted DEV	2022 Budget Request DEV
Cyber Security	**$ 16,600**	**$ 11,380**	**$ 11,200**
Identity and Access Management - Enterprise (IAM)	$ 16,600	$ 11,380	$ 11,200

Table includes Development subaccount only. See Appendix F for the Operations and Maintenance information

IAM mission-critical services provide Veterans, Beneficiaries, Stakeholders, and VA employees seamless authorized and authenticated access to over 950 VHA, VBA and NCA integrated applications that deliver health care services, process claims, and manage benefits. IAM provides enterprise-level identity, authentication, and authorization services for multiple internal and external systems, which need to be interconnected, providing seamless, authorized and authenticated access to these systems by facility, system and individual entities. IAM, both directly and indirectly, supports the Veteran, beneficiary, and family member experience by providing both single sign-on and consistent identity and access for every user across the enterprise. As more VA systems integrate with IAM, data security and data quality across the enterprise will continue to improve, resulting in increased customer and employee satisfaction. IAM improves Veteran and customer experience through support for VA's enhanced caregiver program, managing the identities and relationships between Caregivers and Veterans; support for DoD's expansion of patronage, integration with Login.gov.

This effort provides enterprise level authentication and authorization services that authenticate VA persons of interest and automate the granting, maintenance, and removal of electronic permissions to regulate access to VA technology systems, resources, and data. This effort also provides enterprise level identity services that uniquely and accurately identify individuals across the VA. It also helps to determine which VA systems individuals and their associated identifiers are located in. The 2022 request for Cyber Security Congressional Project operations and maintenance will support OIT efforts such as maintaining the cyber security software and COTS solution for the suite of identity and security services, and VAEC MS Azure Government (MAG) environment.

Information Security details are located in Appendix N.

Technology Business Management Implementation

Founded on transparency of costs, consumption, and performance, Technology Business Management (TBM) gives technology leaders and their business partners the facts they need to collaborate on business aligned decisions. TBM provides a standard taxonomy to describe cost sources, technologies, IT resources (IT Towers), applications, and services. The TBM taxonomy provides the ability to compare technologies, towers, and services to peers and third-party options (e.g., public cloud). The three layers of TBM taxonomy comprise:

- Finance, which provides a standard set of Cost Pools and Sub-Pools
- IT, which includes a standard set of IT Towers and Sub-Towers
- Business Services, the highest layer of the taxonomy, which provides a standard set of product and service categories, and business units and capabilities

Building a TBM Model

In order to increase utility of the data reported in the IT Portfolio Summary and other submissions, OMB has mandated the implementation of TBM Taxonomy for reporting on Federal IT spending. The OIT has exceeded OMB's mandate for Capital Planning and Investment Control (CPIC) reporting against the IT Towers and Cost Pools, by building a TBM Cost Transparency Model that maps its budget, obligations, expenditures, and expenses through all four layers of the TBM taxonomy: Cost Pools, IT Towers, Products and Services, and Business Units/Capabilities. By fully implementing TBM, VA OIT was able to get a clearer view into the availability and reliability of its financial and operational data. OIT's main focuses for TBM implementation are:

Financial Data: Automating TBM Mapping in Budget Tracking Tool and Financial System (IT Towers and Cost Pools)

Successes and Challenges

- **Mapping Financial Data (Non-Labor):** While OIT can map Budget Object Classification (BOC) codes and Sub-Object Classification (SOC) codes directly to the Cost Pools and Sub-Pools, the biggest challenge with IT financial data is that the current coding within the FMS does not lend itself to automated mapping to IT Towers and Sub-Towers. The TBM team currently manually maps all non-labor dollars to IT Towers and Sub-Towers based on the purchase order descriptions in its Budget Tracking Tool (BTT). IT Budget and Finance (ITBF) is partnering with the FMBT Office to develop codes that will enable coding-driven IT Tower assignments in the future financial system, iFAMS. In the meantime, non-labor dollars will continue to be mapped manually each month.

- **Mapping Financial Data (Labor):** During the initial phases of TBM implementation, OMB issued Capital Planning guidance that required Agencies to report on Internal/External labor categories. In order to meet the requirement, ITRM worked with OIT investment owners to align FTE to the IT investment portfolio by Cost Pool and IT Tower, using average pay to calculate labor cost. This data was used as planning data to inform the activities of the TBM team which needed to be more refined in the TBM Model.

The TBM Model has upgraded from using a static organizational chart to assign labor dollars to the IT Towers to using cleansed payroll data merged with the Position Management Database (PMD) to assign each position in the PMD to an IT Tower/Sub-Tower combination and then use the payroll data to weight the distribution of labor dollars. This provides OIT with a more accurate allocation of labor dollars to the IT Towers and will be used to better inform the budget cycle.

- **Mapping Budget Line Items:** By pulling budget data into the TBM Model, the TBM team was able to compare the mapping of the planned dollars to IT Towers done by OIT budget analysts to the mapping of actual purchase orders to IT Towers that was completed by the TBM team. In doing so, it was determined that there was a training gap between the two teams that completed the mapping, partly because knowledge of the TBM requirement had not spread throughout OIT. This led to the development of TBM training materials for the OIT budget community. These materials were delivered in multiple forums, including the annual IT Financial Management Training Conference, the annual Budget Operating Plan (BOP) Guidance documentation, and by mapping all software in the Technical Reference Model (TRM) to the TBM Towers and Sub-Towers. The TBM team also worked with the Budget Execution and Analysis Service to automatically populate the Cost Pool and Sub-Pool fields in the Budget Tracking Tool based on the end user's BOC/SOC selection.

Operational Data: Moving from Assumption-Based to Consumption-Based Cost Allocations (Products and Services and Business Units/Capabilities)

The TBM Model requires consumption information to accurately allocate costs from the IT Towers and Sub-Towers to the Products and Services Layer and Business Units/Capabilities Layer. The TBM team is partnering with operators and data owners across OIT to improve existing data sets or create required data sets where none currently exist. Here are some of the main allocations used in the TBM Model.

Successes and Challenges

- **Cloud Consumption:** Currently, one of the two true consumption-based allocations in the TBM Model is cloud consumption data for applications that have been migrated to the VA Enterprise Cloud (VAEC) environment. This information is fed directly from the Cloud Service Providers (CSPs) into the TBM Model each month and drives the allocation of cloud cost to the consuming application or service within OIT's Products and Services Layer. The TBM Model requires that all cloud consumption be tied to a VA System ID (VASI ID) or to a TBM Service. The TBM Office continues to work with the ECSO to ensure the cloud data is 100% mapped to the TBM Products and Services Layer. The current model fallout due to cloud is minimal (< 5% of cloud spend).

- **End User Allocations:** The allocation of IT Help Desk and Deskside Support Sub-Towers to the Products and Services Layer is another area where the TBM team has consumption information. The TBM team continues to work with the owners of the service desk tool to ensure that incident tickets can be 100% mapped to the TBM Products and Services Layer based on their Category/Sub-Category assignment and any incident tickets tied to a VASI

ID. The current model fallout due to lack of service desk ticket alignment is minimal, and the mapping is approaching 100% as the service desk eventually eliminates Category/Sub-Category and adopts the Products & Services Layer as a direct field in the service desk tool against which incident tickets are mapped.

- **Infrastructure Footprint:** Infrastructure costs are allocated to the Products and Services Layer based on location data commonly available for applications and for infrastructure elements such as servers, storage, and data centers. Although this information is directionally correct, it is not accurate enough to inform OIT Leadership or VA Business Unit decisions. To resolve this, the TBM team is relying on completion of the internal Configuration Management Database (CMDB) effort to realize actual consumption-based allocation of infrastructure cost to the Products and Services Layer.

- **Labor Allocations:** The allocation of labor costs to the Products and Services Layer mirrors the allocation of non-labor cost, so the operating assumption is that applications and services that consume more non-labor resources also require more labor. Any strengths or weaknesses of the non-labor allocations to the Products and Services are extended to the labor dollars as well.

Framework Integration

The TBM team created a draft Products and Services Layer for OIT and is working to integrate with several other internal and external operating frameworks as they evolve, including the federal government-wide TBM Products and Services Layer adopted by OMB, the OIT DevOps Product Line Management structure, the OIT Franchise Fund service offerings, and the VA Business Reference Model (BRM). Integration of the TBM Products and Services Layer with the various frameworks will ensure cohesive VA OIT internal and external reporting by providing various data views to satisfy stakeholder needs, but ensuring data is collected through one source.

Moving from Data Transparency to Cost Transparency

OIT will shore up the strengths and mitigate the weaknesses of its TBM Model by:

- Continuing to offer TBM training to budget analysts for assigning IT Towers to budget line items
- Continuing to refine the existing consumption-driven allocations of cloud dollars and service desk cost to the Products and Services Layer to eliminate any model fallout
- Supporting the emerging Configuration Management Database (CMDB) effort that will transform the allocation of infrastructure costs from assumption-based (location) to consumption-based
- Integrating the TBM Products and Services Layer with other operating frameworks
- Increasing TBM team outreach efforts to design dashboards and reports for multiple OIT user communities
- Pursuing automation of all financial and operational data into the TBM Model
- Pursuing TBM coding in iFAMS to ensure that IT Tower mapping will be coding-driven in the new financial management system

Please refer to Appendix O (TBM Matrix) for a breakdown of the IT Budget Request by Cost Pools and Towers.

Accomplishments

Health Portfolio

- Implemented the MISSION Act to integrate the VA and DoD medical records system with the Cerner Joint Health Information Exchange (JHIE)

- Developed the Veterans Health Information Exchange (VHIE) Portal as a part of the HealthShare COTS implementation which replaced the legacy Veteran Authorization and Preferences (VAP) application with a streamlined and robust user interface, improving user experience

- Launched the Emergency Care Authorization Tool (ECAT) interface of the CCRA Health Share Referral Manager (HSRM) which allows the VA to process and authorize emergency care within 72 hours of a care event and use Community Care funding to care for Veterans quickly

- Released VA Online Scheduling (VAOS) which provides Veterans with the choice to view and request appointments from mobile and launchpad applications, giving them more flexibility and options to view and/or make changes to appointments on the go

- Launched a Veteran-facing web application that allows Veterans to complete 33 Measurement Based Care Screenings and Assessments on mobile devices, shortening the clinical workflow and providing immediate results during in-office visits

- Completed interface testing with the Cerner Millennium system which provides a more efficient, centralized solution for clinicians and equips employees with a modernized tool that provides the meaningful data they need to provide world-class quality of care and customer service for Veterans

- Enrollment Systems (ES) released 5.8 Suicide High Risk Patient Enhancements, Veteran Medical Benefit Plan (VMBP), and Cerner Notification deployed to production in October 2019 which improved customer service to the Veteran. ES released 5.9 VMBP and Urgent Care deployed to production on November 2019 which included a new document management functionality that enables authorized users to view, search, upload, delete, and view documents to enable Veterans and their families to receive the right benefits, and meet their expectations for quality, timeliness, and responsiveness through accurate records and abilities to manually grant urgent care eligibility

Benefits Portfolio

- Developed Claims Automation enhancements to provide Veterans with better self-service features, more efficient processing capabilities for claims specialists, and reducing legacy system dependencies which enabled VBA to increase the number of filings by 101 thousand, or 64% increase over 20I9

- Pension Automation has taken the VBA's manual claim process and awarded 5,070 claims through automation and is awarding 140 claims on average per night

- Virtual VA (Legacy Content Manager) decommissioning plans were finalized for the BIRLS systems and Veterans Service Network (VETSNET) user interfaces providing functionality to be integrated into the VBMS platform to reduce redundancy in capabilities and lower annual VA system sustainment costs

- Colmery Act (Education Benefits) consolidation of Section 107 and 501 led to a successful go-live deployment in December 2019 that provided agency management support while empowering Veterans access to functions that deliver the benefits provided under each of the legislative mandates which will provide greater access to Education Benefits for Veterans, service members, and eligible dependents

- Life Insurance Policy Administration Solution (LIPAS) commercial-off-the-shelf product, EXL LifePro, was successfully configured and implemented in the VAEC production environment with the new Insurance Service system, VISION, that allows for the migration of policies from the aging 60-year-old IBM mainframe legacy system into a secure and reliable cloud environment

- Loan Guaranty (LGY) achieved the BWN Vietnam Veterans Act of 2019 HR Bill 299 by implementing the BWN Loan Processing which was completed by the expansion of the maximum guaranty amounts for purchase, construction, and cash-out refinance loans to an amount greater than the Freddie Mac conforming loan limit, for Veterans with full entitlement

- VA.GOV developed Performance Dashboard to increase the use of self-service tools, decrease the time Veterans spend waiting for an outcome, and consistently deliver a satisfying, reliable, and secure experience which uses key performance indicators to drive decision making and measure success while demonstrating the benefits and success of modernized, human-centered designed, digital tools, and systems using this data

- The Board of Veterans Appeals launched the Generation 2 functionality of Virtual Hearings that allows Veterans to attend their appeal hearings on their internet-linked devices from the safety of their own homes. Veterans are able to connect with the Board via their mobile phone or laptop when using the VA Video Connect app

- Deployed the "address validation" service, resulting in a significant drop in VA.GOV error rates for mailing addresses (from 17% to 6%), residence addresses (from 5% to 3%) and

a significant drop in VA's Centralized Mail-Out Pharmacy returned mailed prescriptions with a 50% reduction in address discrepancies for pharmacy mailing and a reduction of undeliverable addresses from 0.25% to 0.05%

Corporate Portfolio

- Completed development of all critical interfaces for NCA Go-Live which included 17 internal and external interfaces, and 6 outbound data extractions which will become a part of the iFAMS ecosystem

- Launched the Acquisition Knowledge Portal (AKP) which provides the VA Acquisition Community access to essential acquisition information, tools, and templates

- Released the VIEWS Case and Correspondence Management module which yielded a dynamic workflow for managing Veteran related cases and correspondences of all types. The new module automates request routing, increases correspondence efficiency and improves responsiveness to Veterans' needs and inquiries about VA programs

- Matter Tracking System (MTS) deployment helped the Office of Accountability and Whistleblower Protection (OAWP) collect and manage information, referred to as Matter, reported to OAWP from both anonymous and identified sources

- Police Program Inspection Compliance (PPIC) deployment helped capture individual inspection element data and analyze that data, gather trends, determine root cause, monitor responses, complete reports automatically

Memorial Affairs Portfolio

- MBMS provided improvements to the Veteran search capabilities thru automation of War Periods and Military Service Records selections resulting in continued efficiency of the MBMS Case Management and Eligibility Outreach (CaMEO) and MBMS Cemetery Regulations, Reports and Testing (CeRRT) applications

- Veterans Legacy Memorials (VLM) implemented new "interactive" Tribute and Sentry functionality which provides the public with the ability to honor Veterans by creating tributes directly on a Veteran's profile page, comment on uploaded photographs, view biographical "info documents", and provide a "like" on comments. These new features introduce innovative ways to show appreciation and honor the memory of a Veteran and his or her service

- Established direct data feeds to the data warehouse that allowed for a dramatic improvement in data freshness and availability. Eight executive dashboards have been provided, with data being used in near real-time. By using these dashboards, NCA is now able to spot trends sooner and address issues before they escalate, saving time and cost

Enterprise Portfolio

- Collaborated with VHA to modernize the telephone systems and clinical contact centers at 200 facilities nationwide. As of January 2020, VA reduced telephony service contracts by 50%, a cost-saving and efficiency improvement action. The updated centers increase the enterprise's ability to perform quality monitoring, training, workforce planning, and ultimately improve Veterans care and service

- Launched the DMLSS/LogiCole Resource Center website. The Resource Center provides a comprehensive information repository that will enable the VA DMLSS application end users to access DoD training presentations, interactive eLearning lessons, and other resources

- VA Profile deployed the enterprise Disability Ratings Service which provides Veterans Benefits Administration ratings data to the VHA and other consumers and enabled the Veteran pre-discharge integration between VA Profile, VA and DoD Identity Repository (VADIR), and the MPI

- OIT, QPR Risk Management Directorate (RMD) built and launched the Enterprise Risk Registry (ERR) under budget in less than 14 months. The ERR gives the VA a seamless, single point of entry for mandatory enterprise risk reporting and analysis

- QPR office of Quality Continuous Improvement Organization (QCIO) created the Records Management Meta-Knowledge Repository (MKR) which enhances how OIT maintains compliance with National Archives and Records Administration (NARA) regulations, the FOIA, and the Federal Records Act

- The Service Management Office (SMO) and ITAM team delivered the Software Asset Management (SAM) Minimum Viable Product (MVP) to Infrastructure Operations (IO). This application's functionality supports attempts to formalize VA SAM centralization capabilities to reduce IT costs, improve VA's ability to negotiate with IT vendors, minimize risk of software licensing agreement violations, decrease infrastructure cyber-attack vulnerabilities, and adopt software management best practices

  - Health Data Repository (HDR) successfully completed code and Alert Notification promotion to the VDIF Pre-Production environment and validated the deployment packages which interface and facilitates passing of Health Level Seven (HL7) drug allergy and medication data messages between EHRM and HDR to ensure patient safety through accurate drug order checks within the new EHRM product

  - Administrative Data Repository (ADR) successfully completed releases that supported 6.5 million Veterans receiving VA MISSION ACT benefits by implementing changes that enabled system integration between Enrollment System and CERNER and the database system processed 16.5 million tax forms of ACA enrollment for 9.2 million Veterans and family members in 2019

- Veteran Identity/Eligibility Reporting System (VIERS) performed DevSecOps support for eight core API Soap services which processed over 18.5 million transactions to provide benefits data for Veterans. Specifically, CGS CPE Adapters releases enhanced the find-person operation which impacted two adapters and resulted in improving the timely submission for Veteran benefit claims, and the OneVA Pharmacy (1VAP) development fixed failures with partial or full prescription refill requests which improved pharmacy services for Veterans

- Data Access Services (DAS), Compensation and Pension Record Interchange (CAPRI), and VBMS recently successfully processed the 24th million Disability Benefits Questionnaire (DBQ) record. DAS facilitates electronic transfer of numerous data streams between VA and external partners, including the transmission of DBQ examination results from VHA Clinicians and Veterans Benefits Administration-contracted vendors to the VBMS. The DBQ electronic dataflow is a critical portion of claims adjudication for Veterans benefits and helps speed the processing of Compensation and Pension benefits claims processing

- Section 508 Compliance successfully implemented Colmery Act automation requirements within Congressional and White House deadlines by improving software testing via VA's first combined implementation of automation software testing, cloud technology with Scaled Agile Framework for Enterprise (SAFe) and DevSecOps processes which increased test scripts from 100 to 485 while decreasing test time from nine weeks to half a day and implemented automation testing of key Section 508 points of compliance

- Benefits and Enterprise Platform (BEP) migrated to IAM Single Sign On which ensures that users can always log on using Person Identification Verification (PIV) card credentials rather than maintaining separate usernames and passwords which improves the user experience across applications and increases efficiency for all users

- Digital Transformation Center's (DTC) expansion of the VIP project of DTC Systems and Applications in production has grown by 233%, (70 new applications), where the customer footprint increased by 856,700 of new Software as a Service (SaaS) or Salesforce users and that the delivery model of leveraging low code or no code, reusable products and components has led to a five times acceleration of product releases

- Program Planning and Oversight (PPO) completed the OMB Annual, Passback, and monthly submissions in accordance with updated fiscal year OMB requirements to report progress of development projects meeting the requirements of the Clinger-Cohen Act to publish project level cost and schedule details to the publicly available Federal IT Dashboard

Information Security

- Deployed the Lookout Application to secure all mobile devices within the VA. Lookout verifies that there are no malicious applications or activities on mobile devices and ensures that Wi-Fi and cellular connects are secure and malicious activity is monitored

- Implemented network protection capabilities to protect against malware sent via email, transferred over the network, and at the host level to detect and block 100 million malware events per week
- Deployed a new Phishing Assessment and Reporting Solution enterprise wide on over 516,000 devices. This enabled rapid reporting by users and immediate response to eliminate threats of malicious software executing on VA's network. Reporting immediately increased by 15,000% in the first 30 days

- Established an Adversarial Assessment Program to improve VA's ability to identify, detect, protect, and respond to tactics and techniques leveraged by bad actors. Assessments and recommendations resulted in rapid remediations, enhancing VA's cybersecurity posture

- Developed processes and capabilities to support the successful migration of Medical devices to more secure virtual networks, mitigating threats and vulnerabilities

- Developed a process for authorization of medical device hybrid cloud systems that evaluates the security and privacy risks associated with the medical device, cloud system, and architecture design. The process ensures security and privacy risks and mitigations are addressed before implementation

- Developed and implemented an enterprise-wide, risk-based cybersecurity program to secure VA's Medical Technology (MEDTECH) ecosystem including connected medical devices, health data, cloud and networks and enhancing VA's security posture

- Conducted independent assessments of over 50,000 security and privacy controls for over 60 VA information systems, providing an evaluation of the effectiveness of VA's security and privacy controls in operation

- Established a dedicated Insider Threat Cell to provide technical and cyber analytics support on demand. Successfully completed over 100 Persons of Interest (POI) inquiries within the first 90 days, significantly reducing the risk of inadvertent or accidental leaks, or exposure of sensitive data outside authorized channels

- Successfully supported 25 Software as a Service reviews information completion of the Authority to Operate, maximizing the adoption of cloud capabilities and enabling VA to deliver more effective services to Veterans

- Sustained and expanded the deployment of the VA real-time endpoint visibility and management solution to over 588,000 VA endpoints for incident detection and response, security configuration and compliance reporting

- Developed a Threat Intelligence Platform to aggregate all external cybersecurity threat intelligence feeds with internal visibility and context around events that are being observed on VA networks. The platform will decrease manual processes by 75% and facilitate near

real-time assessment of impact on the confidentiality, integrity or availability of VA data or network assets

- Systems Quality Assurance Service (SQAS) completed testing for the interface to the VA's Financial Management System (FMS). Caregiver Record Management Application (CARMA) was implemented in production and SQAS will continue to support Operations and Maintenance

- Compliance Readiness Division (CRD) developed a virtual FISMA Federal Information System Controls Audit Manual (FISCAM) audit methodology that allowed this annual audit to continue requiring minimal interaction with the VHA, VBA, & NCA staff so their focus would be responding to the pandemic taking care of Veterans and their families. A normal face to face audit is 24 sites and each site takes 1-1.5 weeks to complete with significant interruptions to the local facility staff where the audit is taking place. CRD was able to obtain the over 2000 documents requested by OIG from existing databases and tools

- Closed 74% of GAO report recommendations related to information security of high-impact systems. Internally, OIT has assessed and validated for closure 96% of the recommendations. Efforts in this area supported the VA Digital Transformation Strategy Focus Area 3 – Improve Cybersecurity

Appendix A: Development Subaccount

Information Technology Development Activities Highlights (Dollars in Thousands)	2020 Actuals	2020/2021 Year 2 of 2-year Availability	2021 President's Budget	2021 Enacted	2022 Budget Request	2021-2022 Increase / Decrease
Obligations by Program Activities						
Clinical Applications	31,456	3,031	95,763	95,763	103,624	7,861
Clinical Applications - CARES Act	6,197	3				
Health Management Platform	70,737	13,015	63,827	63,827	69,096	5,269
Health Research and Development					8,660	8,660
Benefits Systems	152,776	5,970	160,216	160,216	87,390	-72,826
Benefits Systems - CARES Act				45,000		-45,000
Memorial Affairs	14,460	1,861	15,130	15,130	9,030	-6,100
Other IT Systems	88,635	5,008	114,550	114,550	-	-114,550
Cyber Security	16,600		11,380	11,380	11,200	-180
Information/Infrastructure Management	20,655	866	34,680	34,680	8,000	-26,680
Information/Infrastructure Management - CARES Act	3,802	11,874				
Total Direct Obligations by Program Activities	**$405,318**	**$41,628**	**$495,546**	**$540,546**	**$297,000**	**-$243,546**
Obligations by Funding Sources						
Appropriation	395,319	67,251	495,546	495,546	297,000	-198,546
Appropriation - CARES Act	9,999	11,877				
VHA CARES Act Transfer (P.L.116-270)				45,000		-45,000
Rescission		-37,500				
Total Direct Obligations by Funding Sources	**$405,318**	**$41,628**	**$495,546**	**$540,546**	**$297,000**	**-$243,546**
Reimbursable Obligations incurred			37,164			
Total Development Obligations	**$405,318**	**$41,628**	**$532,710**	**$540,546**	**$297,000**	**-$243,546**

Appendix B: Congressional Report Summary

Information and Technology Total Budget Authority (Dollars in Thousands)	2020/2021	2020/2021	2021		2022	2021-2022
	Year 1 Actuals	Year 2 of 2-year Availability	President's Budget	Enacted	Budget Request	Increase / Decrease
Development						
Clinical Applications	$ 31,456	$ 3,031	$ 95,763	$ 95,763	$ 103,624	$ 7,861
Clinical Applications - CARES Act	$ 6,197	$ 3	$ -	$ -	$ -	$ -
Health Management Platform	$ 70,737	$ 13,015	$ 63,827	$ 63,827	$ 69,096	$ 5,269
Health Research and Development	$ -	$ -	$ -	$ -	$ 8,660	$ 8,660
Benefits Systems	$ 152,776	$ 5,970	$ 160,216	$ 160,216	$ 87,390	$ (72,826)
Benefits Systems - CARES Act	$ -	$ -	$ -	$ 45,000	$ -	$ (45,000)
Memorial Affairs	$ 14,460	$ 1,861	$ 15,130	$ 15,130	$ 9,030	$ (6,100)
Other IT Systems	$ 88,635	$ 5,008	$ 114,550	$ 114,550	$ -	$ (114,550)
Cyber Security	$ 16,600	$ -	$ 11,380	$ 11,380	$ 11,200	$ (180)
Information/Infrastructure Management	$ 20,655	$ 866	$ 34,680	$ 34,680	$ 8,000	$ (26,680)
Information/Infrastructure Management - CARES Act	$ 3,802	$ 11,874	$ -	$ -	$ -	$ -
Development Subtotal (incl. CARES Act)	**$ 405,318**	**$ 41,628**	**$ 495,546**	**$ 540,546**	**$ 297,000**	**$ (243,546)**
Sustainment /O&M						
Health Operations and Maintenance	$ 513,724	$ 30,201	$ 762,251	$ 762,251	$ 867,260	$ 105,009
Health Operations and Maintenance - CARES Act	$ 80,937	$ 21,007	$ -	$ -	$ -	$ -
Benefits Operations and Maintenance	$ 205,976	$ -	$ 175,666	$ 175,666	$ 276,274	$ 100,608
Benefits Operations and Maintenance - CARES Act	$ 67,134	$ 14,632	$ -	$ -	$ -	$ -
Corporate Operations and Maintenance	$ 37,141	$ -	$ 173,744	$ 173,744	$ 180,129	$ 6,385
Corporate Operations and Maintenance - CARES Act	$ 19,261	$ 2,468	$ -	$ -	$ -	$ -
Enterprise Operations and Maintenance	$ 1,917,725	$ 75,896	$ 2,071,193	$ 2,071,193	$ 1,772,952	$ (298,241)
Enterprise Operations and Maintenance - CARES Act	$ 864,614	$ 705,788	$ -	$ -	$ -	$ -
Memorial Operations and Maintenance	$ 9,529	$ -	$ 22,362	$ 22,362	$ 34,970	$ 12,608
Sustainment Subtotal (incl. CARES Act)	**$ 3,716,042**	**$ 849,992**	**$ 3,205,216**	**$ 3,205,216**	**$ 3,131,585**	**$ (73,631)**
Development	$ 395,319	$ 29,751	$ 495,546	$ 495,546	$ 297,000	$ (198,546)
Development - CARES Act	$ 9,999	$ 11,877	$ -	$ -	$ -	$ -
Development - VHA CARES Act Transfer (P.L.116-270)	$ -	$ -	$ -	$ 45,000	$ -	$ (45,000)
Sustainment/O&M	$ 2,684,096	$ 106,097	$ 3,205,216	$ 3,205,216	$ 3,131,585	$ (73,631)
Sustainment/O&M - CARES Act	$ 1,031,946	$ 743,895	$ -	$ -	$ -	$ -
Staffing and Administration	$ 1,171,728	$ 34,362	$ 1,211,238	$ 1,211,238	$ 1,414,215	$ 202,977
Staffing and Administration - CARES Act	$ 150,378	$ 218,166	$ -	$ -	$ -	$ -
OEF/OIF Supplemental (P.L. 110-28)	$ 2,240	$ -	$ -	$ -	$ -	$ -
Subtotal	**$ 5,445,706**	**$ 1,144,148**	**$ 4,912,000**	**$ 4,957,000**	**$ 4,842,800**	**$ (114,200)**
VACAA Section 801	$ 2,400	$ 2,039	$ -	$ -	$ -	$ -
American Rescue Plan act (P.L. 117-2 Section 8003)	$ -	$ -	$ -	$ 100,000	$ -	$ (100,000)
Recurring Expenses Transformational Fund	$ -	$ -	$ -	$ -	$ 670,000	$ 670,000
Total (includes VACAA and Recurring Expenses Transformational Fund)	**$ 5,448,105**	**$ 1,146,187**	**$ 4,912,000**	**$ 5,057,000**	**$ 5,512,800**	**$ 455,800**
Reconciliation (SF-133) report						
Reimbursable Obligations	$ 89,242	$ -	$ -	$ -	$ -	$ -
Prior Year Recoveries	$ 2,722	$ -	$ -	$ -	$ -	$ -
Total	$ 91,964	$ -	$ -	$ -	$ -	$ -
Grand Total	**$ 5,540,069**	**$ 1,146,187**	**$ 4,912,000**	**$ 5,057,000**	**$ 5,512,800**	**$ 455,800**

Appendix C: Congressional Report Details

Development

Information and Technology Development Detail (Dollars in Thousands)	2020/2021 Year 1 Actuals	2020/2021 Year 2 of 2-year Availability	2021 President's Budget	2021 Enacted	2022 Budget Request	2021-2022 Increase / Decrease
Clinical Applications	**$ 31,456**	**$ 3,031**	**$ 95,763**	**$ 95,763**	**$ 103,624**	**$ 7,861**
Supply Chain Management	$ -	$ -	$ 67,120	$ 67,120	$ 76,105	$ 8,985
Healthcare Administration Systems	$ 9,557	$ 2	$ 11,160	$ 11,160	$ 20,710	$ 9,550
Healthcare Administration Systems - CARES Act	$ 6,197	$ 3	$ -	$ -	$ -	$ -
Registries	$ 2,550	$ 1,000	$ 200	$ 200	$ -	$ (200)
Beneficiary Travel	$ -	$ -	$ 2,540	$ 2,540	$ -	$ (2,540)
Health Data Interoperability	$ 8,719	$ 2,017	$ 8,423	$ 8,423	$ 2,125	$ (6,298)
My HealtheVet	$ 10,580	$ 12	$ 3,200	$ 3,200	$ 4,684	$ 1,484
Research	$ -	$ -	$ 3,120	$ 3,120	$ -	$ (3,120)
Access & Billing	$ 50	$ -	$ -	$ -	$ -	$ -
Health Management Platform	**$ 70,737**	**$ 13,015**	**$ 63,827**	**$ 63,827**	**$ 69,096**	**$ 5,269**
Community Care	$ 40,740	$ 6,768	$ 21,190	$ 21,190	$ 34,853	$ 13,663
Pharmacy	$ 5,262	$ 261	$ 11,010	$ 11,010	$ -	$ (11,010)
Digital Health Platform	$ 5,808	$ -	$ 9,867	$ 9,867	$ 11,807	$ 1,940
Patient Records System (CPRS)	$ 6,183	$ 1,700	$ 7,750	$ 7,750	$ 9,000	$ 1,250
Purchased Care	$ 6,972	$ 4,200	$ 8,410	$ 8,410	$ 6,836	$ (1,574)
Telehealth Services	$ 5,772	$ 86	$ 5,600	$ 5,600	$ 6,600	$ 1,000
Health Research and Development	**$ -**	**$ -**	**$ -**	**$ -**	**$ 8,660**	$ 8,660
Research	$ -	$ -	$ -	$ -	$ 8,660	$ 8,660
Benefits Systems	**$ 152,776**	**$ 5,970**	**$ 160,216**	**$ 205,216**	**$ 87,390**	**$ (117,826)**
Education Benefits	$ 20,687	$ -	$ -	$ -	$ 50,000	$ 50,000
Education Benefits CARES Act	$ -	$ -	$ -	$ 45,000	$ -	$ (45,000)
Colmery Act	$ -	$ -	$ 27,230	$ 27,230	$ -	$ (27,230)
Veterans Customer Experience - VCE	$ 52,313	$ 3,352	$ 66,296	$ 66,296	$ 9,880	$ (56,416)
Veterans Benefits Management	$ 33,276	$ 161	$ 39,230	$ 39,230	$ 14,285	$ (24,945)
Benefits Systems	$ 36,504	$ 2,457	$ 20,630	$ 20,630	$ 9,825	$ (10,805)
Benefits Appeals	$ 5,741	$ -	$ 6,000	$ 6,000	$ 3,400	$ (2,600)
Other Benefits IT Systems	$ -	$ -	$ 830	$ 830	$ -	$ (830)
C&P Claims	$ 4,255	$ -	$ -	$ -	$ -	$ -
Memorial Affairs	**$ 14,460**	**$ 1,861**	**$ 15,130**	**$ 15,130**	**$ 9,030**	**$ (6,100)**
Memorials Automation	$ 14,460	$ 1,861	$ 15,130	$ 15,130	$ 9,030	$ (6,100)
Other IT Systems	**$ 88,635**	**$ 5,008**	**$ 114,550**	**$ 114,550**	**$ -**	**$ (114,550)**
Financial and Acquisition Management Modernization [1/]	$ 58,525	$ 4,440	$ 93,070	$ 93,070	$ -	$ (93,070)
Human Resources [1/]	$ 6,799	$ -	$ 13,980	$ 13,980	$ -	$ (13,980)
Other Corporate IT Systems	$ -	$ -	$ 3,500	$ 3,500	$ -	$ (3,500)
Supply Chain Management	$ 21,596	$ 568	$ -	$ -	$ -	$ -
General Counsel	$ -	$ -	$ 4,000	$ 4,000	$ -	$ (4,000)
Innovation (VACI)	$ 1,715	$ -	$ -	$ -	$ -	$ -
Cyber Security	**$ 16,600**	**$ -**	**$ 11,380**	**$ 11,380**	**$ 11,200**	**$ (180)**
Cyber Security	$ 16,600	$ -	$ 11,380	$ 11,380	$ 11,200	$ (180)
Information/Infrastructure Management	**$ 20,655**	**$ 866**	**$ 34,680**	**$ 34,680**	**$ 8,000**	**$ (26,680)**
Data Integration and Management	$ 20,655	$ 866	$ 34,680	$ 34,680	$ 8,000	$ (26,680)
Data Integration & Management - CARES Act	$ 3,802	$ 11,874	$ -	$ -	$ -	$ -
Grand Total (incl. CARES Act)	**$ 405,318**	**$ 41,628**	**$ 495,546**	**$ 540,546**	**$ 297,000**	**$ (243,546)**

Note: 2020/2021 Year1 Actuals Details do not include VACAA 801/802 and prior year recoveries

Appendix D: Operations and Maintenance Categories

Sustainment - Enhancement	Upgrades to new versions of software (SW) including operating systems, deployment of new hardware (HW) platforms, which are significantly different from current operational HW where new skills, equipment and software may be needed
Sustainment - Modernization	Migrations to new computing platforms, e.g. virtualization, cloud computing migrations where new skills, equipment and software may be needed to operate the application, system or infrastructure
Sustainment - Steady State	Operations & Maintenance Costs refers to the expenses required to operate and maintain an IT asset that is operating in a production environment. O&M costs include costs associated with operations, maintenance activities, and maintenance projects needed to sustain the IT asset at the current capability and performance levels. It includes Federal and contracted labor costs, corrective hardware and software maintenance, voice and data communications maintenance and service, replacement of broken or obsolete IT equipment, overhead costs, business operations and commercial services costs, and costs for the disposal of an asset

Appendix E: Operations and Maintenance Subaccount

Information Technology						
Operations and Maintenance Highlights						
(Dollars in Thousands)						
	2020 Actuals	2020/2021 Year 2 of 2-year Availability	2021 President's Budget	2021 Enacted	2022 Budget Request	2021-2022 Increase / Decrease
Obligations by Program Activities						
Health Operations and Maintenance	513,724	30,201	762,251	762,251	867,260	105,009
Health Operations and Maintenance - CARES Act	80,937	21,007				
Benefits Operations and Maintenance	205,976		175,666	175,666	276,274	100,608
Benefits Operations and Maintenance - CARES Act	67,134	14,632				
Corporate Operations and Maintenance	37,141		173,744	173,744	372,586	198,842
Corporate Operations and Maintenance - CARES Act	19,261	2,468				
Enterprise Operations and Maintenance	1,917,725	75,896	2,067,530	2,067,530	2,246,874	179,344
Enterprise Operations and Maintenance - CARES Act	864,614	705,788				
Memorial Operations and Maintenance	9,529		22,362	22,362	34,970	12,608
Total Direct Obligations by Program Activities	**$3,716,042**	**$849,992**	**$3,201,553**	**$3,201,553**	**$3,797,964**	**$596,411**
Obligations by Funding Sources						
Appropriation	2,684,096	106,097	3,205,216	3,205,216	3,131,585	-73,631
Appropriation - CARES Act	1,031,946	743,895				
OEF/OIF Supplemental (P.L.110-28)	2,240					
Transfer from Recurring Expenses Transformational Fund					670,000	670,000
North Chicago Transfer			-3,663	-3,663	-3,621	42
Total Direct Obligations by Funding Sources	**$3,718,282**	**$849,992**	**$3,201,553**	**$3,201,553**	**$3,797,964**	**$596,410**
Reimbursable Obligations incurred	76,051		21,777	89,784	68,951	-20,833
Total Operations and Maintenance Obligations	**$3,794,333**	**$849,992**	**$3,223,330**	**$3,291,337**	**$3,866,915**	**$575,577**

Table does not include $100 million provided for Supply Chain Modernization under P.L. 117-2, American Rescue Plan Act, Section 8003

Appendix F: Operations and Maintenance Details

Operations and Maintenance (Sustainment)					
(Dollars in Thousands)					
Congressional Program/Congressional Project	2020 Actuals	2021 President's Budget	2021 Enacted	2022 Budget Request	2021-2022 Increase / Decrease
Sustainment - Steady State	**$ 2,657,224**	**$ 2,785,215**	**$ 2,938,237**	**$ 2,903,864**	**$ (34,373)**
Health Operations and Maintenance	**$ 545,257**	**$ 762,251**	**$ 803,565**	**$ 823,853**	**$ 20,288**
IT Support Contracts	$ 109,899	$ 169,327	$ 169,327	$ 179,013	$ 9,686
Software Maintenance	$ 235,376	$ 139,965	$ 170,166	$ 149,753	$ (20,413)
Health Data Interoperability	$ 17,273	$ 55,178	$ 55,178	$ 104,356	$ 49,178
Health Data Interoperability - CARES Act	$ 8,576	$ -	$ -	$ -	$ -
Community Care	$ 26,598	$ 130,266	$ 130,266	$ 85,899	$ (44,367)
Community Care - CARES Act	$ 4,065	$ -	$ 3,231	$ -	$ (3,231)
Healthcare Administration Systems	$ 29,710	$ 80,440	$ 80,440	$ 74,467	$ (5,973)
Healthcare Administration Systems -CARES Act	$ 9,310	$ -	$ 90	$ -	$ (90)
Hardware Maintenance	$ 53,999	$ 43,231	$ 43,231	$ 43,000	$ (231)
Digital Health Platform	$ 5,162	$ 9,502	$ 9,502	$ 40,034	$ 30,532
Digital Health Platform - CARES Act	$ 844	$ -	$ -	$ -	$ -
Supply Chain Management	$ -	$ 44,400	$ 44,400	$ 31,158	$ (13,242)
Purchased Care	$ 4,611	$ 13,063	$ 13,063	$ 19,000	$ 5,937
Purchased Care - CARES Act	$ -	$ -	$ 1,566	$ -	$ (1,566)
Connected Health/Mobile Apps	$ 1,816	$ 12,000	$ 12,000	$ 14,230	$ 2,230
Connected Health/Mobile Apps - CARES Act	$ 9,472	$ -	$ 28	$ -	$ (28)
Pharmacy	$ 357	$ 10,490	$ 10,490	$ 14,128	$ 3,638
My HealtheVet	$ 7,424	$ 12,061	$ 12,061	$ 12,664	$ 603
My HealtheVet - CARES Act	$ 2,900	$ -	$ 319	$ -	$ (319)
Scheduling	$ 4,550	$ 22,757	$ 22,757	$ 12,150	$ (10,607)
Scheduling - CARES Act	$ 4,106	$ -	$ 3,210	$ -	$ (3,210)
Research	$ -	$ 1,114	$ 1,114	$ 11,425	$ 10,311
Telehealth Services	$ 1,522	$ 7,056	$ 7,056	$ 6,423	$ (633)
Registries	$ 1,611	$ 3,741	$ 3,741	$ 6,000	$ 2,259
Genomic Information System for Integrative Service (GenISIS)	$ 1,028	$ 2,194	$ 2,194	$ 5,279	$ 3,085
Access & Billing	$ -	$ 350	$ 350	$ 4,500	$ 4,150
Lab	$ 3,614	$ 3,988	$ 3,988	$ 4,044	$ 56
Registration, Eligibility, Enrollment	$ 208	$ 228	$ 228	$ 3,500	$ 3,272
Registration, Eligibility, Enrollment - CARES Act	$ 600	$ -	$ 2,668	$ -	$ (2,668)
Patient Records [System (CPRS)]	$ 309	$ -	$ -	$ 2,080	$ 2,080
Beneficiary Travel	$ 318	$ 900	$ 900	$ 750	$ (150)
Benefits Operations and Maintenance	**$ 216,611**	**$ 164,476**	**$ 169,715**	**$ 260,887**	**$ 91,172**
Veterans Customer Experience - VCE	$ 47,966	$ 24,630	$ 24,630	$ 81,063	$ 56,433
Veterans Customer Experience - VCE - CARES Act	$ -	$ -	$ 4,985	$ -	$ (4,985)
IT Support Contracts	$ 78,980	$ 79,070	$ 79,070	$ 79,000	$ (70)
Veterans Benefits Management	$ 35,090	$ 40,342	$ 40,342	$ 59,415	$ 19,073
Veterans Benefits Management - CARES Act	$ 15,428	$ -	$ 254	$ -	$ (254)
Other Benefits IT Systems	$ 5,370	$ 3,187	$ 3,187	$ 21,370	$ 18,183
Other Benefits IT Systems - CARES Act	$ 2,875	$ -	$ -	$ -	$ -
Benefits Appeals	$ 6,764	$ 4,850	$ 4,850	$ 9,100	$ 4,250
Benefit Systems	$ 3,458	$ 1,676	$ 1,676	$ 6,125	$ 4,449
Education Benefits	$ 13,448	$ 10,721	$ 10,721	$ 4,814	$ (5,907)
Education Benefits - CARES Act	$ 1,976	$ -	$ -	$ -	$ -
C&P Claims	$ 5,256	$ -	$ -	$ -	$ -
Corporate Operations and Maintenance	**$ 46,758**	**$ 173,744**	**$ 176,212**	**$ 269,480**	**$ 93,268**
IT Support Contracts	$ 2,374	$ 67,958	$ 67,958	$ 91,943	$ 23,985
TAC Fees [2/]	$ -	$ 75,257	$ 75,257	$ 69,921	$ (5,336)
TAC Fees - CARES Act [2/]	$ -	$ -	$ 2,468	$ -	$ (2,468)
Human Resources[1/]	$ 1,695	$ 2,644	$ 2,644	$ 69,571	$ 66,927
Financial and Acquisition Management Modernization[1/]	$ 10,816	$ 17,990	$ 17,990	$ 19,780	$ 1,790
Other Corporate IT Systems	$ 16,261	$ 3,697	$ 3,697	$ 16,315	$ 12,618
General Counsel	$ -	$ 3,376	$ 3,376	$ 1,950	$ (1,426)
Construction and Facilities Mgmt	$ 2,546	$ 2,822	$ 2,822	$ -	$ (2,822)
Supply Chain Management	$ 13,067	$ -	$ -	$ -	$ -

Operations and Maintenance (Sustainment) Detail Cont.					
(Dollars in Thousands)					
Congressional Program/Congressional Project	**2020 Actuals**	**2021 President's Budget**	**2021 Enacted**	**2022 Budget Request**	**2021-2022 Increase / Decrease**
Enterprise Operations and Maintenance	**$ 1,839,068**	**$ 1,664,282**	**$ 1,768,283**	**$ 1,526,872**	**$ (241,411)**
Telecommunications	$ 289,519	$ 276,084	$ 276,114	$ 274,047	$ (2,067)
Data Integration and Management	$ 168,273	$ 227,581	$ 229,016	$ 269,996	$ 40,980
Data Integration and Management - CARES Act	$ 140,314	$ -	$ 27,643	$ -	$ (27,643)
Cyber Security	$ 224,348	$ 224,189	$ 224,189	$ 257,781	$ 33,592
Cyber Security - CARES Act	$ 5,895	$ -	$ -	$ -	$ -
Software Maintenance	$ 415,920	$ 407,424	$ 407,424	$ 243,983	$ (163,441)
IT Support Contracts	$ 274,587	$ 283,368	$ 283,368	$ 161,725	$ (121,643)
IT Support Contracts - CARES Act	$ -	$ -	$ 462	$ -	$ (462)
Hardware Maintenance	$ 123,870	$ 105,636	$ 180,067	$ 91,814	$ (88,253)
Enterprise Service Desk	$ 50,060	$ 48,599	$ 48,599	$ 77,737	$ 29,138
End User Operations	$ -	$ -	$ -	$ 52,000	$ 52,000
Privacy & Records Management	$ 22,585	$ 38,447	$ 38,447	$ 42,000	$ 3,553
Network Operations Center	$ -	$ 50,862	$ 50,862	$ 39,866	$ (10,996)
Enterprise Command Center	$ -	$ -	$ -	$ 12,624	$ 12,624
Repositories	$ 1,422	$ 2,092	$ 2,092	$ 3,299	$ 1,207
Enterprise Infrastructure	$ 25,778	$ -	$ -	$ -	$ -
Activations	$ 490	$ -	$ -	$ -	$ -
Activations - CARES Act	$ 2,661	$ -	$ -	$ -	$ -
TAC Fees [2/]	$ 40,317	$ -	$ -	$ -	$ -
TAC Fees - CARES Act [2/]	$ 53,032	$ -	$ -	$ -	$ -
Memorial Operations and Maintenance	**$ 9,529**	**$ 20,462**	**$ 20,462**	**$ 22,772**	**$ 2,310**
IT Support Contracts	$ 95	$ 11,762	$ 11,762	$ 11,762	$ -
Memorials Automation	$ 6,696	$ 8,700	$ 8,700	$ 7,010	$ (1,690)
Memorials Legacy	$ 2,738	$ -	$ -	$ 4,000	$ 4,000

Operations and Maintenance (Sustainment) Detail Cont.					
(Dollars in Thousands)					
Congressional Program/Congressional Project	**2020 Actuals**	**2021 President's Budget**	**2021 Enacted**	**2022 Budget Request**	**2021-2022 Increase / Decrease**
Sustainment - Enhancement	**$ 810,411**	**$ 128,414**	**$ 675,038**	**$ 369,575**	**$ (305,463)**
Health Operations and Maintenance	**$ 46,730**	**$ -**	**$ 9,894**	**$ 43,407**	**$ 33,513**
Community Care	$ -	$ -	$ -	$ 11,469	$ 11,469
Community Care - CARES Act	$ 19,726	$ -	$ -	$ -	$ -
Healthcare Administration Systems	$ 7,725	$ -	$ -	$ 7,956	$ 7,956
Healthcare Administration Systems - CARES Act	$ 3,235	$ -	$ 6,250	$ -	$ (6,250)
Purchased Care	$ -	$ -	$ -	$ 7,447	$ 7,447
Purchased Care - CARES Act	$ 1,674	$ -	$ -	$ -	$ -
Health Data Interoperability	$ -	$ -	$ -	$ 4,851	$ 4,851
Health Data Interoperability - CARES Act	$ 1,228	$ -	$ -	$ -	$ -
Registries	$ -	$ -	$ -	$ 2,500	$ 2,500
Beneficiary Travel	$ -	$ -	$ -	$ 2,000	$ 2,000
Pharmacy	$ -	$ -	$ -	$ 1,900	$ 1,900
Pharmacy - CARES Act	$ 2,819	$ -	$ -	$ -	$ -
My HealtheVet	$ -	$ -	$ -	$ 1,816	$ 1,816
Research	$ -	$ -	$ -	$ 1,488	$ 1,488
Digital Health Platform	$ -	$ -	$ -	$ 1,000	$ 1,000
Patient Records [System (CPRS)]	$ -	$ -	$ -	$ 980	$ 980
Telehealth Services	$ 275	$ -	$ -	$ -	$ -
Telehealth Services - CARES Act	$ 1,567	$ -	$ -	$ -	$ -
Access & Billing	$ 339	$ -	$ -	$ -	$ -
Hardware Maintenance - CARES Act	$ 5,450	$ -	$ 1,544	$ -	$ (1,544)
Registration, Eligibility, Enrollment - CARES Act	$ 2,692	$ -	$ 2,100	$ -	$ (2,100)
Benefits Operations and Maintenance	**$ 40,610**	**$ 3,200**	**$ 10,122**	**$ 15,387**	**$ 5,265**
Veterans Customer Experience (VCE)	$ 5,936	$ 3,200	$ 3,200	$ 9,579	$ 6,379
Veterans Customer Experience (VCE) - CARES Act	$ 31,435	$ -	$ 6,922	$ -	$ (6,922)
Veterans Benefits Management	$ -	$ -	$ -	$ 5,808	$ 5,808
Benefits Appeals	$ 3,238	$ -	$ -	$ -	$ -
Corporate Operations and Maintenance	**$ 9,644**	**$ -**	**$ -**	**$ 103,106**	**$ 103,106**
Financial and Acquisition Management Modernization	$ -	$ -	$ -	$ 103,106	$ 103,106
Other Corporate IT Systems	$ 6,061	$ -	$ -	$ -	$ -
Human Resources - CARES Act	$ 3,000	$ -	$ -	$ -	$ -
General Counsel	$ 583	$ -	$ -	$ -	$ -
Enterprise Operations and Maintenance	**$ 713,429**	**$ 125,214**	**$ 655,022**	**$ 195,477**	**$ (459,545)**
Activations	$ 48,012	$ 48,802	$ 48,802	$ 112,072	$ 63,270
IT Service Management	$ -	$ 18,682	$ 18,682	$ 55,660	$ 36,978
Cyber Security	$ 37,030	$ 45,730	$ 45,730	$ 27,745	$ (17,985)
Cyber Security - CARES Act	$ 14,592	$ -	$ 15,066	$ -	$ (15,066)
Data Integration and Management	$ 1,727	$ 12,000	$ 12,000	$ -	$ (12,000)
Data Integration and Management - CARES Act	$ 53,954	$ -	$ 38,045	$ -	$ (38,045)
Activations - CARES Act	$ 338,141	$ -	$ 278,724	$ -	$ (278,724)
Hardware Maintenance	$ 8	$ -	$ -	$ -	$ -
Hardware Maintenance - CARES Act	$ 14,309	$ -	$ 11,897	$ -	$ (11,897)
Software Maintenance	$ 1,469	$ -	$ -	$ -	$ -
Software Maintenance - CARES Act	$ 88,592	$ -	$ 53,632	$ -	$ (53,632)
Enterprise Service Desk - CARES Act	$ 4,004	$ -	$ 10,964	$ -	$ (10,964)
IT Support Contracts - CARES Act	$ 42,571	$ -	$ 17,846	$ -	$ (17,846)
Telecommunications - CARES Act	$ 69,020	$ -	$ 103,634	$ -	$ (103,634)
Memorial Operations and Maintenance	**$ -**	**$ -**	**$ -**	**$ 12,198**	**$ 12,198**
Memorials Automation	$ -	$ -	$ -	$ 12,198	$ 12,198

Operations and Maintenance (Sustainment) Detail Cont.					
(Dollars in Thousands)					
Congressional Program/Congressional Project	2020 Actuals	2021 President's Budget	2021 Enacted	2022 Budget Request	2021-2022 Increase / Decrease
Sustainment -Modernization	**$ 248,407**	**$ 291,587**	**$ 441,933**	**$ 528,146**	**$ 86,213**
Health Operations and Maintenance	**$ 2,674**	**$ -**	**$ -**	**$ -**	**$ -**
Community Care - CARES Act	$ 2,674	$ -	$ -	$ -	$ -
Benefits Operations and Maintenance	**$ 15,890**	**$ 7,990**	**$ 10,461**	**$ -**	**$ (10,461)**
Veterans Customer Experience (VCE)	$ 470	$ 7,990	$ 7,990	$ -	$ (7,990)
Veterans Customer Experience (VCE) - CARES Act	$ 15,420	$ -	$ 2,471	$ -	$ (2,471)
Enterprise Operations and Maintenance	**$ 229,843**	**$ 281,697**	**$ 429,572**	**$ 528,146**	**$ 98,574**
Infrastructure Readiness Program (IRP)[1/]	$ 172,774	$ 250,585	$ 250,585	$ 477,543	$ 226,958
Infrastructure Readiness Program (IRP) - CARES Act	$ 20	$ -	$ 104,977	$ -	$ (104,977)
Cyber Security	$ 19,362	$ 21,738	$ 21,738	$ 22,022	$ 284
Cyber Security - CARES Act	$ -	$ -	$ 2,197	$ -	$ (2,197)
Telecommunications	$ -	$ 8,000	$ 8,000	$ 18,458	$ 10,458
Data Integration and Management	$ 156	$ 1,374	$ 1,374	$ 10,123	$ 8,749
Data Integration and Management - CARES Act	$ 37,509	$ -	$ 40,701	$ -	$ (40,701)
Repositories	$ 22	$ -	$ -	$ -	$ -
Memorial Operations and Maintenance	**$ -**	**$ 1,900**	**$ 1,900**	**$ -**	**$ (1,900)**
Memorials Automation	$ -	$ 1,900	$ 1,900	$ -	$ (1,900)
GRAND TOTAL	**$ 3,716,042**	**$ 3,205,216**	**$ 4,055,208**	**$ 3,801,585**	**$ (253,623)**

Note: Numbers may not add due to rounding.
2020 Actuals includes prior year unobligated balance brought forward and CARES act funds. The 2021 Enacted column includes prior year unobligated balance brought forward and CARES act funds
Table does not include $100 million provided for Supply Chain Modernization under P.L. 117-2, American Rescue Plan Act, Section 8003
[1/] In 2022, Congressional Projects will be funded by Recurring Expenses Transformational Fund
[2/] Technology Acquisition Center (TAC) Fee realigned from Enterprise Portfolio to Corporate Portfolio for 2021

Appendix G: Amounts Available for Obligation

Information and Technology Systems Appropriation/Obligations (Dollars in thousands)					
	2020/2021	2021		2022	2021 - 2022
Description	Actuals	President's Budget	Enacted	Budget Request	Increase / Decrease
IT Systems Appropriation	**$4,371,615**	**$4,912,000**	**$4,912,000**	**$4,842,800**	**-$69,200**
Rescission from Unobligated Balance			**-$37,500**		**$37,500**
Total IT Appropriations	**$4,371,615**	**$4,912,000**	**$4,874,500**	**$4,842,800**	**-$31,700**
Reimbursements					
IT Non-Pay Reimbursements	$76,051	$58,941	$89,784	$68,951	-$20,833
IT Pay Reimbursements	$13,191	$16,647	$15,216	$19,161	$3,945
Total Reimbursements	**$89,242**	**$75,588**	**$105,000**	**$88,112**	**-$16,888**
Budgetary Resources	**$4,460,857**	**$4,987,588**	**$4,979,500**	**$4,930,912**	**-$48,588**
Adjustments to Obligations					
Unobligated Balance (SOY)	$111,701		$207,710		-$207,710
Unobligated Balance (EOY)	-$207,710				
Veterans Choice Act 801 (SOY)	$4,439		$2,039		-$2,039
Unobligated Choice Act 801 (EOY)	-$2,039				
CARES Act, P.L. 116-136 (SOY)	$2,150,000		$973,938		-$973,938
CARES Act, P.L. 116-136 (EOY)	-$973,938				
VHA CARES Act Transfer (P.L.116-270)			$45,000		-$45,000
American Rescue Plan [P.L. 117-2 Section 8003] (SOY)			$100,000	$100,000	$0
American Rescue Plan [P.L. 117-2 Section 8003] (EOY)			-$100,000		
OEF/OIF Supplemental (P.L. 110-28) (SOY)	$2,240				
OEF/OIF Supplemental unobligated (EOY)					
North Chicago Transfers	-$7,780	-$8,085	-$8,085	-$7,993	$92
Appropriations transferred from other accounts (Treas Acct)[1/]				$670,000	$670,000
Recoveries	$2,722				
Change in Unobligated Balance (non-add)	**$1,079,635**	**-$8,085**	**$1,220,602**	**$762,007**	**-$350,885**
Unobligated Balance Expiring (Lapse)	-$423				
Total Obligations	**$5,540,069**	**$4,979,503**	**$6,200,102**	**$5,692,919**	**-$399,473**
Outlays, Gross	**$5,010,000**	**$4,848,000**	**$5,826,000**	**$5,019,000**	**-$807,000**
Less Collections	-$89,242	-$75,588	-$105,000	-$88,112	$16,888
Outlays, Net	**$4,920,758**	**$4,772,412**	**$5,721,000**	**$4,930,888**	**-$790,112**
Direct civilian full-time equivalent employment	7,656	7,772	8,168	8,668	500
Reimbursable civilian full-time equivalent employment	71	113	83	98	15
CARES Act , P.L. 116-136 civilian full-time equivalent employment	101		903		
Total Full Time Equivalents (FTE)	**7,828**	**7,885**	**9,154**	**8,766**	**-388**

Note: Numbers may not add due to rounding
1/Reflects transfer to OIT from Recurring Expenses Transformational Fund

Appendix H: Object Classification

(Dollars in Thousands)	2020	2021		2022	2021 - 2022
	Actuals	President's Budget	Enacted	Budget Request	Increase / Decrease
Direct Obligations:					
Personnel Compensation:					
Full-time permanent	747,729	792,253	910,025	942,873	32,848
Full-time permanent - Choice Act, (P.L. 113-146, Sec. 801)					
Full-time permanent - CARES Act, (P.L. 116-136)	58,030		144,316		
Total Personnel Compensation	**$805,759**	**$792,253**	**$1,054,340**	**$942,873**	**-$111,467**
Civilian personnel benefits	292,868	261,751	303,341	314,157	10,816
Civilian personnel benefits - CARES Act, (P.L.116-136)	3,334		48,105		
Travel and transportation of persons	3,586	14,078	14,079	13,047	-1,032
Communications, utilities, and miscellaneous charges	1,062,306	1,061,700	1,056,784	979,324	-77,459
Communications, utilities, and miscellaneous chargess - Choice Act, (P.L.113-146, Sec. 801)	62				
Communications, utilities, and miscellaneous charges - CARES Act, (P.L. 116-136)	719		509		
Other services from non-Federal sources	1,714,989	2,092,866	2,111,212	1,956,466	-154,746
Other services from non-Federal - Choice Act, (P.L.113-146, Sec. 801)	2,819		2,039		
Other services from non-Federal - CARES Act, (P.L. 116-136)	750,749		562,735		
Other services from non-Federal sources - American Rescue Plan [P.L. 117-2 Section 8003]				100,000	
Other services from non-Federal sources - Recurring Expenses Transformational Fund				670,000	
Supplies and materials	10,028	17,379	21,053	19,509	-1,543
Supplies and materials - Choice Act, (P.L. 113-146, Sec. 801)	-7				
Supplies and materials - CARES Act, (P.L. 116-136)	32		23		
Equipment	440,036	663,688	657,233	609,060	-48,173
Equipment - Choice Act, (P.L. 113-146, Sec. 801)	-17				
Equipment - CARES Act, (P.L. 116-136)	363,198		263,250		
Land and structures	139				
Land and structures - Choice Act, (P.L. 113-146, Sec. 801)	-3				
Insurance claims and indemnities	228	200	400	370	-29
Subtotal, Direct obligations	**$5,450,827**	**$4,903,915**	**$6,095,102**	**$5,604,807**	**-$490,295**
Reimbursable obligations:					
Personal compensation:					
Full-time permanent	8,212	10,130	9,351	11,914	2,563
Civilian personnel benefits	2,224	3,377	3,117	3,971	854
Communications, utilities, and miscellaneous charges	6,892	6,446	7,337	6,747	-590
Other services from non-Federal sources	51,474	39,399	54,536	48,431	-6,105
Equipment	20,440	16,236	30,658	17,048	-13,610
Subtotal, Reimbursable obligations	**$89,242**	**$75,588**	**$105,000**	**$88,112**	**-$16,888**
Total new obligations, unexpired accounts	**$5,540,069**	**$4,979,503**	**$6,200,102**	**$5,692,919**	**-$507,183**

Note: Numbers may not add due to rounding

Appendix I: Budgetary Resources

Office of Information and Technology Budgetary Resources (Dollars in Thousands)	2020	2021		2022	2021 - 2022
	Actuals	President's Budget	Enacted	Budget Request	Increase / Decrease
Budgetary resources:					
Unobligated balance:					
Unobligated balance brought forward, Oct 1	118,380		209,749		-209,749
Unobligated balance brought forward, Oct 1 - CARES Act, (P.L. 116-136)			973,938		-973,938
Unobligated balance brought forward, Oct 1 - American Rescue Plan [P.L. 117-2 Section 8003]				100,000	100,000
Recoveries of prior year paid obligations	2,722				
Unobligated balance (total)	**$121,102**		**$1,183,687**	**$100,000**	**-$1,083,687**
Budget authority:					
Appropriation	**$4,371,615**	**$4,912,000**	**$4,912,000**	**$4,842,800**	**-$69,200**
Appropriations transferred to other accounts [1/]	-7,780	-8,085	-8,085	-7,993	92
Rescission from Unobligated Balance			-37,500		37,500
CARES Act, (P.L. 116-136)	2,150,000				
VHA CARES Act Transfer (P.L.116-270)			45,000		-45,000
American Rescue Plan [P.L. 117-2 Section 8003]			100,000		-100,000
Recurring Expenses Transformational Fund				670,000	670,000
Appropriation (total)	**$6,513,835**	**$4,903,915**	**$5,011,415**	**$5,504,807**	**$493,392**
Spending authority from offsetting collections:					
Collected	89,242	75,588	105,000	88,112	-16,888
Spending authority from offsetting collections, (total)	**$89,242**	**$75,588**	**$105,000**	**$88,112**	**-$16,888**
Budget authority (total)	**$6,603,077**	**$4,979,503**	**$5,116,415**	**$5,592,919**	**$476,504**
Total budgetary resources available	**$6,724,179**	**$4,979,503**	**$6,300,102**	**$5,692,919**	**-$607,183**
Unobligated balance expiring	-423				
Unexpired unobligated balance, end of year	-209,749				
Unexpired unobligated balance, end of year - CARES Act, (P.L. 116-136)	-973,938				
Unexpired unobligated balance, end of year - American Rescue Plan [P.L. 117-2 Section 8003]			-100,000		

1/ Reflects transfers from OIT to the North Chicago Facility

Appendix J: Staffing and Admin Support by Object Class

Staffing & Administrative Support Services by Object Class (Dollars in Thousands)	2020	2021		2022	2021-2022
	Actuals	President's Budget	Enacted	Budget Request	Increase / Decrease
Total Full-Time Equivalent (FTE) Employment	**7,828**	**7,885**	**9,154**	**8,766**	**-388**
Direct civilian full-time equivalent employment	7,656	7,772	8,168	8,668	500
Reimbursable civilian full-time equivalent employment	71	113	83	98	15
CARES Act , P.L. 116-136 civilian full-time equivalent employment	101		903		-903
Direct Obligations:					
Personnel compensation:					
Full-time permanent	747,729	792,253	910,025	942,873	32,848
Full-time permanent - CARES Act, P.L. 116-136	58,030		144,316		-144,316
Total personnel compensation	**$805,759**	**$792,253**	**$1,054,340**	**$942,873**	**-$111,467**
Civilian personnel benefits	292,868	261,751	303,341	314,157	10,816
Civilian personnel benefits - CARES Act, P.L.116-136	3,334		48,105		-48,105
Travel and transportation of persons	3,577	14,000	14,000	10,000	-4,000
Communications, utilities, and miscellaneous charges	21,670	31,867			
Communications, utilities, and miscellaneous charges - CARES Act, P.L. 116-136	18				
Other services from non-Federal	103,382	96,216	8,540	137,413	128,873
Other services from non-Federal - CARES Act, P.L. 116-136	88,597		25,620		-25,620
Supplies and materials	631	4,874	4,874	5,000	126
Equipment	1,564	5,455			
Equipment - CARES Act, P.L. 116-136	400		124		-124
Land and structures	79				
Insurance claims and indemnities	228	400	400	400	
Direct obligations	1,322,106	1,206,816	1,459,344	1,409,843	-49,501
Reimbursable obligations	13,191	16,647	15,216	19,161	3,945
Total new obligations, unexpired accounts	**$1,335,297**	**$1,223,463**	**$1,474,559**	**$1,429,004**	**-$45,555**

Note: Numbers may not add due to rounding

Appendix K: Employment Summary – FTE by Grade

Employment Summary - FTE by Grade							
	2020 Actuals		2021	2021 Enacted		2022	2021-222
# of FTE	Base Appropriation & RA	CARES Act	President's Budget Base Appropriation	Base Appropriation & RA	CARES Act	Base Appropriation & RA Request	Increase/ Decrease
SES	35	-	31	36	2	39	3
GS-15	237	1	230	257	5	273	16
GS-14	1,082	4	1,065	1,164	37	1,237	73
GS-13	2,533	10	2,523	2,882	90	3,062	180
GS-12	1,487	5	1,467	1,549	41	1,646	97
GS-11	1,960	38	1,988	2,016	342	2,142	126
GS-10	2	-	1	2	-	2	-
GS-9	254	20	325	247	175	262	15
GS-8	1	-	2	2	-	2	-
GS-7	106	23	208	67	207	71	4
GS-6	24	-	39	23	3	25	2
GS-5	5	-	5	5	1	5	-
GS-4	1	-	1	1	-	-	(1)
GS-3	-	-	-	-	-	-	-
GS-2	-	-	-	-	-	-	-
GS-1	-	-	-	-	-	-	-
TITLE 38	-	-	-	-	-	-	-
Wage Grade (non-GS)	-	-	-	-	-	-	-
Total Number of FTE	**7,727**	**101**	**7,885**	**8,251**	**903**	**8,766**	**515**

Note: Numbers may not add due to rounding
Table includes reimbursable and Budget Authority (BA) FTE's

Appendix L: Staffing and Admin Support by OIT Organizations

(Dollars in thousands)	2020 Actuals		2021 President's Budget		2021 Enacted		2022 Budget Request	
	Staffing	Administrative Support Services	Staffing	Administrative Support Services	Staffing	Administrative Support Services	Staffing	Administrative Support Services
ITOPS	$ 685,558	$ 3,208	$ 700,454	$ 5,490	$ 809,020	$ 5,490	$ 894,630	$ 5,822
ITOPS - CARES Act	$ 59,077	$ 82,914	$ -	$ -	$ 128,333	$ 4,796	$ -	$ -
EPMO	$ 196,012	$ 5,374	$ 207,030	$ 701	$ 202,740	$ 701	$ 175,998	$ 5,198
EPMO - CARES Act	$ 1,502	$ -	$ -	$ -	$ 12,546	$ -	$ -	$ -
OIS	$ 42,193	$ 876	$ 38,723	$ 1,034	$ 48,323	$ 1,034	$ 40,737	$ 1,063
OIS - CARES Act	$ 68	$ -	$ -	$ -	$ 3,438	$ -	$ -	$ -
QPR	$ 35,295	$ 459	$ 26,158	$ 722	$ 47,078	$ 722	$ 41,607	$ 1,877
QPR - CARES Act	$ 63	$ 3,031	$ -	$ -	$ 5,856	$ 2,509	$ -	$ -
ITRM	$ 35,667	$ 116,951	$ 43,903	$ 143,444	$ 42,450	$ 18,444	$ 38,240	$ 122,001
ITRM - CARES Act	$ 202	$ 2,499	$ -	$ -	$ 37,903	$ 16,839	$ -	$ -
DevSecOps	$ 20,056	$ 1	$ 14,892	$ -	$ 26,047	$ -	$ 31,604	$ -
DevSecOps - CARES Act	$ 155	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Strategic Sourcing	$ 18,604	$ 758	$ 16,402	$ 1,101	$ 24,046	$ 1,101	$ 22,761	$ 1,121
Strategic Sourcing - CARES Act	$ 239	$ 571	$ -		$ 1,855	$ -	$ -	$ -
AMO	$ 7,211	$ 3,503	$ 6,442	$ 321	$ 13,662	$ 321	$ 11,453	$ 15,731
AMO - CARES Act	$ 58	$ -	$ -	$ -	$ 2,490	$ 1,600	$ -	$ -
Total [1/]	**$ 1,101,961**	**$ 220,145**	**$ 1,054,004**	**$ 152,813**	**$ 1,405,787**	**$ 53,557**	**$ 1,257,030**	**$ 152,813**

Numbers exclude reimbursements and transfers
1/ After North Chicago Transfer

Appendix M: Portfolio Details

Health Portfolio

Congressional Project *(Dollars in thousands)*	2020/2021 Year 1 Actuals DEV	2020/2021 Year 1 Actuals OM	2020/2021 Year 2 of 2 year Availability DEV	2020/2021 Year 2 of 2 year Availability OM	2021 Enacted DEV	2021 Enacted OM	2022 Budget Request DEV	2022 Budget Request OM	2021-2022 Increase/ Decrease
IT Support Contracts	$ -	$ 109,899	$ -	$ -	$ -	$ 169,327	$ -	$ 179,013	$ 9,686
Software Maintenance	$ -	$ 235,376	$ -	$ 30,201	$ -	$ 139,965	$ -	$ 149,753	$ 9,788
Community Care	$ 40,740	$ 26,598	$ 6,768	$ -	$ 21,190	$ 130,266	$ 34,853	$ 97,368	$ (19,235)
Community Care - CARES Act	$ -	$ 26,465	$ -	$ 3,231	$ -	$ -	$ -	$ -	$ -
Health Data Interoperability	$ 8,719	$ 17,273	$ 2,017	$ -	$ 8,423	$ 55,178	$ 2,125	$ 109,207	$ 47,731
Health Data Interoperability - CARES Act	$ -	$ 9,804	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Supply Chain Management[1/]	$ -	$ -	$ -	$ -	$ 67,120	$ 44,400	$ 76,105	$ 31,158	$ (4,257)
Healthcare Administration Systems	$ 9,557	$ 37,435	$ 2	$ -	$ 11,160	$ 80,440	$ 20,710	$ 82,423	$ 11,533
Healthcare Administration Systems - CARES Act	$ 6,197	$ 12,545	$ 3	$ 6,340	$ -	$ -	$ -	$ -	$ -
Digital Health Platform	$ 5,808	$ 5,162	$ -	$ -	$ 9,867	$ 9,502	$ 11,807	$ 41,034	$ 33,472
Digital Health Platform CARES Act	$ -	$ 844	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Hardware Maintenance	$ -	$ 53,999	$ -	$ -	$ -	$ 43,231	$ -	$ 43,000	$ (231)
Hardware Maintenance - CARES Act	$ -	$ 5,450	$ -	$ 1,544	$ -	$ -	$ -	$ -	$ -
Purchased Care	$ 6,972	$ 4,611	$ 4,200	$ -	$ 8,410	$ 13,063	$ 6,836	$ 26,447	$ 11,810
Purchased Care - CARES Act	$ -	$ 1,674	$ -	$ 1,566	$ -	$ -	$ -	$ -	$ -
Research	$ -	$ -	$ -	$ -	$ 3,120	$ 1,114	$ 8,660	$ 12,913	$ 17,339
My HealtheVet	$ 10,580	$ 7,424	$ 12	$ -	$ 3,200	$ 12,061	$ 4,684	$ 14,480	$ 3,903
My HealtheVet - CARES Act	$ -	$ 2,900	$ -	$ 319	$ -	$ -	$ -	$ -	$ -
Pharmacy	$ 5,262	$ 357	$ 261	$ -	$ 11,010	$ 10,490	$ -	$ 16,028	$ (5,472)
Pharmacy - CARES Act	$ -	$ 2,819	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Connected Health/Mobile Apps	$ -	$ 1,816	$ -	$ -	$ -	$ 12,000	$ -	$ 14,230	$ 2,230
Connected Health/Mobile Apps - CARES Act	$ -	$ 9,472	$ -	$ 28	$ -	$ -	$ -	$ -	$ -
Telehealth Services	$ 5,772	$ 1,797	$ 86	$ -	$ 5,600	$ 7,056	$ 6,600	$ 6,423	$ 367
Telehealth Services - CARES Act	$ -	$ 1,567	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Scheduling	$ -	$ 4,550	$ -	$ -	$ -	$ 22,757	$ -	$ 12,150	$ (10,607)
Scheduling - CARES Act	$ -	$ 4,106	$ -	$ 3,210	$ -	$ -	$ -	$ -	$ -
Patient Records [System (CPRS)]	$ 6,183	$ 309	$ 1,700	$ -	$ 7,750	$ -	$ 9,000	$ 3,060	$ 4,310
Registries	$ 2,550	$ 1,611	$ 1,000	$ -	$ 200	$ 3,741	$ -	$ 8,500	$ 4,559
Genomic Information System for Integrative Service (GenISIS)	$ -	$ 1,028	$ -	$ -	$ -	$ 2,194	$ -	$ 5,279	$ 3,085
Access & Billing	$ 50	$ 339	$ -	$ -	$ -	$ 350	$ -	$ 4,500	$ 4,150
Lab	$ -	$ 3,614	$ -	$ -	$ -	$ 3,988	$ -	$ 4,044	$ 56
Registration, Eligibility, Enrollment	$ -	$ 208	$ -	$ -	$ -	$ 228	$ -	$ 3,500	$ 3,272
Registration, Eligibility, Enrollment - CARES Act	$ -	$ 3,292	$ -	$ 4,768	$ -	$ -	$ -	$ -	$ -
Beneficiary Travel	$ -	$ 318	$ -	$ -	$ 2,540	$ 900	$ -	$ 2,750	$ (690)
Total Health Portfolio	**$ 108,390**	**$ 594,661**	**$ 16,049**	**$ 51,208**	**$ 159,590**	**$ 762,251**	**$ 181,380**	**$ 867,260**	**$ 126,799**

Table does not include $100 million provided for Supply Chain Modernization under P.L. 117-2, American Rescue Plan Act, Section 8003
1/ Supply Chain Management Congressional Project was realigned to the Health Portfolio in 2021

Benefits Portfolio

Congressional Project (Dollars in thousands)	2020/2021 Year 1 Actuals DEV	2020/2021 Year 1 Actuals OM	2020/2021 Year 2 of 2 year Availability DEV	2020/2021 Year 2 of 2 year Availability OM	2021 Enacted DEV	2021 Enacted OM	2022 Budget Request DEV	2022 Budget Request OM	2021-2022 Increase/ Decrease
Veterans Customer Experience - VCE	$ 52,313	$ 54,372	$ 3,352	$ -	$ 66,296	$ 35,820	$ 9,880	$ 90,642	$ (1,594)
Veterans Customer Experience - VCE - CARES Act	$ -	$ 46,855	$ -	$ 14,378	$ -	$ -	$ -	$ -	$ -
Education Benefits	$ 20,687	$ 13,448	$ -	$ -	$ 27,230	$ 10,721	$ 50,000	$ 4,814	$ 16,863
Education Benefits - CARES Act	$ -	$ 1,976	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Education Benefits - VHA CARES Act Transfer	$ -	$ -	$ -	$ -	$ 45,000	$ -	$ -	$ -	$ (45,000)
Veterans Benefits Management	$ 33,276	$ 35,090	$ 161	$ -	$ 39,230	$ 40,342	$ 14,285	$ 65,223	$ (64)
Veterans Benefits Management - CARES Act	$ -	$ 15,428	$ -	$ 254	$ -	$ -	$ -	$ -	$ -
IT Support Contracts	$ -	$ 78,980	$ -	$ -	$ -	$ 79,070	$ -	$ 79,000	$ (70)
Benefit Systems	$ 36,504	$ 3,458	$ 2,457	$ -	$ 20,630	$ 1,676	$ 9,825	$ 6,125	$ (6,356)
Other Benefits IT Systems	$ -	$ 5,370	$ -	$ -	$ 830	$ 3,187	$ -	$ 21,370	$ 17,353
Other Benefits IT Systems - CARES Act	$ -	$ 2,875	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Benefits Appeals	$ 5,741	$ 10,002	$ -	$ -	$ 6,000	$ 4,850	$ 3,400	$ 9,100	$ 1,650
C&P Claims	$ 4,255	$ 5,256	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Benefits Portfolio	**$ 152,776**	**$ 273,110**	**$ 5,970**	**$ 14,632**	**$ 205,216**	**$ 175,666**	**$ 87,390**	**$ 276,274**	**$ (17,218)**

Memorials Portfolio

Congressional Project (Dollars in thousands)	2020/2021 Year 1 Actuals DEV	2020/2021 Year 1 Actuals OM	2020/2021 Year 2 of 2 year Availability DEV	2020/2021 Year 2 of 2 year Availability OM	2021 Enacted DEV	2021 Enacted OM	2022 Budget Request DEV	2022 Budget Request OM	2021-2022 Increase/ Decrease
Memorials Automation	$ 14,460	$ 6,696	$ 1,861	$ -	$ 15,130	$ 10,600	$ 9,030	$ 19,208	$ 2,508
IT Support Contracts	$ -	$ 95	$ -	$ -	$ -	$ 11,762	$ -	$ 11,762	$ -
Memorials Legacy	$ -	$ 2,738	$ -	$ -	$ -	$ -	$ -	$ 4,000	$ 4,000
Total Memorial Affairs Portfolio	**$ 14,460**	**$ 9,529**	**$ 1,861**	**$ -**	**$ 15,130**	**$ 22,362**	**$ 9,030**	**$ 34,970**	**$ 6,508**

Corporate Portfolio

Congressional Project (Dollars in thousands)	2020/2021 Year 1 Actuals DEV	2020/2021 Year 1 Actuals OM	2020/2021 Year 2 of 2 year Availability DEV	2020/2021 Year 2 of 2 year Availability OM	2021 Enacted DEV	2021 Enacted OM	2022 Budget Request DEV	2022 Budget Request OM	2021-2022 Increase/ Decrease
Financial and Acquisition Management Modernization[1/]	$ 58,525	$ 10,816	$ 4,440	$ -	$ 93,070	$ 17,990	$ -	$ 122,886	$ 11,826
IT Support Contracts	$ -	$ 2,374	$ -	$ -	$ -	$ 67,958	$ -	$ 91,943	$ 23,985
TAC Fees[2/]	$ -	$ -	$ -	$ -	$ -	$ 75,257	$ -	$ 69,921	$ (5,336)
TAC Fees[2/] - CARES Act	$ -	$ -	$ -	$ 2,468	$ -	$ -	$ -	$ -	$ -
Human Resources[1/]	$ 6,799	$ 1,695	$ -	$ -	$ 13,980	$ 2,644	$ -	$ 69,571	$ 52,947
Human Resources[1/] - CARES Act	$ -	$ 3,000	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Other IT Corporate Systems	$ -	$ 22,322	$ 568	$ -	$ 3,500	$ 3,697	$ -	$ 16,315	$ 9,118
General Counsel	$ -	$ 583	$ -	$ -	$ 4,000	$ 3,376	$ -	$ 1,950	$ (5,426)
Construction and Facilities Mgmt	$ -	$ 2,546	$ -	$ -	$ -	$ 2,822	$ -	$ -	$ (2,822)
Supply Chain Management	$ 21,596	$ 13,067	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Innovations	$ 1,715	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Corporate Portfolio	**$ 88,635**	**$ 56,402**	**$ 5,008**	**$ 2,468**	**$ 114,550**	**$ 173,744**	**$ -**	**$ 372,586**	**$ 84,292**

1/ In 2022, Congressional Projects will be funded by Recurring Expenses Transformational Fund
2/ TAC Fee realigned from Enterprise Portfolio to Corporate Portfolio for 2021

Enterprise Portfolio

Congressional Project (Dollars in thousands)	2020/2021 Year 1 Actuals DEV	2020/2021 Year 1 Actuals OM	2020/2021 Year 2 of 2 year Availability DEV	2020/2021 Year 2 of 2 year Availability OM	2021 Enacted DEV	2021 Enacted OM	2022 Budget Request DEV	2022 Budget Request OM	2021-2022 Increase/ Decrease
Infrastructure Readiness Program (IRP)[1/]	$ -	$ 172,774	$ -	$ -	$ -	$ 250,585	$ -	$ 477,543	$ 226,958
Infrastructure Readiness Program (IRP)[1/] - CARES Act	$ -	$ 20	$ -	$ 104,977	$ -	$ -	$ -	$ -	$ -
Cyber Security[2/]	$ 16,600	$ 280,739		$ -	$ 11,380	$ 291,657	$ 11,200	$ 307,548	$ 15,711
Cyber Security - CARES Act	$ -	$ 20,487	$ -	$ 17,263	$ -	$ -	$ -	$ -	$ -
Telecommunications	$ -	$ 289,519	$ -	$ 30	$ -	$ 284,084	$ -	$ 292,505	$ 8,421
Telecommunications - CARES Act	$ -	$ 69,020	$ -	$ 103,634	$ -	$ -	$ -	$ -	$ -
Data Integration and Management	$ 20,655	$ 170,156	$ 866	$ 1,435	$ 34,680	$ 240,955	$ 8,000	$ 280,119	$ 12,484
Data Integration and Management - CARES Act	$ 3,802	$ 231,778	$ 11,874	$ 106,389	$ -	$ -	$ -	$ -	$ -
Software Maintenance	$ -	$ 417,389	$ -	$ -	$ -	$ 407,424	$ -	$ 243,983	$ (163,441)
Software Maintenance - CARES Act	$ -	$ 88,592	$ -	$ 53,632	$ -	$ -	$ -	$ -	$ -
IT Support Contracts	$ -	$ 274,587	$ -	$ -	$ -	$ 283,368	$ -	$ 161,725	$ (121,643)
IT Support Contracts- CARES Act	$ -	$ 42,571	$ -	$ 18,308	$ -	$ -	$ -	$ -	$ -
Activations	$ -	$ 48,502	$ -	$ -	$ -	$ 48,802	$ -	$ 112,072	$ 63,270
Activations - CARES Act	$ -	$ 340,802	$ -	$ 278,724	$ -	$ -	$ -	$ -	$ -
Hardware Maintenance	$ -	$ 123,877	$ -	$ 74,431	$ -	$ 105,636	$ -	$ 91,814	$ (13,822)
Hardware Maintenance - CARES Act	$ -	$ 14,309	$ -	$ 11,897	$ -	$ -	$ -	$ -	$ -
Enterprise Service Desk	$ -	$ 50,060	$ -	$ -	$ -	$ 48,599	$ -	$ 77,737	$ 29,138
Enterprise Service Desk - CARES Act	$ -	$ 4,004	$ -	$ 10,964	$ -	$ -	$ -	$ -	$ -
IT Service Management	$ -	$ -	$ -	$ -	$ -	$ 18,682	$ -	$ 55,660	$ 36,978
End User Operations	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 52,000	$ 52,000
Privacy & Records Management[2/]	$ -	$ 22,585	$ -	$ -	$ -	$ 38,447	$ -	$ 42,000	$ 3,553
Network Operations Center	$ -	$ -	$ -	$ -	$ -	$ 50,862	$ -	$ 39,866	$ (10,996)
Enterprise Command Center	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,624	$ 12,624
Repositories	$ -	$ 1,443	$ -	$ -	$ -	$ 2,092	$ -	$ 3,299	$ 1,207
Enterprise Infrastructure	$ -	$ 25,778	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TAC Fees	$ -	$ 40,317	$ -	$ -	$ -	$ -	$ -	$ -	$ -
TAC Fees - CARES Act	$ -	$ 53,032	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total Enterprise Portfolio	**$ 41,057**	**$ 2,782,340**	**$ 12,740**	**$ 781,684**	**$ 46,060**	**$ 2,071,193**	**$ 19,200**	**$ 2,250,495**	**$ 152,442**

1/ In 2022, Congressional Projects IRP will be funded by Recurring Expenses Transformational Fund
2/ See Appendix N for Cyber Security and Privacy & Records Management details

Appendix N: Information Security Details

Information Security Details (Dollars in Thousands)	2020 Actuals		2021 President's Budget		2021 Enacted		2022 Budget Request		2021-2022 Increase/ Decrease	
	Development	OM	Development	OM	Development	OM	Development	OM	Development	OM
CRISP Operations	$ -	$ 81,723	$ -	$ 75,085	$ -	$ 75,085	$ -	$ 51,129	$ -	$ (23,956)
Information Security Operations	$ -	$ 102,985	$ -	$ 102,885	$ -	$ 102,885	$ -	$ 127,743	$ -	$ 24,858
Cybersecurity Implementation Strategy	$ -	$ 28,102	$ -	$ 60,870	$ -	$ 60,870	$ -	$ 60,000	$ -	$ (870)
Cybersecurity Implementation Strategy - CARES Act	$ -	$ 20,487	$ -	$ -	$ -	$ 17,263	$ -	$ -	$ -	$ (17,263)
Network Operations Security[1/]	$ -	$ 1,004	$ -	$ 2,400	$ -	$ 2,400	$ -	$ 1,536	$ -	$ (864)
Information Security Policy and Strategy	$ -	$ 43,580	$ -	$ 30,617	$ -	$ 30,617	$ -	$ 45,340	$ -	$ 14,723
Privacy & Records Management	$ -	$ 22,585	$ -	$ 38,447	$ -	$ 38,447	$ -	$ 42,000	$ -	$ 3,553
Cyber Security	$ 16,600	$ 23,346	$ 11,380	$ 19,800	$ 11,380	$ 19,800	$ 11,200	$ 21,800	$ (180)	$ 2,000
Subtotals	**$ 16,600**	**$ 323,812**	**$ 11,380**	**$ 330,104**	**$ 11,380**	**$ 347,367**	**$ 11,200**	**$ 349,548**	**$ (180)**	**$ 2,181**
TOTAL Development and OM	**$**	**340,412**	**$**	**341,484**	**$**	**358,747**	**$**	**360,748**	**$**	**2,001**

1/ In 2020, programs within Network Operations Security such as Network Operations Center (NOC), Business Continuity Support (COOP), and Field Security Services were aligned to Information Security. In 2021, the decrease of Network Operations Security Program is a result of NOC being reclassified as a Delivery program and supports IT Infrastructure. COOP and Field Security Services remain aligned to Information Security

Appendix O: IT Investments by Portfolio

Portfolio	Investment Type	Unique Investment Identifier (UII)	2020 Actuals				2021 Current Estimate				2022 Budget Request			
.			DME	OM	RA	FTE	DME	OM	RA	FTE	DME	OM	RA	FTE
HEALTH			**$ 212,547**	**$ 1,743,102**	**$ 723**	**613**	**$ 321,715**	**$ 3,078,388**	**$ 9,839**	**817**	**$ 254,281**	**$ 3,176,118**	**$ 2,200**	**969**
Access to Care	Major	029-555555300	$ 4,880	$ 29,297	$ -	42	$ 7,600	$ 46,557	$ -	45	$ 2,146	$ 37,758	$ -	19
Health Data & Information	Major	029-555555301	$ 37,670	$ 62,495	$ -	230	$ 29,813	$ 97,970	$ -	254	$ 20,648	$ 136,599	$ -	125
Health Management Platform	Major	029-555555302	$ 124,780	$ 92,151	$ 723	148	$ 94,726	$ 189,864	$ -	154	$ 109,705	$ 197,013	$ 2,200	308
Electronic Health Record Modernization (EHRM)	Major	029-555555305	$ -	$ 1,510,029	$ -	114	$ -	$ 2,607,000	$ -	282	$ -	$ 2,663,000	$ -	337
Supply Chain Management	Major	029-777777502	$ 22,968	$ 14,952	$ -	19	$ 169,168	$ 46,201	$ -	20	$ 80,631	$ 32,764	$ -	42
Other Medical IT Systems	Non-Major	029-555555306	$ 21,561	$ 32,463	$ -	52	$ 16,631	$ 86,829	$ -	54	$ 31,002	$ 86,732	$ -	100
Health Research	Non-Major	029-555555303	$ 686	$ 1,714	$ -	8	$ 3,778	$ 3,966	$ 9,839	8	$ 10,148	$ 22,252	$ -	38
BENEFITS			**$ 230,420**	**$ 160,398**	**$ 58,503**	**285**	**$ 252,597**	**$ 115,416**	**$ 61,666**	**304**	**$ 123,948**	**$ 226,274**	**$ 49,636**	**497**
Benefits Appeals	Major	029-666666400	$ 9,322	$ 7,450	$ -	6	$ 6,329	$ 5,508	$ -	6	$ 3,838	$ 11,436	$ -	19
Benefits Payments	Major	029-666666401	$ 39,239	$ 5,344	$ -	23	$ 22,074	$ 2,327	$ -	24	$ 17,271	$ 8,333	$ -	74
Veterans Benefits Management	Major	029-666666402	$ 35,875	$ 53,433	$ -	32	$ 40,871	$ 45,540	$ 7,755	27	$ 23,013	$ 66,277	$ -	67
Customer Relationship Management	Major	029-666666404	$ 113,809	$ 51,890	$ -	66	$ 99,714	$ 33,531	$ -	69	$ 28,950	$ 103,548	$ -	219
Other Benefits IT Systems	Non-Major	029-666666403	$ 32,174	$ 42,281	$ 58,503	158	$ 83,609	$ 28,511	$ 53,911	178	$ 50,876	$ 36,679	$ 49,636	118
CORPORATE			**$ 81,900**	**$ 395,557**	**$ 3,582**	**470**	**$ 123,429**	**$ 601,475**	**$ 2,970**	**601**	**$ 107,632**	**$ 701,480**	**$ 3,920**	**559**
Financial Management	Major	029-777777501	$ 59,454	$ 11,331	$ -	6	$ 98,003	$ 20,951	$ -	6	$ 107,340	$ 20,802	$ -	36
Other Corporate IT Systems	Non-Major	029-777777503	$ 22,445	$ 35,916	$ 594	115	$ 25,426	$ 103,052	$ 593	122	$ 292	$ 90,756	$ 634	22
VA Franchise Fund_IT Spending	Non-Major	029-777777212	$ -	$ 154,708	$ -	-	$ -	$ 187,761	$ -	-	$ -	$ 232,320	$ -	-
eGov LoB Benefits.Gov	Non-Major	029-444440020	$ -	$ 335	$ -	-	$ -	$ 347	$ -	-	$ -	$ 334	$ -	-
eGov LoB E-Rulemaking	Non-Major	029-444440060	$ -	$ 205	$ -	-	$ -	$ 218	$ -	-	$ -	$ 270	$ -	-
eGov LoB Grants.gov	Non-Major	029-444440160	$ -	$ 143	$ -	-	$ -	$ 150	$ -	-	$ -	$ 152	$ -	-
eGov LoB Integrated Award Environment	Non-Major	029-444440230	$ -	$ 2,731	$ -	-	$ -	$ 2,731	$ -	-	$ -	$ 2,731	$ -	-
eGov LoB Financial Management	Non-Major	029-444441100	$ -	$ 159	$ -	-	$ -	$ 159	$ -	-	$ -	$ 159	$ -	-
eGov LoB Human Resources Management	Non-Major	029-444441200	$ -	$ 274	$ -	-	$ -	$ 274	$ -	-	$ -	$ 274	$ -	-
eGov LoB Geospatial	Non-Major	029-444443100	$ -	$ 25	$ -	-	$ -	$ 25	$ -	-	$ -	$ 25	$ -	-
eGov LoB Budget Formulation and Execution	Non-Major	029-444443200	$ -	$ 110	$ -	-	$ -	$ 120	$ -	-	$ -	$ 120	$ -	-
eGov LoB Disaster Assistance Improvement Plan	Non-Major	029-444444100	$ -	$ 61	$ -	-	$ -	$ 66	$ -	-	$ -	$ 66	$ -	-
Corporate IT Support ITRM	Non-Major	029-777777015	$ -	$ 189,560	$ 2,988	349	$ -	$ 285,621	$ 2,377	473	$ -	$ 353,471	$ 3,286	501
ENTERPRISE			**$ 993,357**	**$ 3,272,157**	**$ 26,435**	**6,561**	**$ 1,097,406**	**$ 3,377,472**	**$ 30,525**	**7,699**	**$ 754,154**	**$ 3,025,279**	**$ 32,356**	**7,032**
Enterprise Data Services	Major	029-888888601	$ 123,496	$ 359,337	$ 2,679	330	$ 107,039	$ 219,428	$ 904	90	$ 19,583	$ 233,778	$ 964	63
Enterprise Security Services	Standard	029-888888600	$ 88,782	$ 337,282	$ -	451	$ 97,262	$ 374,800	$ -	587	$ 70,838	$ 378,744	$ -	592
EPMO Enterprise Support	Standard	029-888888610					$ -	$ 99,330	$ 2,585	272	$ -	$ 63,372	$ 2,627	19
IT Operations Enterprise Infrastructure	Standard	029-888888602	$ 172,794	$ 364,606	$ -	379								
IT Operations Network	Standard	029-888888603	$ 69,020	$ 352,729	$ 1,165	426	$ 166,585	$ 317,317	$ 1,283	297	$ 155,458	$ 321,096	$ 1,170	321
IT Operations Data Center and Cloud	Standard	029-888888604	$ 1,593	$ 287,006	$ -	1,232	$ 50,000	$ 206,430	$ -	299	$ 98,000	$ 147,548	$ -	339
IT Operations Platform	Standard	029-888888608					$ -	$ 114,140	$ -	511	$ -	$ 124,346	$ -	555
IT Operations End User	Standard	029-888888605	$ 537,672	$ 1,571,196	$ 22,591	3,743	$ 657,838	$ 1,130,701	$ 25,753	3,896	$ 354,615	$ 886,826	$ 27,595	3,322
IT Operations Application	Standard	029-888888606					$ -	$ 765,621	$ -	1,035	$ -	$ 725,052	$ -	1,107
IT Operations Delivery	Standard	029-888888607					$ 18,682	$ 149,705	$ -	712	$ 55,660	$ 144,517	$ -	714
MEMORIAL AFFAIRS			**$ 15,146**	**$ 10,978**		**13**	**$ 19,713**	**$ 10,337**		**15**	**$ 23,418**	**$ 15,536**		**46**
Memorials Automation	Major	029-666666700	$ 15,146	$ 10,978	$ -	13	$ 19,713	$ 10,337	$ -	15	$ 23,418	$ 15,536	$ -	46
		TOTAL	**$ 1,533,370**	**$ 5,582,194**	**$ 89,243**	**7,942**	**$ 1,814,860**	**$ 7,183,088**	**$ 105,000**	**9,436**	**$ 1,263,433**	**$ 7,144,687**	**$ 88,112**	**9,103**
TOTAL REPORTED in VA IT PORTFOLIO (Exhibit 53)			**$ 7,204,806**			**7,942**	**$ 9,102,948**			**9,436**	**$ 8,496,232**			**9,103**

Notes: 1) The table above reflects the OIT investment structure for 2020, 2021 and 2022. Per OMB guidance, it reflects (all funding sources (Budget Authority (BA) – Pay and Non-Pay, Reimbursements (RA), E-Gov Initiatives and Franchise Fund_IT Spending). The information in the table gets submitted to the OMB IT Dashboard; (2) The DME column combines Development, Sustainment Modernization and Sustainment Enhancements (shown separately in the Operations and Maintenance appendix).

Appendix P: TBM Matrix

2020 IT Investment Portfolio TBM Matrix												
(Dollars in Thousands)		IT Towers										
		Data Center	Compute	Storage	Network	Platform	End User	Application	Delivery	Security & Compliance	IT Management	Grand Total Cost Pool
Cost Pools	Internal Labor	322	12,857	12,494	32,672	30,174	476,043	311,856	63,555	134,723	280,970	**1,355,666**
	External Labor	27,171	372,123	56,067	71,875	32,297	21,957	703,942	72,556	151,098	212,207	**1,721,294**
	Outside Services		16,391	13,401	56,818	18,908	80,398	389,066	14,737	20,775		**610,493**
	Hardware		10,780	4,919	211,532	1,445	230,709	20,015	650	6,274	120,398	**606,723**
	Software	42	2,798	1,276	19,208	4,670	271,508	721,316	1,467	4,591	193	**1,027,071**
	Facilities & Power				885							**885**
	Telecom			134	384,734		1,739	1,628		590		**388,824**
	Other						149				1,489,659	**1,489,808**
	Internal Services										4,043	**4,043**
	Grand Total IT Towers	**27,535**	**414,949**	**88,291**	**777,725**	**87,494**	**1,082,502**	**2,147,823**	**152,966**	**318,052**	**2,107,470**	**7,204,806**

Note: The 2020 VA IT Investment Portfolio total amount of $7,204.806 million includes the following funding sources:
1) OIT Budget Actuals in the amount of $4,274.764 million plus $89.242 million in Reimbursable.
2) CARES Act Actuals in the amount of $1,176.062 million.
3) OEHRM budget Actuals in the amount of $1,510.029 million.
4) Franchise Funds Actual Spending in the amount of $154.709 million.

2021 IT Investment Portfolio TBM Matrix												
(Dollars in Thousands)		IT Towers										
		Data Center	Compute	Storage	Network	Platform	End User	Application	Delivery	Security & Compliance	IT Management	Grand Total Cost Pool
Cost Pools	Internal Labor	3,108	16,487	23,489	33,738	38,307	493,254	297,613	75,338	191,494	344,091	**1,516,919**
	External Labor	3,982		5,922		1,473		336,330	6,529	75,888	370,057	**800,181**
	Outside Services	38,045		56	104,263	19,536	178,699	347,103	18,682	193,725	52,111	**952,220**
	Hardware		153,999	74,461	1,323	43,231	444,504			17,328		**734,846**
	Software			1,117			407,445	1,532,980	54,597	10,804	36,299	**2,043,242**
	Telecom				443,744		10,002	7,319				**461,065**
	Other			591				14,985			2,574,808	**2,590,384**
	Internal Services										4,090	**4,090**
	Grand Total IT Towers	**45,136**	**170,486**	**105,637**	**583,068**	**102,547**	**1,533,903**	**2,536,329**	**155,147**	**489,239**	**3,381,456**	**9,102,948**

Note: The 2021 VA IT Investment Portfolio total amount of $9,102.948 million includes the following funding sources:
1) OIT Enacted Budget in the amount of $4,912 million plus $105 million in Reimbursable.
2) Unobligated balance brought forward, Oct 1 in the amount of $172.249 million.
3) CARES Act unobligated balance brought forward, Oct 1 in the amount of $973.938 million.
4) VHA CARES Act transfer of $45 million
5) American Rescue Plan Act [P.L. 117-2 Section 8003] in the amount of $100 million.
6) OEHRM Budget Estimate in the amount of $2,607 million.
7) Franchise Funds Spending Projection in the amount of $187.761 million.

2022 IT Investment Portfolio TBM Matrix												
(Dollars in Thousands)		IT Towers										
		Data Center	**Compute**	**Storage**	**Network**	**Platform**	**End User**	**Application**	**Delivery**	**Security & Compliance**	**IT Management**	**Grand Total Cost Pool**
Cost Pools	**Internal Labor**	2,638	22,855	30,177	39,423	47,337	413,028	313,399	83,354	137,528	270,677	**1,360,416**
	External Labor			6,529			566	273,800	17,086	74,864	498,620	**871,465**
	Outside Services				12,676	20,514	90,361	253,623	55,660	82,164	73,240	**588,238**
	Hardware		189,414			43,000	407,316			13,643		**653,373**
	Software						244,004	1,503,664	39,866	63,495	53,236	**1,904,265**
	Telecom				430,456			9,226				**439,682**
	Other									21,861	2,617,733	**2,639,594**
	Internal Services										4,130	**4,130**
	Facilities & Power	830					1,535	339		85	32,280	**35,069**
	Grand Total IT Towers	**3,468**	**212,269**	**36,706**	**482,555**	**110,851**	**1,156,810**	**2,354,051**	**195,966**	**393,640**	**3,549,917**	**8,496,232**

Note: The 2022 VA IT Investment Portfolio total amount of $8,496.232 million includes the following funding sources:

1) OIT Budget Request in the amount of $4,842.800 million plus $88.112 million Reimbursable.
2) Recurring Expenses Transformational Fund in the amount of $670 million.
3) OEHRM Budget Request in the amount of $2,663 million.
4) Franchise Funds Spending Projection in the amount of $232.320 million.

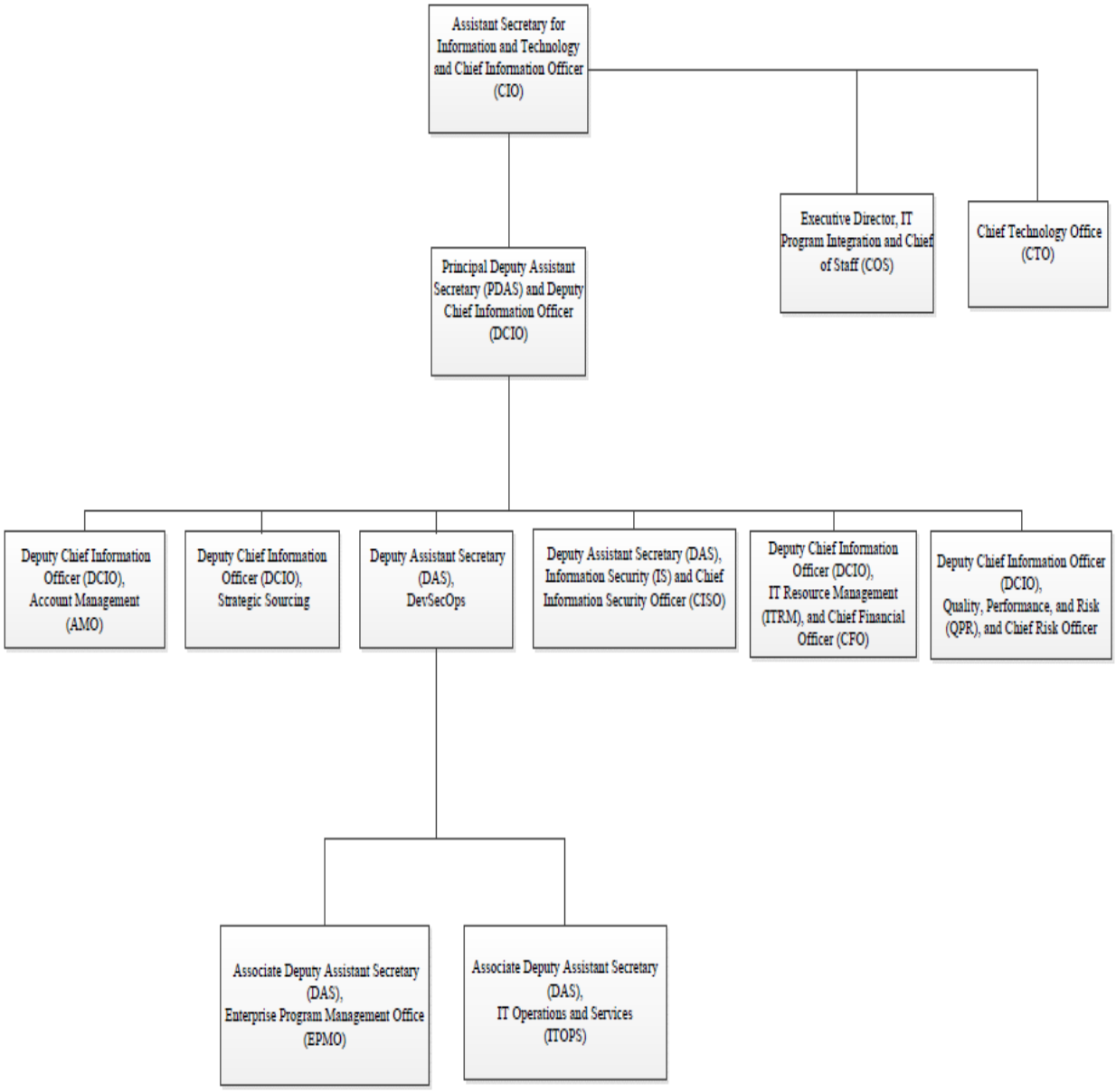
Appendix Q: IT Systems Appropriations History

(Dollars in thousands)

	Budget Request to Congress	Appropriation	FTE
2009	2,442,066	2,539,391 1/	6,710
2010	3,307,000	3,307,000	6,853
2011	3,307,000	2,993,604 2/	7,004
2012	3,161,376	3,111,376	7,311
2013	3,327,444	3,323,053	7,362
2014	3,683,344	3,703,344	7,291
2015	3,903,344	3,902,278	7,419
2016	4,133,363	4,133,363	7,745
2017	4,278,259	4,270,259	8,334 3/
2018	4,055,500	4,055,500	7,899
2019	4,184,571	4,103,000	8,138
2020	4,343,000	4,371,615	7,890
2021	4,912,000	4,874,500	8,251
2022	4,842,800		8,766

Note: The Information Technology Systems account was established in P.L.109-114.
FTE includes Reimbursements.
1/Includes $50 million in emergency funding provided in P.L.111-5.
2/The 2011 appropriation was $3.141 billion (including ATB rescission) with an additional $147 million in unobligated balances rescinded.
3/ FTE includes VACAA FTE funded by the IT Appropriation.

Appendix R: Office of Information Technology Organization Chart



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